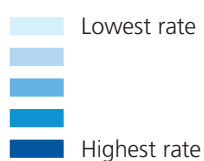


## EMERGENCY CARE

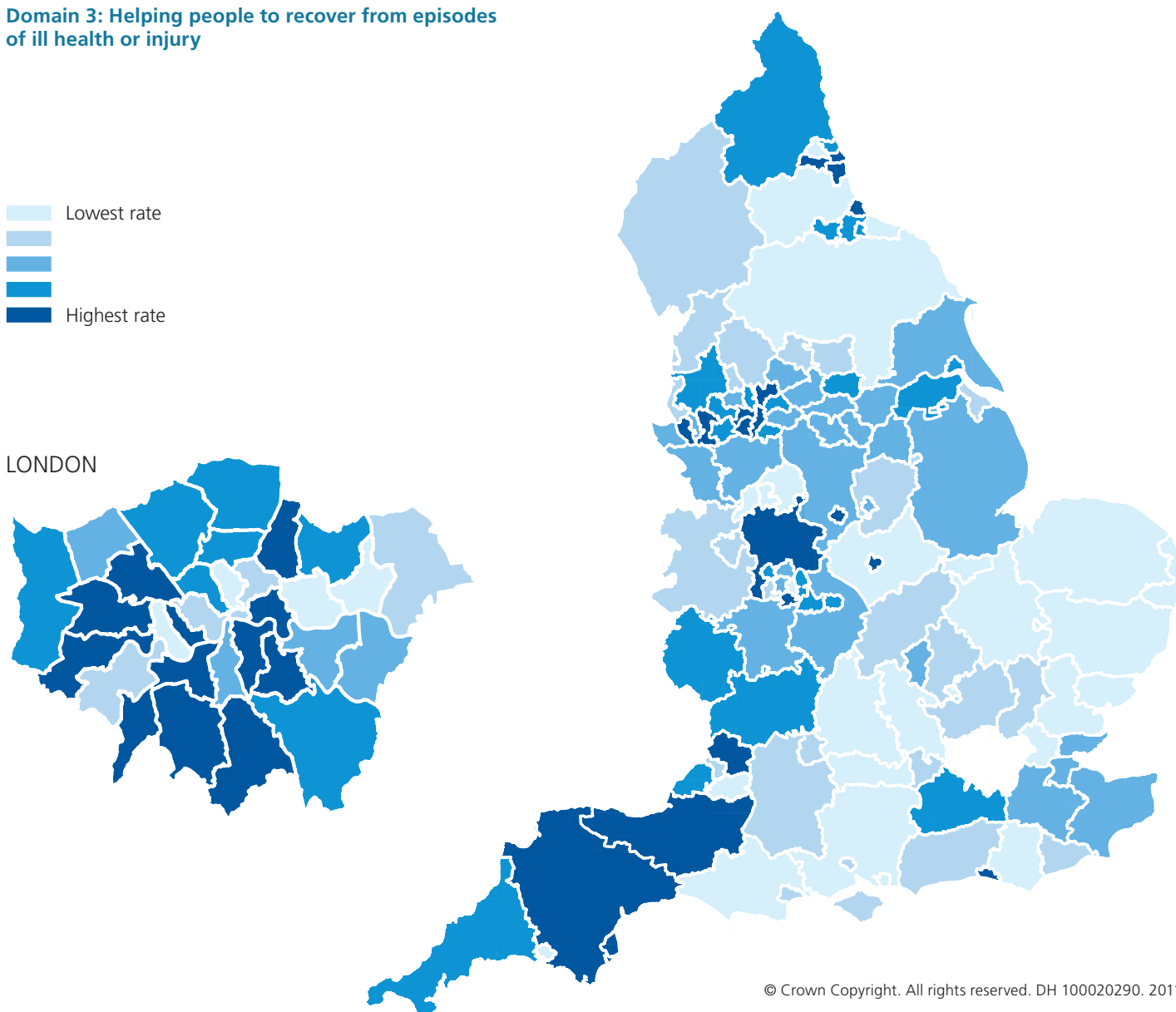
## Map 62: Rate of accident and emergency (A&E) attendances per population by PCT

