Five Essays on Emergency Pathways

A study of acute admissions to London hospitals

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D C Morrell, J Green, D Armstrong, J Bartholomew, F Gelder, C Jenkins, R Jankowski, S Mandalia, N Britten, A Shaw, R Savill

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Jenkins C, Bartholomew J, Gelder F, Morrell D C 'Arranging hospital admission for acutely ill patients'. British Journal of General Practice 1994; 44:251-254;

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CHAPTER 1

Introduction

In 1992 the King's Fund Commission on the Future of London's Acute Health Services published a report, *London Health Care 2010: Changing the future of services in the capital,* (King's Fund Commission, 1992). Using national and local statistics, the Commission reviewed the development of health care in London, current resources in primary and secondary care, and the uptake of secondary care services in the capital. It recommended changes in the provision of care, some of which were later embraced in the report of the Tomlinson Committee (Tomlinson, 1992).

London Health Care 2010 was not able to describe in any detail the actual delivery of acute medical care in London. This required a more in-depth study of care, based on the collection of data at the grassroots. Recognising this omission, the Commission asked the Departments of General Practice and Public Health Medicine at the United Medical and Dental Schools of Guy's and St Thomas's Hospital (UMDS) to undertake a series of studies that would describe the process of arranging acute medical admissions to hospital for London residents. In view of the impending report from the Tomlinson Committee on the provision of medical care in London, the Commission asked for these studies to be carried out and reported on within a period of 12 months. They took place between September 1991 and May 1992 and the report was presented in October 1992 to the King's Fund Commission. This publication describes the results of these studies.

The overall objective of the studies was to describe the problems of admitting acutely ill patients into the wards of London hospitals. The researchers envisaged that a proper understanding of this process would require data collection from a variety of sources. Firstly it was necessary to collect the views of the providers of care as represented by hospital managers, bed managers, senior nursing and senior medical staff. This was achieved by qualitative research involving a series of semi-structured interviews with these officials in a variety of London hospitals. The results are reported in Chapter 2 of this publication. The next logical step, reported in Chapter 3, was to describe in detail the experiences of general practitioners trying to admit acutely ill patients to hospital. This was carried out by studying the experiences of a sample of practitioners working in one Family Health Services Authority area over a period of seven weeks. The choice of the sample was determined by the fact that these doctors had previously worked with the Department of General Practice at UMDS in data collection and were thus familiar with such activities.

The third phase of the studies, Chapter 4, was concerned with the

passage of patients through the accident and emergency (A&E) departments of hospitals. A great deal of anecdotal evidence relating the work of A&E departments to the general practitioner services has been published, and some was indeed included in the Commission's original report on London health care. This study provided an opportunity to examine some of these anecdotes and involved meticulous data collection on all admissions by the use of fieldworkers working round the clock in A&E departments. The study was carried out in two London teaching hospitals and one hospital outside London. This sample of accident and emergency departments was necessary in order to validate statements made about A&E departments in inner London compared with those in the provinces.

The overall concern in the process of admission of acutely ill patients to hospital is the welfare of the patients. To study this aspect of the acute admission procedure, over eighty interviews were carried out with patients who were admitted as acute emergencies to two London hospitals. The interviews, which took place on the wards, were recorded and subsequently analysed. Chapter 5 describes these patients' perceptions of the whole process of admission.

A major problem concerned with acute admissions to hospital is the difficulty of discharging patients in order to free up the beds. The original Commission's report draws attention to the problems at the hospital/primary care interface in the process of arranging discharges from hospital. In order to look indirectly at this problem, a study was carried out of patients discharged from hospital who were referred to district nurses in the districts surrounding the two London hospitals in this study. The problems encountered by district nurses as a result of poorly planned discharges are described in Chapter 6.

The objective of these studies was not just to describe the problems associated with arranging the admission of acutely ill patients to hospital. It was hoped to identify ways of facilitating the whole admission process and improving the experience of general practitioners, hospital doctors, nurses and patients.

Since this research was undertaken, the document *Making London Better* (Department of Health, 1993) has been published by the government and recommends the closure of about 2,000 acute hospital beds in the capital. Unless substantial changes in the efficiency of the management of acute hospital beds and the provision of alternative facilities can be established, it seems likely that major problems will occur in the management of acutely ill patients in London as a result of these government recommendations. The papers presented in this publication seek not only to illustrate the current problems but also to propose a range of solutions.

Professor D C Morrell

CHAPTER 2

The views of service providers

JUDITH GREEN AND DAVID ARMSTRONG

Introduction

"Emergency admissions" are the patients who present with a problem that is seen to need immediate attention in a hospital bed. They may be "heralded" admissions, if a General Practitioner (GP) has warned the hospital about their imminent arrival, or "unheralded" if they have walked or been brought into the hospital's Accident and Emergency (A&E) department. Providing for such patients has been presented as a "problem" in two senses: as a "challenge" for hospital administrators or managers and, more recently, as a persisting and unsolved problem indicating more widespread deficiencies in health service provision, particularly in London.

Emergency admissions have long been characterised as a "challenge" or a potential problem for efficient hospital administration and have attracted considerable attention in management literature. The arrival of such patients, unlike those admitted on a date planned in advance, necessitates the existence of beds which may theoretically be empty. If too many beds are kept empty, the hospital is seen to be running at less than maximum efficiency. Keeping a balance between flexibility for admitting emergency patients and high bed occupancy has been an indicator of good hospital management since before the establishment of the National Health Service (NHS). "Unoccupied" beds were the subject of a King's Fund report in 1930, which cited the fluctuating demand for beds for "Fevers and Accidents" as a problem for the rational planning of bed allocation. "The hospital", the report noted, "has the daily problem of keeping its beds as fully occupied as possible, and at the same time keeping beds available for emergencies" (Hospital Economy Committee 1930:10).

Although the case-mix of emergency admissions may have changed in the intervening sixty years, the characterisation of the problem in much of the literature has persisted. Emergency admissions, by their nature, are unpredictable at the local or short-term level, and potentially disrupt the orderly allocation of beds to clinically prioritised cases from the waiting list.

In the literature on bed occupancy and admissions, such problems are largely seen as the domain of good management rather than resources. Despite some evidence to the contrary (van Doorslaer and van Vliet, 1989), there is a conventional view that demand will expand to fill available supply and that problems result from uneven demand or inefficient management rather than lack of supply. Solutions have, then, been sought in the efficient management of beds to achieve

increased throughput, by decreasing both length of stay and turnover intervals (the time a bed is unoccupied between patients).

Policy and administrative suggestions have covered the range of factors that could have an effect on turnover. There has been a continuing trend towards shorter inpatient stay (Department of Health and OPCS, 1989), and much debate about the extent to which variations are due to clinical need or poor management. Given that one study looking at differences in European admission rates found no fewer than 68 factors affecting length of stay, covering demographic, cultural, social and economic as well as medical variables, there is presumably considerable scope for initiative (European Public Health Committee, 1968). The use of emergency admission and observation wards as "buffers" (Dallos and Mouzas, 1981) to absorb some or all of the unplanned admissions, so reducing disruption to the rest of the hospital has received some attention (Maimaris and Kirby, 1991). The need to plan admission so that days are not wasted through waiting for consultant ward rounds or for diagnostic tests has long been recognised (Hospital Administrative Staff College, 1954) as has the need to avoid "blocked beds" at the other end of a hospital stay by ensuring good liaison with social and community services (Ashley *et al.,* 1981) or establishing pre-discharge wards (Yates, 1982).

More recently emergency admissions have emerged as a problem in the second sense, as indicating deficiencies in health service provision, and have attracted attention in both professional and public media (*Evening Standard,* 2nd Jan 1991, O'Sullivan, 1990), particularly in London (Beardshaw, 1991).

Much of the evidence for the existence of a problem has been anecdotal; from general practitioners (GPs), for example, facing problems in obtaining immediate admission for their patients. The research presented in this chapter provides some substantive evidence of GPs' problems while earlier systematic research demonstrates cause for concern. Evans (1984) assessed the Emergency Bed Service (EBS) in London, which acts as an "honest broker" between GPs and admitting hospitals, and concluded that the difficulties faced by GPs necessitated its continuation. Delays in Accident and Emergency departments, due to lack of available beds, resulting in distress and discomfort for patients and disruption to the smooth running of the rest of the department, have been described. Delays in admitting patients from waiting lists, partly attributable to pressure of emergency admissions, have caused public and professional concern (College of Health, 1990, Frankel 1989, Doran 1990), particularly in certain specialties (Frankel, 1989).

Despite the continuing interest in emergency admissions, the views of service providers have received little attention. This chapter describes a study which canvassed the views of hospital staff involved in the process of emergency admissions, to investigate their perceptions of the "problem". It was hoped that a more systematic study of these views would provide a useful perspective on the problem as characterised above, showing how hospital staff cope with the existence of the unpredictable in an organisation that is increasingly stressing rational management.

Method

General considerations

There is a considerable body of research on the views of patients about the health services they receive, but the views of providers of those services have been relatively neglected. Most commonly health care providers have been asked about their knowledge about a certain clinical problem (Hatton, 1990, Smithson, 1988), or their views on the problem (Josephs and Sims, 1986). More recent studies inviting health professionals to give their views on the quality of certain services have begun to address the question of what is to count as a problem in service provision (Bowling *et al.,* 1991).

Surveys of the views of health care providers have tended to treat variation in these views as part of a "normal" distribution, or as contributing to a common professional view. Fineman (1991), for instance, analysed the views of doctors, social workers and alcohol counsellors at a multi-service health care agency in terms of how they established the notion of non-compliance from unacceptable patient behaviour. The subject of the study was how the workers in the agency created and shared the category of "non-compliant patients", rather than an examination of any differences between the professional groups. Hughes (1989) similarly analysed the work of casualty clerks to see how they contributed to patient categorisation and the "casualty culture" through their discretion over and elaboration of bureaucratic rules: "integration into department life", noted Hughes, "depends on the cultivation of shared ways of seeing". Sociological research on health care providers has tended to focus on how professional ideology or culture is created or interacts with "lay" or patient behaviour. However, there is some evidence that disagreement between health professionals may of itself be significant in understanding the reported nature of health service problems (Grace and Armstrong, 1987). Cant and Calnan (1991), for example, report an exploratory study of 18 "alternative" practitioners that examined the strategies they used to develop occupational status and found considerable variation both between professional groups and between individual therapists about such issues as whether they saw themselves as complementary or supplementary to conventional medicine. Such an approach can usefully uncover the inter-professional differences that might impede the development of professional autonomy.

Quantitative surveys suffer from being unable to identify the detailed perceptions of the protagonists, and there would seem to be a case for unstructured or semi-structured interviews to explore these issues in more depth. Stevens and Gabbay (1989) reported finding this approach useful when they interviewed managers and clinicians for their views on the functions and funding of a gynaecology service, although the results of their study did not report on specific findings. More recently, Pope (1991) carried out an interview and observation study of waiting list clerks and found that while there was a general public and professional perception of the waiting list "problem", its reality in the clerk's office was very different.

Box 2.1

INTERVIEW TOPICS

1 **Whether the respondent thought that emergency admissions presented a problem for their hospital;**

2 **how such problems were managed;**

3 **how conflicts over bed availability were resolved;**

4 **to what extent consultants still control beds;**

5 **the technology used to track beds and patients in them;**

6 **how the system used was planned;**

7 **changes they had noticed over the last few years and their views on why the problem, if there was seen to be one, was particularly acute in London.**

The interviews

It was therefore decided to use semi-structured interviews to canvass views, backed up where possible with observation of staff at work. A "snowball" sample of hospital staff was recruited by asking respondents who else in their hospital had contact with emergency admissions and whether they could give us the name of anyone in other London hospitals who did their job. This produced a sample of hospitals covering all four Thames Regions. A pilot study used unstructured interviews with personal contacts to provide a list of salient topics. These contacts helped generate the sample and a list of topics to raise in semi-structured interviews. These topics are described in Box 2.1.

Interviews were recorded on audio tape where possible, and direct quotes taken from these tapes are included here. Notes from observations were written up at the time or immediately after the visit and quotes are near verbatim. Interviews were conducted between October 1991 and February 1992.

The sample

The hospitals included were not randomly sampled, but did provide a range of London hospitals with emergency admissions. Nine hospitals were included, covering all four Thames Regions. Six hospitals were central London teaching hospitals and three were non-teaching general hospitals in outer London. Eight have their own Accident and Emergency departments and the ninth takes emergency admissions through the A & E department in a linked hospital. The initial contact at each hospital was usually the person identified as responsible for bed management. After the interview respondents were asked to name anyone else who had a role in emergency admissions. Forty interviews were completed. As respondents were assured anonymity, neither their names nor the hospitals have been identified in this report. The main respondents came from the following staff groups: 8 A&E medical staff, 5 A&E nursing staff, 9 bed managers, 6 clinicians from other specialties, 6 nurses from other specialties and 6 other hospital managers.

Three of the bed managers were also "shadowed" for a shift, allowing observation of how the system worked in practice. In addition to the formal interviews, time was spent observing Bed Bureau and Admissions clerical staff at work in two hospitals. All of those approached agreed to be interviewed.

The problem: "living on a knife edge"

The existence of the problem

All except two of the staff interviewed said that emergency admissions presented or potentially presented a problem, but there was less consensus about whether that problem was being managed adequately or not. The two who did not consider emergency admissions to present a problem were both A&E nurses, who considered all their workload to consist of "problems". They did not perceive emergency admissions to be a more difficult part than any other, and had not experienced any

particular recent increase in difficulties.

When asked how emergency admissions presented as a problem, staff could not always separate difficulties resulting from emergency admissions from more general causes, such as limited resources or, in some cases, the move towards trust status. The following is a brief summary of the ways in which the current management of emergency admissions themselves was seen to affect adversely either the respondents or their patients.

Excessive waits in A&E for patients wanting beds

In some hospitals waits for beds once patients had been accepted for admission were seen as too long. Views of an acceptable wait varied, with some staff seeing anything over an hour as "unacceptable", and other hospitals reporting routine waits of several hours. Delays in finding beds for patients meant that they had to wait on trolleys in the A&E department, potentially exacerbating the condition of the patient (eg bed sores in the elderly) and causing distress, as A&E departments were busy, lacked privacy and were difficult environments in which to provide good patient care. One hospital had a policy of providing beds rather than trolleys for patients likely to remain in the A&E department for some time, although staff in other hospitals considered that this would provide an unwelcome precedent. As well as distressing patients and relatives, excessive waits for beds disrupted the other work of the A&E department, as cubicles and trolleys became blocked and nursing resources stretched.

The difficulties in negotiating beds for patients

Some respondents reported that the actual task of negotiating a bed, particularly for what were seen as "social admissions" was a stress in itself, and took up an unreasonable amount of nursing or clinical time.

The increasing number of "outliers"

Patients seen to be on the "wrong" ward (ie not one that the consultant they had been admitted under usually had patients on) could present a problem for nursing staff in terms of patient care and job satisfaction (for example sickle cell patients need regular pain relief, which may be difficult to provide on a ward not staffed to administer it). Clinicians also noted that they needed to do more ward rounds as a result, and some wards had so many different consultants' patients that there were not enough nurses to join every ward round. The need, later, to move patients again onto the "right" ward was seen as distressing to patients, particularly the elderly, and wasteful of hospital resources such as portering and linen.

Hospital workload was becoming more acute

There was disagreement about whether elective patients were waiting longer for admission: on the one hand this increased their risk of being admitted as acute emergencies, on the other hand their illnesses were likely to be more "acute" when they did eventually get their elective bed. Some respondents felt that these phenomena had inflated the number of acute admissions.

Waiting list patients being cancelled to accommodate emergency admissions

For many respondents the most important result of the difficulty in admitting emergency patients was the cancellation of routine work when beds were full with emergency patients.

Transfers

The pressure on beds meant that patients sometimes had to be transferred from casualty to distant hospitals, causing distress to patients, inconvenience to relatives and, according to one respondent, potential exacerbation of medical conditions. Convalescent patients were reported to have been transferred out in some cases to make room for incoming acute admissions.

High occupancy and turnover

The constant pressure of acute admissions presented particular problems for ward-based staff, who often had patients accepted for admission to "empty" beds before either the discharged patient had gone home or the body, in the case of a death, had been taken away. Apart from the increased work this high turnover caused (and the difficulty in getting porters to undertake relatively more moves), some nurses reported distress caused to themselves, and other patients, when bodies had to be removed more quickly than decency demanded.

The nature of the problem

The nature of the problem, as one respondent put it, was one of "living on a constant knife edge". Many respondents mentioned that they were expecting problems to intensify as winter drew on, given the usual rise in medical and orthopaedic admissions at that time of year. They also expressed concern that there was no longer enough slack in the system to cope with the expected increases. Given this, and the recent media coverage of acute admission problems as indicative of a crisis in the London health services, it was notable that few respondents saw resourcing to be the only, or even the major, solution to the problem. Many saw emergency admissions as being an inherent problem in organising hospital care, which could be ameliorated, but never eradicated. In short, although the word crisis suggests an acute and temporally limited problem, there was a view that emergency admissions constituted a constant "crisis". For example one respondent said:

> *... it's crisis management all the time and it, bed management, won't be anything else unless there is no casualty, no clinics, no emergency services and no domiciliary referrals from GPs ... and as long as you've got those issues, then bed management will always be in crisis management.*

The nature of emergency admissions was seen to be intrinsically problematic: they are randomly distributed and it is not possible with reduced bed numbers to allow for the unexpected. Despite this, some respondents from all staff groups felt that a small number of extra beds might provide an adequate safety net. However, they also implied that such beds would soon be filled as expectations for admission would

begin to change. Many saw more beds as only at best a partial solution.

Thus one doctor claimed that *the obvious solution is more beds* but then qualified this with *I think that demands sort of increase exponentially to fulfil supply*. Although this suggests that clinical criteria for admission would change with pressure on beds, no clinicians claimed that any patient of theirs who needed admission had been refused a bed. There was, though, a more general perception that criteria were informally changed by a diminishing bed stock. Thus one clinician said, *I think you manage, you do shift your clinical practice according to your bed numbers*.

In general, however, this (like the tendency to earlier discharge) was difficult to attribute unambiguously to bed shortages rather than to current clinical practice. As one consultant noted:

> *I mean when I first qualified we'd admit people for investigations, when they were perfectly capable of coming backwards and forwards ... we just don't do that now, ever.*

Other changes, such as the difficulty in admitting patients for "social" reasons, were more clearly linked by respondents, particularly in A&E, to beds. Two respondents thought that other clinicians tried to use worries about the bed stock for "political" reasons, either to avoid admitting unpopular patients, or to make a point about their allocation. As one bed manager claimed:

> *... he'd [a clinician] seen this burn, and it was quite a nasty burn of the leg, and he'd called me and said, "oh, X, you must come and see this. I mean I'm sending things home that lesser people would admit". And when I saw the state of this patient ... he was going to give her a dressing and send her home ... and we would have been in big trouble ... we never, never, never send patients away from here [if they need a bed].*

Some clinicians felt that rather than the problem being too few beds in the system, it was a matter of a "misallocation" of the existing bed stock between specialties, with too few medical and care of the elderly beds.

Respondents also talked – sometimes at length – about other problematic aspects of their work that were not directly within the remit of this study, but had a bearing on it. In A&E there was concern that on-call teams did not always have someone available to come down to assess patients in A&E, so delaying the decision to admit. There was an almost universal concern about the difficulties of discharging patients who needed some form of community care, particularly Part III accommodation. These problems were intensified in one area by a long-running strike of local social workers. Another hospital considered the problem had been considerably eased by the employment of staff responsible for discharge planning.

Relationships with local GPs were of concern to many hospital staff, with some hospitals providing direct lines for GPs to contact relevant registrars to arrange admissions for their patients in recognition of the difficulties GPs report in getting beds. In accounting for recent exacerbations of problems in admitting emergency patients, many respondents cited wider social factors, such as deprivation and an ageing local population, as well as resource factors within the NHS.

Balancing emergency and elective work

Many managers described their activity as balancing the need to maximise bed occupancy while providing enough beds for emergency admissions. In the words of one manager:

> *I have a triangle; I'm asked to live within a budget, reduce waiting lists to regional norm ... and finally I'm asked to keep my casualty department open 24 hours a day for emergency admissions and I don't think they're actually all possible at the same time.*

Although bed managers tended to see their role as one of "defending" emergency admissions, other managers accepted that sometimes the balance in practice would be in favour of high occupancy. A&E clinicians, not surprisingly, prioritised emergency work in their accounts of how the hospital should be run, claiming that emergencies should always take priority over elective admissions. Although no clinicians from other specialties complained directly about emergency admissions undermining their elective work when there were fewer beds, some did imply that the universal prioritisation of medical emergencies was based on a generous definition of what constituted an 'emergency'. Thus it was claimed:

> *The difficulty is not in surgery, it's in medicine where ... you know 80 per cent of admissions are emergency, that's very much in inverted commas, "emergencies": there are diabetics who are not so well controlled or there's a man whose angina is worse than it was.*

The balance was perceived, then, as one of maintaining an adequate supply of beds to cope with the emergency admissions from A&E and GPs whilst making sure the elective work was done (particularly if there were Waiting List Initiative funded beds) and beds were not left empty. The nature of emergency admissions meant that on a day-to-day basis it was impossible to plan on a generous enough scale to cope with the busiest of periods, and there was a sense of constant impending crisis in juggling these conflicting demands.

Coping with the problem

If there was a perception of constant challenge, there was also a perception of constant coping. Not surprisingly, given that providing adequate patient care is a sign of professional competence, no manager or clinician claimed not to be coping with the situation: this was an important finding as the study was concerned with their perceptions rather than any "objective" standards of "managing". However, this coping was seen to be "at a cost". As one manager put it:

> *The cost is not always to us, the cost is to waiting list patients (as they get cancelled by the dozen), the cost is to patients being nursed in inappropriate locations – it might be very heroic for X Hospital to put a 25-year-old coronary thrombosis into an orthopaedic bed, but if you happen to be the patient are you getting the best care?*

Worries about the pressure on beds were expressed as a concern that the system, although currently coping, was not elastic enough to cope

with any rise in demand such as might occur in winter. Moreover, the Patient's Charter, possible Trust status, the introduction of contracts and waiting list initiatives were all instanced as problem factors in coping with the current bed situation.

