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Foreword

WA Health has continued to implement strategies to improve the patient experience of unplanned care in recent times. Strategies to address patient flow and bed availability in hospitals, couples with better delivery of services outside hospitals, has contributed to vital improvements in unscheduled care in Western Australia.

Despite the success of these activities, it is acknowledged that a radical change and expansion of improvement measures is required to have a significant impact on the increasing demand for emergency services in Western Australia.

As part of devising a solution to this problem, a group of clinicians from WA Health visited 12 hospital sites in the United Kingdom in November 2008 to look at the model used by the National Health Service (NHS). In this model 98% of patients arriving at the accident and emergency department are seen and admitted, discharged or transferred within a four-hour timeframe. It was widely recognised that to achieve this target whole of hospital change was required, not just a focus on the Emergency Department (ED).

The tour proved to be a valuable experience and provided important lessons for WA Health. The overall findings from the UK tour regarding the introduction, development and implementation of the NHS ‘four-hour target’ program was that:

- The program is a quality initiative with the aim of improving patient care and enhancing the patient journey.
- Successful sites in the UK have sustained the changes they have implemented and NHS staff expressed positive support for the model, with nobody reporting a desire to return to the pre-four hour process.
- Strong leadership and support from all levels of the organisation and Government is required for this model to work effectively.

WA Health delegates to the UK unanimously agree that introduction of a similar model in Western Australia will drive long term system wide reform in WA Health. Furthermore, there is agreement that targets similar to those achieved in the UK, specifically, 98% of patients being seen and admitted, discharged or transferred within a four-hour timeframe, is the appropriate target to drive such a reform.

A similar program would be intended to kick-start a redesign process that focuses on whole of hospital change, and would not be limited to just the front door of the ED.

The following report provides a synopsis of the meetings and site visits made by WA Health delegates in the UK and provides key inferences from the tour.

Dr Robyn Lawrence  
A/Executive Director  
Innovation and Health System Reform
Tour Itinerary

Site visits and meetings attended by the whole tour party:

Monday 17 November: London
• St Mary’s Hospital

Tuesday 18 November: London
• Chelsea & Westminster Hospital
• The Royal London Hospital
• Meeting with Karen Middleton (Chief Health Professions Officer, UK Department of Health)
• Q & A with Prof. Derek Bell (Professor of Acute Medicine Imperial College London)

Wednesday 19 November: London
• Meeting with Peter Coates (Director of Finance and Investment, UK Department of Health)
• Meeting with Philippa Robinson (National Director 18 Week Program UK)
• Meeting with Sir George Alberti (National Clinical Director Managing Demand); Lis Nixon (Consultant Adviser on Emergency Care), Becki Pollard (A & E Policy)
• Meeting with Kerry Sanderson (WA Agent General); Brian Barnes (CEO European Office of the WA Government)
• Meeting with Kevin Cropper (Nurse Recruitment Manager WA Health)
• Meeting with Mark Jennings (NHS Institute for Innovation & Improvement)

Thursday 20 November: Cambridge
• Addenbrooke’s Hospital

Friday 21 November: Bristol
• Frenchay Hospital
• Southmead Hospital

Site visits and meetings attended by WA Health delegates only:

Monday 24 November: Edinburgh
• Meeting with Tony Toft, Consultant Physician at Royal Infirmary of Edinburgh
• Royal Infirmary of Edinburgh
• Royal Hospital for Sick Children
• St Johns Hospital Livingston

Tuesday 25 November: Lanarkshire
• Hairmyres Hospital
• Wishaw General Hospital
• Q & A session with Dr Veronica Devlin (Service Improvement Manager, NHS Ayrshire & Arran)

Wednesday 26 November: Lanarkshire
• Monklands Hospital
• Teleconference with NHS Ayrshire & Arran
**Tour Group**

**Office of the Minister for Health:**
Hon. Dr Kim Desmond Hames MLA MB BS, JP
Deputy Premier; Minister for Health; Indigenous Affairs

Dr Kim Hames (55) was a Member of the Western Australian Parliament from 1993 to 2001. From 1997 to 2001 he was Minister for Water Resources, Housing and Aboriginal Affairs in the Court Liberal Government. He was re-elected to Parliament in 2005 and is currently Deputy Premier, Minister for Health and Indigenous Affairs in the Barnett Liberal Government.

For most of his career, Dr Hames managed his medical practice and worked in skin cancer clinics in Perth. Dr Hames has a keen interest in Aboriginal health in remote localities and also ran his Aboriginal Heritage consultancy from 2001 to 2005.

