shaping the health debate

THE NHS CONFEDERATION

Why we need fewer hospital beds

Summary

The NHS is doing more than ever before while the number of hospital beds has fallen by one third in the last twenty years. This briefing aims to explain why. It sets out seven scenarios in which the number of beds can be reduced:

1. When patients prefer to be treated somewhere else
2. When care is more effectively provided elsewhere
3. When technology has changed the type of treatment needed
4. When chronic disease management improves
5. When changes to emergency care reduce admissions to hospital
6. When it is safe for patients to be at a specialist hospital rather than a local one
7. When hospitals cut out the waiting around.

Introduction

Since its creation in 1948 the NHS has consistently improved the quality of care and increased the services it provides to patients. Today, more people are treated faster and more effectively than ever before. At the same time, the number of actual hospital beds in the UK has been steadily falling.

This closure of beds causes emotions to run high both publicly and politically, because people are rightly protective of their local hospitals. However, evidence from the public consultation, Your Health, Your Care, Your Say suggests that people will support difficult decisions when fully involved in the discussions leading up to them.

This briefing is calling for a more informed debate about whether beds, bricks and mortar are necessarily the right places to be putting valuable NHS cash, rather than staff, medicine, technology and other services.

The facts

The number of hospital beds has fallen in the last 20 years by 31 per cent from 211,617 in 1984 to 145,218 in 2004.

The downward trend of hospital beds is not a new phenomenon. The number of hospital beds fell by 40 per cent from around 245,000 to 145,218 between 1959 and 2004.

At the same time, hospitals have seen a 57 per cent increase in inpatients in the last 20 years from 1984 to 2004. There has been a 341 per cent increase in day cases in the last 20 years from 1984 to 2004.

Year	Acute	Geriatric	Maternity	Total
1984	138,84	55,571	17,198	211,617
1985	136,093	55,320	16,648	208,061
1986	133,067	54,588	16,166	203,821
1987/88	127,615	53,275	15,933	196,823
1988/89	123,445	51,042	15,367	189,854
1989/90	121,172	48,733	14,709	184,614
1990/91	116,788	45,902	14,170	176,860
1991/92	115,140	42,107	13,770	171,017
1992/93	112,862	40,346	13,167	166,375
1993/94	109,713	37,440	12,521	159,674
1994/95	108,008	36,795	11,971	156,774
1995/96	108,296	34,328	11,358	153,982
1996/97	108,869	31,646	11,000	151,515
1997/98	107,807	30,240	10,781	148,828
1998/99	107,729	25,495	10,398	143,622
99/00	107,218	27,862	10,203	145,283
2001/02	107,956	27,838	9,767	145,561
2002/03	108,706	27,973	9,356	146,035
2003/04	109,793	27,454	9,309	146,555
2004/05	109,505	26,619	9,095	145,218

(Department of Health official statistics)

1. When patients prefer to be treated somewhere else

Providing care away from hospitals can be more expensive and challenging, but it is sometimes the right thing to do. While politicians and sections of the media often focus on hospital beds as a measure of how well the NHS is doing, many patients prefer not to be in hospital beds if they don't need to. The recent NHS Confederation Briefing *Improving end-of-life care*[1] reported that over 50 per cent of people wish to die at home but only 20 per cent do.

Advances in treatments such as chemotherapy drugs, intravenous antibiotics or some of the new long-acting drugs for long-term conditions replace those that used to be given to patients when they were in hospital. Now a new generation of drugs, a better skilled workforce and better information technology mean that this can be done at home or in more local, community settings.

This means patients can get on with their own lives. A patient's time is not free. We should not keep them in hospitals just because this suits the way that hospitals have historically functioned. For example, in the past when lengths of stay were longer, consultants often only saw patients once or twice a week. The patients might have to wait days to be discharged even thought they were fit. New work practices increasingly mean that patients are only admitted on the day of their operation and are discharged when they are ready. This is better for the patient and more convenient for them. For vulnerable patients unnecessarily long stays in hospital run the risk of their social networks breaking down. Being treated at home also saves on individual expenses such as parking costs for friends and family. It also limits the risk of being exposed to hospital acquired infection.

Case study: Healthcare at Home Ltd

Healthcare at Home Ltd offers chemotherapy services for colo-rectal cancer patients in Yorkshire in their own homes. This service means that some patients receive their 5FU Adjuvant Chemotherapy at home, rather than having to go to hospital on five consecutive days every month for six months. Commissioned by Richmond and Hambleton Primary Care Trust, the service was formally piloted and published evidence has shown that patients prefer home treatment where possible and are highly satisfied with the service.

