



Acute Hospital Portfolio Review 2005/2006

Report on presentation to NW London Heart Failure Group

Background

The Acute Hospitals Portfolio Review was originally developed by the Audit Commission and is now run via the Healthcare Commission on an annual basis, to inform the annual health check process. It is a collection of care reviews spanning a number of acute topics considering quality of care, efficiency and effectiveness and is intended to provide information to help trusts improve their services. As part of the 2005 Acute Hospitals Portfolio Admissions Management Review, a survey of heart failure emergency admissions was carried out across the country; each Trust was asked to provide a 'snap-shot' of care processes for a small sample of patients.

The intention of the audit was to find out what happens to patients who were admitted to hospital as an emergency with heart failure. The audit also considered the general pathway taken by emergency medical admissions alongside the investigation, treatment and management of heart failure admissions.

Key indicators that informed the review included:

- Admission rates
- Readmission rates
- Bed days
- % of patients on optimum medication (evidence based treatment)
- Mortality rates

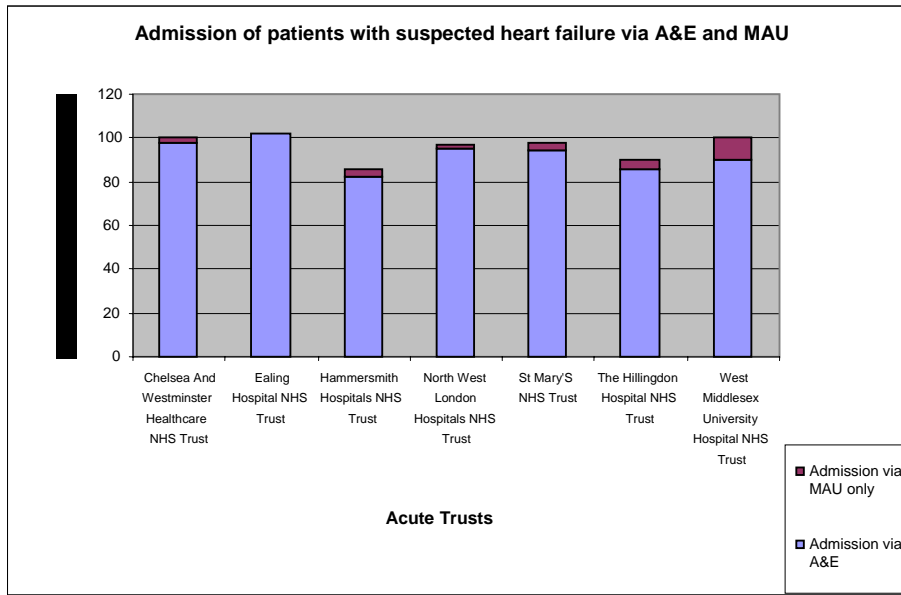
Trusts were asked to review the casenotes for a sample of 50 patients who had been admitted with a diagnosis of heart failure. The audit was retrospective and Trusts were given a starting date of 30th September 2005 and asked to work backwards until 50 samples had been collected. Patients who were still in hospital at the time of the audit were excluded but patients who had died in hospital were included.

This report presents the information collected on some of the key data points by each NW London Trust and provides an analysis and review of the data relating to the specific indicators that make up the audit. It should be noted that there are caveats within the audit that should be taken into consideration, where possible these have been identified.

The report concludes with points for discussion and recommendations for further work to assist Trusts in improving their services.

Admissions

Figure 1



As indicated in Figure 1, all but one Trust has a medical admissions unit (MAU) or similar, to take direct referrals from GPs or heart failure clinics. However, only a small number of the total percentage of emergency admissions goes via this route with the majority being admitted through A&E. It is unclear from the data whether this is due to local admission practices or capacity issues within the MAUs.

