PATIENTS' FORUM

FOR THE LONDON AMBULANCE SERVICE

TRANSFORMING EMERGENCY CARE IN THE NHS

Report on Joint Public Meeting

Tuesday, 15 March 2023

Speaker

DR. KATHERINE HENDERSON

Immediate Past President, Royal College of Emergency Medicine (RCEM)

Meeting held jointly between
Patients' Forum for the LAS
and
Healthwatch Hackney

DR. KATHERINE HENDERSON

Dr Henderson has been a Consultant in Emergency Medicine (RCEM) for over 20 years and was until recently President of the RCEM. She has been the Clinical Lead at both the Homerton Hospital and St Thomas' and led St Thomas's ED through a major expansion of the Emergency Department (ED) and its consultants, in response to significantly increased demand for emergency care.

HEALTHWATCH HACKNEY

Healthwatch Hackney is the local health and care watchdog, with statutory powers to monitor the NHS and adult social care. Its vision is for a borough where health and social care provision is equal and accessible to all; where residents are at the heart of the design, delivery and improvement of health and adult social care.

The ambition of Healthwatch is to improve health and social care provision and outcomes for people in Hackney by working to ensure that both treatment and care are of the highest quality, and are provided with respect and dignity, valuing diversity, encouraging participation and working together. It does this by being the independent champion for residents and people who use services, ensuring the voices of people across the Borough are heard, in order to influence decision makers.

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PATIENTS' FORUM FOR THE LONDON AMBULANCE SERVICE

The Patients' Forum has monitored the LAS and other urgent and emergency care services across London for 20 years.

Its members are local people who examine services both as users and active lay people. It obtains the information it needs to monitor health services from many sources including the LAS, the Commissioners and NHS service providers across London.

The Forum raises awareness of the needs and views of patients and the public and attempts to place them at the centre of health service decision-making.

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RESUSCITATING THE A&E SERVICE

Dr Henderson opened the Meeting by saying that her presentation is about resuscitating the ED service to a level that we have a right to expect.

Very basic covenants have been broken in the NHS. The basic one is that if you were in trouble, and an ambulance was needed - and you have rung 999 - an ambulance would arrive quickly. It is hard to believe that this is now not the case and, therefore, a most startling failure of the NHS system!

Dr Henderson referred to a Private Eye joke published recently about people at a funeral, standing beside a gravestone with RIP written on it. The joke was that '*the ambulance had only just turned up*'.

Five years ago, when presenting at City Hall, this joke would not have made sense! Today, long waits for ambulances are the norm.

For patients who do need the services of an A&E Department and an ambulance, these headlines do not inspire confidence and can cause great alarm.

Many people are frightened at the thought of lying injured and not being able to get an ambulance, or getting to hospital and being in the back of an ambulance waiting on a ramp to get in, or lying on a trolley in a corridor for hours.

People who are very vulnerable and do need to go to hospital are frightened. The dilemma is getting the message out to the public that there is a major problem in our EDs, and the concern that by sharing the message we scare people.

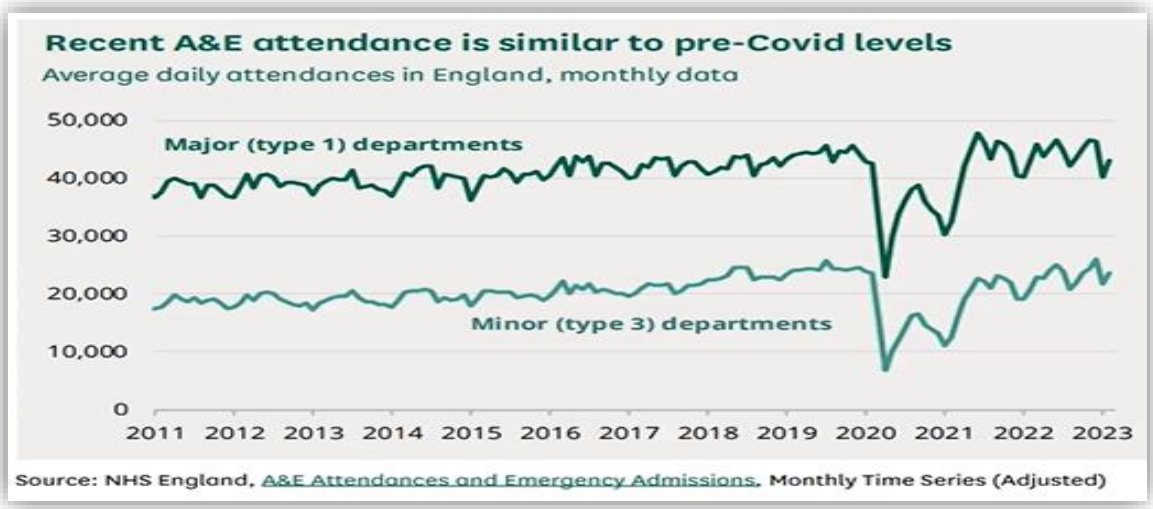
I was the RCEM's President until October 2022, and we were always aware of our responsibility to the public when saying that we were committed to significantly improving this service. We recognise that NHS emergency services are in trouble - but we do not wish to put people off who need to come to hospital.

