Institute of Healthcare Management

The Winter's Tale

Leadership lessons from Emergency Departments under pressure

By Richard Vize

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Uncovering the leadership secrets of high performing emergency teams

Every emergency department is finding it tough; even the best feel under intense pressure, there is a national shortage of experienced emergency care consultants, and money is tight everywhere.

But given these constraints, there are striking contrasts between departments who feel confident in their decision-making and systems and see themselves as being on a journey of improvement, and those where morale has collapsed, staff feel isolated, patient safety is compromised and there is a pervasive feeling that it will only get worse.

The Institute for Healthcare Management has interviewed a wide range of staff across the country involved in emergency care to understand what differentiates the high performers from the rest.

This short report is not intended as a definitive guide to how to run an emergency department, but to identify key lessons for managers working in or with them.

It shows how the best teams and leaders are tackling everything from empowering their consultants to putting social workers and therapists at the heart of the machine, and making good emergency care a priority for the entire hospital.

Jill DeBene
Chief executive
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A long, hard winter

Across the country the story has been the same; compared with just a year earlier there was a substantial increase in the numbers of patients arriving at emergency departments and the severity of their illnesses this winter, and more of them had to be admitted: "It's been a challenging winter in terms of the volume of patients coming through and the acuity – they have been a lot sicker. We had an intense period of respiratory illnesses in both adults and children."

One department reported periods of two or three hours when a patient was arriving every 90 seconds.

Overwhelmed by the pressure

While every emergency department has found it tough, there is a divide between those which work as teams, operate in systems and are learning and improving, and those that are being overwhelmed.

"When you are running a shift it is very difficult to manage. You feel as if you are being pulled from every angle. You have the shift to manage and the staff welfare to look after, you have patients inside the department to worry about, you have the patients outside in the ambulances to worry about, you have patients in the community waiting for ambulances to worry about, and you then have the pressures within the hospital to worry about because you can't get patients into beds.

"All the time you are having pressure from senior managers to achieve targets, which is not possible because we do not have flow out of the department. I felt like I was personally responsible for the fact we were never going to meet them and that not all the patients were getting the care they needed. I was regularly getting chest pains and wasn't sleeping."

By contrast, staff at a hospital which had turned around its performance felt that even when the going was hard, the systems were robust enough to cope and the difficulties would soon pass: "We had a couple of weeks when it was slightly more pressurised, but even then we recovered quite quickly. It used to take a long time to recover once we had entered level 4 escalation, but this winter if Sunday night was bad, by Tuesday at the latest we were back to normal."

"I was regularly getting chest pains and wasn't sleeping"

Falling off a cliff

While some departments have been all too aware that they were floundering, others who believed they were performing well have suddenly tipped into crisis when a shock from elsewhere in the system – typically social services – has exposed underlying weaknesses in their operations: "We were a really successful organisation, we didn't have any performance issues, and then something seemed to go horribly wrong, which coincided in particular with the council falling off in terms of their social care provision. That had a massive impact. We really lost the plot."

When performance suddenly drops, it is easy to get defensive and look for someone to blame. One hospital saw relations between senior managers and local commissioners deteriorate because "we felt like they were marking our homework and looking at the organisation rather than the system. It was really infuriating". But the realisation quickly followed that while the system needed strengthening, the emergency department itself needed substantial reforms.

"We didn't have any performance issues, and then something seemed to go horribly wrong"

Beginning the turnaround – look to the future, not the past

The temptation for an organisation in crisis is to analyse endlessly what has gone wrong, soaking up time, resources and emotional energy in allocating blame that could be better spent building a shared commitment to finding a way forward.

"We spent ages trying to work out what had gone wrong, why we had fallen off a cliff. The board tried to do it, the execs tried to do it, everybody tried to do it. If an organisation spends all its time looking backwards and trying to find the data you will be there for ever."

That sounds counterintuitive; surely understanding what has gone wrong is an essential first step to getting it right? But with scores of factors, from primary care to care homes, each making their contribution, there is almost no limit to the amount of analysis that can be undertaken, and at the end of the process nothing will have changed. There is neither the time nor the money for that level of introspection. Instead, teams need to tap into the vast amount of experience and good practice guidance available and start building new ways of working.