Directly age-, sex- and deprivation-standardised rate 2010

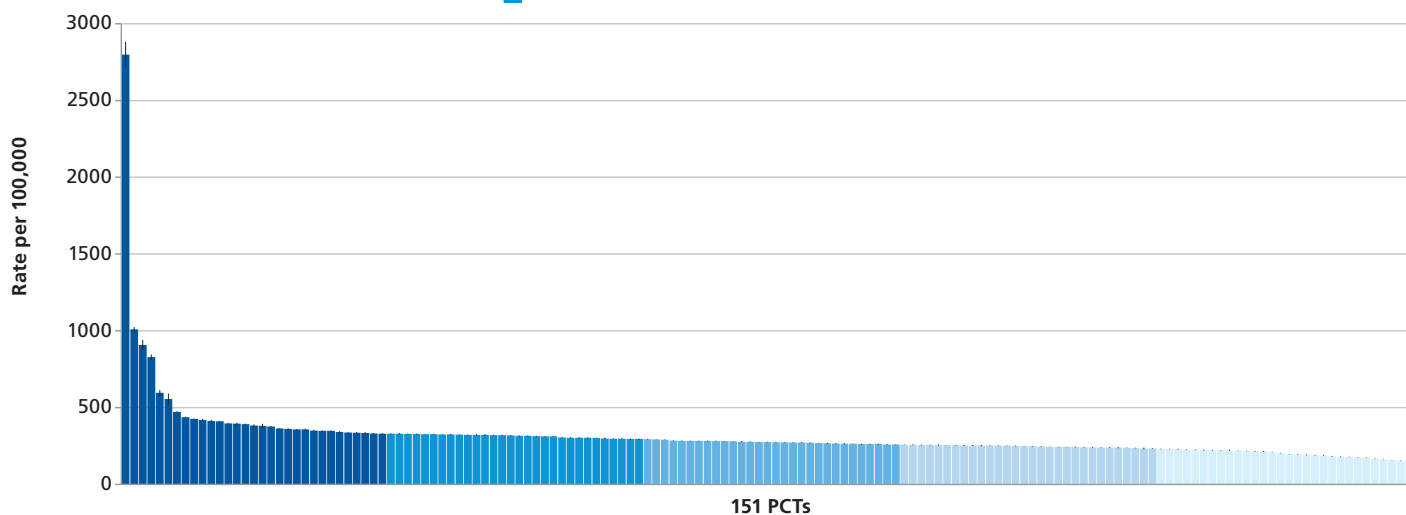
Domain 3: Helping people to recover from episodes of ill health or injury



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## Context

In England, there were about 21.4 million attendances at all departments in 2010/11. On average, a person attends accident and emergency (A&E) once every five years. Rate of attendance is higher for people during the first and the last five years of life. Reasons for attendance at A&E vary with age:

- Children attend for illness and injury;
- Young people attend usually by reason of an accident, which may be related to sport or alcohol consumption in those aged 15–30 years;
- Older people attend for acute episodes of illness or because of deterioration in functional ability often related to multisystem failure.

## Magnitude of variation

For PCTs in England, the rate of A&E attendances per 100,000 population ranged from 148.9 to 2798.2 (19-fold variation). When the five PCTs with the highest rates and the five PCTs with the lowest rates are excluded, the range is 174.8–556.0 per 100,000 population, and the variation is 3.2-fold.

Reasons for variation include differences in:

- Health profiles of populations, including the number of people with chronic disease;
- Injury rate in different areas;
- The way different groups choose to access healthcare.

Reasons for unwarranted variation include differences in:

- Ease of access to primary care and alternative urgent care services;
- Access to other services and facilities in the community, e.g. community nurses for the management of long-term conditions;
- Re-attendance rates (although some variation is warranted when patients are advised to return);
- The proportion of 999 calls closed with telephone advice or managed without transport to A&E where clinically appropriate.

## Options for action

To prevent attendances related to chronic disease, commissioners and providers need to review chronic

disease and case management for the local population, with the emphasis on care being available in the community.

To prevent attendances by older people in nursing or residential care homes, commissioners and providers need to explore the options that would enable older people to remain in the home, rather than be taken to hospital (see Map 65), or to die in their usual place of residence (see Map 66).

