The Impact of Targets on the Quality of Care: NEAT and NEST

The Taming of the Queue
29 March 2012

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THE EXPERT PANEL MEMBERS

- Associate Professor Brian Owler
- Professor Michael Grigg
- Dr Heather Wellington
- Dr Mark Monaghan
- Ms Julie Hartley-Jones
- Professor Chris Baggoley (Chair)
OUTLINE OF PRESENTATION

- Personal Experience
- Current Situation
- Terms of Reference
- Guiding Principles
- Guiding Philosophy
- Recommendations
- Current Situation
NHS Modernization Agency Perspectives

- Success due to
  - Process review
  - ED from ‘bloody nuisance’ to ‘essential focus’
  - Others taking on roles – nurse practitioner, care assistant
  - ED Collaborative
  - RCS/RCP edict – registrar review in one hour

Sir George Alberti 2004
NHS Modernization Agency Perspectives

- Success due to
  - Political resolve – PM direct involvement
  - Bad winter 2000/2001
  - Sacking first CEO
  - Bed management improvement

Dr Matthew Cooke 2004
NHS Modernization Agency Perspectives

- Lessons learned
  - Not tackle big issues early enough
    - Mental health
    - Bed management
    - Changing/challenging culture
    - Focus management on electives

Dr Matthew Cooke 2004
Lessons learned

- Too ED focussed early v hospital, primary care, ambulance
- 100% 4 hour target unattainable

- Now ‘2% operational limit’
- Starting with ‘waits’

- Should start with quality

Dr Matthew Cooke 2004
Royal Adelaide Hospital
Patient Flow Initiative
Emergency Care: 2004-2005
RAH Mental Health ED flow map

Map 2-RAH Mental Health ED current flow map (Arrival by Ambulance)

Pt Arrival: SAAS (some pre-notified)

Triage RN

Guard if detained/aggressive

Notified arrival
1st Assessment at Triage (re safety) by:
• M.H nurse
• ED nurse
• ED Dr
• Security

No notification
1st Assessment, at Triage (re safety)
• Given ATS priority
• May inform: Security ACIS Nurse or ED Resus Dr

Psych Reg consult

Admit as per map

Seek bed

EECU Ward/C3/Gen Glenside Other out Hosp at home

If clear medically hand formally to MH

If discharge: ACIS GP drugs OPD Home

Discharge

Predominantly MH problem

Parallel process

Medical cause

Rapid Med & MH Assess treat investigate +/- drugs

2nd assessment (team as above)

A-side seclusion Room (aggressive)*

Interview room (if deemed safe)

medical response

Yes

No

Predominantly Med problem

Medical treatment general pt pathway

Tests may be needed against pts will, therefore detained. Pt can appeal if formal MH exam not undertaken

Admit-discharge
### RAH ED Comparison

**1st Jun – 28th Feb**

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Total patients registered</td>
<td>38,102</td>
<td>40,865</td>
<td>2,763 (7% increase)</td>
</tr>
<tr>
<td>Average per day</td>
<td>140</td>
<td>150</td>
<td></td>
</tr>
<tr>
<td>Average wait to be seen by a doctor</td>
<td>66 mins</td>
<td>45 mins</td>
<td>21 mins (32% decrease)</td>
</tr>
<tr>
<td>Patients who did not wait</td>
<td>3,212 (8.5%)</td>
<td>1,731 (4%)</td>
<td>1,481 (46% decrease)</td>
</tr>
<tr>
<td>Patients actually treated</td>
<td>34,890</td>
<td>39,134</td>
<td>4,244 (12% increase)</td>
</tr>
<tr>
<td>Patients treated in their triage threshold</td>
<td>19,918 (52%)</td>
<td>25,130 (61%)</td>
<td>5,212 (26% increase)</td>
</tr>
</tbody>
</table>
Hospital bed situation critical across NSW
The Daily Telegraph – 10 February 2010
Wait at hospitals is a test of patients

Source: Herald Sun, Thursday June 2, 2011
Aged Care shortage chokes hospitals

Source: The Age, Thursday June 2, 2011
Patients are forced to wait in a hospital emergency room
Emergency doctor:

We can't cope!

