additional work for all teams because the ED team must conduct a full assessment and inpatient teams then need to assess the patients in the ED.

Anecdote also suggests that there is a subset of GPs who do most of the referring to outpatient clinics and the ED. A review of the data could be utilised to identify these GPs and then engage with them on referral practices. This work could be lead by the GP Liaison Unit.

c. **Urgent Outpatient Surgical Clinics** - A number of specialties require their registrar to review patients in the ED, prior to accepting clinic referral from a doctor who has assessed the patient in the ED. This process creates extra work and delays as well as additional work for the surgical registrars. This could be significantly simplified by allowing ED Consultants to have the authority to refer to outpatient clinics without the need for additional surgical assessment. This would clearly require a simple set of guidelines, appropriate authorities and a process for escalating concerns about appropriateness of referrals.

d. **Outpatient Clinic Referral to ED** – there is a current practice in outpatient clinics to refer patients with more complex issues to the ED for admission. It is suggested that this should become the absolute exception, inpatient teams should be asked to manage this process directly into the hospital. It is recognised that there are complexities in this issue but these matters should be rightly considered and built into any solution to this issue.

e. **Medical Imaging** – currently the only mechanism by which a GP can secure urgent medical imaging is via an admission to ED. Where this occur it is necessary for the ED team to conduct a full assessment process. A linked issue relates to outpatient clinics that require urgent scanning. There is no clear process for a medical officer to secure an urgent scan in an outpatient clinic in order to be able to support medical decision making. In order to access an urgent scan, patients are being directed to the ED for further management in order to secure the scan. This is not an efficient use of the ED's resources.

   One final issue that needs to be properly explored is the availability of ultrasound services at CHHS. Generally there is no out of hours ultrasound service available, which can delay medical decision making processes. Rather than set up an expensive service one possibility would be to have an ED based ultrasound service managed by staff in the ED.

f. **Community Services** – consideration should be given to ensuring that CHHS Community Service has a bias toward direct admission of their patients to CHHS ward areas rather than through ED. Teams where this should be actively considered include:

   I. Hospital in the Home;
   II. RADAR;
   III. Mental Health Teams; and
   IV. Community Nursing.

   What is required is a full review and change to practice around how a range of CHHS units access the hospital with an approach that means patients do not access inpatient services via the ED.

g. **Admissions from other hospitals** – current practice involves many inter hospital transfers being sent through the ED even when they have been accepted by an inpatient team. All inpatients teams to be asked to have appropriate process for accepting admissions from other hospitals so that patients are admitted directly to ward areas rather than through the

ED. If further investigations are required then these should be managed from the ward and not the ED. An example of this type of process centres on cardiology. In 2015/16 cardiology and the Division of Critical Care worked in partnership with NSW Ambulance, ACT ambulance and Southern LHD to enact a change that resulted in patients requiring urgent angiography being transferred directly to the catheter lab and not being assessed in ED. This was a complex piece of work that required careful consideration on how risk should be managed but it has now been working successfully for a number of months.

h. **Orthopaedic Services** – it is noted that GPs will often send patients to the ED for orthopaedic management. A pathway could be established that will allow for direct admission or referral to an outpatient clinic. If plastering is required this could be a service that was delivered by the Walk-in-Centres in partnership with general practice. As part of this approach greater training could be provided to GPs in the management of fractures.

i. **Obstetric Services** for women bleeding in the first trimester of pregnancy – the system of referral to the Early Pregnancy Assessment Unit (EPAU) needs to be opened up to GPs. Currently access to the EPAU must be via the ED which requires triage and full assessment before referral to the EPAU. A previous system of patients being assessed by the triage nurse and then being sent to the Gynaecology ward appeared to work well and needs to be considered for re-institution.

j. **ED Practices**

Literature shows that one of the major reasons patients present to the ED is the convenience of the "one stop shop". CHHS ED has increased this convenience and inadvertently re-directed the patients to ED as opposed to general practice.

i. **Medication provision** - An example is the provision of take home packets of medication. Medication should be given in take home single packs and the patient directed to a pharmacy for the balance of the script. Provision of a full course of antibiotics is not appropriate and simply encourages representations as the cheaper most convenient option for the patients. The exception would be where the patient was struggling to get access to pharmacy services out of hours. This type of subtle disincentive needs to be built into hospital process where appropriate and clinically safe.

ii. **Regional Demand** - Coordinate Yass/Cooma/Goulburn/Queanbeyan referrals. A relatively simple and cost effective approach would be to engage with regional hospitals with a clear process for referral to ACT hospitals. The current tendency is to send any referrals to CHHS. However a clear engagement and communication strategy should be employed to emphasise what can be transferred to Calvary. Examples include non STEMI chest pain and drug overdoses.

3. General Practice

i. Consideration needs to be given to providing incentives to general practices to improve and expand out of hours services provided across the ACT – this a complex and much fraught piece of work. GP clinics are pulling back from Out of Hours Care. The reasons for this are complex and include issues of cost, the increasingly part time nature of the GP workforce, generational change as well as the competition provided from the National Home Doctor Service and high level services provided by

EDs and the WiCs. A clear GP strategy needs to be developed that promotes more active partnership. An example could be support for general practice through the use of "in-reach" services into general practice provided by ACT health community teams or partnership in the running of specific clinics in WiCs. An example could include a GP lead fracture clinic.

ii. GP availability is likely to have a much higher impact on presentations to the ED than issues around the availability of WiCs. This issue requires full investigation but key processes that would assist GPs with out of hours service would be to improve medical imaging and pathology service availability out of hours. How such support would be structured will require careful consideration.

