

Health

Acute hospital portfolio

Briefing



Acute hospital portfolio reviews 2003

The Audit Commission is an independent body responsible for ensuring that public money is spent economically, efficiently and effectively, to achieve high-quality local and national services for the public. Our work covers local government, housing, health and criminal justice services.

As an independent watchdog, we provide important information on the quality of public services. As a driving force for improvement in those services, we provide practical recommendations and spread best practice. As an independent auditor, we monitor spending to ensure public services are good value for money.

Introduction

- 1 The 14 years since the Audit Commission began auditing the NHS have seen much improvement. In some areas, such as the increased use of day surgery, progress has been rapid. However, auditors have found one thing to be constant throughout this period – the unexplained variation between hospitals in the efficiency and effectiveness with which they deliver services. This remains equally true of the core services covered by this briefing. The conclusion cannot be avoided that some trusts could improve the services they deliver significantly within their existing resources.
- 2 In its recent report on progress in the implementation of the NHS Plan, the Audit Commission^I described the effect of this variation in performance on meeting national targets. The reviews covered by this briefing extend this by:
 - focusing on broader patient experiences and on the roles of NHS staff and use of public money, which are as important as the targets; and
 - identifying many specific ways in which trusts could improve.

The four reviews that form part of this year's Acute Hospital Portfolio work cover outpatients, waiting times, bed management and operating theatres. Along with tailored auditor assessments already produced for most trusts – underpinned by a detailed comparative database – these represent powerful tools aimed at helping trusts to make the changes that are necessary.^{II}
- 3 There is no panacea for improvement. Some of the variation in performance is due to different levels of investment and resources. However, simply adding more resources will not always achieve the desired improvement in services. The answers also lie in the processes through which care is delivered; in the way people organise their work and the quality of the overall management capacity in the trust. Often this requires a shift in attitudes or behaviour – not just from managers, but from everyone (and especially doctors) whose decisions affect the efficiency and effectiveness of patient services.
- 4 This is often complex and difficult, and different approaches are needed at different trusts, but some trusts have shown that they can achieve high levels of performance in the key areas raised in the reviews, for example:
 - Achieving relatively low levels of inconvenience and disruption caused to patients by minimising cancellations of outpatient appointments for management and operational reasons, as at Calderdale and Huddersfield NHS Trust. Trusts that reduce waits for appointments will find this easier to achieve as appointments are not made so far in advance. Better planning and management of staff leave to avoid last minute cancellations is also important.
 - Admitting non-urgent patients in order from waiting lists so that patients are treated equitably and unnecessarily long waits are reduced, as at Royal Bournemouth and Christchurch Hospitals NHS Trust. It is surprising that many trusts do not already do this.

^I *Achieving the NHS Plan: Assessment of current performance, likely future progress and capacity to improve*, Audit Commission, 2003.

^{II} For details of availability of the individual publications go to www.audit-commission.gov.uk/itc/acuteportfolio.shtml

- Avoiding excessive lengths of stay for routine elective procedures, such as at Gloucestershire Hospitals NHS Trust. The reasons for long lengths of stay vary from trust to trust, but all trusts should agree care pathways for these procedures that can be applied uniformly within the trust.
- Achieving high levels of utilisation of their operating theatres, such as at Southern Derbyshire Acute Hospitals NHS Trust. The section on operating theatres below explains how this can be done.

5 The reviews have important messages for all those involved in improving the management of healthcare:

- the Government, which sets targets and standards;
- service commissioners, who make investment decisions on behalf of their local communities;
- trust managers, who plan and run services; and
- consultants and other frontline staff, who organise and deliver patient care.

Each has a contribution to make to raising standards and to closing the gap between the top and bottom performing trusts. They should make full use of these reviews and of the local reports for each trust mentioned earlier.

Outpatients

5 Outpatient services are one of the key pillars of the Government's modernisation programme. They involve huge numbers of patients (over 40 million per annum) and impact immediately on patient perceptions of the NHS. The two key aspects being targeted by the Government are reductions in waiting times and the introduction of booking systems that give patients a choice of date.

6 English trusts have achieved significant reductions in waiting times – most were able to keep the bulk of their waits to within six months at March 2002. Since then performance has continued to improve and the number of people waiting for more than 13 weeks has come down dramatically to 120,000. But many trusts will find it very challenging to meet the 2005 target – that no patient should wait more than 13 weeks. In Wales, waiting times for appointments tend to be longer than in England, but trusts have significantly reduced the number of patients who wait for longer than 12 months for an appointment.

