Innovation Alliances

Putting people first

Working together in preparation for peak activity periods (Winter 2016)

Metro North Hospital and Health Service *Putting people first*

New South Wales, Whole of Health MASTERCLASS #8

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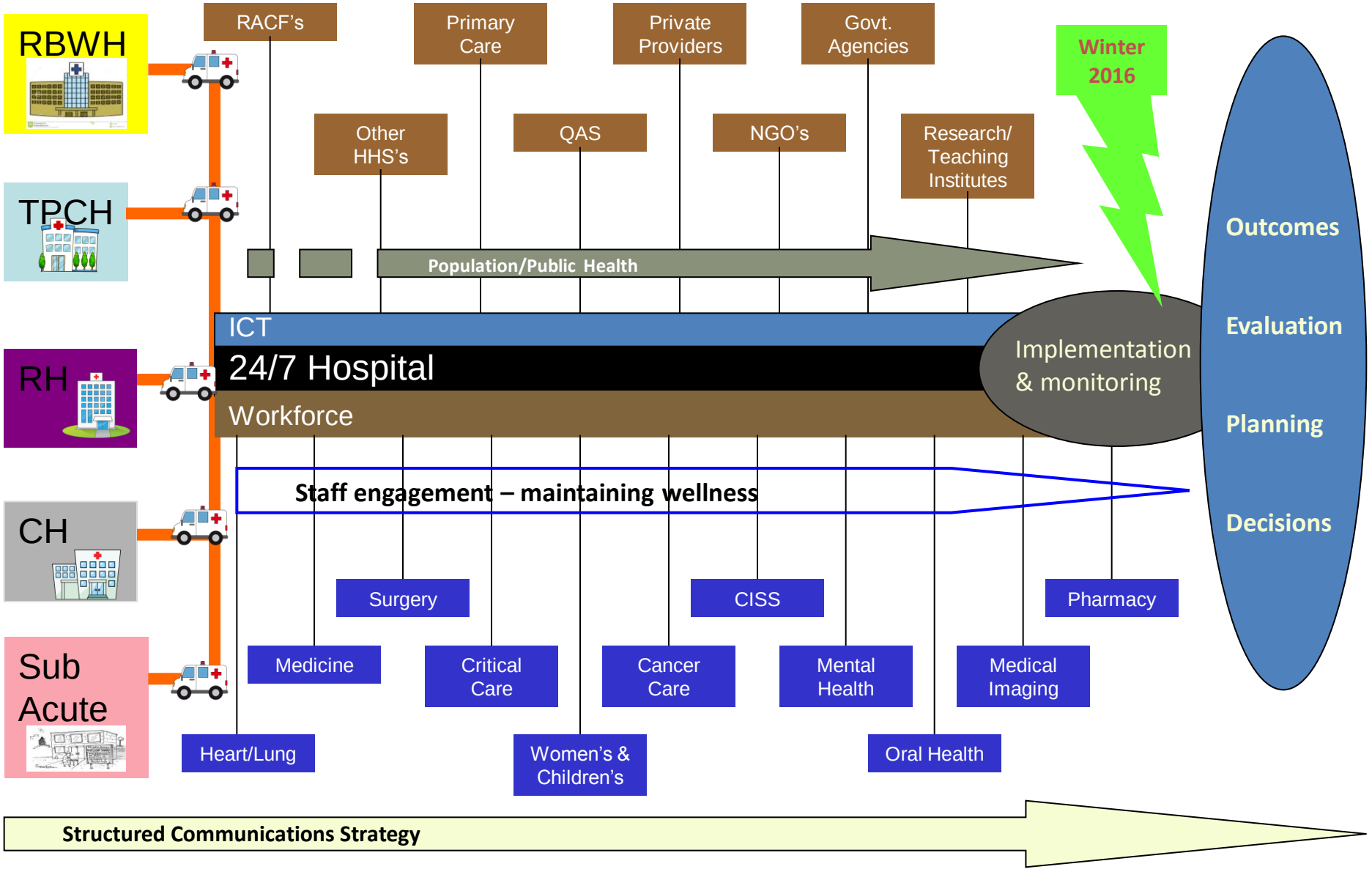
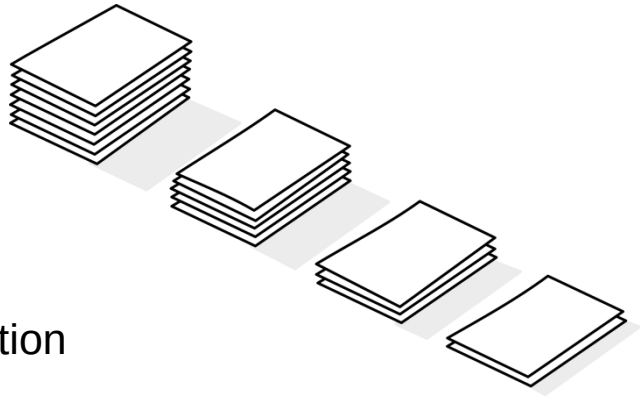
Putting people first:

