FOR HEALTHCARE LEADERS

HSJ | EMERGENCY CARE SUMMIT

In association with **MHI**

McKinsey Perspectives

Presentation

12 February 2015

Contents

- **Perspectives on short- term solutions**

- Perspectives on longer term solutions

We follow a 3-step approach - clarify the problem, initiate step-change, and implement systems to enable sustained improvement

1 **Establishing the "one version of the truth"**

– Understand and quantify the root-causes of poor performance across the entire emergency pathway

– Build alignment among hospital and partners (primary, community, social services, and commissioners) on what the priority issues are

2 **"Breaking the cycle"**

– Implement operational changes that deliver a step-change in performance
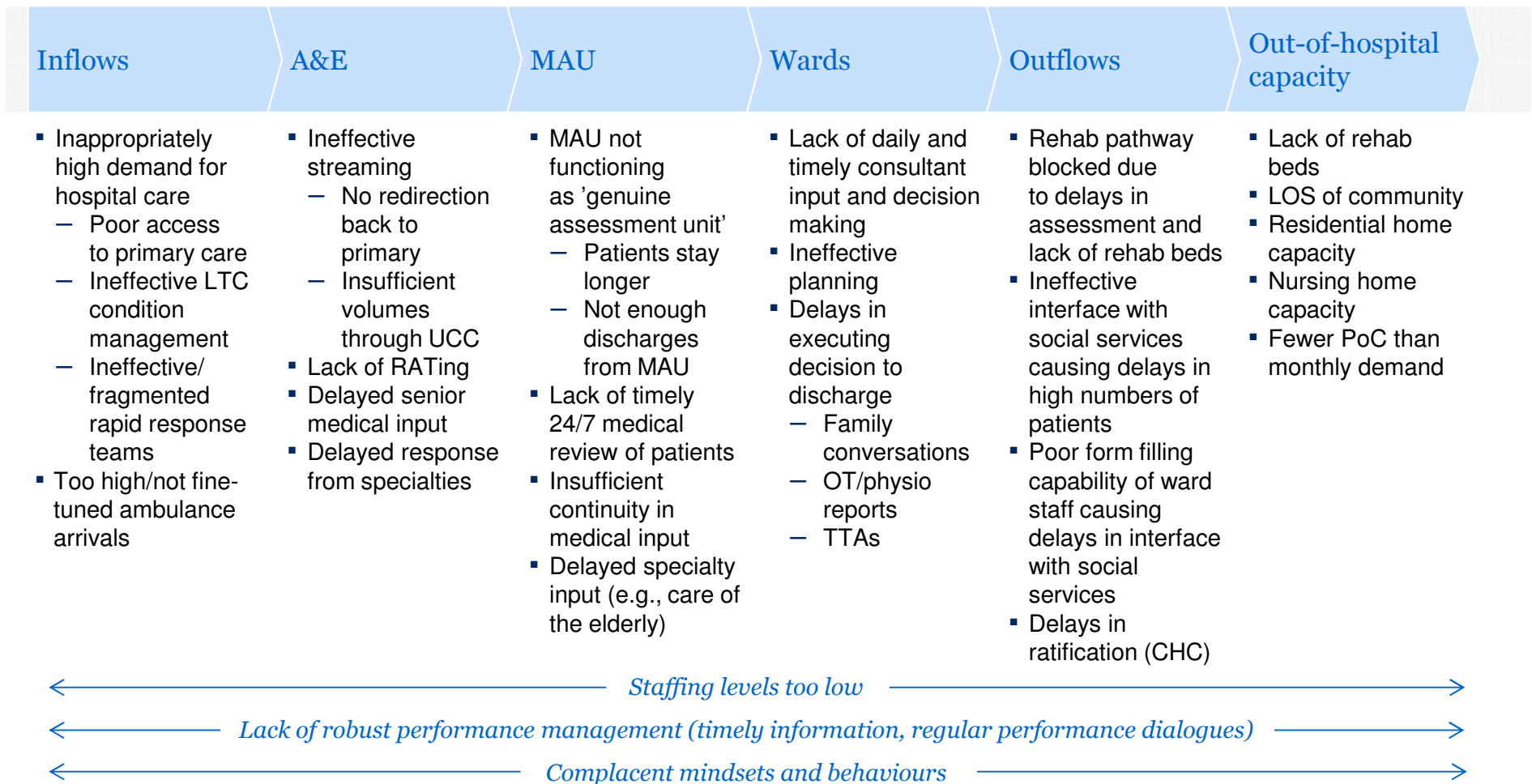
3 **Sustaining performance through transparent reporting**