"Stop hitting your head against a brick wall doing the same things, find some best practice, find some new ways of working that will give you the biggest bang for your buck and focus your time and the resource there, rather than have a 600 page action plan. Do loads of PDSA [Plan, Do, Study, Act] to see if those interventions work, and keep measuring."

"If an organisation spends all its time looking backwards you will be there for ever"

Command and control has its place – but not for long

Getting a grip on a department in crisis often doesn't leave time for the niceties of consultation and engagement. In the short term staff generally respond well if they can see someone taking firm action and setting a direction, but that is not an excuse to stop communicating: "People like structure. It helped people feel there was a way out.

"Make it simple – break it down to manageable actions that people can do and where they can see something happen as a consequence. Otherwise everyone goes into chaos, you are making up processes on the hoof, you are forcing people to do things that they don't understand and don't agree with."

The advice from managers who could see a short-term need for command and control was to explain the decisions as best you can, and move from direction to engagement as quickly as possible: "We need to engage the staff so they can see the context for the decisions that we take. Now we are out of chaos we need to stop telling and start asking more. Let's stop being directional and use the opportunity for engagement so people have the opportunity to contribute to decisions, so even if they don't agree they will understand why we are doing things and have their voices heard."

"Now we are out of chaos we need to stop telling and start asking more. Let's stop being directional and engage"

This is everyone's problem

Emergency departments in difficulties often feel cut off from the rest of the hospital and are seen as the cause of problems rather than a symptom.

One department felt that "nobody in the rest of the hospital quite believes us about how pressed we are, and we don't feel there is a pressure on the wards, so when we phone up and say can you take this patient because we have seven ambulances outside, we are told someone's on a break or the bed isn't clean yet. You feel as if you are fighting on the home front as well as every other battlefield. We are never accepted on wards with great delight – it becomes a personal battle because no-one is ever pleased to see you".

To move forward, the whole institution has to share responsibility. This can require tough tactics.

"There was a lack of ownership in the system for the four hour standard – the attitude was 'it's all A&E, they're terrible, it's just rubbish'. A&E had become desensitised and accepted the blame. So the first thing we had to do was shock the rest of the system and say 'this is your problem as well'.

"So we put an extra patient on every ward when the emergency department was crowded. It was unpalatable for them – they disliked it and it really kicked off – but they realised that if they didn't play their part that's what would happen.

"Myself and my colleagues were like a dog with a bone in terms of escalation phone calls. We were relentless in – dare I say it – wearing people down, saying 'it's not fixed, it's not resolved, hello I'm still here'. It's pretty tiring but you've got to do it because the daily intensity of keeping everybody informed is required."

Bringing in external support, such as the national Emergency Care Intensive Support Team (ECIST) can provide a fresh perspective and help break down antagonism. One trust found that external support "had a fundamental impact in terms of starting to bring us together even though we didn't like each other. Within a few months we were starting to get on; there wasn't total trust or buy-in but it was starting to happen".

Getting everyone to own the problem requires clear leadership from, in particular, the chief executive and the medical director: "There needs to be a cultural change, and that is all down to managerial and clinical leadership. Neither party can do it on their own; if it's just managers leading eventually the clinicians will disengage, while leaving clinicians to manage on their own is also doomed to failure because we are not managers. There has to be mutual respect."

> "We had to shock the rest of the system and say 'this is your problem as well"

Building relationships across the system

Running an efficient emergency department needs to be an endeavour shared with everyone in the system, from GPs and ambulance crews to social workers and pharmacists.

While some trusts take the approach of "we are in difficulty, what you going to do to help us?", others build credibility and buy-in by demonstrating the work they are doing to get their own structures and systems working well before making demands on others.

One hospital had been lashing out at the local authority before realising that "the first thing we had to do was recognise that it wasn't just the external world, it was about what we were doing. There are some skeletons in our cupboard that we really had to get into and be honest with ourselves".

System leadership begins with the development of personal bonds built around mutual respect for the contribution of each individual and team: "You need to find some common ground and share a bit of yourself with your partners. There is something very special about sharing and building that trust together. The senior team inside and outside the organisation need to have some sort of organisational development to get to know each other as a team. Then you can ask for help and know you can trust getting it."

