Emergency and Urgent Care – What is happening and what’s to be done

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Purpose

• Understanding the “real” picture on demand and capacity

• Disseminate evidence base regarding potential solutions

• Influence development of effective strategies and co-ordinated response to managing EUC in England
Approach

• Huge, complex area
• Huge existing literature – evidence and opinion
• Identify key pressures underlying current “crisis”
• Summarise what we understand and how this can be used to move forward
Emergency care in crisis admits NHS regulator

NHS emergency care is “out of control” across large swathes of the country, the chairman of the health and social care watchdog has warned.

Mr Prior called for large-scale closures of hospital beds and investment in community care

By Laura Donnelly, Health Correspondent
10:00PM BST 08 May 2013

Too many patients — especially the elderly — are arriving in hospital as an emergency, when they should have received help much earlier, said David Prior, head of the Care Quality Commission (CQC).

As a result, he added, the healthcare system is on the brink of collapse and regulators cannot promise to prevent further scandals like Mid-Staffordshire.
shown experimentally, the epithelial cells of the intussusception are quickly converted into goblet cells swollen with mucus, the source of the jelly. It is not known to me whether it has been shown that in children with intussusception or any other type of acute intestinal obstruction, large amounts of mucus develop in the upper gastrointestinal tract. I have certainly not recognized such mucus production.

The concern about the reduction of an anatomical leading point lesion expressed in the conference by a member of the audience is, of course, a common one. One would agree that it is precisely those intussusceptions with polyps, enterogenous cysts and Meckel diverticula which are least likely to be successfully reduced by barium enema, and, in any case, these are not lesions which are, in themselves, as inherently dangerous as let us say a carcinoma causing intussusception of the colon in an adult.

It is difficult to escape the conviction that a very large proportion of accidents to children due to The Increasing Use of Emergency Services: Why Has It Occurred? Is It a Problem?

The annual number of emergency room (ER) visits in this country has risen from 18 million in 1958, to 44 million in 1968, and 77 million in 1977.6.8 Although many of these visits are for emergency conditions, it is clear that as many as 70 percent to 85 percent are for nonurgent problems.4,8 Blaisdell notes in the Trauma Rounds elsewhere in this issue of the journal that these trends were not caused by a recent epidemic of emergencies. Their roots are found in social and economic forces that must be understood in order to decide whether a problem exists that requires action.

As is the case with rising health care costs, the greater use of emergency services seems to be associated with factors related to both the demand and the supply of services.

THE WESTERN JOURNAL OF MEDICINE 67

Variation in demand for Accident and Emergency departments in England from 1974 to 1985

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Summary Over the period 1974–85 the range of mean annual new attendance rates at Accident and Emergency departments among English health districts was 36–673 per 1000 residents. The socio-economic diversity of these districts explained only one-third of the variation. The rates rose significantly (p < 0.05) in 89 per cent of districts over the twelve years. Again, socio-economic variation only partly explained differences in district trends. Increases were greater among districts with higher mean rates. In order to plan first-contact care rationally we need a better understanding of the factors underlying these trends.

Annual new attendance rates at Accident and Emergency (A & E) departments vary considerably between health authority regions in England.6,7 The highest annual rate in 1983 was 266 per 1000 resident population for the North East Thames region and the lowest was 137 for East Anglia.4,6 These regional figures probably hide much greater inter-district differences. As well as these geographical variations there have also been striking changes with time. The number of new attendances at A & E departments per 1000 population in England has been rising constantly since the late 1950s.4,5 Between 1961 and 1972 the annual rate for England rose from 105 to 171 (a 63% increase) and between 1973 and 1983 it rose from 180 to 212 (an increase of 18%). These variations which have occurred over more than a decade and seek an explanation in what is known of the socio-economic characteristics of the populations served.

