

Warrington

Joint Strategic Needs Assessment (JSNA)

Unscheduled Care, 2015

May 2016

The Joint Strategic Needs Assessment (JSNA) considers a wide range of factors that affect the health and wellbeing of the people of Warrington. The objective of the JSNA is to involve partner organisations, such as the local NHS, local authorities, Police, Fire and third sector organisations in order to provide a top level, holistic view of current and future need within the borough. The JSNA is used to agree key priorities to improve the health and wellbeing of all our communities at the same time as reducing health inequalities

EXECUTIVE SUMMARY

1.0 Introduction

The purpose of this JSNA chapter is to summarise the different types of unscheduled care (unplanned health care) available to patients living in Warrington. It will focus on Warrington patient activity relating to 111 (telephone service for non-emergency medical situations), General Practitioners Out of Hours (GP OOH) Service, Emergency Department (ED) presentations and emergency hospital admissions up to March 2015.

1.1 Types of Unscheduled Care

There are various services that offer unscheduled care to patients depending on their need for immediate medical attention. The following list details the types of services that are currently in place in England:

- **111:** This is a telephone service for non-emergency medical situations. The service is staffed by fully trained advisors and is supported by qualified nurses and paramedics. The advisor will ask the caller a series of relevant medical questions and then direct the caller to the most appropriate route of support needed. If needed, 111 can arrange for an ambulance to be sent straight to the patient (NHS Choices, 2015a).
- **GP Out Of Hours:** GPs can choose whether to provide 24-hour care for their patients or to transfer responsibility for out-of-hours services to the relevant NHS England Area Team. Out-of-hours cover can include the following services: GPs working in emergency departments or Minor Injuries Units (MIU), teams of healthcare professionals working in primary care centres, ED, MIUs, urgent care centres or NHS walk-in centres, healthcare professionals (other than doctors) making home visits following a detailed clinical assessment, ambulance services moving patients to places where they can be seen by a doctor or nurse in order to reduce the need for home visits (NHS Choices, 2015b).
- **Urgent Care Centre/Minor Injury Units:** If an injury is not serious, a patient can attend a minor injuries unit or urgent care centre (UCC), rather than going to an ED. MIUs and urgent care centres are usually led by nurses and an appointment is not necessary (NHS Choices, 2015c).
- **Walk in Centres (WIC):** NHS walk-in centres (WICs) offer convenient access to a range of treatments. WICs are managed by Clinical Commissioning Groups (CCGs), dealing with minor illnesses and injuries. NHS WICs are usually managed by a nurse and are available to everyone. Patients do not need an appointment. Most centres are open 365 days a year and outside office hours. They have proved to be a successful complementary service to traditional GP and ED services. Some NHS WICs offer access to doctors as well as nurses. However, they are not designed for treating long-term conditions or immediately life-threatening problems (NHS Choices, 2015d).
- **Ambulance Service:** Ambulance services help many people with serious or life-threatening conditions. They also provide a range of other urgent and planned healthcare and transport services. Patients will always be taken to hospital when there is a medical need for this. However, paramedics now carry out more diagnostic tests and undertake basic procedures at the scene. Many crews also refer patients to social care services, directly admit patients to

specialist units and paramedics administer a wide range of drugs to deal with conditions such as diabetes, asthma, allergic reactions, overdoses, and heart failure (NHS Choices, 2015e).

- **Emergency Departments (ED):** Major EDs offer access 24 hours a day, 365 days a year, although not all hospitals have an ED. At an ED a doctor or nurse will assess a patient's condition and decide on further action. (NHS Choices, 2015f).

In addition, another type of unplanned care is emergency hospital admissions. These are hospital admissions that are not predicted and happen at short notice because of perceived clinical need (HSCIC, 2015). 1 in 5 people who attend an ED will be admitted into hospital (Kings Fund, 2014).

1.2 National Strategy

The demands being placed on urgent and emergency care services have been growing significantly over the past decade. Data shows that the demand on the NHS is substantial and increasing across the whole system, including:

- Rising numbers of GP consultations per patient per year. Some patients have found it more difficult to access their GP quickly, resulting in increased demand for urgent or emergency care services;
- 8.47 million calls to emergency 999 services in 2013/14;
- 11.3 million calls to NHS 111 in 2014/15;
- 4.75 million emergency ambulance journeys in 2013/14;
- 21.7 million attendances at emergency departments, minor injury units and urgent care centres in 2012/13. These attendances increased by 32% since 2003/04. The increase was found to be particularly high in minor emergency department attendances (for example, urgent care centres, minor injury units and walk-in centres). Attendances at major emergency departments increased at a lower rate (13% between 2003/04 and 2012/13), in line with what would be expected from population ageing and growth;
- 5.2 million emergency admissions to England's hospitals in 2012/13. Emergency admissions, which include short-stay and zero length-of-stay admissions (a patient admitted and discharged on the same day) have increased by 40% between 2003/04 and 2010/11 (NICE, 2014).

In response to the increase in the demand of urgent and emergency care services, NHS England (2013) has reviewed the NHS urgent and emergency care system in England in two phases. The first phase described the current system, gathered research evidence and consulted with patients, clinicians and commissioners to propose a new NHS urgent and emergency care system. The findings of this phase identified five key elements which should be implemented to reduce demand on NHS urgent and emergency care services in England:

- Provide better support for people to self-care;
- Help people with urgent care needs to get the right advice in the right place, first time;
- Provide highly responsive urgent care services outside of hospital so people no longer choose to queue at ED;

- Ensure that those people with more serious or life threatening emergency care needs receive treatment in centres with the right facilities and expertise in order to maximise chances of survival and a good recovery;
- Connect the whole urgent and emergency care system together through networks (NHS England, 2013).

The first document of the second phase, published in August 2014 (NHS England, 2014); acknowledges that the five key elements will take three to five years to fully implement. The document also provides an update on key actions that were expected to be implemented within six months of the release of the document. At present, no documents have been published to evidence the completion of the quick win key actions (NHS England, 2014).

The National Institute for Health and Care Excellence (NICE) are currently developing guidelines in relation to service delivery and organisation for acute medical emergencies, and these are expected to be released in November 2016 (NICE, 2014). The Department of Health have asked NICE to consider within the development of the guidelines:

- Urgent and emergency care;
- Out-of-hours care;
- 7-day working;
- Consultant review within 12 hours of admission;
- Acute medical admissions within the first 48 hours;
- Discharge planning to reduce readmissions (NICE, 2014).

Key Findings, Issues and Gaps

- There are no urgent care centres (UCC) or walk in centres (WIC) (excluding ED at Warrington hospital) located in Warrington. However, Warrington Clinical Commissioning Group (CCG) commission specific services across the health system to see and treat patients who might otherwise have attended an UCC or WIC.
- There was a very high volume of calls to the GP OOH Service for patients aged 0 to 5 years (22.5%). Almost half of these phone calls resulted in a visit to the Primary Care Centre (patients referred for an OOH GP appointment at the OOH Service located at Warrington Hospital);
- Attendance at ED was highest for the very young (0 to 4 year olds) and older populations (aged 75 years and above);
- Attendance at ED peaked between 9am and 1:59pm and between 6pm and 6:59pm;
- Of those patients who attended ED for a short time (less than 3 hours), 41% (16,550 attendances) were discharged and required no follow-up treatment and 29% (11,743 attendances) were discharged to their GP. A proportion of these patients could have been treated elsewhere.
- Attendance rates at ED were significantly higher in patients living in the 40% most socio-economically deprived areas of Warrington. A similar pattern was also seen for repeat attenders at ED. However, Warrington Hospital is located in an area that falls within the 40% most deprived areas.

- As with ED attendances, emergency admissions to hospital were highest for the very young (0 to 4 year olds) and older populations (70 years and above);
- 36% of all emergency admissions were for less than 24 hours (0 Length of Stay). As the age of the patient increased, the length of stay also increased;
- Emergency admissions were significantly higher for patients living in the most deprived areas of Warrington. Admissions for males living in the 20% most deprived areas were 46% higher than expected (when compared to the overall admission rate for all males).

Recommendations for Commissioning

- Ensure that robust monitoring of ED patient flow is routinely undertaken by Warrington CCG. The routine monitoring should capture information that informs the commissioner that the services have been commissioned to sufficient capacity;
- Develop a Warrington specific patient awareness raising campaign to advise on the most appropriate setting to attend with health issues; this could be promoted through local health and social care providers (GPs, pharmacies, dental practices, opticians etc.) who will display consistent self-care patient education materials. Public Health can support this programme by promoting universal prevention interventions;
- Continue to develop robust services to avoid the need for emergency admission and/or improve treatment timelines to reduce length of stay specifically for the frail and elderly.

1) Who is at risk and why?

The following section has been extracted from The Kings Fund (Purdy, 2010, p3-5) which has identified groups who are particularly at risk of emergency admissions. A number of factors are associated with increased rates of admission, and are therefore important to consider when targeting interventions to reduce avoidable admissions.

Age is a risk factor for emergency hospital admission, with babies or very young children and older people being at higher risk. However, it is important to recognise that only those aged 5 to 14 years have low risk.

Social Deprivation: There is evidence from the UK, North America and Europe that people who live in areas of socio-economic deprivation have higher rates of emergency admissions, after adjusting for other risk factors. In the UK, admission rates are significantly correlated with measures of social deprivation (Majeed et al., 2000). Socio-demographic variables explain around 45 per cent of the variation in emergency admissions between GP practices, with deprivation more strongly linked to emergency than to elective admission (Reid et al., 1999; Duffy et al., 2002). Practices serving the most deprived populations have emergency admission rates that are around 60–90 per cent higher than those serving the least deprived populations (Blatchford et al .,1999; Purdy et al .,2010a).

Morbidity Levels: Higher levels of morbidity (illness) in a population are associated with higher levels of emergency admission. Admission rates are also correlated with chronic illness (Majeed et al., 2000). Higher levels of recorded morbidity and chronic disease in patients registered with GP

practices have also been shown to be associated with higher rates of emergency admission from those practices (Bottle et al., 2008; Donald and Ambery, 2000).

Area of Residence: Those who live in urban areas have higher rates of emergency hospital admission than those in rural areas; for example, a 16 per cent higher rate of asthma admissions for urban patients compared with rural patients (Purdy et al., 2010a). What is uncertain is whether these rates are lower due to better management in the community or because patients who live further from an ED and therefore have more difficulty accessing services (O'Donnell, 2000). It was also found that those who live closer to an ED have higher rates of admission (for instance, a 12 per cent higher rate of admission for asthma), even after taking into account other risk factors, including living in an urban area (Purdy et al., 2010a).

