Only strategic collaboration will cure NHS’ A&E ills

The NHS should cut the millions of pounds it spends on inappropriate hospital admissions by giving GPs and hospital bosses the time and space to collaborate on new ways of solving problems like the looming A&E crisis. That is the view of Warwick Business School Professor of Healthcare Eivor Oborn who fears the recent Sir Bruce Keogh review will be used by the Government to implement a one-size-fits-all solution on emergency services across England.

Instead Professor Oborn believes it is not the management consultants and government reviews that will solve NHS’ problems like the overcrowding of A&E, but the doctors, nurses, surgeons, executives and managers working at the coalface day after day.

“These people know how the system works, but they are so performance managed by the Department of Health that they have little time to work out innovative solutions at a local level,” said Professor Oborn, who has worked alongside Lord Darzi who led a major review of healthcare in London in 2007 with a Framework for Action.

“There is no co-operation between hospitals, GPs or community services to work on the A&E problem because there is no structure for them to meet and come up with innovations and new forms of service delivery that are suited to the modern age. GPs and hospitals only meet in adversarial situations, not to discuss a collaborative approach to stop A&E being clogged up with people who don’t need to be there. They only meet to see which services GPs can obtain from the hospital in the quasi-market that has been set up. They are so caught up in their job to meet Government targets that finding time and space to create new service innovations to tackle the A&E problem is not their priority.”

Business tackling A&E problems

Professor Oborn is part of Warwick Business School’s Organising Healthcare Research Network (OHRN), an interdisciplinary group which is one of the biggest academic healthcare units in the country. As well as looking at knowledge mobilisation and innovation, OHRN researches issues as diverse as how to stop the frail elderly needlessly ending up in A&E; designing the physical environment to improve the well-being of cancer patients – a project being done by the Behavioural Design Lab, which is a collaboration between Warwick Business School and the Design Council.

With Professor Oborn’s research interests including organisation theory and chance and health service innovation she is ideally placed to look at the complex issues surrounding the current overcrowding of A&E departments.

Sir Bruce Keogh, the national medical director of NHS England, said in his report Transforming urgent and emergency care services in England that 40 per cent of people who go to A&E are discharged requiring no treatment.

“Patients may not be able to access their GP or they can’t get an appointment because it is out of hours. There are also a number of people without a GP requiring healthcare like tourists, commuters, refugees or temporary migrants - this is a particular problem in London,” said Professor Oborn. “In the community sector, non-medical healthcare support like district nursing and physiotherapy has suffered cuts, so there is less capacity for GPs to organise community-level support in many instances.

“Once in hospital it is increasingly difficult to discharge patients needing community services - the budgets for these have been drastically cut so it is more difficult for the NHS to rely on community-funded support. On top of this there has been significant ongoing reorganisation of community-based care and the system remains lower in capacity due to the ongoing flux and change. This sits on top of the decreased willingness to accept risk of patient relapse, since this is accompanied by penalties to the hospital whereas increasing the length of stay does not.

“And yet going to hospital increases people’s risk of falling ill, with approximately 10 per cent of admissions picking up hospital-acquired complications, so we need to keep those who don’t need to be there out.”

“The performance managed culture in NHS is driving out the opportunity for local innovations to solve problems like overcrowding in A&E. It is a top-down approach where the Government imposes targets and so hospitals and GPs form strategies and behaviour to meet them. It promotes a blame culture where people are looking to make sure they are meeting targets rather than working together.”

“Often when looking at problems in the NHS it revolves around using management consultants, but they often don’t know what is going on at ground level here, what works in the US probably won’t fit in the NHS. The real players, the Clinical Commissioning Groups, hospitals, GPs, surgeons, nurses and managers on the wards, need to come together to collaborate on new solutions. Paying management consultants would probably cost more money than allowing the real players to take time out to tackle issues like the A&E overcrowding.”

A&E set for worst ever winter

The College of Emergency Medicine, which represents A&E doctors, has warned this winter could be the worst yet with increasing waiting times at A&E departments. Sir Bruce Keogh’s review revealed there were 5.2 million emergency admissions to hospital last year, yet up to 1.2 million of them could have been avoided.

“At the moment A&Es have a target of four hours to get people through... A number of A&Es have coped with the target pressure by setting up a parallel ward for observation; more of these flexible types of care should be encouraged”

“At the moment A&Es have a target of four hours to get people through,” said Professor Oborn. “A number of A&Es have coped with the target pressure by setting up a parallel ward for observation, more of these flexible types of care should be encouraged. This way full admission is avoided and a crisis can be averted with a more realistic timeframe for getting a community package in place for the person, which is often what is needed.

“Arranging home or community-based care can take a lot of time and phone calls to sort out so under pressure some A&Es may feel it is expedient to admit first. There are also
many patients who need observation rather than acute medical intervention, but given time constraints they can’t keep this category of patients in A&E.”

**CCGs need to work with hospitals more**

Professor Oborn believes better community-based care and keeping basic care including managing chronic illnesses and frail elderly “nearer to home” and out of A&E, as Sir Bruce Keogh’s review aims for, needs GPs to work closer with hospitals.

“One solution to support better social and health service integration would be for social and community services to have ring-fenced funding to support hospital discharges,” said Professor Oborn. “Given the difference in budgets, with Health not having any needs assessments attached, but community services attached to needs and ability to pay, there is an ongoing incentive for social care budgets to shift costs to the health sector. A patient might need help with their meals when they are discharged, but doesn’t qualify to get it free through social services and they are reluctant to use their savings or capital in their house to pay for it, so they don’t eat properly and end up back in hospital. If a budget was ring-fenced for this through social services it would stop this increasing problem.

“In addition, CCGs and GPs more widely need to be incentivised and encouraged to work more closely with the hospital sector and vice versa. The divide between hospital and primary care medicine is historic and longstanding, yet there continue to be few forums and opportunities for these groups to meet up, other than across the commissioning bargaining table. This does not encourage long-term relationships and strong collaborative networks, where we know that trust and ongoing contact are important. Trust and increased dialogue is essential in order to shift the institutional divide between specialist and primary medicine. Yet if CCGs are given adequate support, collaboration across the institutional boundaries can yield innovative solutions.

“Also a wider skill set than GPs should be drawn on in primary care, such as nurses and occupational therapists. The latter are particularly important in supporting discharge from hospitals as they can assess and support mobility, home safety, and management of basic activities of daily living.

“There is also an increasing need to educate the public on how to navigate the healthcare system and the costs associated with their care in general. As tax-paying citizens the public also have a role beyond that of a consumer; there needs to be more mechanisms or dialogue in place for the public to become engaged with healthcare costs and how they use the system.”