

RCPE BRIEFING:

INAPPROPRIATE ADMISSIONS TO HOSPITAL: MYTH VERSUS REALITY

Overview

The Royal College of Physicians of Edinburgh is keen to state from the outset that no consultant physician wants to admit a patient to hospital unless it is absolutely clinically necessary: pressures on acute beds mean that only patients who are in urgent need of medical care are admitted.

We are concerned that a damaging misperception is emerging in Scotland regarding the level of inappropriate admissions to hospital, and that two unproven principles are now generally accepted: that care of patients outwith acute hospitals will be at least as safe and effective as hospital care, and that it will be better value for money.

As the King's Fund stated in 2010,¹ despite a longstanding ambition within the NHS to 'manage demand' and reduce unplanned hospital admissions, this has yet to be realised. For example, a recent Audit Scotland report found that attempts to provide enhanced care services in the community through Community Health Partnerships (CHPs) had made little impact, as emergency admissions for older people increased in three-quarters of CHP areas between 2004/05 and 2009/10.²

There is no doubt that the health service faces unprecedented financial challenges, and cost effective, efficient healthcare is something that we all must strive to achieve. We acknowledge that the status quo in the health service is not tenable in the long term due to economic constraints. However, when examining the shift of care from the acute sector to the community in 2011, the Health Foundation published a report which stated 'the research literature did not reveal any examples where establishing community-based services had led to a reduction in, or decommissioning of, the corresponding acute inpatient service'.³

While the aspiration to reduce acute hospitalisation of older people is laudable, there is still limited evidence on the effectiveness of interventions aimed at reducing unplanned admissions.¹ We feel in these circumstances that it is vital that the promotion of admissions avoidance, particularly of older people, does not restrict appropriate access to best care at times of medical need.

Large scale, widespread pilot programmes are needed to examine the potential of all strategies to move acute care services into the community in Scotland: this is especially important given the remote and rural nature of many of our communities.

The ambition to reduce reliance on the acute sector should not be pursued to the detriment of quality of patient care. We must not allow patient safety to be compromised by the implementation of this approach without clear, established evidence that care of patients outwith acute hospitals will be as safe and effective as hospital care. We support shifting care closer to home but not at the expense of quality.

What the evidence actually says

Audit Scotland: *Review of Community Health Partnerships* (June 2011)

Audit Scotland found that:

... despite initiatives aimed at supporting older people to stay at home longer, emergency admissions for older people increased in three-quarters of CHP areas between 2004/05 and 2009/10. Over the same period, there was also an increase in the number of older people admitted to hospital as an emergency on more than one occasion in-year in Scotland.²

The Health Foundation: *Getting out of hospital? The evidence for shifting acute inpatient and day case services from hospitals into the community* (June 2011)

This Health Foundation report found that more evidence is needed to establish whether shifting care from the acute sector to the community will prevent hospital admissions or reduce costs.

In general, there was only sparse reporting of information about how the community-based services were started up. The level of infrastructure, planning and start-up costs needed to shift services into the community has not usually been reported in studies that evaluate the effectiveness or cost-effectiveness of these services compared with inpatient care.⁴

The evidence is still not sufficient for us to be certain that shifting care into the community will always reduce costs.⁵

The research literature did not reveal any examples where establishing community-based services had led to a reduction in, or decommissioning of, the corresponding acute inpatient service.⁶

We need more evidence on the resources needed to deliver the kind of community-based services that are likely to prevent admission to hospital or facilitate early discharge from hospital.⁶

The King's Fund: *Avoiding hospital admissions: What does the research evidence say?* (December 2010)

The King's Fund looked at an extensive range of research evidence on this subject. Some of the points highlighted in their report include how changes in primary care have influenced the level of admissions; the lack of evidence showing that intermediate care has any positive impact on hospital admission levels; and the fact that many admissions labelled as 'avoidable' are necessary as the only place that the services which are clinically required are available is the acute sector.

In contrast, the report found that the availability of a senior clinician in the hospital emergency department could reduce inpatient admissions to the acute unit by a significant amount.

On the relationship between unplanned admissions and primary care:

In the UK, unplanned admissions have risen steadily over the past 10 years. There is some evidence that this rise may be partly attributable to changes in out-of-hours provision that occurred in 2004 with the new GP contract. ... Short-stay admissions for minor illness episodes in children have increased substantially. Most of these unplanned admissions occur out of hours, and most are via A&E. The authors suggest that these findings may be evidence of both a lack of access to primary care and a failure of primary care services to manage minor illness in children in a timely and appropriate way.

A five-fold variation in out-of-hours admission rates has been observed between GPs working for the same out-of-hours service and caring for the same patient population, suggesting that clinician factors play an important part in determining admission rates. Qualitative research in the same group of GPs suggests this may be due to lack of confidence, feelings of isolation, aversion to risk and lack of awareness of alternatives to admission.⁷

On intermediate care:

Most available evidence on intermediate care shows no reduction in admissions.⁸

Early senior clinician review in A&E:

Making a senior emergency medicine clinician (a consultant equivalent or middle-grade experienced specialist trainee) available to review patients in the emergency department has been shown to reduce inpatient admissions by 12 per cent, and specifically reduced admissions to the acute medical assessment unit by 21%.⁹

On the label of 'avoidable admissions':

It is important to note that, for some patients, admission to hospital is the best course of action, despite the fact that the clinical condition for which the admission is arranged is categorised as a 'potentially avoidable admission'. This may be because of the severity or complexity of the condition, associated or underlying health problems, or the patient's home situation. There are also situations where admission is required in order to obtain a diagnosis, to rule out more serious diagnostic alternatives or to treat a condition in the optimal way.¹⁰