Ethnicity: Data on the impact of ethnicity on risk of emergency admission are fairly limited. Being from a minority ethnic group is associated with a higher risk of emergency admission (Bottle et al., 2006). For example, in the UK, asthma admission rates for South Asian patients have been double those of white patients, and are also high for black patients (Gilthorpe et al., 1998). Different ways of coping with asthma exacerbations and accessing care may partly explain the increased risk of hospital admission among South Asian patients (Griffiths et al., 2001).

Environmental Factors: The evidence for environmental risk factors is variable across diseases. For example, air pollution and meteorological factors in the UK are probably less important in relation to cardiovascular admissions than they are in respiratory conditions such as COPD, where cold weather is associated with increased rates of admission (Maheswaran et al., 2005; Moran et al., 2000; Marno, 2006).

2) The Level of Need in the Local Population

2.1 Calls made to 111

The 111 scheme has been in place in Warrington since April 2013. Data has been made available in relation to the number of calls made to 111 by patients registered at Warrington GP practices during April 2015. Data has been supplied and analysed by the North West Ambulance Service (NWAS). Therefore, any findings from this data analysis should be treated with caution as it only relates to activity from one month. During April 2015, there were 4,527 phone calls made to 111 by patients registered at Warrington GP Practices. When taking into account the population size of each CCG in the North West, Warrington had the second highest rate of 111 phone calls (21.4 per 1,000 population), Blackburn with Darwin had the highest rate of phone calls (22.5 per 1,000) whilst the average for the North West was 8.7 per 1,000 population).

Caller treatment:

- 5% of callers terminated the call during triage (7% North West);
- 2% of callers were identified as a repeat caller (4% North West);
- 26% of patients spoke with a clinician (26% North West);
- 56% of patients were offered a call back if it was required (49% North West);
- 46% of patients received a call back within 10 minutes (51% North West);

Referral given:

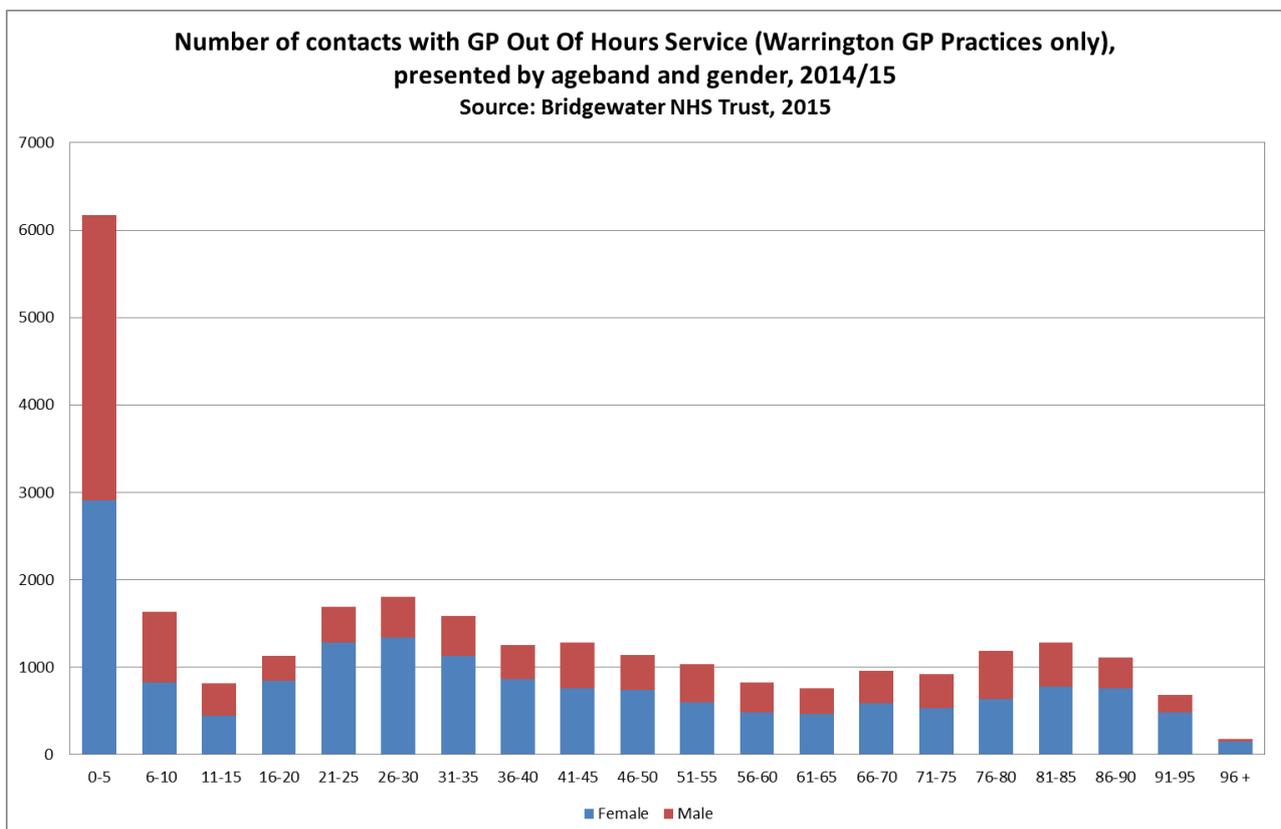
- 8% of calls required an ambulance to be dispatched (11% North West);
- 9% of callers were told to attend an ED (10% North West);
- 67% of callers were told to contact primary and community care (61% North West);
- 3% of callers were advised to contact other services (1% North West);

The data above highlights that a slightly larger proportion of Warrington patients were advised to contact primary and community care when compared to the average for the North West; Warrington CCG had the largest proportion of patients given this particular recommendation out of all CCGs in the North West. It is expected that a large proportion of these patients would have been directed to the Warrington GP Out Of Hours Service and would have received advice and/or treatment from this service.

2.2 GP Out Of Hours (OOH) Service

During 2014/15, there were nearly 27,500 phone calls to GP OOH Services by patients who were registered at a Warrington GP Practice. Chart 1 illustrates the age and gender distribution of phone calls made to the GP OOH service. Just over a fifth (22.5%) were in relation to patients aged 0 to 5 years. A higher proportion of females than males accessed the GP OOH service (61% and 39% respectively); this pattern was observed for each of the age bands as presented in Chart 1, with the exception of patients who were aged 0 to 5 years (53% of calls for boys and 47% of calls for girls).

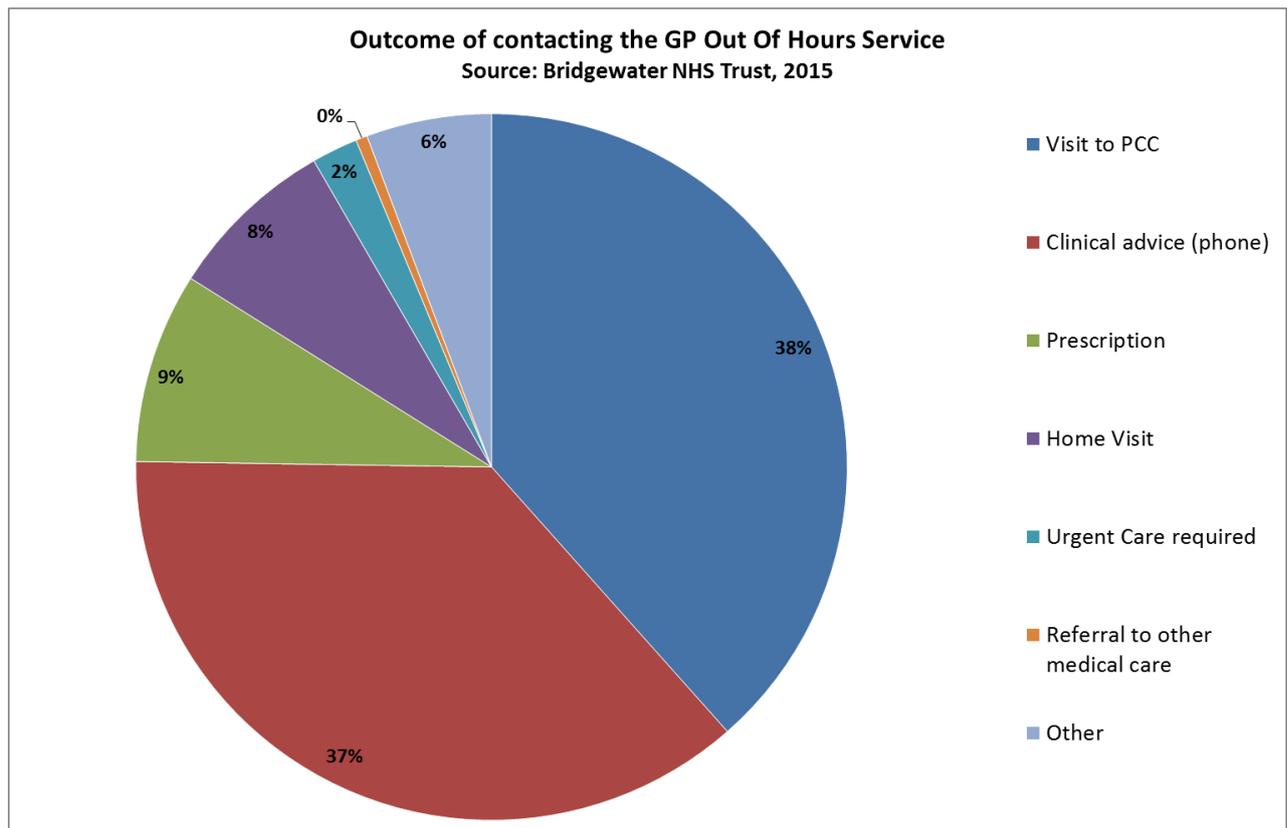
Chart 1: Number of contacts with GP Out Of Hours Service (patients registered with Warrington GP Practices only), presented by age band and gender, 2014/15



Each month during 2014/15 there were at least 1,900 phone calls made to the GP OOH Service. These peaked during the winter months (November 2014 to January 2015), with December experiencing the highest volume of calls (3,039).

