



Kent Joint Strategic Needs Assessment (Kent JSNA)

Kent 'Urgent Care' JSNA Chapter Summary Update '2014/15'

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Kent Urgent Care JSNA Chapter Update 2014

Definition

Urgent care is an umbrella term to include unscheduled care, unplanned care and emergency care. It is the range of response that health and care services provide to people who require – or who perceive the need for – urgent advice, care, treatment or diagnosis. People using the services and carers should expect 24/7 consistent and rigorous assessment of the urgency of their care need and an appropriate and prompt response to that need. This can include many specialist secondary care services, Emergency Departments (ED), urgent care centres, walk-in centres and minor injury units, the ambulance service, GP practices and primary care services and other health and social services.

The national picture so far

Changing demographic trends in Great Britain have led to increased life expectancy since the NHS was created in 1948. This has resulted in substantial demographic changes of hospital inpatients who are now older and frail with multiple long-term conditions.

Figure 1 shows growth in age groups 60-74 and 75+ is greater than the growth in finished consultant episodes (FCEs) as a whole, with the growth in the 75+ age group being much larger than that of FCEs as a whole (61% growth from 2002-03 to 2012-13 in the 75+ age group compared to 39% growth in all FCEs) (HSCIC 2013).

Figure 1: Indexed change in the number of finished consultant episodes by age group 2002-03 to 2012-13 (Indexed 2002-03 = 100)

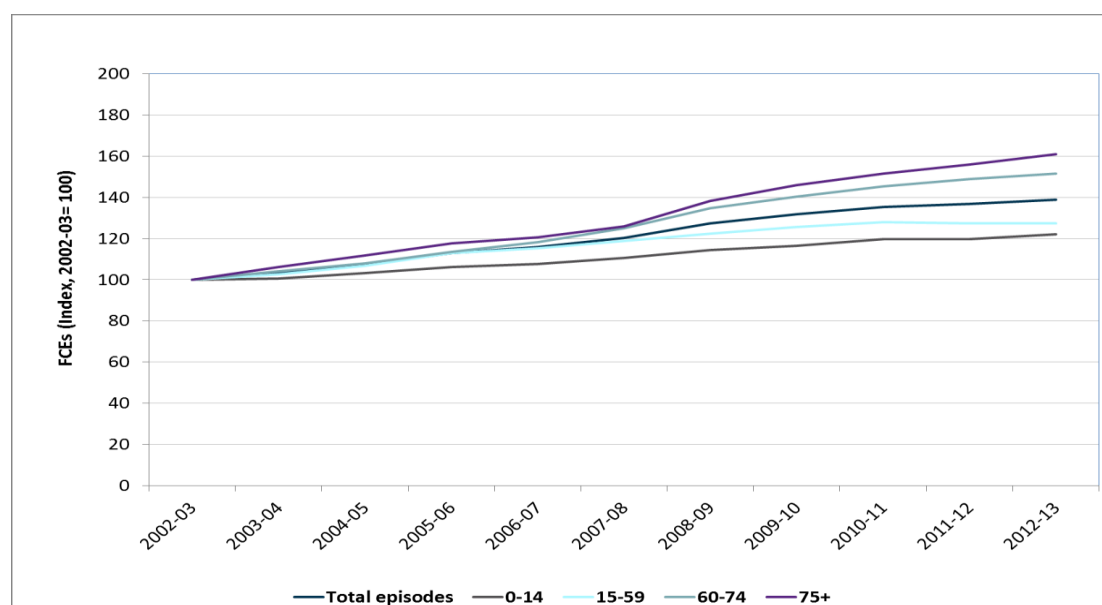
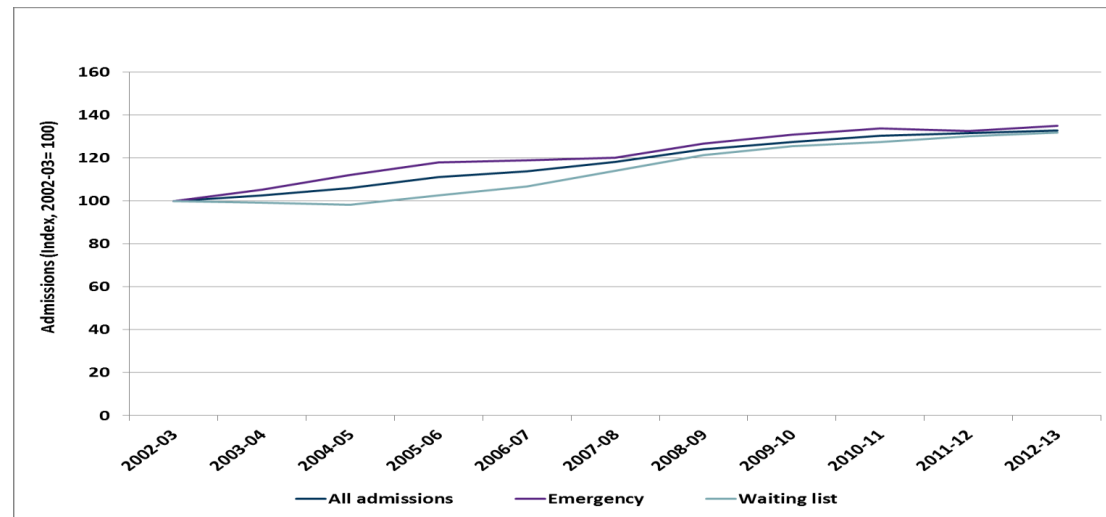


Figure 2 shows data for finished admission episodes has been indexed to its 2002-03 levels, showing the relative growth rates of emergency and waiting list admissions. The overall increase in both emergency admissions, where the patient is admitted as an emergency either via A&E or other means (such

as from their GP) and waiting list admissions, where the patient is admitted after being put on a waiting list, since 2002-03 is approximately the same in percentage terms (HSCIC 2013).

Figure 2 Indexed change in the number of finished admission episodes by admission method 2002-03 to 2012-13 (Indexed 2002-03 = 100)



Source: HSCIC

<http://www.hscic.gov.uk/catalogue/PUB12566/hosp-epis-stat-admi-summ-rep-2012-13-rep.pdf>

The Royal College of Physicians (2012) states that despite the high cost of hospitalisation, the NHS has been slow to develop comprehensive, effective alternatives to admission related to the following issues:

- a Although patients become acutely ill 24 hours per day, seven days per week, the current drive to seven-day working in secondary care is not matched in the community.
- b Out-of-hours GP coverage has become more fragmented since the introduction of the GP contract in 2004. This has led to increase in out of hours' hospital admissions and prolonged length of stay and inpatients unable to access pathways out of hospital seven days per week, disrupting the capacity to manage new admissions.
- c Integration of primary and social care and primary and secondary care have both been shown to reduce hospital admissions.
- d Increased public expectation leading to more self-referral to NHS care is a possible explanation of the increasing admissions, as are changes in clinical-decision making and 'defensive' medicine. In support of this contention, the majority of additional A&E attendances are for minor conditions.
- e Changing demographics make new demands on staff. This in turn affects the staffing ratios that are needed in order to deliver effective, safe care.
- f The skills, knowledge and experience that staff need are also affected. Many healthcare professionals working with patients over 80 will not have had geriatric training, despite the significant percentage of these patients in hospitals.

The Nuffield Trust (2010) states that emergency admissions grew by almost 12% from 2004 to 2009, costing approximately £11 billion a year. They are costly and frequently preventable but every year more patients are being admitted in this way. The key factors for the increase in emergency admissions have been identified:

- a Population aging – up to 40 per cent of the increased number of emergency admissions can be explained by the effects of this.
- b Short-stay admissions – advances in clinical practice have increased hospital efficiency by faster and earlier supported discharge. However this has also increased bed availability but, with no concomitant improvement in integrated health and social care service provision outside hospital it has resulted in a large rise in short stay admissions creating more inefficiency in the wider economy.
- c Except for a few PCTs, central policy initiatives such as the ED four-hour waiting time target, PbR and NHS foundation trusts do not appear to have had a significant effect on the increase in admissions.
- d The number of A&E attendances grew by 1.2% during the said period, but the proportion admitted grew by 14.3%, with significant variation between individual trusts.
- e Although admission rates are known to be higher in more deprived areas, there is no clear link between deprivation and the rise in emergency admissions.

The Kings Fund (2012) states there is significant variation in the use of hospital beds by people over 65 admitted as an emergency. These result, in almost equal part, from variation in rate of admission and variation in length of stay. The potential reductions in emergency bed use by patients over 65 are considerable - if all primary care trusts (PCTs) achieved the rate of admission and average length of stay of the lowest 25th percentile, 7,000 fewer hospital beds would be needed across England.

The drivers of variation are complex, and their relative strength varies. But PCTs with the highest bed use tended to have excessive lengths of stay for patients for whom hospital was a transition between home and supported living. Areas that have well-developed integrated services for older people have lower rates of hospital bed use. Areas with low bed use also deliver a good patient experience and have lower readmission rates. Areas with higher proportions of older people have lower rates of emergency bed use. These areas may be more likely to have prioritised the needs of older people and to have developed integrated service models.

Commissioners buying a high proportion of their overall activity from one provider have lower rates of hospital bed use. This may be a result of increased capacity to develop integrated service models; it may also be a proxy indicator for the population's overall access to hospital care. Any local strategy should look across the system and align ways of working between primary, community and acute care to reduce avoidable admissions and length of stay in hospital.

Much of the focus has been ED, out of hour's services and ambulance services, focused on timeliness and driven by national targets. CCGs need to have an overview of the commissioning processes as a (big picture) "whole system" and what this means in practice so that they can develop strategies which ensure: a coherent 24 hour seven day urgent care service with greater consistency, improved quality and safety, improved patient experience, greater integration and better value for the taxpayer.

Key Issues and Gaps

The way forward

The Primary Care Foundation (2011) states there is currently a real opportunity for the whole network to think afresh about how to get the best possible urgent care system across a local community. Some things are different and distinctive based on the needs of the local population or specific geography, but many other features are common across all. Urgent care of the future needs to be more joined up, provide better value for money and offer better patient care.

Too often the incentives in the system encourage organisations to work against each other rather than as partners bound together to deliver the best possible care. The current pressure on budgets, combined with a fresh policy perspective from a new administration that is prioritising integrated 24/7 urgent care, makes it possible for commissioners to take a long, hard look at the current pattern of provision.

The six central themes that have been suggested are:

1. Build care around the patient not the existing services.
2. Simplify an often complicated and fragmented system.
3. Ensure the urgent care system works together rather than pulling apart.
4. Acknowledge prompt care is good care.
5. Focus on all the stages for effective commissioning.
6. Offer clear leadership across the system, while acknowledging its complexity.

NHS 111 (Turner et al 2013)

NHS 111 was developed as a solution to problems in accessing urgent care services, by offering a telephone service to manage all requests for urgent help including requests for out-of-hours primary care, urgent problems that may currently be directed to 999 ambulance services and health information and advice. The expected benefits of NHS 111 were to improve access to urgent care, increase efficiency by directing people to the 'right place first time' including self-care advice, increase satisfaction with urgent care and the NHS generally, and in the longer term reduce unnecessary calls to the 999 emergency ambulance service and so begin to rectify concerns about the inappropriate use of emergency services. NHS 111 was established in four pilot sites in England in 2010. It is rapidly becoming available nationally and there is international interest in telephone access to urgent care through non-clinical triage. A mixed methods evaluation focusing on processes, outcomes and costs was conducted in the four pilot sites. Impact of NHS 111 was analysed on improving efficiency of service use across the emergency and urgent care system by shifting care from emergency to urgent services. In the first year of operation NHS 111 pilot sites triaged almost 300 000 calls, 72% of these calls were managed by non-clinical call handlers and just over half of the calls were directed to primary care. However, there was no evidence that NHS 111 changed use of most of the emergency and urgent care services it was possible to measure. There was a large reduction in use of NHS Direct as calls transferred to NHS 111 but an increase in numbers of emergency ambulances sent to patients and there is potential that overall demand for services across the emergency and urgent care system could increase.