Methods

The annual number of new attendances at A & E departments for each English health district between 1974 and 1985 reported in the SH3 statistical returns was obtained from the statistics division of the Department of Health and Social Security. The 191 health district areas existing in 1985 were used as a basis for comparison for the whole period. Thus for any health district with different boundaries prior to 1985, the annual numbers of new attendances of the 19191 district populations were apportioned.

1961-72 63% increase
1973-83 18% increase
Demand for ED

- Over 40 years demand for type 1 ED doubled from 6.8m to 13.6m
- Increase from 138 per 1000 people per year to 267 per 1000 people
- Average annual growth 1.75%
- From 2006/7 annual rate has remained at 267 per 1000
- Type 2/3 increased 46% from 4.7m in 2006/7 to 6.9m
An International problem

- **Australia** – 3.6% average annual increase
- **NZ** – 20% average growth per year
- **Switzerland** – Ave annual increase 5.9%
- **Canada** – 50% increase in 10 years
- **USA** 3.2% average annual increase

Ambulance demand

- 160% increase in 20 years
- 1994/5-78 calls per 1000 people
- 2012/13 – 171 calls per 1000 people
- Proportionally fewer transports - but highly variable
Internationally

• Melbourne – Annual growth 4.8%
• Singapore – 8.4% increase 2012/13
• South Africa – 11.9% increase per year
• Canada – 36% over 7 years
• Scotland 1.5% per year
What about the rest? – whole system demand

- More difficult to measure
- 3 years whole system data for 7 sites
- Standard reference costs for each contact
- “burden” – annual increase from £2.9m to £3.3m, 4% per year
Discussion Point 1

People access emergency and urgent care via a range of services within a system. Can a system understand the demand it needs to respond to without good data on whole system demand?
Why is demand increasing?

- Poorly understood in terms of empirical evidence
- Some evidence for parts of system but not whole system and particularly interrelationships between services
- Ageing population is most frequently cited as a key driver of demand for EUC
Is this true?
Challenges of providing ED care to older people

- More frequent visitors to ED
- Higher acuity problems
- Spend longer in the ED
- More likely to be admitted - <65 -16% admitted, >85-60%
- More likely to re-attend
- Higher rates of adverse health outcomes

Other factors

- Loneliness & lack of social support
- Mainstreaming psychiatric care and frequent attenders
- Access to primary care and co-payments
- Health promotion and awareness campaigns
- Convenience – Accessibility & “one stop shop”
- Appropriateness of use and risk aversion
- Increased ambulance utilisation

And ambulance demand?

- Less investigation of profile of EMS population – but clear it is no longer about emergencies
- Some limited evidence of similar factors to ED
- Ageing population, poor mobility, lack of transport
- Social isolation, deprivation, geography, campaigns may have an impact
- Accessibility, immediate response, risk aversion

Turner J. Epidemiology and understanding demand for 999 ambulance services in Building the Evidence base in pre-hospital emergency care. 2010, Department of Health
An ageing population is clearly placing stress on the EUC system – but it is not the only factor. Can a system respond appropriately without good data on the profile and casemix of people accessing care?
Impact – Emphasis on four hour target

- Target addressed crowding by mandating patients leave the ED at 4 hours
- Enormous effort and resource poured into sustaining this
- Recent de-emphasis of target has led to increased crowding and more breaches
- This has impact on morale of staff and quality of patient care
What does this mean

It is not

- associated with rise in visits
- associated with “unececcsary” minor problems – breaches highest in admitted
- associated with GP contract

It is

- associated with the change in target
- typical of performance measures
Implications – does it matter

• No evidence 4 hour target led to worse outcomes or that breaches do

• Reducing time in department is desirable

  • Patients prefer it
  • Long stays associated with worse outcomes for those discharged home
  • Long stays increase crowding – growing evidence base that it is associated with poor outcomes
  • Long term increases in attenders will cause more crowding unless capacity is increased
Canadian response to same problem