Of the 27,500 phone calls made during 2014/15 three quarters resulted in the patient either visiting the Primary Care Centre (patients referred for an OOH GP appointment at the OOH Service located at Warrington Hospital) (38%) or the patient receiving clinical advice over the phone (37%).

Chart 2: Outcomes of contacting the GP Out Of Hours Service



2.3 Calls made to North West Ambulance Service (NWAS)

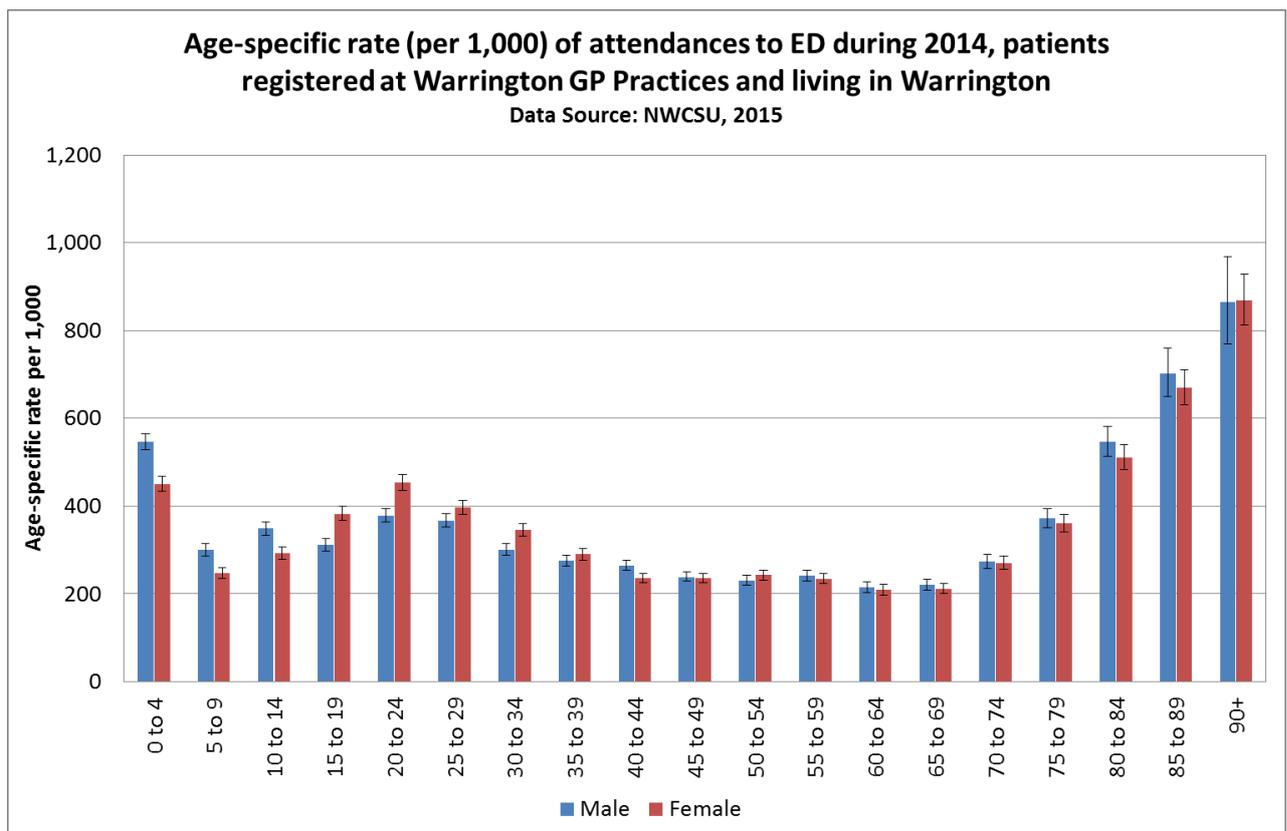
Between April 2015 and February 2016 there were 26,503 phone calls made to NWAS by patients registered at a Warrington CCG GP Practice. The Department of Health requires that the ambulance service reaches 75% of category A¹ (life-threatening) calls within eight minutes. If onward transport is required, a suitable vehicle should arrive on the scene within 19 minutes. During the time period stated above, there were 667 calls categorised as a Red 1 (Category A), of these calls 75.3% were responded to within 8 minutes, this was similar to the North West average (75.6%). 10,232 calls were classified as Red 2 (Category A), 71.9% of Red 2 calls were responded to within 8 minutes and again this was similar to the North West (71.6%). 95.8% of all red calls had a suitable vehicle arriving within 19 minutes; this was slightly higher than the North West (93.2%).

¹ Category A (Red 1 and Red 2) ambulance calls are those that are classed as life threatening and the national standard sets out that 75% of these calls should receive a response within eight minutes.

2.4 Emergency Department Attendances

During 2014, Warrington GP registered patients made approximately 64,500 attendances at ED. A slightly higher proportion of females (51%) attended ED when compared to males (49%), however in each of the youngest age bands (0-4, 5-9 and 10-14) and 40 to 44 years the rate was significantly higher in males than females, whilst in the age bands 15-19, 20-24 and 30 to 34 the rate was significantly in females than males. Attendance by age band show higher rates of attendance for the very young (0 to 4 years) and older age groups (ages 75 and above); there was also a higher rate of attendances for young people aged 20 to 24 years, as presented in the following chart.

Chart 3: Age-specific rate (per 1,000) of attendances to ED during 2014



The most common cause of attendance at ED was due to sprain/ligament injuries (7,768 attendances). The following table provides details of the top 5 causes of attendance at ED during 2014.

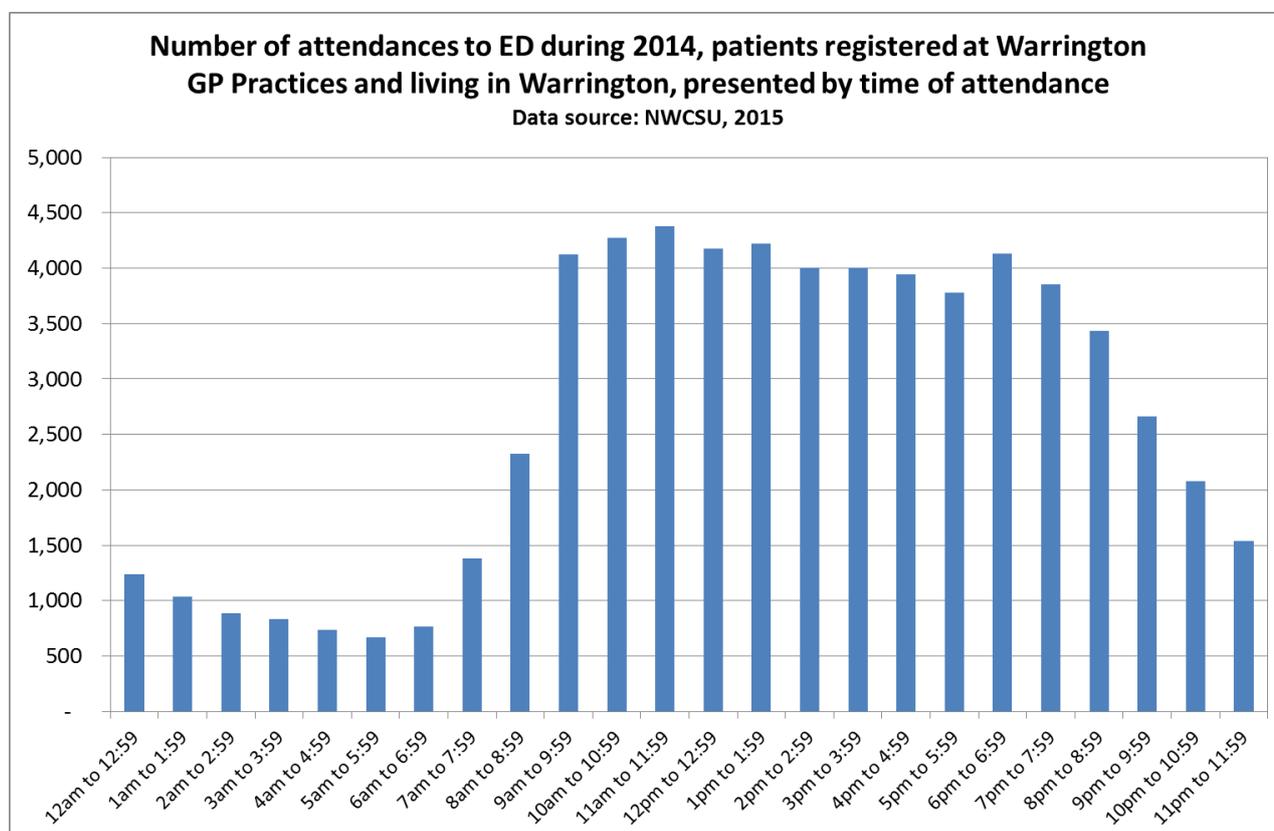
Table 1: Top 5 causes of attendance at emergency departments by gender

Rank	Males		Females		Total	
	Cause	No.	Cause	No.	Cause	No.
1	Sprain/ligament injury	3,868	Sprain/ligament injury	3,900	Sprain/ligament injury	7,768
2	Diagnosis not classifiable	3,055	Diagnosis not classifiable	3,158	Diagnosis not classifiable	6,213
3	Laceration	2,684	Dislocation/fracture/joint injury/amputation	2,214	Dislocation/fracture/joint injury/amputation	4,598
4	Dislocation/fracture/joint injury/amputation	2,384	Gastrointestinal conditions	1,896	Laceration	4,424
5	Cardiac conditions	1,624	Laceration	1,740	Gastrointestinal conditions	3,361

Attendances at ED during 2014 varied each month, with the lowest number of attendances during February (4,603) and the highest during July (5,846). The largest proportion of visits to ED took place on a Monday (10,201 – 16% of all visits), and the lowest on a Friday (8,585 – 13% of all visits).

