CUH Looking beyond the hospital for solutions

ED More than a hospital department – Room with a view.
Avilene Casey Executive Performance Improvement Lead (USC) HSE.
Life expectancy is increasing

LIFE EXPECTANCY AT BIRTH FOR IRELAND AND EU-28 BY GENDER, 2003-2012

With healthy years added

LIFE EXPECTANCY AND HEALTHY LIFE YEARS AT AGE 65 BY GENDER, IRELAND AND EU-28, 2012

Source: Eurostat.
### Health in Ireland Key Trends 2015

- **Acute Beds**
  - 2008: 11,847
  - 2014: 10,480
  - % Change: -11.54%

- **In Pt discharges**
  - 2008: 592,133
  - 2014: 622,763
  - % Change: 5.17%

- **Day cases**
  - 2008: 770,617
  - 2014: 957,258
  - % Change: 24.22%

- **Emergency Attendances**
  - 2008: 1,150,674
  - 2014: 1,217,572
  - % Change: 5.81%

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Length of stay reduction equates to extra 1000 beds.
Is homelessness increasing or decreasing in Ireland? Unfortunately, homelessness is increasing year on year. Between December 2014 and December 2015 there was a net increase in the number of people recorded as homeless of 1,700 people, an increase of 43%.

- Population has grown by 1.8% since 2010
  - and is projected to increase by 4% by 2021
- Since 2010,
  - 18% increase in those aged 65yrs and over; and
  - 17.5% increase in those aged 85 years and over (with a 4% increase predicted in 2016)

### Total Population - All Ages

<table>
<thead>
<tr>
<th>Year</th>
<th>Population (000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>4554.8</td>
</tr>
<tr>
<td>2011</td>
<td>4574.9</td>
</tr>
<tr>
<td>2012</td>
<td>4585.4</td>
</tr>
<tr>
<td>2013</td>
<td>4593.1</td>
</tr>
<tr>
<td>2014</td>
<td>4609.6</td>
</tr>
<tr>
<td>2015</td>
<td>4635.40</td>
</tr>
</tbody>
</table>

### Population Age Groups (over 65yrs)

- 65 - 69 (up 24%)
- 70 - 74 (up 17%)
- 75 - 79 (up 12%)
- 80 - 84 (up 12.5%)
- 85 years and over (up 17.5%)
ED Crowding

Pines describes
‘ED crowding is the elephant standing in the room; it is just very difficult to describe how heavy he is, how bad he smells, and just when the floor might give’

Pines JM. Moving closer to an operational definition of ED crowding Acad Emerg Med 2007; 14: 382-383
Failure Demand

• **Failure demand** is a systems concept used in service organisations first discovered and articulated by Professor John Seddon as

‘demand caused by a failure to do something or do something right for the customer’

• “Question is not efficiency its effectiveness”
• Prioritisation of need, standardisation to the exclusion of variation does not meet peoples need
• System does not distinguish between demand and demand failure.
National survey of General Practitioners on services for patients with COPD

T McCarthy, M Walsh, M O’Connor, on behalf of the National COPD Strategy Group
Population Health, HSE, Dublin; General Practitioner, New Ross & DMP

Examples of waiting times
- Pulmonary rehab programmes – one week to 12 months (23.9% no access)
- Chest x-ray – 24 hours to six weeks
- Long term oxygen therapy assessment – 3 days to 12 months
- Respiratory consultant OPD – one week to 12 months
- Physiotherapy – days to six months

Summary
- 53.7% of GPs have access to spirometry within their own practice. A practice nurse usually conducts the test (64%) and a GP interprets the results (83%). Almost half have no arrangements in place for calibration and maintenance of their spirometers.
- Many practices report that their patients are unable to access patient support groups (21.1%), pulmonary rehabilitation (23.9%), rapid access respiratory clinics (37.6%) or community options for management of an exacerbation – home based (49.1%) or local community unit/district hospital (80.9%).
- Services that are difficult or difficult to access include support groups (49.1%), pulmonary rehabilitation (53%) and long term oxygen therapy assessment (56.3%).
- Waiting times are up to six months for physiotherapy and pulmonary function testing and up to one year for respiratory consultant review, long term oxygen therapy assessment and pulmonary rehabilitation.
- This survey highlights geographical variation and service gaps which must be addressed so that a shift can occur towards a community-based, responsive, flexible service for patients with COPD.

An Audit of Discharges of Patients Hospitalised with an Acute Exacerbation of COPD
Is there a need for a Discharge Bundle of Care?