Working together in preparation for peak activity periods (Winter 2016)



What have we received?



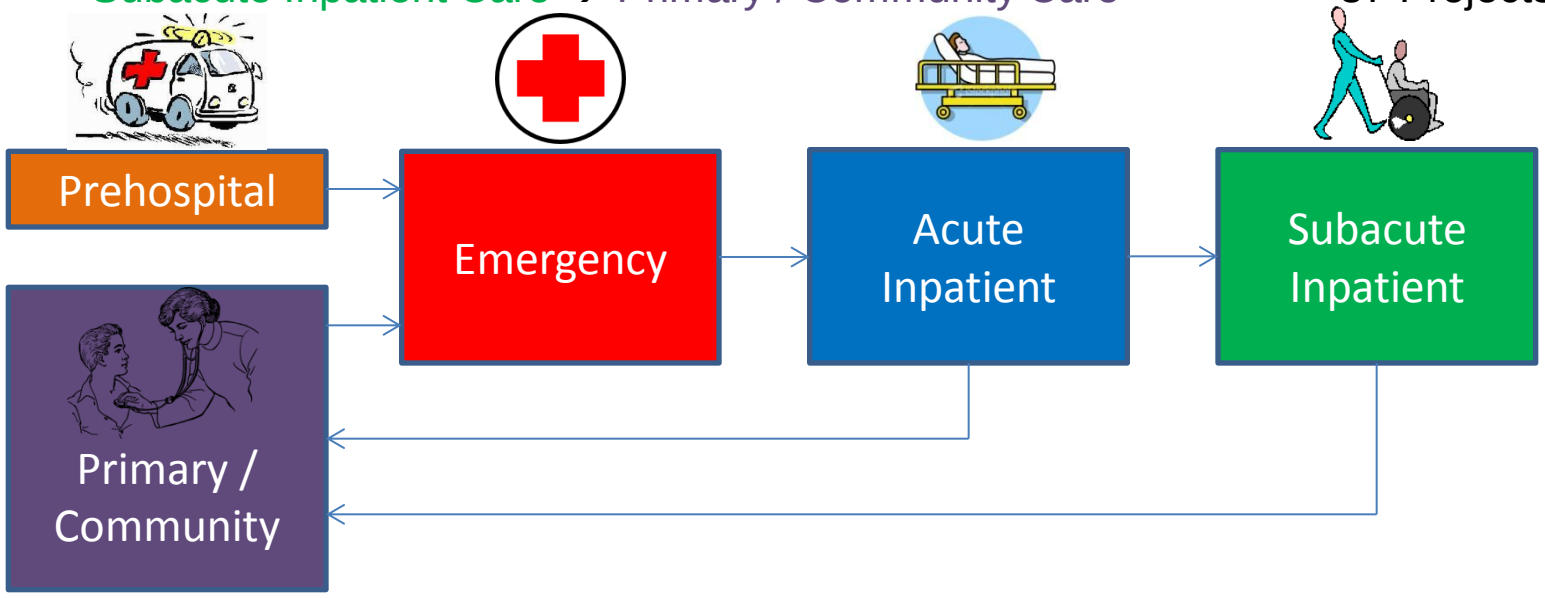
- More than 500 unique projects or initiatives
- Initial list filtered to focus on in-scope projects that will commence prior to Winter 2016
- A draft list of 328 projects circulated to all presentation participants in late December

- Following receipt of further projects, your feedback, and the exclusion of projects relating solely to other key project such as Operation Outpatient, a revised draft list of **268** projects will circulated by mid-February 2016.

