All I wanted was for two almost identical holes to be dug……

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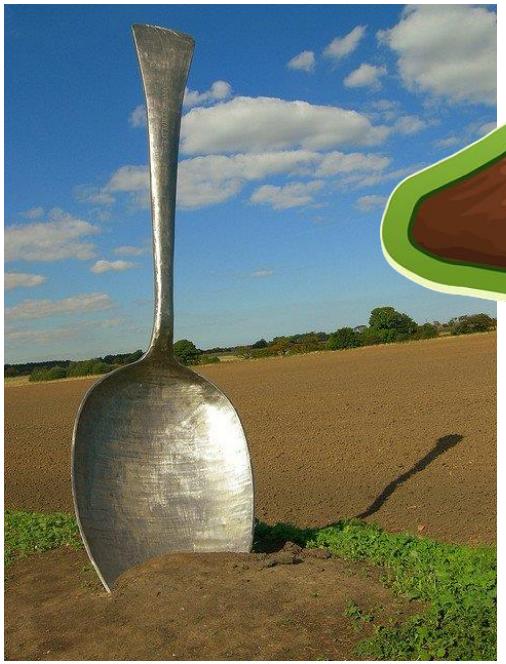
One hole at Nowhere-Special District General Hospital……



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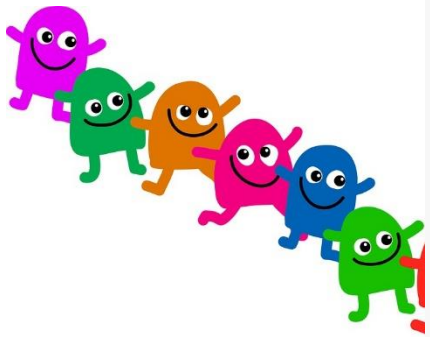
And one hole at St Brilliantine's University Teaching Hospital……



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Performance at Nowhere-Special District General Hospital……

Emergency Care Intensive Support Team (ECIST)

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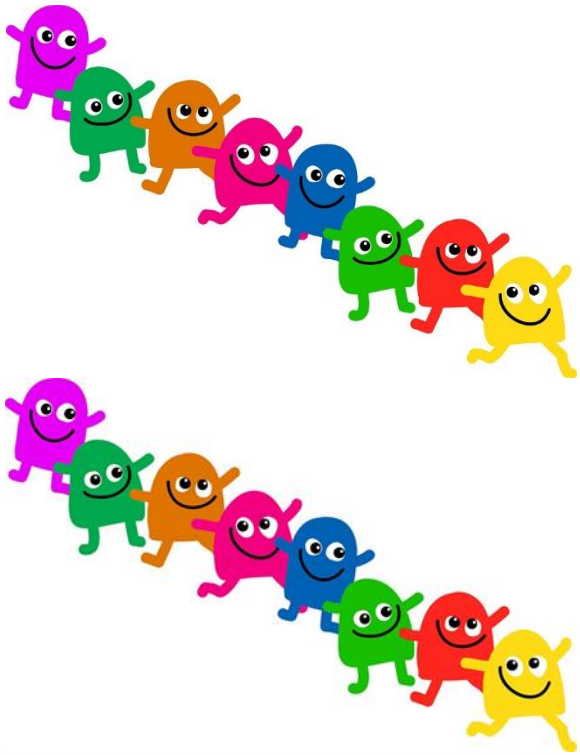
Performance at St Brilliantine's University Teaching Hospital……



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NHS

Facilitating patient flow in emergency care: treacle, glaciers and GIRFT for Emergency Medicine

Chris Moulton (National Co-Lead for GIRFT-EM)

GIRFT is delivered in partnership with the Royal National Orthopaedic Hospital NHS Trust and NHS Improvement

GIRFT-EM

The first non-surgical GIRFT programme

Started May 2017

Our team: Chris Moulton and Cliff Mann

Darren Best [and Andrew Boasman]

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Just another dashboard, I suppose?

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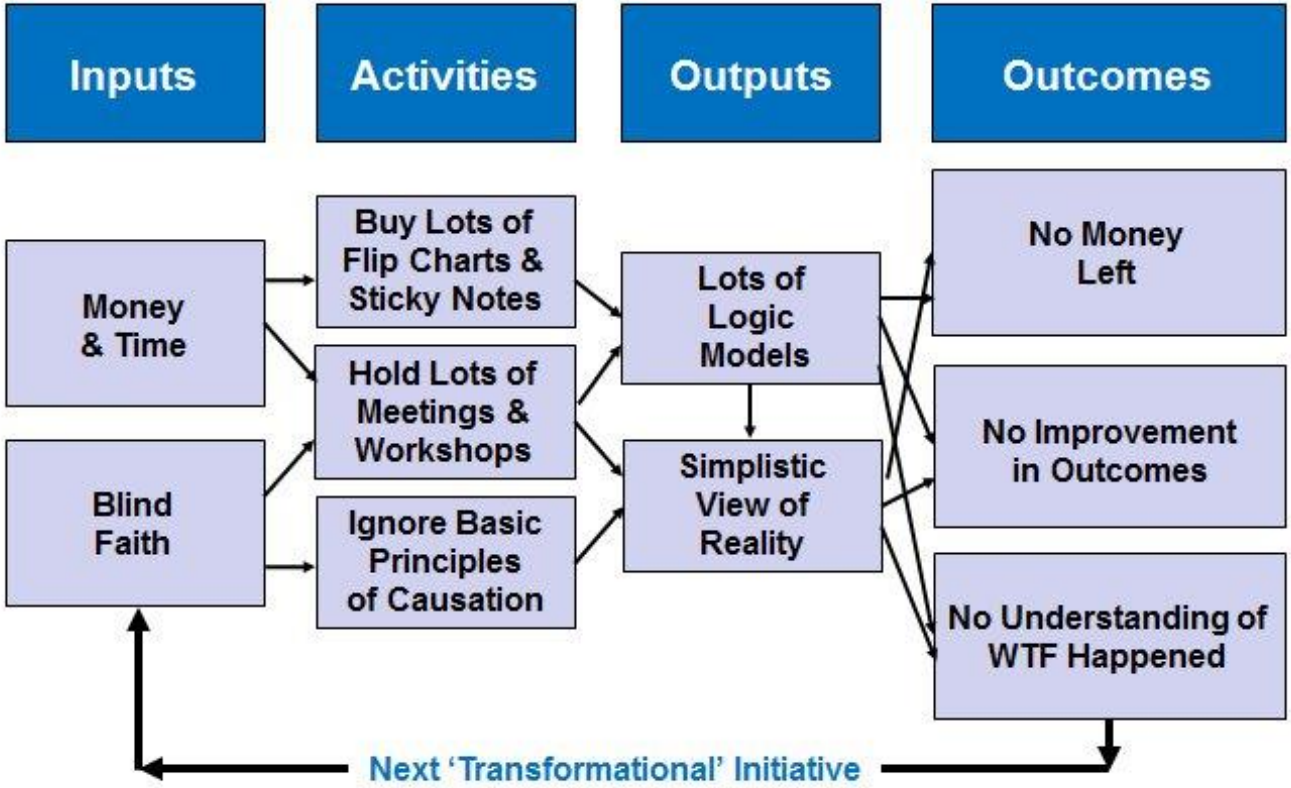
Another transformational project, perhaps?



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Unwarranted variation!!

Hospitals with behavioural, communication and other human-factor issues

- Very common
- Frequent requests for help to national agencies
- Not well-suited to the GIRFT methodology!