It was felt that there were disasters "waiting to happen". One A&E clinician expressed concern about the need for transfers of patients to other hospitals when there were no beds left, describing the situation as *very unsafe and sooner or later there will be a tragedy, there will be a disaster.* Another believed that, although patients needing admission were never refused, pressure to discharge as early as possible meant that *we're very much on the borderline, I think, of running a safe service – we're very much on the edge.*

Summary

Given the nature of emergency work, it was perceived that acute admissions would always present a challenge to hospital managers. Whether this challenge constituted a "problem" in the sense that managing it caused disadvantages for patients, was more contentious. Although there were few reports of clinical care being adversely affected by the problems of arranging acute admissions, it was felt that there was potential for such damage. Indirectly, there certainly seemed to be "knock-on" effects for patients waiting for elective admission.

Perceived reasons for the "problem" of acute admissions were less clear. It was felt that recent increases in pressure in some hospitals resulted from the need to protect more beds for elective work, which had shifted the existing balance between acute and planned admissions. But the views on resources were the most salient. The role of extra resources in alleviating problems was mentioned by most respondents, but usually qualified by a recognition that more beds would probably result in more admissions or longer stays. Given the conventional wisdom that problems of acute emergency admissions can be laid at the door of resource constraints, it was somewhat surprising to find that no respondent accepted that more resources/beds was a solution in itself, especially as this position would seem to fly in the face of their self-interest as well. This may reflect a professional pride in coping with limited resources. Nevertheless, it does suggest that health care providers have endorsed an argument – that more resources is not the key to a solution – which represents a major shift from the traditional health provider role of making claims on the public purse on behalf of their patients.

The structural context of the problem – moving from ward to hospital to consortium

Many respondents described a hospital world that existed in the distant past, before there were bed managers or indeed any need for formal management of beds. In this world, it was not the hospital that was organised so much as the individual ward, under the control of a single consultant and their firm, and a nursing sister, who between them controlled access to the beds and case mix.

Consultants then were felt to have "owned" their beds, but this has become less and less the case. Respondents described bed management as arising from a crisis in this old order, when control by consultants broke down and staff were spending increasing amounts of time searching for beds and arguing about their relative "rights" to admit patients to them. As one bed manager put it:

> *the work that was supposed to be going on wasn't going on because consultants, nurses, administrators, managers were spending every working day of their lives arguing for beds ... and at the end of the day people weren't getting treated.*

Previously, finding beds for patients had been an administrative function, carried out under the direction of consultants. In the new order, beds are a resource to manage centrally. Ownership has passed from the individual clinician to the organisation itself, personified by the bed manager. One A&E doctor described the omniscient bed manager thus:

> *They [bed managers] literally know every acute patient ... And they've got their finger on the pulse so they know exactly what's going on. They know exactly when a bed is coming up, they know exactly when someone's died and when someone's getting more urgent on a waiting list ... they're thinking ahead for the whole week ...*

Various causes were proposed to account for this disintegration of consultant control. One was the increasing number of consultants – particularly in London teaching hospitals. From "owning" perhaps most of the beds on one ward they have far fewer allocated beds.

If the process is described in three phases: disintegration of the old order into crisis followed by a rationalisation, epitomised by bed management, then elements of all three phases were apparent, often in the same hospital. Where some consultants had lost the right to beds on certain wards, they were perceived by colleagues to be resistant to other consultants maintaining such control. Bed management, as a strategy for hospital organisation, is differentiated from earlier forms largely by the global nature of its power, as compared to consultants who are, or were, only interested in their part of the organisation.

The disintegration of the specialty structure

The loss of consultant control was reflected by a disintegration of specialties to some extent. Most hospitals reported that "outliers", that is patients on the "wrong" ward, as described previously, were a persistent problem. There was also a sense in which the criteria for appropriateness to a ward were becoming looser. One A&E doctor described the situation:

> *their sanitary facilities and so on means that it's very difficult to mix the sexes ... we're beginning to do that and to hell with the sanitary arrangements;*

or, as one bed manager said:

you're not always putting them on the right wards ... you're not necessarily putting a medical patient on a medical ward, or a neurology patient on a neurology ward. You're putting them, if they come through A&E, where there is a space.

Some managers talked overtly about trying to bring about this loosening of ownership. One said

it's a whole culture [to] change – and that's very difficult?

Spreading the risk

The hospital emerged at the end of the eighteenth century as the dominant arena of patient care (Ackerknecht, 1967), in which increasingly specialised wards emerged to reflect the increasing specialisation of medical knowledge. The hospital bed was seen as the archetypal locus of both serious illness and medical education (Atkinson, 1981).

There are, though, signs that the hegemony of the hospital, arranged around the patient in a bed, is weakening. The views of the respondents in this study can be seen, in this context, as perceptions of a very real, but long-standing problem, being given a new salience by emergent management structures and a background of the declining importance of the hospital itself.

Increasingly, the hospital is being challenged as the undisputed centre of medical education. The community has recently been seen as a legitimate place to learn undergraduate general medicine as well as general practice (Jewell, 1991, Oswald, 1991) and indeed as a preferable place to acquire less compartmentalised medical knowledge (Oswald, 1989). At least one London medical school is now providing a medical firm based in general practice (Tucker, 1991). This shift is relatively recent, but studies of community-based teaching have already suggested that this new location might enable different kinds of medical knowledge to be produced (Sankar, 1988).

In a practical sense the challenge to the hospital is seen in its declining role as the proper place to be ill. The amount of time the patient spends in the hospital has decreased dramatically. The average length of stay for patients in acute specialties fell from 9.4 days in 1979 to 6.4 in 1989 (Department of Health, 1991a). The number of patients treated as day cases increased from 398,000 in 1972 (when the number was first recorded) to 1,163,000 by 1989/90 (Department of Health, 1991a). Day-case surgery is seen as the ultimate goal for an increasing number of conditions and procedures, and was presented as a preferable option for care by many of our respondents. This not only reduces the overall time the patient spends in the bed, but also increases opportunities for new management techniques. The discharge timing of day-case patients has been, in most cases, predetermined by their very designation: as a "day-case" it is expected that they will leave the ward before the evening, not when the clinician's ward round happens. In this sense day cases can be contrasted with emergency admissions as opposite ends of a continuum of "manageability". Day cases are regular and scheduled: the volume and case mix can be organised in advance by managers, and adjusted to fulfil supra-regional contracts or other

local considerations. Day cases are the ideal patients of the new order: predictable, routine and capable of being dovetailed with service providers' contractual needs.

Emergency admissions form, by contrast, a demand-led work load. The volume and case-mix are unpredictable at the local management level, and it was felt to be impossible to provide spare capacity to cope with the extreme numbers that may come in. Emergency admissions thus present a problem for the rational organisation of the hospital, and many of the techniques of bed management aim at bringing the apparently random fluctuations in acute admissions numbers into a planned system. Buffers provide one method for doing this, particularly an Admission Ward, which can act as a "holding station", allowing emergency admissions to enter the main hospital wards at a planned rate. Other, less formal, buffers can perform the same function; such as particular wards or units which can legitimately have empty beds some of the time (such as private patient wings, or units with special functions) and be used to take up the excess when high numbers of emergencies threaten the ability of the hospital to cope.

A second method is the attempt to rationalise the individual admission decision, and is evidenced by the growing literature on admission protocols, originating in the USA, but attracting growing interest in Britain (Siu *et al.*, 1986, Anderson *et al.*, 1988). None of the respondents in this survey claimed to have developed such protocols, and decisions about criteria for admission were local and negotiated.

The third possible approach is aggregation: using the rules of scale to ensure that the numbers of admissions are large enough to be predictable. A single ward might expect two emergency admissions, but the actual number might be anything from zero to seven; a large hospital with five admitting wards might accordingly expect ten emergencies, but relatively the "confidence intervals" for the actual number would be considerably smaller than for the single ward. In similar fashion, if the admitting "unit" were to be a consortium of several hospitals then the unpredictability of patient numbers would be similarly reduced. In other words, the managerial and resource allocation problems of coping with potentially large variations in admissions can be minimised by increasing the size of the admitting unit. This phenomenon no doubt accounts for some of the move from ward-based to hospital-based emergency admissions, and from hospital-based towards inter-hospital cooperation, though there was some resistance to the latter strategy.

In one of the larger hospitals, one manager claimed that no other hospital could cover them, because of their size, so they consequently never offered cover to other hospitals, other than for paediatrics. This isolationist policy was described as "we will consume our own smoke". Most hospitals did not have the bed numbers to allow for this, and so had to use other methods of increasing the safety net. This can be achieved by reducing the number of ports of entry so that perhaps only one hospital in an area has an accident and emergency department, or having hospitals on a rota to accept admissions. Although none of the hospitals in our sample ever closed their A&E departments, and they

were all vehemently opposed to such a practice, some claimed that other hospitals had done this when the pressure got too much. At a local level, attempts at aggregation were evidenced by the London hospitals who "went out for cover" for particular specialties at times when bed numbers were short. Although some managers considered this to be a waste of time (as all hospitals were likely to be short of the same kinds of beds at the same time), almost all did rely on other hospitals to cover for at least some specialties some of the time, particularly for paediatrics.

One clinician claimed *When I was a lad, you just put up extra beds in the middle of the ward.* The ward itself coped with unexpected peaks in admissions by simply increasing the number of beds temporarily. Perceptions of bed availability have shifted from this ward level to a global view of beds as a hospital resource, with buffers such as Emergency Admission Wards, and traditionally under-utilised bed stock (such as private patient wings) providing temporary capacity at times of pressure. It is suggested that to cope with emergencies now, with further pressure on beds resulting from the need to cut waiting lists, the hospital may not always have enough flexibility. There are limits to how feasible or desirable it is to treat beds "flexibly", given the particular clinical or nursing needs of particular categories of patient. It may be necessary to move towards a more formal use of the hospital "consortia" that are emerging from the current practice of "going out" for cover at times of pressure, with an increased role for the London Emergency Bed Service.

Bed management as a solution to bed shortages

What is a bed?

As a key resource in the allocation of hospital treatment to patients, it is worth examining how beds were conceptualised by respondents. They were classified along a number of variables: they could be identified by the consultant's name, by specialty, by social characteristics (eg paediatric cot, male bed) or by particular services provided by the hospital – such as private patients' beds or research beds. In terms of accessibility beds could be available, empty, or occupied. The first two categories were not synonymous, as a bed could be empty but "booked", for instance to a patient coming in from the waiting list or returning from the intensive care department, or a bed could be declared as available (ie the patient in it had died or was discharged) but not yet be available, as this ward nurse explains:

> *You see, the bed manager might just say "there's a bed". He doesn't say "but there's a bed that, you know, a patient has just died. So check with the ward, the body might still be there". So he just says "there is bed on, in such a place", you know, and they think, "well there's a bed". As far as they're concerned "there is a bed" means "there is a bed empty, made-up, ready for a patient".*

Another dimension sometimes affected accessibility: the amount of protection afforded a bed. Some hospitals had "ring-fenced" beds

which were available only to waiting list patients and never to emergencies, sometimes with protected Waiting List Initiative funding. Others had such beds that were prioritised for waiting list patients but could be used for emergency admissions in a crisis. For example, as one respondent reported:

> *We have degrees of use. For instance ENT beds would be the last used because we have a waiting list initiative – they are favoured rather than protected.*

Beds were also classified by the likely length of stay of the patient: from day care beds, through Accident and Emergency observation ward and Admission Ward short-stay beds, acute unit beds to long-stay continuing care beds. Finally, the physical beds themselves were classified: from trolleys in the A&E department, to divans put up in day rooms for pre-discharge patients to conventional King's Fund beds in increasing order of desirability.

At times of crisis these rules classifying which beds are allocated to patients can all be broken, even if there are – sometimes strenuous – efforts to place patients in the "right" bed most of the time.

Negotiating access to the bed

Bed managers differed in how overt the power they had over bed occupancy was and was seen to be, depending on the extent to which beds were still identified as "belonging" to particular consultants and on their personal and professional qualities. Power could be exercised at various points during the patient's passage through the hospital, most noticeably over the decision to admit, the decision about which bed to admit to and the decision to discharge, thus leaving the bed available for another patient.

At one hospital, which was seen by many respondents to be in a "crisis" phase, the bed manager talked about authority in terms of "a good relationship" and "not wanting to be a dragon":

> *It's important that they do trust me and we do have this good relationship ... I try not to give them something that they won't be able to cope with ...*

Here there was an emphasis on negotiation and maintaining the good relationship. However, at other hospitals, where the beds were seen as a hospital resource rather than as belonging to wards or consultants, the bed managers clearly saw their role as one of undisputed authority, despite also routinely mentioning the importance of a "good relationship". For example, in the words of one bed manager:

> *At the end of the day I can insist they take a patient, you know, over moans and groans and whatever. It doesn't matter – if I insist they will take the patient.*

Another bed manager claimed such authority was essential if bed management was going to work:

> *... you need to have a senior position in the hospital because you need the authority ... You need to have a very firm admissions policy which has been agreed at the operational board level ... which is policed.*

Bed managers, and other hospital managers, frequently talked overtly about "bringing clinicians into line" and about the techniques they used to extend their control over the beds or to loosen the consultant's control. These included circulating admission strategies, speaking to new medical and

nursing staff early on in their career at the hospital and bringing consultants into the apparatus of bed management. The control of information was seen as a key to rational management, and bed managers talked about the power of rational argument backed up by information as an effective method of persuasion. Thus one respondent claimed:

> *... those clinicians that are on it [group for monitoring beds] can see what the problem is now, they can see who it is who's leaving their patients in A&E [ward] for four, eight whatever days, they can see where the outliers are ... the facts are there, and it shows what's happening.*

Resistance to bed management

Although, perhaps surprisingly, there was little open opposition from clinicians to the role of the bed manager or the diminishing control they had over beds, some resistance was evident. Often couched in terms of the particular needs of the specialty or the patients, this can be seen as opposition to the encroachment of "management" over beds. One nurse describes reluctance to accept outliers on the ward:

> *They think we're being stroppy and just don't want to give up the bed or to use the bed or something like that, but we're trying to avoid all this moving around for the patient.*

Some object to having to justify what is seen as a purely clinical decision that someone needs a bed. It was felt that there was still an element of consultant control that evaded the bed manager in the hospitals where bed managers had not achieved full authority, evidenced by the fact that it was easier to find beds at night, when night staff, who were not part of this day-time system of control, were on duty. One nurse gave an example where on a recent late shift he had been told there were no beds, yet an hour later, after the night staff had started, thirteen patients from A&E had been placed.

Others described "cheating" and "bed games" being played. A manager described one of the "hundred and one ways of cheating":

> *Don't let the discharges go home. Get the cold admissions up by getting your junior house officer to phone patients out of hours, and then get the ... patient in the bed and the patient wanting to go in the bed and then quickly swap them round so the bed manager doesn't get a chance to grab the bed.*

Even clinicians described such tactics as "games". In the words of one A&E doctor:

> *You know what I mean by "games"? We only discharge on the day of our take, otherwise if we discharge the day before somebody else fills them with their smelly patients;*

and although, not surprisingly, none admitted to using such tactics themselves, the fact they were referred to as "playing games" or "cheating" indicates a basic acceptance of bed management in principle.

Summary

The power of the bed manager, to be effective, has to be constantly reproduced through the technology of the bed state and bed monitoring.

Many respondents commented on the increased efficiency evident in having information about bed availability and need channelled through one person or office, rather than having the inaccurate accounts that were seen to exist previously. Bed states were remembered as, in the pre-bed management days, unreliable and subject to the biases of individual consultants or ward sisters. The power of clinicians resided in the gaps between what was available and was declared; beds left empty for chosen waiting list patients, or protected from encroachment from other specialties.

In the "new order", although elements of this former power were still reported, accuracy was a primary goal. Managers saw accurate information on bed occupancy and use as a key to the acquiescence of clinicians: no one can argue with hard data. Such data also provided a means of surveillance. A "good" consultant was defined on the one hand as one who discharges promptly to clear the bed and doesn't feel possessive of "their" beds, but on the other hand as one who doesn't admit too often to other people's beds and doesn't try to admit too many waiting list patients. The "good" nurse is one who promptly declares empty beds on their ward, and provides accurate data about expected empty beds later in the day. Such standards can be monitored through the technology of bed states, with ranking of clinicians along criteria such as their average length of stay, the number of cancellations they have incurred by attempting to book too many patients, and the number of outliers they have on other wards. In some cases "hiding" beds, or providing inaccurate information on bed availability, was made into a disciplinary offence for nurses, although peer pressure was the most common form of control of consultants. Production of set standards allows the setting of normative values of use and misuse. One manager claimed that if consultants were given control over their own beds it would be disastrous because of the misuse that would occur.

It would be expected that there would be a considerable amount of resistance to this shift in power in the hospital, and the changing nature of the hospital itself. As some of the respondents pointed out, though, the number of consultants has risen while the number of beds has decreased. In England in 1971, there were 9,490 consultants and 425,982 beds (Department of Health and Social Security, 1973): crudely giving an average of 45 beds each. By 1989, there were 14,847 consultants and 270,334 beds: an average of 18 beds each (Department of Health, 1991a). In the London teaching hospitals this reduction in the average number of beds per consultant is particularly stark, as many consultants hold joint teaching and clinical appointments, so there are consequently more of them. At one hospital, a manager claimed that there were more consultants than there were beds. In short, by 1989, clinicians had less to defend.

With fewer beds, and patient stays so short that they may not be seen on a twice weekly ward round, consultants are less central to the whole process of admitting and discharging patients. The ward round itself, a potent symbol of both the consultant's power and the centrality of the passive patient in hospital medicine, may be declining. One ward nursing manager reported never providing a nurse any more for ward

rounds, because there were not enough nurses to cover them all. Certainly the pressure on beds means discharge decisions cannot wait for a ward round. The ward sister, with many consultants admitting patients to their ward, no longer has any incentive, or ability, to protect beds for a consultant. Their loyalty too is to the hospital as a corporate body rather than to the consultant firm.

Hospital clinicians, although traditionally seen as part of the problem and resistant to management initiatives, are now comfortably seen as involved in hospital management, as being part of the hospital rather than defenders of their specialty. In one report on the organisation of acute admissions, for instance, Baderman *et al.,* (1973) noted that control over actual beds was a sign of the consultant's status in the hospital as well as their clinical autonomy over the patient, and that such control could act as a constraint over the efficient allocation of beds.

More recently, though, hospital doctors have been appealed to directly as managers themselves. Yates (1982), for instance, urges clinicians to form alliances with managers on "neutral territory" (he mentions the changing rooms and the bar) in order to put forward their own rational solutions: establishing 5-day wards, admission wards and pre-discharge wards. The problem is medically framed as one of "diagnosis and management", with diagnosis based on reliable collation of local statistics on turnover and occupancy and management reliant on establishing agreed criteria of admission and appropriate length of stay. There is an acceptance that clinicians will have a role in such management issues as planning of bed numbers and will need to negotiate with managers on the basis of shared information (St George, 1988).

It would also be a mistake to see the medical profession as a monolithic institution, in terms of their reaction to bed management or to the reductions in bed numbers. Even in this small sample there were examples of conflict between specialties, and indeed many bed managers saw their role as essentially one of "honest broker" between competing demands from different specialties. Most noticeable was the conflict between A&E clinicians, where consultant status is relatively recent, and other hospital specialties. One A&E consultant claimed that the A&E department could be run much more efficiently if they had admitting rights, but when this was proposed other clinicians claimed he was trying to "usurp their rights to admit their own patients".

In the new hospital order, the medical task itself is being dissipated. Clinicians are drawn into corporate management, and managers are increasingly claiming authority to perform tasks that were traditionally the prerogative of the clinician: delaying admission, transferring patients, suggesting discharge.

Conclusion

This chapter has examined the views of acute sector service providers on emergency admissions. Forty respondents from nine London hospitals were interviewed. They were not randomly sampled and the

aim was to explore the issues rather than provide an exhaustive or necessarily representative account of the views of London hospital staff.

All but two of those interviewed considered that emergency admissions presented them with problems in providing high standards of patient care. However, although they felt in general that the pressure on beds constituted a constant threatened "crisis", few examples could be cited of patient care being compromised by this situation. Given that professional competence is defined to a large extent by the ability to provide care, even in difficult circumstances, this was hardly surprising.

It was felt, though, by the majority of respondents that pressure on beds caused stress – though this could be relieved. There was considerable uncertainty about how this could be achieved, with many respondents (from management, clinical and nursing groups) considering that the bed stock had fallen below an adequate level, causing unmanageably high occupancy rates but also, curiously, claiming that simply providing more beds would not in itself solve the problem. In the views of the various health care providers interviewed, the problem of acute emergency admissions could not be reduced only to one of resources.

One of the principal features of acute emergency admissions, repeatedly stressed by the respondents, was their unpredictability. Emergency admissions have always presented this problem but it has become increasingly salient as the number of beds in the acute sector has declined. The novel solution was a formal strategy of bed management. In part this represented a consolidation of general management as contrasted with traditional hospital administration: perhaps emergency admissions demonstrate a classic need for "management" of an ongoing problem rather than merely the administration of routine procedures.

Taken in the context of decline in the provision of beds, particularly in London, bed management also appears to herald a new, more global approach to the hospital, with a shift in focus from the ward and its limited number of consultants to the whole organisation, integrated through management policies and protocols and a federal "care group" or "directorate" structure. With a decreasing stock of beds, it appears that even the hospital as a whole will not provide a large enough pool, and it will be necessary to formalise arrangements for bed borrowing between hospitals.

On the whole, bed management as a partial solution to the problem of acute emergency admissions was welcomed as in the interests of the whole hospital, even though this potentially threatened some established interest groups, especially clinicians. Further extension of this strategy might be expected, particularly in terms of hospital units collaborating in providing cover for each other. And although no respondents suggested admission protocols – in which patients must meet certain predetermined criteria of needing a hospital bed – it is possible that these might also find their way into the management repertoire for reducing uncertainty and maximising the efficiency of bed usage.

Overall, in terms of their bed resources and systems of control

based on the doctor's clinical autonomy, the hospital has undergone major changes in the last decade or so. The signs are that in many ways hospital medicine may be losing the dominance it has enjoyed over the provision of medical care. Nevertheless, in coping with the challenges of acute emergency admissions, the respondents in this study revealed that the hospital has been, and is, willing to adapt itself in response to external events.

