Middlesbrough Council

Middlesbrough moving forward

AGENDA ITEM: 6

OVERVIEW & SCRUTINY BOARD
6 SEPTEMBER 2005

EMERGENCY ADMISSIONS INTO JAMES COOK UNIVERSITY HOSPITAL

FINAL REPORT

PURPOSE OF THE REPORT

1. To outline the findings of the Health Scrutiny Panel's review into Emergency Admissions at James Cook University Hospital.

INTRODUCTION

2. Emergency Care and the way in which Emergency Admissions are handled is a topic that has traditionally attracted significant attention. More recently it has been made a priority by central government with significant targets for improvement being set. It has been the subject of various Department of Health publications including a ten year strategy entitled *Reforming Emergency Care* published in October 2001 and a 2004 report by Professor Sir George Alberti entitled *Transforming Emergency Care in England.*

3. The document *Reforming Emergency Care,* which is the basis for changes in the Emergency Care sector, is based on six key principles. These are outlined from 4 to 9 inclusive:

4. Services should be designed from the patient's point of view

5. Patients should receive a consistent response, wherever, whenever and however they contact the service.

6. Patients' needs should be met by the professional best able to deliver the service.

7. Information obtained at each stage of the patient's journey should be shared with other professionals who become involved in their care.

8. Assessment or treatment should not be delayed through the absence of diagnostic or specialist advice; and

9. Emergency Care should be delivered to clear and measurable standards.

10. Further to that, the Carson Report in 2001 reviewed Out of Hours services and made recommendations which led to the new Out of Hours services, as part of the new General Practitioners contract.

11. It has recently being reported by Sir George Alberti in his publication *Transforming Emergency Care in England*, that there has being great strides forward in the handling of Emergency Care. The report states that at the start of 2003, almost a quarter of patients spent more than four hours in Accident & Emergency. The report goes on to say that presently, it is less than one in twenty patients, who have to wait for more than four hours.

12. It is important to remember however, that whilst such information is helpful in considering the topic, the topic of Emergency Admissions is not solely concerned with how those who attend facilities are treated.

13. The Panel was aware of significant anecdotal evidence to suggest that the rate of Emergency Admissions nationally is so high as to be a cause for concern. The role of the Scrutiny Panel is to gather evidence to support or challenge this point. A key part of the Review was investigating the reasons behind the rate of emergency admissions and whether an emergency admission is always the most appropriate way to deal with a matter, or if an alternative can be found.

AIMS OF THE REVIEW

14. Emergency Medicine is one of the most visible and high profile elements of the National Health Service. All available national evidence indicates that Emergency Admissions are rising at quite a pace and local evidence indicates that the rise at James Cook University Hospital is particularly pronounced. This Review was aimed at investigating the reasons for the increase, and whilst not straying into clinical fields in which the Panel is not qualified, investigating any means which could be employed to reduce the rising rate. In addition, to ensure that those accessing Emergency medicine are doing so appropriately and the service is not dealing with those whose needs could be handled perfectly adequately in a non-emergency setting.

TERMS OF REFERENCE

15. The Panel agreed the following Terms of Reference to direct the Review.

a) To establish the rate of emergency admissions into James Cook University Hospital and relate to national figures;
b) To investigate why the numbers of emergency admissions into JCUH are at their current level, with special attention being given to the high incidence of emergency admissions with a psychiatric element to them;
c) To investigate methods of reducing the amount of 'unnecessary' emergency admissions;
d) To investigate the impact developments such as Out of Hours, Minor Injury Units, Walk in Centres and Emergency Prevention has or could have on emergency admissions at JCUH;
e) To investigate to what extent a 'revolving door syndrome' exists, whereby the same people are admitted and discharged from hospital on a regular basis and the costs this incurs;
f) To examine performance indicator information relative to the interface between the NHS and Social Services in dealing with patients coming out of acute care into primary care;
g) To ask whether there are predictable trends in Emergency Admissions and could elective surgery be planned to complement any trend.

MEMBERSHIP OF PANEL

16. Cllr E N Dryden (Chair), Cllr H Pearson OBE (Vice Chair), Cllr E Lancaster, Cllr F McIntyre, Cllr K Walker, Cllr R G Regan, Cllr S K Biswas & Cllr T Mawston JP (from the start of the 2005-6 municipal year).

METHODS OF INVESTIGATION

17. The Panel met formally between December 2004 and June 2005 and a detailed record of the topics discussed is available on the Committee Management System (COMMIS). During those meetings evidence was taken from invited speakers. Further to considering the matter in a formal meeting setting, the Panel also completed a number of site visits to medical facilities around the town. These were the Emergency Department at the James Cook University Hospital, Carter Bequest Hospital and the Intermediate Care Centre in Netherfields.

FINDINGS

18. The Panel took evidence from representatives of South Tees Hospitals NHS Trust on 21 December 2004. As the Panel were addressed on the range of services offered and being developed at JCUH, it was reminded that they were led by such national regimes as the Accident & Emergency Modernisation Team, European Working Time Directives, National Service Frameworks, NHS Plan targets and a review of GP Out of Hours services.