– Agree performance metrics and how they should be used to sustain impact

– Introduce sustainable performance management involving all partner organisation

Most systems need to address breakdowns along the entire emergency pathway

Example issues encountered along the emergency pathway

Inflows	A&E	MAU	Wards	Outflows	Out-of-hospital capacity
▪ Inappropriately high demand for hospital care 　– Poor access to primary care 　– Ineffective LTC condition management 　– Ineffective/ fragmented rapid response teams ▪ Too high/not fine-tuned ambulance arrivals	▪ Ineffective streaming 　– No redirection back to primary 　– Insufficient volumes through UCC ▪ Lack of RATing ▪ Delayed senior medical input ▪ Delayed response from specialties	▪ MAU not functioning as 'genuine assessment unit' 　– Patients stay longer 　– Not enough discharges from MAU ▪ Lack of timely 24/7 medical review of patients ▪ Insufficient continuity in medical input ▪ Delayed specialty input (e.g., care of the elderly)	▪ Lack of daily and timely consultant input and decision making ▪ Ineffective planning ▪ Delays in executing decision to discharge 　– Family conversations 　– OT/physio reports 　– TTAs	▪ Rehab pathway blocked due to delays in assessment and lack of rehab beds ▪ Ineffective interface with social services causing delays in high numbers of patients ▪ Poor form filling capability of ward staff causing delays in interface with social services ▪ Delays in ratification (CHC)	▪ Lack of rehab beds ▪ LOS of community ▪ Residential home capacity ▪ Nursing home capacity ▪ Fewer PoC than monthly demand

← *Staffing levels too low* →

← *Lack of robust performance management (timely information, regular performance dialogues)* →

← *Complacent mindsets and behaviours* →

Our approach aims at "upgrading the software" in each of the areas of operational transformation

Acute hospital emergency pathway

ED	MAU	Wards
Operating systems • Streamline flow of patients to the appropriate setting of care, e.g., majors, UCC or Paediatrics • Introduce senior clinical decision making early, e.g., RATing • Matching availability of clinical personnel to demand patterns • Enhance parallel processes in evaluation and treatment	• Rolling rounds (patients to be seen within 1 hour) • Strengthen MDT working, e.g., MDT 8am board round • Introduce specialty medical input	• Ensure daily ward round by senior decision makers • Enhance planning and PDD • Improve interface with social services and community

