Emergency Care Improvement Programme

Safer, faster, better care for patients

A SAFER Start to 2018

The aim – a whole system approach to reduce hospital crowding following Christmas 2017

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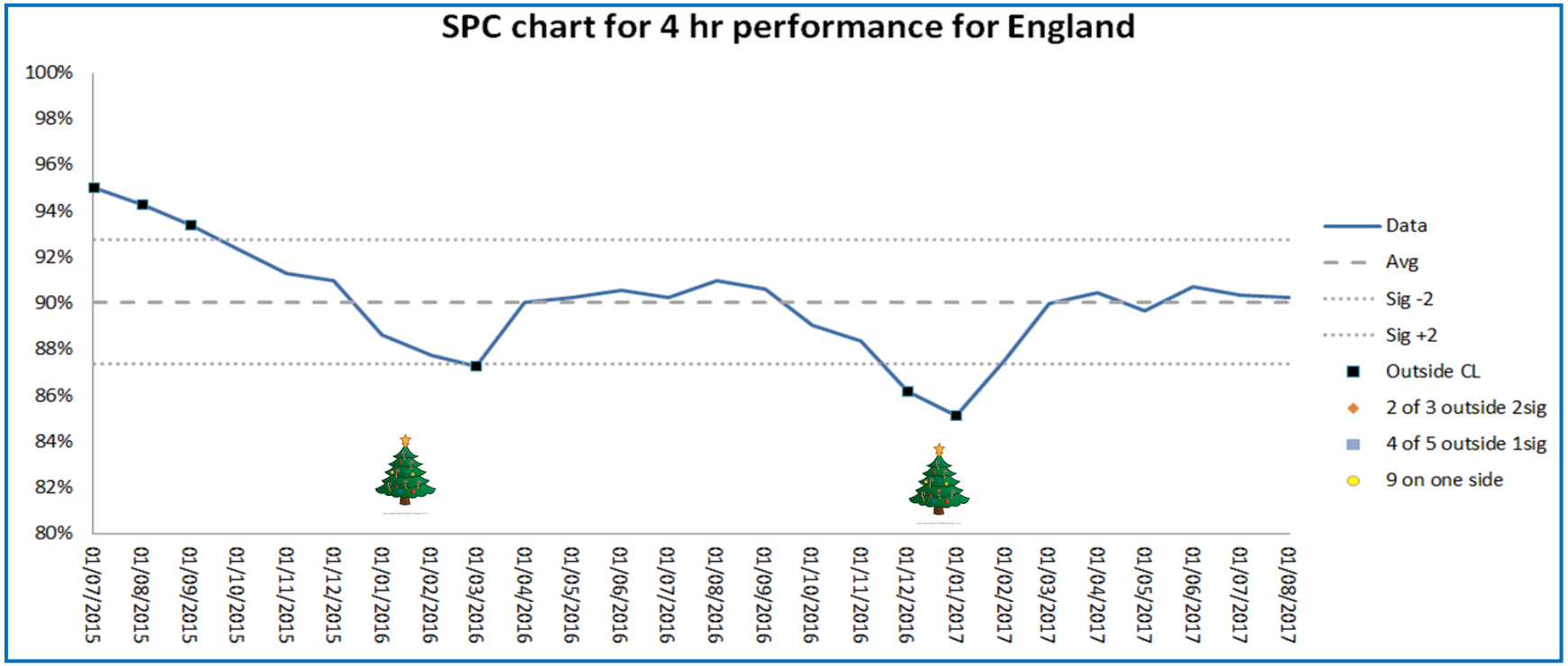
Situation

- Every year there is a significant dip in 95% performance following Christmas.
- It will happen this winter - crowded hospitals pose a significant safety risk to patients and cause untold staff fatigue.
- We are encouraging systems to take proactive action to mitigate these risks.

National 4 hr performance



A compelling story – the evidence

- #Last1000days #Red2Green #endPJparalysis
- ***"Patient time is the greatest currency in health & social care"***

Prof Brian Dolan @BrianwDolan

•48% of people over 85 die within one year of hospital admission

Imminence of death among hospital inpatients: Prevalent cohort study
David Clark, Matthew Armstrong, Ananda Allan, Fiona Graham, Andrew Carnon and Christopher Isles, published online 17 March 2014 *Palliat Med*

•10 days in hospital (acute or community) leads to the equivalent of 10 years ageing in the muscles of people over 80

Gill et al (2004). studied the association between bed rest and functional decline over 18 months. They found a relationship between the amount of time spent in bed rest and the magnitude of functional decline in instrumental activities of daily living, mobility, physical activity, and social activity.
Kortebein P, Symons TB, Ferrando A, et al. Functional impact of 10 days of bed rest in healthy older adults. J Gerontol A Biol Sci Med Sci. 2008;63:1076–1081.

