Enhancing acute & emergency care – Improvement Programme

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3 successes

- Clinical engagement – leading workstreams
- Simple metrics and messages – framing the problem and solution
- Lots of ideas and initiatives tried

3 challenges

- Time & resource
- Embedding change and refreshing focus/motivation
- Engaging wider workforce

Improvement Programme – some achievements

	Change / initiative
1	Morning ward rounds
2	Phlebotomy start times
3	Daily white board rounds embedded
4	Discharge co-ordinators
5	Predicted discharge dates
6	Weekend discharge team
7	Day-2 Acute Care Unit Review
8	Peer Review panel
9	Weekly metric report
10	Daily consultant ward round pilot
11	Medically Optimised Patient data
12	Full Ambulatory Care service piloted

What was key to success?

- Early engagement from a range of stakeholders including senior doctors, nurses, therapists, managers and Executive members.
- Clinical leadership of project and workstreams
- Persistent and consistent project oversight – same management over 2 years, familiarity with trust and processes. Commitment to the project and overall vision. 3 away days with exec input.
- Measuring of impact, sharing of data and results – monthly consultant meeting
- Dedicated clinical and project resource freed up to focus on this
- Engaged group of clinicians prepared to try new things and happy to co-operate
- Freedom and flexibility to try things and not be fearful of failure
- Accountability for actions - weekly meetings with Executive

Questions & discussion

Improvement Programme – Phase I

1. **'Front door' improvements** – led by Nora Thoua, consultant gastroenterologist
2. **Ward discharge improvements** – led by Louise Egan, Head of Nursing
3. **Pathway enhancements** – led by Piero Reynolds, consultant rheumatologist
4. **Ambulatory care** – led by Carlo Prina, consultant geriatrician

Key Interventions

Ward Discharge Improvements

- Consultant ward rounds are now occurring in the mornings, enabling senior decisions to be made earlier.
- Phlebotomy rounds are commencing at 07:00 to ensure blood tests are ready for review in the morning.
- Daily white board rounds are taking place on every ward with senior medical and nursing input. This gives the team an allocated time to discuss any blockages to discharge and expedite any additional actions that may be required.
- Utilisation and management of Planned Discharge Dates for all patients is continuing on the wards. This maintains the team's focus on discharge.

Ambulatory Care

- A clinical model was produced identifying patient cohort, access/exclusion criteria
- Minimal staffing was recruited to in order to run a 3-month pilot
- The pilot ran successfully for the period but had to cease due to the requirement for a business case for more resources and lessons to be learnt from the original pilot

‘Front door’ improvements

- Consultants attending the ACU on day-2 to review all patients from the previous day’s take
- Patients are now being given predicted dates of discharge (PDDs) on ACU which are reviewed at the handover meeting. Patients with a PDD of over 3 days will be transferred to the wards which others will remain on ACU. This is embedded and working well.

Pathway improvements

- A new alcohol detoxification policy was approved
- Awareness of the Outpatient Antibiotic Therapy (OPAT) service has been raised and discussed in detail with the consultant body
- The discharge management team was restructured to provide greater support for complex discharges combining the team with the ward-based discharge co-ordinators
- Section 2 and section 5 referral forms are now on EPR.

Further interventions…

Peer Review Panel of long stay patients

An MDT panel was established consisting of consultant, nurse, therapist, social worker and discharge planner. The panel convenes once a week and will discuss 2-3 patients over a 60-90 minute period. A member of the team looking after the patient would present the case to the panel and the panel would have the opportunity to see the patient and ask questions. Recommendations would be documented on EPR.

