Foundation Trust Network

Briefing

October 2012

DRIVING IMPROVEMENT IN A&E SERVICES

A&E departments are a beacon to patients in need of emergency medical care. These departments offer guaranteed access 24 hours a day seven days a week to patients with a range of health needs. The volume and complexity of patients continues to increase and NHS providers of these services are faced with significant challenges and cost pressures.

To meet these challenges acute trusts are implementing initiatives to deliver safe, timely and high quality clinical care in A&E. This FTN Benchmarking study brings together 11 acute trusts with A&E services ranging from major specialist trauma centres to primary-care-led urgent care centres. Using comparable and validated information on their services these trusts shared best practice and developed action plans to improve their services.

KEY MESSAGES

- The majority of trusts are losing money on their A&E services. Trusts are continuing to improve their efficiency, but fundamental problems remain on the funding of A&E and emergency services.
- The Department of Health should re-examine the policy of paying for some emergency admissions at 30% of the standard tariff.
- Risks and responsibility for avoiding emergency admissions should be more fairly shared between acute trusts and primary and community care.
- Trusts with primary care or urgent care centres within their A&E departments have faster average treatment times. Trusts that use senior clinicians as part of a rapid assessment team have faster initial assessments for the most acute A&E patients.
- There is no 'one-size-fits all' approach to staffing an effective A&E service; trusts can use their freedoms to innovate and develop different service models that meet local health needs.
- Nearly half of all A&E attendances for older patients (75 yrs +) end in admission. Multidisciplinary teams in A&E reduce admissions of elderly patients, who receive nursing, occupational therapy and physio services in A&E before being discharged home rather than having an overnight stay.
- Trusts have reduced reattendance rates by providing comprehensive information and follow-up advice when patients leave A&E.
- More available out-of-hours primary and community services, particularly those covering mental health and addiction, would reduce frequent A&E attendances.

KEY FINDINGS AND RECOMMENDATIONS			
	What do the data show?	*Recommendations for A&Es to consider*	*Wider recommendations*
Demand manage-ment	The 3% annual growth in A&E attendances shows no sign of declining Patients aged 75 years and older account for over 12% of all A&E attendances; nearly half of these attendances end in admission to hospital. Chronic repeat attenders to A&E account for up to 8% of all A&E attendances.	Services must be responsive to the needs of their local populations, for example by providing dedicated specialist geriatric care within A&E for frail elderly patients, or providing urgent care centre facilities for patients with minor injury or illness Integrated multidisciplinary discharge teams can help reduce attendance rates and waiting times for frail elderly patients	A&E departments operate 24/7 while many other services do not. Primary and community services can be more available and responsive to the needs of patients with mental health issues in particular. More engagement between GP commissioners and acute, primary and community services is needed to support the delivery of integrated care closer to home.
Patient flow	Over half the participating trusts did not meet the A&E four hour standard. Delays for inpatient beds, specialist input and initial assessment are the most commonly cited issues Trusts with primary care treatment areas, urgent care centres, and rapid assessment teams displayed faster average treatment times	Extended admitting rights and protocols for senior A&E staff can reduce delays in admitting patients Having dedicated streams for minors patients (whether in a UCC, primary care area or ENP-led area of ED) and majors patients (through a Rapid Assessment Team) can improve initial assessment times for patients	A whole hospital approach is needed to rapidly execute decisions to admit a patient; admitting medical teams can collaborate further with A&E colleagues to streamline admission protocols.
Clinical quality	The time to initial assessment and the seven day reattendance rate are the most challenging clinical quality indicators to achieve for participating trusts	Trusts have successfully reduced reattendance rates by developing condition-specific discharge information for patients, and increasing patient access to post-operative support and information	Rationalising the central collection of patient experience data could considerably reduce the burden on NHS providers of A&E services

KEY FINDINGS AND RECOMMENDATIONS			
	What do the data show?	*Recommendations for A&Es to consider*	*Wider recommendations*
Workforce	There is significant variation in A&E staffing establishment levels, skillmix and workloads Significant challenges remain in recruiting middle grade A&E doctors	Trusts should engage proactively with local education and training boards (LETBs) to support the development of the local workforce	There is no one-size-fits all approach to staffing an effective A&E service; trusts can use their freedom to innovate and develop service models that are effective in meeting local health needs
Costs	For the majority of trusts the costs of providing A&E services exceed the income received The A&E attendance tariff does not fully capture the range of services and time A&E staff invest in caring for patients with mental health issues	The adoption of standardized initial assessment protocols can improve the consistency of clinical care and reduce the ordering of unnecessary diagnostic investigations	The Department of Health should reexamine the policy for paying some admissions at a marginal rate of 30% of the tariff. A more balanced approached that more fairly apportions risks and responsibility for admission avoidance is needed. The A&E tariff should recognize the efforts of A&E staff in caring for patients with mental health issues

INTRODUCTION

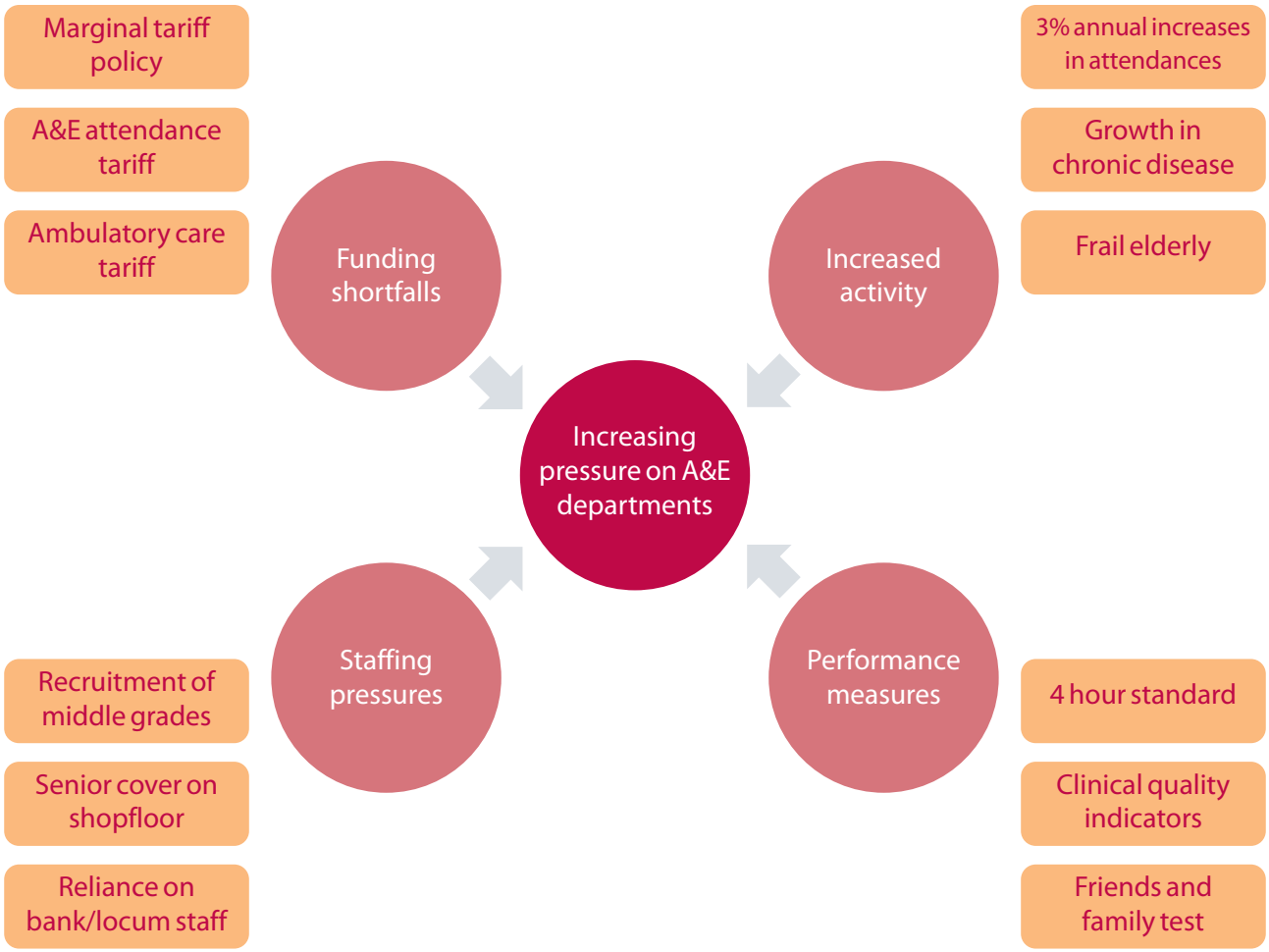
- Nationally, the number of patients presenting to A&E shows no signs of declining. Over 20 million patients visit A&E each year, with a 3.1% annual increase in attendances at A&E over the last five years[1]. This trend is unlikely to change in the near future given the growth in the frail and older population and patients with long term conditions.

