Personal and Health Services Scrutiny Panel

Standardised Mortality Rates at Tameside General Hospital

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PERSONAL AND HEALTH SERVICES SCRUTINY PANEL

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1. INTRODUCTION BY THE CHAIR

I am delighted to present the Personal and Health Services Scrutiny Panel's review of Hospital Standardised Mortality Rates at Tameside General Hospital.

The Scrutiny Panel decided to undertake this review following the publication of the Dr Foster Hospital Guide in 2005 that indicated that the Tameside and Glossop Acute NHS Trust was the eighth worst performing NHS Acute Trust in England out of 153 hospital trusts. In Greater Manchester, only one trust had a higher rate than Tameside.

Once the initial plans for the review had been agreed, we met the Chief Executive of the Acute Trust and she also expressed her concern at the results and promised her full co-operation and that of her staff. I am confident in saying that the Scrutiny Panel has received full co-operation from the Trust who have provided information requested and attended a number of meeting with the Scrutiny Panel.

The Scrutiny Panel has received information from a wide range of sources in Tameside including Her Majesty's Coroner John Pollard, David Heyes MP, the Primary Care Trust, GPs, residential and nursing homes, Adult and Care Services and of course staff from Tameside General Hospital.

During the course of the review, there was significant local and national publicity regarding comments made by Mr Pollard regarding the standards of care for vulnerable and elderly people at the hospital. The Scrutiny Panel met Mr Pollard who outlined his experience with cases relating to the hospital, but confirmed that the hospital management had always co-operated fully in meeting suggested improvements to service. Taking up some of the concerns made by the Coroner, the Scrutiny Panel joined by David Heyes MP questioned the Chief Executive and senior officers from the Acute Trust with regard to standards of care for elderly and vulnerable people at the hospital. At a subsequent meeting, the same senior representatives from the Acute Trust were again questioned by the Scrutiny Panel, this time joined by two members of the recently formed Tameside Hospital Action Group about the outcome of an internal enquiry held with representatives from the Primary Care Trust and the subsequent action plan. The Chief Executive has been invited to return to the Scrutiny Panel later in the year to discuss the outcomes of the implementation of the Improvement Plan.

Having carefully considered all the evidence received it is very difficult for the Scrutiny Panel to come to a definitive conclusion about the high mortality rate. There are however, strong indications that one of the legacies of the late Dr Shipman is that professionals caring for the very elderly and frail are very reluctant to have final caring responsibility when they die. There is a higher than average admission rate to Tameside General

Hospital for elderly and frail people and this reflects the view that often they are admitted to hospital to die rather than being allowed to die in the community.

The most recent data received via the appropriate Dr Foster data tool indicates that the Hospital Standardised Mortality Rate has reduced to 103 *(see the note in the summary about the revised model for calculation and the revised figures).* If this trend continues and is verified, it will show a great improvement.

This is however, being addressed both by the hospital and the Primary Care Trust and the Council through end of life pathways. These are being introduced to plan the care for the terminally ill in their own homes and to prevent inappropriate attempts at resuscitation and emergency admission to hospital.

I want to thank everyone who assisted with this review and especially the Deputy Chair and the staff from the Scrutiny Support Unit who dedicated so much time and energy to meeting people and gathering information.

Councillor John S Bell
Chair

2. SUMMARY

Low hospital mortality rates are regarded as a good indicator of quality clinical services and the quality of clinical care provided at hospitals within National Health Service (NHS) trusts is measured by the hospital standardised mortality ratio.

The Dr Foster Hospital Guide 2005 indicated that for the 2002-2005 period, Tameside General Hospital was the eighth worst performing NHS Trust in England for mortality, out of 153 NHS Trusts.

Compared to the other eight NHS Hospital Trusts in Greater Manchester, only one other Trust had a mortality rate which was higher than that of Tameside and Glossop Acute Services NHS Trust.

The hospital standardised mortality ratios however, whilst being a good general indicator of potential clinical quality issues, do not provide an indication of the causes for the higher than expected hospital mortality rates at Tameside General Hospital. The Members of the Personal and Health Services Scrutiny Panel were very concerned about this matter and agreed to look into the potential reasons for the high figures.

Following the approval of the initial Project Plan, the Chair and Deputy Chair, together with the Scrutiny Support Officers met with representatives of Tameside and Glossop Acute Services NHS Trust and Tameside and Glossop Primary Care Trust (PCT) to explain the nature of the forthcoming scrutiny review. The Chief Executive of the Acute Trust expressed her support for this review and offered her full co-operation.

The Executives from both Trusts then attended a meeting of the Scrutiny Panel and submitted their theories about the causes of Tameside General Hospital's high mortality rate. The main theory suggested to the Scrutiny Panel was that since 1998, as a consequence of the Dr Shipman case, General Practitioners (GPs) and Care Homes are more likely to refer elderly patients to hospital when they are poorly, rather than providing care themselves, for fear of potential repercussions.

The Trust's theory for the Hospital's high mortality rate arose following a review of the case notes of 100 consecutive deaths, undertaken as part of an NHS Modernisation Agency exercise aimed at reducing Hospital Mortality Rates and improving end of life outcomes. The review found that the majority of the deaths analysed fell into the terminally ill admission category, being mainly elderly people with respiratory or cardiac problems, where little could be done to help them.

On completion of the NHS Modernisation Agency exercise, the Trust purchased the Dr Foster Information System to analyse the data in more detail. The information produced by Dr Foster backed up what was discovered through the review, that elderly people with respiratory or cardiac problems were the key contributors to the higher than expected hospital mortality rate.

The Panel was keen to learn from where these patients had been admitted to the hospital in order to evaluate the care provision within the community or within Care Homes. The Panel felt it necessary to ensure that the borough's elderly population were receiving the care they so rightly deserved during their twilight years in their place of choice. However,

there was no evidence available to confirm whether patients dying at the Hospital had been admitted to the Hospital from their own homes or from a Care Home.

In order to address all these issues, the Panel re-evaluated its initial Project Plan, to incorporate interviews with Nursing and Residential Care Homes in the borough, local Clinicians, General Practitioners, Community Palliative Care Nurses and the South Manchester Coroner.

These expert witnesses have provided evidence which although may not provide a definitive reason for Tameside General Hospital's mortality rates, does offer an insight into a number of issues which are considered to be possible contributors towards the high mortality figures. These issues include the standards of care at Tameside General Hospital and the current system of placements of elderly people to Care Homes in the borough, which is the responsibility of the Tameside and Glossop Primary Care Trust and the Local Authority Social Care and Health Service.

The Scrutiny Panel has explored the issues raised by the interviewees and makes a number of conclusions and recommendations for improvement, which if implemented might improve service provision by Tameside and Glossop Acute Services NHS Trust, Tameside and Glossop Primary Care Trust and Tameside MBC Social Care and Health Service, and ultimately could improve the mortality rates at Tameside General Hospital.

Since the completion of this review, the Dr Foster Organisation published its 2007 review covering hospital standardised mortality figures for the three years 2003 to 2006 and individually for 2006. This showed that for the period 2003 to 2006 the Acute Trust had a mortality rate of 123 and a figure for 2006 of 125. This however, did not take into account the very latest figures for the part year 2006/7 that showed a significant improvement.

The most recently published figures however, follow a revised model that changes the way this calculation is made for all NHS Trusts. This has now been applied to previous years as detailed in the table below.

	2002/03	2003/04	2004/05	2005/06	2006/07
HSMR before model adjustments	132.2	121.7	118.4	116.8	103*
HSMR after adjustments	131.4	123.0	121.2	125.1	108.9*

(*Ten months data)

3. MEMBERSHIP OF THE SCRUTINY PANEL

Municipal Year 2005-2006

Councillor J Bell (Chair), Councillor M Smith (Deputy Chair)
Councillors Brierley (resignation with effect from 1st March 2006), Doubleday, Joe Fitzpatrick (from 10th July 2005), Sweeton, Warrington and Wild

Advisory Group: Dr Chand and Messrs Heald and Eyres

Municipal Year 2006-2007

Councillor J Bell (Chair), Councillor E Shorrock (Deputy Chair)
Councillors Bibby, Doubleday, A Etchells, Joe Fitzpatrick, Middleton, Roberts, Sweeton,

Advisory Group: Dr Chand and Mr A McDermott

4. TERMS OF REFERENCE

The following Terms of Reference and Objectives for the Review were approved by the Panel at its meeting held on 30th November 2005.

Aim of the Scrutiny Review Exercise

"To review the actions being taken to reduce the hospital mortality rate at Tameside and Glossop Acute Services NHS Trust."

Objectives

A. To produce accurate and up to date information about mortality rates at Tameside and Glossop Acute Services NHS Trust.

B. To establish what steps the Trust has taken to investigate the causes of the hospital mortality rate and evaluate the actions being taken to reduce it.

C. To consider the actions taken to reduce the mortality rates at other NHS Trusts and identify areas of best practice.

See Appendix 1 for details of the Project Plan which has been amended during the Review to reflect the updated evidence received. The amended Project Plan was approved by the Scrutiny Panel at its meeting on the 29th March 2006 (Minute 55 refers).

5. METHODOLOGY

5.1 In commencing the Review, Councillors Bell and M Smith the Chair and Deputy Chair of the Scrutiny Panel, together with Scrutiny Support Officers, Ms Paver and Mrs Clough, met with Mrs Christine Green the Chief Executive of the Tameside and Glossop Acute Services NHS Trust, Dr Gideon Smith Consultant in Public Health Medicine, Tameside and Glossop Primary Care Trust and Mr Tony Woodyer Consultant Vascular Surgeon and Medical Director from Tameside General Hospital.

This initial meeting was held in order to obtain background information relating to Tameside General Hospital's Standard Mortality Rates, and to obtain an insight into the Trust's theories for these figures.

5.2 On 1st March 2006, Dr Gideon Smith and Mr Tony Woodyer, together with Mr Philip Dylak attended a meeting of the Scrutiny Panel. They presented information on the figures involved in Tameside General Hospital's Mortality Rates and produced statistical evidence to support their theories.

(On 15th November 2006, Mrs Green, Mr Dylak and Mr Woodyer attended a Panel meeting to inform the Panel on actions taken to reduce the hospital mortality rate and progress to date).

5.3 Councillor Bell, Mr Boots Head of Scrutiny, Ms Paver and Mrs Clough interviewed Dr Chand the Advisory Group representative on the Scrutiny Panel in his capacity as Secretary of the Local Medical Committee. Dr Chand shared his expertise in this matter.

5.4 Dr Rothery Medical Director of the Tameside and Glossop Primary Care Trust presented information to Councillor Bell, Ms Paver and Mrs Clough on her experiences regarding Tameside General Hospital's mortality rates, together with general information regarding primary and secondary National Health Service care in Tameside.

5.5 Forty three care homes from Social Care and Health's Approved List were contacted for consultation. Interviews were carried out with the 7 care homes that responded and the remaining 37 were sent a questionnaire. A total of 14 care homes responded by questionnaire. The consultation sought to determine whether the Care Homes preferred to care for terminally ill residents to the end of their lives or whether they would rather admit their patients into hospital to die. It also asked whether there have been any changes in the way these decisions are taken as a consequence of the Harold Shipman case. These consultations also raised a number of other issues which are mentioned within this report.

5.6 Thirty two GP practices in Tameside were contacted for consultation. Five GPs were interviewed face to face or by telephone. The remaining 27 GPs which didn't participate in interviews were sent a questionnaire, of which nine were returned. The aim of the questionnaire was to gather evidence from GPs about what factors they think contribute to the Acute Trust's high mortality rate, about

the care of terminally ill patients, and whether there have been any changes in the way terminally ill patients are cared for or in the way GPs practice as a consequence of the Harold Shipman case.

5.7 On the 2nd August 2006, the Scrutiny Panel interviewed Mr Colin McKinless the Executive Director Social Care and Health Services and Mrs Stephanie Butterworth, Assistant Executive Director for Adult Social Care and Health regarding the procedures involved in referring elderly people to Care Homes and the Fee Payments payable to these Care Homes.

5.8 Mr John Pollard, Her Majesty's Coroner for South Manchester, attended a meeting of the Scrutiny Panel on 6th September 2006. Mr Pollard provided the Members with his expert advice and opinion on the subject of this Review. He also informed members about many of the inquests that he had conducted where patients, in his view, had received inadequate care at Tameside General Hospital.

5.9 On the 13th December 2006, the Panel met with the following representatives of the Tameside and Glossop Primary Care Trust:-

- Ms Alison Leigh, Associate Director for Planning and Performance;
- Ms Margaret Heyes, Macmillan Palliative Care Team;
- Ms Pauline Sumner, Project Manager for the Gold Standards Framework/Integrated Care Pathway for the Last Days of Life.

The Panel sought information on the National Health Service End of Life Care Pathways, and was particularly interested to learn how the introduction of this initiative could contribute to a reduction in the hospital standardised mortality rate at Tameside General Hospital.

5.10 The Panel invited Mr David Heyes MP and two representatives of the Tameside Hospital Action Group to join them at meetings of the Panel held on 15th November 2006 and 24th January 2007 and clarification was sought from the Acute Trust on issues regarding the standards of care at the Hospital.

5.11 On 24th January 2007, Mrs Christine Green (Chief Executive), Mr Philip Dylak (Director of Nursing) and Mr Tony Woodyer (Medical Director) from the Acute Trust attended a Scrutiny Panel to present the findings of an Inquiry Panel investigation into the alleged deficiencies of care raised by the Coroner at the inquests into the deaths of four patients who had died at Tameside Hospital. Mrs Green, Mr Dylak and Mr Woodyer presented the Inquiry Panel's Report to the Panel together with the resulting Action Plan.