QUESTIONS POSED BY THE PATIENTS' FORUM

1. With reports of excess deaths in A&E, how should emergency care be transformed so that we can return to maximum 4 hour waits?
2. How can we stop patients waiting in ambulances for hours outside A&E, instead of the contractual 15-minute handover target?
3. Are more beds the solution, and if we had them, do hospitals have the staff needed to care for patients in expanded 'emergency care units'?
4. Are local step-down facilities part of the answer, in order to get patients discharged more quickly and efficiently?
5. How do we hold Local Authorities and the Government to account for providing effective social care and enabling faster discharge? Is low pay the problem?

A&E ATTENDANCES

There is plenty of data about Emergency Care which is publicly available. There was a drop off in attendances during the Covid Pandemic, but attendances are now similar to pre-Covid levels.



THE 4-HOUR ACCESS TARGET

The 4-hour access target – that you would be 'seen and sorted', or 'admitted or discharged' within 4 hours has deteriorated, year on year, since 2015. This problem is not specifcally related to the impact of Covid.

The access target came about because a decision was made to focus upon the patients' experience and safety issues - and achieving shorter waits in Emergency Departments.

This is an 'all type' emergency target that refers to:

- Type 1 Departments … … … Consultant-led
- Type 2 Departments … … … Specialist Departments eg: Eyes
- Type 3 Departments … … … Urgent Treatment Centres

There was considerable focus on achieving the 4 hour target and there was specific and quite significant investment to achieve it. The target is is not without problems, because not all patients fit into the bracket of people who ought to be seen and sorted within 4 hours. There are patients who benefit from being a bit longer in ED.

We have what is called the 'hockey stick effect' which is an incredible rush to admit people at 3.5 hours, with people running down corridors to achieve this target. There was a lot of interest in whether there should be some other metrics … and some of you may have been involved in this process.

NHS England set up a Clinical Review of Standards – not just in relation to A&E, but the only one to come through the full process has been in relation to Mental Health. The review relating to Emergency medicine involved quite a large number of different metrics. There were 14 pilot sites reporting on these new metrics.

There was a public consultation (https://tinyurl.com/bdhr3ymf) and it showed general support for saying that a single target has disadvantages. A single target metric is too blunt an instrument and only focusses on one part of the system. A bundle of metrics was suggested as a fairer approach in terms of performance management, and it would look at different parts of the system – primary care, ambulance operations, what happens in Emergency Departments and the flow through the rest of the hospital. However, it was quite a difficult concept to sell politically, because the 4-hour standard is a straightforward single number - you are either in or out of the system within 4 hours – whether you were an admitted or discharged patient, it made no difference.

It was difficult to distil a bundle of metrics into something that was easy to understand – for example something like a CQC ratings. In the end even though the bundle approach had the support of the RCEM, the people who engaged with the public consultation , NHS England and even seemingly the Department of Health, could never get it through No. 10.

We have not managed to get better metrics, and what we now have is an Emergency and Care Access Recovery Plan. This came out at the beginning of 2023, and now has a 76% 4-hour access target, instead of 95% - a huge drop. This 76% has to be achieved by the end of March 2024.

https://tinyurl.com/y7uw5twz

DEMAND AND CAPACITY

Why is there a problem, and why are we struggling so much? When running an Emergency Department, there is a fixed amount of space. Many other services are able to say that they 'are full and unable to take on any more patients'.

The problem with Emergency Departments is that it can never say that it is 'full'. It is very rare for an Emergency Department to close, and so people keep on coming. Unless there is flow out of Emergency Departments, space runs out. What we have seen in that twelve hour stays in Emergency Departments have gone up exponentially, as can be seen in the chart on page 9.

There are 2 types of 12 hour stays – the first has been reported for years - a 12-hour excess from DTA (Decision to Admit). – these are patients who are going to be admitted and a decision has been made accordingly. A performance clock starts and in the past there were very few breaches of 12 hours and this was considered a very serious breach that needed specific reporting and investigation.

The situation is that you may have patients stuck in cubicles in A&E for a very long period and you have to provide care for each patient until a bed is found. Therefore, you cannot get patients out of the waiting room to be seen in A&E, so there becomes a build-up of patients waiting for long periods to be seen.

There is a secret aspect to this, and this is about the 'decision to admit'. The patient could have been in the Department already for 8 hours before the decision to admit is made. We needed 'real data' from arrival to 12 hours.. This is the second and true 12 hour type of stay – from arrival not just from Decision to Admit. This data shows us the scale of the problem facing Emergency Departments. There are about 20 times as many patients from 0-12 hours, as from DTA to transfer to a hospital bed

Not getting patients out of the Emergency Department and getting other patients in, means a backup onto the ambulance service, leading to patients being stuck in the back of ambulances and other patients waiting in corridors to go to a ward. This means that you are running a ward in an Emergency Department, which is extremely dangerous, difficult and an awful patient experience.