To reduce the overall number of attendances, commissioners and providers could use the A&E quality indicator on re-attendance to ascertain the reasons for re-attendance. Effective case management and ensuring patients receive the right care first time will also improve patient experience and outcomes.

To reduce the number of 999 calls resulting in conveyance by ambulance to A&E, commissioners and ambulance trusts should collaborate to ensure that best use is made of telephone advice, definitive treatment at scene and conveyance to community services where appropriate.

To increase access to primary care, commissioners, providers and GPs could:

- implement the Doctor First Programme, developed in East Midlands SHA, an evidence-based method of reversing the rising trend of A&E attendances and emergency admissions through access to GPs by telephone; it also reduced the number of surgery consultations by one-third;<sup>1</sup>
- consult the work of the Primary Care Foundation on Urgent Care in General Practice (see “Resources”).

To simplify access to alternative urgent care services, commissioners, providers and GPs need to ensure the provision of a coherent 24/7 service, together with in-hours GP services, that patients find easy to navigate. Roll-out of the NHS 111 service will support easier navigation.

## RESOURCES

- Primary Care Foundation (2009) Urgent Care in General Practice (report). A web-based tool to help practices write capacity plans to ensure effective resource use and improve the management of urgent care is in development.  
<http://www.primarycarefoundation.co.uk/urgent-care-in-general-practice.html>

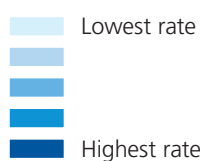
<sup>1</sup> <http://healthcareinnovationexpo.com/sha-nhseastmidlands-transformingurgentcare.asp>

## EMERGENCY CARE

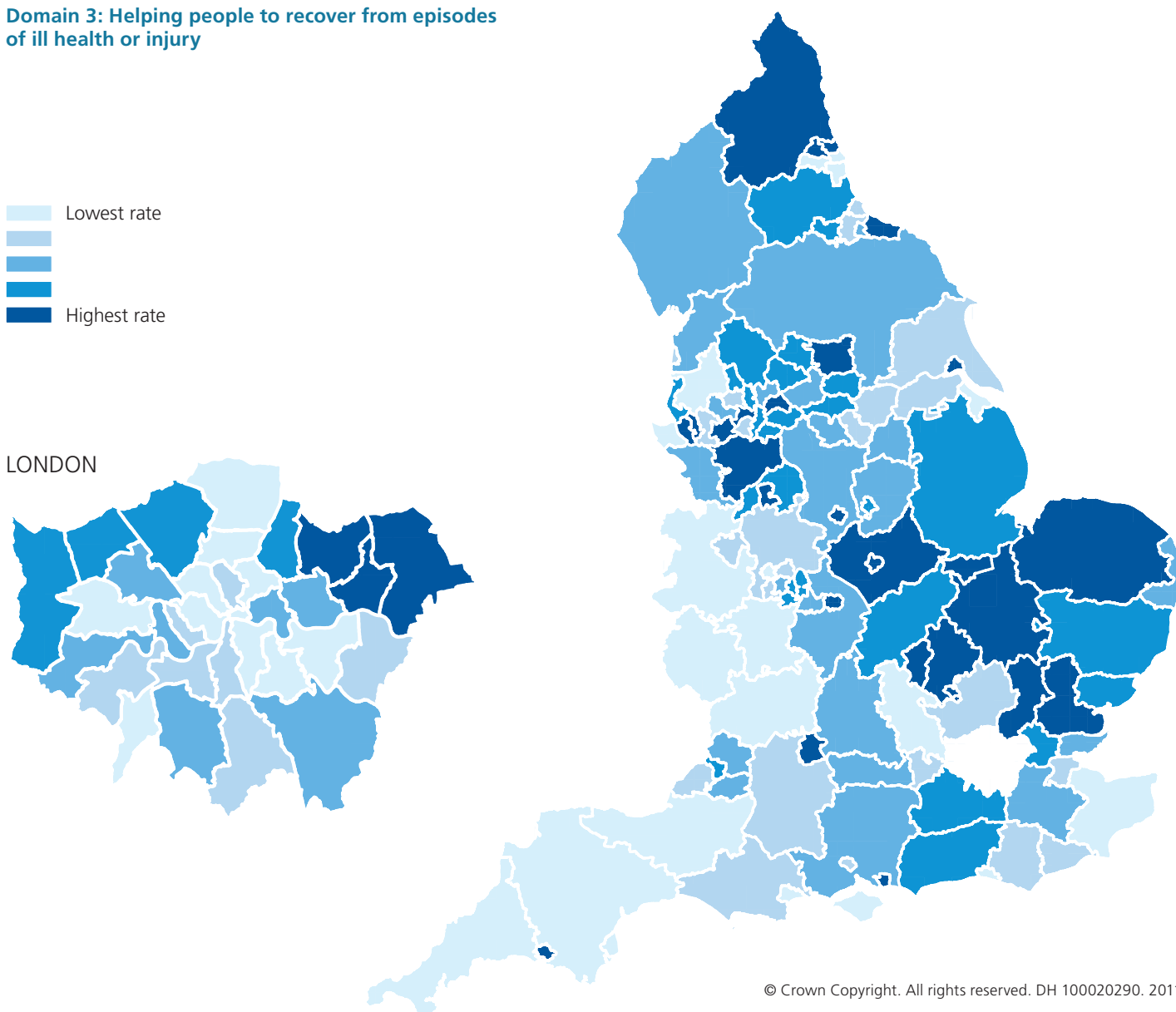
## Map 63: Rate of conversion from accident and emergency (A&E) attendance to emergency admissions by PCT