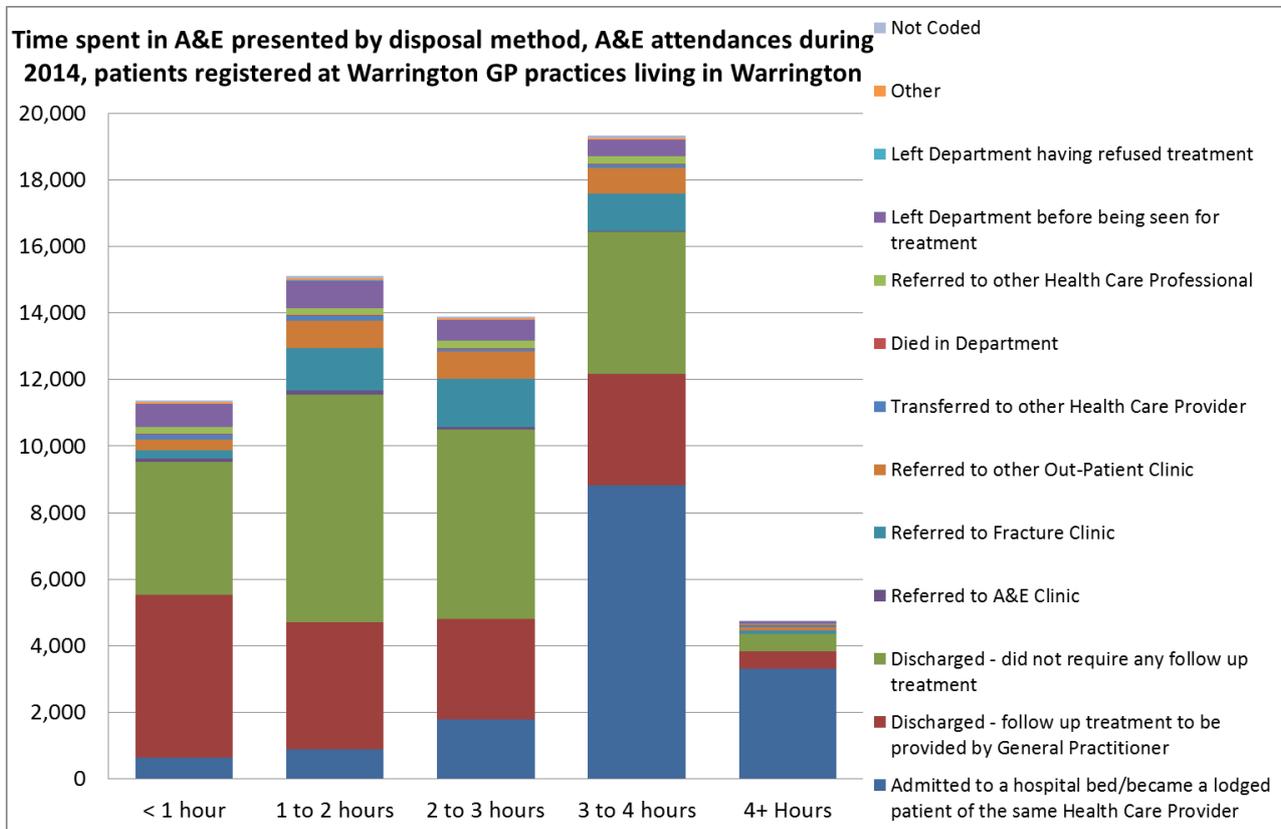
There was a distinct pattern at the time patients attended ED during 2014. Attendances between 11pm and 7:59am were lowest, and then a sharp increase from 9am and remains static until 1:59pm. After a slight drop in the number of attendances, an increase is observed from 6 to 6:59pm, after which the number of attendances steadily reduces, as presented in the following chart.

Chart 4: Number of attendances to ED during 2014 presented by time of attendance



Of the 65,500 attendances at ED during 2014, 94% were either treated/discharged or admitted within four hours. The following chart presents the length of time spent in ED and the outcome of their attendance (also known as disposal method).

Chart 5: Time spent in ED presented by disposal method



The chart above illustrates that a very large proportion of patients who attended ED for a relatively short period of time (less than 3 hours) were either discharged as they didn't require any follow up treatment (16,550 attendances – 41% of all attendances within this time period) or were discharged and their GP was to provide follow up treatment (11,743 attendances – 29% of all attendances within this time period).

It would be inaccurate to assume that all of these attendances to ED were avoidable, as a proportion would have been seen and received treatment within three hours. However, it is valid to question whether ED was the most appropriate location for these patients to attend. Further analysis of this specific cohort has shown that of those who spent less than 3 hours in ED and were discharged with no further treatment required, 41% attended ED due to the following conditions: sprain/ligament injury (21%); laceration (13%); contusion/abrasion (7%).

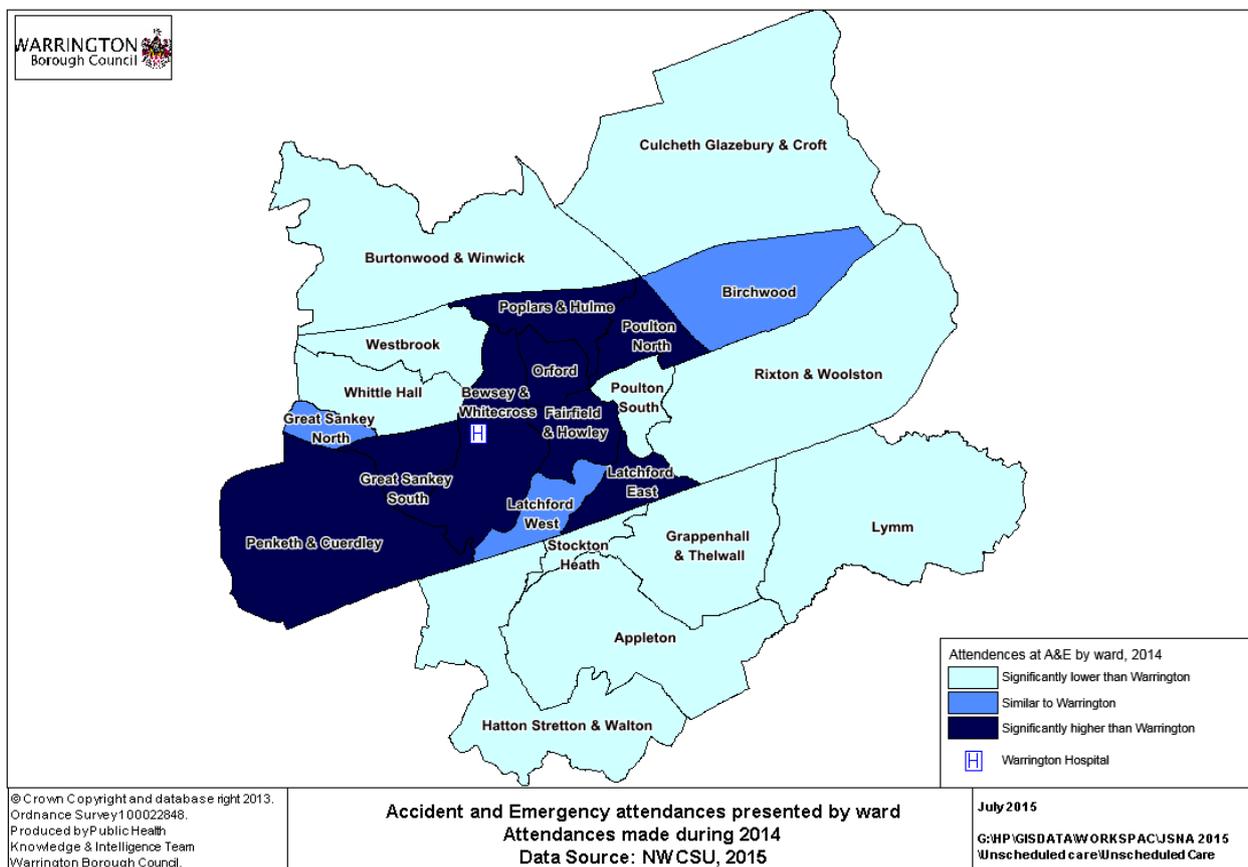
Warrington CCG is the organisation responsible for commissioning local health services for Warrington residents. It currently commissions a number of services to deal with patients with minor ailments/injury such as GP OOH. Warrington CCG commissions services at ED located in Warrington Hospital to deal with minor ailments/injuries rather than commissioning a purpose built UCC or WIC. To ensure that the right level of services is commissioned within the ED, it is

recommended that patient flow is robustly monitored to ensure that the services have been commissioned to sufficient capacity.

Of the patients who attended ED for less than 3 hours and were discharged for their GP to provide follow up treatment, 37% attended ED with the following: nothing abnormal detected (14%); sprain/ligament injury (12%); diagnosis not classifiable (12%). Unfortunately, it is not known if these patients had tried to make an appointment with their GP before attending ED. At present there is a shortage of GPs nationally, most likely resulting in patients having to wait an extended time before being seen by their GP. Whilst there is no local data available on vacancy rates, analysis undertaken in 2015 suggested that Warrington would need approximately 25 more full time equivalent GPs in order for the average list size locally to be in-keeping with the average for England as a whole. Whilst there is no available data on waiting times, it is reasonable to suggest that fewer GPs and larger list sizes may lead to increased waiting times.