If a patient is waiting in the back of an ambulance, the ambulance crew has to wait with them and, whilst giving a great level of supervision, they are not able to go back out into the community to provide care for patients who are seriously ill and needing emergency care. There was once an appalling picture of a man, with a suspected hip fracture, waiting 16 hours in his back garden for an ambulance to come, so his family constructed a tent to surround him.

Much faster flow is needed in Emergency Departments. They have become the bottleneck for all of these problems. What has caused these problems?

Over the last 2–3 years, there has been higher and higher occupancy of hospital beds. Traditionally, hospitals ran with a bed occupancy rate of below 92% - (RCEM feel it should be more like at 85%). There will not be beds in the right place and at the right time unless there is sufficient capacity.. One cannot predict surges. If hospitals are running at 96% or 98% capacity, there will always be long waits in the Emergency Department (ED).

Bed occupancy has increased. Just prior to Covid, the previous CEO of NHS England, agreed that there were too few beds. During Covid, things were a little bit different – demand was different. Coming out of Covid, we are back to a major bed capacity problem. The NHS managed to get more beds last winter and it is hoped that this will happen again next winter. But more hosital beds is only half the story.

The problem is that the patients 'medically fit for discharge' figures are much worse.

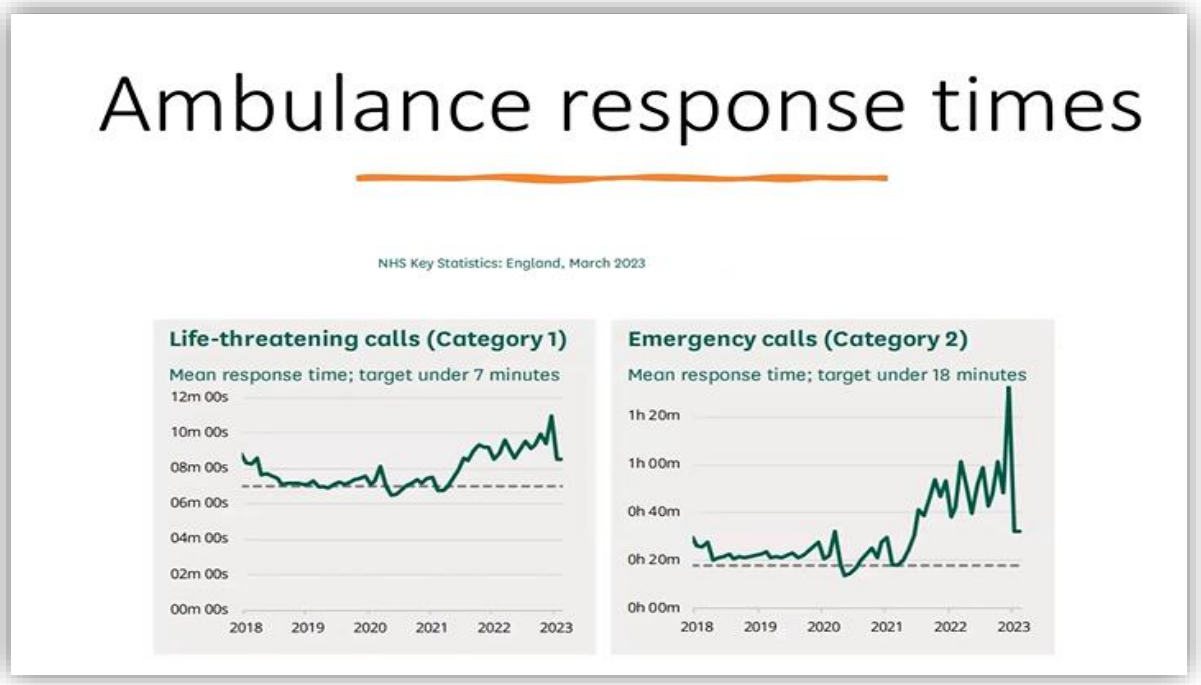
The additional beds put in are shown to be already full. London is leading with this problem, in not being able to get patients who are medically fit for discharge, out of the hospitals. As a result you cannot get new patients in – whether they are walk-in patients or ambulance patients – into the ED.

The ED becomes more disfunctional because, instead of being sure that patients arriving by ambulance are the most sick people … and that people who walk-in can be managed in a different way - there is now the risk that there may be some really sick people in the walk-in queue.

This makes everything much more challenging for the 'front end' to handle and, therefore, more chances of errors.

AMBULANCE RESPONSE TIMES

Ambulance response times have deteriorated considerably.



These are the 'average times'.

Category 1 – average response time 7 minutes – this target is for people suffering cardiac arrest and other life threatenging conditions and is still not being met.

Category 2 – average response 18 minutes. Patients may have suffered a stroke and or heart attack and are of great concern. Delay is the consequence of bottlenecks at hospitals.

