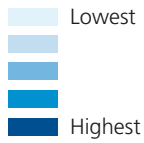


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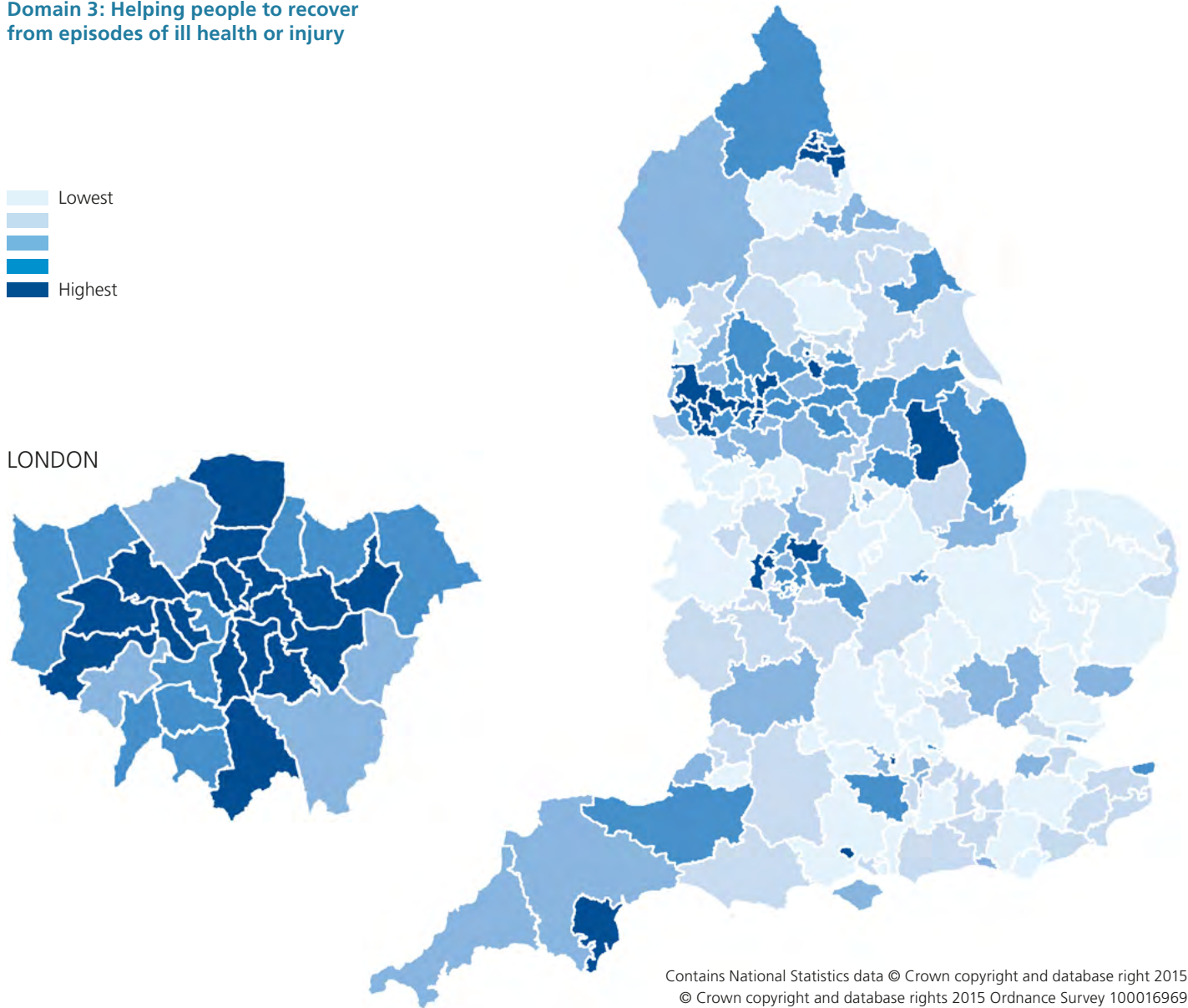
Map 93: Rate of accident and emergency (A&E) attendances per population by CCG

