How can the emergency and urgent care system operate to avoid emergency admissions?

Professor Alicia O’Cathain and Dr Emma Knowles

J Turner, R Maheswaran, S Goodacre, E Hirst, J Nicholl

ScHARR, University of Sheffield with Sheffield Emergency Care Forum
**Funding:** This project was funded by the National Institute for Health Research Health Services and Delivery Research Programme (project number 10/1010/08). The views and opinions expressed therein are those of the authors and do not necessarily reflect those of the HS&DR Programme, NIHR, NHS or the Department of Health.
Some people need an emergency admission but some don’t …..
Some people need an emergency admission but potentially avoidable if...

14 conditions

- chest pain
- abdominal pain
- acute mental crisis
- COPD
- UTI
- Other

Calculated rate

SAAR standardised (age sex adjusted) avoidable admission rate 2008-2011

22%
Explain variation

**Phase 1: Quantitative** Routine data on population (deprivation, health, geography), emergency and urgent care services, and system: regression of 150 systems

**Phase 2: Qualitative** Case studies of 6 systems not predicted by regression. Data, documents, interviews with system stakeholders (n=82)

**Phase 3: Quantitative** Return to regression
How does system work?

Before hospital
- GP
- WIC
- GPOOH
- 999
- Community
- Mental
- Nursing homes

Within-hospital
- Wards and ED

After hospital attendance
- Rapid Assessment Teams, Community, Mental, Social Services, GP
Reduce deprivation? Make schemes work for deprived communities?

Morbidity and comorbidity

Expressed need

Can’t discharge from A&E

72%
Improve access to primary care?

• Use of emergency departments
  – 275 (149, 909) ED attendances per 100,000

• Continuity of care
  – (Huntley et al 2014)

• GP OOH services
Increase use of ambulance non-conveyance?

- 7.5% calls dealt with by telephone only
  - 3% - 13%
- 37% incidents not transported to ED
  - 28% - 52%
- Need for responsive services in locality
Increase senior review?

• Conversion rate from attendance at ED to admission 100 (70, 148)
• Junior doctors...tests...waiting...breaches
• Consultants in ED and medical specialties
Standardise coding?

• 28% staying less than one day
• 14%-41% variation
Help staff to deal with complexity of system?
Have proactive rapid assessment teams?
“and often the easy option the safe option is to send people into hospital, although we know that’s not often the safest option ha! for patients to go into hospital these days”

(Commissioner)
Improve integration?
Is co-location the key to integration?

• Co-location occurred in some services in some systems
• In one system, positive about the co-location of health and social care:

“When you’re talking about like an admission avoidance [...] I can walk out of my office [...] the first desk outside my office is the manager of the social workers. But then my [...] community health staff sit next to the social workers and the social workers’ assistants and if you’ve got somebody that you’re particularly concerned about all parts of the jigsaw need to come together and that’s how we do it here.” (District nurse)
...not necessarily

• Co-location does not always equate to integration: contractual issues or service/personnel related tensions

“where we’re sat now is the GP out of hours so it’s quite close [to the ED] but there’s no link between the pair of us. We’ve been trying you know would you see this patient, we have a barrier caused by the receptionist occasionally and we also have a barrier by the actual doctor that’s here by saying no I can’t see that patient I’ve got a full list even though the next patient hasn’t arrived and they’re [the GP is] sat in here reading the paper.” (Emergency Department)

• Further co-location desirable
Working relationships

• Joint posts/working practices
  - MDT within health/between health and social:
    “We have a social worker within the team as well, so we have got three different stakeholders (ED/community/LA) within one service.” (Community)

• Informal relationships (same/different organisations)
  - facilitated by meetings
  - built up over time
  - stable workforce:
    “But some of that again is because I know the people because I’ve been here for a long time.” (Local Authority)
Building confidence in others’ skills

- AA requires confidence in others – skills/trust
- Built up over time through communication and knowledge of expertise in different organisations:

[Talking about provider confidence] “I think that some of it is just the fact the people get to know you, and what you’re providing and get to know what your service does…..Some may get to see the stats so they see that they are an effective service. Sometimes it is just the fact that they see what the referrals are like, and are generally happy with the referrals.” (Walk-in centre)
Poor experience/communication

• Previous poor experience – impact on referral

“I’ve found that quite a lot of times I’ve tried to refer but the referral’s not been accepted. We have documented the reasons, but a lot of the patients that were deemed ideal for that have been knocked back” (Ambulance service)

• Outcome of poor communication – no referral

“[there is a] need for communication [so that] we can be confident in the support that there is in the community when we discharge these patients back. Too often we are obliged to admit because we don’t have enough information and we’re not confident enough of what exists in the community to support the discharges” (Emergency department)
Complex system – hindrance to integration?
Recipe for integration?

Trust
Communication
Time
Simplicity of system configuration
Commitment
Dissemination


• O’Cathain A et al. Hospital characteristics affecting potentially avoidable emergency admissions: national ecological study. Health Services Management Research 2013, Vol. 26(4) 110–118. open access

• O’Cathain A et al. Explaining variation in emergency admissions: a mixed methods study of emergency and urgent care systems. Health Services & Delivery Research, in press. open access