HOW DOES IT ALL WORK …

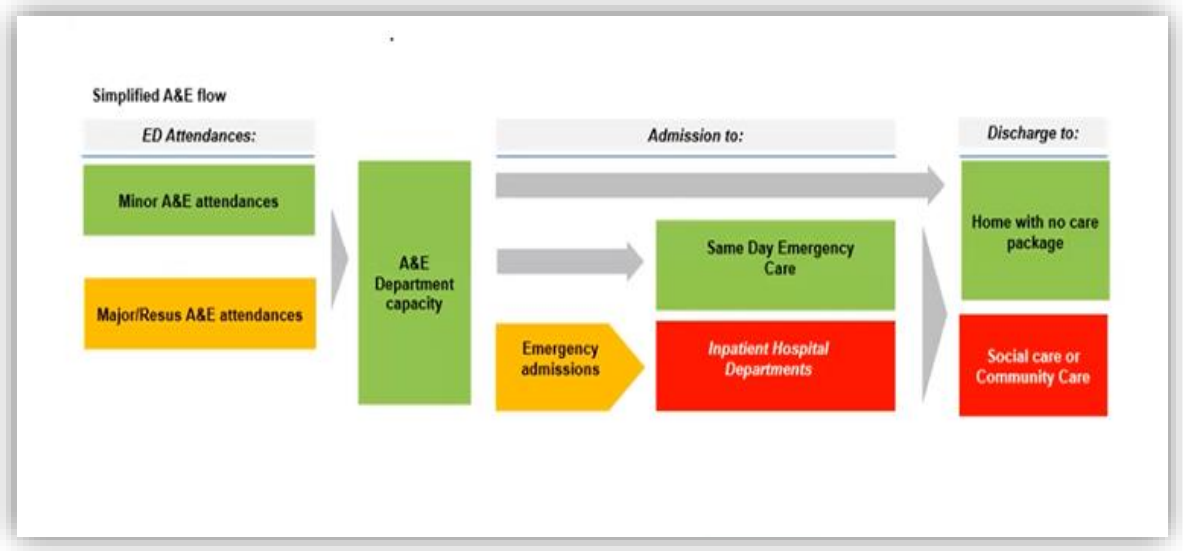
This is one of the most useful statements written by the NHS Confederation about Urgent and Emergency Care.

> "The last ten years have also seen changes to the usage and perception of the Urgent and Emergency Care system, with it often viewed as a problem to be fixed, rather than a symptom of a system not addressing population health and care needs."
>
> www.nhsconfed.org/publications/re-envisioning-urgent-and-emergency-care

It is important to get the system working properly and it is going to be very difficult. Often the focus is on what 'quick wins' can be achieved in the ED, but this is not where the problem lies. The problem is with the conditions surrounding the Emergency Care system and the wider social and economic problems that are faced by the NHS and social care.

HOW ARE PATIENTS STREAMED THROUGH THE SYSTEM?

This is a complex but NHS England have a useful simplifies schematic.



If EDs were managing the number of patients that come for 4 hours, plus a little more time for the more complicated cases, there would probably enough space. The problem is in the hospital itself – length of stay for in-patients and getting these patients discharged. EDs are becoming difficult places in which to work, with the risk of losing staff.

The'front line' feels at times intolerable. Ambulance crews feel that they did not train to spend a whole shift with one patient on an ambulance ramp. This is frustrating

professionally, upsetting and they are aware that they are not providing the care that they were trained to provide. Too often solutions are just 'sticking plasters' and a search for a quick wins. People tend to look at the wrong things, for example, a classic one is placing an ambulance 'off-load tent' or shed or another sort of temporary structure outside the Emergency Department, therefore freeing up the ambulances.

NHS England purchased some of these temporary structures. All that has been achieved is a temporary fix - until they are full. Patients in a shed, in cramped conditions with no oxygen, no suction, and no ability to get pain relief, etc. is not a solution.

The RCEM undertook an 'Options Appraisal' on approaches to the bottleneck problem, and found that if you are coming up with a solution that seems 'too good to be true', then the chances are that it is! This can create a whole series of unintended consequences which might be more dangeous. Erecting tents was a poor solution to a complex problem.

WHAT ABOUT NHS 111?

NHS 111 has also been promoted as being the answer to the ED overcrowding problem. When 111 was set up, it was intended to deal with 'out of hours' GP demand. It was a way of priotising what was happening with GPs.

During Covid, it turned from an 'out of hours' service to a 24-hour service. Now NHS 111 is having to deal with high demand all day and it is, of course, struggling to deal with the rising demand.

The contract for NHS 111 – and how it should be improved - is getting reviewed. This is an algorithm based 'risk-averse' system. NHS 111 services are not designed to respond at a local or neighbourhood level. It expanded before there was adequate evidence of its effectivenes. It's Covid response role was a very different model from that originally set up for the GP 'out-of-hours' 111 service.

A series of other problems has also been created. There have been 'pilots' looking at the how the system performs and in particular at the impact of having clinicians in 111 centres – this does work particularly well for paediatric calls. But there is a need to fully evaluate these systems to see how clinically effective they really are.

