RQIA Unscheduled Care Review

Regional Stakeholder Summit

19 May 2014

The Regulation and Quality Improvement Authority

Background to the review

- On 8 January 2014, a major incident was declared at RVH due to the number of people waiting in the ED department
- On 17 February 2014, RQIA was commissioned by the Minister to review the arrangements for the management and coordination of unscheduled care in the Belfast Health and Social Care Trust and across the wider HSC
- Fieldwork for the review has been taking place from March to May 2014
- RQIA to report to the Minister by 15 June 2014

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Members of Review Team

Dr David Stewart (Chair)	Director of Reviews, RQIA
Professor George Crooks	Medical Director, NHS 24, Scotland
Dr Alistair Douglas	President, Society for Acute Medicine
Kathy Fodey	Director of Regulation, RQIA
Paul Harriman	Asst. Director Service Improvement, Sheffield Teaching Hospital
Dr Taj Hassan	Vice President, College of Emergency Medicine
Niall McSperrin	Lay reviewer
Mary Monnington	Independent Nurse Advisor
Dr Elizabeth Myers	Nurse Consultant, Acute Medicine
Professor Bill Reid	Postgraduate Dean, SE Scotland
Patricia Snell	Dep. Director Quality Improvement and Patient Safety: Guy's and St. Thomas'

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Regional Terms of Reference

- “To consider the operation of the Belfast Trust Emergency Departments in the regional context, in order to assess current practice in unscheduled care services and to identify how existing best practice might be applied through learning across the region.”

- “To review the effectiveness of the arrangements in place for the regional coordination of unscheduled and emergency care, including primary care and ambulance services regionally and arrangements for regional escalation when required. This will include consideration of the effectiveness of planning for periods of increased demand.”

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Approach to the review

- Goal is to promote ***Learning and Improvement***
- Methods:
  - Collect and analyse data
  - Organisational questionnaires
  - Visits and meetings
  - Workshops and summits
  - Sharing and testing ideas and approaches
- A major focus is on ***Understanding and Improving Patient Flows***

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Aims for today

- To learn about a major project designed to test approaches to improve flows
- To share experience from recent initiatives across Northern Ireland designed to improve flows, and thus enhance patient safety and patient experience
- To consider some emerging challenges
- To help inform the recommendations for the review

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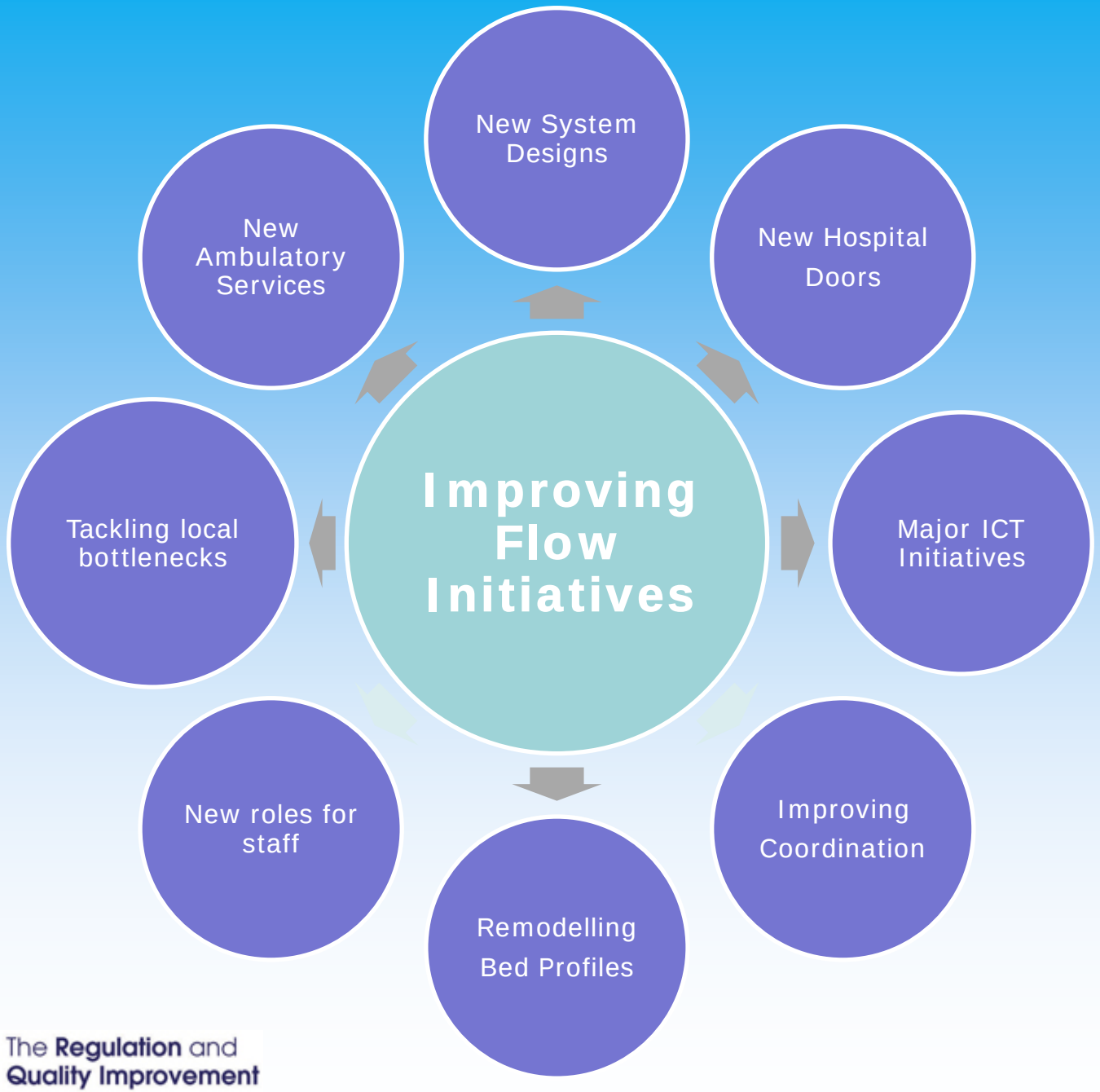

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Pre- lunch exercise
Where are the main bottlenecks?

- Consider a hospital you know well
- Consider the journey of an older person, living in a nursing home, with an acute exacerbation of a chronic illness, who is brought to the hospital
- Where do you think will be the single most significant bottleneck for that patient's journey?
- Place an X on the flow diagram at that position and indicate the hospital(s)
- Remember you are only allowed one X!

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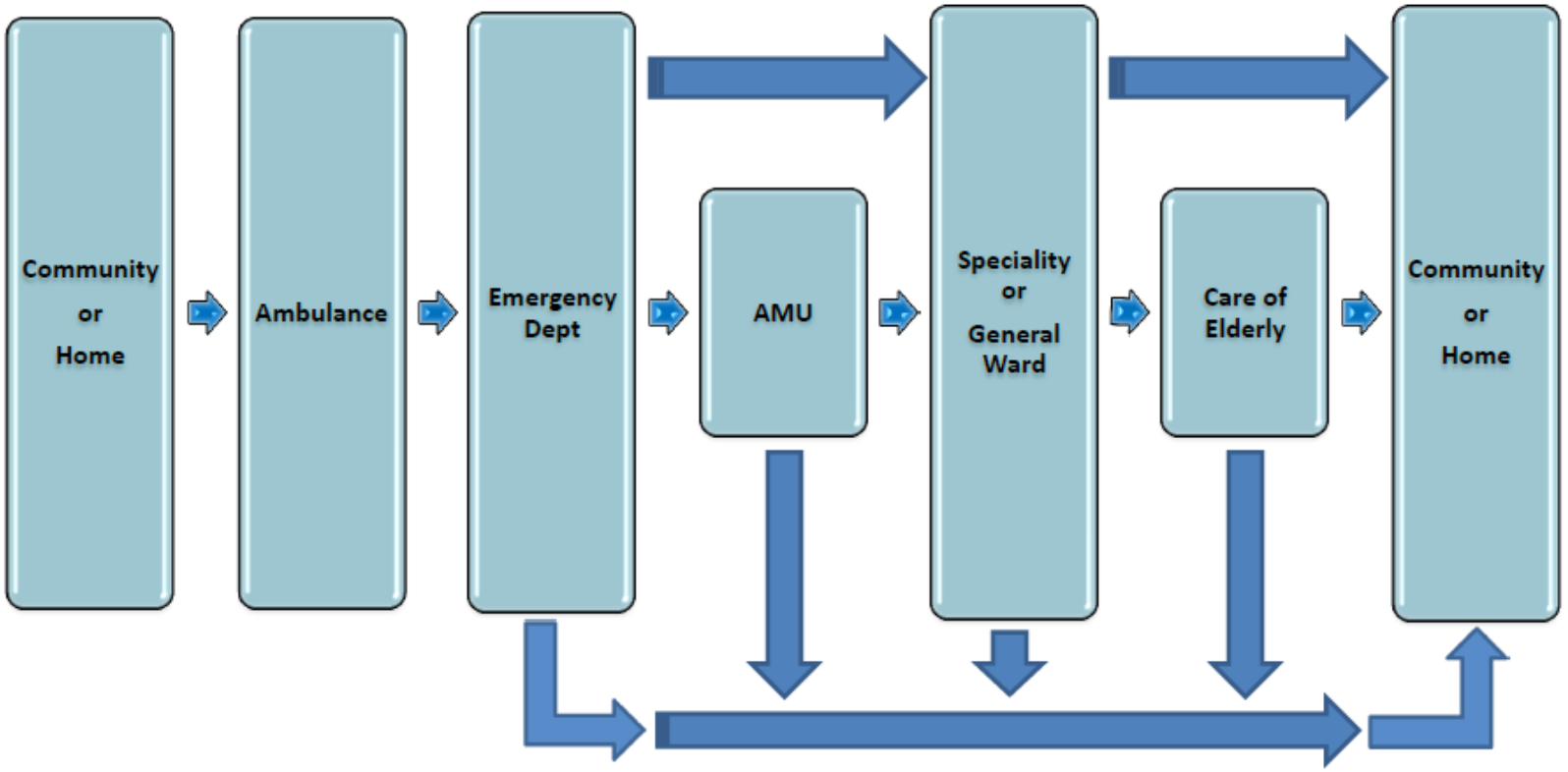
Hospital



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RQIA Unscheduled Care Review

Feedback session

Emerging challenges and possible recommendations

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Possible Success Factors
Everyone understands how system works and their role
Escalation and Contingency plans in place and acted on
Robust Discharge processes
Relevant information is acted on
Innovative models are tested and implemented
Consistency of approach to flows
Sufficient staff in critical areas
Clear System Vision and Design
System is stable
System is well integrated
Balance between flows and capacity
Different patient flow streams are understood and addressed
Clear leadership and responsibility for Flow
Agreed rules are implemented

Each hospital is different with a unique mix of challenges

- Catchment geographies
- Demographic patterns
- Socio-economic patterns
- Disease patterns of patients in catchments
- Sizes and shapes of hospital
- Specialties provided
- Degree of integration with community services
- Staff recruitment and retention

Leading to differences in Flow patterns and possibly different Bottlenecks?

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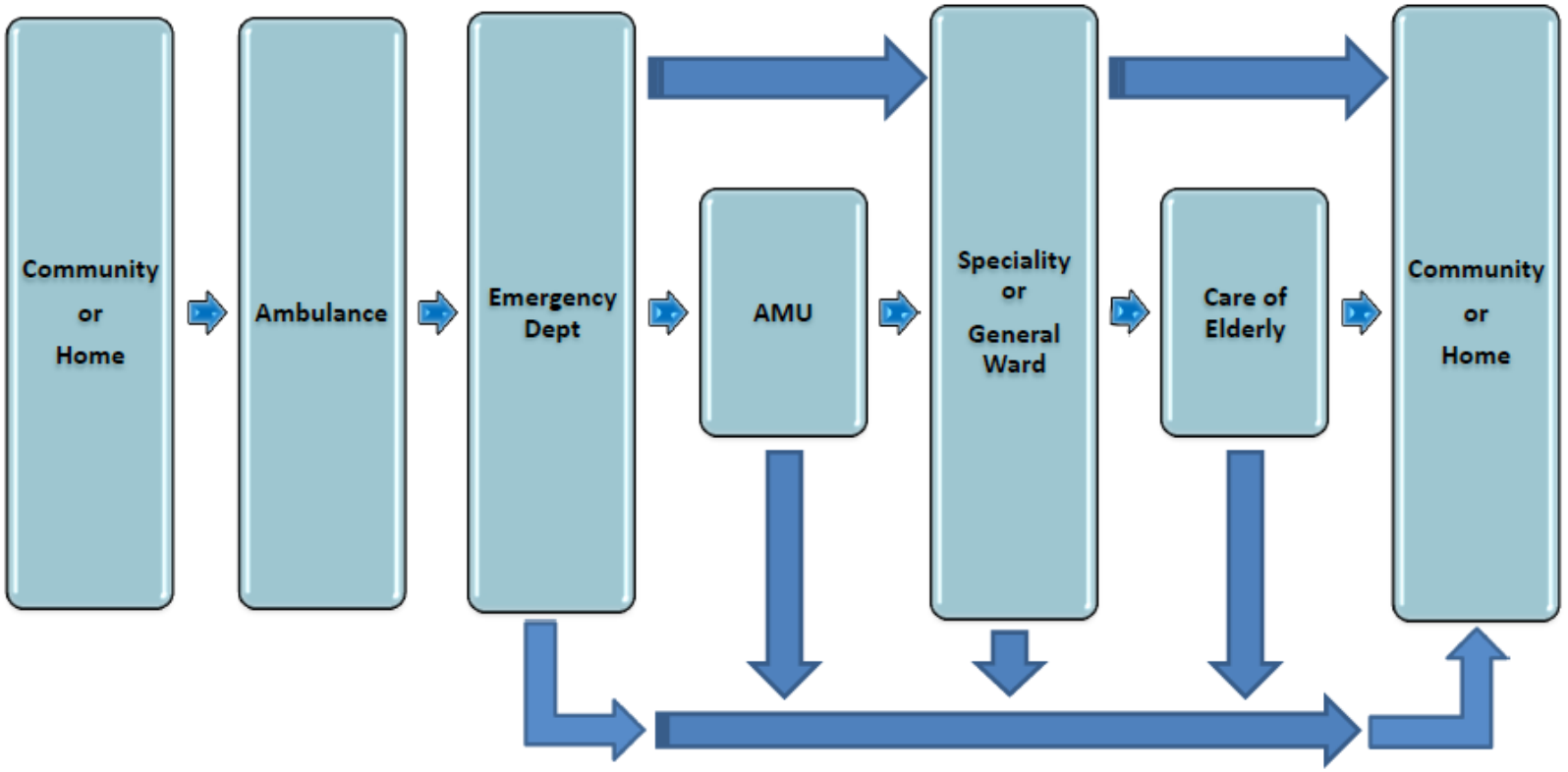
Hospital



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Generic Flow Challenges
1. Emergency or Urgent?

- Throughout the patient journey, Emergencies are prioritised over Urgent patients
  - Nursing homes call 999 or GP
  - GP call 999 or GP Urgent to NIAS
  - NIAS prioritise by emergency category
  - ED triage prioritise by emergency category
  - Admission for specific emergencies and direct specialist service are prioritised
  - Emergency patients prioritised when in hospital
- Impacts
  - Rapid access to care for emergency cases
  - Slower access and flow for urgent patients

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Generic Flow Challenges
2. Timing of flows

- People told us:
  - Patients are arriving at hospitals late afternoon
  - Ambulances are arriving in “batches”
  - Transfers in and between hospitals late in pm
  - Discharges are delayed to later in day
  - Very short windows for patients flows
- Impacts:
  - Unnecessary overnight stays
  - Late transfers of patients
  - Services working later in evening and harder to staff
  - Lack of available transport at key times

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Generic Flow Challenges
3. Changing models of Assessment

- New models are emerging, designed to provide rapid access to specialist assessment
  - Community and ambulatory assessment services
  - Specialist assessment and admission units
  - Specialty assessment teams to EDs/AMUs
- Impacts
  - System flows are becoming increasingly complex
  - Changes in the number of steps in patient journey flows both up and down
  - Significant changes in case mix in hospital wards
  - Challenges in providing the staff needed for 7 day cover
  - Roles of generalists and specialists in period of change
  - Need to ensure patients arrive at the “Right Door”

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Generic Flow Challenges
4. Coordination of flows

- People told us:
  - Coordination of flows to, in, between and out of hospitals now critical to success
  - Real time information is vital to function
  - There are challenges at boundaries, within and between services, in maintaining flows
  - Lack of systems for cooperation across region and clarity of roles when there are major periods of demand
- Impacts
  - System response challenges during peak periods of pressure impacting on more than one organisation
  - Improvements in coordination are leading to improvements in flows

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Generic Flow Challenges
5. Impacts on other key functions

- Changing Unscheduled care flows are impacting on the ***What, Who, How, Where & When*** of service delivery
- Changing requirements for other key functions including Diagnostics, HR and Training
- Impacts:
  - Challenges in matching diagnostic services to demands at key steps in the patient journey
  - Challenges in ensuring the right staff are available at the right time in the right place
  - May be very different training roles and experience in different units, depending on local service models

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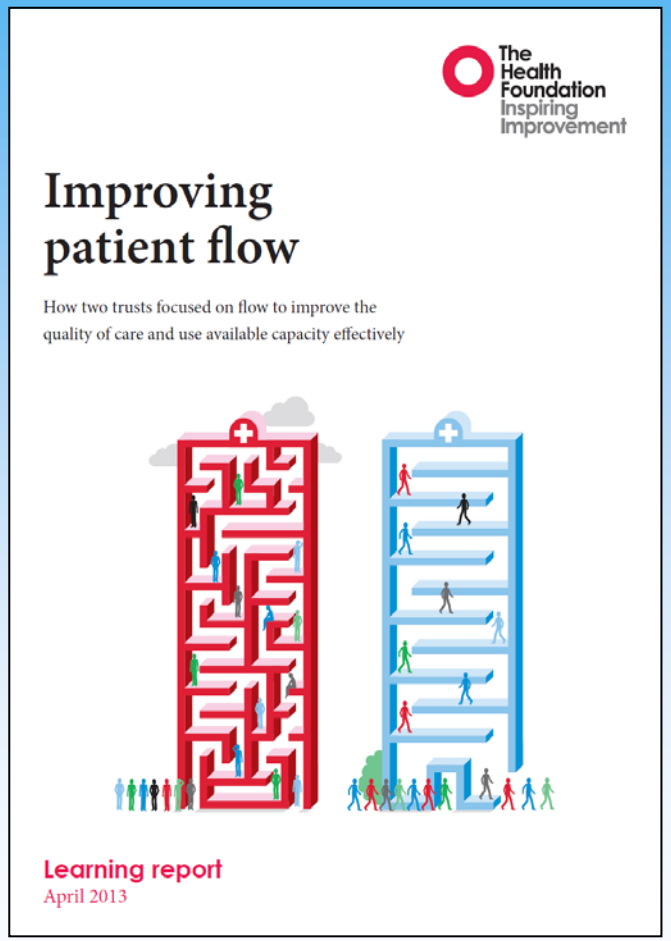
Learning from "Improving Patient Flow"



- Key Learning Points
  - Working on flows is crucial
  - Measurement and analysis is key
  - Involve stakeholders 'up and down stream" to identify problems
  - Use a combination of changes

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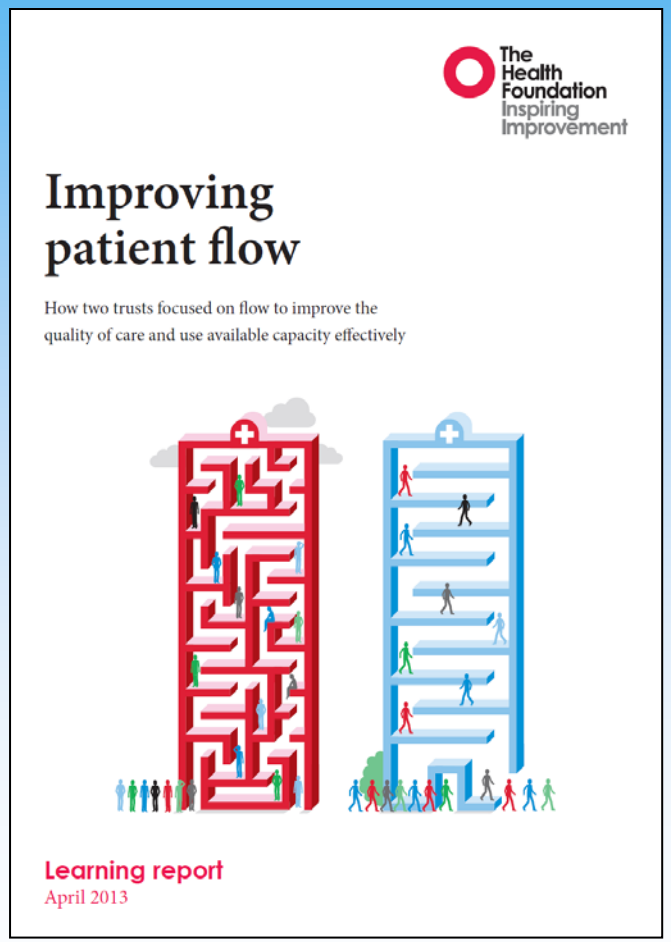
Wider implications of reorganising services to optimise flow



- Change thinking about how organisations work
- Understanding overall impact on cost
- Apply the ‘flow lens’ to all aspects of an organisation
- Managing complex change
- Generating the will for change
- Building capability
- Context and culture
- Achieving impact takes time
- Taking a system approach for executive leaders

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Possible regional recommendations from the RQIA Unscheduled Care Review

- Regional lead and organisational task group to tackle generic system issues including
  - Ensuring patients arrive as early as possible
  - Reviewing regional coordination and escalation
  - Enhancing training and service coordination
  - Ensuring approaches in place on key staffing issues
  - Agreeing information exchange arrangements
- Establish a collaborative approach to building capacity across organisations in flow management
  - Building skills in analysis and management of flows
  - Sharing learning on local and national initiatives

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Next steps

- On-going work with Belfast Trust teams to inform the report of the review
- College of Emergency Medicine Follow Up regional workshop June 2014
- Review report being prepared over next 2 weeks
- Report to be with Minister by 15 June
  - Some immediate steps to prepare for next winter
  - Emphasise need for longer term sustained programme of action on flow to and within hospitals as part of taking forward both ***Quality 2020*** and ***Transforming Your Care***

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Presentation for RQIA Regional Stakeholder Summit

Belfast Health and Social Care Trust

19 May 14

Presentation

- Programme Treatment Unit (PTU) – Dr Johnny Cash
- Emergency Surgical Unit (EmSU) – Caroline Leonard
- Older People's Timely, Interventional and Management Service (OPTIMAL7) – Dr Paul Turkington

Programmed Treatment Unit

BHSCT

2010-present

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The Challenge

- Perfectly justified patient complaint
- Outdated and unsafe service
  - No protocol
  - No governance

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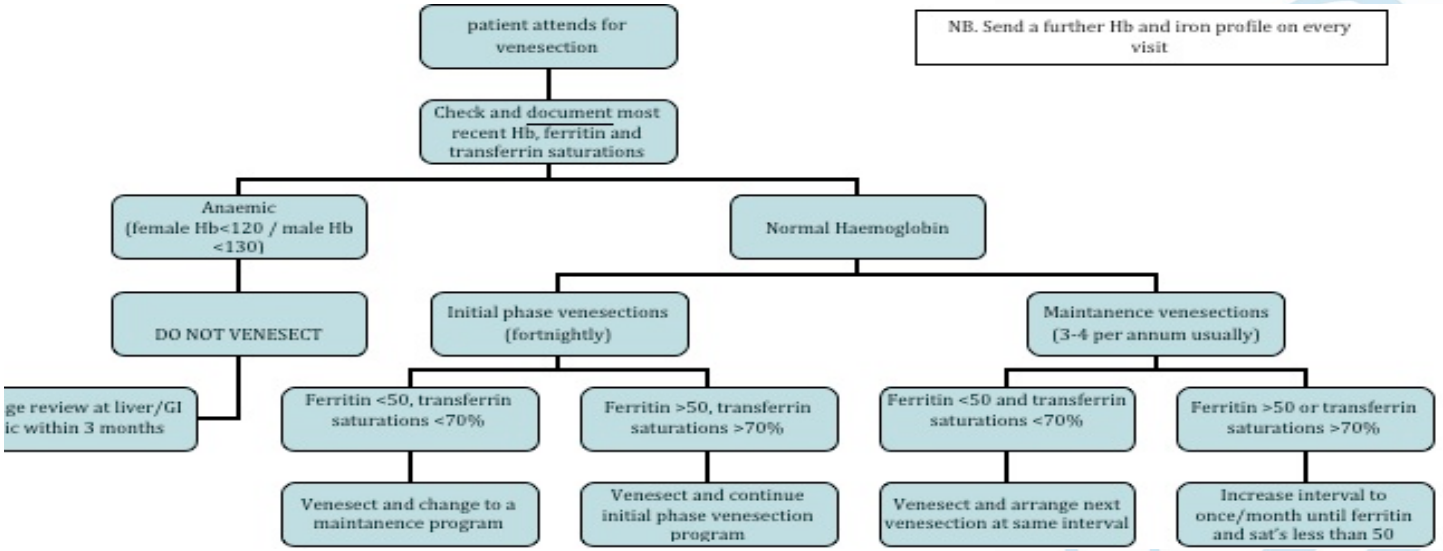
Small beginnings

- 2 chairs
- 1 bank nurse – dedicated training
- Protocol for safety



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Winning hearts and Minds

- Liver transplantation assessments added
  - 1 patient per week
  - Negotiated dedicated slots for tests
  - Now 40+ per annum = 280+ bed days saved

Feb –Aug 2009: 31 patients – mean LOS 11.55 days

Feb – Aug 2012: 33 patients – mean LOS 0.25 days

PTU users group and governance

Operational Policy

Programmed Treatment Unit

Acute Services

Royal Victoria Hospital

Programmed Treatment Unit

Service Application Form

Applicant details: name
Contact number
Email address
Service group
Specialty

Is the applicant the individual accepting clinical responsibility for patients whilst in PTU ☐

Title of service to be delivered:

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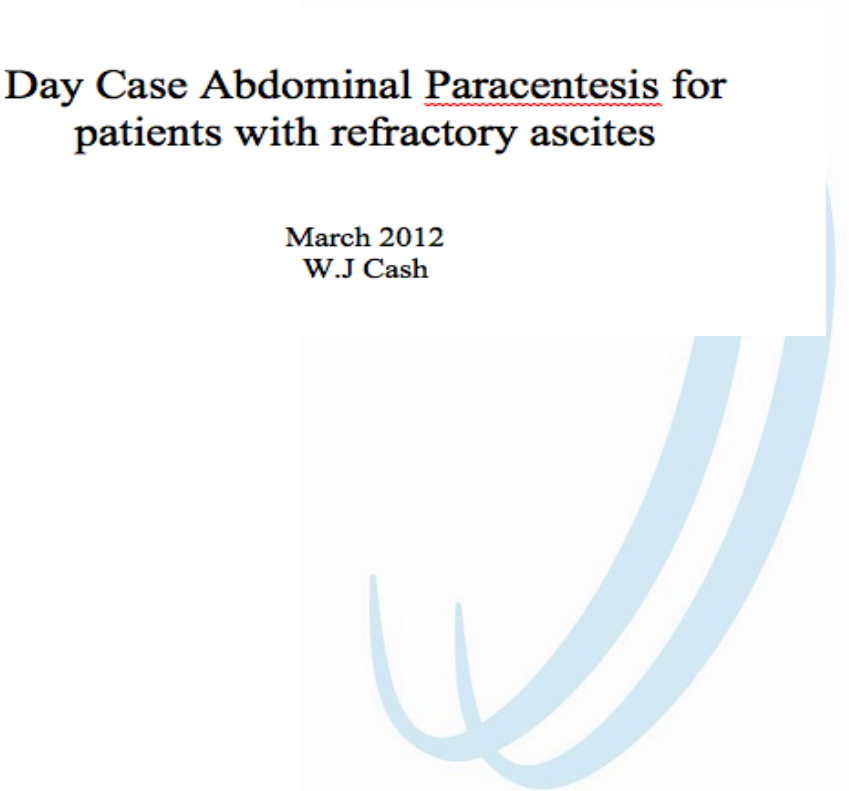
Unit Growth

- 2 beds added
- Day case Paracentesis added with protocol adapted from Hammersmith
- Procedures and interventions requiring short admissions to hospital targeted



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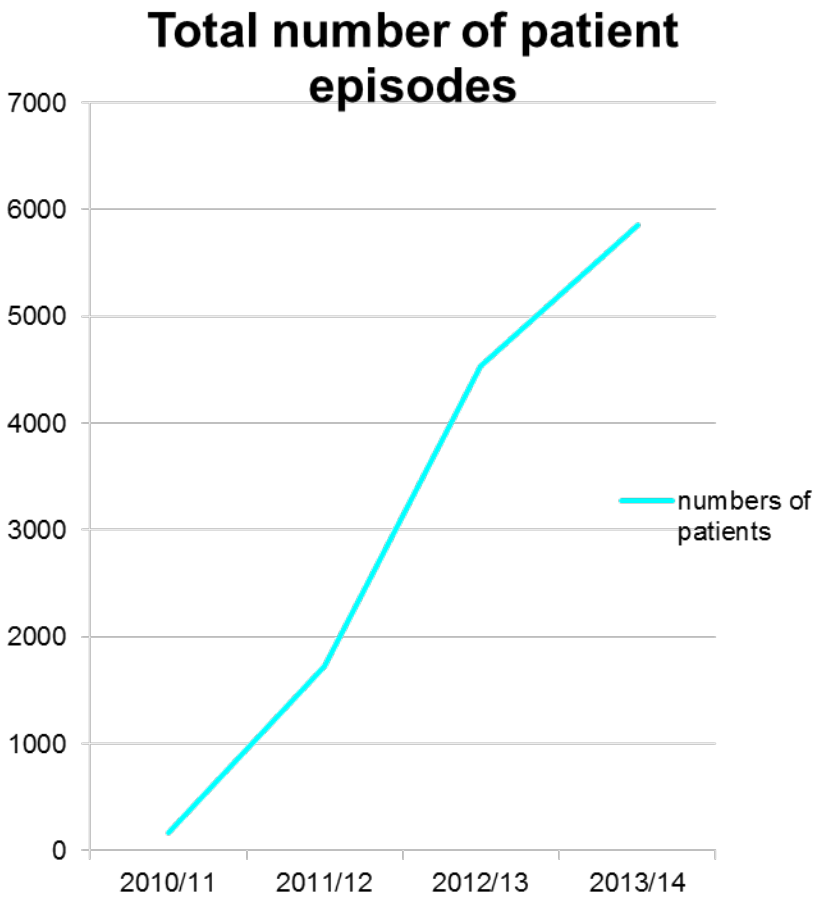
Challenges of a Nomadic existence

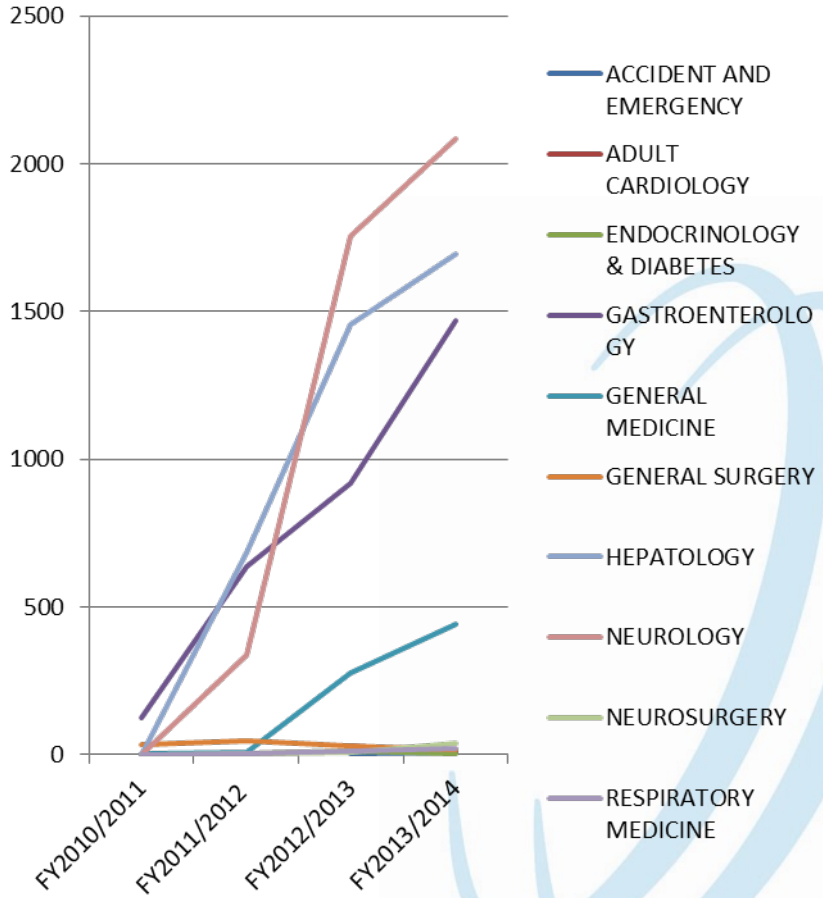
- Several moves required to ensure growth
  - Appointment of a charge nurse and nursing team

- Ultimately housed in current location
  - Full refurbishment of derelict area
    - Estates
    - Pharmacy regulations
    - Infection control

  - Acquisition of furniture computers etc
  - budget for consumables?
  - designated clerical staff
  - designated cleaning staff
  - designated portering service

Patient episodes continues to grow





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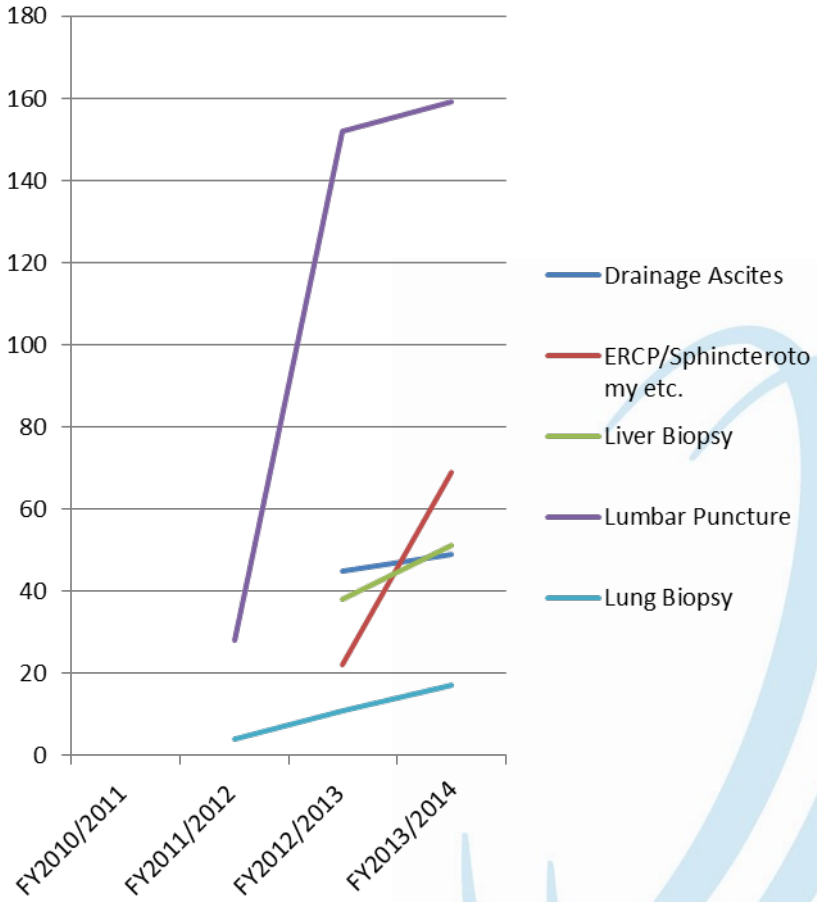
Range and growth of services

- Liver transplant assessments
- paracentesis
- infusions
- venesections
- diagnostic tests
- lumbar puncture
- ERCP
- Liver biopsy
- PEG attenuation
- Lung biopsies
- Transfusions

NB Interface with primary care



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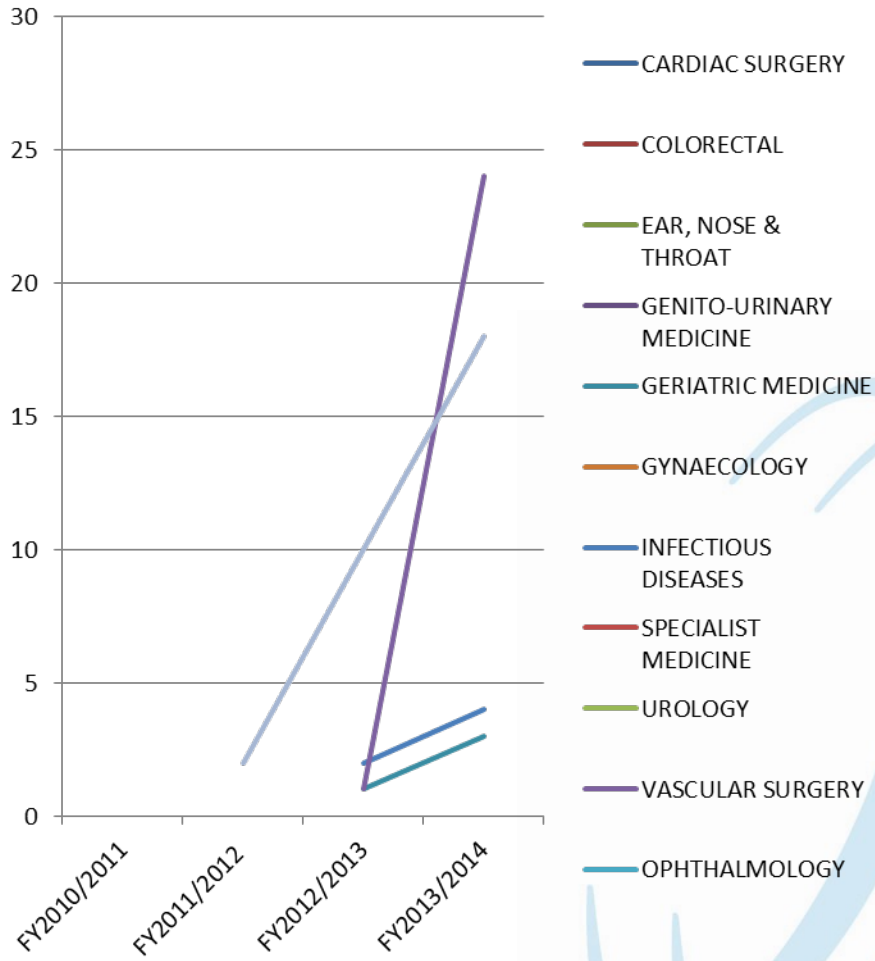
Range and Growth of services

New and growing users



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Safety and Quality

- PTU users group
- Active audit program
- E.g. Venesection audit

  2007

  - 72% patients met national targets (published in journal hepatology)

  2011/12

  - 100% patients met same targets (to be presented as abstract at ISG June 2014)

The Future?