Management infrastructure

Develop performance metrics to create transparency along the pathway
Introduce regular, evidence-based performance management dialogues
Build capabilities
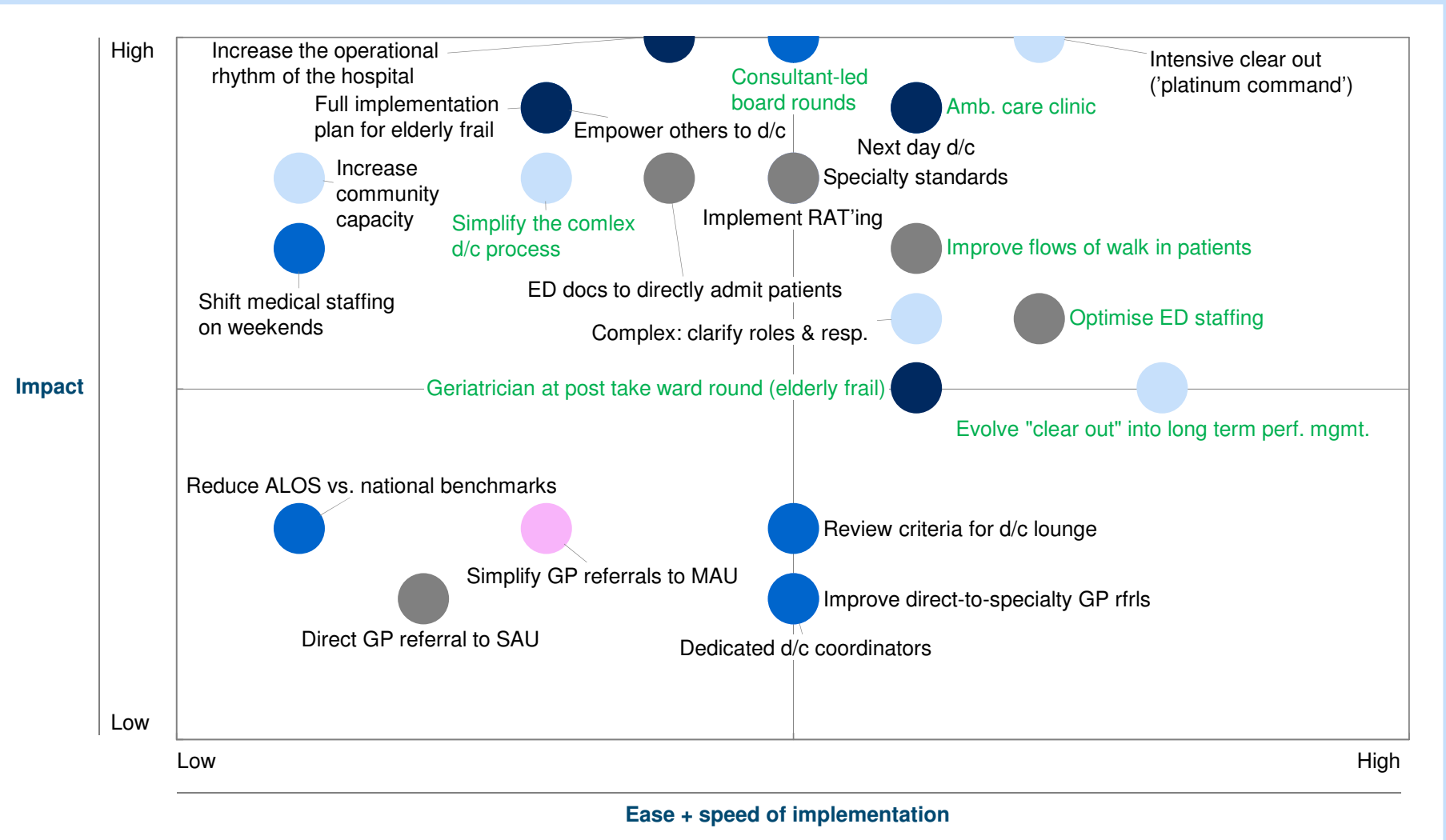
Mindsets and behaviours

My own behavior DOES impact on the entire system
I aspire to these levels of care for patients
Part of my role is to optimise patient experience
I agree to these ways of working and interacting with my colleagues

It is important to focus on the immediate priorities

Legend: ● Supported discharges ● Specialty ● Simple discharges ● Cross-cutting ● MAU ● ED Immediate priority

Prioritsation of initiatives

High / Low — **Impact**

Increase the operational rhythm of the hospital

Intensive clear out ('platinum command')

Full implementation plan for elderly frail

Consultant-led board rounds

Empower others to d/c

Amb. care clinic

Next day d/c

Increase community capacity

Specialty standards

Simplify the comlex d/c process

Implement RAT'ing

Shift medical staffing on weekends

Improve flows of walk in patients

ED docs to directly admit patients

Complex: clarify roles & resp.

Optimise ED staffing

Geriatrician at post take ward round (elderly frail)

Evolve "clear out" into long term perf. mgmt.

