THE SCOTTISH OFFICE

Department of Health

FOR REFERENCE ONLY

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NHS Management Executive
St. Andrew's House
Edinburgh EH1 3DG

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COMMON SERVICES AGENCY
GENERAL MANAGER
TRINITY PARK HOUSE

Dear Colleague

PLANNING FOR ACUTE HOSPITAL SERVICES: THE MANAGEMENT OF EMERGENCY ADMISSIONS

Summary

1. Guidance for the NHS in Scotland on the management of emergency admissions is attached. The Guidance has been prepared following the outcome of the Review of Acute Services Planning Assumptions and takes account of the Review's findings and recommendations. A summary of the Review was published on 11 July 1996. A draft of the guidance was issued for consultation in October 1996.

Action

2. All Health Boards and NHS Trusts were asked to review with their planning partners, their current plans in the light of the Review. Boards and Trusts were also asked to satisfy themselves that their plans are sufficiently comprehensive and robust to meet the demand for emergency admissions in their area and to cope effectively with seasonal pressures and other peaks in demand.

3. Boards and Trusts need to keep their plans for the management of emergency admissions under review. They should now consider the extent to which their current plans are consistent with the enclosed guidance, and if necessary amend them as appropriate.

4. Health Boards are asked to pass copies of this circular to all GP practices within their area. Sufficient copies will be forwarded to Health Boards for this purpose.

Yours sincerely

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LTS14811

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ACUTE SERVICES PLANNING ASSUMPTIONS IN SCOTLAND GUIDANCE FOR HEALTH BOARDS AND NHS TRUSTS

1. In common with the rest of the UK, the NHS in Scotland has experienced a continuing increase in the number of emergency medical admissions in addition to which there are also seasonal peaks in demand.

2. Following a sudden rise in the demand for emergency admission in December 1995 and the early part of 1996 the Secretary of State asked the Chief Executive of the NHSiS to undertake a review of the planning assumptions for acute services used by the NHSiS. The formal terms of reference of the review were:

- To review the planning assumptions used by the NHS in Scotland in developing acute hospital services by considering:

1. trends (in activity and changing patterns of care, resource utilisation, staffing etc);

2. factors which may affect those trends and the response to them (including the need to take account of peaks in demand); and

3. models which may be appropriate for acute services in future.

3. This Guidance reflects the findings of the review and gives examples of different practice models which Health Boards and NHS Trusts should to take into account when planning for the provision of acute hospital services. It will be reviewed regularly.

Policy

4. Policy for acute hospital services has moved from buildings-led planning in the 1960s through service and programme planning in the 1970s and 1980s to the present policy of commissioning for health gain.

5. Changing clinical practices are challenging the traditional ways of providing hospital care. The expanding role of primary and community care, the trends towards day case surgery and research evidence that better clinical outcomes can be achieved for some treatments by centralising clinical activity in specialist centres all have implications for the established network of specialist hospitals, district general hospitals and smaller acute/community hospitals.

6. The Department of Health will be undertaking further work on these matters. This review, which will start later this year, will be taken forward by the Management Executive working closely with senior clinicians and others in the NHS. It will address the need for balance between local and 'centralised' provision of services, taking account of the continued drive for efficiency and clinical effectiveness.

Planning Assumptions

7. The Minister of State has already asked Health Boards and Trusts to review their current plans. In his letter of 12 July 1996, he asked Boards and Trusts to satisfy themselves that their plans would ensure that they are properly prepared to meet local demand and to cope with sudden rises in emergency admissions.

Planning Role of Health Boards

8. Health Boards in particular have a key role to play. They are uniquely placed to take an overview of local services. Since urgent and emergency admissions now account for around 60% of all admissions for inpatient treatment Health Boards should:

- Regularly review the needs of their population for emergency healthcare and commission a network of services to meet these needs taking into account the balance between the emergency and elective workload;

- Support primary care services in reviewing local patterns of emergency admissions;

- Agree with local providers of hospital and primary care the role they are expected to play in effectively managing urgent and emergency care;

- Ensure that GPs are involved in planning local arrangements and options for dealing with urgent and emergency cases when sudden increases in demand occur;

- Agree with hospital providers the arrangements within the hospital and between hospitals to deal with sudden increases in demand and structure and resource service contracts accordingly.

- Regularly review the performance of each part of the service in meeting the demand for emergency admission.

9. The acute bed planning model[‡] which was developed within the Management Executive in 1993 was intended to provide a framework which could be used by Health Boards and Trusts in their long term planning for acute hospital services.

10. Boards and Trusts who choose to use the model should supplement it with local information such as:

- the rate of continuing growth in emergency admissions

- the balance of emergency and elective workload

[‡] Requirements for Acute Beds in Scotland: the Past and the Future Health Bulletin 52(1) January 1994.