Recommendations

Given the nature of this study, which has not attempted any formal review of bed management procedures or any objective assessment of the management of acute admissions, the following are offered only as suggestions based on views of respondents interviewed, rather than recommendations for practice. A recent Audit Commission report (1992) examined the use of medical beds in acute hospitals and does make recommendations for the efficient organisation of emergency admissions.

London consortia

The overall number of beds which need to be provided to cope with unpredictable acute admissions declines with the size of the admitting unit. For example, the mean number of expected emergency admissions in an area of London in one year might be 36,500 patients; in any 24-hour period this would suggest that 100 patients will need beds. However, this latter figure is a "sample" drawn from the year total and will have confidence intervals associated with it. Thus, for a mean expected figure of 100 patients, there might be a 95-per-cent chance that the actual figure will be between 95 and 105 in any 24-hour period. In other words, for this level of "safety" there would have to be 105 beds provided to cope with all but one in twenty situations.

An individual hospital might expect some 20 of these overall expected 100 patients to be referred to it: but this "sample" would carry relatively high confidence intervals of, say, 10 to 30 to contain 95 per cent of likely admissions. For an individual ward the mean might be only 5 patients but with confidence intervals of between 0 and over 20. Thus, whereas an area of London would need to provide 105 beds, if care were provided by entirely separate hospitals, there would have to be 150 beds available in total, and if by individual wards, some 400 or so. In other words, the overall resources needed to cope with the unpredictability of acute emergency admissions decreases significantly the larger the admitting unit. Greater collaboration between neighbouring hospitals would therefore maximise the use of scarce resources. In part the Emergency Bed Service already carries out some of this role and there may be justification for extending its remit and authority.

Bed managers

The bed managers who appeared to have most success in limiting the stress surrounding acute admissions were those that enjoyed a measure

of authority within the hospital. This derived from a combination of a senior level appointment within the management hierarchy, nursing or clinical background and personal qualities. Some managers had the benefit of respect from colleagues who had worked with them in previous posts in the hospital. The bed manager should be the only person who arranges beds, or it is impossible to avoid chaos, and 24-hour cover is needed for it to work most efficiently. To be effective, bed managers needed to be seen frequently on the wards and had to know the current bed state in detail. In larger hospitals it was seen to be impossible to cover the hospital in this manner, and the necessary quality of bed state information was hard to ensure. Bed management was difficult to institute where beds were still being "hidden", and it seems that in such larger hospitals bed management teams would be more helpful than relying on one manager on duty at a time. Bed management was a stressful job needing good support; as well as internal support, some bed managers felt that a London-wide forum where those involved in bed management could meet to exchange views would be a useful initiative.

Buffers

Hospitals which still had Emergency Admission Wards, which could take acute admissions overnight and when there was no "appropriate" bed available, could limit the number of outliers on other wards and could control the random flow of acute admissions into the main hospital to some extent. Such wards needed clear protocols governing the upper limit of stay and, ideally, consultant authority to ensure this. Other, more temporary buffers that were relied on in times of crisis were often almost routinely used in practice, contributing to the feeling of a constant "crisis".

Accident and emergency

The A&E department was often the most disrupted by pressure on beds, although overcrowding and other problems were difficult to distinguish from the particular problems caused by admission delays. Ensuring the organisation of on-call teams such that there was always someone available to assess patients in A&E would reduce the wait for admission decisions and so the overall wait for a bed.

Discharge planning

As beds "blocked" by patients waiting for alternative accommodation were identified as a major source of pressure, the policy one hospital had instigated of appointing designated "discharge officers" was cited as a valuable way of reducing stress.

Involvement of clinicians and nursing staff

Bed managers who had managed to involve clinicians at all levels appeared to be the most successful. This involved organising a rolling training programme in the hospital's admission protocols to cover a high turnover of new staff, and having written guidelines for locums and new staff. Commitment to bed management was achieved through

including clinicians on relevant planning groups, devolving responsibility for organising beds to care groups or clinical directorates and issuing results of monitoring.

Monitoring

Waits in A&E, cancellation rates and the number of outliers on "inappropriate" wards were monitored in some hospitals but it was recognised that in many cases information systems were not ideal to the task. Adequate monitoring seemed useful, as objective data on the performance of individual consultant teams could be produced.

Local GPs

Some hospitals had given thought to the arrangements for admitting acute patients from GPs, including providing direct telephone lines and in one case dividing the A&E reception functions so that a separate service existed for GPs – an internal Emergency Bed Service. The practice of denying admission for GP patients, knowing that the patient would soon be referred in by the EBS, in order to play for time, was recognised as frustrating for GPs, and an enlarged role for the EBS might reduce this practice.

CHAPTER 3

Emergency admissions from a GP's perspective

JENNY BARTHOLOMEW, FIONA GELDER AND CLARE JENKINS

Introduction

While there are anecdotal reports of the problems general practitioners in London encounter when negotiating unplanned admissions for acutely ill patients, these problems have not been the focus of any general-practice-based study. As GPs report arranging acute admissions to a hospital as one stressful aspect of their job (Makin *et al.*, 1988, Cooper *et al.*, 1989) it is an area that needs addressing.

The problems that may arise for the GP can occur at several points during the attempt to arrange an acute admission for the patient. First, there is the time taken to gain access to the correct hospital personnel. Seventy-four per cent of GPs, in a survey by Myerson of 110 urban GPs, complained of difficulties in contacting hospitals and hospital staff by telephone (Myerson, 1990). In the same survey 98 per cent complained of feeling rushed in the surgery; delays in contacting the hospital, while often already in a stressed situation, could magnify these problems.

A survey by Bakhai *et al.* investigating the ease or difficulty of contacting duty doctors responsible for acute medical admissions in 70 randomly selected hospitals in England and Wales found that, despite the GPs' reports of difficulty in contacting the admitting doctor, the hospital switchboards responded within 30 seconds in 74 per cent of telephone calls (Bakhai *et al.*, 1990). In 64 per cent of these calls the duty doctor was contacted within another two minutes. However, 17 per cent of telephone calls were recorded as taking more than 60 seconds to be answered by the switchboard, and 10 per cent of duty doctor contacts took longer than five minutes. Seven calls were abandoned by the researchers after a wait of 12 or more minutes. It must be remembered that this process can take place in the patient's home with an acutely ill and anxious patient, and/or relatives taking an active interest in these negotiations, or in a busy surgery. The study by Bakhai *et al.*, concluded that contacting the duty doctor responsible for acute admissions "seemed fairly easy". This could be seen to reflect the hospital doctor's attitude arising from his or her position in the health care structure. The GP, placed in a different context, is likely to have a different perspective.

Once contacted, the negotiation with the hospital duty doctor may prove lengthy or s/he may be reluctant to admit the patient. The GP may need to make further calls to other hospitals if the admission is refused. In a study of acute admissions to hospitals in Leicester (Fraser *et al.*, 1974), 89 per cent of the patients were accepted immediately, 9

per cent accepted reluctantly and 2 per cent referred to the GP. Further information applicable to London-based GPs is required on this component of the admission procedure.

While there are no data on the actual admission process from the GP's perspective there is information available on admissions to hospital that suggests areas of concern. During 1986-1988, Petty and Gumpel (1990) studied the effects of closing Northwick Park Hospital to acute admissions over short periods. The hospital had closed 31 acute beds in 1987 owing to a projected overspending of the district budget and the hospital was closed to GPs overnight for increasing periods after that. Patients referred by GPs fell from 56 per cent in 1986 to 44 per cent of the total acute medical referrals in 1988, while self-referred medical patients to Accident and Emergency (A&E) rose from 22 per cent in 1986 to 39 per cent of the total in 1988. Petty and Gumpel further suggest that the rise in admissions from A&E over this period, from 27 per cent in 1986 to 47 per cent in 1988, was caused by GPs, who were aware of the bed shortage and the problems of the normal routes, bypassing the admission negotiations and sending patients directly to A&E.

Any difficulties in arranging an acute admission can also be assessed by looking at data from the Emergency Bed Service (EBS). The EBS has been described as acting as an "honest broker" between hospitals and GPs, and as the "barometer of London's health service" (Evans, 1987). One measure of difficulty in getting patients admitted is the number of times cases have to be taken to the "medical referee". This happens after a patient has been refused admission from the EBS by at least four hospitals. The case is reviewed by a doctor acting as an independent arbitrator who can discuss the patient with the GP and sanction or censure the admission. If the admission is approved by the medical referee the hospital responsible for the patient's geographical area is obliged to accept the admission. Evans (1987) examined the pattern of medical-refereed cases in relation to four variables that could affect acute admissions. He concluded that the variable associated with an increase in medical-refereed cases was a reduction in the number of beds.

Increased pressure on beds resulting from bed closures may also be combined with increased pressure from demographic changes. Although the Greater London population fell between 1981 and 1985 by 0.6 per cent, the proportion of those under five years of age and pensioners increased considerably (Evans, 1987). Both groups are high users of acute services.

The final stage in the admission process is arranging for transport for the patient, which again may involve a considerable wait for a positive response. If the admission is taking place from the surgery this task may be handed over to other staff. The government published its ideal standards for emergency care, to be achieved by April 1992, in the Patient's Charter (Department of Health, 1991b), which states:

> *When you call for an emergency ambulance it should arrive within fourteen minutes if you live in an urban area ...*

No such guidelines have been set for the length of time a caller could expect to wait for the ambulance switchboard to answer the call. As the ambulance service can be a crucial part of the admission procedure it should be included in any assessment of problems with acute admissions.

Two studies raise important issues concerning the type of hospital care needed by patients who present as acute emergencies in general practice. What proportion of patients admitted to beds in teaching hospitals (offering high-technology care) need this level of care? What proportion of patients could be equally well managed by their GP in a low technology institution such as a GP or Community Hospital, if such a unit were available in their area? It has been suggested (Trevellyan and Cook, 1974) that the characteristics and needs of patients admitted to GP beds could be differentiated from those of patients admitted to consultant beds. A further study (Treasure and Davies, 1990) showed that a GP hospital in Brecon eased the burden on the local district general hospital at a reasonable cost; the authors concluded that GP hospitals should have a future role in the NHS.

This chapter reports on a study designed to investigate the problems GPs faced when arranging acute admissions in one Family Health Services Authority (FHSA) area in London. The GPs were also asked to assess if the patient would have been suitable for admission to a general practitioner hospital (GPH). For the purposes of this study an 'acute admission' was defined as any patient for whom the GP requested either immediate admission to a hospital or immediate assessment with a view to admission. The use of the term "acute admission" in this chapter is not meant to imply that the patient was accepted from A&E into a hospital bed, as there was no follow-up of patients to see if they were admitted, or how long they waited for a bed once in the hospital.

The aims of the study upon which this chapter reports were:

- To record the number of patients for whom GPs sought acute admissions to a hospital over a period of 47 consecutive days;
- To record the problems GPs experienced with the admission procedure and the ambulance services in referring acutely ill patients to hospital;
- To record the number of patients who were refused admission by the first hospital contacted and the subsequent delay pattern in the admission process, eg contacting the admitting doctor, negotiating admission and arranging transport;
- To record the problems, both medical and social, which led the doctors to decide that an admission to a hospital was necessary;
- To examine the hypothesis that in many cases the GP would have been prepared to care for the patient in a low-technology institution providing good nursing care, such as a general practitioner hospital, if such resources were available locally.

Method

A number of practices in South East London have an established relationship with the Academic Departments of General Practice at the United Medical and Dental Schools of Guy's and St Thomas's Hospitals (UMDS), and King's College School of Medicine and Dentistry, through collaboration on a major study on referrals. They make up approximately a quarter of all practices in the FHSA area and represent a cross-section as to geography and size. All these practices were approached to take part in this study, together with several other practices which provided on-call or out of hours cover for practices that had already agreed to join the study.

In all, forty-three practices were invited to take part in the study. Three of the ten single-handed practices and two of the 33 group practices declined to participate. Thirty-eight practices were therefore identified which were willing to participate. Two group practices were excluded at the end of data collection as their data was incomplete. Eight of the 36 practices held contracts with a local general practice hospital. The total number of doctors employed by these practices over the seven-week period, including principals, trainees, part-timers and locums, was 140.

The GPs were asked to fill in a form each time an acute admission to a hospital was attempted. They were asked to record the time taken to arrange admission, defined as the time from first dialling the hospital to the time the referral was accepted, as well as the time taken to arrange transport, defined as the time from first dialling the ambulance number to the time transport was agreed with ambulance control. Also recorded were the time and date of the referral, the hospitals contacted, the medical diagnosis and the medical and social needs of the patient and whether the patient would have been suitable for admission to a GPH. There was also an open question asking GPs to record any problems they experienced during the admission procedure.

Initial contact with each practice was made in August 1991 by a letter from the head of Department of General Practice at UMDS. Practices willing to participate were sent a further letter outlining the study and asking the practice to appoint a study coordinator. This role was usually taken by the practice manager, a receptionist or a GP. A meeting was then arranged between the coordinator, as many other members of the practice staff as possible, and the members of the research team. At this meeting the data collection procedure was explained in detail. The coordinator was provided with a supply of forms to be completed each time an acute admission was attempted, and a record book in which to keep a list of all the patients for whom a form was completed. The coordinator was also responsible for explaining the method of using the forms to members of the practice staff not at the meeting, for answering any queries, and for checking to ensure that a form was properly completed for every acute admission attempted. For the remainder of the study the study team communicated with each practice through the practice coordinator. If they were absent from the practice for any length of time a deputy coordinator was appointed.

The study started on Monday 30 September, and data were collected until Friday 15 November 1991. This period was chosen as it fell between the quieter summer months and the busier winter period. All the participating practices were visited at least once during the first two weeks of the study when completed forms were checked to ensure accuracy; queries were answered and additional packs of forms were supplied. The practice was visited again during the study period and at the end of the study when the forms were collected. To ensure the anonymity of the study, patients' names were removed from the top of the form, and a code number added. The record book supplied to the practice at the start of the study was used to record the patient's name and code number, so that the practice could link completed forms to named patients in case of data needing to be checked.

In mid-November, a letter was sent to all the participating GPs, trainees and named locums to thank them for their cooperation and to ask them their impressions about the emergency services and the representativeness of the seven-week period in which the study was carried out.

Results

The four hospitals most frequently used for acute admissions by the GPs involved in this study have been called Hospitals A, B, C and D. The participating practices have been numbered from 1 to 36.

General practitioner characteristics

Of the 111 GPs who returned questionnaires, 62 (56 per cent) were male and 49 (44 per cent) were female. Twenty-nine GPs returned no forms over the study period. Many of these were part-time, and some were away from their practice for much or all of the study period. Three practices returned no forms and we were unable to verify whether the four GPs involved had attempted any acute admissions during this time. Fifty-three per cent of the patients were admitted by a male GP and 45 per cent by a female GP (in seven cases, the name and sex of the admitting GP was missing). There were no significant differences between the male and female GPs in the problems they encountered during admission.

GP patient population

The total number of patients registered with the 36 participating practices was 222,672. This registered patient population accounted for 25 per cent of patients registered with practices in the FHSA area. Seventy-five per cent of the patients in the population covered by the study were eligible for some degree of deprivation payment.

Acute admission rates

493 acute admission forms were collected, giving a frequency of approximately two acute admissions for every 1,000 patients in the 47-day study period, equivalent to an annual rate of 16 acute admissions

per 1,000 patients. The 47-day admission rates of the 33 practices who admitted patients ranged from 0.3 per 1,000 patients to 6.9 per 1,000 patients. The mean rate for all seven single-handed practices was 1.11 patients per 1,000 registered, with a standard deviation of 1.16, and for the group practices, the mean rate was 2.33 per 1,000 registered patients, with a standard deviation of 1.53.

Acute admission patient characteristics

Sixty-one per cent of acute admissions were female patients and 39 per cent were male. Thirty-seven per cent of admissions were patients aged 65 years or over and 23 per cent of all admissions were patients aged 75 years and over. The age groups of the 493 study admissions were compared with those of the 222,672 patients registered with the practices taking part. Admission rates were higher in the older age groups – those 75 years and over accounted for just five per cent of registered patients but made up 23 per cent of admissions, while those between 65 and 74 years were six per cent and made up 14 per cent of admissions.

Distribution of acute admissions

The date of the acute admission was recorded in all but two cases: 89 were made in week one, 88 in week two, 86 in week three, 71 in week four, 65 in week five, 63 in week six and 29 in the last five days of the study. Fifteen per cent of the admissions took place over the weekend, the remaining 85 per cent taking place on a weekday. The greatest number (21 per cent) of admissions was attempted on Mondays. Only eight per cent were made during the night-visit hours as defined by the FHSA – between 10.00 pm and 7.59 am – and, as Figure 3.1 shows, admissions peaked in the hour between 10.00 and 11.00 in the morning.

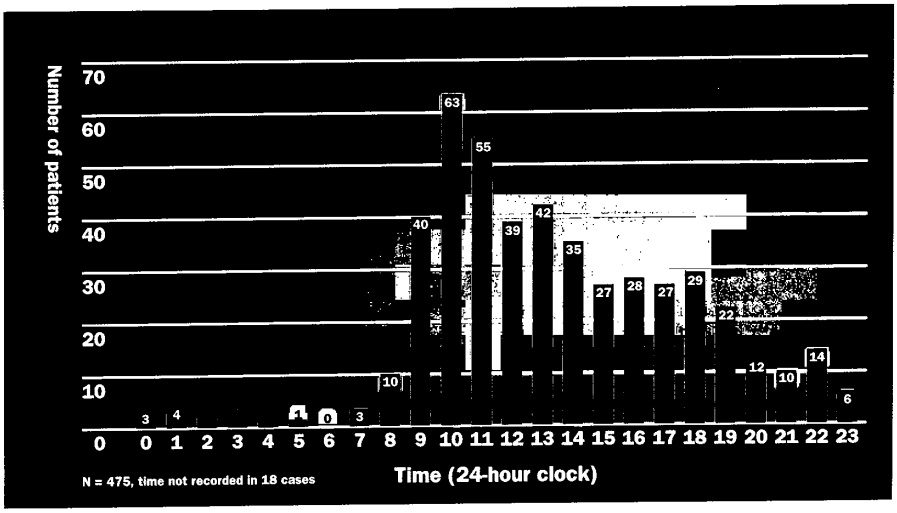
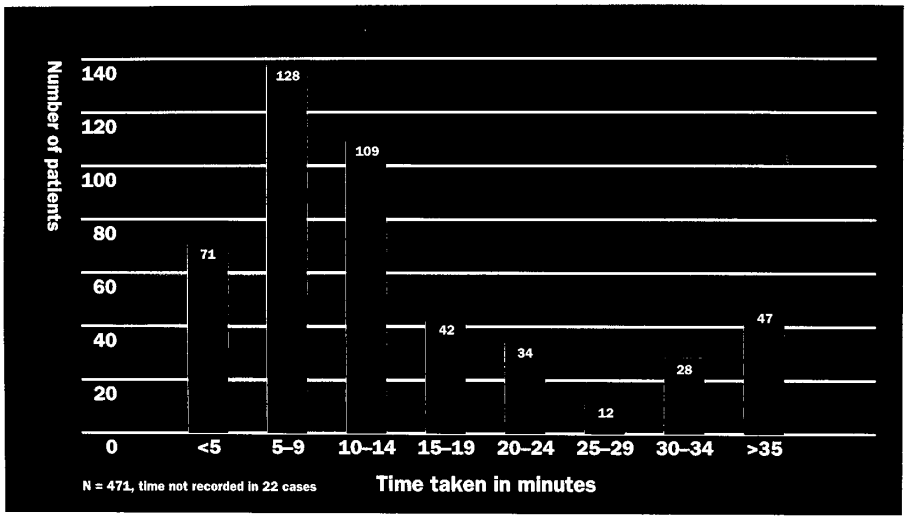


Figure 3.1

Distribution of acute admissions by time admission requested

Figure 3.2

Distribution of time taken to arrange admission



Time taken to admit

The time it took to arrange admission was defined as the time from first dialling the hospital number to the time that the acute admission was agreed by the A&E department. In 471 of the cases, the time it took to arrange admission was recorded; it ranged from one minute to 270 minutes. Figure 3.2 shows the distribution of time taken. The mean time taken to arrange an acute admission was 18 minutes, the median ten minutes. In 58 per cent of cases, the time taken to arrange admission was ten minutes or more.

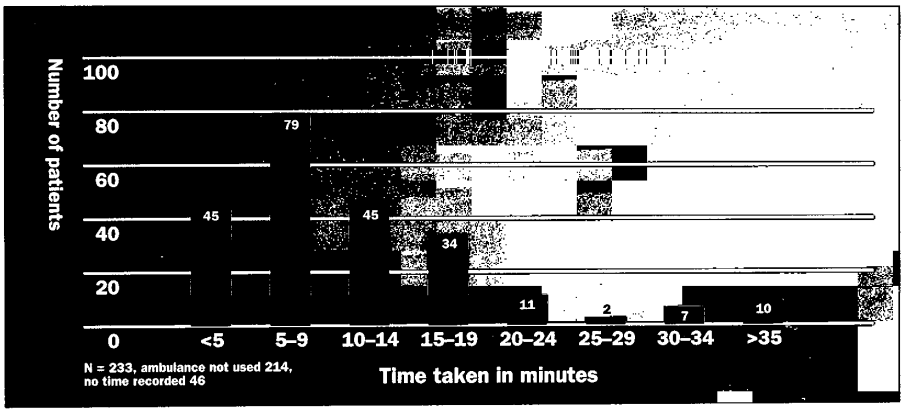
Hospitals accepting admissions

A total of 403 (82 per cent) patients were sent to one of four hospitals within the FHSA area: 154 (31 per cent) to hospital A, 114 (23 per cent) to hospital B, 28 (6 per cent) to hospital C, and 107 (22 per cent) to hospital D. Twenty-three patients were accepted at hospitals outside the jurisdiction of the South East Thames Regional Health Authority, of whom 11 went to hospitals in South West Thames, four to North East Thames and one patient to North West Thames. Four patients were referred to Special Health Authority Hospitals, two to Ministry of Defence hospitals and one to a private hospital.