6. HOSPITAL STANDARDISED MORTALITY RATIOS

6.1 What is a Hospital Standardised Mortality Ratio?

The Dr Foster Unit

6.1.1 Hospital Standardised Mortality Ratios (HSMR) were devised by Professor Sir Brian Jarman and the Dr Foster Unit at the Imperial College of Science, Technology and Medicine in London [1].

6.1.2 The Dr Foster Unit is an independent organisation which collects and analyses information on health services in the United Kingdom. The Unit is headed by Sir Jarman with Dr Paul Aylin as Assistant Director.

6.1.3 One of the services that has been developed by the Dr Foster Unit, in conjunction with NHS Trusts, is an online system that allows Trusts to view information on mortality, day-case, length of stay and readmissions by diagnosis and procedure. In order to access the information available, Trusts must subscribe to the organisation. This performance monitoring system, provides real time data on diagnostic groups and clinical outcomes, which enables Hospital Trusts to benchmark against national performance. It also provides an early warning that events in a Trust are diverging significantly from what is observed in the rest of the English NHS by giving an alert. The Doctor Foster information system does not however, identify the reasons for the figures. This is left for each individual Trust to investigate.

Hospital Standardised Mortality Ratios

6.1.4 HSMRs are a measure of the quality of clinical care and one of the measures produced by the Dr Foster Unit to help improve public understanding of the variation in the quality of healthcare provided by NHS trusts in England.

6.1.5 The HSMR attempts to present a more accurate picture of the number of deaths per hospital by comparing the actual number of deaths with the expected number of deaths. The figures are adjusted to take into account the factors statistically associated with hospital death rates[2]. These factors are:

- Gender
- Age group (in five-year bands up to 90+)
- Method of admission (emergency or elective),
- Socioeconomic deprivation quintile of the area of residence of the patient

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[1] Jarman B; Gault S; Alves B; Hider A; Dolan S; Cook A; Hurwitz B; Iezzoni LI. (1999) Explaining differences in English hospital death rates using routinely collected data. BMJ. 318: 1515-1520; Jarman B; Bottle A; Aylin P; Browne M. (2005) Monitoring changes in hospital standardised mortality ratios. BMJ. 330: 329.

[2] http://www.drfoster.co.uk

- Primary diagnosis of the patient.

6.1.6 An HSMR of 100 represents the national average and means that the same number of in-hospital deaths has occurred as predicted. A higher HSMR means that there are more deaths than expected, and a lower HSMR means that there are fewer deaths than expected.

6.1.7 The mortality rate figures are produced for one and three year periods, the most recent being for 2004/2005 and 2002/2005. The three year figure provides a more stable measure of quality, and the one-year figure enables Hospital Trusts to see the percentage change in the mortality ratio from one year to the next.

6.1.8 Although the HSMR describes the association between sets of data, no matter how strong an association may be, the figures tell nothing about what causes the figures to be as they are.

6.2 How are Hospital Standardised Mortality Ratios produced?

6.2.1 Hospital Episode Statistics (HES) data, together with the NHS Wide Clearing Service raw submissions, were used as the basis for the HSMRs published in the 2005 Dr Foster Hospital Guide.

6.2.2 HES data is submitted by all NHS trusts in England, and records all admissions including inpatients and day cases, together with deaths which occur in hospital. The data also records information such as the patient's age, diagnosis and any operations that they have had.

6.2.3 The data is in the form of consultant episodes, which means the continuous period during which the patient is under the care of one particular consultant. This period is linked into "spells" or "admissions".

6.2.4 Data is released annually or quarterly by the Department of Health, however more up-to-date information is taken from raw submissions submitted by individual hospital trusts to the NHS Wide Clearing Service (NWCS).

6.3 What is Tameside General Hospital's Standardised Mortality Rate and how does it compare locally and nationally?

6.3.1 The Dr Foster Hospital Guide 2005 reported the HSMRs for all NHS Trusts in England for the one year period 2004/05 and for the three year period 2002/05.

6.3.2 The following table shows the NHS Trusts with HSMRs in the bottom ten per cent in England for the three year period 2002/05. As indicated in bold type, Tameside General Hospital was the eighth worst performing NHS Trust in England for mortality (out of 153 NHS Trusts):

NHS Trust	HSMR (2002/05)
Burton Hospitals NHS Trust	122
West Middlesex University Hospitals NHS Foundation Trust	121
George Eliot Hospitals NHS Trust	120
Basildon and Thurrock University Hospitals NHS Foundation Trust	119
Heatherwood and Wexham Park Hospitals NHS Trust	119
Bolton Hospitals NHS Trust	118
Medway NHS Trust	118
Tameside and Glossop Acute Services NHS Trust	116
The Princess Alexandra Hospital NHS Trust	115
Barnet and Chase Farm Hospitals NHS Trust	115
The Dudley Group of Hospitals NHS Trust	114

6.3.3 Compared to the other eight NHS Hospital Trusts in Greater Manchester, only Bolton Hospitals NHS Trust has a higher mortality rate than Tameside and Glossop Acute Services NHS Trust (see table below):

NHS Trust	HSMR (2002/05)
Bolton Hospitals NHS Trust	118
Tameside and Glossop Acute Services NHS Trust	116
Wrightington, Wigan and Leigh NHS Trust	112
Trafford Healthcare NHS Trust	111
Stockport NHS Foundation Trust	110
Pennine Acute Hospitals NHS Trust	109
Salford Royal Hospitals NHS Trust	98
Central Manchester and Manchester Children's University Hospitals NHS Trust	95
South Manchester University Hospitals NHS Trust	83

6.3.4 More up to date mortality figures were supplied by the Acute Trust comparing the most recent mortality data with the figures for the previous year. The data shows a significant fall in the standardised mortality rate at the Hospital from 116.8 for the period April to December 2005 to 103 for April to December 2006 (see Appendix 4, Tables 1 and 2). *As referred to in the summary under the revised model the figures for the ten months of data available for 2006/07, suggest that the HSMR for this period is 108.9.*

CONCLUSION

1. The Panel is pleased to note the fall in the Hospital Standardised Mortality Rate at Tameside General Hospital between 2005 and 2006.

6.4 What has the Acute Trust done to investigate the high mortality rates at the Hospital?

6.4.1 In order to investigate the Hospital's high standardised mortality rate, the Trust got involved in an NHS Modernisation Agency exercise aimed at reducing Hospital Mortality Rates and improving end of life outcomes. For this, the Trust was required to carry out a review of 100 deaths to determine whether:

- critical care facilities were being used appropriately;
- the clinical care of admitted patients is of an appropriate standard;
- a high level of terminally ill patients were admitted, perhaps inappropriately.

6.4.2 The review found that 87 out of the 100 deaths analysed fell into the terminally ill admission category, being mainly elderly people with respiratory or cardiac problems, where little could be done to help them.

6.4.3 Having undertaken this review and despite some initial scepticism, the Acute Trust accepts the Dr Foster figures as the definitive measure of mortality and has since subscribed to the Dr Foster performance monitoring system.

6.4.4 This performance monitoring system provides information directly to subscribing NHS trusts, allowing them to view real time information on mortality, day-case, length of stay and readmissions by diagnosis and procedure. The data provided on diagnostic groups and clinical outcomes enables Hospital Trusts to benchmark against national performance. It also provides an early warning alert to a trust that events are diverging significantly from what is observed in the rest of the English NHS.

6.4.5 The information system has proven to be a very useful tool for the Acute Trust as figures that have previously taken 18 months to gather are now available on a monthly basis and are only a couple of months in arrears.

6.4.6 In order to regularly analyse the hospital's standardised mortality figures, the Trust has established a Clinical Effectiveness Group comprising of Consultants

and Managers who meet monthly with the intention of investigating any statistically significant variations in mortality rates.

CONCLUSION

2. The high mortality rates at Tameside General Hospital relate to specific patterns which occur in three categories:-

(i) <u>Cause of Death</u>

Terminally ill people who have been suffering from respiratory or circulatory diseases;

(ii) <u>Time of Death</u>

The majority of deaths occur within the first three days of admission;

(iii) <u>Age Group</u>

Mortality rates were the highest within the age group 80 to 89.

6.5 What does the data tell the Acute Trust about mortality rates at the Hospital?

Cause of Death

6.5.1 The data shows that the people who die at Tameside General Hospital have in the main been suffering from respiratory or circulatory diseases – 38 per cent more people died from respiratory diseases and 13 per cent more from circulatory diseases than expected in 2005 (see Appendix 2, Table 1).

6.5.2 Patients with other types of disease have the same or less risk of dying at Tameside General Hospital, as with any other hospital in the country. Therefore, if the mortality figures regarding respiratory and circulatory diseases are taken out of the equation, then the picture at Tameside General Hospital is normal.

6.5.3 The patients who do die at Tameside General Hospital come under the care of one of fifteen different consultants who also treat other conditions. This confirms that the problem is not isolated to one or two doctors in the respiratory and circulatory specialties whose performance is not as good as doctors treating other conditions.

Time of Death

6.5.4 The Trust's data shows that the statistical risk of dying at Tameside General Hospital is greatest within the first six days of admittance. In 2005, the majority of deaths occurred on the day of admission (60 per cent more deaths than expected), day 1 (61 per cent more deaths than expected) or day 2 (69 per cent more deaths than expected) (see Appendix 2, Table 3). By the seventh day of

hospital admittance, the risk of dying is less than the national risk and beyond that, it is the same as the national risk.

6.5.5 The Trust reports that the outcome of these statistics confirms that there is no generalised problem of mortality at Tameside General Hospital, and that it is mainly isolated to elderly people, with one of two diseases, who die very soon after admission.

Age Group

6.5.6 Information received from the Trust confirms that mortality rates are highest for the 80 to 84 age group (22.4 per cent more deaths than expected) and 85 to 89 age group (25.3 per cent more deaths than expected) (See Appendix 2, Table 2).

6.5.7 Higher mortality rates for the older age groups follow on from a higher number of admissions for these age groups. Dr Foster data gives an expected admission rate (Standardised Admission Rate) (SAR) adjusted for age, deprivation and gender. An SAR of 100 represents the national average and means that the same number of admissions to hospital has occurred as predicted. A higher SAR means that there are more admissions than expected, and a lower SAR means that there are fewer admissions than expected. Although the expected rate is 100, at Tameside General Hospital the rate for the 85+ age group is 117.5, ie. 17.5 per cent higher than expected for November 2005 to October 2006 (most recent data). This accounts for about 240 more admissions than would be expected during this period. For the 75 – 84 age group, the SAR is 106.6 - 6.6 per cent higher than expected.

CONCLUSIONS

3. The Panel accepts that there is not a general problem of mortality at Tameside General Hospital and that those patients who do die are generally elderly people with respiratory or circulatory diseases within the first few days following admission. If the mortality figures regarding respiratory and circulatory diseases are taken out of the equation, then the picture at Tameside General Hospital is normal.

4. The Panel acknowledges that the higher than expected rate of admission of elderly people at Tameside General Hospital (17.5% - ie. 240 admissions more than expected) might have a potential impact on the hospital standardised mortality rates.

7. CONTRIBUTING FACTORS TO TAMESIDE GENERAL HOSPITAL'S HIGH STANDARDISED MORTALITY RATE

7.1 Is there a Shipman Effect?

7.1.1 Following analysis of the Dr Foster data, the Trust attributes the higher than expected hospital mortality rate to the way that the hospital is being used and that a greater proportion of patients who are terminally ill are admitted to Tameside General Hospital compared to other hospitals.

7.1.2 One suggestion for this is due to what has been described as the "Shipman Factor", whereby the Dr Shipman case has resulted in an increased number of hospital admissions by local GPs and care homes. They believe that local GPs are now more "nervous" about the potential consequences arising from any deaths in a patient's home, and to avoid criticism of their practice, would rather send a dying patient into hospital to die. They also think that local care homes, faced with the prospect of a visit from the police and extensive form filling, would also prefer to send their dying residents into hospital.

7.1.3 Hospital Mortality data shows a rise in Tameside General Hospital's Mortality Rate following Dr Shipman's arrest in 1998 (See Appendix 3, Table 4). However, it is not clear whether this rise is as a consequence of the Dr Shipman Case.

7.1.4 With mortality rates for elderly patients being relatively high at the Hospital, this could intimate that the numbers of deaths in care homes is relatively low. However, the Panel has been unable to obtain the relevant figures in order to undertake an objective analysis for this suggestion.

7.1.5 Evidence gathered through consultation with local care homes and GPs presents a mixed view on the "Shipman factor" theory. In fact, very few of the care homes and GPs consulted said they were more likely to admit their patients into the Hospital to die rather than care for them in the care home or in a patient's own home.

7.1.6 Eleven out of the fourteen care homes who responded to a questionnaire and all of the seven care homes interviewed said they would prefer to care for terminally ill residents at the end of their lives within the care home.

7.1.7 Thirteen out of the fourteen respondents to the questionnaire said they have a procedure in place to care for terminally ill clients at the end of their lives. Decisions are made on a case by case basis in discussion with the client's GP, the District Nurse, the client's family and Social Services.

7.1.8 However, two of the homes interviewed reported that unqualified night staff don't always have the experience or knowledge to enable them to make an educated judgement regarding the health of a client in the absence of the Care Home manager. Consequently, if a client is unwell, an unqualified or less experienced member of staff is more likely to request the services of an

emergency doctor or dial 999. This point was also made by several GPs consulted:

> *"Care homes are only as good as the staff (especially bank staff) who work there. In my experience bank staff are quicker to ask for help out of hours and out of hours doctors more ready to admit."*

> *"EPH and nursing home staff tend to 'play it safe' by calling an ambulance to avoid or prevent criticism by the coroner. Since 'old age' is not acceptable as a cause of death, there is more investigation and occasionally hospital admission of the elderly to satisfy a 'medical' cause of disability/infirmity or distress or frailty."*

7.1.9 The key factor affecting homes' decisions as to whether a terminally ill resident is cared for in the care home or is taken into hospital is what the care and nursing needs of the client are and whether the home has sufficient staff, facilities and resources to meet these needs with the support of the district nurses and the palliative care team.