- Delivering financially sustainable A&E and emergency services continues to be a significant challenge for providers. The continuing reduction in income due to the marginal rate for emergency admissions is compounded by the increased costs of delivering 24/7 care, and difficulties in recruiting non-locum middle grade doctors.

- A whole systems approach is needed to tackle the pressures faced by A&E departments, as these pressures are often due to factors beyond the control of the A&E department. A&E departments are a beacon for patients who do not have sufficient information about the severity of their health needs and the availability and quality of alternative urgent care services such as GP out of hours, community services or NHS Direct. A&E departments are also dependent on the efficient functioning of other parts of the health system to move patients through the department in a timely fashion; a lack of available beds in other parts of the hospital or in the community can often lead to patients spending longer in A&E than is clinically necessary.

1 Quarterly Monitoring of A&E statistics, Department of Health

FIGURE 1: PRESSURES FACED BY A&E DEPARTMENTS



- A theme emerges that A&E and ambulance services operate 24/7 while many other services do not. If a patient with mental health needs attends A&E the provision of expert psychiatric services is generally excellent 9am-5pm, but outside these times psychiatric staff are less accessible, which places the strain squarely on A&E departments to deliver clinical care and manage referrals for these patients.

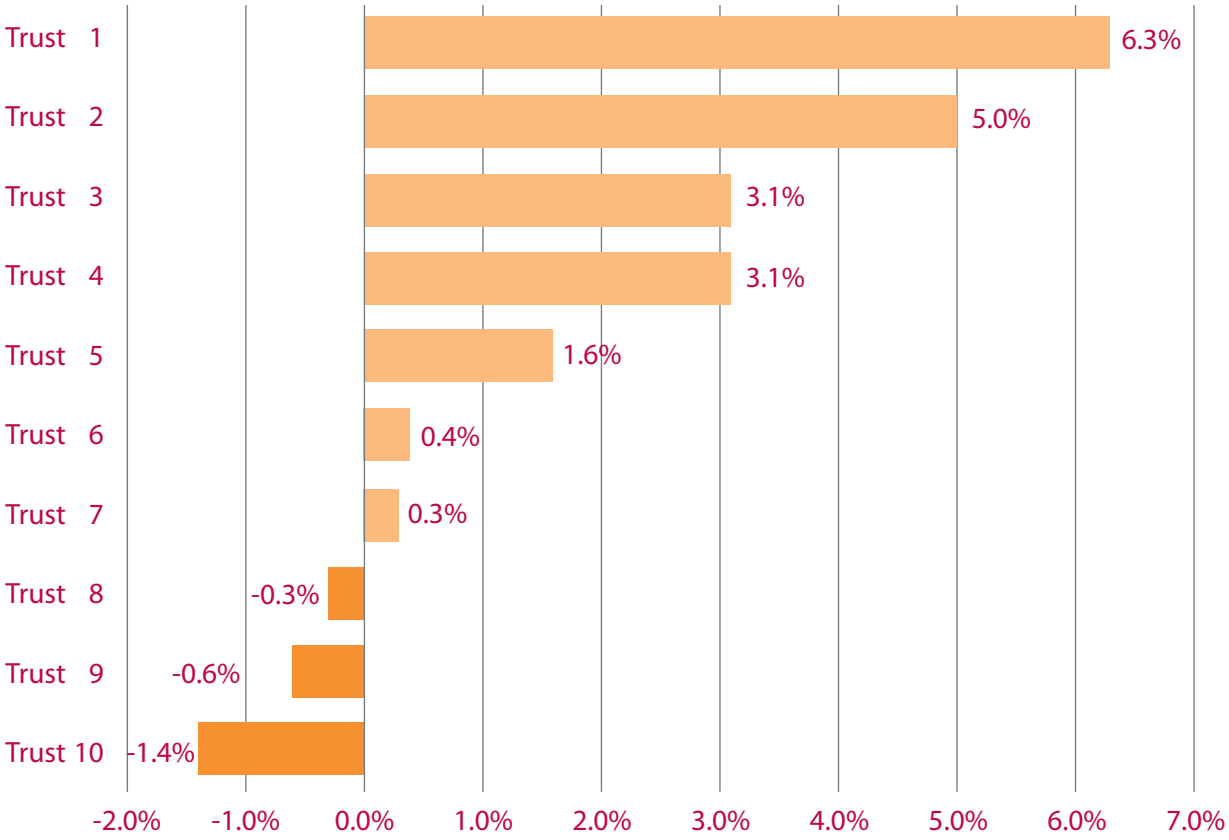
  Similarly, for frail older patients who experience a fall at night, the benefit of an A&E clinician or geriatric specialist rapidly assessing the patient and ruling-out a fractured neck of femur is lost if the patient then has to endure significant waits for private transport, social worker assessments or formal acceptance that the nursing home will receive the patient back; leaving the patient and department with little alternative other than admission to hospital. To support admission avoidance, 24/7 NHS hospital working and the delivery of care closer to home, supporting services need to be available and responsive to A&E departments and patient needs.

- For these reasons, greater engagement is needed between commissioners and providers of primary, community and acute services. It is only through co-designing care pathways and aligning incentives that initiatives such as ambulatory care and rapid assessment teams can be used to deliver transformational improvements to urgent and emergency care.

