

## Is Bigger Better ?

### *Addressing the challenges of Care delivery in the 21st Century*

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### **Danish eHealth Observatory Annual Meeting**

6<sup>th</sup> October 2015, Nyborg, Denmark







# So how well are we doing ?



## The European health report 2015

Targets and beyond – reaching new frontiers in evidence

The European health report is a flagship publication, published every three years. The 2012 report set the baseline for monitoring progress towards the six targets of the European policy framework, Health 2020.

The 2015 report presents the progress made since the baseline. An assessment of the available data on all the targets reveals that the European Region is on track, but much potential remains for further health gains and reductions in inequalities.

The 2015 report gives an update on the challenges in measuring and reporting on progress towards Health 2020, particularly in measuring well-being, and proposes new sources of qualitative evidence to describe and monitor well-being.

Facts and figures are not enough to report meaningfully on what it means to be healthy and well in Europe. The 2015 European health report argues that new forms of evidence are necessary to fully capture this. Stronger international collaboration is required to advance the agenda for health-information research and development in the Region.

## *Similar in AUSTRALIA too!*

*Australia across 28 OECD Health indicators ranks in top third for 11 and top half for 16:*

- Overall mortality is second lowest in OECD at 687/100,000 behind Japan 613/100,000
- One of the lowest smoking rates (17% of people aged 15 and over were daily smokers) **further reduced by plain package cigarettes**
- Life expectancy is amongst the highest: 7th and 6th for life expectancy at birth of males and females respectively, and 3rd and 6th for life expectancy at age 65 of males and females respectively.

***But not all good news...especially in RRR***

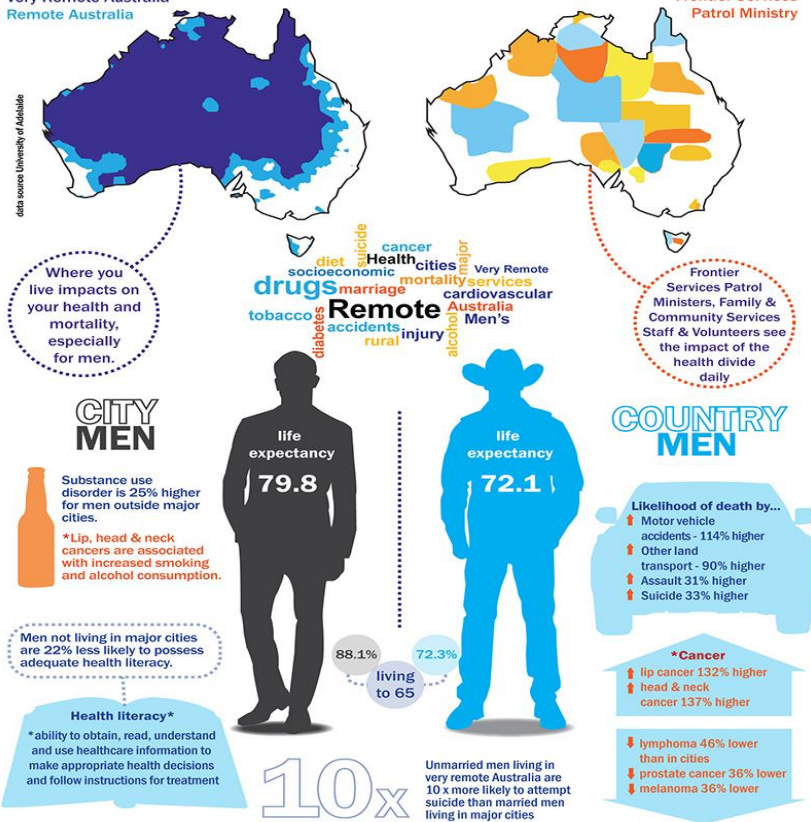


## THE GREAT DIVIDE: MEN'S HEALTH IN AUSTRALIA CITY BLOKES vs. COUNTRY BLOKES

**Frontier Services**  
*serving remote Australia*

Very Remote Australia  
Remote Australia

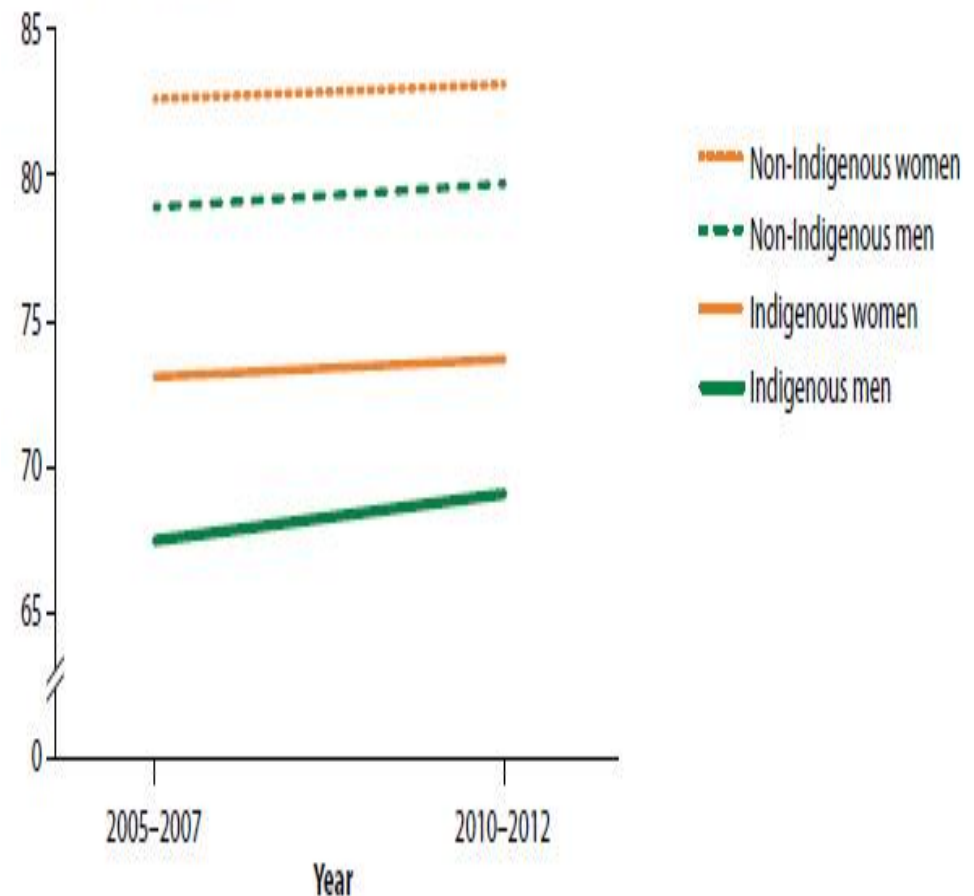
**Frontier Services  
Patrol Ministry**



Source: <http://www.aihw.gov.au/publication-detail/?id=6442468343>

[www.frontierservices.org](http://www.frontierservices.org)

Life expectancy (years)

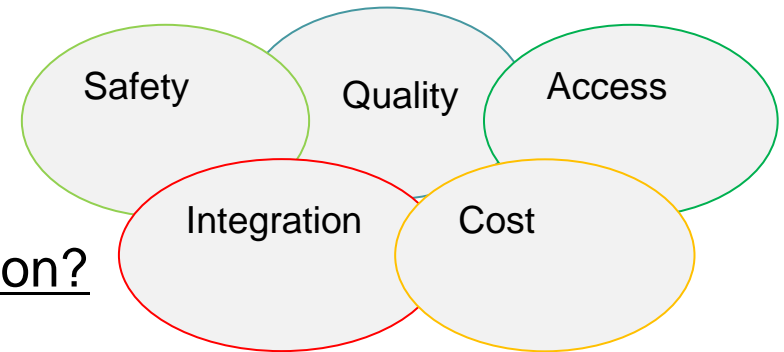


## *So looking to the future → what do we already ?*

- 1. Demography** → Aging, Polychronic, CALD, Gen-i time-bomb, HealthCare Workforce supply, discipline & distribution
- 2. Medical Advances** → cost/availability/capacity for new treatments, medications, diagnostic techniques
- 3. Public Vs Private Provision** → choice, capacity, waiting lists
- 4. Information Technology** → Legacy, interoperability, benefits/impact?
- 5. Patient Engagement** → Expectations, Capability and Motivation, Health and eHealth divide