7.1.10 Similarly, for local GPs, caring for terminally ill patients at the end of their lives outside of the hospital were the most popular responses. Only three GPs said that terminally ill patients would be cared for in hospital.

7.1.11 As with care homes, the GP's decision whether to admit a terminally ill patient into hospital is jointly taken with the client, client's family, district nurse and care home manager where applicable. The key factors affecting these decisions are patients' and carers' wishes, and the patient's condition and their ability to cope at home. One GP said:

> *"…What tends to happen (has been) is that patient is discharged from hospital with a terminal diagnosis, no care package arranged, no liaison with hospital to GPs or from district nurses! So out of hours [they] get readmitted."*

7.1.12 When asked about the impact of the Shipman case on hospital admissions, none of the care homes interviewed thought that there had been any change in the number of clients admitted to hospital since the Dr Shipman case. In contrast, six out of the fourteen care homes who responded to the questionnaire said that changes had occurred in the way decisions to admit terminally ill clients to hospital were taken. Changes described by the homes included:

- Reluctance by GPs to prescribe medication, particularly effective levels of pain relief;
- GPs appearing reluctant to take total responsibility for diagnosis and preferring to get a second opinion from a hospital doctor;
- Care homes and GPs unwilling to take risks that could result in a case being brought before the coroner, resulting in hospital admissions, as one care home manager said:

"Everyone panics and feels you must send them into hospital so you can't get blamed for bad practise and it is on someone else's shoulders to make the final decisions about the welfare of the client. Care homes are very scared about what they can and can't do since Harold Shipman."

7.1.13 None of the GPs questioned said that the Shipman case had caused them to change the way they make decisions about whether or not a terminally ill patient is cared for at home or taken into hospital. However, five of the GPs said that the case had caused them to make changes to the way they practice. Of these, three GPs said that they no longer carry controlled drugs (eg. pain relieving drugs) and one said that they are now more cautious. Without pain relieving drugs, terminally ill patients may not be receiving the pain relief they require and could be unnecessarily suffering as a consequence. These changes could potentially be resulting in more admissions to hospital for terminally ill patients.

7.1.14 During the Panel's discussions with GP's, mention was made regarding pressure they may experience from the Coroner or Police when their patients die, and whether this has a bearing on whether they are now more likely to admit terminally ill patients to hospital to die, rather than to allow them to die in their own homes. One of the GPs thought that some Tameside GPs might feel an element of "looking over their shoulder" as a result of the Dr Shipman case and are aware of possible pressure from the Coroner.

7.1.15 Furthermore, since Dr Shipman, GPs are acutely aware of the consequences of any of their actions and they are more likely to thoroughly consult with the patients family by asking them to clarify their wishes. If the family thinks that the relative might have a chance of getting better in hospital, then the GP will refer the patient.

7.1.16 One of the GPs interviewed also referred to pressure from families saying that it's not always a clear cut decision whether or not a patient is at the end of their life. Patients with Chronic Obstructive Pulmonary Disease (COPD) or heart disease might recover and "*it's a brave person who decides that someone won't make it this time*" – if the patient remained at home and then died a relative might question their decision not to admit them to hospital.

7.1.17 Some of the GPs consulted said that nursing homes are a key part of the problem in unnecessary admissions to hospital. Reasons included:

- Nursing homes not always having a qualified nurse on duty resulting in unnecessary calls to the GP from carers when something happens or when they get scared and pressure to admit clients to hospital.
- Lack of nursing staff in homes that feel confident and are trained in palliative care - Nursing homes frequently readmit patients to hospital - particularly out of hours - if a patient is ill and staff feel unconfident in caring for them.
- Nursing homes only have a couple of nurses and there is a limit to what staff can confidently cope with.

7.1.18 However, one GP identified a particular care home as being a centre of excellence providing quality care for terminally ill patients, and which could be used to share best practice with others.

7.1.19 Four of the GPs consulted also mentioned that patients needing a GP out of hours would not see their own GP and that the out of hours GP would be more likely to admit a patient to hospital.

CONCLUSIONS

5. Although the Panel could not find any conclusive evidence to prove or disprove the Acute Trust's suggestion that the cause of the higher than expected mortality rate at the Hospital is as a result of a "Shipman Factor" it does believe that there are factors indicating that this is a strong possibility, for example:-

(i) The reluctance of some GPs to carry controlled drugs;
(ii) The reluctance of some GPs to make decisions about patients;
(iii) It is the opinion of some of the GPs consulted that the Out of hours GPs are more likely to admit patients into Tameside General Hospital as they are not familiar with individual patients (see 7.1.19);
(iv) GPs and care homes are cautious of making decisions which might result in visits from the police of being brought before the coroner.

6. Although very few local GPs and care homes who were consulted said they were now more likely to admit terminally ill patients into hospital as a result of the Shipman case, the Panel believes that the following circumstances might result in more hospital admissions:-

(i) Unqualified and less experienced care home staff being more likely to call the out of hours GP or an ambulance when clients become unwell;
(ii) Changes to the way GPs practice as a consequence of the Dr Shipman case;
(iii) In some cases nursing homes may prefer to refer terminally ill clients to the Hospital when poorly, particularly if there are no qualified nursing staff on duty.

7.2 Are there Quality of Care issues at Tameside General Hospital?

7.2.1 During this Review, the Panel has received reports of poor levels of medical and nursing care at Tameside General Hospital, mainly from Care Homes and the Coroner.

7.2.2 Concerns were raised about the condition of patients who are discharged from Tameside General Hospital. The Coroner and two of the care homes interviewed reported incomplete patient hospital notes as being an issue, another care home said that on occasions, patients have been discharged with incorrect medication. A further issue reported was of a resident having

previously been referred to the hospital, upon discharge, being returned to one of the care homes without prior notification.

7.2.3 Five of the care homes interviewed complained about levels of care at Tameside General Hospital, problems including elderly patients leaving the Hospital scantily dressed and suffering from severe bed/pressure sores.

7.2.4 Following the meeting of the Scrutiny Panel on the 6th September 2006, the Panel noted several weeks of adverse media coverage at a national level, in the written press and on the television following comments made by the Coroner regarding the lack of basic nursing and medical care at Tameside General Hospital.

7.2.5 The Panel is keen to confirm in this report however, that when interviewed by the Scrutiny Panel, the Coroner did state that when inquests have highlighted issues at Tameside General Hospital, the Acute Trust has always been keen to act on any suggestions for improvement.

7.2.6 The adverse press coverage followed the inquests into the deaths of four patients who had died at Tameside General Hospital. At these inquests, the Coroner was highly critical of the care and treatment of the four patients, describing it as “despicable” and “chaotic”. He was particularly concerned about the levels of basic nursing care provided to the patients, including giving the patients a drink and making sure they had their medication with them.

7.2.7 Following these inquests, over 100 families with similar stories of poor standards of care at Tameside General Hospital formed the Tameside Hospital Action Group (THAG). The Action Group, along with David Heyes MP called for an independent inquiry into the allegations made by the Coroner.

7.2.8 In addition to the Coroner’s comments at the four inquests in September, the Coroner informed the Panel about twenty inquests carried out between January and October 2006 where a death had occurred at the Hospital and the family had made a complaint about the care of their deceased relative. These cases included instances of elderly patients’ meals or medication being left on a table and being unable to eat the meal or take the tablet due to assistance not being given, as well as patients not being cleaned and being left in their own urine and faeces.

7.2.9 The Panel questioned the Trust about these instances of poor levels of care and asked whether the high HSMR could be attributed to standards of care at the Hospital. The Trust reported that poor standards of care had not been highlighted in the review of the 100 case notes made to investigate the high HSMR (see 6.4.1). However, it was accepted that there were some sporadic groups of elderly patients who had not received adequate care.

7.2.10 The Panel also asked the Trust about the possibility that the higher than expected HSMR for elderly people is a result of the care given in the initial period following admission and that where the Hospital is over-stretched, vulnerable elderly people could be either medical outliers (medical patients being nursed in non medical beds) or trolley waits.

7.2.11 However, information received from the Trust shows that Medical outliers (as expressed as a percentage of the number of bed days where a medical patient was outlying over the total number of bed days available to the hospital) have actually fallen over the last few years:

2003/04	6.8%
2004/05	6.8%
2005/06	5.2%
2006/07	2.0% (average for year to date)

7.2.12 The Coroner's comments and the adverse publicity that arose resulted in the establishment of an Inquiry Panel by the Acute Trust Board. The key aim of the Inquiry Panel's review was not to defend against the comments made by the Coroner but to generally review care processes across the Trust and identify any areas for improvement to ensure a high standard of care for all patients using the Hospital.

7.2.13 On December 2006, the Inquiry Panel finalised their review of care processes at the Hospital and published a report outlining their findings and recommendations for improvements.

7.2.14 The Inquiry Panel found little or no evidence of underlying problems in the areas concerned, for example, few shortfalls in nursing staff, minimal numbers of complaints, and no major issues arising through the PALS service or through the Matron's Rounds.

7.2.15 However, they concluded that the care of the four patients involved and for others had fallen below the standard these patients and their carers had a right to expect. Despite these individual failings, the Inquiry Panel reported that there were no systemic failings in patient care systems within the Hospital overall.

7.2.16 This variability in care standards led the Inquiry Panel to conclude that a greater effort is required in meeting the needs of vulnerable older people, particularly those being cared for in the elderly ward.

7.2.17 Overall, they found that the root causes for deficiencies of care for vulnerable older people stemmed from:

- Poor attitude to vulnerable older people
- Inadequate communication with patients and carers
- Insufficient training and inadequate ward organisation
- Inadequate adherence to clinical protocols and standards of practice.

7.2.18 The Trust outlined to the Scrutiny Panel the key measures that will be taken to improve the overall care of the elderly at the Hospital in response to the Inquiry Panel's recommendations. These measures include:

- Matrons Rounds to focus more on vulnerable older people;
- Improved links with external bodies such as Age Concern;
- Better identification and management of nutritional needs of patients;
- Training for some staff regarding the needs of vulnerable older people;
- Recognition of good care and disciplinary action against staff involved in proven failings in basic care;
- Regular visits by senior hospital managers to clinical areas;
- Involvement of patients and carers in care planning and monitoring;
- Patient and relative surveys to enable the Trust to see trends which can be acted upon before they become problems;
- Closer working with the Tameside Hospital Action Group and other patient groups;
- Enhancements to existing complaints facilities;
- Ward Manager training to ensure they fully understand the standards of care expected by patients in their wards;
- Nursing "efficiency and effectiveness" group to eliminate unproductive tasks to enable time to be reinvested back in to direct patient care;
- Involvement of relatives in staff complaints training;
- Director of Nursing to undertake monthly clinical practice days to experience ward environment;
- Improve and audit compliance with clinical protocols and standards of care.

7.2.19 The Trust hopes that implementation of the action plan will ensure that every patient will receive safe, highly personalised care during their stay at the Hospital, that complaints regarding the care of vulnerable patients should be permanently eliminated, and that confidence in the Hospital will be restored.

7.2.20 They reported that the all the actions linked to the recommendations will be completed by July 2007. To ensure improvements are sustained and cultural and behavioural changes occur across the Hospital, quarterly peer reviews will be conducted by Hospital Matrons and reported to the Board for at least a further year. Monthly progress and accountability reports will also be produced and submitted to the Trust Board, PCT and strategic health authority.

7.2.21 Although it was too early to measure the impact of the actions already taken to improve the quality of care at the Hospital, the Scrutiny Panel welcomed the changes set out in the Action Plan and it was agreed that the Trust would return in August 2007 to report on the progress to date.

7.2.22 In January 2007 it was announced that NHS NorthWest would be undertaking an independent, external review of the action plan in collaboration with the Trust, the PCT and the families concerned. The review will be carried out by an expert panel chaired by Professor Dame Pauline Fielding, Honorary Professor of Nursing at the University of Central Lancashire, and supported by Liz Craig, Director of Integrated Governance at North Cheshire Hospitals NHS Trust.

CONCLUSION

7. Although the Trust admits that there have been failings in the basic care of vulnerable older people at Tameside General Hospital, it is unclear whether these have contributed to the Hospital's higher than expected standardised mortality rate. The Panel does however, consider that the actions planned to improve care standards should have a positive impact on the patients and on the mortality rates.

RECOMMENDATION

1. That this Scrutiny Panel monitors on a routine basis the outcomes of the implementation of the Improvement Plan to enhance standards of care for elderly and vulnerable patients at Tameside General Hospital.

7.3 Do Doctor to Patient Ratios have an effect on Tameside General Hospital's Standardised Mortality Rate?

7.3.1 The ratios of the number of doctors and the number of nurses per hospital bed have been found to have an influence on hospital death rates – the higher these ratios, the lower the death rates[3].

7.3.2 The Panel was concerned to hear from some expert witnesses that Tameside General Hospital is under-resourced, particularly in the number of doctors working at the Hospital.

7.3.3 However, data supplied by the Trust indicates that between September 2003 and September 2006 there has actually been an improvement in the ratio of doctors per 100 beds at Tameside General Hospital.

7.3.4 The table below shows the number of doctors and the number of nurses per 100 beds at Tameside General Hospital for the last four years (2003-2006). The data clearly shows an increase in the number of full time equivalent (FTE) doctors from 182.2 in 2003 to 228.7 in 2006. This increase, combined with a reduction in the number of inpatient beds, has resulted in an increase in the number of doctors per 100 beds from 30.4 in 2003 to 53.2 in 2006.