Data sources

SUS

- Live system
- Current
- Data not finally validated

HES

- Quarterly and annually
- Retrospective
- Data validated

NHS

However……

Collaboration with the NHS Benchmarking Network to collect this data via questionnaire

No HES data for:

- Skill mix
- Staff numbers
- Agency spend
- Clinical facilities
- Clinical services (e.g. primary care, frailty, mental health)
- Finance

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Caveats

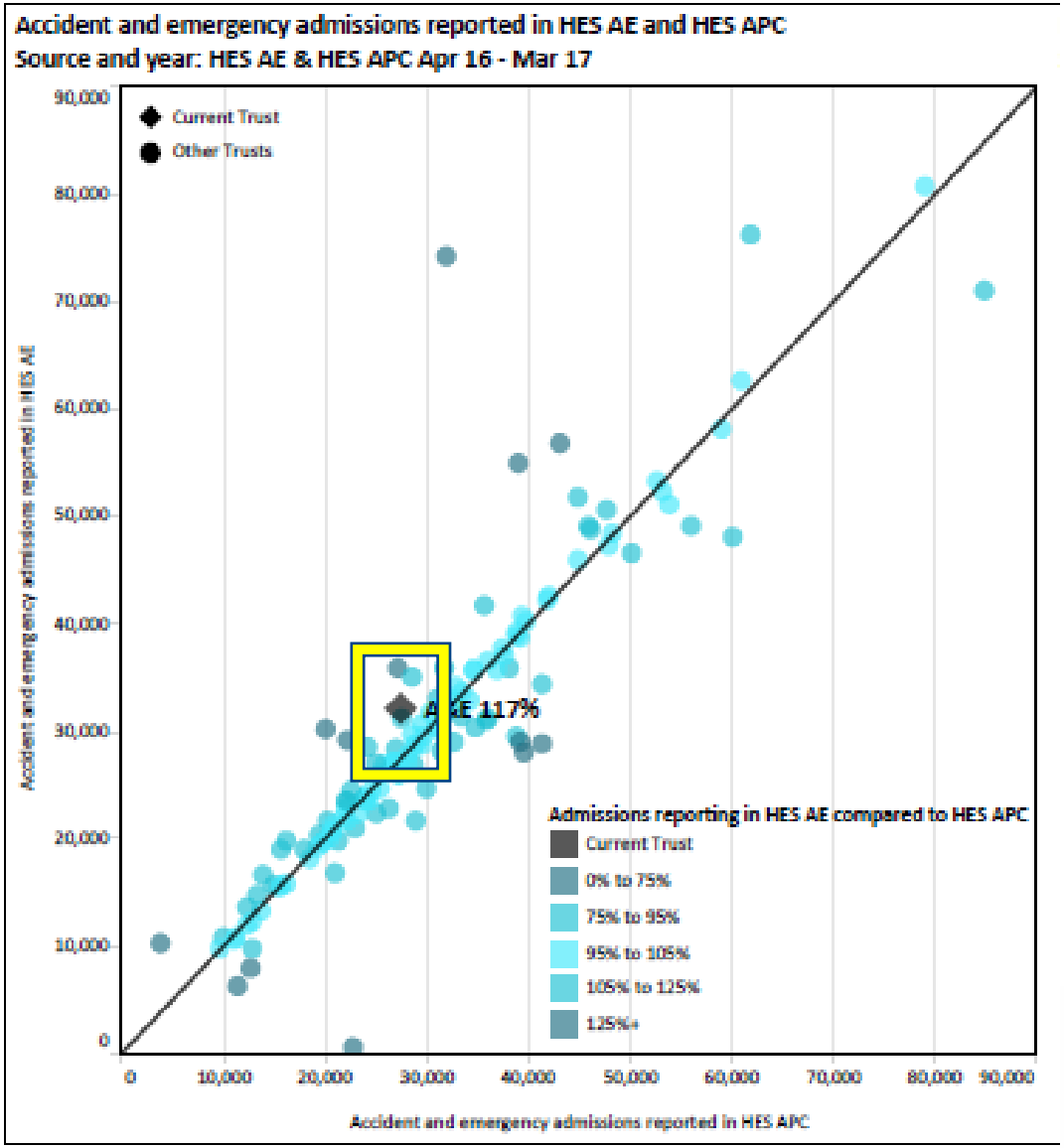
1. Given current pressures on A&E departments affecting all trusts, simple benchmarking against peer performance risks regression to the (mediocre) mean rather than promoting high quality care.
2. Not all data items are current; this reflects HES data availability and annual NHSB returns.
3. There are national problems with regards to the veracity of the data concerning ambulance attendances, bed occupancy rates and the Diagnostic Information Dataset (DID) radiology data for A&E departments.
4. Data are currently trust-based rather than site-specific with consequent loss of relevancy in some areas.

GIRFT-EM is looking at:

DEMAND	• Attendances, ambulance arrivals, admissions, catchment, deprivation, age and co-morbidities
CAPACITY	• A&E staffing and facilities, hospital beds and staffing
FLOW	• DAT standards, APD, APBR, TAF, DDR
OUTCOMES	• Sentinel conditions, waiting times and litigation
CODING and FINANCE	• HRGs, case-mix, ECDS, departmental costs

Coding and accuracy of Trust data

HES AE versus HES APC = 117%



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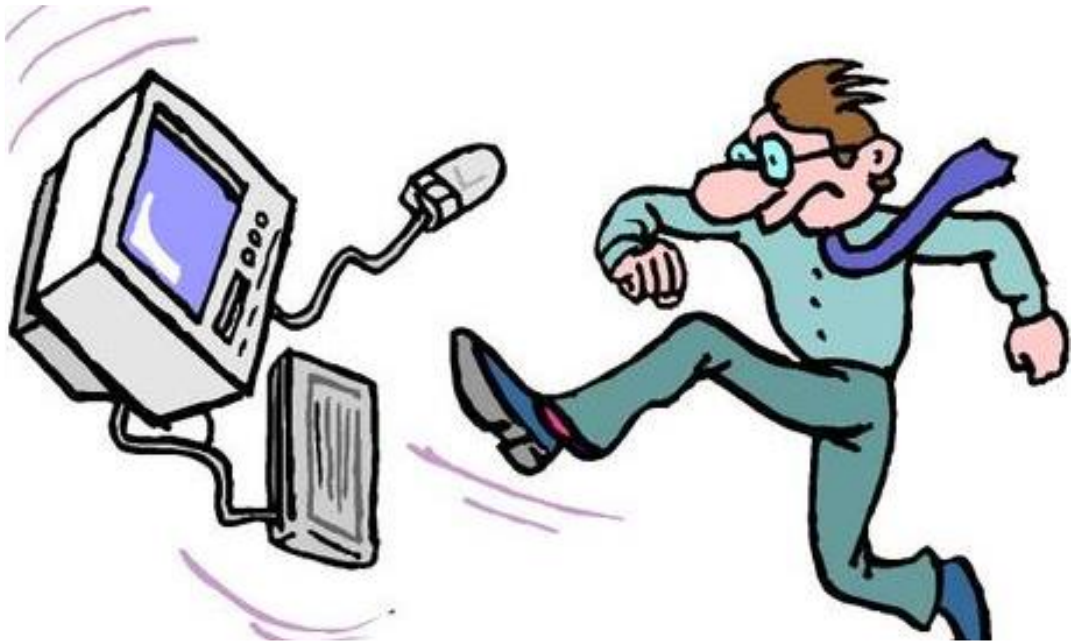
Computers and IT systems

- Long times for log-ins and data entry
- A&E departments paralysed by IT "upgrades"!
- Paperless hospitals!