19. The Panel heard that the James Cook University Hospital serves as a District General Hospital for around 300,000 people. It also acts as a sub regional centre in some specialisms for around 1 million people. The hospital has around 1,300 beds.

20. The Panel was advised that that were two major divisions in the way Emergency episodes presented at JCUH. Firstly, there was the services categorised under Emergency Care, these were Accident & Emergency, the Acute Assessment Unit (AAU) and GP out of hours. The second category is that of Medical Assessment Unit which covers Primary Care, and self-referral.

21. The Panel heard that the aim of the AAU was to provide expert assessment, diagnosis and treatment as soon as possible by teams of skilled doctors and nurses. Presenting patients often had rather complex medical problems such as chronic bronchitis, heart failure and diabetes. Consultants were based in AAU, which facilitated earlier involvement in patient care than under previous arrangements.

22. The Panel was advised that there had been a significant increase in emergency admissions in recent years and 2004 had shown a further 10% -11% increase from the previous year, although it was noted that there was a high turnover of patients within 24 hours.

23. On this point, Members attention was drawn to the fact that there is now an increase in the number of admissions, despite the fact that there has been a decrease in beds. It was noted that the local authority area of Middlesbrough is currently somewhat under provided for in terms of community hospital facilities, especially when compared to East Cleveland, residents from which also access JCUH as a District General Hospital.

24. The Panel learnt that although many patients were admitted to traditional special care wards, more community based facilities were being developed to provide quality patient care at home or in emergency clinics which patients in recent surveys, had shown to be the preferred arrangements.

25. The Panel was advised that a benchmarking exercise had been completed, comparing this element of JCUH's operation to that of a peer hospital between April 2003 and March 2004. Details are laid out below.

Hospital	JCUH	Similar Peer
General Intake Medical Admissions	13,833	Not available
Deaths in Hospital(%)	3.24	5.51
Deaths in 2 days(%)	0.23	0.80
Re-admission rate(%)	10.3	10.54
Discharge to home(%)	92	81.9

26. The Panel heard that a likely reason the deaths are lower for JCUH in the above table is due to the impact that the Acute Assessment Unit has had at JCUH. It was also highlighted to the Panel that Readmission at JCUH was low and would support the argument that a 'revolving door' phenomena is not a significant issue at JCUH, at least for General Medicine. On this point, at the meeting held on 22 July 2005 the Panel subsequently heard that across all specialities, readmissions are slightly higher than the peer hospital. The Panel heard that an audit was being performed to establish reasons for this, which would be ready around October 2005. The Panel expressed a wish to receive this documentation, which would be public information.

27. The Panel heard there were a range of reasons as to why episodes presenting at JCUH were on the increase. Firstly, it is question of demographics. There are more older people in the community and people on the whole are living longer. Almost by definition, this means that there will be more instances of poor health from this cohort of people. There is a higher survival rate for people with chronic diseases, as medical science develops. Whilst more people are living with chronic diseases, it is highly likely that there will also be more hospital episodes involving this cohort.

28. The Panel heard that as chronic disease management plans were being developed to cope with increasing numbers, a point would be reached at which the impact of chronic disease on emergency medicine resources would be lessened from what it is currently.

29. Further to the above, the Panel heard that Patients benefited from urgent treatment centres at hospital rather than at home for such illnesses as severe angina.

30. The Panel was advised that the increased rates of Emergency Admissions were reflective of national trends and following Member questioning on the topic, it was stated that the increase is not specifically the result of 'insufficient' community facilities. The Panel thought this observation was noteworthy and very illuminating.

31. The Panel heard that changes to Out of Hours services had had an integral impact on rising numbers of people presenting at Emergency Medicine facilities. The Panel heard that South Tees' experience indicated that following the changes, people were going to Accident & Emergency as a first port of call, instead of contacting the contracted provider. It was felt this was

an example of national policy influencing the local status quo, with less than ideal consequences for the acute services provider.

32. On the subject of what constituted an 'unnecessary' admission; the Panel were advised it was a very difficult term to define. From a medical point of view, something could be defined as unnecessary if no medical intervention was needed. The point was made to the Panel that episodes where no medical intervention was necessary were a very small proportion of those presenting.

33. From an organisational perspective, the Panel heard that a number of 'unnecessary' episodes may be due to the lack of primary care facilities in Middlesbrough. It was explained to the Panel that if there were insufficient primary care facilities, then all admissions were 'necessary', although if community facilities were improved some admissions to an acute setting may be 'unnecessary'. The Panel learnt that one could only answer the question as to whether something was 'necessary', once the level of community facilities had been assessed.

34. The Panel noted that the AAU model in use at JCUH has won national acclaim and won a national award. The Panel were keen to ensure this matter was brought more fully into the public domain, when any discussion on Emergency Medicine practice at JCUH takes place.

JCUH visit Evidence

35. As part of the Panel's evidence gathering, Members attended a site visit to Emergency medicine facilities at JCUH on 16 February 2005.

