Minutes of the Derby Medical Society, Tuesday 9th October 2018
Derby Medical School Lecture Theatre

Apologies

Mr Keith Dodd

Mr Tony Henry

Dr Sarah Milner

Dr Brian Hands

Speaker

Dr Chris Moulton MRCEM, MRCGP

Vice President Royal College of Emergency Medicine

Consultant in EM at the Royal Bolton Hospital and National Co-Lead for GIRFT-EM

Introduction

Miss Hewitt introduced the speaker for this evening's lecture, Dr Chris Moulton.

Dr Moulton has worked at the Royal Bolton Hospital for the last 24 years and is a MRCEM as well as MRCGP. He wrote the lecture notes series for Emergency Medicine and works as a senior lecturer at Manchester University. He is also in his 6th year as vice President at Royal College of Emergency Medicine. One is his other jobs is working with Cliff Mann on a project called "Getting it right the first time".

In her introduction of Dr Moulton, Miss Hewitt talked about his work with Cliff Mann and that there is huge variation in departments across the country. This variety is in the form of resources, staffing and outcomes. The thinking is that if there is variation then this may be associated with inefficiencies.

As we live in a 24 hour culture with an increasingly elderly population there is a case mix. Advances in emergency medicine require time critical interventions. When designing future care systems, we need something robust and reflexive and responsive. We have had "projections", "forward plans" and "winter plans" - all based on assumptions. It is worth scrutinising these assumptions.

Welcome to Dr Moulton to present his lecture **"Nostradamus, Mother Shipton and NHSI: A discussion of prophecy in the field of Emergency Care"**

Dr Moulton opened his lecture by talking about the 16th Century prophetess called "Mother Shipton" The was the most famous prophetess and got a lot of things right. In France, there was Nostradamus. He was more humble, a herbalist and training to become a doctor but was scuppered by the great plague. Niels Bohr was a more recent person to predict the future. The CEO of IBM when the company was formed predicted that there would room for only 4 computers in a room. He also recalled the prediction of the meteorologist Michael Fish.

The NHS has its own "Nostradamus"- Monitor. They predicted that A&E activity would reduce by 15% in a few years but it actually had gone up by 5%.

The NHS has a no-blame culture but who is to blame? NHSE, NHSI, HEE or the patient? The patient doesn't want to pay for the healthcare. The Kings fund, the Nuffield trust all have vested interests.

As recent records have shown, lowest figures ever were seen within target in February 2018 since records began. 2 trusts were in 50s! In 2014, a 5 year forward view plan was published and nothing happened except that in October 2018, another plan was published! We now have a 10 year plan instead..!

There are many view and predictions regarding the increased demand on A&E. Dr Moulton then went through these different views.

Health education England view:
HEE exists for one reasons - to ensure we have the workforce we need to sustain a service. Jeremy Hunt wanted more than 5000 GPs but numbers are going in opposite direction. Each year percentage of trainees not progressing gets higher and higher. Work related stress is affecting 50% of people and more so in A&E training positions.

Managers' view:
There is no explanation for increasing demand!! However, Dr Moulton showed a graph which demonstrated increasing number of attenders against total population. There was an 11% population increase which correlated with an increase in number of attendances at A&E. In addition there is an increase in ageing population with relative age rising greatly. The average number of diagnoses per age group increased with age so the elderly have a greater number of co-morbidities and therefore health need and burden. Dementia is the biggest cause with more people getting diagnosed and it affected low and middle income countries more than high income due to long term nutritional deficiencies. Dementia care costs over 1% of global GDP in 2015.

Health tsars' view:
Keogh report stated that 40% leave A&E with no investigation or treatment. In reality it is less than 1/3 but most still need advice and reassurance. By not having investigation or treatment, it doesn't mean we are wasting our time. Research shows that 15-20% attenders are suitable for primary care. But even if they all stopped coming, it would make no difference to old ladies waiting for beds for hours in trolleys.

Health economists view: "British people go to A&E too much"
In reality they do not use them excessively and less than USA. The idea is ridiculous. Health economists are actually worried about budget which has apparently gone up and up. In reality, health spending per capita is actually plateauing. Since 2015 per capita spend has actually decreased and not risen. English figure is very, very low compared to British spending due to a Barnet formula when compared with other countries in the UK.

Dr Moulton then discussed the litigation costs for A&E over 4 yrs. He compared RDH and Royal Bolton Hospital (RBH). Average cost / claims = £149000 RBH & £463,000 at Derby. There were 45 claims at RDH and 71 at RBH. Getting it right is always going to be the cheaper thing to do. Overall, number of A&E claims have doubled but quadrupled in cost. NHS Resolution figures show that A&E accounted for £87M in damages and £54M for costs. 40% of these claims were related to failure to diagnose.

The experts view (Kings fund, Nuffield Trust etc): "There are enough beds"
International bed numbers show we are now bottom of beds with only Sweden lower. A graph showed admissions and bed numbers with diverging lines.
Bed availability has decreased but there has been increased occupancy. Due to bed pressures,

readmissions have a gone up by 30%. RCEM issued a report saying there is a need for 5085 beds but NHSE says need 2000 beds. Due to pressure from RCEM, there has been a reversal in the experts' view regarding bed removal and a move to stabilise or increase the bed numbers instead.

NHS managers' view:
NHS provides adequate care.

CCG view: "Divert people away from A&E"
Dr Moulton showed various headlines by Dailymail / BBC / Gazette stating to think before going to A&E. There are also big signs outside RBH and inside, the A&E clinic sign has big signs about not going there! There is a website about "don't come to A&E". In reality, 20% go to A&E go because they can't work out where else to go. The Patient Association data showed A&E was their first choice. This is because A&E is open 24/7, is free and has reasonable waiting time.

Branding experts say: "A&E is a super brand."
We need to have different types of A&E by educating people which is more appropriate. Use the brand name to good effect. Dr Moulton suggested implementation of A&E hub concept by RCEM.

Do diversion and deflection schemes work? NO! Deflection campaigns target the wrong people. It ends up being elderly staying at home getting more unwell rather than the young people who could be diverted but choose to ignore the advice.

Optimists' view: "All A&E depts have roughly same staffing".

In reality, there are 4-17 doctors /100k population. There is massive variation and workload across the country which correlates with mortality.

The GIRFT- EM work has demonstrated that there is good news - there is less variation after all – across the board, there are no staff, no beds, no functional IT systems, no management and…no hope!!

True cost of variation is mortality difference with 17% in some places. Fewer Drs = more deaths and vice versa. Most evidence for Drs compared to nurses etc.

In terms of social deprivations, evidence shows more deprived = 2x increased attendance compared to least deprived. Coastal communities are the worst affected. Heroin deaths are highest in Blackpool. Specific types of hospitals have different problems - rural vs teaching hospital vs DGHs

Blackpool also has first case of monkey pox.

Public health view: "Preventative medicine is the answer."
Health promotion doesn't save money! Why should it? People live longer and get different diseases!! Curing of one disease makes other diseases more prevalent...! Health promotion is a moral argument and not a financial argument.

To end: IPCC predicted we have 12 yrs to save the world so does it all really matter?

Dr Moulton took questions from the floor before the meeting was closed with thanks expressed from Miss Hewitt.

Register:	16 members
	2 associate members
	5 guests
	1 junior doctor
	69 students