3A STUDY

Avoidable Acute Admissions

Learning set meetings

Themes and questions in common

The idea behind the Learning Set meetings has been to provide points in the research process where conversations can be stimulated and connections made, because it is in such spaces where new, challenging and sometimes inspirational questions can take shape.

The purpose of this report is to provide a brief account of four very rich meetings which took place as part of the AAA project at each of the four sites involved in the study. At these meetings small groups met to hear the researchers present interim findings and to have the opportunity to ask questions, to reflect and to talk together about the issues raised. The research has taken two complementary approaches: an ethnographic study and value stream mapping and findings of both these were presented. The threefold purpose of Learning Sets has been to:

1. Form a part of the research process itself, one where professionals are able to input directly into the project
2. Provide an opportunity for these professionals to compare their responses and to talk together about important problems and issues
3. Offer a point of connection for the four sites to use as they wish both for this study and for future learning and change work

The summary aims to provide a resource for further learning conversations; it is part of the sense making rather than a summary of findings. These will be published in due course. The aim of this document is to capture the gist of the meetings and the content therefore comprises largely verbatim quotes which have been organised into three groups:

1. Common themes: what people are saying
2. Questions: what people are asking
3. Burning issues: what people care about

A further opportunity to make progress on the problems and opportunities identified will take place during the stakeholder workshop in November. It is hoped also that the meetings and report will spark further thoughts - all of which are welcomed by the research team as they seek to draw the project together in a balanced way which represents people's reality and gives participants a voice.

Common themes: what people are saying...

"I think one of the issues is it's trying to sort out those pathways and trying to organise that level of health provision when you're dealing with a crisis every day."

THE PRESSURES

"People don't want to work here, it's too busy."

Across the four sites the most pressing common theme is about limited resource and the pressures this creates. Differences in perspective mean that sometimes what is emphasised is staffing...

"...when staffing's at full capacity, everything works when the hospital's green...we used to always talk about winter pressures but there's been no let-up in summer. "

and other times it is care...

"I think we all agree that we feel that as pressures increases we all feel that we start to lose control, and we worry that patients' quality of care is compromised."

but always the common thread is the way resource pressures lead to work pressures. At times participants concentrate on describing what it is like to be in it:

"It is the path of least resistance, because there aren't alternatives out there to avoid them coming in and being admitted – then that compounds the problem further, so it becomes a cycle."

And at other times they suggest ways of making it better:

"Changing the process slightly...so when someone walks in you can say, 'Come and see the nurse practitioner,'

Pressure and crisis management lead to more pressure, and this cycle is an integral part of how decisions get taken:

"I think that we, when we're under pressure we make bad decisions, and we're often under pressure ... we potentially do admit more patients because we haven't got the time to work through the more complex issues with those patients, particularly social issues."

"The other thing I'd like to say is that under-staffing, recruitment and retention issues, I think what we don't necessarily need is lots more doctors. I think what we need is more decision-makers.

THE SYSTEM

The second big theme to cross all four sites has more of a focus on the system as a whole - how it works, what gets in the way and what things might be like if it worked well. People describe aspects of the system and the way they see the connections: waiting times

"...and then all of a sudden there's that almost stop while they're then waiting for something else to happen, I see where the concerns come from."

are connected to the number of beds,

"but there's no other facility provided, no other capacity anywhere else that can ... provide the care that they are, are deemed to require, except in an acute hospital bed.

which in turn is connected to flow.

"...acute admission avoidance is good on its own but it really can't stand in isolation of a wider social care reform...if there's nowhere for that patient to go we can't just, chuck them out of the department,"

There are fewer suggestions for improvement in this theme. The "system" seems almost too big to grasp.

"... it's easy to take it out in bits but the problem doesn't work if you take it out in bits, in some ways it gets worse because you're not doing it in an integrated, system-wide approach"

"...you're constantly crisis managing, and you don't have the head room to think out of the box, as a result there aren't sufficient alternatives to admission... because we're constantly looking at the here and now."

Questions: what people are asking…

How do we take that leap of faith that actually if we do something different it will have a different result?