36. As part of the visit the Panel saw the Acute Assessment Unit, Accident & Emergency facilities and met members of the FAST Team. Following the showround, Members discussed issues relating to Emergency Admissions with clinicians and managers.

37. The Panel heard that the new Out of Hours arrangements have had a significant impact on the amount of episodes presenting at JCUH, with a lot more people attending. The Trust has no extra resources to deal with this upturn in patronage. In addition to this, Members heard that minor injuries, dealt with under the "See & Treat" scheme, was dealing with 20,000 new patients per year.

38. Members of the Panel queried as to how the issue could be tackled, so the sharp rises in Emergency Admissions could be curtailed. Or, at least, those attending as an emergency actually were an emergency.

39. The Panel was told that there is a need for public education about exactly what an Emergency Department at an acute hospital such as JCUH is for, and what sort of medical episodes it is there to deal with.

40. The Panel was also told that in the view of people working within Emergency Medicine at JCUH, there have been developmental problems with Out of Hours service provision, which have impact on its ability to deliver. Consequently, other elements of the local health economy are forced to take the strain. The Panel felt that the Out of Hours service provision may be worth reviewing at some point in the future.

41. The Panel heard that on occasions, people can be kept in the acute setting for too long. This can be due to a delay in assessments being carried out and/or lack of capacity in community facilities. Nonetheless, it has an impact on the service's ability to maintain throughput and cope with demand. On this point, the Panel wishes to highlight that there are no delays due to the actions or inaction's by the Department of Social Care at Middlesbrough Council. Indeed, the Panel heard that there have been no delayed discharges in the last year. The Panel learned that the occasional blockages in the system were due to insufficient community health provision.

42. As regards the planning of medical procedures, the Panel enquired as to whether Emergency Admissions were predictable and as a result other services could be planned accordingly. The Panel heard that on a Macro level Emergency Admissions did follow a trend and were, on a broad scale, predictable.

PCT Evidence

43. At its meeting on 23 February 2005, the Health Scrutiny Panel took evidence from Middlesbrough PCT regarding Emergency Admissions at JCUH.

44. The PCT provided a briefing paper for the Panel which listed the major points which the PCT intended to cover. In addition to that, the PCT provided a commentary and elaborated on those major points.

45. Firstly, the Panel heard that JCUH has the highest Emergency Admissions rate in the country. There has been year on year growth and annual growth has been as high as 8%. It currently sits at 3.2%.

46. The Panel learnt however, that it is not necessarily a bad thing for emergency admissions to be high and the overall aim should not necessarily be to reduce the numbers. The critical matter for the local health economy is that the demand is effectively managed and people are being treated appropriate to medical need.

47. The Panel heard that it was possibly not surprising that JCUH had such a high admissions rate in comparison to the national picture, when one considers the contributing factors.

48. The population served by JCUH experiences high deprivation in relation to other areas and suffers from a body of health complaints partially attributable to the area's industrial heritage. JCUH is a widely renowned, freshly

completed centre of excellence within the midst of an urban centre and there is an ageing population, which brings its own challenges.

49. The PCT provided the Panel with a Data Analysis on Emergency Admissions. Some of the information provided is outlined below.

50. The top ten reasons for admissions had remained consistent over 3 years in respect of respiratory, chest pain, abdominal pain, viral infection and Deep Vein Thrombosis.

51. Although attendance rates at A&E from Middlesbrough PCT residents had increased by 14% this was a lower rate than other PCTs in the locality.

52. There had been significant growth in recent years (12-14%) in admissions under 1 day length of stay, which in view of greater efficiency models of care had not had a major effect on bed capacity.

53. There is also a financial cost to the increasing patronage of Emergency medicine facilities at JCUH, which the PCT is mindful of.

54. The Panel heard that if it were assumed that in 2006 there would be a 1% growth in emergencies and a 3% growth in medicine an extra spend of £750k would be required. Further to that, the Panel heard that each 1% growth in emergency admissions equates to an additional 17.7 beds.

55. The Panel inquired as to the steps the PCT had taken to address the matter.

56. The Panel learnt that the service was now consultant led with a dedicated medical team, plus good discharge links through the FAST team and the tracker nurse. The PCT advised the Panel that the Out of Hours service was in place in excess of six months ahead of the national deadline.

57. The Panel heard that in terms of Intermediate Care the refurbishment of Parklands had commenced ahead of schedule and would provide expansion from 10 to 21 beds plus 2 flatlets.

58. In terms of the future, the Panel's attention was drawn to Action Plans which were in 4 key areas of: analysis of data including reasons for growth; improving the pathway; develop services to avoid admission or shorten length of stays; and develop services to provide alternatives to Accident & Emergency or General Practitioners.

59. The Panel enquired as to the affect the new Out of Hours arrangements have had on the rate of Emergency Admissions at JCUH. The Panel heard that since the new General Practitioners contract has come into force, the 'Out of Hours' period has increased by 7%, (i.e. to 6pm from 6.30pm Mon to Fri and 3 hours Sat am). The Panel heard that Primecare delivers the Out of Hours service, following a competitive tendering process and has a clinic at JCUH.