7.3.5 The information also shows both the Dr Foster data for the number of nurses per 100 beds, which allows for comparisons with other Trusts, and the local data, calculated using a local methodology. In both cases, there has been an increase in the number of nurses per 100 beds, despite the reduction in the overall number of full time equivalent (FTE) qualified nurses.

[3] Jarman B; Gault S; Alves B; Hider A; Dolan S; Cook A; Hurwitz B; Iezzoni LI. (1999) Explaining differences in English hospital death rates using routinely collected data. BMJ. 318: 1515-1520; www.rcn.org.uk/news/mediadisplay.php?ID=2202&area=Press

	30/09/03	30/09/04	30/09/05	30/09/06
Doctors (FTE)	182.2	189	214.1	228.7
Qualified Nurses (FTE)	714	735	699.4	694.6
In Patient Beds (general/acute)	599	558	539	430
Doctors per 100 beds	30.4	33.9	39.7	53.2
Nurses per 100 beds Dr Foster	120.2	127.4	133.2	n/a
Nurses per 100 beds	119.2	131.7	129.7	161.5

CONCLUSION

8. As the ratios of the number of doctors and the number of nurses per hospital bed have been found to have an influence on Hospital Standardised Mortality Rates, the Panel was pleased to note that the Trust has significantly increased the number of doctors and nurses per 100 beds at the Hospital.

7.4 Could the general health of the population affect Hospital Standardised Mortality Rates?

7.4.1 While Tameside as an entire area does not face widespread deprivation, the borough does contain a number of highly deprived neighbourhoods. Overall, Tameside was ranked 49th out of 354 areas in England for Average Score and Average Rank on the Index of Multiple Deprivation 2004 (being ranked first would mean being the most deprived area in England)[4].

7.4.2 People living in areas of deprivation are more likely to experience poor health and to die at a younger age than those living in more affluent areas[5]. In Tameside, Male life expectancy at birth is 74.1 years and female life expectancy 79.4 years – 2.45 years and 1.51 years below the England averages respectively[6].

7.4.3 In producing the Hospital Standardised Mortality Rate figures, the Dr Foster organisation makes adjustments for a number of factors (see 6.1.3) including socioeconomic deprivation.

[4] Quality of Life in Tameside 2006-07: Guide to the Borough, p11
[5] Neighbourhood Renewal Unit: www.neighbourhood.gov.uk
[6] Neighbourhood Statistics: www.neighbourhood.statistics.gov.uk

7.4.4 However, when asked what factors they thought contribute to the Hospital's high mortality rate, two of the GPs and one of the clinicians interviewed, and four of the GPs who responded to the questionnaire said that these factors have contributed to the mortality figures at Tameside General Hospital, causing them to be higher than other NHS Hospital Trusts.

7.4.5 They also reported that generally, in Tameside, patients present themselves to primary care at a later stage of illness than those patients who reside in more affluent areas of the country. Consequently, in some cases, by the time these patients are referred to the Hospital, the degree of illness is so advanced that there is very little that the Hospital can do to assist them.

7.4.6 However, none of the GPs or clinicians could point to any particular weaknesses in Professor Jarman's methodology of adjusting the figures for factors relating to deprivation.

7.4.7 Standardisation of the figures appears to have removed any link between the deprivation of an area and HSMRs. In fact, none of the 11 hospital trusts with HSMRs in the bottom 10 per cent had average deprivation scores higher than Tameside's average score of 29.81, ranked 49th out of 354 local authorities on the Index of Multiple Deprivation 2004[7].

7.5 Is the assessment and care of elderly people in Tameside adequate?

7.5.1 In Tameside, elderly people in need of support and eligible for services are usually cared for by the provision of support from within the community or from within a care home. If a person cannot be cared for adequately on a long term basis whilst living in his or her own home, he or she may be placed into a residential or nursing care home.

7.5.2 Placements to care homes in Tameside are made via one of two routes.

(i) The Community – the local authority social worker undertakes an assessment of the client and makes a decision regarding the need for residential care. If there is a potential nursing need, a qualified nurse must be involved in the assessment.

(ii) The Hospital – the Hospital Transfer Team which, although based at Tameside General Hospital, is a joint service which is the responsibility of the local authority and the Tameside and Glossop Primary Care Trust. Local authority social workers together with nurses from the Primary Care Trust, make patient referrals to residential or nursing homes. Alternatively people can also co-ordinate and organise their own care and fund this privately without any recourse to the Local Authority.

[7] Communities and Local Government: www.communities.gov.uk/SOA/LASummaries2004.xls

7.5.3 The criteria for deciding whether a patient/service user requires residential or nursing care is based on whether or not adequate care of the service user can be done via daily visits at set times throughout the day by a district nurse, or whether the need for nursing intervention is unpredictable and could be required at any time of the day or night which cannot be forecast.

7.5.4 Health professionals have reported that if nursing care is implemented at an early stage, this should subsequently prevent clients from being unnecessarily admitted to hospital at a later date.

7.5.5 In England and Wales, all clients must contribute towards the cost of care provided by a care home. Amongst other considerations, the amount of contribution usually depends on the client's income and capital (in general, most of a clients' income, including benefits, goes towards the cost of residential or nursing care). Consideration of capital however, is excluded for nursing care payments. All are subject to a financial assessment which is a requirement placed on all Local Authorities.

7.5.6 For residential care, the Council's Social Care and Health Service may also make a payment towards the cost of care. As at 2006/07 the maximum contribution payable by the Social Care and Health Service is £356.66 (£388.33 for Residential Elderly Mental Infirm (EMI))[8].

7.5.7 For nursing care, all residents in a nursing placement should have their care provided by a registered nurse paid for by the Primary Care Trust. A registered nurse will assess each resident and the Primary Care Trust will then allocate one of the following payments[9]:-

- High £133.00 per week
- Medium £83.00 per week
- Low £40.00 per week

7.5.8 If the cost of the home chosen by a client or his/her family is more expensive than the maximum rate for this local authority, a third party, often a friend or relative will be required to cover the shortfall.

7.5.9 Some Nursing Homes claim that only one level of nursing care payment is received for their clients and payments are not made in accordance with the level of care required.

7.5.10 Social Care and Health Services report however, that their system shows that payments are issued to the Care Homes based on the three tiers detailed in paragraph 7.6.7. The Planning and Commissioning Team however, reports that only one level of nursing care payment is paid to the Nursing Homes. This clearly indicates that there is a discrepancy in the information provided.

7.5.11 During consultations with care homes, one of the care homes interviewed raised the concern that elderly clients are being incorrectly assessed for residential care rather than for nursing care. In their opinion, the "inappropriate

[8] Social Care and Health: Residential Fees 2006/07
[9] www.tameside.gov.uk

placement of clients" has resulted in a situation whereby occupancy levels in the Nursing Care Homes are extremely low and occupancy levels in Residential Care Homes very high.

7.5.12 The Proprietor of this care home felt that the needs of many of the clients in residential care were not being adequately provided for and suggested that some clients had been inappropriately assessed. He had contacted Tameside MBC's Borough Solicitor regarding this matter and she was dealing with the complaint.

7.5.13 Asked whether this issue could potentially impact on hospital mortality rates, the care home proprietor agreed that this was a possibility.

7.5.14 Information received from Social Care and Health (see the following table) indicates that between March 2001 and March 2006 there has been an overall increase in the number of placements to care homes (nursing and residential). During this period residential placements form the greater proportion of placements made to care homes. However, in contrast to the comments made by a care home regarding the "inappropriate placement of clients" and the resulting situation of low occupancy levels in nursing homes, the data shows that between March 2001 and March 2006 there has been little change in the number of nursing placements as a percentage of the total number of placements (although there was a slight reduction between March and December 2006).

	Mar 2001	**Mar 2002**	**Mar 2003**	**Mar 2004**	**Mar 2005**	**Mar 2006**	**Aug 2006**	**Oct 2006**	**Dec 2006**
Residential	625	598	597	659	610	753	745	757	751
Nursing	397	390	428	446	388	405	383	373	369
Total	1022	988	1025	1105	998	1158	1128	1130	1120
Nursing as a % of total	38.8%	39.5%	41.8%	40.4%	38.9%	35.0%	34.0%	33.0%	32.9%

7.5.15 A further concern raised by two of the care homes was that the fees paid by Tameside Social Care and Health Services for residential care are amongst the lowest in the country. The result of this is that in order for a residential care home to remain viable, it must maintain high occupancy levels. This may cause some residential care homes to accept clients who they would otherwise consider inappropriate for residential care and would really be more suitable for nursing care. *(It has been pointed out by Social Care and Health Services however, that the onus is on the homes not to accept people whose needs cannot be adequately met).*

7.5.16 In order to compare Tameside's fee payments with other local authorities, the following information was gained from the Social Care Commissioning Support Team giving the fee payments made by Greater Manchester local authorities for 2006/07 (please refer to the following table). The Panel notes that Tameside's minimum payment level for Residential Care is the second lowest out of the nine authorities listed but that Tameside's maximum payment level is fourth highest.

Authority	Residential		Residential EMI	
	Min	Max	Min	Max
Bolton	309.88	350.04	350.15	390.31
Bury	339.00	339.00	339.00	339.00
Manchester	398.09	418.84	398.09	418.84
Rochdale	328.41	331.42	365.00	365.00
Salford	310.17	355.52	310.17	355.52
Stockport	326.00	384.00	384.00	384.00
Tameside	271.74	356.66	271.74	388.33
Trafford	333.10	363.80	336.92	378.08
Wigan	264.83	353.44	264.83	353.44
Average	**320.14**	**361.41**	**335.54**	**374.72**

(The minimum Tameside figure quoted, is for a shared room which is only usually commissioned for a couple).

7.5.17 When questioned about fee payments, Mrs Butterworth, Assistant Executive Director for Adult Social Care and Health, stated that fees paid to both Residential and Nursing Care Homes in the borough, are considered to be sufficient for their purpose.

7.5.18 Elderly people in Tameside are also cared for in the community receiving home care support where necessary. This fulfils the Government's policy to support older people in the community for as long as possible. Tameside has more older people aged 65 or over helped to live at home than the national average[10]. However, two of the care homes interviewed reported that as a result of older people remaining in the community for longer, when admitted to residential or nursing care they often have more complex needs than experienced several years ago.

7.5.19 Supporting terminally ill patients in the community is the preferred option for most of the GPs who were consulted (all those interviewed and six out of the nine GPs who responded to the questionnaire). However, for elderly residents this might not always be possible, as one GP reported. They referred to a lack of resources to support older people living in the community. For example, an elderly person living alone who needs regular medication would rely on an already overstretched District Nursing Service to provide much needed support to enable him/her to remain in his/her own home. However, District Nurses may not be able to meet this patient's needs and therefore the patient's GP would have little choice but to admit the patient to hospital when he/she becomes sick.

[10] Department of Health, Community Health Profile

7.5.20 Another GP identified the Rapid Response Team as an example of good practice and an excellent community resource which is available to help prevent unnecessary admissions to hospital. The Rapid Response Team is part of the Community Assessment and Rapid Access (CARA) Team which is a joint arrangement between Tameside MBC and Tameside and Glossop PCT. The Team aims to prevent unnecessary admission into hospital, support discharge from hospital and prevent admission into care homes for patients with long term conditions. Rehabilitation, therapeutic input and social support is provided by a team of nurses, physiotherapists, occupational therapists and professionals from social care who can respond within one hour where necessary.

CONCLUSION

9. The Panel received no conclusive evidence to indicate that the level of fees paid to nursing and residential care homes has any impact on the hospital standardised mortality rate.

10. The Panel believes that home care and district nursing services are essential in maintaining elderly people in the community for as long as possible. The Panel acknowledges that as the population ages, an already overstretched District Nursing Service may find it increasingly difficult to support people in the community which could result in more admissions to the Hospital.

RECOMMENDATION

2. With an increasing emphasis on primary care services to support elderly vulnerable people in the community that when the opportunity arises additional resources be allocated to increase this provision.

8. END OF LIFE CARE PATHWAYS FOR THE DYING

8.1 National Health Service End of Life Care Programme

8.1.1 The National Health Service End of Life Care (EoLC) programme was set up in 2004 following the announcement of £12 million investment over three years to improve care for patients coming to the end of their lives and to widen the pool of staff trained in palliative care.

8.1.2 The EoLC Programme's key objectives are:

- To provide greater choice for patients in their place of care and death;
- To reduce the number of emergency admissions to hospital for those wishing to die at home (and reducing the Hospital Standardised Mortality Rate as a consequence);

- To decrease the number of patients transferred from care homes to hospital in the last week of life;
- To improve the skills of generalist staff in the provision of end of life care.

8.1.3 This Programme is intended for use by health professionals and the patient, to identify an agreed course of action stating amongst other things, whether or not the patient would prefer to die at home, a hospice, in a Nursing Home or in Hospital.

8.1.4 The tools were initially developed for use with cancer patients but are being adapted to meet the needs of all patients requiring care at the end of life.

8.1.5 The following three tools are used to implement the Programme which represent best practice in end of life care:

- The Gold Standards Framework;
- The Liverpool Care Pathway for the Dying;
- Preferred Place of Care tools - a patient-held record detailing patient and carer choices about the care they would like to receive and where they would like to be carer for at the end of their life.

8.2 The Gold Standards Framework

8.2.1 The Gold Standard Framework (GSF) was developed in primary care to provide a framework for GPs, district nurses and other primary care health professionals to improve the organisation and quality of care for patients living in the community in their last year of life.