4. Walk in Centres

The current Walk in centres in Canberra see around 34,000 people per year. The walk centres have two key user groups age 3-6 and ages 18 – 22. In the first quarter of the 2016 – 2017 financial year the WICs saw and treated 81% of the presentations, referred 10% to GP and 7% to ED. In their current form it should be noted that WiCs appear to have had minimal impact on the rising demand for services at EDs. In fact it could be argued that the WiCs have created a "new class" of health consumer who would have probably stayed home previously and self managed the complaint. The data provided below would tend to support this assertion.

The WiC team conducted a survey of all people who presented in June 2015 where the following question was asked:

QUESTION ASKED: "If the Walk-in Centre was not available, where would you have gone instead of today?"

The respondents indicated the following:

- 43% - Would use either their own or other GP (this would have equated to 4536 people in first quarter 16-17)
- 18% - Would use an ED (this would have equated to 1701 people in first quarter 16-17)
- 16% - Would stay home (this would have equated to 1512 people in the first quarter 16 – 17)
- 7% - Would use a Pharmacy / Chemist (this would have equated to 662 people in the first quarter 16/17)

In considering the use of the walk in centres in relation to moderating demand in the ED the following observations are made:

a. It would seem reasonable to include the WiCs in any campaign that seeks to direct the Canberra public to an appropriate service – see discussion below on relevant communication strategy. This should rightly include specific demographic groups;

b. It is clear that in seeking a greater usage of the WiCs consideration should be given to access to such services as diagnostics (Pathology and Medical Imaging). There has been consistent feedback that access to these services, particularly after hours, is a key issue.
c. Further active collaboration with GPs should be considered. One idea that has been put forward is the establishment of GP driven fracture clinics in Walk-in-Centres. This idea has merit in that it works to strengthen the knowledge and skills of general practice, partners properly with primary care and eases demand on hospital based services. The data above does seem to indicate that consumers are using WiCs in preference to GPs to a note insignificant degree. This feeds into some of criticisms by general practice of the WiCs and needs to be considered careful in any GP engagement strategy.

5. Community Communications

One of the key challenges in dealing with the rising demand for ED services is to have a structured "conversation" with the Canberra community. Such a "conversation" must be consistent and delivered across a period of years to encourage ACT residents to make better use of other health services in the community and to ease pressure on the Emergency Department at The Canberra Hospital.

A key issue to note in considering such a strategy is the net movement of patients past Calvary Hospital to CHHS. Data indicates that a significant number of Canberra residents choose to drive past Calvary Hospital to access the CHHS ED. The below data table describes this trend.

Year	Calvary Hospital		CHHS		ACT	
	Daily Presentation rate	Annual Presentation Rate	Daily Presentation rate	Annual Presentation Rate	Daily Presentation rate	Annual Presentation Rate
2013-2014	151	55276	193	70614	345	125890
2014 - 2015	154	56340	202	73624	356	129963
2015-2016	158	57695	212	77747	370	135442
2016-2017	161	37611	232	54210	393	91821

The 3.5 financial years of data presented in the table demonstrates the daily presentation rate at Calvary Hospital has increased by 6.6% across this period. In the same period the daily presentation rate at CHHS has increased by 20.20% across the same period.

The current year on year growth in daily presentation rate at Calvary Hospital is 1.9% and in the 2015/ 16 year it was 2.5%. As noted earlier the growth rate at CHHS this financial year as at the 20th February 2017 is 11.9%. This is clearly placing a significant strain on CHHS and absorbing the planned future capacity of the ED that was delivered by the recent ED Rebuilding programme.

The Communication Strategy would highlight the range of quality primary healthcare service options available within the broader ACT community, particularly in Canberra's north, as well as services available to assist with seasonal healthcare conditions and chronic disease management. This includes the wide range of community services available through ACT Health.

A suite of tools, including digital and hardcopy collateral would be developed in conjunction with other service providers to reach specific demographics and make it easy for people to find the best services available nearest to their home location.

The information would highlight the quality and convenience of services provided at Calvary Hospital – including emergency, paediatrics, mental health, obstetrics, gastroenterology and respiratory care, orthopaedics and surgery; as well as those proposed for the new University of Canberra Public Hospital in areas such as rehabilitation and mental health.

Dedicated campaigns would also be undertaken in the lead up to the flu season, known asthma and respiratory illness peaks and outbreaks of communicable diseases.

Communications would also promote the benefits of visiting GPs and Walk-in-Centres, and other primary and allied healthcare services and would seek to clarify when to visit the Emergency Department at Canberra Hospital.

Furthermore, the strategy would contain tools to evaluate and measure the effectiveness of the strategy on patient behaviour in relation to emergency department presentations.

The development and implementation of this communications strategy would be a key component of the overarching ED Demand Moderation business case. It is noted that the Capital Health Network is already in discussion with ACT health around a social media campaign that is aimed at having ACT residents consider other service options before presenting to the ED.

6. Residential Aged Care Patients

The number of patients presenting from residential aged care facilities (RACF) is relatively small but such presentations have a big impact on the ED and other services at CHHS in terms of the services absorbed, particularly with the increased incidence of dementia. Services that are impacted by this cohort include aged care services at CHHS, ACT Ambulance Service and of course the ED.

This patient cohort present for a range of reasons that include:

- Relatively minor injury and illness;
- Staffing issues in particular facilities
- Lack of regular on call GPs

A better developed in-reach service to these facilities should be considered as an adjunct response to the issue of rising ED demand. It is noted that there have been recent government commitments to additional Nurse Practitioners in the ACT. It is suggested that a portion of these practitioners be deployed to provide further in-reach services to aged care facilities in Canberra working in partnership with general practice.

