A summary reference guide for health organisations wanting to achieve sustainability and improve performance on the National Emergency Access Target (NEAT)

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Tel: 0401 856 705

dean@asehealth.com.au

richard@asehealth.com.au
Introduction

Since the introduction of the National Elective Access Target (NEAT) as part of the National Partnership Agreement on Improving Public Hospital Services; States and Territories have been working in partnership with local health bodies, hospitals and other healthcare organisations and agencies to improve delivery against the target.

Overcrowding and extended stays in the Emergency Department (ED) for patients admitted to a hospital bed are associated with poorer outcomes\(^1\)\(^2\). In order to both improve services

and outcomes for patients, whilst achieving the required improvement in NEAT, healthcare organisations are looking for ways to optimise their processes and support the delivery of safer, higher quality and more effective care.

The aim of NEAT is that by 2015, 90% of all patients presenting to a public hospital ED will either physically leave the ED for admission to hospital, be referred to another hospital for treatment or be discharged home within 4 hours. Attempting to resolve challenges, which can be systemic, cultural, or result from local challenges, such as higher rates of chronic disease or mental health conditions within the population served, can be difficult.

This paper summarises some suggested areas for consideration. It is not exhaustive, represents the views of ASE Health incorporating example practice, and may cover already well understood areas. It should compliment Government improvement programmes, which have supportive processes and resources in place. The paper covers:

- A discussion on diagnosing the challenge(s) as the first course of action, what this might include, and how this could be done
- The key questions that can be considered and worked through to help diagnose any particular issues and improve the patient journey and identify improvements
- National and international examples of both the planning for resilient ED and urgent care services, and the development of models redirecting patients at the ‘front door’ to urgent care and primary care services

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A brief summary of example initiatives already underway as part of the Whole of Hospital Program in New South Wales to improve the patient journey

- The types of support ASE Health could provide in supporting a better understanding of the challenges faced and developing appropriate solutions.

1. Identifying the challenges

One size solution will not fit all and there therefore needs to be a good local understanding of the challenges faced by that local district and hospital in achieving the NEAT. Critically it is important that the focus should not just be on the EDs but also consider the whole hospital and the whole health and social care system.

**A clear understanding of NEAT and its definitions**

There should be a good understanding of the target and the definition should be understood by all those that need to know including clinicians, managers, and others that record and report on NEAT.

Undertaking a review or audit of patients that have gone through the ED pathway may again assist in ensuring that the activity is being collected and analysed according to the
definitions set down in technical guidance. It may uncover inaccuracies in reporting which
could impact positively or negatively on the
achievement of NEAT, and will allow an appropriate
solution to be developed.

**Analysing the activity data**

Reviewing activity data including the available data
on attendances, admittances, and discharges, will
help to identify particular issues during specific days
or times of the week and trends over time. To ensure
that the data can be interrogated deeply the addition
of the severity of the condition, and case mix data
will assist in identifying trends.

NSW Health has published two new tools: one
which will allow hospitals and local health districts to
better understand both delays within the ED and
one that also identifies bed status and capacity on
wards. The latter tool also identifies either legitimate medical treatment purposes or other
reasons for delays. In addition to looking directly at hospital activity reviewing delays in
transfer of case to community based services or nursing homes and the waiting times of
ambulances to transfer patients to ED should be analysed.

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**Questions to consider when reviewing how the hospital and health system operates**

**Emergency Department and Links to Partners on the Patient Journey**

- Does the ED have contingency plans for the unavailability of staff, such as
  transport, childcare or sickness issues?
- What is the relationship with social
  services and is access readily available
  when required? If not, could consideration
  be given to co-location of social services
  within or near the ED?
- Are there any primary care services
  located within or adjacent to the ED?
- Is there signposting and possible
  redirection to primary care and GP
  services where appropriate to do so?
- Does the hospital have an assessment
  unit for patients that require further
  assessment, diagnostics, or monitoring
  but do not require full admission?
- Are ambulance drop offs / attendances
  handled within a timely way and have
  there been discussions with the
  Ambulance organisation about how these
  can be improved for both hospitals and
  ambulances?
Auditing the patient journey

An audit of the patient journey can compliment the above analysis, and alongside the use of clinical audits to better understand particular occurrences of not meeting the NEAT, may help identify the root cause. It is important to look for possible challenges for specific patient groups. For example if a particular cohort of patients is not being seen within the target why might this be. However any review should also look more widely at the available information from partner organisations such as GPs and social care providers, and in addition should look at the clinical, management and governance arrangements in place with oversight of the Department and achieving NEAT.