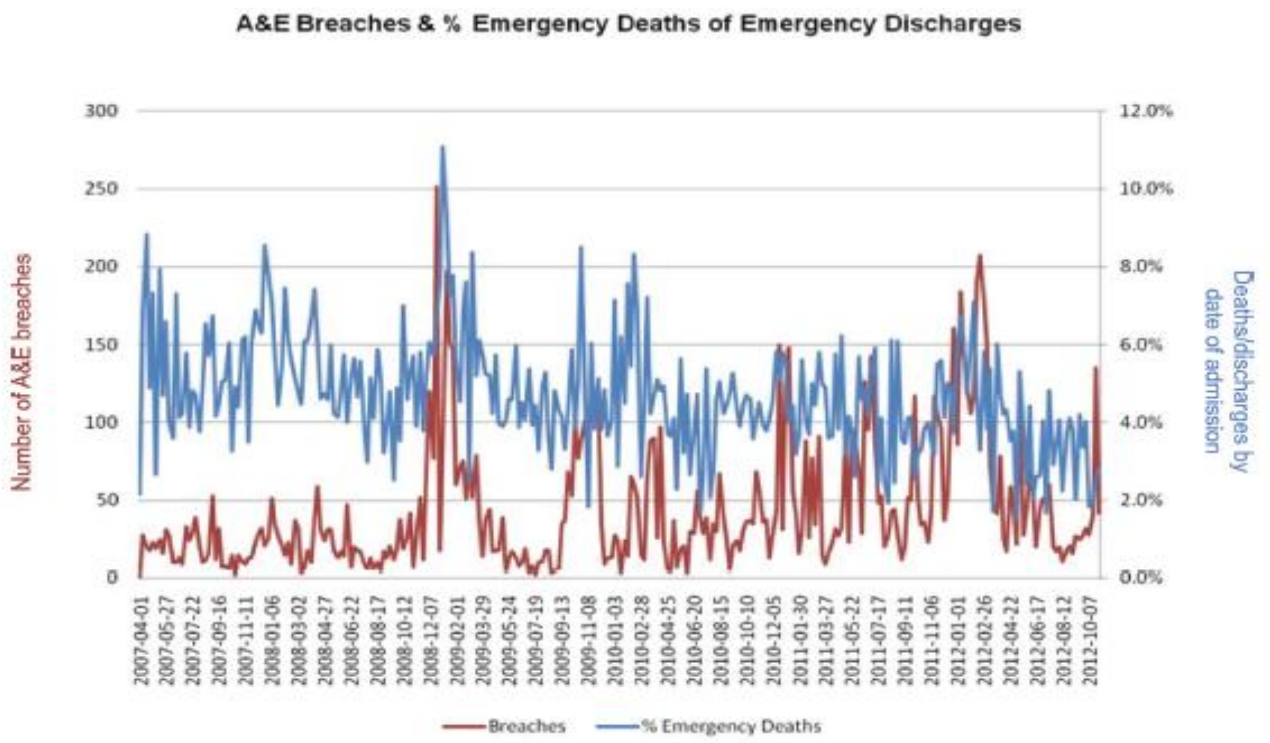
The evidence – compelling story

2015 College of Emergency Medicine – consequences of 'exit block'

- Increased patient **mortality** – the magnitude of the effect is about 13 deaths a year per department seeing 50,000 patients.
- Increased **length of stay** of admitted patients
- **Delays to time-critical interventions** – with less frequent and less adequate pain relief, and delayed antibiotic administration.
- Increased risk of **adverse events**.
- Decreased departmental function – 'under triage', **inferior care** in terms of standard performance measures and delays to departures.
- **Decreased patient satisfaction**.
- Increased **staff stress and burnout**.
- Increased number of patients whose **operations are cancelled**, wasting surgical capacity.

Poor 4-hour performance correlates with increased mortality

Figure WK8: Correlation between A&E performance and mortality rate for adult emergency patients*



* These data were subjected to Statistical Process Control methods (Paper accepted by the *International Journal of Healthcare Quality and Assurance* in November 2012 and now in press: 'Does process flow make a difference to mortality and cost? An observational study').

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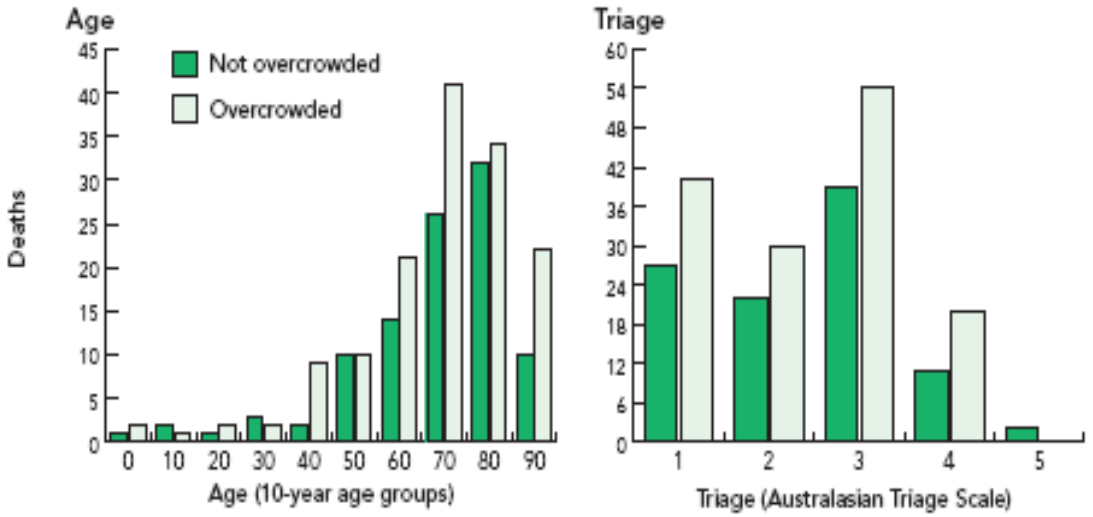
4 Distribution of 10-day mortality by subgroup. The y axis represents the actual number of deaths in each subgroup in overcrowded (OC) and not overcrowded (NOC) cohorts



