

Kingston Hospital NHS Foundation Trust Length of stay case study

October 2014

The hospital has around 520 beds and provides acute medical services for a population of around 320,000 in Kingston, Richmond, Roehampton, Putney, East Elmbridge and adjoining areas of South West London.

Approaches to reducing length of stay

Medicine Pathways Programme

From 2011 the hospital implemented a Medicine Pathways Programme to improve patient care, reduce length of stay, reduce delays and reduce costs. The programme was led by a clinical director, who focused on developing devolved leadership to take the work streams forward.

The approach to the programme was to analyse the current issues within the emergency care pathway, look to adopt and tailor good practice from across the country and to continually look back, learn and change.

The initial set up phase of the programme involved reviewing and mapping the current pathway with internal and external clinicians and stakeholders, this highlighted the need to reduce fragmentation and have a joined up approach. For example to increase discharges of appropriate patients at the weekend the critical action was to have a dedicated registrar at handover on a Friday afternoon to pick up patients ready to leave at the weekend and following this there then needed to be action to address other gaps, such as a social worker over the weekend and pharmacy available on Sunday.

The programme focused on putting in place a bundle of different approaches (outlined below) that were owned and led by clinical leads from inpatient services, the emergency department and acute unit.

Emergency and ambulatory care approaches

- Introduction of emergency ambulatory care pathways for 15 conditions. This is mainly a chair based service to move away from a bed based culture of care.
- Establishing an 'emergency floor', where the acute assessment unit, ambulatory care unit and emergency surgery unit are now co-located. This has enabled easier access to senior review and resulted in clearer pathways for emergency patients.
- Increased consultant review in emergency department.
- Introducing a daily endoscopy list with a defined consultant 'endoscopist of day'.
- 24/7 GI bleed rota was introduced.

Discharge, length of stay and care of the frail approaches

- Since the mid-2000s the hospital increased the consultant capacity in geriatrics and set up dedicated wards for the frail.
- Enhanced medical handover to the weekend; this is particularly focused around the frail and elderly. Consultant geriatricians meet with the weekend on-call team to highlight

patients that need close observation to prevent deterioration and to ensure care and investigations are progressed.

- Increased senior medical staffing and registrars at weekends.
- Increased senior clinical input through daily consultant review early in the day (around 9am).
- Improved monitoring of delayed discharges and enhanced escalation process. The focus of delayed transfer has shifted from patients staying over 21 days to those staying over 7 days.
- Increased nurse ratios on wards.
- Enhanced planning process for peak times.

Other than funding for two consultants in the ED and two acute medicine consultants the programme was delivered within existing funding. Funding was mainly reallocated from the efficiencies made through closing beds as a direct result of reducing length of stay.

Central to these approaches has been the shift to proactive patient management through the use of a live RAG (red, amber, green) board; the board highlights the status of every patient and a consultant led multi-disciplinary team goes through each patient, every day, to progress their care, as well as identify and address blockages. This is currently operational Monday to Friday and the hospital is looking to expand the approach to the weekend and also to regularly include community and social care colleagues in patient reviews.

The programme also had the wider impact of enthusing frontline teams to take ownership and pride in their own service area, providing service line performance information enabled clinical leads to drill down and pull notes on outliers.

Reducing length of stay for elective care

During the mid-2000s the hospital ring-fenced elective beds to stabilise the elective flow and reduce the number of patients being admitted for surgery before medically necessary. This reduced the length of stay (LoS) in elective beds, and the hospital also carried out a number of operational improvements in the elective services that further reduced LoS.

Impact

Length of Stay reductions associated with key Interventions from Medicine Pathways Programme