- individual specialty caseloads and case-mix

- Indicators of quality such as those suggested by the Scottish Office Audit Unit[§]

- Measures of caseload intensity such as patient throughput per bed and nursing dependency scores;

The following should also be taken into account in local plans:

- the totality of the resources available within hospitals and nursing homes which should be used flexibly throughout the year to accommodate fluctuations in urgent and emergency caseloads;

- the contribution which community and other hospitals and nursing homes can make to providing non-specialist care in times of peak demand.

Planning Role of Trusts

a. Admissions

11. NHS Trusts, in consultation with their purchasers, should review their arrangements for receiving emergency admissions. In particular:

- All hospitals should consider introducing an Assessment Unit (AU) which should in the first instance concentrate on medical and elderly patients; the Unit should be led by a Clinical Director or Consultant designated as the Assessment Unit Director. The Unit should have a dedicated team of consultant and junior doctors, nurses and paramedical staff.

- Wherever possible, the on-call team should not have other scheduled duties during their on-call period or the following morning.

- The respective roles and resources of the A & E department and the Assessment Unit need to be clear and co-ordinated in order to achieve a consistent strategy in the hospital for the receipt and rapid assessment and treatment of all emergency patients.

- Both A & E departments and AUs should have specially trained/authorised nurses with the competence and authority to order routine radiological and laboratory tests, and standard ECG.

- The provision of fast track diagnostic investigations including laboratory and radiological services is required to support both A & E and AUs. These need to be available, with reserved slots, over extended hours as reflected by admission patterns. They also need to cover weekends and public holidays.

[§] Managing the Use of General Medical Beds: Scottish Office Audit Unit 1993.

- In the longer term, hospital clinicians and GPs should agree admission protocols for a specific range of more common conditions in both A & E and AUs to assist decision making on admissions by junior medical staff.

b. Management of Beds

12. Bed management is a key to successful handling of peaks in demand. Trusts should consider:

- The appointment of a senior member of hospital staff as bed manager. This individual should have information on the bed state at all times and authority to access beds for cases requiring admission.

- Reviewing bed allocations by specialty should be undertaken at least annually in relation to the contract targets and more frequently in the light of progress or difficulties in delivering those contracts. The transfer of beds or shared bed allocations between specialties to respond to changes in demand should be considered.

- The development of a policy for dealing with outliers (boarders). Bed allocations ideally should reflect real needs but as an alternative, outliers should, whenever practical and possible, be drawn together into a single ward to facilitate good patient care and avoid excessive transfer documentation for nursing and medical staff. This might be under the management of the Medical or Medicine for the Elderly directorate, but could look after surgical outliers with suitably trained medical and nursing staff.

- The scope for step down arrangements from specialist care to sequential stages of care for medical and elderly patients.

Purchasers and providers should together develop indicators to monitor the performance of acute services and the resulting pressures on staff and other resources. Clinicians should set standards for the quality of emergency care and agree with managers the local indicators to measure these. The areas which such indicators should cover will include:

Indicator	**Measure of**
1. Time spent by GP securing admission	Access to specialist advice and availability of hospital care.
2. Percentage of self referrals to A&E	Balance between GP and A&E service access.
3. Time spent in A&E	Adequacy of liaison with receiving team.
4. Time between admission and examination by consultant	Adequacy of access to key decision makers.

5. Level of inter-specialty transfers	Effectiveness of receiving arrangements.
6. Level of boarding out	Reasonableness of length of stay; availability of appropriate accommodation; barriers to discharge.
7. Length of stay for specific diagnoses by specialty	Consistency of clinical practice.
8. Proportion of cases with length of stay above defined threshold	Proper functioning of discharge procedures.
9. Number of planned elective admissions cancelled/postponed	Balance between elective/emergency care planning
10. Unplanned re-admission rate within a certain time	Medical complications or incidence of potential premature discharge
11. Timescale for issue of discharge letters	Proper continuity of care

Based on: Managing the Use of General Medical Beds. Scottish Office Audit Unit 1993

c. Staffing

13. In developing their plans for dealing with and resourcing the demand for acute emergency services, NHS Trusts and Health Boards must take full account of the way existing and prospective changes in staff training and working patterns will impact on staff and their ability to deliver acute care for both elective and emergency patients.

14. The "new deal" on junior doctors' hours of work sets a maximum average 72 hour working week and a target of no more than 56 hours a week of work. Most of the effects of this change are already being dealt with by NHS Trusts, for example by the employment of more consultant and other career grade doctors.

15. Changes in the training arrangements for junior doctors; and the increasing trend to specialisation and sub-specialisation on the part of career grade doctors mean that NHS Trusts (in consultation with their purchasers) will have to ensure that their arrangements for providing emergency and elective acute services do not lead to unreasonable or unduly protracted excessive demands on medical and other hospital staff.

16. In reviewing their response to these changing pressures on medical staffing, NHS Trusts should consider extending the scope of professional practice of registered nurses. There is no one model for developing and extending the role of nurses. The range and scope of many of the possible developments will reflect local circumstances, the vision and leadership of the executive nurse director, relationships with medical colleagues and the abilities and willingness of staff locally to widen the scope of their professional practice.