The NHS tends to do 'pilots', but does not evaluate the results properly. NHS 111 has its positives, but there are also enormous problems and there is the risk it can further burden emergency services. There has never been a convincing evaluation on how well 111 is working and achieving what it was hoped to achieve.

SAME DAY EMERGENCY CARE - SDEC

Same day emergency care (SDEC) enables specialists to care for patients within the day of arrival in hospital, as an alternative to hospital admission, removing delays for patients requiring further investigation and/or treatment. There is a good evidence-base for this system, but it is being implemented in an incredibly piecemeal way and there is a weak evaluation of how it operates.

SDEC has become confused in people's minds with 'Virtual Wards', which enble people to go home and receive clinical care there instead of an admission to a hospital bed.

It has been claimed that Virtual Wards are saving numerous beds for patients who need admission to a 'physical' beds, but there is still the necessity for staff to manage this system. SDEC has an important place in providing same day clinical care, but it does not mean that it is necessarily cheaper, nor does it mean that it is necessarily offering better care for patients through enhanced access for clinicians.

SDEC has really good patient advantages, as it may minimise the amount of time people may stay in hospital and speeds up discharge. However, the patients do need 'follow-up' and input and a personalised Care Plan.

At the moment, SDEC does not have the required workforce and it is not always available and effective, yet there are high aspirations for the service. There are only a few places actually managing that level of service, including the Acute Frailty Service, which is an acute assessment unit focused on improving patient experience and quality of care for patients 65 years and older.

Patients receive rapid assessment and care designed to meet individual needs. Is SDEC saving money, improving patients' safety, and maximising the use of the workforce … or is this just an attempt to 'shuffle deck chairs on the Titanic'?

WHAT ARE THE SOLUTIONS?

Very few of the solutions lie within the Urgent and Emergency Care system or provide the means to actually transform the system. We end up being reactive to a whole chunk of things going on outside our world, e.g. poverty, the social determinants of health and what is going on in social care and primary care. Secondary care is a small part of what is going on with the nations' health and we need to focus on service developments and investment being in the right place.

The most deprived 10% of the population tend to be in areas where there is poor primary care provision, poor access to social care, and poverty is rife, so it is not surprising that we end up with people attending EDs who could be getting care elsewhere, if the services were there for them. A level of need is around child health and early-start years. This is where we should be focussing our work.

The NHS for example in Lambeth and Southwark has agree on the following urgent and emergency care priorities for 2023-24.

LAMBETH AND SOUTHWARK
URGENT AND EMERGENCY CARE PRIORITIES 2023 - 2024

➢ Increasing Urgent and Emergency Care Capacity

- Additional hospital bed capacity - to meet immediate pressures and reduce bed occupancy and to meet demand for health and care.

- Increasing the ambulance service capacity – eliminate the 'over 60-minute' handover delays and work with the ambulance service to provide additional capacity to divert patients to alternative services if appropriate.

- Improving processes and standardising care – working with partners to standardise care at the ED front door, including mental health care and continue to increase care pathways.

➢ Increase workforce and flexibility

- Support retention and expand the Urgent and Emergency Care workforce.

➢ Improve Discharge

- Scale up Intermediate Care – review and implement a national standard for rapid discharge
-

➢ Enhance Access to Social Care Services

- Scale up Social Services – work with Local Government and Social Care Providers to optimise access to social care.

➢ Expand care outside Hospital

- Expand new types of care outside Hospital – urgent community response, falls service, enhanced nursing home support and a high intensity users programme.

- Expand Virtual Wards – scale up standardisation and implementation of new pathways/models of care to reduce acute length of stay (LOS) and in-patient bed occupancy.

- Local Authorities to review local plans – ensuring sufficient capacity to enable flow into social care settings, and agree plans to address shortfalls.

➢ Making it easier to access the right care

- Review 111 and develop greater alignment of 111 with primary care services provide access to more effective clinical assessment, and expansion of 111 into Urgent Care Services and other appropriate alternative pathways where appropriate.

- Access to a 7-day a week urgent and emergency care services and better enabling care pathways – review opening hours of these pathways across all systems and ensure that all services and new developments focus upon the time of patient presentation and demand, as opposed to times when the services can be offered.

These are also priorities of the South East London Integrated Care System – commissioners and funders of the NHS.

RECOMMENDATIONS FROM THE ROYAL COLLEGE OF EMERGENCY MEDICINE TO THE UK GOVERNMENT

Resuscitating Emergency Care Priorities

1. Eradicate overcrowding and corridor care for patients.

2. Provide UK with the Emergency Medicine workforce it needs to deliver safe care.

3. Ensure the NHS can provide equitable care to all emergency patients.

4. Focus on evidence-based interventions to tackle ED overcrowding.

5. Introduce meaningful and transparent metrics to facilitate performance and better outcomes for patients.

6. The UK Government must open enough staffed beds so that hospitals run at no greater than 85% bed occupancy.

7. The UK Government must fund an expansion of community and social care to ensure patients are discharged safely and promptly, when their medical care is complete.