60. The Panel heard that there is a perception locally that the changes to the Out of Hours services have increased acute activity and thereby placing additional pressure on an already stretched service. The PCT advised the Panel that there is no evidence locally or nationally that demonstrates the Out of Hours arrangements have increased Accident & Emergency and Emergency Admissions.

61. Having made that point, the PCT conceded that the Out of Hours arrangements had endured difficulties as they came fully online, although on the whole the systems put in place had managed. The difficulties which had been experienced, were being examined with a view to making improvements to the service and providing a more consistent approach.

62. The Panel enquired as to whether a community hospital and any other development would reduce the rate of Emergency Admissions. The Panel learnt that the PCT is committed to developing the primary care infrastructure and is currently developing the following services

(a) Community Stroke Beds,
(b) Intermediate Care and Interim Care
(c) Chronic Disease Management Approach including intensive case management (target 15 community matrons), Disease specific (Heart Failure, Respiratory, Diabetes) and Self Care

63. The Panel learnt that there are a number of factors to consider when considering whether community infrastructure would reduce Emergency patronage at JCUH.

64. Firstly, the Panel was told that there is something of a local culture, whereby General Practitioners seem to prefer referring matters to JCUH almost as a 'safety first' default option. The Panel noted that this may be a self protective measure on behalf of General Practitioners with regards to patient safety and the increasingly litigious society within which the medical profession works. Nonetheless, the Panel heard that on a historical basis General Practitioners have been reluctant to use community hospitals.

65. Secondly, the Panel heard that Community Hospitals would not reduce the amount of Emergency Admissions per se, as they would not have the facilities to cope with such cases. Nonetheless, they would make a critical contribution to a local health economy in the sense that they can reduce the length of stay of patients in an acute setting. This would enhance the throughput of such facilities as JCUH and therefore increasing the capacity of the acute sector.

66. The Panel enquired as to the affects that other such developments such as Walk in centres and Minor Injury Units could have on the local health economy and specifically the rate of Emergency Admissions at JCUH.

67. The Panel heard that the viability of Walk in Centres was currently being considered by Middlesbrough PCT. The Panel learnt that Walk In Centres and other related developments would enhance the local health economy,

because they would add a further level of service to local people. There is, however, no evidence to demonstrate they reduce the rate of emergency admissions. The Panel also heard, that, as entities in their own right, they have significant costs attached to them, which can often be prohibitive. The Panel heard that facilities such as JCUH, though a very expensive establishment, can pass on certain economies of scale compared to Walk In Centres and similar facilities.

TNEY Evidence

68. At it's meeting on 23 February 2005, the Panel also took evidence from the Tees & North East Yorkshire NHS Trust, which is a Mental Health & Learning Disabilities Trust. The Panel was particularly interested in hearing about the rate of Emergency Admissions with a psychiatric element to them and the nature of services provided for such cases.

69. The Panel heard that of 296, 000 local people who use JCUH as a District General Hospital, there were around 2,000 cases of Deliberate Self Harm last year, (although this is escalating every year) with around 700 patients going home from Accident & Emergency with no psychosocial assessment and no follow up. This, therefore, increases the likelihood of such people being involved in future episodes, including suicide.

70. The Panel learnt about a tool now in use in this field, entitled the Integrated Care Pathway(ICP). An ICP is a tool that determines locally agreed, multidisciplinary practice based on guidelines and evidence where available, for a specific client group. It forms all or part of the clinical record, documents the care given, and facilitates the evaluation of outcomes for continuous quality improvement.

71. The Panel heard that the ICP was implemented due to concern over the figures outlined above and specifically, the number of people leaving the acute setting following a Deliberate Self Harming episode without a proper consultation. The Panel was advised that the aims of the ICP is;

(a) To set standards and equity providing a seamless quality service
(b) To highlight the milestones of the patient's episode providing a structure for clinical care
(c) To support informed decision making/change
(d) Focus on 'lost' patients, in house risks.

72. As regards the results of the ICP, the Panel heard the following. The ICP has increased the service's 'catch' from 52% to 78% of the Deliberate Self Harming Population over one year. The Repetition rate since the ICP's implementation has fallen from 17.4% to 11.2% and it is felt there is a better dialogue, rapport and identification of mental illness by Accident & Emergency staff. Indeed, Members were told that the ICP had increased the number of potential patients by 32% and there was evidence that acting on self harm reduced repetition and suicide. The Panel heard that all partners involved with

the ICP, such as the South Tees Trust, PCT, TNEY and the Strategic Health Authority feel there is a common sense of purpose, in providing the service.

73. During the debate, which followed a presentation, the Panel heard that there was a proposal to implement a 6-bed unit dedicated for deliberate self-harmers who accessed JCUH through Emergency medicine. The Panel heard that often this cohort's behaviour can be disruptive or problematic and this can often cause wider problems within an Accident & Emergency setting. The desire to self-harm may occur whilst in Accident & Emergency. The benefits of a dedicated unit would be that this cohort was self-contained and that a stable, set environment would be familiar to repeat patients and would create a continuity of care.