[1] *Improving end-of-life care.* NHS Confederation 2005. www.nhsconfed.org/publications/leading_edge/leading_edge12.asp

2. When care is more effectively provided elsewhere

Day and short-stay surgery are increasingly used for procedures that previously needed a long stay in hospital. Practitioners with special skills can undertake some procedures in the community, such as endoscopy, minor surgery and vasectomy.

In the past, some patients have been admitted to hospital purely because 24-hour care was not available in the community. Now that health and social care are increasingly planned and provided together this means that patients can stay in their own homes, for example, through night sitting services.

In addition, a good deal of rehabilitation is now undertaken in community settings or intermediate care units out of hospital, for example with stroke patients. Using staff time and skills differently means that patients can be safely sent home from hospital earlier by using early discharge teams.

Palliative care services are an excellent example of how health and voluntary sector partnerships can be used to deliver home-based packages, such as the Marie Curie home care service for cancer patients.

Other organisations such as Crossroads also provide sitting services for the frail elderly which are linked to community-based health and social care services.

Overall this means that beds are still available for patients but in a wider range of settings more appropriate to patient care. Shutting beds in a district general hospital in this case is a success as care is being provided in a more appropriate setting for the patient.

Case study: rehabilitation services in Ealing

Rehabilitation services in Ealing: a musculoskeletal triage pilot has demonstrated that up to 75 per cent of knee referrals and more than 90 per cent of lower back pain referrals can be seen within a primary care setting. Previously patients would have been referred to hospital consultants. A joint service for all Ealing patients will be implemented later in the year.

3. When technology has changed the type of treatment patients need

Treatments have changed as technology has developed. This has reduced the need for acute hospital beds in three main ways.

By developing more straightforward medical procedures which reduce demand for more complex surgery. In heart disease, the use of angioplasty (a medical procedure in which a balloon is used to open narrowed or blocked coronary arteries) has reduced the demand for more complex surgery as it helps to prevent problems earlier on in the diagnosis of heart disease.

By developing less invasive procedures which have a shorter recovery time. The introduction of keyhole surgery, new anaesthetics and other new technology have meant that patients do not need to stay as long in hospital after their operations. They only need a very short stay to recuperate.

Through advances in telemedicine. The developments in information technology mean that monitoring patients at home is now a practical alternative to keeping people in hospitals. For example, this can be used for the more effective management of heart failure in the community. Good monitoring prevents patients suddenly deteriorating and needing an emergency admission. Patients with a number of long-term conditions can have their condition monitored by specialist equipment that helps them manage their own care and give early warning to health staff that their condition is deteriorating. This allows a much earlier intervention that can avoid the need to be admitted to hospital.

4. When chronic disease management improves

Currently over 17 million people in the UK have a long-term condition such as asthma or diabetes. By working proactively to help people manage their conditions, the number needing emergency admission into hospital can be reduced. This reduction in admissions frees up acute beds.

There are several national initiatives to help achieve this. The introduction of community matrons to co-ordinate care has improved the care packages that can be delivered in the community. The Expert Patient Programme and improved patient and carer information will also help people manage their own conditions.

Case study: Kingston Primary Care Trust: chronic obstructive pulmonary disease (COPD) developing proactive management in primary care

COPD is a general term which includes the conditions chronic bronchitis and emphysema. Smoking is the cause in the vast majority of cases and over the winter months COPD is the main cause of emergency admission. In autumn 2005, Kingston GPs saw over 1,300 COPD patients to review their care, develop a self-treatment plan with information about what to do if their health got worse, and give them a prescription for emergency antibiotics and steroids to keep at home with an instruction sheet detailing when they should be taken and how to re-order.

This has reduced the number of emergency admissions by 20 per cent, saved over £370, 000 and had positive feedback from patients and staff.

5. When changes to emergency care reduce admissions to hospital

Reducing unnecessary admissions to hospital makes the service better for patients and saves resources.

Using staff skills differently in emergency services can improve the way patients are treated. There is evidence that suggests that where GPs work in accident and emergency departments, they admit fewer patients than junior doctors and are more likely to arrange community follow-up services. In general, patients prefer to be treated outside hospital; avoiding admission removes the risk of social support breaking down, for example through the removal of homecare.