This has:

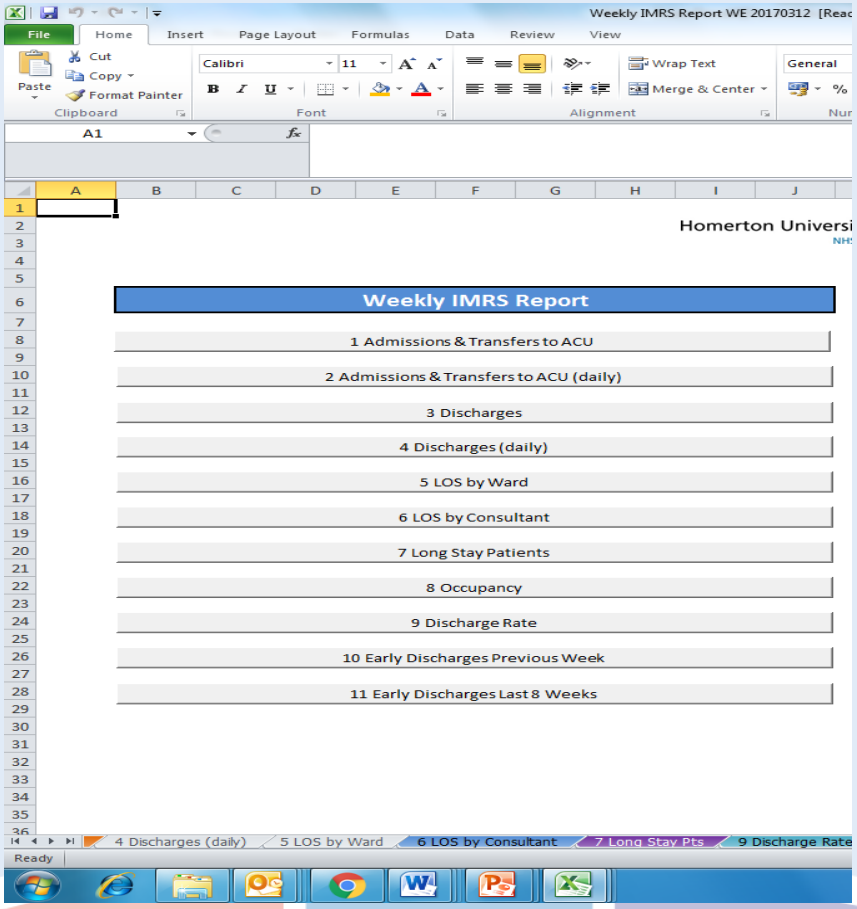
- Given an opportunity to share views and considerations on fitness for discharge and functionality.
- Allowed alternative discharge strategies to be considered
- Brought a fresh perspective on long-running challenges
- Provided reassurance for both patient/carer and clinical team that all options are being considered

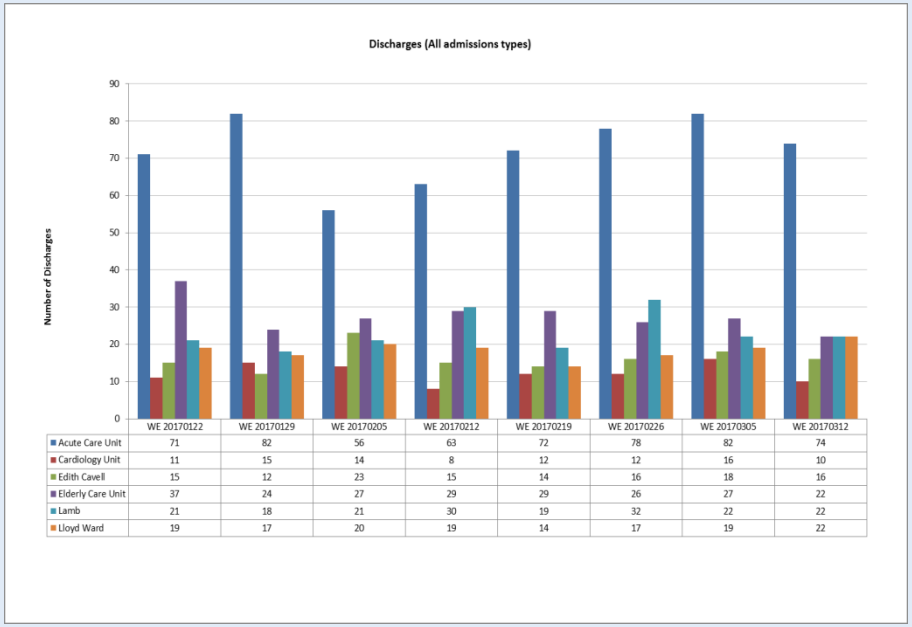
Weekly reporting suite for IMRS ward performance

Homerton University Hospital NHS Foundation Trust

We devised an agreed set of metrics to publish each week and circulated to the consultant body. Includes, admissions, discharges, length of stay, occupancy and times of discharge.

