Timely Quality Care
Innovation & Improvement across the patient journey

NSW Whole of Health Program Master Class #9
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Overview

• System wide transformational change program
• Strong clinical engagement, support and ownership at local level to imbed the model
• Continuous evolution and spread of model
Alfred Health

- 3 hospitals;
  - The Alfred
  - Sandringham
  - Caulfield Hospital (sub-acute)
- Approximately 900 beds; 100,000 ED presentations; 110,000 inpatient events; 170,000 outpatient attendances
- Approximately 5000 equivalent-full-time staff made up by around 8500 people
- State-wide services for trauma, burns, heart & lung transplants, HIV / AIDS, hyperbaric service, cystic fibrosis, haemophilia, Melbourne Sexual Health Centre
- $1.1 Billion per annum
Why TQC?

- Emergency Target
- Elective Target
- Financials
- Quality marker

But........It was HARD!
Hospitals are traditionally organized in vertical structures.

But patients make horizontal journeys through our organisations.
An opportunity to TRANSFORM our patient care....
THE 6 PRINCIPLES OF TIMELY QUALITY CARE

PRINCIPLE 1
Patients that present to the E&TC will be assessed, have treatment and investigations initiated and a management plan in place within 60 minutes of arrival.

PRINCIPLE 2
Patients will be discharged from E&TC or admitted to the hospital as decided by the E&TC consultant staff.

PRINCIPLE 3
Patients will be reviewed by the inpatient team within 2 hours of being referred for admission.

PRINCIPLE 4
Patients will be admitted to a bed in the most appropriate clinical place, the first time.

PRINCIPLE 5
Patients will have their investigations, consultations and interventions completed as soon as possible, in order of request and in no longer than 24 hours.

PRINCIPLE 6
Patients will be actively managed to ensure they are only in hospital for as long as is clinically necessary.
TQC Re-design Programs

- **Bed Management Redesign**: To ensure patients will be admitted to a bed in the most appropriate clinical place, the first time.
- **Radiology Redesign**: To ensure patients will be seen in turn in a timely way, irrespective of where they are in the hospital.
- **Subacute Redesign**: To ensure patients commence their subacute care as soon as clinically appropriate.
- **Surgical Stream Redesign**: To ensure the safe and timely management of the emergency surgical patient.
- **E&TC Redesign**: To ensure that on arrival, all patients will be seen without delay by a Consultant led interdisciplinary team who will initiate assessment, investigations & treatment.
- **Medical Stream Redesign**: To ensure the safe and timely management of the emergency medical patient.
- **Quality, Safety & Evaluation**: To monitor clinical indicators to ensure high quality, safe care and that change has been worthwhile and effective.
- **Hospital – After Hours**: To ensure the safe and timely management of patients in the after hours period.

TIMELY QUALITY CARE STEERING GROUP
The Journey

2012
- May 2012: Study tour to UK
- Aug-Sep 2012: Alfred model launch
- Nov 2012: TQC SG and WGs established

2013
- Feb 2013: Hospital @ Night model
- Jul 2013: Caulfield (RACC) model launch
- Aug 2013: Clinical carps
- Oct 2013: eBet

2014
- Jun 2014: Sandringham model launch
- Jul 2014: Principles of excellence in ward governance

2015
- Feb 2015: Seamless transfer - AH to CH
- Sep 2015: Ward rounding principles
- Now: Ward excellence initiatives

2016
- Next: eTQC
- Next: Outpatients
Key Projects

• Emergency Department model of care
• Bed profile remodelling
• After Hours model
Emergency Department Model of Care
Re-thinking ED Practices & Processes

Completely change triage
- Move from triage to streaming model

More timely care to reduce ED occupancy
- Upfront senior clinical decision making
- “Treat in turn” instead of “triage and wait

ED to use their authority to admit
- Reduce need for negotiation & delay

New team structures & treatment areas
- Clarity of Roles & Responsibilities
From Triage to Streaming

- Timely assessment (30 second maximum)
- ATS allocated (is it still relevant)
- Patients streamed to either:
  - Resus & Trauma:
  - RITZ:
    - Prioritise Cat 2 & AV to front of queue
    - Everyone else treat-in-turn
  - Fast Track:
    - Treat-in-turn
THE 6 PRINCIPLES OF TIMELY QUALITY CARE

PRINCIPLE 1
Patients that present to the E&T C will be assessed, have treatment and investigations initiated and a management plan in place within 60 minutes of arrival.

