

Emergency access

*Clinical case for change: Report by Sir George Alberti,
the National Director for Emergency Access*



Emergency access

If your life is threatened, Sir George Alberti, the National Director for Emergency Access, wants you to be given the right treatment at the right time in the most appropriate place.

Choices

When he was bitten by a farm dog while walking home in the Lake District, the walker had a choice.

Did he get in his car and drive 45 minutes to Carlisle Hospital's accident and emergency (A&E) department and then wait to be seen and treated, or did he go down the road to Keswick community hospital's minor injuries unit?

The walker opted for Keswick and, although it did not have the full panoply of A&E services, his wound was dressed, he had his anti-tetanus shot, and he was back home, three miles away, in the time it would have taken him to drive to Carlisle.

But what if the walker – who in this case was actually me – had collapsed with a heart attack? Keswick does not have an A&E department so surely his life would be seriously endangered travelling 45 minutes to Carlisle?

Probably not, if I had a heart attack on Scafell Pike, rather than a dog bite, I would want to go somewhere where I could have the state of the art treatment – and that wouldn't even be in Carlisle – it would be a trip by a land, or possibly even air, ambulance straight to James Cook Hospital, Middlesbrough. The same would apply if I lived in Durham or Stockton, where there are perfectly good standard A&E departments.

I spend a lot of time walking in the Lake District thinking about these questions, and being bitten by a dog confirmed to me the advantages of having a choice of emergency care and local services for less serious problems.



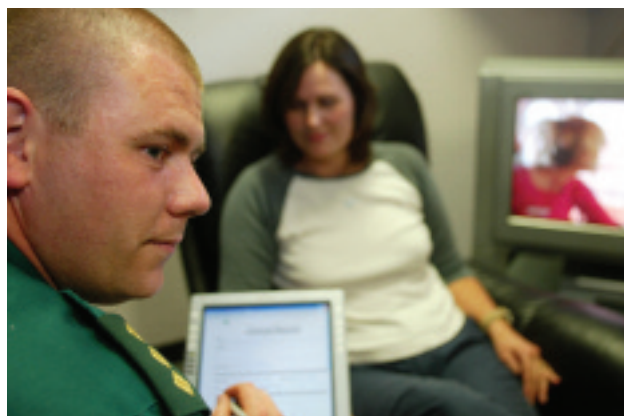
Safe, high-quality care

Care for emergencies is good, and indeed there has been a transformation in A&E departments over the past five years. However, medicine is continually evolving and there have been recent major developments and improvements in care for serious emergencies – a message that has not yet been transmitted properly to the public. With increasing specialisation, we need to ensure that people are seen quickly by an experienced doctor or health professional, whatever the time of day and then go straight to the appropriate specialist if necessary. This is beginning to happen in A&E departments, as the number of A&E consultants expands. For life-threatening emergencies, this means having teams of specialists available 24 hours a day, seven days a week.

The NHS has always responded to the latest treatments by organising itself to deliver that care: specialist cancer surgery is undertaken in cancer centres, paediatric intensive care is provided by specialist children's services. And A&E has also moved with the times. If you have a rupture of a major blood vessel, you need an experienced vascular surgeon, radiologist and theatre team, rather than generalists who have less experience of such operations, for this reason your local A&E probably transfers patients to a vascular centre. Similarly, very serious head and chest injuries are likely to be transferred to a specialist centre. All of these changes have improved the quality of emergency care for patients even though they have moved services out of the local hospital.

Technology is making it possible for the NHS to dramatically improve the life chances of patients suffering medical emergencies provided we organise services to meet the challenge. As Professor Boyle explains in his paper, "Mending Hearts and Brains", the right care for strokes is to have a CT brain scan within three hours, followed by aggressive rehabilitation with thrombolysis in appropriate cases. Few places can provide this on a 24-hour basis.

We have to be upfront and tell the public that, in terms of modern medicine, some of the A&E departments that they cherish are not able to provide this type of care and cannot and will not be able to provide the degree of specialisation and specialist cover that modern



medicine dictates the public deserves. That means we have to change things so we can deliver safe, high-quality care to everyone who needs it, when they need it.