Figure 2

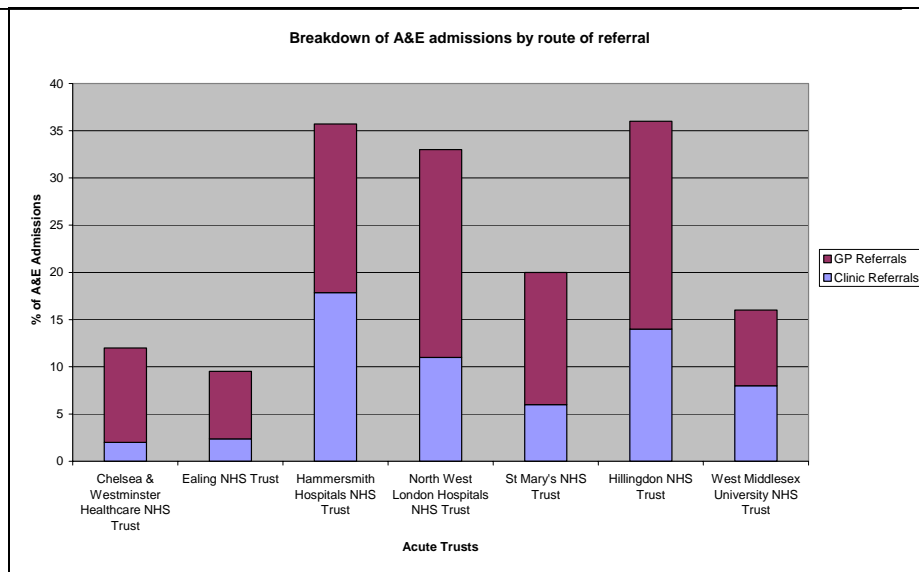


Figure 2 shows the percentage from the studied sample of patients who were referred as emergencies via either a GP or an outpatient clinic. The graph indicates that the majority of referrals came via a GP route and this concurs with expected patterns.

Figure 3

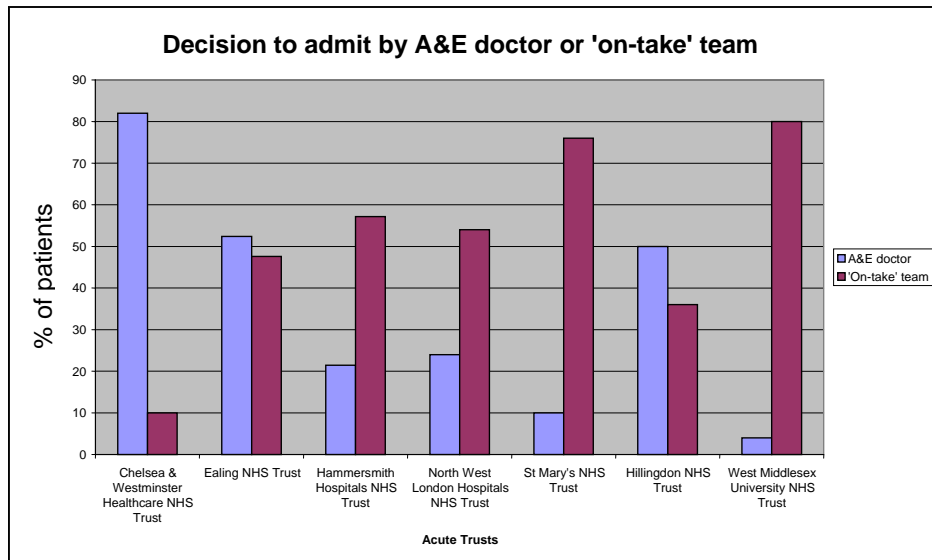
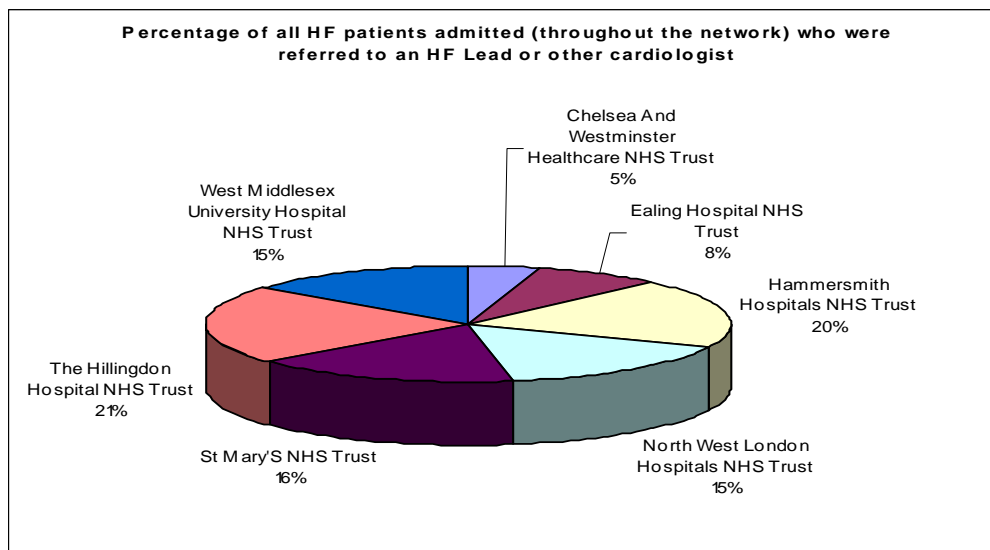


