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6 Essential Actions National Programme

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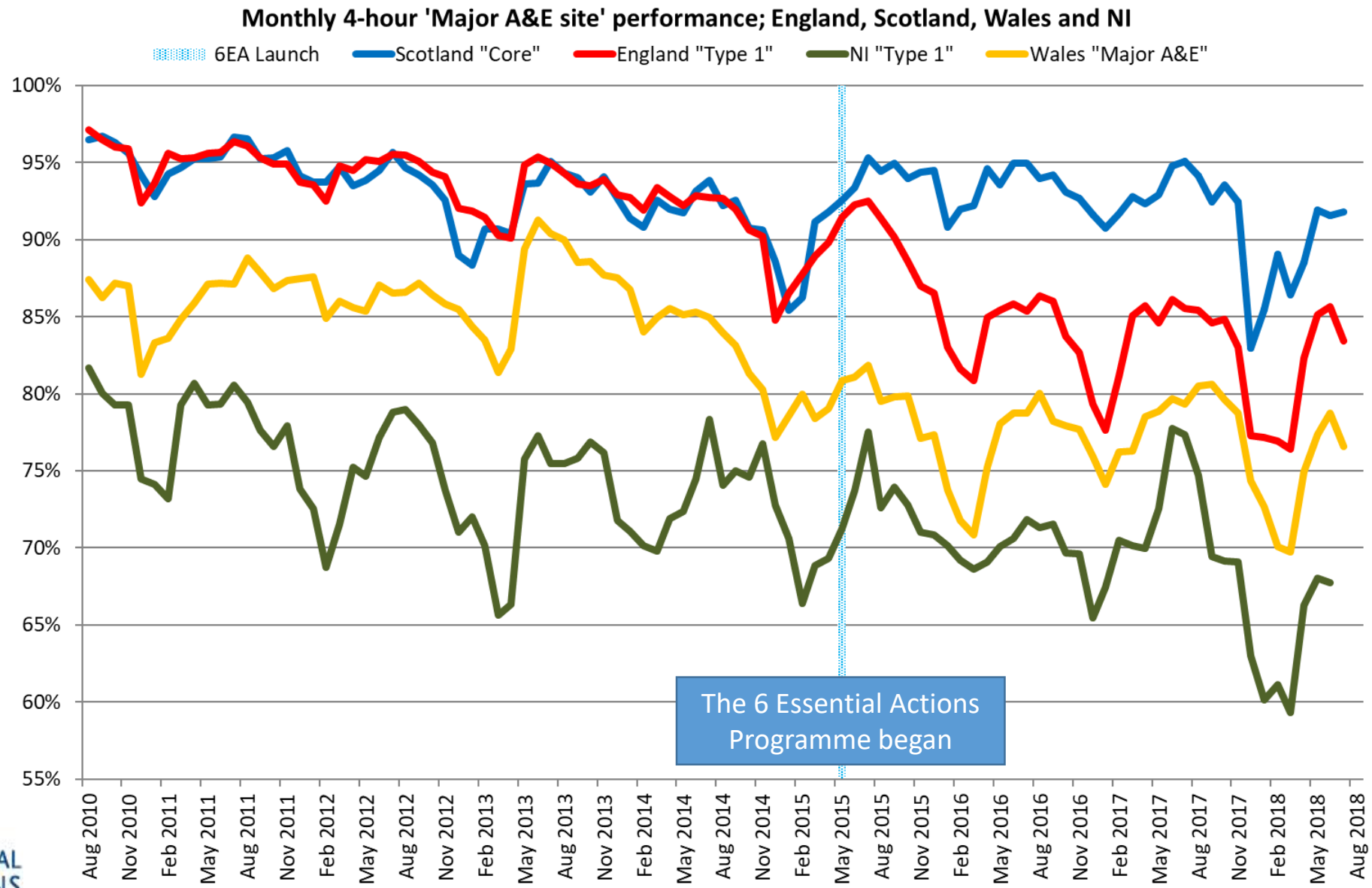
Urgent Care in Scotland

The Emergency Access Standard

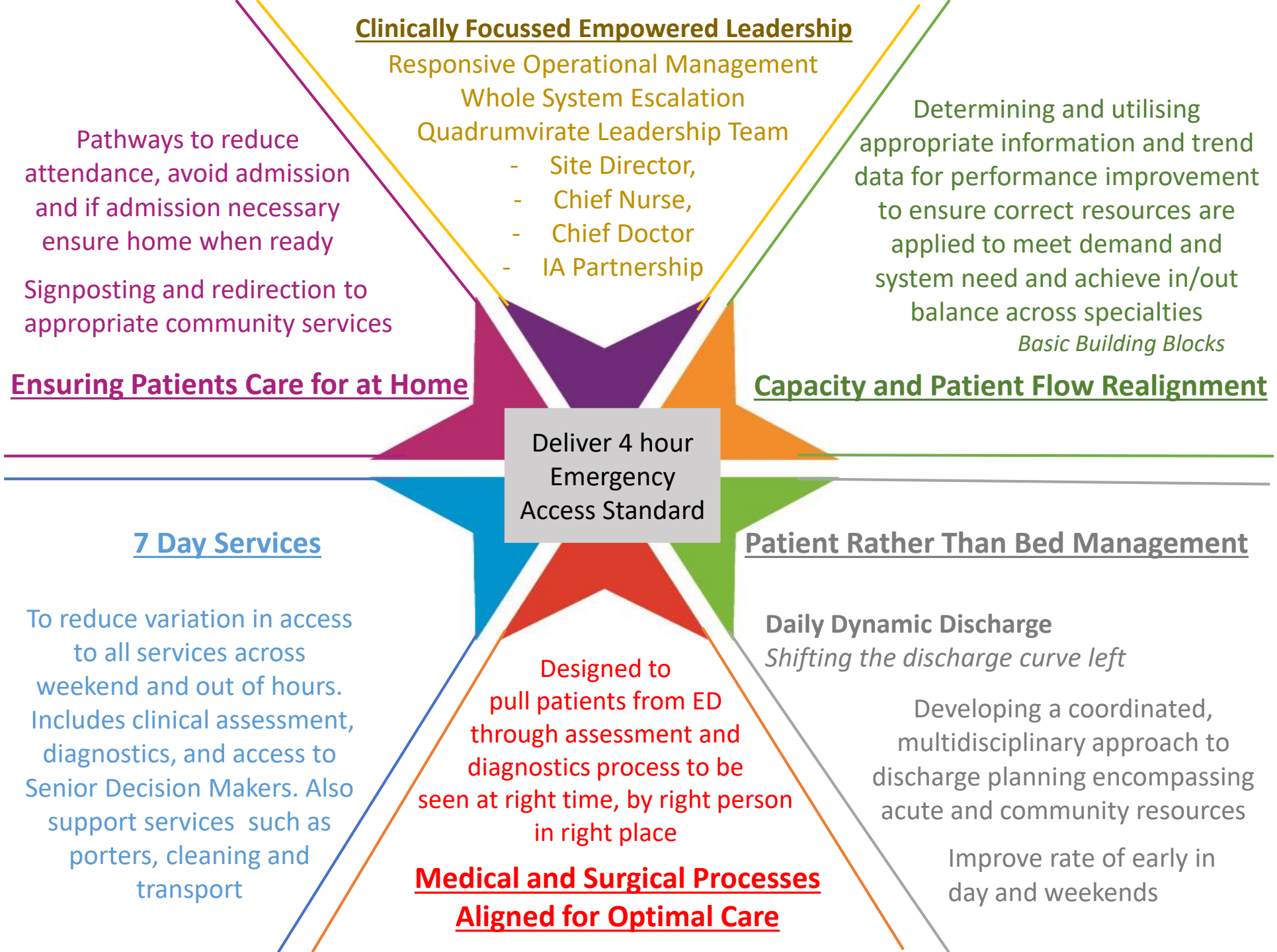
The barometer of the whole system

- Emergency Departments cannot deliver this target alone
- It requires a whole system response to ensure capacity is aligned with demand - by hour of the day and day of the week