Directly standardised rate, adjusted for age and sex, 2012/13

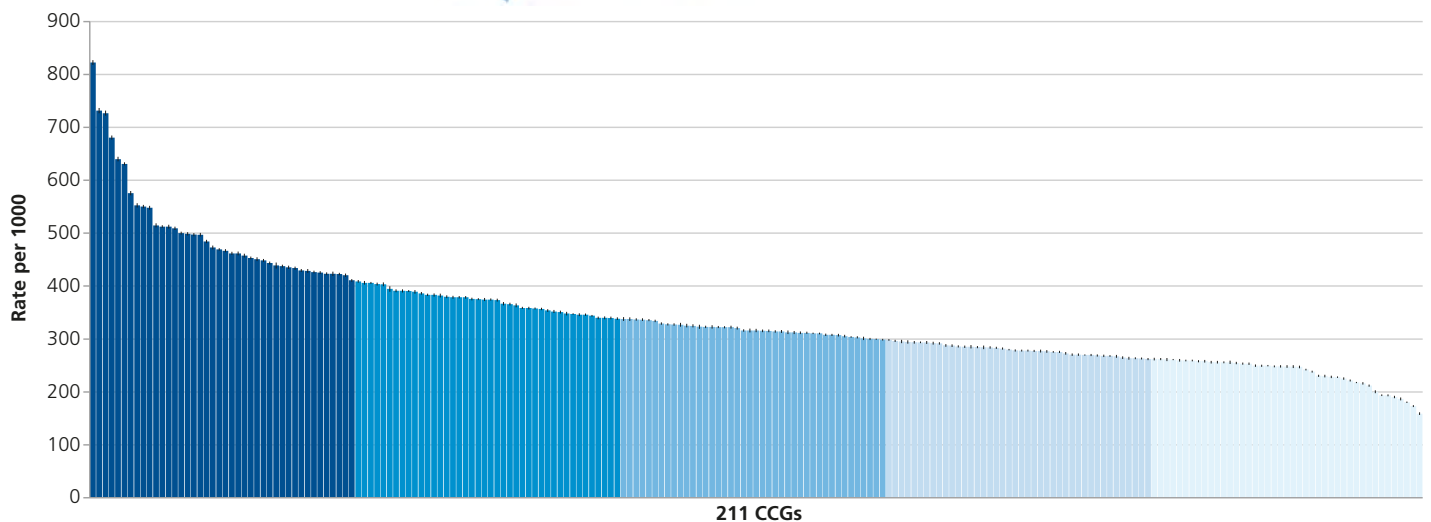
Domain 3: Helping people to recover from episodes of ill health or injury



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Context

In 2012/13 in England, there were almost 14.9 million attendances at Type 1 and Type 2 accident and emergency (A&E) departments, increasing to 15.2 million in 2014/15.¹

Rates of A&E attendance have increased over recent years, with a particular growth in attendance by younger children, young adults and older people. Reasons for attendance vary with age:

- illness and injury in children;
- accidents in young people, which may be related to sport or alcohol consumption;
- acute episodes of illness or a deterioration in functional ability, often related to multisystem failure, in older people.

A&E Departments can also act as a "safety net":

- people attend because there is no alternative service available to them at that time;
- people attend on the advice of other healthcare providers;
- A&E departments are understood to be always open and able to deal with a wide range of problems in a prompt and reliable way.

Magnitude of variation

For CCGs in England, the rate of A&E attendances ranged from 158.8 to 822.6 per 1000 population (5.2-fold variation). When the seven CCGs with the highest rates and the seven CCGs with the lowest rates are excluded, the range is 200.2–552.7 per 1000 population, and the variation is 2.8-fold.

Reasons for the degree of variation observed include differences in:

- health profiles of local populations, including the number of people with long-term disease, and levels of deprivation;
- injury rates in different areas;
- geographical factors – people are more likely to attend an A&E department if it is close to their home;
- the way different population groups 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 re-attendance is warranted when patients are advised to return should their condition deteriorate;
- the proportion of NHS 111 and 999 calls closed with telephone advice or managed without attendance at an A&E department, where clinically appropriate.

Options for action

To reduce attendances related to long-term disease, commissioners and service providers need to review long-term disease and case management for the local population, with the emphasis on care being available in the community.

