

STABILISING THE EMERGENCY SERVICE

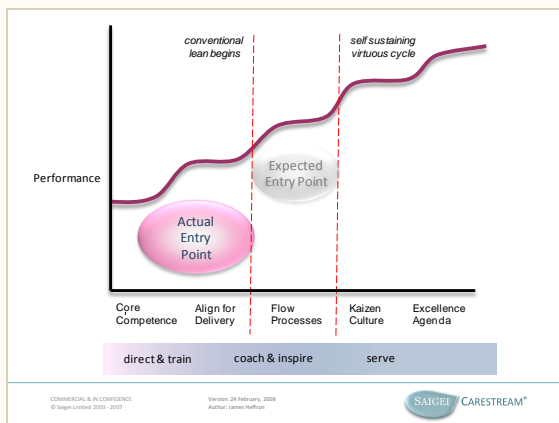
A FOUR MONTH ASSIGNMENT

THE TASK

The client was a three hospital site Trust, failing to meet financial and delivery targets. A new chief executive had started in December. The assignment began at the end of January.

The objective was to stabilise emergency performance before the new Trust year began.

On arrival, the Saigei team assessed the task. It concluded that the Trust had competent individuals but was not aligned for delivery. The task was not therefore one of improving capability but rather of designing and implementing a basic operating model.



understanding the nature of the task

ORGANISING WITH PURPOSE

The starting was to put in place a means of concentrating activity around the Trust objective of stabilising emergency performance.

The Chief Executive made clear that stabilising emergency performance was the number one priority. And four teams were created:

The coordination team – this put the clinical directors for A&E, surgery and medicine in the same room as the chief executive, the operations director and the Saigei principal

once every week. Its purpose was to agree direction, resolve ambiguity, focus resources, and clear barriers.

The clinical reference group – from the outset, clinicians were given time and responsibility for designing the model that would deliver the outcome. This group met bi-weekly, contained all of the senior clinicians and grew to include all interested parties.

The Intervention Team – the operations director for emergency services and six of the best nurses and service managers from A&E, medicine, surgery, and site management were given four days a week to research the issues, engage staff in choosing the way forward, then implement and manage the new model.

The General Managers – a standing item was put on the general managers' agenda to make sure that (a) they were fully involved at every stage; and (b) that tactics were agreed and implemented through normal operational lines.

SERVING NEEDS

Over the first two weeks the intervention team gathered views from staff as to why the system was failing and what was required. Each assertion was given equal weight but thoroughly researched to establish the operational facts and the root causes.

The Clinical Reference Group (CRG) reviewed these facts and preferences, then outlined a preferred solution to be worked up and their recommended order of play.

What followed was a series of iterative cycles: put the detail to the change, get it reviewed by the (CRG), communicate the results and invite comment; secure those that were willing to start and respond to those with concerns; start the change; work to ensure lessons were

captured and the change successful; move to the next priority.

The principal operational changes were:

- Clarify use of the observation area.
- Create an MAU with the single purpose of rapid diagnosis and routing.
- Agree changes to doctor & surgeon rotas to ensure the MAU was staffed all day.
- Agree a ward zoning model.
- Coach the bed managers to manage outliers and keep the MAU flowing.
- Agree an escalation mechanism that opens easily then concentrates effort on closing.
- Engage ward nurses in shortening stays (only possible once they had right patients).
- Extend the discharge lounge service to include collection and cleaning bed-bays.
- Put in place measures that were informative and gave people time to take action.
- Document and publicise succinct and useable standard operating procedures.

