Campbelltown Hospital

The Art and Science of Transformational Change

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Relevant Background

- Commenced with WoHP Program October 2013
- Completed WoHP diagnostics at same time (WAISH, Latent Capacity etc)
- Initial focus – Patient Journey Boards, Patient Flow & Discharge Transit Unit
- Concurrent – $129 Million redevelopment / refurbishment

Where were we starting from - Demand?

- 2 ED's admitting to one hospital (2014)
  - Campbelltown **58,836** ED Presentations
  - Camden **12,775** ED Presentations
  - Total of **71,611** ~ Adm Rate of **32%** 2014 (no ESSU)
- Discharges required (ED Accessible) per day 70+. Acute **ED Accessible Bed base = 274 beds**
- 2013/14 Average Daily 0800hrs queue = **21 adult** pts waiting for a bed from day before (with 2-3 days per week >25). **Clinical spaces in the ED = 32**.

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Where were we starting from – relevant KPI's 2013/14?

- Transfer of Care (TOC) 2013/14? **69%**
- Number of weeks we met TOC Target of >90% in 2013? **1 week out of 52**
- NEAT as at December 2013? **59%**
- No of Patients spending >24hrs in our ED's 2013:

2020

NOT AN ACCEPTABLE STATE FOR OUR COMMUNITY

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Transformation at Campbelltown

- *Transformational change* was a pillar for the strategy development and change initiatives
- *Executive ownership* and vision for “Safe and Timely Access to High Quality Care at Campbelltown”
- *Cultural Change* – an avalanche that was unavoidable if we wanted to deliver our vision
- Accountability, governance, capability building & transparency
- Managing our workforce variation
- *Operationalising our vision*
- *Busting* traditional silo’s

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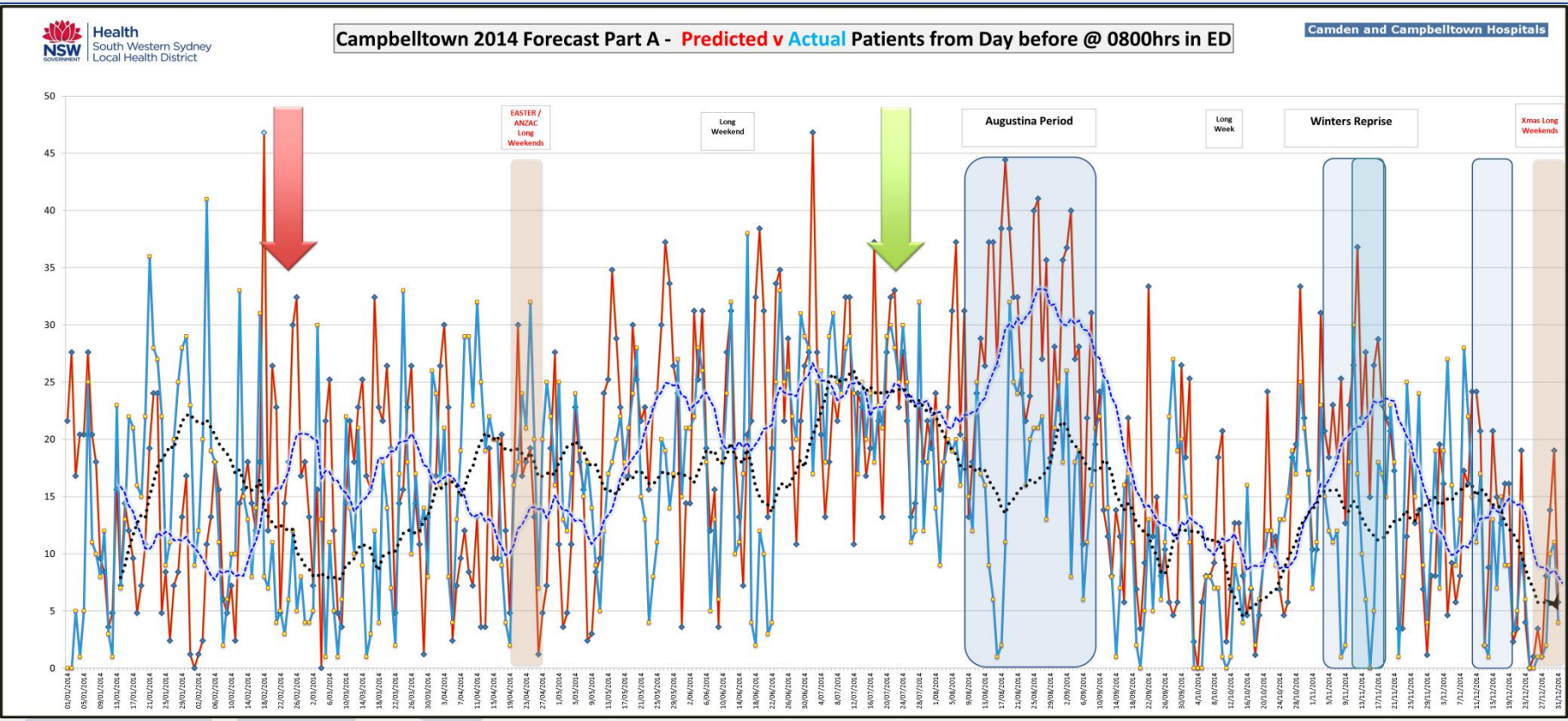
Forecasting (a storm)