Selected information shared at monthly consultant meeting





	WE 20170122	WE 20170129	WE 20170205	WE 20170212	WE 20170219	WE 20170226	WE 20170305	WE 20170312
Acute Care Unit	71	82	56	63	72	78	82	74
Cardiology Unit	11	15	14	8	12	12	16	10
Edith Cavell	15	12	23	15	14	16	18	16
Elderly Care Unit	37	24	27	29	29	26	27	22
Lamb	21	18	21	30	19	32	22	22
Lloyd Ward	19	17	20	19	14	17	19	22

Phase III

Why phase III?

Continuous improvement now becoming embedded together with an approach of generating ideas, trying things, evaluating and adapting.

On-going review of agreed metrics and tracking trends and patterns.

Strong operational and clinical performance maintained throughout winter of 2016/17 – **2nd best performing trust in London on the Emergency Care 4-hour target**

4 further projects established in this time:

1. Full 12-month Ambulatory Care Pilot planned to go live 19th April 2017
2. Daily consultant ward rounds Monday to Friday – 6-week pilot
3. Greater focus on morning discharges
4. Establishing data-set of medically optimised patients on each ward

Homerton Ambulatory Medicine Unit (HAMU)

Homerton University Hospital NHS
NHS Foundation Trust

Full 12-month pilot to commence

It was apparent from the initial pilot that significant resources would be required to run a longer more substantial pilot of an ambulatory care service including additional consultant staff. A business case was approved by the trust in November 2016 making the clinical and economic case based on the reduction of inpatient beds together with a local CCG-agreed tariff for follow up attendances at HAMU. This allowed staff to be appointed for a fixed term to run a 12-month pilot commencing on 19th April 2017.

This incorporates:

- Feedback on initial pilot and current function
- New Front door arrangements
- Expedited Discharge Model
- Relationships with Specialties and Exit strategies

It will be staffed by:

4x Consultants
2x Junior Doctors
4x Nurses
Open 8am-8pm Mon-Fri (plus weekend nursing cover)
Consultant Presence 10am-6pm

Key objectives:

- Reduction in emergency admissions to ACU
- Reduction in length of stay with ward discharges

Morning discharges

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Measuring and publishing performance

Following the changing of all consultant ward rounds to take place in the morning, wards were set a target of 30% of discharges over a week to take place before 13:00. The discharge lounge was promoted actively on all wards and clinical a managers attended white board meetings to challenge teams and query why patients could not be discharged before 13:00. Performance was measured by ward and circulated to the clinical teams.

After an initial improvement, performance plateaued with some wards performing better than others.

Further work is being done to address potential barriers to early discharge including pharmacy and transport delays.

