Future Hospital
Chief registrar showcase event
8 June 2017
Service improvement as a Chief Registrar

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Main problem facing most trusts = patient flow:
- ED/A&E to Medicine
- GP to Medicine
- Medicine to social/community care

Other key trust wide issues are:
1. Junior doctor morale
2. Training versus service provision
3. Communication gap between senior management and those on the shop floor.
1. Evaluating the problem at both sites

1. Pareto Charts
2. Analysis of patient flow/heat maps
3. On the ground experience from acute take
4. Meeting with Chiefs of Medicine and Medical Director
5. SI analysis
6. Monthly M&M learning themes
The ‘Problems’ with flow at Wexham Park

• Under-utilisation of Ambulatory care
• Poor communication between ED and Medicine
  – Electronic referral system
• Lack of triage of GP referrals to the appropriate stream
### Starting point at Wexham Park

<table>
<thead>
<tr>
<th>% of the take admitted VIA GP</th>
<th>% of take sent to AECU</th>
<th>ED to Medicine conversion rate</th>
<th>% admission avoided via phone</th>
<th>Disposal rate from A&amp;E (%)</th>
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<tbody>
<tr>
<td>55.3%</td>
<td>25.0%</td>
<td>45.0</td>
<td>2.0</td>
<td>1.0</td>
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#### Baseline Data for flow around the acute medical take
The issues at Basingtoke

• Lack of an Ambulatory Care Unit.
  – Patients admitted
  – Poor patient experience
  – Increase burden on medical take
  – Increase bed occupancy and overnight stay.

• No formal process to ambulate a patient. Adhoc basis.

• 4 hour wait target below national average.
The issues at Basingtoke

• Lack of exposure to clinics for CMTs. Reasons for this multifactorial:
  – Not prioritised
  – Rota gaps
  – Lack of room space
  – Number of clinics required gone up - now 20/year.

• Impact
  – failing ARCP
  – Deanery criticism
  – Feeling undervalued, low morale
How the Chief registrar programme helped initial analysis

1. Matt Tite away day in Gloucester
   - training on Pareto charts, SPC...
   - Process maps- ‘British Cycling approach’

2. Chief registrar ‘Whatsapp’
   - peer-peer support
   - ‘data’ sharing across 15 trusts

3. Formal educational modules on change management, QIP + action learning sets..
2. Enacting the change – model QIPs?

• Pilot programmes
• Running data analysis
• Patient and stakeholder feedback...
What we did to help flow at Wexham

• Stakeholder engagement **Key**
• Unified single clerking proforma
• Serial pilot programmes using QIP methodology to address each aspect of flow:
  a) **Expansion of ambulatory care**—Chief SpR clinical support/new pathways for referral
  b) **GP referral & triage pilot study**
  c) **ED to Medicine referral redesign**
New Single Clerking proforma

- ED and Medicine were **BOTH** key stakeholders
10 Streamlined AECU referral pathways

**Pleural Effusion Pathway – Wexham Park Hospital**

- **Pleural effusion on chest X-ray**
  - **Unilateral effusion**
    - Check U&Es, LDH, BNP, FBC + clotting.
  - **Bilateral effusion**
    - More likely transudate? E.g., LVF, hypoalbuminemia, liver failure, renal failure.
    - Check BNP, LFT, U&Es.

**Could this be managed as an outpatient?**

- **No**
  - Complete pleural effusion ICE referral
  - Is the patient compromised?
    - **Yes** - Urgent
      - Out of hours
      - Bleep med SpO2 on 4724
    - **No** - Non Urgent
      - Send pleural effusion referral

**Yes**

- **Could this be managed as an outpatient?**
  - Large bilateral effusions + no evidence of CCF – consider pleural referral
  - Small bilateral effusions/ features of CCF/high BNP – consider referral heart failure team via ICE

