



# briefing

December 2010

## FTN Benchmarking

### Driving performance improvement in Accident & Emergency

A&E services remain a central strategic focus for trusts due to growing numbers of patient attendances and admissions. Patients have increasingly complex conditions that present quality and operational challenges as well as significant cost pressures. These effects will be compounded by financial penalties after the implementation of the 30 per cent marginal tariff for non-elective admissions.

In the Foundation Trust Network's (FTN) first benchmarking project looking at A&E services, it was found that the majority of A&E departments were losing money on their A&E service as their costs were higher than the national average income per attendance. However, some trusts have been able to balance income with costs. The causes of these differing outcomes were investigated as part of the project.

#### Summary of key findings

A comparison of 17 foundation trusts showed significant variation in performance across quality, patient flow, workforce and costs, as well as examples of best practice that all participants in the study can learn from. Some of the key findings are summarised below:

- Although government policy has relaxed the four hour A&E target, quality and outcomes remain the focus, with timeliness still an important part of these standards. Participant trusts monitor A&E quality and are working towards increasing the number of clinical quality metrics tracked. However, at present there is no consistent set of measurements collected to assess A&E performance.
- Registration, triage and initial assessment processes remain a challenge, despite the focus on patient flow to avoid long waits. The period from registration to initial assessment takes 75 minutes on average, regardless of whether the patient is admitted or discharged. Hospitals need the whole organisation to work smoothly to improve the efficiency of their accident and emergency departments and cut patient waiting times. For example, if patients throughout the hospital are discharged early in the day, other patients can be admitted from A&E, reducing waiting times and freeing staff to see and treat other patients.
- A suitably senior workforce able to work flexibly is essential to manage variations in patient attendances. But it contributes significantly to costs. A shortage of middle grade doctors and reliance on bank, overtime, agency and locum staff also contribute to higher costs.

## The benchmarking process

This is the FTN's first A&E benchmarking project, and was delivered with support from McKinsey & Company. Each participant trust established a project team with a clinical, data and operational lead, and a board-level sponsor to oversee the project. Following an initial scoping phase, trusts attended a workshop where the template for collecting data was discussed in detail. Participants collected activity, cost, staffing and quality metrics for the period April 2009 to March 2010, together with departmental structure and strategy information. Detailed patient activity and the weekly staff rota for two weeks in June 2010 were also collected. During the data collection and validation stages, support was provided by the FTN Benchmarking team, with regular contact to ensure trusts were collecting comparable data, and individual site visits.

For this project, a staff survey was also conducted to assess perceptions of clinical quality, team and operational effectiveness within A&E. A findings workshop provided an opportunity to discuss data findings, share learning resulting from different practices, and identify improvement opportunities. Trusts gave presentations on aspects of their services that the benchmarking study identified as high performing or innovative practice, and Professor Matthew Cooke, National Clinical Director for Urgent & Emergency Care, Department of Health gave a progress update on the development of quality indicators. Individual trusts developed six-month action plans that will be revisited in a follow-up workshop to encourage further improvements.

## Quality

### Key findings

1. Participant trusts have processes to monitor clinical quality through trust-level groups, where A&E is represented by individuals accountable for this area. However, many important quality metrics are not yet consistently tracked.
2. The percentage of patients returning to A&E within seven days of discharge varies significantly from 3.3 to 9 per cent of all attendances (mean 6.2 per cent). On average, 27.5 per cent of the returning patients were admitted with the range across trusts from 15 to 37.8 per cent.
3. During 2009-2010 only 2 per cent of all attendances breached the four hour target across all participants. However, in-depth analyses showed that:
  - the four hour breach rates are far higher in winter than summer (2.6 per cent compared with 1.5 per cent average across all trusts)
  - on average 13 per cent of all

mental health patients attending A&E were there for more than four hours

- the breach rate increased progressively with age at all trusts, rising on average from 1.3 per cent for patients under 17 to 6 per cent for patients over 85.

