VIEWS AND REVIEWS

ACUTE PERSPECTIVE

David Oliver: Reducing delays in hospitals

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I've written before about rising demand for acute care in the United Kingdom, insufficient capacity in community services, delayed transfers of care, and the comparatively low number and high occupancy of hospital beds.¹⁻⁴ But hospitals shouldn't default to blaming other services. Some of the major variation in bed occupancy among hospitals might be explained by what happens there—our internal processes and delays.⁵⁻⁷

Hospitals shouldn't default to blaming other services

Here are some suggestions on how we might tackle the problems, but I'm hardly alone in making them.⁷⁻⁹ They aren't all supported by robust evidence but may lend themselves to pragmatic local improvement studies in real time.¹⁰ And I don't pretend that we can afford or reliably implement them all, but we should surely try:

- Have senior decision makers at the front door, and rapid ambulatory alternatives, to get more people straight home sooner, avoiding transfer to deeper wards. Early specialty input could ensure expert management and get patients rapidly diverted to outpatients or directly admitted to a specialty ward.
- Have clinically led standards on how long inpatients should have to wait for investigations or specialist opinions, with performance monitoring.
- Plan patients' discharge from hospital and community support from day one, involving patients and families early in goals and plans, being honest with them about limitations on acute beds and reasonable lengths of stay.
- Ensure that all patients have frequent multidisciplinary and senior clinical reviews.
- Challenge your own decisions often. Ask, "Where would that patient best recover?" and "Are we doing everything to expedite transition and tackle process delays?"
- Use real time, whole hospital data to analyse external delays and to inform operational discussions with partner organisations in the community—not just to apportion blame.
- Create systems to help more people leave hospital earlier in the day and at weekends.

- Avoid ward moves, which increase the length of stay and wreck continuity.^{11 12} Aim to stream patients to the right ward first time. Aim to limit clinical teams to care for a fixed number of patients on established home wards—rather than on safari around several.
- Make sure that inpatients don't decompensate functionally or cognitively, and invest in vital early rehabilitation.¹³

Ideas such as these have been applied and evaluated by teams in several NHS hospitals using clinically led quality improvement approaches.^{14 15} Shouldn't we strive to test and implement similar approaches to improve patient flow and processes in hospital, and to reduce the delays we do control?

Developing, implementing, and evaluating solutions in a local context requires local leadership. But, if something clearly works, we shouldn't be precious about adopting the generic lessons in an acute care system under critical pressure.

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