7 Waiting times could be further reduced by better control of cancellations. On average, trusts cancel 12 per cent of appointments and one in ten trusts cancels 20 per cent or more, which is disruptive to patients and suggests poor planning (**Exhibit 1, overleaf**). A significant cause of cancellations is the failure of staff to give sufficient notice of their absences, something managers and clinicians should address. A further 10 per cent of patients do not attend (DNA) and give no notice, so their slot is wasted. This figure rises

English trusts have achieved significant reductions in waiting times.

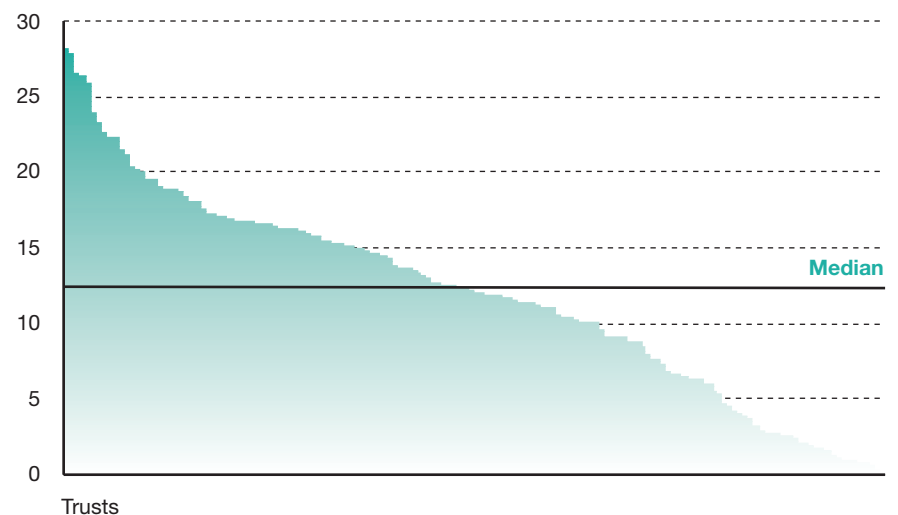
to 18 per cent for London teaching hospitals. Many trusts respond by overbooking their clinics – about one-half report that they overbook all or most of their clinics by 25 per cent or more.

Exhibit 1

Percentage of appointments cancelled by the trust – general surgery

Some trusts inconvenience a lot of patients by cancelling their outpatient appointments.

Percentage of appointments cancelled by trust



Source: Audit Commission survey, 2002, England and Wales

- 8 Some of these problems should be alleviated by introducing the booking systems required by the Government, and some trusts have reported improved performance as a result. However, the Audit Commission survey did not find any generally improved DNA or cancellation rates in trusts that had introduced booking systems. At the time of the survey less than one-half of patients were booked. More time is needed for the systems to become more widely established. The need for staff to change administrative procedures and the lack of appropriate computer systems may be inhibiting more rapid introduction.
- 9 The workload of doctors varies widely between trusts. In general surgery it ranges from 600 to 3,000 attendances per annum per doctor. However, there is no association between the workload and the time that new patients have waited for their appointments since they were referred. Some trusts could ease their workloads by reducing the ratio of follow-up to new patients which varies, for example, from 3:1 to 1:1 in general surgery.

- 10 Managers and clinicians need to use information more effectively in order to improve performance in outpatient services. They receive reports on waiting lists monthly – the area under greatest pressure – in 85 per cent of trusts and consultants also receive them in 71 per cent of trusts. But for DNAs and cancellations – which are also very important – only 61 per cent of outpatient managers receive reports as often as monthly.