74. The Panel also heard that in addition to the benefits such a dedicated unit to the clinical outcomes for people involved, it would also reduce the strain on generic Accident & Emergency services.

75. It was noted by the Panel that there has been significant national and international interest in the ICP developed locally. The Panel felt it was an example of good practice and the fact it was developed locally was something to champion.

76. On the topic of Emergency Admissions with a psychiatric element to them, the Panel heard that there was only so much any organisation could do to prevent the rate of such instances as deliberate self harm. There are other social issues at play, more people suffer from stress, there is a perception that life is faster and there are, on the whole, weaker personal support networks for people, such as families. The Panel heard that the best outcome that such tools as the ICP is to provide the appropriate treatment when people present and therefore do as much as possible to prevent readmission or re-enacting such behaviour.

Social Care Evidence

77. Throughout the course of the Review into Emergency Admissions, the Panel was particularly interested in learning to what extent a revolving door existed for people coming out of Acute care into primary care.

78. To this end, the Panel met on 8 April 2005 and took evidence from the Intermediate Care Services Manager.

79. The Panel heard that there are several types of support people may receive on discharge from an acute setting. These are

(a) No services
(b) Home Care
(c) Intermediate Care
(d) Interim Care
(e) Community Hospital
(f) Residential Care

(g) Nursing Care
(h) District Nursing Service

80. The Panel heard that Middlesbrough & Redcar Intermediate Care Services in accordance with Standard 3 of the National Service Framework for Older People, is a whole system approach designed to; prevent avoidable admission to hospital or long term care; assist safe and prompt discharge from hospital and promote independent living and rehabilitation. The Panel heard that the Middlesbrough Residential Rehabilitation Unit was currently based at Netherfields House and has 10 beds offering intensive rehabilitation.

81. The Panel were told of the South Tees Discharge Partnership, which has developed over a 12 month period working closely with Discharge Nurses; Social Work Team and the FAST Team in the Medical Assessment Unit. The Bed Manager who is a qualified senior nurse, for Intermediate Care and Community Hospital works alongside such services.

82. The Panel was advised of the Referral Pathway, which is outlined as an Appendix to this report.

83. The Panel enquired as to the exact role of the Bed Manager and were advised that they would provide a point of contact for advice to all professionals, work collaboratively with the Discharge Partnership and helps with signposting and assessing patients to ensure they receive the most appropriate services for their needs.

84. The Panel made enquiries as to the possible gaps in service provision in relation to discharge, which the Panel were advised included the following.

85. The Panel heard that there is limited Occupational Therapy and Physiotherapy input on Acute Wards. The Panel was further advised that, in the opinion of the witness, there are too few Occupational Therapy home visits after discharge. The Panel learnt that occasionally, patients can be discharged “too early” i.e. when they are medically fit to leave acute care, although this may not necessarily mean they are wholly ready to leave. Members were also advised that there are High Dependency levels of patients supported in the community. A particularly noteworthy point for the Panel was that patients can refuse home care services due to the charging for these services (intermediate care is free). This can lead to people becoming unwell again and re-entering the acute care sector of the local health economy. The Panel also heard that there is, at present, poor access to EMI services.

86. The Panel enquired as to the work going on to improve the process involved with discharges and prevent a revolving door phenomenon. The Panel heard that this included increased use of assistive technology, further development of reliable overnight care, working with the PCT in more robust palliative care services, recruitment of a community geriatrician and increased EMI provision.

87. The Panel acknowledged a lot of work was taking place and a lot of good things were been done, although was interested to know if any patients were being discharged without appropriate care packages in place to assist them.

88. Members learnt that, in the opinion of the witness, some people do leave an acute setting without an appropriate care plan, thereby increasing the likelihood of them being readmitted to Acute Care within a short time span with a related complaint. The Panel was also told that, at times, it was probable that some people were discharged before it was appropriate due to pressure on acute beds.

89. Members enquired as to what the process for someone being discharged was. They were told that often there is a discussion between the Bed Manager and relevant consultant. Whilst the Panel was clear that they could not take a view on clinical decisions, due to a lack of expertise in that field, the Panel was interested in the process involved in a discharge and to this end, undertook to discuss this matter with officers from the South Tees Hospitals NHS Trust.

South Tees Hospitals NHS Trust Evidence

90. At its meeting on 8 June 2005, the Health Scrutiny Panel took evidence from a representative of South Tees Hospitals NHS Trust, with reference to discharge practices at JCUH. This was with particular reference to one of the Panel's terms of reference for the review regarding as to whether a revolving door exists between primary and acute care for some patient groups.

91. The Panel heard that the vast majority of in patients at JCUH start as Emergency Admissions and that there are between 70 and 100 emergency admissions a day.