Hospital ‘overcrowded, overwhelmed’

The Age – 6 October 2011
I'm afraid you're rather ill. How long have you been waiting for a bed?

Ever since you hired me as an intern.
Literature Review

“The priority is not simply devising yet more standards and indicators, but working on the nuts and bolts of how we turn measurement for improvement into tangible change in practice”

Source: Scott, I & Phelps G
“Measurement for Improvement: Getting one to follow the other” IMJ 2009, 39, 347-351
The available evidence suggests that targets face resistance at local level if they are imposed on those who must implement them. Mechanisms that foster participation and a sense of ownership are an important element of a target based strategy.”

Source: Ernst, K., Wismar, M et al Chapter 4 “Improving the Effectiveness of Health Targets” In “Health Targets in Europe: Learning from Experience”, European Observatory on Health Systems and Policies, Observational Studies Series No 13, 2008
Literature Review

“A target should be sufficiently challenging to stimulate new and better ways of doing things rather than simply waiting for nature to take its course”

"The most difficult phase of redesign is not identifying issues or designing new solutions; it is implementing those solutions and embedding the redesigned model into core business processes."

Source: O'Connell, T, Ben-Tovim, D., McCaughan B, and McGrath, K

"Health services under siege: the case for clinical process redesign" MJC 2008, 188, S9-S13
Literature Review

86 cases of hospital process redesign that have not led to consistent improvements in either patient outcomes or system performance

Literature Review

NHS Solutions to reducing emergency department and waits: a systematic review

- Fast track systems for minor injuries reduce emergency department length of stay (LOS) and ideally include senior staff in their configuration
- Specialist nurse care in CHF, COPD and DVT can reduce hospital admissions
- Observation wards may reduce ED LOS and avoid admission
- Home support can reduce hospital admission and ED Visits
- Allowing ED staff for unpredicted surges may reduce delays

Source: Cooke M, “Reducing attendances and waits in Emergency Departments” 2005 Report to the National Co-ordinating Centre for NHS Service Delivery & Organisation R&D
Literature Review

NHS Solutions to reducing emergency department and waits: a systematic review (Cont)

- Teams of staff for unpredicted surges may reduce delays
- Rotational allocation of patients may be better than clinical self-determination over which patients staff treat
- Provision of care by senior staff may reduce admissions and delays
- There is no evidence that GPs working in EDs affect LOS
- Primary care gate-keeping can reduce ED attendance, but safety unknown
- Walk in centres and NHS Direct have not been shown to reduce ED attendances

Source: Cooke M, “Reducing attendances and waits in Emergency Departments” 2005 Report to the National Co-ordinating Centre for NHS Service Delivery & Organisation R&D
LITERATURE REVIEW

Disincentives to clinician involvement in sustained quality improvement and practice change

- Lack of sustained and visible support from senior management and clinical leaders
- Inadequate resources allocated for change implementation
- Insufficient staff time for participation and retraining
- Failure to develop robust measurement and data feedback systems
- Misalignment of incentives structures
- Resistance to change from professional and/or organisational cultures

Source: Scott, I and Phelps, G “Measurement for Improvement: Getting one to follow the other” IMJ 2009, 39, 347-351
LITERATURE REVIEW

Risks of performance targets

- “Hitting the target but missing the point”, ie quantity not quality
- Alienation of key stakeholders where there is a lack of consultation, planning and communication
- “Gaming” including cherry picking of patients and manipulating data

Literature Review

Emergency Department Targets

- Strong evidence linking ED overcrowding and access block to poorer patient outcomes in Australia
- Similar association in Canada, USA and UK
- ED overcrowding and access block contribute to 20 - 30% excess mortality rate
- Also contribute to prolonged inpatient length of stay