Migone C1, O’Connor M1, Kelly E1, McDonnell T1
1 Department of Public Health, HSE East, Dublin 5
2 St. Vincent’s University Hospital, Dublin 8

Background
Chronic Obstructive Pulmonary Disease (COPD) is responsible for approximately 210 admissions per year to SVUH and over 3000 bed days. Spectacly, 40% of patients admitted with an Acute Exacerbation of COPD (AECOPD) are readmitted within 90 days of discharge. Internationally, a number of interventions delivered prior to discharge have been shown to improve COPD care. They have been grouped into a Discharge Bundle of Care and have been implemented in a number of hospitals. This audit evaluates to what extent these interventions are carried out in SVUH.

Aim
To audit discharges of patients hospitalised with AECOPD against interventions, known as being effective in reducing re-admissions, reducing mortality or improving quality of life for patients admitted to hospital with COPD.

Standards
All patients admitted with an AECOPD should have documentation at the time of discharge, that the following interventions have been delivered:
- Review of inhaler technique
- Written Management Plan given to the patient
- Smoking cessation assistance offered to current smokers during admission
- Smoking cessation assistance offered to current smokers at the time of discharge
- Pulmonary Function, as evidenced by FEV1 documented in the patient’s chart
- Oxygen requirements assessed
- Referral for Pulmonary Rehabilitation offered to the patient if appropriate
- Follow-up arrangements made
- Influenza Vaccine discussed with the patient
- Pneumococcal Vaccine discussed with the patient
- Arrangements for Vaccination made if necessary

Results
Characteristics of discharges is shown below.

<table>
<thead>
<tr>
<th>Age in years</th>
<th>Median</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>64</td>
<td>44.75</td>
</tr>
<tr>
<td>Female</td>
<td>64</td>
<td>47.4</td>
</tr>
<tr>
<td>Yes</td>
<td>38</td>
<td>29.3</td>
</tr>
<tr>
<td>No</td>
<td>50</td>
<td>43.2</td>
</tr>
<tr>
<td>Medical Card</td>
<td>Yes</td>
<td>143</td>
</tr>
<tr>
<td>No</td>
<td>17</td>
<td>14.1</td>
</tr>
</tbody>
</table>

The proportion of admissions who received each intervention is shown below.

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Delivery</th>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inhale technique</td>
<td>103</td>
<td>59.2</td>
</tr>
<tr>
<td>Written Management Plan</td>
<td>40</td>
<td>21.0</td>
</tr>
<tr>
<td>Smoking Cessation Assistance</td>
<td>27</td>
<td>42.2</td>
</tr>
<tr>
<td>Elemental Analysis</td>
<td>36</td>
<td>51.1</td>
</tr>
<tr>
<td>FEV1 recorded</td>
<td>100</td>
<td>57.5</td>
</tr>
<tr>
<td>Oxygen Requirements Assessment</td>
<td>181</td>
<td>88.8</td>
</tr>
<tr>
<td>Pulmonary Rehabilitation</td>
<td>16</td>
<td>11.1</td>
</tr>
<tr>
<td>Follow-up arrangements</td>
<td>100</td>
<td>57.5</td>
</tr>
<tr>
<td>Influenza vaccine</td>
<td>27</td>
<td>17.8</td>
</tr>
<tr>
<td>Arrangements for Vaccination</td>
<td>16</td>
<td>86</td>
</tr>
</tbody>
</table>

Results
- Smokers: no discharges received all 11 recommended interventions. Median number of interventions delivered was 5.
- Non-smokers: 27.7% discharges received 10 recommended interventions. Median number of interventions delivered was 9.

Conclusions
A considerable proportion of patients hospitalised with AECOPD did not receive a group of interventions which would be in place at the time of discharge from hospital. The introduction of a Discharge Bundle of Care for patients admitted with AECOPD should be considered.
Older persons by numbers

**NEED**
- **2011 – 2026**
  - >65 yrs population: +60%
  - >85 yrs population: +100%
  (Source: CSO)

**LIFE EXPECTANCY 1993 - 2013**
- >75 female: +29%
- >75 male: +39%
  (Source: Eurostat 2014)

**INPATIENT DISCHARGES 2015 - 2021**
- >75 yrs will increase: +28%
  (Source: HIPE)

**ACCESS**
- **ADMISSION RATE**
  - >75 yrs: 48%
  - >95 yrs: 64%
  (Source: SDU 2016)

**PET TIMES**
- PET times increase with age.
  - 30-50% of all 24 Hr breaches are >75 yrs (BII 2014).
- **24 HOURS**

**RESOURCE**
- **NHSS** - €940
  - Home Care and Transitional Care
  - 15,000 HCP
  - 130 iHCP

- **€20 million**

**TRANSITIONAL CARE BEDS**
- 313 beds
- 17 acute hospitals

**DEMENTIA IN IRELAND**
- 50k with dementia
- 4k new cases every year
- €1.69 billion per year
- 100k cases by 2026
  (Source: ICGP 2014)

**LONG STAY PUBLIC BEDS**
- 5,255 beds
  (Source: SCD Operational Plan 2016)

Slide courtesy PJ Harnett National Clinical & Integrated Care Programmes
Older People and their experience in hospital

- Older people account for the majority of inpatients.