8. NHS in all four UK Nations must expand and retain the Emergency Medicine workforce to achieve a safe patient-to-clinician ratio. There must be an accompanying increase in ED nurses, AHPs and SAS doctors, and the facilities to train them.

   'SAS doctor'- Specialty doctors and specialist grade doctors with at least four years of postgraduate training, two of which are in a relevant specialty.

   'AHPS' – Allied Health Professionals - work with people to improve their health and well-being, e.g. paramedics, physiotherapists.

9. The UK Government should evaluate any new initiatives aimed at tackling overcrowding in ED and publish the results in full, in order to support the NHS to provide timely and safe care to patients.

10. The UK Government must resource the health and social care system and outline plans to meet the 95%, 4-hour ED target in the long-term.

11. The UK Government must disaggregate performance figures to provide transparency and better opportunities for benchmaking.

12. NHS England must publish 12-hour data from the patient's time of arrival in EDs, on a monthly basis for each Emergency Department.

POLITICS

Nobody plans to be an A&E patient. It is difficult to get political interest in A&E departments, because people are more focussed on elective care and access to GPs.

All the choices around healthcare are political, and this is one of the problems that Emergency Care pathways suffer from.

QUESTIONS TO DR. HENDERSON AND RESPONSES

Logie Clohendran

Concerning the discharge of patients – would it be better and more effective if social care comes under the control of the NHS?

Dr. Henderson

Yes. There would be great advantages if this were a 'single system' with no division between social care and what is delivered by the local Council. To have this all integrated would make a huge difference. I work in an Integrated Care Trust and it is clear that often the systems that work better are those that are providing a lot of their own community services – even if it is not the full Social Care package

Gay Lee

I am a retired Nurse and I am interested in thinking about solutions to the workforce crisis. Clearly the long-term workforce plan is important but it seems to be delayed because of lack of funding. What are the pressure points?

The Nursing and Midwifery Council, and probably the General Medical Council, are definitely legally responsible for patient and public safety. Why are they not putting more pressure on the Government? If there was a ground-swell of opinion from key decision-makers in the system, could they not be pressuring the government to say that they cannot do their jobs because, legally, we are not keeping people safe? People are suffering from high degrees of morbidity and mortality because of what is going on. Do you have discussions with the organisations that are supposed to be safeguarding patients and the public, and is there anything that can be done for them publicly in order to shame the Government into doing something about resources?

Dr. Henderson

One could argue that the strikes represent an enormous frustration, particularly by nursing staff, in the deterioration in the ability to retain the workforce and to provide safe levels of staffing.

The strikes are, perhaps, one end of the pressure that is being applied. We are saying that we have reached the point where we shall not have an adequate workforce until the government are prepared to fund that workforce, not just in shear numbers but actually paying them appropriately. People have been trying to apply pressure for years. There are lots of calculations about safe staffing levels, but great reluctance for them to be published. The training and education body has merged with NHS England with the hope that the service requirements, versus the training requirements would be a lot more obvious. However, it does not seem to be playing out like that. There has been a recent announcement about apprenticeships for doctors as another route in. There is a rationale for that, in increasing diversity and who becomes a doctor, which is admirable.

You won't find doctors always hugely supporting what might be an expansion because of pressure on training. There was one group expansion – Physician Associates – which was a new workforce coming through University. This is still not regulated … and this is a failure of the Department of Health who promised to do that, at the beginning of Covid, and to get this through the GMC.

This is like dealing with an Octopus! There is not the will by the government to publish their workforce plan. It is difficult to know where to go next, and this could be why we are in the current strike situation.

Alan Alexander

Regarding discharge figures: there are about 35% - 40% of people being discharged who were medically ready to be discharged. But 60% were ready to be discharged but were not. Is this correct? As an observation: In the Emergency Day Care in my local Hospital in the North West of England – we are finding that GPs tend to work all over the place and we lose some of our GPs from surgeries because they are working for the 'Same Day Emergency Care' Department (SDEC) instead. There are, therefore, no gains. Regarding the deprivation figures: is there any sort of analysis to show what sort of symptoms, or what people are suffering from, who ends up in areas of high deprivation in A&E?

Dr. Henderson

The discharge figures: You are ending up with a group of people who, within the month, could have been discharged, but were not within that timeframe.

The deprivation figures: Areas of high deprivation tend to have poor access to GP services, so the classics would be coastal towns where GP numbers are extremely low and that is one

of the big issues. The Marmot Report looked at these issues and showed inequity of access to health care by deprivation.

If you cannot get access to a GP, you do not access the health stepping stones – particularly with children – but also with checking blood pressure, getting anti-natal care. This ends up with illnesses that could have been prevented, and also end up with people who cannot get an appointment and then default to the Emergency Care system.

Anybody who has access to a private GP will, very rarely, use an Emergency Department for anything other than a very significant emergency. However, if you have a feverish child on a Saturday night and you have no way of making a GP appointment … and you cannot get to the GP for lack of transport, the risk is that you find yourself calling an ambulance and ending up in an ED when you did not really need to be there. It is completely understandable that this happens.