PRINCIPLE 2
Patients will be discharged from E&T C or admitted to the hospital as decided by the E&T C consultant staff.

PRINCIPLE 3
Patients will be reviewed by the inpatient team within 2 hours of being referred for admission.

PRINCIPLE 4
Patients will be admitted to a bed in the most appropriate clinical place, the first time.

PRINCIPLE 5
Patients will have their investigations, consultations and interventions completed as soon as possible, in order of request and in no longer than 24 hours.

PRINCIPLE 6
Patients will be actively managed to ensure they are only in hospital for as long as is clinically necessary.
# General Surgery Initial Investigations Checklist

Investigations commenced/completed prior to ward transfer from E&TC
E&TC will order investigations based on the co morbidities of the individual patient
All orders must be accompanied with clinical information justifying the request

<table>
<thead>
<tr>
<th>E&amp;TC Diagnosis</th>
<th>FBE</th>
<th>U&amp;E</th>
<th>Glu</th>
<th>LFT</th>
<th>INR/APTT</th>
<th>G&amp;S</th>
<th>Ca, Mg, PO4</th>
<th>ABG</th>
<th>CXR</th>
<th>AXR</th>
<th>CT</th>
<th>US</th>
<th>MRI</th>
<th>OTHER / TREATMENT</th>
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<tbody>
<tr>
<td>1. Appendicitis</td>
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<td>2. Abdominal Pain Fl</td>
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<td>3. Bowel Obstruction</td>
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<td>4. Biliary Colic Acute Cholecystitis</td>
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<td>✓</td>
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<td>✓</td>
<td>If imaging required then non-contrast CT first line (not AXR)</td>
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<td>5. Strangulated Hernia</td>
<td>✓</td>
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<td>6. Abscess/ Haematoma</td>
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<td>7. Acute Pancreatitis</td>
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<td>✓</td>
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<td>✓</td>
<td>LDH, AST</td>
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<td>8. Laparotomy (inc TRMA)</td>
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**KEY:** ✓ = order unless contraindication (document contraindication where applicable); +/- = order if clinically indicated; (blank) = not routinely required for this presentation

Please refer to Appendix 1.3 for a complete listing of clinical abbreviations.
E&TC Admission Process

Decision to admit
- Interns & Residents must discuss all patients requiring admission with the E&TC Consultant (Reg overnight) regarding:
  - Decision to admit
  - Choice of unit
  - Interim orders
  - Actions that need to be completed prior to transfer

Admission phone call
- Hi thanks for calling back.
- I'm ................ one of the Emergency ..................
- I've got a patient who needs admission under ...............unit, with ..................
- Clinical information – ISBAR format
  - Treatment initiated
  - Pending investigations and results
- Patient will be transferred to ward bed once available if clinically safe

Interim orders
- Complete E&TC Medical Record
- Document inpatient unit plan
- Complete interim orders
- Commence medication record

Escalation
- Remind that decision rests with E&TC Consultant
- Inpatient unit may refer on to another unit if they wish
- Inform that further escalation will occur to
  - E&TC and Inpatient Consultants
  - E&TC Director
  - Hospital Executive