PATIENTS PRESENTING TO A&E DEPARTMENTS

- Despite the national trend of steadily increasing attendances, some participating trusts achieved reductions in A&E attendance volumes over the

FIGURE 2: AVERAGE ANNUAL CHANGE IN A&E ACTIVITY (2009/10 TO 2011/12)



Source: 2009/10 & 2010/11 Quarterly Monitoring of A&E; 2011/12 Situation Reports, Department of Health.
Notes: Excludes data for one trust that had introduced a new minor injuries unit in 2011/12

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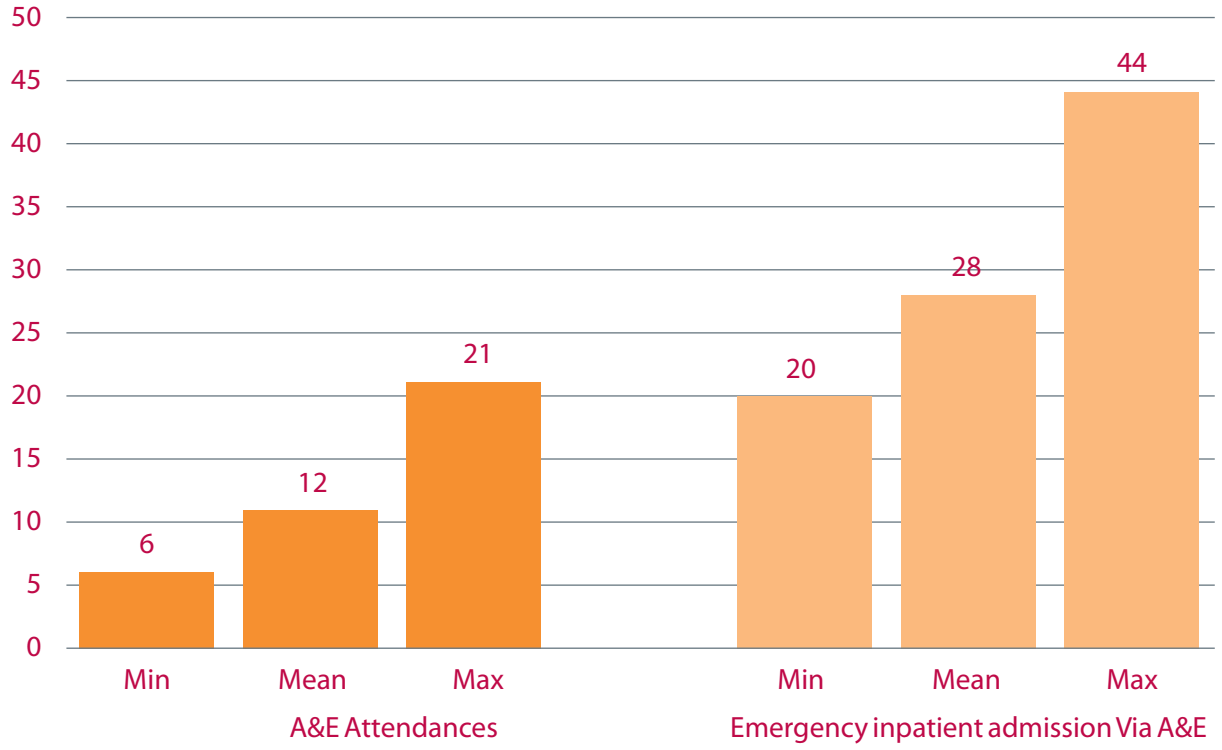
past three years. Of the trusts in this study three trusts saw a reduction in activity over the last three years; another two trusts had increases of under 0.5%, while for the other five demand increased by between 1.6 and 6.3%. (Figure 2).

- In addition to knowing the age and number of patients presenting to A&E, it would of course be useful to know why patients have attended A&E: both in terms of their presenting medical condition and the alternative healthcare services they explored prior to arrival at A&E. Unfortunately, the diagnostic information collected as part of the national A&E Commissioning Data Set still demonstrates poor coverage, quality and limited relevance to clinicians or policy-makers. A significant proportion of attendances are not given an A&E CDS diagnostic code, and the diagnostic categories are not sufficiently granular to inform improvement plans within A&E departments. The College of Emergency Medicine has begun development of a Unified Diagnostic Dataset that aims to enable more consistent and meaningful coding of A&E attendances.

- Across the 11 trusts, patients aged 75 years and older account for between 6-21% (mean 12%) of all A&E attendances and 20-44% of (mean 28%) of emergency admissions. Nearly half of attendances for these older patients ended in admission (compared to 16% of attendances ending in admission for younger patients).

- Older patients are a high need, high cost patient group due to the complexity of the clinical conditions they present with, and the high level of support that is often needed following discharge from A&E. These patients are also more likely to

FIGURE 3: PERCENTAGE OF A&E ACTIVITY ACCOUNTED FOR BY OLDER PATIENTS (AGED 75 YEARS AND OVER)



breach the four hour A&E waiting time standard; on average 11% of patients aged 75 and over spend longer than four hours in A&E.

- Trusts are developing specific initiatives to deliver more comprehensive specialist care for older patients. For example trusts are:

  - Providing more dedicated specialist care within A&E (e.g. specialist geriatric emergency nurse practitioners).

  - Developing specialist geriatric short stay wards to provide ongoing multidisciplinary specialist support to older patients.

  - Collaborating with community services to provide integrated discharge services for older patients with complex social and health care needs.

With the help of these multidisciplinary rapid response teams in A&E, patients who would previously have been admitted can now be seen by nursing, occupational therapy and physio services in A&E before being discharged home. For example, with the support of an integrated discharge team frail older fallers who have a fractured neck of femur ruled out are now fully assessed and discharged safely to a nursing home rather than admitted overnight.

- Chronic attenders[2] account for between 1-8% of all attendances across trusts, with higher chronic attendance levels observed in areas of greater deprivation. Trust are taking action to segment and understand their patient population and put specific plans in place to meet their health needs. Considerable focus was placed in implementing support services such as community alcohol teams, and Rapid Assessment, Interface and Discharge (RAID) services for patients with mental health needs. Trusts note that timely access to out of hours psychiatric liaison services remains a considerable challenge to be addressed by health services.

2 Defined as patients who attend A&E more than 3 times in any calendar month, or over 8 times in the period Apr 2011-Jan 2012

A TRUST COLLABORATING WITH COMMUNITY AND PRIMARY CARE PARTNERS TO MANAGE DEMAND

Aim: To improve patient flow and admission avoidance

Initiative: Whole system re-design with collaborative working between GP commissioners and the A&E department. Key aspects:

- Improve GPs direct mobilephone access to acute care consultants, to allow greater discussion of emergency referrals and alternatives to admission.
- Agree locally that GPs working in the same practice can rotate their time spent on home visits. This could smooth out the timing of emergency referrals and reduce the peak in referrals to A&E at 7pm (by which point alternatives to admitted care have closed shop for the day).
- Foster and support small practical ideas for improving admission avoidance. For example, invest in key fobs for frail older patients that contain community team/matron contact details; the increased accessibility of this information can help reduce automatic conveyance to A&E and can support care delivery in the patient's own home.