What have we learned?

- Many existing projects are clustered around <u>handover points</u> in the patient journey:

Prehospital Care → Emergency Care	14 Projects
Primary / Community Care → Emergency Care	21 Projects
Emergency Care → Acute Inpatient Care	67 Projects
Acute Inpatient Care → Subacute Inpatient Care	48 Projects
Acute Inpatient Care → Primary / Community Care	98 Projects
Subacute Inpatient Care → Primary / Community Care	37 Projects



Any recurring themes?

- There is substantial diversity in the way we manage and measure our projects across the HHS
- Many projects take a facility-based approach, which has the potential to limit organisation-wide learning and HHS-wide patient flow improvement

- Pattern of project focus indicates that we know what we need to improve - but there is not always coordination between similar projects, even projects that are supposed to address the same problem

What questions will Innovation Alliances be answering?

As an organisation, we need to answer these questions:

As an Organisation:

1) What should we be measuring to ensure that we maintain patient flow during Winter 2016, and how should we measure it?

2) What are we already doing that aids patient flow and should be maintained or expanded during Winter 2016?

3) What additional projects or initiatives do we need to implement or fast-track ahead of Winter 2016?

- Alliances to consist of participants from all relevant facilities and professional streams, and from a variety of backgrounds
- Each Innovation Alliance will elect an Ambassador to represent the agreed outcomes of the Alliance
- Each Innovation Alliance will have a facilitator to guide discussion and support actions
- Attendance will be required at <u>five</u> meetings between now and Winter 2016:

Timelines and expectations

Alliance 1: Prepare & review

Alliance 2: Refine & define

Alliance 3: Refine & solution design

Alliance 4: KPIs

Mid Winter Spot Check

Post Winter 2016 Reflection

Strategy design for NEXT winter

Team working principles

1. **Interdisciplinary and Collaborative**

   Alliances should consist of a range of professional disciplines and work together toward achieving shared outcomes.

2. **Peer Support**

   Innovations Alliances are to work under a peer support approach whereby knowledge, experience, information and practical assistance is freely provided in support in the Winter 2016 Strategy. Peer support approaches are typically non-hierarchical, empathic, and non-directive in nature.

3. **Continuous Learning**

   Innovation alliance are to support continuous learning whereby lessons learned are fed back at a service, facility and whole-of-Metro North level

4. **Systems Approach**

   The Alliances are to consider the Metro North system wide opportunities and impacts on the projects and initiatives under consideration.

5. **Informed problem solving**

   To the greatest extent possible, Alliances are to share uniquely held information and data to support the range of projects and initiatives under consideration.

Looking for opportunity in the projet…

Target Outcomes

I. **Fast Tracking** – Innovation Alliances may influence the fast tracking of initiatives. The development and dispersal of innovations often takes time and the innovation alliances may find ways to accelerate these processes
II. **Quality improvement** – The multidisciplinary nature of the alliances may support quality improvement of innovations and initiatives across Metro North
III. **Test and/or Enhance Generalisability**- Discrete service initiatives related to improving hospital demand management may be very relevant to other service areas across Metro North. Innovation alliances will assist in testing or enhancing the applicability of initiatives across facilities and services within Metro North.
IV. **Dissemination** – Many high quality practices and innovations don't go beyond a service or facility within Metro North. The alliances (alongside the work of clinical networks and other established governance structures) will support the dispersal of service improvements across Metro North
V. **Facilitate Systemic Data Improvements -** *What's Measured, is what Matters*……. This adage is very true in healthcare whereby performance is often judged against headline indicators such as emergency department treatment rates. However, there is also a range of other performance data and indicators that are very relevant to assessing the performance status of Metro North, particularly in relation to hospital demand management. This is an area with great scope for improvement in Metro North and Innovation Alliances may assist in bringing forward and standardising performance data and indicators related to demand management.