- pathways with primary care to diminish ED attendances
  - Now providing blood transfusions for primary care
- Pathways with ED to reduce admission rates
- Continued engagement with clinical teams to reduce unnecessary admissions and reduce length of stay
  - Ambulatory workshops etc

SAFETY SAFETY SAFETY

Thank you

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Reshaping Emergency General Surgery

Caroline Leonard
Co-Director Surgery & Specialist Services

Belfast Health and Social Care Trust

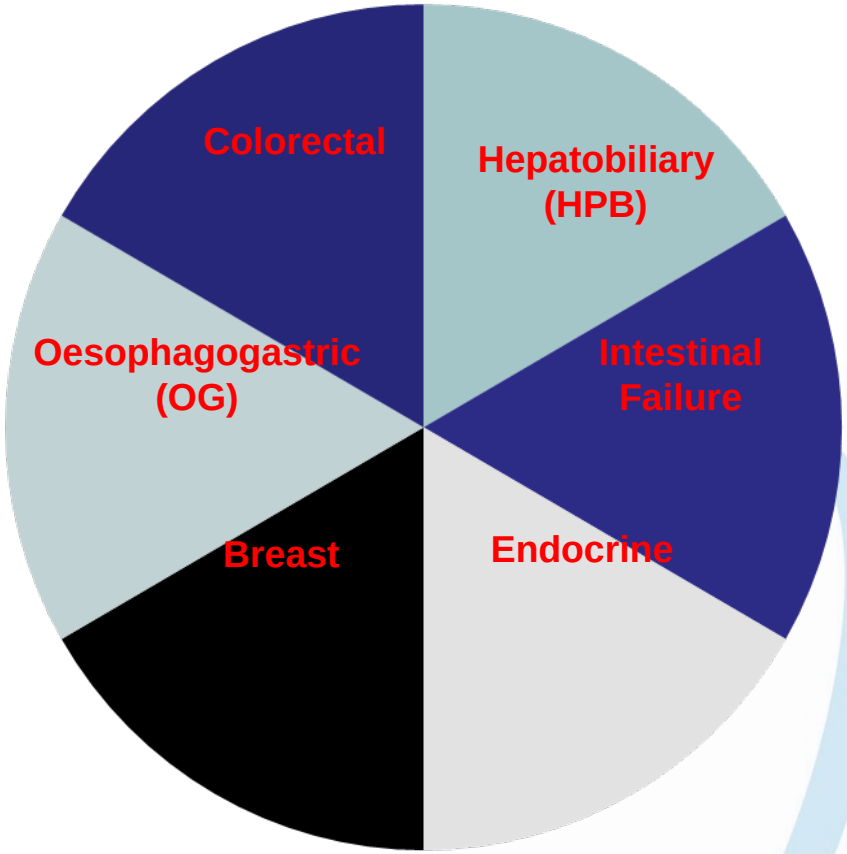
BHSCT General Surgery - Context

19 General Surgeons, 148 beds

3 hospitals (BCH, Mater & RVH)

8,498 FCEs)
4,457 Theatre Visits

Budget £18 million



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Drivers for change

Quality / Patient Risk

- ***"Those requiring emergency surgical assessment or treatment are among the sickest patients in the NHS. Often elderly, frail and with significant co-morbidities, the risk of death or serious complication is unacceptably high."***

  Royal College of Surgeons 2011

- ***"There is too often a dependency on doctors in training to provide service; they may be exposed to circumstances beyond their capability; the necessary senior clinical leadership and wisdom is absent at times when it is most needed and could be most effective. The service is at its most fragile overnight and at weekends."***

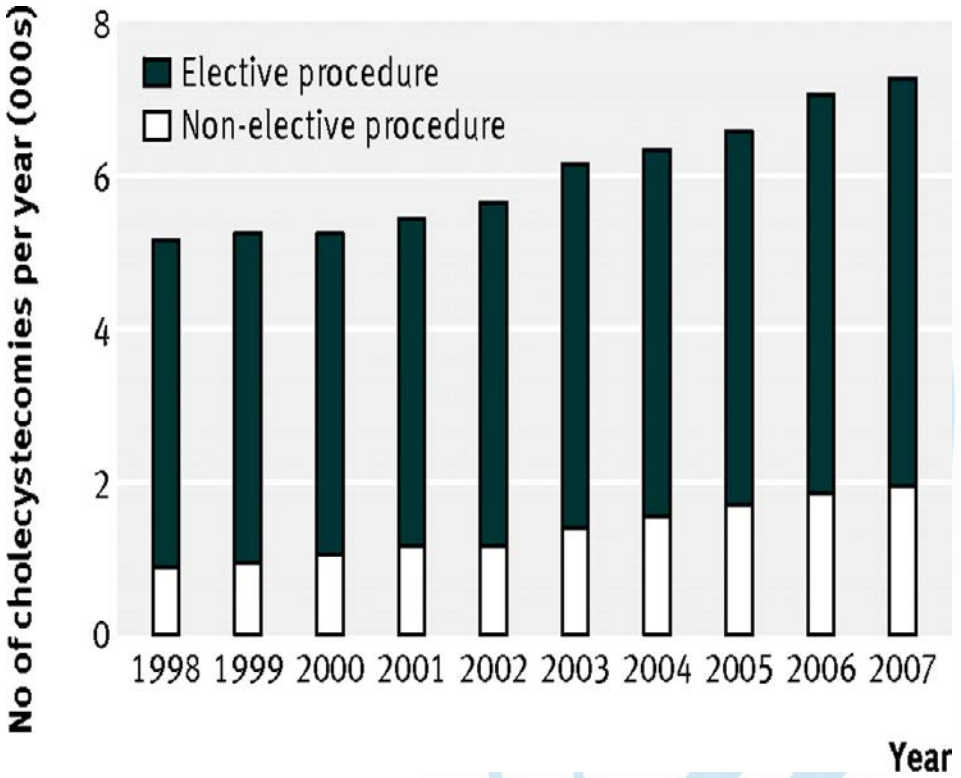
  Royal College of Surgeons 2011

- **Surgeons believe that dedicated operating theatre time for emergency cases; better care for high risk patients before and after surgery; and greater availability of consultants in a dedicated Assessment Unit would save lives and shorten hospital stays for emergency patients**

Drivers for change

Access to theatre, elective cancellations and multiple ED readmissions

- Less than 5% operated on first index admission
  700 acute abdominal pain (colic and cholecystitis)
  300 acute appendicitis
- Surgery often performed after hours
  (an increased variation in outcomes such as LoS, re-admission and mortality rates)
- Uncertainty and stress for patients awaiting surgery - often with multiple readmissions whilst awaiting definitive treatment
- Poor 4 hour ED Performance (20% of attendances require surgical opinion = 29,000 PA)
- NIAS Patient transfers between sites both in and out of hours (20/30 per day)



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Drivers for change

Separation of emergency and elective surgery

- Emergencies compete with elective patients
- Upset of elective cancellations to individuals and cost
- Dedicated beds, theatres and staff for either elective or emergency surgery can reduce cancellations and delays, achieve more predictable levels of work, and provide supervised training opportunities

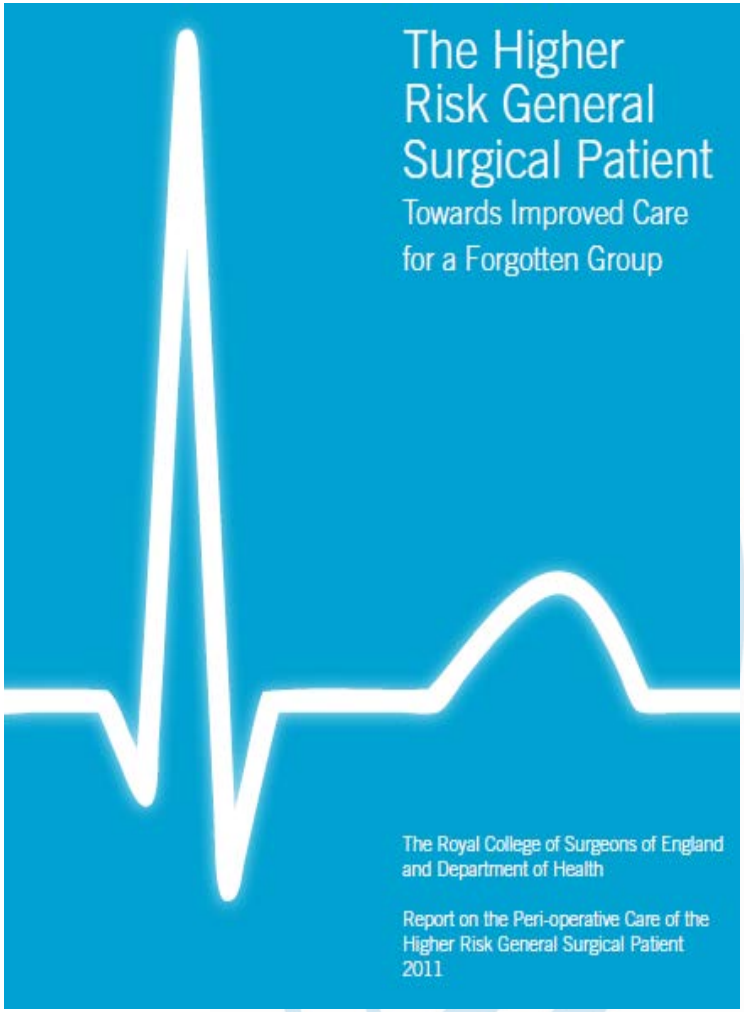
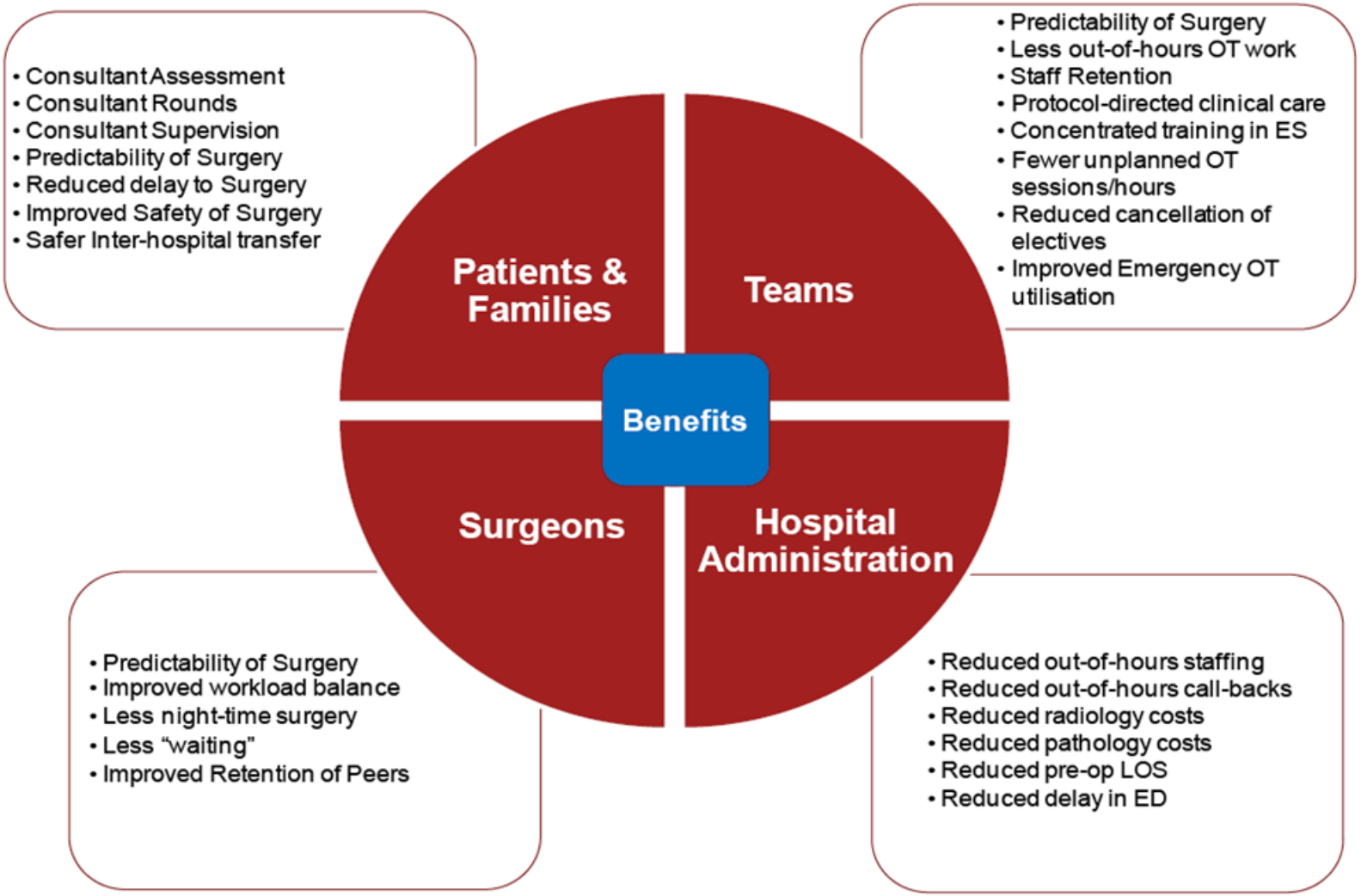


Figure 1 Benefits of Emergency Surgery Redesign



Emergency Surgery standards

- National recommendations state that **consultants** should be available on site for emergency admissions.
- Best practice recommendations state that emergency admissions should be seen by a consultant within **12 hours**.
- On-take consultants should have **no other planned commitments** when they are responsible for emergency admissions.
- Best practice is for **twice daily ward rounds** to take place, **seven days a week**

Emergency Surgery Redesign : KPIs

- Timeliness of surgery and better access to theatres
- Surgery on first admission
- Better access to consultant care
- Better monitoring of emergency patients
- Timely Discharge
- Reduced Inpatient length of stay
- Fewer elective cancellations
- Fewer operations out of hours
- Fewer transfers between sites
- Cost reduction

General Surgery - Redesign

Aim : An Elective/Emergency Spilt

- To use the consultant of the week model to establish the EmSU at RVH for rapid assessment & treatment of general surgery non-elective admissions
- To develop **Specialist Elective Units** for colorectal/IF surgery and oesophagogastric surgery in BCH
- To develop a specialist unit for the delivery of day case/23 hour stay in the Mater Hospital

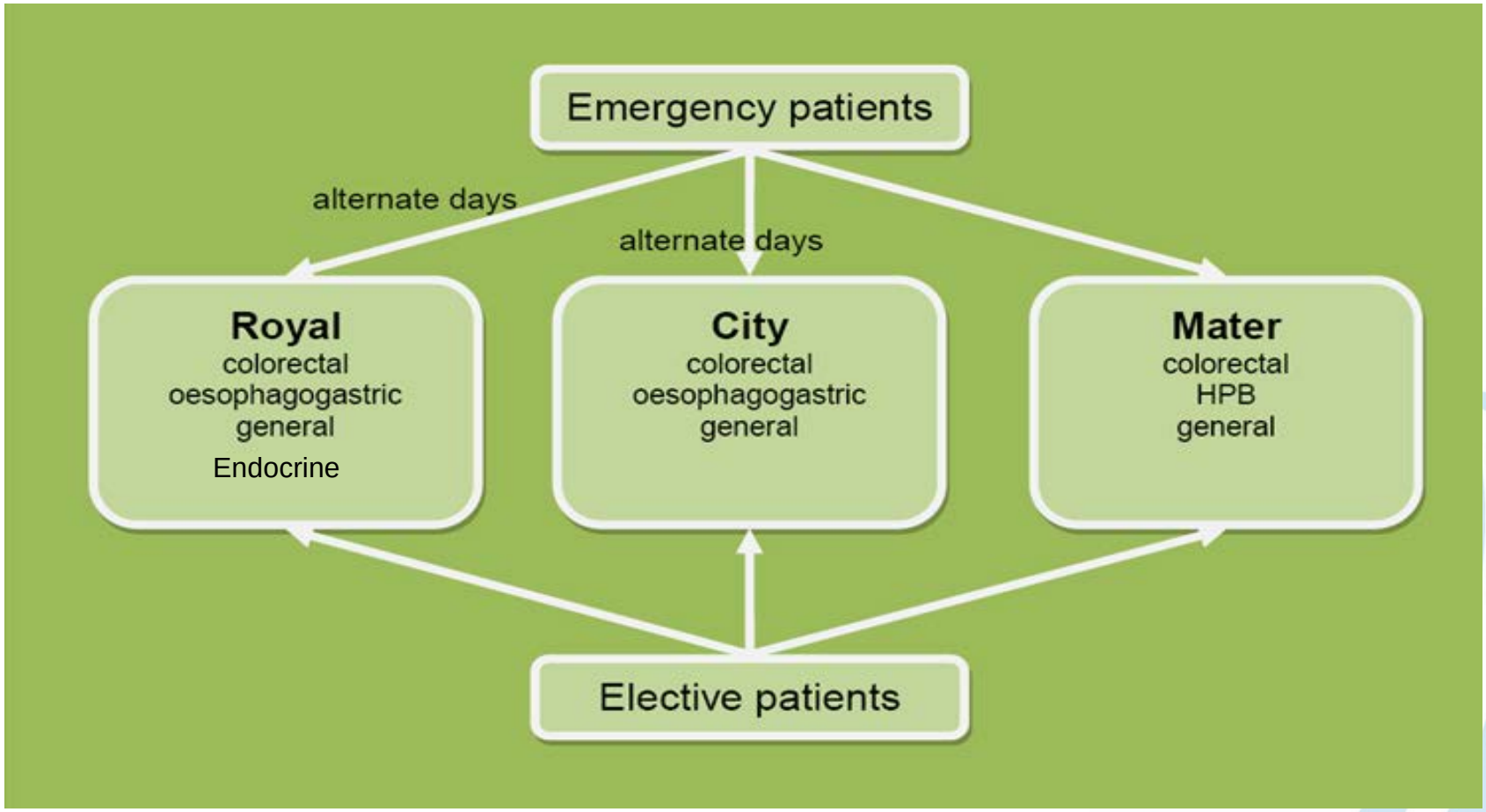
Phase 1: June 2013

- Cessation of alternative RVH/BCH Gen Surgical take
- A dedicated environment for the assessment & management of the BCH/RVH gen surgery take-in at RVH (EmSU)
- All OG cancers treated on BCH site by a team of four dedicated surgeons

Phase 2: October 2013

- Cessation of MIH Gen Surgical take
- MIH ED transfers to EmSU
- All elective Colorectal and IF surgery transferred to BCH site

Flow of surgical patients in previous system



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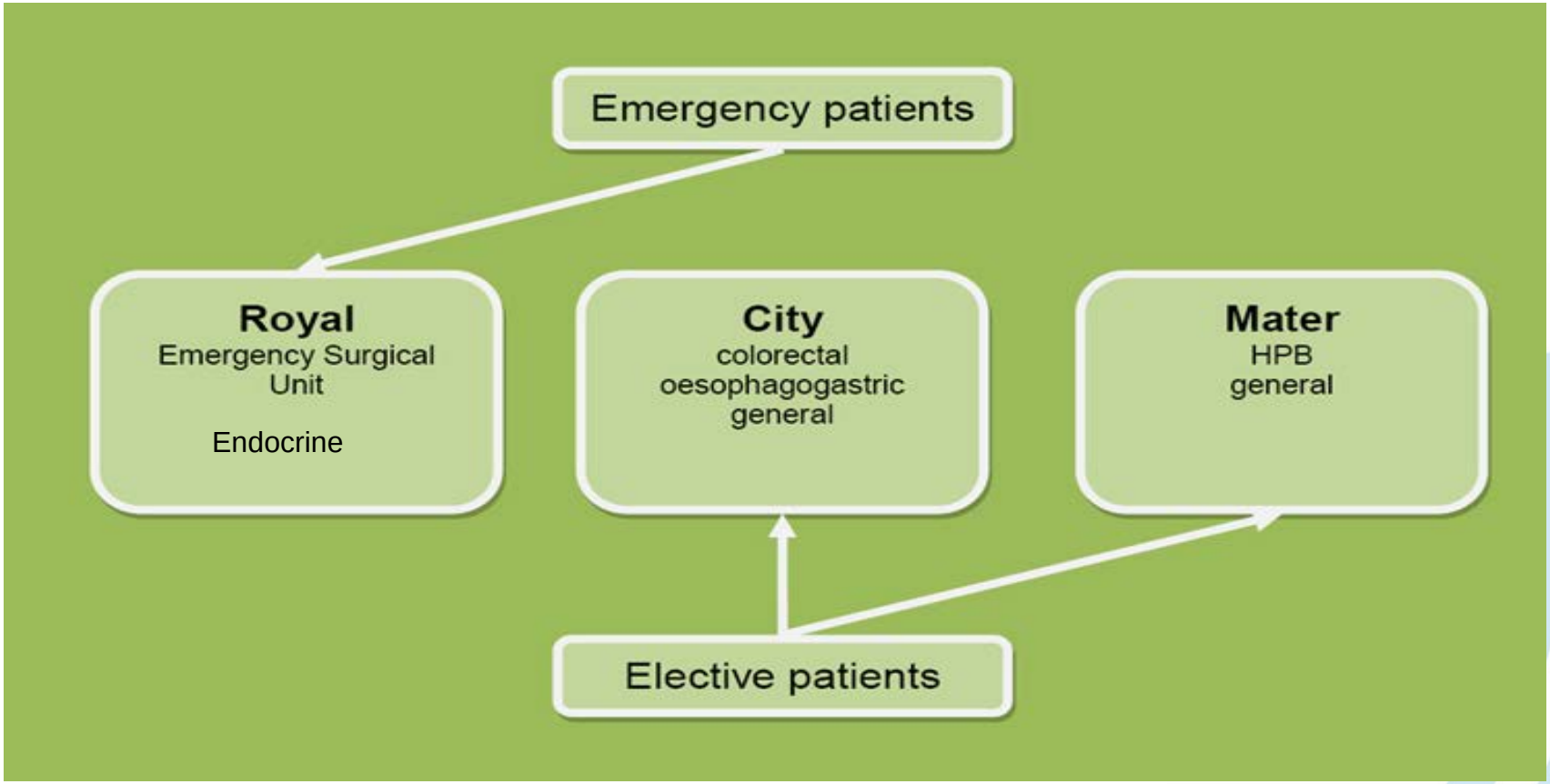
Flow of surgical patients in the new model



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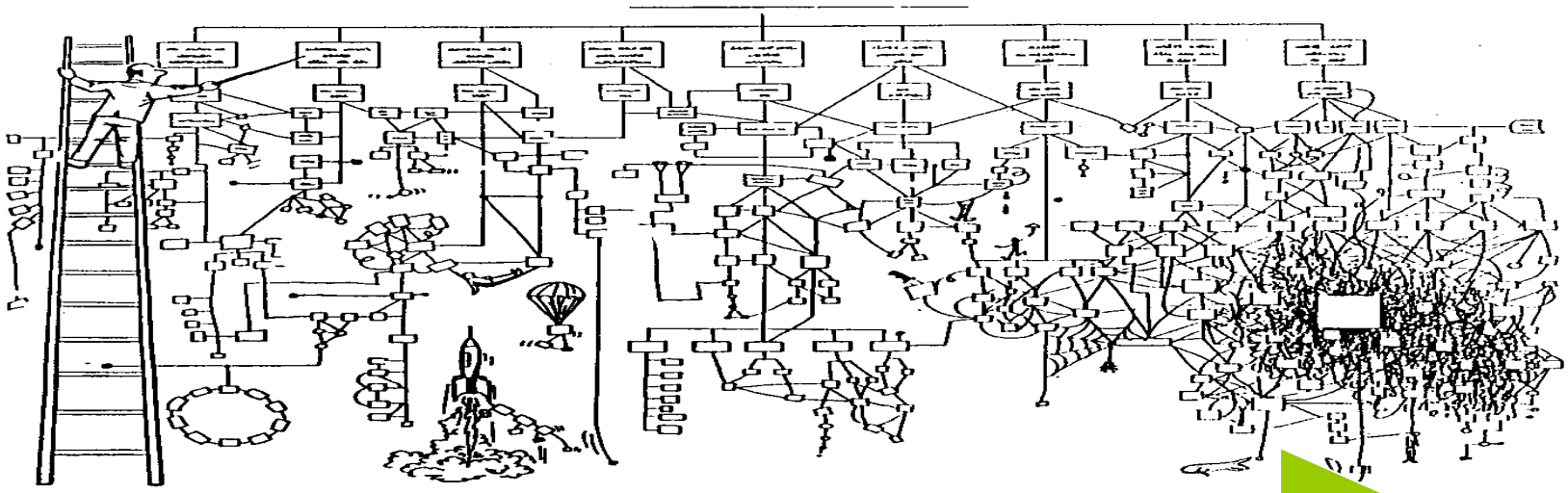
Emergency Surgical Unit (EmSU)

- 56 beds (47 inpatients, 9 assessment)
- Managed by two consultants of the week continuously.
- 20 hrs allocated to urgent bookable/emergency theatre sessions (5 x CEPOD lists per week) plus 24/7 emergency theatre access
- Out of hours cover 1 in 7 UGI surgeon rota [OG and HPB] & 1 in 7 Colorectal surgeon rota covering the Trust.
- Assessment area: one port of entry, focused assessment, treatment plan initiated.
- Focus on optimising the Patient Journey, Care Pathways and new ways of working.

Patient & staff input to improve systems and processes



Patient Pathway

Acute cholecystitis, Obstruction of the colon, Upper GI bleeding, Chronic Pancreatitis, Surviving Sepsis, Pain linked to potential Gallstones, Mechanical Bowel Obstruction and Diverticulitis

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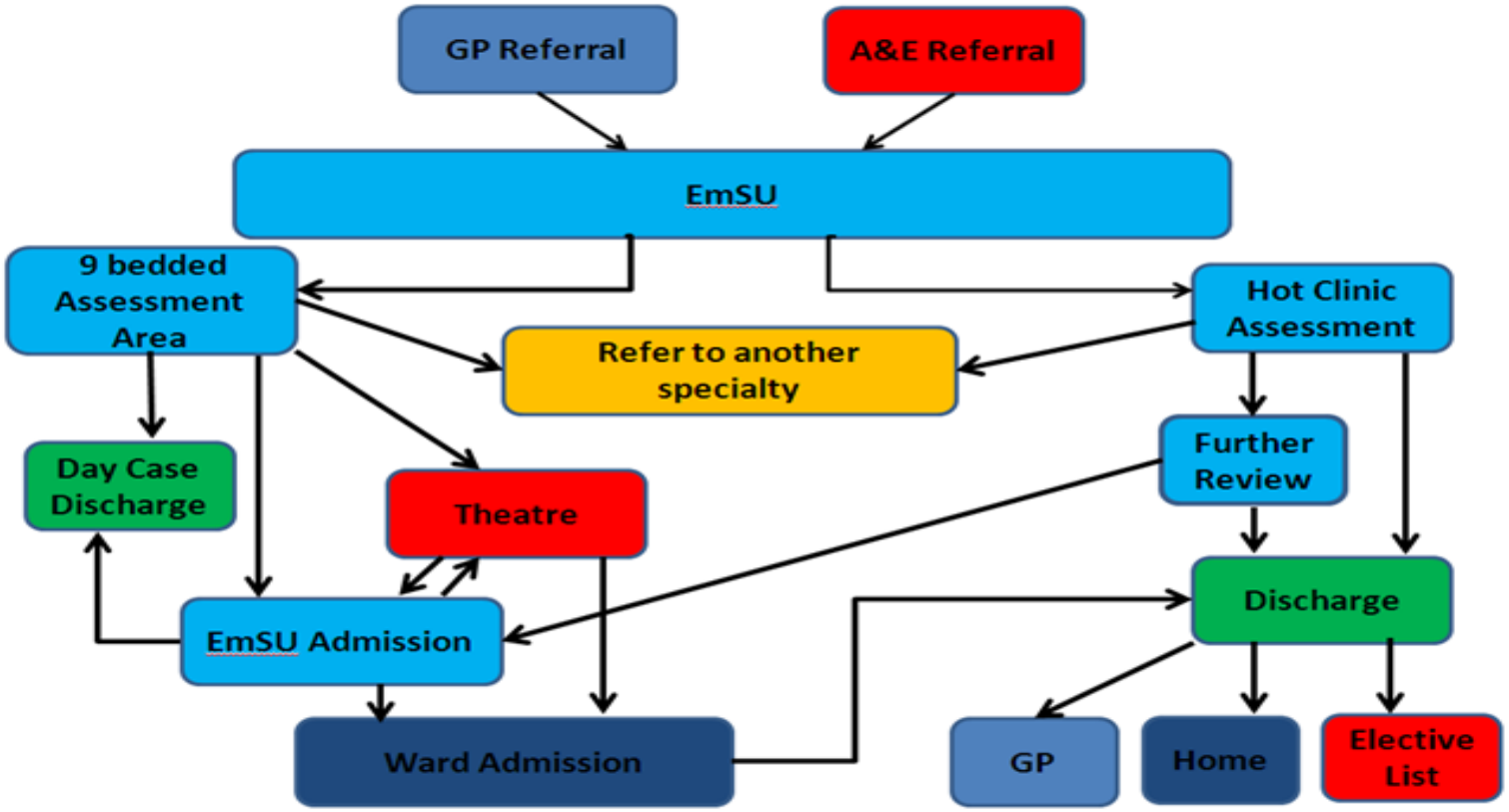
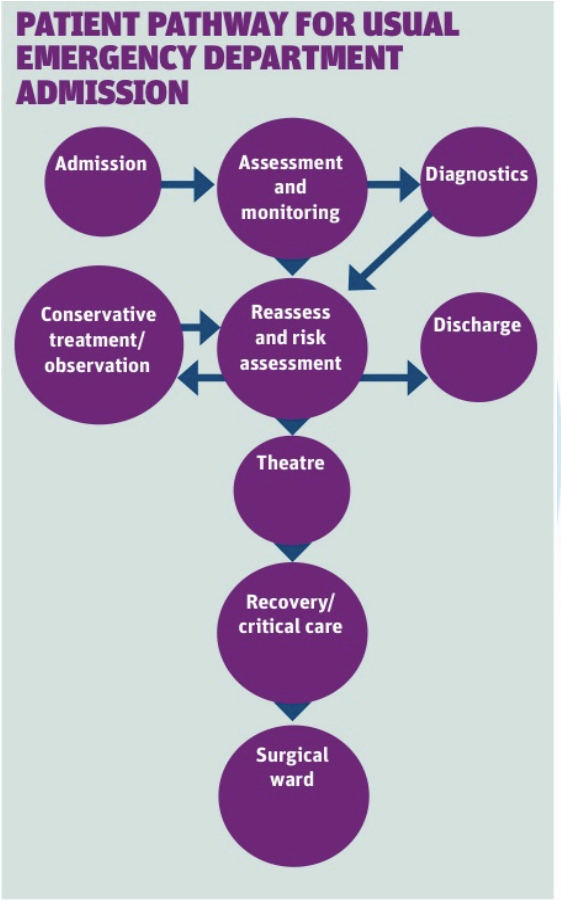
New Ways of Working



Activity

EmSU Activity June to Sept 2013

- 2822 attendances referral from ED or GP
- 2306 overnight admissions
- 516 patients discharged same day
- 431 patients treated & discharged in hot clinics
- 112 patients sent directly to theatres (June-Sept 2013)

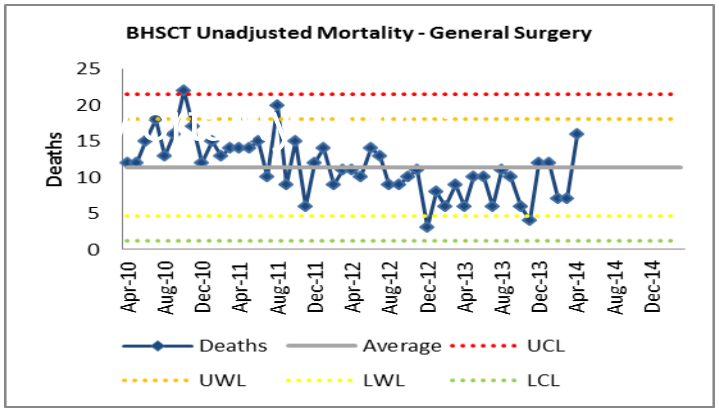


Measuring Outcomes

Site RVH/BCH	June2011 to March 2012	June 2012 to March 2013	June 2013 to March 2014
Non- Elective LOS	6.0	5.9	5.0
Non Elective Zero LoS	77	55	551
Total Activity	2427	2190	3701

	Readmission Rate	Peer
Total	6.20%	6.10%

Mortality Rates



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Measuring Success

Less Clinical Risk

- Rapid assessment and immediate referral to the right specialty team
- Improved access to laparoscopic surgery by senior surgeons
- 112 operated on first admission
- Significant reduction in number operated on OOH

Efficiency

- Significant increase in patients discharged same day
- significant reduction in patient length of stay
- Reduction in ED readmissions
- Junior Doctor F1 rota compliance

Conclusion

- Safer system
- Popular with patients and relatives
- Greater team working
- Better for emergency patients
- Improved efficiency

Next Steps

- Evaluation against KPIs
- EmSU Improvement Team
- Key clinical relationships – ED, Theatres, Imaging, Diagnostics

OPTIMAL7

Dr Paul Turkington

May 2014

Belfast Health and Social Care Trust

Outline

- Aspirations of how frail older people should be managed
- Recent redesign in services across the trust
- Design of OPTIMAL7
- Early experience
- Future direction

How should frail older people be managed?