Literature Review

Evaluation of the NHS Four Hour Target
Kelman and Friedman Analysis

- As performance improved, the death rate decreased in emergency department patients
- Fewer stays longer than four hours were associated with lower mean length of stay times and a higher fraction of patients treated in under two hours
- Improved performance was not associated with increased admissions to inpatient wards
- Although there were reports of extra support for emergency departments during the week of performance measurement of the NHS star rating, including staff redistribution from other areas in order to meet the targets, much of the performance improvement from the monitoring week persisted thereafter

Literature Review

Evaluation of the NHS Four Hour Target

- Number of emergency admissions discharged on the same day rose by 43%
- Increase in discharge activity in the last 20 minutes of the four hours
- Target did not impact on care or resources
- Target not result in increased return visits or deaths
- Did force hospitals to address the problems of ED overcrowding

Access Block and the Introduction of The Four Hour Rule Program in 4 Western Australia Hospitals
Monthly performance against the Four Hour Rule Program in Western Australia July 2008 – April 2011

Monthly Performance—Percentage of ED attendances with LOE ≤ 4 Hours (July 2008–April 2011)

- 100%
- 95%
- 90%
- 85%
- 80%
- 75%
- 70%
- 65%
- 60%
- 55%
- 50%
- 45%
- 40%
- 35%
- 30%

Month

- July 2008
- August 2008
- September 2008
- October 2008
- November 2008
- December 2008
- January 2009
- February 2009
- March 2009
- April 2009
- May 2009
- June 2009
- July 2009
- August 2009
- September 2009
- October 2009
- November 2009
- December 2009
- January 2010
- February 2010
- March 2010
- April 2010
- May 2010
- June 2010
- July 2010
- August 2010
- September 2010
- October 2010
- November 2010
- December 2010
- January 2011
- February 2011
- March 2011
- April 2011

- 4 Hour Rule Program Commencement
- Hospital 1
- Hospital 2
- Hospital 3
- Hospital 4
- Adult hospital interim target (85%)
- Paediatric hospital target (98%)
Literature Review

Elective Surgery Targets

Problems with Patient categorisation

- Variation in use of urgency categories across surgical specialties and between hospitals
- Variation according to socio-economic status of patient and remoteness from health services

Literature Review

Elective Surgery Targets

NHS Improvement Plan

- March 2005 fewer than 1,000 patients waiting more than 12 months for surgery
- August 2009: 93% of admitted patients waited less than 18 weeks from referral to treatment

Literature Review

Elective Surgery Targets

NHS Improvement Plan

- Gaming effect, including apparent fraud from three Trusts
- Time waited overall did reduce
- 30 day mortality reduced
- Total number of admissions rose

Elective Surgery
Urgency Categories

Cat 1  Admission within 30 days desirable for a condition that has the potential to deteriorate quickly, to the point that it may become an emergency

Cat 2  Admission within 90 days desirable for a condition causing some pain, dysfunction or disability, but which is not likely to deteriorate quickly or become an emergency

Cat 3  Admission within 365 days for a condition causing minimal or no pain, dysfunction or disability, which is unlikely to deteriorate quickly and which does not have the potential to become an emergency

Cat 1  Admission within 30 days desirable for a condition that has the potential to deteriorate quickly to the point that it may become an emergency

Cat 2  Admission within 90 days desirable for a condition which is not likely to deteriorate quickly or become an emergency

Cat 3  Admission within 365 days acceptable for a condition which is unlikely to deteriorate quickly and which has little potential to become an emergency

Cat 4  Patients who are either clinically not ready for admission (staged) and those who have deferred admission for personal reasons (deferred) (Not Ready for Care)