He is married to Stephanie. They have six children and one grandchild. He is a keen sportsman who enjoys golf and fishing in his spare time.

**Christian Allier, Principal Policy Advisor to Minister for Health**

After a long career with Telstra Corporate Communications, Christian Allier (61) joined Dr Kim Hames in 1993 as campaign and political advisor and has worked with him since. He was the Principal Policy Advisor to Dr Hames as Minister for Water Resources, Housing and Aboriginal Affairs from 1997 to 2001 and also joined him in the Aboriginal Heritage consultancy after 2001. Christian also spent two years as political advisor to Senator Sue Knowles, Chair Public Affairs Senate Legislative Committee (Health and Family Services) from 2001.

He is married to Sally-Ann and father to two children and two grandchildren. Christian enjoys reading politics and history and is an avid collector.

**WA Health:**

Dr Robyn Lawrence

Dr Robyn Lawrence is currently A/Executive Director, Innovation and Health System Reform, which includes leading the emergency demand reforms in WA Health. She is also Executive Sponsor for Elective Surgery and Ambulatory Care and working with the Director General of Health on additional areas such as Aboriginal Child and Maternal Health.

Dr Lawrence was trained at the University of Western Australia (UWA) and worked as clinician at Sir Charles Gairdner Hospital before commencing training in Medical Administration in 1997. She was awarded Fellowship Royal Australasian College Medical Administrators in 2003 and has undertaken senior administrative roles at Osborne Park Hospital, King Edward Memorial Hospital, Princess Margaret Hospital, Sir Charles Gairdner Hospital and Royal Perth Hospital prior to her current position.

Away from work, Dr Lawrence is married with two boys aged 7 and 9. This role helps maintain a grounding in what is important, and contributes to the vision of what she is trying to achieve for health in WA.

**Dr Frank Daly**

Dr Frank Daly is Staff Specialist Emergency Physician and Director of Clinical Toxicology at Royal Perth Hospital (RPH). The ED at RPH is a major adult tertiary unit with 58,000 presentations, 42% admission rate, and approximately 550 major trauma cases each year. Dr Daly is also Director of Clinical Services Redesign Royal Perth Hospital, with current projects including Elective Surgery and Unplanned Patient Admission.

Dr Daly is an Associate Professor at the University of Western Australia, Chair of Business Readiness Subcommittee; member of the Project Council of the Western Australian eHealth Project; Clinical Leader of the Emergency Department Task Force; and was previously Director of Emergency Medicine at Royal Perth Hospital.
Associate Prof Gary Geelhoed
Associate Prof Gary Geelhoed is Director of Emergency Services at Perth’s tertiary children’s hospital, Princess Margaret Hospital for Children. Associate Prof Geelhoed is a graduate of the University of WA and after a number of years in adult medicine trained in general paediatrics with a special interest in the assessment and treatment of children with acute respiratory problems.

A Fellow of both the Australian College of Emergency Medicine and the Royal Australasian College of Physicians, Associate Prof Geelhoed is also the President of the Australian Medical Association (WA).

Dr Anthony Ryan
Dr Tony Ryan is a general physician with a special interest in diabetes. He is Head of Department of General Medicine at Fremantle Hospital and Consultant Physician at Armadale Hospital as well as seeing private inpatients/rooms, and is a periodic rural hospital visiting physician.

He is on the planning committee of Fiona Stanley Hospital, a major new tertiary hospital and is the lead clinician for the General Medicine Clinical Service Redesign group. He is on the Australian Medical Association council and is treasurer of the Internal Medicine Society of Australia and New Zealand.

Jenny Brenton
Jenny Brenton has been a nurse in the Western Australian health system for over 30 years. For the last 12 years she has held positions in senior nursing administration in regional and metropolitan areas and in private and public sectors. After coordinating acute demand management across the metropolitan area, she moved into her current position of three years as Nursing Director Patient Flow at Fremantle Hospital. Over the last six years she has been involved in the development of bed management and data IT systems which she administers for the metropolitan area.

Anthony Dolan
Anthony Dolan has been a registered nurse for 20 years. He completed his nursing training in Scotland. His academic qualifications include - RN training, BSc Nursing, Post Graduate Diploma - Clinical Nursing (orthopaedics) and is due to complete a Masters in Nursing in December 2008.

Anthony’s clinical background is orthopaedic nursing and more recently nursing management. His current position is Nurse Co-Director for Osborne Park Hospital (OPH). In this role he has the governance and management of nursing services, the service improvement team (quality, risk and occupational health) and allied health services. OPH is a 207 bedded general hospital which operates the following clinical services - Rehabilitation and Aged Care, Obstetric Services and Surgical Services (Surgicentre).