Geriatric Nurse Practitioners – approximately 10 years ago 2 geriatric nurse practitioners were trained. The ideal position would be that each (major) nursing home has an allocated Geriatric NP attached to their facility. The function of these practitioners would be to:

- co-ordinate Advance Care Planning;
- immunisations,
- PED and IDC tubes falling out /blocking /
- simple lacerations /wound management,
- subcutaneous fluid replacement for gastro,
- simple antibiotics for UITI etc.

It should be noted that there are a wide range of nurse practitioner services available already through ACT Health that include:

- CNC Complex care;
- Wound – Nurse Practitioner;
- ASET nurse
- Community nutrition Team
- Etc.

The question to be asked is whether a more strategic approach to the use and structure of these services would assist in moderating RACF referrals to ED. This issue requires close review and consideration.

7. Research into the Challenge and Learning from other Jurisdictions

Prof Kirsty Douglas Professor of General Practice (ANU) and Director - Academic Unit of General Practice ACT Health, will be undertaking a body of work in April 2017 that is a study into the use of After-hours Primary Health Care Services in the ACT in an 84-hour snapshot study. This is a repeat piece of work that will be utilised to inform the ongoing work that is aimed at moderating the demand for service at the CHHS Emergency Department.

It is understood that while demand moderation represents a significant challenge it is an issue that receives considerable attention in other jurisdictions. To that end it is recommended that an immediate review of the literature be undertaken to inform the Demand Moderation Strategy in the ACT. Recent discussions have highlighted an initiative in the North East of England that engaged health, police, community services etc that was successful through a shared strategy in moderating the year on year rise in presentations. Such an approach should be fully considered in the ACT. Initial efforts in reviewing demand moderation strategies could be undertaken by key academic staff at CHHS.

8. More controversial ideas

Consideration of a trial of directing selected patients elsewhere after arrival at Canberra Hospital ED, rather than waiting for non-urgent assessment/management. This could, for example, include a trial of an Emergency Medicine Specialist at/in the triage area for peak periods from late morning to early evening. The peaks in presentations during this period are increasingly frequent and problematic. Such a trial may show that selected patients can be directed away from the ED after a very brief assessment of the presenting problem. It is not suggested that this be a first tier response for demand moderation given the significant, clinical, operation, reputational, political and legal risk

that such an approach could entail. It also important to note that there would likely be significant debate within the ED and wider hospital team as to the merits of such an approach

9. Recommendations for Action

Recommendation 1 (Project Governance) –

a. That a formal body of work be established in ACT health known as the ED Demand Moderation (EDDM) Programme

b. That the EDDM programme be under the direction of an Operational Executive Director;

c. That EDDM be a formal body of work that is fully supported as a SIP project for at least the next 2 years.

Recommendation 2 (Streams of Work)

a. **Stream 1 - Community Communication –** That a detailed Community Communication packaged be developed in detail and implemented from 1 June 2017 in preparation for the 2017 Winter Season in the first instance. The annual communication packaged addressing seasonal issues should be developed and rolled out year on year once the winter package is developed and implemented. This stream would be driven through Elizabeth Tobler's media and Communication Team **(Delivered within existing resources)**

b. **Stream 2 - Frequently Presenting Patients –** A detailed business strategy for dealing frequently presenting patients or those at risk of frequently presenting be developed and implemented. This stream of work should be supported by SIG but will require funding for a 0.5 staff specialist working with a skilled project manager for a period of 12 months. Assuming such a project was to get underway by late April it is expected that the initial strategy will commence implementation by 1 August 2017. **(Additional Funding Required)**

c. **Stream 3 CHHS Internal Practices –** this is a significant body of work that will require:

    a. a detailed business strategy be developed to address changes to inpatient and community team practices that refer patients to the ED;

    b. Significant internal consultation and debate

    c. A minimum of 12 months to establish

    Implementation of this initiative would be staged as each piece of work was completed. It is expected that first phase implementation could commence in July assuming a rapid project development through SIG. This work would be supported by the staff specialist position described in Stream 2. It is expected that a full time SIG project manager would be applied to manage both the Stream 2 and Stream 3 work **(within existing resources assuming SIG resources are available)**

d. **Stream 4 – General Practice, Walk-in-Centres, Residential Aged Care** – this is a significant body of work that will require:

a. An executive lead working with a dedicated project manager. This lead could be an operational Director of Nursing for example and does not necessarily need to be an Executive Director;

b. A detailed consideration around how current services sit together to assist in ED Demand Moderation. Key issues that would be considered include:

   i. Detailed understanding of how current services sit together;

   ii. Use of outpatient clinics by general practice;

   iii. Deployment of current community services and potential future nurse practitioners into RACF;

   iv. Partnership between general practice and the WiCs perhaps in the form of GP lead clinics.

c. A significant engagement with key stakeholders, hence the suggestion of an Executive Lead;

d. Delivery of a range of initiatives over a 12 – 18 month period.

This programme of works would need a dedicated project manager and possibly 1 or 2 clinicians to work on discrete initiatives. Resources could be drawn from SIG for the project management piece depending on demands in relation to SIG. **(Likely additional Funding Required)**

10. Conclusion

It is very apparent that in order to deal with ongoing and increasing demand for ED services at CHHS that a comprehensive organisational and possibly governmental approach is required. In order to have an impact on this rising demand the following must occur:

- A clear, multipronged strategy must be deployed;
- The strategy must be a whole of organisation (ACT Health) response signed off by organisational executive with a clear expectation that all areas of the organisation address this key challenge as appropriate to their area of operation; and
- That a demand moderation strategy must run across years (and be ongoing) in order to have any serious impact on this key health service challenge.