## Major care delivery challenges will continue: S-QA/C



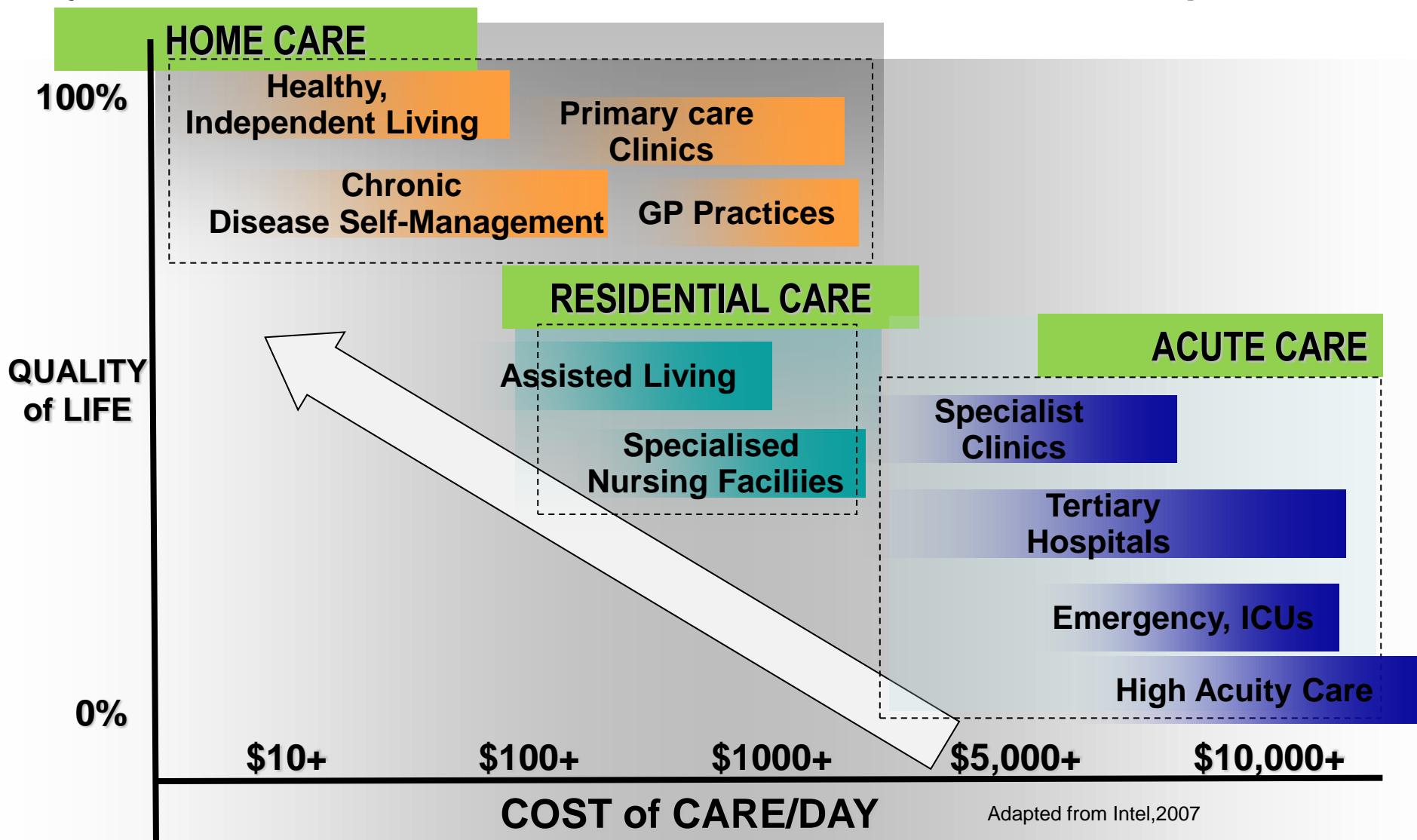
1. **Safety** → System, Patient, Population?
2. **Quality** → EBM, Variation Reduction ?
3. **Access** → Inequity and inequality related to services and outcomes
4. **Integration** → Services, Technologies, Treatments (anticipatory and curative), Patients /Citizens?
5. **Cost** → Optimising resource use, ensuring affordability and reducing waste and inefficiency?

Are we responding with Systems: 'Fit for Purpose'?





## Systems of Connected Care: Prevention, Maintenance & Empowerment



# ***What about Health Information Systems: Are they fit for purpose ?***

**Key benefits and beliefs we have about introducing eHealth**

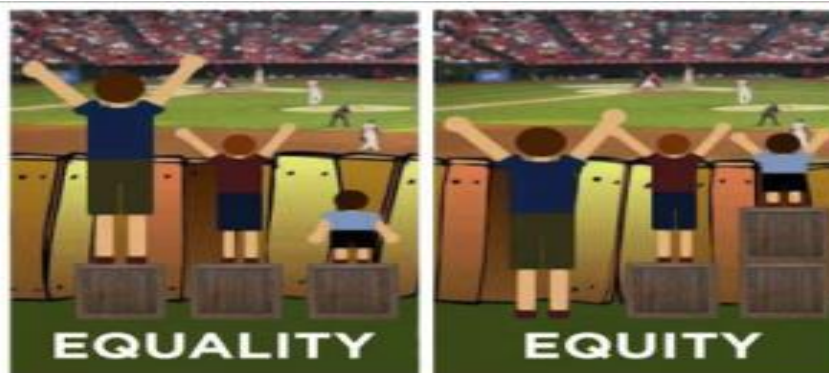
**Easy to answer**

**Diffusion of eHealth Systems, Services & Applications is clearly making things better right ?**

**Not as easy to answer or to provide strong evidence in terms of impacts / benefits / outcomes for patients**

**Is there a danger these systems could extend the Health and eHealth Divide ?**

**Disparities in Health Outcomes and Access to Health Services remain!**



Perhaps we need some *Flexible* standardisation

**What about PLUs → Let's do a quick straw-poll on this social network in relation to consumer eHealth:**  
**Access, Use and Impact**

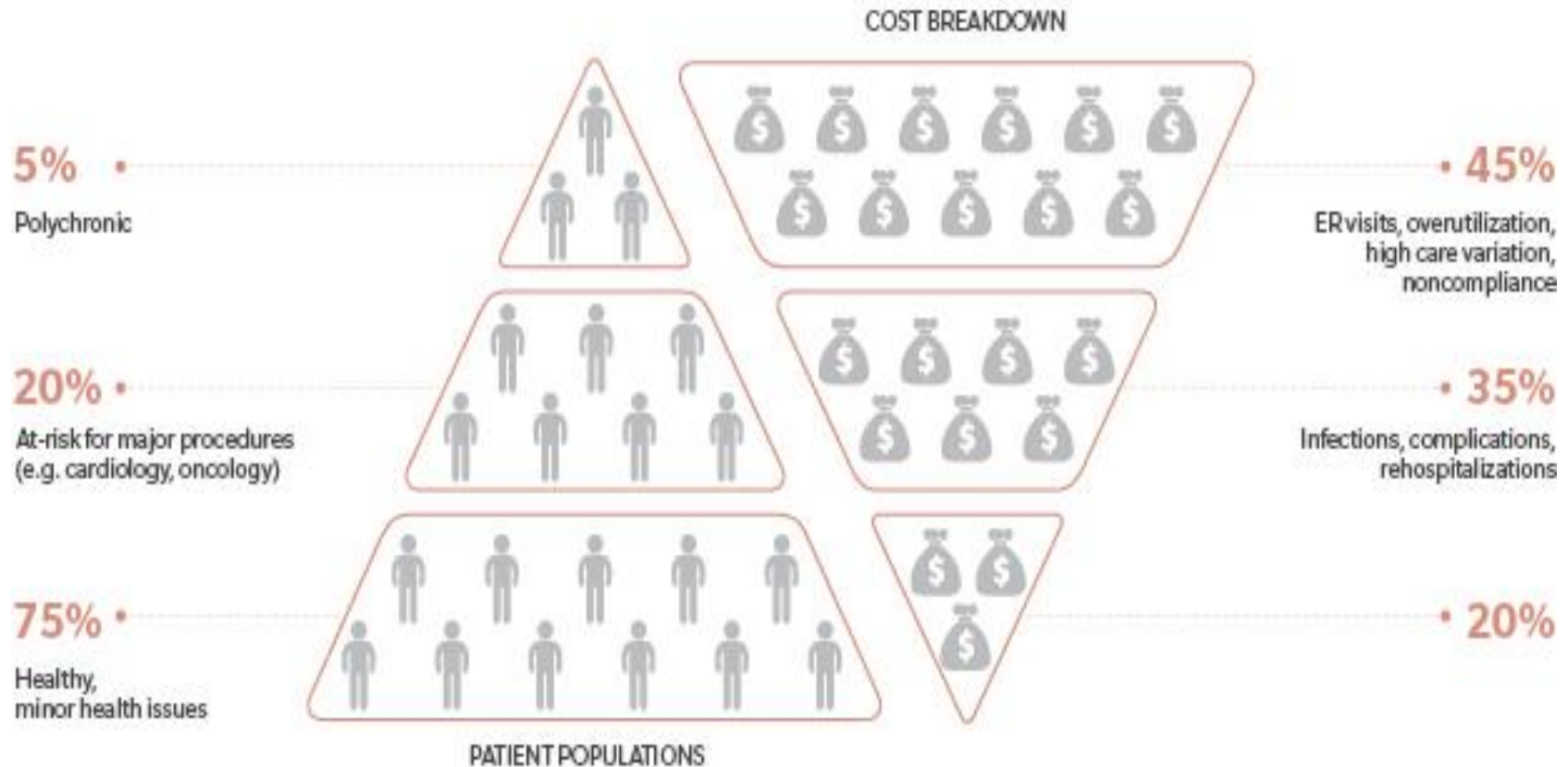
1. Please stand up if you have a smart-phone
  2. Please sit-down if you do not have health and/or well-being applications on your phone or do not have a fit-bit or similar device
  3. Please sit-down if you have these applications but no longer use them
- Please stand-up if you have done 30 mins of moderate exercise today
  - Please stand-up if you have 3 alcohol free-days per week
  - Please sit-down if you smoke
  - Please sit-down if you work (in your office or your home) more than 50 hours per week

Please sit-down if you are not already doing so ! **How is it for DDDs ?**

## Where are the major challenges again?

### THE UPSIDE DOWN PYRAMID (TODAY)

Population health must target the top two layers and use the savings to keep the bottom layer healthy