The principal effort was devoted to:

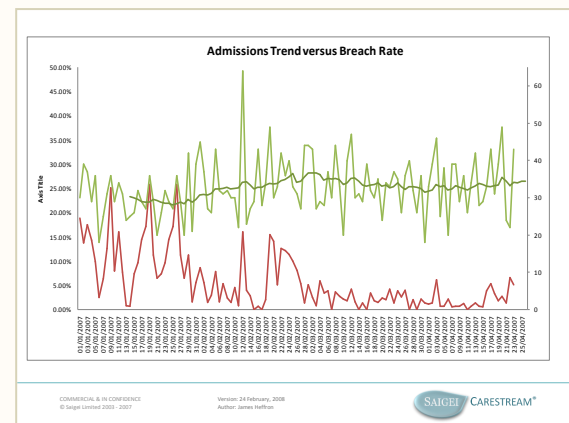
- involving people in understanding the changes and their part in success.
- following through on the ground to make sure that changes were communicated across shifts until they became habit.
- helping those struggling with the change to find a way through the upheaval.
- identifying and addressing the performance of those hurting the organisation.
- Surfacing differences and helping people put them to rest and agree one way of working.
- anticipating and dealing with absenteeism, holidays, failures to plan, surges in demand, lapses into old behaviours etc.

- Repeating the message that the Trust was serious: patients must come first.

The process was not always elegant. The Intervention Team was often heard to say “as you approach the sound barrier turbulence increases dramatically”. Their ethos was: “get the plane in the air and steer. Don’t stand around arguing about where we it might go.”

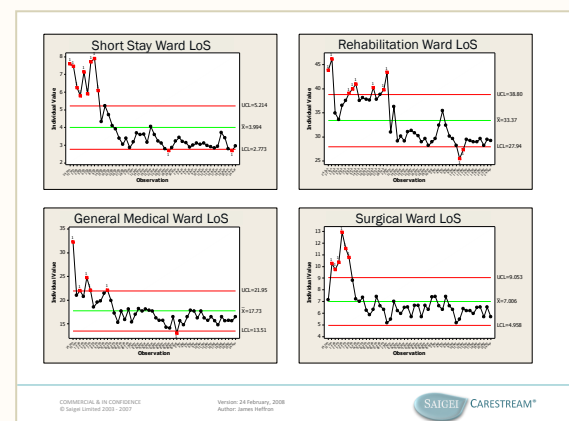
MEASURING OUTCOMES

The operation met 98% (red line) at all sites after 6 weeks. It started an unbroken run after 12 weeks despite rising demand (green line).



It would have happened earlier but for a confidence wobble on the second weekend of half-term which took 1½ weeks to recover.

The performance is attributable to 16% fewer emergency admissions; reduced lengths of stay for all wards; and 50% of all discharges arriving in the discharge lounge before midday.



WHY IT WORKED

Saigei and the new Chief Executive were able to agree that until emergency performance was stabilised the staff would not believe any money saving programme could work. So there was no ward closure agenda undermining the message that patients must come first¹.

Clinicians were made accountable for designing the changes they wanted. And though it took time to win their confidence, once they believed that the organisation respected their views, they committed to absorbing tactical challenges and making the changes stick.

The Intervention Team *served* first. Where most change teams focus on telling and project plans. The intervention team focussed first on understanding what was concerning people and then on responding to their requests. This gave the team the platform to ask for help later.

The change was owned and implemented by the line, and the best people were given the time to understand the problems and engage their colleagues in solving them. That meant taking them out of fire-fight and constantly clarifying that they were not to get drawn back in but rather to solve the causes of the fire.

The operational and clinical leaders stayed close to the detail, frequently mobilising personally to keep the conversation out of unproductive areas (like job-planning); help broker treaties (like who owned MAU); and rally a response from colleagues in difficult days to keep the fledgling MAU alive.

The assignment brief included the people dimension and the operational and clinical leaders did not shy away from dealing with the “elephants in the room” or those individuals hurting the organisation.

The Trust leaders did not snatch defeat from the jaws of victory. Instead, they committed resources to sustaining the change until the management and clinical teams were confident that they could continue without assistance.

This assignment was positioned as the first in a programme of taking care of what mattered, namely patients, and of restoring pride in the services the Trust provided. It was a cause that resonated with everyone.

Ends...

For further information contact:

James Heffron
+44 (0)7779 702159
james.heffron@saigei.com

Saigei Limited
41 Ormond Avenue
Hampton
Middlesex TW12 2RY

www.saigei.com

¹ Ward closures were achieved in subsequent engagements without jeopardising emergency performance because clinicians could see that the Trust was recovering unused capacity not simply trying not to spend money.