92. Members learnt that the majority of discharges are judged as 'simple' discharges, where the patient's needs are not complex and they can either look after themselves or have the sufficient family and social network whereby their needs can be met.

93. For those discharges which are not as straightforward, there is a 4 strong discharge team, who are all clinically trained nurses. Following assessment, anybody who requires a care package goes through the Discharge Panel for consideration, as a care package may represent expenditure. The Panel heard that the rest of the work of the Panel involves visiting wards assessing people. The Panel acknowledged that the Discharge Panel must have a very difficult task, as if 70 – 100 emergency admissions are generated each day, presumably the requisite space has to be generated each day.

94. The Panel felt that this point supported a point made by Middlesbrough PCT during earlier evidence gathering. That is, although a community hospital would not reduce the amount of emergency admissions for JCUH to deal with, it would certainly increase the throughput of patients and increase the local health economy's capacity to absorb more patients. More people would be

moved out of acute care quickly and, therefore, more space would be generated for the next inevitable tranche of emergency admissions.

95. It was, therefore, clarified for the Panel that there are three major cohorts of discharge. A simple discharge whereby someone can go straight home, an Intermediate discharge whereby someone goes to an Intermediate facility before being ready to go home and a Residential discharge, whereby someone is going to be most appropriately accommodated in a residential home.

96. The Panel enquired as to whether everyone who needs a package actually receives a package at the appropriate time, which the Panel were assured they should do.

97. The Panel was told that before a discharge is made, an assessment should always be performed regarding the patients needs, although it was acknowledged that this system was not guaranteed or 'foolproof'. It was acknowledged that the above is what would occur when the system was functioning effectively. The Panel were particularly interested to know if the system ever broke down and to what extent it broke down, with people not receiving assessments they require before being discharged.

98. The Panel heard that those figures are not monitored as such by the Trust, as should those instances occur, the rate of their occurrence is so small as to not show in Trust statistics. Whilst the Panel acknowledged such a cohort made up a small number in relation to the global discharges figure, the Panel had received previous evidence that a small number of people were discharged without appropriate care packages put in place.

99. It was acknowledged that in any system administered by people, mistakes or omissions were possible. The Panel felt that whilst the occasional omission may not be significant enough to be visible on the Trust's records, it is wholly significant to the person who has not received the due attention or treatment. It is processes to prevent these instances, or to put these instances right which the Panel was interested in exploring.

100. The Panel heard that often discharges were actually held up due to the Trust being cautious in ensuring people were not discharged until there was a Community Hospital bed and/or an assessment had been completed. The Panel learned that in a 'bad' week, JCUH could lose 70-80 bed days a week because of such delays.

101. The Panel heard that some people might be discharged 'inappropriately' or without the necessary care package in place partly as a result of their own doing. The Panel was told that on some occasions, when an assessment is being completed, some patients overestimate their capabilities through misplaced pride or through a feeling of not wanting to be a burden. Unfortunately in such circumstances, there is an expectation that the patient will answer questions regarding their capabilities honestly. If they do not the necessary services cannot always be called upon, thereby massively

increasingly the likelihood of people having to be readmitted with related complaints.

102. Having made that point, the Panel heard that the Trust would hope that in such circumstances where patients are denying blatant needs, health professionals would use their instinct and expertise to find the best outcome for the patient. Although health professionals would not, for obvious reasons, be in a position to force an individual to agree to a particular course of action.

103. The Panel enquired as to what would a patient be best advised to do should they be discharged without the appropriate care package and could not manage. The Panel heard that they should telephone their GP during working hours or telephone their District nurse. The Panel was concerned that this message may not be made as public as it should be and such courses of action may only open to those who 'know the system'. The Panel expressed the view that such information should be made available to all.

104. The Panel heard that when someone is discharged, they are given a 'flimsy', which is a document detailing their condition, medication and any other relevant information the patient should be aware of.

105. The Panel heard that it was not clear as to whether or not such documentation detailed what should be done, if any problems as outlined above arose. The Panel asked for a selection of such documents to be sent for information, and should there not be sufficient information on flimsies, it was felt there was a possible recommendation aimed at delivering improved information for people finding themselves in such situations, however rare its occurrence is.

106. The Panel explored further as to whether there are systems in place to right an inappropriate discharge. The Panel heard that the best thing for someone to do should they find themselves in that position would be to contact the ward from which they were discharged. To clarify, however, the Panel heard there are no set procedures in place to address such a scenario. Members were concerned that any rectification of such a scenario may be down to contacts and personality types involved as opposed to a structured procedure.

107. The Panel heard that patient tracking systems are in place so an audit trail can be performed over any case where the appropriate measures have not been put in place, although it was unclear to the Panel as to whether regular audits were performed.

108. Further to this, the Panel was pleased to hear that an audit system was in place which would be able to track the patient journey in cases where something had gone wrong, so to enable lessons to be learnt.

109. Having made this point, on the balance of evidence received the Panel was not clear that sufficient formalised processes exist to remedy any inappropriate discharges. On this point, the Panel was at pains to clarify that it was not suggesting that some people leave acute care without appropriate

packages with the knowledge of the relevant parts of the local health & social care economy. Indeed, throughout the course of this review the Panel has been impressed with the dedication of the organisations and individuals involved.