Benefits realised: With its focus on patient-centered care pathways this trust demonstrated the lowest rate of chronic attendance for frail older patients, and the best performance for patients aged 75 years and over against the four hour waiting time standard.

PROVISION OF SUPPORTING URGENT AND EMERGENCY CARE SERVICES AT ACUTE HOSPITAL SITES

PRIMARY CARE TREATMENT AREAS AND URGENT CARE CENTRES

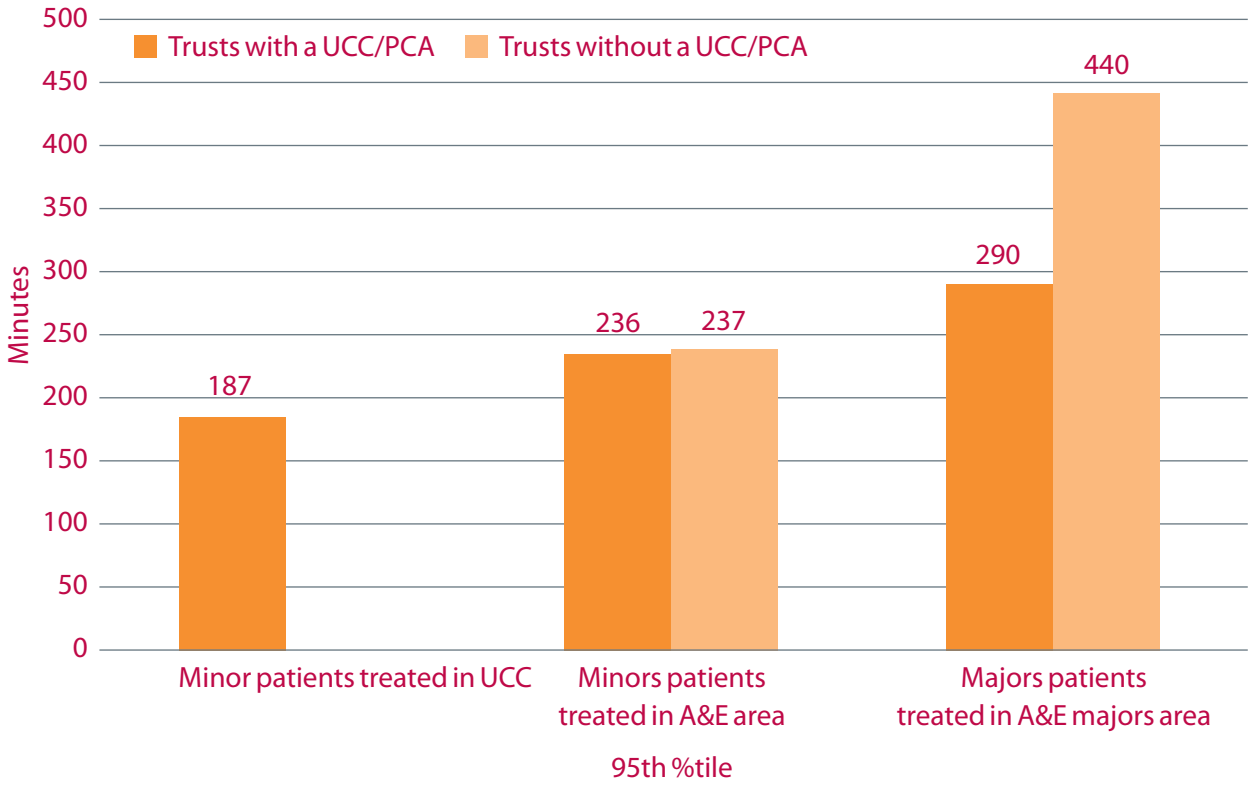
- To meet the needs of patients who present to A&E with minor illness or injury, trusts have created a range of primary care "offers" to patients. These include primary care treatment areas (PCA) within the A&E department itself which are staffed by primary care nurses and GPs; urgent care centres (UCC), and Minor Injury Units (MIU) staffed by GPs and emergency nurse practitioners. The organisation of services differs considerably across trusts: in some trusts the UCC shares nursing and medical staff with the A&E department and acts as a "front-door" to the department, in other trusts the UCC is under separate clinical management and is located in a different part of the hospital campus to the main A&E.

- Having a dedicated area and staffing support for patients with minor conditions was associated with shorter treatment times for this patient group. Across all trusts, patients with minor injuries of illnesses seen in a UCC or PCA have a median stay of 81min, compared with 135 min for patients treated in minor areas of the main A&E department[3].

- Having a UCC/PCA was also associated with secondary benefits of faster treatment times for patients with major conditions presenting to A&E. The 95th percentile for the total time in department for majors patients across trusts with a UCC/PCA was shorter compared to trusts without these facilities (290 mins compared with 440 minutes) (Figure 4). The group of trusts operating UCC/PCAs also have a lower breach rate (4.9%) compared to those that do not have these facilities (6.3%). Having dedicated space and staff with the expertise to rapidly treat and discharge patients with minor illnesses and injuries can have a considerable benefit to the treatment of these patients and the smooth operation of the wider A&E department.

3 It is noted that the acuity and casemix of presentations seen in UCCs and PCAs varies across trusts e.g. although all UCCs treated patients with minor illness, only one trust treated patients with minor injuries in UCC

FIGURE 4: COMPARISON OF A&E WAITING TIMES (95TH PERCENTILE FOR TOTAL TIME IN A&E) FOR TRUSTS WITH OR WITHOUT AN URGENT CARE CENTRE (UCC) OR PRIMARY CARE TREATMENT AREA (PCA)



Source: FTN Benchmarking patient-level data.

SHORT STAY WARDS FOR PATIENTS ADMITTED VIA A&E

- Once a decision has been made to admit an A&E patient to hospital it is essential that the patient is actually provided with an inpatient bed with minimal delay. Trusts differed in how A&E was supported by short term wards in particular to execute these 'decisions to admit'.

- Participants all had medical acute units to receive patients for a period of between 48 and 72 hours. On average, only 55% of the patients admitted to these units will then be admitted onto inpatient wards. For a majority of trusts, surgical patients have a separate area. Some trusts have also set up specialist short stay assessment services for specific patient groups (e.g. older and paediatrics).

- Although all trusts have medical assessment units, how they are managed, and procedures for admitting patients to the units differed considerably. For example, in some trusts these assessment units are under the management of the emergency department, while in other trusts the unit is part of the general medicine division.

- Trusts report that executing decisions to admit a patient was significantly easier when there were clear protocols in place for accessing this short stay bed stock, whether this was via extended admitting rights for senior A&E staff, streamlined nurse-to-nurse or consultant-to-consultant referral processes, or the coordinating work of non-clinical bed managers.

- These admitting protocols for A&E staff can be of considerable use in cases where making or executing a decision to admit would have been delayed; where admitting clinicians and surgeons are otherwise occupied in operating theatres; or in delivering inpatient care. Although these changes to operating practice are not always easy to introduce, especially where admitting medical teams prefer to gatekeep access to their short stay beds, A&E staff note that audits indicate that where A&E staff are given increased admitting rights there

are few instances of patients being admitted inappropriately.