Monthly 4-hour 'Major A&E site' performance; England, Scotland, Wales and NI
6EA Launch
Scotland "Core"
England "Type 1"
NI "Type 1"
Wales "Major A&E"
100%
95%
90%
85%
80%
75%
70%
65%
60%
55%
Aug 2010
Nov 2010
Feb 2011
May 2011
Aug 2011
Nov 2011
Feb 2012
May 2012
Aug 2012
Nov 2012
Feb 2013
May 2013
Aug 2013
Nov 2013
Feb 2014
May 2014
Aug 2014
Nov 2014
Feb 2015
May 2015
Aug 2015
Nov 2015
Feb 2016
May 2016
Aug 2016
Nov 2016
Feb 2017
May 2017
Aug 2017
Nov 2017
Feb 2018
May 2018
Aug 2018
The 6 Essential Actions Programme began

The Six Essential Actions for Improving Unscheduled Care

- Launched in May 2015
- Developed in partnership with the Academy of Royal Colleges, NHSScotland and Scottish Government
  - Based around known causes of poor performance
- Aimed to improve the patient and staff experience of Unscheduled Care
- Created to deliver the target
  - 95% of all patients to be admitted, discharged or transferred from the Emergency Department within 4 hours
  - Aiming towards a standard of 98%
- Ministerial objective


Clinically Focussed Empowered Leadership
Responsive Operational Management
Whole System Escalation
Quadrumvirate Leadership Team
- Site Director,
- Chief Nurse,
- Chief Doctor
- IA Partnership
Pathways to reduce attendance, avoid admission and if admission necessary ensure home when ready
Signposting and redirection to appropriate community services
Ensuring Patients Care for at Home
Determining and utilising appropriate information and trend data for performance improvement to ensure correct resources are applied to meet demand and system need and achieve in/out balance across specialties
Basic Building Blocks
Capacity and Patient Flow Realignment
Deliver 4 hour Emergency Access Standard
7 Day Services
To reduce variation in access to all services across weekend and out of hours. Includes clinical assessment, diagnostics, and access to Senior Decision Makers. Also support services such as porters, cleaning and transport
Patient Rather Than Bed Management
Daily Dynamic Discharge
Shifting the discharge curve left
Developing a coordinated, multidisciplinary approach to discharge planning encompassing acute and community resources
Improve rate of early in day and weekends
Designed to pull patients from ED through assessment and diagnostics process to be seen at right time, by right person in right place
Medical and Surgical Processes Aligned for Optimal Care

The Local 6 Essential Actions Infrastructure

- Unscheduled Exec Lead – Required
- Quadrumvirate Team – Chief Nurse, Chief Doctor, Site Director and Integration Board Lead Officer - Required
- Local Improvement Team (Funded)
  - Full Time Programme Manager (Health Board)
  - Full time Service Improvement Manager (Site)
  - 2 sessions Clinical Lead (Site)
  - Full time Analyst (Site)

The Improvement Approach

6 ESSENTIAL ACTIONS Unscheduled Care

Programme Team

Programme Manager Action and Progress (PMAP) Monthly Meetings

- Data for Improvement
- RADAR (scorecard)
- Progress Action Plan
  - PDSA 30, 60, 90 days
- Case Studies
- Peer support
- NIA – Challenge

Local Structure:

1. Unscheduled Care Exec Lead
2. Quadrumvirate (4)
3. Programme Manager
4. Clinical Lead
5. Service Improvement Leads
6. Data Analyst

Site Visits

Peer Support Improvement Focus

- Every Site over: September, October, November
- Data for Improvement
- Action Plan

Format:

- Max 10 per visit
- External peer support/review
- Walk patients journey
- Prompted questions for each area – reinforces high impact areas for change
- Peer review site feedback
- Improvement report issued
- Follow up on progress to visit team.
- Baseline
  - monitoring improvement

Collaborative Events

Learning Events:

- Winter review/ planning
- Celebrating Success

Regional Meetings:

- Sharing best practice
- Aligned to regional working

Team Based:

- UC Exec Leads Quadrumvirates
- Clinical Leads
- Service Improvement
- Analysts

Topic Based:

- Shifting The Curve
- Improvement Methodology
- ED / Acute Assessment Flow
- Surgical Flow
- Flow Hubs

DashBoard:

- Robust data for Improvement/Performance (SG)
  - National – weekly, monthly , YTD
  - Local
- Local Data
  - Reaching appropriate teams