To prevent attendances by older people who live in nursing or residential care homes, commissioners need to specify that service providers explore options that enable older people to remain in the home, rather than be taken to hospital (see Map 62, pages 176–177), or to receive end-of-life care in their usual

place of residence (see Map 67, pages 185–187). These include advanced care planning and additional input from primary care.

Improved capacity within, and access to, general practice will reduce A&E attendance rates. This can be supported by introducing new models of primary care access, for example:

- increased use of the telephone and electronic communication;
- an enhanced role for non-medical practitioners;
- the provision of minor ailments schemes in community pharmacies.

To reduce the number of NHS 111 calls that result in A&E attendance, commissioners and providers should consider how patient data can be more effectively shared between services, and the provision of enhanced clinical input, for example, through the development of an urgent care clinical hub.

To reduce the number of 999 calls resulting in conveyance by ambulance to A&E, commissioners and ambulance trusts need to collaborate to ensure that best use is made of telephone advice, definitive treatment at scene and conveyance to community services where appropriate. This is likely to involve an up-skilling of the ambulance workforce with enhanced support from primary and secondary care. NHS Blackpool and NHS Fylde & Wyre CCGs have achieved considerable improvements at very little cost through a "High Intensity Users" project led by an advanced paramedic (see "RightCare Casebook").

To reduce the overall number of attendances, commissioners and service providers need to review the attendance pattern at A&E, and consider the provision of alternative services to meet demand, such as an enhanced role for primary and community services, and the provision of effective social care, dentistry services and mental health services. Important components of this role are:

- primary and/or community service triage as the first point of contact in A&E departments;
- co-location of an Urgent Care Centre with A&E.

RIGHTCARE CASEBOOK

- Johnston M, Monteith R. Commissioning for Value: Reducing the Number of High Intensity Users of Unscheduled Services. Right Care Casebook Series. February 2015. bit.ly/rc_blackpool

RESOURCES

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- The King's Fund. A selection of policy analysis and other content regarding urgent and emergency care. <http://www.kingsfund.org.uk/projects/urgent-emergency-care?gclid=CKzD4P7J1sECffMzAodX1wAsg>
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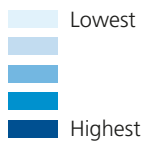
1 NHS England. A&E Attendances and Emergency Admissions 2012-13. <http://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/weekly-ae-sitreps-2012-13/>

