Access Issues at NSW Public Hospitals

Key Strategies

NSW HEALTH
Working as a Team

NSW DEPARTMENT OF HEALTH
73 Miller Street
NORTH SYDNEY NSW 2060
Tel. (02) 9391 9000
Fax. (02) 9391 9101
www.health.nsw.gov.au

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Locked Mail Bag 5003
Gladesville NSW 2111
Tel. (02) 9816 0452
Fax. (02) 9816 0492

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Introduction

NSW public hospitals are experiencing problems with the flow of patients through Emergency Departments, inpatient areas and discharge into the community. Emergency Departments are regularly experiencing access block – that is, patients waiting longer than eight hours before admission to hospital wards from the Emergency Department.

The incidence of access block has been increasing over time. Bed numbers have been declining – while this has been an appropriate response to declining length of stay and improved rates of day only surgery and day of surgery admissions, increasing numbers of emergency medical admissions to the public health system have put pressure on inpatient beds.

The Commonwealth Government's private health insurance policy has encouraged private hospitals to concentrate on more profitable, less complex elective surgery. State public hospitals are therefore taking on an increasing share of the emergency workload of the entire system. In 2001/02, the public hospital system treated 95% of all emergency admissions. From 1999/2000 to 2001/02, emergency admissions to NSW public hospitals increased by 11.3%, or 61,000. This increase in emergency admissions is placing a strain on the public health system. Additionally, the decline in bulk billing, the reduction in after hours General Practitioner services and ever increasing out-of-pocket costs for consultations have resulted in a shift in patient load from the primary to the acute hospital sector.

Access block is the result of inadequate systems or processes to ensure beds are available at all times. The current systems, whilst achieving good individual patient care, do not focus on assessing patients and moving them through the Emergency Department efficiently and effectively and into a hospital ward quickly. If the systems are not working, a process to change or redesign those systems must be introduced. Staff in emergency departments and wards know what the delays are and can design solutions. The process must be facilitated by managers and resources allocated to implement sound systems. Key performance indicators for each stage of the journey must be established, for example: waiting times, length of stay and discharge rates. Systems need to be put in place to ensure these targets are met.

The lack of available beds also impacts on the movement of patients from critical care areas to the hospitals wards, tying up valuable resources and contributing to delays in operating theatres. The patient's journey through the hospital system and out into the community or residential care is also critical. These factors combined with variation in clinical practice and the increasing number of aged people with complex health problems present significant challenges for the NSW health system.

Variation in clinical practice and discharge rates impact on the quality of care and cost of services, as well as the flow of patients through hospitals. A number of patient flow issues are being addressed through the Institute for Clinical Excellence's Patient Flow and Safety Collaborative, which aims to improve patient access to acute services through the adoption of existing best practice.

Some older people have special, complex needs, due to the combination of advanced aged, problems involving a number of body systems, chronic diseases that impair cognitive and physical function, especially the neurodegenerative diseases of older people, and loss of informal care networks. Some older sick people may present with a multitude of problems that may be compounded by confusion and depression. As the population ages, chronic and complex diseases will underlie an increasing proportion of acute, potentially reversible illnesses in people presenting to the Emergency Department.

The effective and efficient care of older people with multiple problems is a significant issue. Geriatricians have tried to meet the inpatient needs of this growing number of patients but their workforce is inadequate. The solution to the problem of how to care for this group of patients will require planning by both the State and Commonwealth governments, together with the Royal Australasian College of Physicians.

Some patients with chronic and complex problems may be admitted to hospital, when ambulatory and other community services may be more suitable to meet their needs. However, hospital admission is sometimes necessitated due to the non-availability of these services on a twenty four hour basis. Older people often decline functionally and cognitively with acute illness. While they may recover reasonably quickly from the acute aspect of their illness, their functional and cognitive recovery may take much longer. It is important to allow older people time to achieve recovery to their optimal functional level, but this does not need to take place in an acute hospital and, in fact, may be more effectively achieved in a non acute environment.

To achieve changes in the health system, leaders must establish clear expectations. Targets that meet patient expectations need to be set to enable innovative solutions to be considered, and the process radically redesigned if necessary. Rigorous regular analysis and monitoring of key indicators and systematic redesign of processes to enable targets to be met is essential.

The solutions are not simple. They require a multidisciplinary approach and also require staff to change traditional practice models especially around the teaching of junior doctors, the capacity of nurses to make clinical judgements and initiate care, the role of emergency physicians in decisions to admit patients and the role of clinical support services such as radiology and pathology.

Management needs to initiate a strong team effort, to develop systems and processes that work, but mostly to believe and inspire that it can be done.

Lasting improvement, involving major systemic change, needs longer-term solutions. The Key Strategies outlined in this document include some immediate and some longer-term strategies. The focus of these strategies are to better meet the needs of three target patient groups, namely, elective patients, complex dependent patients, and emergency/critical patients. Chief Executive Officers of Health Services and hospital General Managers, in partnership with clinicians, are responsible for implementing these strategies.

The way forward

Strategies for immediate implementation

General

NSW Health will ensure that:

- Chief Executive Officers of Health Services are mindful of their accountability for hospitals' performance in relation to access block and off stretcher delays
- the General Managers of hospitals are authorized and accountable to resolve any access block and off stretcher delays
- Chief Executive Officers in the Sydney metropolitan area will continue to implement the Framework for Standard Measurement of Hospital Capacity for all hospitals. The Emergency Department Network Access (EDNA) plan will be developed by each Health Service as part of the implementation
- General Managers will undertake a daily review of issues identified to streamline processes.

Bed availability

Health Services will:

- review and adjust the hospital inpatient bed base to satisfy any shift in demand for services (eg between medical and surgical)
- ensure that all projected winter beds are available
- review booked admissions with the aim of shifting activity to less busy days, where practicable
- review the bed base to ensure sufficient beds are staffed and available on the most busy days, ie Sunday to Tuesday
- ensure the efficient use of all sub-acute beds through the use of performance indicators involving assessment, outcome and discharge planning
- improve processes for transferring patients to rehabilitation and to aged care beds after-hours and on weekends, and consider conversion of the aged care service from a 9 to 5 hour service to a 24 hour service
- improve day of surgery admission and day only surgery rates for all clinical specialties, while continuing to encourage transfer of treatment from the inpatient to ambulatory setting, as appropriate.

Discharge planning

Where they have not already done so, public hospitals will implement:

- daily morning rounds by senior medical officer(s) and senior nurse(s) to ensure the most timely discharge of appropriate patients
- daily afternoon rounds to ensure discharges actioned in the morning have occurred
- the appointment of a senior doctor and nurse at each hospital to coordinate weekend discharges
- reviews by General Managers and clinicians of length of stay for each specialty, to improve discharge planning.