Marani Hutton
Marani Hutton, Physiotherapist, has spent the past 18 years working for WA Health, and has experience in general private practice and self employment in training and education. She spent 14 years working for the WA Country Health Service across the remote North West Kimberley region, and moved to Perth in 2005. Marani has lead a number of projects in WA Health, most recently the COAG (Council of Australian Government) funded Long Stay Older Persons Initiative for the South Metropolitan Area Health Service (SMAHS).

Marani currently works as the Area Allied Health Advisor for SMAHS, and manages the SMAHS Older Persons Initiative (OPI) Emergency Department based Care Coordination Teams. She continues to work clinically as a Senior Physiotherapist in the Emergency Department of Sir Charles Gairdner Hospital on intermittent weekends.
Emergency Demand in WA Health

Overview

In Western Australia, data gathered comparing year to date (YTD) figures from 2008/2009 with those from 2007/2008 show a slight increase in attendances at adult general tertiary hospitals and a minimal reduction in attendances at secondary hospitals.

Instances of people being admitted to hospital from ED increased in 2008/2009 compared with figures from the previous year, with admissions from ED increasing at both metropolitan secondary hospitals and adult general tertiary hospitals.

WA Health has continued to implement strategies to improve the management of unscheduled care, including delivery of better services outside of hospitals and the freeing up of capacity within hospitals through improved patient flow and increased availability of beds. Specific strategies have included:

1. The Clinical Service Redesign Program (CSRP) to assist with hospital flow and continuous improvement across the system. $1.456M has been allocated to CSRP to improve emergency patient flow.

2. Implementing assertive patient flow and bed management strategies for mental health patients.

3. Area Health Services continue to implement strategies to increase hospital substitution and avoidance (ambulatory care initiatives such as HITH, RITH and HITNH), and increase the number of Care Awaiting Placement (CAP) beds in the community.

4. Working in partnership with St John Ambulance (SJA) to reduce ramping, including a trial to increase referrals of non-urgent SJA ’000’ calls to Healthdirect for triage by a nurse.

5. Continuing to identify alternate bed sources in the private and community sector.

6. The development of recruitment and retention strategies for health professionals, and the training of Assistants in Nursing in the North and South Metropolitan Area Health Services.

7. The establishment of an ED Taskforce to lead improvement strategies to address overcrowding in Perth’s metropolitan Emergency Departments.

Despite the success of these activities, it is acknowledged that a continuation and expansion of improvement measures is required to have a significant impact on the increasing demand for emergency services in WA.
Reform in the NHS

The National Health Service (NHS) in the United Kingdom (UK) was established in 1948 on the founding principles of providing access to care for all based on need, not ability to pay (Department of Health, 2000). Since the inception of the NHS, service provision within emergency departments has changed markedly.

At the outset, emergency departments were staffed mainly by junior doctors with a focus on dealing with trauma. This evolved over the decades to a consultant-supervised system and the emerging specialty of emergency medicine, dealing with more medical and major trauma patients. By the turn of the century emergency departments had become generally overcrowded, not well organised and had very long waiting times, reflecting their low priority for investment (Alberti, 2004).

As the first step to addressing the issues in the NHS, the Department of Health published ‘The NHS Plan’ (2000) which indicated that 90% of all people attending emergency departments should be seen and admitted or discharged within four hours, kick-starting a raft of reforms to emergency services within the UK.

In 2004 the target was subsequently changed to 98% of patients being seen and admitted or discharged from emergency departments within four hours.

The “four hour rule”, as it became known, led to system wide reform in the NHS as it was recognised that problems in the ED were often created by processes further down the line, such as poor bed management.

One outcome of the redesign process in the NHS is that patients are now seen by more experienced staff members early in their presentation to ED. This has led to increasing Consultant presence in EDs and the uptake of Emergency Nurse Practitioners and Specialist Musculoskeletal Physiotherapists to carry much of the burden of treating ‘minor’ injuries.

The other major area for change was community services. The NHS created ‘walk in centres’ and minor injury units based in the community to relieve EDs in major hospitals. Links were forged with teams dealing with the elderly, those with mental health conditions and for chronic disease management, to ensure a continuum of patient care across the spectrum.

Despite initial criticism, the NHS target of 98% of patients being seen and admitted or discharged from ED within four hours was achieved by most institutions in England by 2005. Meeting the target was a result of relentless commitment and hard work, however there is an overwhelming feeling that the reforms have created positive change within the NHS.