110. Nonetheless, the Panel are aware that in any system which is administered by humans, error or omission is possible, if not a fact of life.

111. In a system which is of such importance, the Panel felt there should be proscribed systems or processes in place in acknowledgement that mistakes can happen and to remedy any such instances.

112. The Panel was encouraged to hear that such instances are a rarity and considered it testament to the skill of the organisations and individuals that this is so. Nonetheless, the fact that it is a rarity would not be a consolation to a person whose discharge or accompanying support package was inappropriate and without the contacts and/or frame of mind to challenge it.

Conclusions

(a) That at present, there is no evidence to suggest that a revolving door exists in relation to some groups of patients between primary and acute care.

(b) That there is no evidence that Walk in centres and other such developments would impact on the rate of Emergency Admissions at JCUH.

(c) That the development of community hospital facilities would increase the capacity of the local health economy to deal with the current rate of Emergency Admissions by enhancing throughput at JCUH

(d) That there have been initial teething problems with the new Out of Hours service arrangements. This in turn may have contributed to increased patient flows to JCUH.

(e) That it is possible a small number of people are discharged without a proper assessment of their needs and an appropriate care package being put in place for them.

(f) That the processes around discharge should be kept under constant review to ensure no one is inappropriately discharged.

(g) That on the basis of evidence received, there could be improvements made to the information provided to patients leaving acute care about what to do should they feel they have not had due attention paid to their condition and possible needs prior to discharge.

(h) That the Health Scrutiny Panel would like to conduct a review into the provision of the Out of Hours service provision.

(i) That as the demographics of the area change with more older people and more people surviving certain conditions, Emergency Admissions are likely to remain high.

(j) That the development of a dedicated unit in relation to the ICP at JCUH would be of great benefit to the local health economy in providing a settled familiar facility for self harmers to be treated by specialist staff, with ready access to acute care.

(k) During the course of the scrutiny review, concerns were expressed to the Panel regarding complaint procedures of organisations. Essentially, The Panel heard that family members of patients are not permitted to complain on behalf of relatives and the patient affected must make any complaint. The Panel does not feel it is necessary to make a recommendation around this topic. It would, however, urge the local health and social care economy to check it's complaints systems are flexible enough to allow complaints on behalf of patients, thereby allowing the maximum feedback and enabling services to improve where necessary. The Panel would welcome responses from the local health and social care economy confirming this.

Recommendations

(a) That Middlesbrough PCT, with partners in the local health & social care economy investigates the viability of enhancing community facilities in the town.

(b) That the processes around discharge are kept under constant review to aim that no one is inappropriately discharged.

(c) That the information provided to people upon discharge is reviewed to ensure it contains appropriate information regarding the process to follow should they feel they have been inappropriately discharged.

(d) That a system is prepared to ensure anybody who has been inappropriately discharged, following notification, is subject to a rapid assessment and the appropriate action taken. Further to this, such system should be made public and as transparent as possible.

(e) That should it become clear that anybody has been inappropriately discharged, an investigation is undertaken to ensure lessons are learnt.

(f) That Middlesbrough PCT continues to monitor the effectiveness of the Out of Hours services as provided by Primecare.

(g) That a dedicated unit in relation to the Integrated Care Pathway as outlined in the report is advanced with a view to implementation as soon as possible.

Acknowledgements

113. The Panel would like to commend the South Tees Hospitals NHS Trust on its speedy and positive response to some of the issues raised in the course of this scrutiny review. In a meeting on 8 June 2005, Members asked a series of questions around discharge practices at the Trust. At the meeting of 22 July 2005, where the Draft Final Report was discussed, the South Tees Trust were able to inform the Panel of a number of changes made to discharge processes. This included the production of a new information leaflet for patients to be issued with, following the gaps highlighted by the Health Scrutiny Panel.

114. The Panel was very pleased it had been able to act as a force for development and would like to commend the Trust on the prompt and constructive way in which it reacted to the Health Scrutiny Panel's inquiries.

115. The Panel has received a great deal of assistance in conducting this Review and consequently would like to thank the following people.

116. Dr Vincent Connolly, Annette Hurndell, Jill Moulton and Claire Young, Mr Adrian Clements Consultant and Mr Kean Chew Consultant at South Tees Hospitals NHS Trust.

117. Linda Brown and Martin Phillips at Middlesbrough Primary Care Trust

118. Peter Moore, Middlesbrough Council Department of Social Care

119. Sharon Tulloch and Lucy Campbell at Carter Bequest Community Hospital, James Cook University Hospital and the Intermediate Care Centre for making Members of the Panel feel so welcome on visits, despite their very busy working lives.

120. Dr Amanda Gash at the Tees & North East Yorkshire NHS Trust.

BACKGROUND PAPERS

121. *Transforming Emergency Care in England*, A Report by Professor Sir George Alberti. Published by Department of Health, October 2004.