Ambulance transfers

Ambulance patients will be transferred to hospital care within targets set by the NSW Department of Health, in consultation with the Ambulance Service of NSW.

Key outcomes

Implementing these strategies will ensure that key outcomes are achieved, by meeting:

- triage category targets
- access block targets
- benchmark times for admitting and operating on clinical priority category 1 and 2 booked surgery patients
- booked patient delay targets
- ambulance off-stretcher time targets
- benchmark targets for long wait patients
- day of surgery admissions and day only surgery benchmarks in all specialties
- weekend discharge rate targets.

Longer term strategies

The Key Strategies spell out our longer-term strategies to address hospital and community capacity and patient flow.

The NSW Department of Health will establish an *Access Improvement Task Force* to monitor and assist with the development of a Hospital and Community Capacity Management Strategy in each Health Service. The Task Force will have an independent Chairperson, and will consist of medical, nursing and management experts.

To assist and support the Task Force, the NSW Department of Health will establish a team which will provide relevant data to clinicians and managers. The team will conduct detailed audits of hospital and community services, and will assist Health Services to redesign services and engage senior clinicians in this process.

The NSW Department of Health team will work with Health Services to ensure that, in the longer term, all services:

- meet length of stay targets
- meet readmission targets
- meet Emergency Department treatment time targets
- include key performance targets in Staff Specialist Performance Agreements and contracts with Visiting Medical Officers (VMOs)
- include key performance targets in the Chief Executive Officer and Health Service Board Performance Agreements.

Only a comprehensive, system wide approach to improving patient flow and work practices, in both hospital and community settings, will provide lasting and effective solutions for access issues.

Over the next two years the NSW Department of Health and Health Services will focus on nine key strategy areas: older people, chronic care, ambulatory care, hospital and community capacity, incentives, appropriateness of care, hospital networks, discharge practice and work practices. As previously stated, the focus of these strategies is to better meet the needs of three target patient groups, namely, elective patients, complex dependent patients and emergency/ critical patients, and to lay the foundation for more effective patient care in the public health system.

Key strategies

The Key Strategies discussed in this document are to be implemented for each of the three target patient groups, as illustrated below:

Elective patients	Complex dependent patients	Emergency/critical patients
Focus on care for older people in NSW		
Further develop the management of chronic illness		
Expand ambulatory care and community-based services		
Develop a hospital and community capacity management strategy		
Introduce incentives to improve teamwork and performance		
Address appropriateness of care		
Develop local hospital networks		
Improve discharge practices		
Analyse work processes to improve patient flow		

Focus on care for older people in NSW

1

Resources and planning will be focused on the needs of older people to improve their care pathways, to prevent unneccessary admissions and to further develop community health services and resources for older people and their carers

The current situation

All health systems are facing the challenge of improving care for older people as the use of health services by this group increases. Australians aged 65 and over account for 12% of the Australian population. In NSW, 29% of acute bed days are for patients aged 75 years and over, an average annual growth of almost 1% per year since 1997.

Most people aged 65 years and over using the health care system use mainstream services in the same way as people of all ages. However, hospitals are not always oriented to caring for the particular needs of older people.

Some older people have special, complex needs, due to the combination of advanced age, problems involving a number of body systems and medical specialties, chronic diseases that impair cognitive and physical function, especially the neurodegenerative diseases of older people, and loss of informal care networks.

Some older sick people may present with a multitude of problems that may be compounded by confusion and depression. As the population ages, chronic and complex diseases will underlie an increasing proportion of acute, potentially reversible illnesses in people presenting to the Emergency Department.

Older people often decline functionally and cognitively with acute illness. While they may recover quickly from the acute aspect of their illness their functional and cognitive recovery may take much longer. It is important to allow older people time to achieve recovery but this period of recovery does not need to take place in an acute hospital setting.

There has been a significant and rapid growth in the number of people from certain culturally and linguistically diverse (CALD) backgrounds (Greek, Italian, German, Eastern European) who are now ageing (eg 47% of the 65 years and over age group in Central Sydney Area Health Service is from a non-English speaking country of birth, and similarly 39% in South Western Sydney Health Service). Research suggests that English language competency of people from CALD backgrounds tends to decline more rapidly as they age, particularly beyond 75 years.

In recent years, there has been an 8% annual increase in attendances by patients over the age of 80 years in Emergency Departments. The Emergency Department is the entry point for inpatient care for 90% of this age group.

To address this issue, in 2002/03, 36 Aged Care Services Emergency Teams (ASETs) have been established in metropolitan and rural hospitals. These multi-disciplinary teams work alongside Emergency Department staff to provide care for older people identified as potential aged care clients.

NSW acute patient separations and length of stay by age 1997-2001

	Under 65 years		65-74 years		75 years and over	
	% of total	Average growth	% of total	Average growth	% of total	Average growth
Separations acute patients	70%	-0.4%	13%	-0.9%	17%	3.6%
Bed days acute patients	55%	-2.7%	16%	-4.2%	29%	0.8%

Source: NSW Inpatient Statistics Collection (ISC)

A number of hospitals have initiatives such as 'Hospital in the Nursing Home', where training and patient support is provided to aged care facilities. Treatment is provided in the aged care facility and may reduce the need for aged care residents to be sent to the Emergency Department. These programs are often linked with Health Services' Post Acute Care Programs.

The Care of Older People Committee was established in 2003 to oversee the implementation of initiatives from the *Report of the Working Group on the Care of Older People*. A framework which will assist Health Services to improve the care of older people is being introduced in 2003. The framework is centred on a model of care for older people who may require aged care services. Health Services will be asked to identify current gaps in service delivery to ensure appropriate care can be delivered. Other initiatives include the development of performance indicators and targets to monitor improvements in the care of older people, local screening systems to identify older people who should be offered multidisciplinary geriatric evaluation and management, and extending the concept of networking ASETs across all Emergency Departments in NSW.

The ageing of the population will increase the number of people in hospital with delirium or dementia.

An effective interface between the health and aged care systems is essential. It is estimated that in NSW at any one time 800 older people are waiting in public hospitals for residential aged care places. NSW and the Commonwealth are jointly running three pilot programs in NSW, providing rehabilitation and aged care services for older people making the transition from hospital to the community.

NSW Health will continue to promote more positive attitudes towards older people at all levels of the NSW health care system.

The way forward

Strategies for immediate implementation

The NSW Health Care of Older People Committee is coordinating both immediate and long-term initiatives to improve health services for older people. The NSW Department of Health will:

- roll out to AHSs a model of care for older people who may require aged care services, by December 2003
- develop performance indicators to measure improvements in care, by December 2003
- evaluate performance and KPIs of ASETs, and determine the need for expansion of ASETs, by February 2004
- integrate and coordinate current and future intiatives to address the care of older people across the health system.