8.2.2 The Framework was initially intended for cancer patients but it is now being used for any patient with an advanced, life-limiting illness (eg. heart failure, Chronic Obstructive Pulmonary Disease (COPD) or frailty), in any community setting, including patients' homes or care homes.

8.2.3 The GSF incorporates three processes:

1) Identifying patients in the palliative stage of their disease and near the end of life (last one to two years of life);
2) Assessing the patient's symptoms, care needs and preferences;
3) Developing a proactive care plan to enable these needs and preferences to be fulfilled.

8.2.4 However, the PCT reported that in contrast to patients with cancer, it is often difficult to diagnose when a patient with heart or respiratory difficulties is at the end stages of their life. This follows what one GP reported through consultation (see 7.1.16). For patients with these diagnoses, it is up to the consultants in the Hospital to have the conversations required to inform patients when hospital treatment will no longer make a difference.

8.2.5 The objectives of the Framework are to help control patients' symptoms, to enable them to live well and die where they choose, to provide security and support for patients and their carers through better advanced care planning,

information, and fewer crisis admissions to hospital, and to promote confidence, team working, satisfaction and communication amongst staff.

8.2.6 In order to achieve these objectives, there are seven standards the GSF aims for – known as the "7 C's":

Communication

Practices should maintain a Supportive Care Register to record, plan and monitor patient care, and as a tool to discuss at regular primary health care team meetings.

Co-ordination

Each primary health care team should have a nominated co-ordinator for palliative care (eg. a district nurse) to ensure good organisation and co-ordination of care in practices.

Control of symptoms

Each patient's needs, preferences and symptoms (physical, psychological, social, practical and spiritual) should be assessed, recorded, discussed and acted upon, according to an agreed process.

Continuity

The GSF developed out the need to prevent out of hours crises in primary care which were causing most unnecessary hospital admissions. Through the GSF, systems should be developed to ensure continuity of care between primary care teams and Out of Hours providers. Information about palliative care patients should be transferred from practices to the Out of Hours service, building in anticipatory care to reduce crises and inappropriate admissions to hospital.

Out of hours emergency care includes:

- Communicating with the carers about what might go wrong, what to do if it does and who to contact;
- Communicating with the Out of Hours providers and identifying palliative care patients to enable an appropriate response;
- Informing ambulance services and others of an Advance Care plan or Do Not Attempt Resuscitation (DNAR) request;
- Leaving anticipatory drugs in the home and providing detailed instructions on administering these so that medical staff completely understand what drugs the patients must be given and when;
- Rapid discharge from hospitals for those wishing to get home quickly.

Continued learning

The primary care team should continue inter-professional learning based on real clinical problems.

Carer support

This approach encourages practices to work in partnership with carers and also to consider their needs. Practical support should be provided where possible, for example, night sitting, respite care, and aids for the home.

Care in the dying phase

Recognition of the dying phase and discussing these issues with the family and carers is an important part of the process. Once this phase has been acknowledged, patients should be cared for appropriately, for example, by using the minimum protocol or following the Liverpool Care Pathway. This could include leaving standard drugs in anticipation of need, stopping non-essential interventions and drugs, and considering comfort measures, psychological support and bereavement planning.

8.2.7 The GSF is currently being implemented for patients in Tameside nearing the end of life and living in the community. Thirty-eight practices in the borough of Tameside are now registered on the gold standards framework national programme, all to differing degrees.

8.2.8 Strong links have been developed with the Out of Hours provider, Go-to-Doc, who is aware of all patients on the Gold Standards Framework and the Advanced Care Plans set up for each patient. Handover forms are produced for all patients on the GSF effectively "electronically tagging" them so that the out of hours GP knows they are on the Framework.

8.2.9 The Framework is also currently being piloted in two Tameside Nursing Homes in which systems are being put in place to prevent crisis admissions to hospital. Training for the programme is undertaken slowly to ensure sustainability in the long term and can only be offered to two care homes simultaneously due to staff resources (they only have four Macmillan nurses able to offer the training required). However, a number of nursing and residential care homes have expressed their interests in becoming involved in the programme and training will be offered when available. As one care home consulted said:

"Clear guidelines on end of life would make things easier for families, residents, GPs and [care] home staff."

8.3 Liverpool End of Life Care Pathway

8.3.1 The palliative care team at the Royal Liverpool Hospital and the Marie Curie Hospice developed the Care of the Dying Pathway in 1998 with the aim of improving the care that people receive at the end of life.

8.3.2 The Liverpool Care Pathway (LCP) is aimed at transferring a hospice model of care into other care settings, such as hospitals, enabling generalist staff to provide a high level of care for dying patients. The LCP focuses on the end

stage of a patient's life (last 48 to 72 hours), providing a plan of care that aims to keep the patient comfortable and maintain their dignity during this period.

8.3.3 The overall aims of the Pathway are:

- To provide comfort measures and symptom control to ensure a pain free death;
- To address the psychological and spiritual needs of the patient and the family at this time;
- To improve communication with the patient and their family;
- To improve communication between health professionals.

8.3.4 The LCP is currently being implemented by the Hospital Trust and it is intended that the Pathway be fully implemented in all clinical specialities by the end of November 2006. The Pathway is also implemented within the community and the two nursing home GSF pilots for patients in their last few days of life.

8.3.5 Patients in Tameside General Hospital are considered for the pathway if they meet a series of trigger questions and criteria which indicate that the patient is at the end stage of their life. The process is often initiated by the nurses, or any member of medical staff, however, the actual decision to start a patient on the pathway is made by the doctors looking after the patient, following discussion with the multi-disciplinary team, relatives and carers, and the patient themselves if appropriate.

8.3.6 The Pathway intends to plan for a comfortable and dignified death for patients at the end of their lives. Staff are given a guide to treatment including an assessment of a dying patient's medication so that non-essential medication and other inappropriate interventions can be discontinued together with a facility to enable a rapid referral for supported discharge for terminally ill patients. As relatives and carers are involved in the process from the outset, any decisions to stop non essential medication and other inappropriate interventions should already have been understood and agreed.

8.3.7 The PCT and the Acute Trust are working in partnership to develop integrated care pathways between the Hospital and the community. Close working relationships have been formed between the Acute Trust's Integrated Care Pathways (ICP) Co-ordinator and the PCT's Project Manager for the Gold Standards Framework/Integrated Care Pathway for the Last Days of Life.

8.3.8 It was reported by the PCT that difficulties can arise within primary care for patients on the Pathway with a Do Not Resuscitate instruction. The Ambulance Service has no choice but to try and resuscitate someone when they have been called. Therefore, the challenge for the PCT is to try and pre-empt relatives and carers from calling an ambulance in the first place. For the majority of patients in the community this isn't a problem, however, for nursing homes this does occur. The roll out of end of life care pathways should help to resolve this problem.

8.3.9 The Scrutiny Panel asked the PCT if there is any evidence to show that End of Life Care Pathways are reducing unnecessary admissions to hospital and therefore helping to reduce hospital mortality rates. The PCT reported that

even though there is no evidence yet to show a fall in the number of unnecessary admissions to the Hospital, anecdotal reports from nurses is that for patients who would previously have been admitted to hospital, the pathways have enabled them to be cared for at home. The GSF and LCP actually act as a protection for nursing homes and GPs and the education and training provided as part of the pathways enables them to care for dying patients properly.

8.3.10 The majority of the GPs consulted by questionnaire thought that end of life palliative care services, including the Gold Standards Framework, are effective at preventing emergency admissions to hospital for the terminally ill. However, there was some concern, as two of GPs said: "*the unexpected always happens*" and "*not all end of life events can be managed at home with the resources available to families at present*".

CONCLUSION

11. The Panel concludes that End of Life Care Pathways, if implemented effectively and are sufficiently resourced, will have a positive impact on reducing unnecessary admissions to Tameside General Hospital resulting in a fall in the standardised hospital mortality rate.

RECOMMENDATION

3. That this Scrutiny Panel supports the continued development of the End of Life Care Pathways in care homes and general practices, as detailed in this report as the most appropriate means of improving end of life outcomes.

9. SUMMARY OF CONCLUSIONS

1. The Panel is pleased to note the fall in the Hospital Standardised Mortality Rate at Tameside General Hospital between 2005 and 2006.

2. The high mortality rates at Tameside General Hospital relate to specific patterns which occur in three categories:-

(i) <u>Cause of Death</u>

Terminally ill people who have been suffering from respiratory or circulatory diseases;

(ii) <u>Time of Death</u>

The majority of deaths occur within the first three days of admission;

(iii) Age Group

Mortality rates were the highest within the age group 80 to 89.

3. **The Panel accepts that there is not a general problem of mortality at Tameside General Hospital and that those patients who do die are generally elderly people with respiratory or circulatory diseases within the first few days following admission. If the mortality figures regarding respiratory and circulatory diseases are taken out of the equation, then the picture at Tameside General Hospital is normal.**

4. **The Panel acknowledges that the higher than expected rate of admission of elderly people at Tameside General Hospital (17.5% - ie. 240 admissions more than expected) might have a potential impact on the hospital standardised mortality rates.**

5. **Although the Panel could not find any conclusive evidence to prove or disprove the Acute Trust's suggestion that the cause of the higher than expected mortality rate at the Hospital is as a result of a "Shipman Factor" it does believe that there are factors indicating that this is a strong possibility, for example:-**

(i) **The reluctance of some GPs to carry controlled drugs;**
(ii) **The reluctance of some GPs to make decisions about patients;**
(iii) **Out of hours GPs are more likely to admit patients into Tameside General Hospital as they are not familiar with individual patients;**
(iv) **GPs and care homes are cautious of making decisions which might result in visits from the police of being brought before the coroner.**

6. **Although very few local GPs and care homes who were consulted said they were now more likely to admit terminally ill patients into hospital as a result of the Shipman case, the Panel believes that the following circumstances might result in more hospital admissions:-**

(i) **Unqualified and less experienced care home staff being more likely to call the out of hours GP or an ambulance when clients become unwell;**
(ii) **Changes to the way GPs practice as a consequence of the Dr Shipman case;**
(iii) **In some cases nursing homes may prefer to refer terminally ill clients to the Hospital when poorly, particularly if there are no qualified nursing staff on duty.**

7. **The Trust admits that there have been failings in the basic care of vulnerable older people at Tameside General Hospital. It is not known however, whether these have contributed to the Hospital's higher than expected standardised mortality rate. The Panel considers that the actions planned to improve care standards should have a positive impact on the patients and on the mortality rates.**

8. As the ratios of the number of doctors and the number of nurses per hospital bed have been found to have an influence on Hospital Standardised Mortality Rates, the Panel was pleased to note that the Trust has significantly increased the number of doctors and nurses per 100 beds at the Hospital.

9. The Panel received no conclusive evidence to indicate that the level of fees paid to nursing and residential care homes has any impact on the hospital standardised mortality rate.

10. The Panel believes that home care and district nursing services are essential in maintaining elderly people in the community for as long as possible. The Panel acknowledges that as the population ages, an already overstretched District Nursing Service may find it increasingly difficult to support people in the community which could result in more admissions to the Hospital.

11. The Panel concludes that End of Life Care Pathways, if implemented effectively and are sufficiently resourced, will have a positive impact on reducing unnecessary admissions to Tameside General Hospital resulting in a fall in the standardised hospital mortality rate.

10. SUMMARY OF RECOMMENDATIONS

1. That this Scrutiny Panel monitors on a routine basis the outcomes of the implementation of the Improvement Plan to enhance standards of care for elderly and vulnerable patients at Tameside General Hospital.

2. With an increasing emphasis on primary care services to support elderly vulnerable people in the community that when the opportunity arises additional resources be allocated to increase this provision.

3. That this Scrutiny Panel supports the continued development of the End of Life Care Pathways in care homes and general practices, as detailed in this report as the most appropriate means of improving end of life outcomes.

11. OVERALL CONCLUSION AND RECOMMENDATION

FINAL CONCLUSION

The Panel has been unable to determine one specific cause of Tameside General Hospital's higher than expected standardised mortality rate. The Panel concludes however, that the issues highlighted in this Report may have had an impact on the Hospital's standardised mortality rate, and that if actions are taken to address these issues, then the standardised mortality rate at Tameside General Hospital may be reduced.

FINAL RECOMMENDATION

That this Scrutiny Panel monitors on a routine basis the hospital standardised mortality rate for Tameside General Hospital.

12. COMMENTS FROM THE TAMESIDE AND GLOSSOP ACUTE SERVICES NHS TRUST

The comments from the Tameside and Glossop Acute Services NHS Trust have been incorporated into this report.

13. COMMENTS FROM THE EXECUTIVE DIRECTOR (SOCIAL CARE AND HEALTH SERVICES)

The comments from the Executive Director (Social Care and Health Services) have been incorporated into this report.

14. COMMENTS FROM THE BOROUGH SOLICITOR

The Borough Solicitor has commented as follows:-

“There are no significant legal issues arising from this report, except to acknowledge that whilst the Scrutiny Panel are not medically qualified they are charged by law to act as an independent body to analyse trends and understand the why and the how - with a view to challenging so that greater understanding and improvement can be facilitated in an open and transparent way.”

15. COMMENTS FROM THE BOROUGH TREASURER

The Borough Treasurer has commented as follows:-

"There are no direct financial implications arising for the Council from this report."

PERSONAL AND HEALTH SERVICES SCRUTINY PANEL

REVIEW OF HOSPITAL MORTALITY RATES

DECEMBER 2005

AIM OF THE SCRUTINY REVIEW EXERCISE
To review the actions being taken to reduce the hospital mortality rate at Tameside and Glossop Acute Services NHS Trust.

OBJECTIVES

A. To produce accurate and up to date information about mortality rates at Tameside and Glossop Acute Services NHS Trust.