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How should frail older people be managed?

1. Use CGA
2. Focus on frailty
3. Specialist elderly care wards
4. Liaison services / specialist advice
5. Maximising continuity of care / minimising ward moves
6. Improving safety
7. Minimising harms of hospitalisation
8. Improved care for inpatients with dementia /mental health problems
9. Focus on dignified person-centred care

Service redesign

- Many changes and initiatives within BHSCT over last number of years to improve quality

- Some issues for Older peoples services

  Geriatrician in the AMU no longer linked specifically with specialist teams nor in a dedicated ward environment

  Inpatient bed base for older people mostly on BCH and MPH sites – issues with continuity, transfers, delays

OPTIMAL7

Older People's Timely Intervention, Management and Admission service on Level 7 South BCH

- Started March 2014
- To streamline access to elderly care wards for older persons in need of input from a Geriatrician
- Start up
- How are patients identified

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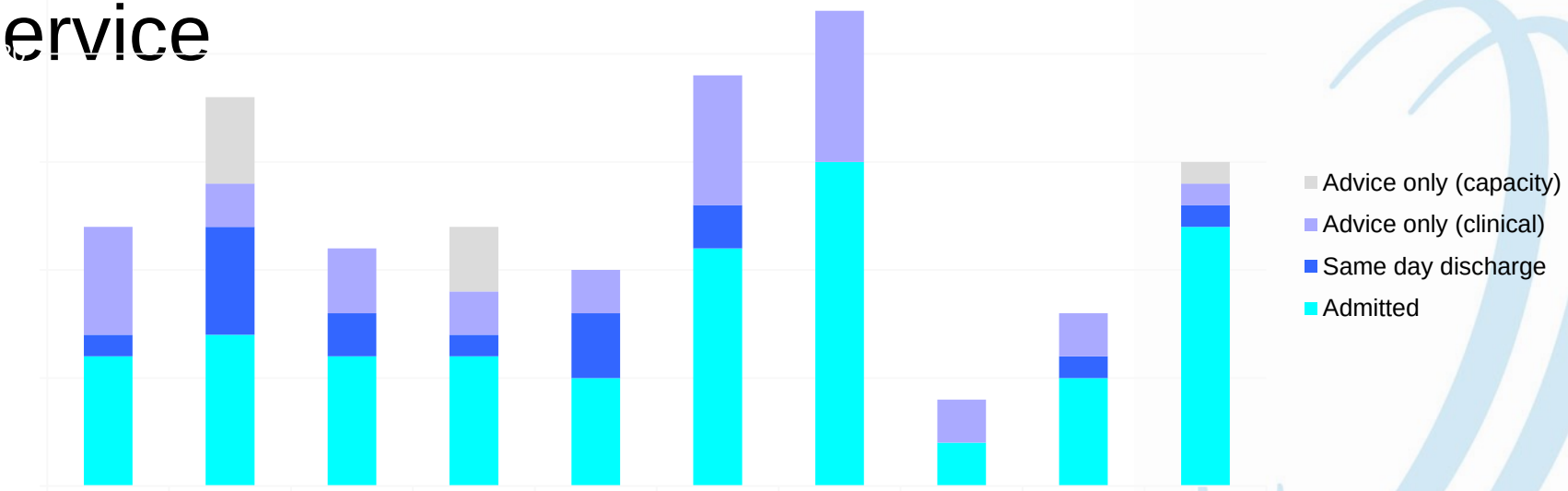
OPTIMAL7 - Performance

- Positive feedback from patients and primary care
- Wide range of GP practices engaging with service



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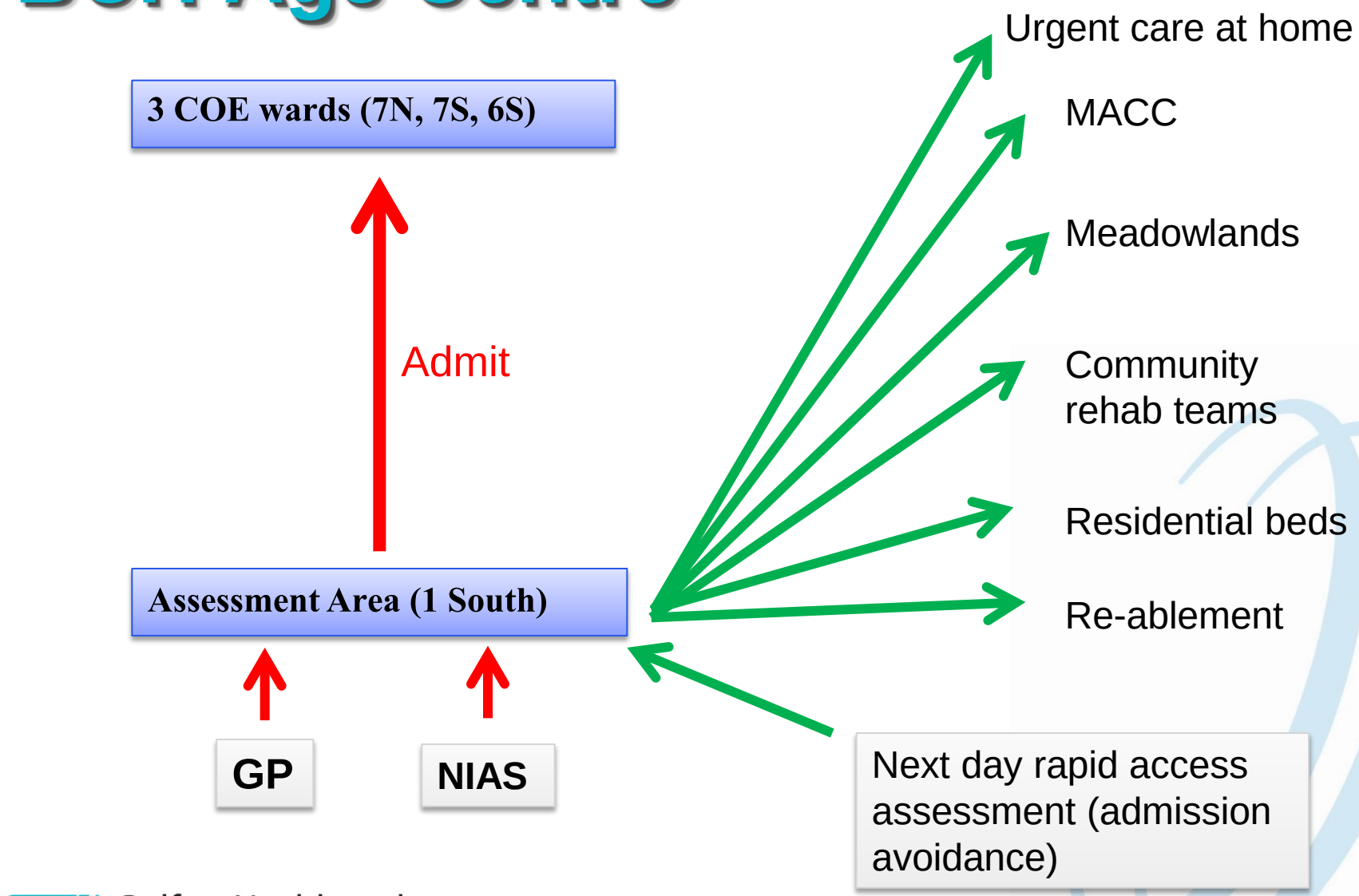
Where next?

- Still relatively small numbers
- Need to capture more individuals who can benefit
- Need to move to 24/7
- Engagement with NIAS
- Redesign and simplify access to older peoples services
    - Incorporate OPC and MACC services in one place

BCH Age Centre



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Questions?

- To discuss and arrange direct admission:

07917244532

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Northern HSC Trust
Unscheduled Care Review

HSC Summit Event

19th May 2014

Northern Health
and Social Care Trust

Strategic Context

- 3 independent reviews in 2012/13
  - Dr Rutter (Primary Care / AAH interface)
  - M Hinds (Unscheduled Care Pathway at AAH)
  - S Page (3 Stage process for Trustwide improvement)
- Changes in Senior Leadership
  - Chief executive leaves organisation
  - Turnaround Team appointed in May 2013
    - 2 Senior Directors and 2 AD's
  - Interim medical director appointment (May 2013 / Feb 14)
  - New Director AHS appointed (Dec 2012/Jan 2014)

Strategic Context

- Turnaround Report (2013)
  - **Phase 1 -** the outcome for Phase 1 should be both acute hospital sites and PCCOPS operating efficiently and effectively as independent business units however the interface between clinical teams must be seamless
  - **Phase 2** - undertake service reviews to re-integrate Trust
  - **Phase 3** – TYC focus

Bi-weekly meeting with focus on detailed improvement plan, which had specific improvements, with nominated leads and timescale, chaired by Senior Director for Turnaround

Summary of Unscheduled Care

AAH	ED Attendances	4 Hour Performance	12 Hour Breaches	Unscheduled Admissions	Unscheduled ALoS
2010/11*	70,902	71%	2,440	24,465	5.4
2011/12	71,175	73%	3,041	25,315	4.9
2012/13	70,859	64%	1,810	26,892	4.5
2013/14	72,037	71%	885	28,199	4.4

CAU	ED Attendances	4 Hour Performance	12 Hour Breaches	Unscheduled Admissions	Unscheduled ALoS
2010/11*	43,695	86%	319	9,922	5.2
2011/12	43,080	83%	1,020	9,751	5.7
2012/13	42,774	80%	726	10,520	5.2
2013/14	41,798	79%	171	10,483	4.8

HSC Northern Health and Social Care Trust

*In summer 2010, Mid-Ulster and Whiteabbey A&E's downgraded to MIU Service

Focus for Today

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   - *The Assessment Unit*
2. Bed Re-modelling
   - *Unscheduled Care Admissions Pathway Reform*
3. Improving Discharges at Weekends
   - *Utilisation of Discharge Doctor*
4. Causeway improvements

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The Assessment Unit – the starting pilot

- A **dedicated assessment area** in the Acute Medical Unit (AMU) with a combination of chairs and trolleys, protected for the use of assessing medical patients referred into the hospital by GPs (October 2012).
- Available 11am - 5pm - Unit had 4 trolleys, 3 chairs
- GPs could call a **direct number**, speak to a **senior doctor** and have a clinical discussion regarding the patient.
- Following the conversation, if the patient needed a medical assessment they came directly to Assessment Unit where they were assessed by the senior doctor, with investigations starting immediately.
- Thus better patient experience and reduction in referrals to ED
- **Previous to Assessment Unit, these patients would have attended Antrim ED.**

The Assessment Unit – beyond the pilot

- In April 2013, new (replacement) ward opened
- Assessment Unit relocated from temporary home to dedicated floor space
- Moved again to old ED in September 2013
- Allowed for expansion of service to M-F 9am -6pm
- Introduction of Rapid Access Medical Clinic (RAC)
  - Significant challenge in defining cohort of patients, not so sick that requires seen today but too sick to wait for regular OP.
  - RAC used by ED as admission avoidance and by hospital teams to support early discharge (rapid review in RAC)

Month	Contacts	Acute Assessment	Admissions	Discharges	Discharge Rate*	RAC Use
April	42	33	22	11	33.3%	
May	127	106	52	54	50.9%	25
June	102	97	52	45	46.4%	23
July	171	148	79	69	46.7%	35
August	155	139	73	66	47.5%	19
September	179	114	80	71	47.0%	37
October	276	88	83	62	42.8%	57
November	231	140	83	95	53.3%	38
December	244	150	90	111	55.2%	51
January	311	176	104	152	59.4%	80
February	225	114	65	105	61.7%	56
March	213	135	66	115	63.5%	46
TOTAL	**2776**	**1338**	**849**	**956**	**54.6%**	**467**

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*discharges as % of total arrivals in unit, not as % of contacts with service

What have the Patients said...

- Retrospective survey sent to 200 random patients
- 111 replies (56% return rate)
- 88.3% reported experience as excellent or good
- 2.7% recorded a poor experience

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Bed Readjustment – pathway reform

- Understanding what is coming in the door?
- Not all patients going to right beds
- AMU too big for resource covering
- Respiratory too small – constant outliers
- What resource you have available?
- Safari ward rounds
- Inbred inefficiency

HRG Analysis

- Any change must be driven by evidence and supported by robust data
- HRG analysis of admissions and converted to bed stock required for each specialty
- Showed specialty bed day utilisation
- This said we needed to double dedicate respiratory bed base
- Had to be considered in line with new (not additional) ward opening

Bed Remodelling – what we did?

- Data and paper of analysis presented to clinical leads on Antrim site
- Clinical leads had ownership of the reform and improvement
- Weekly meetings over a number of weeks to iron out operational issues
  - Definition of criteria for admission directly to specialty bed
  - Triage / handover of patient?
  - OOH arrangements
  - Ownership of outliers?
  - Reallocation of juniors
  - Consultant on call
  - Funded v non-funded bed stock

Operational Issues

- Definition of criteria for direct admission
  - Each specialty defined cohort of patients who would benefit most from earliest intervention
- Reallocation of juniors
  - Reallocated on basis on changing bed stock, e.g. reduction to 1 AMU, acute team gave away junior and respiratory team gained as bed stock doubled
- OOH arrangement
  - Medical specialties operates H@N model; thus after 8pm all admissions through Acute Medical Unit for cohorting of sick patients for safety reasons
- Ownership of Outliers
  - Specifically in relation to outliers from Acute Medical Unit

Operational Issues

- Triage / Handover / Review of Patients
  - H@N Handover meeting
  - 8AM – 4 take medical consultants present
  - Patients commence journey with most appropriate specialty
  - Previously this arrangement was a bit ad hoc
  - Teams had to arrange to ensure all patients admitted to specialty ward were seen same day
  - Medical wards implemented morning ward round and PM review of new and board round of ward, a practice which was already well established in Surgery and was made more robust through this process
  - Ward rounds and same day review became challenge when demand got even greater (winter) - "stretching the elastic"

Antrim Area Hospital Configuration

- 302 funded beds
  - 355 adult operational beds (March 2014)
  - 274 medical beds – 54 COE, 175 medical specialties, 35 cardiology, 10 observation beds
  - 71 surgical
  - 10 gynae beds
- This is core bed stock – not counting ad hoc additional temporary beds and trolley waits bed days
- Hospital consistently running with minimum 334 beds open
- GP Access to Assessment Unit M-F, 9.00-18.00
- Below shows number of beds required since 2009 (unscheduled only) at 85% and 90% occupancy on HRG analysis)

Occupancy	Bed Required / Year				
	2009/10	2010/11	2011/12	2012/13	2013/14
100%	270	314	289	284	288
90%	300	349	321	316	320
85%	**352**	**410**	**377**	**372**	**377**
ALoS	**6.5**	**6.4**	**5.7**	**5.1**	**4.8**

Focus for Today's ...

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Weekend Discharges and Discharge Planning

- Weekend discharging does not *just happen* at the weekend – needed focus effort and plan
- Starts with weekend discharge planning meeting – ensure plans in place as required
- Discharging patients can be a complex task involving multiple professional groups
  - Increased consultant presence
  - Discharge doctor (middle grade)
  - HSW / OT / physio have dedicated weekend discharge Increased pharmacy availability
  - ICC on site with greater community services
  - Senior manager on site support

Discharge Planning Meeting

- Consistent and focused
- Led by senior operational management
- Outcome is clear plan for all patients to go home with actions identified
- List of patients prepared for weekend discharge doctor
- Followed through on Saturday and Sunday

Specialty Discharge Doctor

- SD from 10.00-16.00 at weekends on both sites
- Allows juniors to support consultant ward rounds with increase consultant presence at weekends
- SD will ensure those identified for discharge go on basis of weekend handover
- Cost pressure – reliance on locum (in house), at times challenging to fill
- Performance can be person specific (drawback of not a substantive role function)
- 13/14 saw 8% increase in weekend discharges vs 12/13.

A few other initiatives...

- Crisis response
  - Currently a specialty doctor from CRT working in ED, plans to relocate CRT to Antrim site to improve response times, flexibility within team and co-ordination of care
- Old age psychiatrist
  - Consultant available on site to support management of elderly patients requiring specialist mental health issues. Invaluable asset across site supporting delivery of high quality care
- Community rapid response
  - Pilot from September 2013 to allow GPs, extending to ED and Assessment Unit to have patient need assessed in their home within 1 hour of referral to prevent unnecessary ED attendances and hospital admissions

A few more initiatives...

- Diagnostics – additional CT/USS at weekend
  - This ensures reduced non-value time in patient journey and also supports weekend discharge
  - GP have direct access to a range of diagnostic tests, including over 4200 plain film referrals in 2013
- Up stream social intervention
  - SSW aware of every potential EOAE and up stream work to prevent unnecessary delays. Information passed through daily planning meetings
- Qlikview
  - Use of technology to inform senior staff when pressures and beginning to build, specifically in relation to patients waiting on an admission bed.

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What has happened in Causeway?

- Still significant challenges with recruitment and retention
- Site management – management based on site
- Doctor in charge – direct support and challenge
- Daily 8.30 meetings with clinical and management teams
- Fortnightly team meetings to resolve issues on site
- Discharge doctor at weekend
- Onsite management presences daily including weekend

What next...?

- Site management Antrim
- Person in charge – complete oversight of site every day
- Morning safety huddle -reflect on past 24 hours i.e. flow, safety, events, issues
- Review daily operational schedules
- Admission avoidance – OPALS, ambulatory care
- Continue to negotiate sufficient bed stock and associated resources

Thank you very much!

Questions?

Northern Health and Social Care Trust

Southern Health and Social Care Trust

Quality Care - for you, with you

Transforming our Patient Flow processes and links with community

Caitriona McGoldrick
Catriona Kavanagh
Charlotte-Anne Wells

Monday 19th May 2014

Context

- Historically Southern Trust performed well in terms of Unscheduled Care access standards across the patient's journey
- Strong 12 hour position, however performance with 4 hour position continues to be a challenge and must be improved
- Strong operational focus on patient flow daily
- Strong links across Directorates and shared ownership for flow
- However, there continues to be pressures in the system and therefore there was a need for transformational change to move us to a more sustainable and improved position

Our approach

- Wanted to build on the strong foundations we already had in place – operational focus on flow and strong links with other Directorates
- Modernise and reform our processes to add value across the system – focus on the patient and make the job easier for staff
- Maximise the opportunities offered by new technologies
- Simplify and streamline our processes where possible

Key Developments

- Implementation of IMMIX Flow
  - System to support the complete patient flow process from the Emergency Department to Discharge
  - Also incorporates a module we call Clinical Noting which supports medical staff for key tasks including allocation of work and handover
- Implementation of an Information Hub
  - Improving communication between acute and community services
  - Embedded the use of Estimated Date of Discharge (EDD)
  - Supporting proactive discharge planning

Implementing IMMIX Flow

Catriona Kavanagh

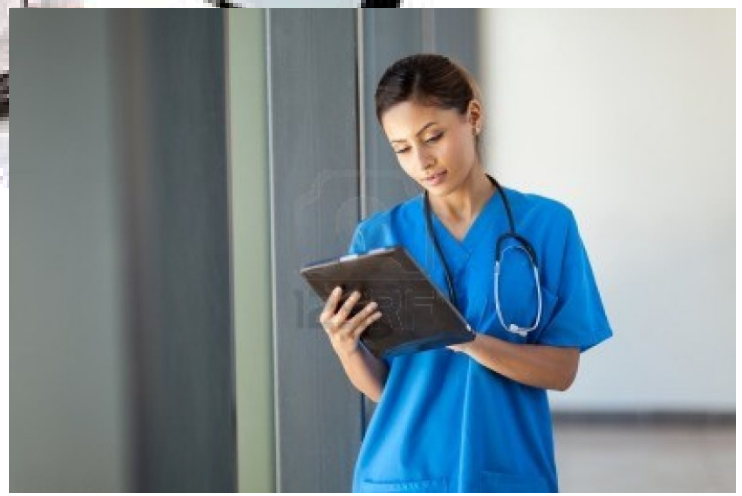
Challenges for Flow

Repetitive,/Illegible,
Heavy, Hard to store &
Vital information lost

Interactions untraceable

Saves space, Creates
efficiencies, Easier and safer,
Primary and secondary
care/interdepartment

Right information, Right patient,
Right time, Right location



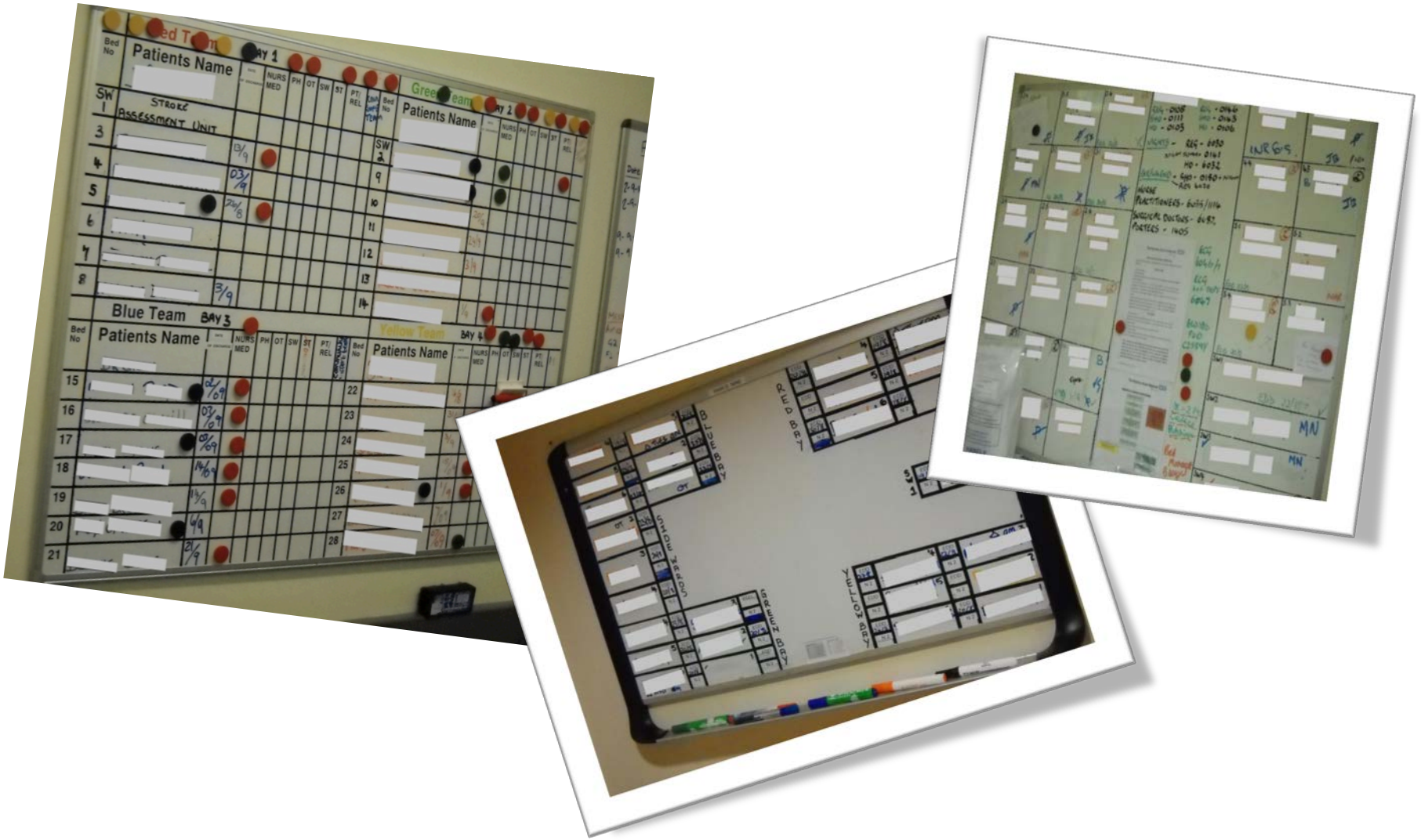
Embracing Technology

- Existing processes labour intensive
- Find a smarter and more efficient way of working
- How do we release time to care – patient focus
- We need to plan ahead and develop more proactive systems instead reacting to issues
- Create a solid IT infrastructure on which we can build new developments to meet emerging needs
- Need for robust information allow us to plan and improve

Fundamentals for Patient Flow

- Electronic bed management system
- System to manage patient pathways
- Instant snapshot of bed availability and occupancy
- Multi-disciplinary info on any patient on a ward
- Information accessible from any Trust PC
- Slicker and smarter processes for staff
- Be able to trace a patients journey at the click of a button

This is what we had....



Issues

Issues with white board
Transcribing errors
Multiple phone calls to check receive information
Viewable at only one point /out of date information
Time wasted
Visually confusing and all information viewable by public
Miscommunications/ inconsistent patient data
Inability to track orders

Solutions

Solutions with flow
Demographics always correct as PAS fed
Up to the second live data transmitted
All information viewable and can be updated from any PC
Efficient
Aesthetically pleasing, sensitive data only viewable by permitted individuals
Information standardisation/Configurable to wards
Full audit trail on all transactions

Simplifying the process

OLD PROCESS	New process
11 Forms	1 Form
6 Phone calls / bleeps	1 Phone call
Multiple emails	Information available at a click

immix

Current 2:26pm 9-May-2014

Southern Health and Social Care Trust
Quality Care - for you, with you

HSC

ckava001

Consultants | Specialties | Wards

Hospital: CRAIGAVON AREA HOSPITAL [Clear filter]

Beds: 401

Occupied 339		Closed 1		Empty 61	
169 Male	170 Female	1 Male	0 Female	36 Male	25 Female

5 DELAYED DISCHARGE	38 EDD TODAY	5 PDT TODAY	43 AVERAGE STAY (LIVE)	0 AVERAGE STAY (WEEK)
0 AVERAGE STAY (MONTH)	1 NO EDD SET	22.9% DISCHARGE BEFORE 11 TODAY	24.2% DISCHARGE AT WEEKEND	

Your widgets

Smith, Mia (Ms..)	*Born* **15-Sep-1997** (15y)	*Gender* **Female**	*H+C No* **1900398850** *PMI No* **112265243**

Address **20 Nenthead Road Gellio...**	*Phone and email* **077 4584 6251**	*Next of Kin*	*GP* **Quinn Dr R P Unknown**	**Allergy status unknown**

Bed Request Form

Admission from
A&E

Reason for admission
Broken arm

Admission notes
Low B/P, open wound

Department
Surgery

Hospital
CRAIGAVON AREA HOSPITAL

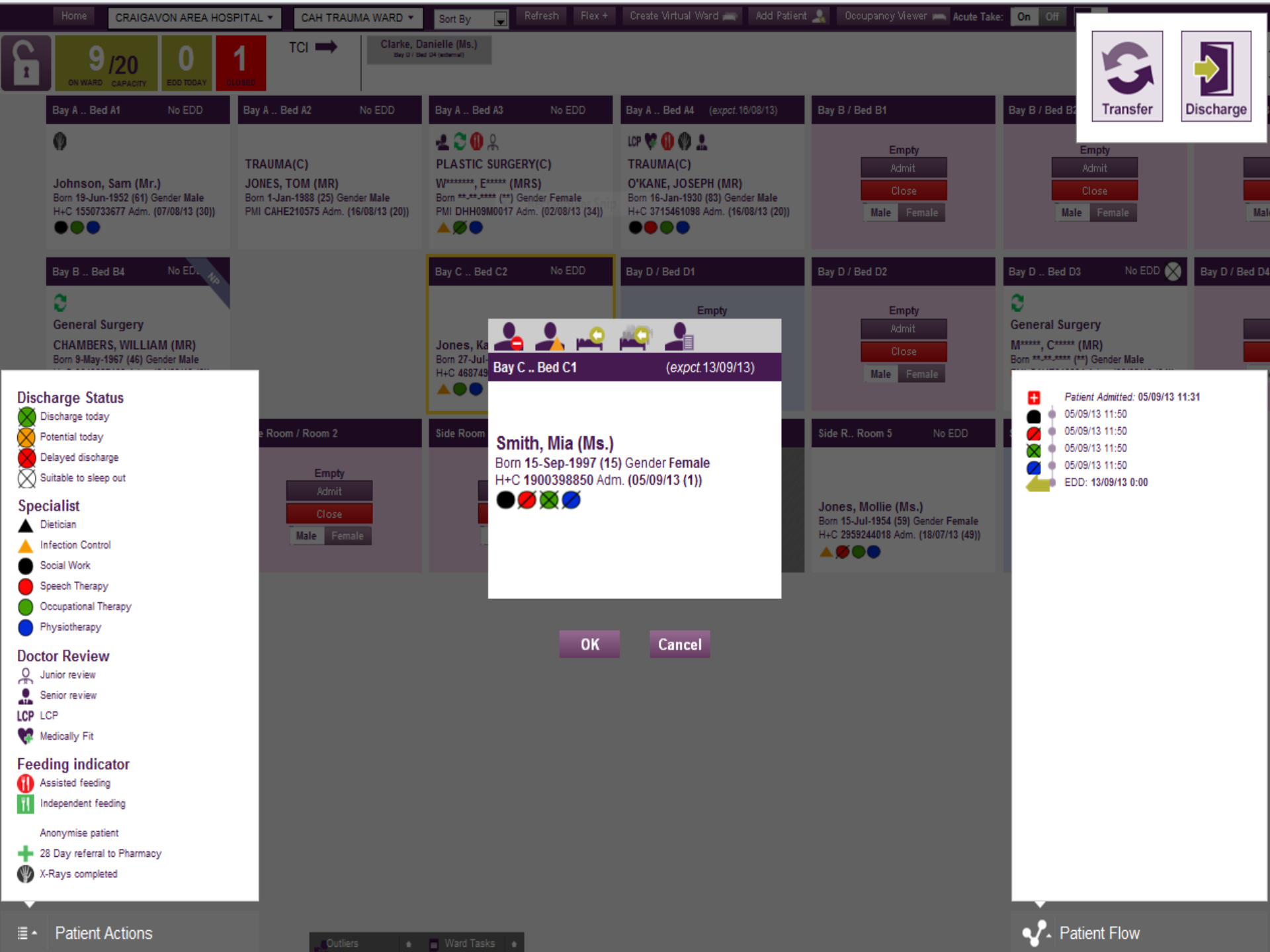
Has the patient been seen by a consultant?
Yes

Search for Consultant
WEIR - MR C.D.

