Unblocking patient flow

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Big trends

There are 40% fewer acute beds than in 2001 but:

- 97% more activity in medical specialties
- LOS has halved

>>> System is fragile

Huge skew in the distribution. In medical specialties:

- 28% of patients stay > 6 days
- Consume 70% of the bed days

>>> Averages are not helpful
Overall approach

Stabilise the system before trying to change it

Equip staff with a method for studying and fixing underlying problems & the time to do this

Don’t just optimise the boxes – look at the connections too
Demand

Measure and anticipate demand

Turn some activity into scheduled work rather than purely responsive

Hot clinics / Booked slots

Smooth the flow of GP urgent cases
Initial decision making

Senior decision making as early as possible
- Senior decision maker at the front of the process
- 7 day working & extended hours

Phone contact to senior clinician
Planning and management

- Continuity and blocks of rota coverage
- Plan for every patient every day
- Visual control systems
- Escalation available rapidly to unblock problems
Plan for Every Patient Boards

By the Hour in ED

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By the Day on Wards

- January 08
- Plan: Jane Doe, Jim Doe
- Actual: Jane Doe, Jim Doe

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The Visual Hospital
### Nursing Availability to Discharge from Wards

| Time     | 07:00 | 07:30 | 08:00 | 08:30 | 09:00 | 09:30 | 10:00 | 10:30 | 11:00 | 11:30 | 12:00 | 12:30 | 13:00 | 13:30 | 14:00 | 14:30 | 15:00 | 15:30 | 16:00 | 16:30 | 17:00 | 17:30 | 18:00 | 18:30 | 19:00 | 19:30 | 20:00 | 20:30 | 21:00 | 21:30 | 22:00 |
|----------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| Hand Over|                   |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |
| Drugs    |                   |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |
| Meals    |                   |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |
| Staff Breaks |               |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |
| Dr. Rounds |               |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |
| Taking Bloods and Chasing Results |               |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |
| Chasing Imaging Results |               |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |
| Ensuring TTOs are Written |               |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |
| Discharge Planning for Next Day |               |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |
| Visiting Times |               |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |
| Overall Availability to Discharge |               |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |

**Legend:**
- **Green:** Full Availability to Discharge
- **Yellow:** Limited Availability to Discharge
- **Red:** No Availability to Discharge
Access to alternative services

- Rapidly available
- Less complex & easier to understand
- More consistent
Eligible for lower levels of care

- 20-25% of admission could be cared for at a lower level of care
- 45-55% of bed days
Top 7 Service Levels Required for Non-Qualified Days

*more than 80% of all service levels required*

- Home with Services (25%)
- Intermediate care (20%)
- Home (15%)
- Nursing Home (10%)
- Rehab community (7%)
- Subacute Care (5%)
- Rehab Alternative (3%)
Top 7 Reasons for Non-Qualified Days

*More than 90% of all reasons*

- Med team did not consider LOC
- Test/consult/procedure not done
- Consultant orders continued stay
- Alt. care unavailable
- Waiting SS package of care
- Insufficient documentation
- Discharge planning issues
Out of hospital services

Response times

- Synchronised clock speeds
- Get what is needed when it's needed

Are community services trying to manage too many different types of process?

Should acute trusts run / sub-contract out of hospital care for:

- Admission prevention
- Post discharge care
Decision making

- EDD?
- Are alternative modes of care considered?
- Are decisions actively made?
- Are they documented?
- Are they then executed?
- Early ward rounds & discharges
39% of issues were beyond the control of the trust.
31% of reasons were related to consultant issues.
17% of reasons were related to discharge planning issues.
Other reasons occurred less than 1% of the time.
Relationships & communication

MDT meetings & ward rounds

Trusted assessment

Do nursing and residential homes trust the hospital

Does the NHS properly support them?

Section 2 & 5 – fines and penalties
Conclusions

Multiple complementary interventions
Excellent operational management
Improvement methodology
Think beyond the hospital

Some questions for further investigation
• Future of community services support
• Making senior opinion more easily available
• Splitting frailty from acute med or other carve out