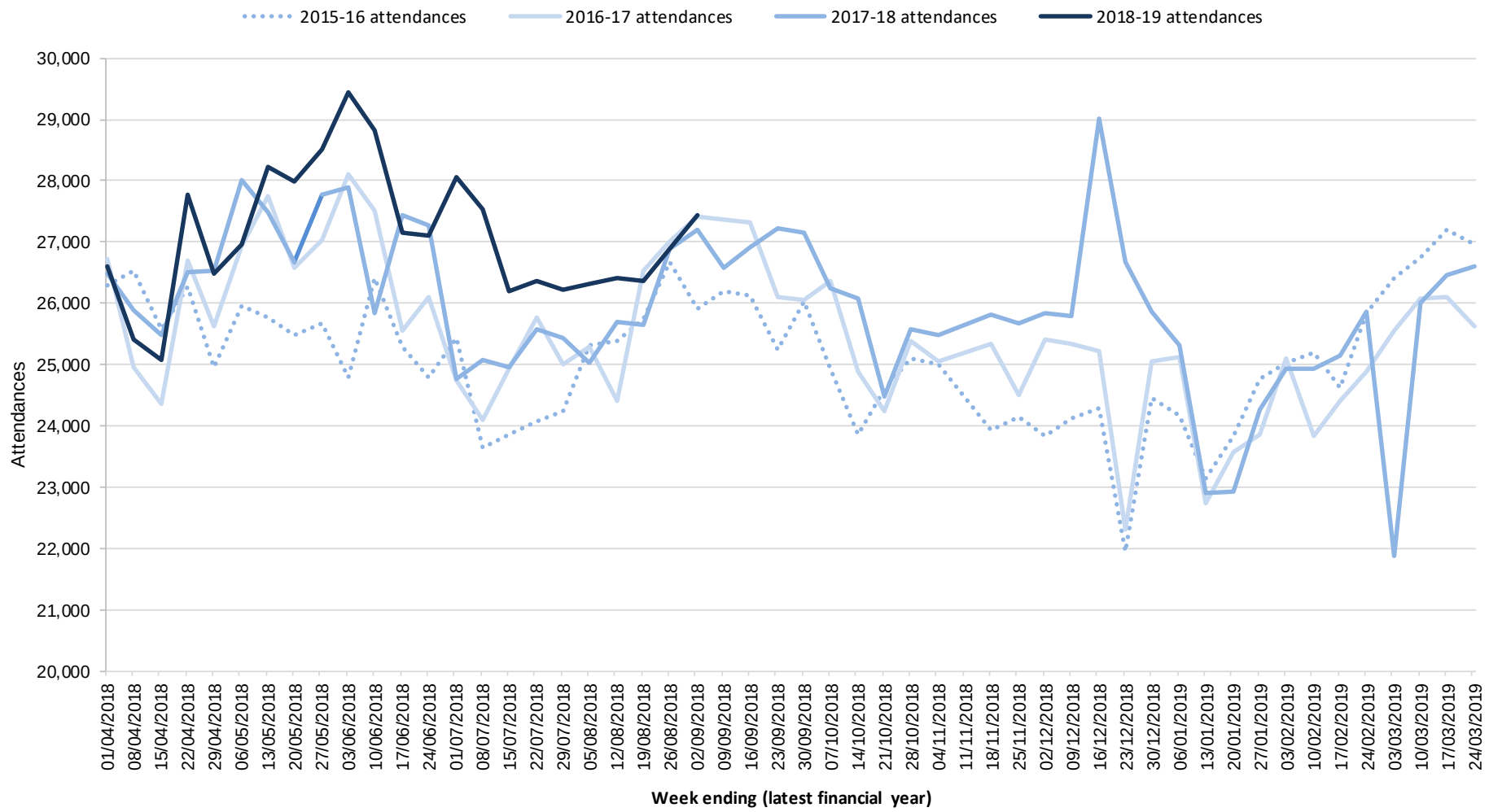
Yes, But…

Still a way to go

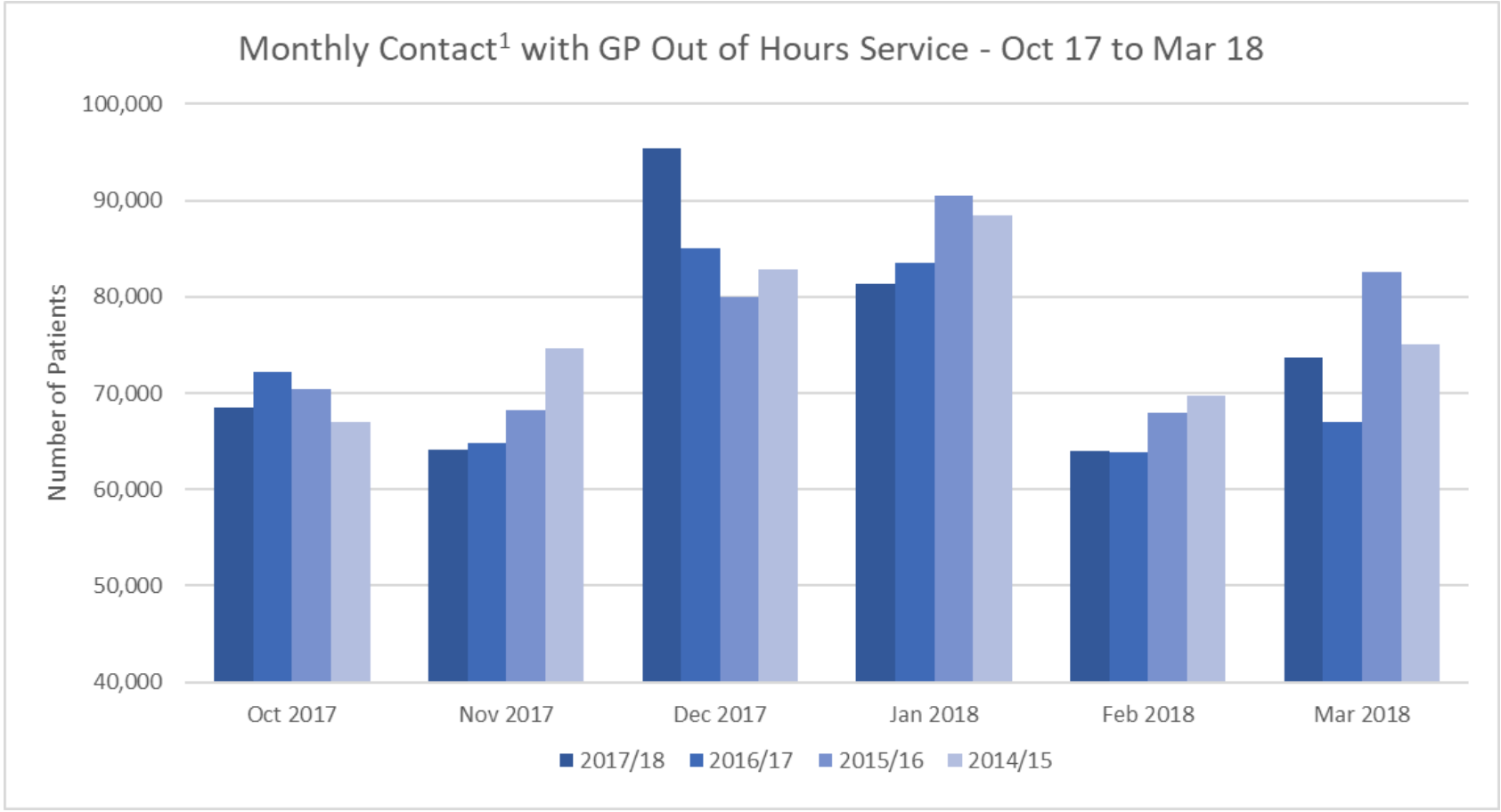
The NHS in Scotland delivered increased levels of activity

- 800,586 A&E attendances in winter 2017/18, the highest winter levels since reporting began.
- December 2017 had the highest number of GP Out of Hours contacts in any month since reporting began in 2014/15.
- Emergency inpatient admissions over Christmas and New Year increased by 7% compared to previous year.
- Overall Scottish Ambulance Service demand (Cat A, Cat B, Cat C) up 7.8%.
- NHS 24 experienced their highest ever call volume over the winter period. Call demand 30% above forecasts over the 2 public holiday periods around Christmas and New Year.

Number of AE attendances for Scotland (core sites only) by week, 2015-16 to 2018-19