There were 7% more presentations and 43% more deaths in the OC cohort compared with the NOC cohort. ♦

6 Cumulative deaths per 1000 new emergency hospital admissions associated with an Overcrowding Hazard Scale > 2

Censoring date	Hazard ratio (95% CI)	Deaths per 1000 emergency hospital admissions (95% CI)	P
Day 2	1.3 (1.1–1.6)	1.0 (0.4–1.4)	0.001
Day 7	1.3 (1.2–1.5)	1.9 (0.7–2.5)	< 0.001
Day 30	1.2 (1.1–1.3)	2.3 (1.2–3.2)	< 0.001

43% more deaths when emergency departments are crowded (10-day mortality) than when there is no crowding

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Crowded emergency departments

- Dangerous
- Correlates with increased length of stay

1: Means (95% CIs) of inpatient length of stay and excess* inpatient length of stay

	Emergency department length of stay			
	≤4 hours	4–8 hours	8–12 hours	>12 hours
IPLOS (days)†	3.73 (3.53–3.93)	5.65 (5.48–5.82)	6.60 (6.31–6.89)	7.20 (6.91–7.49)
IPLOS – SALOS* (days)†	0.39 (0.21–0.57)	1.30 (1.15–1.45)	1.96 (1.71–2.21)	2.35 (2.08–2.62)

*Excess inpatient length of stay is defined as inpatient length of stay exceeding the state average length of stay for the diagnosis-related group (IPLOS – SALOS). IPLOS = Inpatient length of stay. SALOS = State average inpatient length of stay (for specific diagnosis-related group). †$P < 0.001$ for difference, on analyses of variance (ANOVA).

- Retrospective analysis of 694 patients with community acquired pneumonia
- Delayed delivery of antibiotics in 4 hours
- ED not crowded – 31%
- ED overcrowded – 72%

Pines JM et al. The impact of emergency department crowding measures on time to antibiotics for patients with community acquired pneumonia. Annals of Emergency Medicine, 2005, 50(5):510-516

Patients waiting over 12 hours for a bed have a 2.35 increase in their hospital length of stay.

Essential drugs are delayed when an emergency department is crowded

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Patients boarding in the wrong ward: 50% higher mortality; adds 2 days to length of stay

	Ave LoS	Readmissions		Mortality		Notes
		7 day	30 day	7 day	30 day	
Non-Boarded	2.3	4.6%	7.5%	1.4%	2.8%	
Boarded	6.5	7.5%	11.0%	2.0%	4.2%	
Wards boarding pts out	4.2	4.8%	10%	2.5%	3.7%	Highest no of patients

Mortality on wards that board patients out is 30% higher than on those that don't