### Actions

Trusts identified ways to improve quality:

- Develop robust IT systems to track relevant, validated metrics in line with new quality indicators
  - these should record the right level of granularity to inform decision making (for example, capturing time points for mental health pathways).
- Improve patient experience and clinical outcomes by:
  - having appropriate levels of community services support at weekends
  - actively managing patient expectation through clear, timely communication during

attendance and after discharge

- creating mental health 'suites' designed for mental health patients.
- Involve staff and recognise their contributions in improving quality and creating a quality culture (for example, providing nurses with the resources to undertake initiatives and giving them responsibility for them).

## Patient flow

### Key findings

1. Responding to variations in A&E attendance by flexing staff numbers is still a challenge for a number of participating trusts, although the peaks and troughs in patient attendances are relatively consistent (and therefore potentially predictable) for individual hospitals. For many participants, handover periods restrict the number of staff on the 'shop floor', often during busy periods.
2. Registration, triage and assessment processes vary across trusts. The period from

registration to initial assessment is generally the same irrespective of the ultimate outcome, an average of 75 minutes. The proportion of the total stay in A&E that this represents depends on the outcome: over 60 per cent of the stay for discharged patients and almost 40 per cent of the stay for admitted patients (See Figures 1 and 2).

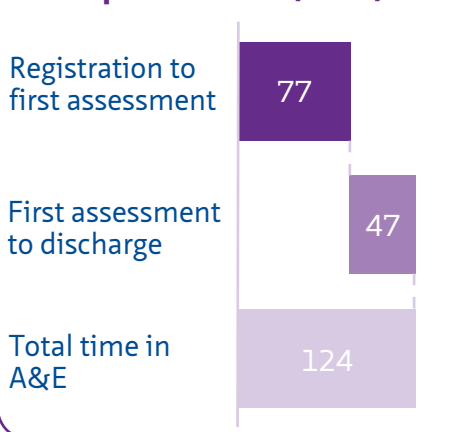
- Trusts had varying availability and differing use of assessment and observation units, and had a range of protocols governing them.
- Discharge from A&E has been a focus for improvement to ensure unimpeded patient flow. Trusts have implemented initiatives to speed admission (e.g. direct streaming for obvious specialties, expansion of admission units/ ring-fencing of beds to deal with delays in discharge elsewhere in the hospital) and discharge processes (e.g. rapid access clinics, post-discharge and admission avoidance teams working with community services).

### Actions

Trusts identified actions to improve the flow of patients through A&E:

- Reducing inappropriate attendances to A&E by redirecting patients to alternative care providers within safety protocols and appropriate timeliness.
- Ensuring that senior clinicians assess patients rapidly and devise care plans early on to speed patients' progress through A&E, especially for 'major' patients who may need admission.
- Continuous monitoring and assessment of bed requirements by a dedicated bed coordination

**Figure 1. Discharged patients: time spent in A&E (mins)**



team working across the trust and supported by a real-time electronic bed management system to improve patient flow.

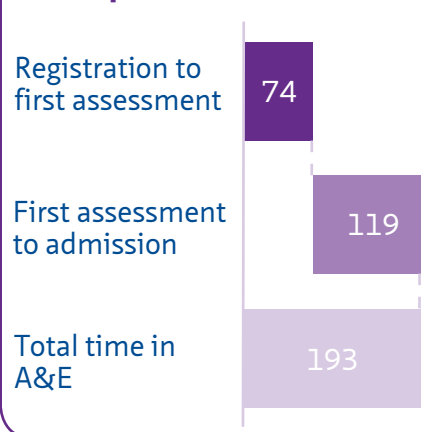
- Bringing the A&E department and admission/assessment units under the same management to improve coordination of the admission process.

### Workforce and costs

#### Key findings

- Based on 2009-2010 financial data, A&E costs exceed income for all but three trusts despite significant variation between trusts' overall financial performance. This does not appear to be related to the volume of A&E activity (See Figure 3).
- Reliance on bank, overtime, agency and locum staff varied across trusts (from 0 to 45 per cent of medical staff pay and 0 to 36 per cent of nursing staff pay).
- The staff skill mix varied significantly across participants. Consultants comprised on average 19 per cent of all medics (ranging from 5 to 36 per cent) with middle grades under-represented. Senior nurses, in bands 7 and 8,

**Figure 2. Admitted patients: time spent in A&E (mins)**



comprised 15 per cent of nursing staff on average (ranging from 4 to 32 per cent).