Morning discharging – results

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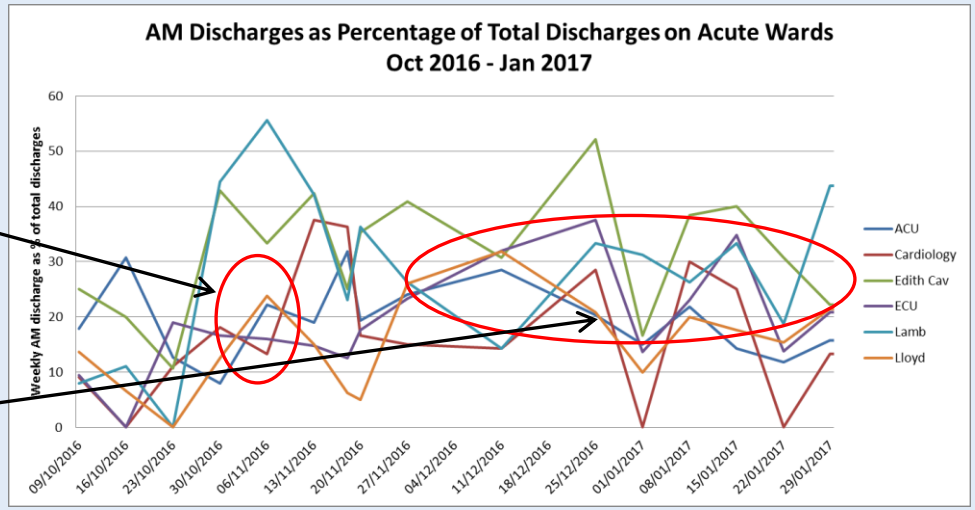
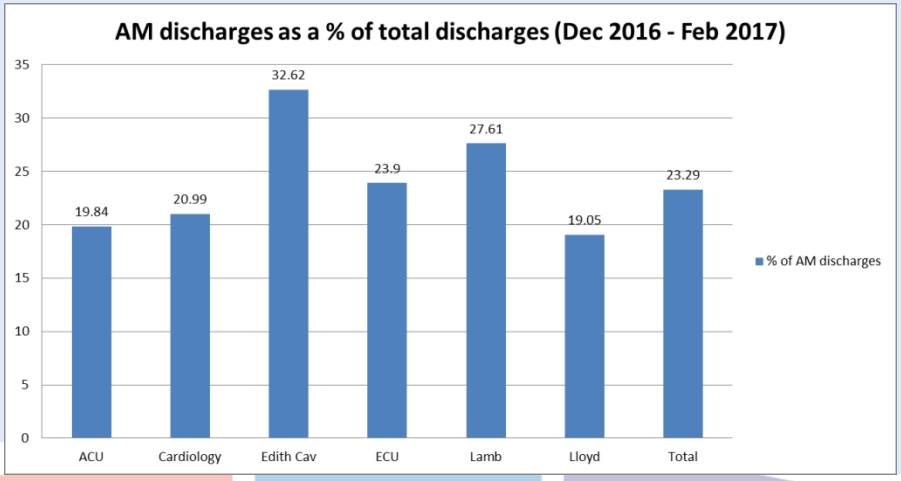
Initial improvement seen

On-going performance variable





Overall performance over 3 months – significant improvement from December starting position

Medically Optimised Patient (MOP) Data

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The over-arching purpose of this is to have a clear picture of the status of every inpatient in the hospital from a clinical and discharge perspective. A recent Day of Care Audit found that up to 40% of patients did not need to be in an acute hospital bed from a medical point of view were there suitable alternative facilities available e.g. social care, intermediate care.

Having this data readily available by ward will do two things:

1) Provide a clear picture of the operational pressures and opportunities that exist across the hospital
2) Provide evidence as to where resources should be best targeted to expedite hospital discharge and improve patient flow

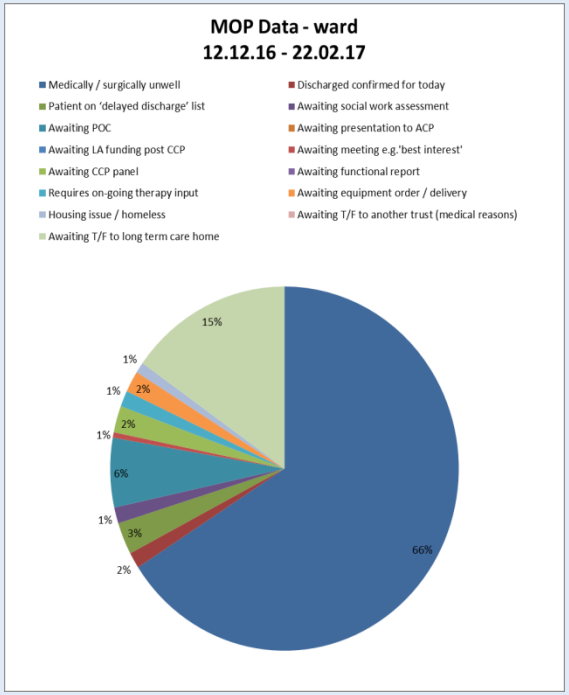
This data is currently unavailable by automated or electronic means and so is collected manually on each ward.