Prepared by:

Mark Dykgraaf
Executive Director – Division of Critical Care
In consultation with:

- Professor Kirsty Douglas – Academic Unit of General Practice
- Ms Joanne Greenfield – Director, Health Promotion Branch

- Ms Rachel Hawes – Senior Manager, Stakeholder Engagement
- Mr Tim Keun – Manager, Walk-in-Centres
- Mr Michael Phipps – Manager, Business intelligence
- Mr Hai Phung – Senior Manager, Epidemiology Branch
- Ms Elizabeth Tobler – Director, Communications
- Dr Suzanne Smallbane – Deputy Director, Emergency Department – CHHS

ACT Government Health

Patient Flow Action Plan – July/ August 2017

Key Targets for All Areas

- Wards – 1 discharge by 10am all areas, further 2 discharges by 12md all areas;
- Weekend discharges – hospital target 150 each weekend
- Daily discharges – hospital target 120
- Long stay patients – hospital target below 250 patients

KEY FOCUS AREAS	PRIORITIES FOR IMPROVEMENT	KEY STRATEGIES FOR ACHIEVING PRIORITIES	KEY PERFORMANCE MEASURES	REPORTING TIMEFRAME	RESOURCES	UNIT/PERSON RESPONSIBLE	2017-18 TARGET	RESULT	STATUS	COMMENTS
Data Management	Benchmark Reporting	Monthly Round Table Reports	Monthly reports by Unit and ward delivered to all areas	Monthly	Existing	Pieta McCarthy working with Leslie Dickens	31 July 2017			
	Daily Reports – provided to key managers across the organisation	NEAT performance	1 patient discharged from all wards by 10am	Daily	Existing	Pieta McCarthy Debby carriage	31 July 2017			
		Long Stay report	All Divisions, wards and Units to set a Long Stay target	Daily	Existing	Pieta McCarthy Debby carriage	31 July 2017			
		EDD Compliance report	All Units to have defined EDD for greater than 90% of patients	Daily	Existing	Pieta McCarthy Debby carriage	31 July 2017			
	Use of Performance Information Portal	Education session on the use of the portal to be provided through the CDN Train the Trainer Programme	Education sessions complete	24th August – Training complete	Existing	Lyn O'Connell ADONs – ensure CDN attendance	24 August 17			
		Information sent to all medical, nursing and allied health managers on use of the portal	Information prepared and distributed	11th August	Existing	Lyn O'Connell Pieta McCarthy	10th August 17			
Operational Targets	Key operational Targets defined for patient flow and understood and delivered by all key managers and leaders	All Divisions to deliver plans regarding hitting defined operational targets	NEAT – 81% Admitted NEAT 50% Daily discharges – 110 – 120 hospital wide Long stay patient targets by Division Weekend Discharge target 150 patients – Divisional targets to be defined	Monthly	Existing	Mark Dykgraaf – Define and deliver template to all Divisions for completion	Template prepared and sent to each Divisions – 19 July 2017 Divisional Targets set by 31 July 2017			

KEY FOCUS AREAS	PRIORITIES FOR IMPROVEMENT	KEY STRATEGIES FOR ACHIEVING PRIORITIES	KEY PERFORMANCE MEASURES	REPORTING TIMEFRAME	RESOURCES	UNIT/PERSON RESPONSIBLE	2017-18 TARGET	RESULT	CURRENT STATUS	COMMENTS
Communication with Key Managers	Regular communications to key managers	Monthly Operations Update	Monthly Operational Update delivered by the first Monday of each month	Monthly	Existing	Pieta McCarthy – first draft development in discussion with Operations Leadership Team (DC, PM, Lyn O'Connell and MD)and Debby Carriage to manage the production timeline and distribution	First Monday of each month			
	Briefings for Leadership Teams	CHHS Executive	All leadership teams to attend designated briefings as per relevant calendar All key managers to have a clear understanding of the expected KPIs for their area	Briefing 14 July 2017	Existing and PowerPoint presentation	Mark Dykgraaf	N/a	Complete		
		Divisional Executive Ward/ Unit Leadership Teams	All Division and ward leadership teams brief on key initiatives around flow and the need to achieve operational performance targets	11 August	Existing Resources	Mark Dykgraaf working with Executive Directors	Complete by 11 August			
		Nursing 3,45 meetings	All 3,4,5 meetings brief on key initiatives around flow, and the need to achieve operational performance targets	From Lyn	Existing Resources	Lyn O'Connell	Complete 24th August 17			
Clinician Engagement	Doctor engagement strategy	All Unit/ Clinical Directors receiving regular communications on key issues	• Receiving monthly Chief of Clinical Operations bulletin • Semi-regular communications on key issues – EDs copied in on communications	Monthly Ad hoc	Existing resources	Mark Dykgraaf	First Monday of each month			