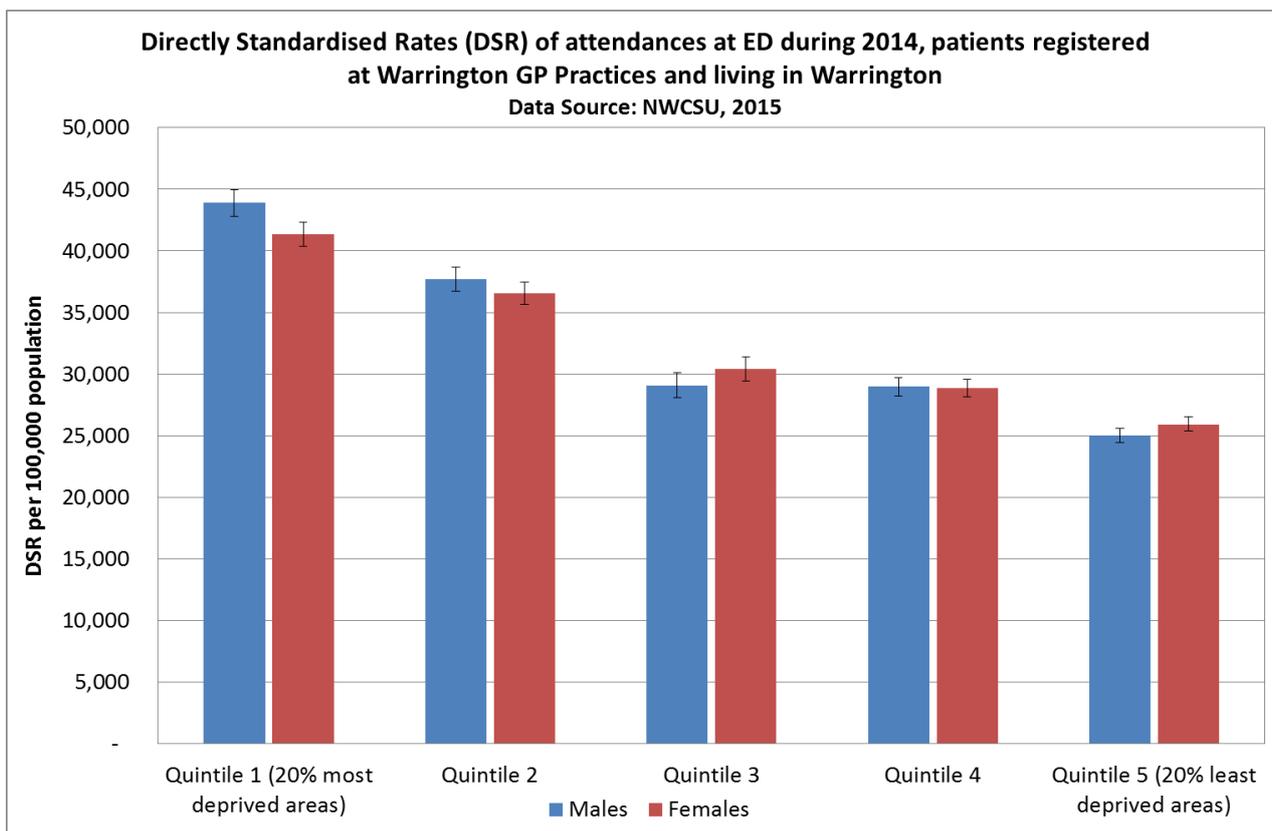
Attendance rates at ED were highest in the central and western areas of Warrington as illustrated in the following map. The electoral wards coloured the darkest shade of blue had significantly higher attendance rates when compared to the overall Warrington attendance rate. Further analysis was conducted to examine whether the pattern of ED attendance altered when removing repeat attendance episodes. This method aimed to identify ward rates based on the number of individuals who attended ED rather than the total number of times over a 12 month period. This methodology helps to identify the volume of need (the need of ED services) in each ward of Warrington. This analysis resulted in a very similar pattern of attendance as presented below.

Map 1: ED attendances of patients registered with Warrington GP practices presented by ward, 2014



Attendance rates at ED when presented by deprivation quintile, illustrate that the most deprived areas of Warrington (deprivation quintiles 1 and 2) have significantly higher attendance rates when compared to the remaining areas of Warrington (as presented in the following chart). Rate of attendance at ED was significantly lower in quintile 5 (20% least deprived areas of Warrington) when compared to the remaining four quintiles.

Chart 6: Rate of attendance at ED during 2014, presented by deprivation quintiles



A similar pattern to that shown above was also present when analysing repeat attendances at ED. When investigating the proportion of patients who have attended ED on more than 5 and 10 occasions over a 12 month period, it was found that those living in the most deprived areas of Warrington had a higher rate of repeat attenders at ED, as presented in the following table.

Table 2: Percentage of patients repeatedly attending Emergency departments, presented by deprivation quintile

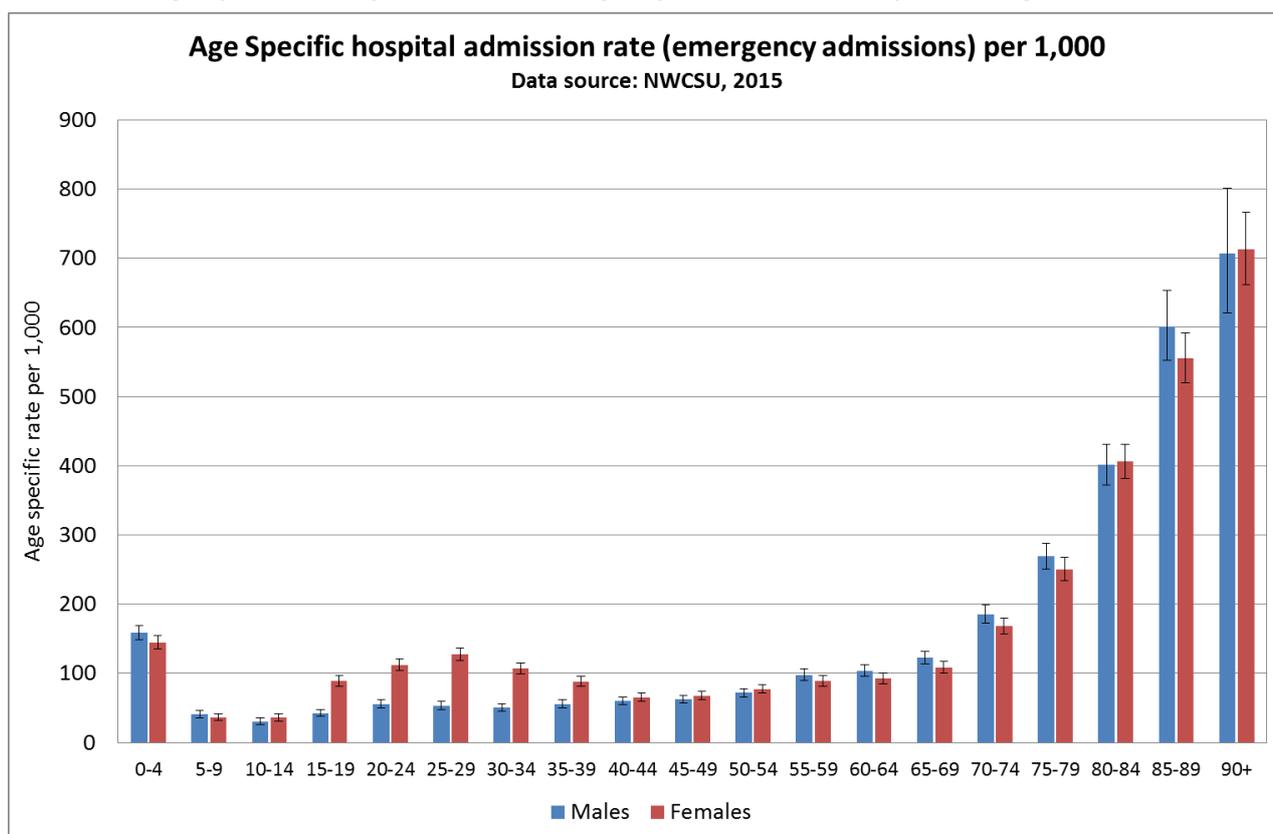
	% of patients attending ED on 5 or more occasions over a 12 month period	% of patients attending ED on 10 or more occasions over a 12 month period
Quintile 1 (20% most deprived areas)	2.7%	0.31%
Quintile 2	2.2%	0.27%
Quintile 3	2.0%	0.25%
Quintile 4	1.8%	0.13%
Quintile 5 (20% least deprived areas)	1.1%	0.04%

2.5 Emergency Admissions

During 2014 the GP registered population of Warrington experienced 21,800 emergency admissions to hospital. Admissions were higher in females (12,228 emergency admissions compared to 9,600 male admissions) resulting in an admission rate that was significantly higher than males.

Admission by age show high admissions for young children (aged 0 to 4 years) and older populations (aged 70 years and above). Females had significantly higher admission rates when aged 15 to 39 years (these admissions do not include maternity delivery admissions), for the remaining age bands there was no statistical difference between the sexes.

Chart 7: Age-specific rate (per 1,000) of emergency admissions to hospital during 2014



During 2014, almost two thirds (65%) of emergency admissions were admitted through ED (14,130 admissions); whilst 29% of admissions were through a GP requesting a bed directly with the hospital (6,303 admissions). There was a substantial increase in the number of admissions via GPs during 2014, when compared to 2013 (an increase of 1,165 admissions). It is believed that the increase may be due to changes in the coding of admission methods that was implemented at Warrington and Halton Hospital Foundation Trust during 2014.

The table below presents the top five causes of emergency admissions to hospital during 2014. The most common cause of emergency admission during 2014 was due to *symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified* (5,242 admissions). This covers cases where a specific diagnosis could not be made before the patient was discharged from the hospital. Within this, there are sub-categories which provide further detail of the cause of

admission. There were differences between the genders in these subcategories. The most frequent for males was *symptoms and signs involving the circulatory and respiratory systems* (817 admissions); whilst for females it was *symptoms and signs involving the digestive system and abdomen* (974 admissions).

The second most frequent cause of admission was *injury, poisoning and certain other consequences of external causes* (3,556 admissions); within this category further analysis shows that for both males and females, *injuries to the head* was the most common (850 admissions).