Following assessment of vomiting and diarrhoea is isolation required?
No


CRAIGAVON AREA HOSPITAL
FIRE PRECAUTIONS
Instructions to Staff

Bay A .. Bed A1 — No EDD	Bay A .. Bed A2 — No EDD	Bay A .. Bed A3 — No EDD	Bay A .. Bed A4 — (expct:16/08/13)	Bay B / Bed B1	Bay B / Bed B2
WEIR MR C.D. Johnson, Sam (Mr.) Born 19-Jun-1952 (61) Gender Male H+C 1550733677 Adm. (07/08/13 (30))	BUNN MR J JONES, TOM (MR) Born 1-Jan-1988 (25) Gender Male PMI CAHE210575 Adm. (16/08/13 (20))	EARLEY MR M W******, E***** (MRS) Born **.**.**** (**) Gender Female PMI DHH09M0017 Adm. (02/08/13 (34))	LCP BUNN MR J O'KANE, JOSEPH (MR) Born 16-Jan-1930 (83) Gender Male H+C 3715461098 Adm. (16/08/13 (20))	Empty Admit Close Male Female	Empty Admit Close Male Female
Bay B .. Bed B4 — No ED.. NP	**Bay C .. Bed C1** — No ED.. NP	**Bay C .. Bed C2** — No EDD	**Bay D / Bed D1**	**Bay D / Bed D2**	**Bay D .. Bed D3** — No EDD
MACKLE MR E. CHAMBERS, WILLIAM (MR) Born 9-May-1967 (46) Gender Male H+C 3648287109 Adm. (04/09/13 (2))	WEIR MR C.D. Smith, Mia (Ms.) Born 15-Sep-1997 (15) Gender Female H+C 1900398850 Adm. (05/09/13 (1))	MCGLEENON DR B Jones, Kai (Mr.) Born 27-Jul-1935 (78) Gender Male H+C 468749352 Adm. (07/08/13 (30))	Empty Admit Close Male Female	Empty Admit Close Male Female	MACKLE MR E. M*****, C***** (MR) Born **.**.**** (**) Gender Male PMI CAHE210204 Adm. (02/08/13 (34))
Side Room / Room 1	**Side Room / Room 2**	**Side Room / Room 3**	**Side Room / Room 4**	**Side R.. Room 5** — No EDD	**Side Room / Room 6**
Empty Admit Close Male Female	Empty Admit Close Male Female	Empty Admit Close Male Female	Closed Open Log Closed since: 01/01/70 1:00am	Jones, Mollie (Ms.) Born 15-Jul-1954 (59) Gender Female H+C 2959244018 Adm. (18/07/13 (49))	Empty Admit Close Male Female


Home
CRAIGAVON AREA HOSPITAL
CAH TRAUMA WARD
Sort By
Refresh
Flex +
Create Virtual Ward
Add Patient
Occupancy Viewer
Acute Take:
On
Off
9 /20
ON WARD CAPACITY
0
EDD TODAY
1
CLOSED
TCI
Clarke, Danielle (Ms.)
Transfer
Discharge
Bay A .. Bed A1 No EDD
Johnson, Sam (Mr.)
Born 19-Jun-1952 (61) Gender Male
H+C 1550733677 Adm. (07/08/13 (30))
Bay A .. Bed A2 No EDD
TRAUMA(C)
JONES, TOM (MR)
Born 1-Jan-1988 (25) Gender Male
PMI CAHE210575 Adm. (16/08/13 (20))
Bay A .. Bed A3 No EDD
PLASTIC SURGERY(C)
W*******, E***** (MRS)
Born **-**-**** (**) Gender Female
PMI DHH09M0017 Adm. (02/08/13 (34))
Bay A .. Bed A4 (expct.16/08/13)
LCP
TRAUMA(C)
O'KANE, JOSEPH (MR)
Born 16-Jan-1930 (83) Gender Male
H+C 3715461098 Adm. (16/08/13 (20))
Bay B / Bed B1
Empty
Admit
Close
Male
Female
Bay B / Bed B2
Empty
Admit
Close
Male
Female
Bay B .. Bed B4 No EDD NP
General Surgery
CHAMBERS, WILLIAM (MR)
Born 9-May-1967 (46) Gender Male
Bay C .. Bed C2 No EDD
Jones, Ka
Born 27-Jul-
H+C 468749
Bay D / Bed D1
Empty
Bay D / Bed D2
Empty
Admit
Close
Male
Female
Bay D .. Bed D3 No EDD
General Surgery
M*****, C***** (MR)
Born **-**-**** (**) Gender Male
Bay D / Bed D4
e Room / Room 2
Empty
Admit
Close
Male
Female
Side Room
Side R.. Room 5 No EDD
Jones, Mollie (Ms.)
Born 15-Jul-1954 (59) Gender Female
H+C 2959244018 Adm. (18/07/13 (49))
Bay C .. Bed C1 (expct.13/09/13)
Smith, Mia (Ms.)
Born 15-Sep-1997 (15) Gender Female
H+C 1900398850 Adm. (05/09/13 (1))
OK
Cancel
Discharge Status
Discharge today
Potential today
Delayed discharge
Suitable to sleep out
Specialist
Dietician
Infection Control
Social Work
Speech Therapy
Occupational Therapy
Physiotherapy
Doctor Review
Junior review
Senior review
LCP
Medically Fit
Feeding indicator
Assisted feeding
Independent feeding
Anonymise patient
28 Day referral to Pharmacy
X-Rays completed
Patient Admitted: 05/09/13 11:31
05/09/13 11:50
05/09/13 11:50
05/09/13 11:50
05/09/13 11:50
EDD: 13/09/13 0:00
Patient Actions
Outliers
Ward Tasks
Patient Flow

Smith, Mia (Ms..) *WEIR MR C.D. - - CAH TRAUMA WARD*	*Born* 15-Sep-1997 (15y)	*Gender* Female	*H+C No* 1900398850 *PMI No*

Address 20 Nenthead Road Gelllo...	*Phone and email* 077 4584 6251	*Next of Kin*	*GP* Quinn Dr R P Unknown	Allergy status unknown

Current Admission

Patient Status: Inpatient (Normal)

- ☐ Does the patient have Diarrhoea?
- ☐ Medically Ready
  0 tasks outstanding
- ☑ FP ☐ LCP ☐ QH?
- ☐ Infection Control Status
- ☐ DNR ☐ Deceased
- ☑ EDD
  September | | 13 | | 2013 | |

Admission date	Reason for admission	Discharge Summary
5-Sep-2013	Broken arrm Last updated by Southern Trust Demo Account at 11:31am, 5-Sep-2013	Summary In Progress

Previous Events

Inpatients | Outpatients | Other

Details	Reason for adm.	Diagnosis on Discharge	Notes and Tasks	Discharge Summary
20-Jul-2010 - 22-Jul-2010 PAEDIATRIC ALJARAD DR. B	prolonged seizure	Prolonged focal seizure	1 Notes and 0 tasks	Completed Summary

Patient Notes

Add: ○ Note ◉ Task

(choose one)

Assign to

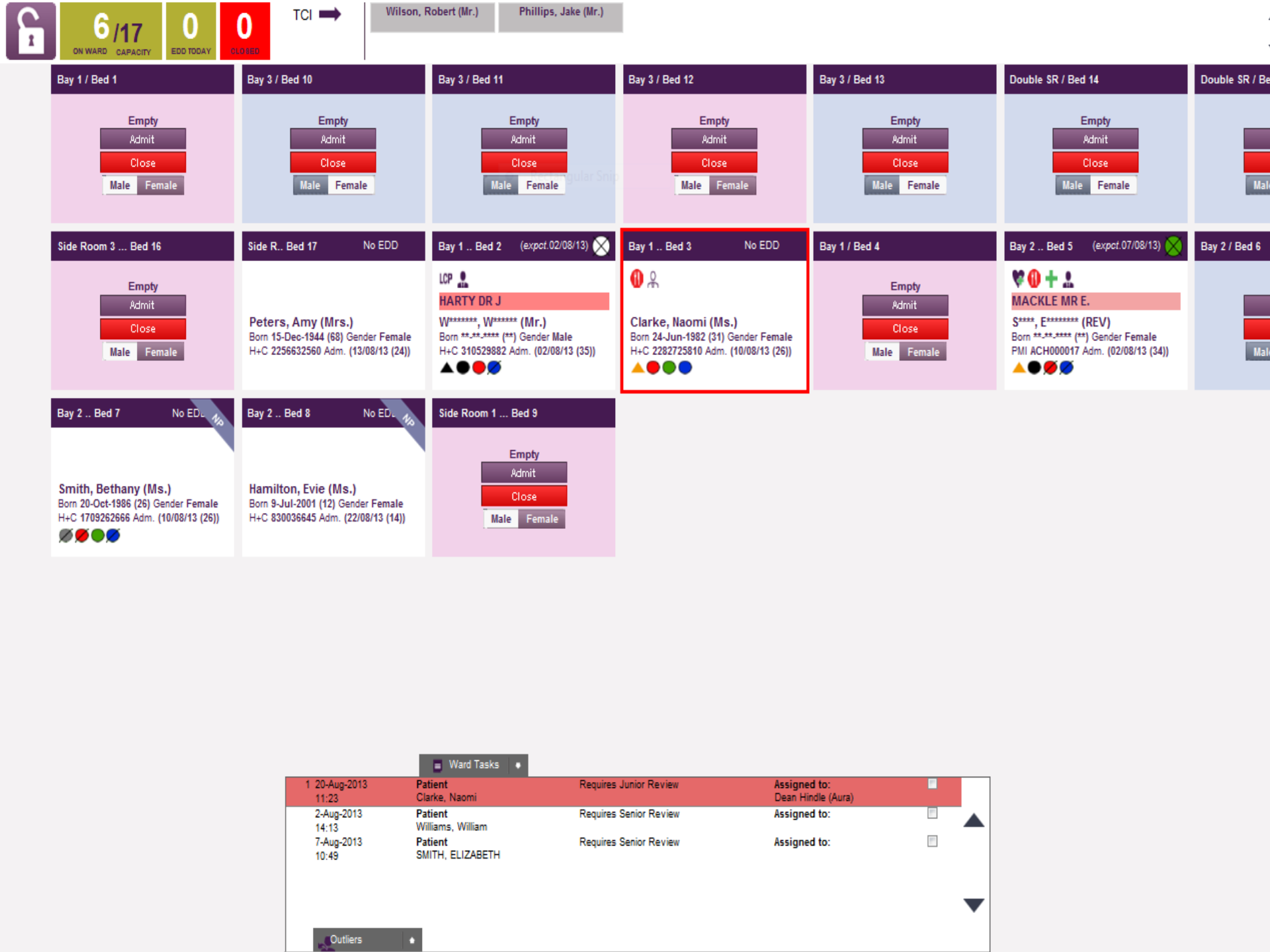
Priority

Add

Clear

Show completed tasks ☐ | Combined | Tasks | Notes | Observations

1	5-Sep-2013 12:45	Created by: Southern Trust Demo Account	Blood cultures need to be taken	Assigned to: Cathy Newell Hadden	
	5-Sep-2013 12:45	Created by: Southern Trust Demo Account	please order MRI and have results for ward round.		


6 /17
ON WARD CAPACITY
0
EDD TODAY
0
CLOSED
TCI
Wilson, Robert (Mr.)
Phillips, Jake (Mr.)
Bay 1 / Bed 1
Empty
Admit
Close
Male Female
Bay 3 / Bed 10
Empty
Admit
Close
Male Female
Bay 3 / Bed 11
Empty
Admit
Close
Male Female
Bay 3 / Bed 12
Empty
Admit
Close
Male Female
Bay 3 / Bed 13
Empty
Admit
Close
Male Female
Double SR / Bed 14
Empty
Admit
Close
Male Female
Side Room 3 ... Bed 16
Empty
Admit
Close
Male Female
Side R.. Bed 17 No EDD
Peters, Amy (Mrs.)
Born 15-Dec-1944 (68) Gender Female
H+C 2256632560 Adm. (13/08/13 (24))
Bay 1 .. Bed 2 (expct.02/08/13)
LCP
HARTY DR J
W*******, W****** (Mr.)
Born **-**-**** (**) Gender Male
H+C 310529882 Adm. (02/08/13 (35))
Bay 1 .. Bed 3 No EDD
Clarke, Naomi (Ms.)
Born 24-Jun-1982 (31) Gender Female
H+C 2282725810 Adm. (10/08/13 (26))
Bay 1 / Bed 4
Empty
Admit
Close
Male Female
Bay 2 .. Bed 5 (expct.07/08/13)
MACKLE MR E.
S****, E******** (REV)
Born **-**-**** (**) Gender Female
PMI ACH000017 Adm. (02/08/13 (34))
Bay 2 / Bed 6
Bay 2 .. Bed 7 No EDD NP
Smith, Bethany (Ms.)
Born 20-Oct-1986 (26) Gender Female
H+C 1709262666 Adm. (10/08/13 (26))
Bay 2 .. Bed 8 No EDD NP
Hamilton, Evie (Ms.)
Born 9-Jul-2001 (12) Gender Female
H+C 830036645 Adm. (22/08/13 (14))
Side Room 1 ... Bed 9
Empty
Admit
Close
Male Female
Ward Tasks
1 20-Aug-2013 11:23 Patient Clarke, Naomi Requires Junior Review Assigned to: Dean Hindle (Aura)
2-Aug-2013 14:13 Patient Williams, William Requires Senior Review Assigned to:
7-Aug-2013 10:49 Patient SMITH, ELIZABETH Requires Senior Review Assigned to:
Outliers

[Close]

TCI

Clarke, Danielle (Ms.)

	Bed Capacity	Occupied	Bay Beds Avaliable	Side Beds Avaliable	Closed	Discharge Today	Potential Discharge Today	Delayed Discharge (EDD)	TCI
	male | female	male | female	male | female	male | female	male | female	male | female	male | female	male | female	
(CDL)	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0
1 NORTH CMED DAYCASE WARD	1 1|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	1
1W	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	1
2 NORTH HAEMATOLOGY & MEDICINE	17 7|10	6 1|5	7 4|3	4 2|2	0 0|0	1 0|1	0 0|0	2 1|1	2
2 NORTH MEDICINE (RESPIRATORY)	18 13|5	11 6|5	3 3|0	2 2|0	2 2|0	1 1|0	0 0|0	3 1|2	5
2 SOUTH GERIATRIC ACUTE	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0
2 SOUTH STROKE UNIT	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0
2E	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0
2N	1 1|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	2
2S	1 1|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	1
2W	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0
3 SOUTH ELECTIVE WARD	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0
3S	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0
3SS	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0
4	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0
4N	34 28|6	11 6|5	18 18|0	5 4|1	0 0|0	0 0|0	0 0|0	1 1|0	4
4S	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0
ACC	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0
AEA	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0
CAH DAY CLINICAL CENTRE	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0
CAH DERMATOLOGY WARD	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0
CAH ED Transfer Ward	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0
CAH ORTHOPAEDIC WARD	15 10|5	10 6|4	1 1|0	3 3|0	1 0|1	1 0|1	2 1|1	4 1|3	5
CAH TRAUMA WARD	20 9|11	9 6|3	6 1|5	4 1|3	1 1|0	0 0|0	0 0|0	1 1|0	3
CATH LAB WARD, CAH	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0
CCU/CARDIOLOGY 1 NORTH	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	2
CLINICAL DECISION UNIT SHORT S	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0 0|0	0
CRAIGAVON-MANDEVILLE UNIT	0	0	0	0	0	0	0	0	0

Bay B / Bed B1

Empty

Admit

Close

Male Female

Bay D / Bed D2

Empty

Admit

Close

Male Female

Side R.. Room 5 No EDD

Jones, Mollie (Ms.)

Born 15-Jul-1954 (59) Gender Female

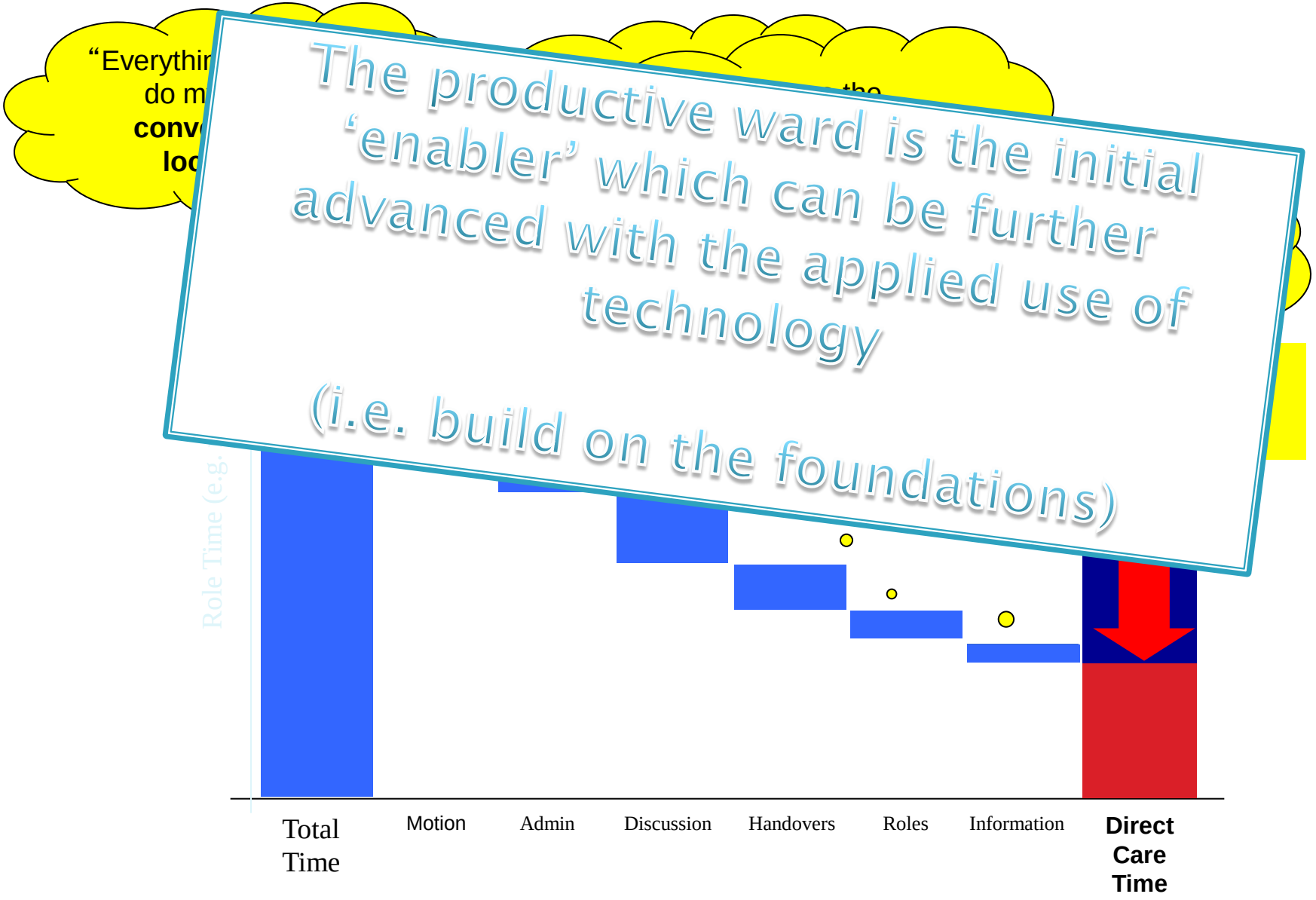
H+C 2959244018 Adm. (18/07/13 (49))


14/17
3
0
PHILIPS

Progress with IMMIX Flow

- Major focus on realtime information on Patient Administration System (PAS)
- Electronic Whiteboards operational in all wards and in our Emergency Departments – both CAH and DHH
- Patient flow staff now using hand held devices
- Focus now on increased rollout of Clinical Noting
- Real team effort in delivering the change – significant support from colleagues in IT Department

Feedback from nurses – more time to care



Implementing the Information Hub

Charlotte-Anne Wells

THE SOUTHERN TRUST INFORMATION HUB

CONNECTING SERVICES & SERVICE USERS

AIM

To support the proactive coordination of all complex and non-complex hospital discharges for patients aged over 65years on both Acute Hospital sites.

Kathy Foy (L) and Sarah McClelland (R)
Information Hub Officers

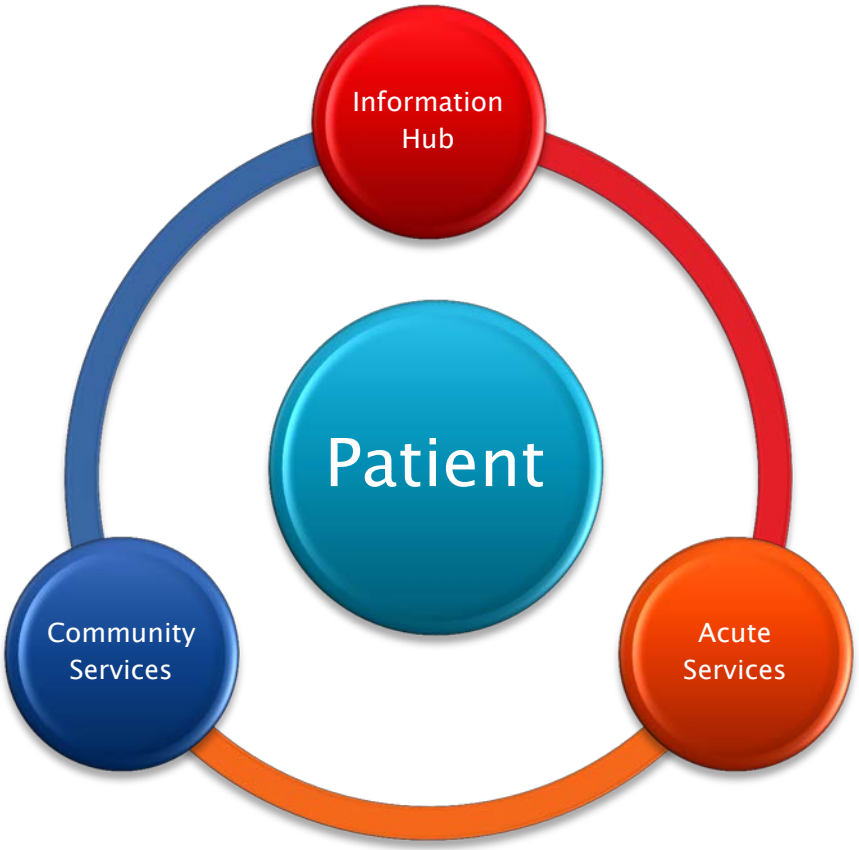
The Southern Trust Information Hub provides a central point to coordinate patient information that is relevant and essential to patient care and facilitates safe and effective discharge planning

Acute and Community Services work effectively together to allow the patient to achieve their full potential with the patient receiving the right service in the right place at the right time.

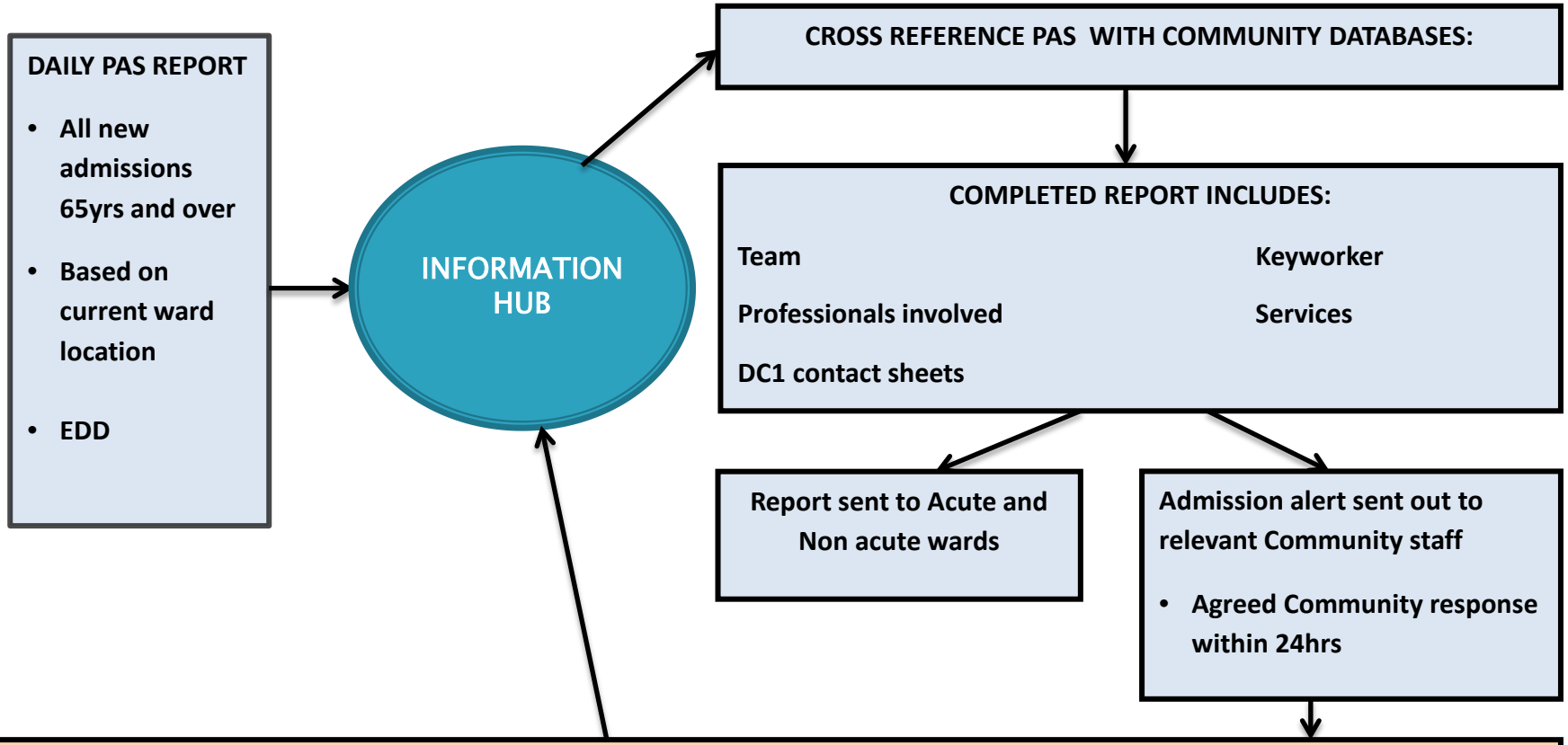
RAPID IMPROVEMENT DISCHARGE PROJECT: RATIONALE

- Discharge Workshop May 2013
- Acute and Older People Directorate

- Communication
- Integrated working
- Proactive coordination of Discharge
- Patient Centred



HUB PATHWAY AND PROCESSES



Email template completed by the keyworker and forwarded directly to the patients Acute location – establishes 2 way communication from admission

- Accommodation type
- NOK
- Main Carer
- Professionals involved
- Pre-admission level of function/independence
- Pre-admission cognitive status

Details of Care
Equipment in place
Risks
Issues and or concerns relevant to discharge planning
Contact details

WHERE ARE WE NOW?

- The ‘Hub’ is established
- Systems in place and developing further
- Integration into A&I
- Monitoring
- Pilot phase over

CHALLENGES

- Systems
- Staff application, utilisation, and compliance
- Key Performance Indicators
- Patient transfers
- EDD

Stakeholder Feedback

"It is great to be informed that patients have been admitted to hospital as we often do not find out until discharge! Also it helps in the discharge planning process if there are certain things the hospital staff need to be aware of, we can flag them up prior to discharge"

"The Standard Operating Procedure…… means that when information requests arrive from the HUB they can be quickly identified and forwarded to the worker Named in the Subject Heading. The process also enables me (as a line manager) to check on a regular basis that emails are being returned to the Ward in a timely manner; as …… also receives a copy of the reply to the ward"

"Ward are making more appropriate referrals to hospital social worker due to info hub as they are quickly aware patient has a package of care (POC) which will need reviewed/restarted"

"Timely information re: hospital admission. Helpful in managing domiciliary care expenditure."

I believe the improvement in interface between community and acute services had allowed for a better decision process within acute. This improved decision making has reduced the number of inappropriate referrals to intermediate care services and has streamlined the patient journey in terms of involving the right service at the right time to deal with patient discharge

Some real examples..

Case study 1: Newly diagnosed Palliative patient

Hub alert - existing POC and named contacts in ICT

Discharge pathway - ICS for increase POC and a specialist bed/matress

Potential delayed discharge – bed ordered but not for delivery until following week

Direct contact with the named keyworker – necessary adjustments possible.

In this case the smooth and coordinated discharge of the patient with the people who knew her allowed her to die at home in accordance with her wishes – patients needs were met

Some real examples..

Case Study 2: Potential delay, Home O2 , Rails

Patient flow informed by Nursing staff of potential delay- home oxygen and a second handrail

Using Hub information the keyworker was contacted directly - oxygen and rails were recently in place

Liaison with named keyworker ensured that patients discharge was coordinated, smooth and timely

Some real examples..

Case Study 3 – Clinical Decision Unit – potential to discharge or admit

Telephone call to the ‘Hub’ to request if patient was known

Obtained details that patient was known to Reablement and was awaiting an OT home visit the following week

Ability to contact the named person in Reablement and Community OT

Patient went home same day

Some real examples..

Further Case study examples include:

Confirmation from OPPC re: the status of placements –

PVA issues forwarded directly to acute–

Up to date ICS forms, Reablement summaries being sent into Acute from OPPC

Transfer of information from Acute to non-Acute sites for continuity of care

Unlocking the Potential

- Expanding into other Directorates and systems : Mental Health and Disability, Enhanced Services..
- Expansion of the role within ED, CDU, Ambulatory Care & GLT
- Further development within Access and Information
- Link to IT developments: IMMIX, CIS, ECR

In summary

- Both major transformation projects have been implemented and are making a real difference
- Once embedded, the changes will make our processes more sustainable and patient focussed
- Creates further opportunities – for example, in due course we plan to integrate the Information Hub into IMMIX Flow
- The opportunities are endless…

Thank you…

Emergency Care Summit

19th May 2014

Unscheduled Care Improvement

South Eastern Trust

South Eastern Health and Social Care Trust

Our Journey:

Internal turnaround team est Sept 13

Aim: To eliminate/reduce 12 hour waits

To refocus on 4 hour performance

Equal focus on safety/quality

Partnership with Alamac Feb 14

Aim: To sustain 12 hour performance

Improve 4 hour performance

Maintain safety/quality

Turnaround Overview:

- Governance Structures created:
  - Improvement Board monthly
  - Steering Group fortnightly
  - Project team weekly
- Assistant Director assigned to lead project
- Project team to support work established (AD Primary Care, ECR Manager, Planning staff, HR, Mgt Trainee)
- Critical friend procured to advise on best practice

Turnaround Focus

1. Enhanced focus on USC performance, safety, quality
2. Extensive staff engagement/communication
3. Identifying opportunities to improve collaboration between hospital and community/primary care
4. Challenging custom and practice where appropriate
5. Identifying “quick wins”, some small investments to gain confidence and kick start process
6. Greater focus on weekend performance
7. Targeted use of winter pressures funding

Turnaround Actions

1. New or extended roles: eg Trackers in ED, AD'S, Clinical Managers,, AHP's, Social Work on site at weekends

2. New ways of working:

- Daily clinical handover at 11am in AMU
- Pharmacy opened Sundays
- Secured red cross service to transport patients home as alternative to NIAS
- Extended admission criteria to community hospitals

Turnaround Actions

4. Improvements to systems and processes

- Streamlined process for ordering equipment
- Use of EPMS as a system for tracking patients through the journey and enabling electronic referrals for investigations

5. Improved relationships/processes with other hospitals:

- Improvements in cardiac delays/ Belfast Trust
- Better use of repatriation arrangements to Downe and LVH

Winter pressures funding/Nov 13

- 10 additional medical beds
- Extended pharmacy on Sun
- Extended pharmacy support for community
- Rapid Response Nursing
- Additional intermediate care beds
- AHP/Social work into community
- Red cross

Some results from turnaround

- 90% reduction in 12 hour waits

Month	No of 12 hour breaches
Apr -13	282
May-13	77
Jun-13	196
Jul-13	164
Aug-13	103
Sep-13	52
Oct-13	47
Nov-13	8
Dec-13	21
Jan-14	19
Feb-14	38

Partnership with Alamac- Feb 14

Aims:

1. Sustainability of 12 hour position

2. Assist Trust to deliver improvement in 4 hour performance

3. Ensure safety and quality underpins all work

Alamac Methodology

- Understanding patient flow in numbers.
- Identifying ‘what good looks like’.
- Relentless daily focus on the numbers.
- Developing the art of prediction
- Encourages small step improvements
- If we fail, learn quickly and move on

Alamac (cont)

- Providing challenge
- Added independence
- Helping to drive cultural change.
- Assisting the teams to be accountable to one another.
- Replacing emotion, myth, ancedote with evidence and reality based on numbers

What it looks like on the ground…

- Approx 30 people inputting data on a “kitbag” daily ie ward managers, bed team, ED etc
- Daily call of 15 mins–ED, Wards, Social Work, Bed Flow, Surgery, Belfast Trust
- Call focuses on what actually happened the previous day and predicts the current day activity
- Plans agreed to ensure predictions happen

EXAMPLE

Each Ward inputs…..