To improve the flow of older patients from hospital to community, Health Services and hospitals will be required to streamline the processes involved in transferring patients to rehabilitation and aged care beds after hours and on weekends. They will also need to consider converting the aged care service from a 9 to 5 service to a 24 hour service.

The efficient use of sub-acute beds should be ensured by the implementation of key performance indicators involving assessment, outcome and discharge planning.

Longer-term strategies

A program is required to ensure the timely transition of older patients from hospital to the community. Trials have indicated that the use of 'transitional beds' is highly effective, meeting the aged care needs of patients and reducing blockages due to the inability to discharge older patients to suitable placements. It should be noted that Multi-Purpose Services in small rural towns are ideally placed to provide 'transitional beds'.

The development of Transition Care Programs (TCPs) should be considered, both to support patients in their homes as they await residential aged care placement, and to support earlier discharge of patients requiring a high level of community care services upon their return home.

Health Services should consider expanding post acute care services to meet the needs of older people at home.

The NSW Department of Health will engage the Commonwealth Government and the Royal Australasian College of Physicians to improve the care of multi problem older people and supply of the medical workforce.

Health Services should implement the Strengthening Health Care in the Community strategy.

NSW Health will continue to work with the Commonwealth to develop services at the interface of the health and aged care sectors.

NSW needs an improved model of acute, post acute and chronic and complex care for older people. The challenge is to better integrate hospital aged care services, the hospital-community care interface and community health services, so that older people can get the right care at the right time. The roles of State Government Residential Aged Care Facilities and Confused and Disturbed Elderly (CADE) units in providing care for this resident group must be carefully reviewed.

NSW Health is addressing the care of older people on a system-wide basis. It remains to:

- integrate and coordinate current and future initiatives across the health system
- evaluate initiatives, and fund and widely implement successful strategies, where appropriate
- work with Health Services in developing local responses which are based on better practice
- develop performance indicators to ensure Health Services focus on improving the care of older people
- address workforce issues, including adequacy of aged care staffing and hospital workforce perceptions of older people
- improve care pathways for older people moving through the health and aged care systems, with a focus on joint ventures with the Commonwealth and non-government sectors
- strengthen community health services to provide services to improve older people's capacity to maintain independence and remain at home, and to prevent unnecessary hospital admissions
- develop appropriate environments and effective systems of assessment and care of older confused patients in hospital.

NSW Health will continue to develop and integrate services with the Departments of Ageing, Disabililty and Home Care at the local and Departmental levels.

Reference

NSW Dementia Strategy – *Future Directions for Dementia Care and Support in NSW*
www.health.nsw.gov.au/policy/hsp/publications/dementia/future_directions.pdf

Further develop the management of chronic illness

2

Resources and planning will be focussed on the expansion and further development of services for patients with chronic illness

The current situation

In 1999/2000, 17% of hospital admissions and 36% of total public hospital bed days were for the chronic illnesses of respiratory and cardiovascular disease, diabetes and cancer.

Cancer is the second most common cause of disease burden in males and females in NSW. There were 28,889 new cases of cancer and 12,185 deaths due to cancer in 2000. Incidence rates for all cancers rose by almost 25% between 1980 and 2000, reflecting earlier detection, a real increase in the incidence of some cancers, and better notification processes.

Chronic Obstructive Pulmonary Disease (COPD) is the fourth leading cause of death in Australia and internationally (2000), accounting for 1,945 deaths in NSW in 2000 and 18,000 hospital admissions (1999/2000).

Australian rates for asthma are among the highest in the world. It is the sixth most common reason for General Practitioner consultations. Deaths from asthma have decreased by 40% over the last 20 years. In NSW there were 180 deaths from asthma in 2000, and 16,000 hospital admissions in 1999/2000.

The incidence of Chronic Heart Failure (CHF) is increasing faster than any other cardiovascular disease. Prevalence is predicted to double over the next 30 years, due to the ageing of the population. CHF affects 1% of the general population and 10% of those aged over 75 years in western countries, with 50% of patients dying within five years of becoming ill. The profile of people with CHF is changing – it now shows that there are more older patients, more females, and more patients in whom the underlying cause of CHF is ischaemic heart disease. In NSW, CHF accounted for 13,326 hospital admissions in 1999/2000, with a long average length of stay of 12-13 days.

Dementia is the second largest cause of disability burden in Australia after depression, and will become the largest by 2016, outpacing other chronic illnesses (Access Economics Report: *The Dementia Epidemic: Economic Impact and Positive Solution for Australia*, March 2003). It is estimated that approximately 1 in 20 people over the age of 65 years and 1 in 5 people over the age of 80 have dementia. In NSW there are over 55,000 people with dementia. Patients with dementia currently have a length of stay that is four times longer than patients without the disease and their casemix complexity is almost double that of other patients. NSW Health and the Department of Ageing, Disability and Home Care have jointly developed the Future Directions for Dementia Strategy which has $11.043m allocated over four years for implementation. The Strategy aims to address the needs of people with dementia (and their carers and families), across the range of care settings – community, hospital and residential aged care, covering issues from diagnosis to palliative care.

The cost of providing care for people with chronic illness, focusing on cardiovascular disease, diabetes, respiratory disease and cancer was estimated at $1.1 billion in NSW in 1999/2000.

The NSW Chronic Care Program was set up in 1999 to address the increasing needs of people with chronic and complex illnesses.

By March 2003, this program had established sixty programs, serving 33,000 patients across NSW, to enhance systems of care for patients with chronic respiratory and cardiovascular disease, and cancer.

Results from approximately half of these 60 programs to March 2003 indicate that:

- 2,600 presentations to Emergency Departments were avoided
- 2,900 hospital admissions were avoided.

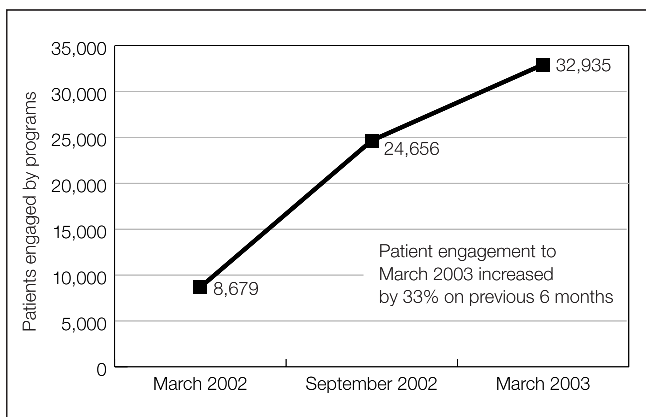
In 2003/04 funds will be allocated to implement Clinical Service Frameworks across NSW. Clinical Service Frameworks in the three priority areas of respiratory disease, heart failure and cancer, were launched in July 2003.