The themes in the previous section are the those that people are certain of: "These things we know." The conversations did not all have this tenor. Across all four sites there are problems and issues to which people do not yet have answers. Spurred on by a need to understand and to improve, at times people enter into a more reflective and enquiring mode. Normally, the pace of work is relentless and there is little time to think or reflect together. The main question, which appears in many different forms, might be paraphrased as, "How can we influence this thing which is so much bigger than us?" Beneath this, again paraphrasing, are two further lines of enquiry:

1. How can we stop people attending ED who shouldn't be there?
2. Once they are there, how do we make ED a place of safety?

Across the sites, these questions keep coming back:

"…we need to find ways of seeing more of the patient rather than being always influenced by all the different targets… So … I'm not entirely sure what the answer is here, you know, it's probably more resources, but also in terms of, how can we stop patients attending ED who shouldn't really be there, as well?"

"…to be honest I try to see patients and to keep them as safe as possible…but if the number of patients is increasing exponentially… there's no way we can do things just by adding a doctor or a nurse every two years"

"I think we have to decide as a service what an acute bed in the hospital is for.."

"I'm just thinking about how I want to structure the question, but what I would like to be able to do is try and really understand what is going on in the community, because there is a huge amount of knowledge and talent there…"

Burning issues: what people care about

"Nobody comes to work and says that I want to do worst for my patient today, we come here to make sure that we do the very best for the patient"

Everything in these conversations is a burning issue: people are passionate about their work and about finding solutions to the problems they face. Emotions and passions run high throughout. However, there are two which stand out from the rest and both of these are about patients. First is the tension between targets and the provision of quality care. This theme appears time and time again:

"...we put together a statement for the rest of the hospital, which was about providing the care for patients that you would want to receive yourself or that you would want a member of your family to receive. I think if you remember that then you won't leave someone lying in urine-soaked bed sheets to meet a target."

"I'm aware that we sometimes don't do patients favours because of time pressure…sometimes I wish that there would be exceptions where I can keep this patient for an hour or two for various reasons without being penalised for doing so - and that's more in the patient's interests than mine."

A second issue people really care about is putting the patient at the centre of what they do. This is a fundamental professional imperative

"…spending that extra bit of time pays huge dividends in patient quality of care, and also as a clinician you get positive feelings if you feel that you've done a good job and your patient's happy and they're discharged fully knowing what you want them to know…"

"…the amount of times patients say, 'Oh actually I need the commode,' and everyone's like, 'Well you can't put them on the commode because they're on four hours and then they're going to breach,' that happens all the time, and you just have to prioritise nursing care…"

and as a compass for quality care

"The main focus for us is that the patient has always got to come first, and then we just need to work out the best patient care pathway around that."

LEARNING, RESEARCH AND NEXT STEPS

A clear message from participants is the desire to see some concrete improvements coming out of the AAA research project. The research team are committed to ensuring the final report incorporates this. They will to work at the system and put energy and care into its improvement is at the heart of all these conversations and any recommendations will acknowledge and respect that.

Learning

From a learning perspective, it would seem sensible to ensure that future conversations consider how and what different professionals in the system are learning about how to make useful progress on opportunities or problems in the real world. And to do that people need to connect and to have the time and space to think and reflect together. This is a challenge of course but every possible moment should be grasped. The relationships made in the AAA project may well offer some useful learning connections, which given the right conditions, have the potential to offer moments of unexpected insight. Learning about the system cannot take place in complete safety: it involves risk and taking actions which might not work, but an organisation which continues to express only the ideas of the past is definitely not learning.

Research

The AAA research project is an observational research study. This means that it has taken a "snapshot" of the experiences of adult patients attending emergency departments with acute medical problems, and of the healthcare professionals who treated them, in a representative sample of acute hospitals in the South West of England. AAA is a patient-centred project that has probed patient experiences and factors that might be associated with better or worse experiences for both patients and clinical staff. AAA did not change patient care, but the study raises many questions and points towards to possible remedies for the currently perceived "crisis" in emergency medicine provision. It will be for subsequent research to examine the impact of change on patient experience.

Next Steps

The final report on AAA will be submitted to the National Institute of Health Research in February 2015. Following this, the full research output of AAA will be published in the scientific literature. When the full analysis of AAA has been completed, and there has been reflection on the learning from AAA, it is envisaged that the consortium of patients, researchers from three universities and clinicians from four hospitals who have worked together to make a success of AAA will build upon this flagship project, and together make suggestions and implement change to enhance patient experience in the NHS.