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So we knew what lay ahead – next steps?

- Developed and implemented multiple strategies targeting both the ED Journey and Back of House
- Absolute trust & understanding of our key metrics– knowing our business at depth where we were able to ‘see’ things tipping over that day and action ‘same day’ and normalising this approach

2 Examples of targeted strategies at Campbelltown:

- **Back of House Navigation**
- **RAAA (Rapid Ambulance Assessment Area)**

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Back of House Navigation

- **Key principles**
  - Rounding – targeting PJB's. Asking the following:

    "Are they safe to sleep in their own beds tonight?"……..

    1. **Going**….Discharge Transit Unit
    2. **Should Go**….document the plan and who is responsible
    3. **Could Go IF**….this was the focus on Back of House Navigator
  - Escalating and never failing to follow-up and through (Accountability)
  - Senior Management led – ability to make effective decisions
  - Partnering operationally with Community Nursing, Aged Care and Chronic Care
  - Building Capability

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Rapid Ambulance Assessment Area & Who Owns our RED?

- Zero tolerance of keeping an ambulance away from our community – clear mantra across organisation
- Created offload area in the ED but would not be owned by ED
- Back of House responsible for offload area – commenced with an additional nursing resource however now only on days of forecast increased demand
- Focus was on changing the conversation concerning ambulances – escalation and definitive action at the moment of any delay
- Major cultural shift in the ED