KEY FOCUS AREAS	PRIORITIES FOR IMPROVEMENT	KEY STRATEGIES FOR ACHIEVING PRIORITIES	KEY PERFORMANCE MEASURES	REPORTING TIMEFRAME	RESOURCES	UNIT/PERSON RESPONSIBLE	2017-18 TARGET	RESULT	CURRENT STATUS	COMMENTS
Clinician Engagement (cont)	Doctor engagement strategy	How Can I Help You Programme	Correspondence to staff specialists, VMOs across the organisation	August 2017	Existing resources					
		Ongoing Operational Meetings	Briefing at Medical team meeting	September 2017	Existing resources	Debby Carriage to schedule session Mark Dykgraaf to attend sessions	Finalise by October 2017			
	Nursing Engagement Strategy	ADON Meetings	Weekly meetings to deal with flow issues through the Winter season – then review	Commence July 2017	Existing resources	Debby Carriage to schedule and Minute Mark Dykgraaf to Chair				
		3,4,5 Meetings	Lyn O'Connell to brief 3,4,5 meetings by Division on Patient Flow strategies and expectations	Commence July 2017	Existing resources	Lyn O'Connell working with Narelle Aldridge in RSDU	Finalise in August 2017			
		DON Meetings	Brief DONs on approach being taken on patient flow issues	Meeting briefing 1 August 2017	Existing resources	Mark Dykgraaf				
	Allied Health Engagement Strategy	Brief Allied Health leads on patient flow strategies	Briefing complete	August 2017	Existing resources	Mark Dykgraaf Sam Lazarus				
Escalation Processes	Divisional Escalation Process to hit occupancy targets	Each Division to set Occupancy targets by ward and Unit for the winter season by actual number of discharges per day	Targets set for each Division	11 August 2017	Existing resources	Executive Directors working with team	18 August to implement			
Seasonal Demand Management	Winter Bed Management Strategy	Strategy complete and circulated to all Units	Distribution complete	30th June 17	Existing resources	Lyn O'Connell Mark Dykgraaf to sign off and distribute	30 June 17			
	ICU bed management	ICU Bed Adjustment Summer/ Winter – 2 beds	Downsize ICU by 2 beds in the summer months January – March 2 additional ICU beds brought on-line August to November	10 August 2017	Existing resources	ICU leadership team	10 August 2017			

KEY FOCUS AREAS	PRIORITIES FOR IMPROVEMENT	KEY STRATEGIES FOR ACHIEVING PRIORITIES	KEY PERFORMANCE MEASURES	REPORTING TIMEFRAME	RESOURCES	UNIT/PERSON RESPONSIBLE	2017-18 TARGET	RESULT	CURRENT STATUS	COMMENTS
Policy	Defined Organisational Position	Winter bed Management Plan	Distributed to all key leaders in the organisation	June 2017	Existing resources	Mark Dykgraaf Lyn O'Connell	30 June 2017			
		High Demand Policy	Policy signed off by CHHS executive	June 2017	Existing resources	Mark Dykgraaf	August 2017			
			Audit of all relevant clinical areas for suitable space	July 2017	Existing resources	RSDU	July 2017			
			Implementation across CHHS	Commence process August 2017	Additional for room modifications	Mark Dykgraaf	Complete – October 2017			

Prepared by:

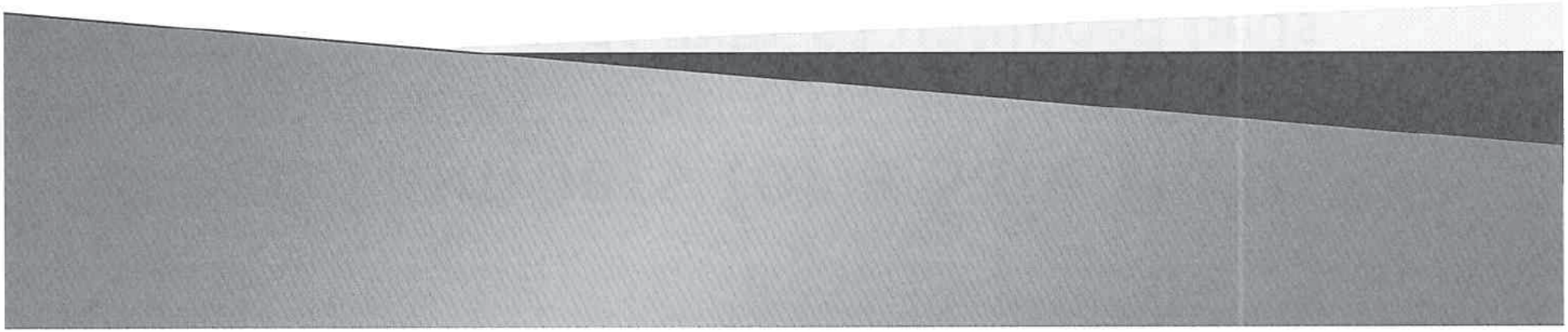
Mark Dykgraaf

A/g Chief of clinical Operations

July 2017

The Safe Hospital- A Shared Challenge Winter 2017 .....and Beyond

Mark Dykgraaf
A/g Chief of Clinical Operations



Broad Numbers for a Safe Hospital

- CHHS – 620 beds with 34 unfunded beds used for Winter Bed Strategy
  - 85% – 527
  - 90% – 558
  - 95% – 589
  - 105.5% – 654
- Literature – 85% occupancy is required for a safe, smoothly running hospital
- CHHS
  - Operating comfortably at 90% occupancy
  - Difficult at 95% occupancy

CHHS – from beginning of June 2017

- Last 8 weeks hospital has been operating at 100% plus occupancy
- Last 8 weeks between 26 and 34 unfunded beds have been open every day – significant impact on staffing, particularly nursing but other resources as well
- Last 8 weeks there have been patients waiting for beds every morning in ED and ICU – recently also CCU
- Last 8 weeks – between 5 and 10 subacute patients have been waiting for CHHS beds at Calvary and in regional hospitals

Examples of Significant Successes over the Last 12 months months

Work is of course ongoing

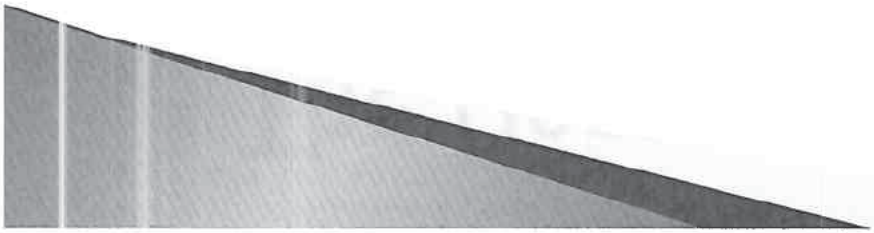
- Haematology change in model of care and reducing length of stay
- Geriatric change of model of care and advent of GAPU – reducing length of stay
- Mental health Units – length of stay and access
- Improvement in ED performance and bed block across the organisation – next slide