King's Fund conclusion:

Our summary of the research evidence on the effectiveness of different interventions to reduce avoidable hospital admissions finds that there is insufficient evidence to support many of the interventions currently being implemented.¹¹

ISD: *Increasing emergency admissions among older people in Scotland: a whole system account.* Steve Kendrick and Margaret Conway, ISD Scotland Whole System Project (2003)

Assuming that there has not been a step change since the publication of this ISD report, which stated that an average of 70% of emergency inpatient admissions in Scotland are the result of a GP referral, the implication is that these admissions to hospital are necessary as they cannot be handled in the community. ISD reported that:

There is perhaps a tendency for the primary care sector to see any attempt to explore the dynamics of referral behaviour as an attempt to assign blame. This sensitivity was captured very well in the major study of the influences on emergency admission carried out in Scotland in 1997. Of all the groups asked to participate in the study, concerns were most common among GPs:

'Of the concerns expressed by many GPs, prominent was a feeling that many secondary care based doctors had a false belief that many GP referrals were 'inappropriate' in that the patient could have been treated at home. GPs believed that hospital based doctors had no real understanding of the pressures GPs faced when working in the community. In drawing a contrast between examining patients at home and in hospital many GPs stated that when examining patients hospital doctors have access to diagnostic techniques and laboratories for tests. In contrast many GPs, particularly when outwith the surgery, are

alone, have no guiding diagnoses, are not specialists and have no immediate access to specialist advice. GPs may 'play it safe' by referring but, in the opinion of many GPs, hospital doctors would act in the same manner if placed in the same position in which GPs often find themselves.'

We share these concerns. We have assumed, as an order of magnitude estimate, that 70% of emergency inpatient admissions are the result of a GP referral. This estimate is based on the survey of emergency admissions carried out in 1997 which showed for example that in Ayrshire and Arran Health Board 62% of emergency inpatient admissions came via GP referral whereas in Highland the figure was 81%.¹²

KEY MESSAGES

- The RCPE supports shifting care closer to home but never at the expense of quality.
- While the aspiration to reduce acute hospitalisation of older people is laudable, there is still limited evidence on the effectiveness of interventions aimed at reducing unplanned admissions.
- Large scale, widespread pilot programmes are needed to examine the potential of any strategies to move acute care services into the community in Scotland: this is especially important given the remote and rural nature of many of our communities.
- Patient safety must not be compromised by the implementation of this approach: we need clear, established evidence that care of patients outwith acute hospitals will be as safe and effective as hospital care, as well as better value for money.

References:

- 1 Purdy S. *Avoiding hospital admissions. What does the research evidence say?* [Internet]. London: The King's Fund; 2010 [cited 2012 April 19]. p. 3. Available from: http://www.kingsfund.org.uk/publications/avoiding_hospital.html
- 2 Audit Scotland. *Review of community health partnerships* [Internet]. Edinburgh: Audit Scotland; 2011 [cited 2012 April 19]. p. 7. Available from: http://www.audit-scotland.gov.uk/docs/health/2011/nr_110602_chp.pdf
- 3 The Health Foundation. *Evidence: getting out of hospital? The evidence for shifting acute inpatient and day case services from hospitals into the community* [Internet]. London: The Health Foundation; 2011 [cited 2012 April 19]. p. 9. Available from: <http://www.health.org.uk/public/cms/75/76/313/2539/Getting%20out%20of%20hospital%20full%20version.pdf?realName=k31uoL.pdf>
- 4 The Health Foundation. *Evidence: getting out of hospital? The evidence for shifting acute inpatient and day case services from hospitals into the community* [Internet]. London: The Health Foundation; 2011 [cited 2012 April 19]. p. 6. Available from: see above.
- 5 The Health Foundation. *Evidence: getting out of hospital? The evidence for shifting acute inpatient and day case services from hospitals into the community* [Internet]. London: The Health Foundation; 2011 [cited 2012 April 19]. p. 9. Available from: see above.
- 6 The Health Foundation. *Evidence: getting out of hospital? The evidence for shifting acute inpatient and day case services from hospitals into the community* [Internet]. London: The Health Foundation; 2011 [cited 2012 April 19]. p. 10. Available from: see above.
- 7 Purdy S. *Avoiding hospital admissions. What does the research evidence say?* [Internet]. London: The King's Fund; 2010 [cited 2012 April 19]. p. 7-8. Available from: see above.
- 8 Purdy S. *Avoiding hospital admissions. What does the research evidence say?* [Internet]. London: The King's Fund; 2010 [cited 2012 April 19]. p. 11. Available from: see above.
- 9 White AL, Armstrong PA, Thakore S. Impact of senior clinical review on patient disposition from the emergency department. *Emerg Med J* 2010; 27:262-5. <http://dx.doi.org/10.1136/emj.2009.077842>
- 10 Purdy S. *Avoiding hospital admissions. What does the research evidence say?* [Internet]. London: The King's Fund; 2010 [cited 2012 April 19]. p. 17. Available from: see above.
- 11 Purdy S. *Avoiding hospital admissions. What does the research evidence say?* [Internet]. London: The King's Fund; 2010 [cited 2012 April 19]. p. 19. Available from: see above.
- 12 Kendrick S, Conway M. *Increasing emergency admissions among older people in Scotland: a whole system account* [Internet]. Edinburgh: ISD Scotland; 2003 [cited 2012 April 19]. Available from: http://showcc.nhsscotland.com/isd/files/whole_system%20_wp1_text.pdf