NHS

31,250 available shifts per year

174 shifts for each A&E department per year

One extra minute per patient spent using computers in A&E departments = 250,000 hours per year

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IT burden for A&E staff

Basic GIRFT-EM script time = 10 minutes

A&E computer system = Nosolution

NHS

10 minus 5 minutes = five extra minutes per patient

94,607 x 5 minutes = 7,884 hours per year

Nowhere-Special DGH's A&E c
may be losing the equivalent of
hour doctor shifts per ye

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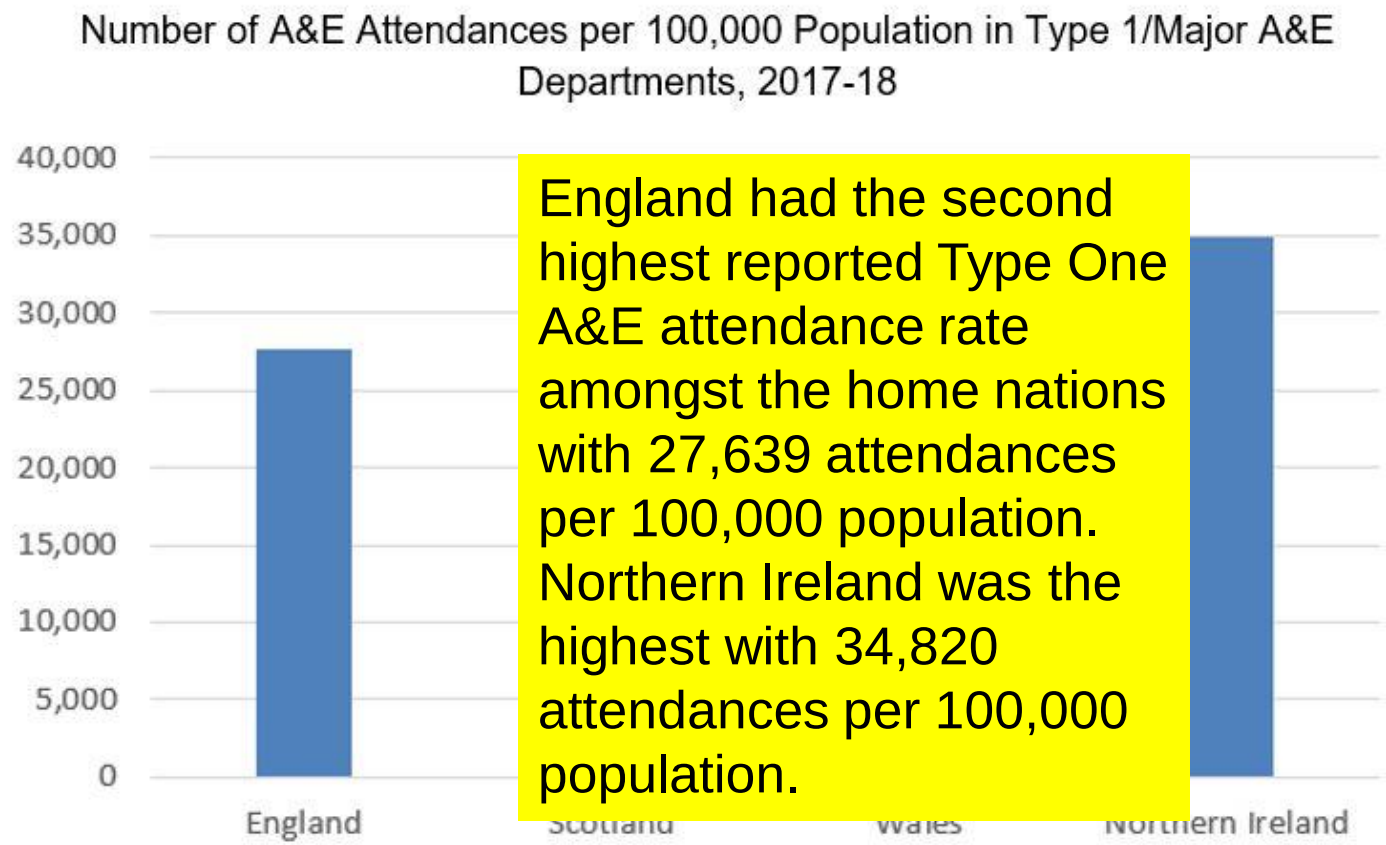
Variation in A&E attendance rates across the UK……



England had the second highest reported Type One A&E attendance rate amongst the home nations with 27,639 attendances per 100,000 population. Northern Ireland was the highest with 34,820 attendances per 100,000 population.

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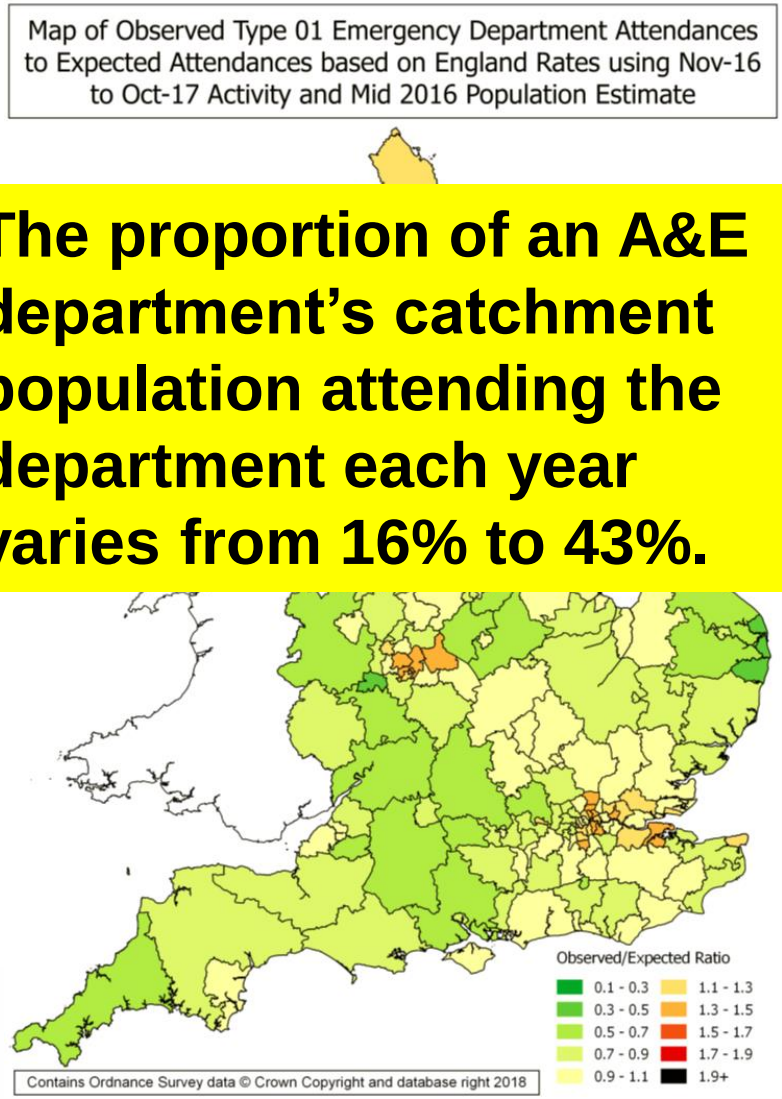
Different levels of A&E attendance across England

The proportion of an A&E department's catchment population attending the department each year varies from 16% to 43%.