Directly age-, sex- and deprivation-standardised rate 2010

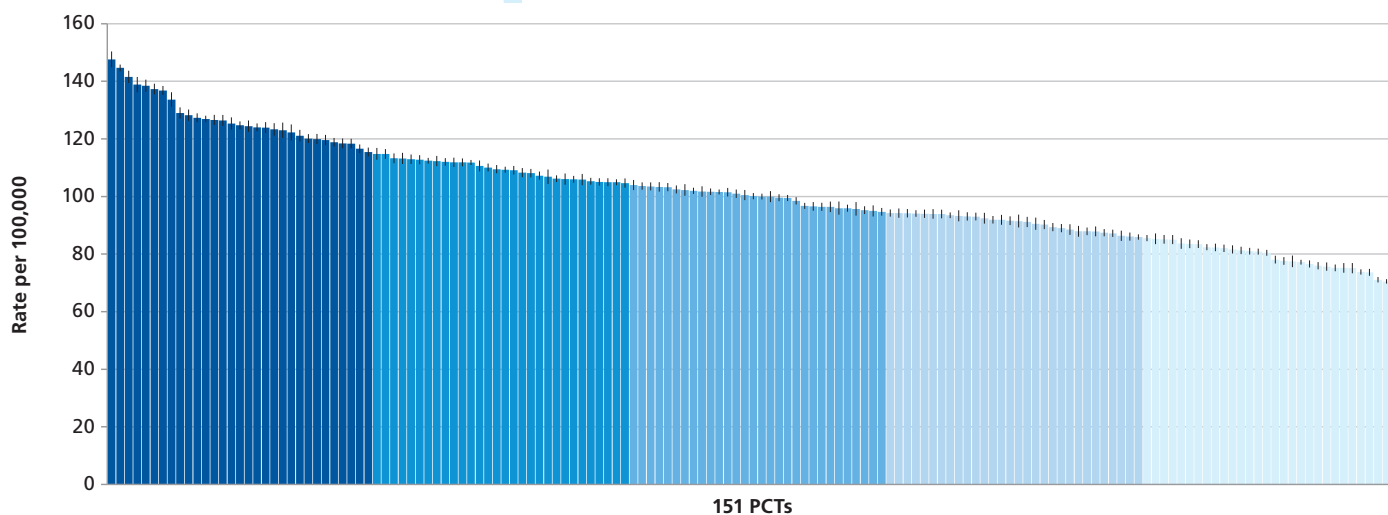
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## Context

The majority of conversions of accident and emergency (A&E) attendances to admissions are medical; only a minority are related to major trauma.

The conversion of an A&E attendance to an admission has a considerable impact on the cost of care.