NEAT has been set up with a threshold that allows for those patients that will clinically require more than four hours within the Emergency Department. For example patients may require monitoring or a diagnostic test followed by a watchful approach. By reviewing this cohort of patients in detail it may identify provision or model of care that could meet these needs such as a clinical assessment unit or ambulatory care service, and allow focus on those remaining patients that do not clinically require longer than four hours in the ED.

Questions to consider when reviewing how the hospital and health system operates

**Hospital Discharge**

→ Where appropriate, has the hospital considered nurse led discharge from hospital?
→ Are the processes different for discharging at weekends? If so, does this have any impact on the ability to discharge? If not, do processes need to be revised to make discharge smoother at weekends?
→ Is there a discharge lounge in place and is this being utilised as effectively as it could be? Can drugs required for discharge be made available via the lounge?
→ What processes are in place for providing required drugs for discharge and are these processes appropriate?
Collecting information to support the achievement of NEAT and quality services

In addition to the 4 hour waiting time target, the NHS in England (UK) has introduced additional measures to monitor the quality of services provided in emergency departments. Based on feedback from senior clinicians, ED sites are encouraged to locally publish information on the A&E (ED) indicators in the form of a clinical dashboard. These eight indicators allow clinicians and managers to see the quality of care that is being delivered in the ED, such a model may provide Australian hospitals with a powerful tool to encourage service improvement or celebrate successes.

<table>
<thead>
<tr>
<th>Effectiveness of care</th>
<th>Patient experience</th>
<th>Patient safety</th>
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<tbody>
<tr>
<td>1. Ambulatory care (attendances and admissions for cellulitis or DVT)</td>
<td>4. Left without being seen rate</td>
<td>6. Time to initial assessment</td>
</tr>
<tr>
<td>2. Unplanned re-attendance rate</td>
<td>5. Service experience</td>
<td>7. Time to treatment</td>
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<tr>
<td>3. Total time spent in the A&amp;E (ED) department</td>
<td></td>
<td>8. Emergency Medicine Consultant sign-off for certain at risk patients before being discharged</td>
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Financial Incentives

Finally the hospital and the local health district may find it useful to review the financial incentives / disincentives that may impact on decisions within the system causing delays.

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For example what incentives can be introduced to ensure primary care, mental health, and social care providers receive and act upon referrals with a limited time delay.

**Confirming the challenges**

The outcome of the review or diagnosis of the challenges within the ED and the whole system may uncover both system challenges and more local challenges which only affect that hospital or health district.

3. **Developing solutions to meet the challenges identified**

**Making changes along the whole patient journey**

It is important that appropriate changes are made along the whole patient journey. The Emergency Care Institute New South Wales has some helpful resources available on its website. This includes some top tips and suggestions for what the ED can do.\(^4\) Some tips are:

- Match staffing levels to arrival times and peak activity; Maximize the use of all clinicians in the ED looking at skill mix and task allocation so that all providers are working according to the top of their scope of practice.

- Consider the use of a Navigator Role. Also investigating admitting rights for designated medical staff in the ED, determining how referrals to the admitting team work and the process after acceptance to ensure timely departure from the ED.

● Have agreed turnaround times for investigations, tests and pathology to reflect clinical urgency and consider exploring enhanced access to radiology and pathology, including point of care testing with agreement on who can request according to protocols.

● Utilise Models of Care that are appropriate for case mix, complexity and activity in the department, such as Fast Track, Early Treatment Zone, Senior Assessment.

NHS Interim Management and Support (IMAS) in the UK, has published helpful papers on its website which summarise good practice tactics that have been proven to reduce bed occupancy, cost and harm events, while increasing the satisfaction of front line clinicians and the rest of the team.