- The staff survey showed that overall, staff were positive about being part of the A&E workforce. However, it also highlighted that staff thought morale and performance could be increased with improved availability and quality of training by senior staff, as well as low cost recognition of staff contributions.

#### Actions

Trusts identified actions to improve workforce and costs:

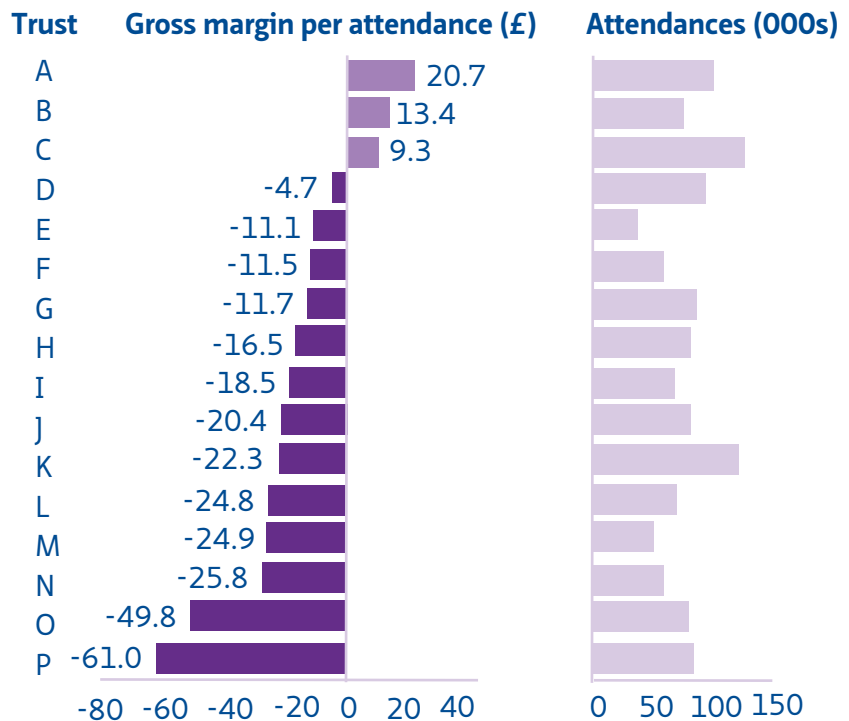
- Reviewing and understanding the total departmental contribution to trust finances when analysing profitability (i.e. for admitted patients, across the whole patient stay, not just their time in A&E).
- Ensuring reference cost submissions reflect the full cost of treatments (including diagnostic costs).
- Developing the staffing skill mix by finding alternative, flexible roles to cover skill gaps and matching staff levels to predictable patterns of patient attendance to avoid bottlenecks in A&E.

For example:

- developing advanced nurse practitioner (ANP) posts as a cost-effective way of covering for middle grade doctors with highly experienced, stable members of staff who can help with training
- developing the emergency nurse practitioner (ENP) role across A&E to increase flexibility (with potential to work across the department and urgent care centres as well)
- using more allied health professionals (AHP) in 'minors' for example, advanced physiotherapists able to treat and discharge patients
- offering joint clinical fellow posts (for example, ultrasound and A&E)
- generating and sharing standard or 'best practice' staffing models for A&E.

Participating trusts found that taking part in this benchmarking study provided strong ideas to improve performance as a result of considering the data analyses and by sharing ideas with peers on how to tackle common issues.

**Figure 3. Average income per A&E attendance less average cost**



### The Foundation Trust Network

The Foundation Trust Network (FTN) provides a distinct voice for NHS foundation trusts. We aim to improve the system for the public, patients and staff by raising the issues facing existing and aspirant FTs and strengthening the influence of FTN members. The FTN runs a series of benchmarking projects, open to all FTN members. For more information, visit [www.nhsconfed.org/FTNBenchmarking](http://www.nhsconfed.org/FTNBenchmarking) or contact Liz Smith, Benchmarking Manager, at [liz.smith@nhsconfed.org](mailto:liz.smith@nhsconfed.org)