Reduce ALOS vs. national benchmarks

Review criteria for d/c lounge

Simplify GP referrals to MAU

Improve direct-to-specialty GP rfrls

Direct GP referral to SAU

Dedicated d/c coordinators

Low / High — **Ease + speed of implementation**

Supported discharges

Objective	▪ Reduce the current number of bed days occupied "ready for discharge" ▪ Increase the operational discipline for timely execution of the supported discharge processes

Immediate initiative – to be launched in the next two weeks

		Key actions	Targets
1	**Set up "Platinum Command": Short-term intensive "clear-out" of safe to transfer patients**	▪ Work from one list of all supported patients ▪ Agree on clear targets for reducing the number of "ready to discharge" (RFD) patients ▪ Conduct regular (daily) reviews of long-stay patients to ensure actions are completed, engaging senior decision makers where necessary ▪ Identify and systematically address the primary drivers of delay that surface through this process ▪ Align discharges from the community with hospital discharge to better enable flow	▪ 50% reduction in RFD patients to ▪ ~100 RFD patients[1]

Potential further Initiatives – to launch in the next 6 weeks

		Key actions	Targets
2	**Dramatically simplify the Supported discharge processes**	▪ Reduce the number of steps in the process ▪ Align Greenwich & Bexley processes as far as possible	50% reduction in RFD patients
3	**Clarify roles/ responsibil-ities of teams involved**	▪ Identify key roles for each community service & in-hospital step ▪ Agree expectations for that role ▪ Agree processes for adherence to expectations	
4	**Evolve the short-term intensive "clear-out" into long-term performance management**	▪ Design the long-term performance management with appropriate frequency of performance meetings and senior input	

● Emergency department

Objective	Manage patient flow through the ED and enhance ED controllable processes to expedite decision to admit or discharge

	Key action steps	**Targets**
① Ensure early senior medical input at all times (RATing)	▪ Ensure area available at all times (e.g., ring-fence area, such as beds in Blue) ▪ Adjust staffing rota to accommodate 24h RATing	>70% of patients RATed
② Increase CDU focus on short stays (<24h) while maintaining some flexibility to alleviate flow issues	▪ Define criteria for CDU admission in normal and in no flow situations and in transition between the two	>180 patients per week through CDU <24h AloS in CDU
③ Optimise staffing roles and resources	▪ Match medical staffing rota to ED attendances ▪ Review rota of staff capabilities to ensure high performance level across all shifts	>70% <45' time from triage to assessment

Other initiatives under consideration

- Performance manage UCC contractor
- Obtain dedicated and increased porter service
- Extend flow nurse coverage (7AM-2AM)

- Introduce minors navigator to get patients appointments with GPs
- Introduce ED-dedicated imaging service
- Extend EPU hours, train more nurses on scanner & acquire new CT scanner for early pregnancies

Simple discharges

Objective	Ensure that outstanding tasks required to declare a patient "ready for discharge" are completed as early as possible. Eliminate delays between RFD and patient departure to increase # of patients discharged before 12

		Key steps	**Target**
1	**Implement early morning (9am) consultant-led board rounds**	▪ Ensure early & consistent senior presence on wards to set criteria for discharge ▪ Introduce "best-practice" board round ▪ Generate consultant ownership of EDD vs. ADD	60% of daily discharges before 1PM
2	**Identify and prioritise next day discharges**	▪ Focus attention on patients RFD on same / following day ▪ Introduce afternoon huddle to discuss next day's EDDs and any gaps on "ticket home"	10% of daily discharges before 9AM (ticket home finished night before)
3	**Empower nurses / junior staff to discharge based on clear criteria set by consultant**	▪ Establish clear discharge criteria for staff to discharge confidently in absence of consultant ▪ Empower nurses to actively address remaining barriers to discharge and be accountable for RFDs not discharged before next board round	100% of discharges with clear criteria acted upon by nurses/junior staff

Enabler	Increase traffic through discharge lounge to ~50 a day by empowering the team to influence which RFD patients are appropriate to wait for TTOs and transport in discharge lounge

Other initiatives under consideration

▪ Base pharmacist in discharge lounge for TTOs   ▪ Ongoing portering support for discharge lounge

Specialty response

Objective	Improve interface between referring areas and specialists and the speed at which response is provided

		Key steps	**Targets**
1	**Define clear standards between referring areas and specialties and introduce transparent reporting to facilitate accountability**	▪ Propose and agree on a set of clear, comprehensive professional standards, including ED referral and specialty response times, and escalation policies	Conversion rate referral to admission [tgt by specialty]
		▪ Define more specific standards with each specialty (e.g, outline tests specialists can request pre-intervention)	Time from assessment to referral <1h
		▪ Review performance regularly to hold people accountable and address issues as needed	Specialist response time within 1h

Other initiatives – under consideration

- Shorten diagnostic response time (TBC)
- Improve direct-to-specialty GP referrals (already in use)

Robust bed management addresses all areas of operational transformation…..

