

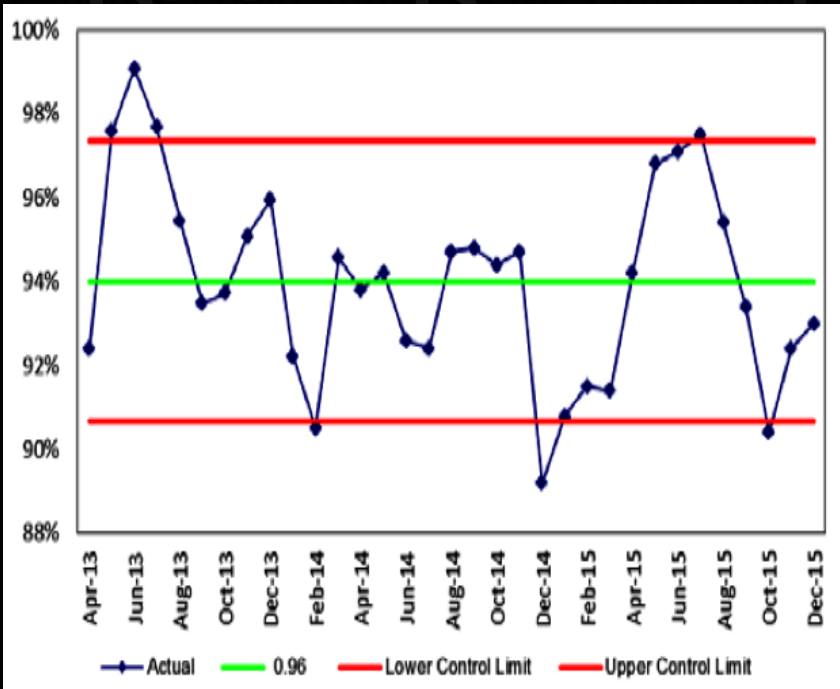
# **Understanding Patient Demand: A Better Way to Make the NHS Work**