- The length of time a person spends in hospital is directly related to age.

- Older patients are more likely than others to be readmitted to hospital within a short time of discharge (the older the patient is, the more likely it is to happen more than once in the same year)

- They are often moved about within the hospital
# Admission Rates/Attendance Profiles Jan-Dec 2015

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Children</th>
<th>Adults</th>
<th>Older Persons</th>
<th>% older</th>
<th>Children</th>
<th>Adults</th>
<th>Older Persons</th>
<th>% Admitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beaumont Hospital</td>
<td>318</td>
<td>32864</td>
<td>13069</td>
<td>28%</td>
<td>26</td>
<td>6265</td>
<td>5726</td>
<td>8.2%</td>
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<tr>
<td>Cavan General Hospital</td>
<td>7525</td>
<td>14884</td>
<td>6204</td>
<td>22%</td>
<td>980</td>
<td>3169</td>
<td>3193</td>
<td>13.0%</td>
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<tr>
<td>Children's University Hospital Temple Street</td>
<td>46370</td>
<td>601</td>
<td>0</td>
<td>0%</td>
<td>5105</td>
<td>15</td>
<td>0</td>
<td>11.0%</td>
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<tr>
<td>Connolly Hospital - Blanchardstown</td>
<td>211</td>
<td>24322</td>
<td>6341</td>
<td>21%</td>
<td>0</td>
<td>5735</td>
<td>3751</td>
<td>0.0%</td>
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<td>34448</td>
<td>14913</td>
<td>25%</td>
<td>2834</td>
<td>8339</td>
<td>6719</td>
<td>22.7%</td>
</tr>
<tr>
<td>Galway University Hospitals</td>
<td>12991</td>
<td>33565</td>
<td>11722</td>
<td>20%</td>
<td>3138</td>
<td>6624</td>
<td>5688</td>
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<tr>
<td>Kerry General Hospital</td>
<td>6193</td>
<td>16972</td>
<td>7205</td>
<td>22%</td>
<td>1518</td>
<td>3183</td>
<td>3881</td>
<td>22.2%</td>
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<td>5907</td>
<td>19519</td>
<td>9549</td>
<td>27%</td>
<td>1518</td>
<td>4853</td>
<td>4991</td>
<td>25.7%</td>
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<td>Mater Misericordiae University Hospital</td>
<td>9</td>
<td>43324</td>
<td>12289</td>
<td>22%</td>
<td>2</td>
<td>7053</td>
<td>5212</td>
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<td>Mayo General Hospital</td>
<td>7728</td>
<td>18420</td>
<td>8650</td>
<td>25%</td>
<td>2151</td>
<td>3183</td>
<td>3881</td>
<td>27.8%</td>
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<td>Midland Regional Hospital Mullingar</td>
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<td>Midland Regional Hospital - Tullamore</td>
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<td>18513</td>
<td>6438</td>
<td>26%</td>
<td>0</td>
<td>4246</td>
<td>4195</td>
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<td>National Children's Hospital at Tallaght Hospital</td>
<td>30263</td>
<td>68</td>
<td>0</td>
<td>0%</td>
<td>4694</td>
<td>19</td>
<td>0</td>
<td>15.5%</td>
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<tr>
<td>Our Lady of Lourdes Hospital Drogheha</td>
<td>16337</td>
<td>24783</td>
<td>7920</td>
<td>16%</td>
<td>3010</td>
<td>4981</td>
<td>3728</td>
<td>18.4%</td>
</tr>
<tr>
<td>Our Lady's Children's Hospital, Crumlin</td>
<td>33062</td>
<td>205</td>
<td>0</td>
<td>0%</td>
<td>4476</td>
<td>72</td>
<td>0</td>
<td>13.5%</td>
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<tr>
<td>Our Ladys Hospital - Navan</td>
<td>0</td>
<td>17934</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>989</td>
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<td>Portiuncula Hospital Ballinasloe</td>
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<td>11038</td>
<td>5101</td>
<td>23%</td>
<td>1932</td>
<td>2838</td>
<td>2933</td>
<td>30.1%</td>
</tr>
<tr>
<td>Sligo Regional Hospital</td>
<td>6396</td>
<td>16975</td>
<td>8079</td>
<td>26%</td>
<td>1363</td>
<td>3753</td>
<td>4067</td>
<td>21.3%</td>
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<tr>
<td>South Tipperary General Hospital</td>
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<td>13610</td>
<td>6340</td>
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<td>10942</td>
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<td>6933</td>
<td>6098</td>
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<td>Tallaght Hospital - Adults</td>
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<tr>
<td>University Hospital, Limerick</td>
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<tr>
<td>University Hospital Waterford</td>
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<td>10166</td>
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<td>3314</td>
<td>3781</td>
<td>3418</td>
<td>39.0%</td>
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<td>16973</td>
<td>6686</td>
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<td>4283</td>
<td>3461</td>
<td>28.4%</td>
</tr>
<tr>
<td>National Total</td>
<td>240999</td>
<td>661852</td>
<td>199875</td>
<td>18%</td>
<td>52832</td>
<td>122619</td>
<td>105045</td>
<td>21.9%</td>
</tr>
</tbody>
</table>