## Magnitude of variation

For PCTs in England, the rate of conversion from A&E attendance to admissions per 100,000 population ranged from 70.1 to 147.6 (2.1-fold variation). When the five PCTs with the highest rates and the five PCTs with the lowest rates are excluded, the range is 75.1–137.3 per 100,000 population, and the variation is 1.8-fold.

Although the degree of variation for this indicator is less than that seen for A&E attendances (see Map 62), the cost of conversion to admission is much greater than that for A&E attendance. Thus, the financial implications of variation in this indicator are of greater concern, but offer an opportunity for maximising value for patients and local populations by improving the quality of care.

Reasons for variation include differences in:

- Access to primary and community services for long-term conditions;
- Service models for urgent and emergency care, and, in particular, the availability of ambulatory emergency care;
- Disease case-mix in different populations.

Although there are differences in case-mix, variation is still observed across the country in conversions for the same condition in the same age-group. This would indicate that there is some unwarranted variation in the conversion of A&E attendances to admissions.

Another reason for unwarranted variation could be differences in access to good-quality primary and community care for long-term conditions at the time of need, which means that for some patients their condition declines to the point that a hospital stay is required.

Once a patient's condition requires an emergency response, the availability of ambulatory emergency care services, in which the patient can be treated without the need for admission to hospital, can have a considerable impact on variation (see Map 64).

## Options for action

Commissioners and providers need to review the case-mix seen at A&E, and the conversion of A&E attendance to admissions, and ascertain the reasons for the rate observed locally. For instance:

- conversion rates could appear to be high if A&E departments deal with only major cases, and minor injuries are dealt with in community hospitals;
- conversion rates could appear to be low if minor injuries are dealt with at A&E.

A key element in the review is to investigate short-stay admissions, and assess whether people are being admitted for assessment rather than being assessed then admitted, although advances in medical practice have led to some reductions in length of stay.

Commissioners and providers should consider:

- The ways in which unplanned admissions to hospital can be reduced [see table on page 33 of Ham (2006) under "Resources" for a summary of evidence about interventions to reduce unplanned admissions and length of stay];
- The role ambulatory emergency care can play in treating patients effectively without the need for hospital admission (see Map 64).

## RESOURCES

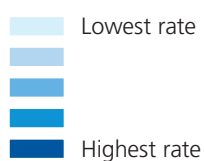
- Ham C (2006) Reducing unplanned hospital admissions. HSMC, University of Birmingham.  
<http://www.birmingham.ac.uk/Documents/college-social-sciences/social-policy/HSMC/publications/2006/Reducing-unplanned-hospital-admissions.pdf>
- The College of Emergency Medicine.  
<http://www.collemergencymed.ac.uk/>