- No of actual admissions previous day
- No of actual discharges previous day
- No of patents out before 11am previous day
- No of predicted discharges current day

Focus on predicting and planning…

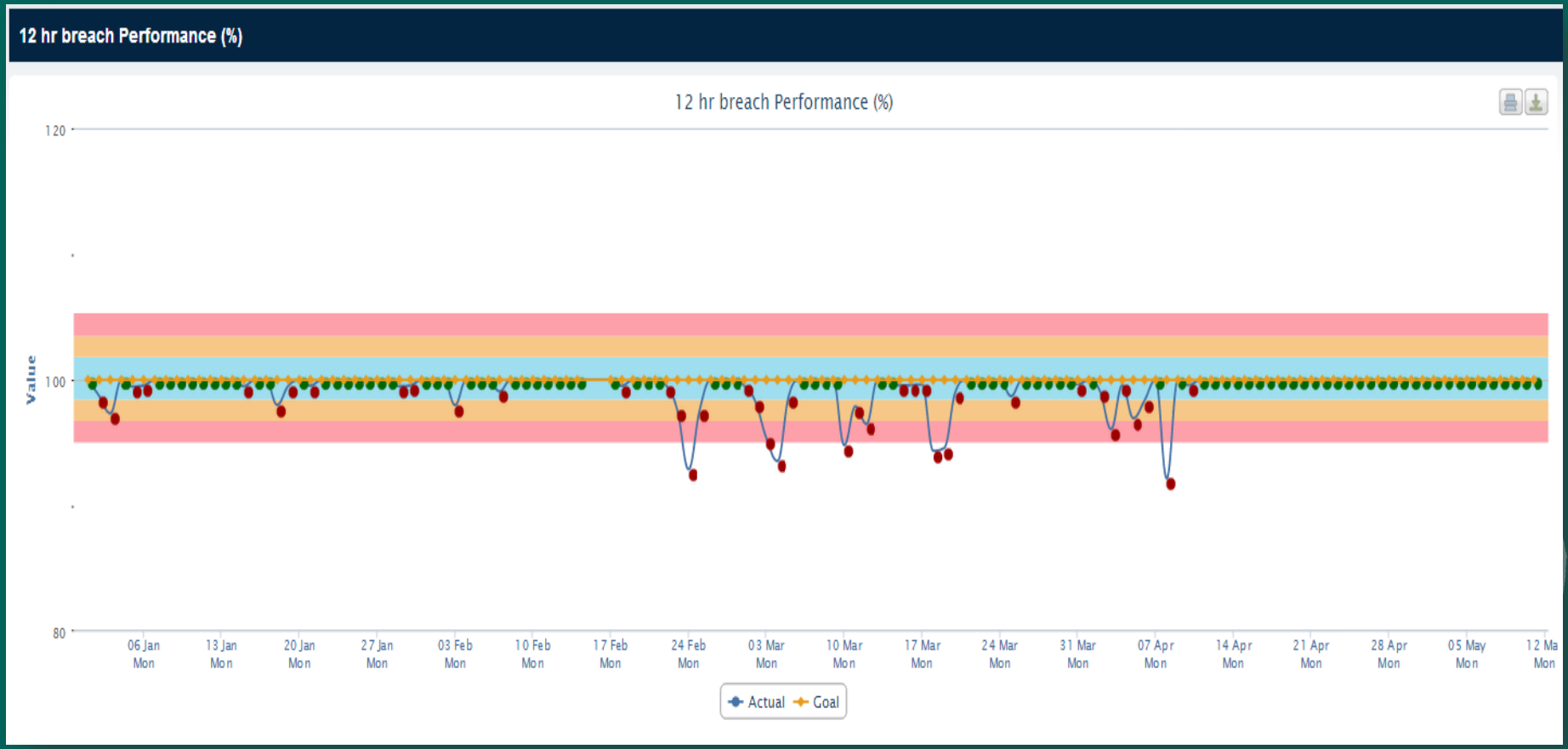
- Outlier Plan-10 by Fri/20 by Mon
- Cap on complex delays…. 20 daily
- Discharge plan- 48 medical per day to ensure flow
- Weekend plan agreed each Fri based on knowledge of past week and predictions for Sat /Sun

Have agreed what good looks like for us…. but kept under review

- Triage > 85%
- Discharge -48 medical pts daily
- Complex pts - 8 discharges daily
- Outliers - 10 by Friday
- ED spaces at 8am > 18
- No. of pts waiting speciality beds < 30

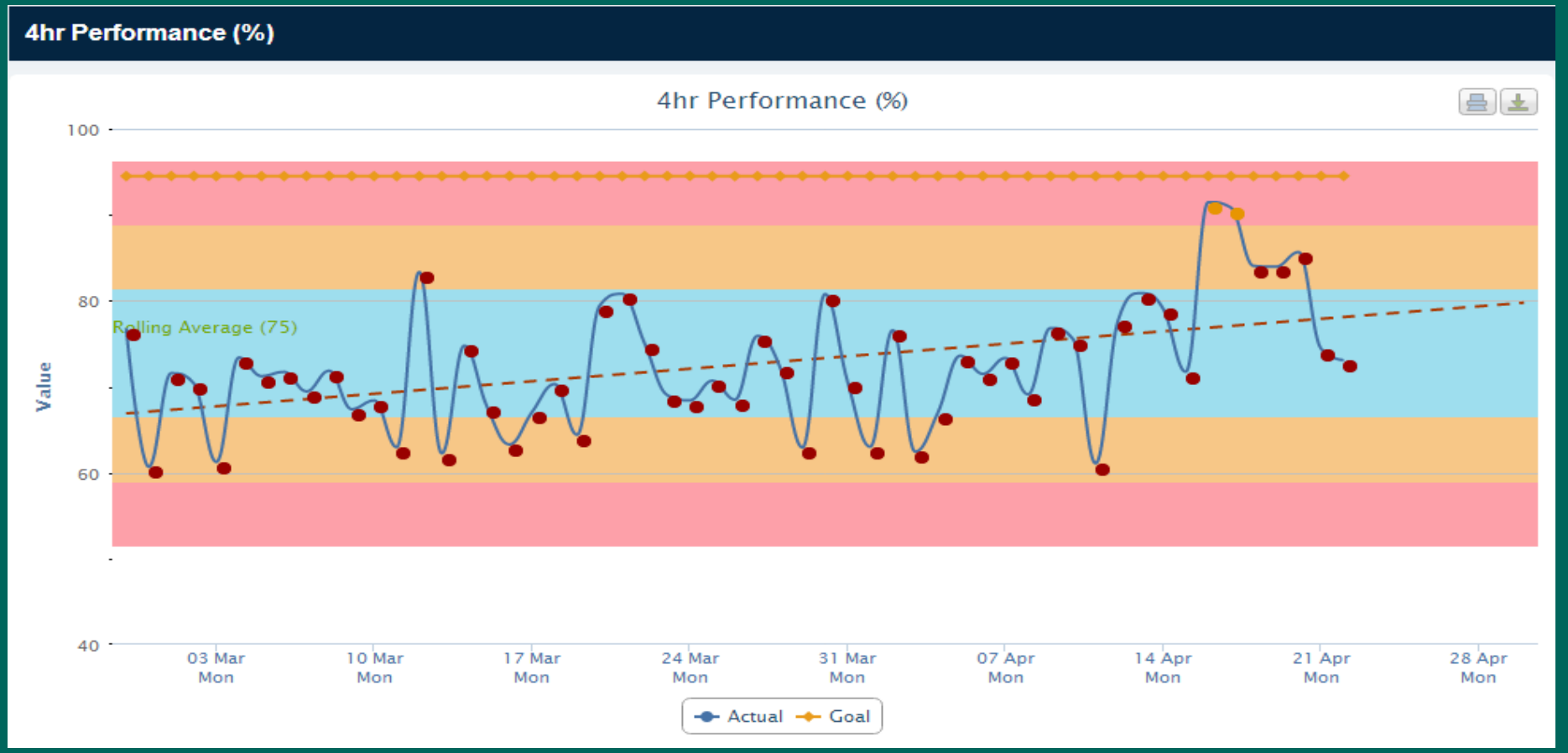
Results: 4 weeks zero 12hrs

-Capacity created in the system- Winter beds now closed



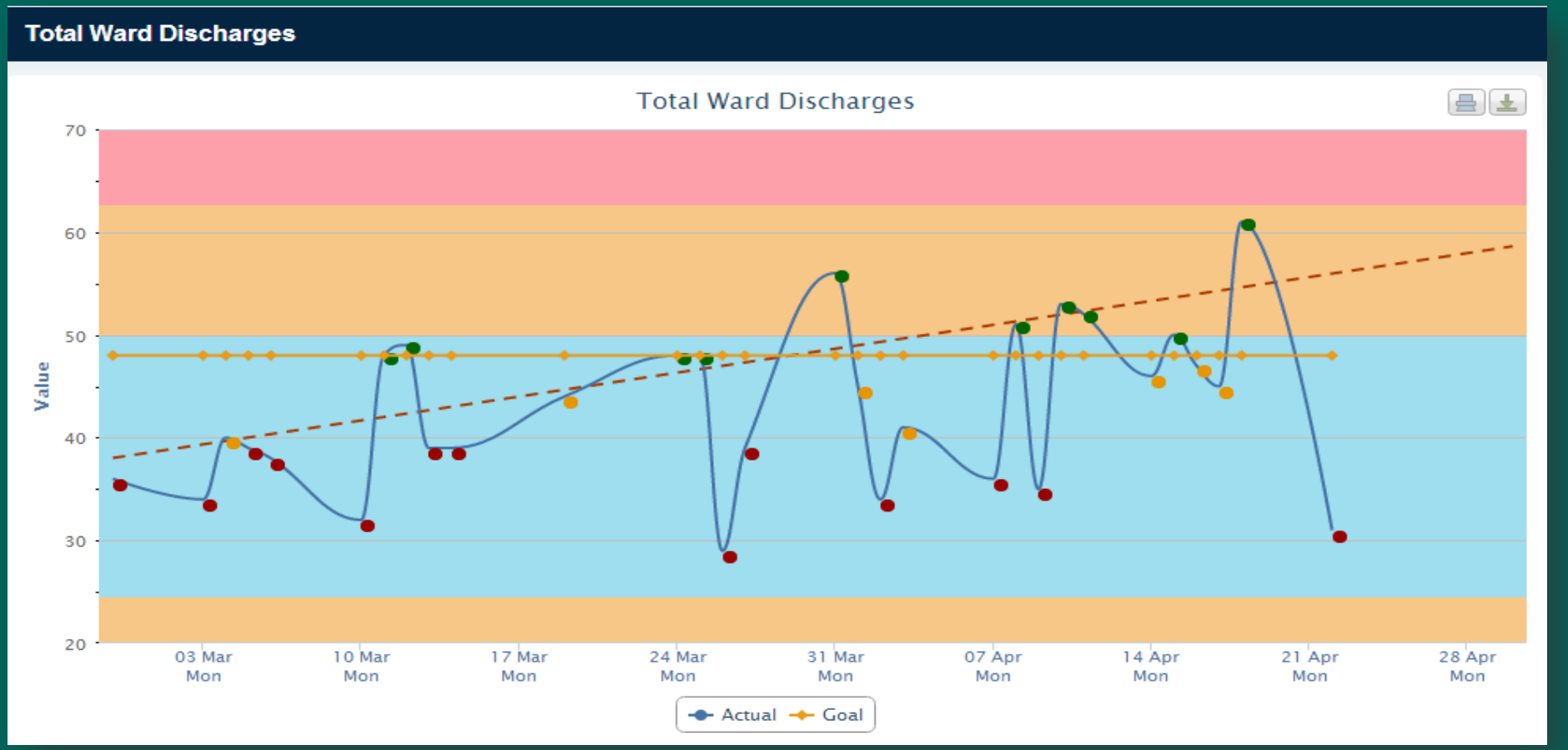
South Eastern Health and Social Care Trust

Results: Improving 4hr waits…



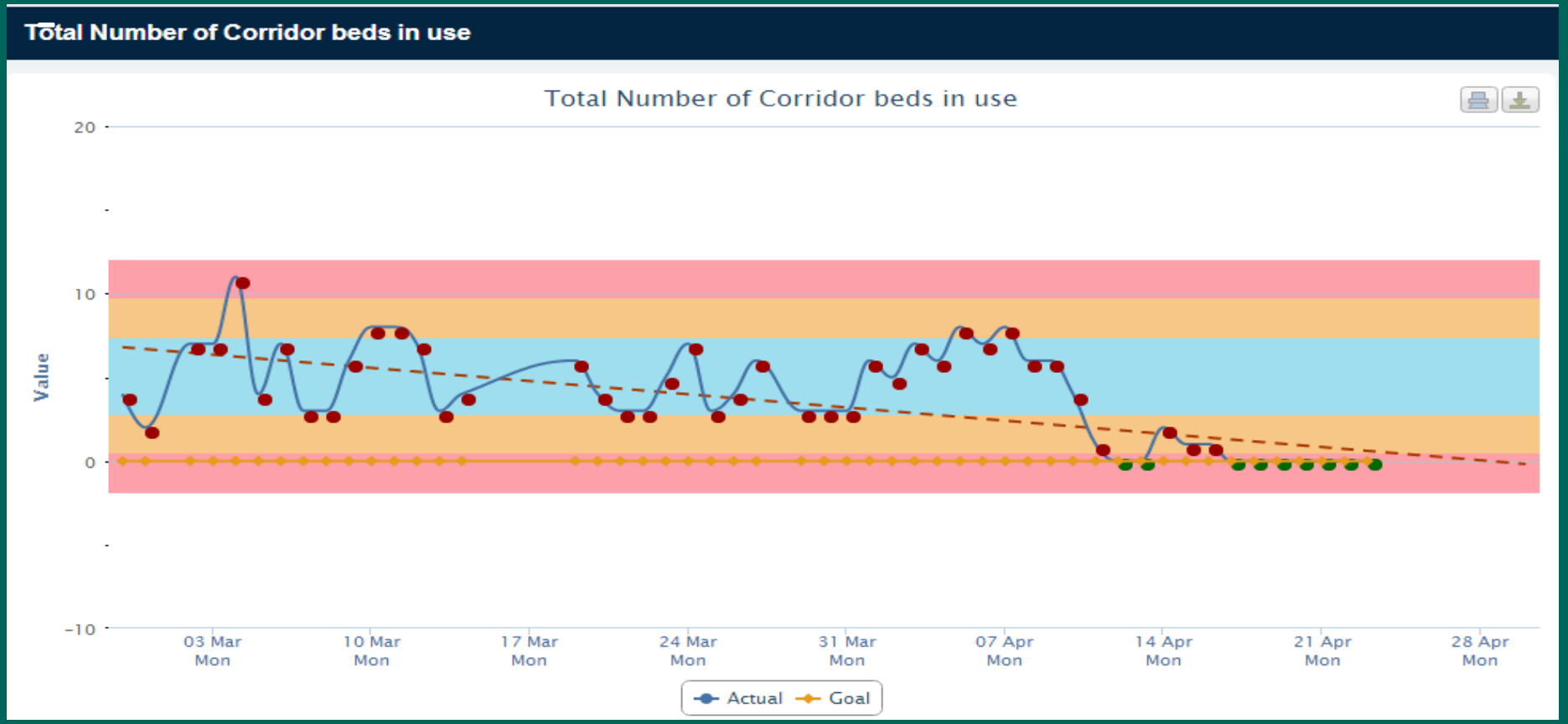
Results: Weekday medical discharges >48

-Now striving for consistency



South Eastern Health and Social Care Trust

Results: No patients being cared for in non designated bed spaces.



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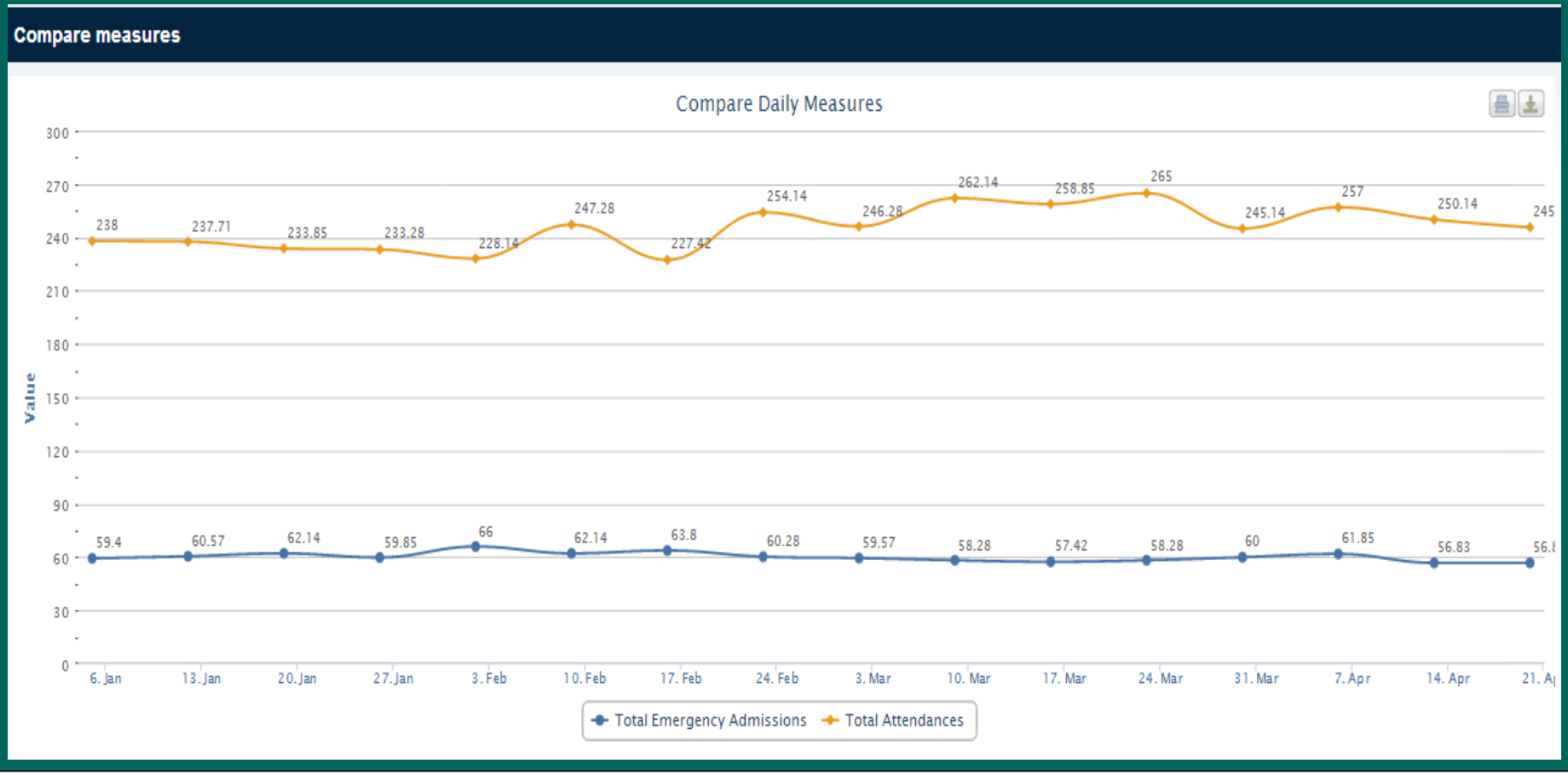
Demand: Increasing attendances but emergency admissions currently stable.



South Eastern Health and Social Care Trust

Next Steps…..

- Discharge lounge – 19th May. To create bed capacity earlier in the day and push forward on “out before 11am”
- Bed management role to focus more into ED – flow out of ED
- Piloting new discharge co-ordinator role
- Community Hospitals to join daily call

Next steps….

4 hour plan in draft form by mid June to include:

- Refining of Triage processes
- Introduction of self registration kiosks
- Adaptations to clinical environment
- Review of staffing levels
- Ensure all improvement work reflects CEM standards for patient safety

So in summary…….

12 hr performance

- 95% improvement in 12 hour performance
- Several zero 12 hour breach weeks Oct 13 to April 14. Have had 36 consecutive zero 12 hour breach days

4 hr performance

- 4 hr performance remains variable, but improvement evident. Ave now 73%. Working towards 85%.

What has worked

1. Dedicated management time on daily/weekly is key;
2. Dedicated resource vital in key areas – eg Tracker invaluable, Red Cross Ambulance Service, Discharge Manager, Clinical Manager at weekends to provide challenge focus;
3. Weekend funding of Pharmacy, AHP's and SW enabling patients to be seen and discharged faster – better patient experience;
4. AMU new pull model improved clinical outcomes and faster result for some patients;
5. Alamac support has created sustained focus on "numbers" and kitbag approach has encouraged shared approach to ED pressure and ownership of patient flow across Directorates and out of Hospital.
6. Excellent clinical/management relationships
7. Strong hospital, community collaborative working

Challenges going forward

1. Sustaining improvement on 12 hour performance;
2. Development of plan to further improve 4 hour performance
3. Embedding turnaround work into normal business
4. Work with HSCB to agree current capacity demand shortfall in acute medical beds
5. Development of real time performance management systems to support unscheduled care
6. Delivering the “big ticket” reform of the system that is needed to meet ever more complex needs eg 7 day working, TYC etc
7. Getting the balance right between safety, quality, experience and quantitative improvements ie being driven by doing the right thing not by the target

THANK YOU FOR LISTENING

South Eastern Health and Social Care Trust

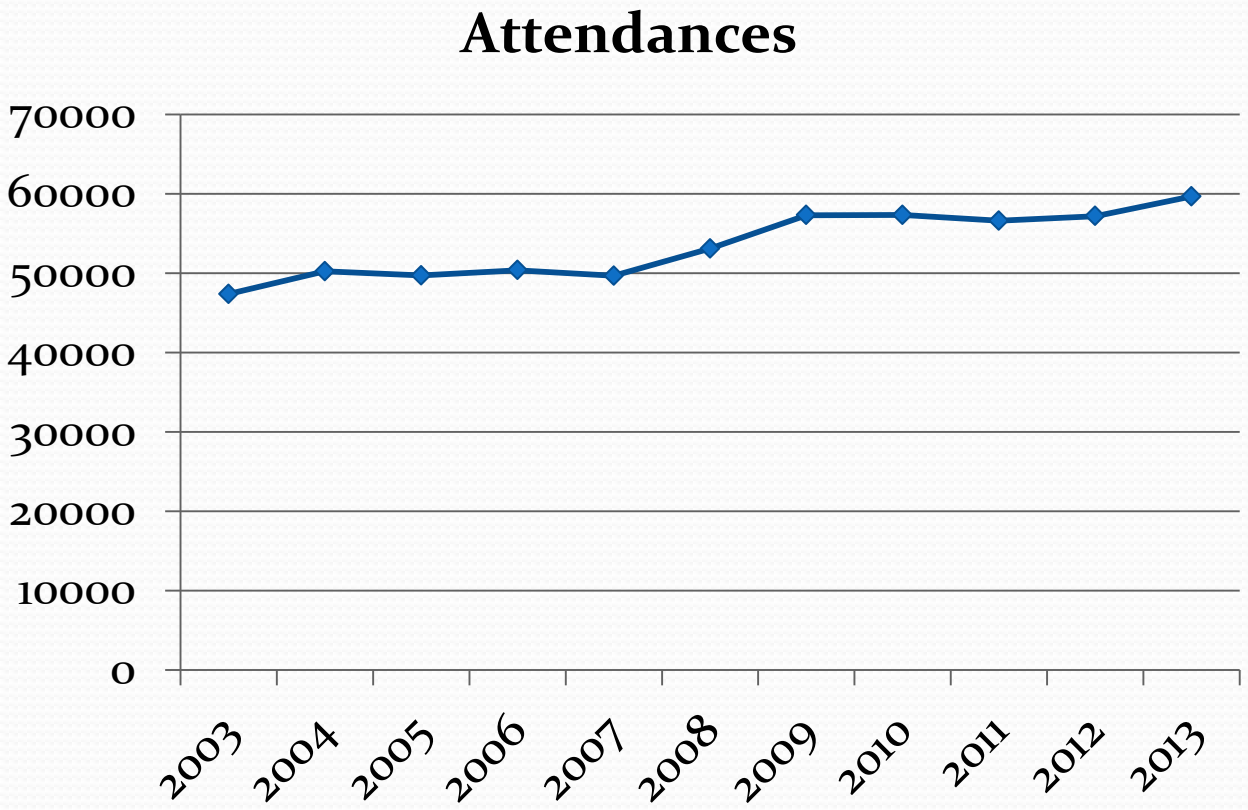
Issues Facing Emergency Care in Altnagelvin

19 May 2014

RQIA Unscheduled Care Summit

Mr. James Steele Consultant Emergency Medicine/Clinical Lead
Mr. Raymond Jackson Unscheduled Care Manager

Workload


Attendances
70000
60000
50000
40000
30000
20000
10000
0
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013

Workload

- From 2003 – 2013 26.10% increase
- From 2012 – 2013 4.33% increase
- Acuity

Space

- Small department
- Interim measures – “Bolted-on areas”
- Refurbishment
- New Department

Staffing

- Medical

Consultants:	3 Substantive ~~2 Locums~~ ~~1 Locum~~ ~~0 Locums~~ 1 Locum
Middle Grade:	1 Associate Specialist 3 SAS/SG 2 ST4+ 2 Locums
"SHOs":	1 CT3 (EM) 3 GPST1 3 F2 1 Locum

Staffing

- Nursing

Band 7 (ENP)	4.32	WTE
Band 6	5	WTE
Band 5	25.62	WTE (Funded)
	5	WTE (Temporary)
Band 3	1	WTE
Band 2	6.67	WTE

ED Staffing

- Will not solve throughput.
- Is a safety/quality issue.

Performance

- 2013:

  95.59% against 12 hour access standard

  70.16% against 4 hour access standard

- 2014: (to 11 May)

  99.97% against 12 hour access standard

  69.72% against 4 hour access standard

Biggest Issues

- Approximately HALF of the patients who breach have been seen and are waiting for a bed.
- Approximately ONE THIRD of the patients who breach leave between 4 and 5 hours.

Historical Position

- Direct GP admissions to specialist wards

Then…

- Patients diverted to ED
- Resulting in GRIDLOCK

Response

- Acute Medical Unit - 22 Beds
  6 Assessment Trolleys

- Surgical Assessment Area
  - 3 Assessment Trolleys
  1 Chair (for R/V patients)

Aspiration

- "Back to basics" - What is Emergency Medicine about?

- Larger, fully resourced Acute Medical Unit.
- Larger, fully resourced Surgical Assessment Unit.
- Separate area for e.g. Fracture reductions.

- ED no longer seen as everybody's Assessment Area

- Alternative options for Primary Care

Unscheduled Care Project

- Informed/Supported by Director of Clinical Development, GMCSU.

- However, it is the Western Trust's project.

Unscheduled Care Project

No.	THEME	NUMBER OF ACTIONS
1	New Policy, Practice and Support Tools	8
2	Workforce	11
3	Discharge Process	6
4	Short Stay Treatment Pathways	4
5	ED	5
6	Capital Works	4
7	Bed Re-Modelling	1
8	Acute Medical Unit	1
		TOTAL 40

Unscheduled Care Project

- Some specifics:

  “Supernumerary” Resuscitation Room Nurses.

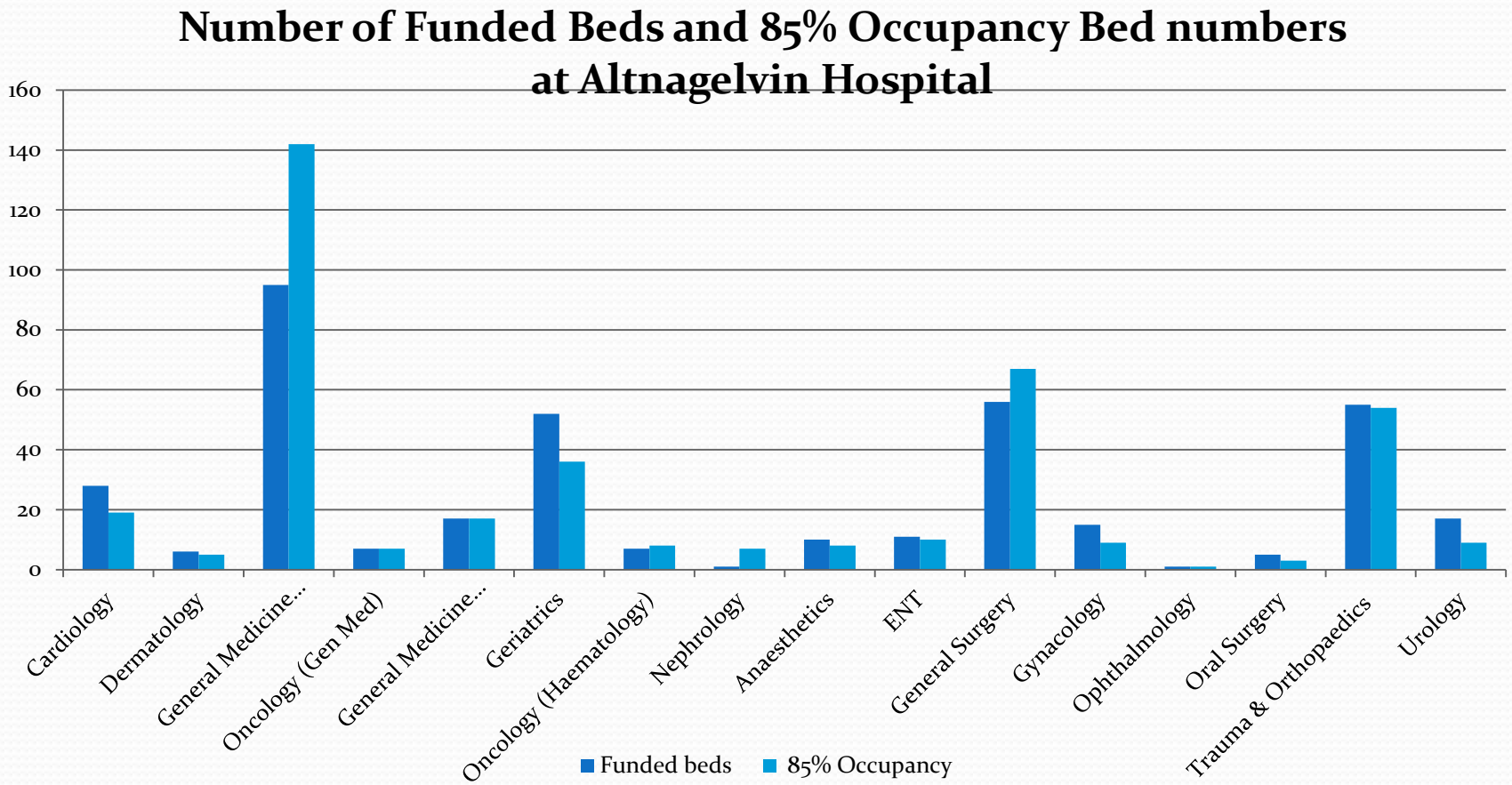
  Improve Streaming (ED refurbishment)

  Admission avoidance shouldn’t mean extra work in ED.

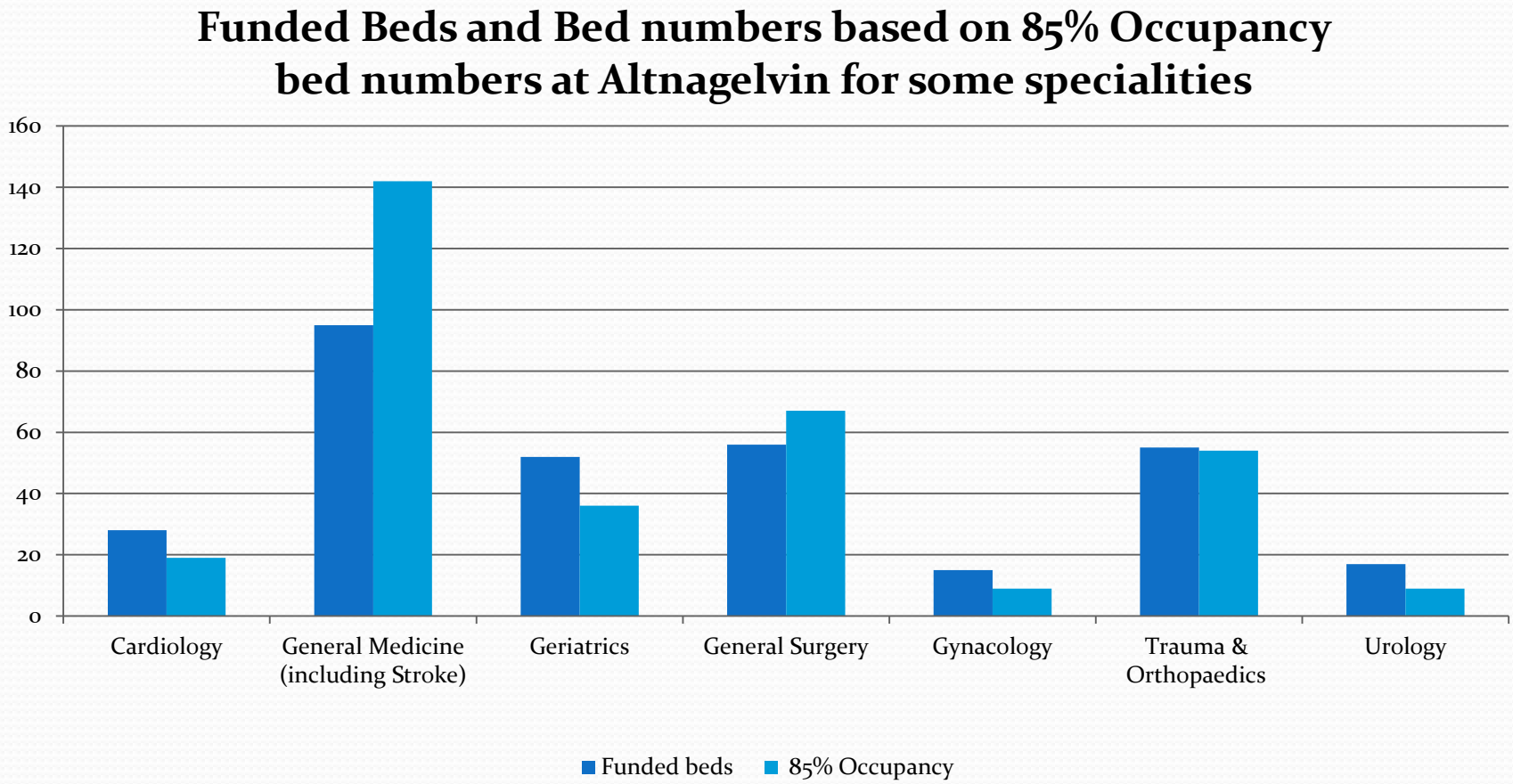
  Recruitment of ANPs

Any Questions?

Bed Remodelling



Bed Remodelling



Escalation Plan

- Refine “Triggers.”
- Earlier activation.
- More proactive.

Any Questions?

The Flow Cost Quality Programme

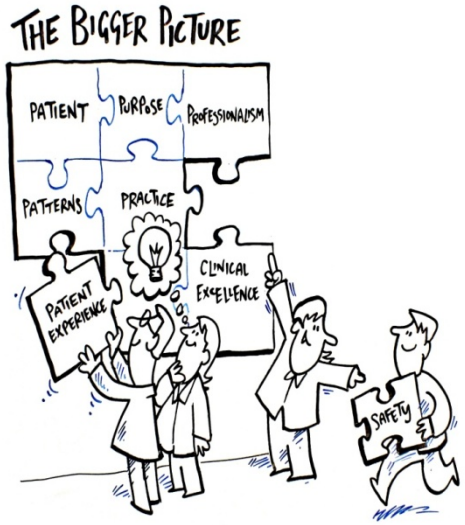
Dr Jane Jones
Health Foundation
19 May 2014

The Health Foundation

The Health Foundation is an independent charity working to improve the quality of healthcare in the UK.

We want the UK to have a healthcare system of the highest possible quality – safe, effective, person-centred, timely, efficient and equitable.

What does the Health Foundation do?



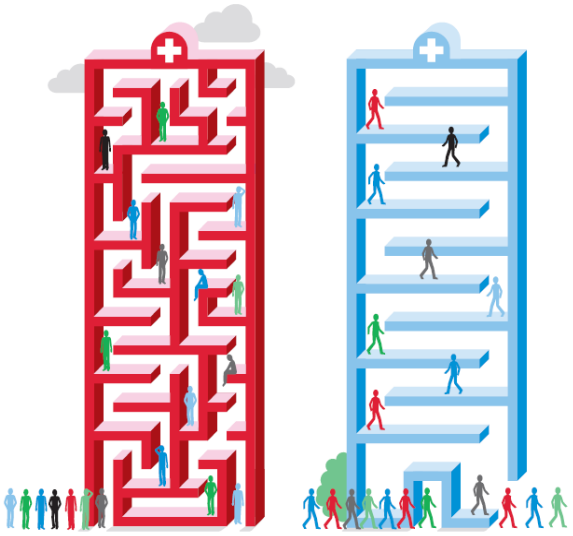
We are here to inspire and create the space for people to make lasting improvements to health services

We conduct research and evaluation, put ideas into practice through our improvement programmes, support and develop leaders and share evidence to drive wider change to the quality of healthcare in the UK

We also have two priority areas where we actively influence healthcare policy and practice: patient safety and person-centred care

The Flow Cost Quality Programme

How a focus on patient flow improved the quality of the care and patient experience at a time of financial pressure



We need to act now

Pressure on hospital capacity is growing in all 4 health systems of UK

- All admissions up 3.7% in Northern Ireland between 2008/09 and 2012/13
- Emergency admissions up 12% since 2007/08 in England and 9% over last decade in Scotland

Health budgets across the UK have slowed in response to austerity

- Between 2010/11 and 2012/13, the annual rate of growth in cash terms were 2% in Northern Ireland, 1% in England and Scotland and in Wales a 1% reduction

The **population** is getting older, frailer with many living with multiple, long-term conditions

- Life expectancy 12 years longer than in 1948
- People over 60 yrs = nearly 25% of UK population and 50% have chronic illness

Interest in patient flow is rising

"Good patient flow through the hospital system can reduce costs and significantly improve patient outcomes; however patient flow is often impeded by inefficient hospital systems"

NHS England Urgent and Emergency Care Review Evidence Base, November 2013

"The smooth flow of patients through hospital from their initial attendance at the emergency department to eventual discharge is fundamental to the operation of an emergency department"

House of Commons **Health Select Committee**, July 2013

"We need to address workforce and demand issues at the 'front door' to ensure effective 'flow' and the efficient, safe and effective care of patients in emergency departments and acute medical units"

Urgent and emergency care: a prescription for the future, **Royal College of Physicians,** College of Emergency Medicine, Society for Acute Medicine, NHS Confederation, July 2013

In Northern Ireland

"Improved patient flow will help reduce the pressures on Trust Emergency Depts"

Northern Ireland Health and Social Care Board and Public Health Agency 2013-14 Commissioning Plan

In Scotland

"Designing care systems with effective patient flow is critical to the delivery of NHS Scotland's Quality ambitions of safe, person centred and effective healthcare."