Waiting for elective admission

- 11 Waiting times for a non-emergency hospital admission (typically for a surgical operation) are also improving and more patients are being given the opportunity to book an admission date that is convenient to them. At the end of March 2003, most NHS trusts in England had met the Government's current 12 months maximum wait target and the number of people waiting for admission fell below one million. Welsh trusts have been set different, more selective targets and there have been some improvements; but both total waiting lists for admission and percentages of long waits are still rising.
- 12 The pace of change will need to be even faster if, by the end of 2005, nobody in England is to wait more than six months for inpatient treatment, as the Government has promised. Improvement will rely on the successful introduction of new, more efficient ways of working, as well as on the additional surgical facilities now being provided outside acute hospitals and in new Diagnosis and Treatment Centres (DTCs). But there are also some simple things that trusts could do to reduce waits further.
- 13 Even at the same trust, non-urgent patients with very similar clinical needs are often not admitted in order, but wait very different lengths of time (**Exhibit 2, overleaf**). This is unfair for the patients involved and may also unnecessarily worsen trusts' waiting time performances. Trusts should admit similar patients in order of wait. More standardisation of waiting list administration and pooling of similar lists across a trust would facilitate this. Trusts should also secure local clinical consensus for each common elective procedure about the percentage of cases that are likely to be urgent. This will inform planning and monitoring.

Trusts should admit similar patients in order of wait.

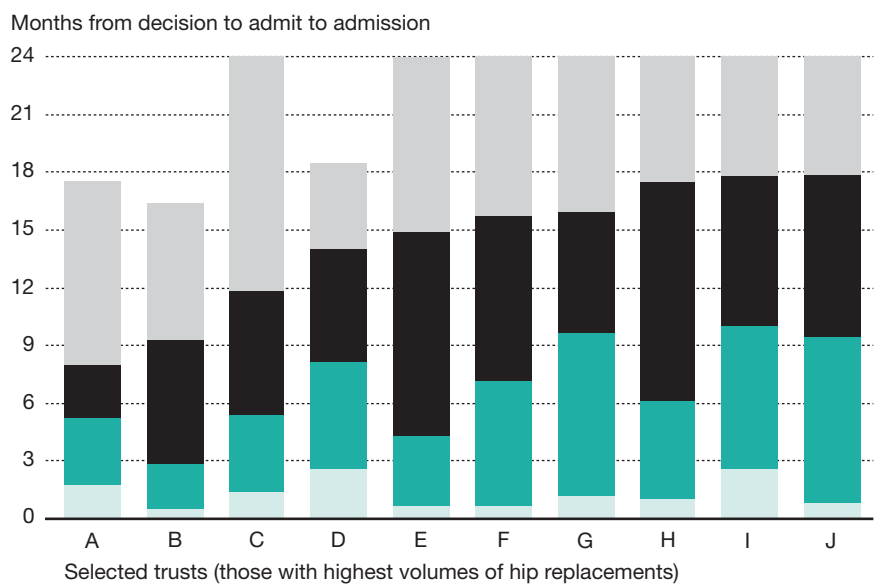
Exhibit 2

Variation in wait for a hip replacement

Non-urgent patients at the same trust may wait very different times for the same procedure.

Percentage of patients admitted

- All
- 90%
- 50%
- 10%
- 0%



Source: Audit Commission from Hospital Episode Statistics for England and Patient Episode Data for Wales (2001/02) – (Procedure W37)

- 14 On average, about 6 per cent of intended elective admissions are cancelled within one week of the intended admission date by managers or clinicians (**Exhibit 3**). These rates are much higher at some trusts, resulting in inefficient use of hospital resources and surgeons’ time, as well as potential distress for patients. One in five of the reported cancellations occurred only after the patient had been admitted. Cancellation is often for non-clinical reasons (for example, lack of a suitable bed or unavailability of theatre time, a surgeon or anaesthetist). However it may also occur because patients are found, belatedly, to be unfit for surgery and many admissions are also cancelled or deferred at the last minute by patients themselves. Cancellations might be reduced if more patients were pre-assessed to ensure their suitability for surgery and to provide them with better information about the proposed operation. Also, each trust needs a manager or clinician with sufficient authority and support to monitor and balance the competing demands of emergency and elective pressures and to ensure that all bed and theatre resources are utilised fully.