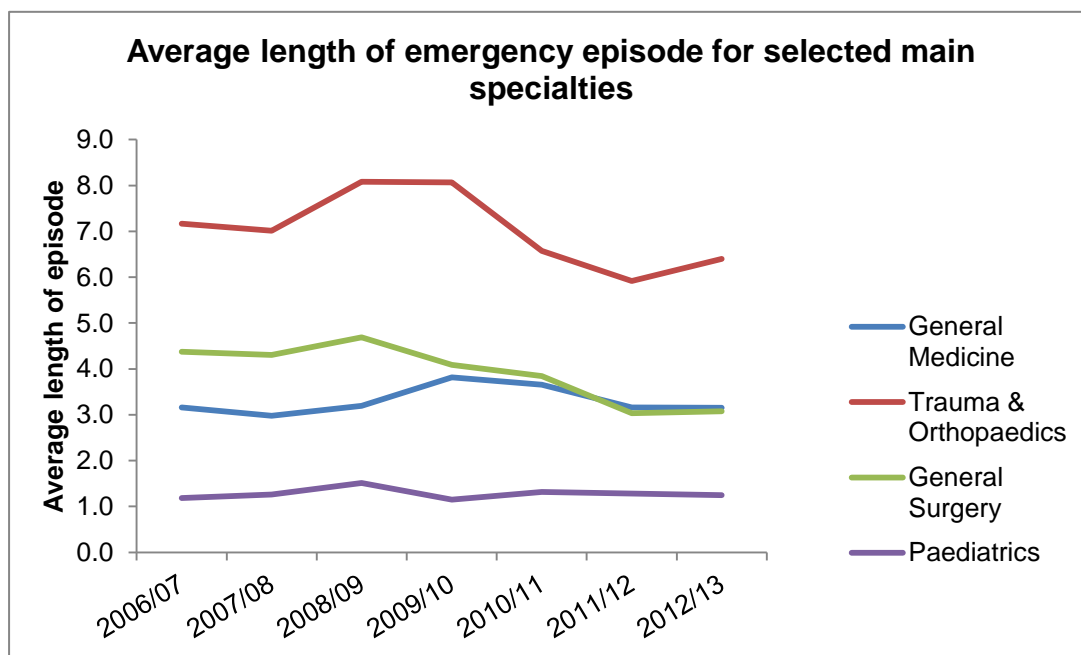
Kingston Hospital **NHS**
NHS Foundation Trust



Source: Kingston Hospital NHS Foundation Trust

- Analysis of data from Kingston Hospital NHS Foundation Trust indicates that between 2007/08 and 2012/13 the average length of stay in hospital decreased from 5.7 days to 5.0, a reduction of 12.7%. This compares with an overall reduction of 6.1% nationally over the same time period.

Changes in average length of emergency episode for selected main specialties:



Source: Nuffield Trust analysis

- There has been no indirect impact on 28 day readmission rate from the approaches. Readmissions have decreased from 6.9% in 2009/10 to 6.2% in 2012/13.
- There is an increased percentage of emergency patients managed without overnight stay.
- Significant financial savings have been achieved through bed closures (around 100 beds have closed over the last 4 years).
- There are a reduced number of reported delayed transfers of care.
- The development of the clinical leads and success of the programme led to the hospital further devolving responsibility and accountability through dividing the hospital into 13 service lines, each with a leadership team comprising of a clinical lead, manger and senior nurse. These teams have access to service level data and are empowered to identify the key challenges and improve the service. This approach has also led to some internal competition, further improving service delivery.
- Understanding across the whole system – the programme brought GPs, consultants, hospital and community nurses and other professionals together and enabled the transfer of knowledge and understanding of the different sections of the system. It also enabled myths to be challenged (e.g. the view that the hospital ‘keeps’ patients to increase payments).

Critical success factors

- Changing clinical behaviours and approaches was only possible through making the programme clinically led and finding the ‘hooks’ to incentivise clinical culture change. The main programme had a clinical leader who was an enthusiastic realist who maintained a positive approach to engaging clinicians.
- The programme sought out current good practice in other areas and adapted approaches.
- The programme approach was to look to implement improvements within existing resources, there was an initial review of what the problems were and by addressing these the length of stay reduced, freeing up funding for changes that had been identified as needing investment (such as funding additional consultants to enable cover until midnight).

- Getting the programme off the ground and quick wins provided momentum and a strong platform for wider engagement.
- Clear leadership and governance – The hospital recruited a dedicated Pathways Programme Manager, who was backed up by strong engaged leadership from the executive and clinical leadership. There were regular Board meetings for the programme that reported into a sub-group of the main Trust Board.
- Close working across the health system – The programme sought to actively involve GPs and community care representatives at all levels and the King's Fund and ECIST was used to support joint working and prioritising areas to focus on.

Challenges

- Joining up the flow across the acute and community sectors remains a challenge and the hospital recognises that it needs to work with community colleagues to reduce delays across the health system.
- Maintaining changes is a challenge and the local health and social care economy have set up a sustainability group to continue to drive service improvement.
- The pattern of increasing and decreasing the number of acute medical beds is likely to continue with associated challenges around:
 - Maintaining quality and safety
 - Recruitment and retention
 - Seasonal changes in workload

Next steps

- Age is an increasing influence on LoS and the hospital recognises that a high proportion of patients who stay over 21 days are over 90 years of age and at risk of rapidly decompensating. The hospital is working with the CCG and whole system transformation board to set up a discharge to assess model to particularly target patients at risk of decompensating if admitted.
- There remains a challenge in achieving seven day a week consultant led care in all specialities and access to support services. This requires change in culture and working patterns to meet demand peaks (e.g. most elderly patients are now presenting between 4pm-9pm).