Information was recorded about the number of hospitals contacted for 487 of the 493 acute admissions. In 373 cases (77 per cent) one hospital was contacted. In 34 cases (seven per cent), a second hospital was contacted, and in 11 cases (two per cent) a third hospital was contacted. Nineteen patients were sent to A&E departments without a bed being arranged and 50 patients (ten per cent) were referred to the Emergency Bed Service. For six of the EBS patients, the GP contacted the EBS directly without contacting a hospital first, 36 patients were referred to the EBS after the GP had contacted one hospital, and eight patients were referred to the EBS after two hospitals

Figure 3.3

Time taken to arrange ambulance transport



had been contacted. The general practitioner hospital was contacted on 13 occasions – in 11 of these cases contact was made as a first resort, in one case the GP had already contacted one hospital, and in one case, the GP had contacted two hospitals.

Transport

Ambulances may be called in two ways: the 999 emergency ambulance; and the 'other' ambulance which is a telephone number the GP can call when an ambulance is required less urgently, but within the hour. 118 patients (24 per cent) were taken to hospital in an ambulance arranged by a 999 call, 99 (20 per cent) were taken by an ambulance arranged through the 'other' ambulance number and 214 (44 per cent) made their own way to hospital. Of the remaining 62 cases, there were seven where the GP started with the 'other' ambulance number and switched to a 999 call, six where patients called the ambulance themselves, 30 organised by the EBS and one where the patient was taken to hospital by the GP. Information was missing for 18 cases.

The time taken to arrange transport was defined as the time from first dialling the ambulance number to the time the details were accepted by the ambulance control. The time taken ranged from one minute to 120 minutes, the mean time being 11 minutes and the median 7 minutes (see Figure 3.3).

In the 249 cases where the expected time of arrival of an ambulance to collect the patient was recorded, 70 (28 per cent) were expected to arrive immediately, 127 (51 per cent) were expected to arrive within the hour, while 52 (21 per cent) were expected to arrive in one hour or more. Of this latter group of patients, the expected time of arrival ranged from one hour to 30 hours.

Although no specific question was asked regarding problems with ambulances, problems were recorded by the GPs in 11 per cent of 999 ambulance bookings and 22 per cent of 'other' ambulance bookings. The comments centred around the time waiting to get an answer from the switchboard or the delay in the ambulance arriving.

Medical and social needs

The 493 study patients had a range of medical and social needs. Medical needs were defined as requirements such as observation, diagnostic procedures, and treatment. Medical needs were recorded in 192 cases; in 296 cases the question was not answered; in five cases no medical need was perceived. Of the medical needs specified, 79 were for investigations and diagnostic procedures, and 111 for specialist treatment. Only two cases mentioned nursing care as a medical need.

Social factors were identified in 80 cases, no social needs were specified in 37 cases, and the question was not answered in 376 cases. Only one patient was admitted for purely social reasons, and he was admitted to the GP hospital. The social factors mentioned were: the patient living alone (35 cases), the home being unsuitable (42 cases), the carer was ill (2 cases) and one other unspecified case.

Medical diagnoses

Medical diagnoses were entered for all cases and were coded using the 1987 International Classification of Primary Care (ICPC). In cases where more than one medical problem was recorded, the first problem was classified as the primary medical diagnosis and the second as a secondary diagnosis. The most common primary diagnoses were problems of the circulatory system (20 per cent), problems of the digestive system (19 per cent) and problems of the respiratory system (19 per cent).

Referral to general practitioner hospital

Ten patients were admitted to the local general practitioner hospital, nine of whom were aged 65 years or over, and three patients were refused admission. Seventy-six patients were considered suitable for admission to the general practitioner hospital by their GP. These included five (7 per cent) paediatric patients, eleven (14 per cent) aged 16 to 64 years, and 60 (79 per cent) aged 65 years or more. In all but four of the 76 cases, the admitting GP would have been willing to provide cover for their patient. Although only three study practices used the general practitioner hospital during the seven-week study period, eight study practices held contracts with the hospital.

Problems during admission procedure

GPs were asked to record if they experienced any problems in negotiating the admission. 171 (35 per cent) admissions were described as having difficulties, ie the GP wrote a comment on the form which described some difficulty during the admission negotiation. In eight cases a favourable comment was recorded. The number of times problems were recorded by the GP varied according to the age of the patient, as can be seen in Figure 3.4.

The types of problems experienced by the GPs were categorised and the number of times each category of problem was mentioned is shown in Figure 3.5. Frequently mentioned problems were lengthy negotiations before the patient was admitted (33 cases); and commu-

Figure 3.4

Problems during admission by patient age

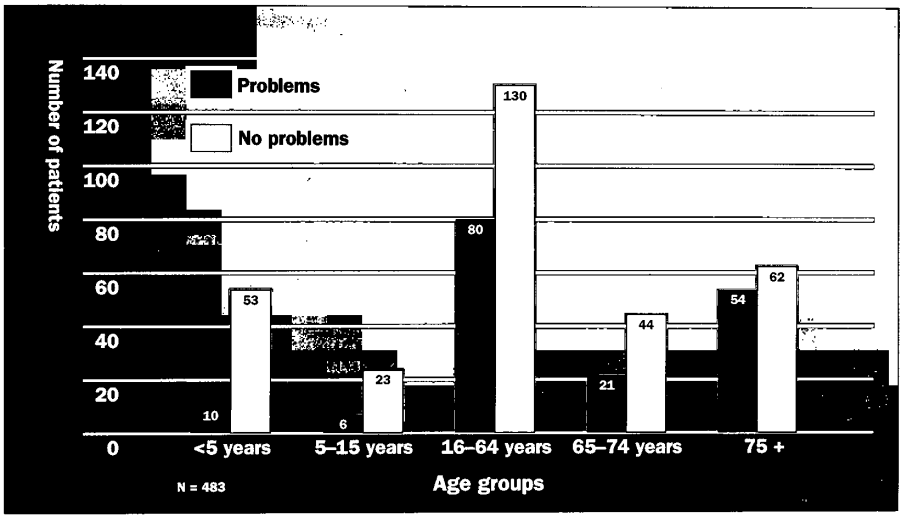
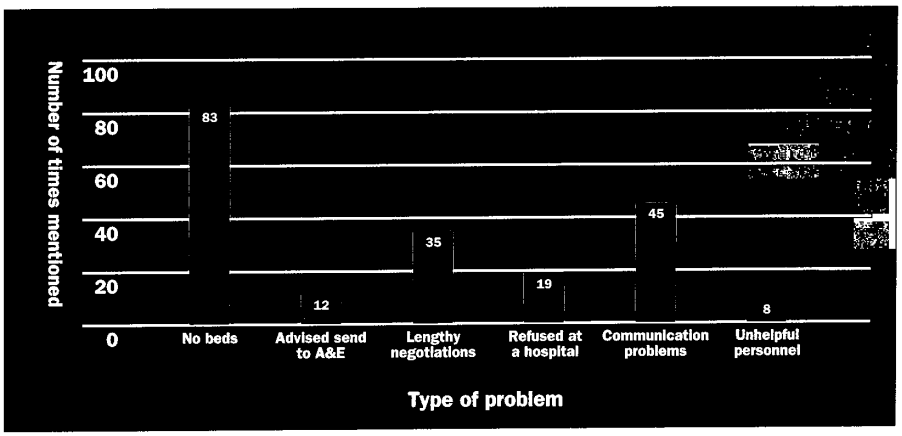


Figure 3.5

Frequency of categories of problems



nication problems which involved the time taken to answer the call by the hospital and time taken to find the duty doctor in charge of admissions (45 cases). These were not associated with increasing age, although the paediatric cases had fewer "lengthy negotiations".

The problem mentioned most often was "no beds" and this was analysed in relation to age groups. While the problem of "no beds" applies to two (3 per cent) of the patients aged under 16 years, and 38 (18 per cent) of 16 to 64-year-olds, it applies to 35 (30 per cent) of those aged 75 years or over.

Conclusion

Accuracy of data collection

Collecting information in an emergency situation, often in the patient's home, is notoriously difficult. There was a fall-off in the number

of forms completed as the study progressed. Data collected by general practitioners could be compared with hospital admission data in only two hospitals. This confirmed that the apparent fall-off in admissions with the passage of time was largely due to a failure of general practitioners to complete forms. This was most common in the age groups 65–75 years but did not affect particular diagnostic groups. It suggests that the number of referrals recorded in this study is an underestimate of the actual referral rate but reflects fairly accurately the types of problems encountered in arranging admissions.

Demand and availability

It is apparent that demands for admission vary greatly, according to day of the week, and time of the day. The highest number of requests for acute admissions recorded in this study occurred on Mondays and the most common times for seeking acute admissions was between 9.00 am and 1.00 pm. Requests for admissions on Saturdays and Sundays from general practice were revealed as relatively infrequent.

As the previous chapter discussed, emergency admissions present a challenge to efficient administration owing to their unpredictability. The patterns revealed here may have some implications for hospitals in preparing for admissions on different days of the week and different times of the day.

The case for the EBS

Many reported problems appeared to be due to lack of availability of beds. Problems encountered in organising admissions occurred most frequently with those patients over the age of 65 years, and the explanation for the non-admission of patients that no beds were available was most likely to occur with patients over the age of 75 years. Not infrequently, patients who were refused admission on the first contact with the hospital were subsequently admitted to the same hospital through the Emergency Bed Service. In this study 44 (nine per cent) acute admissions that had been refused after one or two direct hospital contacts, were referred by the doctor to the EBS. While it has been reported that some GPs try to avoid these difficulties by putting the patient in an ambulance and sending them to the Accident and Emergency Department (Petty and Gumpel, 1990) this hypothesis was not examined.

On a number of occasions, it appears that rejection of a patient by the admitting medical officer is subsequently overturned by the Emergency Bed Service refereeing system. Would it be more sensible for all acute admissions to be arranged through a central agency? As suggested by Green and Armstrong in Chapter 2, one way of dealing with the unpredictability of demand is to increase the pool of available beds by uniting a number of hospitals, whose bed stock could then be handled by a central organisation such as the EBS. This would appear to breach the convention of inter-professional consultation between hospital doctors and general practitioners leading up to an admission, but how often is this negotiation a confrontation rather than a consultation?

The case for bed managers

Problems encountered during the attempted acute admission were also concerned with difficulties in locating the hospital doctor responsible for admissions with lengthy negotiations about the need for admission. Unless the GP is asking the admitting doctor for advice or a second opinion, lengthy negotiations between them could be seen as a querying of the GP's professional judgement as well as a way of protecting the available beds.

The question of admission could be handled by bed managers who would be available to hear the case from the GP and would have an up-to-the-minute knowledge of the bed state. Such an arrangement might be seen again to undermine the professional relationship between GP and hospital specialists, but it can be argued that the GP who has assessed the patient and is familiar with their medical and social needs is in the best position to make a decision about whether a patient should be admitted. Once the patient is admitted, a meaningful dialogue could take place between the GP and the hospital doctor.

The case for general practitioner hospitals

For 15 per cent of all the acute admissions requested, the GP considered that the patient could have been cared for in a low-technology institution providing good nursing care, such as the local general practitioner hospital. This option was most frequently preferred in patients over the age of 75 years, that is, those for whom admission to hospital is most difficult. It would appear from this study that if 15 per cent of patients admitted to high-technology hospitals could be adequately managed in local general practitioner hospitals, where they would receive continuity of care from their own GP, this would help to relieve the bed availability problem. Some elderly patients "block" high-technology beds, as once admitted they are difficult to discharge because of poor integration of the hospital, community nursing and medical services, and social services. Centres such as the Lambeth Community Care Centre are closely linked into the community services, with well developed physiotherapy, occupational therapy and social services which facilitate early discharge from institutional care. Five or six such centres in an FHSA area could provide more appropriate inpatient facilities for the increasing elderly population than high-technology teaching hospital beds.

Transport problems

Serious problems identified in this study were concerned with the ambulance services. For 75 per cent of 999 calls it took 5 minutes or longer to arrange transport, and 30 per cent took 10 minutes or more. Reports of being held in a queue before the call was answered were made by GPs in this study, and by patients interviewed about their experiences of emergency hospital admissions (see Chapter 5). For an emergency number this seems unacceptable.

In terms of collecting patients to take them to hospital, the expected time of arrival for the ambulance was "immediately" in 28 per

cent; "within an hour" in 51 per cent and "over an hour" in 21 per cent. Although these times were often settled by agreement, in other cases they were all the service could offer. In 44 per cent of cases, the patients made their own way to hospital, and one was taken in the GP's car. Although changes have since been made to the organization of the ambulance service, at the time this study was carried out serious difficulties were being experienced in arranging ambulance transport to hospital for acutely ill patients. For a doctor working in a patient's home and trying to arrange an acute emergency admission, this was a major source of frustration and an unnecessary waste of professional time.

Recommendations

The problems experienced during one third of admissions can be seen to focus around problems in communication and lengthy negotiations for beds, particularly in admissions for the elderly. Such problems would be alleviated by:

- an increase in the numbers of general practitioner beds in local community hospitals available for patients not requiring inpatient care in a high-technology teaching hospital.
- the Emergency Bed Service taking over all negotiations for emergency admissions, with access to a "bed pool". The advantages of a greater pool of acute beds have been argued in Chapter 2 by Green and Armstrong. It should be accepted that, once a GP who has the medical and social facts available decides that an admission is necessary, that admission should take place. The benefits of a consultation, or often confrontation, between an admitting general practitioner and a hospital physician seem to be strictly limited.

Major changes are clearly necessary in the accessibility and availability of ambulance services. If the 999 ambulance does not meet the expectations of an emergency service, general practitioners may be unable to provide patients with the care they urgently require.

- The 999 ambulance line should be answered immediately. It is unacceptable that emergency calls be held in a queueing system.

CHAPTER 4

Workload and procedure in A&E departments

RAYMOND JANKOWSKI AND SUNDHIYA MANDALIA

Introduction

Preliminary discussions with health professionals working both in primary care and in hospitals in inner London suggested that the commonly perceived difficulty with acute emergency admissions to hospital beds was the length of time spent in the accident and emergency (A&E) departments (Warden, 1992). Emergency admissions are often seriously ill patients who present with painful conditions that can rapidly worsen and lead to life-threatening complications should they not receive the appropriate medical care. Frequently, the delays were perceived as being due to the large proportion of the patients attending the departments who were elderly, homeless, tourists and commuters, and those living alone (Inwald, 1980, Milner *et al.*, 1988). The Tomlinson report (1992) and the King's Fund report (1992a) emphasised that there was a higher proportion of elderly people in London, often with social problems that made hospital admission more likely, than outside London. In addition, both reports suggested that London A&E departments had to deal with a greater proportion of attenders with minor illnesses than was the experience outside London. These cases, it was argued, meant that A&E staff had less time to spend on assessing potential emergency admissions and therefore delays were more likely. This was seen as a particular problem in London because of the poor organisation of general practice (Tomlinson, 1992, King's Fund Commission, 1992a, Farmer and Chambers, 1982).

The emergency admission process in A&E departments often involves several stages, a number of doctors and many investigations before a decision to admit the patient is made. Some staff in the departments thought that a significant delay was in getting the specialty doctors to come to see the patients referred to them. Apart from studies reporting on the waiting time of attenders up to the point of first being seen by a doctor, (Royal Institute of Public Administration and Social and Community Planning Research, 1988, Haringey CHC, 1984) no study could be found which attempted to objectively measure the various time intervals that made up the stages during the admission process.

This chapter presents the findings of a prospective study that describes the characteristics of attenders in an inner London department (A) and a department outside London (B) to try to identify problems unique to the workload of the department in inner London. A third department (C), also in inner London, was added in order to

Box 4.1

GLOSSARY OF TERMS

Departmental registers – all three A&E departments kept records of the time of arrival, the name, age, address, presenting complaint and outcome of attendance (discharge/admission). In hospitals A and B at the time of study these were paper records, whereas hospital C had a fully operational computer system complete with a document-reading machine to read coded A&E cards.

Long-distance commuters – those attending one of the two A&E departments in inner London who said they did not have a permanent address with a London postcode OR those attending the A&E department outside London who did not have a postcode within the catchment area of the hospital AND who were regularly in the area on business purposes.

Tourists/Occasional visitors – those attending one of the two A&E departments in inner London who said they did not have a permanent address with a London postcode OR those attending the A&E department outside London who did not have a postcode within the catchment area of the hospital AND who were in the area for recreational/sight-seeing purposes.

Triage – system for allocating clinical priority to patients. Usually run or supervised by senior experienced A&E nurses.

Minor Area/Unit – separate area in A&E department, to deal with minor traumatic complaints. Usually run by A&E doctors at SHO level, supervised by registrar.

Major Area/Unit – separate area in the A&E department where patients who do not present with minor traumatic problems are assessed for treatment or admission.

ICPC – the International Classification of Primary Care as developed by WONCA (World Organisation National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians). It consists of 17 broad alphabetical 'systems' classifications from A to Z. Each of the general Alpha codes can be subdivided into a maximum of 99 numerical codings for more specific complaints, eg K75 – acute myocardial infarction, D88 – acute appendicitis. The particular advantage of this classification for this study was that it accommodates the uncertainty of diagnosis that characterises primary care as well as the A&E department. It forms a bridge between the more specialised ICD-9 classification and lay terminology and common descriptions of symptoms and complaints in the community.

study the characteristics and admission procedure of emergency admissions in three departments.

The study was divided into two parts. The first part undertook to compare the socio-demographic characteristics, diagnoses, and mode of referral of people attending two A&E departments: one in inner London (A) and the other in a town about 30 miles outside London (B).

The second part of the study:

- compared the socio-demographic characteristics and diagnoses of patients admitted in the two A&E departments A and B, with the addition of a third department, C, in inner London;
- compared the frequency and the nature of social factors that are thought to have influenced the decision to admit;
- documented time intervals at six stages of the emergency admission procedure in the two inner London departments (A and C) and in the department outside London (B).

Based on the findings of these studies, recommendations for good practice in the emergency admission procedure have been made in the final section of this chapter.

Box 4.2

DEFINITION OF TIME INTERVALS

Transit time **– the interval between arrival of the patient in the A&E department and the patient leaving the department.**

The components of transit time were defined as follows.

Waiting time to be seen by A&E doctor **– the interval between arrival in the department and first being seen and assessed by the A&E doctor.**

Waiting time to be seen by the specialty doctor **– the interval between arrival in the department and first being seen and assessed by the specialty doctor.**

Time between first seen to decision by A&E doctor **– the interval between first being seen by the A&E doctor and the A&E doctor making the decision to refer on to the specialty doctor.**

Time between first seen and decision to admit by the specialty doctor **– the time between the specialty doctor first seeing and assessing the patient and the time when the specialty doctor stated to the fieldworker that he/she had made the decision to admit the patient.**

Time between the decision to admit by the specialty doctor and finding a bed **– the time between the specialty doctor making a decision to admit and a bed being identified by the bed manager or the specialty doctor as suitable for the patient to be admitted to.**

Time between finding a bed and the patient leaving the A&E department **– the time between a bed being identified for the patient and the patient being observed by the fieldworker to be physically leaving the department.**

Method

The three A&E departments were chosen because they report similar annual numbers of new attenders (from 60,000 to 63,000). This places the study hospitals at the upper end of the most common size band for accident and emergency departments in England (35,000 to 65,000 new attenders per annum) (National Audit Office, 1992). All three hospitals had similar policies with respect to patient attendance; emergency admissions via the accident and emergency department accounted for 88 per cent and 90 per cent of all emergency admissions in the inner London and outside London hospitals respectively. The three A&E departments had a similar number of medical staff at each grade.

Data were collected on new adult attenders at each A&E department. The inner London department (A) was studied over the first two weeks in December and the department outside London (B) during the last two weeks in January. The adult emergency admissions were studied in the third department (C) during the last two weeks in November. Children under 16 years, psychiatric patients, and private patients were excluded as they did not compete for the same bed pool.

Data in all three departments were collected by the same ten trained fieldworkers, organised in shifts, using a standardised questionnaire and protocol. The data were obtained by interviewing both doctors and patients. Where this was not possible, for example where the patient was unconscious or confused, data were sought from relatives or companions. The details recorded included socio-demographic characteristics, the context of this attendance, the diagnosis, the investigations and the treatment for each patient. Diagnoses were then coded according to the International Classification of Primary Care (ICPC) (Lamberts and Wood, 1987).

For the purposes of analysis, long-distance commuters were defined as those who regularly travelled to work in the area of the hospital but whose permanent home was outside the London postal area for the inner London departments or outside the catchment area for the department outside London. A tourist was defined as a person visiting the areas on vacation whose permanent address was outside these same areas.

General practice referrals were classified as formal (where contact was made by letter or telephone to the A&E staff) or informal. Informal referrals were defined as those patients who were advised to attend the A&E department by their general practitioner or practice staff without the practice contacting the A&E department.

Specialty doctors were defined as doctors who were a member of a hospital specialty team whose duties included assessing patients referred to them by A&E doctors and GPs. Their grade could be a junior house officer, senior house officer, registrar or senior registrar.

The standardised questionnaire was designed to allow the fieldworkers to observe and document up to six time intervals for each emergency admission (see Box 4.2). A summary interval, the transit time for emergency admissions, was defined as the interval from the patient's arrival in the A&E department to leaving for a bed on a ward.

Statistical analysis

In Part I confidence intervals were calculated using a Confidence Interval Analysis programme. In Part II medians were chosen to best represent the skewed distributions. The analysis was carried out using the Minitab Statistical Package. The Mann-Whitney test adjusting for ties was used to assess the statistical significance of the difference in time intervals between the two London hospitals. The two inner London hospitals were separately compared with the hospital outside London.

Results

Part I

Data collection was completed on a total of 3,039 attenders at the two departments. Of 1,565 eligible attenders in inner London (A) and 1,585 outside London (B), 1,476 (94 per cent) and 1,563 (99 per cent) respectively had questionnaires completed. The pattern of attendance by day of the week and time of day was similar in the two hospitals.

Attenders

The characteristics of attenders in the two departments are summarised in Table 4.1. Although the proportion of elderly patients is similar in the two hospitals, other socio-demographic characteristics differ between inner London and outside London.