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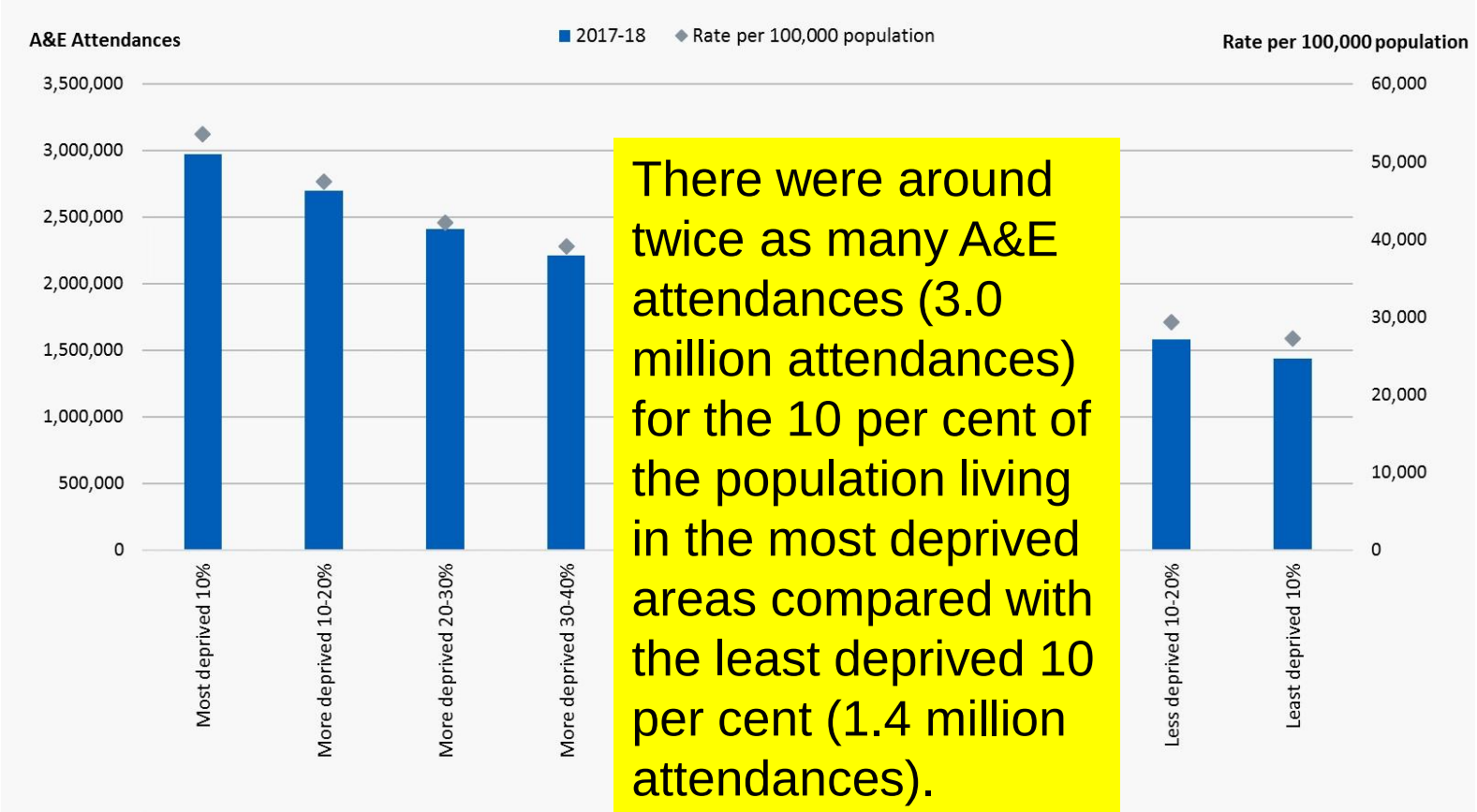
The effect of deprivation……



There were around twice as many A&E attendances (3.0 million attendances) for the 10 per cent of the population living in the most deprived areas compared with the least deprived 10 per cent (1.4 million attendances).

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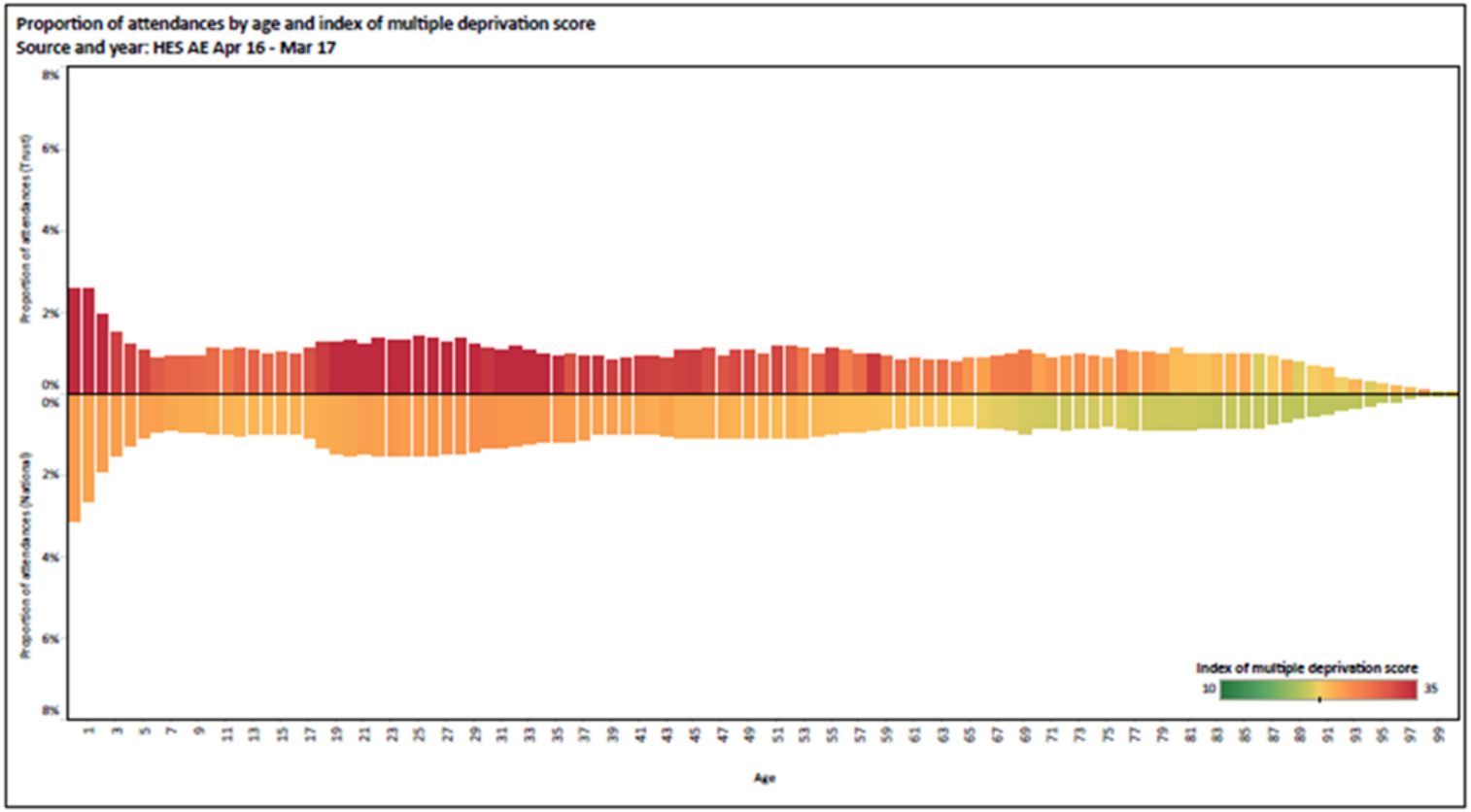
Age and deprivation profile of attendances