Recommendations for commissioning

- a Understanding urgent activity is extremely complex due to the diffuse nature of how activity is generated. There are various disease conditions, programme areas and high risk groups which impact on urgent care which require further discussion and analyses.
- b A fuller understanding of urgent care requires more in depth analysis by various factors such as age, deprivation, case mix and use of services.
- c Based on analyses carried out so far, a significant proportion of urgent care activity is related to older people with complex health and social care needs, particularly dementia, falls and perhaps end of life.
- d Pathways need to be reviewed end to end with the purpose of defining a seamless approach to integrated care. The frail elderly will be complex and have multiple morbidities. Their current management requires a whole systems transformational change, moving towards an integrated care team approach using risk stratification and patient empowerment methods through self-care and self-management. (See the JSNA [*House of Care*](#) chapter)
- e Key elements that make up the House of Care model will determine the success of urgent care interventions most notably information governance for the linking of information systems between different provider organisations as well as the use of technology for the effective delivery of integrated teams.

- f Under five admissions is potentially another area that will need to be managed by crafting innovative pathways improving access to specialist input in primary and community care settings obviating the need for hospital referrals.
- g Understanding alcohol use related urgent care activity by analysing attributable admission activity is insufficient in estimating the full impact on urgent care services. ED attendance data needs to be more robust to quantify burden of alcohol consumption, falls and other public health issues of importance. IBA to manage ED alcohol related attendances and admissions should be offered as part of an integrated lifestyle / health and wellbeing set of services. (See JSNA [Alcohol Chapter](#))
- h A refresh of the urgent care needs assessment is required to include more information on service mapping and examples of best practice to obtain a more detailed picture of urgent care activity.

Evidence of What Works

In 2013 NHS England published a policy document on urgent and emergency care, entitled: 'High quality care for all, now and for future generations: transforming urgent and emergency care services in England'. This document described the outcomes of the NHS England Urgent and Emergency Care Review's engagement exercise. The vision for urgent care is stated as:

- a For those people with urgent care needs we should provide a highly responsive service that delivers care as close to home as possible, minimising disruption and inconvenience for patients and their families.
- b For those people with more serious or life threatening emergency care needs, we should ensure they are treated in centres with the very best expertise and facilities in order to maximise the chances of survival and a good recovery.

The main recommendations of the report are that the health service should: support self-care; help people with urgent care needs to get the right advice or treatment in the right place, first time; provide a highly responsive urgent care service outside of hospital so people no longer choose to queue in A&E; ensure that people with more serious or life threatening emergency needs receive treatment in centres with the right facilities and expertise to maximise chances of survival and a good recovery; connect the whole urgent and emergency care system together through networks.

The evidence behind this review was also published (NHS England 2013a). An update on progress since the publication of this review was published in 2014 (NHS England 2014).

In a discussion paper, Monitor and NHS England set out their current thinking on options for reforming the urgent and emergency care payment approach (Monitor/NHS England 2014). Monitor also produced guidance to support NHS healthcare providers and commissioners with their planning for operational resilience during 2014-15 (Monitor 2014).

Other reports

The Royal College of Physicians of London (2013) has produced recommendations for the future of urgent and emergency care. They have developed a ten point vision for addressing challenges of emergency departments:

1. We must develop effective and simplified alternatives to hospital admission across seven days.
2. We must adjust the financial incentives across the system, so that they support effective management of demand for unscheduled care.
3. We must focus on supporting patients to leave hospital seven days a week.
4. We must organise high-quality consultant-led hospital services across seven days.
5. We must promote greater collaboration within the hospital and beyond to manage emergency patients.
6. We must ensure that there is sufficient capacity within the hospital, and the wider system, to meet changing demand.
7. We must focus on ambulatory ('day case') emergency care where appropriate.
8. We must develop a sustainable workforce, fit for the future.
9. We must show leadership.
10. We must focus on public health and preventive health strategies.

The College has also set out 13 recommendations for acute and emergency care (Royal College of Physicians of London 2014). The college believes that implementing these measures will help build an urgent and emergency care system that is resilient, fit for purpose and sustainable. The recommendations cover key areas such as access and alternatives, closer system collaboration, workforce, training, funding and technology.

The Royal College of General Practitioners (2011) has released guidance on the commissioning of urgent and emergency care services, to help commissioners take a strategic approach which is patient-centred and focused on improving clinical outcomes. Together with other bodies they have published the 'Silver Book' (2011a) which aims to present an overview of many of the most pressing and clinical and social problems met by older people when they present in an emergency. Despite the majority of urgent care being delivered in the primary care setting, an increasing number of older people are attending emergency departments and accessing urgent health and social care services.

The College of Emergency Medicine has produced a report (2014) containing a series of recommendations applicable to local and national health economies involved in the delivery of urgent and emergency care. Informed by discussions at a roundtable event, the College has drawn up 13 recommendations it says must be addressed in order to avoid an annual crisis response and to build a resilient system for the future.

Its recommendations are divided into six areas – access and alternatives; skill mix; integration and communities; seven days service; funding and fair reward; and information technology.

The NHS Confederation has also published several documents commenting on urgent and emergency care. In 'Ripping off the sticking plaster' (2014), from the Urgent and Emergency Care Forum, it responds to reports of mounting pressures on services by producing a roadmap to the fundamental changes required to create a sustainable and high-quality urgent and emergency care system that can meet the needs of patients now and in the future.

Case Studies

The NHS Confederation has also looked at a series of case studies in which a variety of projects try to improve services and outcomes (Innovation in urgent and emergency care 2014a), and in a briefing on a workforce fit for the future (2014b) it reported on the learning from two workshops which explored how to develop a more flexible, integrated workforce to deliver urgent and emergency care.

Another case study was reported by NHS Improving Quality (2013) on engaging with the workforce to redesign urgent and emergency care pathways in Manchester. Here, a seven day service delivery model for acute and general internal medicine was developed in response to increased demands on urgent and emergency care, the need to develop a formal rota for gastrointestinal bleeding, and in response to Royal College Physician guidelines.

The National Institute for Health Research Service Delivery and Organisation (2010) looked at the impact of changing workforce patterns in emergency and urgent out-of-hours care on patient experience, staff practice and health system performance. In eight organisational case studies with varied out-of-hours staffing, maps of all possible patient pathways through out-of-hours care were developed.

The Primary Care Foundation (2012) looked at the different models for providing urgent care services and evaluated their impact. Through site visits to 15 urgent care centres and a literature review, as well as the support of a reference group, some criteria were identified that define a service capable of delivering high quality, clinically appropriate and cost-effective care.

The University of Bristol (2012) carried out a series of systematic reviews to determine the effectiveness of a range commonly used interventions to reduce unplanned hospital admissions such as:

- case management
- specialist clinics
- community interventions
- care pathways and guidelines
- medication review

- education & self-management
- exercise & rehabilitation
- telemedicine
- vaccine programs
- hospital at home

There was evidence that education/self-management, exercise/rehabilitation and telemedicine in selected patient populations, and specialist heart failure interventions can help reduce unplanned admissions. However, the evidence to date suggests that majority of the remaining interventions included in these reviews do not help reduce unplanned admissions in a wide range of patients. There was insufficient evidence to determine whether home visits, pay by performance schemes, ED services and continuity of care reduce unplanned admissions. However it is important to remember that in many health and social care economies while a number of interventions are introduced across the system there are little or no studies that evaluate **system wide approaches** hence highlighting the importance of doing the same.

The Level of Need in the Population

Urgent care activity in acute trusts in Kent & Medway

Based on current SUS data, the total number of admissions and attendances in Kent in 2013-14 was 145, and 410,176 respectively, costing more than £290 million (Figure 3a and 3b). Almost half of that activity was generated by the East Kent Hospitals Trust. A quarter of activity was generated by Maidstone and Tunbridge Wells NHS Trust.

Figure 3a

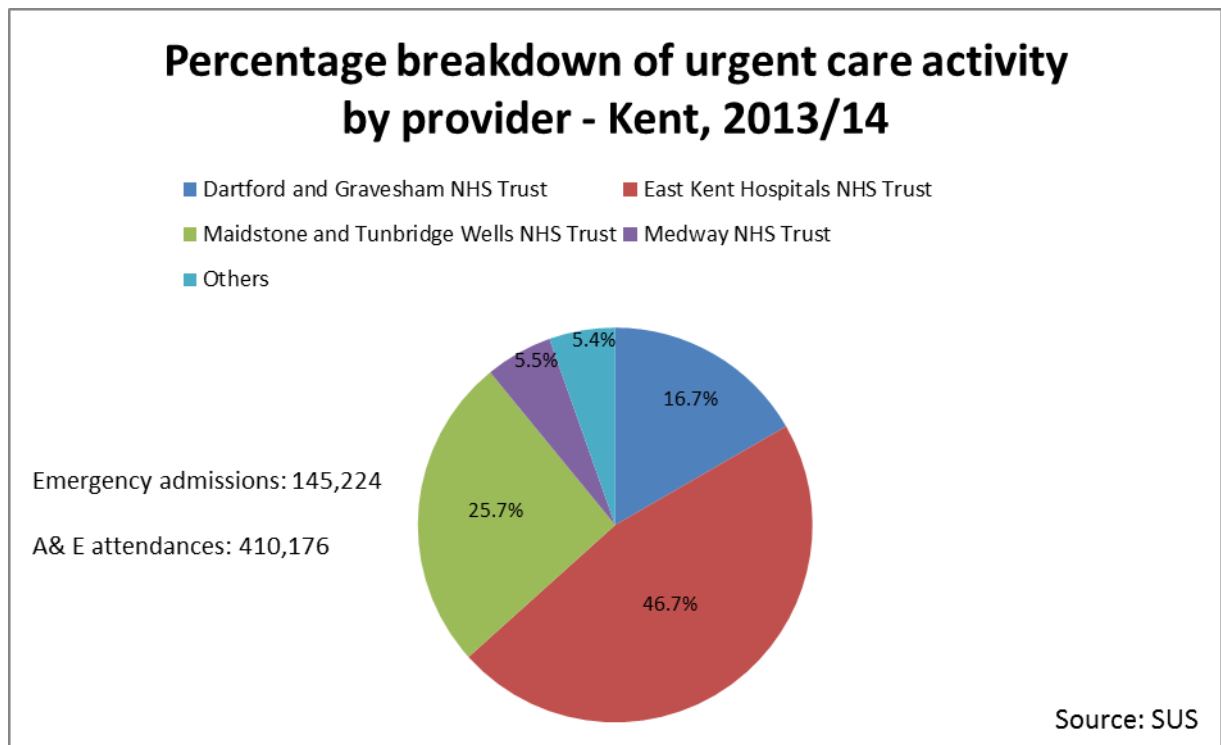
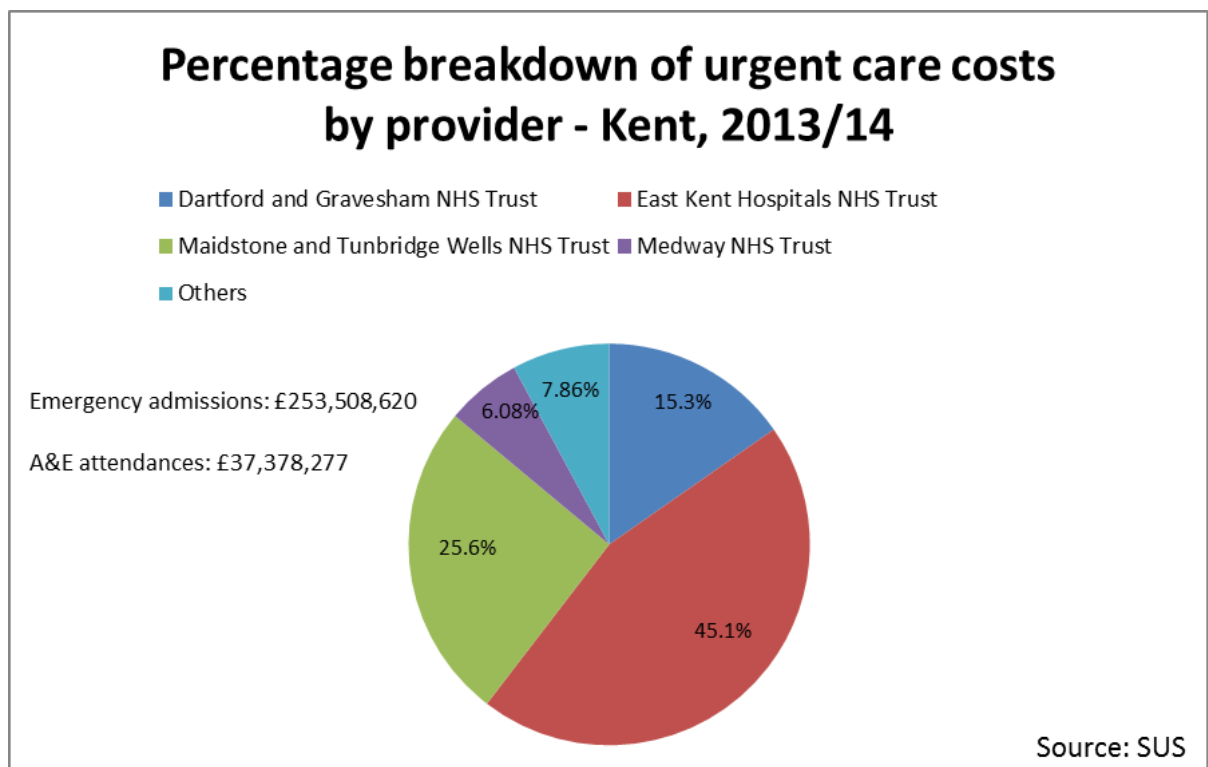


Figure 3b



Exploring A&E Attendances across Kent

Figure 4a shows the number of attendances for each of the seven CCGs which have changed very little over the last four years.