My Health Record, a folder recording information about the individual patient's medical condition and treatment, was launched in 2002 and is proving to be an effective tool for better self-management by patients with chronic illnesses.

NSW Health has developed initiatives with a specific focus on increasing access for Aboriginal people with chronic illnesses. The Aboriginal Vascular Health Program has well-targeted strategies to assist this population. In addition, funding has been allocated in 2003/04 from Aboriginal Health Enhancement funds for Aboriginal Vascular Health initiatives.

The Aboriginal Chronic Disease Framework, complementing the Clinical Service Frameworks, is due for release in 2003.

Growth in priority health care programs



Source: Data supplied by individual Health Services

The way forward

Longer-term strategies

Trends in population health and hospital service utilisation indicate that chronic disease management is a major issue for future health service delivery. Implementation of the Clinical Service Frameworks, with six monthly monitoring, aims to minimise the future burden of chronic disease on the NSW health system.

Following the successful introduction of the Patient Flow and Safety Collaborative into acute health settings, the Chronic Care Collaborative is now being developed in conjunction with the Institute for Clinical Excellence to ensure continuous improvement in the care of people with chronic illnesses, with linkages between acute health services and health care in the community.

NSW Health is the national leader in the introduction of Clinical Service Frameworks, setting measurable targets for more efficient and effective delivery of quality health services to people with chronic illnesses. The NSW Department of Health will continue to liaise with the Commonwealth and other States and Territories through the National Health Priorities Action Council (NHPAC) and related committees, to progress national chronic disease initiatives, including the National Strategies Improvement Framework (NSIF).

Based on work in this state in developing programs for people with chronic illnesses, NSW is leading discussions nationally, in collaboration with the Northern Territory, on the inclusion of Chronic Disease Management in the Australian Health Care Agreement.

Dementia is the second largest cause of disability and will outpace other chronic illnesses in the future. Based on this, Health Services should review dementia services focussing on support services, staffing and accommodation.

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A Clinical Service Framework for Optimising Cancer Care in NSW 2003
www.health.nsw.gov.au/pubs/c/pdf/cancercare_guide.pdf

Clinical Service Framework Quick Guides
www.health.nsw.gov.au/pubs/a/pdf/chronic_resp_sheets.pdf

NSW Chronic and Complex Care Programs Progress Report for Program Activity to 30 September 2002 (March 2003)
www.health.nsw.gov.au/pubs/c/pdf/cccp_report_020930.pdf

NSW Clinical Service Framework Chronic Respiratory Disease (Executive Summary)
www.health.nsw.gov.au/pubs/c/pdf/chronic_resp_summ.pdf

NSW Clinical Service Framework Chronic Respiratory Disease (Volume One)
www.health.nsw.gov.au/pubs/c/pdf/chronic_resp_vol1.pdf

NSW Clinical Service Framework for Heart Failure (Executive Summary)
www.health.nsw.gov.au/pubs/c/pdf/clinical_heartfail_summ_a4.pdf

Patient Flow and Safety, and Chronic Care
www.health.nsw.gov.au/pubs/c/pdf/patient_flow_safety.pdf

Expand ambulatory care and community-based services as alternatives to hospital care

3

Ambulatory care and community-based services will be expanded to provide effective high quality services so that patients are appropriately followed up after discharge, thus avoiding inappropriate hospital admissions

The current situation

There is a clear relationship between access block in public hospitals and the capacity of community-based services to address health problems in the community setting. Although the further development of Community Acute/Post Acute Care (CAPAC) programs will improve access to public hospitals, a stronger primary health care system is needed to assist with managing demand across the health care system.

CAPAC is a substitute for acute care provided in hospital; in its absence, the patient would be admitted to hospital or have to remain in hospital. CAPAC services provide personal and clinical support, and effective coordinated management of an acute clinical condition, for a defined period. The patients considered for inclusion in these programs are medically stable, do not require high level clinical support, but may include multi-morbid patients with complex needs. The care setting is often the patient's place of residence, but could equally be an outpatient clinic, or day only treatment centre.

The term Community Acute/Post Acute Care (CAPAC) is now being used to classify a number of programs including: Hospital in the Home (HITH), Post Acute Care (PAC) and Ambulatory Care (AC). There are currently over 30 CAPAC programs operating in NSW.

The HITH program implies that the care received by the patient at home is equivalent to the care she or he would have received in a hospital bed. If the need for clinical intervention is the only basis for hospital admission, and it is clinically feasible for the patient to receive their treatment at home, then the out-of-hospital option can be considered.

PAC can apply to any episode of care that follows acute care. While a patient may not need to be hospitalised to receive clinical intervention, she or he may have complex health care needs that require urgent attention and monitoring, eg following an acute event or an acute-on-chronic episode, or a breakdown in health and/or social support systems. For further deterioration and decline to be avoided, the patient needs timely and coordinated interventions – whether in hospital, or through a PAC program.

AC programs, like HITH and PAC, strategically enhance community-based service delivery in an increasing range of clinical therapies and health services. An AC program may even include pre-admission screening and planning, some of which (education, risk assessment, discharge planning, mobility assessments, equipment needs assessment and training) is currently done by post-acute teams. This reflects CAPAC program staff recognition that effective pre-acute management is an essential component of effective acute and post acute care.

A range of community-based services (eg home nursing services), are available across NSW to support people in their homes. These Home and Community Care (HACC) services are jointly funded by the Commonwealth and State governments and are provided by the Department of Ageing, Disability and Home Care, NSW Health, non government organisations and private agencies. The demand for these services exceeds their supply, and waiting lists are not uncommon.

A key strategy currently being piloted across a number of Health Services is a community management model which has three components:

- hospital/inpatient
- Emergency Department
- home/residential care.

In the early stages of the program, most attention has been given to implementation of the first component. The overall objective is to provide timely interventions which avoid or minimise hospital inpatient stays,

where the care and support needs of the individual can be met just as well in his/her home.

The hospital inpatient component (ComPacks) involves community case management for inpatients with multiple needs and aims to assemble individualised community care designed to meet patients' clinical and support needs, thereby allowing their timely and safe return to their home environment with appropriate care in place.

The way forward

Longer-term strategies

An independent review commissioned by NSW Health in 2002 found evidence of the effectiveness and acceptability of CAPAC programs, which supports the need to establish and/or expand CAPAC programs in major population centres in NSW. NSW Health is currently preparing a business case for this.

An implementation plan for enhancing and expanding CAPAC programs across NSW should be developed by the proposed relevant Health Priority Taskforce and Community Acute/Post Acute Care Steering Group (CAPACSG).