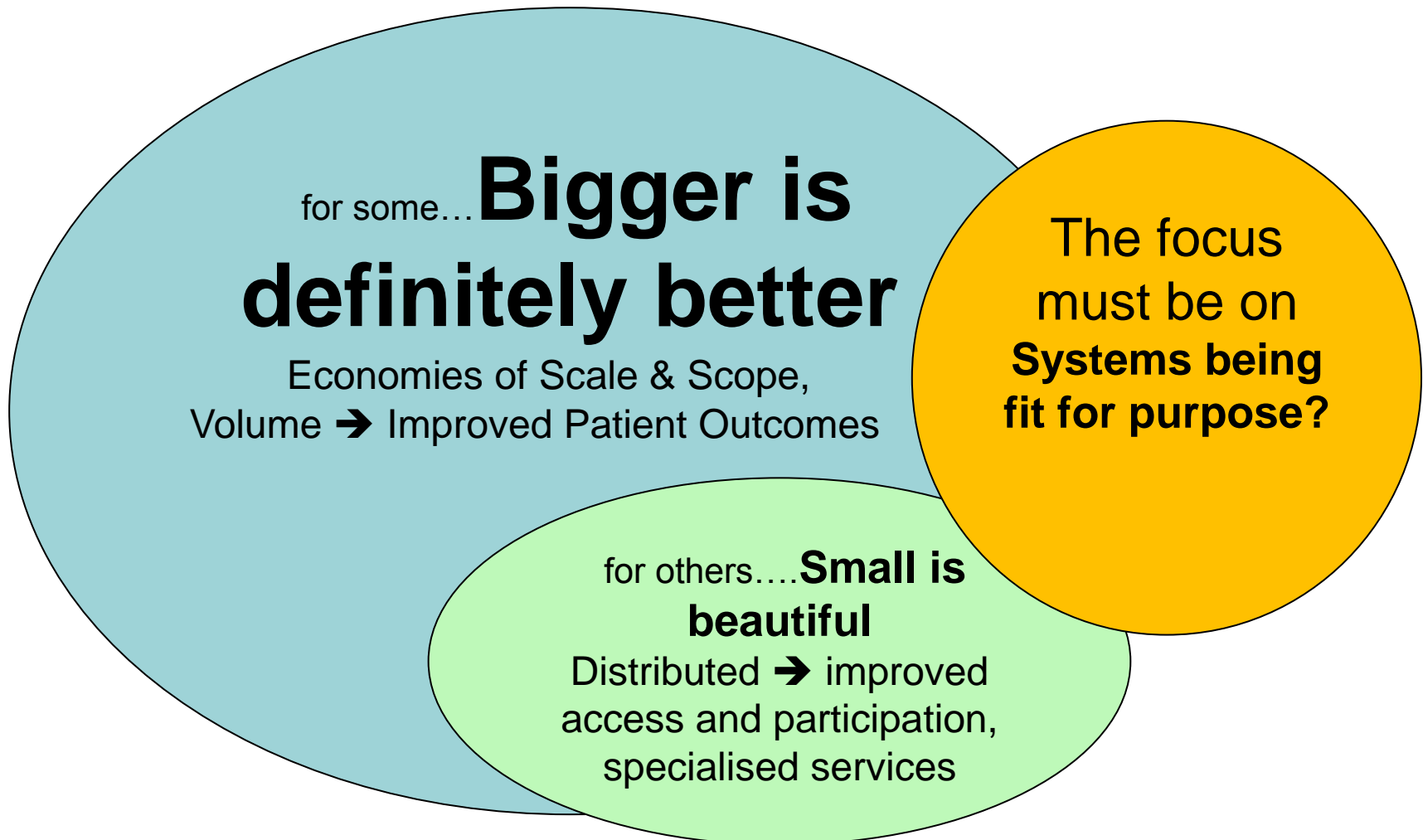


<http://www.oliverwyman.com/insights/publications/2012/nov/the-volume-to-value-revolution.html#.Vfka9Jeyp-8>

Oliver Wyman 'The Volume to Value Revolution'



**So where are hospitals in this mix ? Where is the evidence ?**



...There is no doubt we are building bigger hospitals around the world..



## TEXAS MEDICAL CENTER

<http://www.texasmedicalcenter.org/about/facts-figures/>

**7.2million visits per year**

**106,000 employees**

**7000 patient beds**

**171,000 surgeries/year**

***They are clearly good for Television...***



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# Superhospital

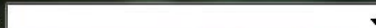
ITV1's Superhospital

See what it's like to work in our Superhospital:

Working at our Superhospital



Address



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4/09/2015

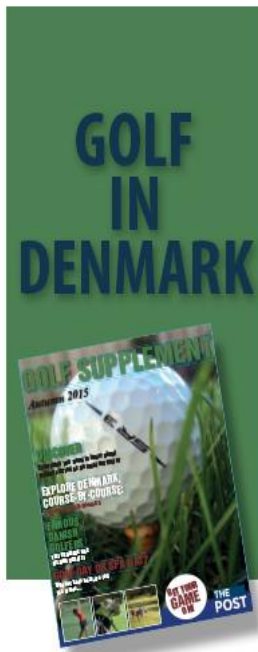


# Building them is also good for the economy

cpbpost.dk/news/business/danish-superhospitals-creating-5000-new-jobs.html



Search



## Danish superhospitals creating 5,000 new jobs

Since 2010, the historic construction project has already provided work to 12,000 new employees



More work opportunities call for more qualified workers (photo: iStock)

August 6th, 2015 11:47 am | by Lucie Rychla



The construction and expansion of 16 superhospitals across Denmark is expected to create 5,000 new jobs in construction this year.

### Latest News



Jump in syphilis cases for second year in a row



Helle Thorning-Schmidt cl...



Art review: Modernism, mo...



This week's TV: Whe...



Hello heritage at Golden days



Money ballerz: FCM the ne...



Coming up soon: Flødebøl...

## WELCOME TO VIETNAM

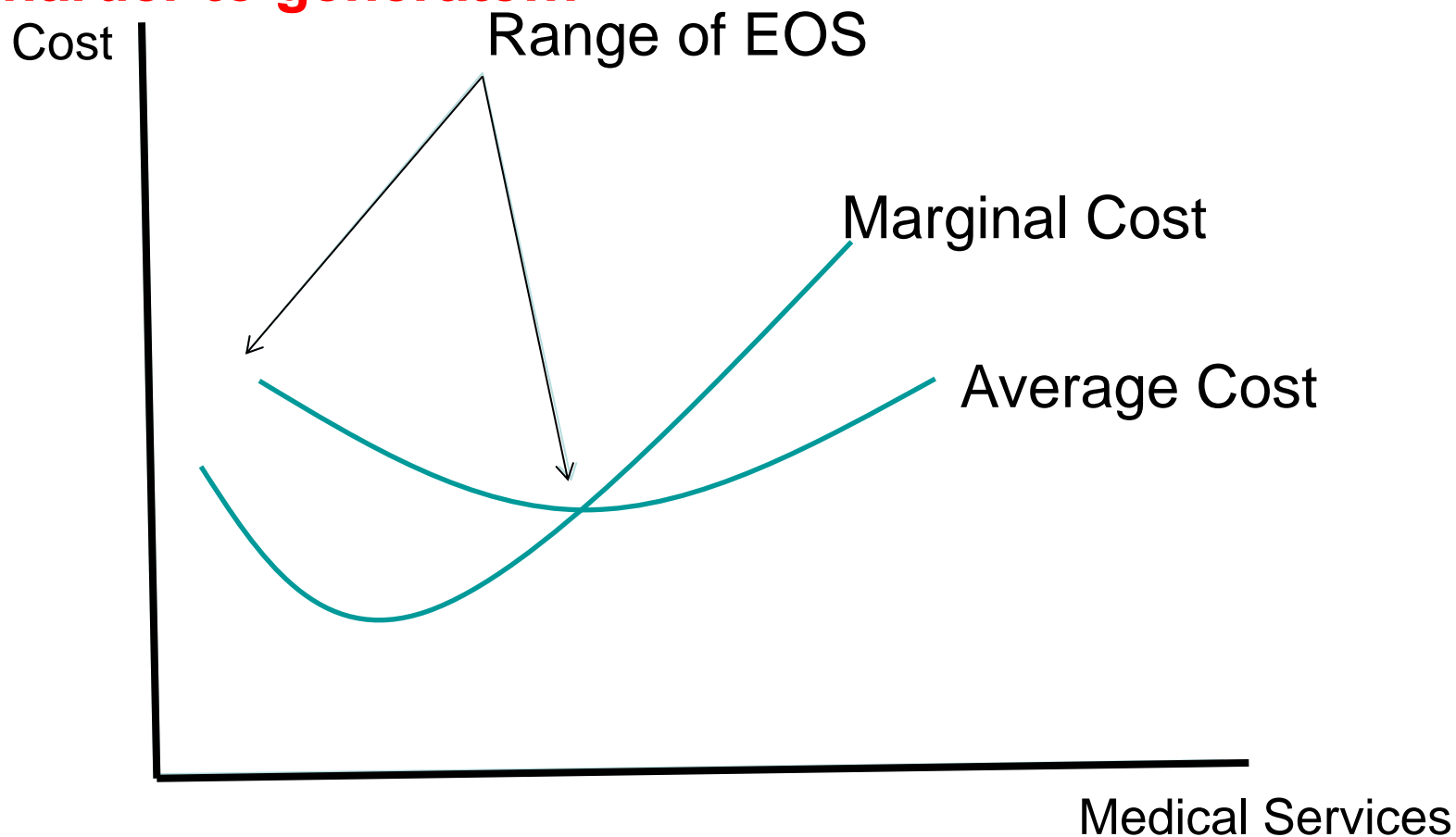


Get your free Royal Danish Theatre Card and get special offers, free arrangements and much more!

THE ROYAL DANISH



**Turns out evidence on other assumed benefits is harder to generate...**



## ***Of course, DENMARK maybe different...***

- Kristensen et al (2012) **Economies of scale and scope in the Danish hospital sector prior to radical restructuring plans**

*Identified moderate-to-significant economies of scale and scope...indicating that the Danish hospital sector was characterized by unexploited gains from consolidation ...* [www.sciencedirect.com/science/article/pii/S0168851012001054](http://www.sciencedirect.com/science/article/pii/S0168851012001054)

## ***But in Australia the debate has continued for many years***

- Wang et al (2006) **Relative Efficiency, Scale Effect, and Scope Effect of Public Hospitals: Evidence from Australia**

*Investigated hospital-level inefficiency in NSW*

- *Inefficiency accounts for 9.3% of total hospital costs in large hospitals and 11.3% in small hospitals, **when including complexity indicators.***
- *diseconomies of scale exist in very large hospitals, whereas scale economies appear in very small hospitals.*
- *Economies of scope effects are found in both large and small hospitals.*

<http://ftp.iza.org/dp2520.pdf>

# In Canada... there are concerns over operating budgets...

## As Montreal's skyline changes dramatically with the construction of two new superhospitals, an ominous cloud hovers in the form of sharp funding cuts.