**Exclusion criteria:**
1. $SpO2 <92\%$ room air
2. Respiratory Rate $>25$
3. Pulse $>100$
4. Systolic BP $<100$
5. Fever or suspected empyema
6. Severe breathlessness
7. Lives alone, unable to seek help or no telephone contact
8. Unable to complete ADL at home, bed bound or confused

**Patient presents to ED with a TLOC/Syncope**

- **Red Flags:**
  - Abnormal observations or Neuro observations
  - Found on the floor with delayed or no spontaneous recovery
  - Head injury/trauma
  - Persisting acute focal neurological, e.g., imbalance or slurred speech
  - Family history of sudden cardiac death or arrythmia
  - Syncope during exertion
  - Presence of heart murmur or ICD
  - Known IHD + LV dysfunction
  - Unexplained shortness of breath

- **Has specific cause been identified for episode?**
  - **Yes**
    - Review of results investigations
    - Discharge criteria:
      - Examination findings of unstable IHD, CCF, Ventricular Arrhythmia, cardiomyopathy or significant respiratory disease?
      - Dynamic $SpO2$ changes?
      - Patient still feels unwell after 3-4 hours of observation?
      - $HsTnT<14ng/L$
    - Discharge
      - Discharge letter on MBS/ICE
      - Consider outpatient Echo + 24hr Tape
      - ICE referral to Rapid Access Syncope ClinC
      - Driving advice as per DVA
      - GP Follow up as required
    - **No**
      - Treatment for cause
      - Refer to Ambulatory Care on Ext 4237
      - It is Monday-Friday between 10am and 4pm
      - Patient ambulatory, observations stable and suitable for transfer

- **No**
  - Yes
    - Treat in ED
    - Hourly BP: Lying and standing 1 and 3 mins after standing up to 3 hours
    - $SpO2$ is Monday-Friday between 10am and 4pm
    - Patient ambulatory, observations stable and suitable for transfer

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  - **Yes**
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Issues to address at Basingstoke

1. Staffing
   - Medical (1 acute Medical consultant)

2. 1 in 14 SHO rota with 5 gaps... Admin/Nursing- difficulties to recruit

3. Space- From broom cupboard to ACU

4. How do we incorporate Ambulatory care with ED and AMU?

5. How do we get CMTs to reach clinic requirement?
What we did at Basingstoke?

• Found out what other trusts do- shared learning.
• Took on the medical rota!!
  – Rota’d each SHO to spend 2 weeks/4 months in ACU
• Fought for bigger space occupied and underutilised by ED.
• Pulled patients from ED/Corridor. Removed barriers.
• **Success** = no more staff, just doing things differently.
  – CMTs met clinic requirements.
THE NEW BASINGSTOKE ACU
Our @Wessex_FSchool GP trainees providing a great service in our ambulatory care unit @HHFTnhs @tanujlad @DrCarlBrookes and smiling!
3. How did being a Chief Registrar help change management?

- Recognition and respect from peers
- Recognition and respect from clinical leads
- Access to data collection teams/analysts
- Access to Chief /medical director etc...
- Educational modules on team building, leadership emotional intelligence:
  - FMLM and RCP education fantastic support!!
- Time!!!

‘Change agent’: credible yet not threatening
4. Service redesign

- Did we actually make a difference?
Impact of Serial Pilots at Wexham on Patient flow
Economic impact

- From GP referrals: reduction of 7 inpatient stays/24hr period (mean LOS 3 days)
  - SAVING OFFSET AGAINST AECU VISIT/FUP =

- From A&E referrals: reduction of 6 admissions of mean length 3 days
  - SAVING OFFSET AGAINST AECU =
Impact of change at Basingstoke

FOLLOW-UP
NEW
Morale

• 80% reduction in Junior doctor sickness over a 6 month period

• Would you recommend this job to others in the deanery?
  • February 2016- Yes 10%
  • February 2017- Yes 92%

• 2 new acute medical consultants recruited
5. Challenges we encountered and What next for each trust?
Wexham challenges and development areas

- **Patient and family**: Positive – room for improvement....
- **Communication barriers**: between ED and AECU and AMU – Human factors...
- **Sustaining** the pilot successes in the long run
  - Matron AECU: Sean Harding- MA project on service optimisation
  - Change in consultant job plans....
- **Expanding AECU** to 7 days 10-10pm
- **New build Emergency floor** 2018/19
Challenges at Basingstoke...