"The Whole System Patient Flow Improvement Programmes vision for NHS Scotland aims to move away from focusing on a specific areas of flow i.e. unscheduled or elective in isolation and will bring together a whole systems approach to patient flow designed to ensure patients receive the right care at the right time in the right place by the right team".

NHS Scotland Quality Improvement Hub

In Wales

"*A&E departments are under increasing pressure to effectively meet the needs of the people who use them. NHS Wales organisations are working together to identify the blockages and delays in their hospital systems, to identify ways of achieving smoother patient flow. This will improve patient outcomes and experience, and alleviate the pressure on staff."*

1000 Lives Plus

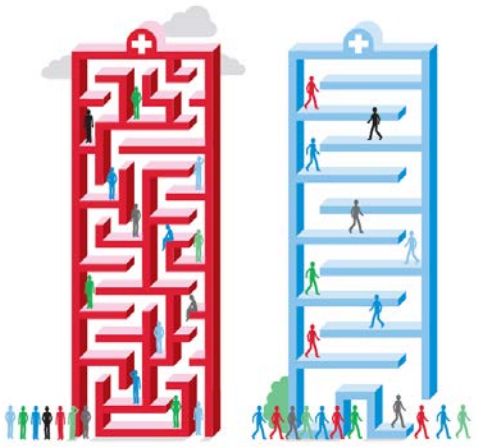
What was the Flow Cost Quality Programme?

2 NHS trusts:

- South Warwickshire NHS Foundation Trust
- Sheffield Teaching Hospitals NHS Trust

Large scale implementation of known approach

Experimental and ambitious



Why did we focus on flow?

Poor systems deliver poor results – for patients, NHS staff and taxpayers

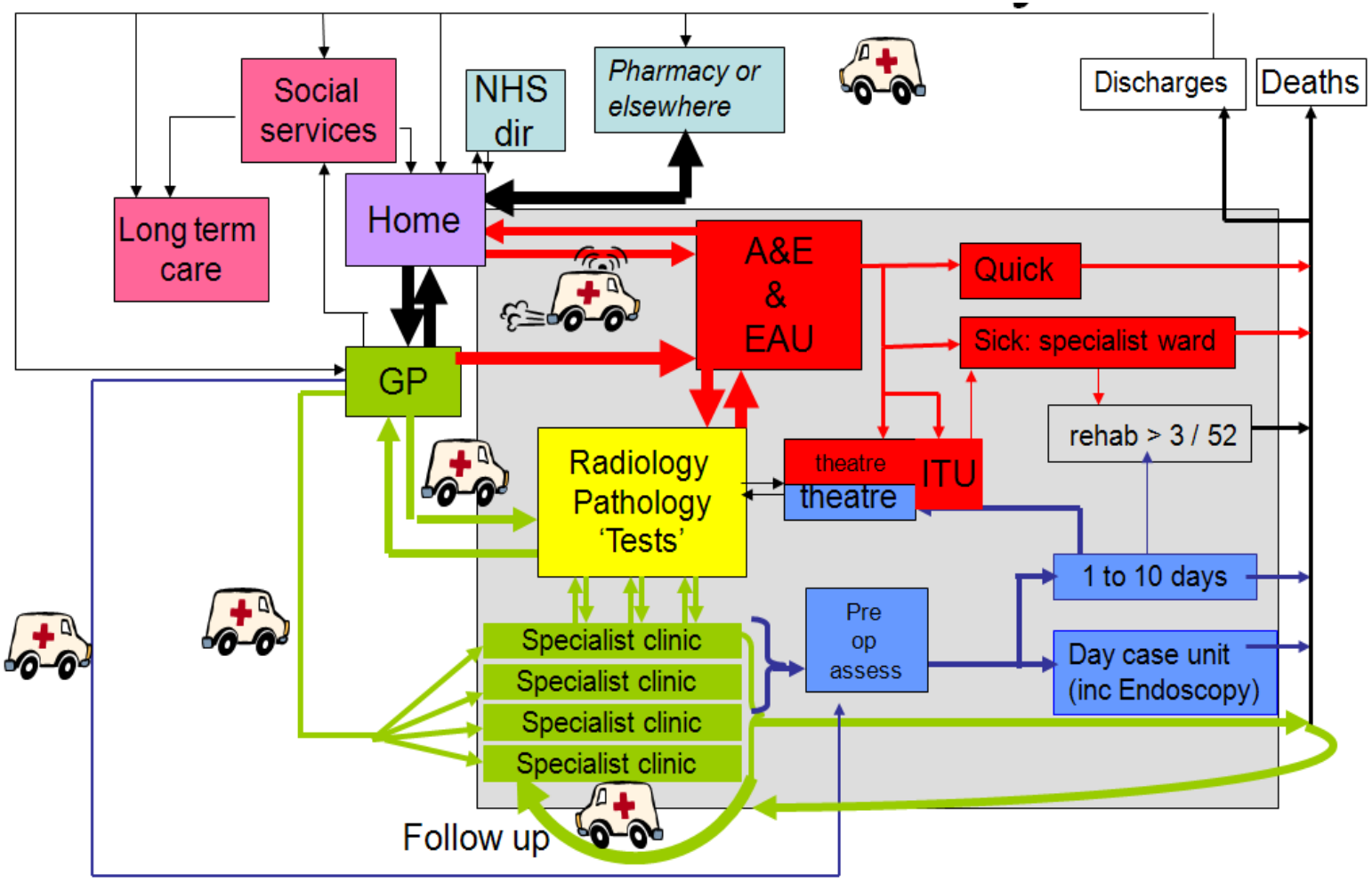
- **Complex systems**
  organised by function not pathways/value stream

- **Invisible problems**
  no one responsible or seeing the whole patient pathway

Flows in a Healthcare System

The Health Foundation Inspiring Improvement

- how, when, where & who = impact quality



Why did we focus on flow?

Poor systems deliver poor results – for patients, NHS staff and taxpayers

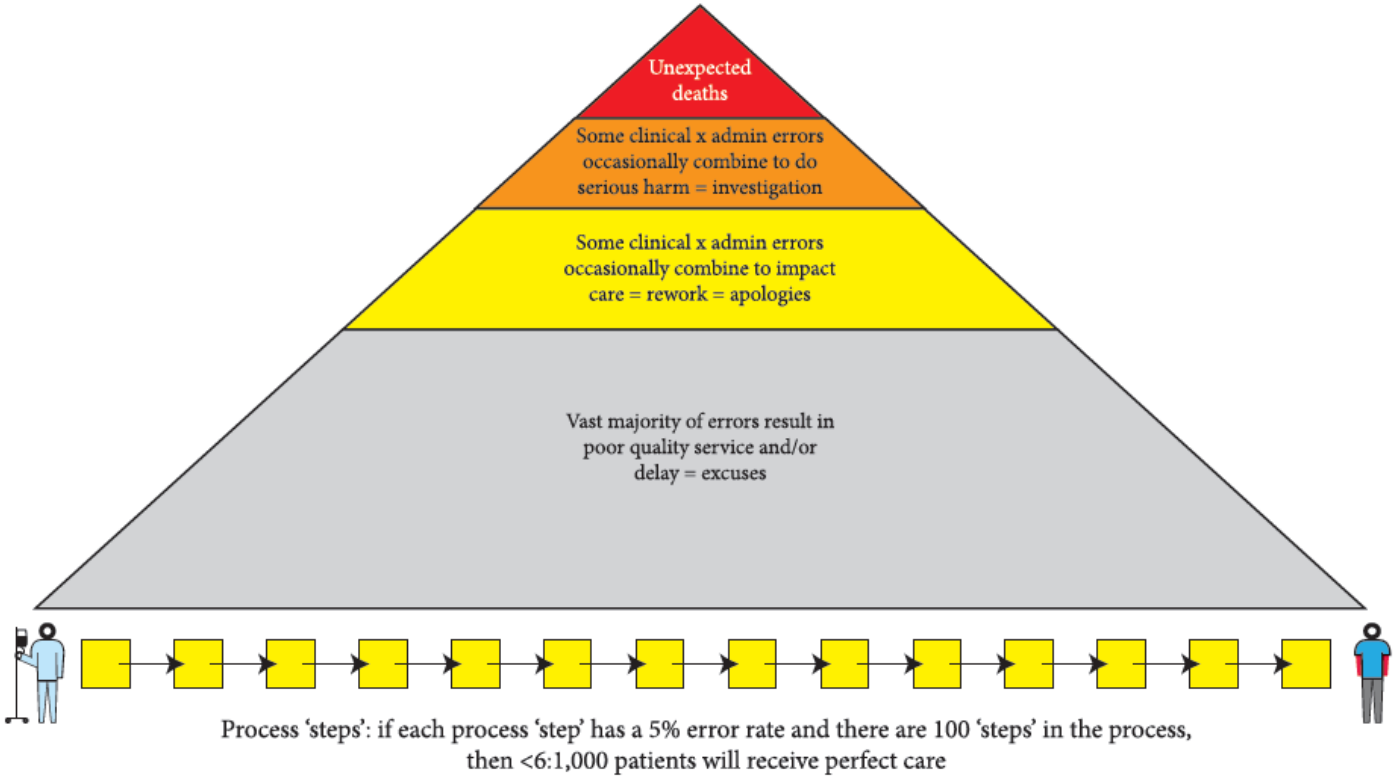
- Complex systems
  (organised by function not pathways/value stream)

- Invisible problems
  (no one person responsible or sees)

- **Poor quality at many steps in care pathways**

The quality triangle

The relationship between patient flow, quality and cost in a care system



Improving the quality of each task by 1% and removing 10% of tasks in a 100 step patient journey would result in 25 out of 1,000 patients receiving perfect care

Focus on the patient: the case for change

Day 1
Sunday
Presents to A&E with melaena
Assessed by Dr 1
Transferred to Assessment unit and **reassessed** by Dr 2

→

Day 2
BH Monday
Consultant 1
Ward round a.m.
Endoscopy p.m.
Midnight transferred to Rheumatology ward

→

Day 3
Tuesday
Missed on round
'Not his Consultant'
Reassessed by Dr 3

→

Day 4
Wednesday
Consultant 3
Stop aspirin and clopidogrel
Possible **home Tomorrow**

→

Day 5
Thursday
Chance meeting with Consultant 3
Can't go home
HB 8.00g/dl
transfusion required
Dr 4 Cross match 1st **unit at 8 pm**

↓

Day 6
Friday
2nd unit
Dr 5
Query needs Helicobacter irradication?

←

Day 7
Saturday
Home tomorrow
If Hb okay
Blood check

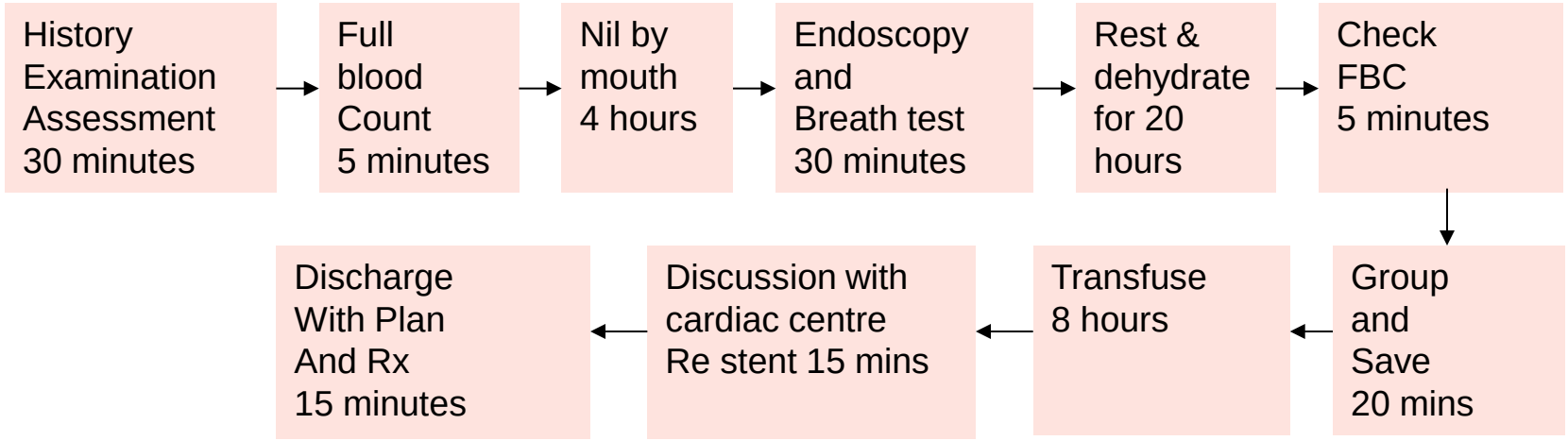
←

Day 8
Sunday
Dr 6
Discharged with Helicobacter Eradication

Patient had negative breath test on endoscopy
Aspirin and clopidogrel required for cardiac stent
Patient's wife consulted with Cardiology centre, not staff!

Quality System?
Quality outcome?
Quality experience?

The patient experience: an effective use of time and resources?



Value adding / Non value adding = 34 hours / 8 days x 24 hours = 18% of time value adding

82% of time and resource wasted – A poor quality experience and outcome from a poor quality system

The programme rationale

Root cause of delays lies in planning process

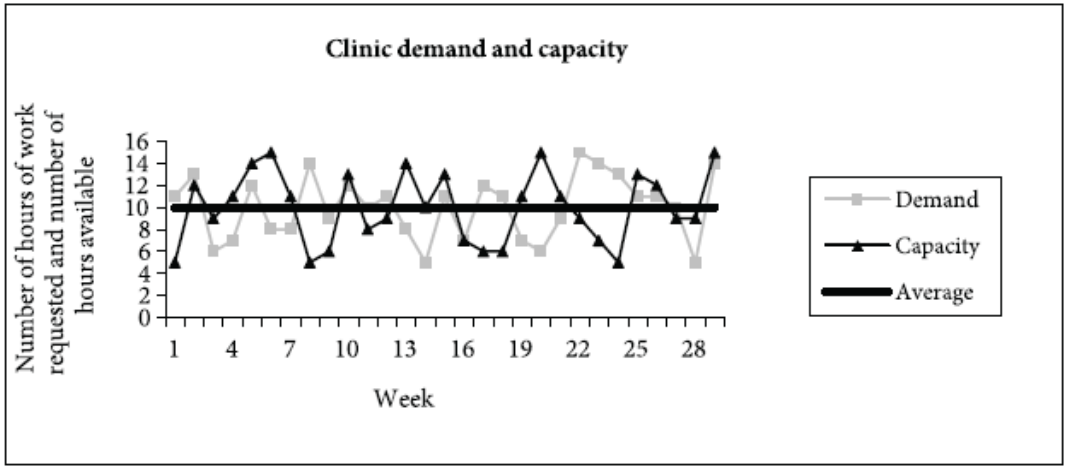
Usual capacity plans based on average levels of past activity (patients seen), not on demand (requests for care)

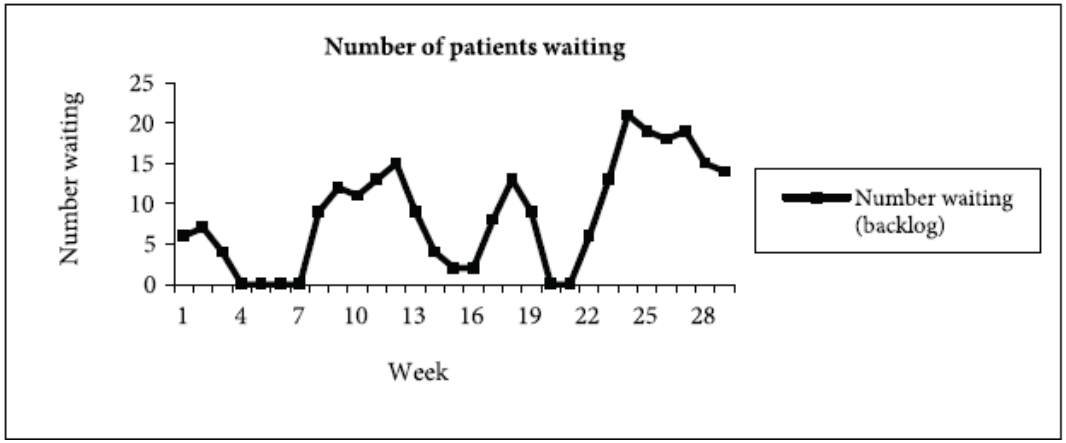
Mismatches between daily variations in demand and staff capacity result in queues and waiting lists at every stage along patient's pathway of care

Focusing on patient flow along the care pathway and taking a 'whole systems' approach ensures that capacity is better matched with demand

The flaw of averages

Basing service delivery on average weekly patient demand levels can cause a mismatch between service capacity and demand





Aims of the programme

The teams were supported to:

- **understand the emergency care patient pathway** & how it relates to wider healthcare system
- **understand demand being placed on every organisation & department** from all sources (emergency, planned, outpatient & follow-up care)
- **develop capacity plans to meet variations in demand** & prevent queues – assess gap between current & required capacity
- **test impact of changes** to capacity by reducing capacity variations, improving productivity, & reallocating resources to where needed

The improvement approach

Require **systematic approach** when faced with complexity
(large organisations, numbers of people, complex processes)

Clinically driven – executive led/ facilitated

Underpinned by:

- **principles of lean,**
- **theory of constraints**
- **clinical systems improvement**

Different **programme management** approaches- traditional vs lean

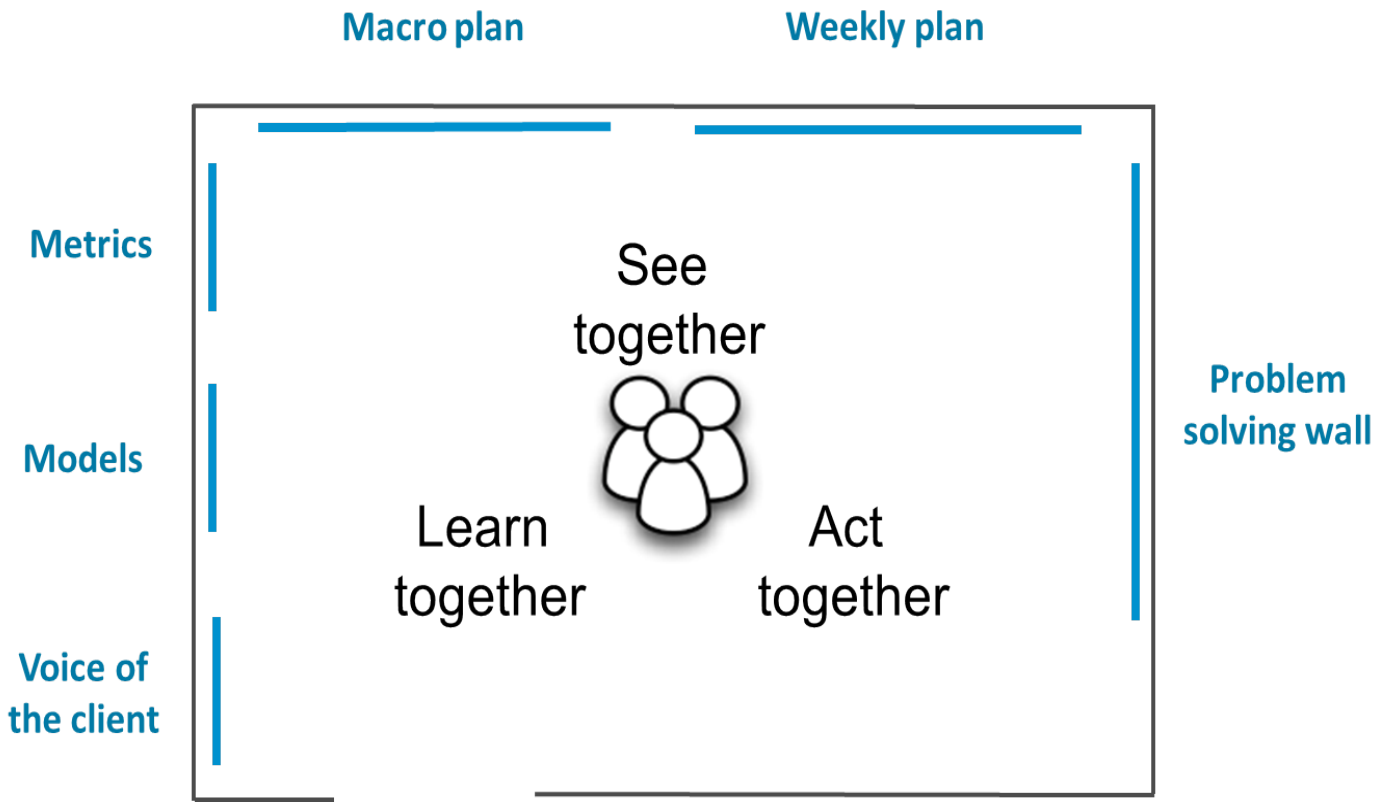
- **A3 process**
- Use of 'big room' method and **visual management**

The A3 process template

Title of problem: Owner and date

Box 1 Issue or problem	**Box 4 Current state map (current condition)** *What is happening currently?*	**Box 7 Improvements required** *(countermeasures to reach the future state)* *What changes are required?*
Box 2 Background *How has this problem come to light?* *How important is it to:* *Business?* *Customers?* *Suppliers?*	**Box 5 Analysis: DATA** *Why are these problems happening?*	**Box 8 Weekly review meetings** *What change* *By who* *By when* *State of completeness*
Box 3 Stakeholders *Who is affected by this problem?* *Who is involved in the process?*	**Box 6 Future state map (target condition)** *What would the process look like if all the waste was eliminated?*	**Box 9 Measures for improvement** Time Cost Quality **Target condition achieved by:** Date Cost/benefit Signed off by

The Oobeya (big room) process



Case Study 1: Providing patients with early access to senior decision makers

The problem

- Frail elderly **waiting in A&E <4 hrs** hours before **transfer** to Assessment Unit (MAU)

- 2/3 admissions arrive in MAU **after 6pm – only junior medical staff** available. Results in **overnight stay** to see consultant next day

-Further delay - first by physician before **referral** to geriatric medicine consultant

The solutions

- Changed consultant timetable to match admission patterns

- Geriatric medicine consultants **available 'at the front door'**

- Faster turnaround process for **diagnostic tests**

- Dedicated MAU for frail older people established co-locating multi disciplinary team

- Pooled junior doctors to meet patient demand, eliminate repeated assessments

Case Study 2: Discharge to assess

The problem

Data - many frail older people spent **several months** in hospital

Case note analysis - multiple points at which **could have been discharged** discharge services unable to respond in time

On average, these patients spent **4 times longer** in hospital than necessary

The solution

Piloting model of '**discharge to assess**'

Patients discharged as soon as **medically fit** and have prompt **assessment** by social care & community intermediate care teams – in their **own home**

On the pilot ward the time between completion of patients' acute care to their return home has been cut from 6.7 days to 0.4 days

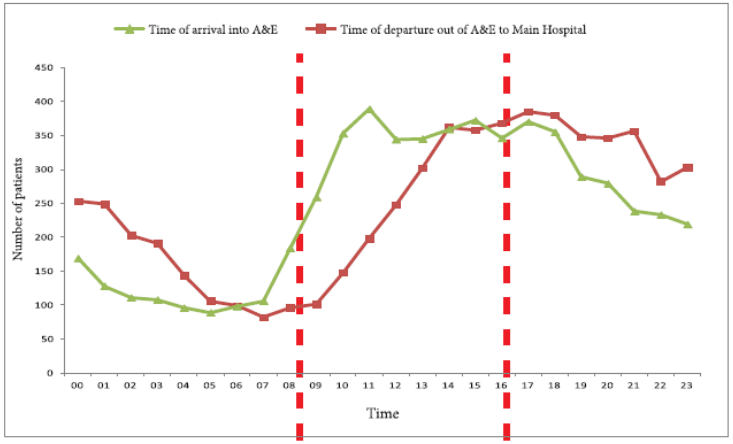
Case Study 3: Pull system

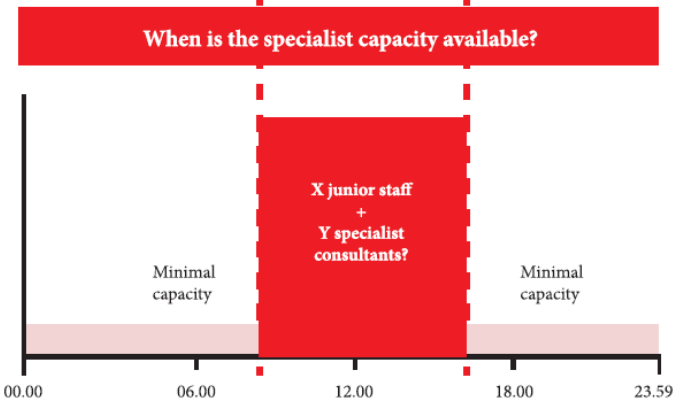
The problem

- Most emergency patients delayed by **multiple assessments** by juniors & then registrar or consultant

- Peak influx of patients from A&E to Assessment Unit in **evenings**

- **Lack of availability** of right staff at right times to meet demand

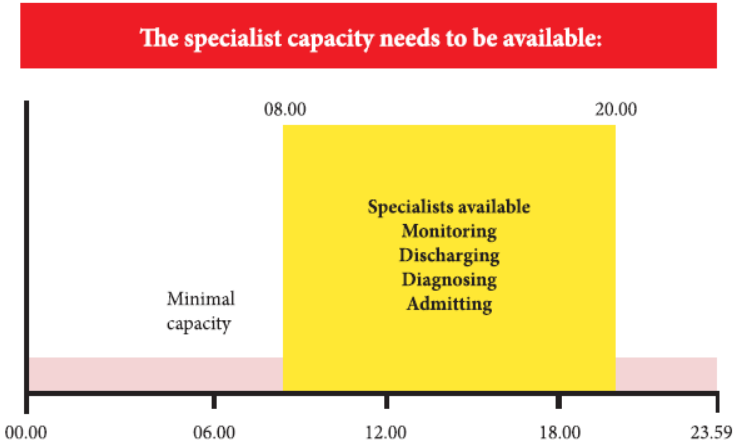




The solutions

- **Senior clinical decision Makers available in assessment unit-** prompt assessment & referral to specialist ward on day of Admission- ‘pulled’ out of MAU

- **Extended & weekend working** For consultants from 8am to 8pm.

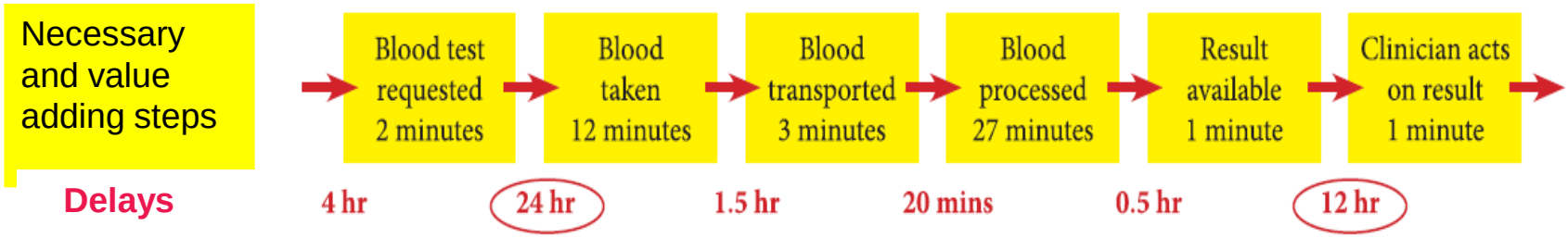


Case Study 4: Blood sciences & imaging services redesign

The problem

Processing of patients' blood tests and consultants' ward rounds not **coordinated**

Clinical decisions on test results at least **24 hours out of date** due to a delay in collecting and processing patients' blood samples



The solution

Multi-disciplinary team re-designed service

Patients' blood taken & **processed same morning** in time for ward round

80% blood results available same day (only 15% before)

Key learning points from the programme

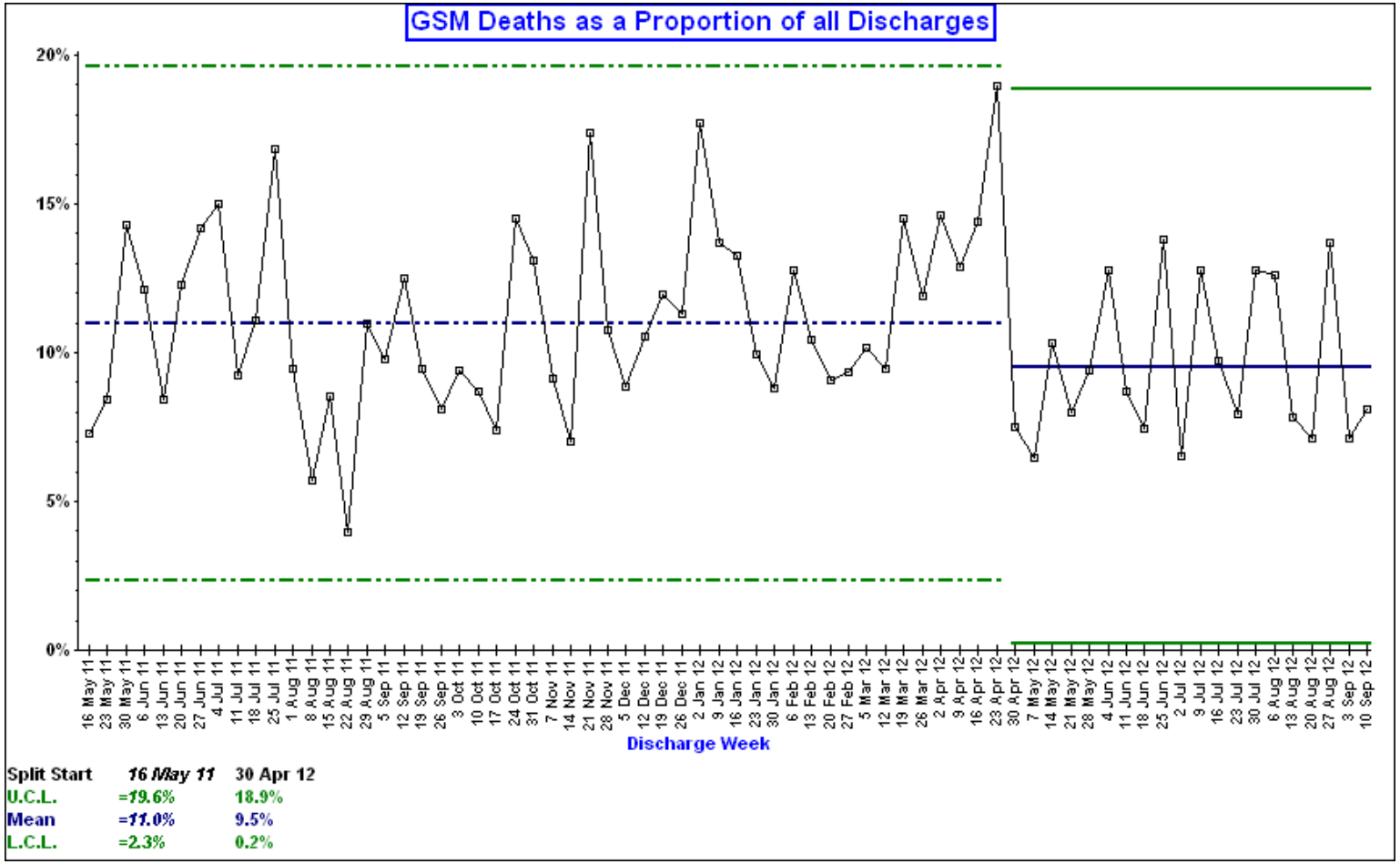
Impact on mortality

The programme demonstrated that **poor flow increases the likelihood of harm** to patients

System-level measures at both trusts showed an apparent correlation between **poor flow and mortality**, while the trusts saw a reduction in mortality as they improved flow

Focusing on patient flow in health and social care systems is crucial to reducing avoidable harm and deaths