Alan Alexander

There is very little transport where I am in a coastal town in the North West of England and I was reading an article about how much even South Western coastal towns have very little and poor transport, as well as the lack of GPs.

James Guest

Age of patients: Together with my wife, we have been caring for my late Mother, aged nearly 101 years, at home.

We have had a number of experiences and if we could have avoided her having to go to one of the West London hospitals by ambulance, it would have been much better for her. An ambulance would have had to get to the hospital - then the triage and the wait, before being seen by the Urgent Care Centre or the A&E (depending upon triage), and then having to get her home.

There would have been many hours – up to 10 hours - of disturbance for her. She was living on the ground floor at home, so we tried to avoid deterioration and muscle waste by helping her to walk, but occasionally she would launch herself at the floor and unless there were three of us – one either side and one behind her – we would have occasional problems.

What we ended up working on was talking with senior paramedics at the A&E Call Centres, discussing how we check mother out, what we had achieved and whether she could stay at home with us looking after her.

We were getting weekly visits from the District Community Nursing Service, which proved to be less distressing for her and a much better use of resources. How can families or friends living near the elderly patient, be empowered to take on more.

Dr. Henderson

In terms of what happens to patients in EDs, the elderly can get a rough deal if they need to be admitted. We know that the long waits can have bad affects on the elderly more than others. The patient may well be on a trolley or trying to get to the toilet, and this can be really dangerous for them.

The ED that is not moving the elderly through, is definitely risky. We are setting a local target of 0 - 6 hours length of stay/wait for admission for the over 75 year old patients.

Increasingly, an ambulance service will have people who are skilled to come and do an assessment and can make the decision that someone can stay at home – may be kept in bed … or can have a conversation with a family member to work out what is the best thing.

A good example of that is when there is a call for an ambulance to a Nursing Home, there should be a senior clinician – a paramedic or a GP – to discuss what is best for the patient. All Nursing Homes should have a GP attached to them.

Somebody who is going to get confused by being sent by ambulance to hospital, may not benefit from that journey. It may be a lot better that they get an evaluation by their own clinician the next day. That is about quality of care – making decisions about what is the right thing to do.

The side effect is that you may stop somebody needing an ambulance, coming to the ED. If the patient is in severe pain, then that is completely different and the patient must be taken to hospital.

Archie Drake

I am wondering if you have a particular view on primary care funding? One of the things that I have heard recently from GPs who I have worked with in research, is about the way payments have changed to GP practices, especially capitation payments and additional payments when working in private areas. Do you think that the way investment in primary care is managed needs to change in order to for primary care to operate more effectively?

Dr. Henderson

I am not an expert in primary care funding. However, what I do know is that if we were setting up the NHS now, we probably would not set it up with the model that we have with primary care. It was a solution to a problem at the time.

There is a problem about parts of the country where there is a shortage of doctors and nurses. So if you are going to become a Consultant, you will probably do so within 50 miles of where you trained. So, if all your training spots are in delightful places, less delightful places are going to struggle to get staff.

We have set outselves up with huge inequalities right from the beginning … about where people train and where people get substantive jobs. This will be true in primary care as well.

Somewhere, along the line, there is going to have to be a rationalisation about where people train – or we do a 'full Australia' (i.e. ensure that doctors in training have to work in areas of deprivation).

There is an expectation that people work in certain areas for a period of their professional life, and they get a huge incentive to do so. In the UK – being a small island – that is going to be quite difficult to achieve. There is an argument that we have to do something radically different. I am not sure how this fits in with primary care funding, but we have a problem whereby a lot of people train in London and the big centres, and then rural and coastal communities just have no-one.

Archie Drake

We need to find urgent solutions to increase the number of doctors, which are not 'sticking plasters' and think creatively about better resourcing the expansion of the pool of doctors, including training programmes that require doctors to work in areas of greater deprivation.

Sister Josephine Udie

I should like your presentation to be made available to a wider public, for instance the Government. They need to listen to your presentation because it appears that there is something wrong with the whole system. I am glad that you spoke about the social determinants of health, which is a key issue especially at the moment with the current economic situation.

People are turning up at the Emergency Departments when they need not. But because of their situations, they see A&E as the quickest fix for their problem/s. I work at the Queen

Elizabeth Hospital in Woolwich and I used to go up to the A&E Department to say 'hello' to patients. I no long like to do this as the situation is terrible … people in the corridors and other struggling with children. Something really needs to be done and I think that your presentation needs to be shown to the Government so that all the Departments see that there is work to be done in order for it to do its job properly and differently, and put in the funding that is needed.

People and families are ready to help, but they do not know what to do and they need that support. My recommendation to the Patients' Forum would be that your presentation should be given to the London Assembly, the Department of Health and the Prime Minister! We need to stand up and say that 'enough is enough', the research and data is available and real leadership is necessary.