The TEN Commandments – things we should achieve

1. Define the problem, review stories/data/evidence,
2. Identify Factors Influencing the Problem and map flow and rate limiting steps
3. Determine focus problem areas
4. Goals and Performance Indicators
5. Solutions? Identify solutions.
6. Shortlist of existing initiatives/projects to be connected to the Winter 2016 Strategy.
7. Implementation? Determine ways to support the solutions, selected initiatives and performance indicators
8. Advancing Performance measurement and monitoring
9. Governance and Scaling up changes
10. Outcomes and Lessons for Metro North

Problem and challenges

Waiting to go home

Hard to get home

Ward readiness

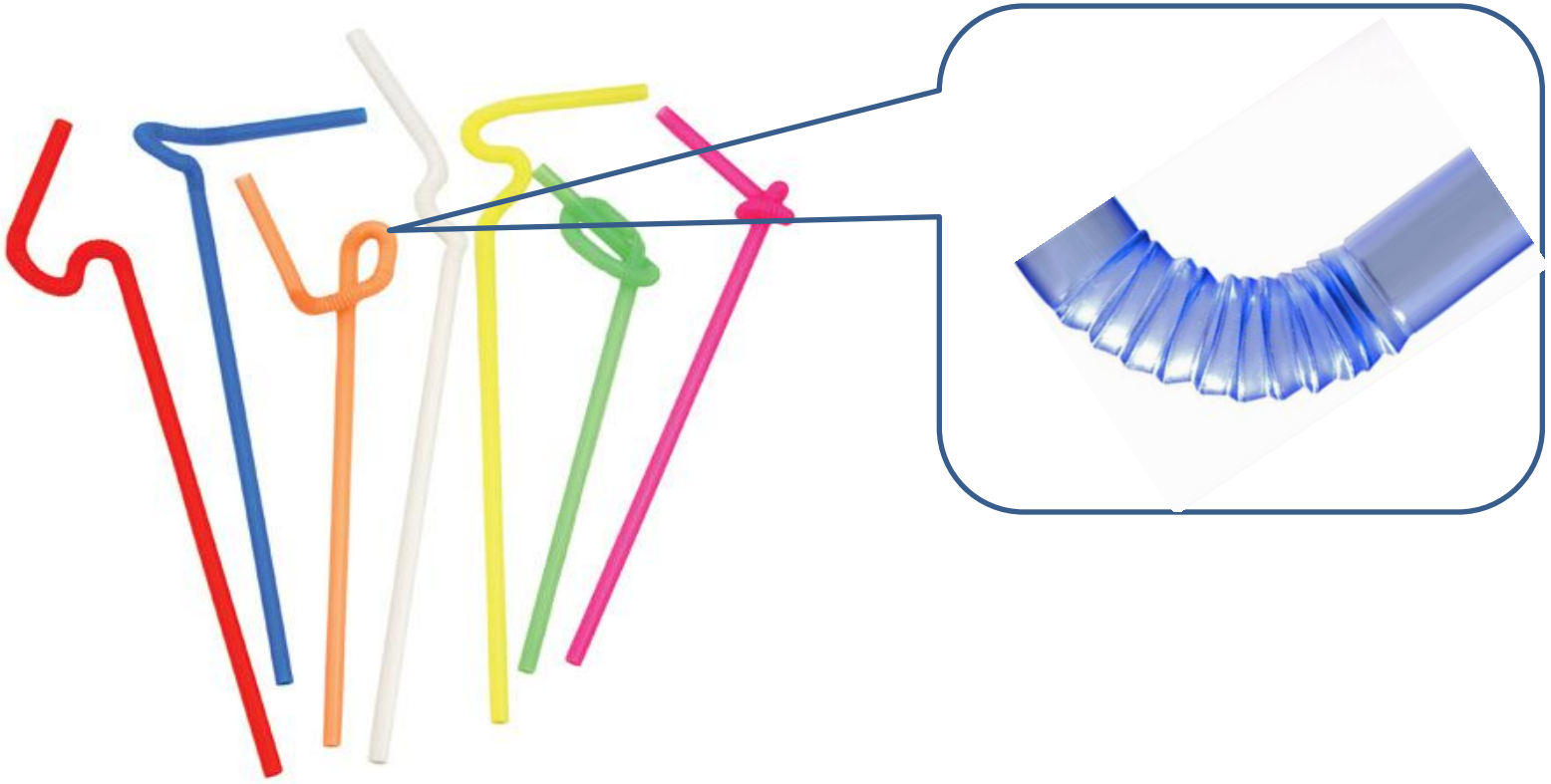
Access to SUB Acute and Rehab

More patients admitted

Community Care Access

The patients are sicker

Focus on this bit….