The Demand and Performance Picture

Indicator	2014 - 2015	2015 - 2016	2016 - 2017
4 hour rule	56.9%	60.2%	70.7%
Average did not wait per day	11	10	6
Average did not wait percentage per day	5.6%	4.7%	2.6%
Presentations - total	73,623	77,747	85,094
Average presentations per day	202	212	233
Admissions – total	24,211	27,944	32,455
Average admissions per day	66	76	89
Average admissions %	32.9%	35.9%	38.1%
Average waiting time	70 minutes	67 minutes	52 minutes
Average treating time	176 minutes	162 minutes	137 minutes
Average bed block time	226 minutes	156minutes	147 minutes
Average see on time	50.8%	51.6%	58.5%

The Daily Challenge

- Multiple Admission Sources
- ED – 90 per day
- Other Sources – 30 – 40
  - Surgery
  - Oncology
  - Medical Procedures
  - Direct Admissions
  - Outpatient Clinics



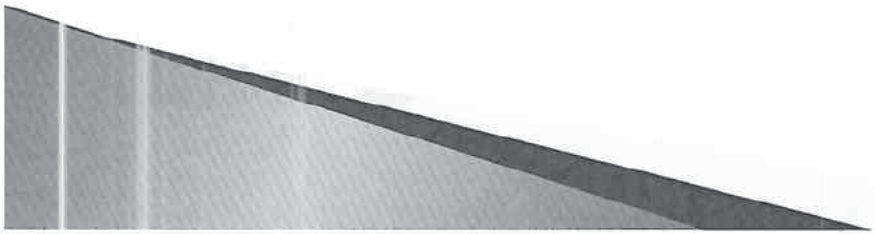
The Daily Challenge (cont)

In order to have the hospital running smoothly

- We need to discharge between 110 and 120 patients per day through the week
- We need to discharge 150 patients over the weekend

The Flu Challenge

- Flu season has not yet peaked in Canberra – starting to see cases come through now which is a month later than last year
- NSW declared four weeks ago
- We are already using our spare flu capacity



Reports

- **Daily**
  - NEAT performance Report
  - Long Stay Report
  - Estimated date of Discharge
- **Health Round Table – by July 31**
  - Monthly
  - Quarterly
- **Reports will be provided to:**
  - Executive Directors
  - Clinical/ Unit Directors
  - DONs, ADONs, CNCs, Clinical Co-ordinators
  - Allied Health Directors

Our Response - Next 4 months

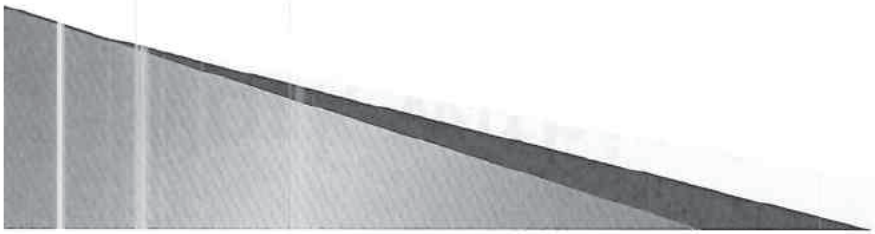
- Hospital Occupancy maintained below 95%
- 110 - 120 patients discharged per day - Monday to Friday
- 150 patients discharged over the weekend - key issue working with medical, nursing and allied health teams
- 42% of all patients admitted to wards within 4 hours of arrival (17/18 target - 50%)
- 81% overall NEAT
- 1 patient discharged from all wards before 10am
- A further 2 patient discharged from designated wards by 12md

Work within Divisions/ Wards/ Units

- Clear communication with Clinical/ Unit Directors, ADONs, CNCs, Clinical Co-ordinators around the current and ongoing challenge
- Wider communication and education to teams
- Targets by ward and unit for daily number of required discharges and in particular weekend discharges
- Define and implement daily approach to achieve daily/ weekly approach within each Division to achieve 95% occupancy target
- Define and implement weekend bed management strategy
- Asking All Divisions to define actions and responsibilities - template to be provided

Tools Already in Place

- Reports
- Electronic patient Journey Boards
- EDD reports
- Whiteboards at the end of beds
- 6 Ps of discharge
  - Planned Discharge date
  - Patient informed of planned discharge date
  - Prioritise the ward round – unwell first, discharge second, then remain patients
  - Pharmacy – script by 3.30pm
  - Pathology
  - Paperwork
- Performance Information Portal

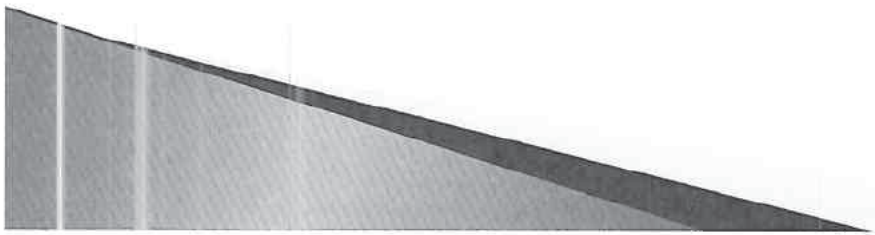


Division of Operations – actions

- Education/ Information programme – commencing next week
  - Nursing Leadership Teams
  - Allied Health Leadership Teams
  - Medical Leadership Teams
- "How Can I help You" Initiative for medical teams