Table 3: Top 5 causes of emergency hospital admission by gender for patients registered at a Warrington GP Practice and living in Warrington

Rank	Males		Females		Total	
	Cause	No.	Cause	No.	Cause	No.
1	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	2,255	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	2,987	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	5,242
2	Injury, poisoning and certain other consequences of external causes	1,663	Injury, poisoning and certain other consequences of external causes	1,893	Injury, poisoning and certain other consequences of external causes	3,556
3	Diseases of the respiratory system	1,093	Diseases of the respiratory system	1,243	Diseases of the respiratory system	2,336
4	Diseases of the circulatory system	895	Diseases of the digestive system	969	Diseases of the digestive system	1,787
5	Diseases of the digestive system	818	Diseases of the genitourinary system	870	Diseases of the circulatory system	1,759

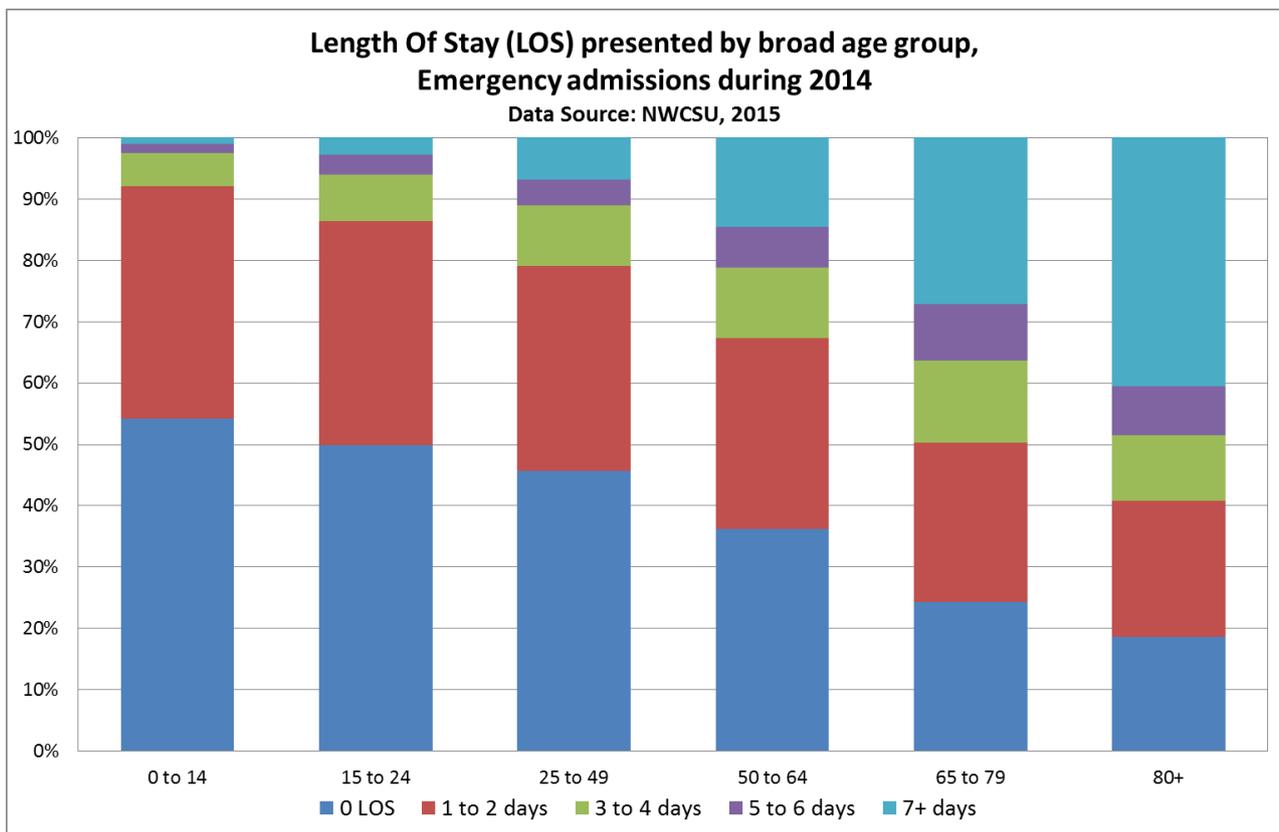
The length of time an individual stays in hospital is called Length of Stay (LOS). A zero (0) LOS signifies when a person has been admitted and discharged on the same day. During 2014, 36% (7,847 admissions) of all emergency admissions were 0 LOS. The following table presents the proportion of emergency admissions by LOS grouping for all emergency admissions during 2014.

Table 4: Length of stay, 2014

	0 LOS	1 to 2 days	3 to 4 days	5 to 6 days	7+ days
Number	7,847	6,584	2,239	1,296	3,862
Percentage	36%	30%	10%	6%	18%

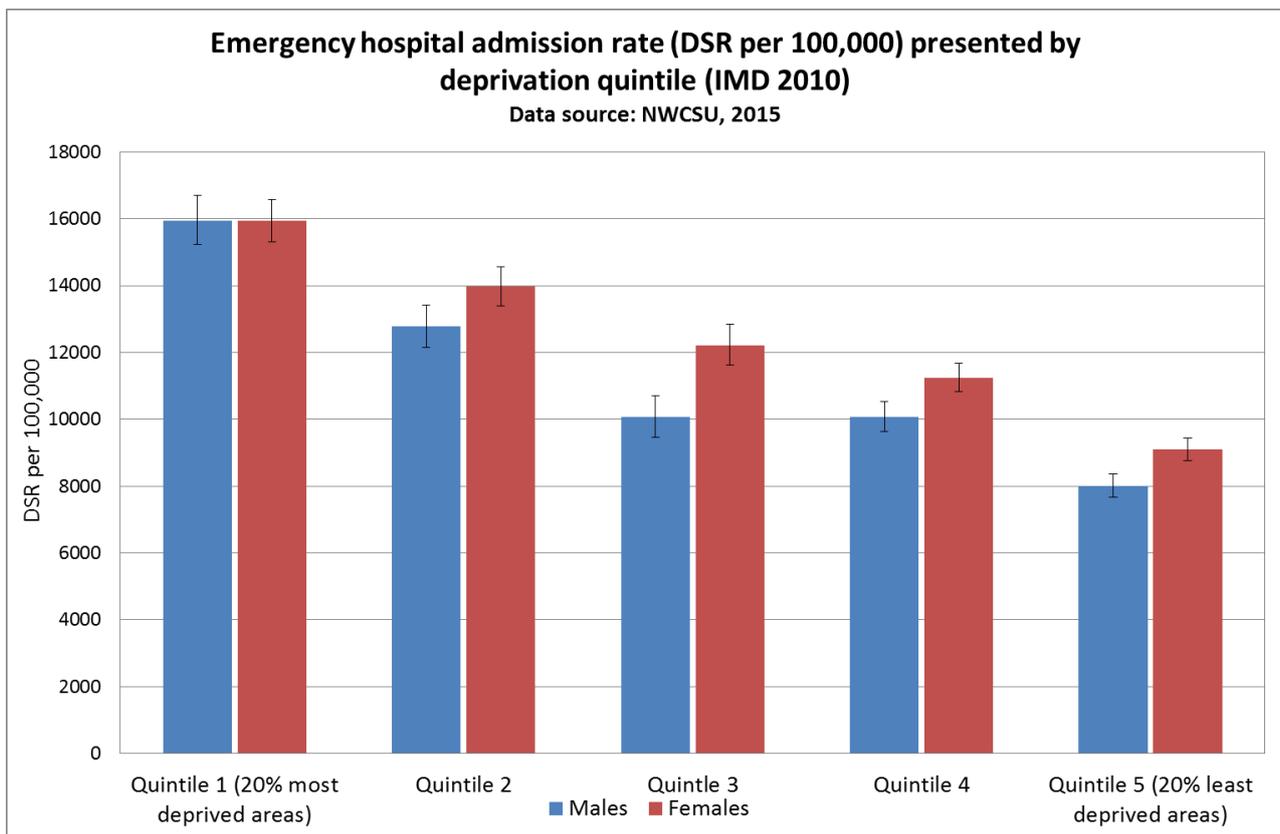
Analysis has shown little difference in the LOS grouping when presented by gender or deprivation quintile. However, when presenting LOS by broad age groups, this analysis showed that as the patient age increased, the LOS increased substantially, as presented in the following chart. Length of stay depends not only on clinical necessity to remain in hospital care, but also on the availability of somewhere appropriate to discharge a patient to.

Chart 8: Length of stay presented by broad age group for patients registered at a Warrington GP Practice and living in Warrington, 2014



Analysis by deprivation quintile shows that the emergency admission rate was significantly higher in the most deprived areas of Warrington, and significantly lower in the least deprived areas of the borough. Females had significantly higher admission rates than males in quintiles 3, 4 and 5. However, male and female rates were relatively similar in quintiles 1 and 2; this suggests that higher than expected admission rates for males were seen in the 40% most deprived areas of Warrington.

Chart 9: Rate of emergency hospital admissions during 2014 for patients registered at a Warrington GP Practice and living in Warrington, presented by deprivation quintiles

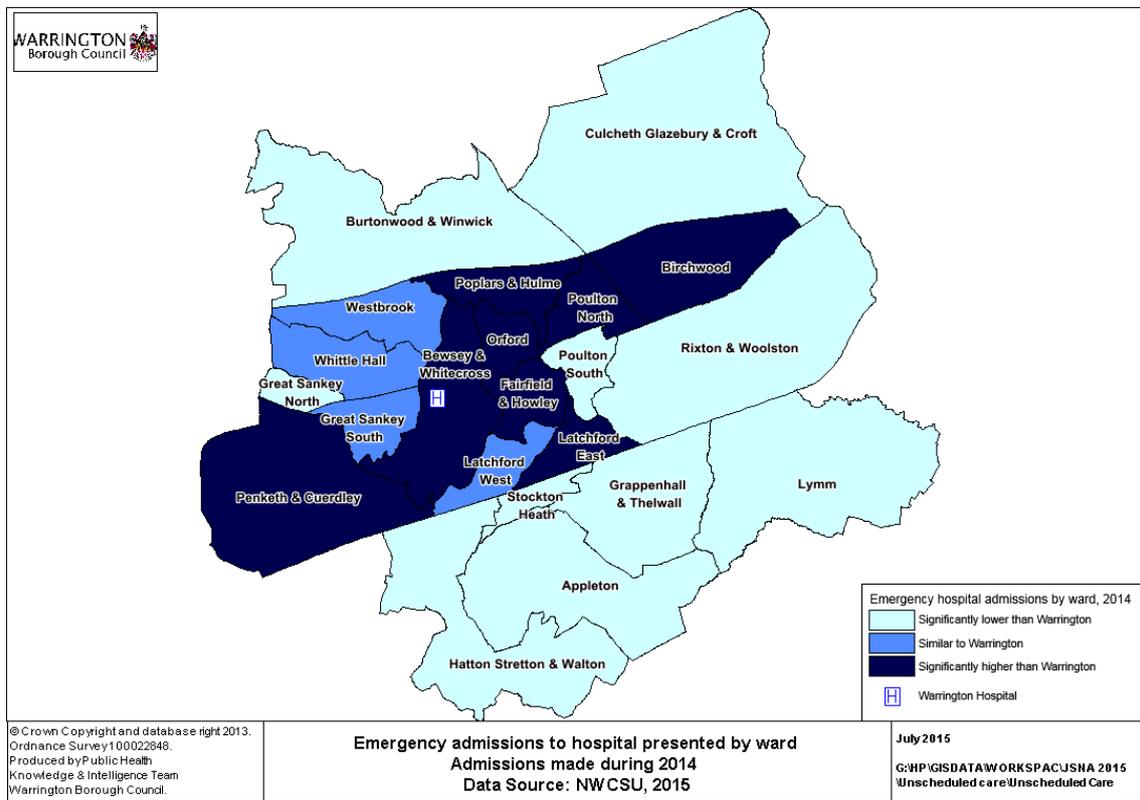


The hospital admission rate for males from quintile 1 is approximately 46% higher than expected (when compared to the overall admission rate for all males); whilst in quintile 2 the admission rate was approximately 23% higher than expected (when using Standardised Admission Ratios SAR).