## National Total

<table>
<thead>
<tr>
<th>Children</th>
<th>Adults</th>
<th>Older Persons</th>
<th>% older</th>
<th>Children</th>
<th>Adults</th>
<th>Older Persons</th>
<th>% Admitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>240999</td>
<td>661852</td>
<td>199875</td>
<td>18%</td>
<td>52832</td>
<td>122619</td>
<td>105045</td>
<td>21.9%</td>
</tr>
</tbody>
</table>

*ED Attendances (New) 2015 vs. ED Admissions YTD 2015 % Admitted*
Impact on beds of 10% volume increase - a Rising Tide

<table>
<thead>
<tr>
<th>sample site CUH 11% increase</th>
<th>day1</th>
<th>day2</th>
<th>day3</th>
<th>day4</th>
<th>day5</th>
<th>day6</th>
<th>day7</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Monday</td>
<td>Tuesday</td>
<td>Wednesday</td>
<td>Thursday</td>
<td>Friday</td>
<td>Saturday</td>
<td>Sunday</td>
</tr>
<tr>
<td>Expected Emergency Admissions</td>
<td>67</td>
<td>55</td>
<td>65</td>
<td>58</td>
<td>45</td>
<td>37</td>
<td>42</td>
</tr>
<tr>
<td>Actual ED Admissions</td>
<td>74</td>
<td>61</td>
<td>72</td>
<td>64</td>
<td>50</td>
<td>41</td>
<td>47</td>
</tr>
<tr>
<td>Bed Gap</td>
<td>-7</td>
<td>-6</td>
<td>-7</td>
<td>-6</td>
<td>-5</td>
<td>-4</td>
<td>-5</td>
</tr>
<tr>
<td>Cumulative Bed Gap</td>
<td>-7</td>
<td>-13</td>
<td>-20</td>
<td>-26</td>
<td>-31</td>
<td>-35</td>
<td>-40</td>
</tr>
</tbody>
</table>

Applied to 10,000 in patient bed base, then over the Christmas New Year period, this equates to additional 900 bed demand by end of first week of surge based on indicative levels of increased presentations of 9%
What does this mean for patients?

- Patients run a **43 per cent increased risk of death after 10 days** if they are admitted through a crowded accident and emergency (A&E) department (Richardson DB, 2006).

- Waiting for admission in A&E is also associated with **significantly longer hospital length of stay** – on average 2.35 days longer where a patient stays in A&E for more than 12 hours. (Liew, D. Kennedy M, 2003).

- Patients admitted at the weekend have **longer lengths of stay and higher morbidity and mortality** (Bell et al 2001, Bell 2013)

**Capacity is created by decision makers & action takers it is not just cubicles, trolleys, beds, chairs**

Dr Vincent Connolly -Consultant Physician, Medical Director, Emergency Care Improvement Programme (ECIP) @vincentconnolly

SDU
Measure the flow not the crowding
Framework to Guide Focus

Patient Flow

Front End-Inflow
- Patient assessment and streaming
  - Acute assessment
  - Minor injuries
  - Ambulatory Care/Rapid Access
  - Diagnostics
- National Clinical Care Programmes

Throughput
- High Impact Changes
  - Meaningful use of pdd/los
  - Home by 11am/ward levelling
  - Weekend discharges
- Specialty/Core wards
- Navigation Hub
- Los monitoring by condition, by team by consultant
- Specialty consults