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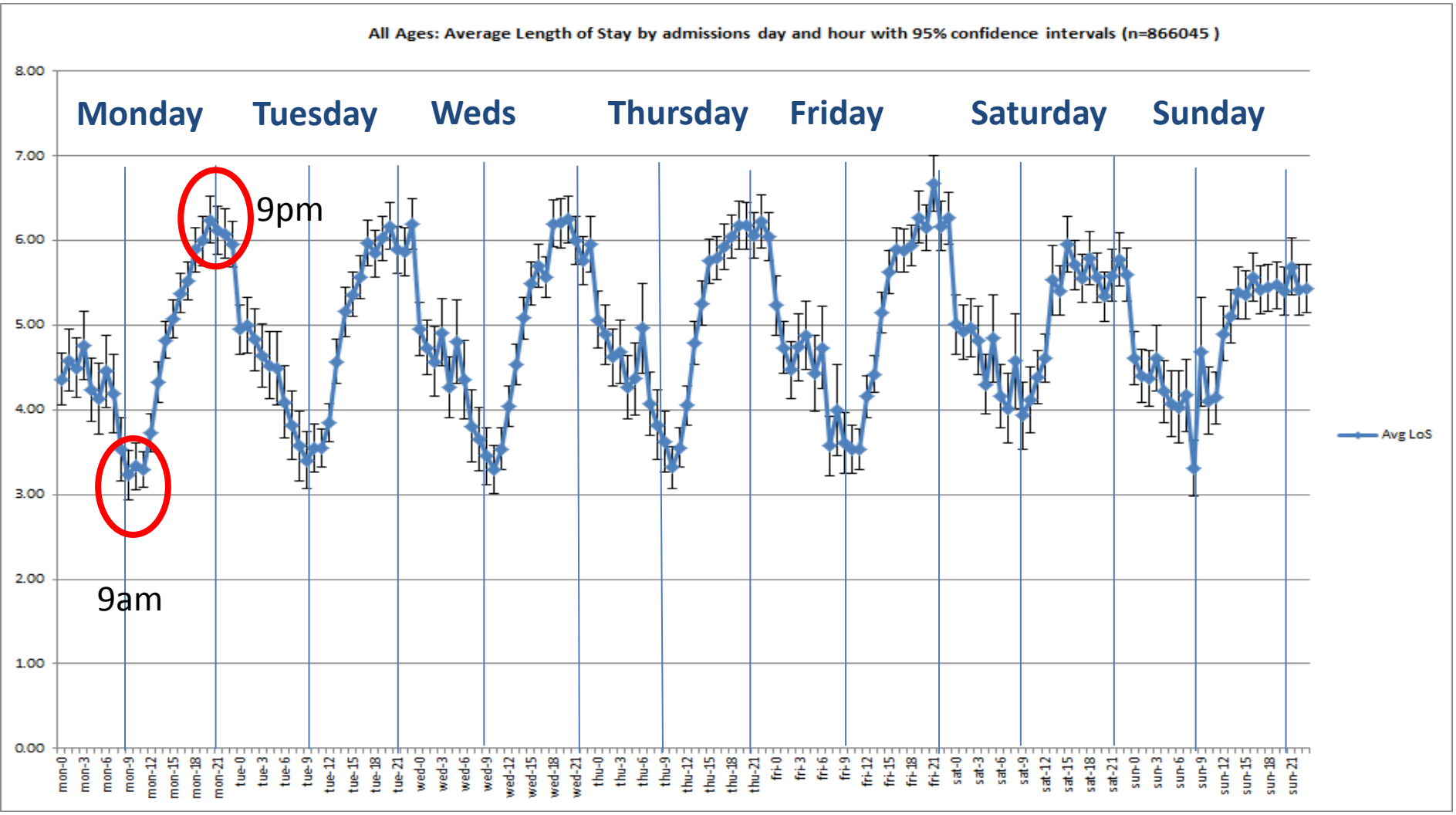
Early admission for assessment is crucial – late admission = ⇧ LoS



3-day LOS difference between 9am and 9pm admissions (four days for >75 year cohort)

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There are no silver bullets – but this will help (if the right approach is adopted)

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We know what works

Good practice guide: Focus on improving patient flow /

https://improvement.nhs.uk/resources/good-practice-guide-focus-on-improving-patient-flow

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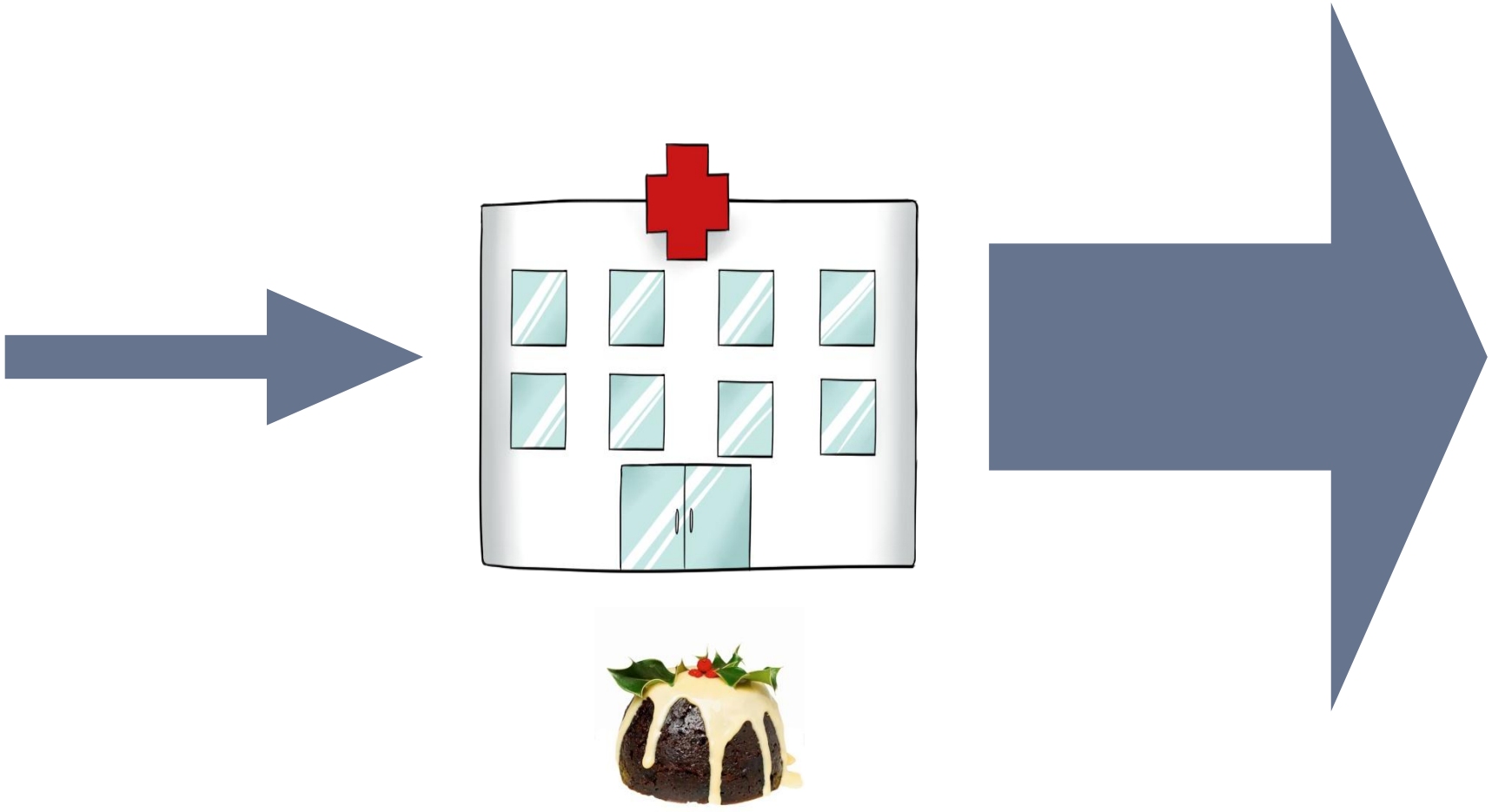
“The Christmas Eve effect”