Figure 3 indicates the percentage of patients where the primary decision to admit was made by an A&E doctor (often a junior doctor) compared with the 'on-take' medical team. The graph indicates significant variation across Trust's reflecting the different care processes in place for managing emergency admissions. Unfortunately, there is insufficient data to assess and conclude how significant the choice of primary admitting doctor is upon subsequent investigation, diagnosis and management of heart failure patients.

Figure 4



For patients to receive optimum care, referral to a cardiologist or lead consultant for heart failure during their hospital admission is considered best practice. From the audit, however, figure 4 demonstrates very low percentages of patients being referred appropriately and illustrates a significant gap within internal Trust referral processes. In some Trusts, although patients may have seen a cardiologist at some point during their stay, their care and management does not appear to transfer across to the specialty. Without direct cardiology management, there is a significant risk that heart failure

patients will not be adequately investigated, managed or followed up post discharge resulting in a higher risk of future emergency readmission. As such, this is one area where all acute Trusts are recommended, as a matter of urgency, to internally investigate local processes and implement appropriate change to address this issue.

Figure 5

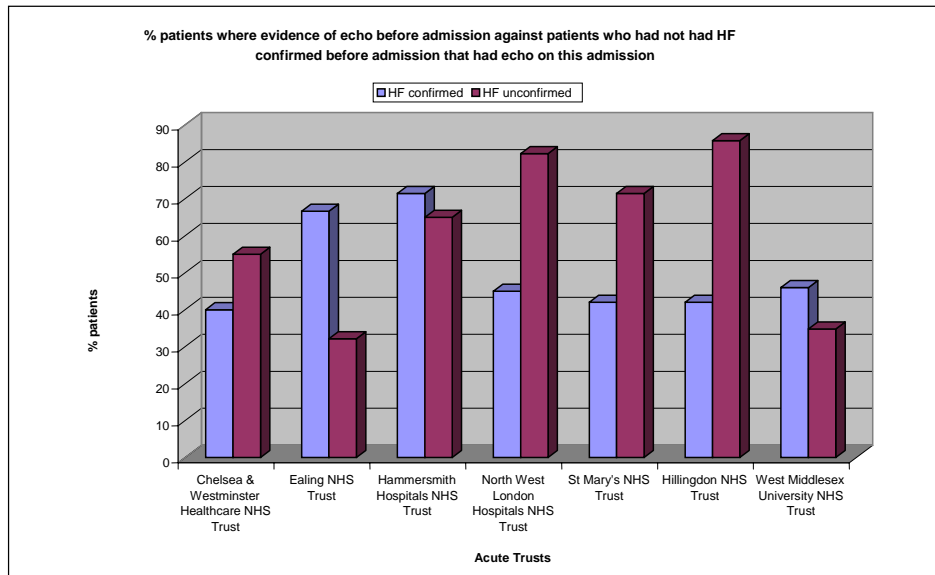


Figure 5 shows a comparison of heart failure admissions that a) had evidence e.g. echocardiography, in their casenotes confirming a diagnosis of heart failure prior to admission against those that b) did not have evidence in their casenotes confirming a heart failure diagnosis but who had an echo performed as part of their current admission.