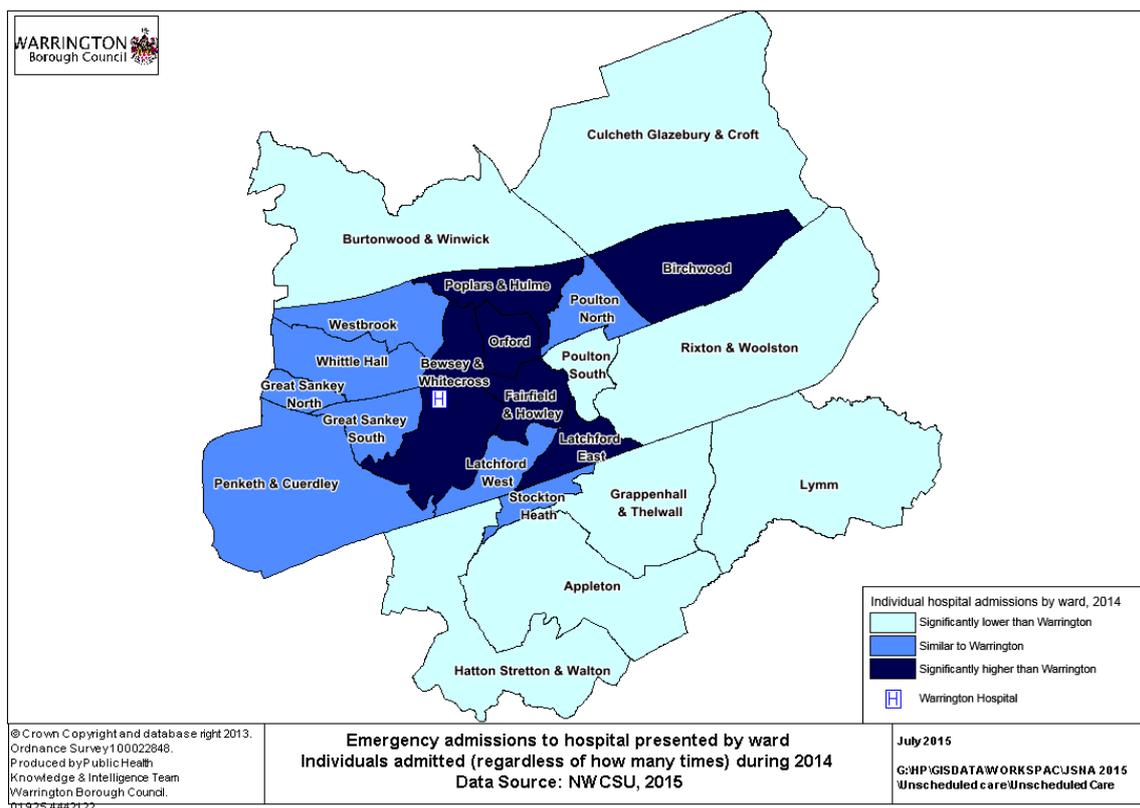
At ward level there were a number of wards with very high hospital admission rates, as presented in the Map 2. The wards coloured the darkest shade of blue had the highest admission rates and are generally located in the central areas of Warrington, with the exception of Birchwood (located in the east) and Penketh and Cuerdley (located in the west of Warrington). This map shows a similar pattern to Map 1.

As with ED attendances, further analysis was conducted to examine the pattern of admissions once repeat admissions were excluded (i.e. an individual would only be counted once, regardless of how many times they were admitted. Repeat admissions may be necessary for certain health conditions, however the inclusion of the repeat admissions in analysis can artificially inflates the admission rate for a ward). This analysis illustrated that the central wards of the town and Birchwood had significantly higher admission rates, as presented in Map 3.

Map 2: Emergency admissions to hospital (DSR) presented by ward for patients registered at a Warrington GP Practice and living in Warrington, 2014



Map 3: Individual emergency admissions to hospital (DSR) presented by ward for patients registered at a Warrington GP Practice and living in Warrington, 2014



3) Current Services in Relation to Need

Across Warrington services are working closely together to establish and sustain an urgent and emergency care system that is able to meet the needs of the population of Warrington within the resources available, to deliver improved clinical outcomes, quality and patient experience.

In order to deliver this, services will need to evolve to meet new challenges; Warrington has a population that is living longer, and with more complex health issues. A sustained engaged relationship with patients, carers, and citizens is required to promote well-being and prevent ill health.

There are a broad range of services across Warrington that all contribute to meeting the urgent care needs of the Warrington population:

- **Self-care/self-management**
There are 44 community pharmacies across Warrington that can offer an element of urgent advice and products to enable appropriate self-care and treatment. There is provision across the borough for 24 hour access to a pharmacy although out of hours this is a reduced provision. For more information about pharmacy provision, please visit: <http://www.warrington.gov.uk/jsna>.
- **NHS 111**
The Warrington directory of services to support 111 is regularly reviewed to ensure the full range of local services is detailed for patients. Access to an out of hours GP within Warrington is via the 111 service.
- **Primary care**
There are 26 GP practices across Warrington that meet the primary care needs of the local population. This is delivered through an appointment system directly with the patient's registered GP practice. Primary care responds to an element of same day urgent requests to see patients and can directly refer urgent patients for assessment within ED. Across Warrington there is extended access for primary care planned appointments over 7 days and up until 8.00pm. Within primary care, services are being expanded to provide care closer to home and to deliver an increased range of out of hospital services.
- **GP OOH's**
Out of hours primary care is provided via one centralised service that responds to the primary care needs of the population of Warrington. This service can offer self-care advice or an appointment if the need is urgent and the patient cannot wait to see their own GP.
- **Acute visiting scheme**
This service works closely with the ambulance service and provides a clinician to clinician prompt discussion to agree management of a patient in situations where the paramedic has assessed the patient and clinically they do not need to attend an emergency department. The service is 24/7 and covers all of Warrington and demonstrates an emergency deflection rate of consistently above 90%, thus enabling patients' needs to be met closer to home.
- **Ambulance services**
Within Warrington the ambulance service is currently provided by North West Ambulance Service (NWAS) who provide the emergency service and the planned patient transport service (PTS).

The provision of the range of urgent care services across Warrington is currently fragmented with numerous providers and pathways which generate confusion amongst patients as to how and where to access services. As a result, ED with its central location, easily known brand and one stop shop is often the default service for patients where an alternative community service may have been able to meet their needs. Thus it is key going forward to:

- Improve the use of 111 so patients can be more accurately directed to appropriate services available to patients;
- Continue to integrate services where clinically appropriate to improve the patient journey;
- Continue to improve the efficiency of commissioned services to ensure patients receive the best quality of care and response;
- Ensure that the most appropriate services are commissioned to accommodate clinical need and demand for unscheduled care;

Nationally there is recognition that the demand for unscheduled care is financially unsustainable and requires alternative solutions to hospital based care. There needs to be a shift in the way care is provided and how the person is involved in their own care.

The first stage report of Professor Sir Bruce Keogh's review of Urgent and Emergency Care recommended the development of Urgent and Emergency Care Networks (this has now been established), and also the designation of Urgent Care Centres, Emergency Centres and Major Emergency Centres (now referred to as Emergency Centres with specialist services) within those networks.

The long-term vision is to create an urgent and emergency care system that is capable of delivering the right care, first time, for the majority of patients through a networked model 7 days a week, and which is easy for patients to navigate and understand. NHS England advise that implementation of the network model, which will occur progressively, will be complete by autumn 2017. Thus the national work will underpin and shape local service design and development, and will factor into the ongoing review of local urgent care services, in line with the JSNA and the Health and Wellbeing Strategy.

4) Projected Service Use and Outcomes in 3 to 5 Years and 5 to 10 years

Demand for unscheduled care is expected to increase over the coming years if recent trends of hospital activity are to continue (National Audit Office, 2013). The combination of increasing population sizes (the population of Warrington is expected to increase by 7% over the next 10 years), an ageing population (over the same time period, the over 65 population is expected to increase by 23%), an increase in the proportion of the population making poor lifestyle choices (smoking, consuming alcohol to excess, having a poor diet and/or inactive lifestyles, which leads to obesity), and increasing expectations of patients to receive care quickly, will all have an impact on the demand of unscheduled care services in the future.

As highlighted by the National Audit Office (2013) a system such as the NHS needs simple, easily understood pathways guiding patients to the most appropriate treatment. Without this, some patients may inappropriately end up in the more easily available and visible elements of the system (O'Keeffe, 2013; National Audit Office, 2013).

5) Evidence of What Works

The Kings Fund (Naylor et al, 2013) developed ten priorities for commissioners to transform the health care system in England. The tenth priority focusses on managing urgent and emergency activity. The paper highlights findings from analysis conducted by the Department of Health which shows that even with the introduction of new forms of urgent care (for example, walk-in and urgent care centres) these have failed to reduce the number of ED attendances. The analysis found that ED attendances grew by 30% between 2008/09 and 2011/12. It was also found that the new forms of urgent care had also failed to reduce the number of emergency hospital admissions; emergency admissions grew by 5% between 2008/09 and 2011/12. The report recognises that redesigning the urgent and emergency care system would be highly challenging; the following specific actions for commissioners had been identified:

- Providing effective signposting to help patients choose the right service;
- Ensuring that hospital and community services can adjust service levels in response to changes in demand, so that need and provision are kept in balance;
- Ensuring that emergency departments adopt best practice for handling 'majors' including early senior review;
- Ensuring that hospitals and local authority social service and housing departments work effectively together to reduce delayed discharges and shorten lengths of stay;
- Mapping and analysing patient flows around the system to identify bottlenecks and the scope for changing pathways, in order to reduce the use of hospitals and to ensure that there is sufficient capacity across the health and social care system (Naylor et al, 2013).

As identified in section 1.2, NICE will be publishing guidelines in relation to service delivery and organisation for acute medical emergencies. This is expected to be released in November 2016.

