Coordinating care, prioritising patients

QFI Consulting's Alex Knight provides insight into Theory of Constraints principles that can help to eliminate disruption and delay and put patients back at the centre of care…

The Royal College of Physicians (RCP)'s report 'Setting higher standards' presents an alarming picture of England's health and social care system and calls for a radical change in thinking to alleviate increasing pressure on our hospitals. It is my view that the problems highlighted in the report are not caused by insufficient capacity or resources, but by a lack of synchronisation and prioritisation of care, which in turn causes delays, harms quality of care and wastes resources.

The RCP's extensive research into the state of the UK healthcare system is a valuable call to action to halt a widespread trend. But amid ensuing demands for more beds and greater resources to be made available, it is necessary to look first of all at the work of some pioneering NHS trusts, which have made compelling and sustained improvements in service delivery and length of patient stay, simultaneously increasing the quality and timeliness of patient care within ever-tighter budget constraints.

The impact of disruption and delay

In my experience of working in acute NHS hospitals, most doctors and nurses spend a considerable portion of their time dealing with disruption and delay rather than providing high-quality care. For patients, this means most of their journey is spent waiting for treatment rather than receiving it. This disruption and delay is evidenced through queues that come and go throughout the system – the phenomenon of the wandering bottleneck – and is most often due to a lack of prioritisation or synchronisation in the delivery of treatment. The outcome is that many patients will be rehabilitated more slowly than necessary, often remaining in expensive acute settings longer than they need to, increasing the cost of their treatment and the chance of them succumbing to secondary health complications, particularly in the case of elderly patients.

If we consider that each patient requires the work of many different resources – people and treatments – before they are clinically fit to go home or into community-based care, then it follows that a failure to coordinate resources across their entire journey will result in a loss of productive capacity, wasted operating expense, reductions in quality of care and increase in pressure on staff.

When each individual delay is multiplied by the thousands of patients admitted each year, the enormous scale of waste in productive capacity and operating expense felt by the entire healthcare system, including acute, community, rehabilitation and mental healthcare, comes into stark focus.

Extensive research and common anecdotal evidence from health professionals indicate that the quality and timeliness of care rapidly deteriorate when staff are over-stretched or have too many simultaneous demands on their time. Indeed, catastrophic failures most often occur during extended periods of unreasonable staff pressure. Simply adding extra resource does not address the root cause of the problem and instead risks financial viability by increasing operating expense in a time of zero revenue growth. At the same time, trying to find system-wide consensus of the underlying cause of delay and disruption is, not surprisingly, met with finger pointing and resentment.

Root causes

A major stumbling block to reducing delay and improving patient flow through hospitals has been the seeming complexity of the task. Many hospitals have attempted to address the problem by trying to improve the performance of each patient pathway. But with thousands of patients suffering from thousands of conditions that require thousands of treatment permutations, often in many different areas of the hospital, this has proved a lifetime's work. And this approach inevitably leads to a series of local efficiencies that are quickly hampered by the inefficiencies of other departments.

Theory of Constraints principles offer an alternative view: that the more complex a goal-oriented system appears, the fewer obstacles or constraints are impacting on its performance. Therefore, identifying which resource causes the most disruption and delay to most patients' journeys, and therefore which improvement would have the most positive system-wide impact on patient flow, has been shown in practice to result in the quickest and most dramatic improvements in performance.

In most hospital settings, two categories of disruption and delay typically exist: internal factors, which often relate to conflicting priorities and the inevitable bad multi-tasking of clinicians and support departments (such as physiotherapy, radiography or pharmacy) and external factors that disrupt the timely flow of patients out of acute hospital care where the synchronisation of resources is required across organisations and multiple

Identifying and addressing the biggest disruptions to patient flow enables system-wide improvements to be made

stakeholders. Here the lack of synchronisation and bad multi-tasking manifests itself in extended delays due to the necessary but largely administrative form-filling required. Patients are clinically fit to be discharged but are stuck in the most expensive part of the whole system.

A patient-centric approach

In my experience, the key to reducing disruption is to take a very patient-centric approach to care. This includes setting planned discharge dates for each patient and then sequencing clinical and administrative tasks to provide the patient with the right care at the right time to prepare them for discharge. In the case of patients who are expected to need ongoing care in a community setting, for example, it also means increasing the regularity and clarity of communication with external agencies including rehabilitation providers and social services. In this way, increasing patient flow through the most appropriate channels of care, and ensuring each patient receives care in a timely manner, has always been achieved without increasing capacity or financial resources.

Take, as examples, the work of Derbyshire Community Health Services Trust, Barnet, Enfield and Haringey Mental Health Trust, and Princess Alexander Hospitals NHS Trust, all of which improved the quality and timeliness of care and cut excess bed days by between 20% and 48% within six weeks by introducing systems to synchronise and sequence tasks and improve coordination between internal departments and external agencies. This approach, which follows Theory of Constraints principles, was designed to identify and overcome the few common underlying restrictions and

increase patient flow through and out of high-cost environments in a sustainable way.

Affordable healthcare

However much we improve the performance of our health and social care system, as a nation we still face a major challenge: with such a dramatic change in demographics, even doubling the productivity of our hospitals – an achievement that I believe is totally practical and possible within a short period of time – may still prove to be insufficient, making some increase in expenditure and associated taxes inevitable.

But if, by making workable and sustainable changes, we could become the highest quality and most cost-efficient healthcare system in the world, and demonstrate it, then the NHS could once again become a global leader. Such status would in itself attract new sources of revenue and opportunities for new partnerships, including those with the global pharmaceutical industry. Rather than simply a tax-funded expense, ours could be the first country to see its health system as a competitive advantage and driver of economic growth.

1   Developing a System Resilience Approach to the Improvement of Patient Safety in NHS Hospitals, M Williams (Williams, April 2011). (North Staffordshire) The Mid Staffordshire NHS Foundation Trust Inquiry, Robert Francis inquiry report into Mid Staffordshire NHS Foundation Trust. Department of Health, 2010

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