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| <b>Report to:</b> | <b>Trust Board – 28<sup>th</sup> March 2013</b> |
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| <b>Title</b>                         | High Level Indicators of Trust Efficiency   |
| <b>Sponsoring Executive Director</b> | Peter Herring – Chief Executive   |
| <b>Author(s)</b>                     | Peter Herring – Chief Executive   |
| <b>Purpose</b>                       | To inform the Trust Board of performance against high level indicators of efficiency. |
| <b>Previously considered by</b>      | Not applicable  |

### Executive Summary

This report summarises the Trust's performance against high level indicators of efficiency in the use of its available bed capacity, the timeliness of treatment, appropriateness of admission and discharge, and the use of planned surgery and outpatient services.

| <b>Related SATH Objectives</b>  | <b>SATH Sub-Objectives</b>   |
|---|--|
| A – Financial Strength<br>B – Patients and Commissioner<br>C – Quality and Safety | The report covers a range of organisational sub-objectives in the three strategic domains. |

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| <b>Risk and Assurance Issues (including resilience risks)</b> | Ensuring that we develop robust measures to assess strategic performance will minimise the risk associated with the delivery of our strategies and provide a warning system for the Trust Board where further attention is required. |
| <b>Equality and Diversity Issues</b>                          | None   |
| <b>Legal and Regulatory Issues</b>                            |  |

### Action required by the Trust Board

The Trust Board is asked to **NOTE** the relative efficiency of the Trust compared to national benchmarks.

## HIGH LEVEL INDICATORS OF TRUST EFFICIENCY AND USE OF CAPACITY

### Introduction

1. In considering the issues relating to the capacity of the Trust to adequately cope with current levels of demand it is important that the Board have a perspective on our relative measures of efficiency in the use of our inpatient beds and other facilities. The attached Annex A illustrates a number of key indicators of efficiency in comparison with national benchmarks.

### Relative position

2. It is recognised that many of these indicators also have a quality perspective, however, the focus of this paper is to demonstrate that whilst there are some areas for improvement, on the whole the Trust is very efficient in the use of its available beds, day-case and outpatient services.
3. The enormous pressure from emergency admissions over the past three months has however adversely affected the efficient working of the two hospitals and in particular has resulted in significantly higher levels of cancelled operations and the inability to conduct routine elective day-case and inpatient surgery on many occasions. It is inevitable that because of the cancellation of the short-stay surgery that the average length of stay will be longer in the last quarter of the year.

### Capacity gap

4. Whilst utilising our available service capacity at efficient rates the Trust is nevertheless unable to meet its performance targets and avoid cancelling elective operations due to a deficit in the available bed capacity required to meet the emergency demand.
5. The Trust has modelled current levels of activity and with the current lengths of stay (which are already relatively efficient) there is on average a gap of 70 beds and potentially a greater deficit during the winter. If we consider the number of admissions per bed (indicator 5), were the Trust operating at the national mean for admissions per bed we would have the equivalent of an additional 120 beds. Our relative efficiency in comparison with most Trusts, however, reduces our estimated deficit to the smaller gap of 70 identified above.

### Resolving the capacity gap

6. The options for resolving this capacity gap include:
  - Introducing new initiatives in the wider health economy to provide alternatives to hospital attendance and admission;

- Further improving acute bed efficiency through reducing lengths of stay, increasing the use of ambulatory care, and improving processes for discharging patients;
  - Minimising the number of medically-fit patients who remain in a hospital bed awaiting assessment, placement in nursing, residential or community beds or awaiting packages of care; or
  - Increasing acute bed capacity.
7. The Shropshire and Telford Urgent Care Network oversees a programme of initiatives to minimise emergency presentations and provide primary and community care based alternatives to attending the hospital. As reported at a previous Board meeting and referred to in the Integrated Performance Report, ATOS Healthcare have been jointly commissioned by the Trust and the two CCGs to conduct a whole system review of urgent care provision across the community and this will inform the future programme of work.
  8. It is clearly the least desirable option to increase acute bed capacity, particularly in the context that the Trust currently has no empty accommodation to deploy as inpatient wards without considerable capital expenditure. More importantly, however, as we have in the order of 50 to 60 patients classified as no longer requiring medical care (i.e. care by a doctor) it is appropriate that we explore the potential for providing more suitable non-acute accommodation, and as referred to in the Integrated Performance Report a new model of care for this category of patient is currently being explored.
  9. There is potential for the Trust to improve even further our internal levels of efficiency and the A & E action plan reported to the January Board together with the internal reconfiguration of available beds, and other initiatives in the development phase, will aim to achieve more effective use of available beds. It should be remembered, however, that the lengths of stay achieved by acute Trusts are also a product of the relative provision of community, rehabilitation and social care provision and the best performing economies have a good balance in all these forms of capacity. Putting this aside, we estimate the Trust's 'internal' potential to be more efficient in the use of available beds to be between 10 to 20 beds, but this opportunity can only be fully exploited if the current levels of pressure on the hospitals are relieved.
  10. In the context of the overall capacity gap there remains a significant residual gap that will need to be resolved by the alternatives considered above.
  11. The BOARD are asked to note the Trust's relative levels of efficiency and further reports on initiatives to close the capacity gap will be reported to future meetings.