Figure 4a

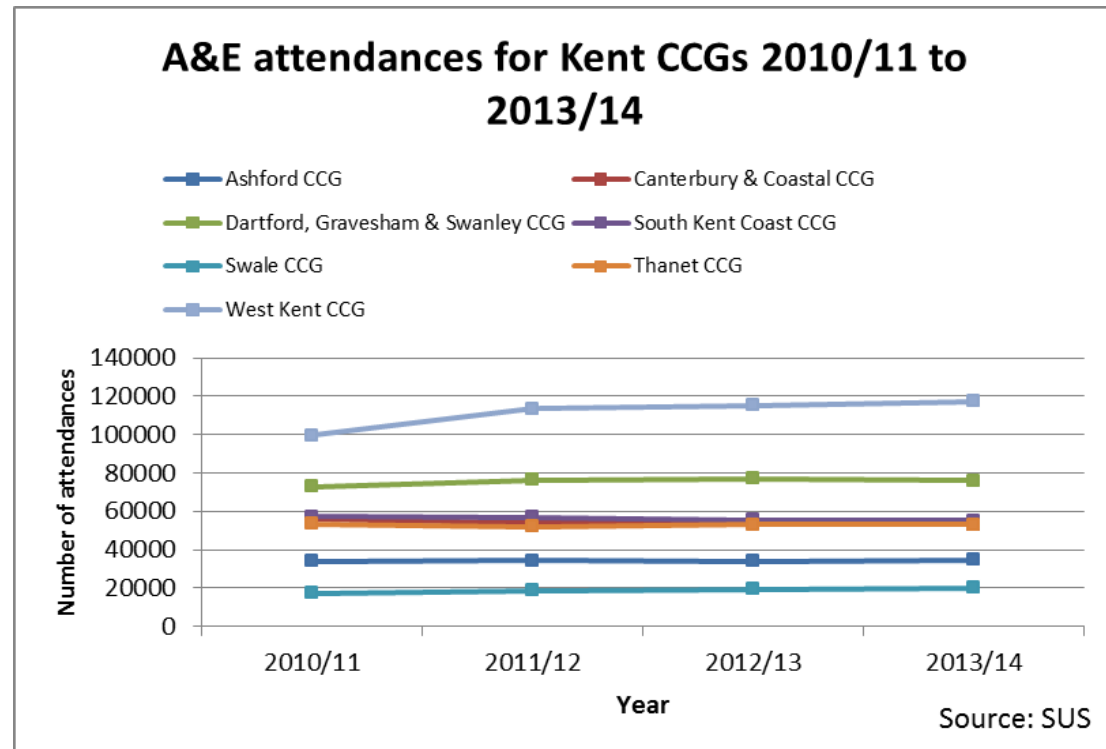
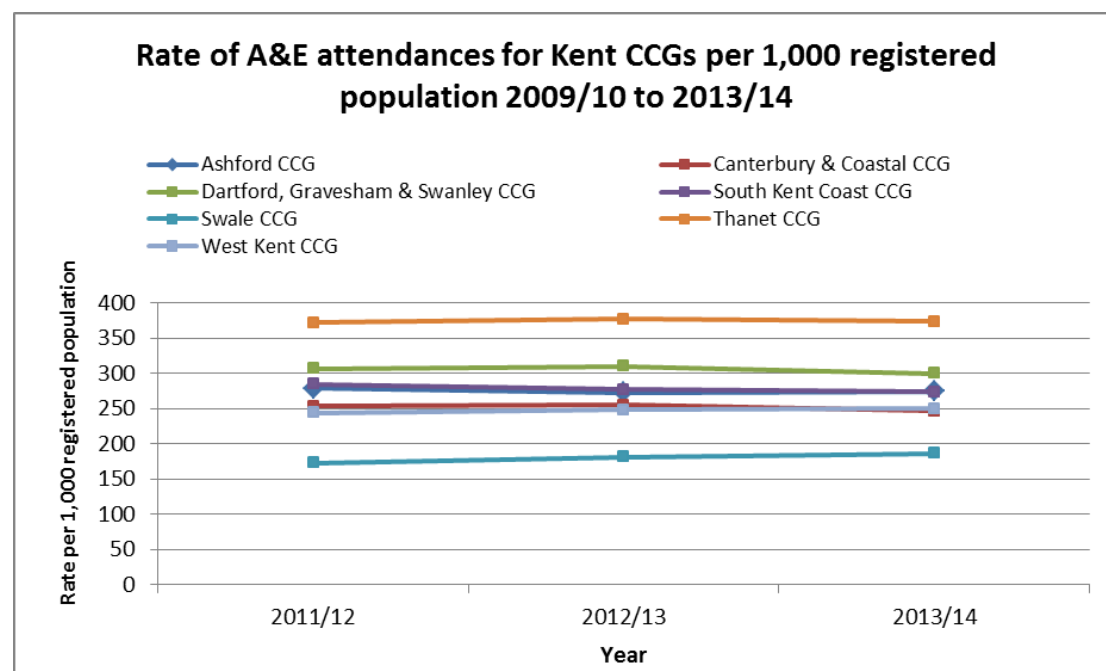


Figure 4b



In terms of the volume of attendance by age, there are two peaks - one in the 0-4 year olds and a second in the 15-24 year old age groups. Numbers of

attendances continue to fall by age from 25 years onwards apart from three smaller peaks in the mid-40s, mid-60s and mid-80s age groups (Figure 5).

In terms of attendance rates, evidence of several small peaks were found in 0-2 years and 15-24 years are in evidence, but the rates rise significantly by age after this, peaking rapidly at 90 yrs even as the volume of attendances fall.

With respect to the >90 years population, approximately 11,785 attendances were created 6,733 patients of which over 50% attending more than once and handful of patients more than 10 times (Table 1).

Figure 5

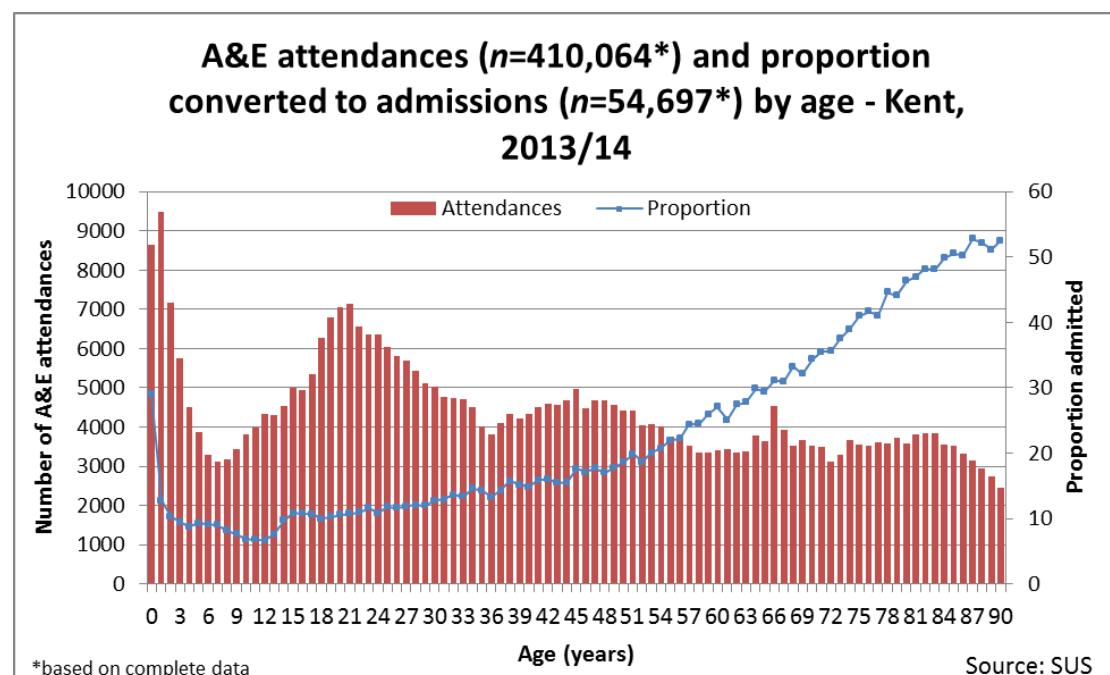


Table 1

Number of repeat attendances	Number of individuals	Number of attendances
38	s	s
18	s	s
15	s	s
14	s	s
12	s	s
11	s	s
10	6	60
9	7	63
8	13	104
7	27	189
6	70	420
5	129	645
4	291	1164
3	654	1962
2	1520	3040
1	4008	4008
Total	6733	11,785

s - denotes data supression

Source: SUS

Figure 6

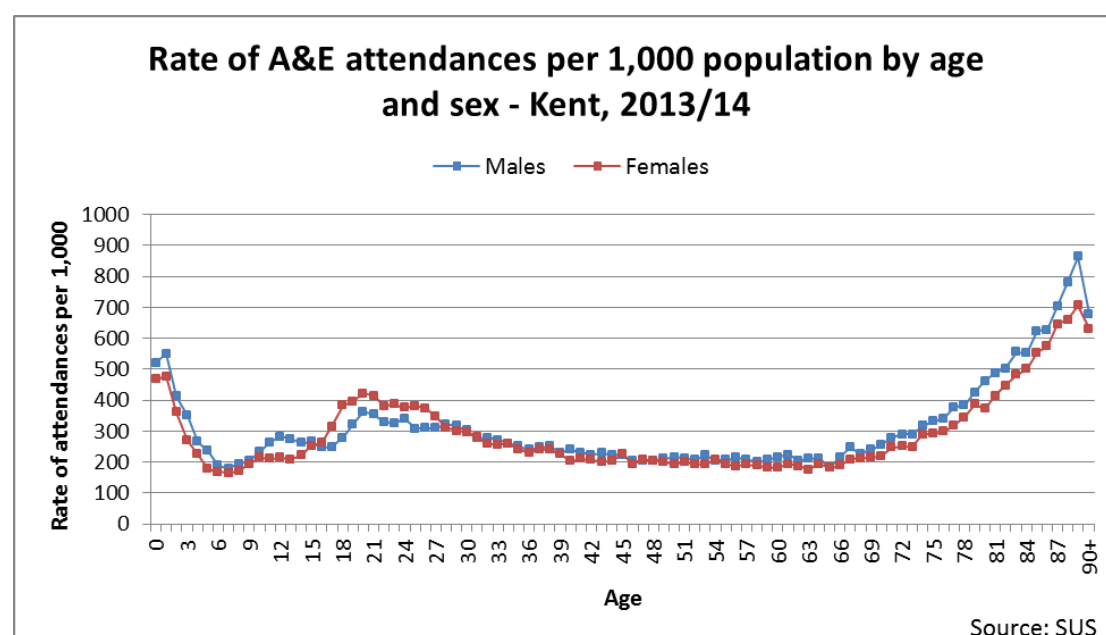


Figure 6 shows little difference in attendance rate by gender. Gender difference in attendance activity looks inconsistent in some age groups such as 15 to 24yrs and after the age of 80yrs. Overall it appears that men attend A&E in greater numbers in all ages (Figure 6).