The development of new practitioners will have an impact on how hospital beds are used in the future. For example, the introduction of emergency care practitioners in the ambulance service has meant that patients can be treated in their homes and appropriate support arranged, rather than simply being transported to hospital. The recently announced strategy for ambulance services is a very imaginative approach to radically changing the nature of ambulance services to allow them to deliver a much wider range of care that could reduce the journeys to hospital by up to a million per year.

Primary care trusts have had success in reducing the number of emergency admissions by introducing safe alternatives such as emergency social care and home nursing which enables people to be treated at home in the first instance.

This process is still at an early stage of development but the implication is that these changes together will lead to fewer emergency beds being needed.

Case study: Sussex Ambulance Service NHS Trust

Sussex Ambulance Service NHS Trust is currently developing new ways of working. New methods of assessment, treatment regimes and the use of emergency care and critical care practitioners, will mean that more sophisticated triage and specialised treatment can be provided to patients at the scene of the incident. This means that the ambulance service has more time to transport patients to specialist units where appropriate in order for them to receive state-of-the-art care that could not be provided at the local hospital.

6. When it is safer for patients to be at a specialist hospital rather than a local one

There is a growing body of evidence that suggests that there is a clear relationship between quality and the volume of work in a hospital i.e. the higher the number of times a certain type of procedure is performed the better the outcome is likely to be for the patient. So medicine is becoming increasingly specialised and some beds may close in local hospitals as a consequence of centralising some types of care.

In emergency aortic aneurysm surgery, some cancer surgery, neonatal intensive care and the treatment of multiple trauma, it is generally better to travel to an expert centre serving a large number of patients than be treated in units where there is less expertise.

In addition, the impact of the European Working Time Directive and changes in medical training mean that it might be more effective to centralise staff, particularly in paediatrics and obstetrics. There are solutions that mean that local people can continue to receive much of their routine and follow-up treatment close to home but for some rare and life-threatening events it may be necessary, and safer to travel.

7. When hospitals cut out the waiting around

Patients spend a lot of time in hospitals waiting for things to happen, for example, waiting for CT scans, waiting for pharmacy and waiting for consultant ward rounds. Often this stems from tasks in hospitals traditionally happening in a series rather than happening at the same time. As hospitals streamline their processes, patients can find they do not need to be in hospital for so long and so the number of bed days needed is reduced.

This can be particularly effective if hospitals and other organisations like the ambulance service work together locally to review the way patients are cared for across their organisational boundaries. This can improve services and reduce the time patients wait unnecessarily in hospital beds for treatment.

Case study: NHS Heart Improvement Programme

Recent work carried out by the NHS Heart Improvement Programme and cardiac networks in England showed that the mean wait between the first hospital admission to the time of procedure for all urgent cardiac patients fell from 11.66 to 6.40 days between April 2004 and October 2005. The data from the follow-up audit clearly suggests that service improvement techniques have the potential to reduce waste and make the transfer between services more efficient, as well as improving the quality of care provided to patients. The audit figures for all patients in the study showed that a mean total of 26,866 bed days were saved during the month-long audit period. This equates to 350,233 bed days each year or around 960 beds.

For more information visit
www.heart.nhs.uk/documents



Conclusion

The NHS is doing more than ever before while the number of hospital beds has fallen by one third in the last twenty years. What we need now is a well-informed debate which is based on evidence about what is best for patients. An obsession with bricks and mortar, as opposed to the actual treatment and service we provide, will not help us improve the NHS for patients.

This is the first of five briefings on the most controversial issues facing the NHS. The series aims to explode some of the most controversial myths that pervade the current debate on the NHS.

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The NHS Confederation brings together the full range of organisations that make up the modern NHS in the UK.

We act as an independent and powerful force in the drive for better health and healthcare. We do this by:

- influencing health policy and the wider public debate
- supporting health leaders with information-sharing, networking and tailor-made services
- promoting excellence in employment to improve the working lives of healthcare staff.

Our work is determined by our members. Our aim is to reflect the different perspectives as well as the common views of the many organisations delivering the new NHS.

Our core membership covers all types of statutory NHS organisation. Our members are the organisations themselves and these organisations are represented by individuals from board level – chief executives, chairs, non-executives and directors. We also have an affiliate membership scheme for commercial and not-for-profit organisations providing frontline services on behalf of the NHS.

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