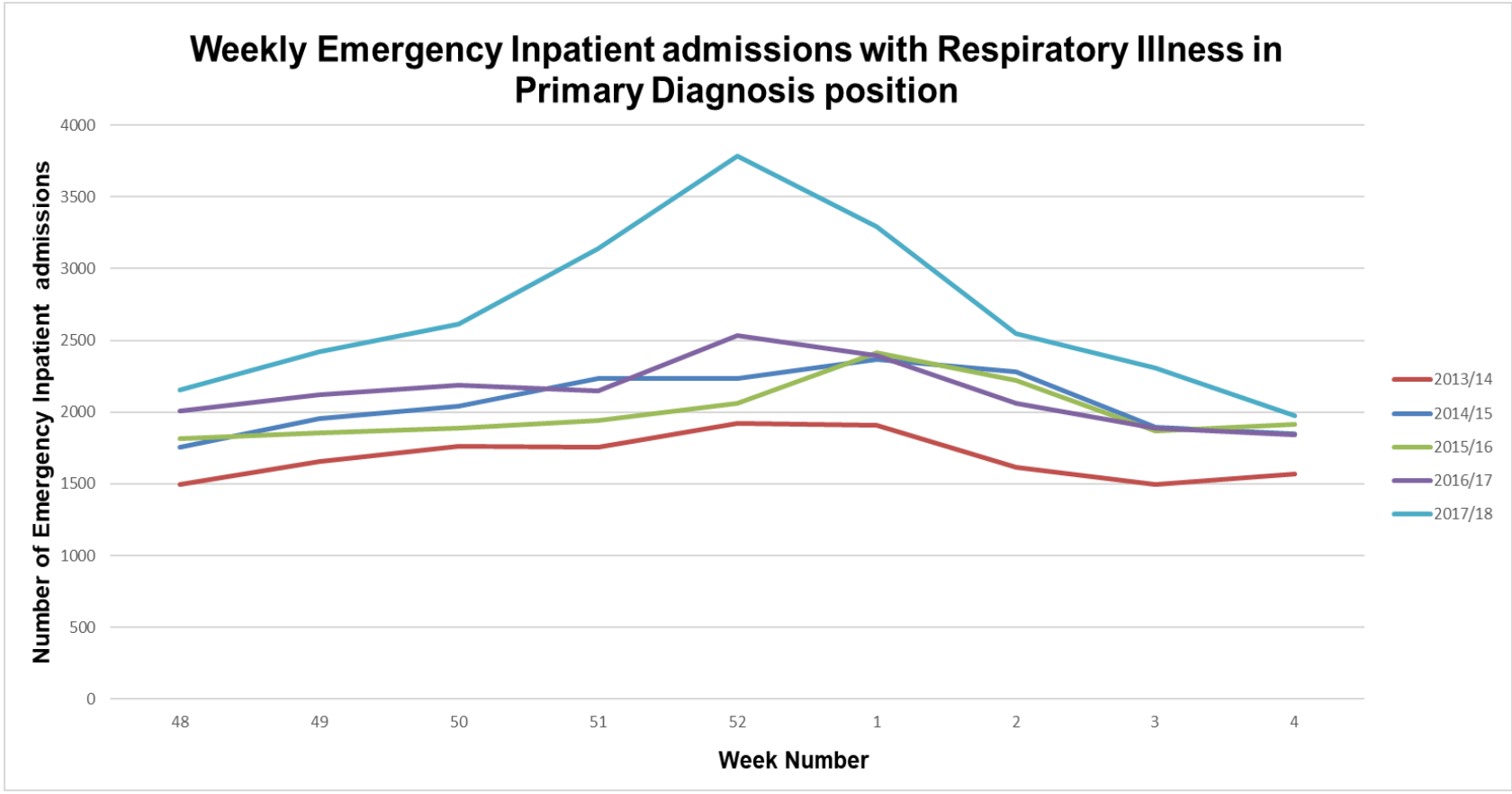
GP Out of Hours



Source: ISD Scotland

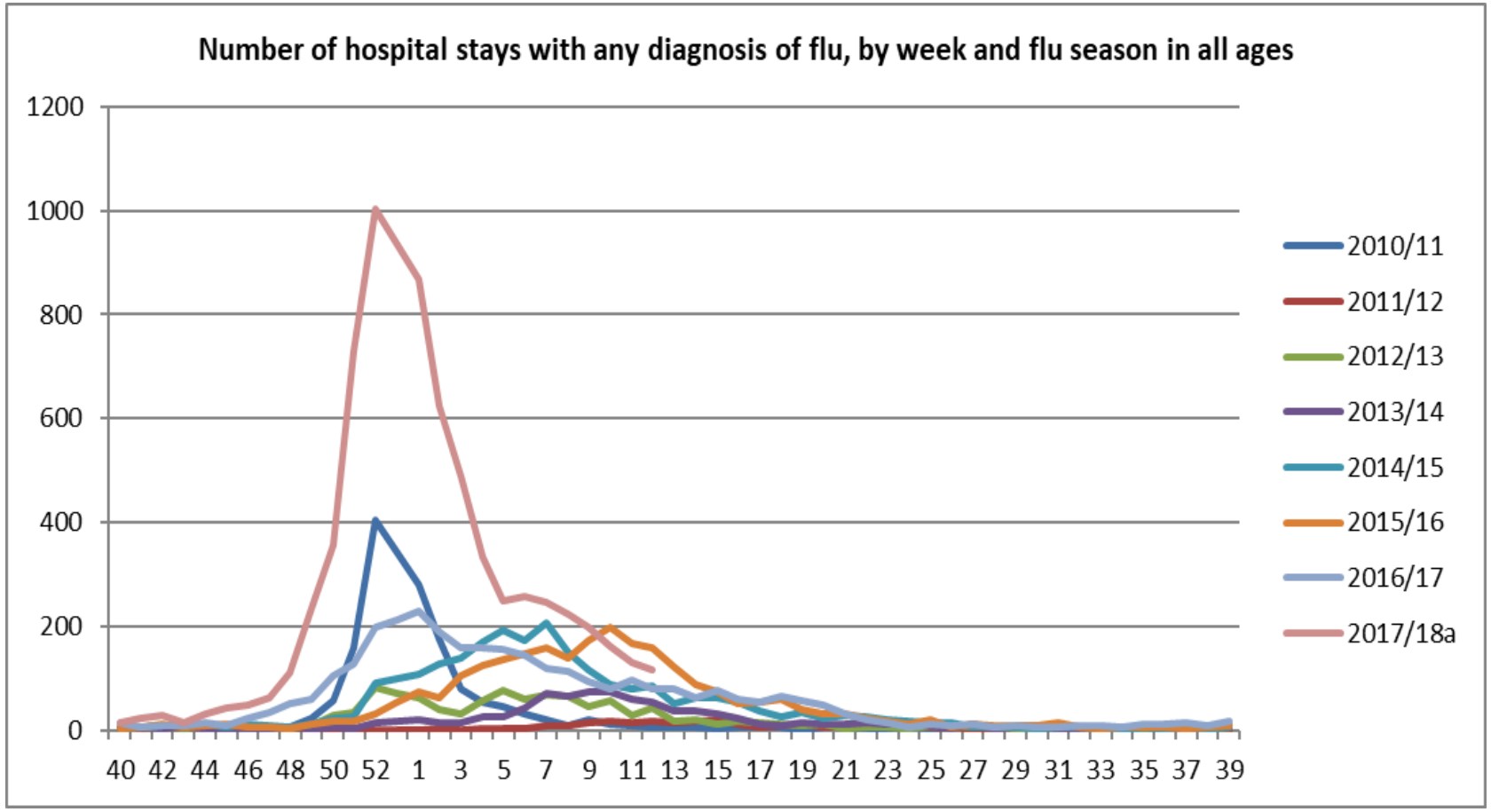
1. A patient (case) may have had more than one consultation, this graph only shows cases.

Respiratory conditions and influenza were key winter factors



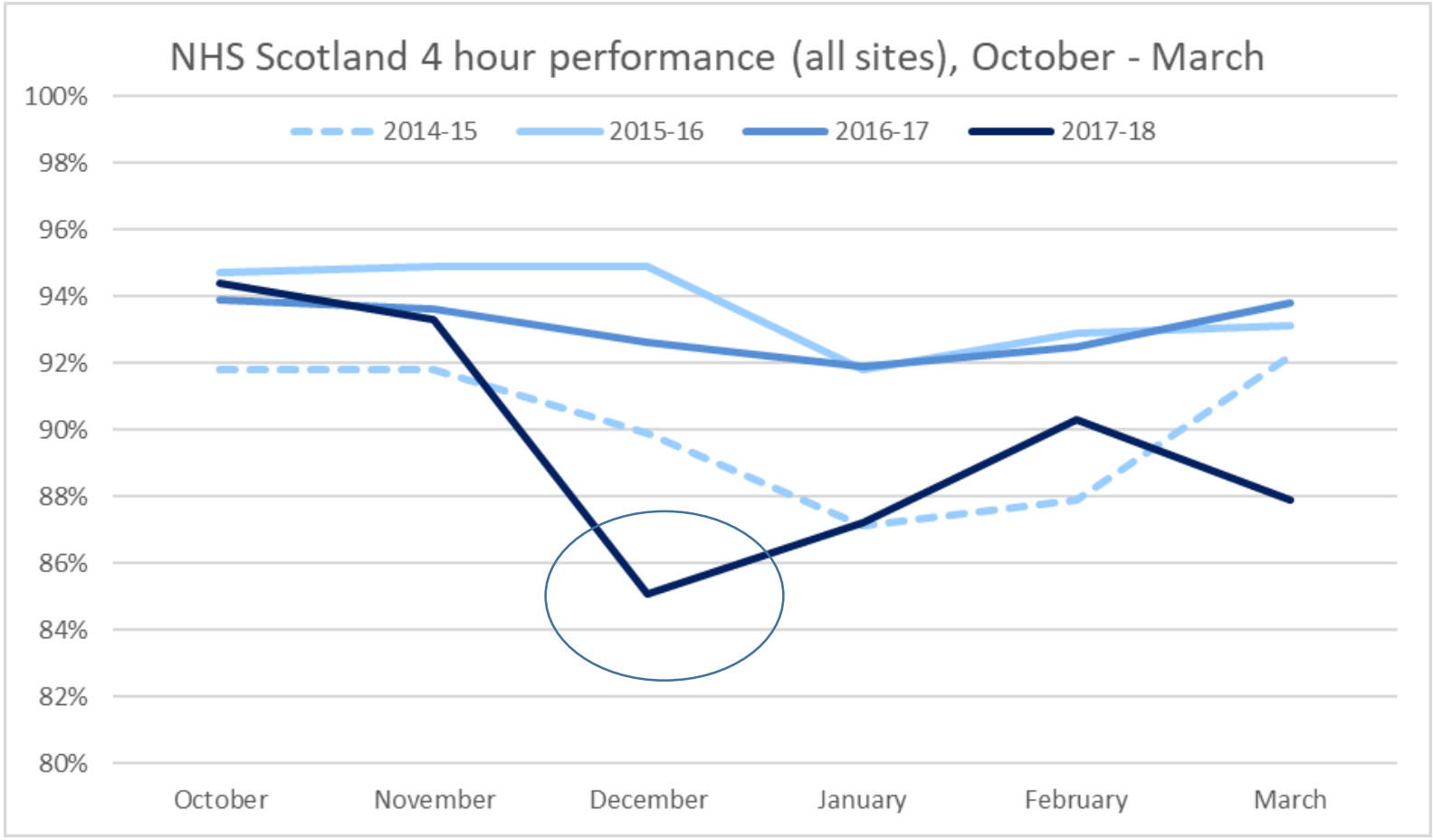
Source: ISD Scotland (SMR01)