## Percentage of patients by Urgency category (2009-10)

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>VIC</th>
<th>QLD</th>
<th>WA</th>
<th>SA</th>
<th>TAS</th>
<th>ACT</th>
<th>NT</th>
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<tbody>
<tr>
<td>Cat 1</td>
<td>26%</td>
<td>27%</td>
<td>37%</td>
<td>28%</td>
<td>32%</td>
<td>39%</td>
<td>30%</td>
<td>42%</td>
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<tr>
<td>Cat 2</td>
<td>30%</td>
<td>48%</td>
<td>45%</td>
<td>36%</td>
<td>35%</td>
<td>41%</td>
<td>50%</td>
<td>39%</td>
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<tr>
<td>Cat 3</td>
<td>43%</td>
<td>26%</td>
<td>18%</td>
<td>36%</td>
<td>34%</td>
<td>20%</td>
<td>20%</td>
<td>18%</td>
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Terms of Reference

To provide advice to COAG on:

a) Implementation of the Elective Surgery Target and the National Access Guarantee

b) The Four Hour National Access Emergency Department Target

c) Overarching considerations

c) Any other matters agreed by COAG

Guiding Principles

1. Targets and the changes required to meet them will require commitment right across the health and hospital system

2. Hospital executives will need to work in partnership with clinicians to achieve sustainable change

3. Clinical engagement and clinical leadership will be essential if the targets are to be met

4. Targets must drive clinical redesign with a whole-of-hospital approach

5. Clinical redesign must ensure patient safety and enhance quality of care

Guiding Principles

6. Definitions to be clear and consistent across all jurisdictions

7. The performance of jurisdictions is not comparable

8. Progress towards the targets needs to be linked with continual monitoring of safety and quality performance indicators and audit

9. The impact of targets on demand needs to be monitored and early strategies developed to ensure achievements are sustainable

10. Quality of training is maintained

Guiding Philosophy of the Panel

“We are fundamentally of the view that strong and public leadership is required at all levels – from Ministers, Commonwealth and State and Territory Health Departments, key stakeholders, Local Hospital Networks and Medicare Locals, Lead Clinicians Groups, hospital managers and clinicians. **If the onus on achieving the benefits that can arise from the process and system redesign falls only to clinicians, they will fail.** Achieving success must be a top priority and responsibility for those in charge of our health system. **The risk we face is that without common support and engagement for whole-of-hospital reform, there is little chance for the necessary system change to be achieved**

Recommendations

Ensuring Sustainable Change

1. Promotion of clinical engagement, best practice and shared learning

2. Establishment of jurisdictional surgical taskforces

3. Collection of suite of indicators to measure impact of NEAT and NEST

Recommendations

National Emergency Access Target (NEAT)

4. National Emergency Access Target replaces National Access Target of Emergency Departments

5. Incorporation of clinical appropriateness into a revised target of 90%

6. Staged implementation across all triage categories, not by triage category

7. Measurement of time in ED defined

8. Removal of Clause C40 of NPA regarding “general practice-type services”

9. Definition of a Short Stay Unit

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<th>2012</th>
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<th>2014</th>
<th>2015</th>
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<tr>
<td>NSW</td>
<td>61.8%</td>
<td>69%</td>
<td>76%</td>
<td>83%</td>
<td>90%</td>
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<tr>
<td>VIC</td>
<td>65.9%</td>
<td>72%</td>
<td>78%</td>
<td>84%</td>
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<tr>
<td>QLD</td>
<td>63.8%</td>
<td>70%</td>
<td>77%</td>
<td>83%</td>
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<td>WA</td>
<td>71.3%</td>
<td>76%</td>
<td>81%</td>
<td>85%</td>
<td>90%</td>
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<td>SA</td>
<td>59.4%</td>
<td>67%</td>
<td>75%</td>
<td>82%</td>
<td>90%</td>
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<tr>
<td>TAS</td>
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<td>72%</td>
<td>78%</td>
<td>84%</td>
<td>90%</td>
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<tr>
<td>ACT</td>
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<td>64%</td>
<td>73%</td>
<td>81%</td>
<td>90%</td>
</tr>
<tr>
<td>NT</td>
<td>66.2%</td>
<td>72%</td>
<td>78%</td>
<td>84%</td>
<td>90%</td>
</tr>
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</table>