Objective	Promote visibility of number of discharges needed by what time by setting bed occupancy parameters per ward. Streamline bed meetings by including relevant participants earlier in the day

1 **Increase operational rhythm throughout site**

Key steps

- Model parameters for bed occupancy by specialty
- Set daily, time-specific discharge parameters for each ward
- Use bed meetings to performance manage parameters, recognising top discharging wards
- Include community representatives at 9:30am bed meeting and reduce daily meetings to 2

Target

Each ward meets daily discharge target by 1PM

Other initiatives under consideration

- Upskill medical nurses (champion surgical nurses)
- Performance manage nursing staff through friends & family feedback forms

To deliver a performance improvement it is necessary to shift the mindsets and behaviours of individuals and teams

EXAMPLE

Patient story 1 – Senior operations manager

I was invited to do a ward round with the care coordination team (CCT). They brought me to a diabetes ward…little did they know I have a background in diabetes!

My attention was drawn to a patient who was identified as medically fit in Horizon 3 days ago after being properly treated for her condition.

I asked the CCT why this patient had not been set up for discharge. The CCT explained that although the consultant identified the patient as medically fit for transfer, the patient was suffering from pain

I reviewed the patient's notes to find she has had pain for 6 years due to her amputation. This was definite. I asked the CCT if they reviewed the patient's history. They had not

Patient story 2 – Care coordination team (CCT)

I was given a referral for a patient that was medically fit for discharge
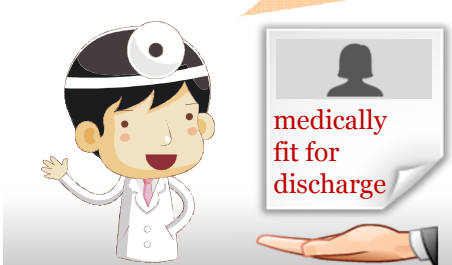
I took a look through the patient's file and the notes just looked dreadful.
How could the consultant have considered this patient as fit for transfer?!

I decided to go see that patient for my own assessment

In just looking at the patient I could tell he was unwell and definitely not ready for discharge. I removed him from the 'medically fit for discharge' pile for further review

medically fit for discharge

Definitely not ready

- ▪ Who has the 'final word' for making the decision a patient is medically fit for transfer?
- ▪ If more than 1 opinion is required, what is the process for making the decision?
- ▪ How long should the decision making process take?
- ▪ What are the 'rules' about challenging the decision?

?

For sustainability, we introduce a well-defined way of managing the pathway in real time

Example daily activities

Gather information

Have discussions

Make decisions/ take action

8am

....

10am

- Visit the ED – review time to 1st assessment (ED issue), evaluate number of DTAs (flow issue), specialty response times; take appropriate action if necessary

....

12pm

- Attend a different ward round each day
- Attend bed meeting and inform and challenge as needed—increase pressure if required

....

2pm

- Go to MAU – ensure there is enough capacity for the flow coming from ED and all consultants have reviewed their patients

....

4pm

- Escalate identified issues as needed
- Handover to evening shift and discuss priorities/actions necessary to continue to deliver performance

It is imperative that this team have access (via in-person conversations or systems) to key performance indicators

ED
- Time to first assessment, decision
- RATing % of majors patients
- Current DTAs
- Specialty response time

MAU
- Beds free at noon
- # of patients that have not been reviewed by a consultant

Wards
- Discharges by 1pm
- Expected daily discharges
- RFD delays

Concluding thoughts on what makes a real difference

- **Upgrading the operating model**
  - **Defining and following operational standards and metrics in each of the areas**
  - **Managing the pathway in real time**

- **Instilling the belief that this is the "new normal," not an extraordinary effort which comes to an end**

- **Leadership role modelling and active participation in managing the pathway is the single most powerful driver of change**

Contents

- Perspectives on short- term solutions
- **Perspectives on longer term solutions**

Framing the debate

| **1** | **What will patients need and want?** |

| **2** | **What new models of care provision could evolve?** |

| **3** | **How to navigate the journey?** |

Taking a patient-centred approach to properly understand their needs has been the starting point for the Nottinghamshire work

Mostly Healthy

People under 75 who are mainly healthy, but who may require urgent care from time to time and are not captured by other patient segments. Convenience may be an important factor when selecting the setting of urgent care.