Respiratory conditions and influenza are key winter factors



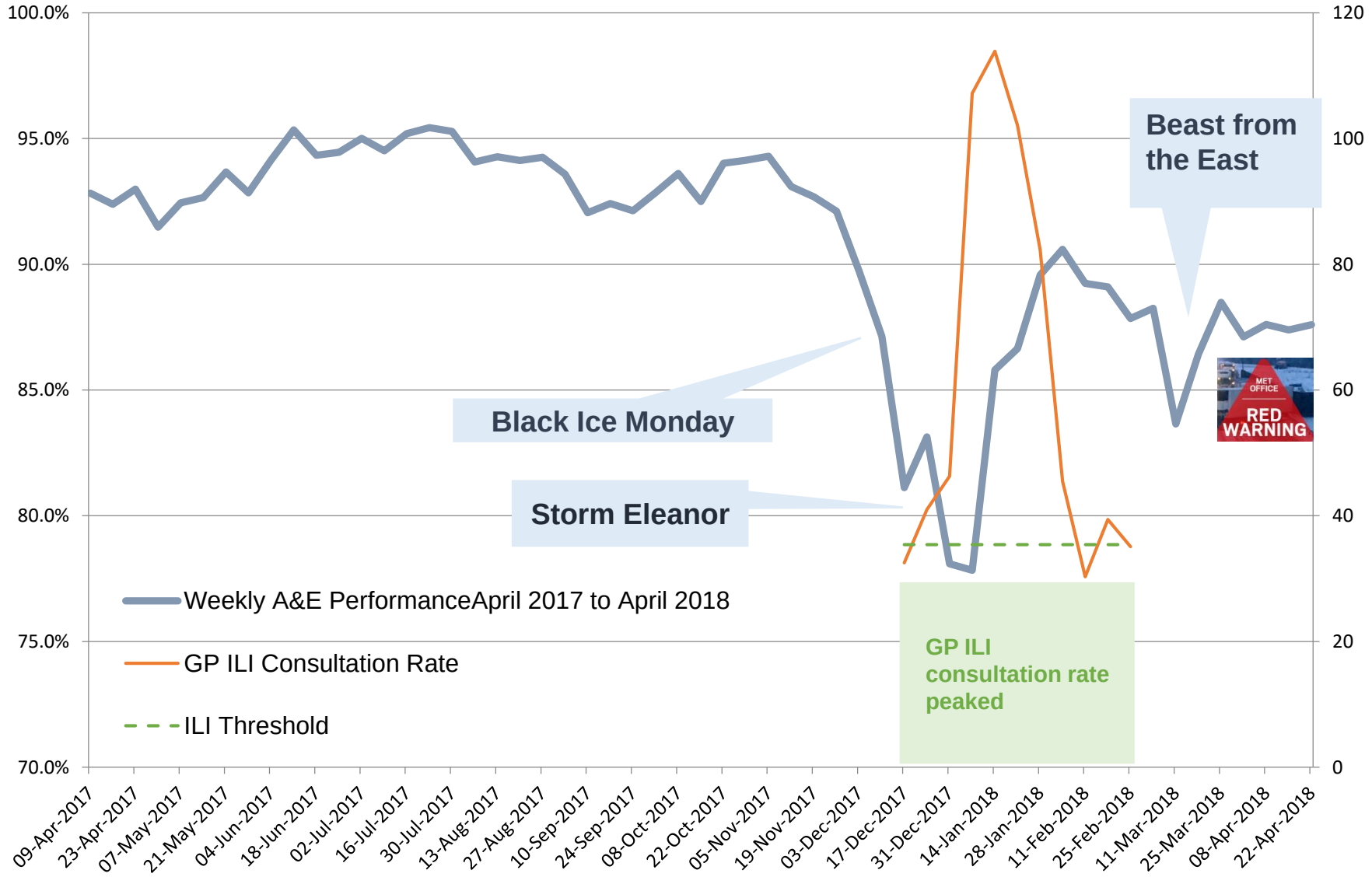
Source: Health Protection Scotland (a = data up to week 12 only)

NHS Scotland 4 hour performance



Source: ISD Scotland

NHSScotland Emergency Access Standard Performance



Weekly core site - Source: ISD Weekly Published Data

Where to next?

- Focus on the non admitted/admitted pathways
  - Breach analysis – where are we losing ground?
  - Pareto principles – where should we focus our efforts to maximise impact?
- Improve resilience and reduce variation
  - Evenings – are our models right?
  - Weekends – how do we improve discharge levels to week days?
- Delivery of 4 hour Emergency Access Standard
  - Set local delivery milestones – how do we create the conditions to deliver consistently AND reach further?
  - 30, 60, 90 days to deliver plan for 2018/19 – how do we ensure focus is kept?

Our approach

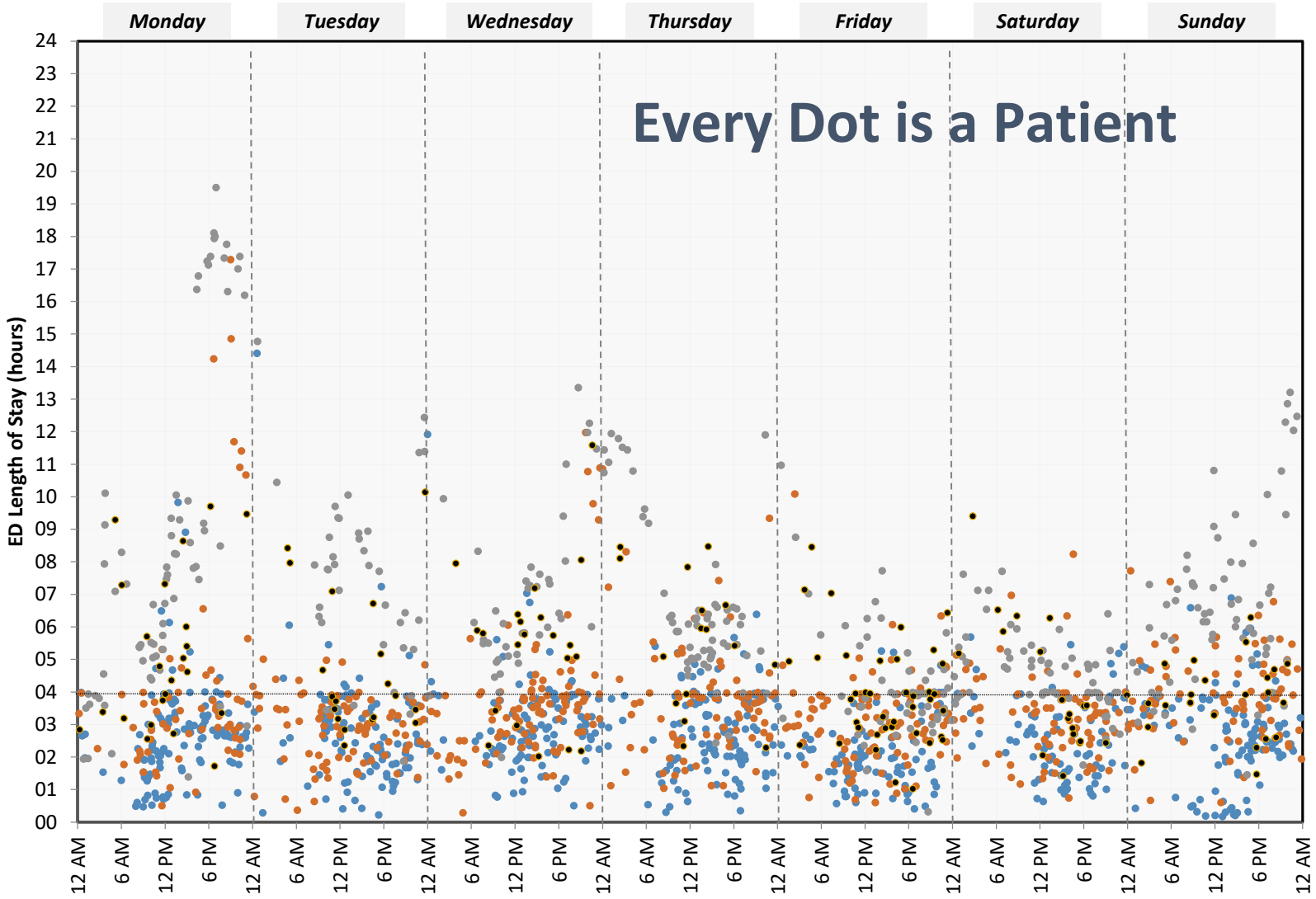
Create Regional Groups to:

- **SET DIRECTION**
  - Local Funding Meetings to review delivery plans
    - Exec lead and Quadrumvirate team
    - Delivery plans presented and discussed
    - Funding to be agreed
- **MONITOR AND MEASURE**
  - Monthly Programme Managers meeting
    - Data for improvement
    - Progress update on UC delivery plan (PDSA 30/60/90 days)
    - Case Study
- **SHARE**
  - Site visits
    - Data for improvement
    - Peer support
    - Share best practice
    - Feedback

Data for improvement

How we link patient experience with the need for change…

Activity through an Emergency Department



Flow Groups

- Flow 1 - Minor Injury and Illness
- Flow 2 - Acute Assessment
- Flow 3 - Medical Admissions
- Flow 4 - Surgical Admissions

Attendance by Flow

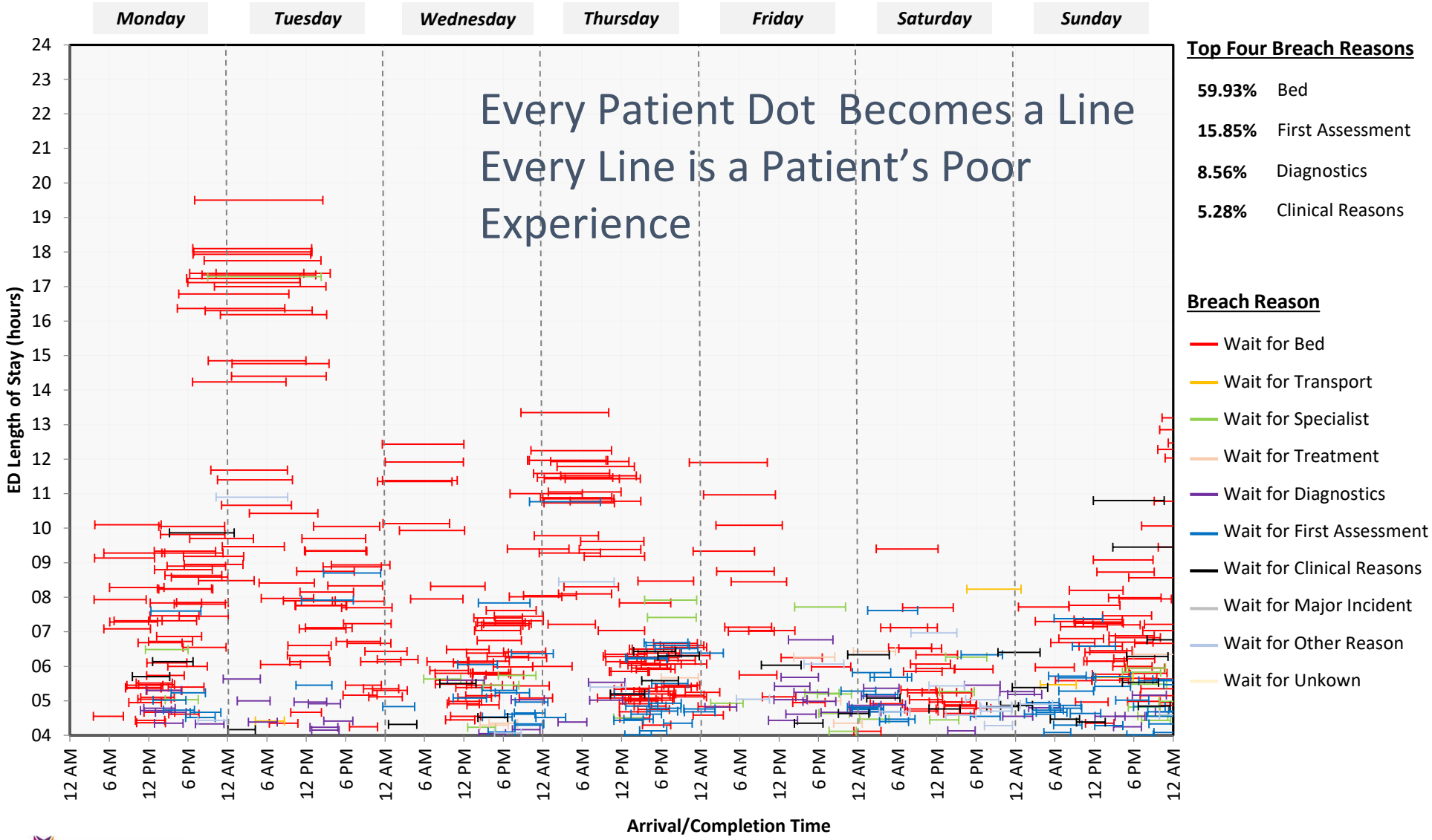
738	Flow 1
601	Flow 2
393	Flow 3
160	Flow 4
1892	Total

4 Hour Performance

Mon
Tue
Wed
Thu
Fri
Sat
Sun

Source: Unvalidated local extracts. Use for management information only.

Crowding and Exit Block



Top Four Breach Reasons

59.93%	Bed
15.85%	First Assessment
8.56%	Diagnostics
5.28%	Clinical Reasons

Breach Reason

- Wait for Bed
- Wait for Transport
- Wait for Specialist
- Wait for Treatment
- Wait for Diagnostics
- Wait for First Assessment
- Wait for Clinical Reasons
- Wait for Major Incident
- Wait for Other Reason
- Wait for Unkown

Source: Unvalidated local extracts. Use for management information only.