B. To investigate the causes of the hospital mortality rate.

C. To evaluate the actions being taken by the Trust to reduce the mortality rate.

D. To consider the actions taken to reduce the mortality rates at other NHS Trusts and identify areas of best practice.

TIMESCALE
August 2006

EQUALITIES ISSUES
To ensure that the standard of care for elderly people is adequate.

APPENDIX 1

DETAILED ACTION PLAN (in broadly chronological order)

Action	Objective met	Timescale	Lead Scrutiny Panel member(s) and/or Scrutiny Support Officer(s)	Monthly update
(1) Produce a briefing paper providing accurate and up to date information about mortality rates at the Trust, considering the issues which underpin mortality rates and why the rate fluctuates from year to year.	A	January 2006	Diana Paver	✓
(2) Contact Walsall Hospitals NHS Trust to speak to the Trust about the actions taken to reduce the hospital mortality rate.	D	March 2006	Chair of the Scrutiny Panel, Diana Paver, Muna Clough	✓
(3) Produce a briefing paper providing information about mortality rates in other areas including Walsall Hospitals NHS Trust.	D	April 2006	Diana Paver	
(4) Contact all nursing/residential homes in Tameside and arrange visits.	B	March / April 2006	Chair of the Scrutiny Panel, member of the Panel, Muna Clough, Diana Paver,	✓
(5) Contact Dr Rotheray, PCT Medical Director / Tameside GPs to discuss GPs' views	B	April 2006	Chair of the Scrutiny Panel and member of the Panel, Diana Paver, Muna Clough,	✓
(6) Contact community palliative care nurses in Tameside and arrange visits.	B	April 2006	Chair of the Scrutiny Panel and member of the Panel Diana Paver, Muna Clough	✓
(7) Meet key hospital consultants, Karen Shingler (Divisional Nurse Manager, Emergency Services), and Sue Saxton (ICP Pathway Co-ordinator)	B	April 2006	Scrutiny Panel	✓
(8) Meet HM Coroner, John Pollard to discuss the procedures following deaths in and out of the Hospital.	B	June 2006	Scrutiny Panel	✓
(9) Meet representatives from the Acute Trust to discuss the actions taken to reduce the hospital mortality rate and consider how effective these actions have been.	C	July 2006	Scrutiny Panel	✓
(10)Produce a draft report including conclusions and recommendations.	ALL	August 2006	Scrutiny Panel	✓

Table 1 - Tameside General Hospital Deaths Mortality Rates by Cause of Death

Provider: **Tameside and Glossop Acute Services NHS Trust** — **Real Time Monitor**

Basket: **Diagnoses - HSMR** | Outcome: **Mortality (in-hospital)**
Chapter: **All** | Diagnosis: **All** | Department: **All** | Team: **All**
First / Last: **Jan-05 / Dec-05** | Admission type: **All** | Sex: **All** | Deprivation: **All** | Age Range: **All**
Spells: **12859** | Superspells: **12829** (11067/1762) | Deaths: **1166** (9.1%) | Expected: **977.1** (7.6%) | Relative Risk: **119.3** (112.6—126.4) | LoS: **9.8/9.7**

Chapter	Spells	Superspells	%	Deaths	%	Expected	%	RR	Low	High
ALL	12859	12829	100%	1166	9.1%	977.1	7.6%	**119.3**	112.6	126.4
Respiratory	3423	3411	26.6%	417	12.2%	303	8.9%	**137.6**	124.7	151.5
Circulatory	2512	2504	19.5%	303	12.1%	258.4	10.3%	**117.3**	104.4	131.2
Digestive	2297	2295	17.9%	75	3.3%	84.5	3.7%	88.7	69.8	111.2
Symptoms and signs	1275	1275	9.9%	15	1.2%	9.6	0.8%	156.7	87.6	258.5
Neoplasms	1020	1018	7.9%	169	16.6%	143.2	14.1%	**118.1**	100.9	137.3
Genito-urinary	585	584	4.6%	35	6%	47.3	8.1%	74	51.5	102.9
Injuries and poisonings	502	500	3.9%	50	10%	42.2	8.4%	118.5	87.9	156.2
Blood	388	388	3%	14	3.6%	8.3	2.1%	169.3	92.5	284.1
Skin	364	363	2.8%	5	1.4%	6.1	1.7%	82.1	26.5	191.5
Perinatal period	205	204	1.6%	20	9.8%	20.4	10%	97.9	59.7	151.1
Mental health	134	134	1%	13	9.7%	15	11.2%	86.8	46.2	148.4
Endocrine	83	82	0.6%	10	12.2%	10.2	12.5%	97.8	46.8	179.8
Infectious and parasitic	71	71	0.6%	40	56.3%	29	40.8%	138.1	98.7	188.1

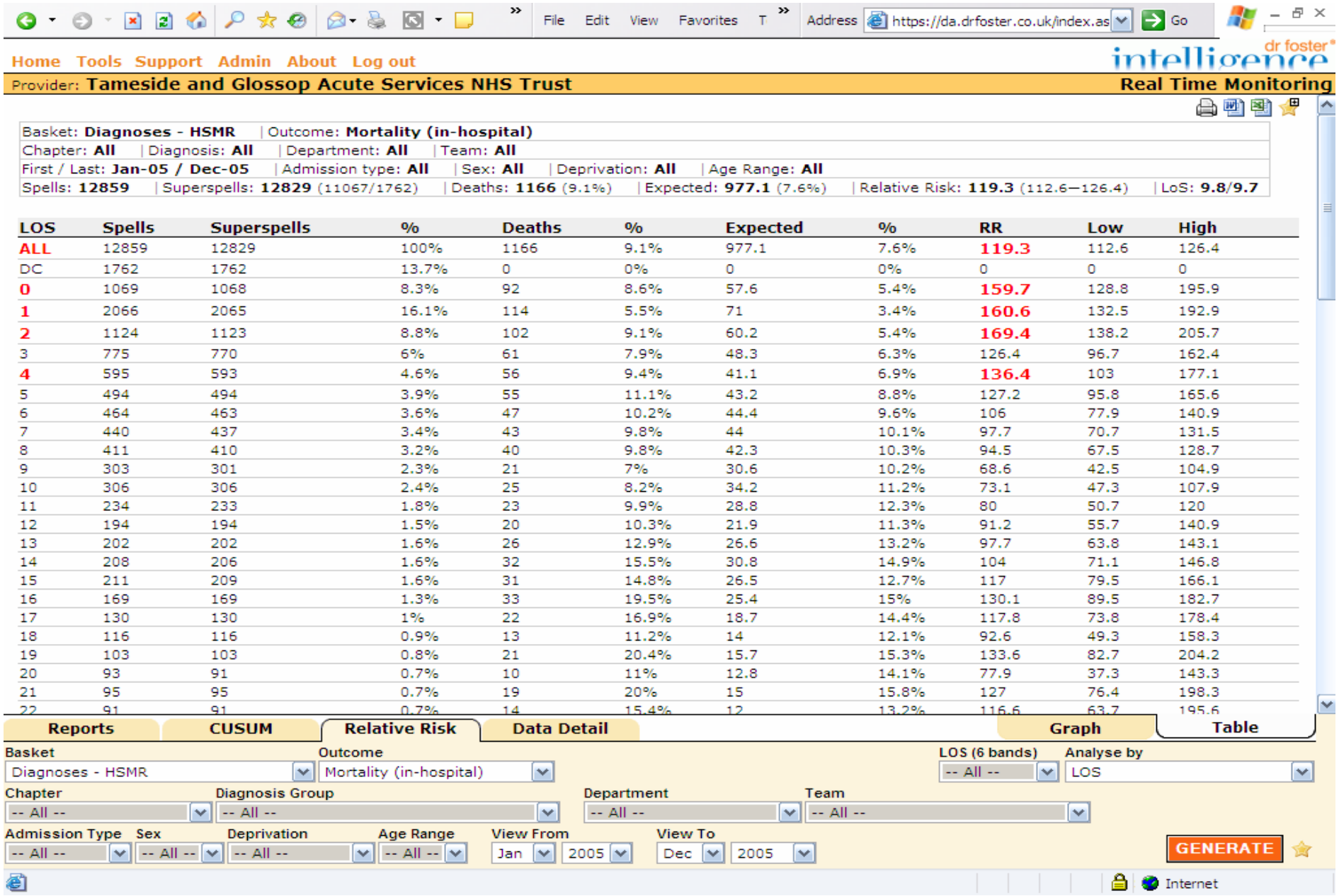
APPENDIX 2

Table 2 - Tameside General Hospital Mortality Rates by Age Group (2005)[11]

Age Range	Spells	Superspells	%	Number of Deaths	%	Number Expected	%	Relative Risk	Low	High
ALL	10743	10720	100%	921	8.6%	808.4	7.5%	**113.9**	106.7	121.5
0	475	474	4.4%	14	3%	15.9	3.4%	87.9	48	147.5
1-4	320	319	3%	0	0%	0.6	0.2%	0	0	630.5
5-9	163	163	1.5%	0	0%	0.3	0.2%	0	0	1318.5
10-14	182	180	1.7%	1	0.6%	0.3	0.2%	350.8	4.6	1951.5
15-19	196	196	1.8%	0	0%	0.5	0.2%	0	0	767.2
20-24	228	228	2.1%	1	0.4%	1	0.4%	103.4	1.4	575.5
25-29	214	214	2%	0	0%	1	0.5%	0	0	365.6
30-34	266	266	2.5%	2	0.8%	1.4	0.5%	144.6	16.2	522
35-39	381	380	3.5%	4	1.1%	5	1.3%	79.6	21.4	203.9
40-44	484	483	4.5%	10	2.1%	8.9	1.8%	112.3	53.7	206.5
45-49	472	472	4.4%	14	3%	13	2.8%	107.4	58.7	180.2
50-54	593	590	5.5%	18	3.1%	16.2	2.7%	111.2	65.8	175.7
55-59	715	715	6.7%	28	3.9%	25.4	3.6%	110.1	73.1	159.1
60-64	777	777	7.2%	43	5.5%	37.6	4.8%	114.5	82.8	154.2
65-69	950	944	8.8%	74	7.8%	62.4	6.6%	118.6	93.1	148.9
70-74	962	959	8.9%	85	8.9%	79.3	8.3%	107.2	85.7	132.6
75-79	1052	1049	9.8%	121	11.5%	114.2	10.9%	105.9	87.9	126.6
80-84	1077	1077	10%	202	18.8%	165.1	15.3%	**122.4**	106.1	140.5
85-89	737	737	6.9%	175	23.7%	139.6	18.9%	**125.3**	107.5	145.4
90+	499	497	4.6%	129	26%	120.8	24.3%	106.8	89.2	126.9

[11] Information received from Tameside and Glossop Acute Services NHS Trust

Table 3 - Tameside General Hospital Mortality Rates by Days after Admission



LOS	Spells	Superspells	%	Deaths	%	Expected	%	RR	Low	High
ALL	12859	12829	100%	1166	9.1%	977.1	7.6%	119.3	112.6	126.4
DC	1762	1762	13.7%	0	0%	0	0%	0	0	0
0	1069	1068	8.3%	92	8.6%	57.6	5.4%	159.7	128.8	195.9
1	2066	2065	16.1%	114	5.5%	71	3.4%	160.6	132.5	192.9
2	1124	1123	8.8%	102	9.1%	60.2	5.4%	169.4	138.2	205.7
3	775	770	6%	61	7.9%	48.3	6.3%	126.4	96.7	162.4
4	595	593	4.6%	56	9.4%	41.1	6.9%	136.4	103	177.1
5	494	494	3.9%	55	11.1%	43.2	8.8%	127.2	95.8	165.6
6	464	463	3.6%	47	10.2%	44.4	9.6%	106	77.9	140.9
7	440	437	3.4%	43	9.8%	44	10.1%	97.7	70.7	131.5
8	411	410	3.2%	40	9.8%	42.3	10.3%	94.5	67.5	128.7
9	303	301	2.3%	21	7%	30.6	10.2%	68.6	42.5	104.9
10	306	306	2.4%	25	8.2%	34.2	11.2%	73.1	47.3	107.9
11	234	233	1.8%	23	9.9%	28.8	12.3%	80	50.7	120
12	194	194	1.5%	20	10.3%	21.9	11.3%	91.2	55.7	140.9
13	202	202	1.6%	26	12.9%	26.6	13.2%	97.7	63.8	143.1
14	208	206	1.6%	32	15.5%	30.8	14.9%	104	71.1	146.8
15	211	209	1.6%	31	14.8%	26.5	12.7%	117	79.5	166.1
16	169	169	1.3%	33	19.5%	25.4	15%	130.1	89.5	182.7
17	130	130	1%	22	16.9%	18.7	14.4%	117.8	73.8	178.4
18	116	116	0.9%	13	11.2%	14	12.1%	92.6	49.3	158.3
19	103	103	0.8%	21	20.4%	15.7	15.3%	133.6	82.7	204.2
20	93	91	0.7%	10	11%	12.8	14.1%	77.9	37.3	143.3
21	95	95	0.7%	19	20%	15	15.8%	127	76.4	198.3
22	91	91	0.7%	14	15.4%	12	13.2%	116.6	63.7	195.6