## EMERGENCY CARE

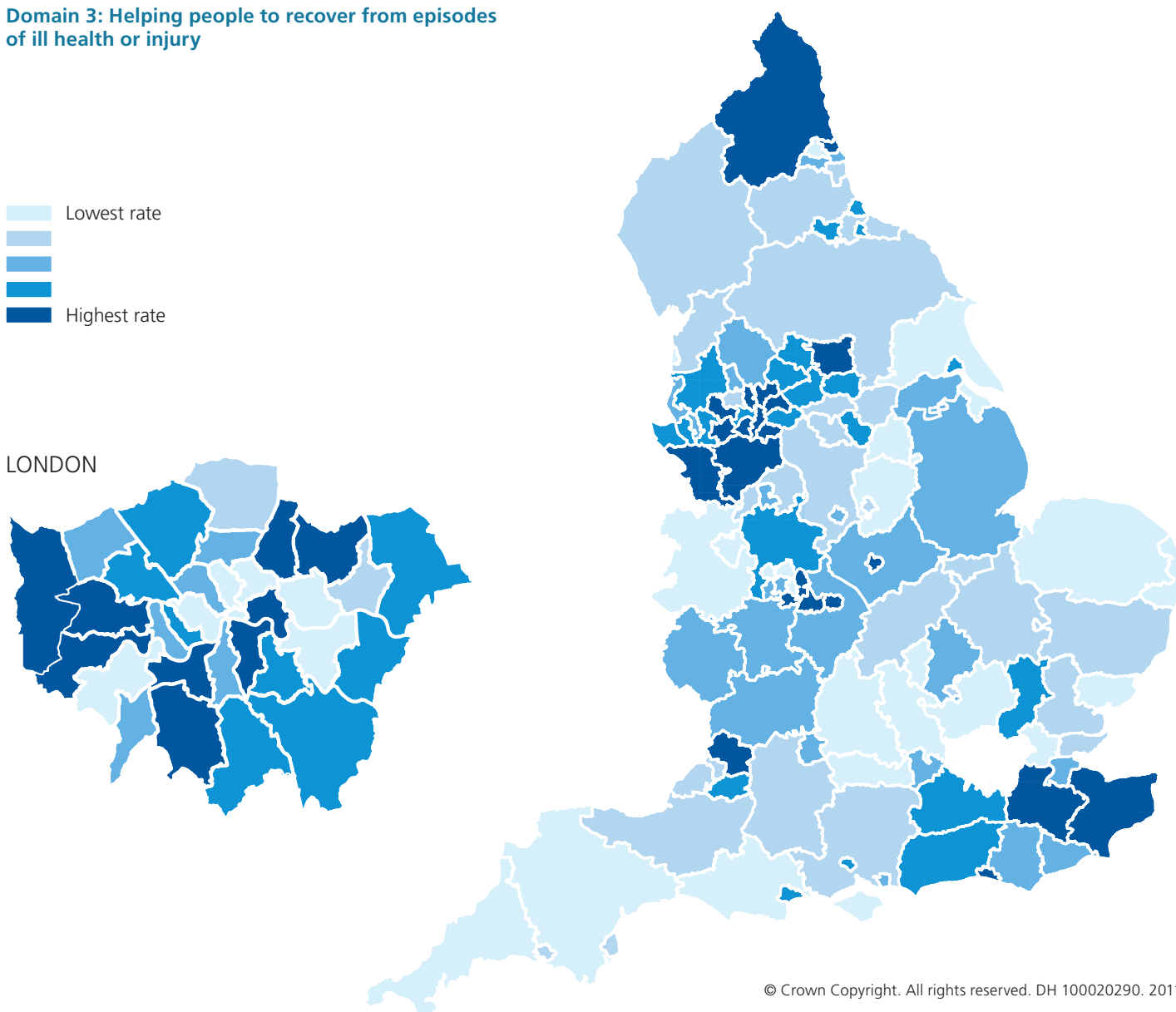
## Map 64: Rate of admissions with emergency ambulatory care conditions (EACCs) per population by PCT

Directly age-, sex- and deprivation-standardised rate 2010

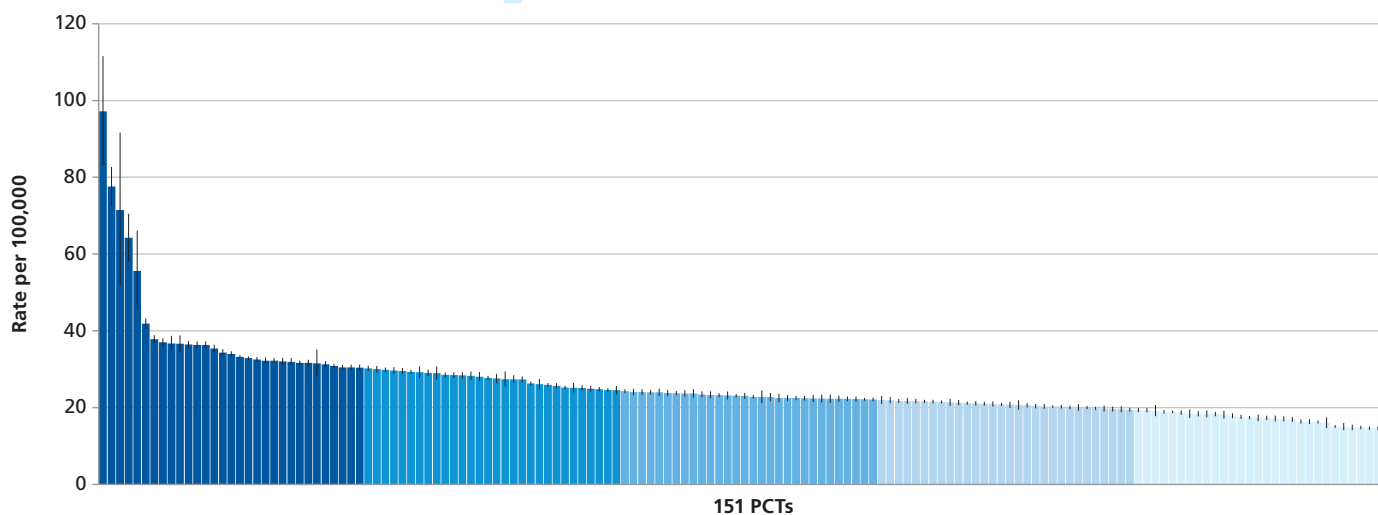
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## Context