Communication

- Monthly Chief of Clinical Operations Bulletin to key leaders
- Through Divisional Structure – requirements regarding operational performance
- Direct Letters to key groups
- Meetings with key leaders and leadership Teams
- Performance Indicators

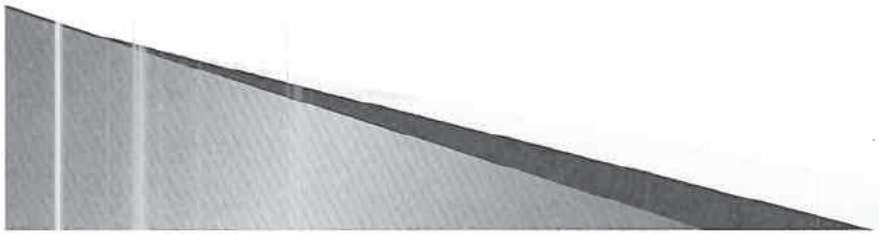


Key Targets Next 4 months

- < 95% occupancy across the hospital
- Weekend Discharges - 150 across the hospital
- Long stay patients - below 250
- All wards achieving one discharge by 10am, further two discharges by 12noon

Questions / Thoughts / Ideas

- Flu Round – Infectious Diseases?
- Team approach by Unit?
- 5 pm – brief rounding?
- Consults with other teams?
- Junior RMOs escalating issues i.e. Other team consults, Medical Imaging dealys, etc



Stevenson, Nicole (Health)

From: Reporting Coordination Unit (Health)
Sent: Friday, 8 February 2019 7:23 AM
To: DSD Information Management Hub
Subject: CHHS Daily Longstay Report [DLM=For-Official-Use-Only]
Attachments: LongstaySummary.pdf

Dear Colleagues

Please find attached a copy of the CHHS Longstay Report. The data in this report is drawn from source operational systems in real-time and as such, this data is subject to data maturation issues which may result in minor changes to the data over time.

Should you need to generate a copy of this report that contains updated data, you may do so online through the Performance Information Portal.

The data provided within this Report is provided for internal purposes only and not for public release. Should there be a requirement to release this data externally, please contact Reporting, Coordination, and Governance as all data released outside of the directorate, must go through mandatory governance processes. This process currently includes additional data validation and formal approval from the Commissioning and Performance Division.

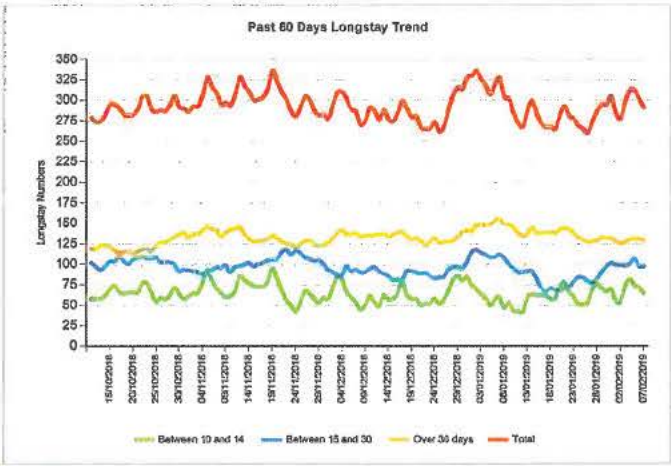
Should you have any questions relating to the data in this report, the staff in Reporting, Coordination, and Governance in the Commissioning and Performance Division would be pleased to assist you. They may be contacted by email (Health.Reporting@act.gov.au), by telephone (02 6207 7660) or may be visited in person on Level 2, 4 Bowes Street, Phillip.

Requests to unsubscribe to this scheduled email or other report subscriptions matters can be addressed to the Information Management Hub, Digital Solutions Division. They may be contacted by email (DSD.InformationManagementHub@act.gov.au), by telephone (02 6207 9003) or may be visited in person on Level 2, 4 Bowes Street, Phillip.

Information Management Hub | Phone: 02 6207 9003 | Email: DSD.InformationManagementHub@act.gov.au
Technology Operations Branch | Digital Solutions Division | Health Directorate | ACT Government
Level 2, 4 Bowes Street, Phillip ACT 2606 | GPO Box 825, Canberra City ACT 2601 | health.act.gov.au

ACT PERFORMANCE INFORMATION PORTAL

CHHS Longstay Patients 08 Feb 2019			
	10-14 (Hospital LOS in Days)	15-29 (Hospital LOS in Days)	30+(Hospital LOS in Days)
CHHS Total (Excluding Hospital in the Home)	56	84	119
ICU (included in CHHS total)	0	0	1
Hospital in the Home Total	4	7	6