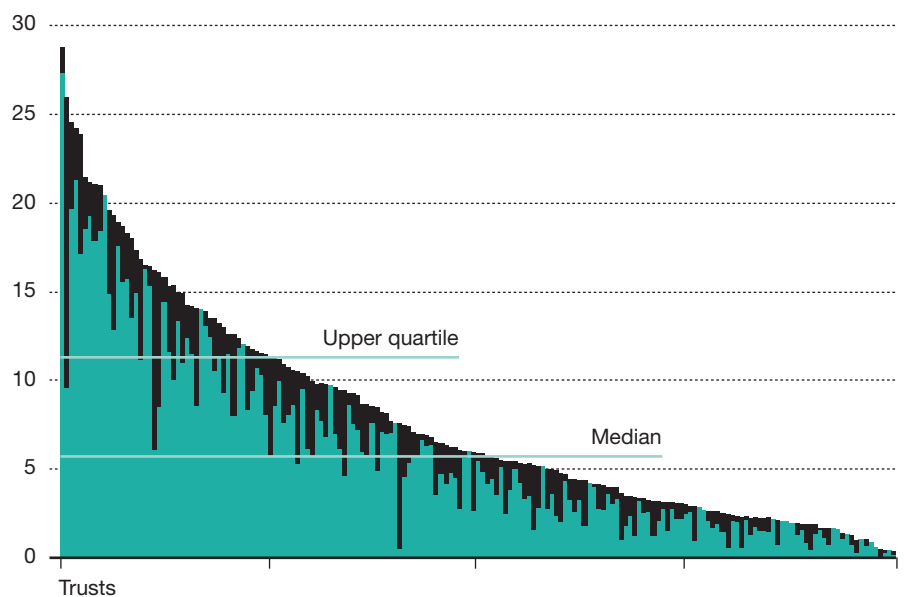
Exhibit 3

Cancelled admissions

On average, about 6 per cent of intended elective admissions are cancelled within a week of admission by managers or clinicians.

■ For clinical reasons
■ By trust for non-clinical reasons

Percentage of planned elective activity cancelled by trust/clinicians



Source: Audit Commission survey (England & Wales): Six-week sample period: May-June 2002

One in five trusts keeps some emergency patients waiting...even though they have been technically admitted. These waits are seldom recorded.

Bed Management

- 15 Providing and managing inpatient beds, together with the staff and services that support them, is both complex and expensive. Beds must be available so that patients do not have to wait when they need admission in an emergency and so that planned admissions for surgery are not cancelled, but equally beds must also be used efficiently.
- 16 On average, 81 per cent of emergency patients who need a bed are admitted within four hours of the time they arrive at the hospital (May 2002). This includes a large proportion of patients who are admitted via routes other than accident and emergency departments, such as via a medical assessment unit. However, one in five trusts keeps some emergency patients waiting temporarily on trolleys or in areas that do not have proper ward facilities even after they have technically been admitted. Time spent in such areas is seldom recorded and does not count against official waiting time targets.
- 17 There is scope to improve bed use in most hospitals by minimising delays that prolong lengths of stay. For example, patients admitted on Thursdays or Fridays tend to stay in longer, because of delays to diagnosis, treatment and discharge that happen over the weekend when services and staff are less accessible.

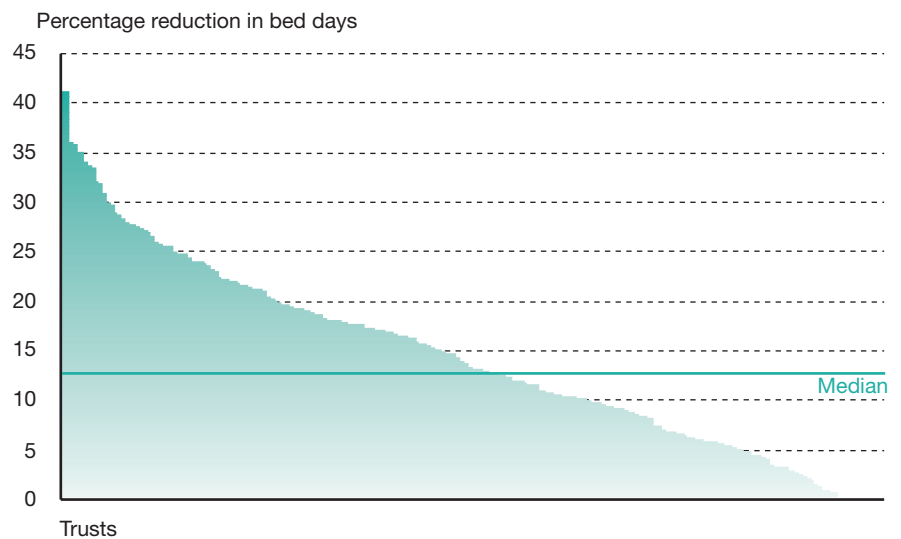
Trusts need to ensure that admission and discharge thresholds do not change as a result of providing more beds.