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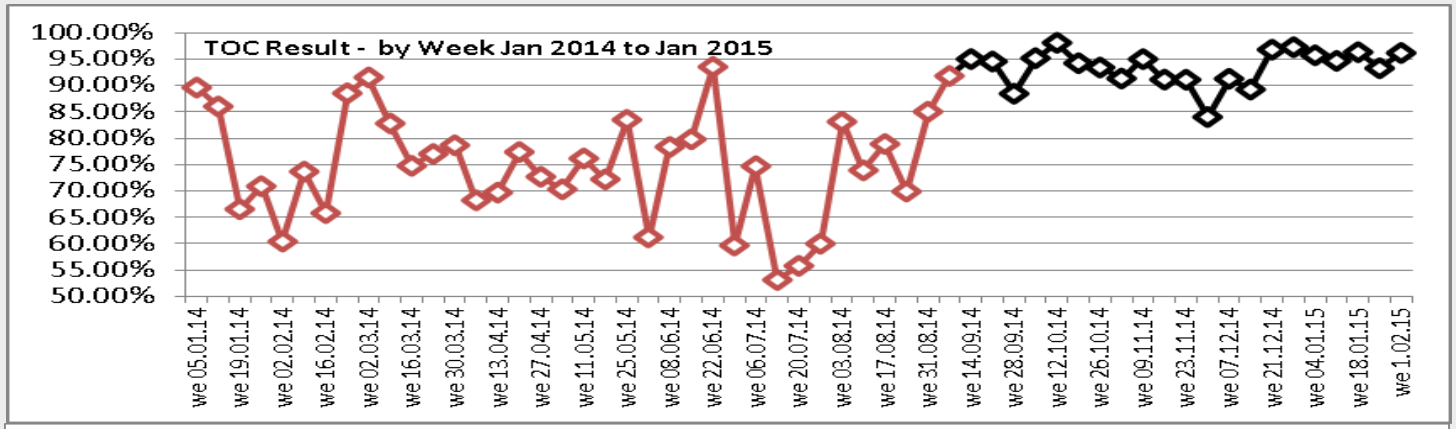