If resistance from inpatient unit

Part of Alfred Health
Roles & Responsibilities

E&TC Team Structure

- Reception
  - Streaming Nurse
  - Ward clerk

- RITZ
  - Consultant RMTL
  - Registrar
  - HMO
  - Nurse Prac
  - MSK Physio

- Resus & Trauma
  - Resus and Trauma Consultant
  - Resus and Trauma Registrar

- Cubicles
  - Cubicles Consultant
  - Cubicles Registrar
  - Cubicles Intern 1
  - Cubicles Intern 2

- Fast Track
  - Consultant RMTL
  - MSK Physio
  - Nurse Prac
  - Nurse

- ESSU
  - Nurse ESSU Team Leader
  - Nurse ESSU
  - Nurse ESSU

- Flight Deck
  - BAT Phone
  - Ward clerk

- Codes
  - Spotless 2

- Pharmacy
  - Allied Health
Bed Profile Re-modelling

- **Unit utilisation review**
  - Reallocation of home unit wards
  - Ward re-profiling (reduction of multi-day beds)
  - Re-distribution of Nursing EFT
  - Separation of emergency & elective streams
  - Medical workforce roster re-profiling

- **Admission bed concept**
  - <100% occupied hospital
  - Matching capacity to demand at peak flow periods
  - Flow on the day

- ‘**Flex’** bed concept
After Hours Model

Limited measurement, poor knowledge

REPORTS on Medical Nightly Activity

Risk

Isolated
Failure to escalate
24/7.

Lonely ...
Unsupported & Unsupervised

NO
Feedback
Training
Supervision

Inequitable workload

Emergency admissions stay in ED until the morning
“it can wait until the day team”

Mindset: Maintain Care
The Challenge

Working as individuals

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<th></th>
<th>Day</th>
<th>evening</th>
<th>Night</th>
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<td>Medical</td>
<td>170</td>
<td>14</td>
<td>9</td>
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<tr>
<td>Nursing</td>
<td>129</td>
<td>114</td>
<td>74</td>
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Part of AlfredHealth
How it Works

- Nursing staff issue clinical task requests from ward computers
- Every member of the Night Team carries a mobile device to track their allocated tasks
- All members of the team can see all the work
- The Clinical Lead has the ability to reallocate work according to demand

Identification
- Patient Name
- Patient DOB
- Patient UR

Situation/Background
- Care Option
- Comments
- Clinical Priority

Assessment/Recommendation
- Ward
- Unit
- Role
- Contact Number

Patient Needs Care!
Monitoring

- Daily CEO Dashboard
- Daily & weekly TQC Reporting
- Weekly TQC Steering committee
  - Engagement of clinicians
  - Interdisciplinary
  - Strategic and day-to-day
  - Sustainability
  - Whole of organisation
## Monitoring – Weekly Data Set