The majority of attenders were self-referred. Referrals from other sources accounted for a similar proportion in the two departments studied. The majority of attenders were seen by the A&E doctors first: 89 per cent in the inner London department (A), and 88 per cent outside London (B). Of the remainder the majority were direct general practitioner referrals to the specialty teams. The proportions in the broad diagnostic categories for attenders seen by A&E doctors in both

Table 4.1

Characteristics of adults attending A&E departments

	Hospital A Inner London (n = 1,476)			Hospital B Outside London (n = 1,563)		
	n	(%)	95% Confidence interval for percentage	n	(%)	95% Confidence interval for percentage
Over 65 years old	269	(18.2)	16.3 to 20.2	279	(17.9)	16.0 to 19.7
Lives alone	360	(24.4)	22.2 to 26.6	225	(14.4)	12.7 to 16.1
Single	634	(43.0)	40.4 to 45.5	505	(32.3)	30.0 to 34.6
Moved in past three months	194	(13.1)	11.4 to 14.9	107	(6.8)	5.6 to 8.2
Homeless	48	(3.3)	2.4 to 4.3	10	(0.6)	0.3 to 1.2
Commuter or tourist	179	(12.1)	10.5 to 13.8	95	(6.1)	5.0 to 7.4

(First published: Jankowski and Mandalia, 1993b)

Table 4.2

Mode of referral to A&E

	Hospital A Inner London (n = 1,476)			Hospital B Outside London (n = 1,563)		
	n	(%)	95% Confidence interval for percentage	n	(%)	95% Confidence interval for percentage
Self	984	(66.7)	64.3 to 69.1	1,058	(67.7)	65.4 to 70.0
Own general practitioner	183	(12.4)	10.7 to 14.1	229	(14.7)	12.9 to 16.4
Deputising doctor	14	(0.9)	0.5 to 1.6	19	(1.2)	0.7 to 1.9
Informal referral from general practice	28	(1.9)	1.3 to 2.7	42	(2.7)	2.0 to 3.6
Office, shop, workplace	64	(4.3)	3.4 to 5.5	75	(4.8)	3.8 to 6.0
Private general practitioner or clinic	5	(0.3)	0.1 to 0.8	18	(1.2)	0.7 to 1.8
Nursing home	20	(1.4)	0.8 to 2.1	14	(0.9)	0.5 to 1.5
Police	18	(1.2)	0.7 to 1.9	18	(1.2)	0.7 to 1.8
Other	69	(4.7)	3.7 to 5.9	63	(4.0)	3.1 to 5.1
Not known	91	(6.2)	5.0 to 7.5	27	(1.7)	1.1 to 2.5

(First published: Jankowski and Mandalia, 1993b).

hospitals were similar. There were few patients at the department outside London who presented with gynaecological or psychological disorders, as these patients were referred elsewhere.

Part II

Emergency admissions

Over the two-weekly periods of fieldwork in each hospital, data were collected on 291, 284 and 308 emergency admissions in departments A, B and C respectively. The proportions in the broad diagnostic categories for emergency admissions were similar in the three departments, except for more circulatory and fewer gynaecological, psychological and urological disorders in the hospital outside London (Table 4.3).

The demographic characteristics of the emergency admissions in the two inner London departments differed less significantly from those admitted in the hospital outside London (Table 4.4).

Emergency admission rates were similar in departments A and B: 19.7 per cent in inner London (A) and 18.2 per cent in the department outside London (B). The emergency admission rate for patients over 65 years old was 42.0 per cent outside London compared with 51.9 per cent in inner London. For both tourists and commuters the rate was 9.5 per cent in both departments. Admission rates could not be calculated for Hospital C as the denominator – workload presenting to

Table 4.3

Diagnostic categories of patients admitted

	Inner London Hospital A (n = 291)		Outside London Hospital B (n = 284)		Inner London Hospital C (n = 308)	
	n (%)	95% Confidence interval for percentage	n (%)	95% Confidence interval for percentage	n (%)	95% Confidence interval for percentage
Circulatory	56 (19.2)	14.7 to 23.8	90 (31.7)	26.3 to 37.1	67 (21.8)	17.1 to 26.4
Gastrointestinal	52 (17.9)	13.5 to 22.3	57 (20.1)	15.4 to 24.7	55 (17.9)	13.6 to 22.1
Respiratory	37 (12.7)	8.9 to 16.5	51 (18.0)	13.5 to 22.4	42 (13.6)	9.8 to 17.5
Musculoskeletal	20 (6.9)	4.2 to 10.4	29 (10.2)	6.7 to 13.7	31 (10.0)	6.7 to 13.4
General (non-specific)	11 (3.8)	1.9 to 6.7	24 (8.4)	5.5 to 12.3	23 (7.5)	4.8 to 11.0
Skin (including minor trauma)	12 (4.1)	2.2 to 7.1	5 (1.8)	0.6 to 4.1	17 (5.5)	3.3 to 8.7
Urological	25 (8.6)	5.6 to 12.0	6 (2.1)	0.8 to 4.6	16 (5.2)	3.0 to 8.3
Gynaecological	29 (10.0)	6.8 to 14.0	1 (0.4)	0.0 to 2.0	27 (8.8)	5.9 to 12.5
Neurological	11 (3.8)	1.9 to 6.7	10 (3.5)	1.7 to 6.4	10 (3.2)	1.6 to 5.9
Blood disorders	11 (3.8)	1.9 to 6.7	3 (1.0)	0.2 to 3.1	7 (2.3)	0.9 to 4.6
Psychological	16 (5.5)	3.2 to 8.8	–	–	7 (2.3)	0.9 to 4.6
Endocrine/ Metabolic	5 (1.6)	0.6 to 4.0	5 (1.8)	0.6 to 4.1	6 (1.9)	0.7 to 4.2
Other	6 (2.1)	0.8 to 4.4	3 (1.1)	0.2 to 3.1	–	–

Table 4.4

Demographic characteristics of emergency admissions

	Hospital A (n = 291)		Hospital B (n = 284)		Hospital C (n = 308)	
	n (%)	95% Confidence interval for percentage	n (%)	95% Confidence interval for percentage	n (%)	95% Confidence interval for percentage
Over 65 years old	113 (38.8)	33.2 to 44.4	142 (50.0)	44.2 to 55.8	154 (50.0)	44.4 to 55.6
Lives alone	81 (27.8)	22.7 to 30.0	57 (20.1)	15.4 to 24.7	86 (27.9)	22.9 to 32.9
Single	84 (28.9)	23.7 to 34.1	45 (15.8)	11.6 to 20.1	77 (25.0)	20.2 to 29.8
Moved in last three months	26 (8.9)	5.9 to 12.8	11 (3.9)	2.0 to 6.8	25 (8.1)	5.3 to 11.7
Commuters/ tourists	17 (5.8)	3.4 to 9.2	9 (3.2)	1.5 to 5.9	6 (1.9)	0.7 to 4.2

Table 4.5

Frequency of social factors identified as important in the decision to admit

	Hospital A (n = 291)		Hospital B (n = 284)		Hospital C (n = 308)	
	n (%)	95% Confidence interval for percentage	n (%)	95% Confidence interval for percentage	n (%)	95% Confidence interval for percentage
Emergency admissions in which social factors were important in the decision to admit	37 (12.7)	8.9 to 16.5	27 (9.5)	6.4 to 13.6	42 (13.6)	9.8 to 19.5
Nature of social factors	**n**		**n**		**n**	
Lives alone, no responsible observer at home	17		11		21	
No support at home/ lives with dependants (eg young children, infirmed relatives)	12		6		13	
Lives in a nursing home	1		7		4	
Other reasons	7		3		4	

(Note: A v B, p = 0.28; B v C, p = 0.16)

the department – was not collected.

Table 4.5 suggests that there were no significant differences between the proportion of emergency admissions in which social factors were important in the decision to admit (according to the opinion of the specialty doctor), when the two inner London departments were compared with the department outside London. The most common social reasons for admission in all three departments were living alone with no responsible observer at home or that there were either young children or infirm relatives at home.

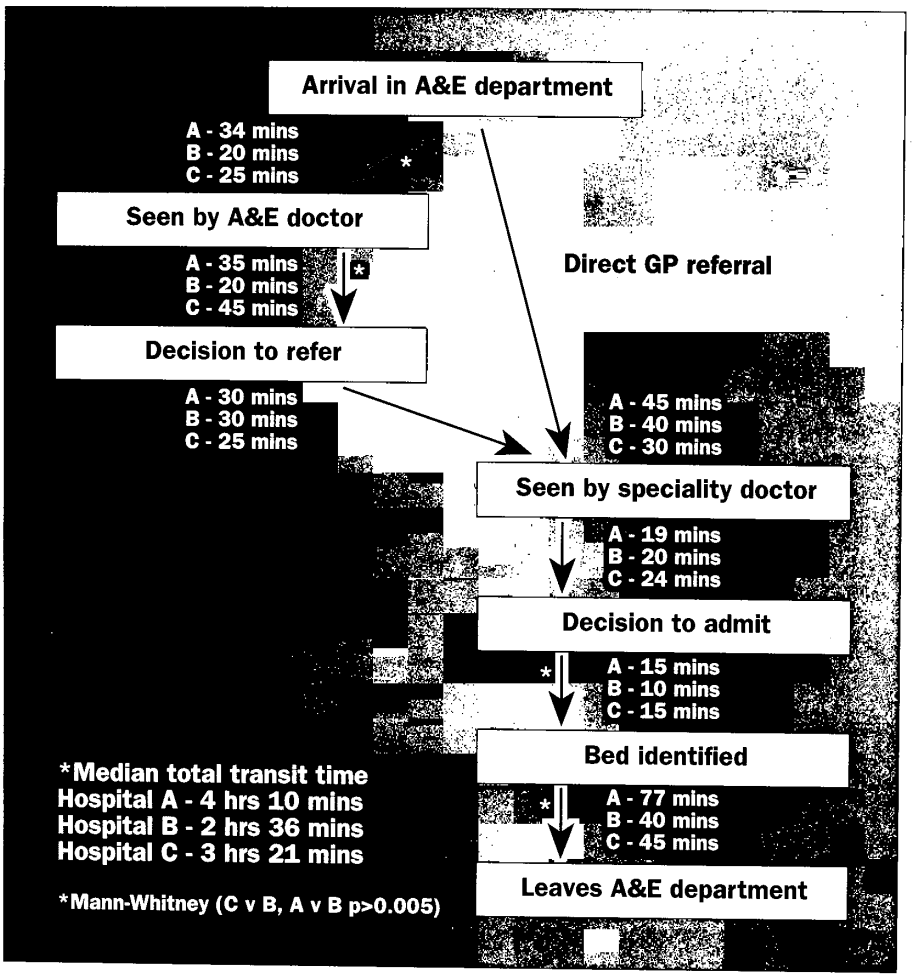
Analysis of transit times for emergency admissions

The median overall transit times were 4 hours 10 minutes for department A, 2 hours 36 minutes for department B and 3 hours 21 minutes for department C. Figure 4.1 (p. 52) shows the transit times for each department divided into six stages for those patients referred to A&E doctors directly and into four stages for those patients referred directly from the general practitioner to the specialty doctor.

An asterisk in the figure indicates that when inner London hospitals, (A and C) median time intervals were each separately compared with the

Figure 4.1

Flow of admissions through A&E (median times at each stage)



hospital outside London (B) by the Mann-Whitney test, the differences were significant ($p<0.005$). In general, intervals for the inner London hospitals were longer than for the hospital outside London. In particular, 39 per cent of the overall difference between hospital A (longest transit time) and B (shortest transit time) was accounted for by the difference in the interval between a bed being identified and the patient leaving the A&E department for a bed on the ward.

The late arrival of specialty doctors was a problem common in each of the departments: they were delayed by more than 30 minutes in 31 to 40 per cent of cases referred to them. A common problem to all specialties was that the doctor was busy seeing other patients on the ward or in the A&E department. For surgery and orthopaedics combined, the doctor was unavailable while in theatre for 28 per cent of cases where delay occurred.

In hospital A there was a difference of 90 minutes between those emergency admissions who had an X-ray performed and those who did not. The differences in hospitals B and C were only 34 minutes and 25 minutes respectively.

Conclusion

Part I of the study

The analysis confirmed earlier research findings that a higher proportion of attenders at inner London A&E departments were single people, lived alone, had recently moved, were homeless or were long-distance commuters and tourists (Farmer and Chambers, 1982). While the same study had found a higher proportion of attenders aged 65 years and over in departments in inner London, in this study that group accounted for similar proportions both inside and outside London.

Despite the greater proportion of attenders in inner London who might not be registered or have easy access to a local GP, such as the homeless, those who have recently moved and those who were long-distance commuters and tourists, there was no significant difference between the two departments in the proportion of GP referrals.

The Tomlinson report (1992) and the King's Fund report (1992a) suggest that a particular problem for A&E departments in inner London is the burden of people attending with minor conditions who could have been more appropriately treated by general practice. This study, however, shows a lower proportion of attenders in the inner London department who presented with musculoskeletal or skin complaints, the majority of which are due to minor trauma. Analysing by broad diagnostic groups has been criticised for its lack of sensitivity to the issue of appropriateness of care (Jankowski and Mandalia, 1993a). Analysis of individual diagnoses indicates that proportions for minor conditions such as acute otitis media, upper respiratory tract infections and urinary tract infection are again similar in both departments, though the absolute figures are small (Jankowski and Mandalia, 1993a). The findings of this study do not therefore support the claims that general-practice referral patterns, including those of deputizing doctors, add substantially to the attendances of A&E departments in inner London. This study suggests that the higher rates of attendance at A&E departments that have previously been observed in inner London (Farmer and Chambers, 1982) may reflect socio-demographic factors rather than primary care referral patterns.

Potential biases

There are three potential biases that may have occurred in this study. First, because of the different study periods in each hospital, attendances at the inner London departments (A and C) could have been inflated with pre-Christmas shoppers. However, analysis of the department register showed that attendance was in fact less than expected for that time of year. Secondly, the overall response rate was lower in the department in inner London compared with outside London. Examination of both medical records and register data in the departments shows that these non-respondents were similar to respondents with respect to mode of referral, place of residence and diagnoses. Thirdly, there were more cases at the inner London department A where data on mode of referral was not learned because of the patient's refusal or

inability to answer. In these cases, the A&E department had no record of a telephone message or letter received from other agencies. Therefore, it is unlikely that a substantial proportion of GP-referred patients are misclassified into this group.

In conclusion, the findings of Part I reveal that attendances at the inner London A&E department were similar to those outside London, with respect to overall numbers and diagnostic categories. The study also suggests that general-practice referral patterns do not account for an increased proportion of attendances at A&E departments in inner London. There are potentially important socio-demographic differences between attenders inside and outside London, but these do not cause excess admission rates. The Tomlinson inquiry (Tomlinson, 1992) identifies general practice as the major weak link in the acute services. This study identifies influences other than general practice that operate to increase the problems of inner London A&E departments. With the possible exception of the tourists, many of these socio-demographic factors may be similar in other inner cities. The real challenge is to devise a strategy to cope with the groups in the population identified in this study that contribute to the burden of A&E departments in London.

Part II of the study

Following on from the previous discussion it was important to examine whether socio-demographic factors or case-mix accounted for different workloads of emergency admissions. The major socio-demographic factor associated with admission was being over 65 years old. A slightly higher proportion of patients admitted outside London was elderly, and the admission rate among the over 65-year-old attenders was also higher than in inner London. Otherwise the demographic characteristics of the patients admitted in the three hospitals differed in the same way as among the attenders. With the exception of those who were single or living alone, however, these socio-demographic differences did not contribute substantially to the number of admissions. In the past, a higher proportion of tourists and commuters attending inner London hospitals has been documented (Farmer and Chambers, 1982) and used as an argument for additional resources. In this study, the absolute difference in the proportion of tourists and commuters among admissions in the three hospitals is smaller than among all attenders. This is because commuters and tourists are less likely than other attenders to be admitted to hospital beds and present largely with minor traumatic injuries.

Overall emergency admission rates in the two hospitals (A and B) are similar. In addition, apart from a larger proportion of circulatory disorders and smaller numbers of gynaecological, urological and psychological cases in the hospital outside London, the case-mix of admissions is similar. The reason for the excess in circulatory disorders is in part explained by the greater proportion of patients aged over 65 years old. The smaller number of gynaecological, urological and psychological problems reflects the fact that these specialties are not based at the hospital outside London.

Specialty doctors in the three hospitals reported similar proportions of the emergency admissions which had identifiable social factors that influenced the decision to admit. In approximately 50 per cent of the cases the reason appeared to be the lack of a responsible friend or relative who could observe the patient at home. Excluded from these figures are the 35 and 19 patients admitted to A&E beds in hospitals B and C respectively of whom about 50 per cent were concussion and drug overdoses.

Analysis of transit time of emergency admissions

The overall transit time for emergency admissions was over 90 minutes in the hospital outside London (B) and 45 minutes shorter than in inner London hospitals A and C respectively (having excluded patients admitted to accident and emergency beds). While the differences were not as great as one might expect from results seen in surveys of A&E departments, it must be remembered that these departments were chosen because they had similar numbers of new attendances and were not dissimilar in the number and grades of medical staffing. A particular problem in discussing transit times and delays is that there are no national or even regionally agreed standards of transit times with which to compare the results of this study.

Comparisons among the three departments reveal delays that can be divided into those common to all three departments and those unique to a particular department.

Common to all hospitals was the frequent problem of the specialty doctors being more than 30 minutes late in arriving to see a patient referred to them. The reasons given depended on the specialty, but the most common reason was that the doctor was seeing patients on the ward or in the accident and emergency department. In the case of general surgery and orthopaedics, the doctors were also commonly in theatre or on a ward round, and thus the availability of the junior doctor was limited by other duties.

There were specific delays highlighted by comparison of individual stages of the overall transit time between the two inner London hospitals and the hospital outside London. First, in the case of department A, 39 per cent of the difference in the overall transit time was attributable to the difference between the time of a bed being identified and the time of the patient leaving the department. As patients admitted to an A&E bed were excluded from this analysis, the provision of A&E beds in departments B and C do not explain this difference. Moreover, this delay was not significantly different between the specialties.

The most frequent "fieldworkers' comments" can be classified as factors that lie outside the control of the A&E department. First, a bed had been identified but was not yet available. In their discussions with bed managers, Green and Armstrong in Chapter 2 noted that even when a bed was identified, it may not be available because a patient had not yet left or a deceased patient had not been moved. In hospital A, there was 95-per-cent or more bed occupancy, which led to this being a particular problem. Another frequent problem was that ward staff in

hospital A frequently delayed the departure of the patient to the ward because staff were away for meal breaks or holding reports at the time. Whether this was due to absolute shortages in staff employed was beyond the scope of the study, but it was less frequently reported in the other two departments. A related issue was the delay caused while waiting for the availability of a nurse escort (from the ward or A&E departments) to accompany ill patients to the ward. In a minority of cases it was the relative lack of portering that was the problem. Interviews with the bed managers at hospital A did not highlight "ring-fencing" as a problem, despite its prominence in the Audit Commission's document *Lying in Wait* (1992).

One factor identified by fieldworkers in a minority of cases was the time taken to photocopy patients' notes so that A&E department could keep the original records for future reference. However, this only accounted for a minority of instances.

In department C, an important specific factor would appear to be its relationship with the X-ray department. Figure 4.1 (p 52) shows that the hospitals generally kept the same ranking at individual stages as for the overall transit time. However, hospital C has the longest time interval for the stage from first seen by the A&E doctor to the decision to refer. Comments from the fieldworkers suggested that the delay may be explained by the apparent policy for the X-ray department (between 9 am and 5 pm) to check and report on the X-rays while holding the patient in the X-ray department. This seems to be supported by the analysis indicating a difference of almost an extra hour for X-rays to be completed at hospital C compared with A or B. As the three X-ray departments were either inside the A&E department (A) or within 20 or 30 yards (B and C), the physical proximity of the X-ray department was not a relevant factor.

The National Audit Office (1992) has emphasised the importance of cooperation from other clinical and laboratory departments to assist in the efficient running of the A&E department and specifically in the assessment and treatment of emergency admissions. The above account provides strong evidence of real problems if this should break down.

In summary, given the similar numbers and broad diagnostic groupings of the emergency admissions discussed earlier, the analysis of transit time for emergency admissions reveals significant differences in the length of time of various stages in the admission procedure in the three departments. These are the time spent in the radiology department in one hospital and the time spent in the A&E department after the decision to admit has been taken. A common problem to all three departments is the frequency of appreciable delays before specialty teams come to assess emergency cases referred to them.

Overall, this suggests that the length of time spent by emergency admissions in A&E departments could be reduced by better support from the other hospital specialties, including radiology.

Recommendations

- It is recommended that hospitals in which acute emergency admissions are a major activity should develop a strategy for such admissions. Specifically, that this strategy should be given higher priority than currently enjoyed.
- That, where acute emergency admissions are received in the A&E department of the hospital, senior A&E staff should be given more senior managerial representation on the relevant hospital committees.
- Specifically that the senior A&E consultants should be able to regularly present problems in the acute emergency admissions procedure to other clinical directorates. This is particularly important in relation to the clinical departments to which emergency admissions are made. However it is also important to include departments such as radiology where acutely ill patients can potentially spend a considerable amount of time.
- That "A&E" transit times should be more correctly seen as hospital transit times. This is supported by the general finding of the study that many factors operating to influence the transit time lie outside the immediate control of the A&E staff.
- That A&E departments should develop computerised systems as recommended by the National Audit Office Report (1992), and that these are designed to highlight problems in the admissions procedure. This is particularly important as this study has found that many commonly perceived explanations of difficulties encountered by emergency admissions were not confirmed by the data collected.
- There is a need to develop district and regional targets to direct and monitor progress. These should have a degree of flexibility to allow for local variations in case-mix and staffing levels.
- In view of the problems highlighted by the frequent delays of specialty teams seeing emergency admissions referred to them, it is recommended that junior doctors from other specialties should be available to assess acutely ill patients referred to them. Acute receiving duties of the team should take priority over elective activities. Where competing acute receiving activities arise there should be clear rules of what can be delegated to other junior members of the receiving teams.

CHAPTER 5

The patient experience of emergency admission

NICKY BRITTEN AND ADRIENNE SHAW

Introduction

Patients' views of hospital services in general have been extensively researched for over twenty years (Cartwright, 1964, Raphael, 1967, Gregory, 1978). However in a literature review carried out for the King's Fund in 1985/6, Jones *et al.* concluded that "compared with the large amount of coverage given to consumers' views of outpatient departments, Accident and Emergency departments have received little. It is difficult to understand why" (Jones *et al.*, 1987). A more recent review, by the King's Fund Centre, endorsed this conclusion (McIver, 1992). It seems that although there is only a small number of published reports based on users' experiences of A&E departments (eg Callaghan and Caple, 1986, Gibson and Walsh, 1990), various other studies have been carried out but not published.