The Kings Fund Recommendations

The Kings Fund, in the UK has produced a helpful summary of the areas it believes need to be tackled by healthcare commissioners in the NHS in England to deliver a sustainable healthcare system. These do not only involve development and change in hospital care but also recommend changes in and greater alignment with primary care, and require the continued input of public health. To this end the 10 changes focus on more systematic and proactive management of chronic disease, the empowerment of patients, a population based approach to commissioning and more integrated models of care. Although all 10 areas make suggestions that should be considered, three areas in particular appear to be

5 http://www.nhsimas.nhs.uk/intensive-support-team/
6 http://www.kingsfund.org.uk/projects/urgent-emergency-care
highest priority for the achievement of NEAT and within the control of hospitals and LHDs.
These are:

1. Managing Urgent and Emergency Activity
2. Managing ambulatory care-sensitive conditions
3. Care coordination through integrated health and social care teams

**Managing Urgent and Emergency Care**

The document includes suggested activities for improvement including:

- Providing effective signposting to help patients choose the right service
- Ensuring that hospital and community services can adjust service levels in response to changes in demand, so that need and provision are kept in balance
- Ensuring that A&E (ED) departments adopt best practice for handling ‘majors’ including early senior review
- Ensuring that hospitals, and social service and housing departments work effectively together to reduce delayed discharges and shorten lengths of stay

**Managing ambulatory care sensitive conditions**

Ambulatory care sensitive (ACS) conditions include chronic conditions for which it is possible to prevent acute exacerbations and reduce the need for hospital admission through active management, such as vaccination; better self-management, disease management or case
management; or lifestyle interventions. Examples include congestive heart failure, diabetes, asthma, angina, epilepsy and hypertension.

As well as recommending disease management and support for self-management for those with long-term conditions, telephone health coaching and behavioural change programmes to encourage patient lifestyle change, the following was recommended

- increase continuity of care with GPs
- ensure local, out-of-hours primary care arrangements are effective
- for those with acute aggravated conditions, ensure there is easy access to urgent care.*
- and conduct early senior review in A&E (ED), and implement structured discharge planning.

*In some UK hospitals a dedicated ambulatory care service has been introduced which patients presenting with certain conditions can be referred or streamed into.

Clearly the latter two points are areas that health districts and hospitals could investigate further in partnership where already not in place.

**Care coordination through integrated health and social care teams**

Robust evidence on health outcomes is limited, but improved care coordination can have a significant effect on the quality of life of older frail people and people with multiple long-term conditions (Hofmarcher et al 2007). The Impact on costs and cost-effectiveness is
less easy to predict and is likely to be low in the short term given the upfront investments required. However the Kings Fund state, health systems that employ models of chronic care management tend to be associated with lower costs, as well as better outcomes and higher patient satisfaction (Singh and Ham 2005)

4. Ideas and examples of success

Operational Resilience and Capacity Planning in the UK

In response to its challenges in delivering against its 4 hour waiting time target the NHS in England (UK) has introduced an approach to its planning process which it says brings together both elements of its planning for non-elective (e.g. emergency and urgent care) and elective care in one forum to achieve ‘whole system resilience’.

‘System Resilience Groups’ will be responsible for developing these plans and will become the forum where capacity planning and operational delivery across health and social care system is coordinated. This approach is to ensure that all parts of the system are resilient year round, pulling in the same direction, and that financial planning is considered. Whilst this model would not be directly applicable to Australian healthcare systems, consideration of this type of whole system planning may assist in the greater coordination of services to reduce demand in EDs and ultimately assist in the achievement of NEAT.

SRGs will be required to develop operational resilience and capacity plans by involving all key local organisations, to fulfil both planning requirements and ensure good system working in the future. The plans must be signed off by SRG member organisations, and have a number of mandatory elements that need to be included. These plans must set out how they meet good practice principles, including during pressured times. See below for examples of these. In addition plans would include proposals to meet additional wider considerations, and build on existing local capacity planning. Describing the underpinning governance arrangements for the planning and plans delivery and oversight and any links with delegated authority.

For non-elective (e.g. urgent and emergency pathways) principles of good practice are listed under a number of headings including ‘Planning’, ‘Primary Care’, ‘Seven Day Working’, ‘Patient Experience’ and ‘Measurement’. Examples of good practice suggested include seven day working arrangements in place for social care workers to facilitate hospital discharge, brokerage of packages of care, and senior social care management sign off of delayed transfers of care. Also having consultant-led rapid assessment and treatment systems (or similar models) within EDs and acute medical units during hours of peak demand to ensure swift, sound clinical decision-making and effective use of staffing and other resources.