The 'Strengthening Health Care in the Community' strategy is to be implemented, with the development of Primary Health Care Networks.

Health Services should trial Transition Care Programs.

Specific resources will be allocated to strengthen community-based primary health care services including prevention, promotion, early intervention and rehabilitation services.

Reference

Strengthening Health Care in the Community Strategy
www.health.nsw.gov.au/policy/gap/bulletins/pdf_files/bulletin7.pdf

Develop a hospital and community capacity management strategy

4

Strategies will be developed to more effectively manage hospital capacity, based on an evaluation of current initiatives and future needs

The current situation

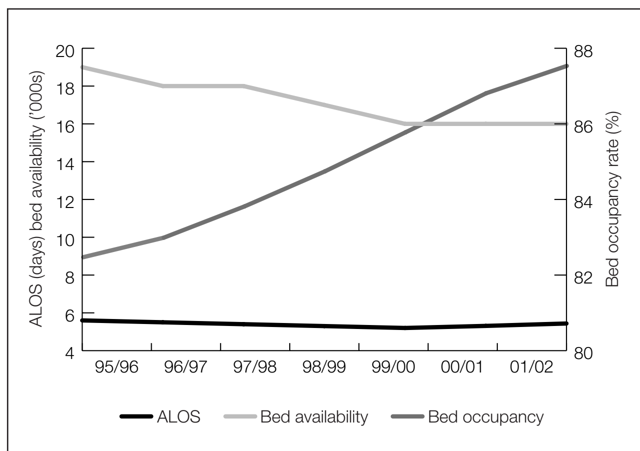
Demand management is about ensuring a cost effective, appropriate and equitable health system to meet the needs of the community. The NSW health system is facing an increasing demand for services. Health service managers have focused largely on emergency demand. It is now clear that a system-wide approach to managing demand is needed. The problems are complex, and are affected by many factors, including the number of beds available, work practices, workforce availability and the ageing of the population.

The Ambulance Service of NSW delivers over 350,000 emergency transports each year. The number of emergency transports has increased by an average of 3.5% per year since 2000/01.

Currently, around 2 million people present each year to Emergency Departments in NSW and some 300,000 people are admitted to public hospitals in NSW for non-emergency booked medical and surgical interventions.

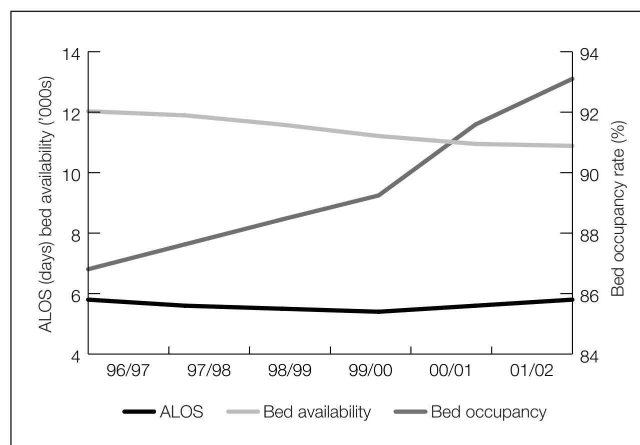
The average number of beds available in NSW public hospitals fell consistently between 1993/94 and 2001/02. Bed occupancy has been rising at about 1% per annum over the same period. In NSW, there has been an increase in bed occupancy from 82.4% in 2000/01 to 86.7% in 2002/03. In metropolitan hospitals, occupancy has been over 90% since 2000/01. Such high occupancy levels lead to frequent access block, and are incompatible with smooth patient flow (Bagust, 1999).

NSW bed availability and occupancy rates, overnight average length of stay 1995/96 to 2001/02



Source: DOHRS

Metropolitan bed availability and occupancy rates in general hospitals, overnight average length of stay 1996/97 to 2001/02



Source: DOHRS

Former steady growth in overnight admissions to hospitals, over the last 10 years has shifted to no growth in the last 1-2 years. There are many reasons for this, including:

- the provision of treatment on a non-inpatient basis
- surgical improvements – improvements in day only surgery rates
- the impact of Chronic Care initiatives, eg programs for asthma management

- the provision of services through 'Hospital in the Home' and Post Acute Care programs.

The following table highlights changes in overnight admissions and length of stay from 1996/97 to 2001/02 and shows the increase in emergency medical admissions.

Acute overnight admissions 2002 and change in last 5 years

	Bed days	Bed day change	Admission change	LOS change
Emergency surgery	466,712	-3%	0%	-3%
Elective surgery	645,590	-26%	-20%	-8%
Emergency medical	1,818,163	-5%	4%	-8%
Elective medical	601,947	-37%	-20%	-21%

Source: NSW Health Inpatient Statistics Collection (ISC)

The reductions in length of stay are related to specific changes in work practice driven by one or more of:

- changes in technology (eg cardiology)
- new care models (eg maternity)
- changes to practice (day of surgery admissions)
- prevention programs (asthma).

Since 1995/96, there has been a fall in separations for all age groups among acute patients, except those aged over 75, where there has been an average annual 3.6% increase. For all patients (ie acute plus non-acute), there has been an average annual 5% increase in separations of patients aged over 75 (AIHW Australian Hospital Statistics, 2001-02).

In June 2000, the Acute Care Implementation Working Group set the day of surgery admission target at 80% and the day only surgery target at 60%. Statewide day of surgery admission rates then stood at 72% and day only rates at 54%. Over 2002/03, the day of surgery admission target was met each month, often by a healthy margin. Some specialties, however, remain significantly below the target. Day only surgery rates have improved less dramatically, nudging the target twice in 2002/03 when rates stood at 59.6 and 59.8%.

Several initiatives have been introduced in metropolitan areas of NSW to ease Emergency Department pressure. In July 2002, the Emergency Department Network Access (EDNA) system was operationalised. This initiative has enhanced the existing Sydney metropolitan network of Emergency Department services and fostered a more system-oriented approach to delivering quality care to presenting patients.

Throughout 2003 further initiatives have been put in place to ease Emergency Department pressure. Emergency Medicine Units (EMUs) provide short-term medical treatment beds to relieve pressure on acute Emergency Department beds. The Rapid Emergency Assessment Teams (REATs) can assist patients and start minor investigations (eg x-rays) prior to full medical assessment. Clinical Initiatives Nurses (CINs) have been appointed to most of the major Emergency Departments in the Sydney metropolitan area. These senior nurses can initiate treatment for patients with less serious conditions and provide information on likely waiting times and alternatives to Emergency Department treatment. Thirty-six multidisciplinary Aged Care Services Emergency Teams (ASETs) have been implemented in Emergency Departments across NSW to care for older patients.

The way forward

Strategies for immediate implementation

Health Services will review and adjust the public hospital bed base to satisfy any shift in demand for services (eg between medical and surgical).

