Keogh report tackles A&E supply but not deeper demand

The “crisis in A&E” has dominated headlines for months, with attention focused mainly on inexorably rising demand, ageing populations, and increased waiting times. In his much **anticipated report (http://www.england.nhs.uk/2013/11/13/keogh-urgent-emergency/)** into how emergency care services are organised in England, Bruce Keogh highlights several distinct issues and offers up some solutions, though one clear problem, the public’s increasing and **intractable expectation (https://theconversation.com/developed-world-cant-have-it-all-or-health-will-hit-the-buffers-16372)** of health services, is missing.

In the review, Keogh writes that A&E services are under intense, growing and unsustainable pressure. To tackle this, he suggests that more services should be delivered outside hospitals for those with urgent but non-life threatening needs, in or as close to people’s homes as possible. For those who do need hospital, he suggests **a two-tier system (http://www.theguardian.com/society/2013/nov/12/plan-a-and-e-crisis)** that will be consistent across hospitals: emergency centres would focus on assessing patients and starting treatments and for those with more serious or life-threatening issues such as stroke or heart attacks, larger, specialist centres with “consistent levels of senior staff and specialist equipment” would provide care.

Finding a way through the confusion

Keogh also suggests rationalising services to reduce confusion – so, walk-in centres, urgent care centres and minor injury units would become simply known as urgent care centres. Ambulances should be seen as a treatment services and not just as transport.

There is an implicit recognition in the report that although the crisis in A&E reflects rising demand, and he highlights an ageing population with increasingly complex needs, it is largely a crisis in way-finding. People come to A&E because it’s there – a warm, well lit, reliably open destination when the alternatives are too vague and uncertain: will the GP surgery be open? How long will it take the nurse to come? What kind of doctor do I need? Is it serious enough for me to call 999? This “confusing and inconsistent array of urgent care services provided outside hospital”, Keogh said, leads to people defaulting to A&E.

This is very true. To many, the A&E department has **come to represent (https://theconversation.com/aande-is-in-crisis-because-we-all-take-it-for-granted-14458)** the face of any and all acute illness, a function well beyond its design brief. To clarify this position will certainly need the decisive actions suggested by Keogh, with distinct, separate pathways to cut through the Gordian Knot, this intractable problem currently besetting the system.

But this disentangling of services, whether there’s a need for hospitalisation, or when people can access services, is actually about the management of risk and the identification of who, or what, is best placed to deal with the various types and levels of risk. Surgery means operating theatres, thrombolysis (breaking down clots) suggests **a stroke centre (http://www.nice.org.uk/newsroom/news/OverHalfOfStrokePatientsAdmittedDirectlyToSpecialistUnits.jsp)**, and so on. Complexity, staff skills and cost are all factors that will need to be understood if Keogh’s suggestions are turned into reality.

But while the multiplicity of roles and centres and services is a problem for the NHS itself, it is nothing compared to the confusion in the public mind. None of us are entirely rational and what reasoning we do have tends to evaporate when we are acutely ill, so the way-finding that is required to effectively navigate the complexities of the NHS has to be entirely clear, or err on the side of paternalism.

Public perception of services

Sir Bruce is absolutely right to distinguish the accidents from the emergencies, and to tease apart the different streams of potential care. But his report only deals with the supply side; there seems to be little if any reference to the need to change public perceptions of demand (a rebalancing self-care and professional care, for instance).

Nor does he address the need to provide expert guidance to patients working their way through the system – though he does suggest bolstering NHS111 into a “one-stop” service with staff that had medical records to hand and a wider range of medical staff including doctors, pharmacists, dental staff and mental health nurses. Actually, it may be that the ambulance services are better placed to pick up this particular baton, as the role of the paramedic continues to develop and grow.

Dealing with our tendency to default to A&E is an enormous, societal task that needs political will and nerves of steel. It remains to be seen if any of Keogh’s suggestions, if taken up by the government, would actually have any effect on this.

But guiding patients through the system should be a natural by-product of the way in which the NHS runs; care co-ordination has been the linchpin of our system since 1948. GPs, each with abilities in each ‘musical section’ are the ‘conductors’ of the NHS orchestra through the new Clinical Commissioning Groups that control most of the NHS' resources. They are well placed to co-ordinate patient journeys effectively and efficiently, by using and enhancing the role of GPs and others including formal case managers, ambulance crews and even NHS111.

The A&E crisis requires three simultaneous approaches, of which Keogh only really mentions one. Rationalising services clearly and decisively makes up most of his report. But weight also needs to be thrown behind strengthening and publicising how patients should navigate the system effectively and analysing the real demand issues – what we consider A&E is for and, even, **what constitutes a disease (https://theconversation.com/developed-world-cant-have-it-all-or-health-will-hit-the-buffers-16372)** – we seem determined to have it all, whatever the cost.

“Dr Keogh’s prescription” will help with symptom control, but won’t cure this underlying illness; for that, we will need to look more closely at the patients, rather than the hospitals.

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