Urgent care: is this the future? Probably

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Most pundits will agree with the Audit Commission that out-of-hours care is inconsistent in both its standard and availability across England.[1] Although this is old news, it is still failing and needs to be considered. The Department of Health published a paper in October 2006, titled ''Direction of travel for urgent care: a discussion document'',[2] which outlines solutions to the problem. This is an important document that, apart from having a snippet of management-speak waffle in its title, needs serious analysis.

The College of Emergency Medicine and other groups with a vested interest in its content will understand that the proposals outlined (or something like them) will be pushed through, regardless of any feedback the government receives. Although we are in the consultation phase of the proposal, the government's track record clearly indicates that the likelihood of them back tracking is remote, whether or not there is any merit, evidence of efficacy or even widespread opposition. Although there has been reversal of some policies emanating from the Home Office and the Department of Education, this is not so in health. PFI hospitals, Foundation Trusts, NHS Direct, Modernising Medical Careers, new employment contracts and the four-hour target are all testimony to this.

Once we get through the pious tone of the first few pages that describe how wonderful the government is at listening to what people want, we are given six identified principles that aim to consider the issues that the government heard when it listened; these six principles are probably no different from what Anueryn Bevin imagined 60 years ago, and reinforce the view that in ''the affairs of man'' there is rarely anything new under the sun. These six principles are followed with a lot of hand ringing about the definition of urgent care. This is either a legitimate exercise in definition or an attempt to obfuscate that much of what they describe is not rocket science but plain old common sense, and they are trying to make it sound as if it is rocket science.

Some clinical case examples show how the brave new world will work.

Emily is a 28-year-old woman with a brain tumour. Her primary healthcare team will draw up a detailed care plan setting out exactly what should be done if her condition deteriorates, copies of which will go to her general practitioner and to the out-of-hours service! (My exclamation mark). The out-of-hours service is told that Emily's condition can change suddenly (believe me in this), emergency drugs that she may need (determined by the detailed care plan) can be kept in the home and her parents are given the telephone number of the out-of-hours service for weekends and other occasions when her primary healthcare team is unavailable. Wow.

Joan, an 82-year-old widow, who, in a crisis (such as a domestic fire), will be identified by urgent care practitioners as a vulnerable old person, and they will refer her to intermediate care or specialist old age services. She will eventually have a long-term support plan put in place. Goodness me.

Polly, a 40-year-old severely depressed teacher with a failed suicide attempt, will have a detailed care plan and some prearranged emergency contacts, who in turn can contact the crisis resolution team (who have direct access to a psychiatrist) in an emergency; this team in turn will draw up a short-term management plan that in itself will include input from other healthcare and social care professionals. This large layered team will stay in touch with her until the crisis passes. They can even arrange for her to be admitted for inpatient care. Phew.

Jack is a 3-year-old boy who has a slight delay in being diagnosed with measles. In the ideal world, he will have access to carers and health professionals who have knowledge of common childhood illness and know how to assess a developing disease. Minor ailment protocols will be agreed across the health community, and there will even be the ability to refer cases to other appropriate services, including health professionals with specific experience in paediatrics; there will even be an ability to refer on for prompt secondary opinion and care. Well, knock me over with a feather. Thank goodness for that.

Forgive me if this reads as cynical and sarcastic, but are we missing something? Didn't this used to take place under the umbrella of something called general practice and family medicine? Didn't those doctors who went into general practice as their preferred career choice want to provide a continuity of care that was missing in hospital practice, being the lynch pin of care for the patient? Watch their patients grow old as they themselves grew old? I know that healthcare and the public's expectations have changed. I know that the working hours were unsustainable and there is a new general practitioner contract. I know that the system was not perfect and had many inconsistencies in it, but have we lost something or am I naive and idealistic? Is a square wheel being invented in place of a round one?

Moving on, the College needs to give a formal opinion to the Department of Health. The precise implications for our speciality are unclear at this stage, but theoretically the volume of attendances in the emergency department will decrease. For those who need admission to hospital, will it be as direct ward admissions or via the emergency department? Who will vet the preliminary community-based diagnoses? Other issues to consider (and not in any particular order of merit) are as follows: where will all the proposed health carers come from, who will employ them, who will train them, where will they be housed and who will be responsible for coordinating them and the promiscuous paper trail (electronic and hard copy) that will inevitably grow? We can also safely assume that there will be a plethora of tick boxes to tick. The government record on NHS software development and inter agency communication is underwhelming in its success, and is thus no guarantee of being the backbone to all this.

Another question comes to mind. If the primary care trusts are managing all this, through practice-based commissioning, and, by acting as the gate keeper manage to keep patients out of hospital and under the care of primary care, will there be a transparent audit trail to ensure that there is no double dipping? Potential or real conflicts of interest will need to be declared.

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