Health Services will also ensure all proposed winter beds are available.

Booked activity will be reviewed by the Health Services with the aim of shifting activity to less busy days, where practicable.

The bed base will be reviewed by the Health Services to ensure sufficient staffed beds are available between Sundays and Tuesdays.

Processes for transferring patients to rehabilitation and to aged care beds after-hours and on weekends will be improved and consideration will be given to converting the aged care service from a 9 to 5 service to a 24 hour service.

Day of surgery admission and day only surgery rates for all clinical specialties will be improved by the Health Services, while continuing to encourage transfer of treatment from the inpatient to the ambulatory setting, as appropriate.

Longer-term strategies

Health Services must develop a Hospital and Community Capacity Management Strategy, to adequately address the complex issues of bed capacity and utilisation, patient flow, and length of stay; this applies also to analysis and modification of work practices.

Systems for dealing with hospitals diverting ambulances will be developed – this will require extensive collaboration and networking amongst hospitals and the Ambulance Service of NSW.

Health Services will develop a stronger clinical program-based management structure, to reduce variation in practice and improve quality, supported by significant improvements to performance and cost measurement.

Health Services will draw on the expertise and knowledge of the Institute for Clinical Excellence to improve their patient flow strategies. The provision of timely data by clinical specialty, hospital and clinician on variations in performance, eg with respect to day only surgery and day of surgery admission rates, will facilitate this.

Investment in Information Technology systems to provide improved efficiency and control of process and quality needs should be explored.

Health Services will improve access to ICU beds as outlined in the Intensive Care Services Plan.

NSW Health, in conjunction with the proposed Health Priority Taskforces will:

- develop day only surgery targets for a specific set of procedures to highlight areas for improvement
- extend the modelling of hospital flow using scenario planning to inform hospital capacity management strategies.

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Introduce incentives to improve teamwork and performance

5

Incentives will be provided to encourage hospitals to introduce practices which enhance teamwork and reduce access block

The current situation

Health care systems are changing. There is an emphasis on continuous quality improvement and accountability. Together these changes are affecting the delivery of health care services.

In NSW, formal Performance Agreements are in place between the Director-General for Health and Health Services. These Performance Agreements cover 17 Health Services, the Corrections Health Service, the Children's Hospital at Westmead and the Ambulance Service of NSW. The Performance Agreements incorporate performance indicators and targeted outcomes, aligned with the four goals of the NSW health system.

The Performance Agreements have been continually refined to become more focused on a smaller number of key performance measures. Due to the medium term nature of the Agreements, one dimension not fully explored is the demonstration of a clear relationship between strategies undertaken, medium-term outcomes and ultimate outcomes desired by the system.

The way forward

Strategies for immediate implementation

An Innovation Fund will be established to help drive system-wide change to better meet the needs of the three target patients groups: elective patients, complex dependent patients and emergency/critical patients. Health Services can apply to the NSW Department of Health for funding to appropriately manage such focused projects.

NSW Health recognised that the system for measuring and reporting on performance needed to be simplified and streamlined. In December 2002, the Department established the NSW Health Systems Performance Indicators Committee, to advise on a limited suite of high-level performance indicators, aligned to the goals of the Health System that could be used to monitor the Health Services and also be reported to external stakeholders. Following extensive consultation, the Committee produced a set of 20 performance indicators.

The set of Dashboard Indicators are intended to:

- Provide a broad overview of NSW Health
- Represent a core set of indicators that would be included in other major indicator sets used by NSW Health, eg Performance Agreements with Treasury and with NSW Health Services
- Focus on a limited number of high level issues

It is proposed that the set of 20 high-level indicators will form the basis of future Performance Agreements between the Director-General and Health Services.

The need to streamline and simplify the current Health Service Performance Agreements was also reflected in the recommendations made by the Independent Pricing and Regulatory Tribunal (IPART) of NSW, in its report *NSW Health – Focusing on Patient Care 2003*.

Longer-term strategies

Performance Agreements will remain the primarily accountability mechanism between the Department and Health Services to ensure the achievement of the System's goals and desired outcomes. The Agreements must clearly distinguish and articulate the roles, responsibilities and accountabilities of both the Department and Health Services for their successful implementation.

Performance indicators must be clear, measurable, and achievable by the Health Services. Monitoring of the Agreements will be underpinned by integrated, compatible information technology systems to ensure efficiently produced and timely performance data.

Organisational incentives and sanctions will be considered for inclusion in the 2004/05 Performance Agreements to be applied on a graduated basis, from minor to major. These incentives and sanctions require further development. This will be achieved through consultation with the Health Services.

Experience in other jurisdictions suggests that there is a need for independent evaluation and audit, especially when incentives and sanctions are involved. The NSW Department of Health will play a key role in the area of evaluation and auditing.

Address appropriateness of care

6

We will build on current initiatives addressing appropriateness of care to ensure that patients receive consistent, timely and high quality care.

The current situation

The delivery of appropriate clinical care is a key aspect of high quality service delivery. Variations in intervention rates and clinical outcomes may indicate inappropriate variation in clinical practice. Care is appropriate if the right intervention is provided to the right patient at the right time and in the right way. The appropriateness of an intervention is judged on the basis of whether a patient has the capacity to benefit from it. An intervention is inappropriate if a patient does not have the capacity to benefit from it. This may be because the potential harm from an intervention outweighs the potential benefit for the patient or because resources are wasted that could otherwise have been used to provide care to another patient.

Access to care may be affected by appropriateness of care, if inappropriate care leads to ineffective or inefficient care. For example, inappropriate care, such as hospital admission for a condition that could be just as effectively treated on an ambulatory basis, may have an impact on access for other patients.

Appropriateness is recognised as a critical clinical issue, but one that is difficult to address. In the context of access, important clinical situations that raise the issue of appropriateness include:

- does a patient need to attend an Emergency Department?
- does a patient need to be admitted to hospital?
- does a patient need a particular procedure or medical intervention?

Some patients attending Emergency Departments would be more appropriately managed by another service, for example, by a General Practitioner. However, the lack of access to alternative services means that patients attend emergency departments for such conditions. For example, it is known that attendances increase at times when General Practitioner (GP) services are not available, and many patients present to Emergency Departments with conditions usually treated by GPs.

Decisions regarding attendance at Emergency Departments are largely beyond the control of those working in them. Individual patients may choose to attend an emergency department (self-referral), be referred by a doctor, most commonly a General Practitioner, or be brought by ambulance. Strategies to lower the rate of inappropriate attendances at Emergency Departments include:

- media releases to the general public emphasizing that Emergency Departments are for emergencies
- GP-type services located alongside Emergency Departments (eg after hours services at Maitland and Campbelltown Hospitals)
- following assessment of the patient, Emergency Department triage staff providing information and assisting appropriate patients to access local GPs
- ambulances piloting a call centre service to some '000' callers
- nursing homes being able to access support without sending patients to the Emergency Department
- patients being transferred between hospitals or from doctors' rooms to hospital, by-passing the Emergency Department.