Indeed, some hospital administrators fear for the future of Quebec's health-care system as the two superhospitals approach completion.

"They're white elephants," Dr. Lawrence Rosenberg, executive director of the Jewish General Hospital, has said of the massive projects.

"Where are they going to get the operating budgets to run them?"

Rosenberg's candour — which he expressed in an interview last May, before Health Minister Gaétan Barrette dispatched a special adviser to the Jewish General to chop the institution's operating budget — belies the optimism surrounding the megaprojects.

The superhospitals are supposed to usher in an age of ultra-specialized medicine — healing for the 21st century. They will house some of the latest cutting-edge medical equipment — everything from robotic surgical arms to super-accurate 3D medical-imaging machines — and every patient will have a private room.

But here is the jarring disconnect: the \$1.3-billion superhospital of the McGill University Health

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**LOCAL NEWS**  
 SQ identifies suspect in Lachute double murder



**LOCAL NEWS**  
 Weekend closures will affect Atwater Ave., Highway 720



**LOCAL NEWS**  
 Ⓞ Waiting and waiting to bring Syrian families to Montreal

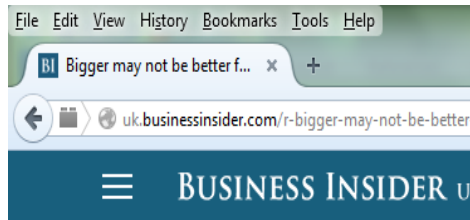


**LOCAL NEWS**  
 CSN members protest Quebec's attitude during negotiations



**NEWS**  
 Historical ruins in the way of Turcot road work

# In China...there are concerns about access...



## Bigger may not be better for China's 'super hospitals'



Alexandra Harney, Reuters

Jul. 15, 2015, 4:17 AM 53



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☐ Repetitive

☐ Not interested

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ZHENGZHOU, China (Reuters) -

Just before midnight, the pavement outside the glowing high-rise towers of the First Affiliated Hospital of Zhengzhou University is littered with slumbering bodies. Splayed on



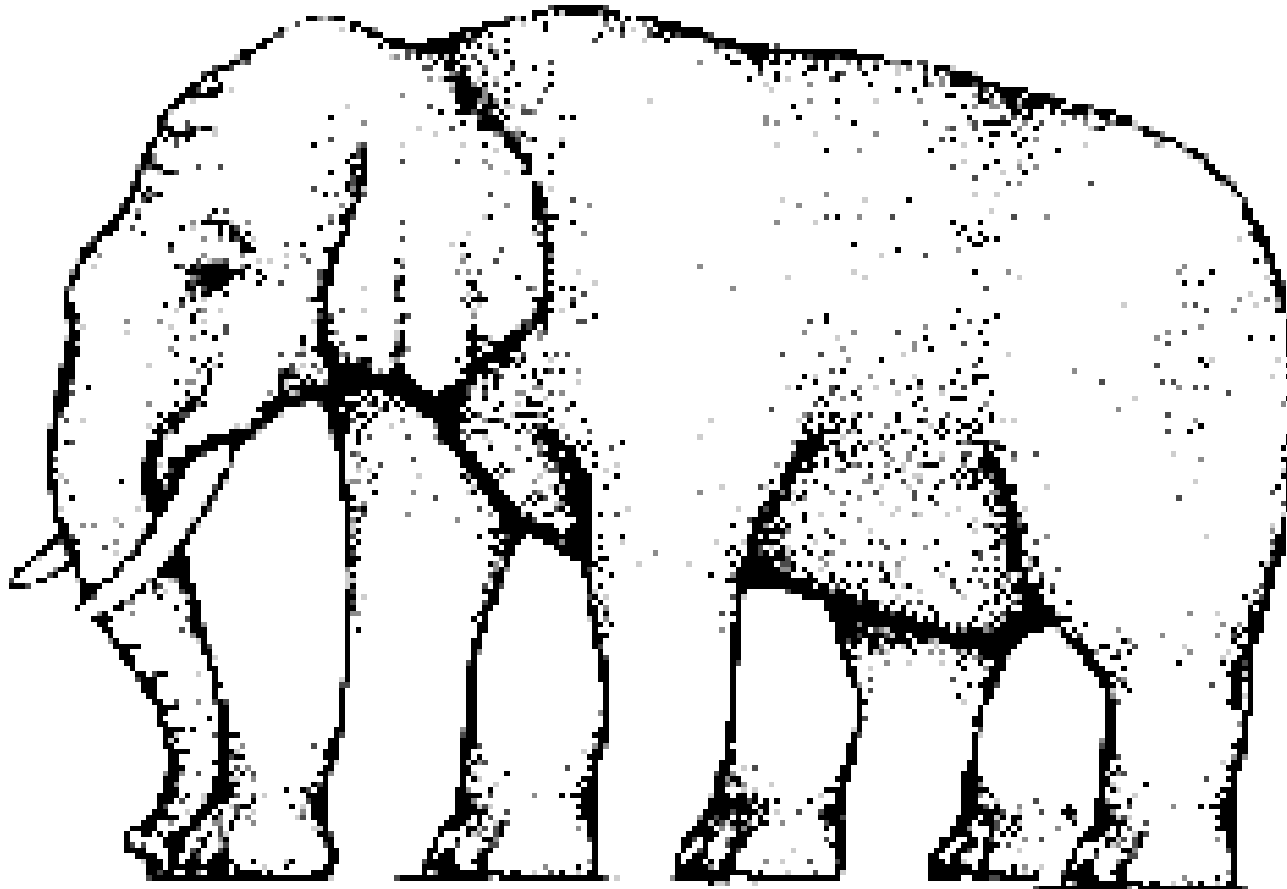


## In France.. long experience with super-hospitals...

Example from Lille 2 Hospital → 3000+ beds

- 11,700 professional non-medical staff
- 3500 medical staff
- The trend is pressure to increase by 4% per year the delivery of treatments to the population (budgetary considerations)
- Bed occupancy continues to rise – 2013 ( 90.14%)
- Appears likely that further hospital mergers will occur in the coming years
- Directly impacted on strategies towards population health, prevention and chronic-disease management

So... While everyone knows what a super-hospital is ...

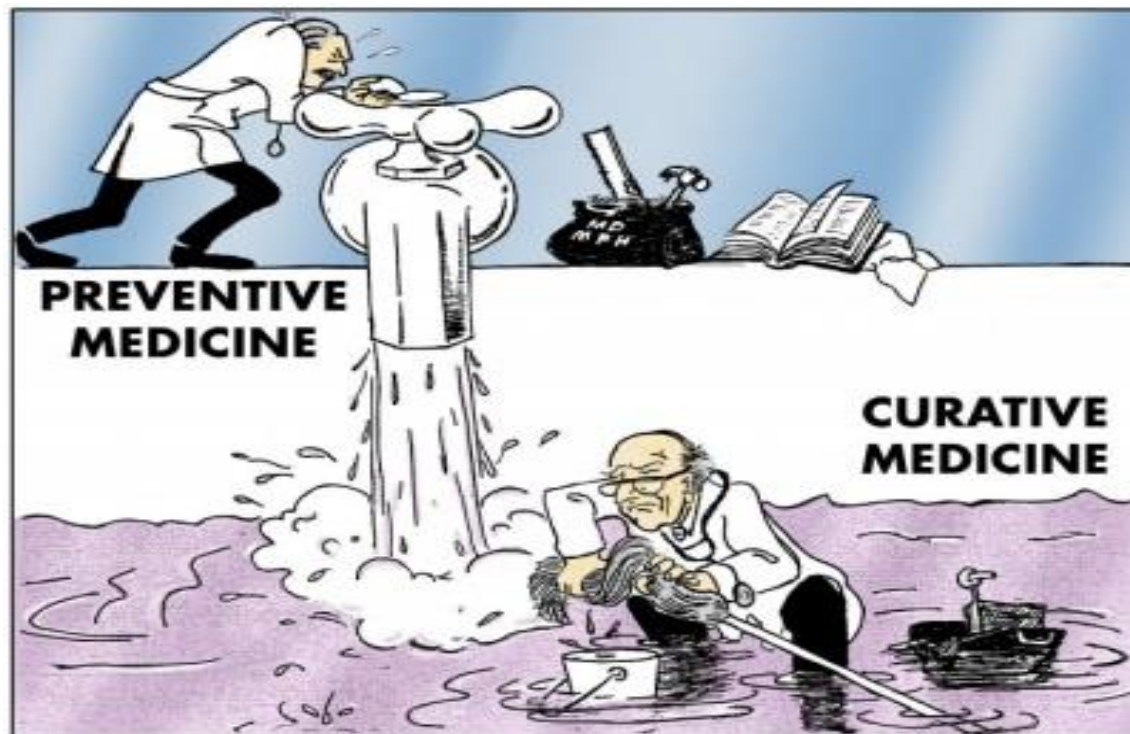


**Clearly beyond any evidence or debate.. larger hospitals are the trend... and the continuing foci for huge investments in many OECD countries..**

- Too simplistic to discuss size in isolation... need to understand how hospitals are coordinated (*or not*) with other healthcare services...
- But more importantly for hospitals themselves its critical to consider utilisation of capacity and the ability of any hospital system to admit, treat and discharge patients safely and smoothly.

Understanding → Coordination across the system and capacity utilisation within hospital service delivery highlight S-QAIC pressure points....