Finally this planning method includes an example ‘good practice’ whole system urgent and emergency care flow model and asks each SRG to consider and populate this with its local system requirements. This is a useful way of testing aspects of the patient journey. The documentation provides Strategic Resilience Groups with example planning templates for
responding with how the plan meets the minimum planning requirements, KPIs, target outcomes, timeframes for completion, leads and costs. Whilst much of this planning process is not applicable to the Australian system, aspects may be useful and local health bodies could consider the development of similar operational resilience plans which bring all partners in the system together to agree a common and workable solution.

**Streaming Patients on Arrival at the Emergency Department to the Right Care Setting**

Many hospitals have changed or adapted the model of care provided to improve the patient journey and ensure that patients are streamed to the correct and appropriate care setting for their needs. This is often effective, better for the patient in terms of clarity on where to access services and can require less unnecessary resource within the ED.

One example is New Cross Hospital in Wolverhampton, UK, which is redesigning its Emergency Department through a capital investment to create an Urgent and Emergency Centre. The local health body (district) and the hospital are working together to simplify and improve urgent and emergency care services. ⁸ A newly built centre will be open 24 hours per day, 365 days per year. The local health body and the hospital plan to bring the existing A&E department, the GP out of hours service and a walk-in service into one building. Patients would go through one front door of the new Urgent and Emergency Centre at the hospital and a clinician would direct them to the best place for their treatment – either the Urgent Care Centre or the Emergency Department. There are also plans to improve the

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other services that work alongside urgent and emergency care, including access to GP appointments, the management of long term conditions and end of life care.

The change is based on feedback from patients that they do not know which service to go to at different times of the day or week. They say this can result in people going from one service to another before they get the treatment they need. Whilst a rebuild of the ED may not be possible, affordable or desirable in all cases, this is an interesting model of care.

In Liverpool, UK, the local health body has approved funds to put GPs in two hospitals in an attempt to alleviate pressure on ED services.⁹ The funding makes permanent a pilot which between November 2013 and July 2014 diverted 2,632 patients from the hospital's ED. There are several areas in England now piloting or investing in this type of scheme. It is understood that some areas stream patients at the ED front door towards a co-located primary care or urgent care service or facility.¹⁰ In some cases these services will signpost patients to a local GP and provide information on local primary care and pharmacy services for future use.

Where the patient has access to a GP the team may work with local GPs to better understand why the patient was unable or unwilling to access a GP appointment.

**Work underway in NSW to improve the patient journey and drive up performance against the NEAT**

In NSW, there are several statewide initiatives underway that are progressively being rolled out or adopted by other districts or hospitals.¹¹

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⁹ [http://www.hsj.co.uk/5076546.article?WT.tsrc=email&WT.mc_id=Newsletter2](http://www.hsj.co.uk/5076546.article?WT.tsrc=email&WT.mc_id=Newsletter2)


Introducing a 'Hospitalist' role has helped hospitals improve NEAT performance through medical and organisational leadership

The Hospitalist has a medical and organisational leadership role in the provision of quality clinical services. They are able to provide ‘clinical expertise and advice, including after hours, and have a special focus on promoting safe, effective and efficient patient care which is coordinated across a range of disciplines and settings.’ At Grafton Hospital the NEAT performance improved 10% in the first 6 months since the hospitalist’s involvement at no extra cost to the health system. During this time the proportion of patients who did not wait for the completion of their care came down from 5.6% to 3.2%, and the waiting times for all Australasian Triage Score (ATS) triage categories trended into the target zone.

The Electronic Patient Journey Board (EPJB) is helping hospitals monitor and improve the patient journey

The EPJB is being rolled out and there are currently 88 wards in 22 facilities who have implemented the EPJB with 90 wards scheduled to roll out in the next few months. The purpose is providing a real time visual overview about the patient’s journey from admission to discharge including completed and outstanding tasks.

Whole of Hospital Clinical Data Dashboard in Northern Sydney

At Mona Vale and Hornsby Hospitals a comprehensive dashboard has been introduced and wards can see at a glance how they are performing on a number of measures, print off
reports and compare trends against other areas or previous years. The dashboard is available to everyone with access to the North Sydney Local Health District Intranet and also displayed for staff, patients and families. The dashboard includes a number of original measures (mortality rates, ward traffic, length of stay, number of patient discharges by day of week, transfers to ICU/HDU and re-admissions within 28 days), and was expanded to include a series of additional measures for all wards to better inform clinicians and managers. The additional fields include fall rates, infection rates, hand hygiene compliance, NEAT, medication errors, percentage discharges before 10am, pressure injuries, ED Average time from triage to first seen, and separate specific measures for wards such as Maternity.

