Redesign of Front Door – Transforming Acute and Urgent Care

• Strategic Background and Context
• Our Change and Improvement Programme
• What have we achieved and how?
• What did we learn?

Ian Aitken, General Manager
Allan Bridges, Associate Medical Director
Vision and Strategy Model 2004/5

- Acute Inpatient Services
- Intermediate Care
- Clinical Support Services
- Emergency Care
- MH & Pal
- Ambulatory Care
- Four Hospitals in Community
- Primary Care
Change and Improvement in NHS Forth Valley

• Longer Term Plan

• More Recently
  – Prioritisation Exercise 2008
  – Development of Change & Improvement Programme March 2009
  – Extensive delivery and learning across all Workstreams & Projects 2009/10
Enabling Work-streams: Leadership & Communication; Information & Metrics; Training; Programme Mgt;

**Urgent & Emergency Work-stream**
- Redesign whole system U&E pathway
- Increase proportion of community based U&E care
- Improve A&E access resilience
  - Improve 'home-to-home' visibility of patient pathway
  - Generate additional capacity (DN and GP)
  - General Practice profiling
  - Systematic improvement in LA supported discharge

**Primary & Community Work-stream**
- Generate additional capacity (DN and GP)
- General Practice profiling
- Systematic improvement in LA supported discharge
- Reduce variation of referrals into care pathways
- Improve 'home-to-home' visibility of patient pathway

**Diagnostics Work-stream**
- Systematic improvement of Labs
- Increase MRI productivity/capacity
- Eliminate ‘unnecessary’ unplanned acute admissions
- Systematic improvement in acute in-patient management

**Elective Work-stream**
- Articulate the productivity benefits from 18 week programme
Triple Aim – concept and design
optimise the health system taking into account 3
dimensions: the experience for the individual; the health for
a defined population; per capita cost for the population
Achieving Quality & Efficiency through Consistency

- Implement change in a systematic way across organisation
- Assessing & Improving quality through application of redesign tools
- Test Efficiency & improve service outcomes
- ‘Radical Service Redesign’
- Achieve the ‘Triple Aim’
- Reduce service variability
- Increase consistency
Call Handling/Referring Services

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<thead>
<tr>
<th>SAS</th>
<th>NHS24</th>
<th>GP Practices</th>
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Scottish Ambulance Service

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<thead>
<tr>
<th>Emergency Vehicles</th>
<th>Community Paramedics</th>
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Urgent Care

- Out of Hours
  - GP services
  - Diagnostic Services
- Minor Injury
  - Urgent Clinics
  - Social Care

Acute Hospital Emergency Care

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<tr>
<th>Resus</th>
<th>A&amp;E</th>
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<tr>
<td>Major</td>
<td>Observation</td>
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<td>Minor Injury</td>
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<tr>
<th>Inpatient Acute Beds</th>
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<tr>
<td>Acute Admission Unit</td>
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<td>(short stay up to 48 hours)</td>
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<td>Speciality Units</td>
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<tr>
<th>Assessment Unit</th>
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<td>GP referrals</td>
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<td>Ambulatory Care</td>
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Community Healthcare & Social Care

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<th>Community Hospitals</th>
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<td>Local units</td>
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<th>24/7 Home Care</th>
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<td>Medicine management</td>
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<td>Complex Care</td>
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<td>Anticipatory/Advanced Care Planning</td>
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<td>Direct Access Diagnostics</td>
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<td>Specialist Outreach</td>
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<td>Supported Discharge</td>
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<td>Community Nursing</td>
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<th>Social Care Package</th>
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<td>Outreach Rehabilitation</td>
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<td>Rapid Response</td>
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<td>Palliative Care</td>
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Why was 5th August 2009 targeted for transformation of ‘Front Door’?
Drivers for change

- Trainee medical staff numbers, skill mix and hours of work reducing
- Achieving Referral to Treatment Targets (RTT) and 4 hr access to Emergency Care
- Improving Efficiency
- Move to new build acute Hospital planned for 2010/11
- Improving patient care and patient safety
Major Goals for Acute and Urgent Care Transformation