The number of A&E attendance by deprivation quintiles shows a marked downward trend (from most to least deprived) which is also similar when standardised for age. People in the most deprived areas are 60% more likely to make an A&E attendance as people in the least deprived areas (Figure 7).

Analysis of deprivation by decile using risk stratification appears to show little difference between the high intensive users of hospital services (risk band 1) and the remaining risk bands (Figure 7a).

<http://www.kmpho.nhs.uk/EasySiteWeb/GatewayLink.aspx?allid=382582>

Figure 7a

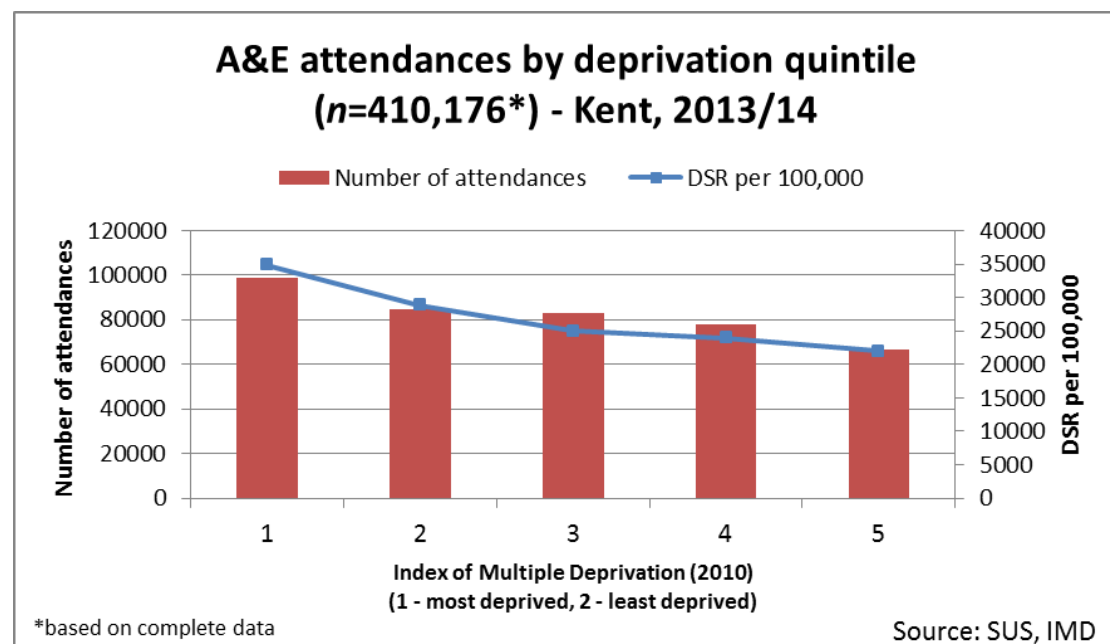
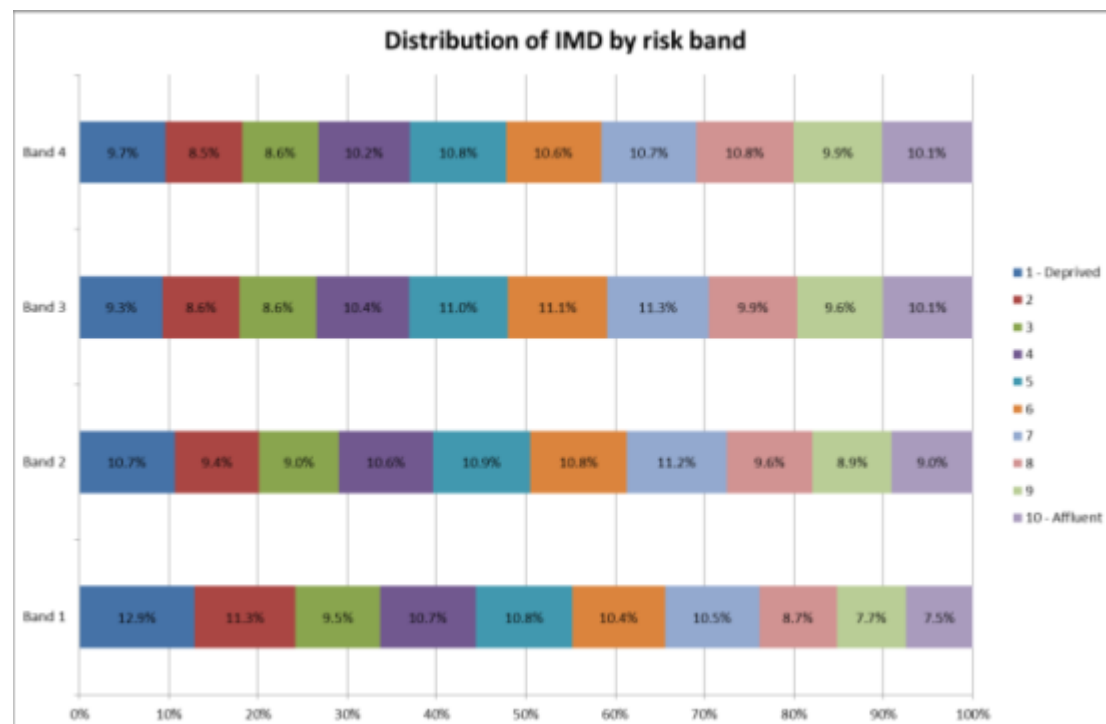


Figure 7b



A&E is generally busiest during normal daytime hours with a peak at the start of the working day (10:00am – 12:00 noon) and again as the working day ends between at 6:00pm – 7:00pm (Figure 8). The number of attendances drops overnight to its lowest point at 5:00am and then begins to increase again from 6:00am onwards.

Patterns of A&E attendances at all four acute trusts for the past three years have remained consistent. The peak in activity starts at 9:00am is sustained throughout most of the day until about 8:00pm, of which the vast majority of these attendances were self-referrals (Figure 9a/b). A 'blow up of the distribution of other sources of referrals are shown on Figure 9a, indicating GP and other emergency services make up the next largest proportions of activity.