The introduction of the dashboard encourages ownership and accountability over performance results. The comparative trend data allow analysis of how different quality projects are working and changes have been made to processes as a result of what the data has shown.

**Nepean Hospital Mental Health Dashboard**

Following the introduction of a mental health specific dashboard selected staff at Nepean Hospital can see at a glance the patients in the ED who have been referred for Mental Health Assessment as well as all admitted Psychiatric Emergency Care Centre (PECC) patients and how long they have been in each area. As a result the hospital believes that Performance against the National Emergency Access Target for mental health patients has started to improve and the time saving tool is preventing duplication as well as improving the process of recording and transferring patient information. The Dashboard was developed on a trial
basis to document all PECC referrals accurately and to replace a large tracking book containing all the details about patients being referred to the PECC. One aspect, which is key for the patient experience as well as safety, is that staff can search for any patient’s presentation details since the system began.

5. Summary

1. **It is important to ensure the challenges are correctly identified and understood before making changes**

Facilities working in partnership with health districts have over the last few years undertaken significant review of their internal processes to improve the patient journey. This activity is one that is ongoing and it is important that all parties continue to be clear on their understanding of NEAT and its definitions; that analysis of the available activity data and using tools to ‘drill down’ further continues; audits of the patients journey are carried out where appropriate; there is consideration of what other available information is available; and that this is brought together to confirm a set of challenges that can be continually tackled.

2. **When the challenges and opportunities are diagnosed it is important to consider the available solutions along the entire patient journey**

There are clear examples of good practice available for improving the patient journey. The NSW Emergency Care Institute for example makes recommendations on matching staffing levels to arrival time and peak activity; agreeing turnaround times for investigations, tests and pathology, and utilising different models of care such as fast track and senior
assessment. The diagram below represents the importance of all aspects of the patient journey and provides examples of areas that can be further investigated.

3. There are many examples in NSW and internationally of change to improve process and drive up performance on ED waiting time targets

In the UK, current thinking includes capacity and operational resilience planning by groups including partners from across hospital, primary, community and social care. The plans developed will be jointly agreed and include responses in a number of areas including how plans meet suggested good practice around joined up working and governance arrangements, 7 day working, and discharge planning.
In addition new emergency and urgent care models are being introduced. For example in Liverpool, UK, the local health body has approved funds to put GPs in two hospitals in an attempt to alleviate pressure on ED services. In Wolverhampton, UK, the hospital is redesigning its ED to create an Urgent and Emergency Centre, where patients would go through one front door and a clinician would direct them to the best place for treatment – either the Urgent Care Centre or the ED. These models may not be appropriate for Australian hospitals but the learning may be useful.

Across NSW there are several examples of change to improve the patient journey and drive up performance on the NEAT. For example the introduction of a hospitalist role has helped hospitals with clinical expertise and advice, including after hours, providing medical and organisational leadership. In addition, the electronic patient journey board (EPJB) is helping hospitals monitor and improve the patient journey, while the whole of hospital clinical data dashboard in Northern Sydney with its comprehensive metric dashboard encourages ownership and accountability over performance results.

4. NSW Health has developed a strong program to support LHDs and facilities. ASE Health can further support programs and delivery of change locally

NSW Health has developed a holistic program of support for LHDs and facilities across the State. This includes the publishing of good practice information, developing and sharing planning tools, and allocating experts to work with local teams to make changes. ASE Health has recently been appointed to a panel which will support the Whole of Hospital Program in achieving further improvements.
6. Methods that ASE Health can deploy to help identify activities for improvement

- Coordinating and managing an assessment of the ‘as is’ situation against good practice provision. Diagnosing and clarifying existing challenges.
- Bringing in appropriate good practice and possible solutions from the Australian and international health systems, where appropriate applying locally.
- Assisting process mapping, clinical pathway mapping and design.
- Building clinical engagement by undertaking 1:1s and workshops.
- Assisting with cultural change and managing change programmes.
- Working with analysts or business intelligence to strengthen data collections.
- Facilitation and development of local strategies or improvement plans to drive up performance on NEAT, providing management support where appropriate.
References

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Highly experienced, mature and approachable, ASE consultants have both front line clinical experience in acute and primary care, and management experience in public and private health companies.

Our team focus on collaborating with clinicians, patients and executives to help optimise the delivery of healthcare.

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