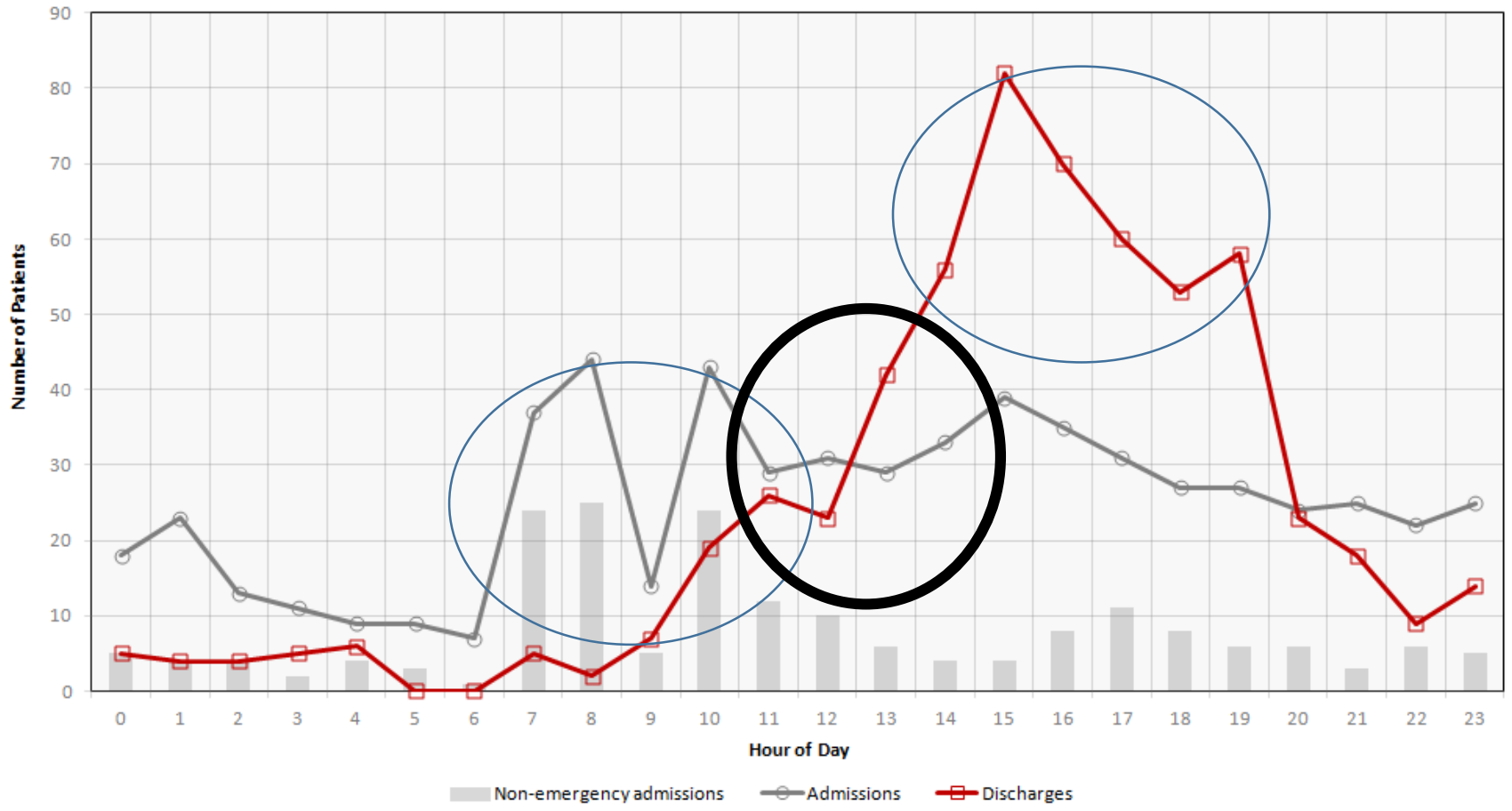
Imbalance – a clear and present danger

‘There is a commonly observed phenomena of periods of mismatched demand and capacity in hospitals.

This occurs when the total number of new admissions outstrips capacity, and necessitates reactive patient discharge so that their beds become available.

The NHS Institute for Improvement

Admissions vs Discharges – the curve



An out of balance system

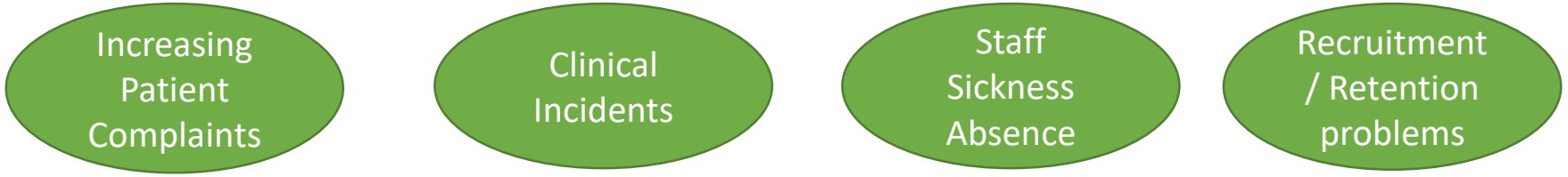
What does it feel like on the ground?

For our patients ?

- Queues
- Delays
- The stress of cancellation
- Not getting to the 'right' ward (boarding)
- Poorer experience
- Poorer quality of care
- Increased Length of Stay
- Distress

For our staff ?

- Pressure
- Stress
- Less than harmonious relationships!?
- Frustration
- Safari Ward Rounds
- Time spent identifying boarders instead of caring for their own patients
- Poor plans for all

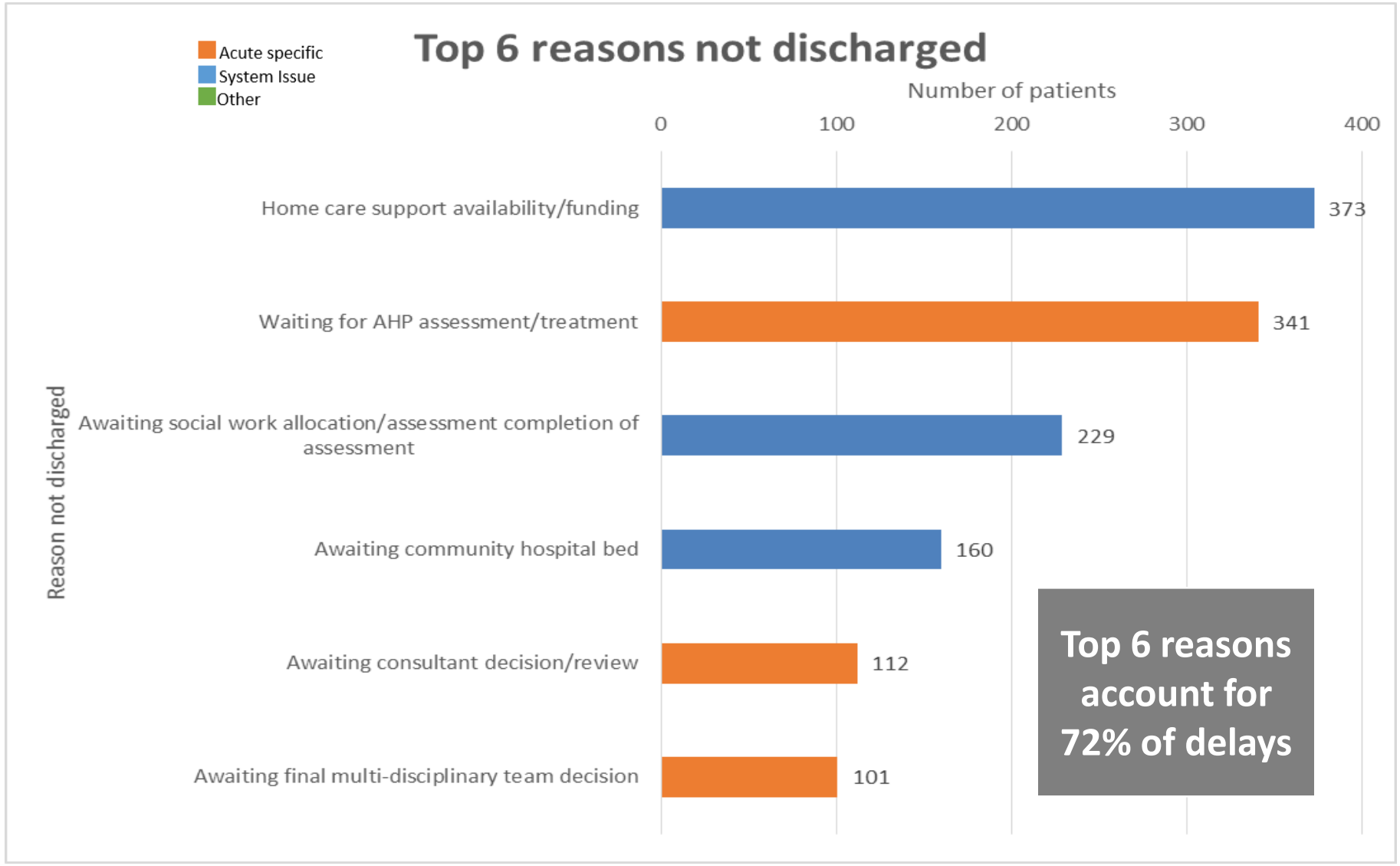


Our direction of travel

Areas for further improvement

- Continue to work with local teams to ***remove exit block*** and better align capacity with demand
- Capitalise on opportunity in the ***non-admitted pathway***
- Reduce the tension between unscheduled and scheduled care through the ***Scottish Access Collaborative***

Removing Exit Block – Pan Scotland Day of Care Survey Key findings



- Reasons are split equally: 3 within and three outwith control of the hospital.