### Hospital Wide Indicators

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<tr>
<th>Indicator</th>
<th>14-Nov</th>
<th>21-Nov</th>
<th>11</th>
<th>12</th>
<th>01</th>
<th>02</th>
<th>03</th>
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<th>Median</th>
<th>Min</th>
<th>Max</th>
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<td>1. E&amp;T C Presentations</td>
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<td>1219</td>
<td>1095</td>
<td>1461</td>
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<tr>
<td>2. % E&amp;T C Patients &lt;= 4 Hours (81%)</td>
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<td>79%</td>
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<td>77%</td>
<td>68%</td>
<td>87%</td>
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<td>3. % E&amp;T C Patients Non-Admit &lt;= 4 Hours (95%)</td>
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<td>92%</td>
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<td>92%</td>
<td>84%</td>
<td>97%</td>
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<tr>
<td>4. % E&amp;T C Patients Admitted &lt;= 4 Hours (70%)</td>
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<td>68%</td>
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<td>67%</td>
<td>50%</td>
<td>80%</td>
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<tr>
<td>5. % E&amp;T C Patients Admitted &lt;= 4 Hours (Excl. ESSU)</td>
<td>37%</td>
<td>40%</td>
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<td>38%</td>
<td>14%</td>
<td>62%</td>
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<tr>
<td>6. % ED Patients Admitted to ESSU &lt;= 4 Hours</td>
<td>96%</td>
<td>91%</td>
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<td>93%</td>
<td>88%</td>
<td>98%</td>
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<tr>
<td>7. % E&amp;T C Patients Admitted</td>
<td>59%</td>
<td>53%</td>
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<td>59%</td>
<td>53%</td>
<td>64%</td>
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<tr>
<td>8. % of E&amp;T C Patients Did Not Wait</td>
<td>26%</td>
<td>24%</td>
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<td>27%</td>
<td>24%</td>
<td>31%</td>
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<tr>
<td>9. % Urgent E&amp;T C Representation &lt; 24 hrs post E&amp;T C Discharge</td>
<td>1.3%</td>
<td>1.0%</td>
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<td>1.0%</td>
<td>0.4%</td>
<td>2.1%</td>
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<tr>
<td>10. % E&amp;T C Patients Seen Within Time (80%)</td>
<td>83%</td>
<td>74%</td>
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<td></td>
<td>74%</td>
<td>63%</td>
<td>86%</td>
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<tr>
<td>11. # E&amp;T C Patients Admitted to Ward (9pm to 7am)</td>
<td>93</td>
<td>95</td>
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<td>92</td>
<td>58</td>
<td>115</td>
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<tr>
<td>12. Deaths per 1000 Separations</td>
<td>7.0</td>
<td>11</td>
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<td>8.3</td>
<td>3.3</td>
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<tr>
<td>13. % Multiday Discharges Readmitted via E&amp;T C &lt; 36 Days</td>
<td>14%</td>
<td>12%</td>
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<td>11%</td>
<td>8.8%</td>
<td>16%</td>
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<td>14. Number of Unit Transfers</td>
<td>30</td>
<td>50</td>
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<td>61</td>
<td>30</td>
<td>95</td>
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<tr>
<td>15. Number of E&amp;T C Admissions Discharged &lt; 24 hrs</td>
<td>368</td>
<td>347</td>
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<td>322</td>
<td>223</td>
<td>398</td>
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<td>16. Number of E&amp;T C Admissions Discharged &lt; 24 hrs Excl ESSU</td>
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<td>31</td>
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<td>28</td>
<td>15</td>
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<td>17. Average Multiday LOS (Emergency Type Patients)</td>
<td>6.0</td>
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<td>6.3</td>
<td>5.2</td>
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Monitoring - Move to whole of organisation

Summary
A significant increase in ED presentations across both AH and SH as a result of Mondays 'thunderstorm asthma' event. Over the Monday & Tuesday an additional 200 patients were seen, however, a majority were in the non-admitted stream, with approximately only 10 patients requiring admission.

Most admission beds were 'filled' at the Alfred on Monday and Tuesday, resulting in another week of high occupied multi-day beds. Although ICU admissions were well below median for the week, the acuity resulted in a reduced number of patients suitable for ward transfer on a daily basis, with ICU running above profile from Monday through to Saturday. There were also some changes to the elective program on Friday due to ICU capacity.

General medicine admissions were constant through the week, with a total of 111 admissions.

Long stay numbers spiked towards the end of the week and continue to remain high with particular focus required on the >15 and >31 day LOS patients.

The changes to the bed profile, as discussed last week, were commenced last Wednesday and a data set to monitor performance of these beds on a daily and weekly basis has been established.

Sandringham had excellent in-patient capacity from Wednesday onwards. Discharges were consistent on a day to day basis, well over the normal and with up to 20 vacant beds at times, beds were flexed down on a shift by shift basis. Short stay utilisation remains efficient with 149 admissions.

 Caulfield data is inconsistent, with CPU following up. Total discharges across all programs were above average and resulted in excellent access to sub-acute.