“Having worked in the NHS in 1992-1993 the improvements we observed from the clinical redesign projects (centred around the four-hour target)...are nothing short of miraculous.”

“Fast-forwarding to the present NHS and the redesign of ED, triage, flows, early diagnosis and review by senior medical staff, coupled with quicker investigations and improved ward management and discharge procedures, has improved clinical outcomes dramatically.”

Dr Tony Ryan
Summary of Tour Findings

The tour proved to be a valuable experience and provided important lessons for proposed reforms in WA Health.

**Strategic Intent**
Themes that emerged at each of the sites throughout the tour were clear and consistent, and provided WA Health delegates with a firm strategic intent for a possible similar program in WA.

Delegates were informed at every site that the program is about providing quality care and enhancing the whole patient journey, not just about meeting targets at the front door of the ED.

Extended roles in medicine, nursing and allied health were also pivotal to the flow of patients through ED in the NHS. This program will offer staff greater prospects to extend their roles and to access research and teaching opportunities.

There was consistent agreement among the UK delegates that the target of four hours, at 98% as set by the NHS Emergency Demand project, is an appropriate and sustainable target to ensure long-term change. At each of the sites visited there was unanimity among leaders and clinicians in the NHS that this target was appropriate and that it was much preferred over the previous system.

**Central Project Management, Local Implementation**
WA Health delegates were continually informed that for successful implementation of the project, hospitals would require direction in what needs to be achieved, but not how to achieve it.

A collaborative approach was used in the NHS to provide central oversight to the project, using a redesign system that mandated such things as methodology, governance, key positions, timelines, outcomes, targets and reporting requirements. Project implementation and the redesign of associated clinical services required strong leadership and relentless commitment at a local level. Clinical leaders in each institution were empowered to analyse current processes and decide how to achieve the target. This involved identifying champions and leaders at all levels; engaging clinicians and patients; and shifting hospital culture to bring diagnosis, management and consultant review forward.

“My impression prior to the visit was that the four-hour rule would be too blunt an instrument that did not allow enough flexibility to deal with individual patients. Having completed the tour, however, I came away convinced that having a four-hour rule applying to patients in the emergency department realises efficiencies throughout the hospital, is both well received by patients and evidence suggests clinical outcomes are also improved. All staff we spoke to spoke positively of the change and all agreed that the current system was far superior to what had existed prior to the four hour rule.”

Prof Gary Geelhoed
Common Redesign Elements
The sites visited by WA Health delegates throughout the UK tour informed the common redesign elements that made the UK program successful.

A recurring theme in the redesign of NHS hospitals was a focus on the patient journey throughout the care process. Examination of the patient journey led to the development of models and protocols for the management of patient care.

Most hospital sites in the UK have modified their approach to nursing triage. It was felt that the previous triage process contributed to queues in the ED and did not add value to the ED patient experience. The triage process has been modified to direct patients to different streams or pathways, such as minor admissions, major admissions, medical admissions and surgical admissions.

Another common approach used in the UK was the use of Acute Assessment Units (AAU) and Clinical Decision Units (CDU) located in or close to the ED. Patients in the CDU are admitted under the care of an ED consultant if they require observation or diagnostics.

It became clear to the delegates that in order to achieve the targets of the emergency demand program in the NHS, early decision making from experienced staff members was necessary. This had a flow-on effect to workforce and training issues such as the role of the physician generalist, extended roles for nursing and allied health, and acute general medicine training. Early decision making was supported by early diagnostics and prioritised access to pathology and radiology for emergency patients.

The targets also encouraged hospitals to create initiatives around discharge of patients from the ED. It has become standard practice to discharge patients early in the morning and on weekends; to proactively seek out patients that could be moved to discharge lounges and/or wards; to have every patient reviewed early in the morning by a senior doctor (or similar) and to actively case manage those patients whose discharge is delayed.

Furthermore, safe and effective discharge of clients was supported by community linkage and ambulatory care initiatives. Closely monitoring and supporting frequent users of the health system, including the elderly and clients with complex care needs, reduced unplanned presentations to the Emergency Department.

Responsibility and accountability for achieving targets has been placed squarely on senior staff at hospital sites and financial rewards have been introduced for those English NHS sites that achieve targets early. Conversely, Trusts who fail to achieve face strict performance management.

“The program was not just about hitting the target, but missing the point. It was driven by a collaborative of people who were willing and passionate about delivering high quality patient care across all levels.”