Improved flow at Sheffield associated with decline in geriatric deaths



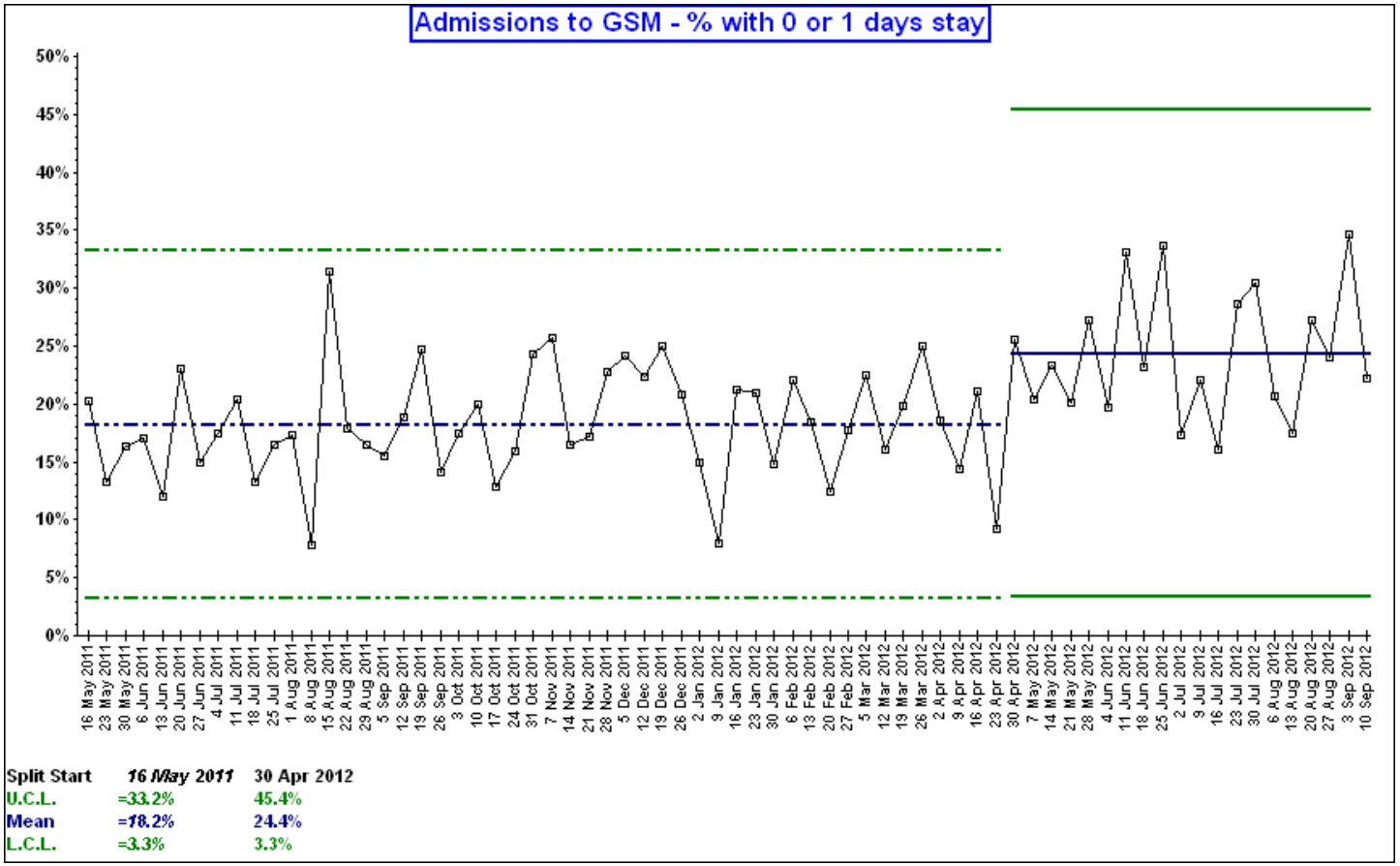
Impact on quality

By reducing **lengths of stay, bed occupancy and re-admissions** the programme helped to improve **patient and carer experience**

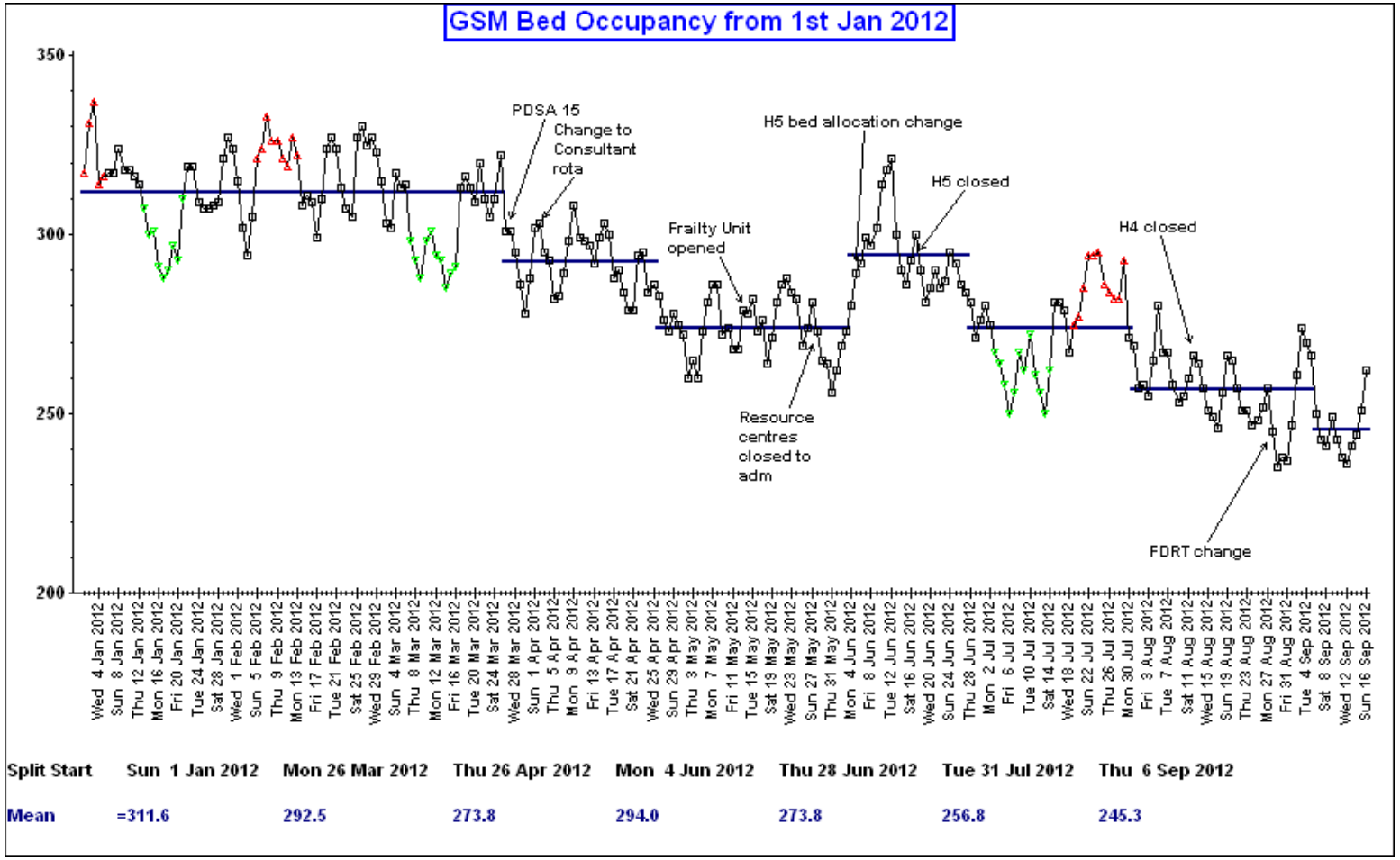
Despite an 11.5% growth in emergency admissions over 12 months, South Warwickshire maintained A&E performance and achieved high levels of patient satisfaction as a result of improved flow

In Sheffield, improved flow led to a reduction in **bed occupancy** and a 37% increase in the number of patients **discharged on the day** of admission or the following day – at a time when demand remained the same

Improved flow at Sheffield associated with increase in percentage of patients discharged from frailty unit on day of admission or following day



Improved flow at Sheffield associated with reduction in bed occupancy



Impact on healthcare costs

The programme demonstrated a correlation between **poor flow and higher costs**

Improving flow **reduces delays and waste**, which can reduce lengths of stay, bed occupancy and re-admissions

Looking at problems and potential solutions within health and social care systems through the ‘lens’ of patient flow will help not only to improve the **efficiency of care processes,** but also the **quality of the overall system**

Embedding and sustaining change

Two years on from the end of the Flow Cost Quality programme both Sheffield and South Warwickshire have succeeded in sustaining its momentum and impact

Sheffield's discharge to assess model is in operation on two wards – and is in the process of being rolled out across the whole city

The discharge to assess model has been shortlisted as a finalist in the Quality Care category in the HSJ's Safety and Care Awards

In January 2014 **South Warwickshire** was able to report that it had hit its A&E targets for 7 consecutive months, had reduced mortality, was operating within tariff and had implemented its own discharge to assess model

Important lessons

Focus on patients' needs - gathering patient stories and using as driver for change

Diagnosis, rigorous data collection & sharing between teams enabled staff to understand why change was necessary

Visual management - making issues, data, patient stories, learning & progress visible widens involvement

Flow solutions involve **cross -departments & function** redesign

Testing ideas on a small-scale - gives confidence and evidence

Improvement strategies tailored to local situation–no one size fits all - an adaptable, participative approach is crucial

Achieving impact takes time –allow time for data collection and analysis and for improvement methods to be understood and embedded. Real change at system level has taken 2 to 3 years

Where next?

It is important to recognise that patient flow is **not just a concern for A&E** departments – every functional service in every tier of the NHS needs to take an interest in flow

The challenge now for healthcare providers across the UK is to ensure that the capacity and staffing level of each service **matches variations in patient demand**

Changes in existing structures, work processes and culture at **every level** are needed in order to improve patient flow across the health and social care system

Sheffield and South Warwickshire have shown what **is possible**

Spread across the UK

We are working with policymakers across the UK to widen the impact of the work of Sheffield and South Warwickshire

NHS Scotland is testing the Flow Cost Quality model in NHS Lanarkshire as part of its Whole Systems Patient Flow improvement programme

The Patient Flow programme in **Wales**, led by 1000 Lives Plus, draws heavily on the Flow Cost Quality programme – the Health Foundation is also funding the evaluation of the programme

In **England** we are working with the Urgent and Emergency Care Review team at NHS England and the Seven Day Working programme team at NHS IQ to identify ways of enabling providers to introduce whole system approaches to patient flow

Health and Social Care Board

Public Health Agency

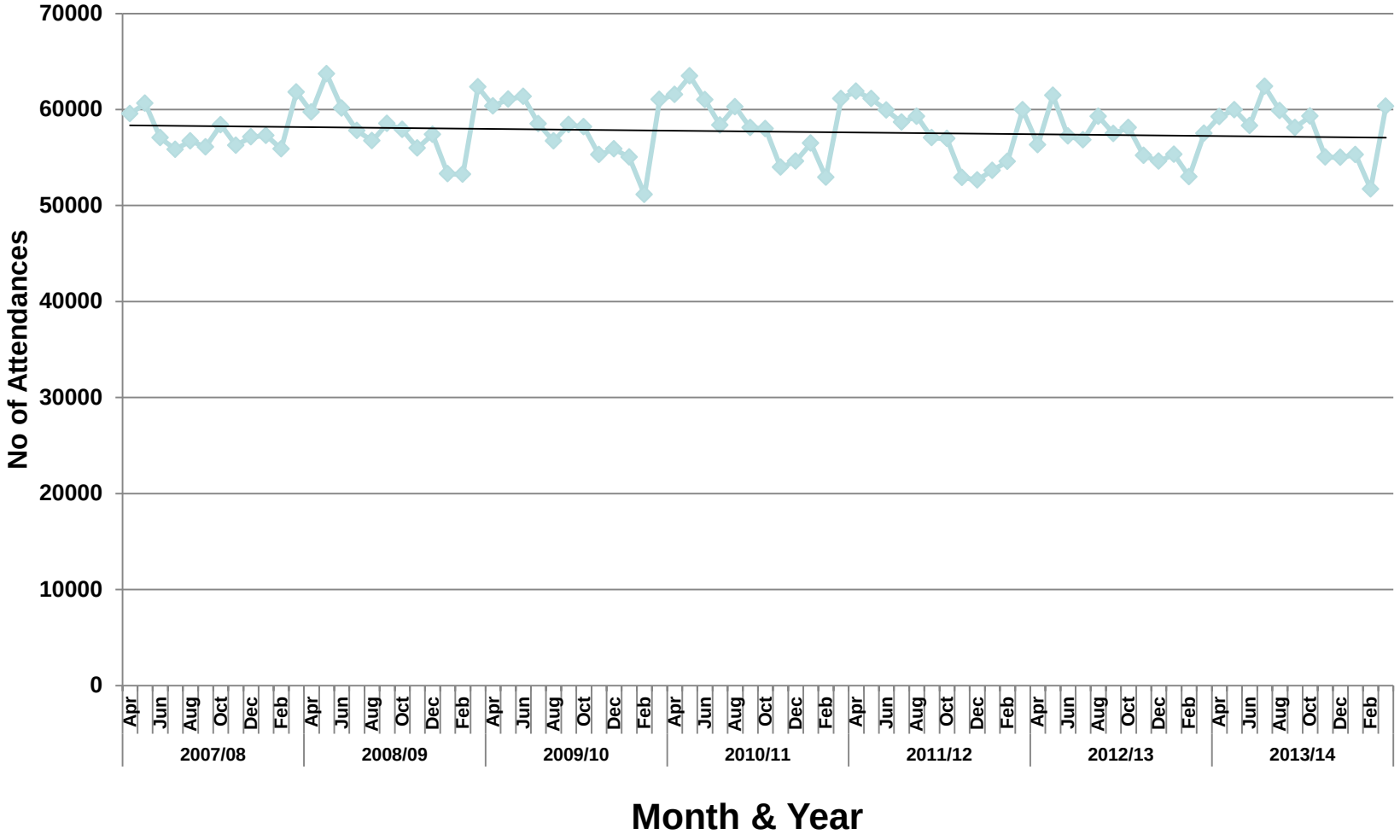
HSCB/PHA
RQIA Summit
Unscheduled Care Presentation

19 May 2014

Health and Social Care Board

Public Health Agency

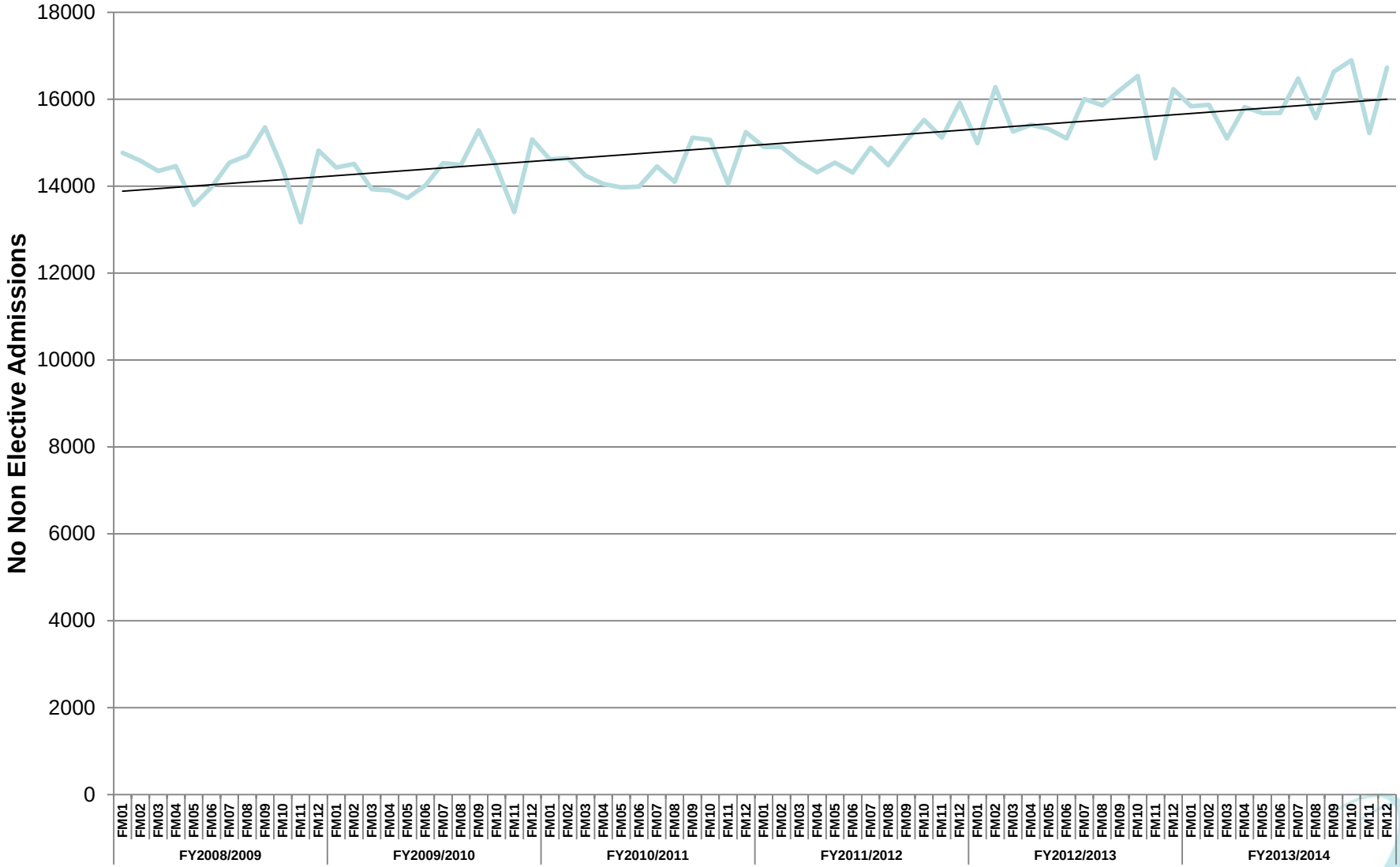
ALL NEW & UNPLANNED ATTENDANCES AT ED 2007-2014



Health and Social Care Board

Public Health Agency

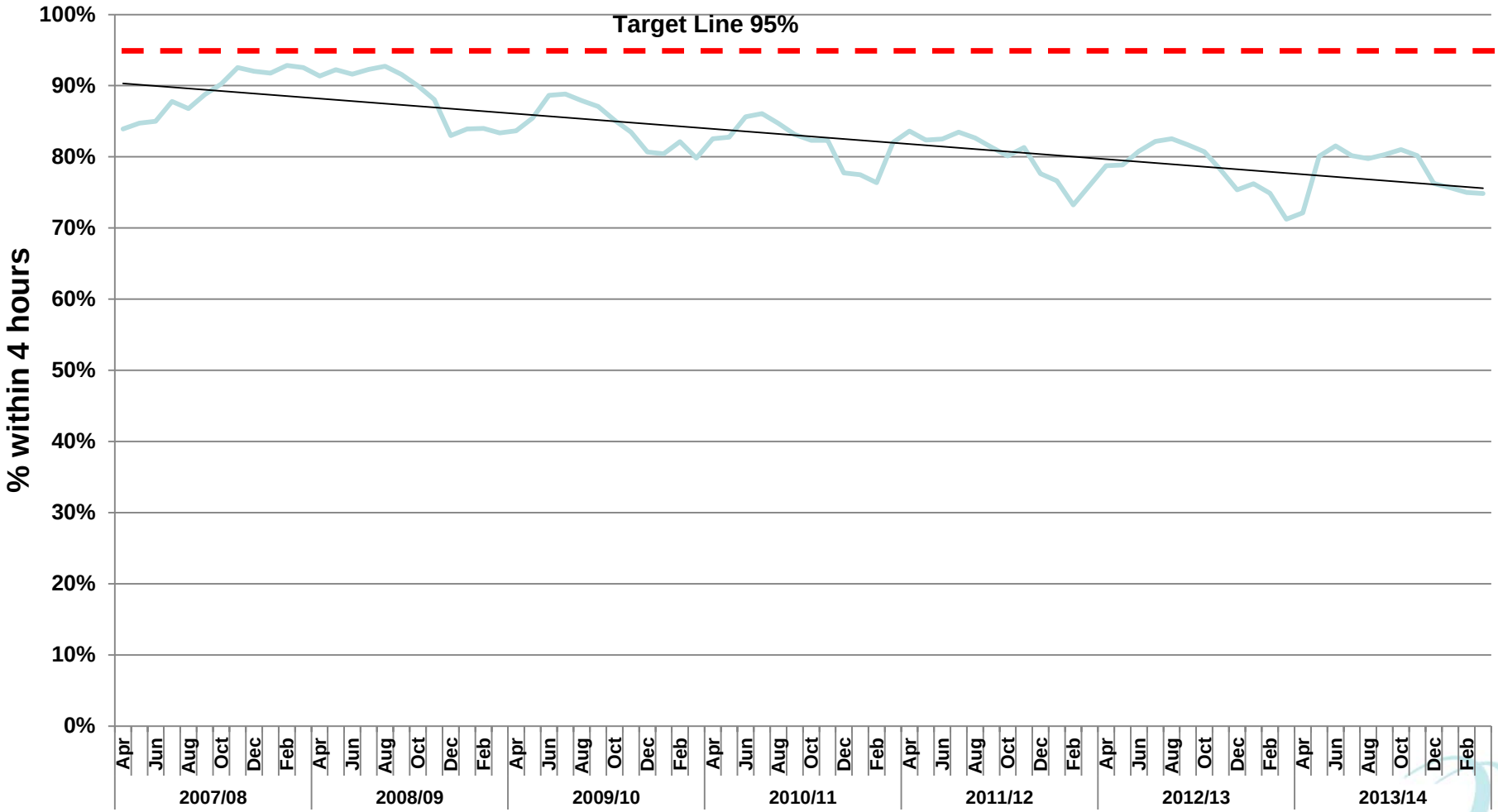
ALL NON-ELECTIVE ADMISSIONS 2008-2014



Health and Social Care Board

Public Health Agency

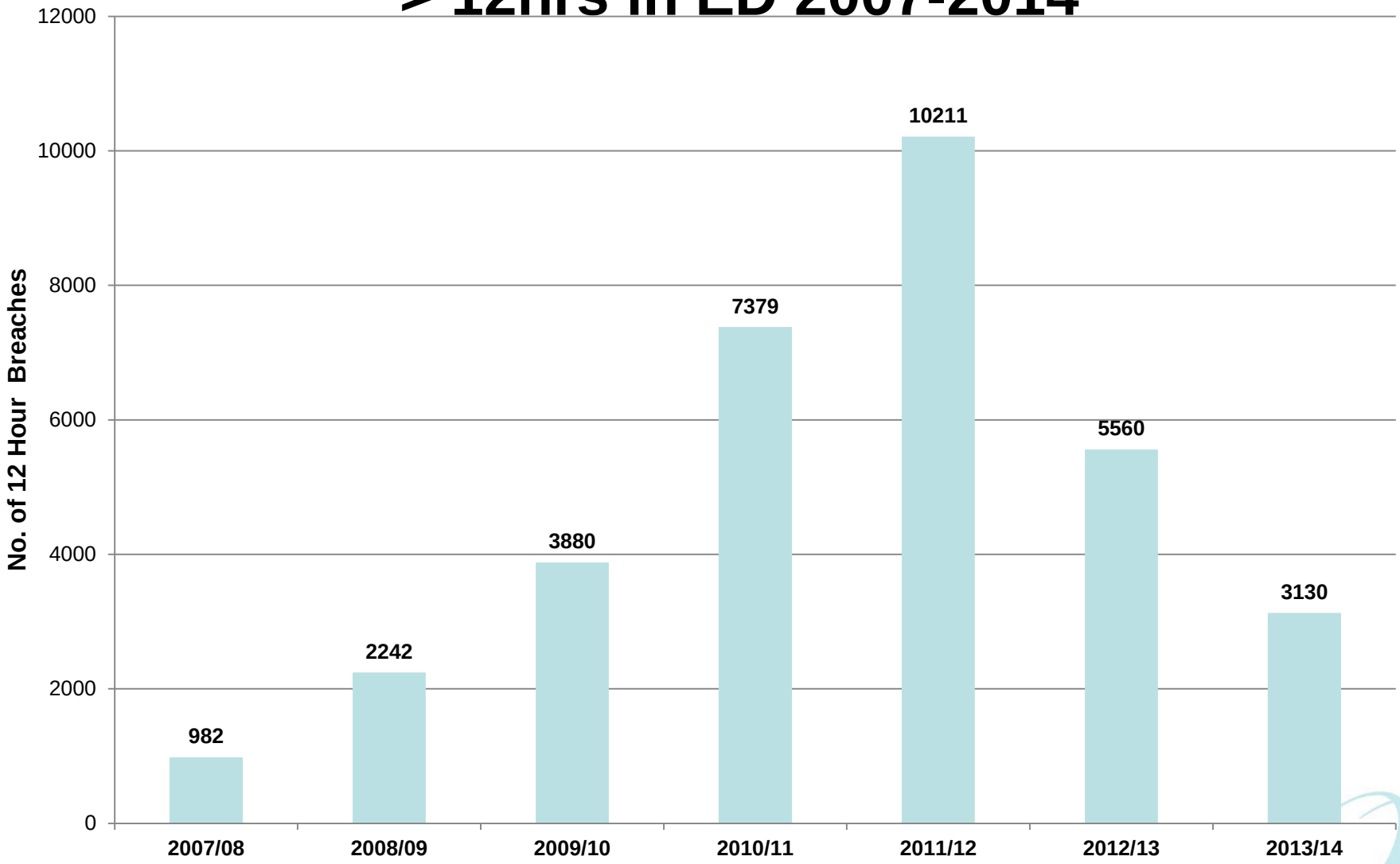
REGIONAL ED PERFORMANCE: % within 4hrs 2007-2014



Health and Social Care Board

Public Health Agency

TOTAL NUMBER OF PATIENTS WAITING > 12hrs in ED 2007-2014



- 07/08 huge efforts were made by everyone however the performance was not sustainable
- Embedding the fundamental best practice principles to improving whole system working remain key to all initiatives working and providing sustainability
- They are the bedrock on which all initiatives/solutions must be built

Improving Patient Flow…HSCB Focus

- Audit of fundamental best practice principles to improve whole system working
- Audits of non–acute beds in relation to effective utilisation
- Bespoke support and advice to Trusts in relation to improving unscheduled care services
- Developed in collaboration with BSO the NIAS dashboard
  - Nine indicators
  - Designed to provide better information to assist NIAS in managing patient flows across the entire system

Audit Headlines

- 11 Acute Sites
- July'13 – April'14
- 800 patients – 85% were Non-Elective patients with only 6% admitted as a 'GP direct' admission
- 66% >65yrs of age
- 4,520 Acute in-patient days reviewed

Audit Headlines

- Outcome Focused Management Plan (OFMP) within 24hrs – evidenced on 43% of patients

- Discharge planning within 24hrs – evidenced on 22% of patients
  - How do we therefore achieve discharging 65% patients in < 2 midnights with this level of discharge planning

- Looking at the overall hospital processes, senior medical review was audited (4,520 days)
  - (776 days) 17% Twice daily senior review
  - (2277 days) 50% Once daily senior review
  - (1467 days) 33% No evidence of senior review

- The further into the inpatient stay, senior review becomes less evident

Audit Headlines

- 50% of all discharges before 1pm – achieved for 18% of patients
  - Linked to lengthy waits for patients in the ED
  - 60% patients do not leave the hospital on the day of discharge until 6pm or later
  - A similar percentage of patients are not being admitted into a bed from ED until 6pm or later
  - 80% of discharged patients everyday are categorised as ‘simple discharges’
  - We need to balance workload with staff resources
  - The challenge is to shave off **6 hours** from the LoS on the day of discharge

Themes From Elsewhere

- Direct admissions for patients not requiring resuscitation
- Direct admitting rights for ED to all specialities
- Ambulatory models of care and patients streamed accordingly
- Specialities taking ownership and ‘pulling patients’ out of ED
- Reducing redundant time for patients in ED
  - Triage and/or patient self selection
  - Identified stream
  - Registration

Themes From Elsewhere

- Escalation at 2/3 hours. Clinical Directors/Executive Directors involved at this point
- Bed/operational meetings chaired by Directors
  - Short, concise and focused
  - Action centred
- A patient waiting longer than 12 hours is a ‘never event’
- Focus on the maximum number of 4 hour breaches each day to ensure a consistent 95% 4 hour performance
- Effective hospital discharge processes which support early planning of patient discharge

Themes From Elsewhere

- No ‘magic bullet’
- An acceptance that 4 hour performance is a Trust wide standard which is measured in ED and therefore its achievement is reliant on everyone performing everyday!
- Creating a culture with corporate ‘buy in’ and ownership of the problem/s across the organisation
- ‘Hearts & Minds’ - influencing behaviour to achieve different and renewed ways of working across all managerial/professional groups

Themes From Elsewhere

- Not about additional capacity per se
- Not a ‘project’ but rather a consistent way of working every single day
- Relentless operational focus which never ends
- Relentless Executive Team focus which never ends
- Patient safety, experience and organisational reputation are key drivers
- Everyone is ‘on message’

True or false?

- A long wait in ED increases the risk of patient harm & death
- ED waits are an indicator of flow in the whole emergency system
- Most of the solutions are outside ED control
- Do clinical staff on wards believe they have a direct responsibility for the safety of future patients who will come in to their ward via ED – but cannot get in because of the way the current ward operates?
- The solutions require a change in longstanding traditional models of care & hence job plans of staff
- **Change to culture and working practices is always hard**

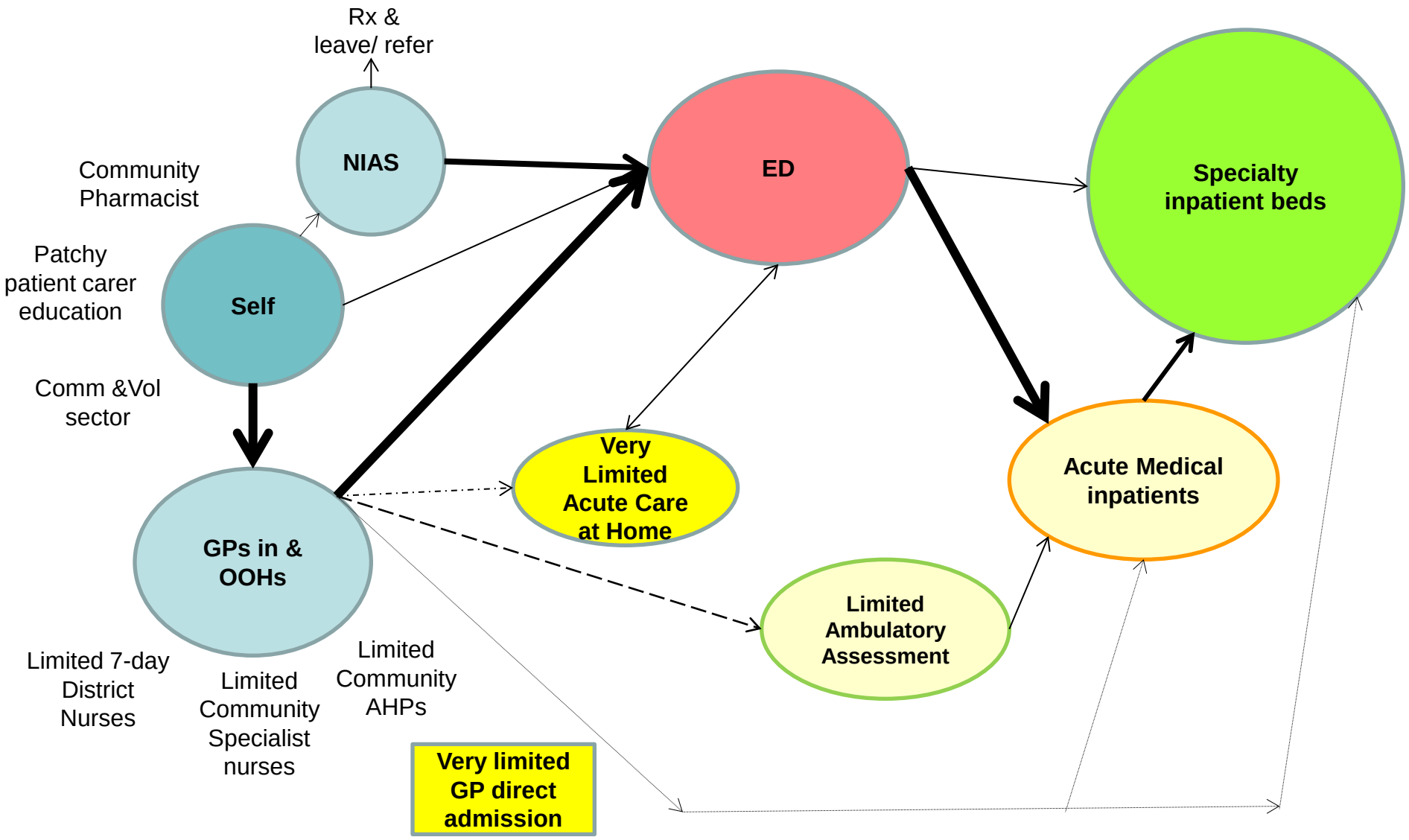
One Trust in NI

On average there were 338 ED attendances per day of whom

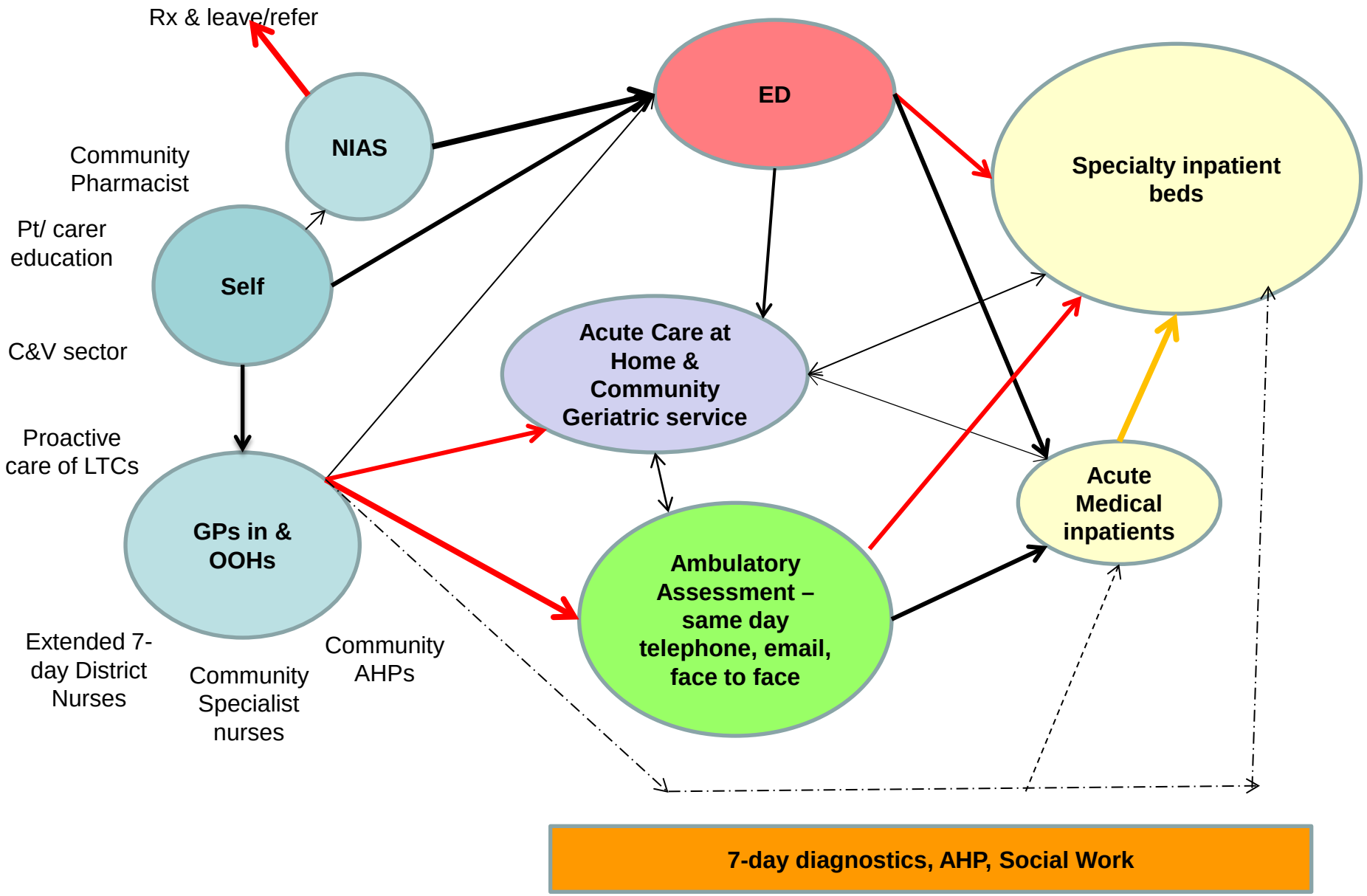
- 79 (24%) NIAS 999 (public and GP calls)
- 21 (6%) GP ‘Urgent’
- 45 (13%) GP referral
- 193 (57%) self-referred

- Variation
- ED Atts 300-415
- Non-elective adms 80-150
- Non-elective discharges 60-200

Current Unscheduled Care Model - inflow



Future Unscheduled Care Model inflows



Closing the Audit Loop

- Repeated audits show that the basic elements needed to fix the ED delays are still not routine practice. Solutions which focus on other issues are not going to succeed long-term
- A smooth patient journey needs a very complex chain of actions & decisions. One weak link can undo the (sometimes superhuman) efforts made by others leading to demoralisation & collapse of early gains
- Leadership by senior clinical staff & management is a vital component to achieve sustainable change

Summary

- No ‘Magic Bullet’

- Commissioning focus on
  - enhanced community response for frail elderly
  - systems for GP referred patients to avoid ED
  - in-day discharge processes
  - 7 day & extended day working
  - rapid access to, patient review and discharge from specialist beds.