The Centre for Reviews and Dissemination (2014) gathered evidence to inform urgent and emergency care systems. The review presented an overview of the evidence for a range of interventions that seek to improve the delivery of urgent and emergency care:

- Telephone consultations by nurses or doctors appear to be as safe and effective as systems involving more face-to-face contact but effects on service use are mixed;
- A primary care front end to the emergency department involving GPs could be used to assess and treat patients presenting with less urgent problems;
- Other potential workforce models include emergency care practitioners (ECPs) and nurse practitioners. ECPs can reduce patient transport to emergency departments, though this appears dependent on the setting;
- Interventions with limited evidence of benefit (in terms of reduced waiting times and or length of stay) include 'fast-tracking', rapid assessment zones, triage liaison doctors and allowing triage nurses to order tests.

6) (Target) Population/Service User Views

The following report produced by Warrington Clinical Commissioning Group (CCG) during 2014, examined the reasons why patients attended Warrington Emergency Department. A total of 217 patients (40% adult males; 42% adult females; 18% children) either completed a questionnaire or spoke with the Engagement Team over a five week period for a total of 32 hours. The main findings and themes of the report are presented below:

CCG Area of residence

The majority of attendees lived in Warrington 77%. Of those that didn't live in Warrington the majority were from Halton (9%), St. Helens (2%) and Wigan (2%). Of those from outside of Warrington and Halton, the main reasons for attendance at Warrington ED were working or visiting partner/ family in Warrington and all of these went directly to ED, not seeking help from elsewhere first. Of those from Halton, the majority came directly to ED (65%), with problems related to pregnancy, road traffic accidents, chest pains/ palpitations and pain or injury.

Reasons for choosing ED

There were numerous reasons why people chose to attend ED:

- **Direct to ED**

The majority of attendees went directly to ED (55%). Of these, over half (51%) had pain or had been involved in an accident (29%). Some felt they needed an X-ray or stitches and so came to ED as a GP wouldn't be able to do this (injuries included head wounds, sliced finger, sore ankle and knees).

- **Patient Education**

Of those that had gone direct to ED due to an accident, some had minor injuries (cut thumb, cut head, foreign body in eye) which had happened days or weeks before, and the majority of these had not thought of going to their GP first. In discussion with the Triage Nurse, the Engagement Team suggested that noting whether the attendance was appropriate or not could be included within the patient's notes. The Triage Nurse felt it was a good idea to add this to a patient's notes, which are returned to the GP. On the patient's next visit to the GP, their GP could ask why they attended ED.

- **Primary Care**

33% of attendees had contacted their GP before attending ED.

- **GP Engagement**

Some people assumed they wouldn't get a GP appointment but hadn't tried; these were from a range of different GP Practices with no practice being identified as being an outlier. 23% of attendees stated the reason they choose ED was that no GP appointments were available. The remainder of attendees had made GP appointments or been offered GP appointments in a few days time but felt they couldn't wait.

- **GP Referral**

Of those attendees that had contacted their GP, 46% saw the GP and 30% spoke to a GP and they had either been advised to attend ED or been referred. For those people who have been formally referred by their GP, there seemed to be some inconsistency with waiting times at ED, and some examples of lack of communication from their GP. Some patients had expected to be a priority when they attended ED and be triaged first, they had not expected to wait in the queue.

- **Other Health Professionals**
Some people had seen another health professional who advised ED e.g. optician, ophthalmologist within the hospital, Clatterbridge nurse, clinic outside of Warrington to see a mental health GP at ED, nurse at work and a GP at St. Mary's Hospital.
- **Ongoing Health Conditions**
Some patients had an ongoing health condition and had been told by their GP to go to ED if it worsened. Some were waiting for further treatments, operations and appointments. Others had been prescribed medication that they felt hadn't worked.
- **111 and GP Out Of Hours**
6% of attendees had contacted 111 (either as the non-emergency number or Out Of Hours) and been advised to go to ED. Hospital staff had said that most people who ring 111 are told to go to ED, sometimes inappropriately.
- **Ambulance admissions**
During the engagement several patients were admitted by ambulance and then directed through to ED waiting room for triage. Several good examples of the paramedic explaining to the patient and their families what was happening were witnessed but also a few that could have been improved. Some patients were unsure why they were being triaged again, as they considered that they had already been triaged to some degree by the paramedic.
- **Paediatric ED**
18% of attendees were children. The majority of these had been due to pain (59%) and accident (30%). There were a minority of children who were attending as 'follow ups' from previous ED attendances for review clinics or redressing.

The report on urgent care engagement work recommended that a Warrington focussed patient awareness raising campaign may be needed for people to understand how to 'Choose Well'. The campaign should be in partnership with the hospital trust to ensure a consistent message. It is recommended that this is further developed by ensuring that all local health and social care providers (GPs, pharmacies, dental practices, opticians etc.) display consistent self-care patient materials. Public Health (based within Warrington Borough Council) can support this programme by promoting universal prevention interventions. Across the system there is a need to encompass public health campaigns and marketing (e.g. Change 4 Life, 5 Ways to Wellbeing) to achieve a step change in patient activation. This involves developing evidence based approaches and communications which are consistent and standardised and enable people to self-care. These messages need to be developed with patients/carers/community and promoted alongside prevention services such as Lifestyle and Wellbeing Services and the Healthy Child Programme 0-19 Service. Communities, primary care, other statutory services and the third sector have an important role to play in supporting and working with universal provision.

7) Unmet Needs and Service Gaps

- There are no urgent care centres (UCC) or walk in centres (WIC) (excluding the emergency department at Warrington hospital) located in Warrington. However, Warrington CCG

commission specific services across the health system to see and treat patients who might otherwise have attended a UCC or WIC.

8) Recommendations for Commissioning

- Ensure that robust monitoring of ED patient flow is routinely undertaken by Warrington CCG. The routine monitoring should capture information that informs the commissioner whether services have been commissioned to sufficient capacity;
- Develop a Warrington specific patient awareness raising campaign to advise on the most appropriate setting to attend with health issues; this could be promoted through local health and social care providers (GPs, pharmacies, dental practices, opticians etc.) who will display consistent self-care patient education materials. Public Health can support this programme by promoting universal prevention interventions;
- Continue to develop robust services to avoid the need for emergency admission and/or improve treatment timelines to reduce length of stay specifically for the frail and elderly.

9) Recommendations for Needs Assessment work

It is recommended that a needs assessment should be conducted that focusses on future unscheduled care need for the population of Warrington. The report should encompass the impact of the growing population, the ageing population and the increase in disease burden from poor lifestyle choices. The findings from the needs assessment could be used to inform the future commissioning of unscheduled care services in Warrington.

10) Key Contacts

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11) References

Centre for Reviews and Dissemination (2014) Evidence to inform urgent and emergency care systems. [accessed on 29/05/2015] [available at:
<http://www.york.ac.uk/media/crd/Evidence%20to%20inform%20urgent%20and%20emergency%20care%20systems.pdf>]

HSCIC (2015) Admission Method [accessed on 14/05/2015] [available at:
http://www.datadictionary.nhs.uk/data_dictionary/attributes/a/add/admission_method_de.asp?sh_ownership=1]

Kings Fund (2014) An alternative guide to the urgent and emergency care system in England [accessed on 14/05/2015] [available at: <http://www.kingsfund.org.uk/projects/urgent-emergency-care/alternative-guide-urgent-and-emergency-care-system-england>]

National Audit Office (2013) Emergency admissions to hospital: managing the demand [accessed on 22/09/2015] [available at: <http://www.nao.org.uk/wp-content/uploads/2013/10/10288-001-Executive-Summary.pdf>]

NHS Choices (2015a) NHS 111 service [accessed on 13/05/2015] [available at: <http://www.nhs.uk/NHSEngland/AboutNHSservices/Emergencyandurgentcareservices/Pages/NHS-111.aspx>]

NHS Choices (2015b) Out-of-hours services [accessed on 13/05/2015] [available at: <http://www.nhs.uk/nhsengland/aboutnhservices/doctors/pages/out-of-hours-services.aspx>]

NHS Choices (2015c) Minor injuries units (MIUs) and urgent care centres (UCC) [accessed on 13/05/2015] [available at: <http://www.nhs.uk/NHSEngland/AboutNHSservices/Emergencyandurgentcareservices/Pages/Minorinjuriesunit.aspx>]

NHS Choices (2015d) NHS walk-in centres [accessed on 13/05/2015] [available at: <http://www.nhs.uk/NHSEngland/AboutNHSservices/Emergencyandurgentcareservices/Pages/Walk-incentresSummary.aspx>]

NHS Choices (2015e) NHS ambulance services [accessed on 13/05/2015] [available at: <http://www.nhs.uk/NHSEngland/AboutNHSservices/Emergencyandurgentcareservices/Pages/Ambulanceservices.aspx>]

NHS Choices (2015f) When is it appropriate to visit an A&E department? [accessed on 13/05/2015] [available at: <http://www.nhs.uk/NHSEngland/AboutNHSservices/Emergencyandurgentcareservices/Pages/AE.aspx>]

NHS England (2013) Transforming urgent and emergency care services in England: Urgent and Emergency Care Review: End of Phase 1 Report: High quality care for all, now and for future generations. [accessed on 27/05/2015] [available at: <http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf>]

NHS England (2014) Transforming urgent and emergency care services in England: Update on the Urgent and Emergency Care Review. [accessed on 27/05/2015] [available at: <http://www.nhs.uk/NHSEngland/keogh-review/Documents/uecreviewupdate.FV.pdf>]

NICE (2014) National Institute For Health And Care Excellence Scope, [accessed on 27/05/2015] [available at: <http://www.nice.org.uk/guidance/gid-cgwave0734/resources/acute-medical-emergencies-in-adults-and-young-people-service-guidance-final-scope2>]

Naylor, C., Imison, C., Addicott, R., Buck, D., Goodwin, N., Harrison, T., Ross, S., Sonola, L., Tian, Y., Curry, N. (2013) Transforming our health care system. The Kings Fund

O’Keeffe, C., (2013) What do we know about why Urgent and Emergency Care demand has increased? [accessed on 22/09/2015] [available at:
<http://www.nhsconfed.org/~media/Confederation/Files/public%20access/SchARR%20literature%20review%20-%20UEC%20demand.pdf>]

Purdy, S., (2010) Avoiding hospital Admissions What does the research evidence say? The Kings Fund

Warrington CCG (2015) Engagement, experience and communications team report on urgent care engagement work