South Warwickshire NHS
NHS Foundation Trust

Warwickshire Health and Wellbeing Board

20 January 2014

Response to the Keogh Report on Accident and Emergency

1. Recommendations

1.1 The Warwickshire Health and Wellbeing Board is asked to note the response from South Warwickshire NHS Foundation Trust in relation to the vision set out in the Keogh plan for 'Transforming Urgent and Emergency Care Services in England'. The Health and Wellbeing Board are also asked to note the Trust's improved performance in this area and the consequential closure of the recent Monitor investigation.

2. Key Issues

2.1 National Policy

2.1.1 The proposals suggest a fundamental shift in how urgent care is to be provided, with more extensive services outside hospital and patients who have more serious or life threatening conditions being treated in centres that have the appropriate clinical teams, expertise and equipment.

2.1.2 The blueprint is the first stage of a review led by Prof. Sir Bruce Keogh, Medical Director of NHS England. Sir Bruce explains in his three to five year 'blueprint' that he feels that changes are necessary and are "the only way to create a sustainable solution and ensure future generations can have peace of mind that, when the unexpected happens, the NHS will still provide a rapid, high quality and responsive service free at the point of need".

2.1.3 The plans will keep patients who do not need emergency treatment out of hospitals. Under the plans Accident & Emergency Departments will be divided into a **two distinct types**. This will take the form of 70 'major emergency centres' which will treat patients who have the most serious conditions; and 100 other centres that will manage patients thought to have less serious injuries. In addition more patients will be treated over the phone, at pharmacies or by paramedics.

2.1.4 Commentators have pointed out that the reforms could see patients who suffer heart attacks and strokes travelling further from home by ambulance in order to access specialist care, which Keogh said cannot be safely provided alongside every casualty unit.

2.1.5 The report puts forward the following proposals in five key areas:

- Providing better support for people to self-care.
- Helping people with urgent care needs to get the right advice in the right place, first by enhancing the NHS 111 service and by creating a 24 hour, personalised priority contact service. Allowing them to speak directly to a

nurse, doctor or other healthcare professional if that is the most appropriate way to provide the help and advice they need.

- Being able to directly book a call back from, or an appointment with, a GP or at whichever urgent or emergency care facility can best deal with the problem.
- Providing highly responsive urgent care services outside of hospital to avoid unnecessary A&E attendance including faster and consistent same-day, every-day access to general practitioners, primary care and community services. Also harnessing the skills, experience and accessibility of community pharmacists; developing the 999 ambulance service into a mobile urgent treatment service capable of treating more patients at scene so they don't need to be conveyed to hospital to initiate care.
- Ensuring that those people with more serious or life threatening emergency needs receive treatment in centres with the right facilities and expertise in order to maximise chances of survival and a good recovery. The NHS will introduce two types of hospital emergency department with the current working titles of Emergency Centres and Major Emergency Centres (around 40-70 nationally). Emergency Centres will be capable of assessing and initiating treatment for all patients and safely transferring them when necessary. Major Emergency Centres will be much larger units, capable of not just assessing and initiating treatment for all patients but providing a range of highly specialist services. The overall number of Emergency Centres – including Major Emergency Centres – carrying the red and white sign will be broadly equal to the current number of A&E departments.
- Building on the success of major trauma networks, the NHS will develop broader emergency care networks. These will dissolve traditional boundaries between hospital and community-based services and support the free flow of information and specialist expertise. They will ensure that no contact between a clinician and a patient takes place in isolation.

2.2 <u>Local Implications – South Warwickshire NHS Foundation Trust</u>

2.2.1 In other parts of the country many of the recommendations made regarding secondary care will change the configuration of local hospital services but in the case of Coventry and Warwickshire, these arrangements are **broadly already in place**. In particular, we have already implemented centralised models (centred around University Hospitals Coventry and Warwickshire NHS Trust) for hyper-acute stroke care, major trauma and for the treatment of heart attacks.

2.2.2 The Trust has been involved in some national development work looking at creating better emergency care across hospital and community settings. A major report was published by the Health Foundation in April of last year entitled **'Improving patient flow'** which was the result of a three year study of a change problem at Warwick Hospital and Sheffield hospitals. The premise of the work was to ensure that we did "today's work today", reducing delays and speeding up clinical processes. We demonstrated that by focussing on immediate tasks, we improved quality and reduced length of stay. In our case we extended some of this thinking into community services and developed services such as the Community Emergency Response Team (CERT) who offer a 2 hour response to speed up discharge and to offer alternatives to admission. Our work is now being replicated in Wales, Scotland and Northern Ireland and was used as evidence to support the original Keogh review.

2.2.3 The hospital based solutions included the development of **7 day working** which has now been adopted as one of Sir Bruce's key "ambitions". As a consequence we now have a consultant Physician supported by consultant Radiology back-up on site over the entire week and closely monitor process flow. At ward level we have moved to single consultants working "hot" weeks, so that they are available to manage patient throughout the entire week, improving on the timeliness and continuity of decision making. We have also improved the frail elderly pathway ensuring that patients get the right specialist assessment during the early part of their stay.

2.2.4 The result of these programmes has been that the Trust has seen a reduction in mortality and length of stay and has now achieved the 4 hour A&E standard in each of the last 7 months, with the latter resulting in **Monitor closing its investigation** into previous breaches of the target. The focus on productivity has also ensured that these results have been achieved whilst being the only acute provider in the local area to be able to operate at below national tariff cost.

3. Conclusions

3.1 The Warwickshire Health and Wellbeing Board is asked to receive and note this report.

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