One possible reason for the relative scarcity of studies about A&E services is methodological difficulty. Dixon and Carr-Hill reviewed customer feedback surveys and concluded that A&E studies were more difficult, costly and time-consuming than outpatient research (Dixon and Carr-Hill, 1989). The problems they highlighted were those of achieving an adequate sample, particularly of patients attending in the middle of the night or those who were emergency cases, and of devising a questionnaire which collected the requisite data but was practical to administer. Their final conclusion was that this was an important area needing much more work.

The aim of the present study was to identify issues of concern to patients admitted to hospital via the A&E department, and in particular to identify areas of satisfaction and dissatisfaction with this process, by means of semi-structured interviews. Throughout this chapter the terms "A&E" and "casualty" will be used interchangeably on the grounds that patients are likely to use both; the authors recognise that the former term is the official designation.

Method

It was decided to use a qualitative method of data collection, in the form of semi-structured interviews with patients admitted via A&E departments. Qualitative methods are preferable if patients' own priorities are to be investigated rather than those of the researchers. It may be that the issues of importance to people admitted to hospital via the A&E department are different from those of other groups of patients, and therefore that questionnaires based on inpatient surveys

may not be appropriate. This strategy overcomes some of the methodological problems identified by Dixon and Carr-Hill (1989). Although time of arrival was not asked, it is clear from some of the accounts that the sample included people who had arrived in the middle of the night. As the sample was of admitted patients only it is likely to under-represent those attending casualty with less severe complaints. By deciding to contact the sample on the wards, difficulties of talking to patients in the A&E department itself were avoided.

Access was negotiated with the nursing administration of two London hospitals. In hospital A five wards were selected for the study: acute elderly; gynaecology; general surgical; general medical; and orthopaedic/trauma. In hospital B the selected wards were gynaecology; general surgical; two general medical wards; and male orthopaedics. Permission was sought from ward sisters and consultants in both hospitals and there were no refusals. Ethical Committee approval was obtained in both hospitals.

Pilot interviews were carried out with seven patients in hospital A, and the main sample, drawn from hospitals A and B, consisted of 83 patients. Altogether there were 46 female and 37 male respondents of whom 61 were aged under 65 years. The mean age was 45.9 years (range 18–91 years). Elderly patients were excluded from the study if they were mentally confused and unable to give coherent responses to the interviewer's questions. Other exclusions were due to extreme deafness, tracheostomy, severe learning difficulties and language problems. Some patients were discharged from the hospital before the interviewer was able to meet them. A total of four patients refused to be interviewed, three in hospital A and one in hospital B. Since this sample consists of admitted patients only, it probably represents about a fifth of all A&E attenders (Jankowski and Mandalia, 1993). Attenders who are not admitted may have different priorities from those who are, but this is beyond the scope of the present study.

Data were collected by means of semi-structured interviews, during the course of which patients were asked to give an account of their experiences and were encouraged to talk freely about their feelings and reactions to events. The interviews focused on the process of admission and experiences in the A&E department, and were tape-recorded with patients' permission. Of the 83 main interviews, 76 were audiotaped. In some cases patients refused to be tape-recorded and in others the interviewer decided that audiotaping would serve no purpose. For example, in one case the patient spoke very poor English and in another the patient was speaking through an oxygen mask. Analysis of the seven untaped interviews was based on the interviewer's notes. Interviews in hospital A were conducted in November and December 1991, and those in hospital B in March and April 1992. The length of the interviews varied. Some were very short and the longest lasted approximately 30 minutes.

The fact that patients were being asked to discuss the events of only one or two days previously may have affected the data obtained. The literature suggests that patients are more critical while still in hospital than if they are interviewed at home after discharge (French,

1981). Conversely Hall and Dornan suggest that patients are likely to be more positive about their own experiences than if they were asked about A&E services in general (Hall and Dornan, 1988). At least the fact that many patients in this study were critical of the services provided suggests they felt free to be honest.

All the audiotaped interviews were transcribed in full and the transcripts were checked by the interviewer for accuracy and completeness. The interviewer systematically coded all the transcripts and notes according to twelve main themes identified from a thorough reading of all the transcripts. The material was reorganised into these themes.

Results

The material presented in this section is a summary of what respondents actually said. The aim is to represent the patient's view as faithfully as possible rather than to corroborate what was said or to reach any judgement about its accuracy in objective terms. People gave their own subjective accounts and the analysis of data has retained this subjectivity.

Ambulance services

Remarks were made about the personal qualities of the ambulance staff themselves, most of which were favourable. Some people made general comments, while others specified the attributes they liked. These were that ambulance staff looked after the patient, that they were gentle in the way they handled the patient, that they were understanding about people's feelings, and that they gave symptom relief.

Some people commented that the ambulance came very quickly, and clearly they were happy about this. Others complained about the length of time that they had to wait. The first problem for some was waiting to be put through on the telephone. Having their telephone call put on hold could be particularly distressing.

> *It was waiting for the ambulance that was my worst time, you know. Not knowing whether the message had gotten in the pipeline, whether the right message had gotten through. Knowing the traffic as I do in London whether there had been a breakdown somewhere.*

If the wait was judged to be too long some people made their own arrangements to get to hospital.

> *I couldn't get an ambulance, so some friends next door had a van so they threw me in the back of the van ... [Interviewer: Did you try to get an ambulance, or did your friends try to get an ambulance?] Yes. But they were put on hold, or something like that, then in the end we said, look, after 20 minutes I was losing so much blood that it was just natural that some transport had to be got.*

Mode of entry to casualty

Clearly there are several different routes into casualty, but the route that elicited the most spontaneous comment from respondents was via the GP. A few other routes into casualty were explicitly mentioned in these accounts.

Via GP

Several people said that the GP arranged their admission to casualty and that because of this they were seen very quickly. There were various aspects of admission by the GP which seemed to speed up the process. The first of these was that the admission had been agreed by the hospital staff, which meant that there were no delays due to negotiations about admission. Related to this was the fact that when the patient arrived at casualty they were expected by the casualty staff and for this reason again their admission was speeded up.

> *I was actually referred up to casualty by my GP ... he actually phoned through to the surgeon registrar so they were actually expecting me when I got up here.*

The third aspect of GP entry which facilitated patients' admissions was the fact that the GP could help overcome any resistance on the part of the casualty staff to the admission. There was one example of the admission via the GP going wrong. In this case the GP had spoken to the specialist and had agreed the admission with the specialist but the casualty staff were not aware of this. As far as casualty staff were concerned there had been no letter or phone call to arrange the admission and because of this the admission was much more problematic.

Other routes

The main method of entry apart from the GP that was explicitly commented on by the respondents was entry arranged by other hospital specialists. There were several accounts of patients contacting doctors who were treating them in other departments of the hospital whose specialists then arranged for their admission via the casualty department. Alternatively the specialist might arrange to meet the patient in casualty and attend to them there.

Clearly the above accounts describe occasions when the entry to casualty was arranged in some way or other. Most respondents entered without prearrangement.

Waiting times

Unsurprisingly, a great deal was said about waiting times. Some people said that they were seen quickly and others said that they had to wait a long time.

Starting with the former, a number of people said they were seen straight away. Some attributed this to the fact that they were admitted by their GP. Others attributed it to the severity of their complaint, the fact that the casualty department was not busy at the time that they arrived, or the time of day. Some expressed surprise and said that they had expected to wait a long time. Those who had been to casualty before commented that it was unusual to be treated so quickly. All of those who had been seen quickly commented favourably on this.

> *It took a lot of worry away, you see, being dealt with so quickly.*

Other respondents had had to wait a long time in casualty, and several were unhappy about it. Although many people expected to wait a long

time they did object when the wait was longer than they had been told it would be. Much distress was caused by people not knowing how long they were going to have to wait.

I mean it's the not knowing, isn't it, and when somebody comes and says "look, you know, we're busy, it might be another hour" then you don't mind. It's when they don't say anything.

Some people felt that the long wait meant that nothing was happening or that they had been forgotten. Waiting for X-ray results, or going for X-rays, was clearly troublesome. For many the waiting was the worst aspect of the whole process.

The worst aspect? ... the last wait. The wait to be moved into a ward when all the decisions had been made, all the information taken and yet still, and by that time you're beginning to feel exhausted by it all and you just couldn't wait for it to happen and yet still even that took a long time, I think that was probably, the waiting was very unpleasant, very unpleasant.

These comments were tempered by an awareness of the needs of other patients. Many people were aware that there were other people in the department whose conditions were more serious than their own. Some people made explicit comparisons between different types of medical condition, indicating which ones they thought were more serious and should be seen to first.

There were other people far more, probably far more seriously injured or ill than I was, so I mean obviously they've got to take preference ... obviously the man coming in with a cut finger that needs probably a couple of stitches is a very low priority to somebody that comes in with severe head injuries or heart attack ... so I don't think that should ever be changed, the fact that, you know – I was here first – that doesn't come into it.

People realised that because of this they couldn't expect to be seen straight away and that they would have to wait their turn.

There were circumstances apart from other people's needs which meant that people didn't mind waiting. If their own immediate needs were being attended to they often said that they didn't mind how long they waited.

They could have just come and seen me and given me the injection. I wouldn't give a care if I sat there all day then.

Other factors associated with acceptance of long waiting times were gratitude, relief at being treated and a lack of awareness of time.

Pain relief

Not all patients admitted via casualty were in pain but the issue of pain relief was the predominant issue for those who were. Pain was described in strong language, as was the often considerable delay in the administration of pain relief.

I was really really suicidal, like, I'd have walked into a wall or anything just to get rid of the pain.

Distress caused by pain sometimes interfered with examination and history taking, but the converse also seemed to be true, that doctors' questions delayed the administration of pain killers.

And then another doctor came and see me during that time and started asking me my history while I was still crying around, rolling around in pain ... it's a bit ridiculous, isn't it, I mean, if you're in pain and you're rolling around, the doctor's trying to examine you while you're rolling, it's no good for him and it's no good for you.

There was a perception by some respondents that staff were reluctant to give them pain relief and this appeared to be a source of tension between staff and patients.

They never wanted to give me the injection.

Reasons were not always given, but some patients were told that they would have to wait until pain relief was authorised by the doctor or until they had reached the ward. Others were told that it would interfere with the diagnostic process.

A particular issue for those suffering from sickle cell disease (who referred to themselves as "sicklers") was the idea of the normal casualty routine. These patients had been to casualty many times before and had clear ideas about good and bad practice. The normal routine involved regular injections and was an acceptable way of proceeding from the sicklers' point of view. If this level of treatment was not forthcoming, respondents were critical.

... normally I get my pain killers. They calm me down first with the pain killer, knowing that I'm a sickler and that, and then they ask questions after that. But this time they asked the questions, then decided to give me pain killers about 3 hours later ... that's what pissed me off.

The issue of answering questions will be discussed in a later section, but in the context of pain relief it was clear that people would be prepared to answer questions once their pain had been relieved.

That's all I wanted was the injections to kill the pain and I said "give me an injection and I'll answer all the questions you want."

Respondents reported that once they had been given medication they felt better. This relief did not always last, as for some people the effect of pain killers wore off. For others the medication was ineffective and so they continued to suffer after they had been treated. Some complained that the medication took a long time to work or that there was a long delay between treatments.

Whether or not the patient wants to be admitted

Bearing in mind that all the respondents in this sample were actually admitted, the issue of wanting or not wanting to be admitted was salient for them. A hard-pressed bed manager might imagine that all patients are desperate to be admitted, but this was not in fact the case.

Some respondents had not been expecting to be admitted and were surprised when it happened. Even when respondents had

recognised that their condition was serious they had not always anticipated admission. The expectations of these patients had been that they would receive treatment in the casualty department and then be sent home.

> *I know it was worse than I've ever been with asthma but I was surprised that they actually kept me in ... at first I thought I'd just come in to have a nebuliser or an injection or something and then be sent home later on that night but then I suddenly found myself on a ward with a drip so I was quite surprised.*

A number of people were not pleased to be admitted and said that they had been upset or "not too thrilled" when it happened because they wanted to go home. Linked to this was the anxiety that some patients felt about their families and children. Some were unable to get in touch with their families to tell them they were being admitted. Others said that they were unprepared for admission and had not brought anything with them.

In contrast to this, other respondents were pleased that they had been admitted. Some were relieved because they wanted their problem sorted out and felt they had got what they wanted. Being admitted was reassuring because it meant that a diagnosis might be reached or because the patient felt safe to be on the ward.

> *... once you got onto the ward then I felt sort of safe and secure sort of thing, you know, whilst down there you don't.*

The reassurance of having good medical care was underlined by accounts of what might have happened if the patient had not been admitted. People were aware, or had been told, of the potentially disastrous consequences of going home in their present condition. The theme of being admitted for one's own good was echoed by other respondents and reflects perhaps some reluctance to be in hospital.

Some patients were aware that the staff did not really want to admit them or had previous experiences of being turned away by casualty. Anxiety could be caused by the uncertainty of not knowing whether one was going to be admitted, caused by the delay in identifying a bed. Those who had been given explanations about the need for admission were reassured. Even those who were reluctant to come into hospital were reconciled after being given an explanation of why it was necessary.

Affective state

Emergency hospital admission can be a powerful experience emotionally and many respondents talked about their feelings while they were in casualty. These feelings are not always a private matter for the individual concerned, as they may affect staff/patient relations or the patient's ability to behave in an expected or acceptable manner.

Feelings of relief at having been admitted were discussed in the last section. Respondents expressed gratitude towards the staff and for the fact that the hospital was there. Several people said that they felt safe to

be in hospital. This feeling of safety or security had to do with being "in good hands".

> *I felt very, very safe in their hands ... that I think to me was the most important, that feeling of security and the feeling that you're with people who know exactly what they're doing, there's no need to panic ... you know when you just know you're not going to die. I'm not going to die ...*

Some people said that their fears disappeared when staff put them at their ease or encouraged them, or when they learned their diagnosis. Others remained terrified despite the reassurance of staff. In fact fear was a common theme and was not always related to anything specific, one person claiming that everyone coming into casualty was frightened. However, several specific fears were mentioned, either of the condition, such as not being able to breathe, or of its consequences, such as disfigurement resulting from injury. Death and pain also featured as causes of fear.

> *Death. Like, I mean, I must be honest. That is what I'm frightened of and that's what still frightens me about it. Pain, yes of course, and having the pain again, but ultimately death.*

Respondents expressed panic, crying, shock and desperation. Several people said that they were worried, about the cause of their symptoms, whether they would be dealt with properly, or by the conditions in the casualty department. Others were nervous, depressed, humiliated or embarrassed, sometimes because of the experiences that had brought them to casualty rather than anything that had happened after arrival. Being tired was also a common experience, either because respondents' conditions prevented them from sleeping or because they had been in casualty a long time without sleep.

> *I mean, I've not slept from 4 in the morning so I feel quite shattered.*

Boredom was also a problem, owing to the long waits and to the fact that people were not well enough to amuse themselves. Feeling unwell also meant that people were unable to complain about what was happening to them. Their passivity meant that the staff were in control and the patients just had to lie back and let it all happen, and it could also be experienced as helplessness or resignation.

Lastly some people were in a state of confusion which affected their ability to recall their experiences in casualty. Some said simply that they could not remember what had happened or were vague about events, perhaps due to distress at the time. Others said they could not think straight and were "not with it". Losing track of time was also a problem and some were comatose or semi-conscious.

Privacy, abandonment and being alone

The experience of being left alone in a cubicle affected people in different ways and this section is concerned with these different interpretations of similar events. It is divided into three categories on the basis of respondents' preferences.

The first category consists of those respondents who wanted privacy. Strong feelings were expressed about the lack of auditory and visual privacy. Cubicle curtains were criticised because everything going on between staff and other patients could be overheard and also because people didn't want others to hear everything that was happening to them. Being overheard entailed a loss of dignity, particularly if it was felt that one's defences had already been stripped.

I found the noise horrendous in there ... you're very conscious of cries and screams and moans and groans and also a lot of the nursing staff standing around giggling and talking and laughing ... it seems to bombard one with noise when you least want it.

Lack of visual privacy was also a problem. Some said that with the curtains billowing other people might as well be in the room and that the curtains were easily pulled aside.

Because anyone could pull the curtains, looking for a brother of his or a relative ... it could be a girl with her legs wide open being checked up ... there's just not a lot of privacy there.

Other problems included being stared at by other people, either in the cubicle, in the reception area or on a trolley. Respondents felt embarrassed, exposed, self-conscious or vulnerable as a result.

You're sitting there losing your baby and everyone is looking at you ... you know losing your baby is private, ain't it?

Other people's relatives stared, but respondents were also concerned about fellow patients witnessing their agony.

You know they're all looking in and you've got one of these open nighties on, and you can't get up out the bed because you're bleeding all over the place. And people looking in at you ... it's not very nice.

The reception area also caused problems for those who did not want

the whole world to know what your problem is.

The second category consisted of those who did not want too much privacy. Some patients made it clear in the interviews that they had wanted to be able to see what was going on in casualty and had wanted to feel that the staff had not forgotten them. Those who had been able to see what was happening, usually as a result of the door being left open, were pleased and those who could not see were not pleased.

the nurse ... opened the door for me and so at least I could see what was happening ... seeing the doctors. At least there was someone to talk to and to ask questions to.

... especially when they shut the door I couldn't see anybody.

Patients felt abandoned when they were given no information or if the staff left them alone for long periods. Conversely respondents were pleased if a member of staff came and talked to them.

they sent a nurse in to sit with me and talk to me ... then someone else came in and was talking to me. So I wasn't left alone for a long time.

The third category refers to the presence of relatives. All the people who commented on the presence of relatives or friends were pleased to have their company. Some talked in terms of their relatives being "allowed" to stay with them and were pleased that this perceived privilege had been granted because it helped to pass the time more agreeably.

my husband was sitting with me all the time. So it was lovely having him to talk to ... I wasn't left alone.

The relatives of some respondents had asked questions on the patient's behalf or at least had given respondents the confidence of feeling that they would deal with problems if they arose. One young woman said that she would not have got through the experience without her mother, who reassured her that everything was going to be all right.

Patients whose relatives could not stay with them or had been asked to leave, were upset to be alone. A few people, mainly men, asked their relatives to go home but it seemed that this was usually for the relatives' sake and not the patient's. Reasons given by male patients for sending their wives home included the prospect of a long wait, not wanting them to travel after dark, and knowing "what casualty is like".

Examination and investigations

As with everything else there were varied reactions to the process of being examined and investigated. Those who disliked the investigations found them painful or unpleasant in some way, while those who were pleased mentioned the reassuring aspects.

Vaginal examinations came in for criticism from several women patients who said they were painful, humiliating or degrading. Repeated vaginal examinations by a succession of doctors tended to aggravate the situation.

I had three of them, three of them ... you'd think that they'd all sort of feel probably the same thing ... and then another one comes and has to have another feel. It's quite degrading actually.

Patients were distressed when things went wrong, if for example a vein could not be found or a needle got bent. The language used could reveal the respondent's distaste for examination. One spoke of being "poked and poked", another of being "pushed" and a third complained of too much "testing" all over the body. A stomach pump was described as being "bloody awful".

When asked about the worst aspect of their casualty admission several people mentioned either the examination or other investigations, mostly in terms of how painful they were. On the other hand, several people were pleased to be examined. For some the examination was reassuring, evidence that their condition was being taken seriously and that they were going to be treated. The thoroughness of the investigations was one of the most reassuring aspects.

I had an X-ray and a blood test and the heart machines, and ECG machine and the drip and steroids and things, so quite, I had quite a lot, got my money's worth.

Respondents expressed relief and satisfaction at having been examined, and for one it was the best aspect of the experience of being admitted. The lack of pain was commented on, the fact that an examination had not been "unbearable" for example. In contrast to the feelings of degradation already referred to, one pregnant woman was pleased that she was not "treated like cattle".

Giving and receiving information

The giving and receiving of information by patients have been separated as they are different issues. Receiving information has been discussed at length in the literature, but the giving of information by patients much less so.

Giving information

Most of the comments about the giving of information by patients were negative, because some questions were perceived as stupid, repetitive, unnecessary or irrelevant. Examples of such questions were the patient's age, number of children, their eating, drinking and smoking habits, whether they had been to casualty before, and their religion. People said they did not want to answer these questions, although nobody said they had refused to do so. Respondents said that they had answered questions asked by one member of staff only to be asked the same questions again minutes later. They knew that they were repeating themselves and that the answers had been written down the first time, and this made them wonder if anyone was taking any notice of what they said or if there was any communication between staff.

Sort of answer one lot of questions to one person and then you get somebody else come in 5 minutes later and asking you the same lot, you'd be thinking, well, I just told somebody all those things ... 'cause you think you're probably just repeating yourself and you think, well, are they actually taking any notice of what you're saying or not.

These complaints were sometimes voiced in the context of the patient's condition. It was pointed out that it was difficult to answer questions when one was not feeling well, and that it could be tiring to do so. Questions seemed to be particularly irksome for those in pain and there was a suggestion that this conflict had the potential to escalate into unpleasant confrontation.

the questions I thought were stupid, you know like asking these questions, have you ever been here before ... I was just ready to grab the doctor ... I was that bad with pain, I must have scared the poor man half to death.

Receiving information

The main focus of complaint was the lack of information about waiting times. People wanted to have some idea of when they were going to be seen, why they were waiting, and what they were waiting for. Other

things that patients wanted more information about included the results of tests such as X-rays or blood tests. It was claimed that "no one even tells you what the outcome is".

People wanted information on what was going to be done to them, whether or not they were going to be admitted and on their condition.

> *They said that I'd had a very bad asthma attack but I was, I was wondering perhaps, you know, whether or not, you know, there was something else that was wrong like that I had lung cancer ... why was I having such a bad asthma attack and they said, they were just sort of vague about why they were keeping me in.*

When asked about the worst aspect of their hospital admission, a few people said it was the long periods without being told what was happening. Suggestions for improvement stressed better communication, on waiting times, on what was happening and what was going to happen. The consequence of lack of information could be that patients felt they had been forgotten. Those with small children needed to know whether they were going to be admitted or not in order to arrange child care.