It also reveals options for alternative ways of doing things  
→ Smooth Patient Flow





## Hospital Service Delivery Challenges:

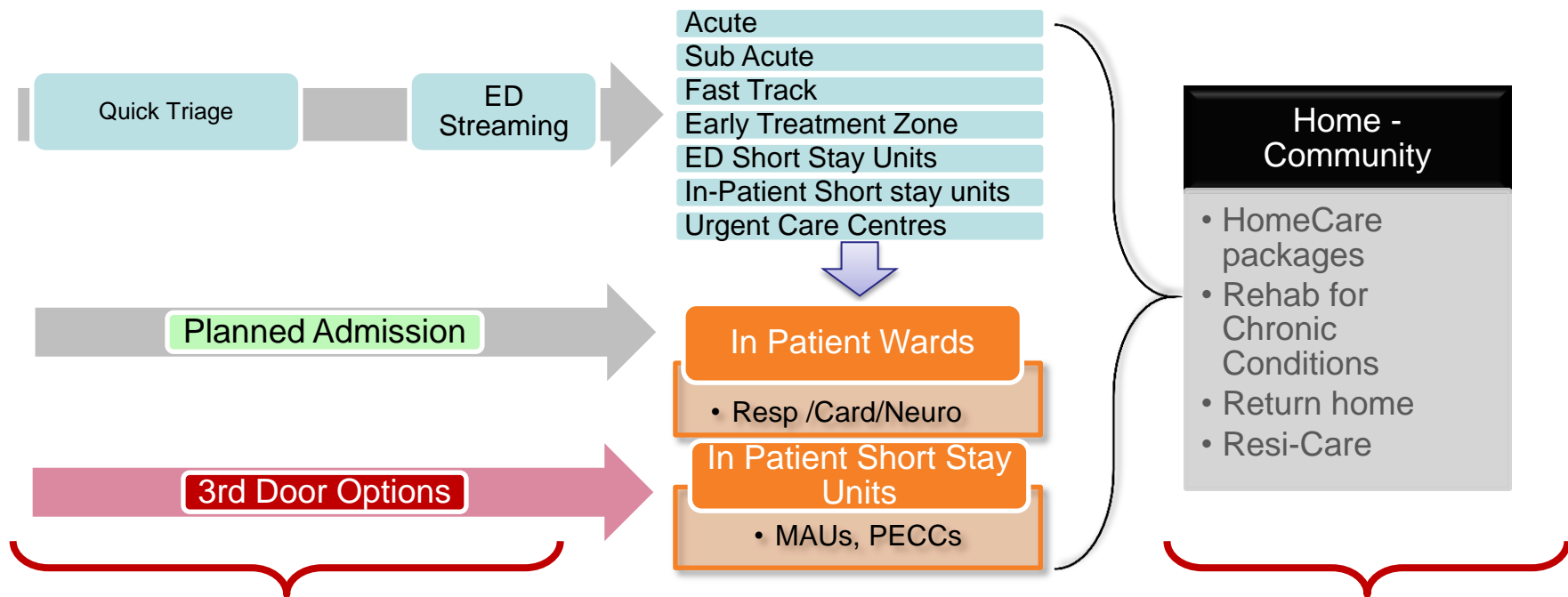


Focused on reducing the waiting time overall (LOS) without changing the clinical care received by the patient

- Access to beds
- Access to diagnostics
- Access to specialty consults
- Access to Allied Health
- Access to timely Transport of patients
- Patient flow services structure (Integration/Coordination)



## Understanding patient flow in your hospital



How many patients are coming into your system?  
Where are they coming from?

**Do Admissions = Discharges?**  
**or**  
**Is there a mismatch/variation?**  
Need to find out why miss matches occur & where they occur?

How many patients are leaving your system?  
Where are they going to?

File Edit View History Bookmarks Tools Help

Agency for Clinical Innovat... x +

www.aci.health.nsw.gov.au

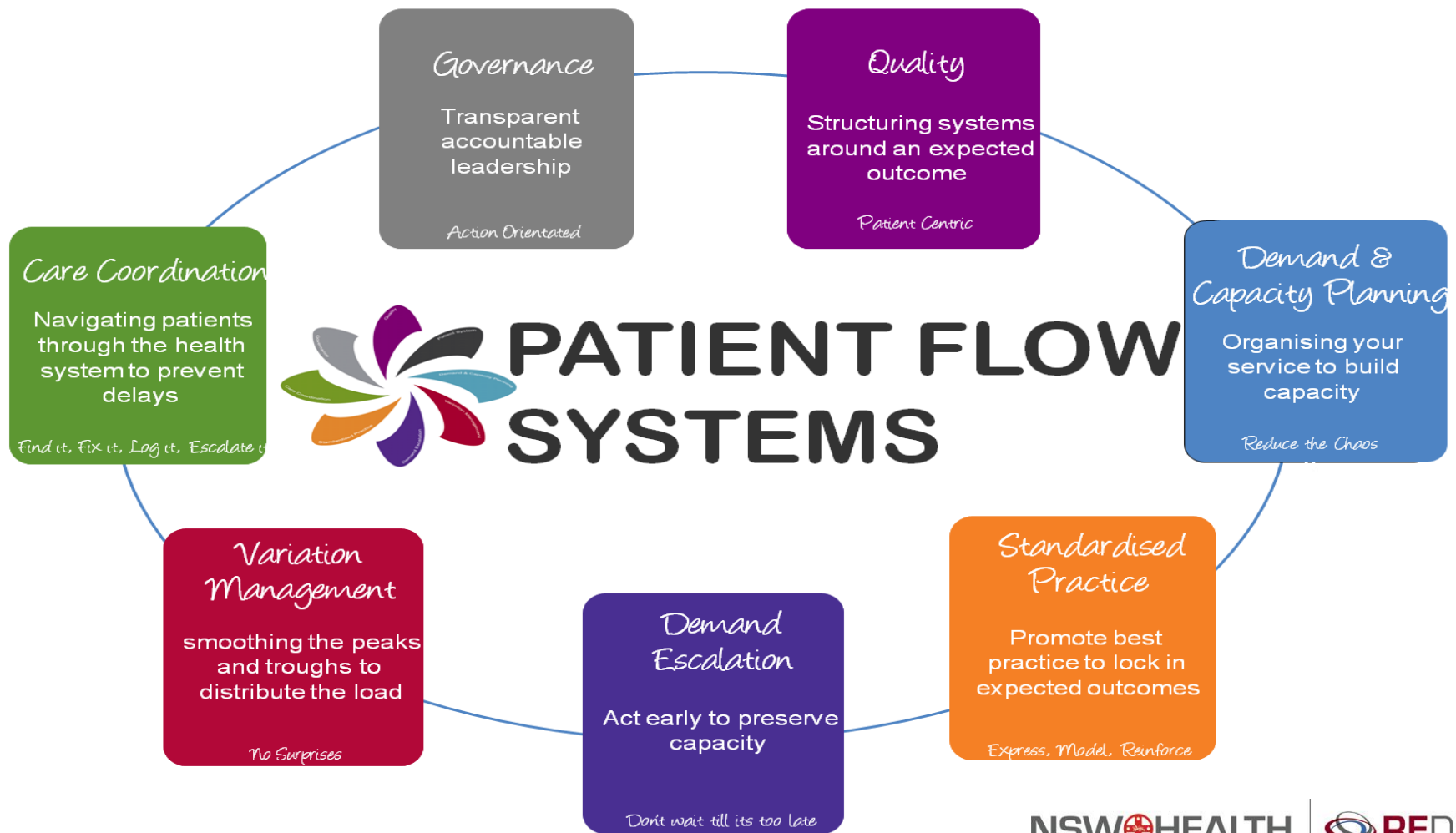


## Innovation Exchange

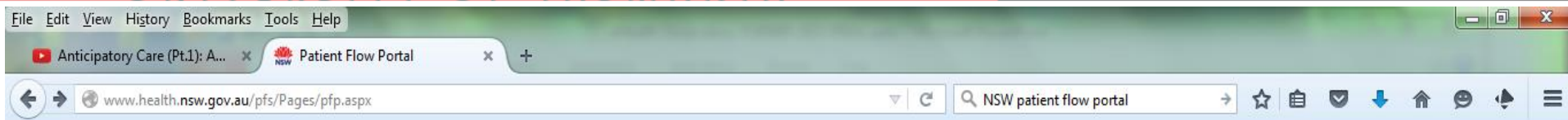
# Networks for knowledge capture and exchange

Watch video

## An approach to support better utilisation of existing resources in hospitals







## Patient Flow Portal

[Patient Flow Systems](#)[Patient Flow Systems Framework](#)[Patient Flow Portal](#)[Patient Flow Resources](#)[Patient Flow Systems Newsletters](#)[Patient Flow Systems Contacts](#)[Electronic Patient Journey Board \(EPJB\)](#)[Care Coordination Patient Brochure](#)[Care Coordination: From Admission to Transfer of Care in NSW Public Hospital - Reference Manual](#)[Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospital - Staff Booklet](#)

The Patient Flow Portal (PFP) supports NSW Health workers to adopt the Patient Flow Systems (PFS) framework through providing accessible, user-friendly tools. The PFP aims to improve patient flow within a hospital or health district assisting staff, and improving patient experience.

The PFP is a vehicle for the delivery of effective patient flow and requires the PFS framework for effective work practice change.