One way to build trust is to be open about money. "At the outset we put our funding position, our money on the table and what we were buying with that money and the outcomes we were achieving, and each year we have gone through that same process to challenge the investments for the coming year. Everyone has to demonstrate they are making a difference and providing value for money. Everyone has participated in that in a transparent way."

With every part of the system – primary care, ambulance, social care and community services as well as the emergency department – under relentless pressure, there need to be strong connections between the system leaders and their frontline staff so that problems can be escalated quickly and effectively to people who can resolve them: "It's important that you have senior people who understand what decisions mean for people for working in the system and how we can support them."

Relationships between emergency departments and ambulance crews are a good test of systems leadership. Incredibly, some hospitals have little meaningful collaboration with the ambulance service around improvement, while high performing departments are confident in the clinical judgements of their crews – "they're better than the junior doctors" – which transforms their ability to prioritise need.

"Ambulance crews are better than junior doctors"

The power of clinical confidence

A defining difference between coping and struggling emergency departments is whether the staff have the confidence to trust their own clinical judgment. Clinicians that feel overwhelmed, undermined and under threat become part of the problem they are trying to solve, by routinely admitting patients for 'observations' and other ill-defined reasons instead of sending them home or to a GP or pharmacist.

"We are overcautious, over-investigate and over-admit from A&E. We have lost that sharpness due to fear of what will happen if someone makes a wrong decision. I was taught that A&E should be the condom for the hospital – we should stop the [wrong things] getting in and get as many people as possible back out into the community. But it feels as if we have done a complete game change, so we are now the ones who push everything into the hospital because we are too scared to send them back out again."

"A&E should be the condom for the hospital – we should stop the wrong things getting in"

Senior staff at the front door

To tackle this, many high performing departments have strengthened their initial patient assessments by making sure the most experienced staff see the patient first and make the big judgment calls.

"You need someone who has the clinical confidence to say no. We've got a 24/7 rapid assessment model undertaken by a consultant or a senior registrar – no faffing around. That has reduced the replication of work – seen by a nurse, seen by a junior doctor, seen by a registrar, then seen by a consultant – you're just seen by a consultant and they say whether you're staying or going, and then say to the staff you need to do this, this and this."

One department which had adopted this approach is now sending 60 to 70 adults a day – about 30% of patients who take themselves to A&E – backed out of the door: "These guys get four minutes to tell them basically you're fine, go home. If we had seen them in the same way as last winter, each patient would get 20 to 30 minutes.

"It's has got a very good evidence base. In fact we know that a good proportion of the people we sent back to their GP never went."

Having consultants on duty round-the-clock makes a huge difference: "We started bargaining with them to do night shifts. Initially there was reluctance, then one of them agreed to do it. We paid them well and the impact was phenomenal on the reduction in admissions, because the junior doctors admit everything through the night."

When putting consultants on the front door, it is important that other pressures on them are reduced: "We started developing pharmacists and paramedics and nurses to take away some of their work."

"The impact of having a consultant on night shift was phenomenal"

It's all about flow – isn't it?

It is now accepted wisdom that "the key to all of this is patient flow. Those trusts that manage patient flow best tend to cope the best. But it is a complex system with many steps on the way and to ease the flow through hospitals requires change at every level".

Of course that is true, but the demonstrable difference made by senior staff making quick decisions to turn people away highlights the fact that a key element of good flow through a hospital is keeping people out of it.

"A key element of good flow through a hospital is keeping people out of it"

Frail, but not an emergency

As well as sending patients back out of the door, efficient streaming of patients who need care is now central to an effective emergency system. One hospital has overhauled its approach to unplanned admissions of frail patients. Ambulance crews identify those who need support from a frailty team rather than emergency care, while the hospital's frailty team has now become a mobile unit rather than exclusively based on a ward.

This approach keeps many frail patients out of the emergency department and speeds up discharge.

"The big difference this year has been great clinical engagement from the frailty team. They focus on picking up those patients they can manage best straight from the ambulance. They cut out all the non-value added time on the patient journey of going through the ED, then acute medicine, then eventually coming to them. They implement their management plan at the front door and keep their ownership of that patient throughout their journey even if there is not a bed for them on the frailty ward. So they became a mobile team rather than waiting for patients to come to the ward. They don't let anyone else touch that patient, and they make sure they are discharged in a timely way."

