# Hospital Activity Review

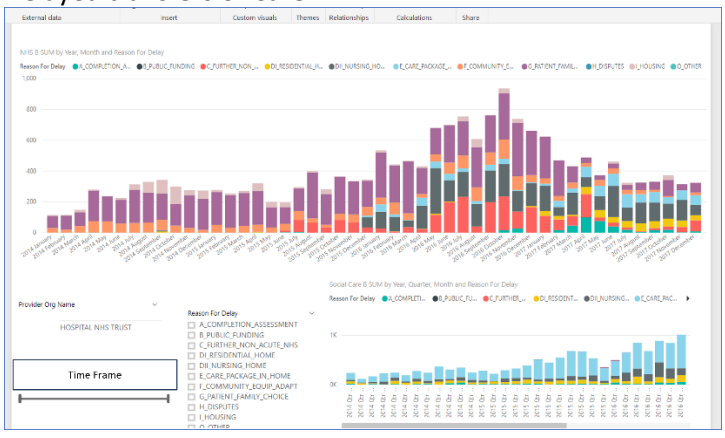
The SIA works with hospital clients and provides a review of services for a given health locality based on health intelligence modelling using both public domain and anonymous hospital data. This data is loaded into the SIA's hospital audit models and public domain health intelligence model for subsequent analysis and review. This review is undertaken by a small group of domain experts aiming to identify the primary issues and opportunities resulting from the analysis. It is believed that an audit review will provide interested stakeholders within a locality, with an essential understanding of the problems, issues and possible solutions associated with the main findings of the modelling exercise.

There are 3 standard Hospital Activity Audit Models developed by the SIA in association with various hospital clients and designed to accommodate hospital activity data for A&E, Inpatients and Outpatients plus complementary public data as deemed useful.
During the development phase we noted that there were a number of issues which together represent the driving force behind the many of the problems that hospitals face on a day-to-day basis and particularly when it comes the annual Winter Crisis.

**Bed blocking**

With an increasing population of elderly people, the problem of "bed blocking" or delayed transfer from hospital is getting worse. The term "bed blocking" is journalistic shorthand for the delayed transfer of a patient from hospital back home, or into some other care, such as a nursing home. The patient has received the treatment they needed from the hospital but cannot be discharged. There are several factors that contribute to bed blocking. They might include waiting for a place in a nursing home to come up, having special adaptations made at home or needing some kind of rehabilitation care.

Delayed transfers of Care



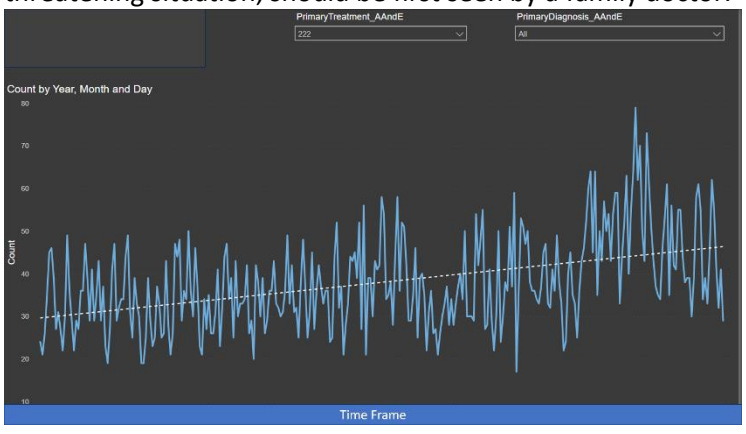

Delayed Transfer of Care has been of interest for more many years. If we look at these in association with the DTOC data provided by NHS England on a monthly basis, then it can be seen, that DTOC's have got steadily worse. We found that this is such a significant issue that the monthly DTOC position should be and are now commonly reported to the Hospital Board on a regular basis. This should ensure that hospitals make improvements and do not slip back after implementing them.

The next major issue identified by our models was that of managing A&E attendance. This area represents one of the main problems effecting performances and with the current NHS environment being such a challenge, it only continues to get worse.

It is generally understood that A&E is the one door into the NHS that does not place barriers in the way of patients. Turn up and be seen albeit when resources are available and now more often than not after the target wait of 4 hours.