In contrast, other respondents were happy with the information they had been given. A few simply said that "everything" had been explained but others specified what it was that they had been told (and had wanted to know). This specific information included the probable diagnosis, the need for treatment, why the patient was being admitted, what the doctors were going to do, what was going to happen, the procedures, what it would be like for the patient and how they would feel afterwards. Several respondents added that this information put them at their ease, or that they didn't feel worried or scared because they knew where they stood, and were not left with uncertainty.

Very few people said that they had actually asked for information. Those who did said that a lot of questions had to be asked before an answer was received and that this had to be done carefully.

> *you've got to be careful even how you ask questions about, because if it's seen that you're questioning medical judgements or whatever then people get very defensive.*

Other ways of obtaining information were mentioned such as overhearing telephone calls to the bed manager.

The difference between those who were satisfied and those who were not may perhaps have more to do with the individual's need for information and coping style than with the amount of information given, but this is beyond the scope of this study. One individual who was happy with the doctor's explanation did say that he thought he could not have coped with more information.

Staff

Comments about staff were often made in a general way, so that it was not always possible to distinguish comments about the nurses from those about the doctors. The group who were clearly distinguished from the others were the receptionists.

Nurses and doctors

Staff in both hospitals came in for a tremendous amount of praise and it would be extremely repetitive to list all the qualities for which they were praised. Nurses and doctors were frequently described as nice, kind, caring, helpful, cheerful, reassuring, charming, polite and attentive.

> *The nurses were very very nice. I felt very good about it because they were all so nice. They're extremely nice in casualty.*

Less frequently than these personal qualities, their professional abilities were also praised. They were described as efficient, competent and as having done everything that they could. Respondents particularly appreciated having nurses beside them and not being left alone. Even if the nurse was unable to stay with them, respondents were pleased when the staff came to see them frequently to check that they were comfortable. Patients liked it when staff put them at ease, and the ability of some nurses and doctors to laugh and make jokes was appreciated. Being treated with respect, as a person and not a patient, was also well received.

> *the doctor's manner ... that was reassuring, you know. It wasn't just like, well this is going to happen ... she didn't treat me like that, she asked me what I'd like to do and we talked it over and treated me nice.*

There was also a strong sense in these accounts that staff had done as much as they could for the patient. People said that nothing had been too much trouble, that all their needs had been taken care of and that everything they had asked for had been done. The fact that patients knew that the staff were around if anything happened was reassuring. The way that staff handled patients physically was also praised, respondents saying that they had been handled gently and carefully. When asked about the best aspect of their time in casualty, many respondents replied in terms of the staff.

> *that was the best aspect, that each of these young persons knew their job, you know, and knew it extremely well ... that I think to me was the most important, that feeling of security and the feeling that you're with people who know exactly what they're doing.*

Coupled with these extremely positive feelings towards staff was an awareness of how busy they were. A lot of people commented on how busy the nurses and doctors were, although this was said in sympathy rather than in criticism. They were seen to be rushed off their feet, to work long hours and to have little time to rest.

> *... they were very busy I didn't see any of them sit down, that was the whole time I was there ... they were just dashing around ... one was complaining that they hadn't had anything to eat yet.*

There was little intimation that this workload interfered with good patient care, although such criticism may have been withheld. One person said explicitly that he could not criticise the hospital because

they were "doing their best for you". Some people, in commenting on staff workload, stated that it did not interfere with good care, by saying for example that staff were not offhand, or were cheerful or efficient. Several people said that more doctors and nurses should be employed and more money injected into the hospital.

> *All the doctors, nurses, everyone was absolutely ace. Lots of people with not enough funds and not enough workers, trying to do and being expected to do what needs hundreds of more people doing it.*

Not all remarks about staff were favourable, however. Some respondents had clearly had arguments with staff and were critical as a result. The arguments seemed to have resulted from doctors or nurses refusing to grant patients' requests, for medication, for quicker attention or perhaps for any attention. Respondents claimed that staff had ignored them or had not shown much compassion.

> *But for someone to come in and say "oh I'm doctor so and so", shove their fingers up you and then say "right, we're admitting you", it's just not the kind of thing that I can sort of relate to.*

In both hospitals it was claimed that doctors sat around chatting and having coffee while maintaining that they were busy. Respondents were not happy to be in the care of junior doctors and student nurses who did not seem to know what they were doing or who had to ask constantly for help. They realised that staff needed to be trained but did not wish to be used as guinea pigs themselves.

People also remarked on staff turnover: positively, that they like seeing the same faces, and negatively, that they were seen by a lot of different nurses all doing different things. It was claimed that there were so many different categories of staff in casualty that patients were not always sure who they were talking to, particularly if name badges were obscured.

Receptionists

Remarks about receptionists were made in only one of the hospitals and these remarks were almost entirely negative. Firstly this had to do with the receptionists' manner, which it was claimed was unfriendly and unsympathetic. A patient from another part of the country was scared by this unwelcoming approach and wished she was going into a hospital in her home town.

> *And you don't get a lot of sympathy from the receptionist. She could just keep you standing there whilst you're bleeding to death, asking you this question and that question.*

Secondly it seemed that the reception desk was not always staffed, so that queues kept forming. It was thought that this happened because the receptionists needed to go and look for patients' notes.

Other people in casualty

Probably the most vivid accounts of what it was actually like to be in casualty were given when respondents talked about the other people

there. Casualty was described as busy and crowded. It was claimed that it was often "packed" in the evenings, both with people who were hurt and with drunks or drug addicts. Some patients arrived with a number of friends or relatives who disturbed other patients, particularly when they "cluttered round a cubicle".

People were distressed by the condition of the other patients, some of whom arrived bleeding heavily or making awful noises. There were victims of violent assaults as well as drunks who had fallen over and cut themselves.

> *... because you see things that are going to frighten you more and it doesn't really help each individual person's problem.*

Fights or scuffles were caused by drug addicts trying to obtain drugs or patients wanting to be seen, and these could easily frighten other people. Some people were distressed by less violent events, for example by seeing a child who was not well or a confused old lady who was left alone for long periods. One woman felt uncomfortable to be in a waiting room full of men laughing and joking after pub closing time. Children running around, especially late at night, were a problem for some respondents. Smoking in the waiting area or relatives smoking in cubicles also evoked adverse comment. Some comfort could be obtained, however: one patient talked to another patient in the same cubicle and they calmed each other down.

It was suggested that the hospital should hire security guards to protect staff, especially at night and at weekends, in order to keep out trouble-makers.

Physical environment

Most remarks about the physical environment and amenities in the A&E departments were critical. The trolleys and beds were uncomfortable. They were described as hard and narrow, at the wrong height and wrong angle so that the patient slid down. Several people said that the toilets were filthy and in one hospital it seemed that they had been smashed by vandals. The waiting areas were described as oppressive and claustrophobic and in need of refurbishment. It was suggested that a bigger waiting area with separate sections for adults and children would be an improvement. The general appearance of both casualty departments was poor, being described as dirty, gloomy, grubby with peeling paint and scuffed lino.

> *the floors didn't look swept and it looked like there was dust on the shelves and it just looked too dirty almost to be a casualty.*

It was suggested that the department could be swept and cleaned more often and that it should be redecorated.

The fact that people were smoking in casualty upset some respondents and others felt that they could not smoke when they wanted to. It was suggested that there should be separate areas for smokers and non-smokers.

The lack of car parking facilities made things difficult for some respondents particularly, those unable to walk who needed to be

dropped off. Other complaints included insufficient telephones, poor ventilation, unpleasant smells, lack of extra pillows and the fact that the pharmacy was closed.

Various suggestions for improvement were made, including more books and magazines, a television room, drinks machines, someone to make tea and coffee, pictures on the walls, a clock, more comfortable seats, better signposting so people knew where to go, and interpreters.

Favourable remarks that people made included the fact that they were given drinks and occasionally food. Some said they were in newly painted cubicles or that it had been bright and cheerful.

It might be thought that the physical surroundings had nothing to do with the standard of care, but two people made explicit connections between these apparently unconnected factors.

> *I didn't think I'd get a good standard of care if the place wasn't swept, you know, I mean, it just seemed like an indication of perhaps all the help would not be good enough.*

Conclusion

The overall impression gained from these interviews is that there was some kind of balance between positive and negative views of the Accident and Emergency departments. Although some people did have unpleasant experiences, these accounts did not corroborate some of the recent media horror stories (Phillips, 1991). These accounts reflect widely shared concerns of the patients, some of which are familiar from previous studies of patient satisfaction. In fact the findings could perhaps be summarised by one of the respondents who said "They don't leave you lying about in corridors like you hear". It may be that horror stories in the media have the effect of lowering expectations, so that patients are pleased when their experiences are not as bad as they might have been. Although more favourable than media reports, these accounts still gave plenty of ideas for improvement.

The fact that positive and negative comments were both received may perhaps provide reassurance about the status of the data. No checks were made about the honesty of patients' responses. In some respects this would have been impossible, for example when people were talking about their feelings. In other respects it would have been difficult, for example in checking information that people said they had been given or not given. For some issues like waiting times or relief of symptoms it might have been possible to verify patients' accounts directly. However no attempt at corroboration was attempted, firstly because it was beyond the scope of this study and secondly because the focus was patients' subjective experiences. If, for example, patients felt that they had been asked irrelevant questions, the fact that the questions were clinically vital is of no help if the patient does not know this. Similarly if patients said that the trolleys were uncomfortable, this is what their experience was, irrespective of objective criteria.

Reference to the literature does not provide clear guidance about

what to expect in terms of the honesty of responses. French discusses the repression of unpleasant experiences, referring to the "progressive mutual reinforcement of time lapse and unpleasantness" (French, 1981). Lack of privacy in hospital may deter people from making criticisms but after discharge there may be a "halo of gratitude". French seems to come down in favour of hospital interviewing. Measuring honesty in terms of patients' readiness to be critical, French quotes evidence that patients are more critical while in hospital except on the issue of receipt of information. The fact that many patients in this study were critical of the services provided suggests they felt free to be honest, at least on this definition of honesty.

Hall and Dornan, in a meta-analysis of patient satisfaction, noted that higher satisfaction scores were received by specific instances of health care (Hall and Dornan, 1988). Evaluations of health services in general were much poorer. This would suggest that patients in the present study would be more positive about their experiences than if they were asked about A&E services in general. Certainly in some of the accounts, people were favourably comparing their own experiences against more negative expectations.

Several themes identified in this study have been discussed in previous studies. Some of them, for instance waiting times or the receiving of information, have been discussed in great detail in other settings. Even so there are aspects of these issues that are particular to the A&E setting, such as waiting for a bed to be found. Other issues would seem to be specific to A&E departments, such as the distress caused by other people in casualty and the problem of urgent pain relief. On most of these issues, it would seem that patients in A&E departments have particular needs that are different from those of patients in other settings. All the issues raised in this study were spontaneously mentioned by respondents and may thus be presumed to be of salience for them. It would be possible to explore these issues further by constructing a questionnaire based on the findings of this study in order to conduct a systematic survey. Specific problems such as pain relief could be measured in terms of prevalence and statistical importance.

It is however possible to make a number of recommendations for good practice based on these results. A few caveats should be noted. Firstly some of the patients' concerns cannot be legislated for. If someone who is seriously ill does not want to be admitted to hospital, few people are likely to recommend that they should not be admitted. Secondly some of the recommendations may not be feasible in particular settings. Thirdly on some issues, such as privacy, there was a range of preferences. The recommendations for good practice may have more to do with sensitivity towards individual preferences than advocating a particular course of action.

Recommendations

Communication

- Staff should be aware that patients can find repeated history taking and repeated examinations tiresome and irritating.
- Staff should be aware that certain lines of questioning can appear irrelevant to patients.
- Staff should be aware that patients like to have the following information:

  i) how long their wait is likely to be, with updates if there are further delays

  ii) reasons for delay

  iii) possible or probable diagnosis

  iv) reasons for admission

  v) need for treatment

  vi) what the treatment will consist of and what will happen to the patient

  vii) how the patient may feel as a result of the treatment.

Pain relief

- Staff should be aware that patients can feel that pain relief is being delayed unnecessarily.
- If pain relief is not given, an explanation should be given of when this might be feasible and the reason for the delay.

Privacy

- Staff should be sensitive to patients' need for privacy and their embarrassment about how they look and what they are saying.
- Facilities should be provided to give privacy to those who feel vulnerable. Walls are preferable to curtains for this purpose.

Companionship

- The opportunity of having the company of friends and relatives is welcomed by patients. It may be necessary to put a limit on the numbers present at any one time.
- If the patient is alone and staffing levels permit, a member of staff should spend time with the patient. If this is not feasible, members of staff should visit patients at regular intervals so that they understand that they have not been forgotten.

Security

- A higher profile from the hospital's security staff would reassure some patients.

Ambulance services

- If delays are unavoidable, patients should be told how long they will have to wait and the reasons for the delay.

Amenities

- Staff should be aware that patients are dissatisfied with many of the amenities, in particular trolleys, signposting, toilets, car parking, cleanliness, and the provision of separate smoking areas, and books and magazines.

CHAPTER 6

District nurses and poorly planned discharges

REBEKAH SAVILL AND JENNY BARTHOLOMEW

Introduction

The Patient's Charter (Department of Health, 1991b) sets out standards for the discharge of patients from hospital. The charter assures patients that before they leave hospital, decisions will be made as to whether or not they need continuing care in the community, and that if required, arrangements for meeting these needs will be made by the hospital before they are discharged.

District nurses are the main providers of professional community care and the poorly planned hospital discharge has been identified as being a major concern for them (Davidson, 1990). A poorly planned discharge is one in which the hospital does not communicate adequately with the district nurse and other caring services in relation to the patient's discharge and the follow-up care required. It is this lack of communication that is at the root of many of the problems that district nurses face when continuing the care of patients discharged from hospital (Evers, 1991).

There are increasing numbers of elderly people being treated in acute hospital beds (Barnes, 1984) as a result of the increase in the population of the elderly, and of the reduced number of long-stay beds. The emphasis on efficiency and cost-effectiveness in hospital performance in an effort to increase bed-occupancy has had the effect of reducing the length of patient-stay in hospital, and Evers (1991) notes that this rapid turnover of acute hospital beds leads to an increase in the numbers of patients, in particular the elderly, coming to the attention of professional community carers.

> *Discharge planning is an interdisciplinary process that provides continuity of care following the patient's discharge from hospital* (Thliveris, 1990).

Furthermore,

> *It should aim at providing a comprehensive assessment of the patient's functional abilities and post-discharge needs* (Arenth and Mamon, 1985).

However, Barnes (1984) regards the transfer of patients from hospital to home as being a multi-faceted problem; this problem was recognised by Roberts (1975) who described as a "vacuum" the gap that existed between hospital and community, noting that the main cause of it was the ineffective mobilisation of caring services. In a study looking at the reasons for early unplanned readmissions of the elderly to hospital (Williams and Fitton, 1990) it was found that there were three types

of problem with the provision of community nursing and social services for such patients once they had been discharged from hospital: services were inefficient and ineffective; there was delay in starting the services; there was inadequate preparation for discharge, with no services organised. It was concluded that the causes of such problems were communication failure, administrative difficulties and insufficient resources.

The Department of Health circular HC(89)5, describing the government's attitude to the hospital discharge process, includes advice to health authorities, requesting them to revise their discharge procedures. It comments that lack of early effective planning of services required after discharge can lead to problems.

The literature reviewed gives some indication of the reasons for poor communication between hospital and community personnel – premature patient discharge being one reason that is highlighted. There is speculation that the pressure on beds may result in patients being sent home from hospital early. However, there is no evidence in the literature to indicate that, where discharges are poorly planned because of lack of warning of discharge, this is because pressure on beds resulted in early discharge; but on commonsense grounds it might be inferred.

The reasons why these discharges are not planned properly seem to be either lack of organisation on the part of the ward staff, especially the senior nurses and junior doctors, or because patients are discharged at too short notice for adequate communication to be made with the district nurse. The latter of these is maintained by Davidson (1990) and O'Leary (1988) and identifies the need for a better understanding between hospital and community personnel. O'Leary acknowledges that although hospitals do have discharge procedures, appropriate information is not always passed on to the district nurses. She considers three possible reasons for this: where the referral is made but the district nurse does not receive it; where the hospital does not refer patients when a referral is necessary; and where the patient is discharged at such short notice that there is no time for a referral to be made.

There is also the issue of the inefficient use of other community services by the ward staff, such as meals on wheels and home-helps, resulting in added pressure on the district nurses and on the patients' families. Often hospital nurses are not aware of local community developments and services, such as the role of the social worker(Barnes, 1984).

Saddington (1985) upholds that one of the reasons for communication breakdown is that too much reliance is placed upon the ward sister to organise patient discharge. The issue of who initiates a referral to community services is examined by Armitage (1985). She maintains that the question of who is responsible for referral is complicated by the lack of clarity in role definition between doctors and nurses. No one has complete responsibility for assessment and decision-making, resulting in lack of preparation planning and missed referrals.

Recent years have seen the development of liaison posts which aim to facilitate planned and organised discharge procedures. These

'liaison nurses' provide a link between community and hospital carers, but this care is not available in all health authorities.

> *Hospitals are merely an extension of the community, with patients spending a very small proportion of their time as in-patients. The care that people receive should not differ from community to hospital and there should be a transition of care from one type of carer to another. This can only be achieved with adequate communication* (Milne, 1988).

The purpose of this chapter is twofold:

- to identify the problems faced by district nurses as a result of hospital discharges that have been poorly planned or poorly carried out;
- to establish from any information gained whether or not there is a link between the problems that district nurses face as a result of poorly planned discharges and inappropriate discharge of patients from hospital.

Method

Two areas were selected to provide a sample from inner London: a health authority in South London, and a borough of a health authority in North London, with populations of 162,000, and between 158,000 and 160,000 respectively. They will be referred to throughout the study as areas S and N. Both these areas were used in other parts of the Emergency Pathways study, supported by the King's Fund. Both areas are divided into neighbourhoods – a neighbourhood being a geographical area with a neighbourhood manager who oversees a certain number of district nurses.

Each neighbourhood manager and his/her nurses are attached either to a health centre or to a clinic. There are six neighbourhoods in area S and eight in area N. The sampling frame consisted of all the neighbourhoods in each district. The criterion for including a district nurse in the study was that he/she should be in charge of a caseload; this amounted to those who were grade G and above.

The district nurses were identified in the following way: the director of community nursing services in each area was contacted by letter by the researcher and a covering letter was sent by the head of the Department of General Practice at UMDS. An arrangement was made for the researcher to meet with each director, during which meeting the proposed study was presented and discussed, and permission was obtained to involve the district nurses in the project. The community directors agreed to contact the neighbourhood managers in their area, informing them of the study, and giving them a brief outline of it. Each neighbourhood manager was then contacted, sent a protocol, and asked to identify the district nurses in their neighbourhood. Fifty-four nurses fitted the criteria for inclusion in the study, 28 in area S, and 26 in area N. The neighbourhood managers were asked to circulate the protocol around their district nurses.

This initial contact was followed up by a phone call in which arrangements were made with each manager for a meeting with them

and their district nurses. At these meetings the proposed study was presented to the nurses, and any points raised by them in relation to it were discussed. The opportunity was taken at this stage to make interview appointments with the nurses to see each one individually over the forthcoming weeks. The nurses were asked to attend the interview having reviewed their nursing documentation for the four weeks prior to the date of the interview. They were asked to come prepared to answer questions in relation to all patients referred to them from hospital, or discharged from hospital and referred to them by the GP, or anyone else, within a week of their discharge. The nurses were contacted the day before the interview to confirm it. It was not always possible to speak to the nurse him/herself, so, in many cases, a message was left and the nurse asked to contact the researcher if the appointment could not be kept. Where nurses failed to keep appointments, two more attempts were made to interview them. If three interviews were missed without having been cancelled, the nurses were dropped from the study.

A semi-structured questionnaire was completed during each interview. Nurses were asked how and when each referral was made; whether or not the referral and discharge were considered to be appropriate, and what problems ensued for the district nurse as the result of the referral procedure. Finally the district nurses were asked what in their opinion should change in order to improve hospital discharge planning.

Results

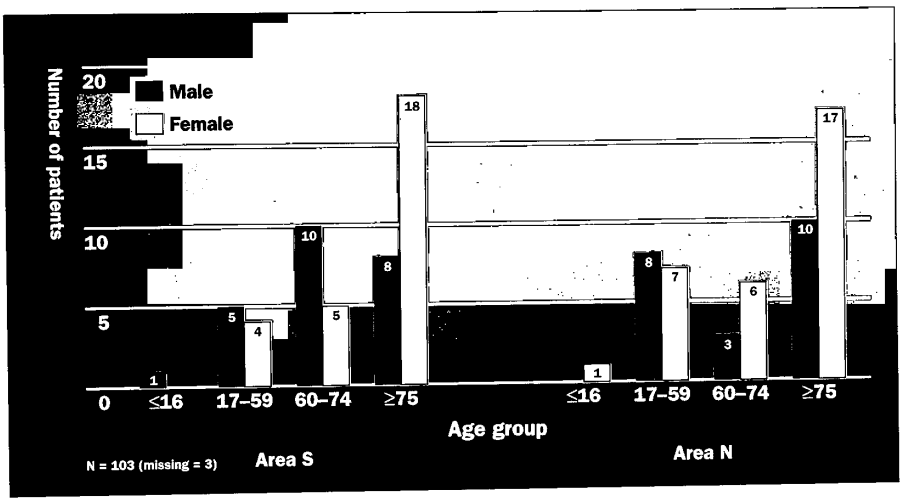
There were fourteen health centres, six in area S and eight in area N, and all participated in the study. The total number of district nurses with a caseload was 54, and 46 were available for interview. The length of the interviews varied from 45 minutes to two hours: this was dependent upon the number of referrals each nurse had; the extent of the problems they experienced with specific referrals; and the extent to which individual nurses discussed problems and concerns. Of the eight district nurses not interviewed, two were absent on long-term sick leave; three were on study leave, and two were on extended/compassionate leave. One repeatedly failed to keep appointments and was finally dropped from the study. The number of district nurses attached to each health centre ranged from 2 to 5.