"The big difference this year has been great clinical engagement from the frailty team, picking up patients straight from the ambulance"

Clinical engagement

Every department which has improved their performance has done so on the back of transforming the relationship between consultants and managers.

"We didn't have the level of clinical buy-in; there was quite a lot from the nursing staff but less from the consultants. The impact was that we saw things spiral throughout this year. Often I could go down to the ED and find four to five consultants sat in an office while we've got patients down the corridor."

Bringing in new clinical leadership turned attitudes around: "We have seen some substantial changes. They now see they have a voice. We demonstrated to them that they had a lot more autonomy than they believed they had, and we were then able to demonstrate that everywhere else in the hospital was supporting them [in turning performance around].

"The level of support within the rest of the organisation isn't perfect but it is substantial. There are some really good, strong examples of clinicians staying late to help ED."

Instead of feeling "betrayed" by the senior management team, these emergency medicine consultants came to trust and respect the hospital's clinical leadership and to see the issues in terms of patient satisfaction, staff satisfaction and patient outcomes. Instead of hiding away they "came to the table really committed to wanting to sort this out".

A common pattern in hospitals trying to implement change has been initial scepticism and resistance among consultants followed by one or two deciding to test out the new approach, then helping win the others around.

Resistance can be down to fear; consultants who were being asked to take a more robust approach in turning people away from the emergency department "were worried about the public's response. They were worried there would be a lot of complaints and the public would be horrid about it. The irony is that the public responded really well. They just wanted someone to say they were okay to go home".

Buy-in from consultants across the hospital is just as important. In one trust a new medical director took the approach that supporting the emergency department, such as by reviewing patients in a timely manner and coming down to see patients, was a matter of professional standards: "For a long time we had the rhetoric but not the support, but the medical leadership started to unlock that."

Supporting improvement is not simply a state of mind; clinicians need to be given the training and support to implement new ways of working. One hospital trained six clinicians as flow coaches, which was all about enabling clinical staff to break down the barriers to effective patient flow. There was an immediate and substantial improvement in clinical engagement: "This year it was so obvious that everyone was ready to go that extra mile on every single occasion."

Action-focused review meetings involving staff from across the system – occupational therapists, physiotherapists, social workers, community nurses and ambulance crews as well as doctors and nurses – can be powerful drivers of change and team spirit, as well as a chance to celebrate progress.

Extraordinary energy can be unleashed through clinical engagement. "We meet every week to discuss patient journeys and identify which part is not value-added; the teams are jumping in to say we need to work different shifts – they changed the rotas themselves so two consultants worked late, while we collected the data and showed them how much difference they were making. So they changed the way they work without the need for any business plans, and there are messages going to them that they are doing a good job."

"This year it was so obvious that everyone was ready to go that extra mile on every single occasion"

Therapists – the secret weapon

Therapists are at the forefront of new ways of working. Instead of patients arriving in the emergency department being passed around the system before ending up on a ward where everything from mobility to continence management can be compromised, therapists engage with frail patients as soon as they enter the hospital, with the intention of getting them back to their own homes as quickly as possible.

"Therapists are absolutely fundamental to this work. What we've done is what we call frontloaded therapy. So we have therapists at the front door making an assessment of what is normal for the patient as a baseline rather than seeing them 24 hours later, when they are all stiff and sore and can't mobilise, and see what can be done to support them back in their home environment. They will do home visits and undertake discharge to assess – assess them in their own home rather than in hospital because they will do much better. It's brilliant."

Giving therapists a leading role has an impact far beyond hospital patient flow; in the next few months this scheme is expected to provide evidence of fewer patients going into care from hospital.

More than one trust has been surprised at the intense commitment demonstrated by therapists when they are made to feel a key part of the team. One manager said: "The therapist team here is always chomping at my ankles to deliver the next great idea, and more often than not they are bloody good."

"Therapists are absolutely fundamental to this work"

Social workers at the heart of the machine

Like therapists, the role of social workers is evolving rapidly. Until recently, many hospitals and adult social care departments tended to see social workers' role as being part of the discharge process rather than integral to hospital care.

So winter pressures for social workers feels like "a lot of intense involvement in escalation processes – daily phone conferences, meetings etc to get into all the detail about people who might be discharged from hospital and so on… It would be unfair to categorise it all as firefighting, but there is a sense of that".

