

# Reducing Length of Stay Supporting Information

Length of hospital stay is one of the greatest variables between NHS trusts. By reviewing and improving admission and discharge processes, trusts can improve the patient experience by reducing the number of days spent in hospital, and save bed days thus increasing capacity and saving money.

As a measure of the scope for improving length of stay we have looked at the number of bed days beyond the average length of stay for each of combination of Healthcare Resource Group, age, sex and social deprivation. We have taken a quarter of this figure as being an achievable level of improvement and expressed it as a percentage of all the Payment by Results bed days at the trust.

The figures are intended to give an idea of the potential for improvement. However, some hospitals would expect to have patients stay longer than the average for patients with the same age, sex and other characteristics. For example, within each HRG some hospitals (eg specialist trusts) may have more complex patients. Also trusts which serve large geographical areas, with patients travelling long distances, may need to have patients stay longer.

There is usually more variation between hospitals in the pattern of discharge than in the pattern of admission. For all hospitals, discharge rates generally peak on Fridays and drop steeply during the weekend. While patients are admitted seven days a week as emergency admissions, most are discharged on five. For patients admitted as an emergency, the reduction in discharges over the weekend compared to weekdays varies from over 75% to less than 15%.

The day of admission also affects the length of time patients with similar clinical requirements stay in hospital. A patient who is admitted on a Friday may have a length of stay 25% longer than a patient admitted on a Tuesday.

Reducing length of stay will reduce the cost per patient episode, the risk of patients being exposed to hospital acquired infections, A&E waits, cancelled elective procedures and waiting times for treatment thus improving clinical outcomes.

## **Key steps to :**

- Benchmark length of stay performance in as much detail as possible down to HRG, operation and even consultant or ward level to identify opportunities for improvement
- Map processes in order to identify potential delays to patients discharge. This analysis should focus on identifying bottlenecks, any disruption to the information flow during the patient journey and on patterns of discharge by day, hour and specialty.
- Give patients a planned date for discharge on, or prior to, their admission. This date should be based on protocols for common conditions. The patient, their family or carer, and where necessary social services, should then be involved in individual discharge planning.
- Discharge patients daily. A regular decision-making ward round should take place at least once per day, including weekends. Staff rotas may need to be adjusted to facilitate this.
- Discharge patients throughout the day. Criteria-led discharge by nurses and other healthcare professionals facilitates discharge at other times of the day, other than the daily ward round.
- Prevent hospital procedures from holding up discharge. Lead-in times for processes required for discharge, including tests and results availability, medicines, transport and social services, should be determined so that measures can be taken to ensure that they do not hold up patient discharge.

- Ensure that the admissions and discharge processes work seamlessly together. Patient discharges peak late in the afternoon, while the peak for admissions is usually earlier.

### Further Information

NHS Elect –Service Transformation Tools  
<http://www.nhselect.nhs.uk/Service-Transformation>

### Information Shown

This indicator shows a percentage bed day saving and associated financial productivity opportunity to be realised by amending processes such that the length of stay of patients over the median value for the casemix group is reduced by 25%. This is expressed as a percentage of all PbR spell bed days in the trust. The data is stratified so that patients of similar age, deprivation, HRG and gender are compared with one another. The bed day saving and productivity opportunity is calculated at the granular level before being aggregated and a provider is likely to show a saving opportunity unless all lengths of stay are below the relevant median value.

#### Organisation Dashboard

The following information is displayed for Reducing Length of Stay.

Latest value - Percentage bed days in excess

Financial Opportunity - This shows the financial value of the number of bed days in excess of the percentile value shown. This is calculated by multiplying the excess bed days by the excess bed day tariff.

Volume Opportunity - This shows the number of bed days that have been used to calculate the financial opportunity based on the percentile value shown.

Rank - This shows the position of the trust when ranked against all trusts.

Rank	Information Shown	Productivity Opportunity	
1	Nhs england south (south west)	13.35	11,689,477.63
2	Nhs england midlands and east (east)	13.51	16,971,630.50
3	Nhs england midlands and east (north midlands)	13.91	15,090,024.63
4	Nhs england north (yorkshire and humber)	14.01	25,179,439.00
5	Nhs england north (cumbria and north east)	14.08	16,695,109.13
6	Nhs england midlands and east (central midlands)	14.08	14,605,170.00
7	Nhs england south (south central)	14.08	11,769,357.38
8	Nhs england south (south east)	14.11	18,877,978.38

9	Nhs england midlands and east (west midlands)	14.12	19,771,494.63
10	Nhs england north (cheshire and merseyside)	14.53	12,538,638.13
11	Nhs england london	14.65	36,033,547.88
11	London Area Team	14.65	36,033,547.88
12	Nhs england north (greater manchester)	14.68	14,194,771.38
13	Wessex Area Team	14.87	12,085,570.00
13	Nhs england south (wessex)	14.87	12,085,570.00
14	Nhs england north (lancashire)	15.14	6,815,108.13