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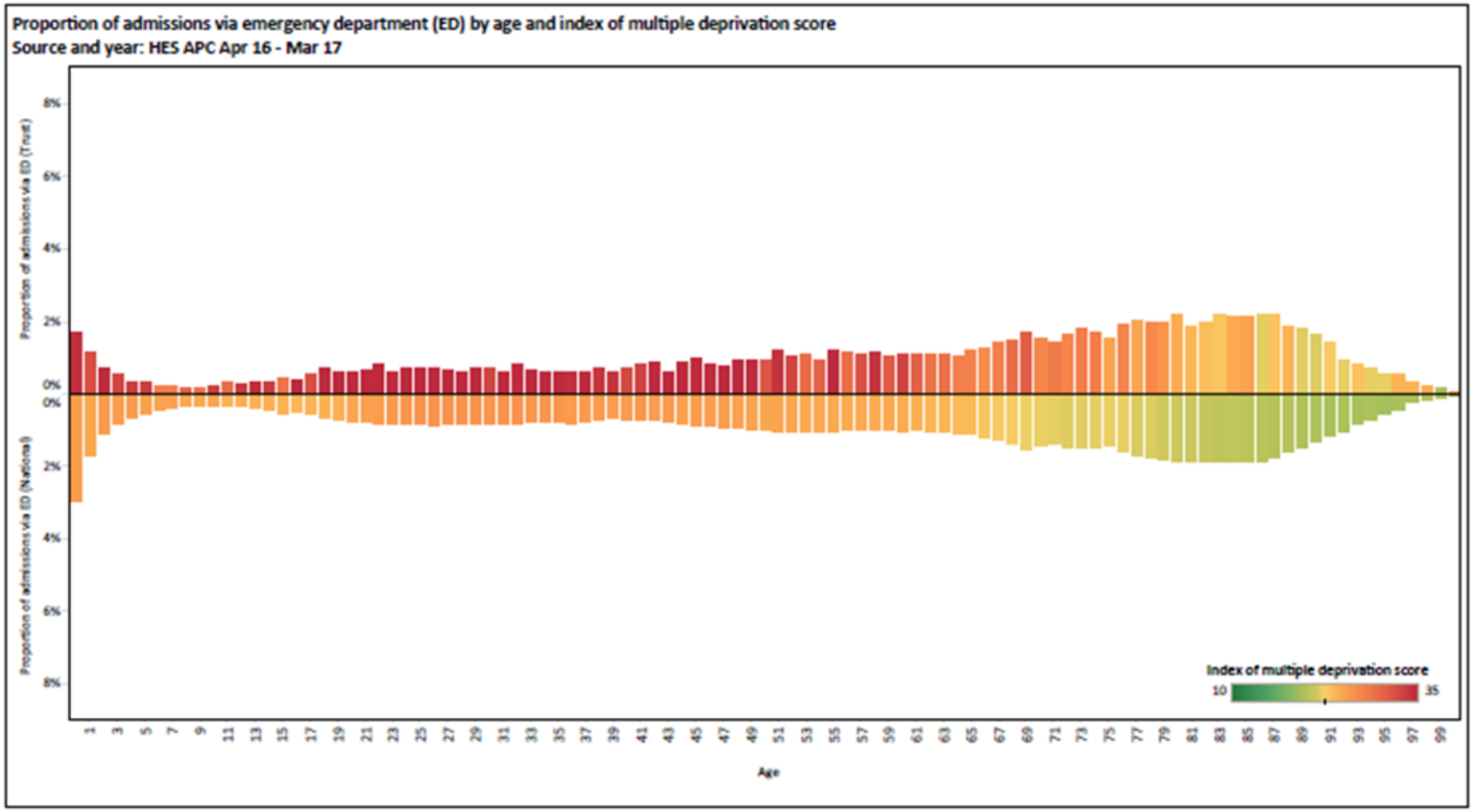
Age and deprivation profile of admissions



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Summary and comparison of demand

	SITE	MEAN	LQ	UQ
% age > 75 years	35%	34%	30%	38%
Deprivation	73%	26%	12%	34%
% population/year	39%	35%	28%	40%
NEAR	57%	51%	48%	57%
NEED	75%	75%	68%	85%
Conversion rate	32%	30%	26%	34%
Trauma	Trauma Unit	59%		

Capacity

- Percentage of acute admissions via A&E
- Hospital admission capacity (general / acute beds and hospital consultants)

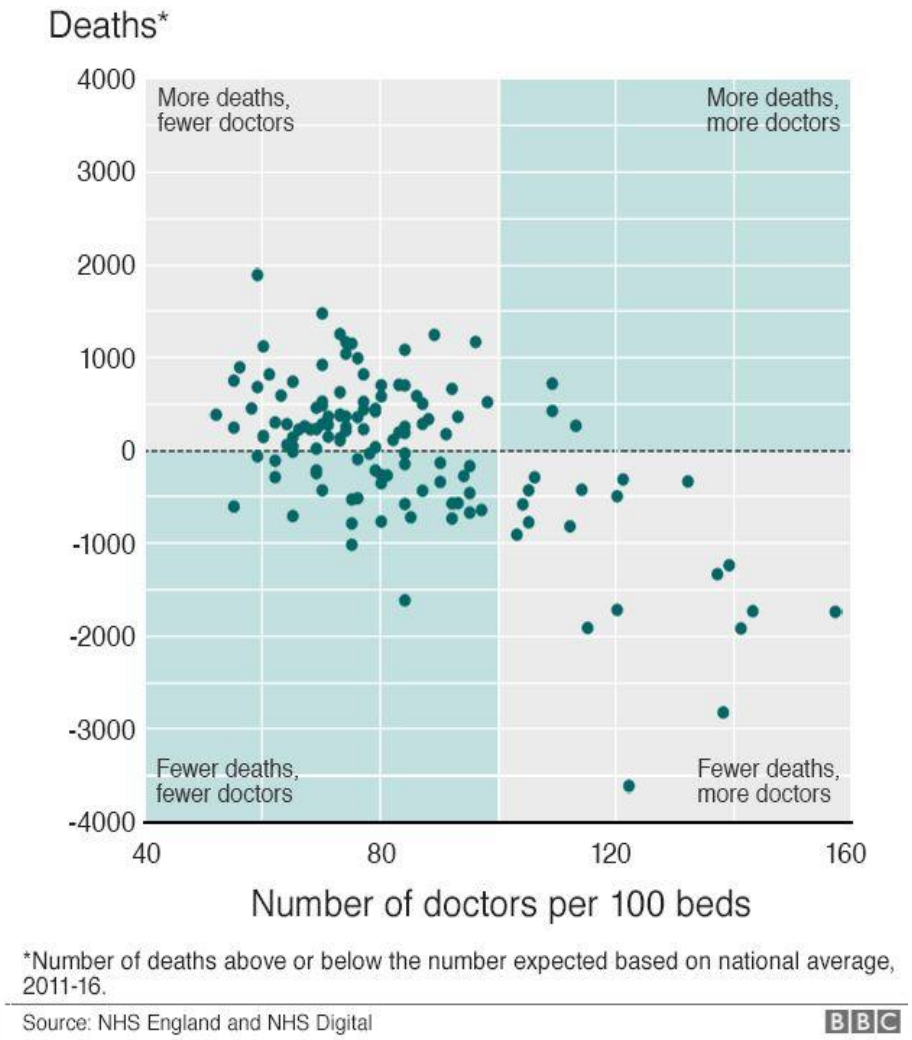
- A&E consultants
- A&E doctors and nurses
- A&E majors cubicles and resus spaces