Admissions to hospital beds can be reduced by introducing ambulatory emergency care models, which avoid unnecessary overnight stays for emergency patients. This change in medical practice, with a shift towards treating people outside the acute hospital setting, has occurred for several reasons:

- Improving patient outcomes;
- Patient preference not to be hospitalised;
- Reduced healthcare costs.

The NHS Institute has compiled a Directory of 49 emergency conditions and clinical scenarios that have the potential to be managed on an ambulatory basis (see “Resources”). Furthermore, the NHS Institute has estimated that reducing variation in the rates of admission with EACCs in England could save £170–£250 million.<sup>1</sup>

The King’s Fund has made managing ambulatory care-sensitive conditions one of its 10 priorities for commissioners to transform the healthcare system (see “Resources”).

## Magnitude of variation

For PCTs in England, the rate of admissions with EACCs per 100,000 population ranged from 14.5 to 97.2 (7-fold variation). When the five PCTs with the highest rates and the five PCTs with the lowest rates are excluded, the range is 15.0–41.9 per 100,000 population, and the variation is 2.8-fold.

Reasons for variation include differences in:

- The number of admissions to hospital that are necessary;
- Co-morbidities patients may have;
- The social circumstances of some patients – can they cope with the condition at home or do they need to be cared for in hospital?

Possible reasons for unwarranted variation include:

- The organisation of local services, including the availability of community services and facilities;

- The capacity and level of expertise among healthcare personnel in the local community, such as nurses able to administer intravenous drugs;
- The level of collaborative working among accident and emergency departments, ambulance services, primary care, and different secondary care specialities;
- Access, including rapid access, to diagnostic services.

## Options for action

Commissioners and providers need to work together to:

- Review the range of chronic conditions for which active disease management can be used to prevent acute exacerbations and reduce the need for emergency hospital admissions in the local population, e.g. diabetes (see Maps 6, 7 and 9), epilepsy (see Map 20), chronic obstructive pulmonary disease (COPD; see Map 36) and asthma (see Maps 38 and 39), taking into account local capacity;
- Develop care pathways for relevant EACCs;
- Learn from the work of other services.

A best practice tariff for Ambulatory Care is starting in 2012. Commissioners and providers could take this opportunity to negotiate appropriate tariffs for EACCs, and ensure there is not a perverse financial incentive to admit patients.

## RESOURCES

- NHS Institute for Improvement and Innovation. Ambulatory emergency care – manage your emergencies as day cases, including the Emergency Care Innovation Delivery Network (which will run for 12 months), The Directory of Ambulatory Emergency Care for Adults (2007), Increasing Day Case Rates for Emergency Care (dataset of Q1 and Q2 2010 data), and How to Implement Ambulatory Emergency Care (2010). [https://www.institute.nhs.uk/index.php?option=com\\_content&task=view&id=1530&Itemid=4009](https://www.institute.nhs.uk/index.php?option=com_content&task=view&id=1530&Itemid=4009)
- The King’s Fund. Managing ambulatory care sensitive conditions, including a link to a risk stratification tool that uses inpatient data to identify patients at risk of re-hospitalisation within 1 year. [http://www.kingsfund.org.uk/current\\_projects/gp\\_commissioning/ten\\_priorities\\_for\\_commissioners/acs\\_conditions.html](http://www.kingsfund.org.uk/current_projects/gp_commissioning/ten_priorities_for_commissioners/acs_conditions.html)

<sup>1</sup> <http://www.productivity.nhs.uk/Indicator/608/For/National/And/25th/Percentile>