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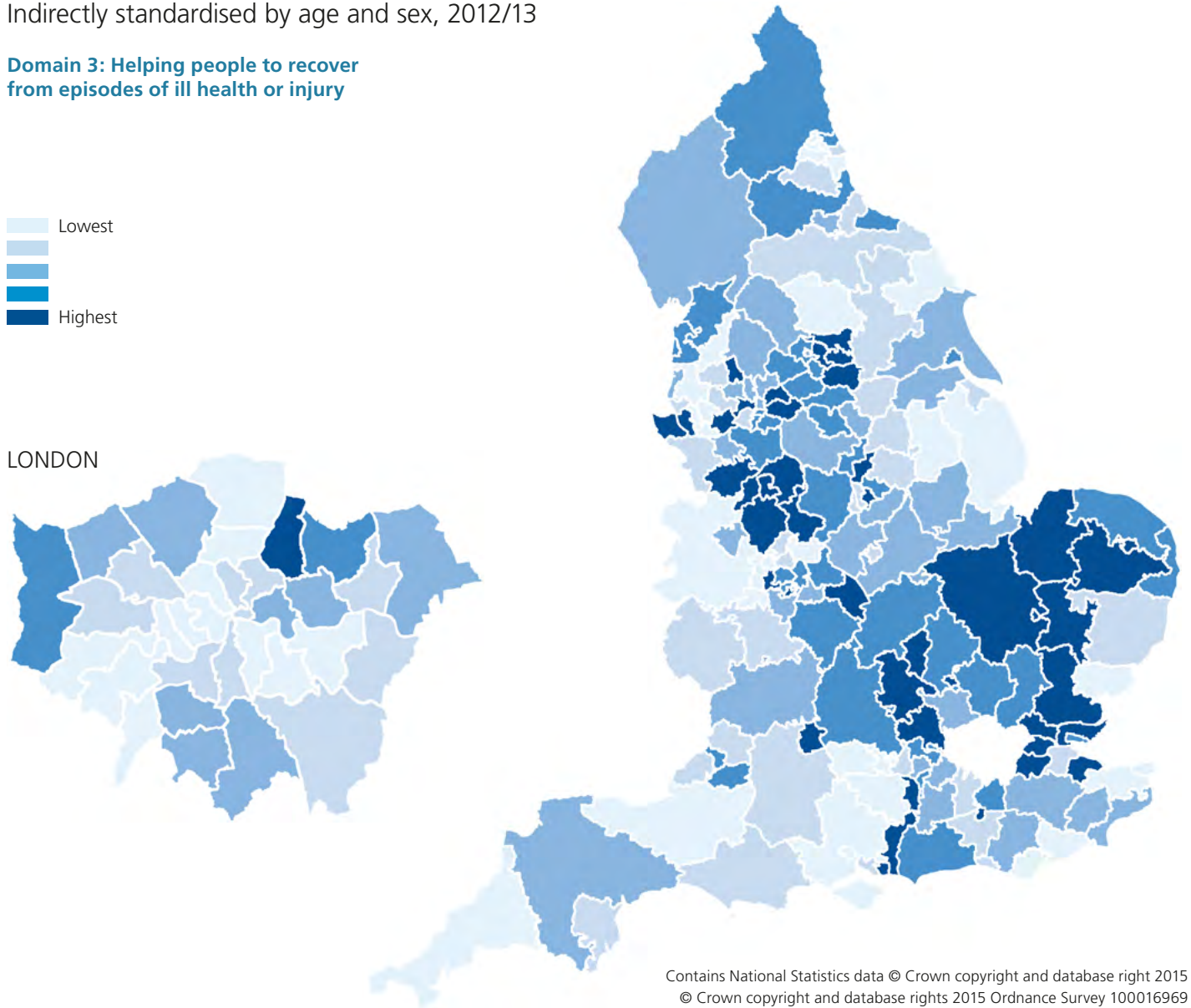
Map 94: Percentage of accident and emergency (A&E) attendances that resulted in emergency admission to hospital by CCG

Indirectly standardised by age and sex, 2012/13

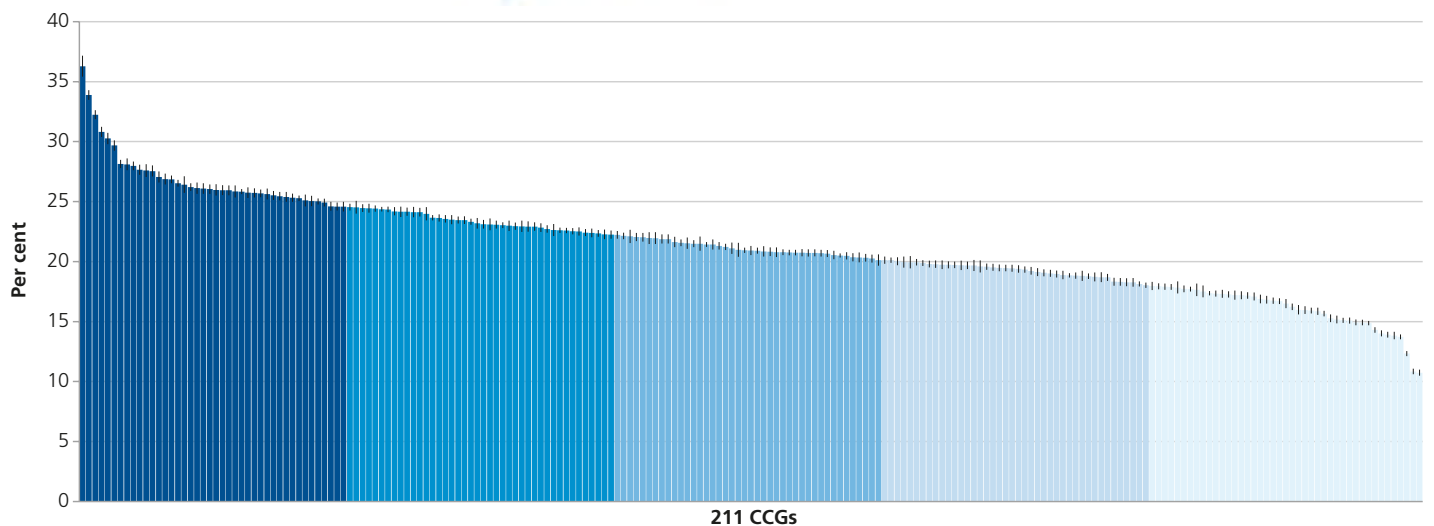
Domain 3: Helping people to recover from episodes of ill health or injury