The aged care re-admissions jumped last week and is currently be looked at in more detail.
# Evaluation

## Timely Quality Care — Evaluation Framework

**OBJECTIVE:** For all patients to receive timely, high quality care consistent with their clinical needs

### EQUITY / ACCESS
- Time to be seen in ED
- Patients in ED that ‘did not wait’
- Ambulance turnaround times and arrivals
- ED Occupancy
- % of elective patients seen within time by category
- Hospital initiated postponements of elective surgery

### EFFECTIVENESS

#### QUALITY
- Patient satisfaction / experience
- % of patients seen by ED consultant led team within 60 mins
- Time from arrival in ED to management plan documented
- % of patients admitted or discharged from ED within 4hrs of arrival to ED
- % of patients seen by inpatient unit within 2hrs of admission to ward
- % of outliers
- Number of patient transfers between units
- Number of ED patients discharged within 24hrs of admission
- % of radiological investigations conducted within 24hrs of referrals
- % of procedures conducted within 24hrs of referral
- % of operations conducted within 24hrs of referral
- % of consultations conducted within 24hrs of referral
- Wait time for transfer from Alfred to Caulfield

#### SAFETY
- MET calls
- Hospital Standardised Mortality Ratio
- Deaths per 1000 separations
- Unplanned hospital readmissions
- Unplanned urgent ED representations
- Unplanned transfers from sub-acute to acute
- % of ambulance handover within 40 mins

### EFFICIENCY
- Number of ED presentations
- Number of admissions (program area and service)
- Number of discharges (weekday and weekend)
- Number of elective surgeries
- Length of stay (average, long stay (>7, >15, >31 days), by program area and service)
- Relative stay index
- Bed occupancy
- Number of investigations
- Number of patient transfers between sites (incl. direct transfers)
- Short stay unit usage (number, percentage and LOS)
- Number of ambulance presentations
- Use of Urgent Care Centre (Sandringham)

### ORGANISATIONAL LEARNINGS
- Staff satisfaction
- Patient outcome and quality metrics
Quality – MET Calls

Alfred Health MET/Code Call Activations

MET/Code Calls per 1000 Admissions
Quality - Cardiac Arrest

Afred Health Cardiac Arrest

Cardiac Arrest per 1000 Admisions

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<td>Value</td>
<td>1.59</td>
<td>1.40</td>
<td>1.48</td>
<td>1.24</td>
<td>1.27</td>
<td>1.08</td>
<td>1.19</td>
<td>1.09</td>
<td>1.07</td>
<td>1.14</td>
<td>1.08</td>
<td>1.06</td>
<td>0.71</td>
<td>0.59</td>
<td>0.59</td>
</tr>
</tbody>
</table>
Quality – HSMR (Health round table)

1.1 - Hospital Diagnosis Standardised Mortality Ratio (HDxSMR)

- Best performing quartile
- Worst performing quartile
- Focus Hospital

Graph showing trends from Oct-Dec 2012 to Jul-Sep 2016.
NEAT

% E&TC Patients within 4 hours
The Alfred 1 Jul 2011 - 30 Jun 2016

- Open Cardiac Access
- Capped physical capacity
- Increased elective target

Part of AlfredHealth
Non-Admit Stream

% E&TC NonAdmits < 4hrs
The Alfred 1 Jul 2011 - 30 Jun 2016

- Actual
- Median
- Lower Control
- Upper Control
Admit Stream (after hours)

% E&TC Admits within 4 hours between 21:00-08:00 excl. ESSU
The Alfred 1 Jul 2011 - 30 Jun 2016

% in 4 hours

- Actual
- Median
- Lower Control
- Upper Control
Patient ‘Did Not Waits’

% of Patients that did not wait
The Alfred 1 Jul 2011 - 30 Jun 2016
Key Learnings

• ‘Whole of Hospital’ to ‘Whole of Organisation’
• Clinician Engagement and ownership of change
  o Acceptance of need to change/reform
• Emphasis on quality of care – ‘focus on the patient’
• Mindset from ‘maintenance’ to ‘progression’ of care
• System must be able to rapidly respond
• Design over resources
With Hindsight