The quality of care received in Emergency Departments has a key role in determining the outcome of care for patients. These departments are the point of entry to the health system for the most seriously ill patients and it is therefore of the greatest importance that the clinical decisions made and care received in Emergency Departments is appropriate and of the highest possible standard. Moreover, Emergency Departments have an important role in defining and initiating the 'care pathway' for patients.

A key decision affecting appropriateness of care is whether to admit a patient. This decision clearly has an important impact on access. Differences in experience and seniority of staff, and availability of diagnostic and support services within an Emergency Department, affect decisions about whether a patient

needs to be admitted to hospital. Access to community support services can also affect this decision; patients may need to be admitted if such services are not available. The introduction of Emergency Medicine Units as an extension of the Emergency Department services has been shown to be an effective tool in reducing admissions to the wards and preventing inappropriate discharges from Emergency Department.

Use of evidence-based guidelines for common presentations to the Emergency Department can have a significant impact on admission rates. The Children's Hospital at Westmead, for example, has developed guidelines that have demonstrably reduced admission rates.

The appropriateness of management of hospital inpatients, beyond the Emergency Department, also has an important impact on access by contributing to variation in:

- hospital length of stay
- weekend discharge rates
- adverse events.

Evidence based guidelines that encompass the management of patients from their point of entry to the system to the point of discharge (and beyond in some cases) can also have a significant impact on the appropriateness and efficiency of hospital services. The Towards a Safer Culture (TASC) project is improving the management of patients with stroke and coronary syndromes. There is also work being done on the appropriateness of booked surgical procedures. The NSW Health Quality and Clinical Policy Branch has initiated a project with two medical professional colleges to develop agreed procedural guidelines for cholecystectomy and cataract operations.

The way forward

Strategies for immediate implementation

The NSW Department of Health will revise the clinical governance structures at the state level in line with the IPART recommendations and engage clinicians further in developing strategies to address appropriateness of care, including the development of evidence-based guidelines.

Longer-term strategies

Clinical governance structures that engage professional groups are essential to address issues of appropriateness. These groups should assess variation in admission rates between hospitals, as well as variance in procedure rates and waiting times between hospitals and peer clinicians. The groups will include representatives from professional colleges, the NSW Department of Health, Health Services, and a consumer representative. They will provide continuous monitoring of the appropriateness, timeliness, and quality of clinical services in the NSW health system, and will report on a regular basis to the Director-General. In particular, they will endorse and oversee the development of evidence-based guidelines that will address the appropriateness of care provided in the NSW Health System.

The concept of guidelines is complementary to that of care pathways and care plans. As far as is possible, patients should have their care managed according to a care plan which is based on the best available evidence of what is likely to benefit them. Clinicians will be engaged through the clinical governance structures at Area and State levels, in their development and endorsement. Such care plans will incorporate key milestones and expected dates of discharge.

The consultation with these groups will play a crucial role in maintaining clinical accountability and ensuring continuous quality improvement. The establishment of the Health Priority Taskforces, as recommended by the Independent Pricing and Regulatory Tribunal (August 2003), will strengthen and streamline clinical governance structures already in place to drive system-wide change. It is proposed that senior medical practitioner Performance Agreements include targets for improvement on a range of indicators, such as weekend discharge and same day surgery rates. Local initiatives for change could be supported through this mechanism. A suite of performance reports will be made available to health services and will be regularly updated to facilitate better targeting of local change initiatives.

[1] NSWHealth, A Framework for Managing the Quality of Health Services, January 1999.

Develop local hospital networks

7

Hospitals in each Health Service in NSW will be linked to form a Hospital Network. The networked hospitals will collaborate to ensure the most efficient use of inpatient facilities across the Health Service

The current situation

Most metropolitan hospitals currently function independently, without any formal linkages to other hospitals in their Health Service which would enable them to cooperatively address situations where one hospital may have an acute shortage of beds, or pressure on emergency services, whilst one or more other hospitals in the Health Service has available beds or a less busy Emergency Department.

This situation also applies in rural Health Services, where there is often enormous pressure and access block at the base hospital, while the district hospitals have beds available. Rural Health Services have experienced increasing Emergency Department demand and access block over the past three years. Emergency Department attendances have increased by 2% each year over the last three years (2000/01, 2001/02 and 2002/03). The level of access block in rural hospitals over the same period has increased from 6.1% (2000/01) to 13.1% (2002/03).

The Emergency Department Network Access (EDNA) system was implemented across the Sydney metropolitan area in July 2002. The initiative involves four components: the Hospital Activity Projection Model; the Framework for Measurement of Hospital Capacity; a new ambulance protocol, and Network Access Coordination. Information can be found at www.internal.health.nsw.gov.au/hospitalinfo/emergency/edna.html

The way forward

Longer-term strategies

A hospital 'networking' system will be introduced in all Health Services, so that when a hospital is experiencing access block, patients can be transported and admitted to the nearest hospital which has appropriate available beds. Clinicians and management need to agree on a bed management plan to formalise this arrangement.

This proposal is consistent with the NSW Rural Health Plan, which recommends the development of clinical networks in rural Health Services.

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Improve discharge practices

8

We will improve discharge practices so that discharge rates are more evenly distributed over the week, and discharge practices facilitate patient follow up and care in the community

The current situation

One of the signs of a successful health care system is effective and efficient processes for patients, from admission to discharge. Effective discharge planning for booked patients begins before a patient is admitted to hospital. For emergency admissions, it begins within 24-48 hours of admission. It includes communication and information sharing between the patient, family and all health care providers. Discharge processes are one of many factors affecting the management of patient flow.

In early 2003, NSW Health conducted a study examining the contribution of low weekend discharge rates to access block. A review of NSW hospital discharge data for emergency medical overnight patients in the period July 2001 to June 2002 indicated that access block and hospital occupancy are highest on Monday to Wednesday. A factor contributing to this is the lower rate of discharge on weekends. Generally in NSW, there is an even flow of emergency medical overnight admissions to hospitals throughout the week. On Fridays discharges increase by about 25% over the Monday to Thursday rate. On Saturdays the rate falls to half of the Monday to Thursday rate and on Sunday the rate is one-third of the Monday to Thursday rate. These rates can differ significantly between specialties in the same hospital, and for the same specialties between different hospitals.

The study found that increasing the number of discharges at weekends is one of several strategies that may improve inpatient flow, and consequently the availability of beds. The project identified both generic and specialty-specific practices and processes associated with better rates of discharge at weekends. To improve weekend discharge practices, consideration must be given to implementation of the report's recommendations.