• Improve patient experience, safety and quality
• Improve resilience of the 4 hour emergency access target
• Manage demand and reduce A&E attendance
• Achieve government efficiency targets for recurring and non-recurring spend
• Agree the delivery of a revised model of Acute and Urgent Care and pilot new ways of working in preparation for a move to a new acute hospital in 2011
• Confirm changes to our workforce and agree the configuration of the Acute Care Team
Organisational Buy in to Change

• Commitment from NHS Forth Valley Health Board and Executives

• A team identified to lead the change process
  – Sponsored by Chief Operating Officer and included a General Manager, Associate Medical Director and Redesign Manager
  – Working Groups established with dedicated time from service managers and Clinical Leads supported by ATOS origin, OD manager and others
  – Look at other sites

• Investment in Organisational Development and Leadership programmes across the organisation
Our Approach to Change

• Sense of urgency created
• An influential partnership of clinicians and managers
• Broad engagement
• Building the system
• Empowering front line staff to deliver change
• Continuous review and revision
• Sustain change
Engagement and Involvement of Staff Groups and Public
Understanding our system
February/March 2009
Old Model of Patient Flow in Stirling Royal Infirmary

Geographical and functional separation of Workforce
A demand pattern that increases 4 fold throughout the day

Consolidated Front Door Demand (Avg 24hr Period)

Patients / Hour (Mean Attendance)

0 5 10 15 20 25

Hour of the day

04h 08h 12h 16h 20h 24h

5.26 patients / hr

19 patients / hr

23 patients / hr

14 patients / hr

20 patients / hr

Consolidated Front Door Demand (Avg 24hr Period)
Communications to confirm plan

• Established a project office - daily meetings and discussions
• Staff briefing sessions and presentations to Clinical Advisory Group and Clinical Boards encouraging engagement
Proposed Solutions

• Sharing care and transfers of care

• Job substitution

• More efficient use of available staff and facilities
Sharing/transfers of care

• Emergency Medicine
  – Take head injuries
  – Responsible for initial evaluation of all patients presenting with general surgical conditions
• Geriatric Medicine
  – Assume care of surgical and orthopaedic patients requiring rehabilitation post op at FDRI
• Acute Medicine
  – Oversee care of all patients in Acute Assessment Unit (AAU)
  – Assume responsibility for stabilisation of surgical patients in AAU when surgeons unavailable
  – Medically stabilise patients with #NOF inAAU
Job substitution

To replace FTSTA posts and lost trainee hours

• More trained doctors
• More Advanced Nurse Practitioners
More efficient working –

- Clarity of roles, responsibilities and timetabling
- Maintain and improve quality of training
- A new model for acute and urgent care
- An integrated acute assessment and receiving area
Improvement Plan for 5th August 2009

- GP call handling
  - Establish call handling for all GP referrals to direct patient to most appropriate location
- Emergency Department (ED)
  - Establish short stay unit for defined patients groups
  - GP surgical referrals managed within Emergency Department
  - Direct Admission to the Acute Assessment Unit (AAU)
- Acute Assessment Unit (AAU)
  - Establish an integrated surgical and medical assessment unit and generate patient flow
- Ambulatory Care
  - Shift inpatient activity to ambulatory/day medicine
  - Condition specific Rapid Access Clinics available
Improvement Plan for 5th August 2009

• Inpatient management across acute and community
  – Develop core infrastructure and governance framework around patient pathways and maximise benefit from speciality working

• Operational Guideline to be developed

• Unified documentation and single kardex to be introduced

• Acute Care Team
  – Establish an Acute Care Team and develop operational guidelines for day, night and weekend working 24/7
  – New roles for staff and departments including speciality/downstream wards
Communications following implementation of new model of working

- Daily issues meeting for 2 weeks following 5th Aug implementation
- Weekly meetings established to identify issues as they arise and confirm plans to resolve them and refine the model of working
- An Issues log with resolution plans is being maintained
Summary of Progress – first 9 months encouraging

• GP calls
  – average 35 per day Monday busiest day

• Emergency Department
  Average length of stay in ED unchanged

• Emergency Admissions
  The number of emergency admissions down from 57 to 53 per day
  Surgical admissions same
  Length of Stay at SRI unchanged at 5 days
  The number of boarders down
Summary of Progress – first 9 months encouraging