- 18 In most trusts, the length of stay for some routine surgical procedures could also be reduced (**Exhibit 4**). The Audit Commission calculated the potential reduction in the number of bed days used for six common surgical procedures at each trust based on reducing length of stay to the lower quartile level. On average, each trust could save 12 per cent of the surgical bed days it uses for these procedures (approximately equivalent to a whole ward).

Exhibit 4

Percentage reduction in bed days used if trusts reduced length of stay for common surgical procedures

If trusts reduced the length of stay for six common surgical procedures to that of the best performing trusts (lower quartile), the average trust could save 12 per cent of their bed days.



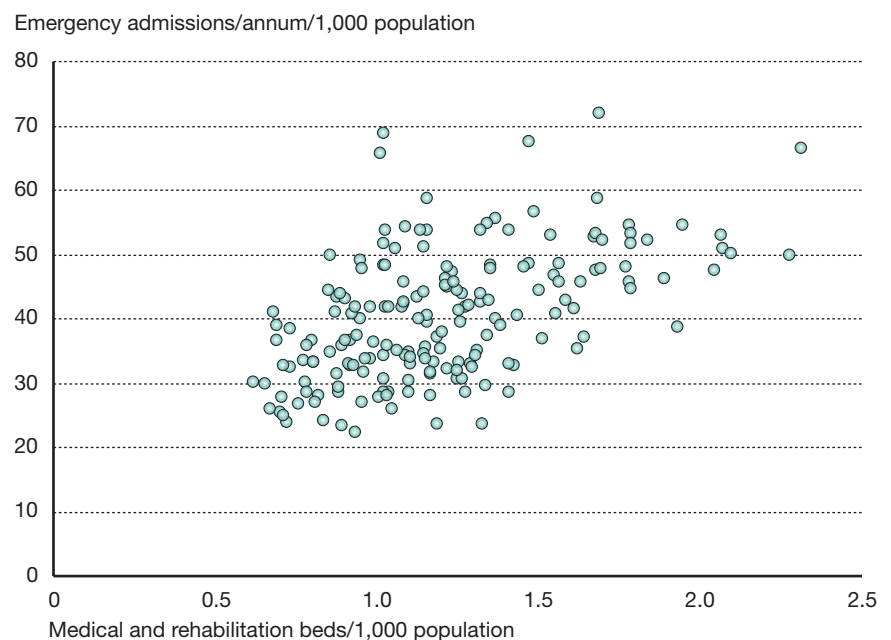
Source: Audit Commission from Hospital Episode Statistics for England and Patient Episode Data for Wales (2001/02)

- 19 While trusts reported that, on average, only 7 per cent of their medical and rehabilitation beds were occupied by patients whose discharge or transfer was delayed because they did not have somewhere else to go, 25 per cent of bed days are used by patients who stay for more than eight weeks. It is unlikely that many of these patients still need diagnosis or acute treatment. This must reduce the ability of trusts to manage their beds effectively.
- 20 On average, 95 per cent of adult beds in acute and multi-service trusts are occupied at midday. By common agreement this is too high and there is evidence to show that high occupancy leads to longer waits for beds. Those trusts with more beds for the populations they serve tend to use up any extra capacity by admitting more patients and keeping them in hospital for longer than trusts with relatively fewer beds (**Exhibit 5**). Trusts need to ensure that admission and discharge thresholds do not change as a result of providing more beds.

Exhibit 5

Emergency admissions and medical and rehabilitation beds per 1,000 population

There is a strong relationship between the relative number of medical and rehabilitation beds that a trust has and the relative number of emergency patients it admits to those beds.



Source: Audit Commission from Hospital Episode Statistics for England and Patient Episode Data for Wales (2001/02) and Audit Commission Survey, 2002

- 21 Trusts must develop a clear understanding of the complex interactions and feedback mechanisms that impact on how they use beds. The number of beds should be increased only if there is evidence that the beds already available are used efficiently.