Figure 8

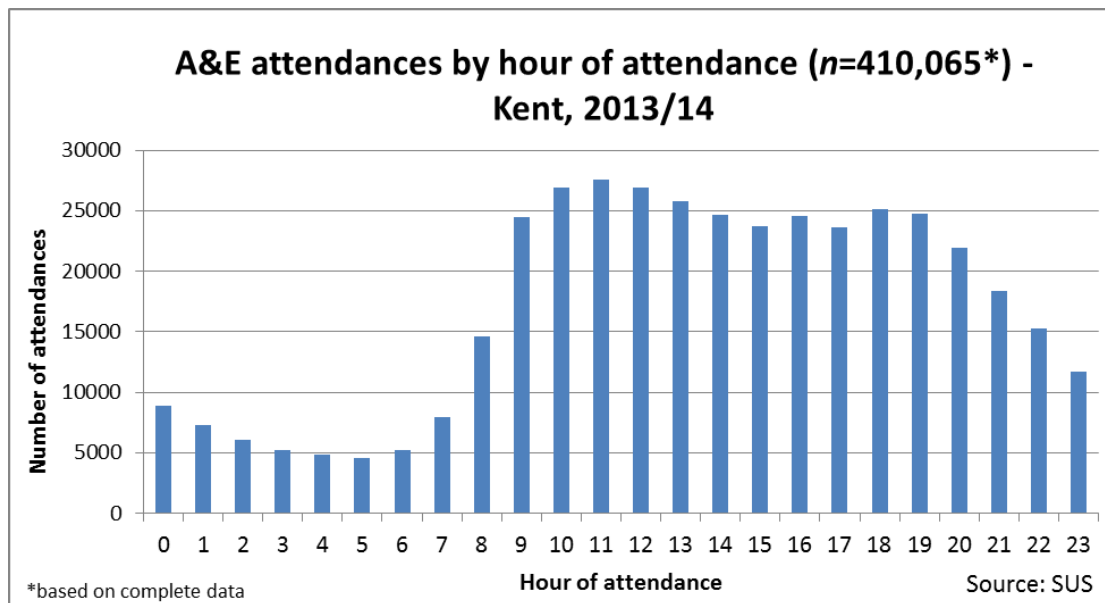


Figure 9a

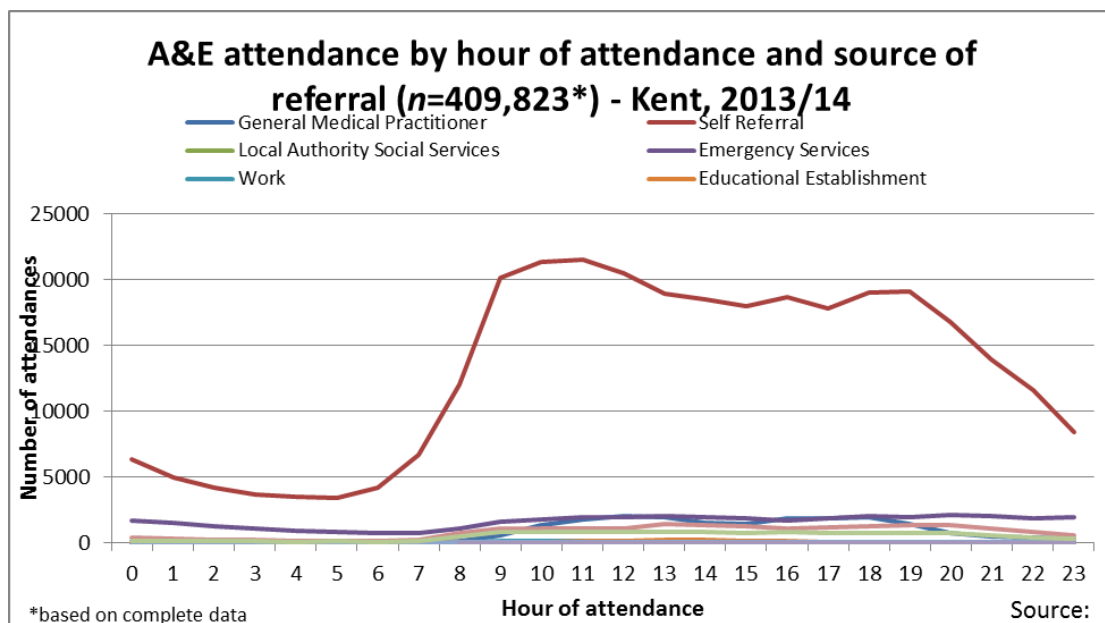


Figure 9b

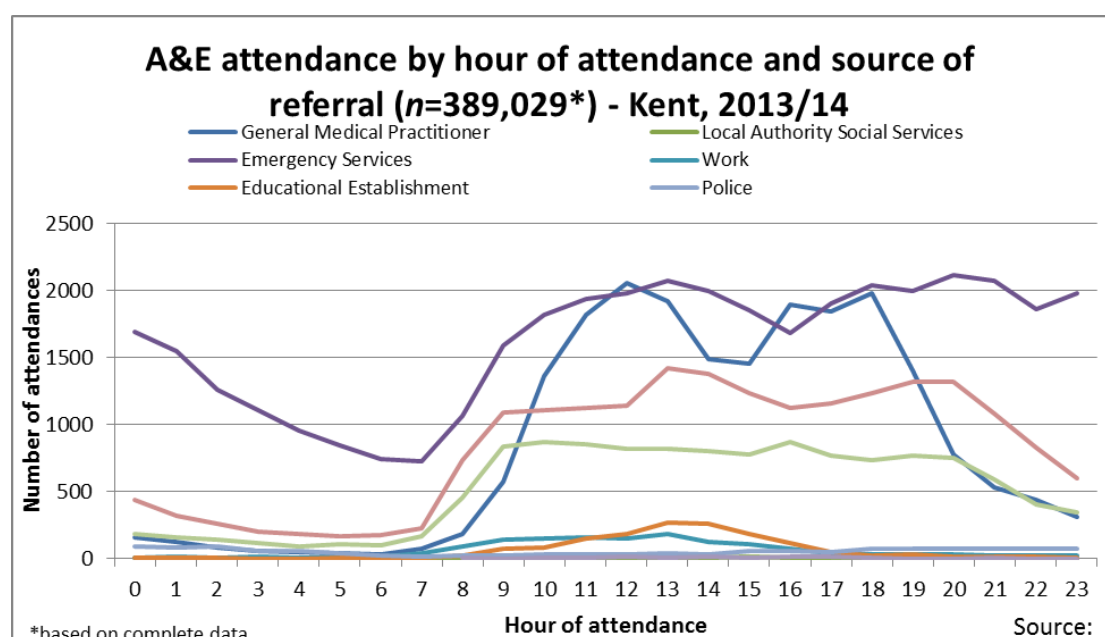


Figure 10

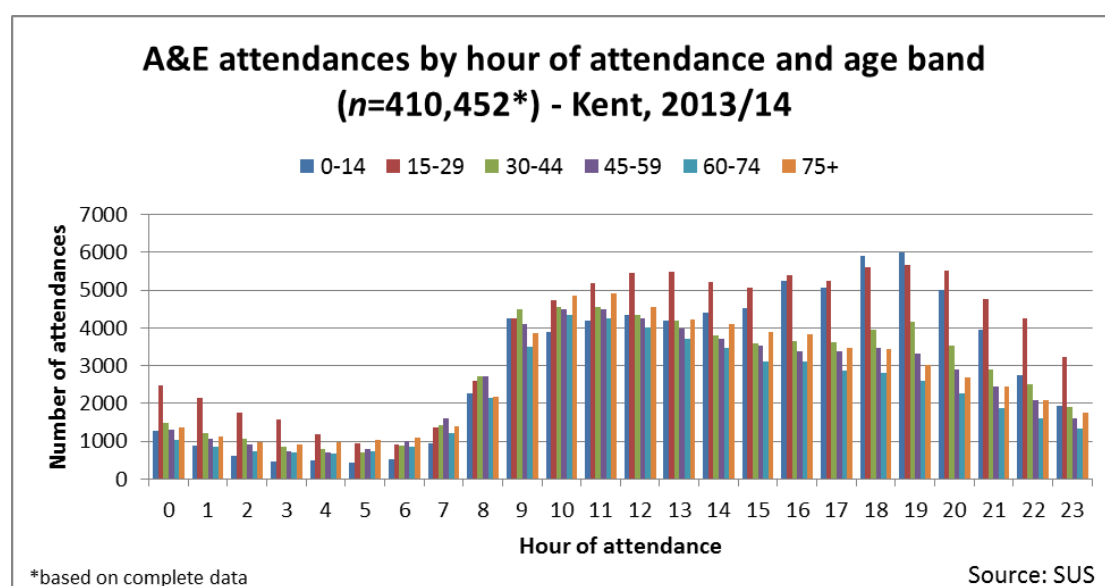


Figure 10 shows that there are some key variations in attendance time by age bands. The main differences are the 0-19 age group has a consistent rise in attendances from 8:00am to 8:00pm before it starts coming down. The 20-44 years age group has a peak then fluctuates throughout the day before dropping down after 8:00pm to consistently low levels in the early morning.

Figure 11

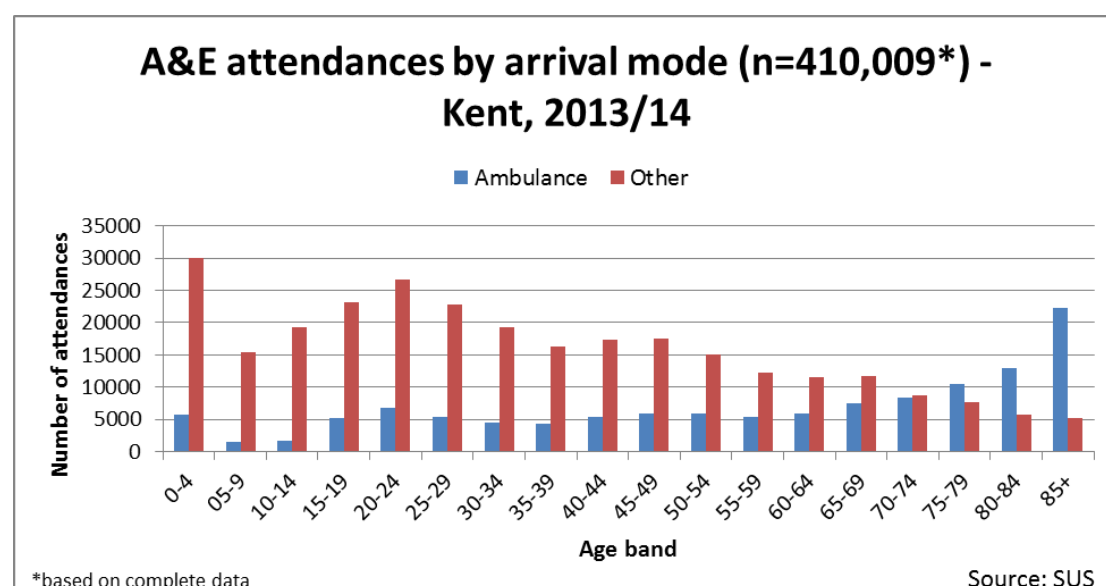


Figure 11 shows the numbers of patients arriving in A&E by ambulance varies with increasing age, the lowest being approximately 5-9yrs age group and the highest being 85+yrs age group. The 70-74yrs age group have almost similar numbers of patients arriving by ambulance versus other means of transport.

Figure 12

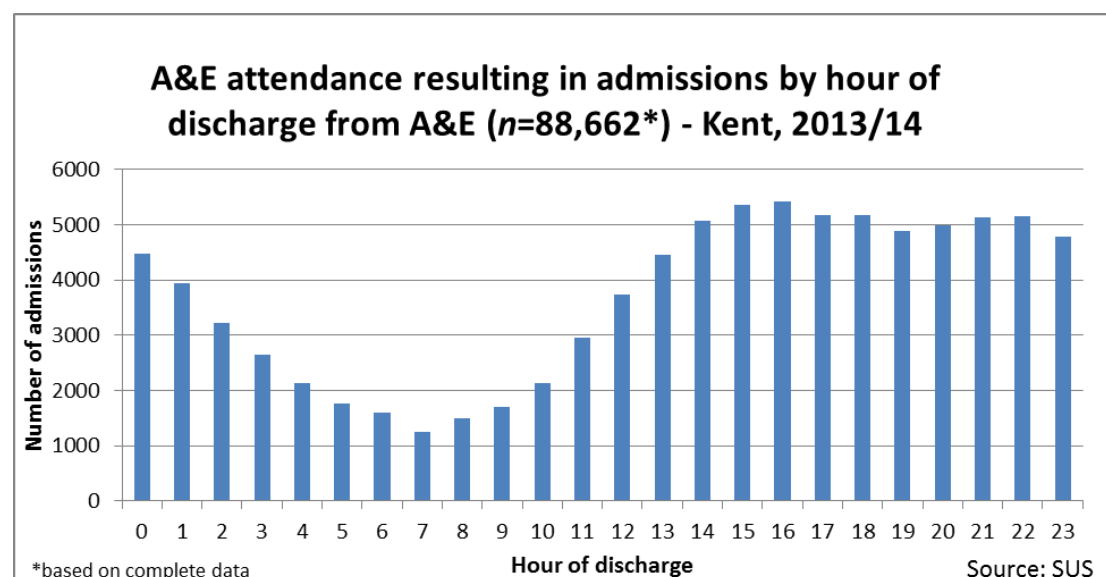
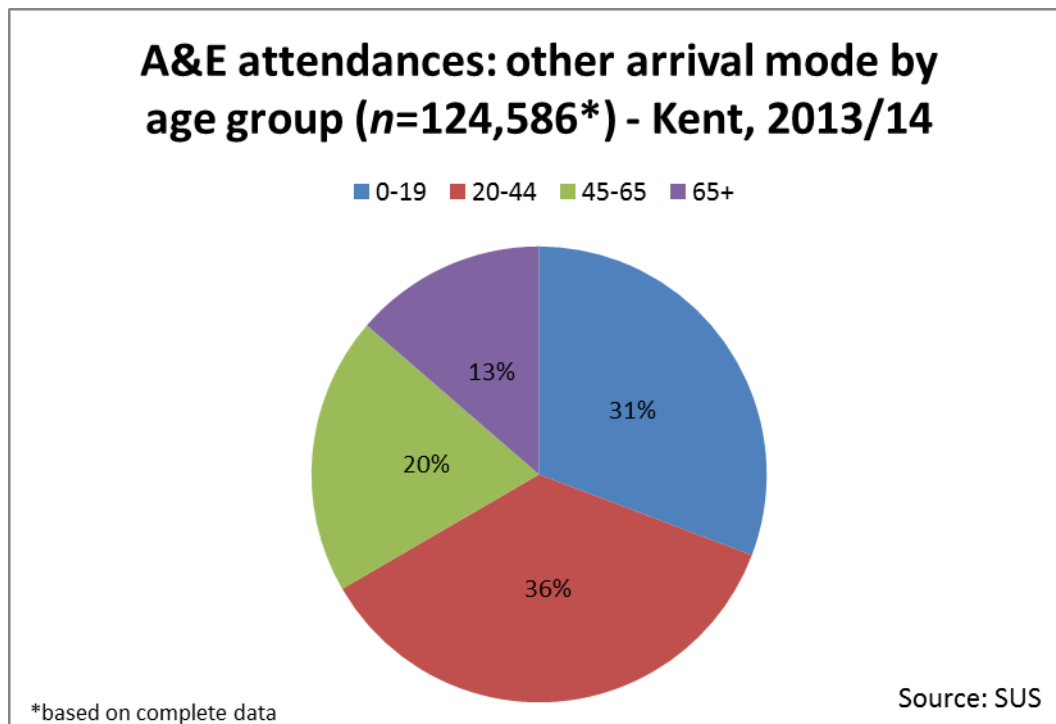


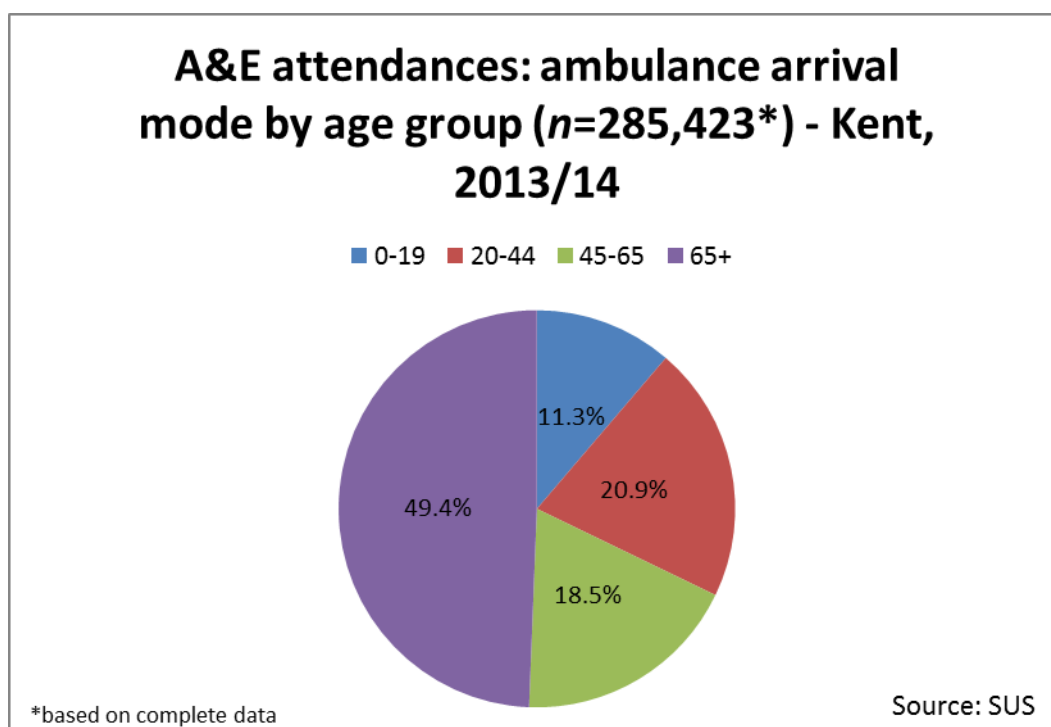
Figure 12 shows the number of admissions from A&E peak between 2:00pm and 6:00pm, approximately four hours after the peak in attendance time at A&E (10:00am to 12:00 noon).

Figure 13



Figures 13 and 14 show that half of all A&E attendances that arrive by ambulance involved patients aged 65yrs and above. In terms of A&E attendances that arrived via other means, this age group represented only 15%.