Contact Officer:

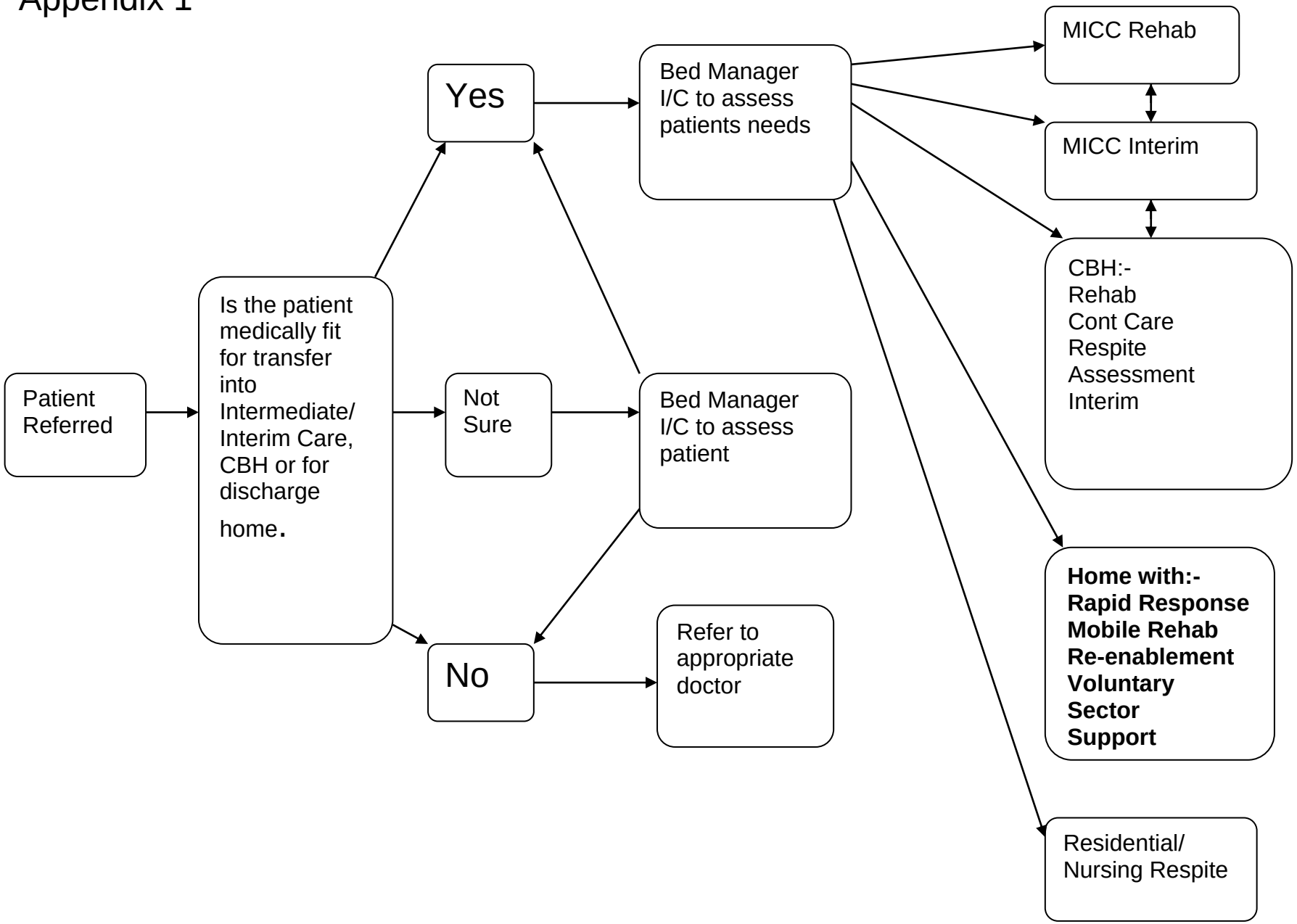
Jon Ord **-** Scrutiny Support Officer

Telephone: 01642 729706 (direct line)
Email: jon_ord@middlesbrough.gov.uk

Glossary

JCUH	James Cook University Hospital, Middlesbrough
AAU	Acute Assessment Unit
GP	General Practitioner
FAST	Fast Access to Social Care Team
PCT	Primary Care Trust
ICP	Integrated Care Pathway
TNEY	Tees & North East Yorkshire NHS Trust
SHA	Strategic Health Authority
EMI	Elderly Mentally Infirm

Appendix 1


Patient Referred
Is the patient medically fit for transfer into Intermediate/ Interim Care, CBH or for discharge home.
Yes
Not Sure
No
Bed Manager I/C to assess patients needs
Bed Manager I/C to assess patient
Refer to appropriate doctor
MICC Rehab
MICC Interim
CBH:-
Rehab
Cont Care
Respite
Assessment
Interim
Home with:-
Rapid Response
Mobile Rehab
Re-enablement
Voluntary Sector Support
Residential/ Nursing Respite