Background

Our context
Hereford County Hospital is a small, rural, District General Hospital situated on the Welsh border. The recent and rapid increase of acute physicians presented an opportunity to trial a novel intervention during a “perfect week” to address inadequate Emergency Department (ED) 4 hour performance.

Summary of the change (Figure 1)

Streaming
- Purpose: “decision making at the front door”, setting a plan and directing patients to appropriate locations, minimising delays.
- Process: loosely defined, allowing consultants to use experience and judgement
- Located in an area of the ED designated the Rapid Assessment Area (RAA).

The Comprehensive Assessment Team
Envisaged as ad hoc multidisciplinary teams assembled around the needs of the patient rather than pre-existing on call teams or departments.

ED 4 hour performance was significantly improved during the 5 days of full senior clinician streaming (94-100% during trial vs Year To Date average of 81%).

Aims of study
1. To use staff experiences to understand how and why this change led to the demonstrated performance benefits.
2. To incorporate theoretical insights, grounded in staff experiences combined with quantitative performance data to guide further improvement efforts.

Methods
Ten staff involved in the delivery of the “perfect week” were invited to participate in this study (Figure 2)
Nine Unstructured interviews were carried out by JB in the week following the “perfect week” then transcribed verbatim and anonymised.

Data analysis
A pragmatic, Constructivist, Grounded Theory approach to analysis was adopted. Transcripts were initially subjected to open, line-by-line, coding; a process of identifying and attaching meaning to the data. Subsequent focused coding grouped the open codes into themes or categories that are presented here.

Results: emergent themes

Streaming was “intense….., busy, but not chaotic” (S1, S2, S5)
Streaming was “physically demanding” “limited by fatigue” and the long term sustainability at the rate and intensity experienced was questioned (S1, S2, S5).
A greater sense of “working with purpose” was experienced extending from streaming and more widely into other areas. (S1, S2, S3, S4, S5)
This was ascribed to an effective early plan; “adding value” and focus to subsequent activities in pursuit of a clearly set goal. (S5, S6, S9)
A “medical & managerial” focus
Control was shifted from the receiving team (medical registrar and post-take consultant) to the streaming consultant. (S5, S9)
Those in more passive roles reported disparity between their support for the underlying principles of the change (early plan by senior physician) with their lived experiences (S9).
Despite a consultant physician streaming, the role was labelled “managerial” and that “speed was valued over quality” or “resource and flow” were valued above “people and care” (S9).

Departmental boundaries are areas of conflict.

The ED and receiving teams normally contest departmental boundaries with negative behaviours resulting in wasteful delays consistent with the limited, existing literature (S1, S2, S3, S4, S5).

ED staff described a “ceasefire” during the perfect week, illuminating the usual state of conflict (S2), replaced with a sense of shared purpose (S4) and rising morale as the week progressed (S1, S2, S3, S5).

Acute physician streaming eliminated boundary contests through a combination of
1. Positional authority: “no one would argue with a consultant” (S1, S3)
2. Trusted negotiator: involving positive personal relationships, sensitivity to departmental pressures and credibility that crossed departmental boundaries in line with previous published literature.

“one of us (acute physicians) in the ED” (S9, S5)
- “Acute consultants not slowing us (ED) down”. (S1)

Discussion

The deliberate effort to capture the narratives of frontline staff and understanding these insights with robust qualitative methodology has proved a compelling adjunct to bland numerical performance data.

Whilst much of the captured experience maybe considered “common sense” to frontline staff, the ability to elevate this praxis to key decision makers ensures it is more difficult to ignore the “wisdom of the frontline” for those in leadership positions.

The negative connotations of a managerial change, and an almost completely lack of understanding of streaming resulted in profound doubt of the link between streaming and performance benefits: “of course, it was just a quiet week” (S1, S2, S3, S7, S8).

In fact attendances and referrals to medicine were higher than usual.

The demonstration of acute physicians as effective agents for change has put our group into an influential position with credibility at both senior trust leadership and frontline clinical levels.

Next steps
Insights have been used to inform the underlying principles of effective improvement in our setting and specific actions that must be directly addressed within this conceptual framework.

This data supports the principle of acute physicians near to the front door minimising non-value adding time in the ED by exploiting their role as an authoritative, trusted negotiator in the otherwise contested acute care pathways.

The next trial will be to use acute physicians to support the development of a nurse led referral process to progress patients to the right place to see the right person more rapidly. Balancing the clear benefits with unavoidable resource limitation.

Specific actions have involved understanding the handover process and matching computer systems to support clinical work streams. The qualitative data has also proved valuable in harmonising the radiology support for acute medical patients with established service for ED.

Subject code | Description of role
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S1 | ED Healthcare assistant
S2 | ED Band 5 Nurse
S3 | CAU Band 5 Nurse
S4 | Acute ward Band 5 nurse
S5 | Acute Medicine Advanced Nurse Practitioner
S6 | Acute Medicine Consultant
S7 | ED receptionist
S8 | Emergency/Acute Occupational Therapist
S9 | On call medical registrar
S10 | Site manager (did not attend interview)

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References

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