Where a NHS Trust concludes that some nurses' role(s) can be developed in this way, it should be done within a clinically supported and educationally sound environment

17. In considering the contribution that registered nurses should make to dealing with the pressures on acute services in NHS hospitals, Trusts must take into account the level of nurse staffing in the light of the patient nurse dependency assessments. Although the number of occupied beds per qualified nurse has dropped since 1990, the number of patients treated per qualified nurse has risen significantly over the same period. In other words, throughput, increasing patient dependency and the complexity of treatments all place additional demands on nursing staff.

18. NHS Trusts will wish to consider the scope for delegating certain tasks currently performed by nurses to others.

19. NHS Trusts will wish to consider carefully the extent to which peaks in demand for acute services can be met by making judicious use of bank and agency nurses. This should not, however, be seen as a panacea. In particular, NHS Trusts must ensure that their plans take account of the needs of particular specialties for specially trained nurses - for example paediatric nurses, intensive care nurses and nursing staff for high dependency units.

20. Alongside doctors and nurses NHS Trusts should ensure that their plans to meet the need for emergency healthcare take full account of the role of the diagnostic and paramedical services and of the professions allied to medicine. Therapists and other paramedical staff have a key role in ensuring patients are properly prepared for timely discharge, thus enabling them to free up beds at times of peak demand as well as throughout the year. NHS Trusts should ensure that the skills of the staff in all supporting services are fully utilised in this process and that these professions are adequately staffed and resourced to meet expeditiously the demands placed on them.

Specialist Beds

21. Health Boards, through their contracts with Trusts, should assure themselves that sufficient beds are available and appropriately staffed to meet expected needs for specialist diagnosis and treatment. In particular, it is desirable that children should be treated in dedicated paediatric wards.

22. Health Boards and NHS Trusts should constantly review the adequacy of their provision of and access to intensive care unit (ICU) beds. They should ensure that the level of demand is monitored and that there are clear agreed procedures for dealing with emergency admissions including clear admission and discharge protocols. High dependency facilities for those who need enhanced nursing should be considered before resorting to ICU beds; and clear arrangements should be in place to ensure appropriate staffing is available when required. Each ICU should take part in the existing liaison arrangements with other ICUs in Scotland to enable them to ascertain rapidly the availability of ICU beds elsewhere if their own ICU is fully occupied.

23. Health Boards, working with NHS Trusts, should consider how information already collected in ICUs on bed use and availability could best be used to establish local bed

bureaux and similar arrangements. The Management Executive will work with Health Boards and NHS Trusts to build on the information already collected to develop a system for exchanging information on the availability and use of ICUs across Scotland and to ensure that the overall national provision is adequate to meet the needs of patients.

Discharge Planning by Boards, Trusts and Local Authorities

24. Health Boards, NHS Trusts and local social work authorities, need to assure themselves that they have jointly agreed robust discharge planning and care assessment arrangements. These arrangements must be clear to all the staff who have to operate them and sufficiently flexible to enable them to continue to operate satisfactorily and quickly even at times when seasonal demand for emergency care in hospital and the community is high. In reviewing their discharge arrangements, they should consider:

- Agreement of joint protocols with social work with agreed standards for timing the various stages of discharge planning and implementation.

- Liaison with GPs, community nurses and other primary care staff on their input to local arrangements.

- Using the Scottish Intercollegiate Guidelines Network (SIGN) guideline on immediate discharge documents.

- Standardised straightforward documentation for discharge planning used by all professions.

- The extent to which social workers are an integral part of the hospital processes and should be directly involved in care planning meetings.

- Identifying a senior member of staff with a lead responsibility for discharge planning. In most cases their role should be to support the direct care givers and to focus on education and system development.

- The establishment of formal multi disciplinary teams to focus on discharge planning: these could be organised on a specialty basis or cross specialty to concentrate on common problems with discharge management and thereby build up expertise in this area.

- Assessing patients' social circumstances on admission and giving patients an expected date of discharge at that time. Whilst this may need to be revised, it should form a crucial part of care and discharge planning.

- The problems associated with discharge planning which may be concerned with logistics or may be the result of a failure to ensure that decisions are taken or acted upon at the optimal time.

- The creation of a Discharge Lounge to be run under the supervision of nursing staff to accommodate the majority of those ready for discharge but where transport/drugs etc are likely to cause a delay.

- The adequacy of existing contracts with Ambulance services to ensure the availability of efficient discharge transport, including over extended hours, at weekends and over public holidays.

**Conclusion

25. Many Health Boards and Trusts are already working together to plan to meet demand for emergency admissions but much remains to be done to ensure that quality standards are set and met and that all available resources are used as flexibly and effectively as possible in adequately meeting the needs of urgent and emergency patients.

** This circular has drawn from other publications on Acute Hospital Services - including 'Emergency Admissions Short Term Policy Solutions - Successful Interventions' - London Health Economic Consortium, September 1995.