- Ward leadership teams
  - Ward governance principles (shared responsibility)
- Capability training
  - The ‘field’ versus the ‘boardroom’
- Evaluation against the principles

Our Challenges

- Winter
- On-boarding
- Continuous improvement
Optimal
Duress, delays
Compromised care, staff stress
Inefficient utilisation
Unsustainable

ADMISSIONS
- Community
  - *New patients
  - Existing patients
- *Readmissions
- Transfers
  - Within Alfred Health
  - *From other hospitals

DETERMINANTS
- Patient Factors
- Processes of care
  - *Quality waste
  - *Efficiency waste
- *Business decisions

TRANSFERS OF CARE
- Community
  - Home +/- services or HITH/Gem@home/MATS/HARPcomplex care
  - Supported accommodation
  - Nursing home
- Other hospital
  - Caulfield aged care and rehabilitation
  - External
  - Hospice
- Deceased

Seeing flow as a funnel

*modifiable factors
How hard are we working (really)?

Are the answers to these two questions the same?
1. Are we working at the upper end of our sustainable work rate?
2. Are we improving our work processes and environment as quickly as we could be?

3rd & 4th question
3. What relative proportion of our total investment/energy is occurring in 1 vs 2 above?
4. What is our role as leaders in influencing this balance?
Improved Care Processes

- Better resource utilisation
- Greater case throughput
- Stronger financial position

Better patient experience and outcomes
- Less quality and efficiency waste
- Engaged staff
- Attract and retain the best staff

Raring to go

Business viewpoint

Clinical staff viewpoint
(Most) Waiting is Waste

Waiting

• For assessment process to commence (to be seen)
• For a decision regarding
  • Diagnosis
  • Prognosis
  • Treatment plan
• For an investigation to be
  • Performed
  • Reported
  • Interpreted in context of that patient
• For a procedure to be performed
• To assess response to treatment/recovery
<table>
<thead>
<tr>
<th>Waiting Type</th>
<th>Factors influencing the wait duration</th>
<th>Patient consequences</th>
<th>Staff consequences</th>
<th>Organisational consequence</th>
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</thead>
<tbody>
<tr>
<td>Waiting for assessment</td>
<td>Process/staff factors</td>
<td>Anxiety/Disease Progression/Deterioration</td>
<td>Stress</td>
<td>$$ quality waste</td>
</tr>
<tr>
<td>Waiting for investigation or response to referral</td>
<td>Process/staff factors</td>
<td>Anxiety/Disease Progression/Deterioration</td>
<td>Frustration/loss of control of process</td>
<td>$$ quality and efficiency waste</td>
</tr>
<tr>
<td>Waiting for decision</td>
<td>Process/staff factors</td>
<td>Anxiety/Disease Progression/Deterioration</td>
<td>Stress</td>
<td>$$$ quality and efficiency waste</td>
</tr>
<tr>
<td>Waiting for response to Rx/recovery</td>
<td>Patient factors/process factors</td>
<td>Anxiety, necessary step</td>
<td>Necessary step, what we are here for</td>
<td>Necessary step</td>
</tr>
<tr>
<td>Waiting for transport</td>
<td>Patient/process/family factors</td>
<td>Frustration</td>
<td>Frustration</td>
<td>$ efficiency waste</td>
</tr>
</tbody>
</table>
The challenge

• What does the funnel look like in your space?
• Where are the modifiable waits?
  • Rate limiting steps and their root causes
• What is required to address the waits so that we stay in the green zone as much as possible?
  • What data do you need?
  • Show us a business case.
Conclusion

• For patient care and clinical staff to thrive (and for the benefit of the organisation) there is no alternative other than to continuously improve the care we provide.

• There is an imperative to ensure that the processes involved in our business decisions is continuously improved.