**Peter Herring**  
**Chief Executive**

## Enclosure 4.1

## Annex A Shrewsbury &amp; Telford Hospital NHS Trust Measures of relative efficiency

| Ref | Metric  | SATH                    | National | Position | Measure of efficiency                            | Source                               |
|-----|---|-------------------------|----------|----------|--|--------------------------------------|
| 1   | Average length of stay (days)   | 4.8                     | 4.9      | Better   | Efficient use of beds                            | National HES database                |
| 2   | Length of stay for >65 years old admitted as emergency                      | 9                       | 10       | Better   | Efficient use of beds                            | Acute Trust Quality Dashboard        |
| 3   | Emergency re-admission rate within 30 days non-elective                     | 11.1%                   | 12.95%   | Better   | Appropriateness of discharge                     | Acute Trust Quality Dashboard        |
| 4   | Re-admissions within a week   | 2.8%                    | 3.1%     | Better   | Appropriateness of discharge                     | Dr.Foster Intelligence               |
| 5   | Number of admissions per bed  | 166.6                   | 141.4    | Better   | Efficient use of beds / adequacy of capacity     | Trust analysis                       |
| 6   | Length of stay reduction potential (excluding specialist Trusts)            | 29 <sup>th</sup> lowest |          | Better   | Efficient use of beds                            | Better Care, Better Value Indicators |
| 7   | Number of patients attending A & E who are admitted                         | 22.7%                   | 23.4%    | Better   | Appropriateness of admission                     | National HES database                |
| 8   | Proportion of emergency admissions for ambulatory care sensitive admissions | 12.4%                   | 12.1%    | Worse    | Avoidable emergency admissions                   | Dr.Foster Intelligence               |
| 9   | % of A & E attendances which are 'inappropriate'                            | 8.5%                    | 15.2%    | Better   | Appropriateness of A & E attendance <sup>4</sup> | Acute Trust Quality Dashboard        |
| 10  | % 7 day Re-attends to A&E   | 7.1%                    | 9.2%     | Better   | Appropriateness of A & E attendance              | Lightfoot (benchmarking analysts)    |

## Enclosure 4.1

| Ref | Metric   | SATH  | National | Banding | Measure of efficiency                | Source                        |
|-----|--|-------|----------|---------|--------------------------------------|-------------------------------|
| 11  | Short-stay admissions without a diagnosis                        | 12.3% | 13.3%    | Better  | Timely treatment                     | Dr.Foster Intelligence        |
| 12  | Excess bed days  | 8.2%  | 11.5%    | Better  | Timely treatment / discharge         | Dr.Foster Intelligence        |
| 13  | Long-stay elderly patients                                       | 28.3% | 29.1%    | Better  | Timely treatment / discharge         | Dr.Foster Intelligence        |
| 14  | Scheduled operations that weren't performed                      | 3.5%  | 3.0%     | Worse   | Efficient use of elective capacity   | Dr.Foster Intelligence        |
| 15  | On the day cancellations of elective surgery per 1000 procedures | 59.0  | 26.8     | Worse   | Efficient use of elective capacity   | Acute Trust Quality Dashboard |
| 16  | Use of day-case surgery  | 93.3% | 91%      | Better  | Efficient use of elective capacity   | Dr.Foster Intelligence        |
| 17  | Rates of non-attendance of outpatients (DNA rate)                | 5.2%  | 8.4%     | Better  | Efficient use of outpatient capacity | Dr.Foster Intelligence        |
| 18  | Outpatient: ratio of follow-up to first outpatient appointment   | 2.0   | 2.2      | Better  | Efficient use of outpatient capacity | Dr.Foster Intelligence        |