Hamish Dibley, Vanguard Consulting  
27 June 2016

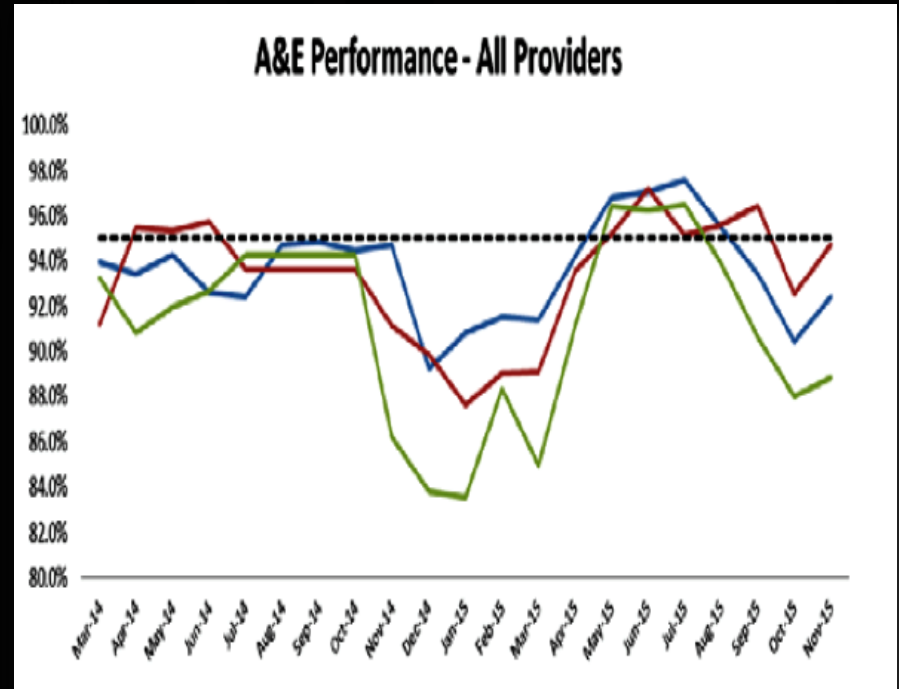
# Context and Convention

## “Activity Obsession Disorder”

A&E Performance – Activity Analysis



A&E Performance – Activity Benchmarking



# Conventional Improvement

## 'Improvement' Approaches

Activity benchmarking

Demand and capacity reports

Hospital / recovery at home

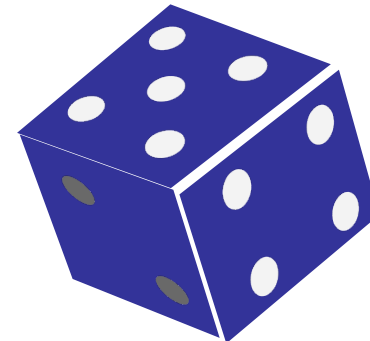
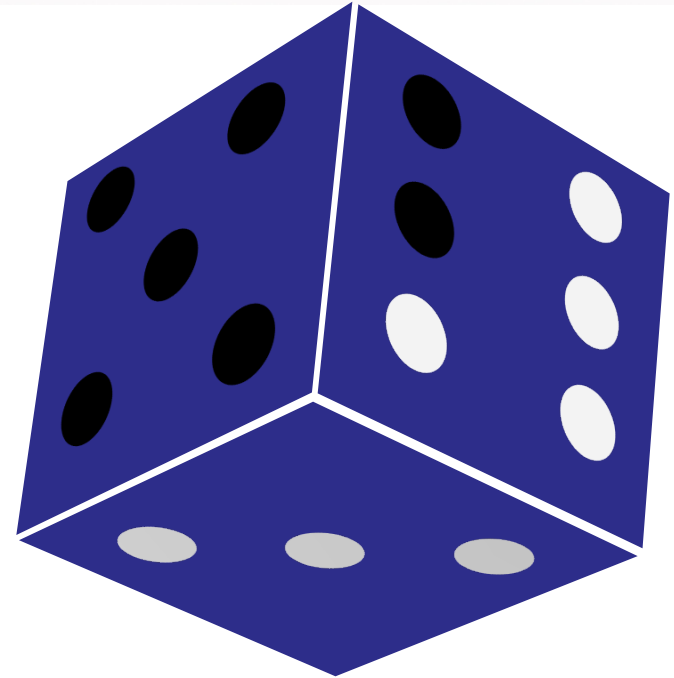
Pathway reviews and redesigns

Patient flow programmes

Reconfigurations and restructures

Service-line reviews and reporting

Virtual and temporary wards



PAC

# Hospital Patient Demand

All Settings	
Distinct Patients	262,990
% of Total	100%



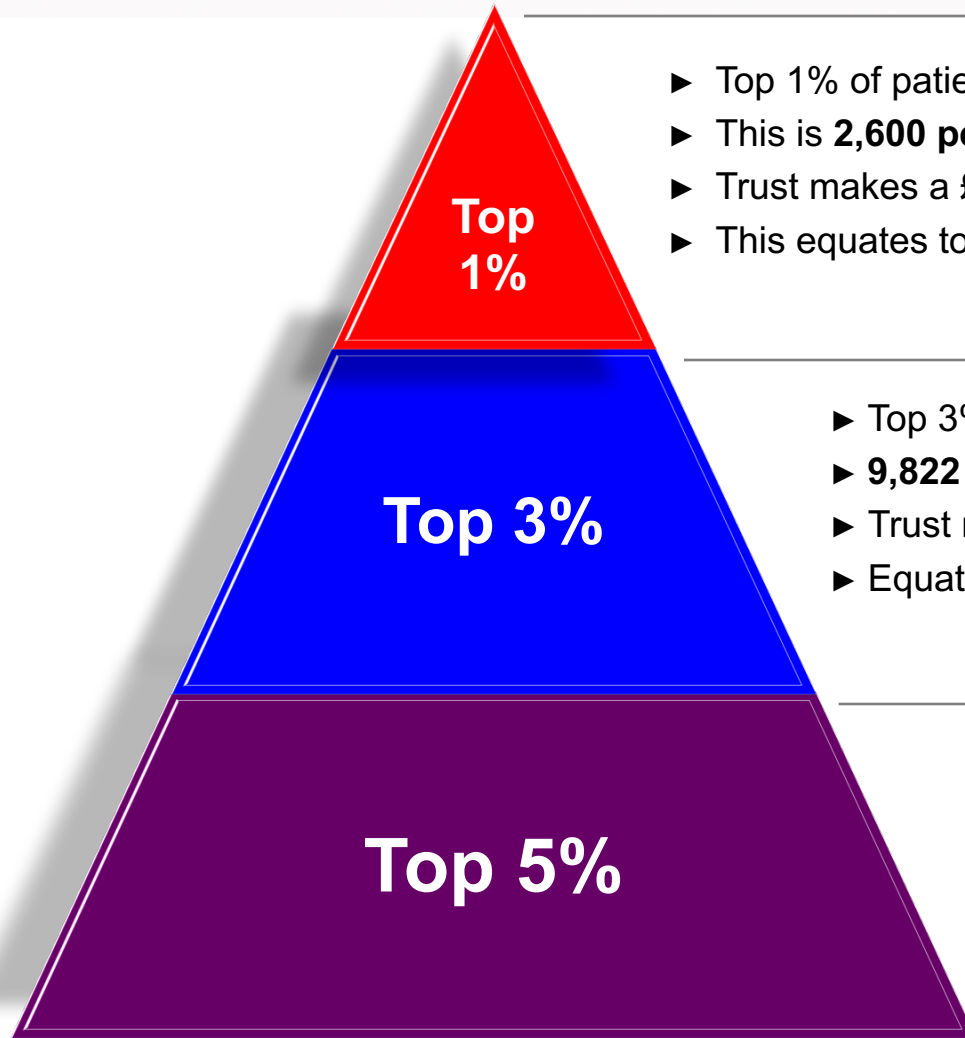
All ED	
Distinct Patients	100,825
% of Total	40%