• Canada – Improving access to emergency care (2006)
• Crowding is result of lack of bed availability and lack of integration between hospital and community resources
• 90% bed occupancy - >85% associated with poor patient flows, delays in admission and lack of surge capacity
• Recommended a set of actions and quality measures including waiting time targets – (6 hours & 4 hours) but also measures for related system aspects including community care access
• Capacity review and funding of additional capacity where needed
• Requires whole system understanding
Staff recruitment and retention

Recent CEM survey (70% response rate) reported:

• 62% consultant workforce state job is unsustainable in current format
• 94% respondents regularly work beyond contracted hours
• Currently only 50% higher training posts in emergency medicine are filled in UK
Implications

• Departments will struggle to simply maintain current operations

• Fewer EDs? – Public opinion, alternatives

• Some evidence that early senior involvement is one way of improving care but this can’t be implemented if insufficient numbers

• Need to also consider ageing workforce - ratio of elderly to workforce able to care for them (Canada, 2006)
If acuity and complexity is increasing (and continues to increase) is a 4 hour target reasonable – split targets
Is a target a help or hindrance
How can the staffing issues be resolved
Could fewer departments cope
Paramedics slam new 111 non-emergency phone service

Paramedics have slammed the new 111 non-emergency phone service today after being sent to deal with a broken fingernail.
NHS 111

• Pilot evaluation showed no significant impact on primary care, ED, but 3% increase in ambulance incidents
• Increase in overall system demand in pilot areas
• Disposition rates have remained stable – no evidence of major shift with national roll out (NHS 111 MDS)
• No assessment of impact of switching off NHSD
• Too early to tell real impact
Ambulance impact

- 24,000 extra incidents per 1 million NHS 111 calls
- 15,000 extra incidents a year for a service responding to 500,000 incidents/year
- Shift in demand profile to OOH and weekends
- Impact on cat A performance
What do users think (NHS 111 evaluation & patient opinion)

- **Like**
  - Immediate response
  - No waiting for call backs
  - Ambulance (sometimes)
  - Appointments being made

- **Don’t like**
  - Waiting for call backs – NHS 111 & OOH GP
  - Long pathways
  - Questioning – if they have a specific request
  - Services not linked with information
Discussion Point 4

What would a good 111 service look like? Integrated with and managed by Ambulance service?

Broader than call handling – on site senior clinician involvement to reduce waits and early resolution?

Development of DoS – system understanding
GPs blamed for crisis in out-of-hours health care

The failure of GPs to provide proper out-of-hours care has forced millions of extra patients to attend hospital accident and emergency departments, where they do not get the medicines, checks or support they need, the Health Secretary will warn on Thursday.

By Robert Winnett, Political Editor
10:00PM BST 24 Apr 2013

Jeremy Hunt will say “disastrous” changes to GPs’ working hours have led to an extra four million people attending hospitals annually, a situation he will demand is reversed.
EUC in primary care

- Primary care is also under pressure
- A significant proportion of unscheduled care is managed by primary care
- Much more difficult to quantify – national data and hence whole system demand
- Population surveys – 1\textsuperscript{st} contact 59% GP in hours, 6% OOH, 12% ED, 6% 999, 17% other (WiC, NHSD, MIU)
- Earlier slide on 4 hour wait
Access

• Perception it is difficult to get appointments
• GP survey – some evidence that people are finding it increasingly difficult to get appointments – doesn’t say anything about those who access other care first
• Some evidence that offering more GP telephone consultations increases efficiency and relationship between good access to appointments reduces ED attendances
Why do people choose to access care in the way they do?

• Not well explored but some evidence
• Perceived difficulties – previous experience
• Dr limited in what they can do – face to face or telephone. Hospital Drs can rule out serious illness
• Think ambulance service can do anything
• Quick response – anytime, no negotiation, one stop shop
• Complexity of pathways – allows bypass
Continued.....