Dr Frank Daly
St Mary’s Hospital, Imperial College Healthcare NHS Trust, London

St Mary’s Hospital in London was founded in 1845. In October 2007 the Hospital merged with four other West London Hospital’s and the Imperial College London Faculty of Medicine to form the Imperial College Healthcare NHS Trust, now the largest NHS Trust in England. In combining the health care expertise of five hospitals and the academic excellence of one of the world’s leading Universities, the Trust has developed the UK’s first Academic Health Science Centre (AHSC) aimed at bringing the benefits of cutting edge research to patients faster.

The Trust has received ratings of “Good” for both ‘Quality of Services’ and ‘Use of Resources’ from The Healthcare Commission.

St Mary’s Hospital houses 715 inpatient beds in the West London area. Key clinical service areas include:

- Medicine
- Surgery
- Cancer
- Maternity and obstetrics
- Paediatric services
- Genito-urinary medicine and HIV/AIDS.

The Emergency Department operates a 24-hour service staffed by accident and emergency Doctors and Emergency Nurse Practitioners. The Emergency Department has dedicated Paediatric and Ophthalmology services.

At St Mary’s Hospital the WA tour delegates met with clinical leaders Dr Rupert Negus, Dr Julian Redhead and Mary Dahwood. They were informed of the huge structural changes across the NHS with the introduction of the emergency demand project, and the willingness to do “whatever it took” to implement the reforms. The WA delegates were told of success stories and ongoing challenges of the redesign process that took place, and learned about ways that St Mary’s Hospital implemented changes at a local level.

Chelsea and Westminster Hospital, Chelsea and Westminster Hospital NHS Foundation Trust, London

The Chelsea and Westminster Hospital, which was officially opened by Queen Elizabeth II in May 1993, became a Foundation NHS Hospital in October 2006. It has recently received scores of ‘Excellent’ for both ‘Quality of Services’ and ‘Use of Resources’ from The Healthcare Commission. This ranks the Trust in the top 5% nationally and the top 4% of NHS Trusts in London.

The Hospital acts as a teaching centre for the Imperial College School of Medicine and Thames Valley University in Nursing, and provides services for local populations in areas of South-West London.

The Chelsea and Westminster Hospital has 665 inpatient beds, and provides services under five Clinical Directorates, including:

- Medicine
- Surgery
- Women and childrens
- HIV and sexual health
- Anaesthetics and imaging.

Source: www.leeds.ac.uk/medhealth/apm/photos/uk.html
The 24-hour Emergency Service deals with 90,000 patients a year, 30,000 of whom are children seen in the separate paediatric unit. The Emergency Department team consists of seven Consultants, seven emergency Nurse Practitioners and a range of allied professionals. Nursing staff are advanced trained to enable them to practice autonomously and with extended scope.

The Hospital has a six-bed observation unit for those patients who may need more intensive investigation, and an Acute Medical Unit including 21 inpatient beds and a five-bed assessment area to provide specialist care for adult patients.

At Chelsea and Westminster Hospital the WA tour delegates gathered further information about local implementation of the emergency redesign process. More specifically, they discussed the set up of the Emergency Department and the Acute Medical Unit, bed management, streaming of patient pathways, staffing profiles, and workforce issues.

The Royal London Hospital, Barts and The London NHS Trust, London

The Royal London Hospital was founded in 1740 and has been located on its current site in East London since 1757. It established the first hospital-based medical school in England (The London Hospital Medical College) in 1785. The Hospital has been part of the Barts and The London NHS Trust since 1999.

In March 2005 planning permission was granted for a £1billion redevelopment and expansion of The Royal London Hospital. On completion of the ongoing project, the hospital will have London’s leading trauma and emergency care centre, one of Europe’s largest renal services and the London’s second biggest paediatric service.

In 2007/2008, 161,598 people attended The Royal London Hospital Accident and Emergency Department (A&E), and it has recently been commended for its delivery of urgent and emergency care. The Healthcare Commission found emergency care at The Royal London Hospital is being delivered well overall, scoring a ‘best performing’ rating. The Commission’s findings noted that the urgent care being delivered was highly effective when assessed against the percentage of people who are returning to A&E within seven days (rating 5 out of 5). The Royal London Hospital A&E was also rated 4 out of 5 for the ability for patients to access treatment in a way that met their individual needs.
Addenbrooke’s Hospital, Cambridge University Hospitals NHS Foundation Trust, Cambridge

Addenbrooke’s Hospital, founded in 1766, is a teaching hospital with close links to the Cambridge University School of Medicine. It has recently received scores of ‘Excellent’ for both ‘Quality of Services’ and ‘Use of Resources’ from The Healthcare Commission.