Recommendations

National Elective Surgery Target (NEST)

10. Development of agreed definitions of elective surgery urgency categories, then to be implemented

11. NEST to replace initial elective surgery target and NAG through two complementary strategies to achieve 100% performance

12. Progression by calendar year, Category 1 patients to be achieved initially, with extended times for NT, TAS, ACT

13. Overdue patient strategy, along same principles as Rec. 12

14. National Elective Surgery Access Time to be developed and used in subsequent agreements

Concept of Management of Strategy 2, Overdue Patients (i)
Concept of Management of Strategy 2, Overdue Patients (iii)

Concept of proposed NEST — Future Profile Cat 2 (2015)

- Clinically Recommended Time for Procedure
- 90 days

Number of patients

Days of waiting list before procedure

Strategies:
- Strategy 1
- Strategy 2
Recommendations

Review and Evaluation

15. Ongoing role of Expert Panel in review of practical implementation, timing, phasing and safety and quality issues that may arise

What's happening to improve elective surgery and emergency access

Western Australia
- Four Hour Rule Program

Northern Territory
- Royal Darwin Hospital 23 hour ward model

Queensland
- Surgery Connect Program

New South Wales
- Fast Track Model of Care
- Clinical Initiative Nurses in EDs
- Nurse Initiated Treatment in EDs
- Medical Assessment Unit Referrals from EDs
- Management of Emergency Surgery
- Predictable Surgery Program

South Australia
- Elective Surgery Waiting List Management SA

Victoria
- Timely specialist medical unit assessment, bed allocation and transfer for patients in the ED
- The Alfred Centre: a dedicated elective surgery centre

Tasmania
- North West Area Health Service Orthopaedic Early Intervention Service
- Prehab Program
The NEAT: An opportunity and a mandate for change

- The success or failure of this program depends completely on the way it is implemented at a site level

- The key is a understanding between clinicians and executive that they are driving this together to achieve better access to care for their patients
Number of presentations to Emergency Departments (EDs) at WA FHR hospitals
Access Block at Metropolitan Tertiary Hospitals
July 2007 - January 2012

Monthly - Access Block (July 2007 - January 2012)
Total Ramping Hours at WA Metropolitan Hospitals
January 2010 to January 2011

Total Ramping Hours in WA Metropolitan Hospitals in 2010 and 2011

Year

Ramping hours

2010

2011
A row of ambulances waits to unload patients at the Austin Hospital, Heidelberg
Percent of patients with an ED length of stay exceeding 12 hours at all FHR Sites – 2010 to 2012

Percent of patients with an ED length of episode (LOE) exceeding 12 hours at all WA FHR sites
Percentage of Attendances Who Did Not Wait (DNW) To Be Seen at Stage 1 Four Hour Rule Hospitals 2008/09 to 2011/12

Month/Year

0%
1%
2%
3%
4%
5%
6%
In Hospital Mortality of Admissions from ED (%)
July 2008 – January 2012

In hospital mortality by FHR stage July 2009 - January 2012

- Stage 1
- Stage 2
- Stage 3
Metropolitan Tertiary and General Hospitals
MRSA Infections per 10,000 bed days: July 2010 – 2011

Average number of MRSA Infections per 10,000 bed days
at Stage 1 and Stage 2 WA Hospitals July 2010 - December 2011

[Graph showing infections per 10,000 beds over time, with trends for Stage 1 and Stage 2]
How the motivation was translated into policy

- The “Four Hour Rule” and all its baggage
How the policy was translated into practice

- Target driven
- Strict time lines
- Redesign based, business case funding
How this is being re-translated into something better

- Understanding the workers motivations
- Communication strategy
- Redefining the governance structure
- Feedback mechanisms
Key principles

- Open, honest two way communication between executive and staff with a shared goal and the right motivation

- A willingness to totally change current processes
Key Principles

- Keep the message simple
- This is a great opportunity for us if we do it right
- This is about access to care, not targets
- Patient care and safety before anything else
Questions