Differentiated / Known condition

People who either have a known, pre-existing condition or who are quickly and easily identifiable as having one so that they can be directed – or will direct themselves – to the service they need, thus avoiding overburdening the acute emergency pathway, including A&E. Within this this segment, there could be differentiated physical health conditions (heart, respiratory, diabetes, cancer) and or mental health conditions

Frail

People with 'undifferentiated', complex needs requiring rapid assessment and for whom A&E may not be the ideal way to access the care they need. They may also be best cared for outside the acute setting, at least after the first few days. Majority of the segment will be elderly (but not all) and we should include elderly beyond a certain age (+75 tbc) automatically reflecting their enhanced risk of health complications

Mental Health

People for whom mental health issues are either the presenting symptom or the main reason why the person needs urgent care. This will be an increasingly important segment and user of urgent care services, as inpatient mental health services become progressively more community based.

Understanding the drivers of behaviours, as well as the care needs will be crucial to develop effective solutions

**HSJ** | FOR HEALTHCARE LEADERS **EMERGENCY CARE SUMMIT** *In association with* MHI

ILLUSTRATIVE

Likely patient sub-segments
Percent

PRELIMINARY

Segment	Brief description	Size
One stop resolution	▪ Come to ED because it's more convenient – no wait for appointment, always open, can get everything resolved at once ▪ Do not have good perception of GP or ED quality	**22%**
Informed but referred	▪ Generally well-informed older patients who know the alternatives ▪ Most patients here were referred by someone of authority, often GPs ▪ Have a sense of guilt for using ED	**19%**
Worried users	▪ Main driver is worry. Believe that their condition is serious emergency ▪ Most females here are carers worried about a child or elderly relative ▪ Also tend to use GPs and other services fairly often	**17%**
Emotionally attached to hospital	▪ Feel that ED doctors are more qualified than GPs ▪ Emotionally attached to hospital because of relatives treated there ▪ Feel hospitals are a dependable resource	**14%**
Confused and dissatisfied	▪ Don't know alternatives – only know GP or ED ▪ Higher proportion of immigrants ▪ Feel that they are treated poorly at hospital	**14%**
Invincible	▪ Young group, mostly male. Believe that for minor things they should self-treat and ED is for major injuries – no in-between ▪ Tend towards DIY self-care (like gluing cuts)	**13%**

Four shifts could change the landscape as we know it

Allowing **patients and carers** to play a much greater role supported by **point of care diagnostics and remote monitoring**
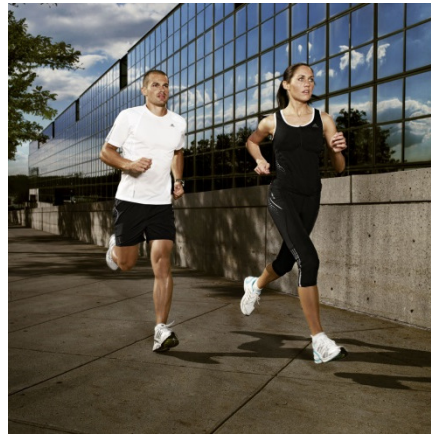
Remote connectivity removing the need for co-location for navigation, diagnosis and some aspects of treatment

Automation of processes within hospitals and the home setting

Increasing use of data to monitor **outcomes and activity in real time** to both drive new payment models and resource allocations

Changing the system will require more than developing the right solutions

Agreement
- Multiple stakeholders, multiple organisations, many individual views, and no definitive answers
- **Who will lead long-term change in the face of the immediate short-term challenges?**

Timescales
- Short-term solutions may not align with the long-term vision
- **Should the vision be compromised or can interim arrangements be put in place?**

Investment
- Funding for technology, skill building and retraining, new facilities and potentially double running costs
- **How to make the business case for system-wide transformation during a period of austerity?**

Incentives
- Current payment mechanisms do not reward innovation or align the interests across the system
- **How much can realistically be changed without wholesale reform of how the funding flows?**