Dr. Henderson

I think that the Government has this information. It is a political choice how much is spent on health and social care. These presentations have been made to the Government, the Department of Health and NHS England. There are other bodies who also do this. The strikes represent a level of desperation amongst staff for them to make these points.

I think that the solutions are difficult for them to take on, but it is a political decision as to whether we choose to work in these areas. There will be a lot of areas coming forward to make the case and there are financial constraints all round.

The risk is that we are going so far down with the problems within the NHS that it is going to take more investment to get us back. It is good money after bad, in a sense. An example of that is, how much money can we spend on most emergencies?

We spend money on getting staff through routes other than our permanent staff, e.g. through agencies. But often staff work for an agency, because they get paid better that way. How did we get ourselves into this position.

Alan Alexander

As a 'rider' on the Australian model, I recall that Canada also requires newly qualified doctors – to work mainly further north where there is little provision, to undertake a 'social return to society'. There was a time when French PT Teachers, who always liked to work in the South of France had to work in the North before they could get a job in the South in the sunshine!

No-one should ever forget that we have had a 'cap' for 12 years, on how many doctors we were in training. We are now so many years behind, because if it takes 10 years to get a viable doctor – and we've done it for 10 years – then we are 100 years behind! That is an awful lot to overcome!

Dr. Henderson

Canada definitely has a remote and rural demand. Some of our hard to fill posts are not particularly remote or rural. People might say that Blackpool is not remote or rural, but it is a struggle to get primary care provision.

How do we use the world of the new Integrated Care Systems to actually look at population need? How do we take some quite hard decisions about where we put money?

The problem is that if you are going to put money into places that need it, you will also be taking money away from places that you also think need it. There is a moment of pain along the way, where some services lose essential components of the way they operate. In the middle of the problems with 'elective care', that is going to be quite an ask. There is a real need to catch up with the demand for 'elective care' and get the Diagnostic Centres up and running. We will need more services in pathology, for instance. What we really need is an agreement from government to provide a huge amount of investment for a period of time, but there is no sign that that is likely to happen.

Alan Alexander

In my experience, there is a massive increase in allied support for GPs. I think that we have probably been forced into doing this, but I think that this is the right way forward, e.g. to have more physios and social prescribers, and so on. They can provide care for people who do not necessarily need to speak to a GP.

Adrian Dodd

In South Africa, before you can get your degree you have to work for 12 months in a deprived area. It can be rural or it can be urban, but it has to be a deprived area and, unless you do that 12 month stint, you do not get your medical qualification.

Malcolm Alexander

The London Ambulance Service has been struggling really hard not to share data about their performance!

In relation to patients in a mental health crisis who are often remaining in an A&E Department for a long period of time, this is sometimes because the rule is that they have to be sent back to their home area. That seems quite strange, compared to all other patients, with physical illnesses who do not need to be sent to their home area.

I wonder what your views are about that, because I have observed at Homerton Hospital that there is this huge battle on how to get a patient out of one A&E and into a mental health bed in another part of London. However, what may happen is that they are sent to another hospital, which can be far away, because the only bed available is a private bed. This does seem a very disfunctional system.

Dr. Henderson

I agree. If we are supposed to believe in parity of esteem between physical health and mental health, you do not go to somebody who is having a cardiac arrest out of their home area, and then tell them that they must wait for a bed to come up in their area and then send them there.

However, we do this if someone is having a mental health crisis, and the logic is that trying to get the patient back into a system that already knows them, is likely to be beneficial.They usually have an acute or chronic condition and so there will be information held about them. There needs to be a decision about how 'acute' is 'acute' and how quickly it then takes to get them to the clinical team that knows them.

Unfortunately, you are completely right, you can end up with a situation with somebody being trapped for days while the debate goes on.

Some of the people who present with a mental health crisis to an Emergency Department are living a fairly chaotic life – a combination of mental health, addiction and homelessness can result in a nightmare series of conversations about where were they last known; where they were last registered with a GP; and when did they last have a social worker visit.

The teams seem to be fighting over who is not going to take the patient, because they do not want to end up with that patient on their books.

This is definitely not good for the ongoing mental health of the patient involved and we need a new way of doing this. At its heart, we also need to understand why there is so much of a problem in trying to get a patient the right bed … and this is, fundamentally, because there are not enough beds!

If we are saying that there is a problem with general and acute beds, there is an even a bigger problem with mental health beds. There is a bottleneck exiting from mental health beds because there is not enough provision of care in the community to then take somebody on at that end of their journey.

A person with an acute mental health problem could find themselves in an Emergency Department cubicle, with the lights on 24/7, with noise 24/7, a security guard on the door and the stimulation of a non-therapeutic environment, and the staff trying to do their best. Its horrible for everybody.

GLOSSARY

A&E	Accident and Emergency Department
DTA	Decision to Admit
ECD	Emergency Care Department
G&A	General and Acute Beds
GMC	General Medical Council
NMC	Nursing and Midwifery Council
OOH	Out of Hours
SDEC	Same Day Emergency Care