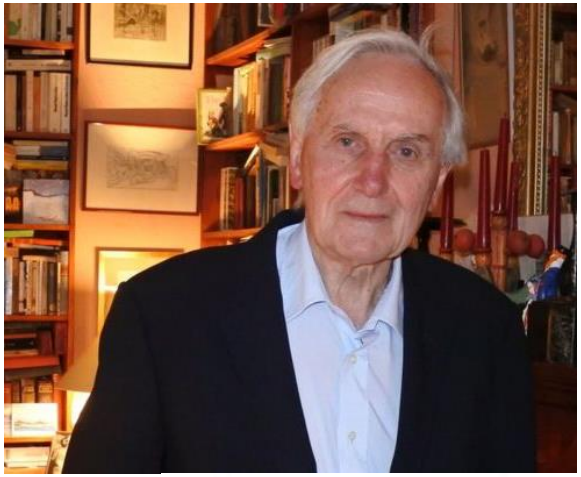
All expressed per admission or per attendance

Hospital admitting capacity

Figures per annum	SITE	MEAN	LQ	UQ
Admissions per M&R cubicle	1,144	1,434	992	1,628
Admissions per ED consultant	1,806	3,367	2,212	3,524
Attendances per ED consultant	7,986	11,181	7,430	12,414
Attendances per ED RGN (all)	1,556	1,254	976	1,414
Acute admissions per G&A bed	103	86	74	94
Acute admissions per H consultant	554	424	362	476

Hospitals with fewer doctors have more deaths





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Better hospital emergency care flow metrics [1]: **DAT Time Standards (Discharge, Admission or Transfer)**

DAT at 2 hours

DAT at 4 hours

DAT-4 = The NHS four-hour operational standard

DAT at 6 hours

DAT at 12 hours

DAT-12 = The NHS central reporting threshold

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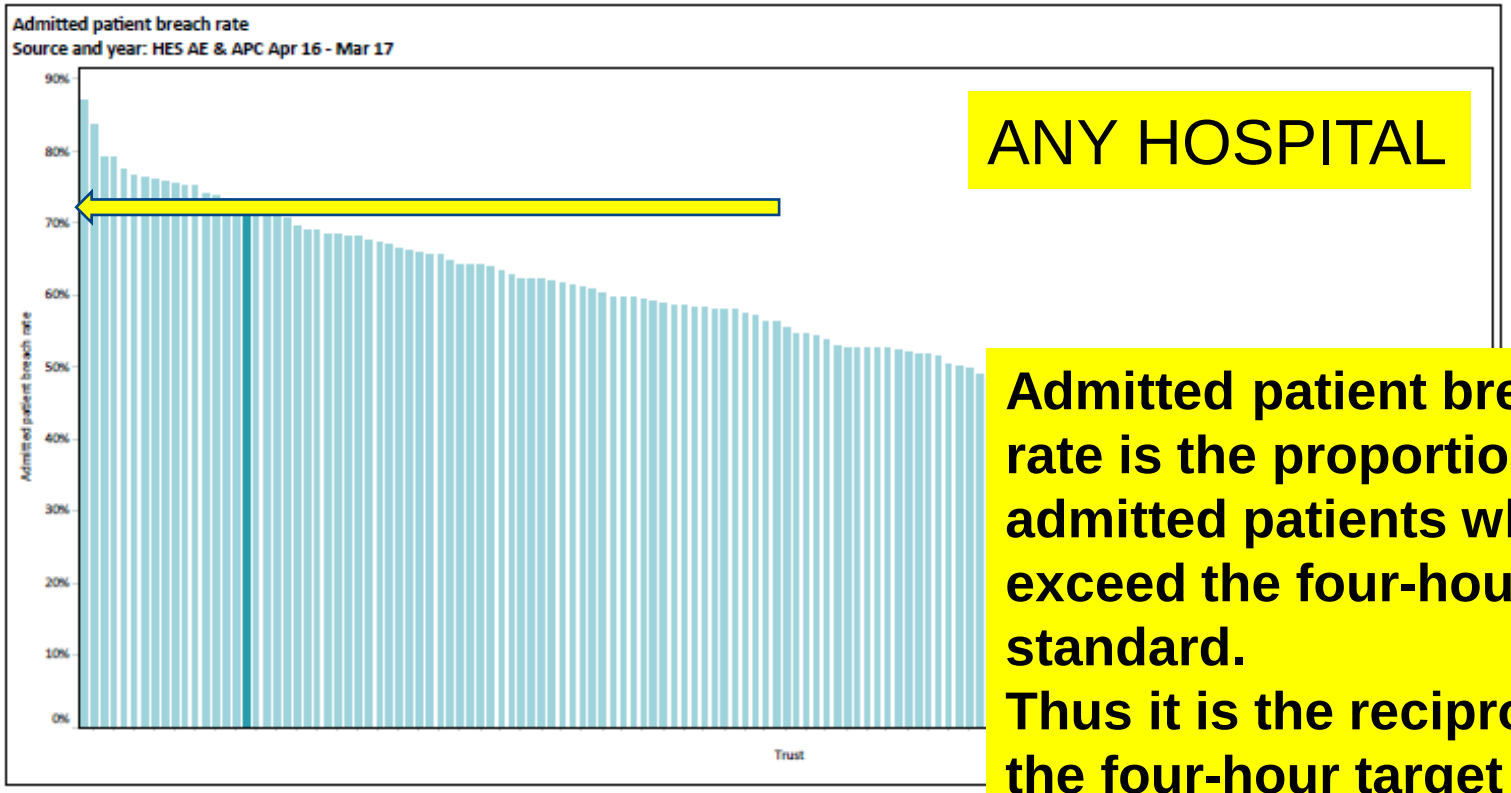
Flow: DAT time standards

STANDARD	PAGE	SITE	ENGLISH AVERAGE
DAT-2	Page 25	22%	28%
DAT-4	Page 32	89%	80%
DAT-6	Page 27	96%	89%
DAT-12	Page 29	100%	98%

Better hospital emergency care flow metrics [2]: **The Admitted Patient Breach Rate**



Admitted patient breach rate is the proportion of admitted patients who exceed the four-hour standard.
Thus it is the reciprocal of the four-hour target figure for admitted patients.