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Context

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

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

Magnitude of variation

For CCGs in England, the percentage of A&E attendances that resulted in emergency admission to hospital ranged from 10.7% to 36.3% (3.4-fold variation). When the seven CCGs with the highest rates and the seven CCGs with the lowest rates are excluded, the range is 14.3–28.1%, and the variation is 2.0-fold.

Although the degree of variation for this indicator is less than that seen for A&E attendances (see Map 93, pages 238–239), the cost of conversion to emergency admission to hospital is much greater than that for A&E attendance. Thus, the financial implications of variation in this indicator are of greater concern, and offer an opportunity for maximising value for patients and local populations by improving the quality of care.

Reasons for the degree of variation observed 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;
- the availability of senior staff and diagnostics at the “front door” of the hospital;
- disease case-mix in local 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 emergency 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 for some patients means their condition declines to a point at which 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 “Resources”).

Options for action

Commissioners and service providers need to review the case-mix seen at A&E departments locally, assess the percentage of A&E attendances that result in emergency admissions to hospital, and ascertain the reasons for the percentage observed.

- Percentage admissions could appear to be high if A&E departments deal with only major cases, and minor injuries are dealt with in other settings.
- Percentage admissions could appear to be low if a large proportion of minor injuries and/or primary-care problems are dealt with at A&E.

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

Commissioners need to specify that service providers consider:

- ways to reduce unplanned admissions to hospital;
- introducing senior decision-making staff (e.g. consultants in Emergency and Acute Medicine working with primary care practitioners) at the “front door” of the hospital, together with immediate access to key diagnostic technologies such as CT scanning;
- the role of ambulatory emergency care in treating patients without the need for hospital admission (see “Resources”) – this service has been shown to be highly effective, and should be developed further wherever possible.

RESOURCES

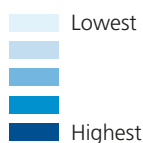
- Royal College of Emergency Medicine. <http://www.rcem.ac.uk/>
- Ambulatory Emergency Care (AEC), including the AEC Delivery Network. <http://www.ambulatoryemergencycare.org.uk/>
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- The King’s Fund. Data Briefing. Emergency hospital admissions for ambulatory care-sensitive conditions: identifying the potential for reductions. April 2012. http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/data-briefing-emergency-hospital-admissions-for-ambulatory-care-sensitive-conditions-apr-2012.pdf