• Relieves anxiety and reassures – particularly if carers/family
• See community options as too slow
• Think will end up in ED anyway
• Waiting and uncertainty – for call backs
• Risk averse – “just want to check it out” and uncertainty about seriousness
What to do

• Hundreds of examples of potential solutions - large and small scale
• Often done in isolation, small, anecdotal, poorly evaluated, not generalisable
• Fragmentation, duplication, confusion, conflict - impact elsewhere in system not considered
• Tinkering and tweaking round the edges
Look at the bigger picture

- Recognition of a system is a big step forward
- How much do we really understand it?
- Have we made any progress in really developing a well functioning emergency and urgent care system?
- Time to take a step back and really get to grips with this
1. Understand demand and the system

- Demand, demographics, casemix - and how it changes (population)
- Map out in detail – services, access points, pathways and links
- Activity across system, flows, pinch points
- Capacity & utilisation
- Fit between system and demand
• Build care around patients not existing services
• Simplify an often complicated and fragmented system
• Ensure urgent care systems work together rather than pulling apart
• Acknowledge prompt care is good care
• Focus on all stages of effective commissioning cycle – (assess, plan, contract, monitor and revise)
• Offer clear leadership across the system while acknowledging the complexity of the system

*Primary Care Foundation – Breaking the mold without breaking the system*
What system is needed?

• Reduce demand, meet, demand, manage demand

• Reduction – consider scope and where this might occur

• Does simplifying access and providing it on demand just increase demand – experience of NHS Direct, WiC, NHS 111 suggests it does

• Elderly care and LTC – keeping people out of hospital but have to be realistic about how much reduction is achievable
Change behaviour to access

• Is this likely – with the exception of some specific conditions evidence shows that this is really difficult – most attempts fail

• Patient first – understand better why they access in the way they do and what they want – still multiple entry points

• Cultural changes – instant access/response

• Phone before you go? 7 day primary care
build system to respond

• stop trying to make people fit the system, design a system that is responsive and efficient to the characteristics of the demand
• Use this to map what needs to be provided, where, when, how
• Interfaces with other sectors
• Courage, vision, collaboration
Manage the system

• Emergency and urgent care networks
• Some evidence of how they can function (Turner 2007)
• Strategic and developmental – oversight and design, collaborative, pulling not pushing
• Performance, monitoring, evaluating, changing, grip
• Funded – for system operation
Knowledge is power- utilise it

• Good examples of how understanding patient groups, pathways and system solutions improves care

• Stroke, STEMI, Major Trauma, falls

• Management of complex elderly in ED – clinical geriatric assessment reduces admissions and re-admissions (Conroy et al 2013)
Interface with primary care

• Primary care in transition - ?Two streams

• Urgent care – some evidence that generalist/primary care alongside ED improves care and efficiency – Netherlands. Integrate in to 111 – deal with the call don’t pass it on

• separated from routine care and management of LTC, chronic illness – increase chances of reducing demand
Ambulance service – care within the community

• Identified as key strategy
• Good evidence that this is clinically and cost effective and patients like it
• Currently huge variation between services in conveyance rates
• Needs clear system pathways and availability
Challenges

- Patient safety and risk – decision making
- Training – confidence in decisions
- Confidence in handoffs – will someone really take over?
- Availability of services and relationships
- Significant development of workforce
- Health care provider – funding
- Tension with 8 minute target
14 years ago...

- Health care not just emergency service
- Increasing advanced clinical practice
- Need to be part of managed care network
- System funding
The Royal College of General Practitioners guidance for commissioning integrated urgent and emergency care (2011) is underpinned by the principle that “Given the complex nature of patient flows across different services, urgent and emergency care services cannot be commissioned in isolation and the process requires a whole system and multidisciplinary approach across acute, primary and community based services and social care. Collaboration between services is key.”
To summarise

• Keep tinkering or be bold
• Back to the drawing board
• Whole system understanding then model to respond
• Fund a system not services
• Manage it - hard
To Discover And Understand.