- Overall, 75% of admissions to medical assessment units are via A&E. However, there is significant variation across trusts in the proportion of GP referrals that bypass A&E and are admitted directly into these short stay beds. One trust had seen a clear benefit in having GP emergency referrals to hospital assessed by speciality teams in A&E. With the rapid access to diagnostics and quick turnaround on medical consultations, up to 40% of these emergency referral patients were subsequently discharged from A&E without admission.

ROLE OF CLINICAL DECISION UNITS

- Half of the participating trusts have clinical decision units (CDUs); these units have short length of stay policies (normally 24 hours) for admitted patients. Over the last decade there has been much debate about the value-adding role of these wards in the patient pathway, with some criticism that trusts have used CDU as a "safety valve" to improve performance against the four hour waiting time standard. As noted by the NHS Information Centre and as shown by the patient-level data in this study, between 25-50% of admissions to short stay wards occur in the last 20 minutes before a patient breaches the four hour waiting time standard (i.e. admission occurs between 3 hrs 40 mins and 3 hours 59 mins of arrival). However, trusts note that rather than reflecting delayed care or rushed 'admit or breach' decisions, this pattern can often reflect A&E departments giving a patient every chance to be assessed and treated in A&E to prevent an avoidable hospital admission or a breach of the waiting time standard.

- Trusts also agreed that CDUs should have a clear role in the pathway, such as serving as short stay observation wards to rule out complications for patients with head injury or chest pain; or stabilisation wards for patients with acute substance abuse episodes; or additional facilities to delivery ambulatory emergency care. However, after reviewing their internal processes at least one trust had decided to remove its CDU to improve the quality and timeliness of patient care in A&E (case study below).

EFFECTIVE USE OF SHORT STAY WARDS

Aim: Improve the quality, experience and timeliness of patient care in A&E by preventing short stay beds from being used as a "safety valve" to avoid breaches.

Initiative: At the beginning of the project CDU was a small mixed-sex unit used as a temporary assessment area for older patients, psychiatric or head injury patients. This often resulted in poor patient experience and the trust decided that the pathway for these patients must be aligned with the intention to deliver clinical care for A&E patients within four hours of arrival.

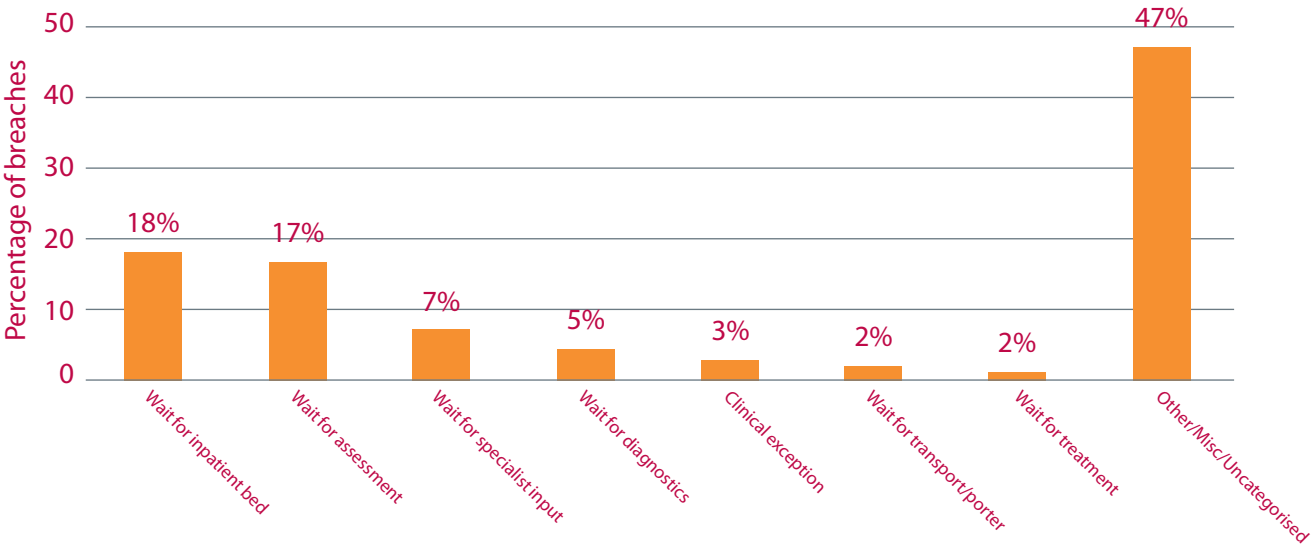
A&E staff agreed more timely assessment protocols for patients requiring specialist referral and invested in a specialist geriatric nurse practitioner to improve assessment and therapy for frail older patients in A&E. To improve bed availability for patients requiring admission from A&E, twice daily ward rounds were introduced to the medical assessment unit supporting A&E to support more timely discharge of patients from the unit. With these new protocols in place the CDU was closed.

Benefits: After an initial reduction in the proportion of patients seen within four hours in A&E, the department has now seen an improvement in patient experience and the flow of patients through the department. The A&E and short stay wards are now operating as a coordinated self- sufficient unit that is not as reliant on bed capacity in the rest of the trust. The reduced admission income from the closure of CDU has also been offset by the provision of increased ambulatory care pathways within the department.

PATIENT FLOW AND QUALITY OF CARE IN THE A&E DEPARTMENT

- The quality of care in A&E departments is measured nationally by:
  - The headline four hour waiting time standard: 95% of patients in A&E should spend no more than four hours from arrival to departure in A&E (this standard is also included as one of the clinical quality indicators).
  - The eight clinical quality indicators for A&E: total time in A&E, time to initial assessment, time to treatment, consultant sign-off rates for high-risk conditions, the rate at which patients leave A&E before being seen; the rate at which patients return to A&E within seven days of a previous attendance; a narrative description of how the trust is addressing patient experience and implementation of ambulatory emergency care.
  - The recently announced Friends and Family test, where patients are asked whether they would recommend the A&E service to a friend or relative.
  - The patient experience survey questions included in the CQC patient surveys, which will be included as part of the NHS Outcomes Framework.
- It is of course vital that patients' experiences of A&E services are accurately measured and used to drive improvements to A&E departments. However, the multiplicity of patient experience data being requested by central government from A&E departments could be rationalised to reduce the administrative burden of these data collections, and to allow clinical and managerial staff the time to actually implement and action these patient-driven improvements to A&E services.
- Improving patient flow through A&E remains a focus for participating trusts. Over the study period over half the trusts did not achieve the standard of seeing over 95% of patients within four hours of their arrival in A&E.
- The most common reason for patients breaching the four hour standard were waits for an inpatient bed, waits for initial assessment in A&E, and waits for specialist input to the clinical decision-making process.
- As noted earlier, trusts are exploring how extended admission rights for senior A&E staff may reduce the delay in accessing an inpatient bed. Where difficulty in accessing specialist staff from other parts of the hospital are causing delays in A&E patients being treated, A&E departments are being proactive in

FIGURE 5: MOST COMMON REASONS FOR PATIENTS BREACHING THE FOUR HOUR WAITING TIME STANDARD (AVERAGE ACROSS ALL 11 TRUSTS)



Note: "Other/Misc/Uncategorised" denotes where the reason for the patient breaching accounted for <1% of breaches, where the reason for the patient breaching was not recorded, or where the breach could not be attributed to a single factor.