PreHospital Care to Emergency Care
Inter Hospital Transfers
Emergency Care to Acute Inpatient Care

QAS to ED Innovation Alliance:

PATIENT

- Sensory overload environment
- Lots of people, little dignity and care
- Can be very lonely. You are talked *about* but not *to.*

STAFF

- Language communicates despondence of all staff groups
- Lack of perceived control of own working environment
- All parties are the meat in the NEAT sandwich
- A slow QAS-ED transition causes an unhappy triad – patients, QAS and ED
- Perception that NEAT 'causes' the problem (reflection of system pressures not NEAT per se)
- Lack of understanding of what both QAS & ED can and can't do
- Perception of many enemies and little team work

LOGISTICS

- Perception of lack of consistency across MN
  - QAS distribution of work
  - Access to ED beds
- Story telling/handover too repetitive
  - Triage
  - Admin
  - CIN/RAT
  - Primary Nurse etc
  - Patient story told many many times

What DATA do we need to understand this Transition more?

FLOW

- Transition zone **Arrival to ED** until crew leaves patient (your TOC)
- Context of pressures:
  - Escalation data – QAS and MN
  - INFLOW (Arrivals)
  - OUTFLOW (capacity and occupancy of ED)
  - Clinical audit snapshot

RESOURCES

- Cost per hour for QAS crew

CARING

- Caring
  - Patient satisfaction of this transition zone
  - Staff and QAS crew views

ED to Acute Inpatient Innovation Alliance:

PATIENT

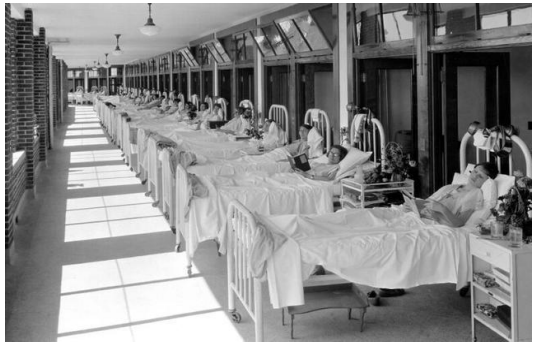
- Lack of effective communication regarding the plan
- Waiting exacerbates fear, insecurity and boredom
- Unable to see decision timeframes

SOCIAL ASPECTS OF CARE PLANNING

- It's a social admission

OR

- Lack of early social planning



MEDICAL REFERRAL

- Inconsistent structure and quality
- Lack of clarity (governance and orientation) around who decides/declines an admission
- Referral behaviours
- Delays due to Reg review occurring in ED

TRANSFER PROCESS

- Delays due to transfer staff availability
- Perception that flow management is passive (numbers) versus active (creating/enabling capacity)

PRE TRANSFER PROCESS

- Inconsistent meds charting practice
- No clarity around mandatory pre-transfer work
- Inconsistent MEWS/ADDs chart responsibility and adjustments
- Lack of process and monitoring for deterioration during transfer
- Medical and nursing handovers are separate processes in space and time

What DATA do we need to understand this Transition more?

FLOW

- Earliest point of referral until departs ED (LOS)

- Context
  - ED LOS
  - ED to inpt rates (excl SSU, incl HITH)
  - Inpt LOS
  - Explore suboptimal admissions

CARING

- How does the patient feel during this transition point?