The 4 hour standard will flow from these changes

- Needs strong leadership and clinical engagement. This is primarily a patient quality issue. All staff – not just those working in ED - need to understand their role in achieving improvement and why that will need changes to longstanding ways of working

RQIA Summit
Improving Care

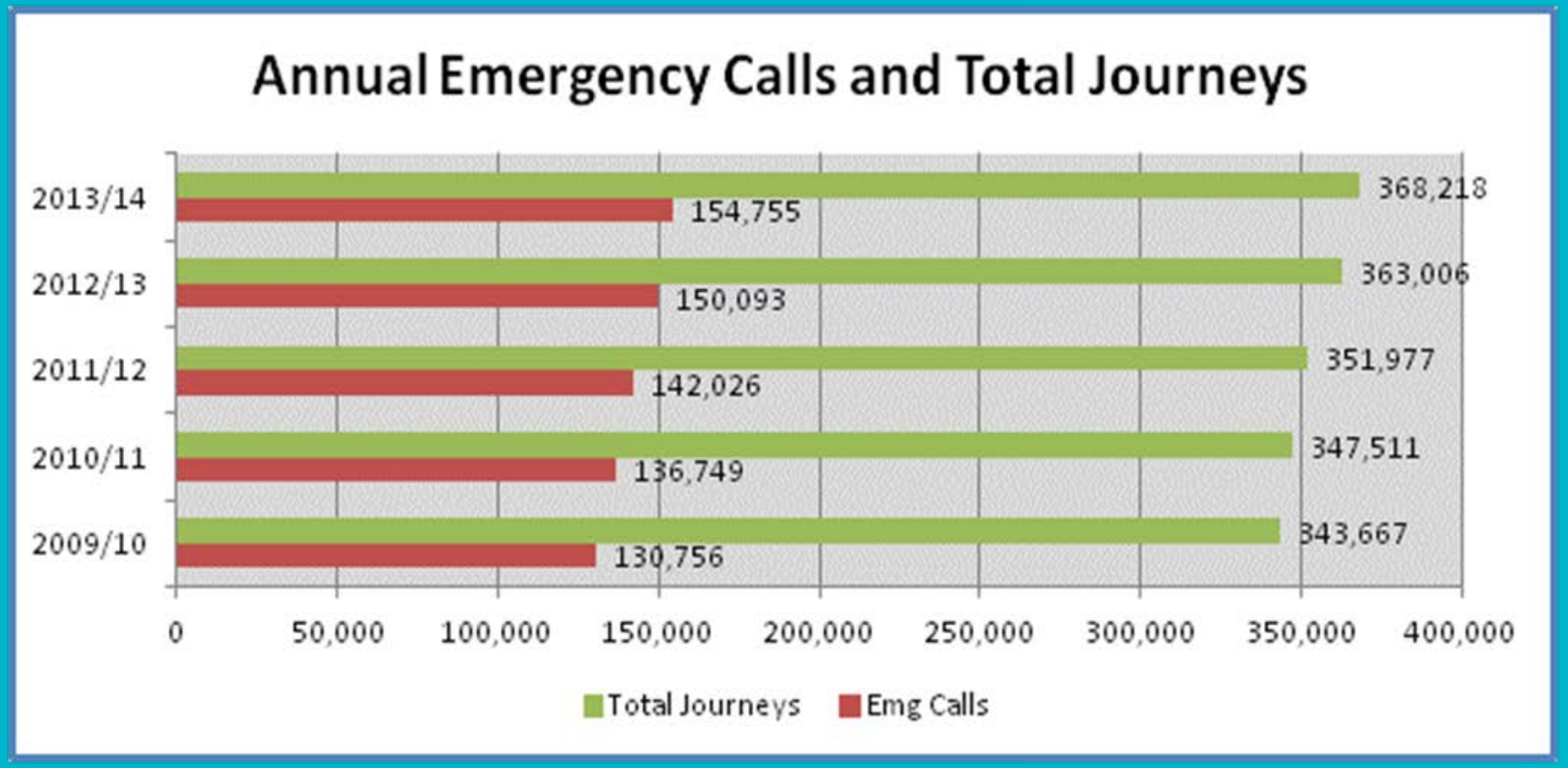
Brian McNeill
Director of Operations (NIAS)

19 May 2014

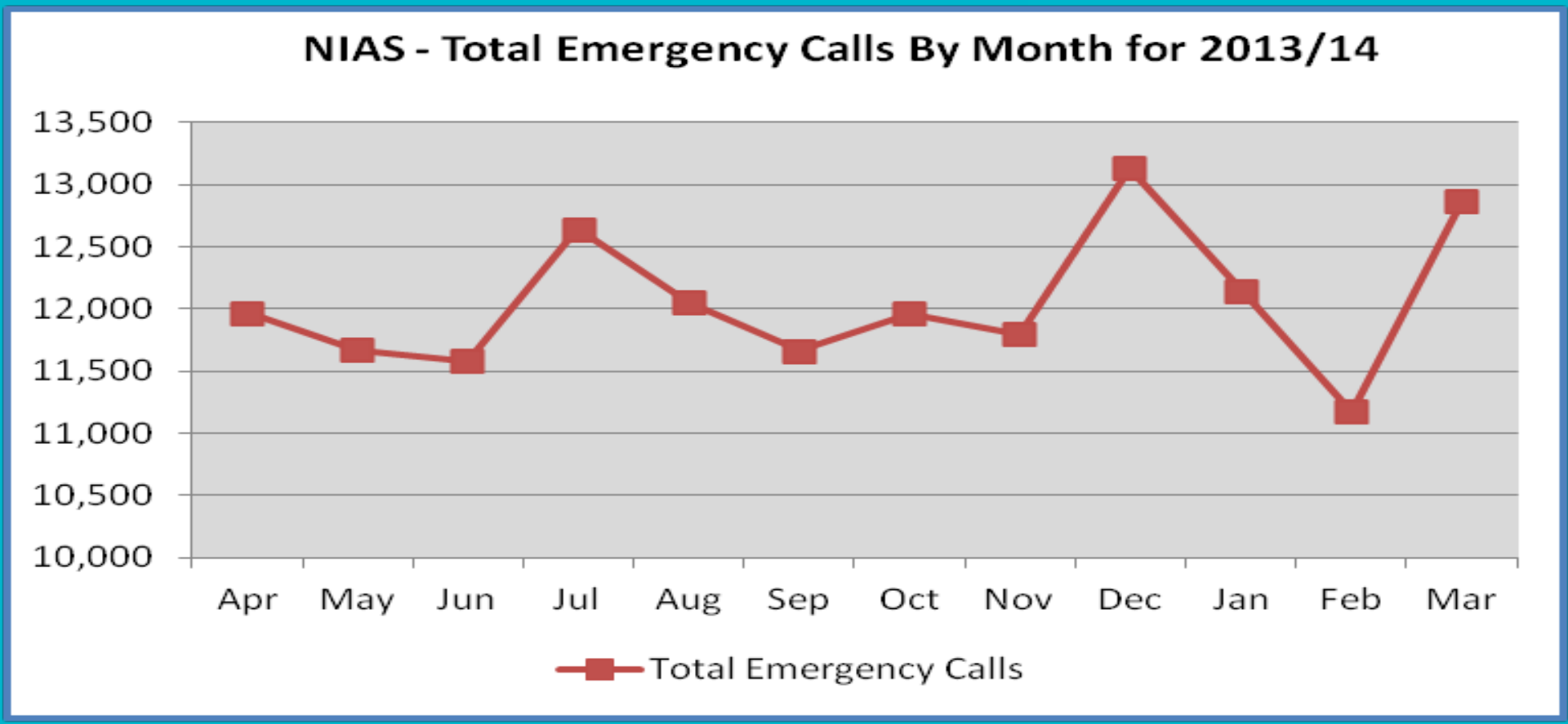
Improving Care.

- **Setting a context**
- **Evaluation of Initiatives**
  - Hospital Ambulance Liaison Officers
  - HSCB Dashboard
  - Use of ICVs
  - **Future Plans**
  - Card 35
  - TYC and New Models

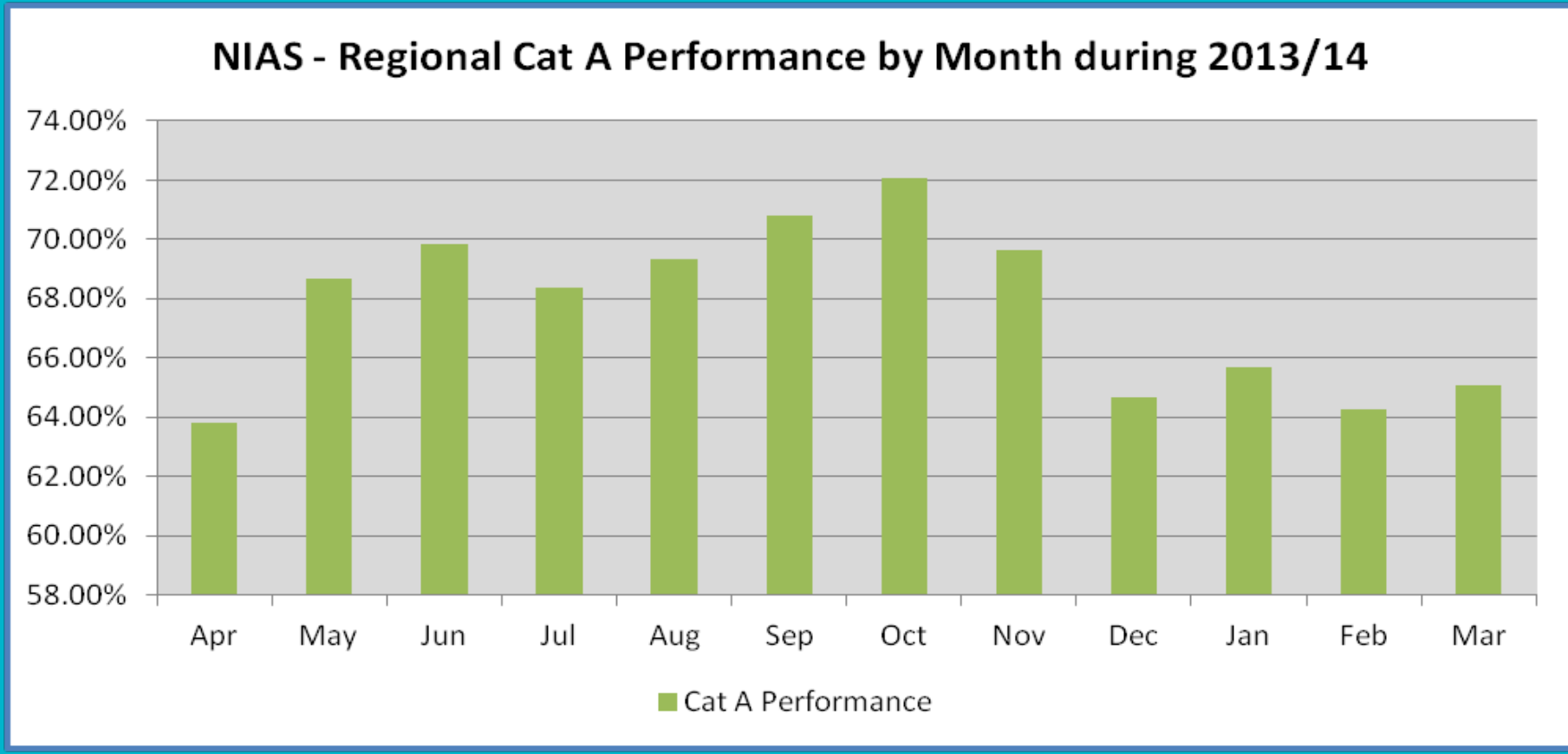
Context : Demand pressures



Context : 999 Activity



How we are measured: 72.5% A8



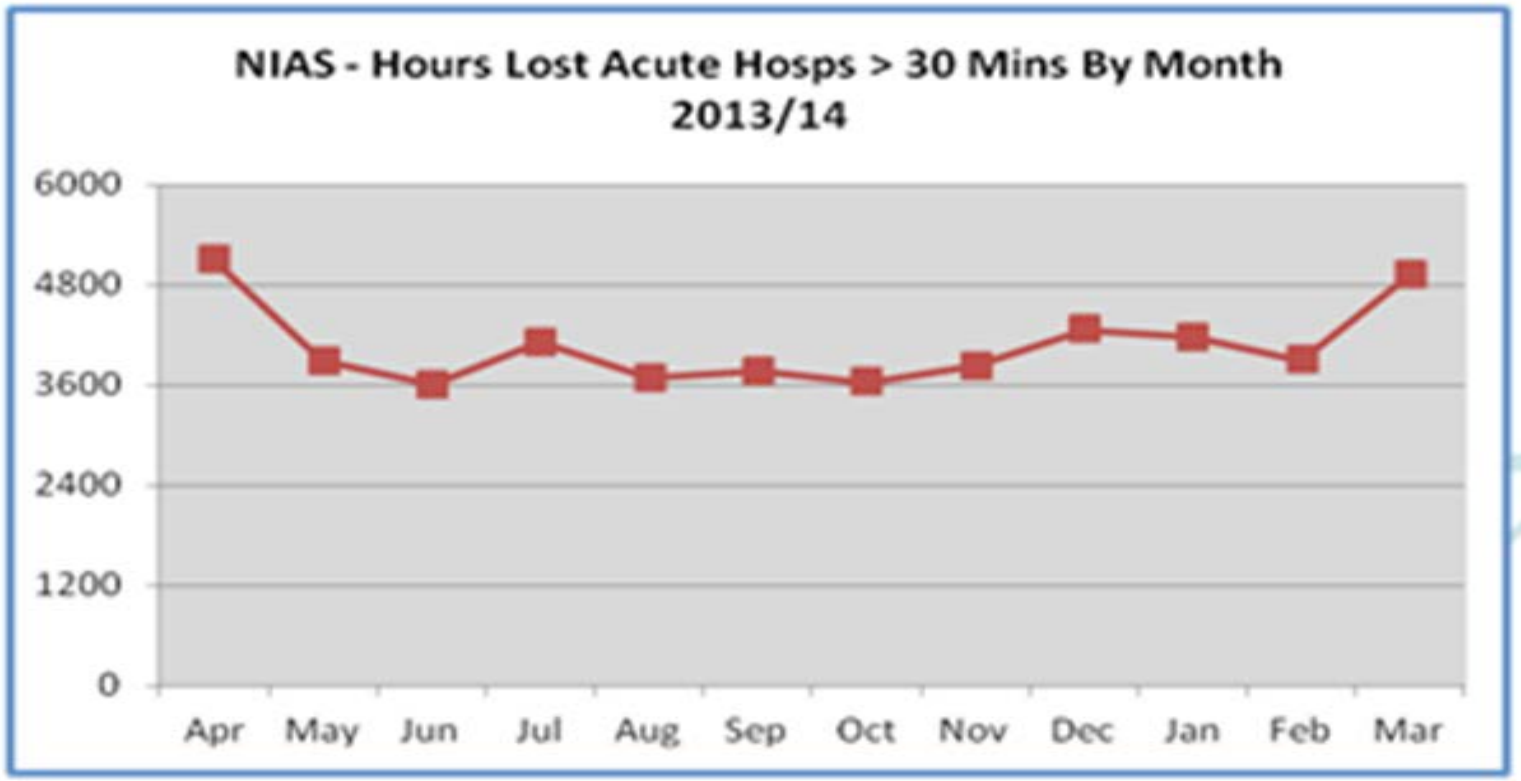
The Challenge

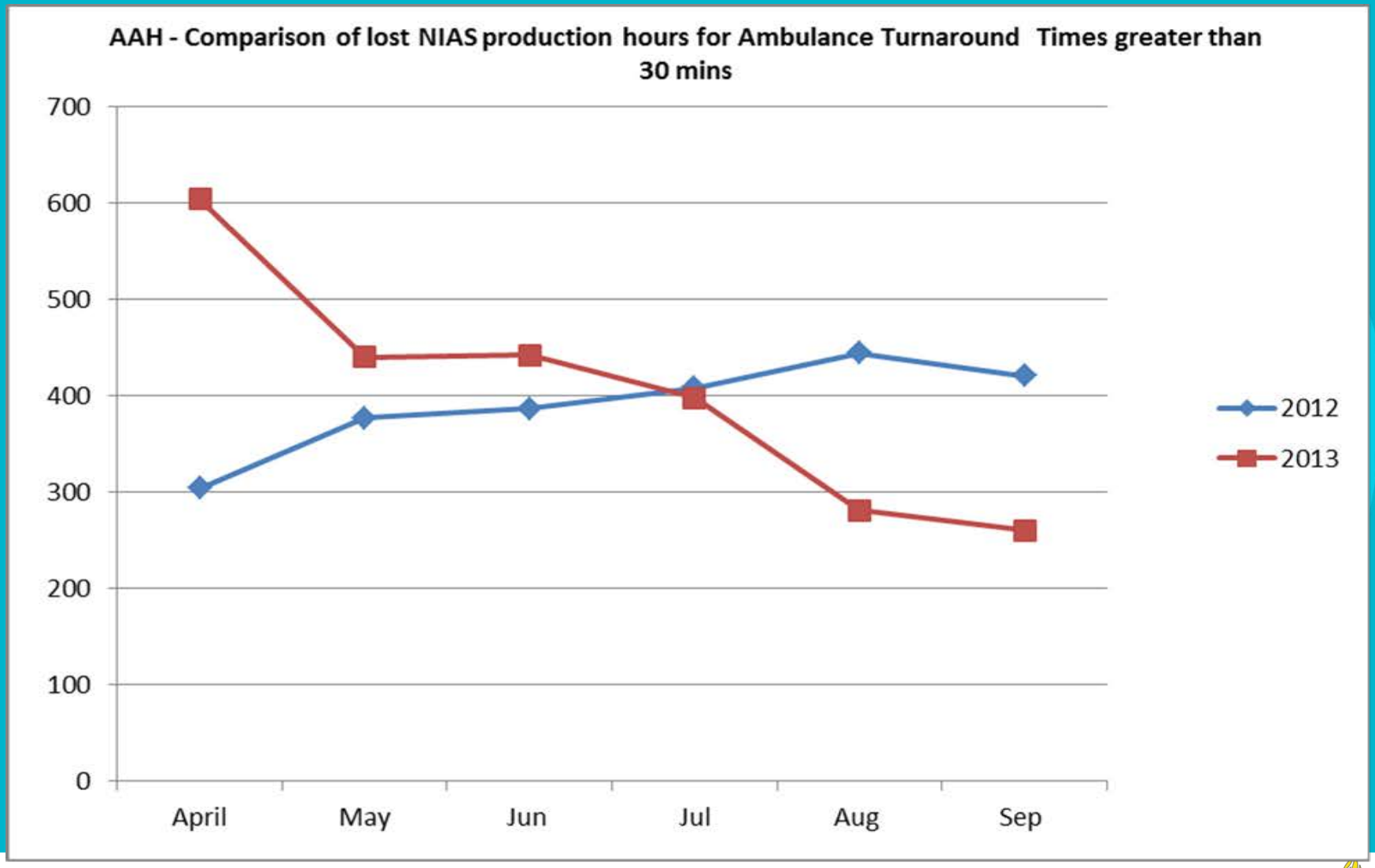
	TOTAL 999 CALLS	% OF TO TAL 999 CALLS	LCG Area Sq km	Population	EMERGENCY AMBULANCE AVAILABLE Day	Night	RRV	EDS	Cat A8 @ March 14
Belfast LCG	37,976	24.7%	200	335,150	7	7	7	2	81
Northern LCG	34,263	22.9%	4,355.7	457,101	17	11	7	2	60
South Eastern LCG	26,796	18%	1,551.2	344,434	12	11	8	3	62.3
Southern LCG	26,293	17.61%	3,187.6	353,908	12	10	5	2	62.7
Western LCG	23,944	16%	4,840.9	298,303	13	12	6	2	66.6
NI	*149,262*	*100%*	*14135.4*		*60*	*51*	*33*	*11*	

Actual Performance

Call Category	Variance 2011/12	
999	+ 3.2% (4,062 calls)	Average 411 Emergency calls per day.
Cat A	+2.8% (1,288 calls)	
Cat A responded to < 8 mins	+ 1.5% (535 calls)	
		Average 1,000 transports per day

HALO


NIAS - Hours Lost Acute Hosps > 30 Mins By Month
2013/14
6000
4800
3600
2400
1200
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar


AAH - Comparison of lost NIAS production hours for Ambulance Turnaround Times greater than 30 mins
700
600
500
400
300
200
100
0
April
May
Jun
Jul
Aug
Sep
2012
2013

HSCB DASH BOARD

Total ED Attendances		
ALT	Activity so far : 48	Daily Average: 162
ANT	Activity so far : 56	Daily Average: 193
CRG	Activity so far : 52	Daily Average: 201
MAT	Activity so far : 42	Daily Average: 123
RVH	Activity so far : 60	Daily Average: 217
ULS	Activity so far : 83	Daily Average: 235

Total Adult NE Admissions		
ALT	Activity so far : 19	Daily Average: 50
ANT	Activity so far : 12	Daily Average: 66
CRG	Activity so far : 16	Daily Average: 54
MAT	Activity so far : 4	Daily Average: 31
RVH	Activity so far : 22	Daily Average: 77
ULS	Activity so far : 17	Daily Average: 69

Total NIAS Arrivals		
ALT	Activity so far : 11	Daily Average: 37
ANT	Activity so far : 17	Daily Average: 52
CRG	Activity so far : 16	Daily Average: 46
MAT	Activity so far : 9	Daily Average: 27
RVH	Activity so far : 21	Daily Average: 66
ULS	Activity so far : 21	Daily Average: 54

Ambulances Currently En Route	
ALT	0
ANT	0
CRG	2
MAT	0
RVH	0
ULS	1

% Of Ambulances Turned Around Within 35 Mins
72
85
100
50
50
100

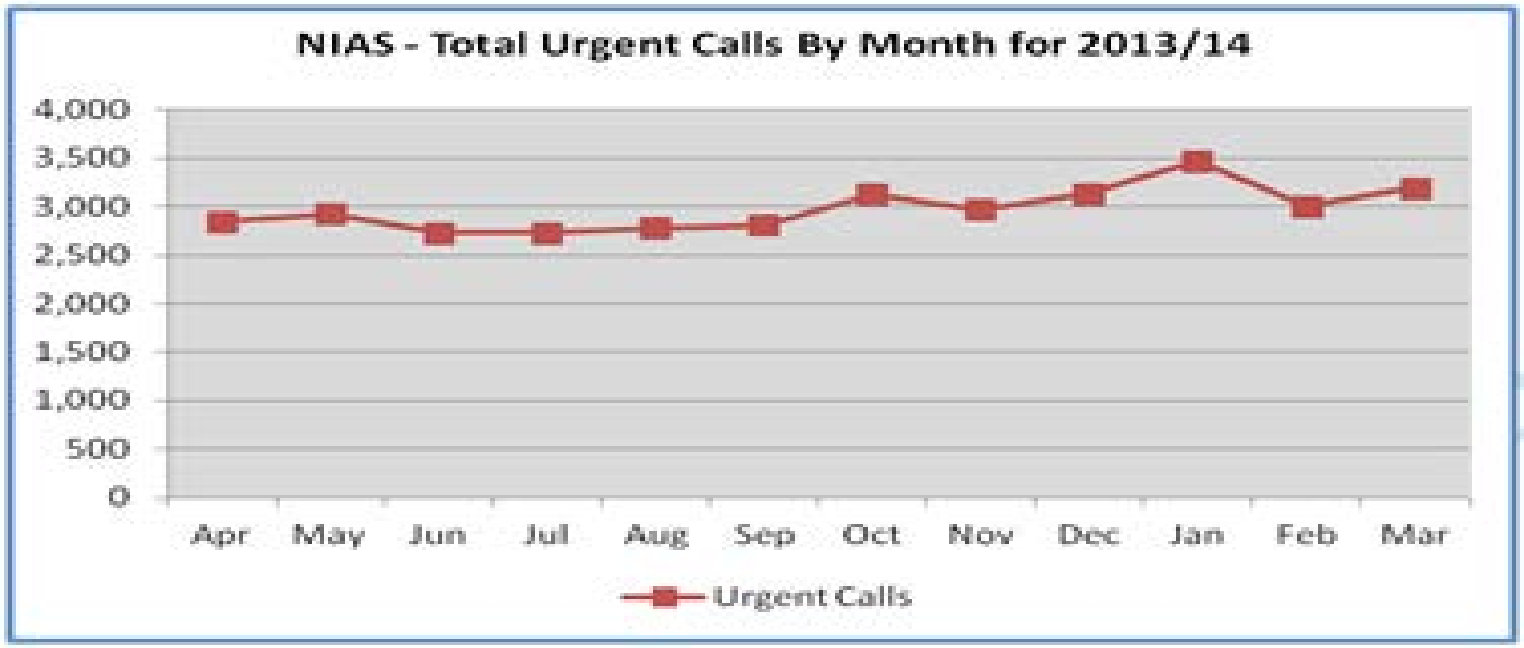
No. Of Ambulances Currently To Be Turned Around
0
2
0
1
3
4

Current ED Waiting Times				
ALT	25	0	0	0
ANT	28	2	2	4
CRG	37	0	2	0
MAT	21	2	2	0
RVH	25	2	3	1
ULS	74	0	0	0
	0-4 h	4-8 h	8-12 h	12+ h

Performance Against 4hr Target
0
0
80
0
0
89

Performance Against 12hr Target
0
0
0
0
0
0

Managing Urgent Demand



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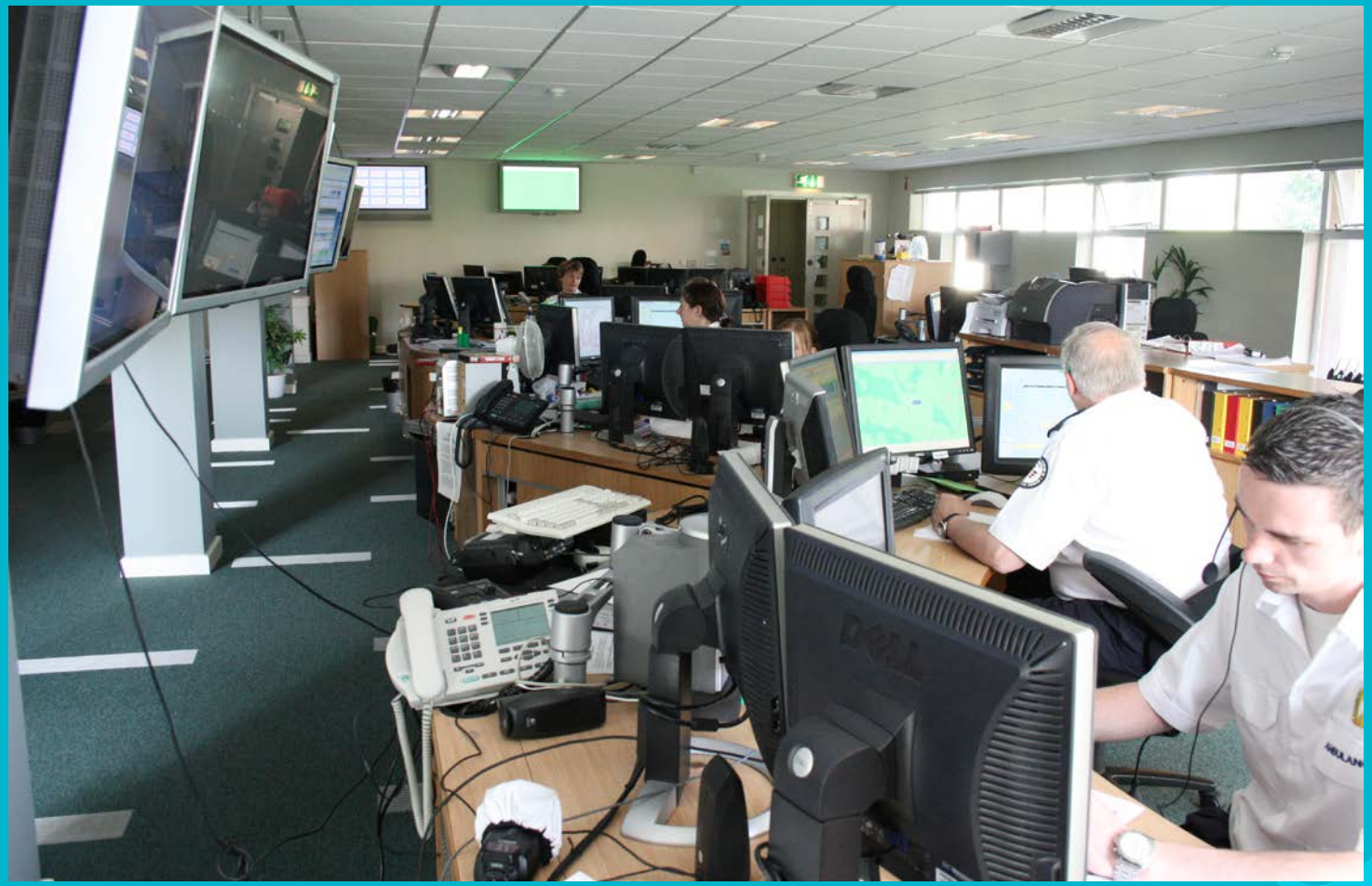
Health Care Professional Card 35



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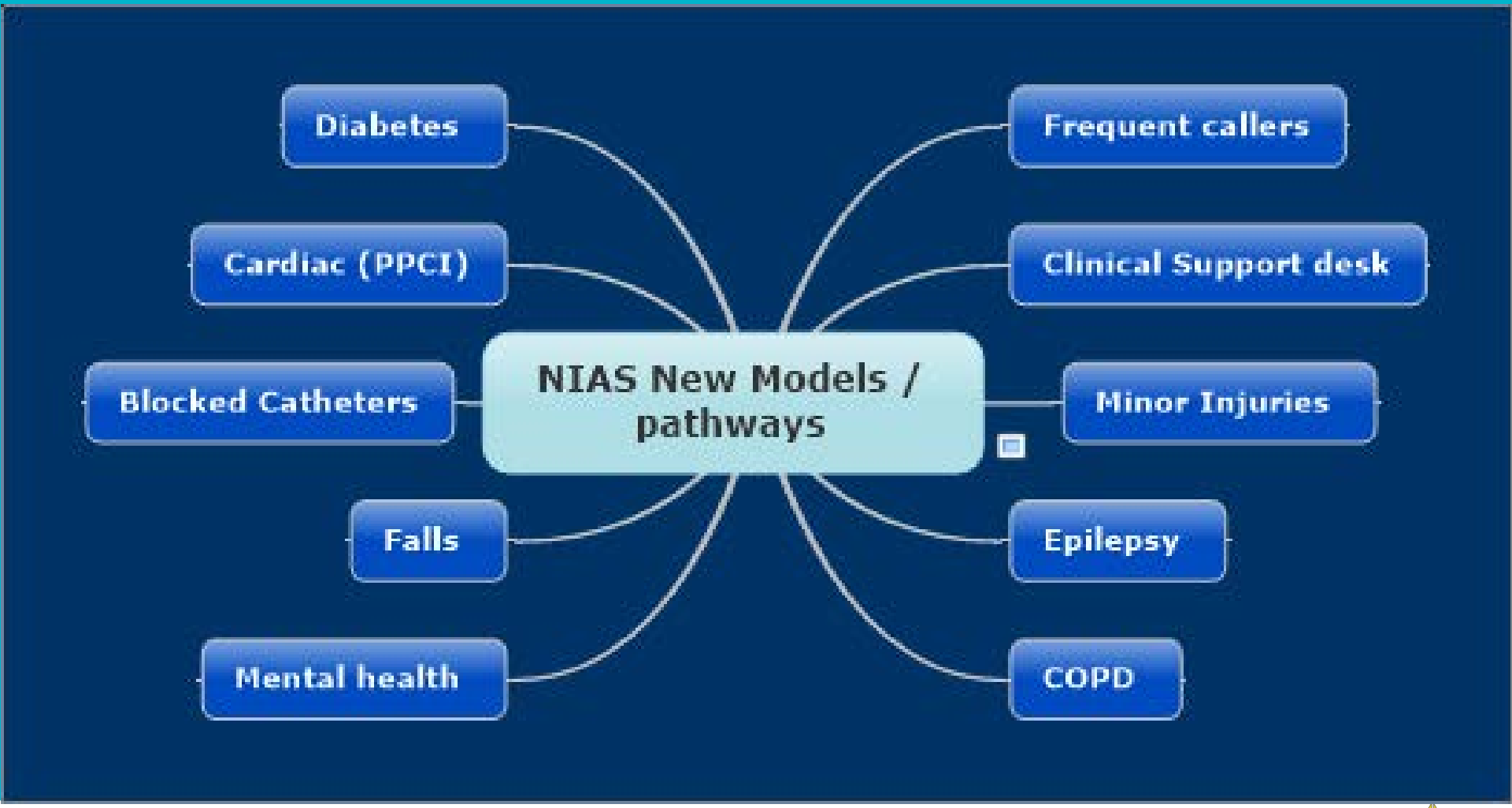
Reducing ED Attendance



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