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Desire to make it happen

Identification of those that are ready for discharge

“The Christmas Eve effect”

Obstacles overcome in real time

Nothing left over because tomorrow is too late

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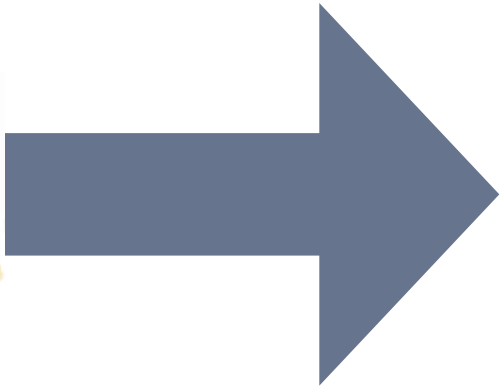
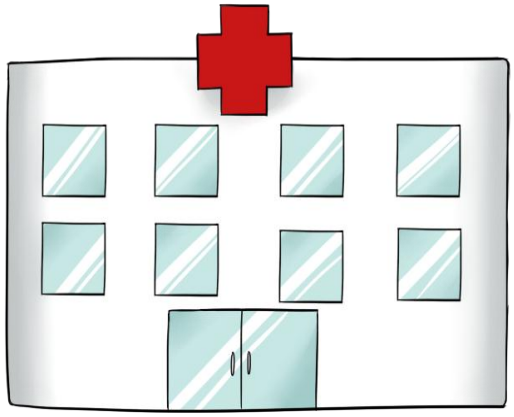
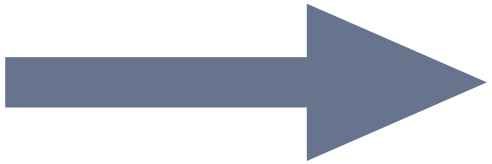
“The Post Christmas Eve effect”







Patients facing eight-hour waits in ambulances outside A&E departments

Sick patients have been forced to wait up to eight hours in ambulances queuing outside Accident & Emergency units amid a crisis in the system.

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We need to Break The Cycle by taking proactive action

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Preparing to have a Safer Start to 2018

- Start planning now (build on your current plans)
  - identify a project lead, ideally a clinician
- Could all system partners agree a united “shared sense of purpose” e.g. reducing unnecessary waiting for patients?
- Good impact can be achieved through either a two day multi-agency accelerated discharge event, a “perfect week” or a bespoke combination – likely to need both
- Once a “shared sense of purpose” has been agreed likely to need to actively work to stay on track
- Keep it simple and focused on patients