• **Acute Assessment Unit**
  - The proportion of patients admitted to the Acute Assessment Unit (AAU) up from 68% (30) per day to 83% (38) per day
  - The number of people discharged or transferred from the AAU within 24 hours up from 13 to 17
  - Bed Occupancy with the AAU at each hour of the day reduced (down from 51 to 45 at midnight)
  - Length of Stay (LOS) within the AAU down from 1.5 to 1.2 days

• **Clinical outcomes and patient experience**
  - Re-admission rates – no change in the overall 28 day rate
  - Mortality rates decreased (down from 4.0% to 3.9% includes all inpatients)
  - A reduction in the number of complaint

..........some examples, still more to do
Patients admitted to AAU

Average AAU Admissions:
Pre - 5 Aug 2008 to 4 May 2009  30
Post - 5 Aug 2009 to 4 May 2010  38

Number of Patients Admitted per Day to AAU
5 Aug to 4 May 2008/09 and 2009/10

% Admissions to AAU
Pre – 5th Aug 08 to 23rd Feb 09  67%
Post – 5th Aug 09 to 23rd Feb 10  84%

Average AAU Admissions:
Pre - 5 Aug 2008 to 4 May 2009  30
Post - 5 Aug 2009 to 4 May 2010  38

Date of Admission

Nmbr of Admissions

2008/09  2008/09 - 28 day rolling average  2009/10  2009/10 - 28 day rolling average
More Efficient Working – workforce

• A dedicated 24/7 Acute Care Team (ACT)
  – Based in acute assessment and receiving wards
  – Utilise all available trainees
    - Generic working at FY1 -> ST1/2 while on the ACT
  – Working with ANPs
  – Led by Acute Medicine consultants
  – Overseeing the care of all patients in the AAU

• Move to ward based clinical teams/specialty wards
Training Grade Doctor & Advanced Nurse Practitioner Workforce

Within Specialty
- Acute Assessment Unit (Wards 23 and 25)
- CAU
- CPAU
- Day Medicine
- All Wards 8.00pm – 8.30am
- ITU
- CCU
- HDU

Within Specialty & ACT
- Acute Care Team (ACT)
Progress to date

- 36 wte trainee posts and hours out of the system on 5th August 2009 ↓15%
- Not all the substitutes were in place at the time
- Of those in place not all are working at the level we can anticipate in the future
- In addition we had unfilled posts in our current allocation of trainees
- European Working Time Regulations and New Deal compliant
HOSPITAL STAFF'S
SAFETY WORRIES

By Kialiya Marjoribanks

A group of junior doctors at Stirling Royal Infirmary are warning that the service is not receiving sufficient support to keep patients safe.

They claim that the growing workload is putting patients at risk and that there are not enough doctors to meet the demands being placed on the hospital.

A Norfolk-based junior doctor has written to the Stirling Observer to highlight the problem.

The letter, signed by a junior doctor from the Norfolk-based hospital, argued that the workload was becoming unmanageable and that there were not enough doctors to cope with the demands being placed on the hospital.

The junior doctor said: "We are being asked to do more with less and it is unfair on patients and staff."

The letter called for more support for junior doctors and for the hospital to be properly resourced.

The junior doctor also said that the workload was putting patients at risk and that there were not enough doctors to meet the demands being placed on the hospital.

The letter concluded: "We are being asked to do more with less and it is unfair on patients and staff."

There is no indication of the identity of the junior doctor or the hospital they are based at.
Learning from our Work

• Robust information motivates individuals and provides evidence to support or refute anecdote
• Continue to develop and change the model of working to address issues as they arise
• Communications, communications, communications……
A Cultural Shift in our approach to change – what makes the difference?

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<th>From</th>
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<tr>
<td>• Change implemented based on anecdote and perceived need</td>
<td>• Robust information used to underpin change</td>
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<tr>
<td>• A separation of clinical and managerial agendas</td>
<td>• Organisational goals combined clinical and managerial agendas</td>
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<td>• Service change evolved based on individual preferences (isolated individual projects)</td>
<td>• Utilising approaches to whole system change and improvement incorporated in a programme of redesign and patient safety</td>
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...we have changed and integrated services in a short time frame whilst achieving positive outcomes for patients and staff