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A&E attendance: the tip of a wider trend

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Recent Money Matters articles have investigated the multiple dimensions behind the recent difficulties with A&E waiting times and A&E attendances. In this final article on these matters the issues surrounding A&E growth will be investigated against a wider backdrop of growth in other aspects of acute activity. While some of the A&E trends are inflated due to data capture issues this will not be so for inpatient activity and will only apply to A&E attendances not resulting in an admission.

Figure 1 is illustrative of the wider trends. As can be seen total emergency admissions (of which admission via A&E is only a part) exhibits the lowest growth followed by day case admissions. Up to around 2010 growth in emergency 'admissions' will most likely be due to 'admission' into assessment units and represents a grey area between A&E and inpatient care (Jones 2010a,b, 2011a,b,e). Likewise some of the growth in day case will be due to a switch from overnight to same day care while much of the residual growth will be due to counting drift as otherwise outpatient tests/procedures are re-badged as 'day case' – a trend which is encouraged by the HRG tariff (Jones 2008). Hence the bulk of genuine inpatient activities are showing only modest growth, i.e. little evidence for any real change in acute thresholds for a genuine admission.

The next highest growth is in total outpatient attendances (first plus follow-up) and is in the context of generally declining follow-up rates (Jones 2012d). This growth is not reflected in the inpatient trends suggesting that the growth is driven by what appears to be appropriate 'refer for an opinion' requests by GP's (Jones 2012a,c). A&E attendances where there is a discharge with no follow-up or there is an onward referral to an outpatient clinic (some of which will be for fractures) show roughly similar growth to total outpatient attendances.

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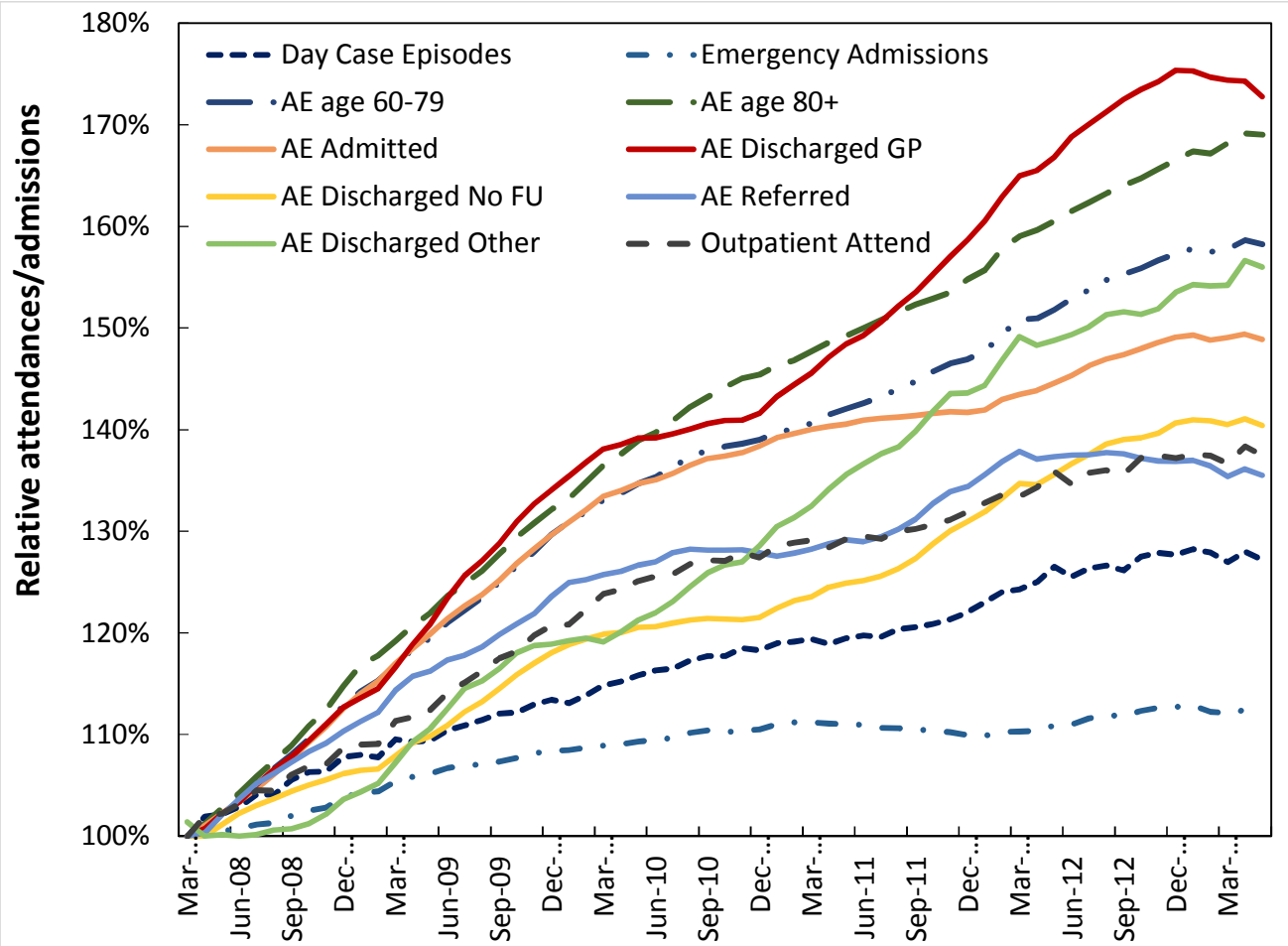
Next are A&E attendances for the two oldest age bands to remind everyone that growth (even after adjusting for demographic change) increases with age (Jones 2012b). And lastly, the jewel in the crown is growth in A&E attendances where the patient is referred back to their GP for care.

Figure 1: Relative growth in acute attendances/admissions



Footnote: Data as per previous articles and is a running 12 month sum incrementing at one month intervals. All activity is relative to the 2007/08 financial year total.

This last group must surely represent one of the more significant points, namely, along with growth in outpatient attendance the whole thing is shouting a message about how primary care may need to be delivered. Achieving economy of scale with fewer major A&E departments and correct levels of inpatient occupancy plus the benefits of integration between health and social care are further parts of the larger jigsaw (Jones 2011a,c,d, 2013b).

While it is true that we have fewer GP's per head of population than most OECD countries (Jones 2013a) and need a degree of expansion in primary care I am not suggesting that we exclusively expand GP numbers ***per se*** but that we seem to need additional GP equivalent points of contact – perhaps aided by a genuinely shared patient electronic record.

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As always the blindingly obvious may be hotly contested, however, is there the political will to tackle this issue in a way that is cost effective and meets the needs of a society which is very different to the one when the NHS was founded? Indeed the whole discussion appears to be conducted in a vacuum. Is this a trend common to all Western health care systems? How are other countries coping and what alternative are they offering? The world is a far bigger place that just England and all of us need a far wider context before jumping to politically correct conclusions.

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