With money so short, it would be understandable for social services departments to strip staff out of the local hospital. But a more enlightened approach is to integrate more as the pressure grows: "Some social services departments had taken their social workers out of the local hospital but we have kept ours in to continue to strengthen those local relationships. A significant priority day-to-day is supporting the system in the hospital. I give a lot of time to the health part of our work.

"Our social workers are expected to work seven days a week in the hospital system. They are everywhere in the hospital. They go to A&E as part of their routine and they attend ward rounds on every ward, so when they are going through the patients even those they don't know about yet might need assessment – it is not just about the formal assessments and waiting for notification, it's about finding out what's happening on the wards."

Visibility in the hospital is key to influencing the system and engaging with patients early: "Number one is presence – they've got to be seen, they've got to be heard, they've got to be a part of it."

But even in the most progressive hospitals, social workers still have to deal with the reality of clinical hierarchies, which makes it essential that frontline staff can get back up from their senior managers: "Social workers are often the poor relation in a hierarchical model. There is often commitment at the top [to work together] but it doesn't get cascaded down because they haven't got the processes and procedures in place.

"If the social care point of view is not being listened we need to make sure they are supported and that the problem is escalated so that we can intervene quickly, such as when there is the risk of an unsafe discharge."

"Our social workers are everywhere in the hospital. It's about finding out what's happening on the wards"

Measurement is key

Data is the basis for a shared understanding of current performance and the impact of new ways of working, as well as being an essential tool in holding people to account. Without data, there is drift: "Before [we had good data] there were a lot of hypotheses and anecdotes. When directors said that something would happen and then it didn't work, another month would go by. Now when things don't work they don't get away with it, but we work together and we are quick to wake up to things."

"Before we had good data there were a lot of anecdotes"

Relentless attention to process and detail

Leadership, data and systems need to be brought together in relentless attention to detail, with a particular focus on handoffs between different teams, such as "making sure that consultants have been brought down to see patients identified for review, making sure that transport bookings have been relayed, paying rigorous attention to process about how you run a bed management meeting, how you run a patient review meeting and using the evidence they generate".

Unwavering focus on process and detail can be emotionally draining for all concerned, but it is an essential part of changing culture, developing a sense of personal responsibility and embedding new systems. It quickly becomes accepted practice when staff can see the progress that results.

"Unwavering focus on process is an essential part of changing culture"

It's a never-ending journey

The improvement journey for emergency departments never ends. In such complex systems involving so many people and professions, and facing the relentless pressures of demand and budgets, staff have to accept that they will never reach nirvana.

Of course, reacting quickly to the unexpected is part of the excitement and motivation of working in an emergency department. The secret is to have consistency in process, systems and leadership to enable the team to cope with the unpredictable.

"I've been at this for over two years. When I came it was a disaster and unsafe. Now we've got really good systems in place, but it doesn't stop the fact that it is crazily busy in ED. It's really tough, but we've put in an enormous amount of work. What we've done is absolutely massive."

"What we've done is absolutely massive"

Personal resilience

Emergency department leaders who are feeling swamped can find it hard to maintain good mental health: "You have to close yourself down emotionally, because it is very difficult to keep taking on the trauma of what's happening. You know you are not doing the best you can so you build a wall around how you feel about things until you have time to process it – and that time may not be for some months. You try not to let junior staff see what you are feeling; you have to be the steadfast point in the shift so they know you are the person they can turn to, even if you don't have anyone yourself."

High performing teams ensure that emergency department leaders feel supported professionally and emotionally: "We have layers of support in place; I don't know how other organisations cope without these support layers." This hospital has one of the three top managers – including the chief executive – providing telephone support every day of the year for the general manager and site operations manager, with a particular focus on patient flow, and there is always a medical director on call. This means that "no one feels they have to take these difficult decisions on their own. I might get called at three in the morning, and that is never an issue. That support structure is there".

Maintaining an appropriate balance between work and home life is crucial: "I've been practising mindfulness which is really important, because I can't change what has been, but being in the here and now is important. I have also been trying to sleep well and eat well. If you are leading an organisation you have a responsibility to look after yourself. People leave that to last, but you're no good if you're knackered and down and angry."

"You have a responsibility to look after yourself. You're no good if you're knackered"

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