Preparing to have a Safer Start to 2018

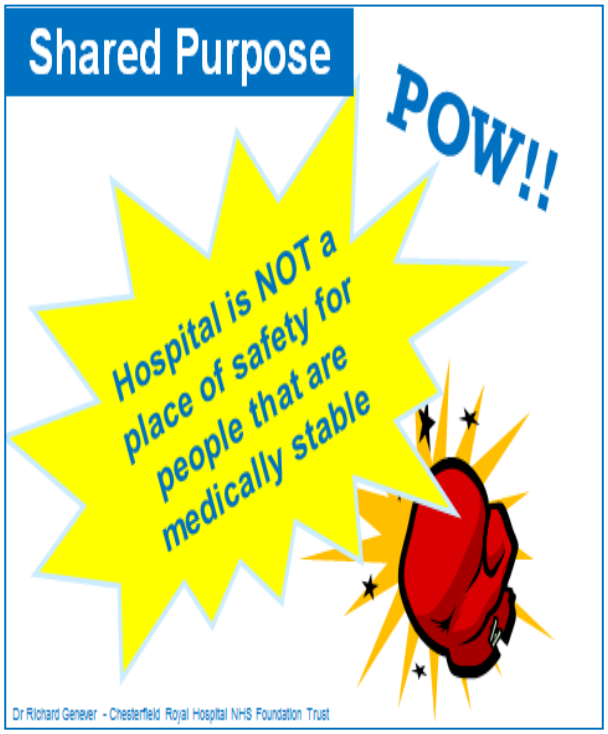
- Agree the duration – 7 days minimum either starting 27th December 2017 or in January 2018 for a “perfect week”
- Cancel **all** non urgent meetings and reduce email traffic
- Two senior reviews (consultant led) per day on every ward with full MDT support - this may require non essential activities to be dropped. Consider annualising SPA time rather than cancelling it to free up resource
- Increased visibility of senior staff across the hospital
- Ideally deploy **Ward Liaison Officers** (WLOs) to wards / departments
- Give explicit permission from executives for front line staff to get on and do things that prevent patient delays (no matter how small)
- Apply the **Good practice guide: Focus on improving patient flow**

Structure - how could it work?

- Clear leadership and management – Bronze, Silver and Gold

- **But** - a balance between control and really letting the front line staff free to deliver the **shared purpose** i.e. to reduce unnecessary waiting which is harmful for patients

- Daily wash up meetings to agree immediate actions to reduce constraints that are causing delays



Preparation - **Ask** and **Offer** sessions

Across the system and in the hospital

Ask and **offer** sessions

Focus on delivering all of the recommendations in the *Good practice guide*: *Focus on improving patient flow*

- the basis of the Ask and Offer conversations

- **Acute Trust**

Ideally the senior team should run a number of sessions with teams, specialties and departments. Each team, specialty or department can **ask** something of the other (if it helps reduce patient's waiting) but they also have to **offer** something in return that will also help reduce patients waiting

- **Whole System**

Ideally the senior leaders across all system partners should run a session and follow the same rules i.e. they can **ask** partners to commit to tasks to reduce patient waiting but must **offer** something in return that will also reduce patients waiting

Record 'ask and offer' commitments with the names of those agreeing to act.
Challenge whether the stretch offer is appropriate

Ward Liaison Officers (WLOs)

- Ideally one per ward / department
- From non clinical backgrounds e.g. HR, Finance. What can be cancelled to enable them to be released?
- WLOs should report to the nurse in charge of the ward
- WLOs should chase and help reduce patient delays as directed by the ward teams
- WLOs don’t become or replace bed managers
- One per ward per week, single days don’t work
- WLOs need a preparation session and written guidance
- Wards should know who is going to be their WLO and be introduced before hand
- Great opportunity for non clinical teams to help clinical staff

Ward Liaison Officers (WLOs)

Every ward every day the WLOs ask 5 patients or their loved ones if they can answer the 4 questions below. Report the results

1. ***Do I know what is wrong with me or what is being excluded?*** This requires a competent senior assessment and discussion.

2. ***What is going to happen now, later today and tomorrow to get me sorted out?*** Inputs needed (diagnostic tests, therapeutic interventions etc.) with specified timelines.

3. ***What do I need to achieve to get home?*** The 'clinical criteria for discharge' (CCD), a combination of physiological and functional parameters. Challenge 'Back to baseline'.

4. ***If my recovery is ideal and there is no unnecessary waiting, when should I expect to go home?*** This is the 'expected date of discharge' (EDD) which should be set along with the CCD at the point of admission.

Local Structure – gold, silver & bronze
Emphasis on sorting todays work today

- **Bronze – Ward / departmental level.** Ward Liaison Officers on each ward to help resolve simple problems and capture issues - no matter how small without delay. Any issues that can't be resolved within 4 hours goes to Silver

- **Silver – Divisional leaders.** Control room / hub to help co-ordinate. 2 x daily meetings Loggist captures issues. Any issue that can't be resolved within 1 day goes to Gold

- **Gold – Executive team**. Available to help resolve any problems that can't be resolved at bronze / silver level. Meet daily with silver. Gold is more about learning and facilitation and helping to sort problems in real time.

All have managerial and clinical representation

The executive team also 'go and see' front line teams during the week. Adopt wards during the week and after visit once weekly.