The Institute for Clinical Excellence is addressing weekend discharge practices, as part of the Patient Flow and Safety Collaborative project.

As a Government Action Plan initiative the Models of Care Implementation Working Group has developed the Effective Discharge Planning Framework and Implementation Strategy for NSW Health.

The Framework provides guidelines to improve discharge planning and processes. It aims to improve outcomes for patients, their carers and families, reduce adverse events, enhance patient safety and improve continuity of care.

The Framework highlights processes that are called 'Critical Must Do's which include: a discharge risk screen on admission for all patients (to ensure that patients with needs for ongoing care are identified); estimated day of discharge to provide a focus for the discharge plan (to be completed on admission and discussed with the patient); and improved communication processes between the patient and his/her/family/carer/s, hospital staff, GPs community health staff and community service providers.
A patient information brochure has been developed which is aimed to assist patients/carers/family in preparing for discharge and ongoing care needs.

Evaluation and monitoring components form an important part of the Framework and this includes the need to obtain feedback about discharge processes from patients and their family/carer/s, GPs and community providers. A pilot project is being conducted on evaluation and monitoring components to inform on suitable processes to obtain this information.

A comprehensive implementation strategy has been included as a component of the Framework. This provides particular detail about each of the Critical Must Do's and what actions are required to support improved discharge practice. Apart from local level implementation a wider implementation process has been included across NSW Health as part of the Patient Flow and Safety Collaborative which is being conducted by the Institute for Clinical Excellence.

The way forward

Strategies for immediate implementation

Implementation of daily morning rounds by senior medical officers and senior nurses to ensure more timely discharge of appropriate patients.

Daily afternoon rounds will be implemented by the Health Services to ensure discharges initiated in the morning have occurred.

Health Services will appoint a doctor and senior nurse to coordinate weekend discharges.

General Managers and clinicians will review length of stay for each specialty, and improve discharge planning to address problems.

Longer-term strategies

Achieving improvements in discharge practices, both at weekends and in terms of overall discharge practice, needs strong clinical leadership to achieve the structural, cultural and process changes required. Consistent monitoring of variations in practice, especially variation in discharge rates across the week, by hospital, specialty and clinician, is required to identify trends and address problems.

The NSW Health *Weekend/Monday discharge processes for emergency overnight medical patients in selected clinical specialties and hospital sites* project identified a number of practices associated with improved weekend discharge rates, including medical weekend rostering practices, discharge planning processes and capacity to place older patients in nursing home or hostel beds. Health Services should implement the report's recommendations.

A suite of performance reports will be made available to health services and will include weekend discharge rates for hospitals. This will facilitate targeting of local change initiatives.

A Discharge Review/Implementation Working Group (DRIWG) will be formed to assist in the review and implementation process. This group should be led by a member of the executive team and should include representation from:

- hospital staff already involved in the discharge process
- medical, nursing, allied health and administrative staff
- General Practitioners
- community health service providers (including a HACC representative)
- patients and carers
- representative from the residential care sector.

Electronic discharge referral systems are being progressively introduced into NSW public hospitals. Electronic discharge referral systems assist clinicians to prepare a summary of the patients' treatment, and immediate care advice for the patient and their GP/community health worker. They ensure community clinicians receive information about the patient as close to their departure from hospital as possible.

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Analyse work processes to improve patient flow

9

We will build on current initiatives analysing work processes in hospitals to develop system-wide strategies to improve care and patient flow through the hospital system

The current situation

Problems experienced by Emergency Departments are system-wide, and cannot be resolved in isolation. When there is a matching of demand and available resources, there is a smooth flow of patients through the hospital. When demand outstrips the services available, a queue develops. If the queue is planned and controlled it tends to be orderly; otherwise, it tends to be disorderly and may lead to problems.

The most relevant flows are those associated with inpatients. Blockages occur at the points of admission and discharge. The flow of inpatients affects the Emergency Department's ability to effectively manage patients. A systematic analysis of workflow, and its correlation with patient flow, is essential if successful outcomes are to be achieved.

Hospitals are continuing to improve processes to better manage the increasing demand for services. Such strategies include:

- regular discharge planning meetings
- more frequent ward rounds to identify the needs of patients requiring discharge in the near future
- improved links with community care services to ensure these services are in place when the patient is ready to leave hospital
- short stay transit units in some hospitals to care for Emergency Department patients, pending transfer to a ward bed
- extra bed capacity at designated hospitals for non-emergency patients to increase bed capacity at hospitals with major Emergency Departments
- analysis of patient flow processes.

NSW Health has facilitated several initiatives to reduce access block:

- The Access Block Continuous Quality Improvement project involves three metropolitan hospitals implementing local initiatives to improve access block. At Liverpool Hospital, weekend ward rounds, faster access to consultants and faster access to monitored beds are all being implemented. Prince of Wales Hospital is using ASETs (Aged Services Emergency Teams) to form linkages with community providers to ensure that admissions to hospital are appropriate. The adoption and transferability of the ASET model to outliers in the inpatient setting is also being examined. At Hornsby Hospital, a computerised Emergency Department Model has been developed to identify the points of care at which relatively small changes in practice can result in major gains in efficiency and patient flow.
- The Institute for Clinical Excellence is supporting a number of projects developing best practice with respect to patient flow, particularly for Emergency Department patients, to reduce the incidence of access block. These projects include:
  - the Towards a Safer Culture (TASC) project, involving twelve Health Services, which aims to improve clinical pathways for patients presenting to Emergency Departments with chest pain or stroke; and
  - the Patient Flow and Safety Collaborative, which aims to improve access to acute hospitals for patients throughout NSW, and reduce the rates of significant adverse events. The Collaborative will involve up to 36 teams from 16 Health Services across NSW working intensively together for 12 months.

A number of Health Services are analysing the patient's journey through the hospital.

The way forward

Longer-term strategies

There has been much excellent work done addressing various aspects of health service delivery, to improve patient flow and reduce access block. However, the factors which impact on patient flow, and hence access block, are too many and complex to permit simple solutions.

There are a number of well-documented methodologies for mapping and analysing the patient journey through hospital and community services. Health Services will select an appropriate methodology to describe and analyse work processes in inpatient, ambulatory and community services. Based on this analysis, administrative and clinical processes will be redesigned to manage patient flow more effectively. The outcomes of these strategies will be assessed on a monthly basis and modified, as required. The cycle of continual monitoring, analysis and work process modification will be an ongoing strategy.

The mapping and analysis of the patient journey, and of inpatient and community work practices, will provide a solid foundation for each Health Service to develop its Hospital and Community Capacity Management Strategy.

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