Egress
- Complex pathways:
  - Flow of HCPs/supported discharge packages of care
  - Rehab services
  - Transitional care
  - Long Term Care
  - CIT
  - Transit/Discharge Lounge
  - Transport

Leadership & Governance

Data and Business Intelligence

Operational Processes and Pathways

Engagement and Integrated Planning
Average demand = Average capacity
Variation mismatch = queue

The Flaw of Averages

Reducing waiting times in the NHS is lack of capacity, the problem?
‘every system is perfectly designed to get the results it gets’
Why The Stranded Patient Metric?
Dr Ian Sturgess Associate Director Monitor

Managing the Streams
Identify the stream
- Short stay
- Sick specialty
- Sick frail
- Complex
- Allocate early to teams skilled in that stream

Clarity of specialty criteria
Specialty case management plan at Handover – no delays
Green bed days vs red bed days

Minimise handover
Decompensation risk
Early assertive management
Green bed days vs red bed days

Complex needs – how much is decompensation?
Detect early and design simple rules for discharge

Number of patients
Length of stay (days)
AMP Data CUH

Opportunities.
In 2-14 day LOS if reduced the 9% difference between current discharges (52.81%) to the target 44% would generate 8,500 bed days (approx)

Currently if patient stays longer than 2 days their LOS will be 11.51 days. Target 10 days

Half day reduction in length of stay results in effective bed gains of:
16 beds in a 200 bedded hospital
33 beds (a ward) in a 400 bedded hospital

Advisory Board Company UK
### Safer Now Bundle.

<table>
<thead>
<tr>
<th>S</th>
<th>Senior Review (board/round) of all patients for planned/potential D/C has happened before 9.00am</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>All patients PDD is documented and plans in place to meet same</td>
</tr>
<tr>
<td>F</td>
<td>First bed free by 09.30hrs on each ward</td>
</tr>
<tr>
<td>E</td>
<td>Ensure 50% of all beds needed are free by 2pm</td>
</tr>
<tr>
<td>R</td>
<td>Review all patients 2-14 days + &gt;14 days reviewed (min every 4 days)</td>
</tr>
<tr>
<td>N</td>
<td>No patient &gt;75yrs greater than 9 hrs in ED (from arrival)</td>
</tr>
<tr>
<td>O</td>
<td>Over 24hr breaches are the accountability of a named person</td>
</tr>
<tr>
<td>W</td>
<td>Weekend d/c are planned and happening (target 25%)</td>
</tr>
</tbody>
</table>
Essential Elements for USC & Patient Flow System Improvement

Navigational Hub

- Executive Sponsor and Clinical Engagement
- Demand and Capacity management
- Acute assessment & Short Stay
- Core Inpatient wards
- Integrated Discharge Planning

Data analysis, Engagement, Improvement methodologies, Care, Compassion, Trust, Learning, Patient empowerment

Burning platform – sense of urgency
Doing value adding things

Ireland
• CUH Plan for every patient
• St James Front door access older person pathway
• Beaumont FITT in ED
• Mater Lean Academy
• Kilkenny AMAU
• Waterford Streaming in ED
• Limerick Navigational Hub
• Connolly Complex discharges

Internationally
• www.kingsfund.org.uk
• www.nuffieldtrust.org.uk
• Chris Ham, Helen Bevan, Derek Bell
• Institute of Healthcare Improvement (IHI)
• Jonkoping Sweden
• Intermountain Healthcare USA
• Virginia Mason Medical Centre Seattle
• NHS Healthcare Improvement Scotland (HIS)
Emerging themes

• Protection of the Acute Floor elements (i.e. ED, AMU, SAU) at times of escalation
• Frail Elderly pathways (SRG/Care Programmes)
• Care Planning for each Patient, empower ward managers
• Medical Model review to support better patient flow (Link with Care Programmes)
• Appropriate 7 day working practices (SRG/Care Programmes)
• Business Intelligence/Real Time Data (ICT/BIU)
Currently the cycle of congestion

- High Volumes presenting / congestion and overcrowding
- Higher conversion rates / variable review times / poor streaming.
- Default to admit. Assessment units blocked - nowhere to move the queue
- Cumulative impact on capacity
- High inpatient volumes / multiple patient moves / delays and days lost / late evening moves to wards
- Longer discharges and later recognition of complexity
- Avlos increases due to inefficient throughput / safari ward rounds / outliers / additional unfunded capacity etc
- Human and resource capacity reaches inflexion point

av/m/jan 2016
Too long a sacrifice can make a stone of the heart

Easter 1916
Author: W. B. Yeats
September 25, 1916