Figure 14



Unscheduled care hospital admissions across Kent & Medway

Figure 15 shows unscheduled care admissions have increased steadily in Kent by 22% from 118,422 in 2006-07 to 145,224 in 2013-14. Figure 16 below appears to show that most of the increase is attributed to the emergency admissions through A&E whereas emergency admissions through other methods.

Figure 15

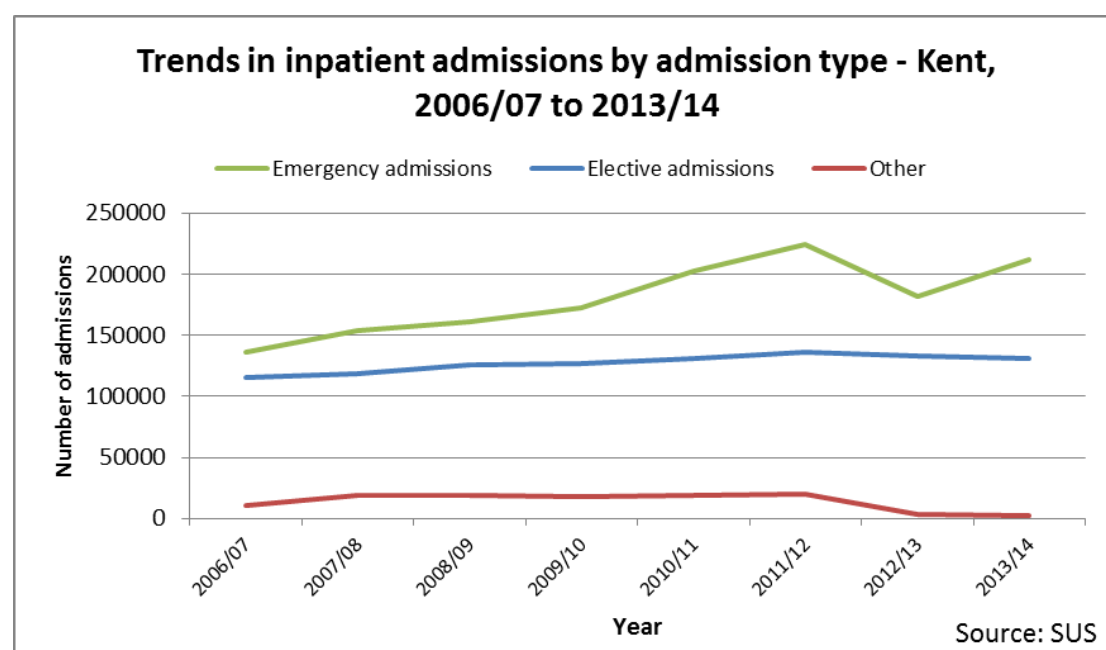


Figure 16

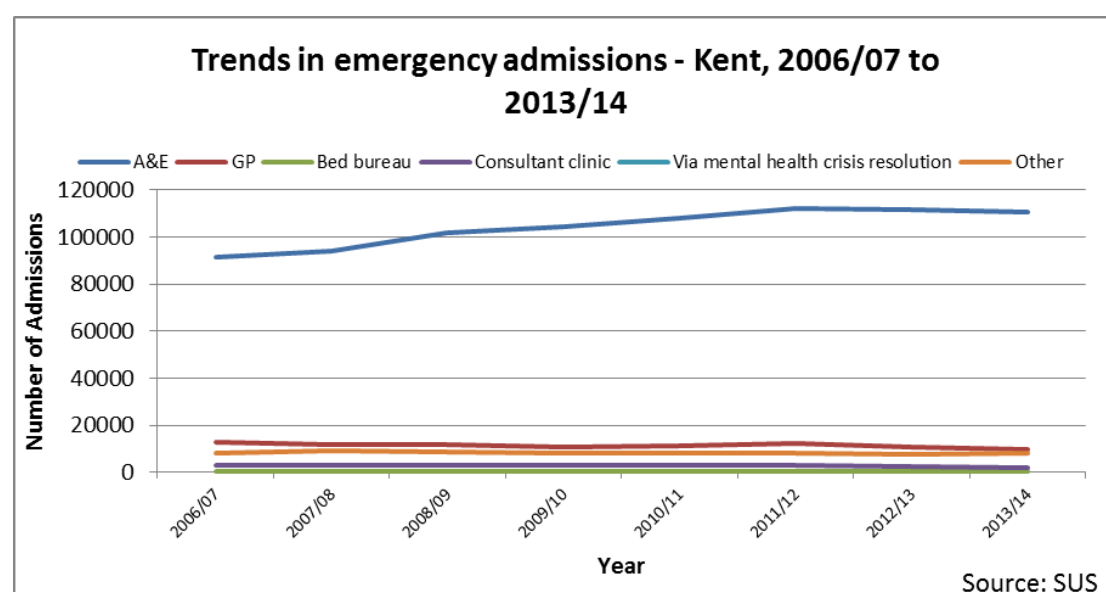


Figure 17a

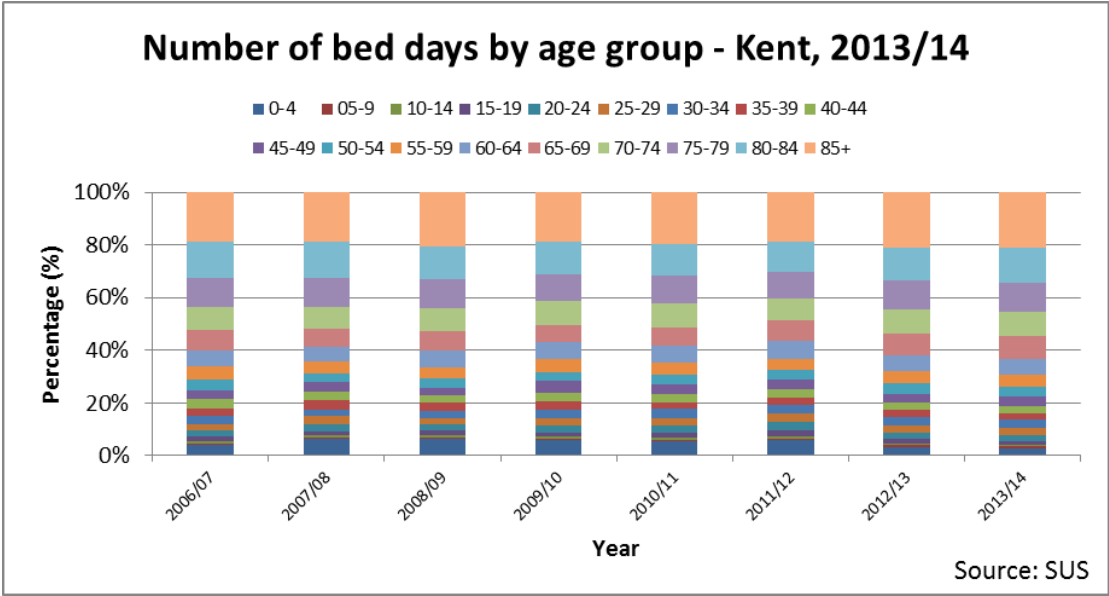


Figure 17b

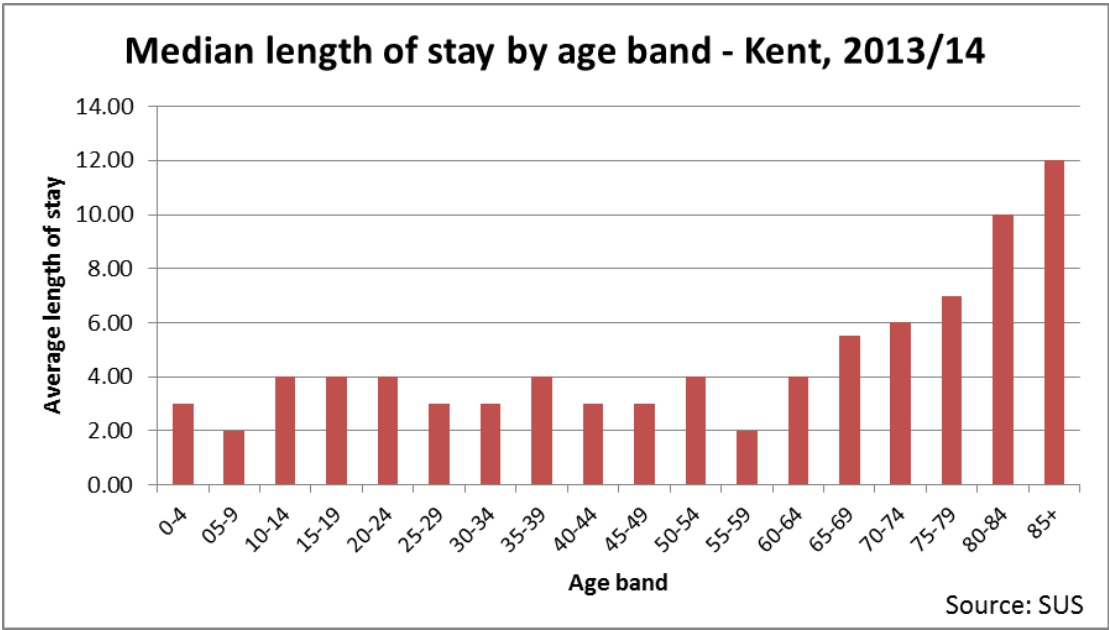
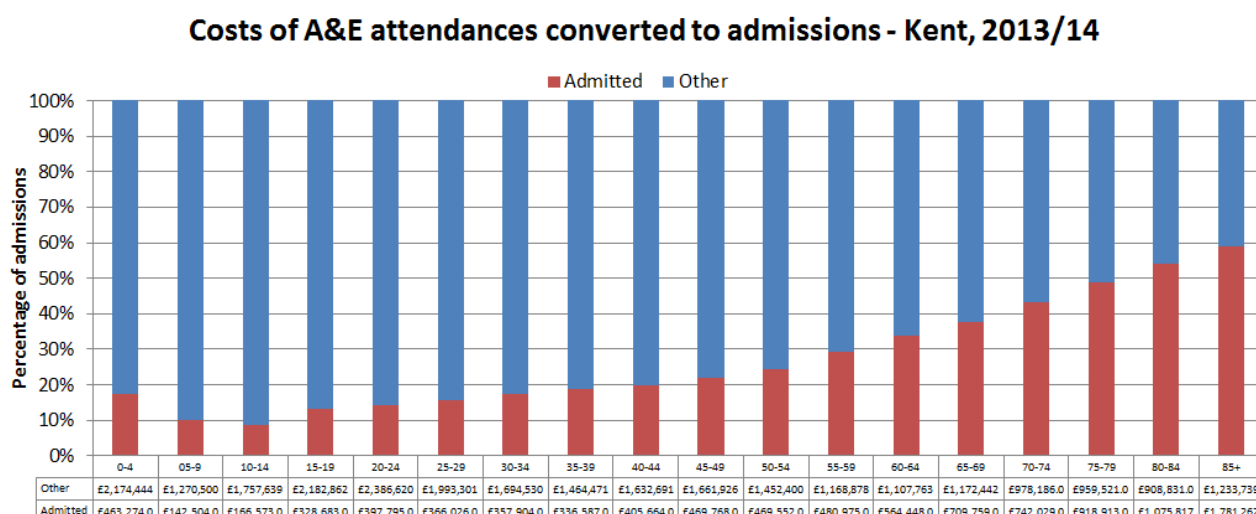


Figure 17c



Figures 17a shows approximately 75% of emergency bed days are attributed to patients above the age of 65yrs. Figure 17b shows the median length of stay by age group, showing a clear increase from 55yrs onwards. Figure 17c shows the proportion of and cost of attendances that led to an admission increases considerably with age with patients above the age of 80 having almost 60% chance of being admitted. Children up to the age of five had a slighter higher rate of around 15%. The overall conversion rate for K&M stood around 20%.

Figure 18 shows the age distribution of A&E attendance activity in relation to conversion to admission rates, which begins slightly higher for under-fives then dropping down in children and teenagers before rising to a maximum for elderly. While the numbers of attendances are particularly high in the under-fives and 16, the conversion rate to admissions has a different trend compared to the attendance rates in the different age groups. For example, the high attendance rate in the 16 to 24 years age group seen in Figure 5 does not resemble the conversion rate in the same group as shown in Figure 18 which appears to be flat.