 How the Patient Flow Portal supports Patient Flow Systems [65KB]

## Patient Flow Portal functions



Electronic Patient Journey Board (EPJB) provides information about every patient on a ward that directly relates to coordinating care and managing patient flow



Dashboard is a one page overview of all Patient Flow Portal Information



Bed Board provides an up to date view of hospital beds and activity



Predictive Tool provides the prediction of hospital overnight



Report Module provides access to pre-defined reports for different functional areas within Patient Flow

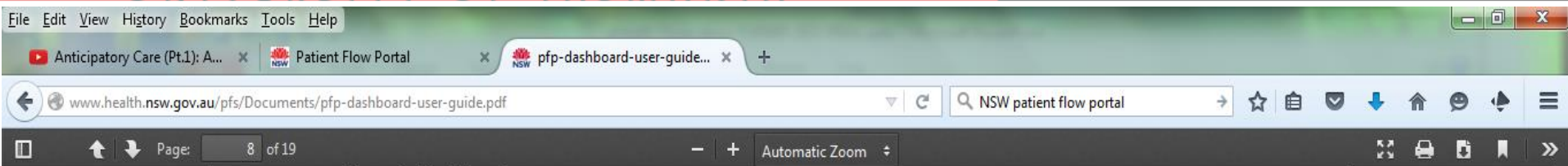
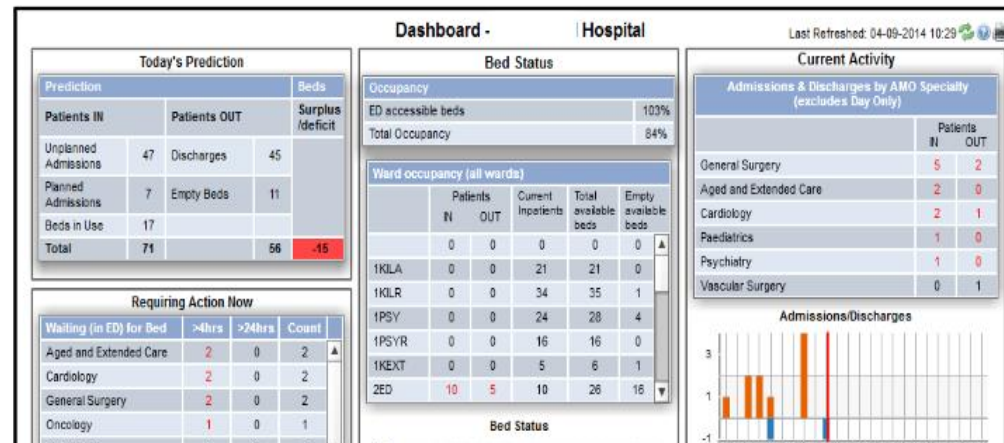


Figure 4: Dashboard

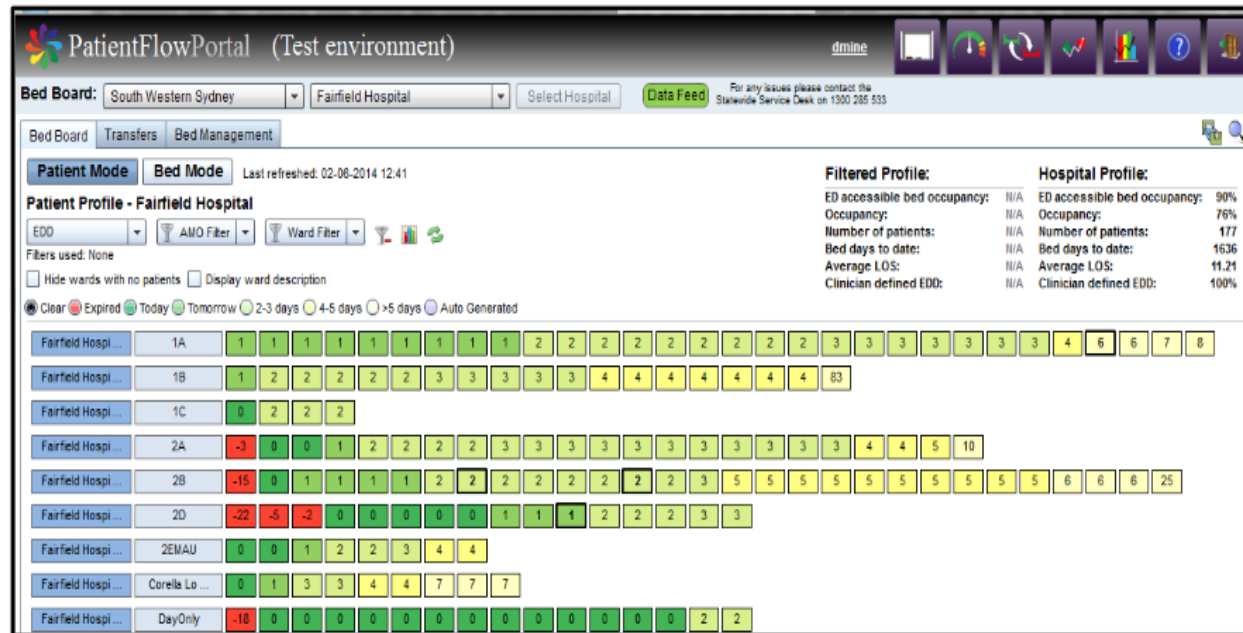


The Dashboard module within the Patient Flow Portal (PFP) is designed to provide a real time view of activity in a given facility. It provides:

- Summary views of current activity in a facility
- An operational overview of activity in a facility
- It allows Hospital Executives, Patient Flow managers and Bed Managers to identify Where potential issues are, in the live environment, and act accordingly

Once a user has successfully logged onto PFP the Bed Board Home Page will be displayed.

Figure 4: Bed Board Home Page



The Bed Board allows the user to:

- Evaluate how beds within a given ward are being used.
- Understand current work practices by being able to identify which beds are open across an organisation to assist with demand and capacity planning.
- Identify an organisation's "tipping points" for demand escalation.

## Predictive Tool

- Many of the data elements have been auto-generated based on historical data. The blue 'prediction' row can be manually altered to better reflect the expected activity. By using the arrows, increase or decrease the predicted number and press **save**.

Predictions

Data Entry

Graphs

Flow Indicators

Retrospective

What If

Beds & Discharges

Unplanned Admissions

Planned Admissions

Select Date: 05/03/2012

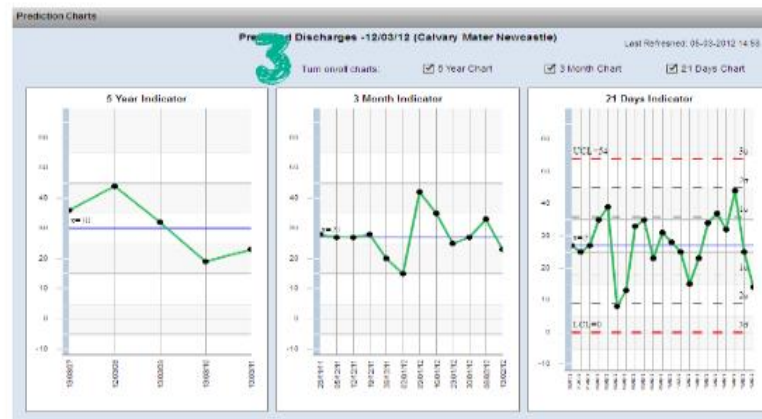
- 14 days

Last Refreshed: 05-03-2012 14:20

Data Entry: Beds and Discharge (Gosford Hospital)

Projection Types	21 Day Indicator	Indicators	Mon 05/03/12	Tue 06/03/12	Wed 07/03/12	Thu 08/03/12	Fri 09/03/12	Sat 10/03/12	Sun 11/03/12	Mon 12/03/12	Tue 13/03/12	Wed 14/03/12	Thu 15/03/12	Fri 16/03/12	Sat 17/03/12	Sun 18/03/12
Predicted Discharges	60	5yr Indicator	70	98	73	80	74	78	77	68	69	73	82	86	77	73
		3mth Indicator	82	80	93	83	100	58	39	82	80	93	83	100	58	38
		Prediction	62	90	83	100	58	39	82	80	93	83	100	58	39	

- To better understand trends in activity, click on the day and indicator to view **prediction charts**. These charts provide detail regarding the three indicators: 5 year, 3 month and 21 days.
- To better view the charts, tick or un-tick the associated boxes.



# 1. Care Coordination

## **Navigating patients through the health system to minimise waits:**

To avoiding or reduce delays

Involves all relevant staff in the planning of a patients care from admission

Should commence from the patient's entry to a service and progress through to discharge and beyond.

## **Toolkits:**

- Assessment and Discharge Risk Screening (DRS)
- Estimated day of Transfer / Discharge (EDT)
- WAND ( Ward Activity Nursing Display)
- Multidisciplinary team review process



# 1. Care Coordination

- **Find it** — if an issue is preventing your patient being transferred, have you identified the issue and its source?
- **Fix it** — what can you do about it? can you or your manager sort it out? If you can, then fix it.
- **Log it** — it is important to log delays so you can keep track of them (they may be happening elsewhere) and report on them (sharing solutions saves people time)
- **Escalate it** — it is assumed that escalated issues have been thoroughly investigated at each level prior to reaching the executive. Any executive decisions regarding the issue need to be fed back to the area where the delay was identified.

## 2. Standardised Practice

- Clinical practice
  - Align with Evidence Based Practice
  - Early identification of deterioration
- Work process practices
  - Communication
  - Referrals
  - Booking procedures
  - Escalating delays
- A **systems approach** to reduce variance and to define what's happening now, who is doing what, what is required.
- We all know we can describe what is next and what is expected and what to expect.
- Not limited to clinical care BUT must relate to how you interact with patients, how you collect specimens or stock a treatment room.

### 3. Variation Management

- Variation in practice affects → LOS, errors, complaints, admission rates, readmission rates, off stretcher time, emergency access performance, diagnostic capacity, delays in consults, staff satisfaction.
- The first step to reducing the variation is identifying sources at the macro and micro levels: E.g:
  - variation in patient admission or discharge processes,
  - variation in clinical management,
  - variation in booking tests or transport,
  - variation in pathology processing.

### 3. Variation Management

For example: **What variation exists in the booked admissions?**

- Do particular days of the week have higher activity?
  - What factors are driving activity? What surgery is being performed on what days and what is the effect of that?
  - Are there duplications in requests?
  - Is the booking / scheduling process causing the variation?
  - Is internal transport causing variation?
  - Is the way we complete tasks causing variation?

