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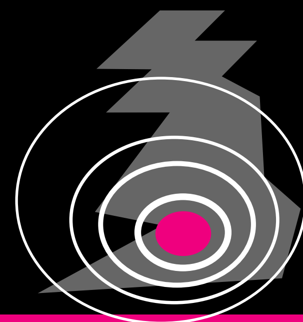

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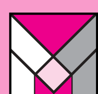
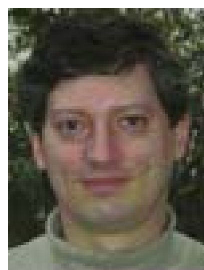


Medical Management Services
Creating Successful Partnerships

Emergency Admissions: How to prevent winter pressures on hospital beds

PCTs could play a key role in preventing hospital bed problems says Michael Damiani, senior data analyst and co-author of King's Fund report* to be published this month.



Michael Damiani

In summer 2000, the London regional office of the NHS Executive commissioned the King's Fund to take a new look at the pressures that face London hospitals every winter. Emergency admissions put an enormous strain on NHS resources. Yet we found that some of these pressures may be preventable through early management of chronic disease in primary care.

We acquired four years of hospital episode statistics (HES) from the Department of Health and analysed it by time, geography, diagnostic code and GP practice. The records included all admissions of patients resident in London.

What diseases cause emergency pressure?

Our first discovery was that the only disease group with a very marked seasonal variation was respiratory illnesses. The weekly number of admissions in summer hovered around 800, yet as many as 3,000 emergency admissions for respiratory disease per week were observed at the end of December 1999. This pattern is closely mirrored by the one seen in data for England as a whole. We also compared the number of weekly emergency respiratory admissions with the number of GP consultations for influenza and influenza-like illness, submitted through the weekly returns service of the RCGP and obtained from the Public Health Laboratory Service. The two datasets showed a strikingly similar pattern - the GP consultations lagged behind by a couple of weeks.

Breaking the respiratory admissions down further revealed that pneumonia, chronic obstructive pulmonary disease (COPD) and 'other acute lower respiratory infections' accounted for the bulk of the winter peak seen in the figure for total emergency admissions. The number of emergency admissions for asthma were highest in September and for bronchiolitis around the beginning of December. These peaks occurred at the same time in every one of the four years, and are therefore highly predictable.

What difference does age make?

The length of stay in hospital varies by age, from about two days for young children and four days for patients aged 30 to a peak of about 17 days in patients aged 90 years or over. Owing to the much higher number of patients over 60, three-quarters of bed days were used by them. The number of bed days by age peaked around the age of 85 for pneumonia and 'other acute lower respiratory infections', while for COPD it peaked about ten years earlier. This might be due to a higher prevalence of COPD in smokers.

What difference does geography make?

Looking at the data geographically, we discovered that the east of London, around the boroughs of Hackney, Tower Hamlets and parts of Newham and north Southwark, had the highest rates. Analysing GP practice standardised rates confirmed this pattern. However, some practices with very high admission rates stood out in a 'low admission rate' area and others for the opposite reason - is there something these practices could learn from one another?

What could be done?

Older people with chronic respiratory disease are identifiable before the onset of winter, particularly by staff working in primary care.

continued on back page

EDITORIAL COMMENT

Proactive management of elderly patients during winter months could reduce the risk of emergency admissions says Michael Damiani. Though his King's Fund research is London-based the findings are relevant to solving winter pressure problems throughout the country. PCTs and PCGs will welcome the author's comment that more resources should be targeted to stretched primary care teams.

ON 'TARGET', page 2, has nothing directly to do with winter pressures or government aims, but the success of Doncaster's protected learning time project has led to improved health outcomes and fewer hospital admissions. Not surprising then, that PCTs from Leeds to Portsmouth have adopted it and more are likely to this new year!

Jenny Sims, Editor

NEWS IN BRIEF

NSF for Diabetes

The NHS Alliance has called for realistic funding for the National Service Framework (NSF) for Diabetes published on December 14. The first NSF to be published in two stages, its emphasis is on locally agreed protocols to meet 12 national standards. The delivery strategy is to be published in the summer. Fuller report next issue.