The Hospital has 1,050 inpatient beds for a catchment population of 500,000, and is considered a regional centre of medical excellence in the key service areas of:

- Specialist services for organ transplantation
- Cancer
- Neurosciences
- Paediatrics
- Genetics.

The Emergency Department, incorporating the Medical Assessment Unit (MAU), acts as a single point of access for all Emergency patients and deals with over 81,000 presentations per year.

Delegates from WA Health heard about ambitious plans for a major redevelopment of the Addenbrooke Hospital site, which includes almost doubling staff numbers, developing public space, public transport services, a hotel and conference centre and a multi-level car park.

Whilst in Cambridge, delegates heard about tight methodology and pluralistic leadership, whereby clinical leaders, project managers and Hospital Executives worked collaboratively to effect change. Leadership groups in the NHS were told WHAT targets to achieve but not HOW to achieve them, further reiterating the importance of local leadership.

Frenchay Hospital and Southmead Hospital, North Bristol NHS Trust, Bristol

North Bristol NHS Trust provides care from two large acute hospitals, Frenchay Hospital and Southmead Hospital. The Trust, which was established in 1999, provides all hospital based medical and surgical services to the local population of North Bristol, South Gloucestershire and North Somerset, and maternity and paediatric services for a local population of approximately 500,000.

The Trust provides 1,028 inpatient beds across the region, and in 2006/07 the Trust delivered over 5,400 babies, cared for more than 86,000 people who presented to the Emergency Department, saw over 318,000 outpatients, and cared for over 115,000 inpatient and day case patients. The Healthcare Commission recently rated the ‘Quality of Services’ provided by the Trust as ‘Fair’.

Tour Group with Sonia Mills (centre), Chief Executive Officer North Bristol NHS Trust, Bristol
Frenchay Hospital, founded in 1921, was originally a sanatorium for children with tuberculosis and has developed into a major Trauma Centre. All the emergency services for the region are provided through the hospital and it has successfully implemented a nurse-led minor injury unit. Other key clinical services provided at Frenchay Hospital include:

- Major trauma
- Regional specialist centre for neurosciences, including neurology, neurosurgery and neuropsychiatry
- Plastic surgery and burns
- Orthopaedics.

Southmead Hospital was opened in 1902 as a 64 bed ‘workhouse’ for poor and sick people. It is currently undergoing redevelopment that will see services diverted from the larger Frenchay Hospital to the Southmead site by 2013. Key clinical services provided by Southmead Hospital include:

- Urology
- Renal medicine and transplantation
- Infectious diseases
- Neonatal medicine
- Maternity services
- Orthopaedic services
- Pathology.

In Bristol Dr Steve Meck, an Emergency Physician, outlined contextual factors to bear in mind when embarking on projects around managing emergency demand. These included patient centred care, models fit for the 21st century and an emphasis on improved health outcomes. He echoed the views of other speakers in the UK by focusing on “whole-system change” inclusive of community and primary care. He demonstrated that projected growth of emergency demand was higher in his area than actual growth, and attributed this to primary care services decreasing presentations to ED.

Royal Infirmary of Edinburgh (RIE), NHS Lothian Trust, Scotland

Established in 2001, NHS Lothian is the “umbrella” organisation for all Lothian health services, including the Royal Infirmary of Edinburgh (RIE), Edinburgh Royal Hospital for Sick Children and St. John’s Hospital of Livingston.

The RIE, established in 1729, is the oldest hospital in Scotland. It provides acute medical and surgical services for patients from across Lothian and specialist services for people from across the south east of Scotland and beyond. Throughout its history it has maintained close ties to the University of Edinburgh.

Key clinical services include:

- Accident and emergency
- Acute medicine
- Cardiology and cardiothoracic surgery
- Gastroenterology
- General surgery
- Maternity, gynaecology and neonatal units
- Orthopaedic surgery
- Renal services
- Respiratory medicine
- Transplant surgery (kidney, liver, pancreas and bone marrow transplant)

The RIE operates a 24-hour Accident and Emergency Department, dealing primarily with the needs of adults. Presently, the Department treats over 1,500 patients every week.

Whilst at the RIE, Joan Donnelly explained to the delegates how their hospital involved patient groups and clinicians in forming strategic decisions. Clinicians were asked to inform executive groups about patient flow and pathways for particular patient groups.