## 4. Demand & Capacity Planning

### The Data:

- We know there is actually little variation in:
  - ED presentations
  - ED admissions
  - Discharges
- *The predictive tool supports collation of:*
  - Patients coming into the hospital
  - Patients exiting
  - Capacity to fit demand
- Uses
  - Historical data
  - Current ED status
  - Expected EDO, DOSA, Surgical and Medical booked
  - Direct admissions
  - Projected discharges / EDT

### Data is used to inform short and long term capacity planning:

- Calculate tipping points in the short and long term
- Analyse daily demand for each ward area – deliver a plan for required discharges each day.
- Analyse demand over the long term (e.g. identifying frequent outliers – does this service require extra capacity?)
- Manage predicted events – medical term change / public holidays / events



## 5. Demand Escalation

- Escalation plans vary..
- Traditionally reactive, and short term fixes to address a short term unforeseen demand capacity mismatch.
- Cancel surgery and open surge beds
- Used frequently (↓effect)
- Used late
- Need to know what are the regular tipping points?
  - Is it ED?
  - Is it staff shortages?
  - Is it patients waiting rehab / transfer
- Is it tracked?
- Do executive know?

## 5. Demand Escalation

Two components of structured demand escalation plans

### Capacity Control Action Plan (CCAP) Pro-active set tipping points

- Planned and Proactive
- Days to Weeks ahead
- Strategically uses predictive data to control booked and predicted urgent work to efficiently manage capacity.
- Requires
  - longer term view
  - Use of data
  - Logging issues
  - Evaluation of effectiveness

### Standardised Short Term Escalation Plan - SSTEP reactive operational

- Reactive / Immediate
- Hours / Minutes
- Reacts to sudden, unforeseen fluctuations in demand
- Needs to be efficient, thus well planned and ready to action
- Should be required less often as improvements in CCAP are made

## 6. Governance

- Robust - in structure to lock in process and behavioural change
  - Defined - with accountabilities at all levels
  - Transparent – with processes and accountabilities
  - Action orientated - to make decisions and solve issues
  - Maintained – throughout the project and beyond – committed
  - Focussed on the patient and staff experience
- ➔ All redesign processes in hospital settings are likely to fail without strong governance

## 7. Quality

The aim of the PFS approach is to improve quality of service, therefore quality outcomes need to drive the evaluation of the systems performance

- Quantitative Data

- Falls, medication errors, wrong surgical site, deteriorating patients, etc

- Qualitative Data

- Patient Experience, Patient Survey, Co-Design, what is our current feedback loop to staff?
  - Staff Experience

If we focus on delivering quality care performance, improvements will follow (high quality is inherent in good performance)

- Using the PDSA cycle, test change and evaluate impacts

File Edit View History Bookmarks Tools Help

NSW Patient Flow Systems Fram... x +

www.health.nsw.gov.au/pfs/Pages/framework.aspx

NSW smooth patient flow

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## Patient Flow Systems Framework

Patient Flow Systems

Patient Flow Systems Framework

Patient Flow Portal

Patient Flow Resources

Patient Flow Systems Newsletters

Patient Flow Systems Contacts

Electronic Patient Journey Board (EPJB)

Care Coordination Patient Brochure

Care Coordination: From Admission

### Evidence-Based Review on Smooth Patient Flow

The Ministry of Health commissioned this independent review to analyse the available evidence on the essentials for good patient flow and how the required systems for flow can be sustained. The reviewers visited many hospitals around NSW and based their feedback on these visits and the available international good practice.

Read the review and consider its implications for your hospital or service as you make plans to improve local access to care. To complement the review, the Health Education and Training Institute (HETI) have now developed a valuable set of targeted education and training resources.

Key Principles of Smooth Patient Flow has been uploaded to the HETI Moodle and HETI Online. This blended learning program has been designed for all staff, both clinical and corporate and gives a system-wide approach to managing patient flow. It contains resources to support more understanding of the factors that affect flow, offers a challenge in the form of a board game to allow the learner to test their knowledge and gives some continuous improvement activities. The blended learning can be done by individuals or by teams.

Address

12:21 27/08/2015



Turns out **we know what to do ...** but in practice it is very hard to deliver...

Need to be aware of differences between:

- What people say they do
- What they think they do
- What they Actually do

*(Christian Nøhr)*

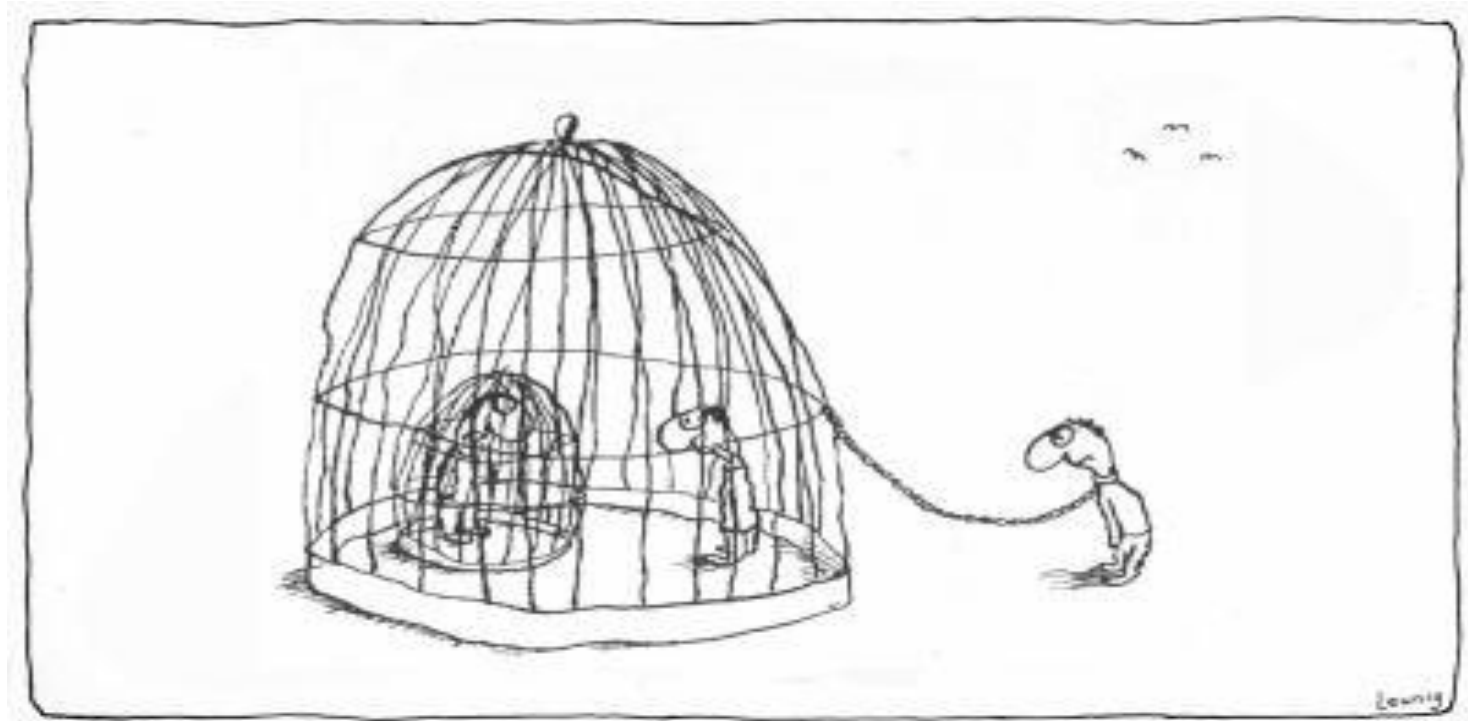
You can't write all that you say

You can't say all that you know

You often don't know what you know – until you need to

*(Branko Cesnik)*

An integrated multi-disciplinary systems level approach requires respect for alternative perspectives and an awareness of our own potential for **Confirmation Bias** and **Belief Preservation** and **Functional Fixedness** ...



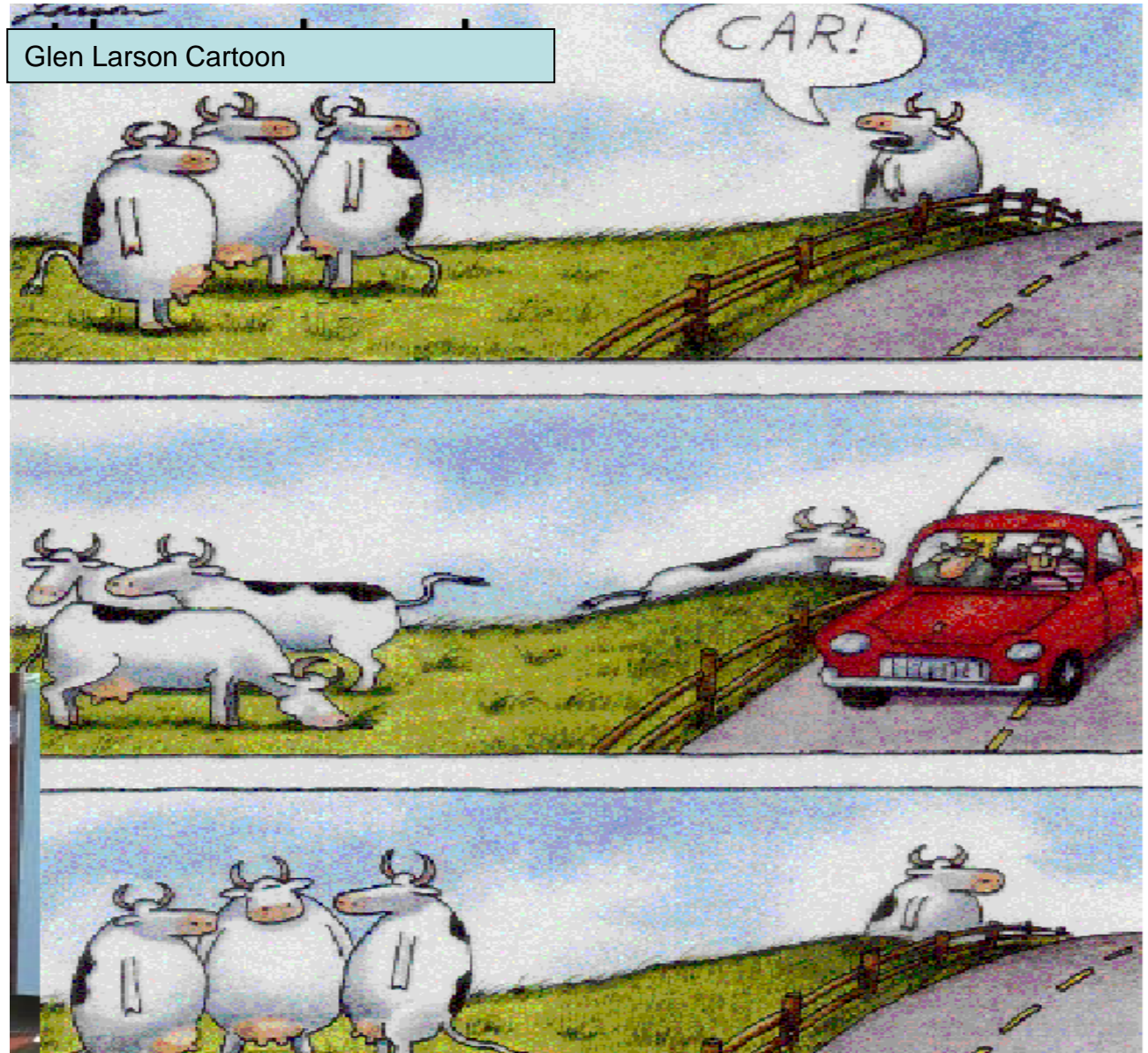
Look at the chart and say the COLOR not the word