Cancer Care Report

The joint report *National Assessment Framework No.1 NHS Cancer Care in England and Wales* from the Commission for Health Improvement (CHI) and Audit Commission looks at the implementation of the recommendations made in the 1995 Calman-Hine report on the commissioning of cancer services. For example, from this month (January) patients will have a maximum of one month wait from being referred urgently by their GP to treatment for children's and testicular cancers and acute leukaemia. Available at the CHI website www.chi.nhs.uk and the Audit Commission website www.audit-commission.gov.uk

Patient Information

Professor Joan Higgins, Professor of Health Policy and Director of the Manchester Centre for Healthcare Management at the University of Manchester has been appointed chair of the newly established Patient Information Advisory Group.

'The group will play a crucial role in ensuring patient-centred consent practice continues by informing patients about how their confidential information is used when it has not been practicable to obtain their consent' said health minister Hazel Blears.

Two new watchdogs

From April two new regulatory watchdogs will be in place to oversee the work of nurses, midwives and allied health professionals. The Nursing and Mid-wifery Council will take over from the UK Central Council for Nursing, Mid-wifery and Health Visiting (UKCC) and the Health Professions Council (HPC) will replace the Council for Professions Supplementary to Medicine (CPSM).

'They will be more flexible, more responsive and will allow development of professional standards to reflect the changing workforce needed by the modern NHS,' said health minister John Hutton.

PCG TIPS: Books and reports

Professor Liam Donaldson

On the State of the Public Health
By Government Chief Medical Officer, Professor Liam Donaldson

CMO Professor Liam Donaldson has called for greater commitment by public and private health services and the voluntary sector to reduce health inequalities. His first annual report since his appointment focuses on five areas for action:

- Health inequalities and the North-South divide
- Untreated high blood pressure
- Liver cirrhosis and increased alcohol consumption by younger people
- The threat from E. Coli O157
- Epilepsy Services

It analyses the effectiveness of current treatments and services, describes government action in these areas and identifies action necessary to bring about improvements. **Available at: www.doh.gov.uk/cmo/annualreport2001**

Why Mothers Die 1997-1999 Fifth report of the Confidential Enquiry into Maternal Deaths

Maternal deaths have been decreasing steadily over the last 50 years and are now at their lowest ever level. However, this report clearly shows that poverty, social exclusion and access to services are major factors in the risk of maternal death. Commissioned by the DoH and carried out by the Royal College of Obstetricians and Gynaecologists and NICE, it analyses deaths during pregnancy, childbirth and one year after birth. Because of its findings NICE have been asked to produce guidelines for routine antenatal care.
Published by RCOG Press London
Available at: www.cemd.org.uk

Medicines Control Agency 11th Annual Report (2000/2001)

MCA Chief Executive Dr Keith Jones said: 'The Agency has had a very busy and challenging year. All quality targets were achieved, new drug applications were assessed in a mean time of 36 days, and all casework was completed within European timeframes. As part of the Agency's quest to improve the quality and standards of its service, a new state of the art General Practice Research Database was introduced.'
Available from the Stationery Office
Tel: 020 7873 0011

Community Care Statistics 2001: Residential Personal Social Services for Adults, England DoH Statistical Bulletin

The total number of nursing homes, private hospitals and clinics fell by around 200 or 3% between 2000 and 2001 which means a loss of 6,500 beds. The number of residential care homes and places fell by 700 and 4,700 respectively. **Available at: www.doh.gov.uk/public/sb0129.htm**

Stephen J Wright, Consultant in Primary Care Medicine writes:

ON *'TARGET'* (Time for Audit, Reviews, Guidelines, Education and Training)

Throughout the nineties, Doncaster GPs Martyn Coleman and Gary Dakin became increasingly concerned that the new Post Graduate Education Allowance was not generating the standard of postgraduate medical education necessary to maintain high quality in general practice. The Deaneries were keen to control the syllabus for registrars, but nothing after that. Drug firms took over as the main providers of easy 'Brownie points' and many GPs slept through talks on the heart, asthma, the upper GI tract, depression and not much else.