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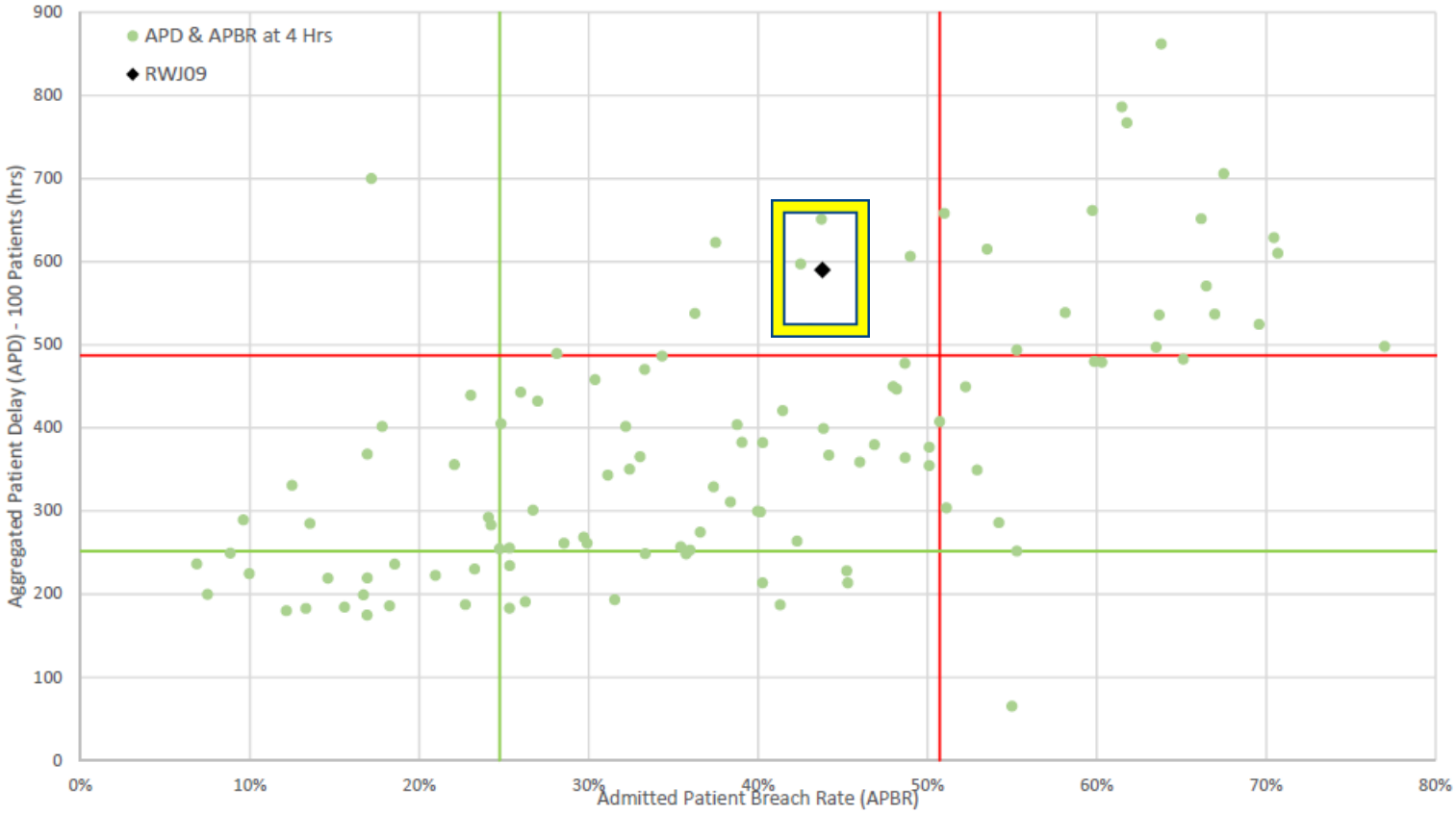
Better hospital emergency care flow metrics [3]: **The Aggregated Patient Delay**

Hospital A	100 patients	Official	APD = 0
Hospital B			APD = 100 mins
Hospital C	11hrs 59mins		APD = 798 hrs 20 mins

Aggregated patient delay is the total time in the A&E department in excess of four hours for all admitted patients expressed as hours per hundred patients.
As it only applied to admitted patients, its use incentivises discharge.

APD-4 plotted against APBR-4



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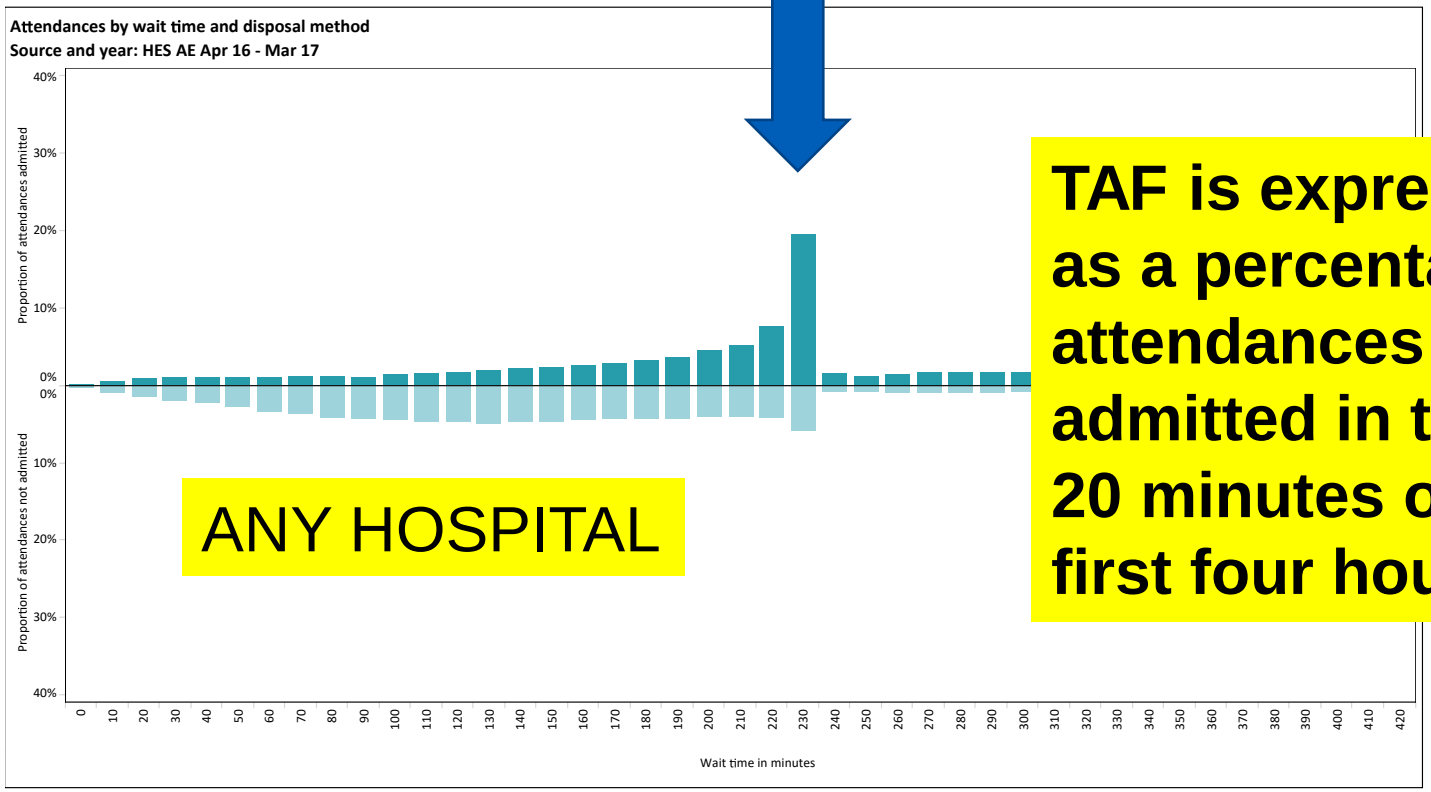
Better hospital emergency care flow metrics [4]: **Target-Associated Flow**

5.1 Admissions by wait time



TAF is expressed as a percentage of attendances admitted in the last 20 minutes of the first four hours.

