The Emergency department

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Blog post

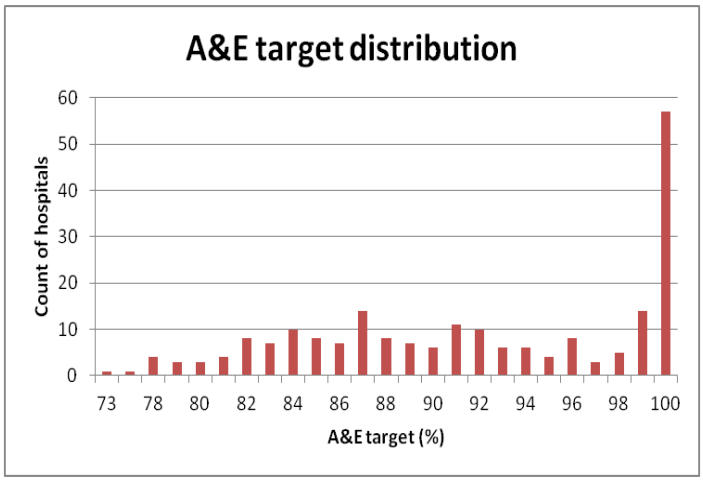
Understanding what stops us from providing high quality, timely patient-centred care

Introduction

In my blog post, 'The assessment unit is at the heart of patient flow', I talk about how the assessment unit plays a critical logistical role in soaking up the variation in arrivals and discharges throughout a day, and by doing so supports the Emergency department in providing high-quality, timely patient-centred care. But what else can the Emergency department do to support the delivery of high-quality, timely and affordable care?

The 4-hour emergency access target

The emergency access target in England states that 95% of all patients must be seen and discharged within four hours[1]. Graph 1 below shows the distribution of performance for all trusts in England against this target during the period between June 2016 and June 2017, and reveals that 124 out of 215 trusts failed to meet this target with the worst failure being 73%. However, it also shows that 4% of all trusts achieved between 95 and 95.99% and only 26% achieve 100%. Of this 26% a very high proportion were very small units, in fact there are only 15 seeing over 1000 patients per week and 1 seeing over 3000 patients per week. If we remove the small units then rather than 60%, it is closer to 75% who are not achieving the target. From this graph we can conclude that it is not easy to meet this target and excelling against it would be difficult.



Graph 1: England, June 2016-June 2017

An analysis, and the common experience of most staff working in this environment, would reveal that the touch time (when the patient is actually receiving treatment) of any one patient flowing through the system would be a very small fraction of the four hours. Of course, the reason why the target is set at 95% within four hours is to allow for those cases where the touch time itself exceeds four hours.

We can only hypothesise that if the target was reset to three or even two hours then currently a very small percentage of trusts would achieve this. If the touch time is such a small percentage of the target time one can only assume that patients are queuing within the system, waiting for their turn with the individual departments, such as x-ray, blood tests, specialist review, etc. As these queues do not appear to be

growing hour-by-hour it can only be that the capacity of the department's resources are not able to respond in a timely manner. One would think, if the queues are eliminated, touch time would make up most of the journey time and there would be no reason not to reduce the target further. Or is it that I just don't understand?

Perhaps the reason I don't understand is because eliminating the queues is not as simple as it looks. Let's follow the principles in *Pride and Joy*.

- Improving patient flow is the primary objective of any methodology.
- A patient-centred, clinically led approach is at the core of the way forward.
- Eradicating local performance measures is essential to improving the whole chain of activities.
- A focused process of ongoing improvement to balance patient flow must be in place.

Chapter six has an explanation of how to turn these principles into a practical mechanism that answers the two important questions:

- Of all the patients I could work on, which one should I work on next?
- Of all the areas I could improve, which one should I improve first?

How can this be applied in the Emergency department?

> *"Look, Linda, what we did was search for a working hypothesis which enabled us to seek a common underlying cause to the disruptions and delays in the Emergency department. We learnt something very important; something that changed our understanding of patient flow through the emergency department. You will remember that we analysed what resource or task was most often causing the most delay to the most patients and then we put all our efforts into eradicating what our analysis revealed was top of the list. But, more than that, we learnt that examining the cause at the four-hour mark proved to be a waste of time. It just showed the last resource causing the delay rather than the true underlying cause. It was only when we examined the timeliness of the flow through the journey and the causes of disruption through the journey that we really got to the bottom of it."*
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> *"Yes, Stevie, that was crafty stuff and it was only when we realised that half the problem was driven by internal behaviours and half by behaviours of resources outside the Emergency department that we were able to really identify the common resource causing disruption not only in the Emergency department but across the whole hospital. This was when we had the real breakthrough. It was only when you insisted we identified the causes of disruption through the journey that the data became meaningful."*

In any seemingly complex system there are only a few places that have the power to affect the performance of the whole system. Often it is not a lack of capacity that is the issue but the way we are managing that capacity. By replacing the local policies and practices with a system-wide perspective an immediate improvement in patient flow and overall performance can be achieved.

[1] NHS England: Improving A&E Performance, Gateway ref: 00062