Table 4 - Tameside General Hospital Mortality Rates by Year

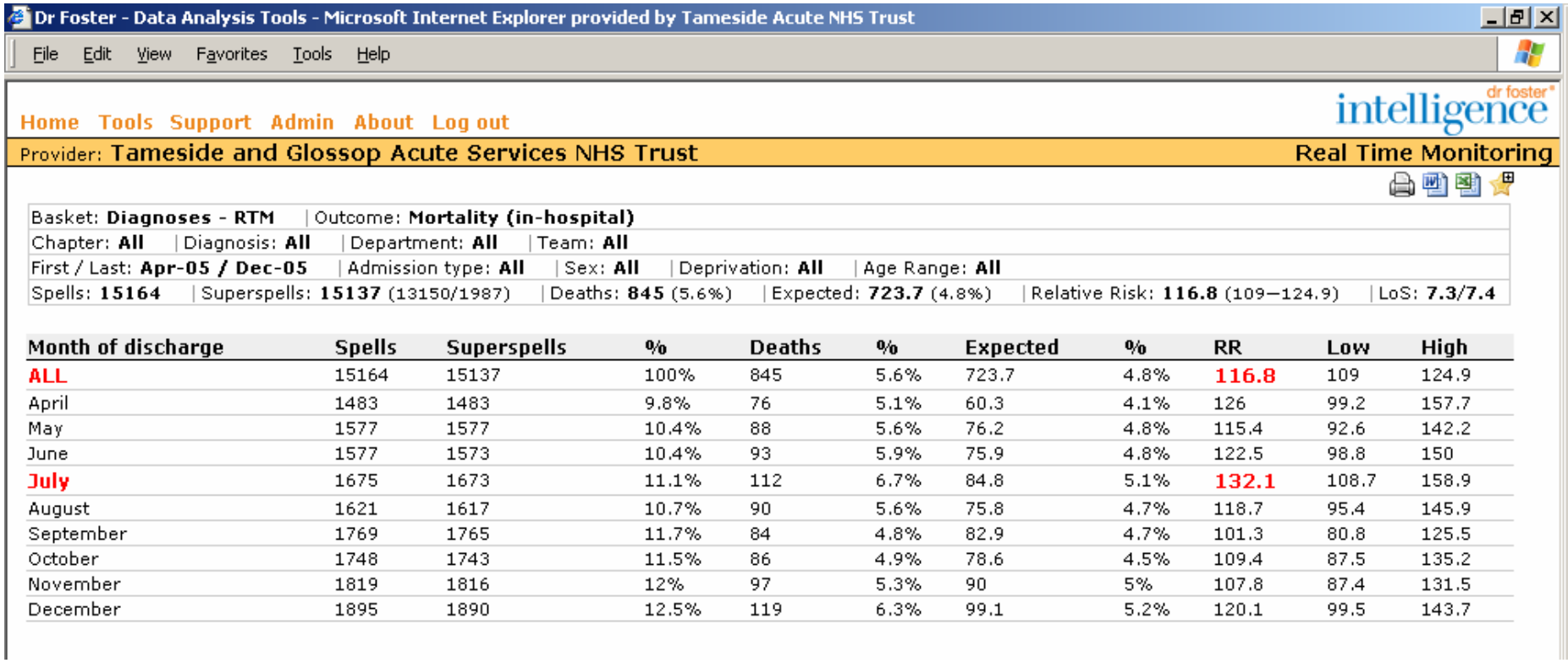
Provider: **Tameside and Glossop Acute Services NHS Trust** — **Real Time Monitor**

Basket: **Diagnoses - HSMR** | Outcome: **Mortality (in-hospital)**
Chapter: **All** | Diagnosis: **All** | Department: **All** | Team: **All**
First / Last: **Apr-96 / Jan-06** | Admission type: **All** | Sex: **All** | Deprivation: **All** | Age Range: **All**
Spells: **90295** | Superspells: **89923** (76021/13902) | Deaths: **6244** (6.9%) | Expected: **5488.4** (6.1%) | Relative Risk: **113.8** (111—116.6) | LoS: **9.1/8.9**

Trend (Financial Year)	Spells	Superspells	%	Deaths	%	Expected	%	RR	Low	High
1996/97	8833	8799	9.8%	531	6%	551	6.3%	96.4	88.4	104.9
1997/98	8558	8507	9.5%	534	6.3%	505.6	5.9%	105.6	96.9	115
1998/99	9153	9113	10.1%	564	6.2%	535.9	5.9%	105.2	96.7	114.3
1999/00	9009	8950	10%	495	5.5%	430	4.8%	115.1	105.2	125.7
2000/01	9206	9130	10.2%	504	5.5%	453.6	5%	111.1	101.6	121.3
2001/02	6386	6364	7.1%	518	8.1%	424.6	6.7%	122	111.7	133
2002/03	7715	7705	8.6%	458	5.9%	346.4	4.5%	132.2	120.4	144.9
2003/04	9439	9413	10.5%	667	7.1%	548	5.8%	121.7	112.7	131.3
2004/05	12376	12341	13.7%	1162	9.4%	981.8	8%	118.4	111.6	125.4
2005/06	9620	9601	10.7%	811	8.4%	711.6	7.4%	114	106.3	122.1

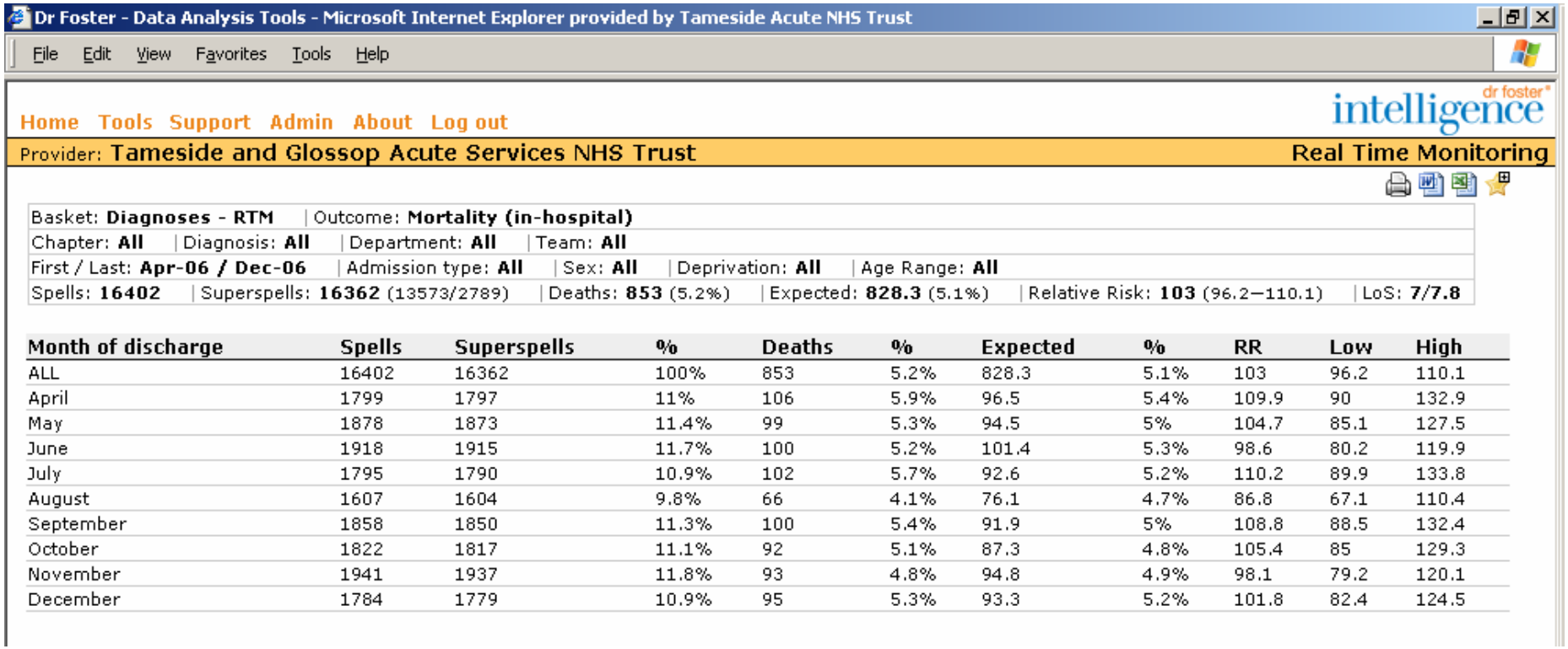
APPENDIX 3

Table 1 – Mortality Rate by month, April to December 2005



Month of discharge	Spells	Superspells	%	Deaths	%	Expected	%	RR	Low	High
ALL	15164	15137	100%	845	5.6%	723.7	4.8%	116.8	109	124.9
April	1483	1483	9.8%	76	5.1%	60.3	4.1%	126	99.2	157.7
May	1577	1577	10.4%	88	5.6%	76.2	4.8%	115.4	92.6	142.2
June	1577	1573	10.4%	93	5.9%	75.9	4.8%	122.5	98.8	150
July	1675	1673	11.1%	112	6.7%	84.8	5.1%	132.1	108.7	158.9
August	1621	1617	10.7%	90	5.6%	75.8	4.7%	118.7	95.4	145.9
September	1769	1765	11.7%	84	4.8%	82.9	4.7%	101.3	80.8	125.5
October	1748	1743	11.5%	86	4.9%	78.6	4.5%	109.4	87.5	135.2
November	1819	1816	12%	97	5.3%	90	5%	107.8	87.4	131.5
December	1895	1890	12.5%	119	6.3%	99.1	5.2%	120.1	99.5	143.7

Table 2 – Mortality Rate by month, April to December 2006



Month of discharge	Spells	Superspells	%	Deaths	%	Expected	%	RR	Low	High
ALL	16402	16362	100%	853	5.2%	828.3	5.1%	103	96.2	110.1
April	1799	1797	11%	106	5.9%	96.5	5.4%	109.9	90	132.9
May	1878	1873	11.4%	99	5.3%	94.5	5%	104.7	85.1	127.5
June	1918	1915	11.7%	100	5.2%	101.4	5.3%	98.6	80.2	119.9
July	1795	1790	10.9%	102	5.7%	92.6	5.2%	110.2	89.9	133.8
August	1607	1604	9.8%	66	4.1%	76.1	4.7%	86.8	67.1	110.4
September	1858	1850	11.3%	100	5.4%	91.9	5%	108.8	88.5	132.4
October	1822	1817	11.1%	92	5.1%	87.3	4.8%	105.4	85	129.3
November	1941	1937	11.8%	93	4.8%	94.8	4.9%	98.1	79.2	120.1
December	1784	1779	10.9%	95	5.3%	93.3	5.2%	101.8	82.4	124.5

APPENDIX 5

Review of Standardised Mortality Rates at Tameside General Hospital

Consultation Report

Consultation with Care Homes

Aim of the Consultation

To determine whether Dr Shipman case has led to any changes to the way care homes care for terminally ill clients at the end of their lives.

Methodology

43 care homes from Social Care and Health's Approved List were contacted for consultation. Of these:

- Semi-structured interviews were carried out with 7 care homes:
  - Moss Cottage Nursing Home
  - Trough House Nursing Home
  - The Lakes
  - Bowlacre
  - Ashdale
  - Oakwood House

- The remaining 37 care homes were sent a self-completion questionnaire and a total of 14 care homes were returned.

Consultation Outline

The care homes were consulted about a number of issues including:

- Where there terminally ill clients are cared for at the end of their lives;
- What procedures they have for caring for terminally ill clients;
- The impact of the Dr Shipman case on their procedures for caring for terminally ill clients.

Summary of Findings

<u>Interviews with Care Homes</u>

- All the Care Homes questioned said they would prefer to care for residents in the care home than admit them to hospital. Decisions are made on a case by case basis between the care home, GP and the client and their family - ultimately the GP's decision. The only time they might advocate a client going into hospital is when the hospital can offer treatment that they can't provide, for example, in an emergency situation.

- The majority of the care homes asked didn't think that there had been any change in the number of clients admitted to hospital to die since the Dr Shipman case.

- Despite residential homes not having nurses, district nurse input enables them to care for people who are no longer able to care for themselves, for example, a terminally ill resident.

- Elderly people are now cared for at home longer than in the past so by the time they reach residential care they have greater needs and are very dependant.

- Most of the Care Homes were concerned about the level of care clients receive when they go into hospital. The Care Homes said that they have more time to nurse people properly, to ensure that people are receiving their medication, and to monitor people's fluid and food intake. Many clients have returned to care homes from hospital with incorrect medication, pressure sores, infections etc.

- One of the care homes complained about the assessment process and related funding of elderly people who require care in a residential or nursing home. They said that there have been many cases where elderly people who require care in a nursing home are being wrongly assessed as suitable for residential home care. These "inappropriate placements" might result in an emergency situation whereby someone who falls ill might then need hospital admission. Early implementation of nursing care could prevent hospital admissions at a later date and allow people to be nursed to the end of life in comfortable and dignified surroundings.

- Two of the care homes also referred to the low fees paid for residential care in Tameside as being amongst the lowest in the country. The result of this is that in order for a residential home to be viable, it must have an occupancy level in excess of 95%. This may force some residential homes to accept clients who they would otherwise consider inappropriate for residential care.

- The assessment of elderly people who require nursing care as residential clients has resulted in a situation where occupancy levels in nursing homes are low.