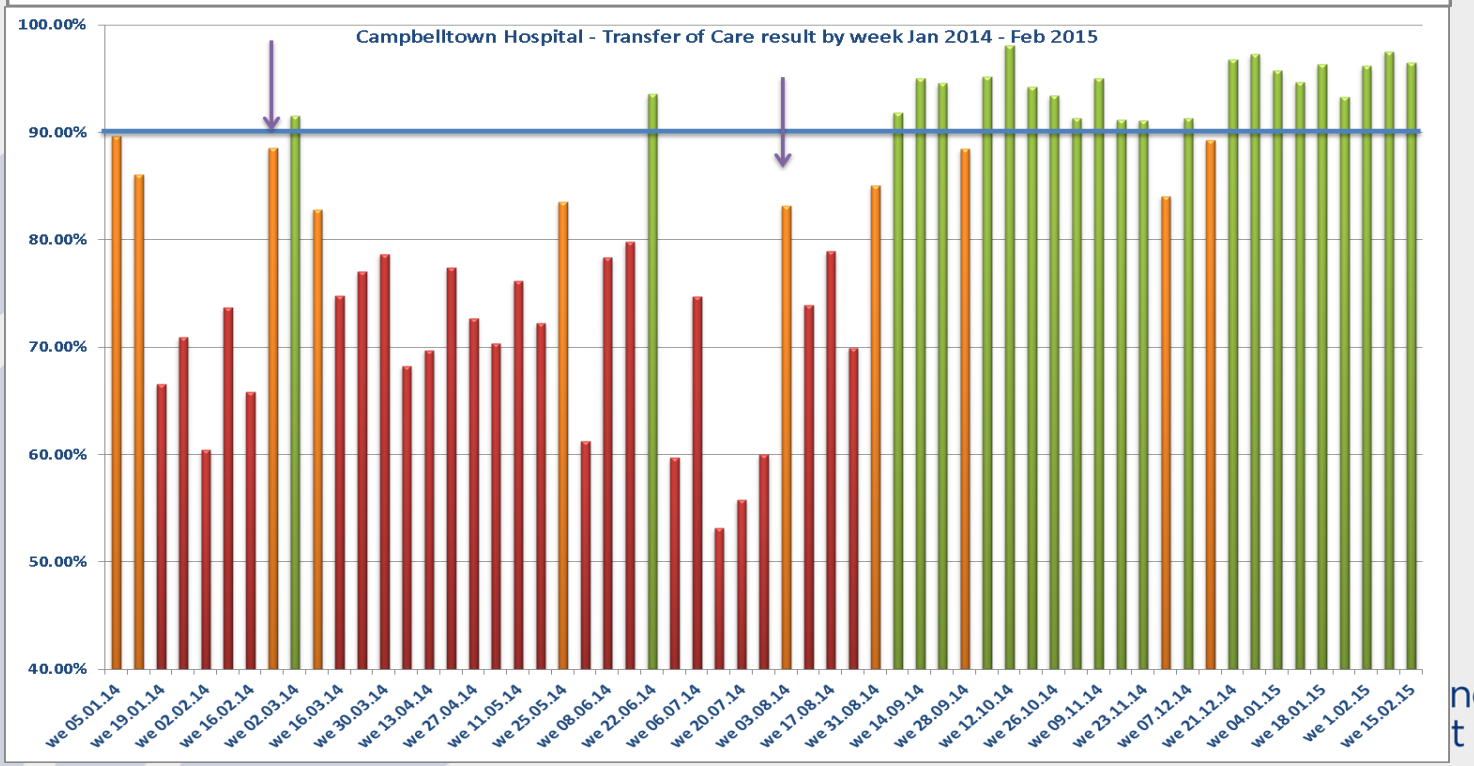
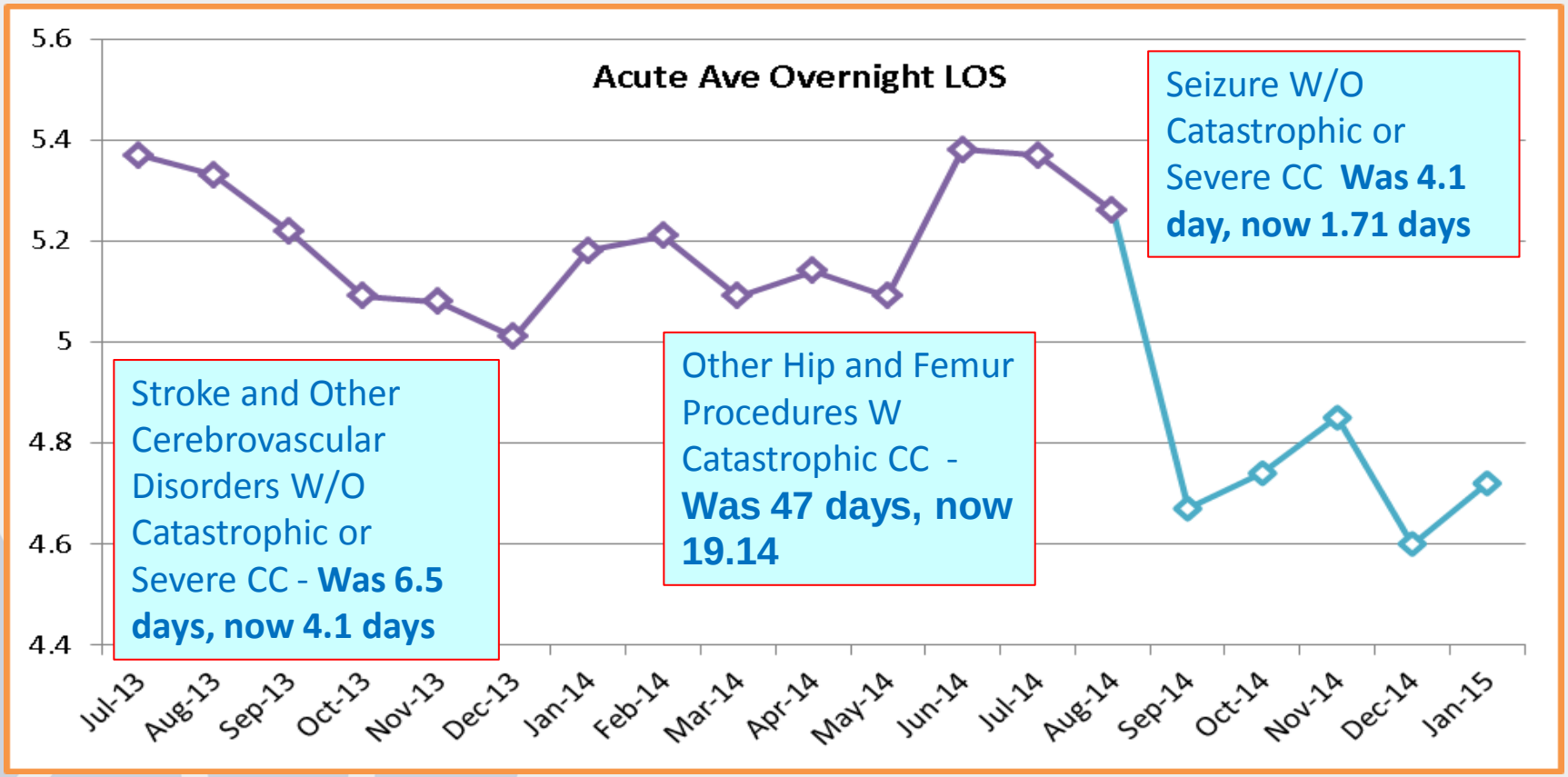
Performance – Transfer of Care