Multi Agency Discharge Event (MADE)

- Brings together the local health system to:
  - support improved patient flow across the system
  - recognise and unblock delays
  - challenge, improve and simplify complex discharge

- Involves senior system clinical and operational staff, significantly enhanced with “expert patient” input

- Focus is on working intensively with a small number of wards and their staff and patients

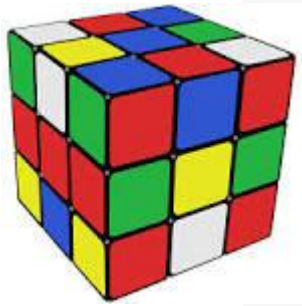
- Can be delivered over one or two days or as part of running a “perfect week” within your Safer Start to 2018

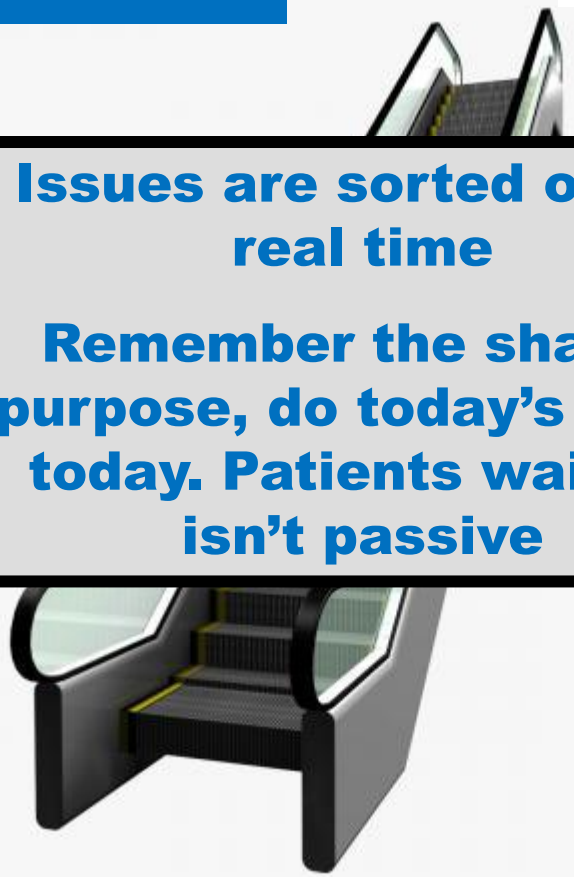
Stranded patients
Daily review – think #Homefirst

- 7 – 14 days - Peer to peer review by a consultant and a senior nurse (doesn't have to be the same specialty). They meet with the senior nurse and consultants on each ward to discuss and supportively challenge three questions:
  - Is the patient sick enough to need to remain in hospital and evidence it (so not just 'because I say so')?
  - If not sick, what is being done to get them home - and assist with unblocking?
  - What could and should have been done on days 1-6 which would have stopped them becoming stranded - the learning question.
- 14 -21 days - the senior nurse of the ward and the consultant need to present to the clinical director why this patient remains in hospital.
- 21 days plus - the senior nurse and consultant (with or without the CD) have to present to the medical director and director of nursing why the patient needs to remain in hospital.

System partners can help with this and should be invited to 14 day plus meetings

Aims of a Safer Start to 2018





Issues are sorted out in real time

Remember the shared purpose, do today's work today. Patients waiting isn't passive