Patient groups felt that the project should focus on quality of care and could see the benefits of using nurse practitioners. They also indicated that they were prepared to travel longer distances for expert care or earlier admission.
Royal Hospital for Sick Children Edinburgh, NHS Lothian Trust, Scotland

The Royal Hospital for Sick Children, which was formally opened by Princess Beatrice in October 1895, cares for around 100,000 children per year in the key clinical areas of:

- Accident and emergency
- Anaesthetics
- Burns
- Cardiology
- Ear, nose and throat
- Gastroenterology
- Haematology
- Infectious diseases
- Neonatology
- Nephrology
- Neurology
- Neurosurgery
- Oncology
- Ophthalmology
- Orthopaedics and plastic surgery
- Paediatric medicine and surgery
- Rheumatology.

The NHS Lothian Health Trust is currently developing plans for a new children’s hospital, due to open in 2012 which will be located adjacent to the RIE.

St. John’s Hospital Livingston, NHS Lothian Trust, Scotland

St John’s Hospital, founded in 1989, is a 550 bed teaching Hospital for the University of Edinburgh School of Medicine. The St John’s hospital recently received a £3.5 million upgrade of its emergency department. It provides key clinical services in the areas of:

- Accident and emergency
- General surgery
- Orthopaedics
- General medicine
- Obstetrics and gynaecology (2,500 births/year)
- Paediatrics
- Psychiatry
- Oral and maxillofacial
- Burns and plastic surgery
- Main regional centre for elective surgery.

Wishaw General Hospital, Lanarkshire NHS Trust, Scotland

The Lanarkshire NHS Trust is responsible for providing services to a population of more than 553,000 people living within the North and South Lanarkshire local authority areas. The Trust manages three hospitals in the region- Wishaw General Hospital, Monklands Hospital and Hairmyres Hospital.

Wishaw General Hospital, opened in 2001, is Scotland’s second largest maternity Hospital with 5,500 births per year. It is also home to a Paediatric Neonatal Unit and Elderly Care and Psychiatric Day Hospitals.

The 24-hour Emergency service contains an integrated Accident and Emergency unit with a 36-bed ward. Each year the Hospital provides around 15,000 emergency inpatient admissions, 13,500 day case procedures, 86,500 new outpatient attendances (including Accident and Emergency attendances) and 34,000 inpatients.

Source: www.nhslothian.scot.nhs.uk/hospitals/rhsc.asp
Monklands Hospital, Lanarkshire NHS Trust, Scotland

Monklands Hospital, founded in 1977, is a medium-sized general hospital serving a population of approximately 260,000 people in the North and South Lanarkshire council areas. There was a local maternity hospital on the site since 1919, which closed in 1962 and was demolished to make way for the Monklands Hospital. The Hospital gained media attention in 2007 when the newly formed Scottish Parliament overturned a decision to close the Accident and Emergency Department.

The Hospital has 473 inpatient beds and provides services in the key areas of:
- Renal services
- Ear nose and throat
- Dermatology
- Communicable disease.

The Emergency Department offers a 24-hour service and is attached to a 36-bed Emergency Receiving Unit (ERU).

Hairmyres Hospital, Lanarkshire NHS Trust, Scotland

Hairmyres Hospital, founded in 1919 as a tuberculosis sanitorium, is a district general hospital serving one of the largest elderly populations in Scotland. The hospital has 415 inpatient beds and 20 day beds and is affiliated with the University of Glasgow Medical School.

The Hospital operates a 24-hour emergency department and services in the key clinical areas of:
- Emergency medicine
- General medicine
- Oncology
- Psychiatry
- Care of the elderly
- General surgery
- Orthopaedics
- Ophthalmology
- Cardiothoracics.

Key themes emerged throughout the meetings with clinical leaders and administrators in Lanarkshire that reinforced the delegates experiences throughout the trip. This included:
- The need to focus on the whole patient journey rather than just the front door of the ED;
- Focusing on quality of care rather than targets;
- Staff expressing that they did not want to go back to the previous system of emergency care;
- The importance of early communication with patients of expectations of their care;
- The need for a commitment and willingness to meet targets; and
- The importance of analysing “breaches”.

“For a system that had had similar demand pressures to those we experience here, it was evidence of the impact that system wide changes have made to walk into a very busy London ED mid morning on a Monday to find a near empty waiting room.

The extent of redesign of processes in all areas of the patient journey and the impact this had, along with the dedication of the staff to improving the patient experience were key aspects of the visit for me.”

Jenny Brenton
Delegate Meetings

Sir George Alberti, National Clinical Director
Managing Demand, Dept Health, UK

Whilst in the UK the delegation met with Sir George Alberti, National Clinical Director of Managing Demand. Sir George emphasised the relentless commitment and serious focus that was required for the NHS to achieve the target of 98% of patients being admitted, discharged or transferred within four hours of presenting to EDs, across England by 2005.