Division	Clinical Unit	Total Number Of Patients		
		10-14 (Hospital LOS in Days)	15-29 (Hospital LOS in Days)	30+(Hospital LOS in Days)
CHHS Total		56	84	119
CACHS	Haematology	3	1	2
	Immunology	0	0	0
	Oncology	6	2	3
	Radiation Oncology	2	1	1
	Total	11	4	6
Critical Care	Acute Surgical Unit	1	2	0
	Emergency Medicine	0	0	0
	Total	1	2	0
Medicine	Cardiology	0	0	6
	Dermatology	0	0	0
	Endocrinology	0	0	0
	Gastroenterology	5	0	2
	General Medicine A	1	1	3
	General Medicine B	1	2	2
	Infectious Diseases	2	2	5
	Neurology	0	1	6
	Renal	2	0	2
	Respiratory	1	3	2
	Rheumatology	0	1	0
	Total	12	10	22
Mental Health	Psychiatry	5	12	28
	Total	5	12	28
RACC	Geriatric Medicine	7	17	22
	Rehabilitation	3	9	13
	Total	10	26	35
Surgery & Oral Health	Cardiac Surgery	2	1	0
	Ear, Nose and Throat	0	0	0
	General Surgery	3	6	2
	Neurosurgery	2	1	2
	Ophthalmology	0	1	0
	Oral-Maxillofacial Surgery	0	1	1
	Orthopaedic Surgery	2	6	10
	Plastic Surgery	0	2	1
	Shock Trauma Service	0	2	0
	Thoracic Surgery	0	0	0
	Urology	0	1	0
	Vascular	3	3	2
	Total	12	24	18
WYC	Gynaecology	6	0	0
	Neonatology	2	5	9
	Obstetrics	1	1	0
	Paediatric Surgery	0	0	0
	Paediatrics	2	0	1
	Total	5	6	10

Division	Total Number Of Patients		
	10-14(Hospital LOS in Days)	15-29 (Hospital LOS in Days)	30+(Hospital LOS in Days)
Hospital in the HomeTotal	4	7	6
CACHS	0	1	0
Medicine	3	4	3
Surgery & Oral Health	0	2	3

Division	Total Number Of Patients		
	10-14 (Hospital LOS in Days)	15-29 (Hospital LOS in Days)	30+(Hospital LOS in Days)
ICU Total	0	0	1
Surgery & Oral Health	0	0	1

Stevenson, Nicole (Health)

From: Hollis, Gregory (Health)
Sent: Tuesday, 5 February 2019 3:33 PM
To: Bone, Chris (Health)
Cc: Boyd, Narelle (Health); Smallbane, Suzanne (Health)
Subject: Medicine - YES! [SEC=UNCLASSIFIED]

Chris,

Suz tells me you approached her with an informal discussion yesterday re your possible intentions to alter the model for Medicine.

The two models below are each in place at large hospitals elsewhere; it's not breaking new ground, but change is needed at Canberra Hospital.

I completely agree with what Suz said, and in fact I've had a number of recent discussions with some senior staff in the Division of Medicine. Including as recently as yesterday evening - informally at the Culture presentation I attended yesterday evening at Bowes street.
I've also briefly consulted Mike Hall on the content of this email.

Clearly this is a Division of Medicine thing, is well beyond my scope, but it really does need changing in many people's opinions.
Also clearly, as with any change, there will be plenty of vested interests and resistance for various reasons – it will need quite a bit of commitment from on high to produce a much needed system change.

Current model
The current model of "after hours" (i.e. over 75% of the working week) is NOT working for anyone and hasn't for some time:

- Physician trainees: The trainees don't have a good system for who is their supervisor, it isn't a popular term, and is hard to recruit to for the Division I believe, it is stressful and difficult for the trainees.
- Inpatient admitting Consultant Physicians – don't get good service, as the "after-hours" medical registrars cover everyone, don't have ongoing responsibility for the patient, and the med reg's are also often very junior as its not a particularly desirable job!
- ED – definitely doesn't work for us, as the patient is often seen by someone several-many years more experienced and inserting a PGY3-4 med reg in the process prior to ward transfer is poor for patient care and patient flow
- The patients – delays movement onwards to an inpatient ward, inserts another person for them to repeat their story to, usually little clinical benefit.

Much needed change – Two real options (using pretty much current funding and redirecting)

The "after-hours" med reg system needs blowing up and replacing with a modern system.

In either option below – get rid of the after-hours medical registrars/ARM's altogether. Use that large amount of $ saved to staff either:

- In option 1 below – pay for Senior trainees to cover all the specialties.
- In option 2 below – pay for the mid-level (mostly med reg) staff to do the work of further filtering/work-up in the acute admissions unit.
  (note – in option 2, you could also remove an intern or RMO1 from the ED to help staff the acute admissions unit, as some of the work being done in the ED at JMO level would now move to the acute admissions unit)

Option 1: Become a proper big tertiary referral hospital and have all the specialties represented with senior trainees on call, who actively attend, determine definitive care. Clear benefits to the patient, the on call specialist, as the

person directing the care "after-hours" at that reg/senior reg/AT level has a higher level of training in that specialty, and importantly has an ongoing vested interest as they will be involved in that patients care in the coming hours and days. Unlike the current ARM/med reg system where that after hours person has zero involvement in the ongoing care of that patient – risks for handover, care coordination etc, etc that we see every day.
This is also much better for the physician trainees as they get to make decisions, and see their results, and continue their involvement with the patients.
In this option, you could consider a bit of a hybrid to help with fatigue of individuals – eg perhaps one person between midnight and 0800 who takes all the admits – could make that one of the AT's & rotate between all, so they do it only once every 3 or 4 or 5weeks. Could sort the detail there I'm sure.

OR

Option 2: An Acute Admissions Unit.

- ED assesses, decides on initial management, admission vs discharge (which we are definitely good at and the best people to do that)
- All Medicine admissions then move to the acute admissions unit which is under the governance of Medicine, not ED.
  - Other than admissions that clearly go on a specific path to specialty units (for eg CCU, Stroke Unit, ICU, and a couple of others, where they bypass the acute admissions unit as they do now)
- Staff $ as above within current resources, plus you can pinch an intern/RMO1 from ED as noted above.

Again, as mentioned above, this is clearly all outside my responsibility, but as you raised it with Suz yesterday, thought I'd expand on that.

There is a definite need for change here.

Greg

Greg Hollis
Clinical Director, Emergency Medicine,
Senior Specialist, Capital Region Retrieval Service
Canberra Hospital

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