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Cite this as: *BMJ* 2022;378:o1686
http://dx.doi.org/10.1136/bmj.o1686
Published: 07 July 2022

Saved bed days: the ultimate currency

The NHS's single minded pursuit of admission avoidance risks ignoring other important outcomes, writes Alison Leary

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Reducing hospital bed days is currently the ultimate currency in healthcare. Large amounts of money seem to increasingly be diverted from tried and tested workforces into new services, new jobs, and new technology in order to prevent patients being admitted to hospital. Some of these new ideas could work well, while others have the potential to be a catastrophe,[1] but what unites them all is a focus on a single outcome: saving bed days in the acute hospital.

In my research, I've been modelling the work of district nurses.[2] Everyone knows that we don't have enough of them, with England losing just under 50% of its district nurses between 2010 and 2017.[3] The research has thrown up some interesting incidental findings, particularly how a plethora of new community services labelled with different names have increased these nurses' workload.

I started to dig into one of the new services that appears to be creating extra work for community teams: virtual wards. In some places, virtual wards have been established for a number of years and offer a short term alternative to a hospital bed. Like many good ideas, virtual wards have been scaled up due to covid-19 using a variety of different approaches.

Looking at the often cited local work justifying the implementation of virtual wards,[4] the primary outcome they assess is mostly saved bed days. Other papers take a more considered look,[5] primarily by evaluating clinical outcomes, with a secondary outcome of saved bed days, but also by describing more comprehensive models of care. These types of services include the resourcing of community specialists and use of the multidisciplinary team. None of the papers I've reviewed look at the impact of introducing these new services on the existing workforce or their workload, particularly when new admission avoidance services draw resources from already overstretched community workforces.

Light on evidence and resources

I was contacted recently by a community nursing team who, in addition to their normal caseload of people needing nursing and end of life care in the community, were now expected to support urgent response, a discharge to assess service, virtual wards, frailty teams, and direct referrals from the ambulance service for lower category calls. They were also expected to respond to the alerts of the more recently deployed and much lauded digital monitoring in places like care homes or virtual wards, which often do not offer 24/7 provision.

Many of these initiatives seem light on detail, evidence, and resources, and more similarly motivated ideas are still being put forward. At the start of this year, for example, Sajid Javid, the then secretary of state for health and social care, announced plans to nationalise general practice with the aim of reducing the use of hospital beds but did not say how.[6] It's a common thread.

Admission avoidance is not in itself a bad thing. If people want to stay at home and the services are available in the community to offer safe care, then it seems like a win-win. The question is, is good quality care still possible in the community if the infrastructure to provide it is not there? Anecdotally, the provision of services often seems patchy at best. We have seen through our modelling work[2] how new services where the needs of patients are poorly understood can increase workloads for existing workers and have unintended consequences in terms of risk,[7] for example, by spreading an already stretched workforce even more thinly, leaving important clinical work undone.

Fast solutions

The scaling up of virtual wards is not the first time a new innovation has been launched on the NHS without a workforce impact assessment being carried out. Indeed, neglecting to do one seems to be the norm in health and social care. Unremitting demand for hospital care inevitably makes people look for fast solutions and it's hard to remember a time when the NHS has been under more strain. A workforce crisis, austerity, and the covid-19 pandemic have not been kind to the NHS or social care, with healthcare workers under extreme pressure. However, adding to their workload by starting up partially resourced services without fully understanding their impact or purpose is likely to only add to that burden, potentially pushing staff to leave.

A workforce model that values volume of provision over managing complexity or, rather, most hands for least money, has seen frontline expertise leak from the system as healthcare professionals become dissatisfied with their work. As a researcher, I have undertaken numerous evaluations of projects or services where the desired outcome was admission avoidance—and, to a lesser extent, safety, quality, or a satisfied workforce. In the NHS, success is measured by the efficient use of resources, instead of patient outcomes or staff experience.[8] It's the result of classical general management thinking, which was introduced in the 1980s along with the internal market to make healthcare more competitive and increase efficiency. While other sectors have cottoned onto its limitations, such as the lack of humanistic workforce planning and a focus on process instead

of outcomes, those who make decisions about healthcare policy have yet to shift their thinking.

Health and social care need to modernise and to become more humanistic in both their policies and approach to the workforce. Implementing large scale change without considering how it may affect the working practices of staff or their workloads is not feasible if we want to improve retention. The NHS needs a workforce who are equipped to recover from the pandemic and respond to the challenges of caring for a 21st century population, not more management thinking from the 1980s.

Competing interests: I have read and understood BMJ policy on declaration of interests and declare the following interests: none.

Provenance and peer review: not commissioned, not peer reviewed.

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