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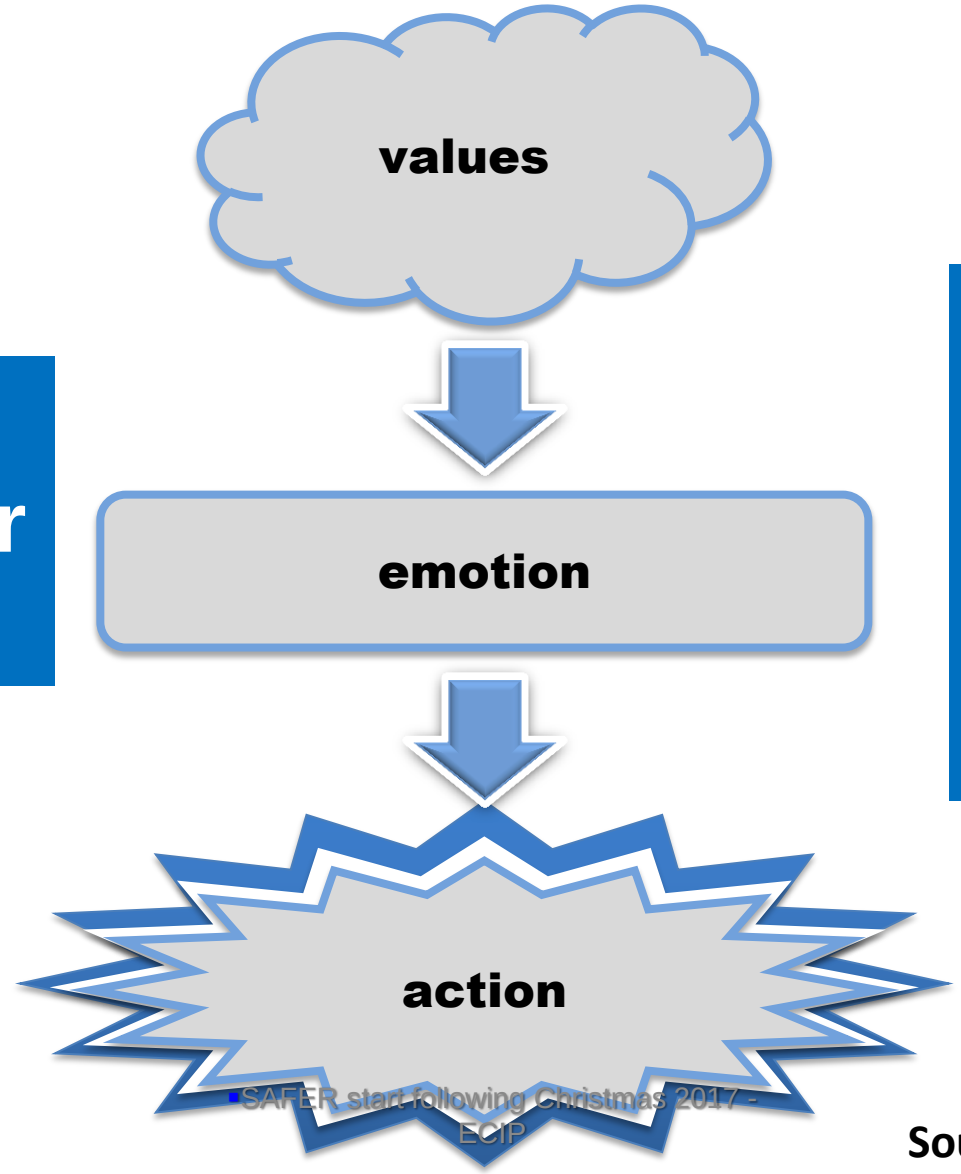
Approach is as important as structure, If we want people to take action, we have to connect with their emotions through values



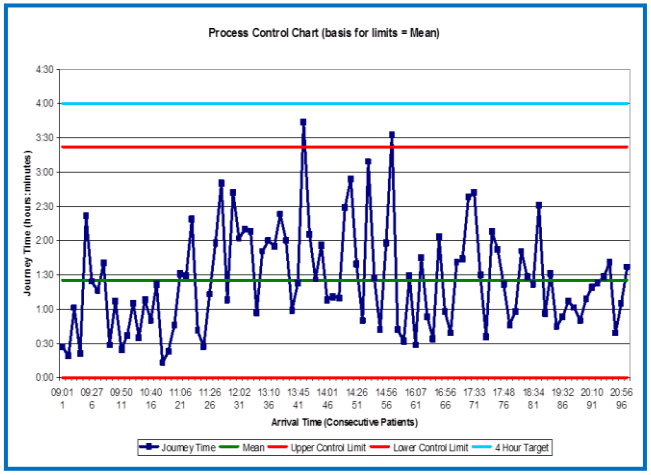
Make it fun – offer prizes

Ask everyone to tell 10 people everyday

Source: Marshall Ganz

Measures – examples

- Number of empty beds at 8am.
- % Patients discharged before midday.
- 4 questions.
- Ambulatory emergency Care % of daily medical take.
- Outliers.
- Number of stranded patients (7 days or greater) and super stranded patients (21 days or greater).
- Pareto chart showing top 5 reasons for red days.
- Compliance with all 5 elements of the SAFER patient flow bundle.



Data on a daily basis and responding to daily in real time i.e. change systems in real time wherever possible

Make sure everyone knows how we are doing – make the information accessible and visible.

Practical tips

- Confirm the dates early to allow appropriate notice
- Make it genuinely clinically led
- Follow the checklist for senior leaders
- #Fit2Sit in the emergency department
- #EndPJparalysis – get as many patients dressed, up and moving
- Think #Homefirst for all patients
- Implement the ED safety checklist
- Ensure all wards follow all elements of the SAFER patient flow bundle
- Use #Red2Green days to highlight and reduce complaints
- Test discharge to assess and trusted assessment with patients
- Wrap up session daily
- Plan a celebratory event at the end of the week
- Ask senior leads to facilitate ‘ask and offer’ sessions and present to your teams.

When planning a Safer Start

- Start early – word of mouth is the most effective
- Agree a communication plan
- Weekly briefings can provide updates on progress of ‘ask and offer’ sessions
- Explain why we are doing this – Safer Start to 2018
- Use all forums e.g. grand rounds, nursing, allied health professional and clinical support forums
- Maximise clinical engagement

Resources

- You and your team
- Safer Start webinair: midday Wednesday 13 December
- ECIP materials here today
- ECIP resources via NHSI improvement.nhs.uk
- Social Media: share in advance and throughout your local Safer Start. Maybe follow ECIST Network on twitter/facebook and encourage your teams to do so
- Call or email an ECIP “critical friend” for advice
- London wide shared learning set?
- Any other requests please let us know via email diane.fuller@nhs.net or via twitter @DianeFuller001
- Thanks for listening