Although there is variation across Trust's, the graph demonstrates that there are a high proportion of patients admitted without evidence of a confirmed heart failure diagnosis. This may suggest that either some patient's are not being adequately investigated and managed within primary care or that communication between the two interfaces is inadequate such that during an admission, secondary care does not have knowledge of a patient's prior management in primary care. However, across NW London, the majority of echocardiography is carried out in the acute sector and the latter explanation is therefore less likely.

Nevertheless, based upon the evidence displayed above, it would suggest that significant numbers of patients admitted require further investigation, in particular echocardiography, to confirm their diagnosis and this has an impact upon the demand for these services.

Echo

Figure 6

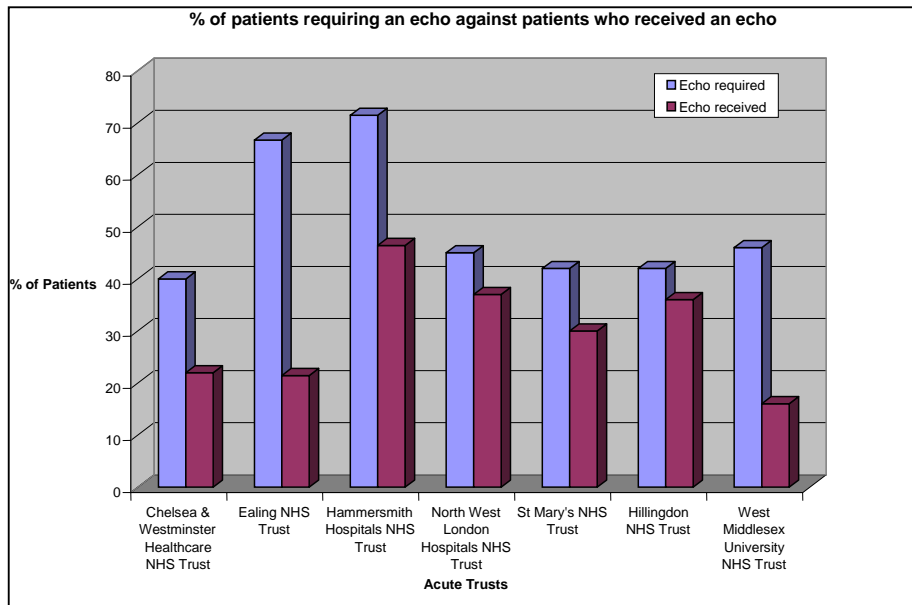
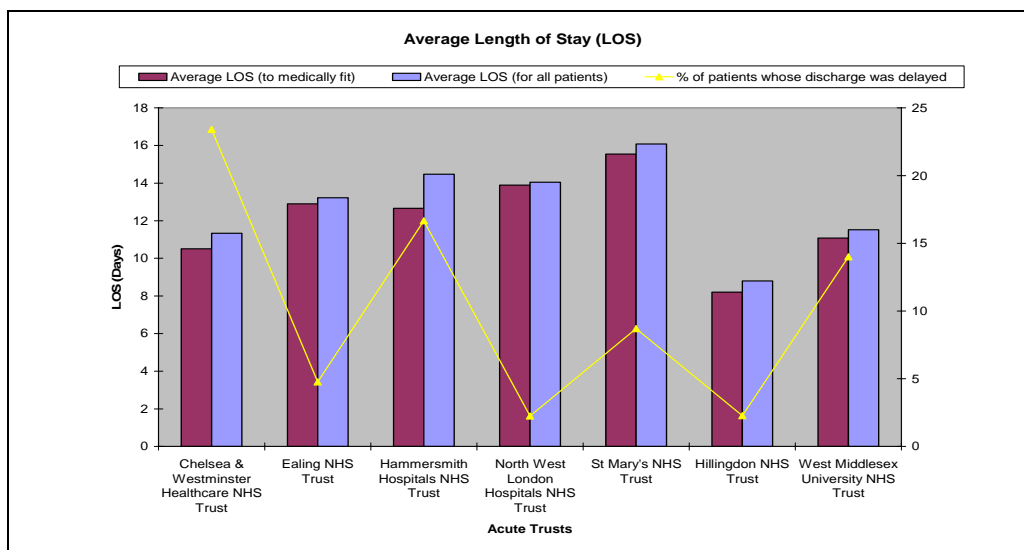