Mean = *23% (LQ = 15%; UQ = 28%)*

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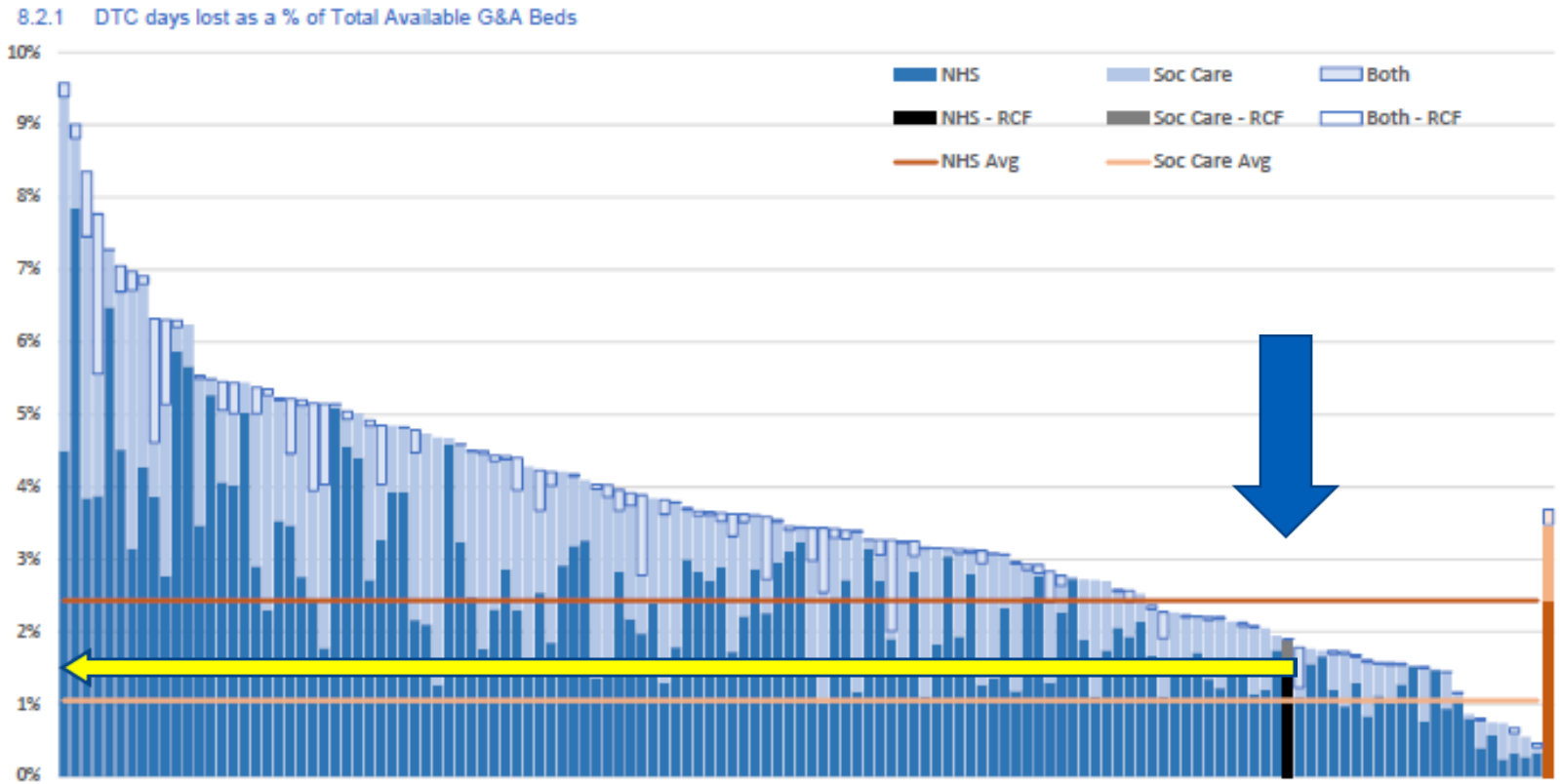
DTOCs (as % of G&A beds)



NB The stacked brown bar on the far right shows the averages for the: NHS; Social Care; and Both (running from bottom to top)
The horizontal brown lines show the individual averages for NHS (c.2.4%) and Social Care (c.1%)

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Same Day Emergency Care (SDEC)

Target = 33%

Mean = 25%

LQ = 21%

UQ = 30%

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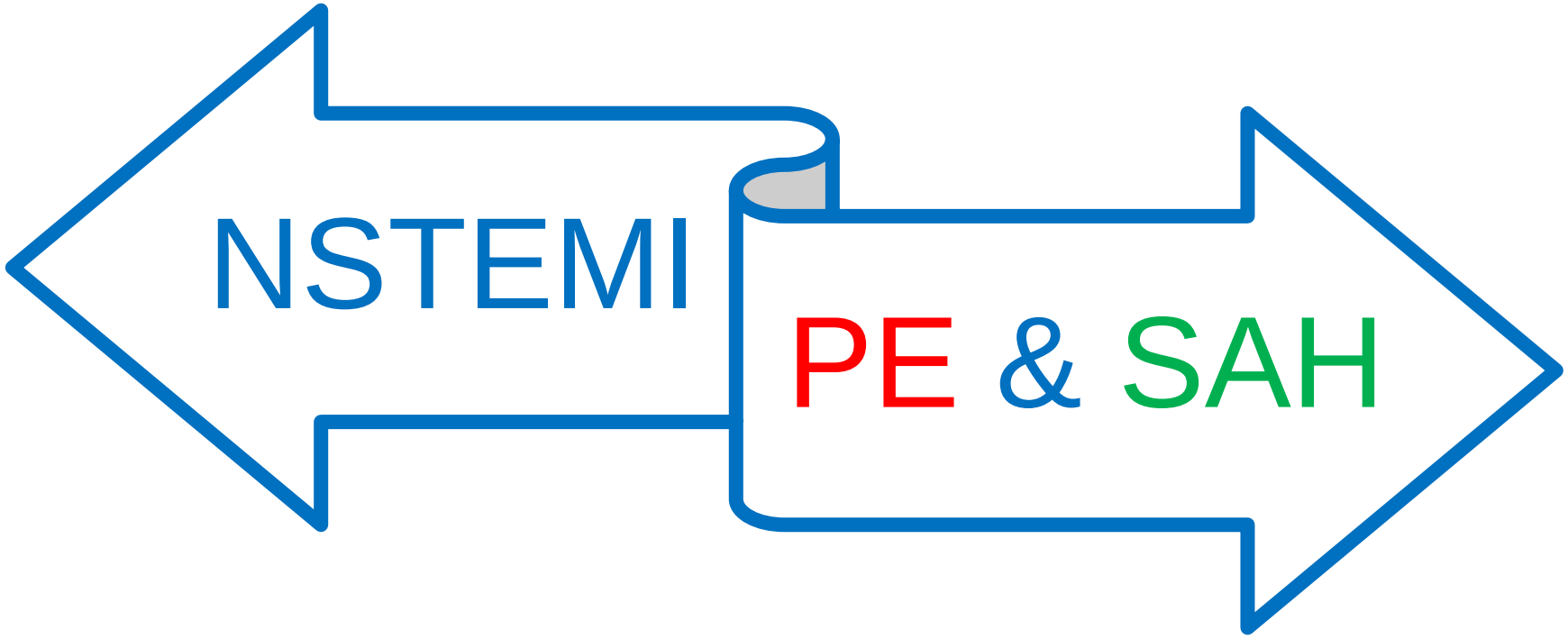
Outcomes

SHMI = 1.00

APD-6 = 340 hours

4HT performance = 80%

Sentinel Conditions



Outcomes

CQC-ED Score = 8.00

Staff Survey Score = 3.76

Family and Friends Test = 88.3% with a 12.2% response rate

A&E litigation over the last five years

Number of claims = 51

Estimated total cost = £9,995,172

(= 16.8% of annual A&E operating costs)

Average cost per claim = £179k

£18.54 per patient!

Specific types of hospital and geographic areas where EM is different or particularly challenging…….

1. Teaching & specialist hospitals / trauma centres
2. Large DGHs near to a teaching hospital
3. Hospitals in a rural or remote location
4. Hospitals in a coastal location

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Visit to see the Nowhere-Special District General Hospital A&E Department's infrastructure

Number of staff toilets now recorded by the NHS Benchmarking Network = 1 (4)
or 147 staff per toilet (53)

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NHS

GIRFT

Twitter: @DrChrisMoulton

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Unwarranted variation!!