EFFECTIVE SENIOR INITIAL ASSESSMENT ON ARRIVAL

Aim: To reduce the clinical risk and delays in care associated with the time the patient spends unassessed in A&E.

Initiative: Implementation of a Rapid Assessment Team (RAT) to rapidly assess majors patients and front-load senior clinical decision making into the assessment process.

This RAT model is staffed by one registrar who takes on the role for the day. The RAT registrar takes a mobile pro-active case-finding approach within the majors area of the A&E department: seeing all majors patients as quickly as possible on arrival, taking a brief history, initiating treatment (e.g. pain management for renal colic, diagnostics such as bedside renal testing), making an initial admit/discharge decision (e.g. "severe asthma – patient likely to be admitted") and documenting a brief management plan. Responsibility then passes to a junior doctor to take a full history and implement the treatment plan.

Benefits: Some staff have noted that a risk of the RAT process is that the shorter initial patient history taken as part of the RAT process could lead to the ordering of unnecessary investigations. However in the main, since implementing the RAT process the trust had seen significant reductions in the time to initial assessment for patients with serious conditions, and more importantly this initial assessment is now a meaningful step in the clinical pathway that is conducted by a clinical decision maker with the ability to define the treatment plan for the patient.

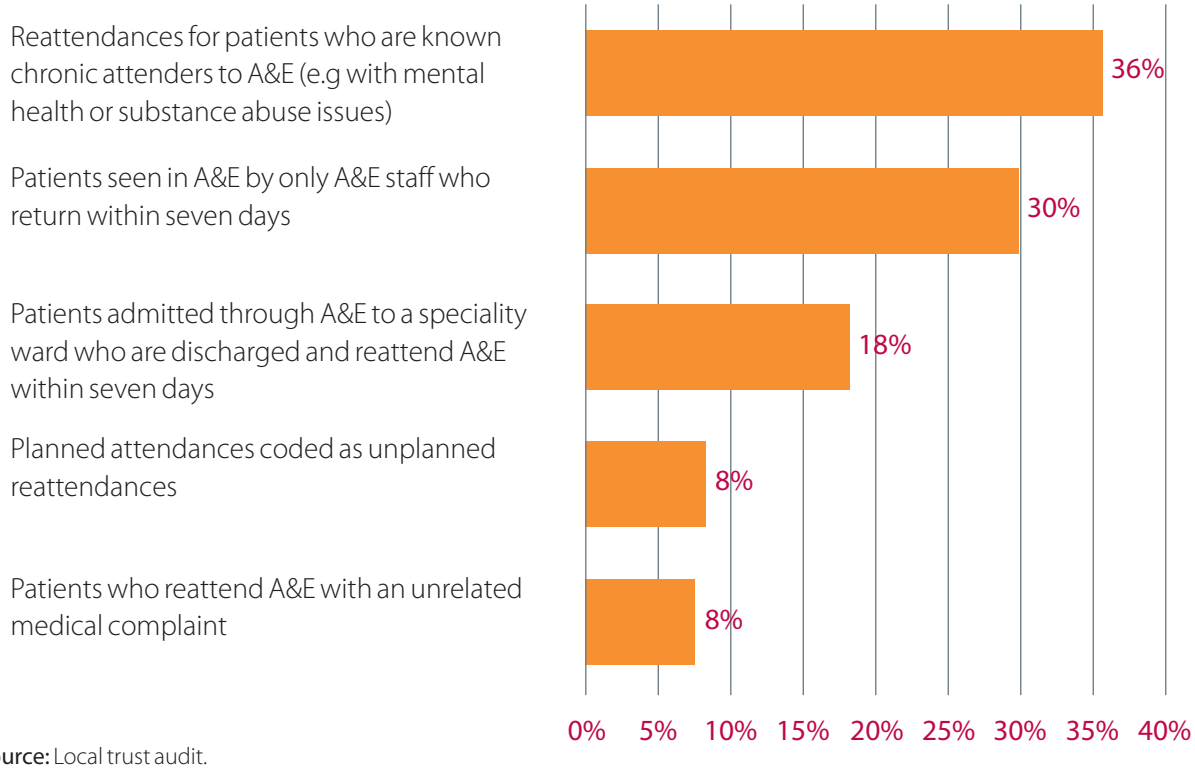
addressing the issue. To facilitate rapid admission decisions and transfer of patients from A&E to inpatients wards, one trust has established agreed protocols for specialist assessment in A&E. If patients referred to a speciality team have not been assessed within 30 minutes then when clinically appropriate the patient can be admitted to an inpatient ward by the A&E team. The senior management team of the trust has also taken an active role in daily bed management meetings to support the flow of admitted patients out of the A&E department.

- Trusts have also made improving initial assessment times in A&E a priority, and have seen significant reductions in the Time to Initial Assessment clinical quality indicator as a result. Initiatives have included the extended use of emergency nurse practitioners in A&E and UCCs to deliver care for patients with minor illness and injury; the introduction of standardised initial assessment protocols to support the provision of more rapid and consistent care for commonly presenting conditions (see case study on improving the efficiency of diagnostic use), and introducing Rapid Assessment Teams to deliver definitive senior assessment of conditions more rapidly following the arrival of the patient at A&E (see case study above).

- In addition to supporting the timeliness-based clinical quality indicators, trusts are also making progress in improving performance against the other clinical quality indicators. For example, many of the trusts have introduced display boards in A&E to show average waiting times and improve patient communication within the department and reduce the number of patients who leave A&E before being assessed.

- Trusts noted that in addition to the four hour waiting time standard the most challenging clinical quality indicators were the time to initial assessment indicator and the reattendance rate. Few trusts had seven day reattendances rates below the recommended threshold, and over a quarter of patients who reattend A&E are subsequently admitted upon their return.

FIGURE 6: REASONS FOR PATIENTS REATTENDING A&E



Source: Local trust audit.

- A trust in London has developed condition-specific patient information leaflets for discharged patients to successfully reduce the rate at which patients reattend A&E. The trust has also provided a hotline to the surgical department to allow discharged patients to access post-operative clinical advice and reduce reattendances at A&E. However, audits of the patients who reattend within seven days of their first attendance at A&E have shown that a sizeable proportion of the patients who return to A&E within seven days could not be attributed to "wrong care first time in A&E", which illustrates that reattendance at A&E is a whole system issue and not purely a barometer of the quality of care delivered in A&E departments.