Referrals

Data were collected on 139 patients referred to the district nurses over the month preceding the interview. The number of referrals per health centre ranged from 2 to 20, and per district nurse from 0 to 7. Seventy-two (52 per cent) referrals were from area S and 67 (48 per cent) from area N. In 106 (76 per cent) cases the district nurse was informed of the patient's discharge by a hospital. In 12 (9 per cent) cases the case was referred by the GP, and in the remaining 21 (15 per cent) cases by the patient, relatives or friends, and in one case by the home-help.

Figure 6.1

Age and sex of hospital referrals to district nurses



Patient characteristics

Sixty (43 per cent) referrals were male, and 79 (57 per cent) were female. Age ranged from 12 to 98 years. 104 (75 per cent) of all referred cases were over the age of 59 years, and 66 (48 per cent) were 75 years or over. Only two (1 per cent) were under the age of 16 years. Figure 6.1 shows the age/sex distribution of referrals from hospital. For patients aged 60–74 years there was a greater proportion referred after discharge by GP, family, or friends than for the other age groups.

Hospital and specialty distribution

Thirty-four (64 per cent) of the hospital referrals in area S and 30 (56 per cent) of hospital referrals in area N came from one major hospital in that area. The remainder were spread over a number of hospitals. The distribution of referrals both from a hospital and from the GP/other sources, showing the type of unit the patient had been discharged from is given in Table 6.1.

Methods of referral

Referrals from hospital were all administered by nurses. The way in which referrals were carried out varied. In 93 (88 per cent) of the 106 hospital referrals a telephone call was made. This was received by a

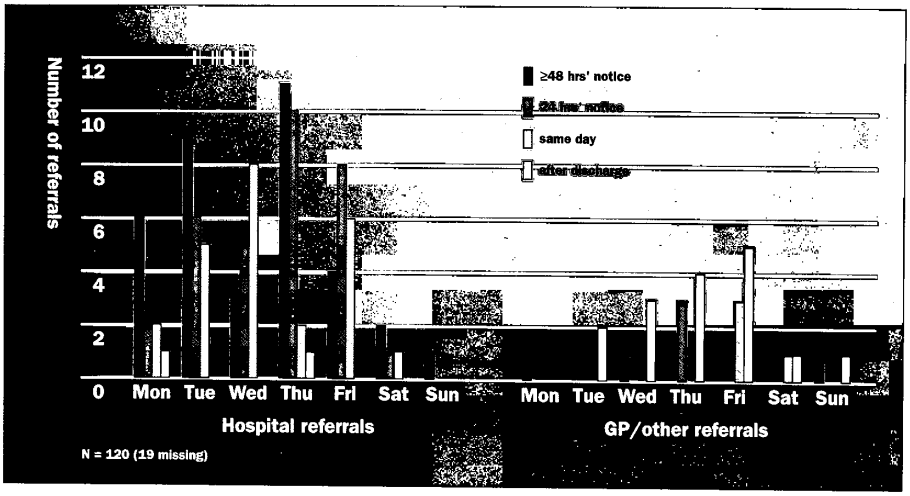
Table 6.1

Hospital wards of referrals

Type of unit	Hospital referrals (n = 101; missing = 5)	GP/other referrals (n = 27; missing = 6)
Elderly care unit	20 (20%)	3 (11%)
Surgical	19 (19%)	7 (26%)
Medical	14 (14%)	1 (4%)
Specialty unit	48 (47%)	16 (59%)

Figure 6.2

Day of discharge and notification time



receptionist (47 cases), a district nurse (27 cases), and 19 cases were undocumented. In 11 (10 per cent) cases a fax was received, and in 3 (3 per cent) a message was left on an answering machine. The form the referral took for the 33 non-hospital referrals was not recorded.

Timing of patient discharge

One district nurse described Friday afternoon discharges as "a nightmare"; 10 others mentioned it as being a major concern for district nurses because of the close down of all social services after 5 pm on a Friday. Several district nurses mentioned, however, that these discharges were acceptable if all pre-discharge planning had been properly carried out. At least 48 hours' warning of discharge was considered desirable. Figure 6.2 shows the notification time on different days of the week.

Reasons for referring patients to district nurse

In 96 (91 per cent) of the 106 hospital referrals nursing care was required, and 10 (9 per cent) were simply to check the patient was all right. Thirty-one (94 per cent) of the 'other' referrals were defined as requiring nursing care. Eighty-four (60 per cent) patients had only one problem (as defined in Table 6.2), 40 (29 per cent) had two problems and 13 (9 per cent) had three.

Information and communication

District nurses felt that in 48 (45 per cent) of hospital referrals and in 23 (70 per cent) of GP/other referrals the initial referral did not provide them with adequate information. The nurses specified that "a lot of information was missing" in (12) 9 per cent of all cases. In 28 (20 per cent) cases there was information missing in relation to the diagnosis and problems of the patient. In 17 (12 per cent) cases facts were either inaccurate or missing, such as date of discharge, name of GP etc. Referral instructions were missing in 14 (10 per cent) cases, informa-

Table 6.2

Patient problems or needs

Type of problem or need	Number of times mentioned	
Dressings	61	(43%)
General care	51	(37%)
Mental/psychological	13	(9.4%)
Social	5	(3.6%)
Supervision of medication	24	(17.2%)
Equipment required	6	(4.3%)
Education	6	(4.3%)
Observation	20	(14.3%)
No problems	3	(2.2%)

(N = 139 Number of problems/needs = 189)

tion relating to the patient's hospital stay in 10 (7 per cent) cases, to the patient's well-being in 9 (7 per cent) cases. Information was missing regarding medication in 7 (5 per cent) cases, equipment required in 6 (4 per cent) cases and information regarding the social services in 3 (2 per cent) cases.

Twelve nurses considered lack of information to be a widespread problem, stating that more specific information was required with most referrals – for example, details of next-of-kin, and the patient's GP, and how to gain access to the patient's home. The amount of missing information varied according to notification time, with the largest percentage recording missing information (66 per cent) in those notifying post-discharge. This can be seen to be related to the source of the referral, as 14 of the 16 post-discharge referrals were from the GP or other sources who would lack knowledge of the inpatient situation.

How additional information was obtained

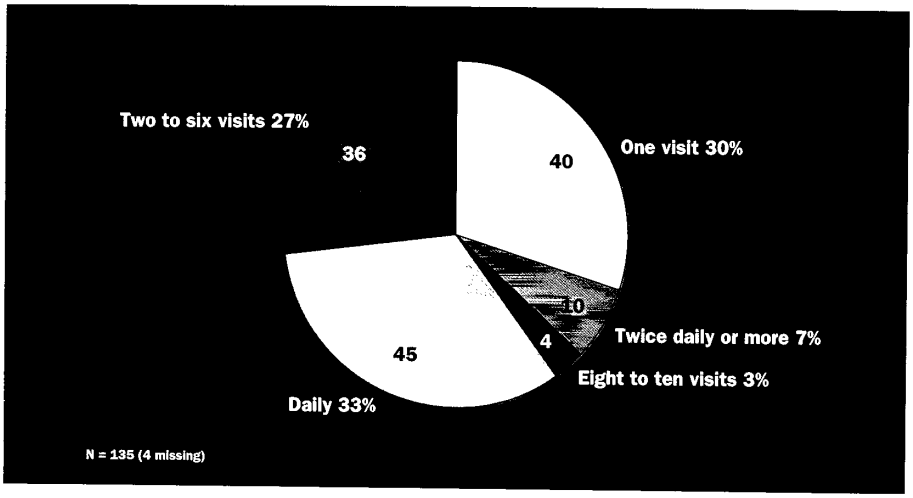
In 25 (18 per cent) of all referred cases the district nurses obtained extra information by talking to and assessing the patient; in 23 (17 per cent) cases the nurses felt that they had to phone the ward in order to obtain extra information. The remainder obtained information by talking to relatives, contacting the GP or other medical personnel or reading GP notes or letters.

Problems caused by lack of information

The initial referral was not considered to have provided adequate information in 69 cases (50 per cent). Nurses felt this did not cause problems for 24 of these cases, but did cause problems for 45. In cases where the nurse had cared for the patient before, the lack of information caused fewer problems; there were fewer wasted visits and fewer problems in allocating time accurately.

Figure 6.3

Number of visits by district nurse in week after discharge/ notification



Discharge nursing letter

64 (46 per cent) patients who were referred for continuing nursing care had a discharge nursing letter sent with them; 43 (67 per cent) of these letters were thought by the nurses to contain extra helpful information.

Time taken for district nurse visits

Figure 6.3 shows the number of visits made for each patient in the first week after discharge/notification. Length of visits varied from 2 minutes to 2 hours. In 28 (20 per cent) of all referred cases the district nurse spent an hour or more with the patient; in 93 (67 per cent) cases the nurse spent between 20 minutes and an hour with the patient, and in 14 (10 per cent) cases the visit lasted less than 20 minutes.

Appropriate discharges

In 22 (20 per cent) hospital referrals the district nurse felt that the patients had been inappropriately discharged in relation to their condition. Three nurses expressed a concern that patients are often sent home too early, still requiring specialist attention to wounds and with severe pain not controlled. Of the 32 referrals from the GP/other sources, 5 (16 per cent) were considered inappropriate discharges and 27 (84 per cent) appropriate discharges. In 16 (50 per cent) of these 32 referrals the case was considered one that should have been referred to the district nurse by the hospital.

Problems with the referrals

For the total number of discharges referred from either the hospital or the GP/other sources the following problems were identified. Poor communication or a lack of it was reported in 31 (46 per cent) cases in area N, and 20 (28 per cent) cases in area S. There were many problems caused by lack of organisation on the part of the hospital, such as services not being organised in 9 (7 per cent) cases; equipment, dressings and medication not being sent with the patient in 16 (12 per

cent) cases. In 12 (9 per cent) cases nurses felt that the referral was unnecessary. Other problems included the patient being discharged too early, not enough warning of discharge being given, no home assessment being carried out, and the patient being ill-prepared for discharge.

The issue of pre-discharge home-assessment proved to be a very real concern, with 17 nurses saying that many more should be carried out, owing to the immense differences between hospital and home surroundings. Nineteen nurses felt that dressings should always be sent with the patient, to last for at least two days, because of the problems they have in obtaining them in the community. Likewise, medication and equipment such as commodes should be sent, particularly medications that cannot be obtained on prescription, for example, charcoal dressings.

There were more problems with referrals when patients were discharged at the weekend. Of the discharges that were carried out on Friday, Saturday or Sunday, 28 (80 per cent) caused problems; 60 (69 per cent) of the discharges carried out on the other 4 days of the week caused problems.

Problems were looked at in relation to the age of the patient. In the under-60 age group, 13 out of 35 (37 per cent) referrals were problem-free. For those aged 60 years and over only 26 out of 104 (25 per cent) were problem-free.

Problems were also looked at in relation to the amount of notice the district nurse was given. Where there was 48 hours' or more notice there were problems with 28 out of 42 (66 per cent) referrals but when there was 24 hours' or less notice this rose to 49 out of 65 (75 per cent).

Table 6.3 presents categories of requirements the nurses thought would have reduced the referral problems.

Table 6.3

Requirements to reduce problems

Problems reduced if:	**Number of times mentioned (n = 93)**
More accurate/more information	36 (38%)
Better discharge organisation	14 (15%)
Other services organised	4 (4%)
Aids and equipment sent	8 (9%)
More warning of discharge	8 (9%)
OT assessment	5 (5%)
Not been referred	7 (8%)
Not been discharged	8 (9%)
If DN had been in contact with hospital	3 (3%)

District nurses' opinions about what should change to improve hospital discharge planning

Eleven district nurses stressed that links should be strengthened between the hospital and the community. A further nine nurses felt that hospitals were unaware of how they worked, having unrealistic expectations of the way in which they planned their time and workload. The education of staff in relation to the role of the district nurse was considered important by three nurses, and several felt that ward nurses should spend time in the community with district nurses.

Thirteen nurses said that it would be an improvement if hospital nurses and doctors did not tell the patients how often the district nurse would visit and what she would do, as this invariably differed from what the district nurse actually did.

Many nurses emphasised that district nurse liaison with the ward staff and patient should begin before the patient is discharged. Six district nurses added that they should visit the patient on the ward before discharge, and a further five nurses felt that they should be included in the pre-discharge home visits.

Conclusion

Some nurses were more vociferous and outspoken than others, and while this may have reflected different experiences to some extent, personal and individual expectations must also be considered, in that what is a problem for one nurse may not be for another.

There are large numbers of elderly people requiring community nursing care following discharge from hospital; this must partly be because the numbers of elderly are increasing. The results of this study showed that the numbers of referrals from Elderly Care Units (ECUs) were small compared with the total number of elderly people referred for continued nursing care. Thus some elderly people were being nursed in "acute" beds, and therefore possibly being discharged sooner than if they were being nursed on ECUs. District nurses experienced more problems with the discharges and referrals of the elderly, especially those over the age of 75; thus, if the numbers of elderly being discharged for follow-up care continues to increase, the problems that district nurses face will also potentially increase. Some district nurses felt that where patients were referred in order for the district nurse to check that they were "generally okay" this was a way of the hospital safeguarding their decision to send the patient home.

In almost a quarter of cases the district nurse was not informed that the patient was coming home. There are many possible reasons for this: for example, because of poor organisation on the part of the ward staff a referral may not have been made; or, if the referral was made, it may not have reached the district nurse; it is also possible that a referral was not made because the ward staff did not think it was appropriate. However, it could also be that in some cases patients were discharged at too short notice for a referral to be made.

This last possibility is further supported by the fact that less than

a third of patients were discharged with at least 48 hours' notice given to the district nurse, and in a fifth of cases, the district nurse was informed of the discharge on the same day that the patient was going home. The poor quality of some of the referrals could be accounted for on the basis that they were made in a hurry. Furthermore, the judgement of the district nurses must also be considered, in that one fifth of all discharges were considered by them to be inappropriate in relation to the patient's condition.

Although district nurses reported more problems with referrals of elderly patients, some did comment that those from specialist ECUs as opposed to general wards were less problematic. This is not surprising as nursing staff on ECUs will be more competent in the identification and assessment of problems experienced by the elderly. The ECU in one major hospital has adopted a model method of referral, which entails the sending of a standard fax. District nurses have reported that they have found this procedure beneficial.

One quarter of all hospital discharges occurred at the weekend, despite the fact that this is the least desirable time for patients to be discharged as far as the district nurse is concerned. It is convenient for hospitals to discharge patients before the weekend when there are fewer medical staff available. The fact that district nurses were less likely to have 48 hours' warning of a patient's discharge if the patient was discharged at the weekend indicates that these discharges were decided at short notice.

Almost three quarters of all referrals were considered to have caused problems, with lack of communication being the most important problem. There is clearly not enough information being passed between ward nurses and community nurses. Furthermore, the fact that more communication problems were experienced by district nurses in area N indicates a possible flaw in its discharge procedure. In area N most hospital referrals to district nurses are taken by a receptionist, as opposed to a nurse, which, presumably, is meant to reduce the time spent by ward nurses contacting district nurses. It is not helpful, however, if it increases the problems district nurses have to face.

The fact that in a quarter of all referred cases the district nurse had to spend more time with the patient than they had allocated implies that the ultimate consequence of hospital discharges that have been poorly planned and carried out, as far as district nurses are concerned, is that extra time has to be spent, whether it is spent with the patient, obtaining supplies, or contacting other medical personnel.

Recommendations

- One way of narrowing the gap between hospital and community would be to involve district nurses in patient discharge planning while the patient is still in hospital.
- After-care planning should be made an integral part of basic nurse training.

- There should be an increase in the number of community liaison nurses, whose role is to gather patient information from the ward staff and the rest of the multi-disciplinary team, and organise continuing care in the community where necessary.
- More attention should be paid to discharges that happen on Friday afternoon and at the weekend. Such discharges are acceptable only if appropriate support services have been arranged.
- There should be an increase in the number of home assessments carried out before the patient is discharged from hospital.
- More information should be given to ward staff in relation to the support services available in the community and how they can be contacted.

CHAPTER 7

Conclusion

DAVID MORRELL

This series of studies was undertaken during the winter months of 1991–1992. Many changes have taken place in London since that time. Most of these have been concerned with a reduction in acute hospital beds and a reduction in accident and emergency services. It therefore seems likely that the problems identified in these studies are even more apposite today. It will probably be several years before developments in primary care can alter the patterns of demand on acute hospital services or improvements in community care can facilitate the discharge of acutely ill elderly patients from hospital. These studies cast serious doubt on some of the hypotheses promulgated by the media and apparently accepted by the Tomlinson committee (1992) that major changes in general practice in inner London would modify the demands made on inner London A&E departments.

This reflects seriously on decision makers who appear to depend more on anecdotal evidence and media pressure rather than invest in serious research which may reveal facts that are managerially unpleasant. A conclusion from this series of studies must be that an ageing population and socio-economic deprivation, with many poorly resourced elderly people living alone, are a major cause of the high demands on A&E departments, high levels of admission and problems associated with discharge procedures. The problems presented in London by large numbers of homeless and mobile populations complicate the difficulties. There is evidence from these studies that major changes in primary care and particularly in community services will be needed to resolve the problems.

Some helpful recommendations have however been made as a result of these studies. The unpredictability in the numbers of patients referred for acute hospital care was identified by Green and Armstrong, and they suggested, as a result of their interviews with hospital staff and statistical estimates of the problem, that a larger reserve of acute hospital beds, based perhaps on a consortium of hospitals, would reduce the problems presented by unpredictable demands. Bartholomew *et al.* expanded this proposal and suggested that the Emergency Bed Service or a bed bureau for the whole of inner London might handle all acute admissions. They presented evidence that general practitioners experience serious problems in admitting acutely ill patients and that the value of the consultation between the admitting general practitioner and the hospital doctor is questionable; such consultation can be a form of confrontation. They demonstrated that, when a general practitioner cannot obtain an admission by negotiation, referral to the Emergency

Bed Service often leads to admission to the hospital originally approached and that the current procedures represent a rather time-wasting charade of no benefit to the patient.

The issue of providing low-technology nursing care for acutely ill patients, particularly the elderly, was raised in the Tomlinson report (1992). The Lambeth Community Care Centre was cited as an example, and in the study of acute admissions by general practitioners, the admitting doctors were questioned about their willingness to use a facility such as a general practitioner hospital. For most of the doctors, this was a hypothetical question, because they had no experience of using such a centre, but for 15 per cent of admissions, the GP judged it would offer appropriate facilities, particularly for the very elderly. Such an institution, which provides very close links between the community nursing and social services and which facilitates planned discharges from care, may obviate some of the problems identified by Savill and Bartholomew. Their study of district nurses reveals enormous gaps in the education of hospital nursing staff about the needs of patients discharged from hospital and methods of communication. This is crucially important to the better care of patients and the effective management of the primary/secondary interface.

The study of general practitioners recorded major problems with the ambulance service. These difficulties have received a very high profile in the press, and major changes have taken place. It must however be stressed that unless immediate access to emergency ambulances is provided, all the training of highly qualified ambulance personnel is wasted. This must be a high priority in the planning of acute emergency services in London and must attract appropriate funding.

A major investment in this research was in providing round-the-clock data collection in the A&E departments of two inner London and one out-of-London hospital. This is a unique study of the demographic characteristics of those using the three A&E departments, and of the flow of patients through these departments. The results confirmed that a high proportion of attenders at A&E departments in inner London were single people, those living alone, those who had recently moved, and those who were homeless, "commuters" or tourists, compared with the attenders at the out-of-London hospital. With the exception of those who were single or living alone, these socio-demographic characteristics did not contribute significantly to the numbers admitted to hospital.

The Tomlinson report (1992) and the King's Fund report (1992) suggest that a particular problem in London is presented by inadequate general practitioner services. These studies analysed both the general practitioner referrals to A&E departments and the case-mix of patients attending and there is no evidence to support such claims. Green and Dale (1992) in another study of an A&E department in South London have suggested that the demands made on the department were not inappropriate, but the responses of the staff were inappropriate, and their work demonstrated the different responses provided by general practitioners working in the A&E departments. This has led planners

to recommend that general practitioners should be employed to work in A&E departments in London. Good general practitioners in inner London are in short supply and to re-allocate them to A&E departments is highly unlikely to improve the overall care of Londoners. However, GPs working in A&E departments are only one solution and another solution might include the extension of GP services within the general practice setting itself. This could mean including not just minor surgery but a range of extended services such as providing clinics for the homeless. The mobile client, which includes the tourist and commuter as well as the homeless, could be catered for in a polyclinic whether in the A&E department or in the primary care setting. In order for these new developments to deliver effective care, evaluation is required to ensure that the service provision is meeting need and not merely satisfying demand.

The study by Britten and Shaw describes the distress experienced by patients in A&E departments due to lack of privacy, inadequate early pain relief, poor communications and long delays. The establishment of well staffed buffer wards, recommended by Green and Armstrong, would go a long way to relieving this suffering and would mitigate the effects of unpredictable demands for acute admissions.

It is clear from all these studies that there is need for a clear strategy for the management of acute admissions to all hospitals, not just those in London, with more involvement of A&E consultants in defining this strategy and in influencing the clinical directorates. This could greatly improve the admission process.

This series of studies has demonstrated that a sensible investment of resources into research can provide factual information which questions a great deal of the anecdotal evidence upon which the future acute medical services in London appear to have depended.

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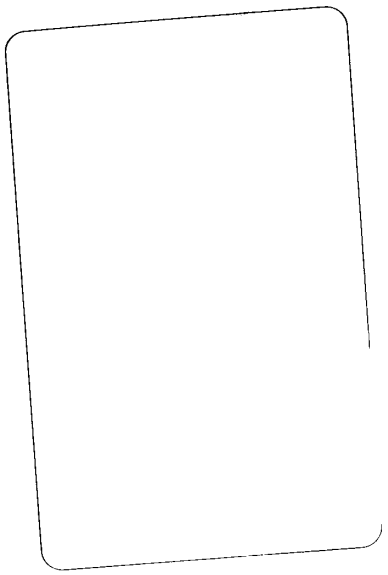

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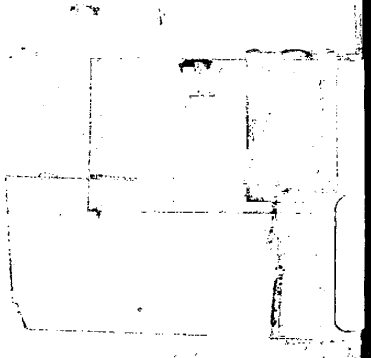

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