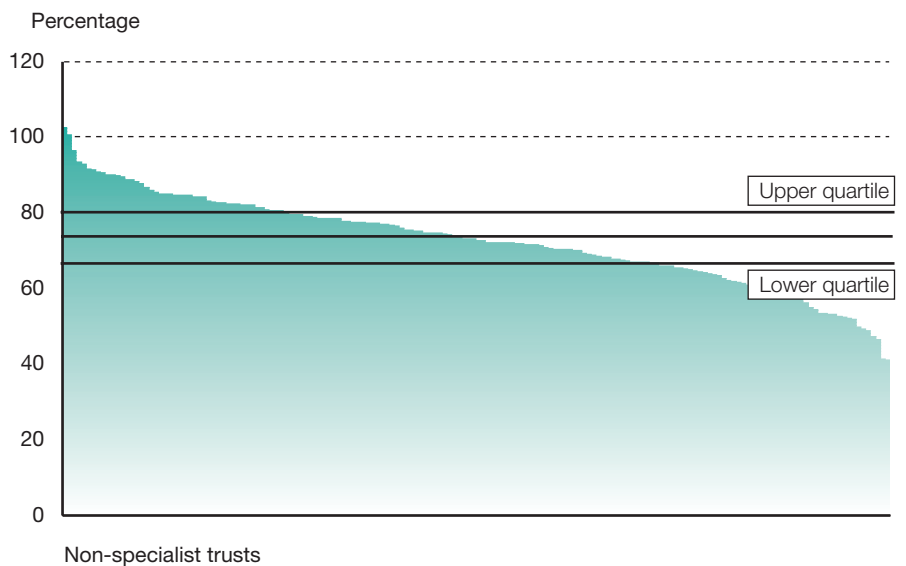
Operating theatres

- 22 Operating theatres are one of the most complex areas to plan and manage. They include highly technical equipment, procedures and skills, all of which have to be deployed in a very precise, timely and well co-ordinated way. Efficient use of operating theatres requires careful balancing of the needs of emergency patients with the needs of patients who need planned elective surgery. Scheduled operating sessions for elective surgery comprise the bulk of the work and there is scope to make more effective use of these. On average, 73 per cent of the time available in these scheduled sessions is used for operating. In one in four trusts it is less than 65 per cent (**Exhibit 6, overleaf**).

Exhibit 6

Utilisation of original planned hours for scheduled elective sessions

The average trust uses 73 per cent of its planned session hours for operations on individual patients.



Source: Audit Commission survey 2002, England and Wales

23 Trusts could improve their utilisation by avoiding:

- cancelling of whole sessions. Currently about 10 per cent of sessions are cancelled mainly due to lack of beds or lack of staff to carry out the operations;
- over-runs or under-runs; and
- excessive gaps between operations.

There are also likely to be differences between specialties in utilisation of their scheduled sessions. Such differences may warrant re-allocation of sessions. Better planning of operations would enable more operations to take place within the existing scheduled sessions.

24 Trusts that are seeking more operating capacity should review how they use existing elective sessions as part of their option appraisals. They should also review the balance between emergency and elective scheduled sessions. Scheduled emergency sessions are important in order to reduce the risks associated with ad hoc arrangements and operating at night. Nevertheless, in some trusts there are too many of these sessions or they have proved ineffective in reducing out-of-hours operating. Some could be replaced by elective sessions. Similarly whole theatres are sometimes dedicated entirely to particular specialties and may be under-used.

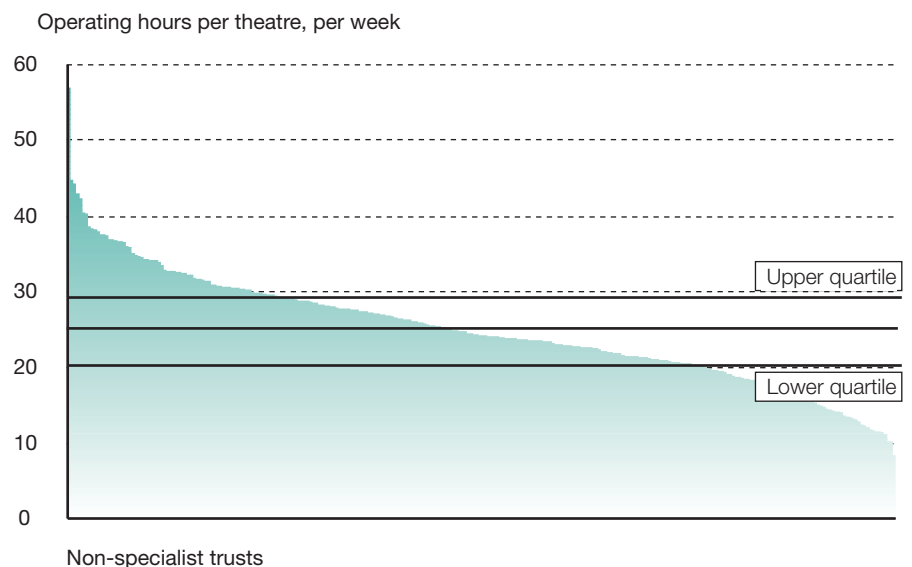
A typical theatre is used on average for 24 hours per week.