Performance – Length of Stay



Estimated Acute Overnight Bed Days saved since September 2014:

5000 bed days

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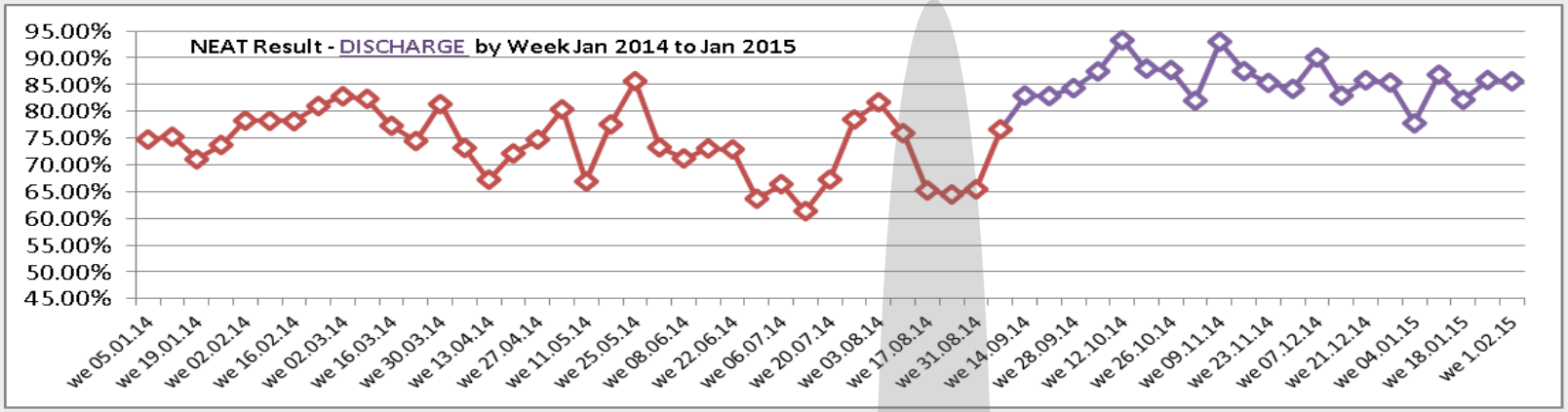
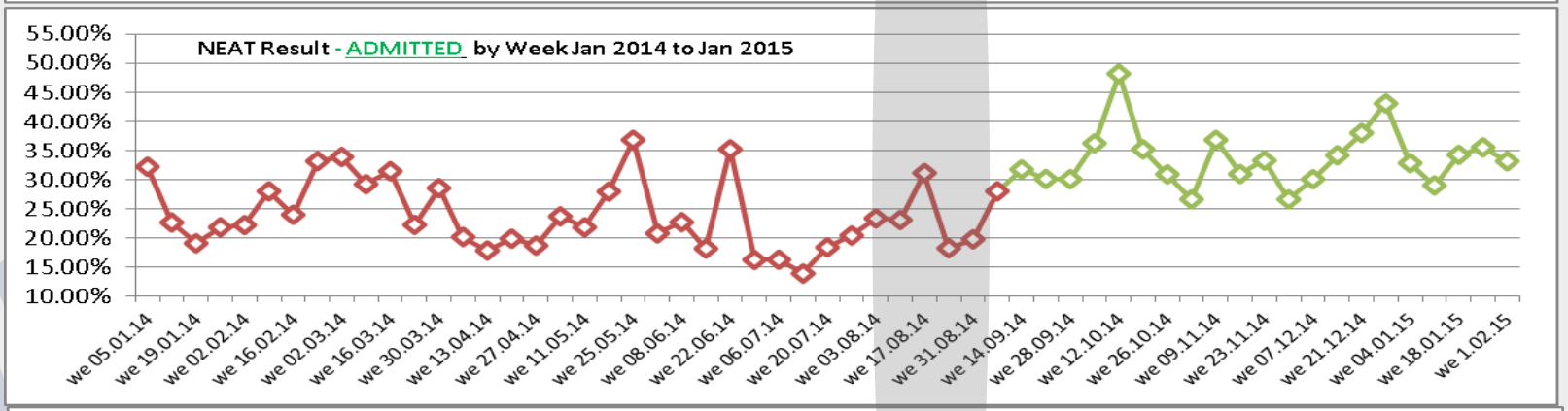
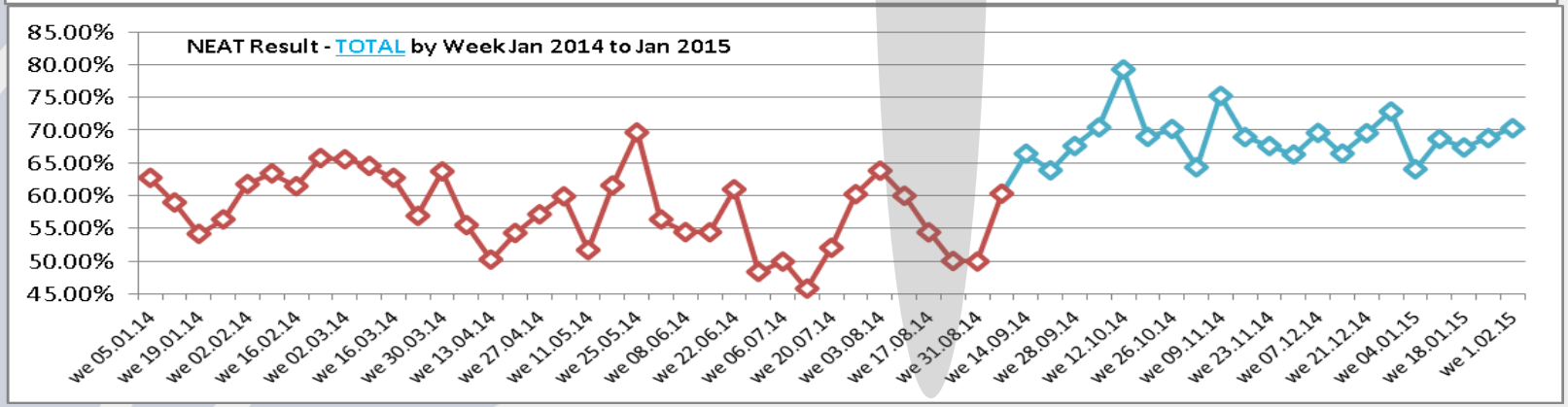
Performance – NEAT







The End of our Beginning…where are we starting from *now*?

- Transfer of Care 2013/14? **69%** Last 6mths: **93%**
- Number of weeks we met TOC Target?

  in 2013: **1 week out of 52**

  Last 6mths: **22 weeks out of 26**
- NEAT as at December 2013? **59%** Last 6mths: **69%**
- No of Patients spending >24hrs in our ED's same 6mth period 2013: **804** Last 6mths: **247**

Still not an acceptable result for our community

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Where to from here

- New Models of Care, ***then*** new beds & **ESSU** to open in mid 2015
- Inter-professional Leadership Frameworks
- Role of our Community Supports – blurring the line between hospital based care and community based models
- Targeting DRG LOS, Readmissions & Representations
- Criterion led discharge and SIBR
- Peer average LOS to drive estimated day of discharge with care pathways developed for each DRG

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