However, Drs Coleman and Dakin did something about this. They knew that education, to be effective, has to be tailored to educational needs. More than this, they recognised that if the new PCTs were to succeed, a lot of this education had to be multidisciplinary. Their idea was not to replace individual development plans, but to augment them with protected learning time.

TARGET meetings (Time for Audit, Reviews, Guidelines, Education and Training) provide protected time for learning for ALL GPs, nursing and other professional staff, managerial and administrative staff working in general practices within the PCT. All practices close down for training one half day every month, and cover is provided by either the Co-op or Deputising Service. Drs Coleman and Dakin thought that if this was necessary for training in industry, then it should be necessary for general practice.

Some of the training is multidisciplinary, and this has proved successful for areas such as triage, appraisal and physiotherapy provision for low back pain. Other areas have proved better for GPs only such as antibiotic usage, congestive heart failure, and prostate problems. Success is confirmed by the fact that in Doncaster, antibiotic usage is markedly reduced, as are sinus x-rays, barium meals and requests for serum iron; there is an increase in the fast-track heart clinic uptake, statin use, triaging of calls in all practices and there are now orthopaedic physiotherapy practitioners who see patients in practices instead of the patient being referred to an orthopaedic surgeon.

TARGET is now a major feature of educational activity in over 50 PCTs from Leeds to Portsmouth including Northern Ireland. There was a first TARGET Foundation 'Protected Learning Time' Conference in Doncaster in September 2001; the next is March 2002. Liam Donaldson and Tony Blair, as well as the Modernisation Agency think TARGET is a great idea. It is not easy to sustain: the course organisers need a lot of energy and new ideas. Politics interfere, as PCT Boards want NSFs and NICE guidance to predominate. Professional Executive Committees feel that this is a project for GPs and their staff, run by GPs and their staff.

Martyn Coleman and Gary Dakin both feel this has been a wonderful experience, knowing that the right sort of education is now reaching everybody concerned, and in a peer group setting. To learn more, look at their websites: www.targetmedicaleducation.org and www.targetfoundation.co.uk

Shared HR Services – a cost effective way of providing expertise

Government initiatives such as the *NHS HR Performance Framework*, *The HR Strategy*, *Improving Working Lives and Agenda for Change*, as well as developments in employment law mean that it is important for NHS organisations to have HR expertise. The question is how can the necessary expertise be provided cost effectively, especially in organisations such as PCTs?

Shared HR services are being seen as a way of meeting these needs. According to a recent report by Pricewaterhouse Coopers:*1…. shared services, properly implemented, are probably the best way of exploiting synergies in people, processes and systems and providing a platform for a more sustained strategic relationship with the business and operations.

The case for some form of shared HR support service is therefore strong, especially in organisations such as PCTs. This article reviews some of the key issues including:

- What is meant by shared services
- Key advantages and disadvantages
- Key steps to be considered in developing services

What are shared services and what are the risks?

Shared services typically involve offering a common HR service to a group of user organisations that choose the level and nature of the service*2. There are various shared service models ranging from:

- Large centres carrying out data processing or providing advice via a call centre. Typically these involve massive investment in IT systems and can only be cost effective where there are significant economies of scale and large numbers of standard transactions. Experience would suggest that it is very easy to overestimate the benefits and underestimate the costs.
- Informal networks of people with expertise in various specialist areas, who contact each other for advice on an informal basis, making use of economies of scope. There are similarities with the concept of the 'learning organisation'.
- In the middle are professional support units consisting of experts providing services to a number of organisations. These range from external providers such as external consultancies, to internal, 'virtual organisations', sharing tasks.

According to a recent IES report, they are being implemented by a number of organisations in the belief that centralisation and standardisation can cut costs and improve the quality of HR services.

The concept of shared services in the NHS is not new. Before the NHS reforms, support services were provided centrally by district health authorities. The problem was that DHAs were too remote. For example, disputes and grievances are unpredictable and require immediate action together with an in-depth knowledge of the organisation, so it isn't possible for a remote provider to deal with them effectively.