Sir George felt that an important element of the success was that the project was clinically led and locally implemented. Six regional leaders were responsible for implementing change in approximately 30 hospitals, each with the regional leaders being supported by local clinical leaders who were senior nurses in each of the EDs. Strict project management protocols were followed whereby tasks were tackled in sequential order and quarterly collaborative meetings were held.

Use of incentives ensured that targets were met by the local sites. These included financial incentives to Trusts who met targets early (English NHS Trusts only), environmental enhancements, and funding linked to ratings from the Healthcare Commission. Conversely, penalties were given to those Trusts who “breached” targets. Penalties included reduced funding, rigid management regimes and reduced Healthcare Commission ratings.

At a clinical level, Sir George discussed the need for early clinical decisions to be made by senior staff. Each Emergency Department is staffed by 10-12 Consultants and around six Acute Physicians staff the associated Assessment Units. Departments also used the skills of Extended Practice Nurses to complement senior medical staff.

Focus on early discharge, from the initial point of presentation, was seen as a key element to ensuring patients were discharged from ED within target timeframes. Every patient was reviewed by the ED team by 11am, seven days a week. Review prior to 11am was found to enhance discharge from ED. Community and social interventions were coordinated early in the presentation, including transport, and primary care teams joined the ED.

Capacity modelling of services outside the Hospitals was something that Sir George felt should be completed early in the process. In the UK, some smaller urgent care centres (called Walk-In-Centres) were run by Emergency Nurse Practitioners and GPs.

“Allied Health Professionals (AHP’s) and Pharmacists contributed significantly to the safe, timely, effective and supported discharge of the elderly and clients with complex needs.

“Quoting Sir George Alberti, ‘Allied health are the jewels in the crown when trying to achieve the targets along the continuum of care.’

It was inspirational to see the collaborative interface between Medical, Nursing and Allied Health professionals working towards a common goal of high quality patient care.

Marani Hutton
Nurse Practitioners were pivotal in the planning, implementation and the ‘doing’ of the four hour rule target in all UK hospitals visited by the ED demand team.

Increased scope and high levels of responsibilities have meant that recruitment and retention of the nursing workforce did not seem to be a major issue for most hospitals.

Anthony Dolan

Prof Derek Bell, Professor Acute Medicine, Imperial College London, Co-Chairman of the Acute Medicine Task Force, Royal College of Physicians London

Professor Derek Bell is the first appointed Professor of Acute Medicine in the UK and the first President of the UK Society for Acute Medicine. He has been involved in the establishment of Acute Medicine as a specialty and is currently Co-Chairman of the Acute Medicine Task Force, Royal College of Physicians, London. Derek has been directly involved in large national reform programs in acute medicine, including the Emergency Services Collaborative, and the Unscheduled Care Collaborative for the Scottish Government. Derek was a valuable resource for the tour group, addressing the progression of emergency demand reforms in England and Scotland and the key factors that drove reform in the UK.

Karen Middleton, Chief Health Professions Officer and Professional Leadership Team

The tour group met with Karen Middleton, the Chief Health Professions Officer and Professional Leadership Team Manager for the UK Department of Health. Karen spoke of the usefulness of the “patient voice” in engaging health professionals to meet the targets set by the UK project.

Karen discussed the roles that key professionals played in the implementation of the project in EDs. She reported that paramedics, physiotherapists and occupational therapists were important team members in preventing unnecessary admissions and dealing with social care issues. Karen also spoke about extended scope and expanded breadth of roles in medicine, nursing, and allied health, and the importance of training staff early in the process.

Karen reiterated the point that several speakers made about examining the whole pathway of patient care, not just a focus on the four hour rule.

Mark Jennings, Priority Programme Director, NHS Institute for Innovation and Improvement

The tour group met with Mark Jennings and discussed delivering quality and value, and ways to increase productivity in the system. Mark led the Prime Minister’s Delivery Unit review which focused on the patient journey through emergency care. Mark was also a member of the project team responsible for reforming Accident and Emergency departments and the four-hour rule.

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References


St Mary’s Hospital (London) photo sourced: http://www.leeds.ac.uk/medhealth/apm/photos/uk.html

The Royal London Hospital (London) photo sourced: http://www.leeds.ac.uk/medhealth/apm/photos/uk.html

Royal Hospital for Sick Children (Edinburgh) photo sourced: http://www.nhslothian.scot.nhs.uk/hospitals/rhsc.asp