Figure 6 considers the number of echo's required against the number of echo's undertaken prior to discharge. It is of concern to note that there is significant variation across the Network with many patients appearing to be discharged home without echocardiography completed. Again, without more detailed information, it is difficult to draw definitive conclusions from this result. However, it is recommended that Trust's review their own individual data to satisfy themselves that processes are in place to ensure that tests are scheduled to be completed in a timely manner such that all patients receive a confirmed diagnosis via appropriate investigation, have the correct management plan commenced prior to discharge and receive correct information about their condition and treatment.

Length of Stay (LOS)

Figure 7



The first column in figure 7 (purple) considers the average LoS from admission to when the patient was deemed as being medically fit. Where the medically fit date was not documented, the average LoS was calculated using the admission and discharge dates. This column excludes any patients who died during hospital admission. The second column (blue) considers the total LoS for all patients including any who died during the admission. The yellow line provides an illustration of the percentage of patients with known delayed discharges, i.e. where their date of discharge varied from their date of medical fitness.

The graph clearly demonstrates that heart failure admissions have long lengths of stay, occupying a large proportion of bed days which will have significant resource implications. Nationally, heart failure admissions tend to have long lengths of stay. From the raw data, it was also noted that those admitted towards the end of the week often occupy beds for longer due to limited or no resources at the weekend.

Furthermore, across the Network there are a significant percentage of delayed discharges, again representing some considerable cost to the local health economy. Reasons for not discharging once the patient is deemed medically fit were varied and ranged from social, housing or carer issues.

Unfortunately, based on the available data and size of the sample available, it is difficult to speculate as to the reasons for the long hospitalisations. PCTs, however, are recommended to assess their local service provision for this patient group such that they are assured that there is adequate social and medical services available within their communities to manage patients appropriately and reduce unnecessary hospitalisations.

Discharge

Figure 8

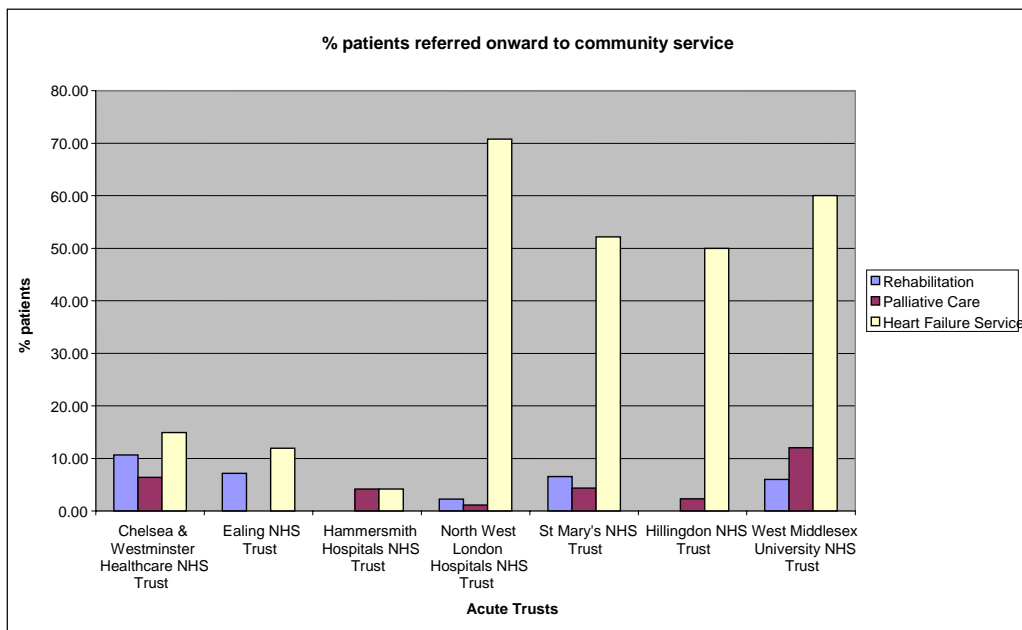


Figure 8 provides an overview of which services patients were referred to following discharge including rehabilitation, palliative care and hospital or community heart failure services (as opposed to being solely discharged to their GP).