I believe the case for changing the way we provide urgent care – from a twisted ankle to a brain haemorrhage – is very clear.

This will mean some A&E departments redesigning their pathways as we centralise expertise to provide safer, quicker, more appropriate care for all.

In a range of very serious emergencies, from strokes and heart attacks to aortic aneurysms, it may be better for patients to bypass the nearest local hospitals and be taken by highly-trained paramedics straight to specialist centres with the equipment, knowledge and experience – gained through treating many similar patients needed to save lives.

At the moment, a patient is likely to be transported rapidly to their local A&E department, arriving in just a few minutes, but that is not a guarantee that the department will have the skills and equipment necessary for that person and their problems.

The changing face of emergency care

1948: Casualty departments – staffed by nurses and junior doctors. No night supervision by consultants. Medical and surgical admissions seen by a junior doctor then referred to the relevant team in the hospital.

1990s: A&E Departments, with waits of up to 12 hours to see a junior doctor common. Supervision by senior house officers.

2001: Publication of Reforming Emergency Care leading to the establishment of Emergency care networks and the Emergency Care Collaborative. Emergency care teams established in trusts to find new ways of improving care. See and Treat introduced to help meet the four-hour waiting time target and run by emergency nurse practitioners. Paramedic and nurse emergency care practitioners now treat and assess patients on the spot.

Emergency care in numbers

18.8 million attendances at A&E departments in 2005/06, of which:

- ~ 72% at major A&E departments
- ~ 3% at single specialty units
- ~ 24% at minor injury units/walk-in centres.

In July–September 2006, 3.5 million patients attended major A&E departments, but only 0.7million (21%) were admitted to hospital.

6.0 million 999 ambulance calls during 2005/06

Sources: Department of Health, QMAE; Information Centre for health and social care, KA34

Every service cannot be offered by every A&E department – it never has been, and never can be – so it makes sense to create networks of care with regional specialist centres to give the best possible treatment to the sickest people.

“But won’t I die on the way?” many people ask. No, you won’t. As Roger Boyle, the National Director for Heart Disease, can confirm, long ambulance journeys do not lead to more deaths.

If they did, patients in America and Australia, where ambulance journeys are much longer, would have higher mortality rates.

We will have to continue to ensure that the ambulance services can all offer “hospital on the move” support to patients. There will be many more paramedics (and nurses) trained to treat people at home and stabilise a patient’s condition for longer journeys, when those



journeys need to be made. In some areas we will make greater use of air ambulances to move patients to specialist units, but in many parts of the country we are simply talking about going directly by road to the specialist facilities at another acute hospital.

However, the changes to local A&E services are not just about the specialist cases, they are also about the opportunity that technology gives us to provide more convenient care, closer to home.

Very few of the people who attend A&E departments have life-threatening conditions. Some are in pain, others are just uncertain. For these people we want to offer more convenient and appropriate care closer to home. This ranges from immediate telephone access to information, assessment and advice on self-care or the best place to seek further help, to home visits and access to centres of care.

Currently a person with an immediate medical need 'out of hours' very often ends up in an A&E department. During the day, Monday to Friday, many, of course, go to their GP. This is an essential and effective service that must continue. But outside that, we want to provide a pyramid of accessible urgent care facilities, that includes GP out-of-hours services, pharmacies, social services, mental health teams, urgent care centres (minor injury units and walk-in centres) and the voluntary sector. Many of these services are in place already, but we want to make it more consistent, and more integrated, across the country.

At the apex of the pyramid therefore, are specialist services for less common conditions, such as severe burns, followed by regional acute hospitals with 24-hour consultant cover in all necessary specialties and access to state-of-the-art diagnostic equipment.

These larger A&E departments, or 'super A&Es', as I'm sure the media will call them will be able to cope with virtually all emergencies. This includes major trauma, vascular surgery,

primary angioplasty for heart attacks and immediate CT scans for strokes and head injuries. They will also probably serve larger 'catchment areas' or populations than current A&E departments.