<b>YELLOW</b>	<b>BLUE</b>	<b>ORANGE</b>
<b>BLACK</b>	<b>RED</b>	<b>GREEN</b>
<b>PURPLE</b>	<b>YELLOW</b>	<b>RED</b>
<b>ORANGE</b>	<b>GREEN</b>	<b>BLACK</b>
<b>BLUE</b>	<b>RED</b>	<b>PURPLE</b>
<b>GREEN</b>	<b>BLUE</b>	<b>ORANGE</b>

### **Left - Right Conflict**

**Your right brain tries to say the color but  
your left brain insists on reading the word**

Glen Larson Cartoon



How we think  
others are →





# predictably irrational

[ABOUT DAN](#)[THE BOOK](#)[NEWS & REVIEWS](#)[WHERE IS DAN?](#)[DEMONSTRATIONS](#)[THE RESEARCH](#)[BLOG](#)[VIDEOS](#) - [TEST YOURSELF](#) - [VISUAL ILLUSIONS](#)

## Chapters at a glimpse

[Introduction: How an Injury Led Me to Irrationality](#)[Chapter 1: The Truth about Relativity](#)[Chapter 2: The Fallacy of Supply and Demand](#)[Chapter 3: The Cost of Zero](#)[Chapter 4: The Cost of Social Norms](#)[Chapter 5: The Influence of Arousal](#)[Chapter 6: The Problem of Procrastination and Self-Control](#)[Chapter 7: The High Price of Ownership](#)[Chapter 8: Keeping doors open](#)

“A marvelous book that is both thought provoking and highly entertaining, ranging from the power of placebos to the pleasures of Pepsi.”  
- Jerome Groopman

PREDICTABLY  
IRRATIONAL  
DAN ARIELY

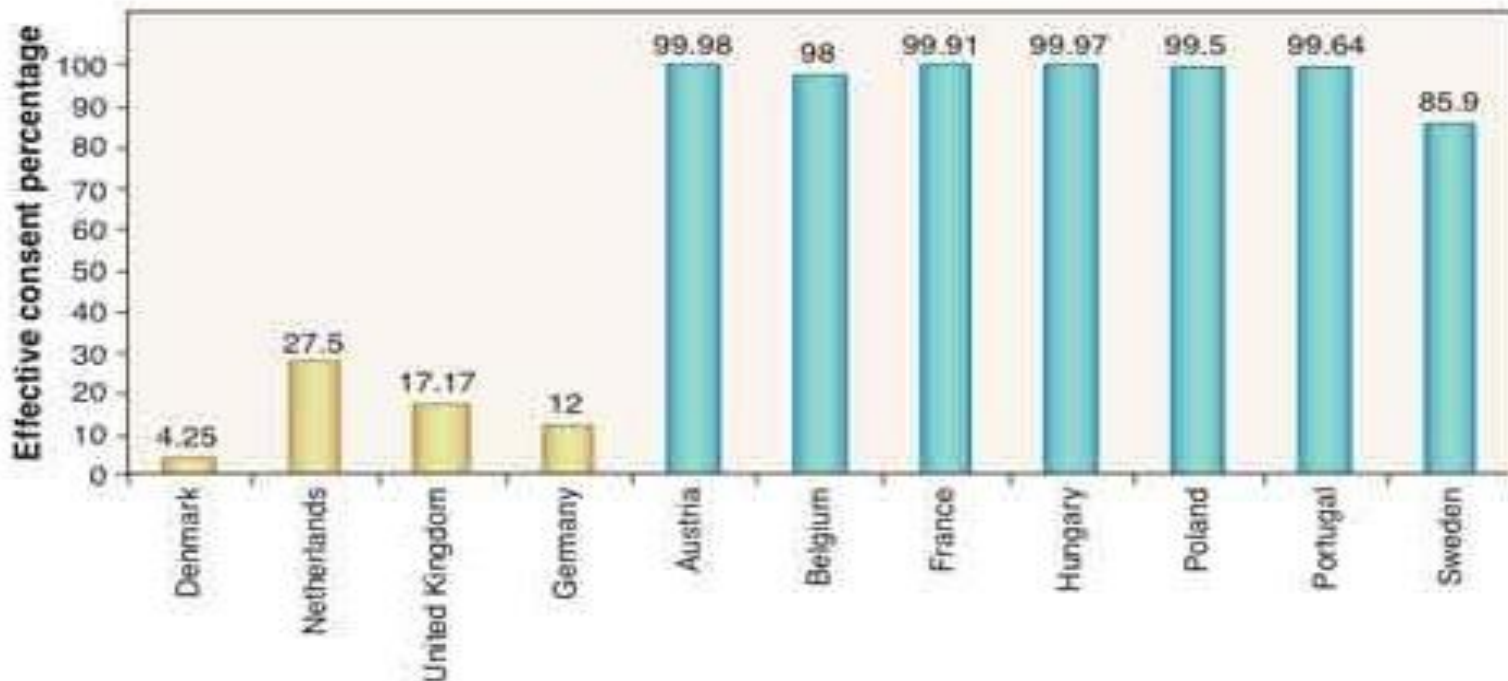
## PREDICTABLY IRRATIONAL

When we make decisions we think we're in control, making rational choices. But are we? Entertaining and surprising, Ariely unmasks the subtle but powerful tricks that our minds play on us.

## Decision-making and Choices

Johnson, Eric J. and Goldstein, Daniel G., Defaults and Donation Decisions (2004). Transplantation, Vol 78 No.12, pp. 1713-1716.

Showed how the no-action default for agreement to be an organ donor has a massive influence on organ donation



Effective consent rates, by country. Explicit consent (opt-in, gold) and presumed consent (opt-out, blue).

# **Delivering Smooth Patient Flow:**

## **Smooth flow and hospital operations**

- Variation Management
- Demand and Capacity Planning
- Demand Escalation
- Governance (executive)

## **Smooth flow and clinical practice**

- Standardised Practice
- Quality & Safety ( Clinical)
- Governance (Clinical)

## **Smooth flow and patient centred care**

- Care Coordination
- Quality & Safety (from patient's perspective)

Ten lessons learnt from work with colleagues in NSW:

*1. The prioritisation paradox*

Assigning a high priority to one patient or one request will displace other work; when the prioritised task is complete, there may be no indication of which “next step” will contribute most to improved flow

*2. It's the system, stupid*

If a hospital has impaired or clogged patient flow most days, that's almost certainly because of the way systems are designed; changing systems is a smarter way to respond than working (even) harder.

### *3. Busy work*

Frantic activity can be a comforting alternative to difficult tasks, but the illusion of intense activity may achieve less in the long run than it seems at first glance.

### *4. Scale, don't flip*

A well designed system should not change to a different set of operating processes when things get busy.



### *5. Always' events and' never' events*

How are they decided on? How are they communicated?

### *6. Agitated intervention disrupts flow*

Smooth flow thrives on standardised practice and predictable process; 'special case' workflow rarely ends well

### *7. Patient moves take time and add risk*

Moving a patient makes nursing work for the wards at both ends, needs careful communication, and may prolong the patient's stay.

### *8. Resourceful patients*

Patients and their carers may be able contribute to the planning of their return home; they haven't got much else to do.

### *9. Hassle doesn't help*

Hassling and nagging staff who are already working under pressure is unlikely to improve their individual task performance, or the performance of the system overall.

### *10. Go away, I'm busy*

The interruption of interruptions

## **Old Patient-centred Rules for Health Care could be:**

- 1. Care is based on continuous healing relationships**
- 2. Care is customized according to patient/consumer needs and values**
- 3. Patient/consumer is the source of control**
- 4. Knowledge is shared and information flows freely**
- 5. Decision making is evidence based**
- 6. Safety is a system property**
- 7. Transparency is necessary**
- 8. Needs are anticipated**
- 9. Waste is continuously decreased**
- 10. Cooperation among clinicians is a priority**

**Are we heading in  
the right direction ?**

Institute of Medicine – Transition to new rules for health care systems (2001)

# THANK YOU

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