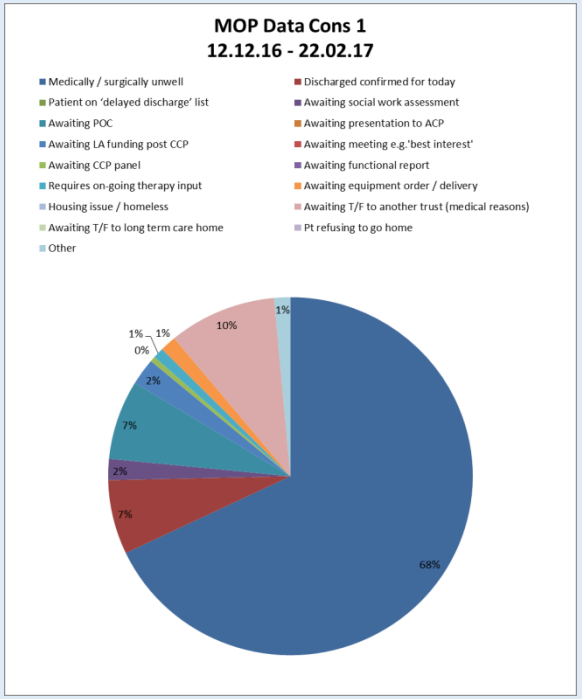
Once embedded this data will be available
3 times per week by ward and by consultant. It will be reviewed weekly by the Divisional management team.

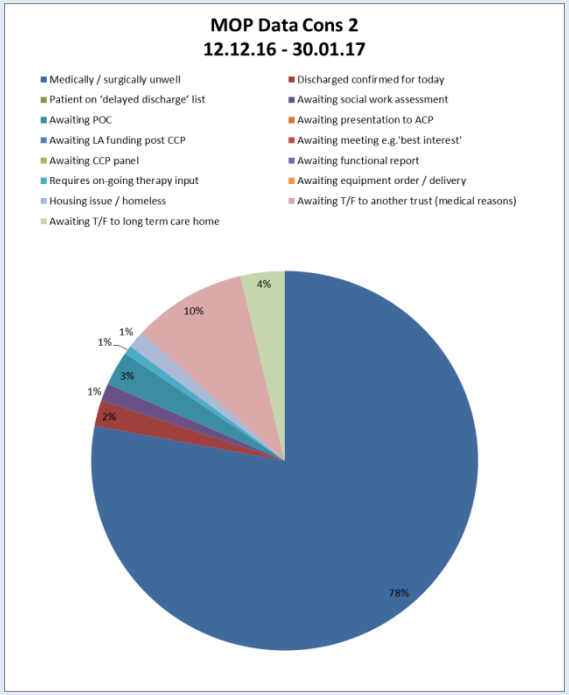
Patients will be given one of the following codes:

1. Medically / surgically unwell a. Needs medications / medical therapy as inpatient b. Awaiting specialist review c. Awaiting test / procedure needed as inpatient d. Awaiting senior review e. Awaiting blood test (or other) result f. Other	**8. Therapy assessment / treatment** a. Awaiting functional report b. Requires on-going therapy input
2. Discharged confirmed for today	**9. Awaiting equipment order / delivery**
3. Patient on 'delayed discharge' list	**10. Housing issue / homeless**
4. social work assessment /on-going review a. Awaiting assessment b. Awaiting package of care c. Awaiting presentation to ACP d. Awaiting local authority funding post CCP decision e. Awaiting meeting (e.g. best interest)	**11. Awaiting transfer to another Trust or long term care home** a. For medical reasons b. For non-medical reasons
5. Awaiting section 2 or 5 to be completed	**12. No clear plan**
6. Awaiting CCP panel	**13. Pt / family refusing to go home**
7. Awaiting Fast-track	**14. Other**

Medically Optimised Data Example – by ward & consultant







Next steps – Phase IV:

Marginal gains, PDSA, feedback, measurement and accountability. This will continue in the expectation that new ideas will emerge and theories can be tested.

A small workshop is planned to review key discharge roles and responsibilities and focus on what the next priorities and opportunities for improvement are. We will bring Local Authority services into scope in an effort to reduce delayed transfers of care and address ‘hidden’ bottlenecks

We will agree a mechanism and structure for earlier identification and intervention to collaborate with and support clinical teams where timely discharging is proving to be problematic.

Questions?