FINANCIAL COSTS OF PROVIDING A&E SERVICES

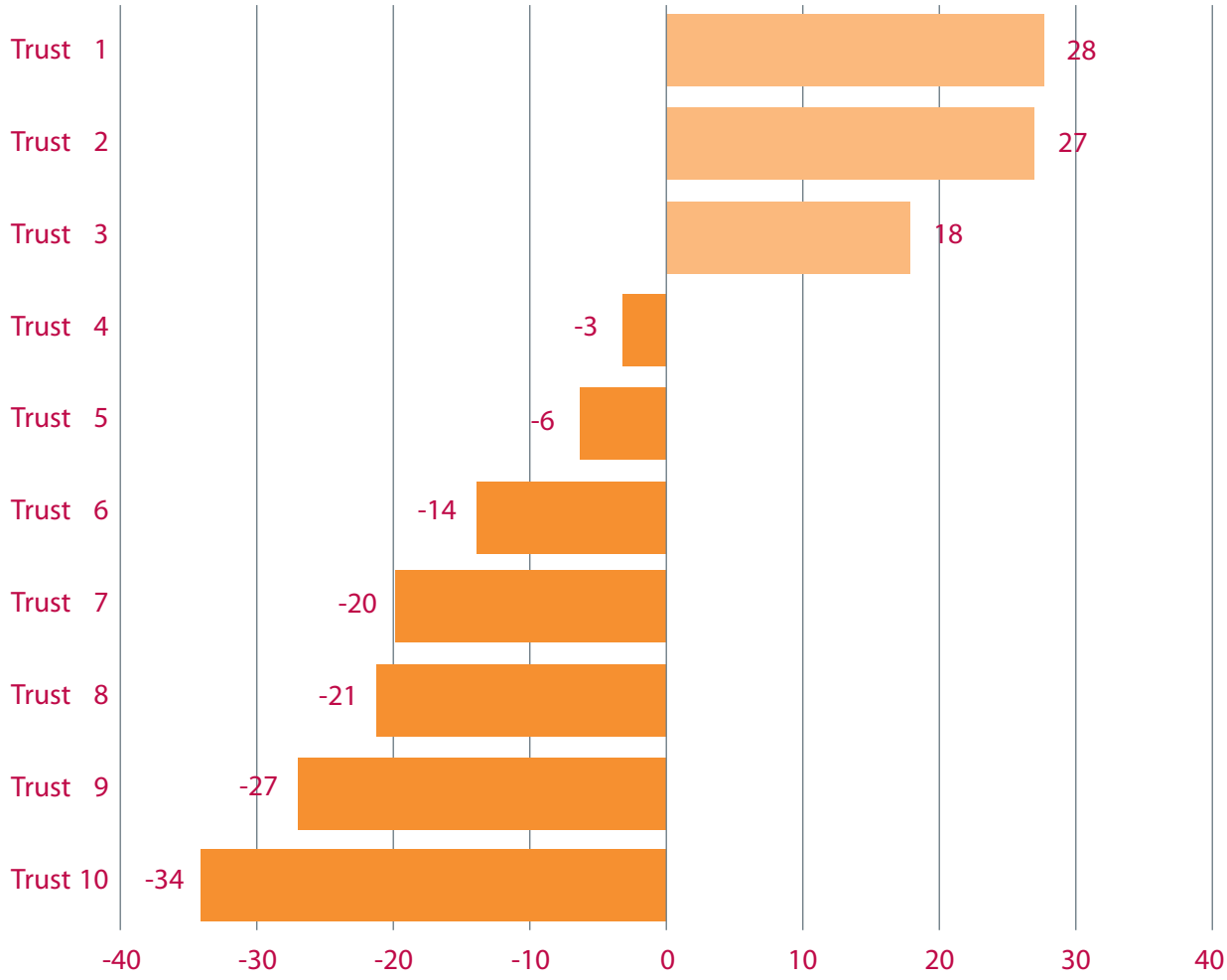
- Only a minority of trusts appear to break even when comparing the average income and costs per A&E attendance. On average for the majority of trusts the income received for A&E attendance does not cover the costs of operating A&E services (Figure 7). This is consistent with the findings from our previous A&E Benchmarking study based on data prior to the adoption of the Health Resource Groups (HRG) 4.0 tariff.

- There is a wide variation across trusts in the reported costs for delivering their A&E service (average cost per attendance ranged from £69 to £129), and similar variation in the average income received per attendance which ranges from £79 to £123 (adjusted for Market Forces Factor). The margin per attendance was not significantly correlated with the average income level of the trust or the overall volume of attendances.

- Diagnostic costs on average contributed 18% of A&E costs and the average number of diagnostic tests per attendance varied from one to five tests across trusts. One trust had implemented a standardised suite of assessment protocols for common conditions to deliver more consistent care and use of diagnostics (case study below)

- As noted by the Audit Commission, accurate coding

FIGURE 7: MARGIN (£) PER A&E ATTENDANCE (MEAN INCOME PER ATTENDANCE – MEAN AVERAGE COST PER ATTENDANCE)



of activity is needed to ensure trusts are fully reimbursed for the care they deliver. A high-level comparison of A&E activity by acuity level, treatment area in A&E and tariff payment category suggests that coding practices within some trusts do not always reflect the true extent of the work conducted. Trusts participating in the benchmarking exercise agreed to share best practice in coding A&E activity amongst the group, to facilitate full and fair reimbursement for the care that is delivered.

- Tariff payments for A&E services are based on the treatments and diagnostics that are completed in the department. Trusts note that this system does not fully reimburse trusts for the resources that are invested in patients with mental health needs who often consume large amounts of staff time, even though specific treatments and diagnostics are not always necessary.

WORKFORCE

- Staff pay costs account for the majority of A&E expenditure, ranging from 54-81% of the average cost per attendance. This variation in part reflects varying reliance on locum and agency staffing. The proportion of medical staff costs allocated to non-contracted staff varies from 3% to 50% with lower variation for nursing costs (6% to 22%) (Figure 8). Trusts note that this reliance on locum and agency staffing is compounded by:

IMPROVING EFFICIENCY OF DIAGNOSTIC USE

Aim: To standardise the investigations and treatment that all patients receive when they present with common complaints and to reduce any unnecessary investigations.

Initiative: Audits showed there was significant variation in the number and range of diagnostics ordered for the same presenting health condition by different members of staff. The trust decided to invest clinician time in developing local standardized initial assessment tool (IAT) pro-formas to support decision making. A&E clinical staff agreed a list of protocols and appropriate diagnostics for the 18 most common conditions coming through their door.

This initiative started with blood tests and plain X-rays. Now there are protocols in place for dealing with patients with a wide range of symptoms such as non-traumatic chest pain, and abdominal pain. These take into account national guidelines, but in most cases go even further to agree the range of investigations.

An education and training programme is being rolled out alongside the introduction of the assessment tools, and information on the protocols is available as pocket-sized cards, laminated sheets and on a dedicated noticeboard as well as electronically. The protocols are living documents that are updated as new guidelines or research becomes available.

Benefits: Implementation of the IAT reduced variation in the use of diagnostics. Audits show £7500 per week savings on unnecessary blood tests have already been realised.

