A SAFER Start to 2018

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

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• 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.

If you had 1000 days left to live how many would you choose to spend in hospital?

SAFER start following Christmas 2017 - ECIP
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.

The evidence – compelling story

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Poor 4-hour performance correlates with increased mortality

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

*A: 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').

• SAFER start following Christmas 2017
  - ECIP
43% more deaths when emergency departments are crowded (10-day mortality) than when there is no crowding.
Crowded emergency departments

- Dangerous
- Correlates with increased length of stay

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.

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

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

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<th>Readmissions</th>
<th>Mortality</th>
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<td>4.8%</td>
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Mortality on wards that board patients out is 30% higher than on those that don’t
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)
We know what works

Good practice guide: Focus on improving patient flow

National priorities for acute hospitals 2017

Good practice guide: Focus on improving patient flow

July 2017

Produced in collaboration with and endorsed by:

- Royal College of Physicians
- The Royal College of Emergency Medicine
- Association of Ambulance Chief Executives
- SAM
- Emergency Care Improvement Programme
- NHS

https://improvement.nhs.uk/resources/good-practice-guide-focus-on-improving-patient-flow
“The Christmas Eve effect”
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.
We need to Break The Cycle by taking proactive action
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
• 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 today’s 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

SAFER start following Christmas 2017
- ECIP
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.

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
You and your team
Safer Start webinar: 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