- 25 Another means of obtaining more operating capacity is to schedule more or longer sessions during the day, for example, running into the early evening rather than ending at 5pm. There is also scope to schedule more work at weekends. A typical theatre is used on average for about 24 hours per week, but this varies between trusts from 8 to 57 hours (**Exhibit 7**). Of course, extending operating hours into the evening and weekends will require changes in staffing arrangements, but this may be a better option than providing more physical theatre capacity – a costly option that should be considered as a last resort.

Exhibit 7

Total actual operating hours per commissioned theatre per week

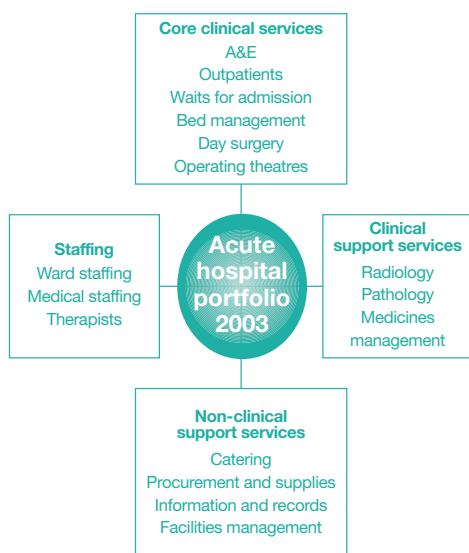
A well-used theatre unit would average more than 40 hours use per theatre per week, but very few units are actually this busy, and the average unit does only 24 hours work per theatre per week.



Note: Total actual operating hours covers all operations regardless of the type of patient, the type of list and the time of the day or week, and the hours are calculated from the start of the anaesthetic to leaving the operating theatre (or nearest timing points).

Source: Audit Commission survey 2002, England and Wales

- 26 While staffing levels in operating theatres are generally closely related to total operating hours, many individual theatre units have staff costs that are well above or below the national average (after adjusting for regional cost differences). These should be reviewed.
- 27 Good information is crucial to managing operating theatres well. While most trusts have adequate arrangements for informing their boards and co-ordinating theatre services across the trust, there is a lack of good-quality basic management information in many trusts. Nearly one-third of theatre units could not produce the basic analysis of theatre operating hours requested by the Audit Commission, either because they lacked a computerised system, or because their system was unsuitable. All trusts should give a high priority to the production of accurate information about how they use their operating theatres.



Acute Hospital Portfolio

The Acute Hospital Portfolio is a performance improvement tool for acute and multi-service NHS trusts. It comprises 16 topics ranging from Accident and Emergency Departments and Bed Management, to Procurement and Supply and Catering.

The topics have been added to the Portfolio in phases of four per year. A 'balanced score card' performance framework is developed for each topic. Data are collected from all relevant trusts in England and Wales (or taken from existing national sources, where possible). The Audit Commission's appointed auditors then provide each trust involved with a tailored performance assessment based on the national comparative data produced and taking account of the local circumstances of the trust. In-depth audit work may also be undertaken at some poorly performing trusts that demonstrably need it. The national results of the surveys are published in short reviews and the data, together with computer software to facilitate their use, are released to NHS bodies.

This briefing summarises the national results of the recent assessments of Outpatients, Waiting for Elective Admission, Bed Management and Operating Theatres. Separate, more detailed reviews on each of these four topics are being published at the same time. Most NHS acute and multi-service trusts will already have received their performance assessments from their auditors and agreed action plans for improvement where these are needed for these four topics. The data on which they are based and comparative analysis computer software will be released to NHS bodies on CDs by the end of June 2003.

Trusts have already received similar material for each of the eight topics covered previously and they are currently collecting data for four more topics: Facilities Management, Information and Records, Pathology and Therapy and Dietetics. Feedback to trusts on these topics will take place in the autumn and the national reviews will be published next year.

Full details of the Portfolio can be found on the Audit Commission website: www.audit-commission.gov.uk/itc/acuteportfolio.shtml

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