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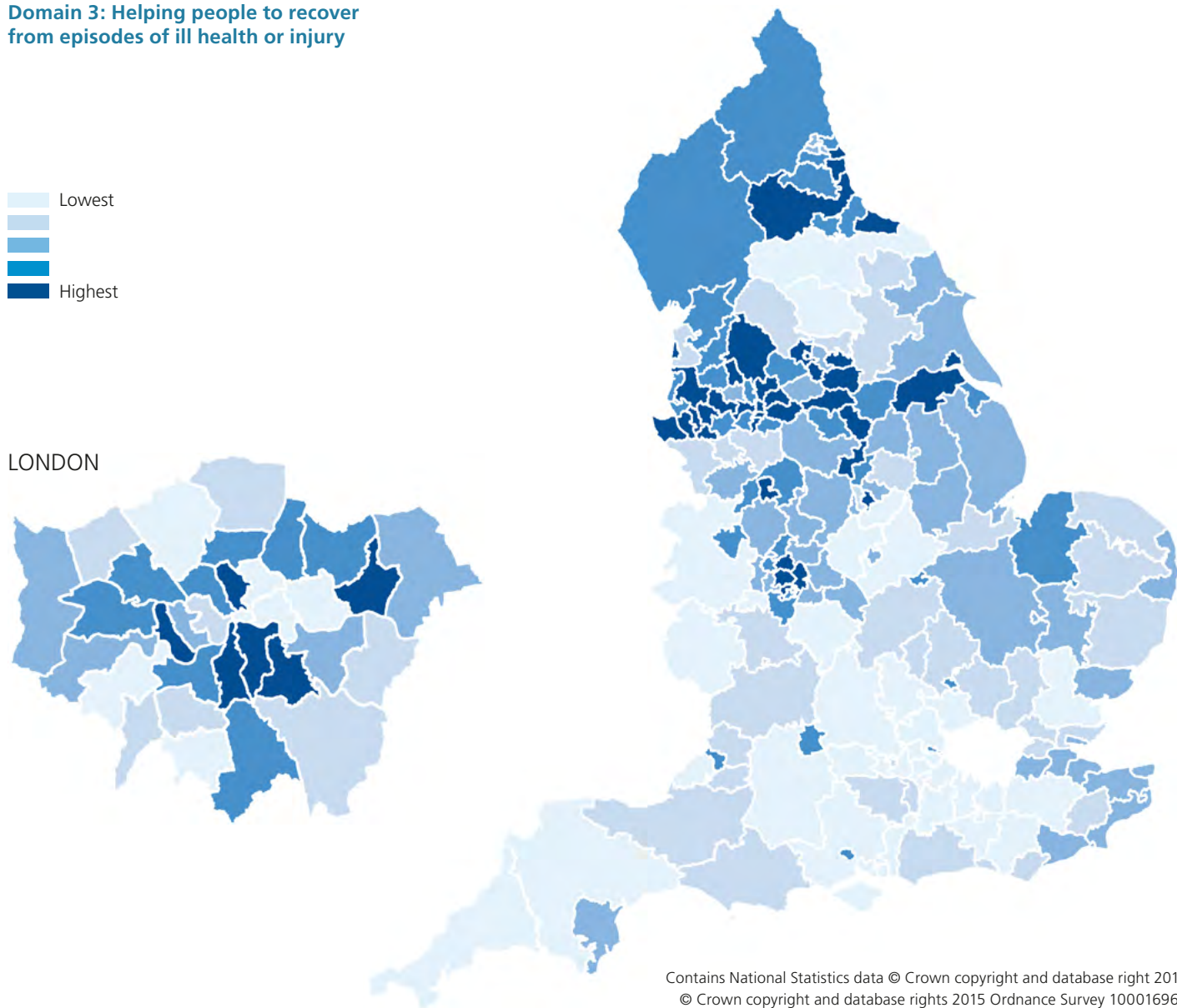
Map 95: Rate of emergency admission to hospital for ambulatory care-sensitive conditions per population by CCG

Directly standardised rate, adjusted for age and sex, 2012/13

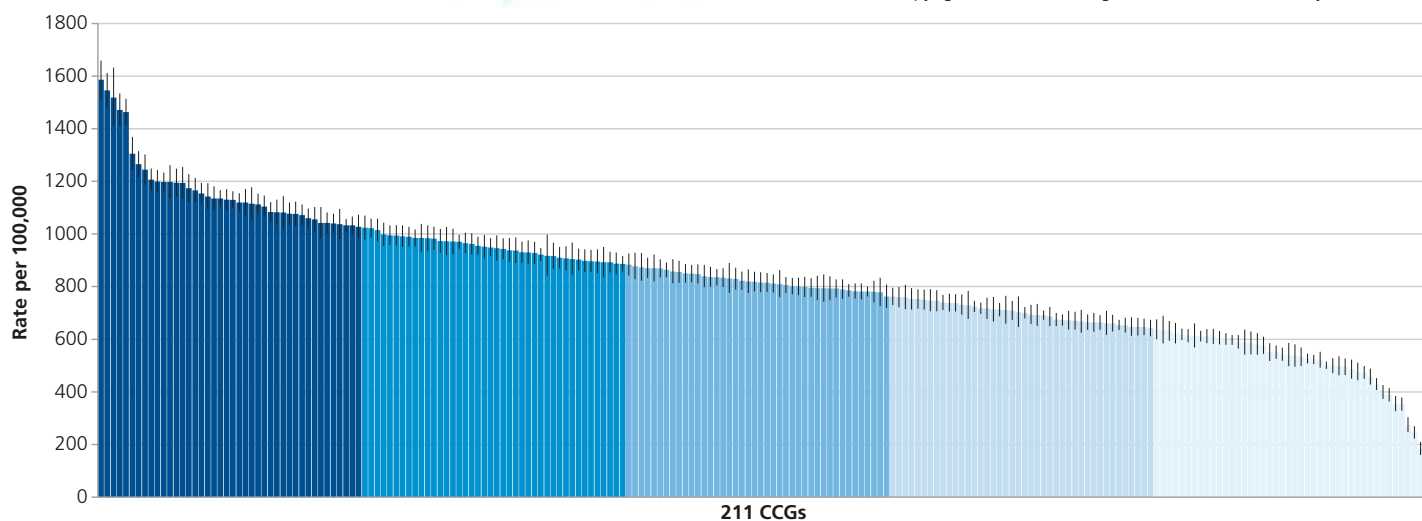
Domain 3: Helping people to recover from episodes of ill health or injury