• Coming from outside and challenging the status quo and implementing change.
  – Daily corridor complaining.
  – Certain consultants wrote to the CEO!

• Did not understand the political structure amongst the consultants.

• Importance of engagement-
  – Backing from the medical director key!
Expanding Ambulatory care at Basingstoke

• Expanding size of Ambulatory care
• Dedicated Ambulatory care consultant
• Incorporating Specialty Ambulatory care
• Frailty Service
Personal and Professional Development

Emily Bowen and Zoe Jones
Chief Registrars
Gloucestershire Hospitals NHS Foundation Trust
In the beginning.....
Learning our ABCs

Management speak turns out to be a whole new language!
Prioritising our time

- The balance of clinical vs management
- Urgent vs important
- Managing that inbox!
- Giving yourself the mental space and time to change things
Solving those problems

Clinical problem solving is one thing...
Finding ourselves

Understanding our personalities brought an even better way of working together and with others.
Leading

Driver or pace setter?
How do we respond under pressure?
What is it that drives us and our teams?
The missing piece?

Of course!
Final thoughts

• Learned a lot!
• ‘Soft’ skills are actually quite hard
• Excellent preparation for being a consultant
Relationship building as a Chief Registrar

Dr Leanne Griffin
Hywel Dda University Health Board

Dr Judy Martin
Oxford University Hospitals NHS Foundation Trust

June 2017
Traditional barriers

- Managers
- Clinicians
- Managers
- Patients
- Doctors
- MDT
- Junior doctors
- Health policy
- Junior doctors
- Chief Registrar
Developing a Triage System in a new AMAU

• Significant change to the front of house at PPH
• Emergency 999 ambulances accepted straight to medicine
• No method of triage
• Challenges
  – No triage tool for medical patients
  – Resources
  – Implementation of a new system
Traffic Light System

**Red**
- NEWS ≥ 7
- Less that alert on AVPU
- Stroke
  - Patient should be seen immediately

**Orange**
- NEWS 5-6
- Chest Pain
- DKA
- Sepsis
  - Patient should be seen within 1 hour

**Green**
- NEWS ≤ 4
  - Patient should wait no longer than 4 hours to be seen
• Regular contact in Front of House Operations Team meetings
  – From attendee to Chair
• Facilitating a two way dialogue between the wards and the board room.
• Presence and participation in fortnightly meetings with junior doctors and nursing staff
The MDT – A valuable lesson in effecting change
  – Active participation in the decision making process
  – Challenges of disagreement within the team
Opportunity to work with colleagues in a different capacity
  – Invited to attend ward meetings
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Acute Hospital at Home

- A new service that aims to bridge the divide between care in hospital and care at home
- Learned to build relationships as a team leader
  - Establishing who the key stakeholders are
  - Getting to know the team members and their strengths and development needs
  - Mentoring and support
  - Engaging the team in developing the service vision
• Working with managers has given us understanding of their roles and the impact this has on patient care.
• Managing projects ourselves has shown us the impact we can have on patient care.
• We have seen the benefits of using patients and patient feedback to help improve our services.
• Initial concerns about how we would be received as "Chief" registrars.
• Established as credible agents of change without being intimidating.
• With greater visibility came more responsibility
  – Bridge of communication
  – Mentorship
  – Concerns
Chief Registrars

• Network of support
• Opportunity to work with trainees from different specialties, different hospitals, different trusts, different countries.
  – Educational/academic benefits
  – Insight into the differences and challenges faced by hospitals/trusts within the same national organisation
  – Development of leadership skills together
• Aim to develop an alumni of chief registrars