<u>Care Home Survey</u>

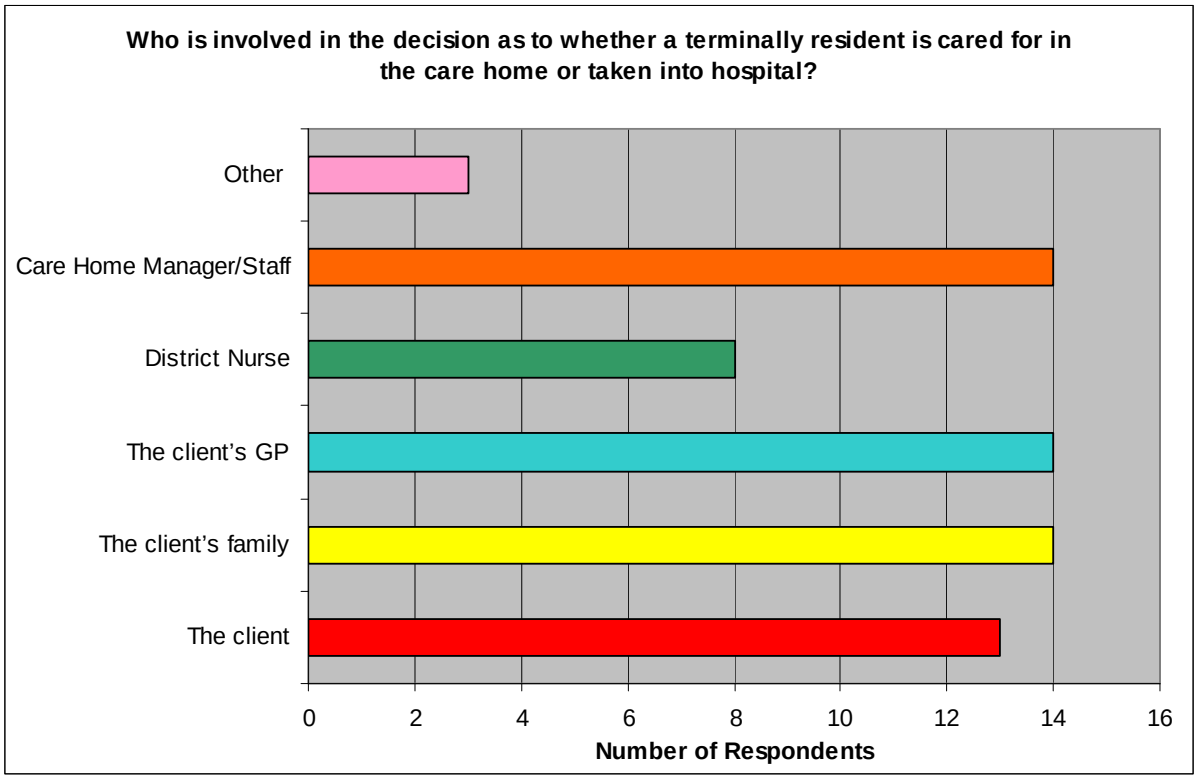
- Eleven out of the fourteen respondents said they generally care for terminally ill residents at the end of their lives and one other home said they would use both the home and the hospital depending on the care needs of the client.

- All but one respondent said they have a procedure in place to care for terminally ill clients at the end of their lives. The majority of homes said that they would discuss the options with the client's GP, the district nurse, the client's family and Social Services and that a joint decision would then be made. Other procedures mentioned include the GP making the decision taking into account

the resident's or family's wishes, and homes carrying out an assessment of the client's needs to determine if they are able to provide the support required.

- The following graph illustrates the wide range of people involved in making the decision as to whether a terminally ill resident is cared for in the care home or taken into hospital. All homes said that the care home staff/manager, client's GP and client's family are involved in the decision, and almost all said they would involve the client.

- The key factor affecting homes' decisions as to whether a terminally ill resident is cared for in the care home or taken into hospital is what the care and nursing needs of the client are and whether the home has sufficient staff, facilities and resources to meet these needs with the support of district nurses and the palliative care team.



- Six out of fourteen respondents said they believe there have been changes in the way these decisions are taken as a consequence of the Harold Shipman case. Changes described by the homes included reluctance by GPs to prescribe medication, particularly effective levels of pain relief, GPs appearing reluctant to take total responsibility for diagnosis and preferring to get a second opinion from a hospital doctor, and care homes and GPs now unwilling to take risks that could result in a case being brought before the coroner, resulting in hospital admissions.

“Everyone panics and feels you must send them into hospital so you can't get blamed for bad practise and it is on someone else's shoulders to make the final decisions about the welfare of the client. Care homes are very scared about what they can and can't do since Harold Shipman.”

- Below are additional comments made by some of the respondents in relation to caring for terminally ill residents in the care home:

“Clear guidelines on end of life would make things easier for families, residents, GPs and home staff.”

“If a service user's family request they would like their relative cared for at the home, we look at all the options if the care needed is intense then it might not be in the service user's best interest. Pain relief is a major factor, if pain killers are working sufficient that the service user is comfortable and only needs tender loving care, turning regular to avoid pressure sores, keeping clean, giving fluids then there is no problem. We always seek advice with GP about pain control.”

“The aim of all care homes in the Meridian Healthcare Group is to meet the needs of our clients so they are pain free, comfortable, [and] dignified at the end of their life. The last resort is sending someone to hospital.”

“The Nursing Home strives to nurse terminally ill residents without hospital admission and have done so on many occasions. Many residents and their families have received support and excellent end of life care in the home, however, all eventualities cannot be accounted for and at these times a hospital admission cannot be avoided. The hospital staff at times can be very critical of this. When I feel we should be working together to ensure from all services the resident is given the treatment and dignity they deserve. People admitted to nursing homes at times have various medical problems and are extremely ill on admission. This scenario has happened on many occasions with the home receiving many residents needing end of life care. The home feels pressure from social services/social workers and hospital staff to accept these residents and all the responsibility that each case entails.”

“Ultimately would love to maintain residents who are terminal in the home however as this requires joint decisions from family and GP depends on circumstances and at times family relations.”

“I think it is a shame that old people don't always have their say because other people aren't aware of what to do so they send them to hospital to move the problem from one place to another but no one ever asked the client what they want. I think myself there should be a document that people fill in to say how they would like to end their days and to stick by it, at the end of it, that's their choice and their rights.”

Consultation with GPs

Aim of the Consultation

To see what factors GPs think contribute to the Acute Trust's higher than expected standardised mortality rate and determine whether there have been any changes in the way GPs practice and care for terminally ill clients at the end of their lives terminally as a consequence of the Dr Shipman case and subsequent pressure from the Coroner.

Methodology

Thirty two GP practices in Tameside were contacted for consultation. Of these:

- Semi-structured interviews were carried out with 5 GPs;
- The remaining 27 GPs were sent a self-completion questionnaire and a total of 9 were returned.

Consultation Outline

The GPs were consulted about a number of issues including:

- Where there terminally ill patients are cared for at the end of their lives;
- The impact of the Dr Shipman case on their procedures for caring for terminally ill patients;
- The effectiveness of End of Life Care Pathways at preventing emergency admissions to hospital for terminally ill patients;
- The factors that they think could be contributing to the hospital's higher than expected standardised mortality rate.

Summary of Findings

<u>Interviews with GPs</u>

- Two of the GPs felt that the Shipman case could have had an effect on the way other GPs practice:
    - Some GPs might feel an element of "looking over their shoulder" as a result of the Dr Shipman case and the subsequent pressure from the coroner.
    - GPs always ask the family what they want now to cover their backs – some families would prefer their relatives went into hospital.
    - Following the Shipman case, many Tameside GPs felt unconfident in prescribing adequate doses of painkillers eg. diamorphine.

- However, one GP believes that the Gold Standard Framework (GSF) is doing a lot to solve this problem and GPs are now able to provide adequate analgesic, anti-sickness medication for patients in the terminal stages of life. District

nurses and GPs are working together and prescribing medication proactively - all the drugs that might be needed for a patients are kept at their home so that the out of hours GP, palliative care nursing service and GP can give them a dose of whatever they need at the right time. Instructions for what to do for the patient are written up so that medical staff feel confident about giving patients the drugs they need. The GSF should have an impact on unnecessary hospital admissions and ultimately on hospital mortality rates.

- Another problem suggested by two GPs was the limited number of nurses that nursing homes have on duty. One of the GPs said that nursing homes only have a couple of nurses and there is a limit to what staff can confidently cope with. The other GP said that in their experience nursing homes do not always have a qualified nurse on duty which results in unnecessary calls to the GP from carers when something happens or when they get scared. This often leads to pressure from the home and the relatives to admit the patient to hospital.

- Another GP agreed that nursing homes are a key part of the problem due to a lack of nursing staff in homes that feel confident and are trained in palliative care. They believe that there should more fully, up to date qualified nurses in nursing homes. Nursing homes frequently readmit patients to hospital - particularly out of hours - if a patient is ill and staff feel unconfident in caring for them. There are, however, centres of excellence which could be used to share information, Moss Cottage being one example of a nursing home with excellent nursing staff who are able to provide quality care for terminally ill patients.

- A lack of resources to support older people living in the community was a problem mentioned by on of the GPs interviewed. For example, an elderly person living alone who needs regular medication would rely on district nurses to provide the support needed. An already overstretched district nursing service would not necessarily be able to meet this patient's needs and therefore the GP has little choice in admitting the patient to hospital.

- In contrast, another GP said that there are resources available to support people in the community and to prevent unnecessary admissions to hospital. They highlighted the Rapid Response Team as an area of good practice but wonders whether other GPs are using these services properly, possibly because of a lack of awareness, and that admitting a patient into hospital is the easy option.

- One of the GPs interviewed believes that it is difficult to diagnose when some patients with a terminal illness are at the end of their life. Unlike cancer, cases such as Chronic Obstructive Pulmonary Disease (COPD) and heart disease are a lot harder to handle. If GPs don't admit these cases to hospital and they then die, relatives might then question their decision – "*It's a brave person who decides that someone won't make it this time*".

- Two of the GPs interviewed referred to deprivation and poor health, caused by high levels of smoking, as being a cause of the hospital's higher than expected standardised mortality rate.

GP Survey

- GPs were asked where their terminally ill patients are cared for at the end of their lives. 6 of the 9 GPs said patients are cared for in their own home compared to just 3 out of the 9 GPs who answered that patients would be cared for in hospital. Another 5 out of the 9 responded "other", 3 of these saying patients would be cared for in a hospice.

- When asked who else is involved in the decision as to whether a terminally ill patient is cared for at home or taken into hospital, all the GPs said that the patient, patient's family and care home manager (where applicable) would be involved. 8 out of the 9 GPs would also involve the district nurse. The Macmillan nurse and Out of Hours were also mentioned.

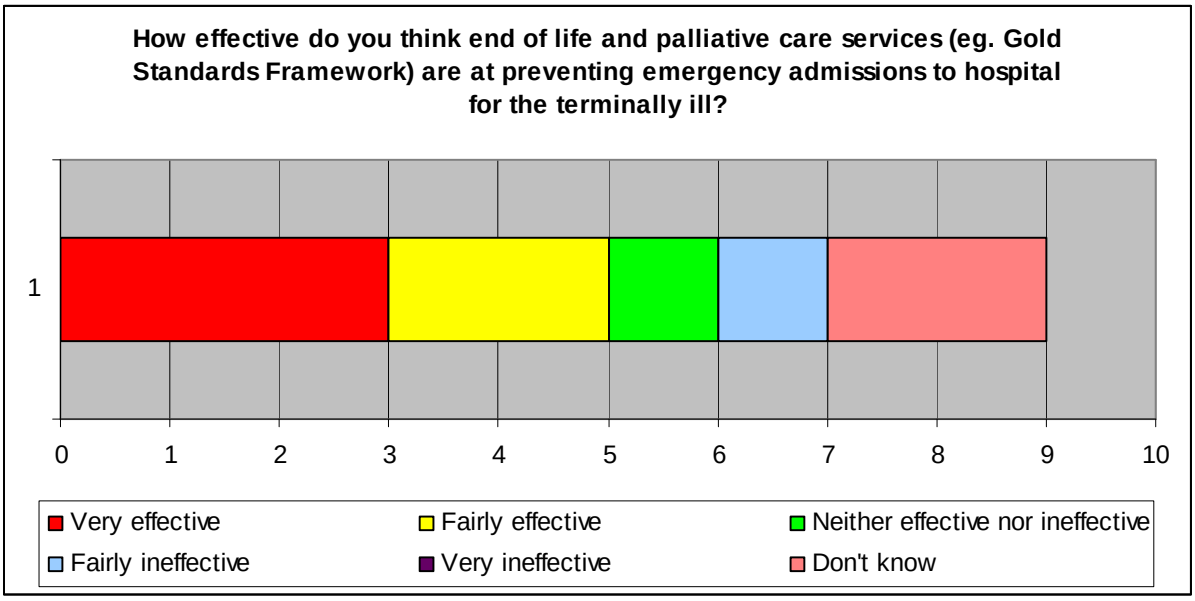
- 8 out of the 9 GPs said that there haven't been any changes in the way these decisions are taken as a consequence of the Harold Shipman case. However, 5 of the GPs said that there been changes to way they practice as a result of the Shipman case. Reasons given include:

  - 3 of the GPs said they no longer carry controlled (pain relieving) drugs;
  - 1 GP said they are now more cautious.

- The GPs were asked to say how effective they think end of life and palliative care services (eg. Gold Standards Framework) are at preventing emergency admissions to hospital for the terminally ill. The following chart shows that the majority of respondents think they are effective at preventing emergency admissions. However, 2 of the GPs were unsure about their effectiveness because it's "*Too early to assess effectiveness*" and because the "*Gold Standard Framework is relatively new, it is improving team work and community care 'in the day'. No studies have been done to demonstrate any prevention of hospital admission*".

- 2 of the GPs think that end of life and palliative care services are not effective at preventing emergency hospital admissions:

  - 1 GP said that they are neither effective nor ineffective, saying "*The unexpected always happens.*";
  - 1 GP said that they are fairly ineffective "*Because not all end of life events can be managed at home with the resources available to families at present.*"


How effective do you think end of life and palliative care services (eg. Gold Standards Framework) are at preventing emergency admissions to hospital for the terminally ill?
1
0
1
2
3
4
5
6
7
8
9
10
Very effective
Fairly effective
Neither effective nor ineffective
Fairly ineffective
Very ineffective
Don't know