The graph demonstrates significant variation across the network. In particular, access to both rehabilitation and palliative care services appears poor and commissioners are recommended to review access and provision of these services within their individual local health economies for this patient group.

Drug Therapy

Figure 9

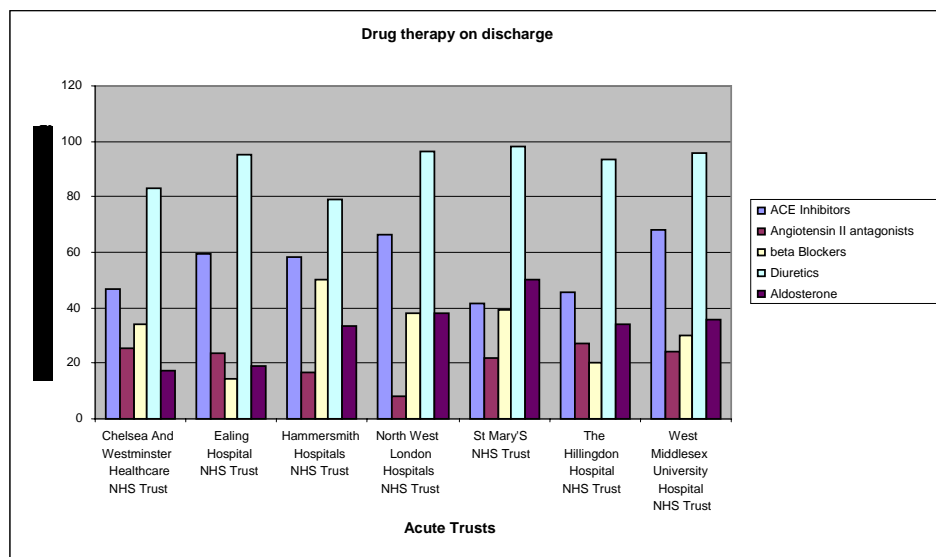
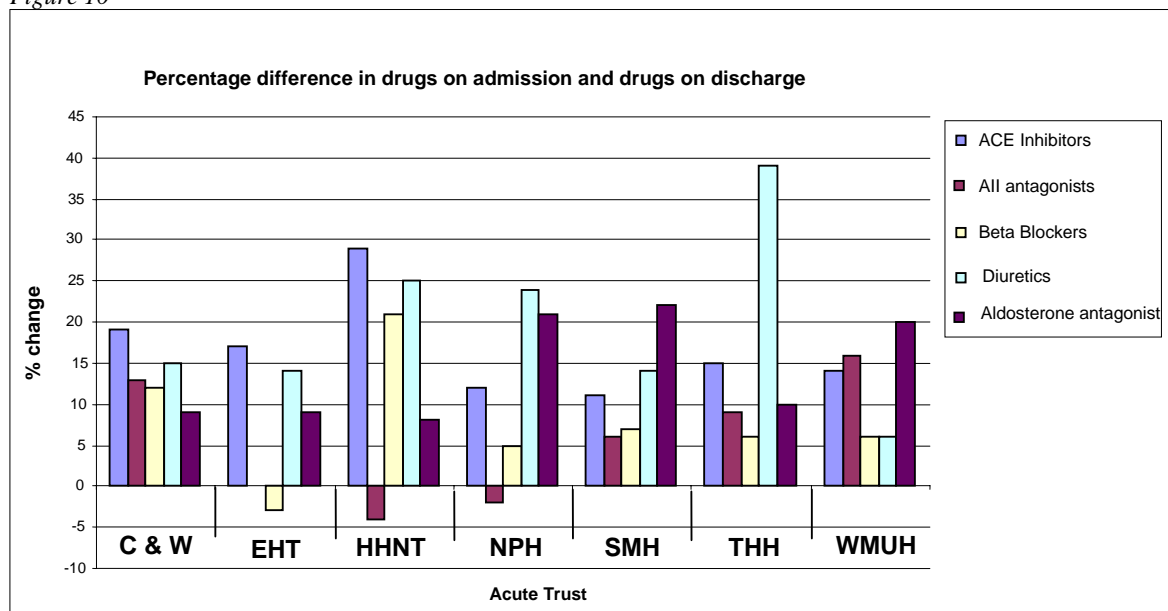