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Context

Ambulatory care-sensitive conditions are long-term conditions for which it is possible to prevent acute exacerbations and reduce the need for hospital admission through active management.¹ Admissions to hospital beds can be reduced by introducing ambulatory emergency care (AEC) 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:

- › to improve patient outcomes;
- › to meet patients' preferences not to be hospitalised;
- › to reduce pressure on hospital beds.

In 2011/12, the NHS Institute worked with acute trusts, commissioners and primary care teams to support and accelerate the local development of ambulatory care through the spread and adoption of good practice and utilisation of improvement methodologies – the AEC Delivery Network (see “Resources”).

Following on from the Institute's work, NHS Elect now hosts the programme. Five consecutive cohorts have completed the programme, with teams reporting considerable progress in converting emergency admissions into “same-day” emergency episodes, thereby reducing avoidable admissions. The Network delivers two cohorts per year; one starting in the Spring and one in the Autumn.

The King's Fund made managing ambulatory care-sensitive conditions one of its ten priorities for commissioners to transform the healthcare system.¹

Magnitude of variation

For CCGs in England, the rate of emergency admission to hospital for ambulatory care-sensitive conditions ranged from 184 to 1586 per 100,000 population (8.6-fold variation). When the seven CCGs with the highest rates and the seven CCGs with the lowest rates are excluded, the range is 429–1245 per 100,000 population, and the variation is 2.9-fold.

Reasons for the degree of variation observed include differences in:

- › the number of admissions to hospital that are necessary;
- › the co-morbidities patients may have;
- › the social circumstances of some patients – whether they are able to cope with the condition at home or whether 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, for example, nurses able to administer intravenous drugs;

- › the extent 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

Taking into account local capacity, commissioners and service providers need to work together to review the range of long-term conditions for which active case management and supported self-management can be used to prevent acute exacerbations, and reduce the need for emergency hospital admissions in the local population, for example:

- › diabetes;
- › epilepsy (see Map 14, pages 70–71);
- › chronic obstructive pulmonary disease (COPD; see Map 22, pages 86–87);
- › asthma (see Map 23, pages 88–89, and Map 82, pages 216–217).

Commissioners need to specify that service providers:

- › develop care pathways for appropriate ambulatory care-sensitive conditions;
- › learn from the work of other services, and participate in the AEC Delivery Network where possible.

A best practice tariff for Ambulatory Care was introduced in 2012, which has been helpful in addressing some of the financial barriers to the effective implementation of new services. Commissioners and providers need to work together to build on this and explore opportunities for further service improvement.

RESOURCES

- › Ambulatory Emergency Care (AEC), including the AEC Delivery Network. <http://www.ambulatoryemergencycare.org.uk/>
- › The King's Fund. Managing ambulatory care sensitive conditions. From: Transforming our health care system. Ten priorities for commissioners. April 2013. http://www.kingsfund.org.uk/current_projects/gp_commissioning/ten_priorities_for_commissioners/acs_conditions.html
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