Local A&E departments will assess, and treat where appropriate, medical and surgical cases with a comprehensive staff of consultants and other experienced clinical staff.

Increasingly many of the patients who currently attend A&E but who do not need the full services of an acute hospital will be dealt with in an urgent care centre – currently called either a walk-in centre or a minor injury unit, either on the hospital site or in a community setting. They will have agreements with other hospitals in a regional network to ensure that all emergencies are covered.

This is how your current A&E department might change, but it is only a small part of the configuration story.

One goal is to get very quick access to specialist services for the very sick; the other is to treat people more quickly and conveniently closer to home, where this is consistent with safety and good quality care.

We want to have more nurses, paramedics and emergency care practitioners (ECP) (nurses or paramedics with additional training) assessing and treating people in their home or workplace.



They are treating patients and are linked to GP out-of-hours services in some parts of the country as well as responding to 999 calls.

That means that, if you cut your hand in the kitchen, an emergency care practitioner or paramedic could arrive and dress the wound there and then organise a follow-up GP appointment.

Alternatively, they could reassure an elderly person who has fallen and make sure they receive a follow-up visit by an appropriate professional the next day. That has to be better than waiting, for example, two to four hours in an A&E department.

Patient feedback, pilots and studies suggest that this type of service is appreciated by the public and that ambulance services could take one million fewer patients to hospital, reducing A&E attendances and emergency admissions.

For the majority of people, care is still going to be as local as it ever was. Major emergencies affect a relatively small number of people. For most people, care will continue to be as local – or indeed more local – than ever.

Older people concerned about being taken too far away from their family should in fact benefit, as receiving immediate state of the art specialist care can lead to shorter lengths of stay in hospital.

This new dimension is also being addressed by Professor Ian Philp, the National Director for Older People, who is advocating intermediate care in the community where patients can be assessed by GPs, social services and geriatricians, and rehabilitation, when needed, can be started immediately.

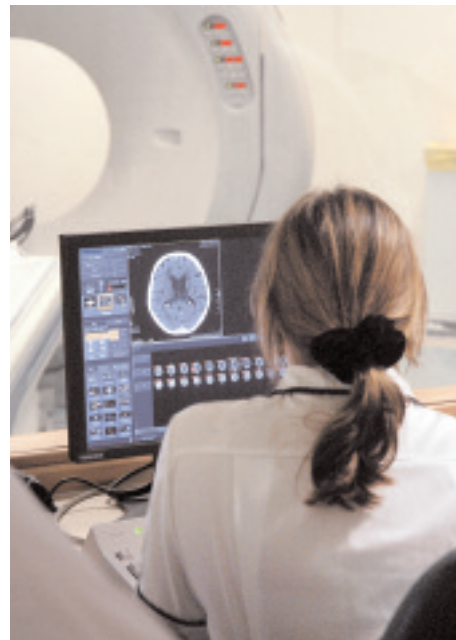
Another vital aspect of this work is the prevention of emergency admissions, a large number of which occur in older people. This is why the work of falls services, respiratory disease workers and heart failure nurses can make an enormous difference.



The twin pressures brought about by new technology, whereby specialist facilities are required to deliver the best outcomes to some patients, whereas other patients can be cared for at home or in the community, avoiding the need for hospitalisation at all, requires us to rethink the role of the local A&E. We cannot have a position whereby patients are being denied access to life saving treatment in a specialist centre or being admitted to hospital unnecessarily in a mistaken attempt to protect local services in an unchanged state.

The public, and some clinicians, are deeply concerned about the suggested reconfiguration of services. We have to explain these changes earlier and I really believe we can allay most of their concerns. Clinicians do understand what we are proposing, but sometimes it does not sit comfortably with them, particularly if the change agenda is simultaneous with responses to financial pressures.

Finances may have been the issue that drew the media's attention, but they are not the reason for reform. Reforming emergency care is about responding to medical advances and providing new and better services in ways that allow the NHS to save more lives.





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