Shared services based on call centres and intranet services in particular also risk over-reliance on technology, which is expensive and 'depersonalises' the service, which discomforts employees and HR staff alike. While there are a number of advantages to shared services, there are problems which need to be addressed.

Key steps in setting up a shared service

- Establish a shared vision and get commitment from service users in principle
- Identify the services that are required. This includes checking whether the present services are what will be required in the future – there is no point in providing outdated, unwanted services.
- Identify the costs and benefits. Decide which will best be provided centrally and which need to be kept in house. Key issues to consider are those which will provide the greatest benefit at least cost or disruption.
- Decide who will employ the staff, a single trust acting as a 'host', using a trading agency concept, or share the employment risk between a consortium.
- Develop a profile and brand image for the service
- Develop a business plan and performance framework

Summary

Shared HR services have a number of advantages, especially in the provision of expertise. Initiatives such as *Agenda for Change*, *Working Together* and *Improving Working Lives* all mean that there will need to be much more HR expertise available to NHS organisations. But because the amount spent on HR management in the NHS is small it would be a mistake to introduce shared services for cost reductions alone. The main problem is how to structure the service to provide the integral HR management organisations require and is responsive to users needs.

John Northrop is Director of PWR an NHS HR research and consultancy organisation. For more information call 01423 720200

*1. The HR Benchmarking Report 2000 Available at www.pwcglobal.com

*2. This (user chooser) aspect distinguishes shared services from more traditional centralised services.

Shared services - summary of advantages & disadvantages

Advantages	Disadvantages
Savings from economies of scale via better use of IT and information processing. IT start-up costs can also be spread between participating organisations	Set up costs such as IT systems, staff retraining and relocation.
More effective use of resources by sharing knowledge and expertise and not re-inventing wheels by for example each organisation's personnel specialists developing separate policies and procedures	Over estimating the cost savings and not having policies and procedures tailored to the individual organisations' culture and context.
A better quality service because more specialist expertise can be available – economies of scope	'Ownership' of policies and procedures is also likely to be a problem.
Small organisations can access quality HR services	Organisations still require a high level of expertise. Local government experience of CCT demonstrated that the quality of bought in services can be at risk without a high level of in-house expertise.
Users are free to concentrate on their 'core' activities and strategic tasks	HR staff may resist changes in their role and location, especially if this means working in call centres
Users can specify the level and nature of the service purchased	Depersonalising the service
An opportunity to review the adequacy and relevance of current personnel services.	Lack of the instant expert support which is often required and responsibility for HR management is not retained in house
Providing more consistent project management and support	Line managers can see HR management as not their job if it is outsourced

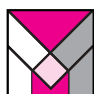
continued from page 1

Could they be subject to more proactive management throughout the winter months in order to reduce the risk of an emergency admission? Such proactive management might include regular reviews during the critical few weeks in December and January and early intervention where appropriate. Influenza vaccinations are an important part of this strategy and ensuring high uptake should be a priority for local teams. Other initiatives with good evidence of improving outcomes for patients with COPD include smoking cessation, pulmonary rehabilitation and education programmes.

It is also important to target some of the limited resources for managing winter pressures on specific parts of London, in particular support for stretched primary care teams. Local data could point to specific problems and could help the primary care trust in setting priorities most appropriate to the area and the local community. There is a wealth of data available that is largely under-utilised, much of which could help with the identification of specific issues that might get overlooked when examining Londonwide or nationwide data.

Respiratory disease is the third largest cause of death in the UK. For COPD, 78% of the secondary care cost is in emergency admissions. A significant part of this money could be better spent preventing these patients from being admitted to hospital in the first place. There is a key role for primary care trusts, with support from acute hospitals, social services, community health services and possibly NHS Direct, in achieving that goal.

* *Managing the Pressure: emergency hospital admissions in London 1997-2001*, by Michael Damiani and Jennifer Dixon available from King's Fund bookshop from 10th January 020 7307 2591.



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Working towards electronic health records

Development and implementation of electronic health records are a key part of the NHS Information Authority's programme to support information management for direct patient care and a vital component in the plan to modernise the NHS.