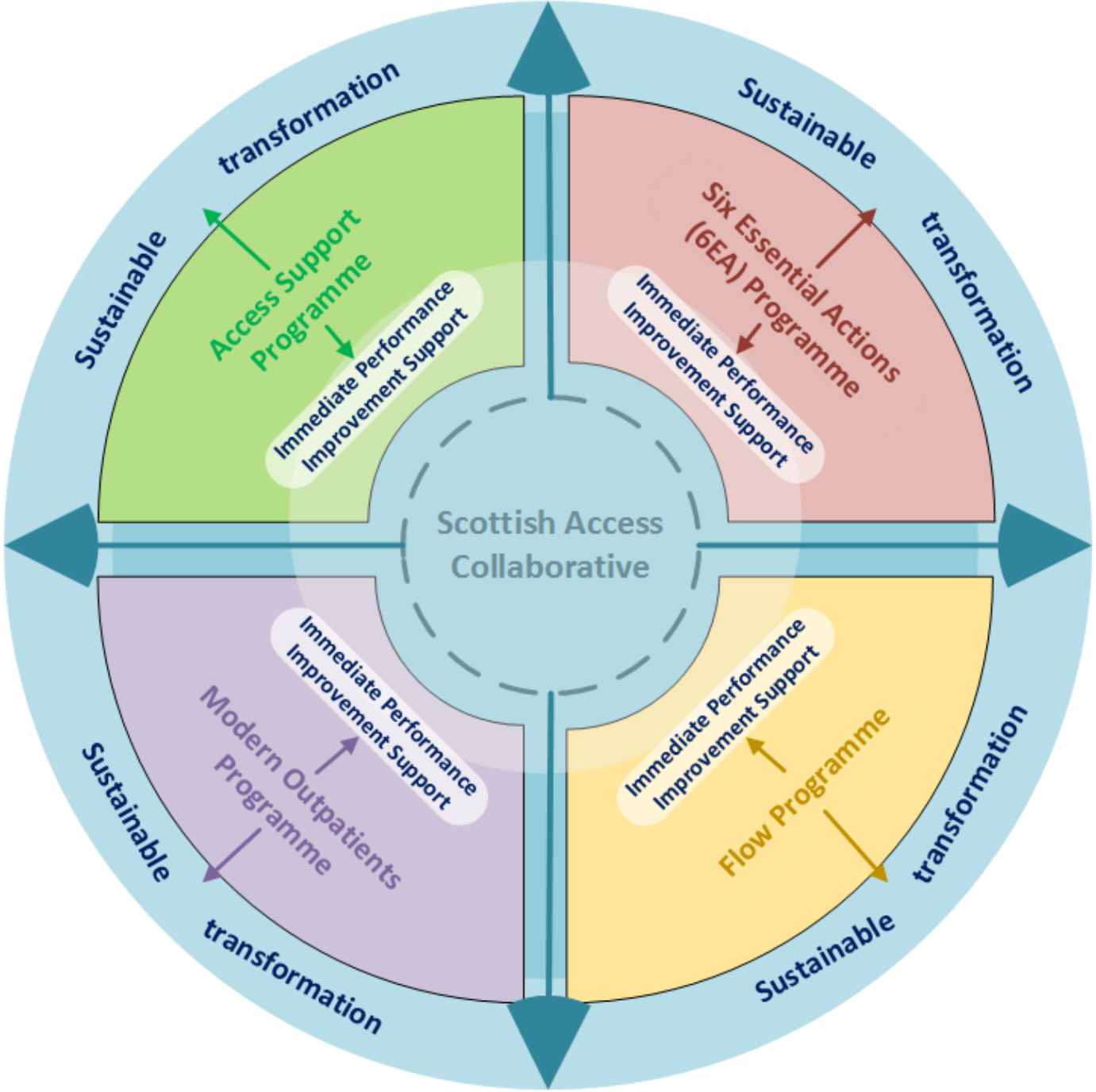
Day of Care survey – Pan-Scotland - Overview

	Pan-Scotland	Medians & Ranges
Number of beds surveyed	10478	Range: 23 -1523
Number of patients surveyed[1]	9946	Range: 15-1430
Bed occupancy (%)	**95%**	Median: 94% **Range: 52% - 131%**
Boarders (%)[2]	**5% (444 patients)**	Median: 4% **Range: 0% - 18%**
Day of Care – criteria met (%)[3]	**80%**	Median: 78% **Range: 55% - 100%**
Day of Care – criteria not met (%)[3]	**20%**	Median: 22% **Range: 0% - 45%**
Of those not met – within hospital control (%)	**34%**	Median: 25% **Range: 0% - 70%**
Of those not met – whole system issue (%)	**63%**	Median: 67% **Range: 0% - 100%**
Of those not met – *Home* designated as most appropriate alternative place (%)	**41%**	Median 45% **Range: 0% - 100%**
ED performance week beginning 23rd April[4]		N/A

1 Total number of patients surveyed on the day of DOCS at site
2 Boarders are patients who are in a ward bed not related to their main specialty needs. This is the % of boarders out of the number of patients surveyed
3 Excludes patients for discharge
4 NHS Improvement A&E performance data (unvalidated)

Overview

- Launched by the Cabinet Secretary for Health and Sport in November 2017
- Aim to sustainably balance demand and capacity
- Multi-organisation and patient stakeholders
- Developed six fundamental principles that will shape and prioritise the way services are provided in the future.



Healthier Scotland
Scottish Government

Founding Principles

1) Patients should not have to travel unless there is clear clinical benefit	2) Senior or protocol led vetting	3) Referral pathways should be clear and published for all to see
4) Systems need clearly defined access to diagnostic services	5) Referral systems need to understand balance between demand and capacity, and link this to unscheduled care	6) Improve metrics of the system, especially of remote access and advice pathways

Specialty Sub-Groups

- Cardiology
- Gastroenterology
- Gynaecology
- Respiratory
- General Surgery
- ENT
- Chronic Pain
- General Medicine
- Orthopaedics
- Ophthalmology
- Neurology
- Urology
- Dermatology
- Oral and Maxillofacial

What will success look like?

- Clinical pathways have personalisation but no unwarranted variation.
- Demand and capacity are in balance
- Effective and efficient interfaces between primary and secondary care
- Funding primarily directed to long term transformation rather than short term activities

Collaborative Challenges

Currently endorsed by the Programme Board

- Waiting List Validation
- Active Clinical Referral Triage
- Virtual Attendance
- Enhanced Recovery after Surgery
- Team Job Planning

Being developed for consideration

- Reliable Results Pathways
- Advice Pathways
- Enhanced roles
- Scottish Pathway Standards

Looking forward
to welcoming you to...

NHS SCOTLAND | 70 YEARS #nhsscot70

Glasgow 2019

FORUM

https://internationalforum.bmj.com/glasgow/