Figure 19 below shows conversion rates as a time trend over the last 18 months. The activity is shown as yearly moving averages to smoothen the seasonal fluctuations. It shows a gradual increase in conversion rates to emergency admissions from attendances over the last 18 months to about 20%.

Figure 18

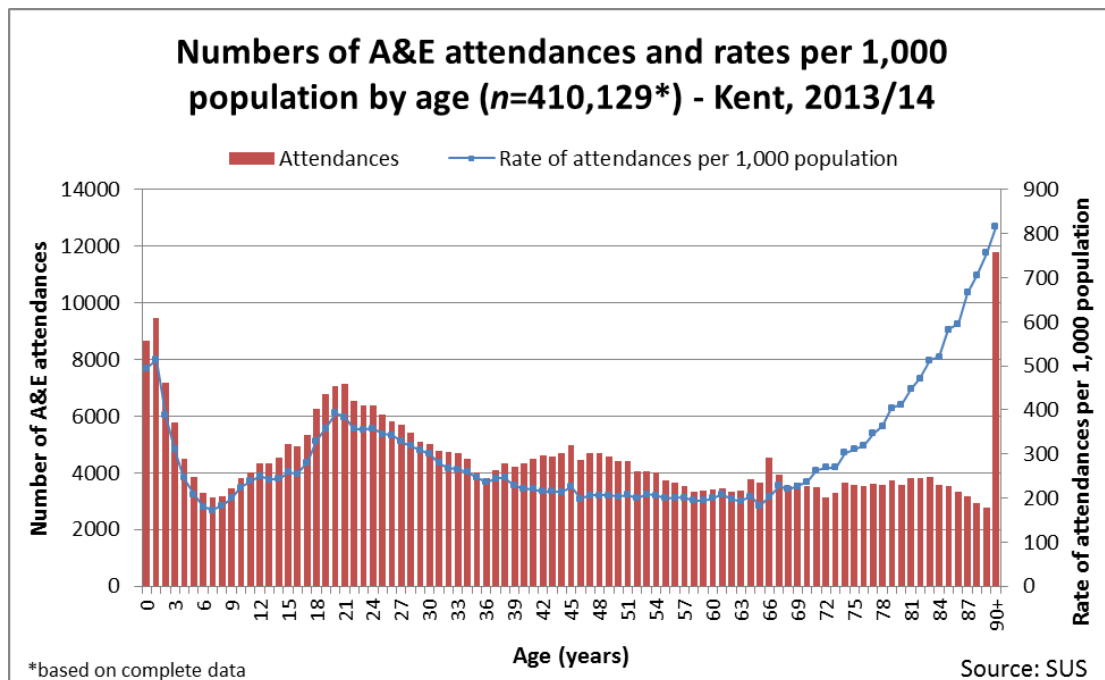


Figure 19

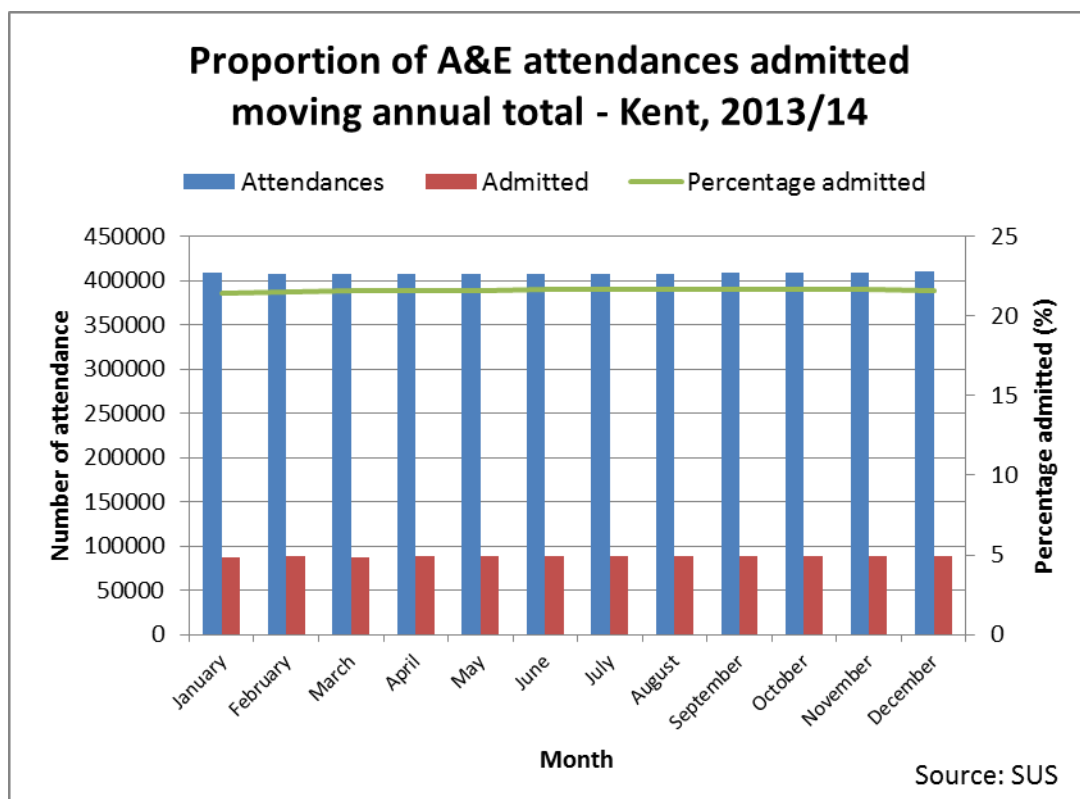


Figure 20

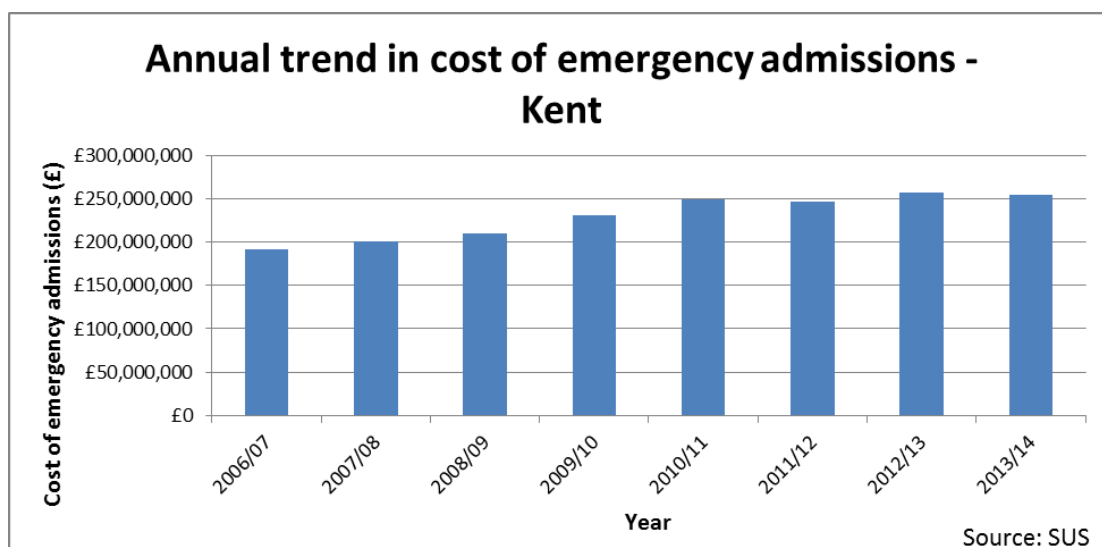


Figure 20 shows the cost of emergency admissions has increased by almost 50% over five years, up to 2010-11 to around £248 million. Since then it has more or less stabilised reaching £255 million in 2013-14. Most of this increase in costs is due to emergency admissions through A&E shown in figure 21.

Figure 21

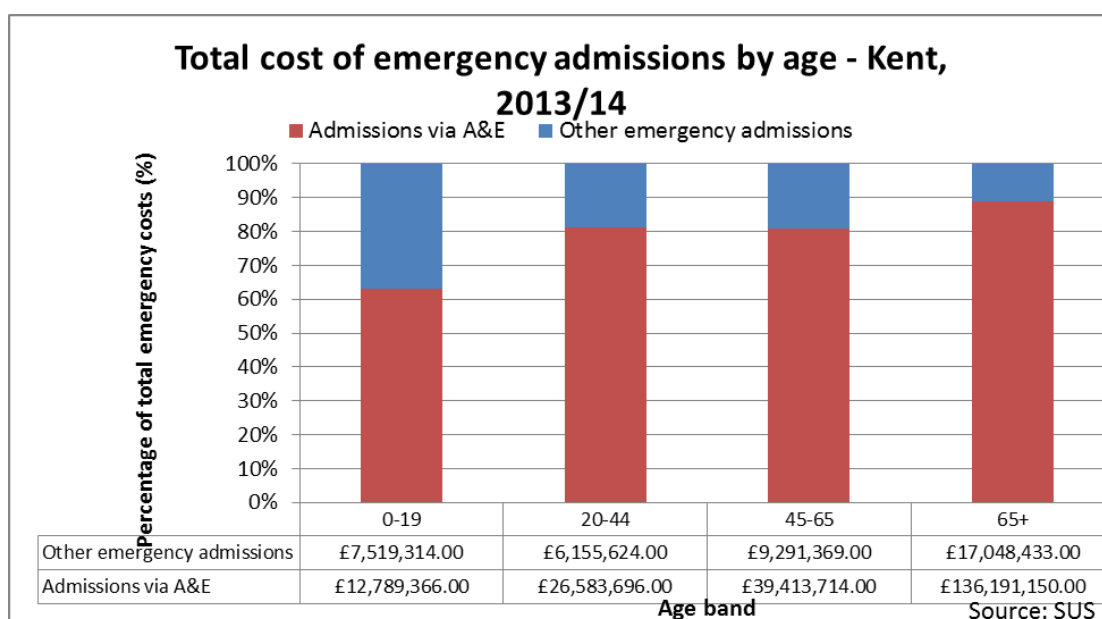


Figure 21 shows that almost two thirds of the total cost of emergency admissions is attributed to the patients aged 60yrs and above who represent approximately 20% of the population.

Figure 22

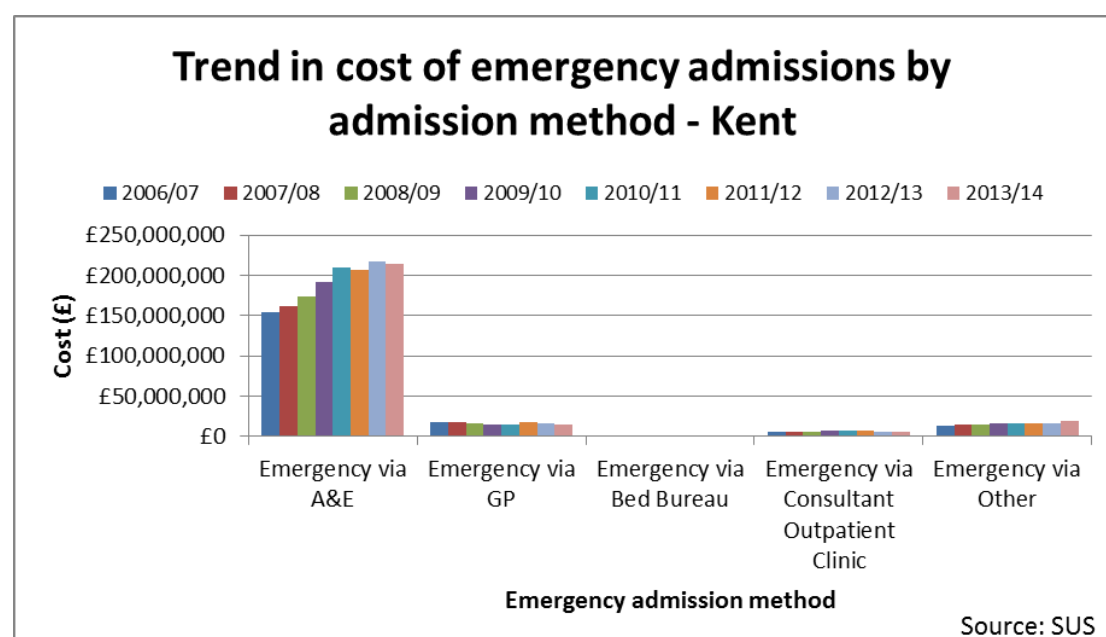


Figure 22 describes costs of admissions by admission method over time, indicating that the largest rate of increase stems from admissions through A&E which is almost 40% over eight years but the rate of increase has reduced, particularly over the last four years.