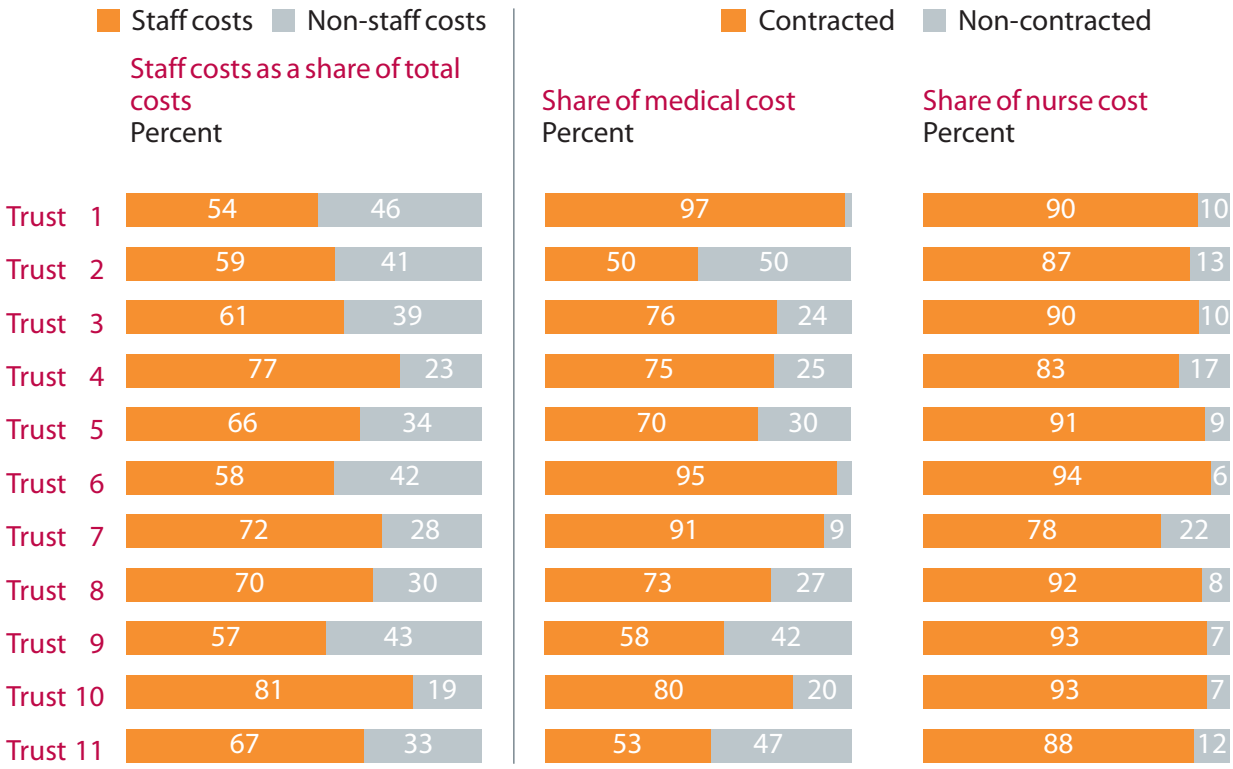
- Significant challenges in recruiting good quality middle grades.
- Cuts in deanery numbers and deanery positions with low fill rates.
- Insufficient consultant numbers to fully support a senior clinical 'shopfloor' presence during out of hours periods seven days a week.
- Shorter Foundation Year 2 posts lasting four months rather than six months, leading to reduced service provision, a requirement for more frequent induction, and a need for closer supervision of activities by senior clinicians

• There was considerable variation in the skillmix of A&E department staffing. The proportion of an A&E department's whole time equivalents (WTEs) that are medical staff varies from 20% to 37% (mean 27%). Other staff groups comprise nurses, other medical staff and non-medical assistants. The proportion of medical WTEs that are consultants varies from 12% to 27% (mean 18%).

• There is also significant variation across trusts in activity loads per WTE. The number of A&E attendances per medical WTE ranges from 1,700 to 2,800 (mean 2,000) across trusts, with A&E attendances per nurse WTE varying from 700 to 1,600 (mean 1,200)

• Sufficient staffing establishment levels are vital for running an effective A&E service, however it is also important for trusts to consider how their staff are strategically deployed to meet local needs. There was no 'one-size-fits-all' approach to staffing an effective A&E department and, for example, trusts have demonstrated success in treating minors patients whether these patients were cared for by GPs based in A&E, emergency nurse practitioners or A&E staff nurses.

FIGURE 8: A&E STAFF PAY COSTS AS A SHARE OF TOTAL A&E COSTS; PROPORTION OF A&E STAFF COSTS THAT ARE NON-CONTRACTED LOCUM OR AGENCY STAFF



FUNDING OF A&E AND EMERGENCY ACUTE SERVICES

- Overall, trusts are continuing to experience funding pressures for their A&E services. A proportion of this deficit can be addressed internally by improving efficiency of the service and more rigorous record keeping for coding activity. However, there are still significant concerns about the fundamental adequacy of current tariff reimbursement for delivering high quality A&E and emergency care services.

- In particular the Department of Health should re-examine the policy of paying emergency admissions above 2008/09 levels at a marginal rate of 30% of the tariff. The desired effect of this policy is to incentivise appropriate admission avoidance and the delivery of care closer to home. However the marginal tariff provides little incentive for primary care to take shared responsibility for emergency admissions. Hospitals are simply earning less for the work they undertake, despite the improvements to early specialist assessment and ambulatory emergency care that trusts continue to deliver.

- A more balanced approach that apportions risks and responsibility across the system and recognizes the responsibilities of primary care would be preferable. Rather than operating a blanket reduced payment policy one suggestion would be for providers and Clinical Commissioning Groups (CCGs) to work together to audit the cause of emergency admissions. These audits would form the basis for rigorous and transparent local discussions about how to manage demand and reinvest money into preventative medicine. Providers must also be given the opportunity to engage in discussions on how to spend the savings from the marginal tariff policies, otherwise this is simply a fine on acute trusts with no opportunity for them to support the goals of integration and care in the community.

THE FTN BENCHMARKING PROCESS

This is the FTNs second benchmarking project on A&E services. Each participant trust established a project team with a clinical, data and operational manager lead, and a board-level sponsor to oversee the project. Following an initial scoping phase, trusts attended a workshop where the data collection and data definitions were discussed in detail and agreed. During the data collection and validation periods support was provided by the FTN Benchmarking team, with regular contact to ensure trusts were collecting comparable and robust data.

Performance across trusts was assessed by collecting trust-level and patient-level information on acute activity, clinical quality, patient safety, staffing levels and workforce costs for the period April 2011 to Jan 2012.

A findings workshop provided an opportunity for trusts to discuss the main findings as a group, share best practice, identify improvement opportunities and develop focused action plans for improving A&E services.

THE FTN BENCHMARKING PROGRAMME

The Foundation Trust Network is the trade association for NHS foundation trusts (FTs) and NHS trusts on the way to becoming FTs. We speak on behalf of over 200 members delivering acute, specialist, mental health, ambulance, and community services in hospitals, in the community and at home.

Our role is to ensure the voice of public providers of healthcare in the NHS is heard loud and clear, to support our members to deliver excellent patient care and to forge relationships across the whole of the health and social care system.

Over the last six years the FTN Benchmarking programme, run in partnership with McKinsey & Co, has facilitated significant cost savings, quality improvements and efficiency gains for over 100 member trusts. For more information visit www.foundationtrustnetwork.org/members/benchmarking/ or contact Sivakumar.Anandaciva@foundationtrustnetwork.org or Isabel.Lobo@foundationtrustnetwork.org