Trend of A&E Waits 4+ Hours


As with DTOCs A&E is such a significant issue that a Monthly A&E position should be reported to the Board on a regular basis. Although this would not prevent slippage of performance, it would go some way to predicting future problems in advance.
One of the main areas of concern regarding A&E identified by our models was that the Primary treatment code, “Guidance Verbal” & “Consider Giving Guidance Verbal” represented a large proportion of admissions, and it was increasing year on year. Many of these were linked to those who have given up on getting an appointment with their GP or simply the worried well who need reassurance. In addition, we found that the under 40s are less likely to accept the trend of GP Practices to asking patients to see any available GP and/or telephone appointments rather than the preferred practice of seeing their GP. These all constitute avoidable emergency admissions where other community services would be more appropriate, and A&E seen as a last resort. In fact, the trend away from Narrative Medicine or the Family Doctor paradigm can be argued to have had a massive effect in increasing avoidable Emergency Admissions. Many senior and experienced Family Doctors would argue that ALL A&E attendees, if not suffering from a life-threatening situation, should be first seen by a family doctor.




Another major issue identified by our models was that of Frequent Attendees or patients that for one reason or another frequently turn up in A&E and then are often transferred to Inpatients. The models found that if we identify patients who have had 10 or more episodes during the year, frequent attendees, then the cost of this group was estimated to be extensive. We found that by designing and implementing admission avoidance programmes for these specific groups along the lines recommended by the College of Emergency Medicines’ Best Practice Guideline, such improvements could achieve reductions of around 30%.

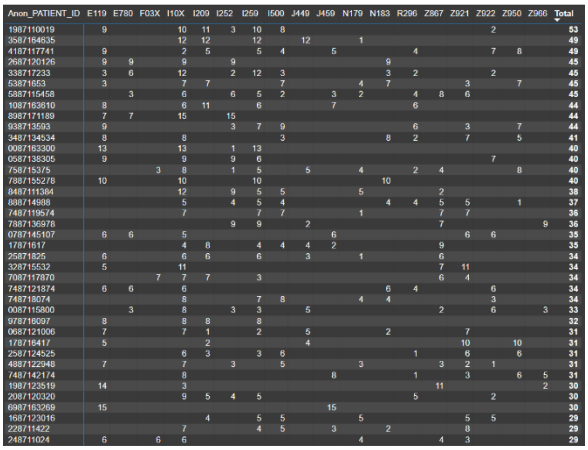
**The College of Emergency Medicine Best Practice Guideline**

SIA Strategic Intelligence Alliance in Healthcare

**Frequent attenders in the Emergency Department**

Summary of recommendations

1. Patients identified as ‘frequent attenders’ should be subject to senior decision maker review on each attendance to the Emergency Department
2. Patients who attend frequently should have a bespoke management plan to inform clinical management and enhance or standardise safe clinical care. This should be considered in all patients where such a plan will enhance clinical care (for example reducing unnecessary tests or provide clear analgesia strategy)
3. Patients identified as ‘very high frequency attenders’ (e.g., 30 or more attendances per year) should have a multidisciplinary meeting and case management, including social care and primary care, with a review of the bespoke management plan.
4. Patients who are both ‘frequent attenders’ and exhibit challenging behaviours should be managed according to current guidance (15). This involves establishing and addressing underlying causes, whilst ensuring safety of patients and staff
5. Patients should be involved all case management and in the production of care plans where possible.
6. Persistent and recalcitrant challenging behaviours should only be subject to civil orders in exceptional circumstances.
7. There should be a process of identifying ‘frequent attenders’ in all Emergency Departments, in order to enable implementation of the above. One commonly used method is to identify the current highest frequency attenders to a department.



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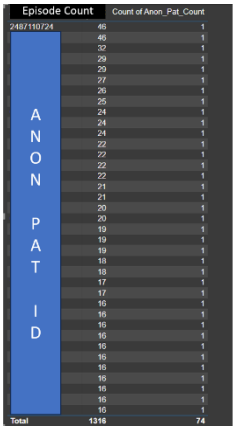
We also found that the Frail and Elderly, who in addition to being frequent attenders, were found to be patients who had 6 or more of the 22 comorbidities defined by senior clinicians working with us as analogues for Frail and Elderly, and therefore patients likely to require proactive management. This meant that patients who had this range of diagnoses codes were defined as frail and elderly with long-term conditions which defined them a high risk. It was felt that by actively managing both frequent attenders & those defined as frail and elderly using this method, significant reductions in hospital attendance could be achieved and more importantly, we could significantly improve the pathway of care for such patients leading to better outcomes.

Another issue identified was that of patients with comorbidities across the range of diagnoses. Understanding the total number of diagnosis codes ICD 10’s that apply to a patient is important to our understanding for both clinical and risk assessment purposes. Again, our models were used to identify such patients allowing the development of a special pathway of care when requiring treatment at hospital.



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