Figure 9 illustrates the percentage of the patients discharged on different types of drugs as a percentage of those discharged, with Figure 10 outlining the percentage change between drugs on admission and at time of discharge.

Considerable variation is evident which may imply that patients are not being adequately optimised prior to discharge. The data may also suggest that patients may not be being adequately optimised in the community prior to admission. Local health economies are encouraged to review their individual practices in light of these findings.

Figure 10



Summary & Recommendations

In summary, this report has provided a benchmarked snapshot of the key acute hospital portfolio indicators for each of the acute trust's across NW London, outlining what happens to patients who are admitted to hospital as an emergency with heart failure. It is clear that patients with suspected heart failure and patients, who have already been diagnosed with heart failure, follow a complex and demanding pathway. In light of the findings, the following recommendations are made:

1. The majority of emergency admissions occur via local A&E Departments with a high percentage being admitted via the A&E teams and not the medical 'on-take' teams. The data would suggest that there is no consistent process or pathway from A&E through to cardiology, indicating that patients often follow an erratic journey at a time when they are vulnerable and confused. Heart failure patients who are elderly, with co-morbidities or at the end of life would benefit from having a clear pathway, providing them with accessibility and equity. All acute Trust's are recommended to review their current A&E pathway's to ensure that all patients admitted with suspected or confirmed heart failure are appropriately triaged, referred and managed.
2. It is evident that few heart failure admissions are referred on to a heart failure lead or cardiologist during their stay and it is recommended that this aspect is addressed as a priority. The propensity in such circumstances is for patients to either a) become lost in the system if they cannot be identified onto a correct pathway or b) not to have their care optimised prior to discharge. Where limited community services are available, these patients become more difficult to identify at a later stage and may take longer to access an appropriate care management plan resulting in possible readmission to hospital. As outlined above, acute Trusts are therefore recommended to urgently review their internal pathway's to ensure that all such admissions are appropriately referred and seen by a Cardiologist/Heart Failure Lead during an inpatient admission.
3. The use of Echo varied considerably across the sector. There were a high proportion of patients being admitted without a previous history of having had an Echo and there were also a high proportion of patients being discharged prior to an Echo being undertaken. The demand upon Echo services appears considerable. PCTs are recommended to consider implementation of BNP testing in their local areas to reduce unnecessary requests for Echo. Acute Trust's are recommended to review their existing internal processes, making any necessary changes, to ensure that Echo's are carried out in a timely manner prior to patient discharge.
4. The report demonstrates that heart failure patients have a long length of stay and there is significant variability in delayed discharges across the network. Local health economies are therefore recommended to review the reasons for delayed discharges in more detail at a local level to address specific local issues. In addition, PCTs, are recommended to assess their community services to ensure that there is adequate social and medical service provision for this patient group within their communities to manage patients appropriately and reduce unnecessary periods of hospitalisation.

5. The provision of adequately resourced community services not only improves quality of life for this patient group but reduces unnecessary hospital admission. However, access and referral to community services appears inequitable. PCT commissioners are recommended to review the provision and access to community heart failure services, rehabilitation services and palliative care services within their local health economies.
6. Evidence collected on drug prescribing suggests that patients are not being adequately optimised on medication either within the community or prior to discharge. It is recommended that both primary and secondary care are encouraged to audit and review in more detail current prescribing practices to ensure that this patient group are on optimal medication to reduce the risk of hospital admission.

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March 2007

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