OUTCOMES

- Readmission rates
- Hospital standardised mortality rates

RESOURCES

- Cost per WAU
- Staff costs – FTE per admitted day

Inter Hospital Transfer Innovation Alliance:

PATIENT

- No one owns the patient
- Ramping at receiving hospital
- Lack of understanding about the difference between hospitals
- Patient uncertainty, lack of planning, lack of involvement, delays to transfer
- Lack of information about receiving hospital
- Lack of inclusion of families in consent and planning transfers
- Anxiety about transfer
- Move to higher level care but it seems disorganised…

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STAFF

- Information incorrect or absent
- Rudeness and behaviour
- Lack of support at receiving hospital (including back transfer)
- Can't rely on any information – times, dates, patient details
- Expectations not met

LOGISTICS

- Protocols are written just not followed
- A lot of phone calls
- IHTs are hidden
- Bed Managers not include in discussion/acceptance of referrals
- Delegations and authority
- Lack of transparency of referral acceptance
- Cost of back transfers

What DATA do we need to understand this Transition more?

FLOW

- Transition zones
  - INFLOW
  - Times of referral at origin until arrival at ward destination
  - Mean LOS
  - OUTFLOW
  - Times of referral until arrival at destinaton or home or RACF

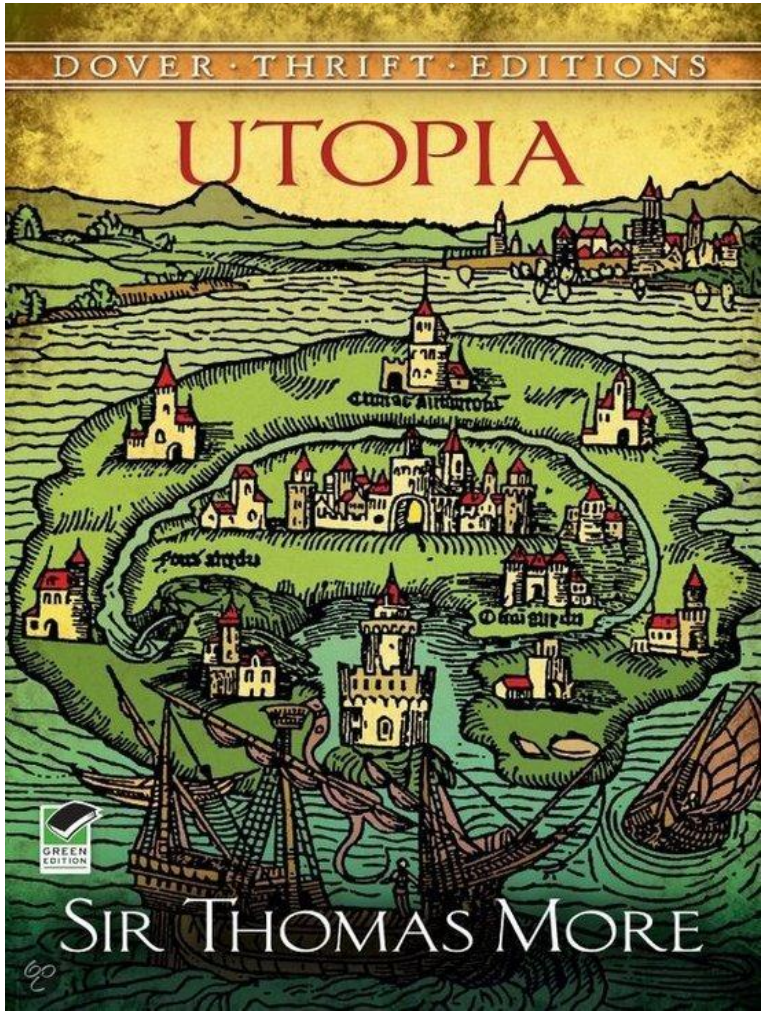
RESOURCES

- Acute ward Cost per day
- Staff cost per 24 hour period
- QAS cost per IHT & delays to offload

CARING

- How does the patient feel during all this?
- Impact stories

What next?


DOVER · THRIFT · EDITIONS
UTOPIA
GREEN EDITION
SIR THOMAS MORE


UTOPIA 8.535 km

- Alliance meetings 3,4,5
- Pick our Watch List
- Work hard
- Review and reflect
- Work together

- Set standards
- Improve
- Putting people first!!