By March 2005 all health care professionals should have access to an electronic patient record. This is one of the strategic goals outlined in Information for Health and the reason for the Information Authority's Electronic Record Development and Implementation Programme, known as ERDIP.

ERDIP is a national co-ordination programme that uses demonstrator health communities to explore and define emerging concepts, such as the First Generation Electronic Health Record, in a wide range of healthcare environments. It also supports implementation issues, evaluates outputs and defines emerging concepts.

Sixteen trail-blazing demonstrator communities are taking part in the programme. Four pan-community sites, Cornwall, South Staffordshire, County Durham and Tees are looking at how electronic records can be used to share patient information across wider health communities. Twelve smaller demonstrators are focusing on specific issues identified in the information strategy for the NHS. These include bringing together patient records for those receiving treatment for cancer and coronary heart disease, and establishing links between health and social care for mental health, child and elderly care, between walk in centres and primary care or NHS Direct and other health organisations.

Cornwall is forging ahead with the development of an emergency electronic health record. Four GPs and their patients will soon start to test a 24-hour emergency health record. This will enable health professionals to look up a patient's details on the spot and will give clinical staff working in A&E and emergency care immediate information about the patient, such as recent treatment, allergies and blood tests.

On February 7 & 8 an ERDIP conference will take place in Cornwall which looks at the issues behind the development of an electronic health record. Speakers are largely drawn from within the Cornwall IT Services and the EHR Team, so participants will have an opportunity to hear at first hand the issues and lessons learnt.

One of the components of ERDIP is the First Generation EHR Definition which aims to co-ordinate, at a national level, the definition and development of the first generation of electronic health records, to be shared by patients and carers.

Patients must eventually be able to access their own personal health-related information through the EHR. An important aspect of the work is to ensure that appropriate infrastructure requirements are identified, including security and confidentiality issues, and that developments are integrated – through formal liaison – with other initiatives such as NHS Connect, which aims to connect all clinical staff to NHSnet by 2002, the National Strategic Tracing Service (NSTS) and NHS Direct. All ERDIP demonstrator sites – with County Durham in the lead – have identified areas where they can offer support and experience.

The Authority's band of work encompasses a number of related projects developing and maintaining information content (Read Codes, SNOMED Clinical Terms, Headings and Context of Care); others based around the use of information in direct patient care (ERDIP, PRIMIS – Primary Care Information Services); and work on clinical messaging standards and confidentiality. On a wider front, the directorate is actively working towards increasing inter-working between programmes and ERDIP forms a natural focus for involvement of individuals from all delivery areas. Finally, there are close links to the Authority's stake-holder relations directorate, enabling projects to be soundly based around meeting user needs.

Patients views on use and access of their own electronic records were tested earlier this year during two pilots at GP practices in Derbyshire and Oxford. Both pilots addressed issues such as secure access, confidentiality and how to manage medical information that may be 'bad news' for the patient.

Evaluation is a vital part of the ERDIP work, with most of the material provided by the demonstrator sites. However evaluation also plays a part in the other components of ERDIP, particularly the EHR concept.

Demonstrator work is reviewed at both national and local level and also in the context of wider electronic record developments, within and outside the NHS. This enables relevant national information infrastructure initiatives to be taken into account.

Varied evaluation activities and techniques will eventually produce baseline assessments, analyses of local costs, benefits and risks, and identification of practical barriers to progress towards these targets. These will be collated to provide national success indications for electronic record implementations (with the emphasis on impact on clinical outcomes), to confirm scalability of local solutions and associated national cost-benefit implications, to identify best practice and inform national policy.

Demonstrator communities taking part are: Bradford, Camden and Islington, Cornwall, County Durham and Darlington, Dorset, Gloucester, Hillingdon, Kingston and Richmond, Merton, Sutton and Wandsworth, North and Mid Hants, South and West Devon, South Staffordshire, Suffolk, Tees, Walsall, West Surrey, Wirral.

For more information call Gill Friend at the NHSIA on 01392 206770 or see www.nhsia.nhs.uk/erdip