Ambulance activity

Tables 2 & 3 detail the number and relative percentage of ambulance attendances across Kent & Medway by reported condition for all those patients who were seen & conveyed' vs. those who were seen and treated. Almost 240,000 callouts were generated, of which 14% were routed to NHS111. In comparison with previous analysis, call outs for falls has dropped in ranking for conveyance to hospital. Trend analysis was not possible owing to the changes in data collection since the introduction of NHS111.

Table 2: Reasons for Ambulance Callout: See & Convey

County : Medway, Kent

Date : Between 01 Apr 2013 and 31 Mar 2014

Reasons for Ambulance Callout See & Convey	Number	Percentage of See & Convey (%)
NHS 111	20090	12.57
Chest Pain/Cardiac Prob	16684	10.44
999 HCP	14859	9.29
Trauma	11751	7.35
Breathing/ENT Problems	10298	6.44
Limb/Pain Injury	8160	5.10
Generally Unwell	8048	5.03
Stroke/Neurological	7180	4.49
Falls <12ft	7064	4.42
HCP Admission 120 minutes	6649	4.16
Total Number of See & Convey	159874	

*Source: South East Coast Ambulance NHS Trust***Table 3: Reasons for Ambulance Callout; See & Treat**

County : Medway, Kent

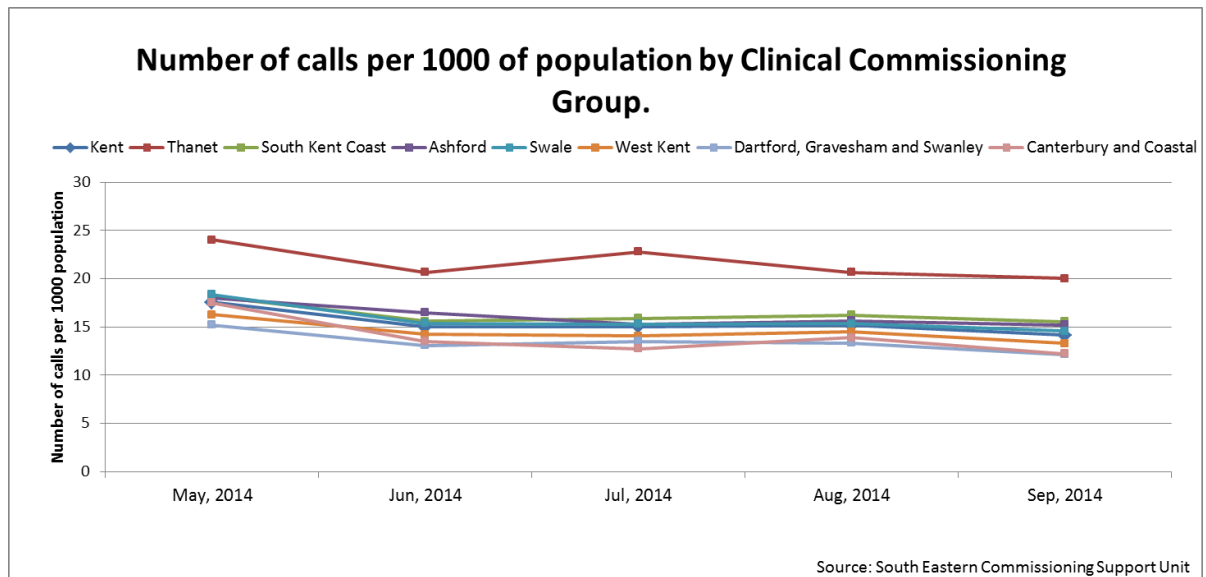
Date : Between 01 Apr 2013 and 31 Mar 2014

Reasons for Ambulance Callout See & Treat	Number	Percentage of See & Treat (%)
NHS 111	12540	15.86
Falls <12ft	11302	14.29
Trauma	6813	8.62
Generally Unwell	5715	7.23
Chest Pain/Cardiac Prob	5435	6.87
Breathing/ENT Problems	4609	5.83
Unconscious/Faint	2746	3.47
Limb/Pain Injury	2471	3.13
Cardiac/Respiratory Arrest	2295	2.90
Mental Health Issues	2144	2.71
Total Number of See & Treat	79068	

NHS 111 activity

Figure 23 shows the call rate for NHS 111 across the seven CCGs, indicating that Thanet CCG consistently having relatively higher rates compared to the other CCGs.

Figure 23



Out of Hours activity

IC 24 is the service provider for OOH in Kent. Information on latest activity is expected to be described in the next urgent care needs assessment.

Urgent Care profiles in North, East & West Kent

[North Kent Urgent Care Needs Assessment](#)

[East Kent Urgent Care Needs Assessment](#)

[West Kent Urgent Care Needs Assessment](#)

User Views

Within the context of the *Choose Well* campaign, the NHS South of England recently commissioned a qualitative study, exploring patient awareness, views and opinions on accessing the different types of NHS services particularly A&E and how available information helped them in this regard.

The study was designed to focus on three target groups which, from NHS statistics, show a particularly high prevalence in figures for overall attendance at A&E departments across the country.

- 19-24 year olds
- Parents with at least one child under-five years
- Individuals suffering from an ACS condition

In total, 156 respondents participated in research. The focus groups were ninety minutes in duration; the paired in-depth interviews lasted between forty five minutes and one hour. Key findings were:

- a All those interviewed in the research strongly believed that their personal use of NHS services was reasonable and responsible. In reality it was clear that this belief masked considerable variation in actual use, particularly around what any individual would define as a sufficiently serious reason to attend A&E.
- b 'Heavy users' of the NHS and A&E in particular, are thought to be the elderly, parents with young children, and young adults affected by alcohol or drugs. However, apart from the last group, and even then usually only if it represents a regular behaviour, this is perceived as being quite distinct from 'abuse' of services.
- c Respondents believed themselves to be far more aware of health issues due to extensive media coverage, access to information via the internet, and high profile campaigns such as 'FAST' and cancer awareness. However, awareness of the current 'Choose Well' campaign was low – although on being prompted with existing material some recalled having seen leaflets or posters in GP surgeries.
- d Overall they felt themselves to be less ready to place implicit trust in the opinion or diagnosis of a doctor than previous generations. A GP was perceived as a 'generalist' rather than 'specialist' and therefore use of A&E to seek a 'second opinion' was not deemed inappropriate. Some felt there was a lack of a consistent 'relationship' with a GP who they believe to know them and their medical history well; it is felt to be

much more likely that something important will simply be missed or overlooked in such a situation.

- e Most had a significant dissatisfaction with the process of booking appointments with GPs and felt this difficulty was a significant factor in increasing levels of attendance at A&E, and were unwilling to criticise people who take this option as a way of seeing a doctor.
- f Respondents in the 19-24yrs age group felt they tended to be quite light and infrequent users of NHS services. Changing behaviour through communications alone is probably unrealistic. Most had not considered using services like pharmacists for minor health issues instead of A&E.
- g Parents with children under the age of five years had a significant level of concern and anxiety about their child's health and often felt that their concerns were not taken seriously enough by GPs. Satisfaction levels were much higher with the treatment received at A&E for their child was usually high - any concerns that they expressed as a parent were listened to carefully and possible causes of the child's health problem were investigated thoroughly.
- h Respondents with ACS conditions had regular appointments with GPs and other medical professionals and likely not to book appointments outside their normal schedule.
- i Accessing A&E by ambulance or '*getting there under your own steam*' are seen by the vast majority as completely different options. Calling an ambulance is seen as a very serious last resort, but getting to A&E by oneself is perceived very differently and is definitely not seen as being appropriate only in very serious or life threatening conditions. This does not match most people's experience of what they observe in A&E departments.
- j Communication needs to be consistent in message and tone of voice. Some of the material exposed in the research, particularly the films, was perceived as inappropriately light hearted which undermined overall communication of the message. There is a strong belief that any communication about inappropriate use of services and what the NHS **does not** want people to do should be matched by clear advice and information about what it **does** want people to do.

Unmet Needs and Service Gaps

There are two critical areas where robust information governance arrangements are urgently needed:

1. The sharing of health and social care intelligence (coded) data to enable robust population risk stratification and accurately estimate population need.
2. The sharing of care records between the various stakeholders of the individual patient's care, contributing towards a more effective, efficient, prompt and real time development of the patient's care plan.

To date, there has not been a consistent or effective framework for the sharing of personal and sensitive patient data between data silos. In this

context data silos sit at various points within the local health economy, on GP Patient Administrative Systems, on mental health provider systems, acute systems and Social Services records etc. Interoperability between electronic systems and inconsistency of record keeping has proved problematic to resolve. This has been further compounded by the lack of a clear and understandable data sharing consent model, whether it be care records or coded data, in order to be shared appropriately and stored securely. This challenge affects all systems particularly urgent care where services like OOH would benefit greatly from accessing appropriate care planning information for prompt effective integrated care.

The other important challenge is the quality and consistency of coded data for commissioning and intelligence purposes. Most of the data that has been described in this needs assessment is based on Secondary Uses Services (SUS) data which follows a national framework for collection, entry and coding of data. In fact this is the most often used data set for understanding population usage of health care services and performance management.

However, understanding the patient journey and how he/she accesses services both in and outside hospital and why, is absolutely crucial for effective joint health and social care commissioning.

Most data that is collected for services outside hospital – primary care, ambulance, community health, mental health, and social care is activity based and is difficult to analyse on its own unless these data sets are linked together using appropriate information governance and interoperability arrangements. These arrangements are part of the whole systems transformational change that is required for better robust commissioning. Some of the data encountered during the course of this needs assessment are:

- a Lack of, and gaps in, consistent historical recording of A&E attendance data in some of the acute trusts particularly Medway Foundation Trust.
- b Lack of a consistent framework of recording reasons for A&E attendance data. For example, current systems such as Symphony which is used by Maidstone and Tunbridge Wells NHS Trust records more detail such as type of injury, anatomical site, than other A&E departments.
- c Attendance recording systems do not have the facility to record important antecedent causes / reasons for attendance of public health importance such as alcohol consumption, falls in the elderly, fragility fractures, self-harm, as well as other important related information such as mode of transport.
- d Conversion rates to emergency admissions differ when using information for A&E attendance information sources compared to hospital admission SUS data.
- e Significant discrepancies were also found in records that had blank NHS numbers and wrong postcodes which were the highest among all the acute trusts.
- f A lack of access and variation in quality of data from the other non-hospital providers. For example, currently ambulance data is not

suitable for trend analysis. Changes in the recording of OOH data meant that trend analyses could also not be carried out.

- g Data linkage through a common identifier ie NHS numbers needs to be the norm not the exception. At the moment, there is limited scope for a robust intelligence system looking at frequent flyers because none of the systems are routinely connected through the data warehouse although this is another initiative already mapped in the whole systems transformational change.

Current Services in Relation to Need

- a A&E attendance rates have only slightly risen over the last three years. However, the increase may be attributed to historical changes in data collection. The under-fives, 15-24 and above 65yrs age groups have the highest rates.
- b Emergency admissions have risen by more than a third in Kent & Medway over the last six years whereas rates have increased by approximately 10%. However there is considerable variation across CCGs.
- c ED is the main route in for emergency inpatient admissions and represents most of the rate increase in activity and spend in non-elective admission activity.
- d Attendances are driven mostly by self-referral in the young age groups and ambulance in the older age groups.
- e There have been activity increases in important programme and disease condition areas (refer to full urgent care needs assessments) over the last six years such as:
 - ambulatory care sensitive admissions
 - fall related admission rates in the elderly
 - dementia related admission rates
 - under-fives related admissions
- f The vision of what a good service looks like involves patients and the public having access to convenient, high quality, timely and cost effective urgent and emergency care services and knowing how to access these services effectively when they require them. The aim must be for 'patients to be seen by the right health and/or social care professional, in the right setting and at the right time, quality and cost'. For this to happen, a paradigm shift in delivery of urgent and emergency care is needed, with more care provided in the community, a greater emphasis on prevention and self-care and less focus on hospitals (RCGP 2011).

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