ED Admitted	
Distinct Patients	30,461
% of Total	12%

ED Not Admitted	
Distinct Patients	70,364
% of Total	27%

# Pyramid of Consumption

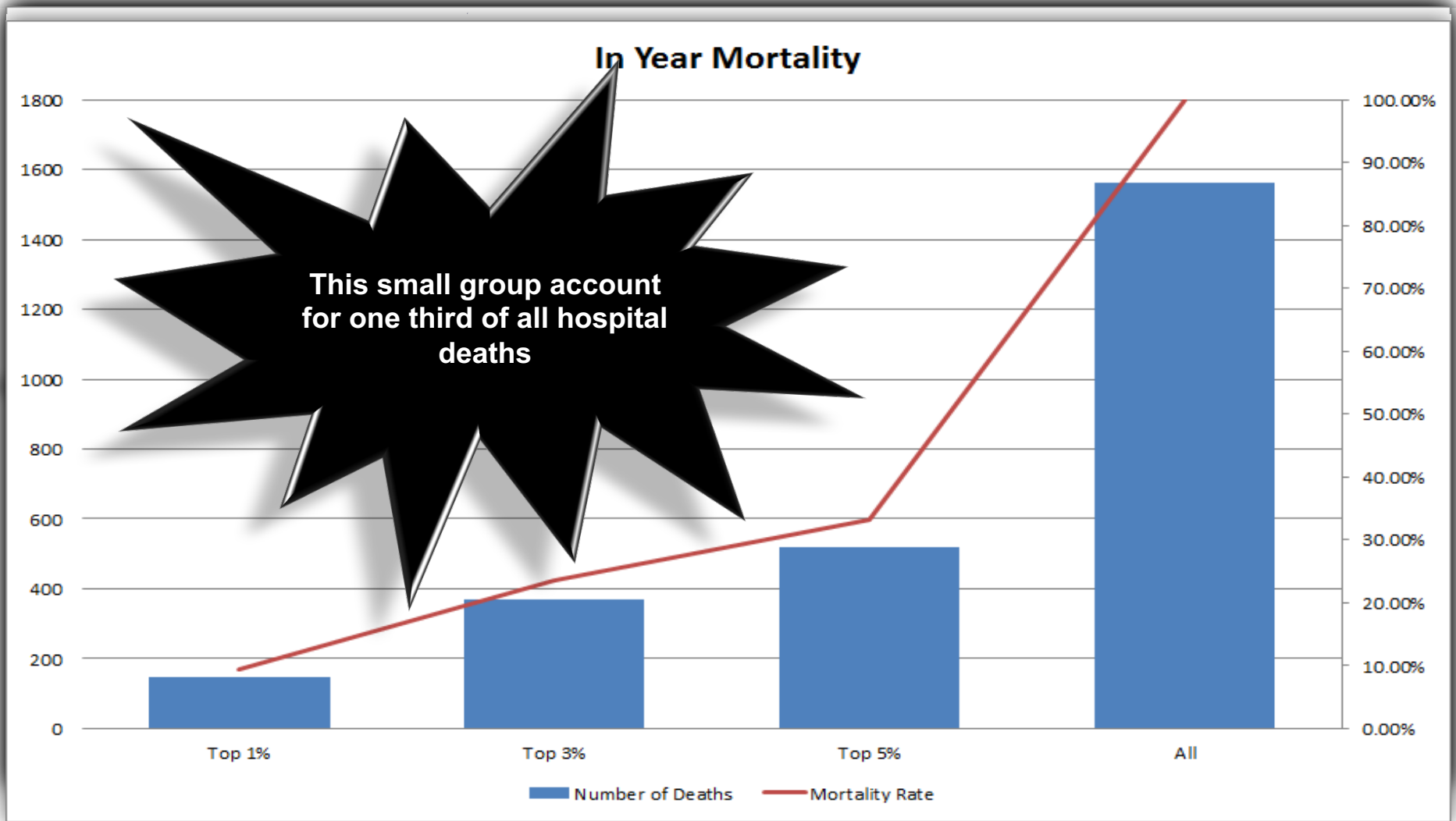


- ▶ Top 1% of patients
- ▶ This is **2,600 people**
- ▶ Trust makes a £5.97M loss on these patients
- ▶ This equates to 35.6% of the total deficit

- ▶ Top 3% of patients
- ▶ **9,822 people**
- ▶ Trust makes a £14M loss on these patients
- ▶ Equates to 91.2% of the deficit

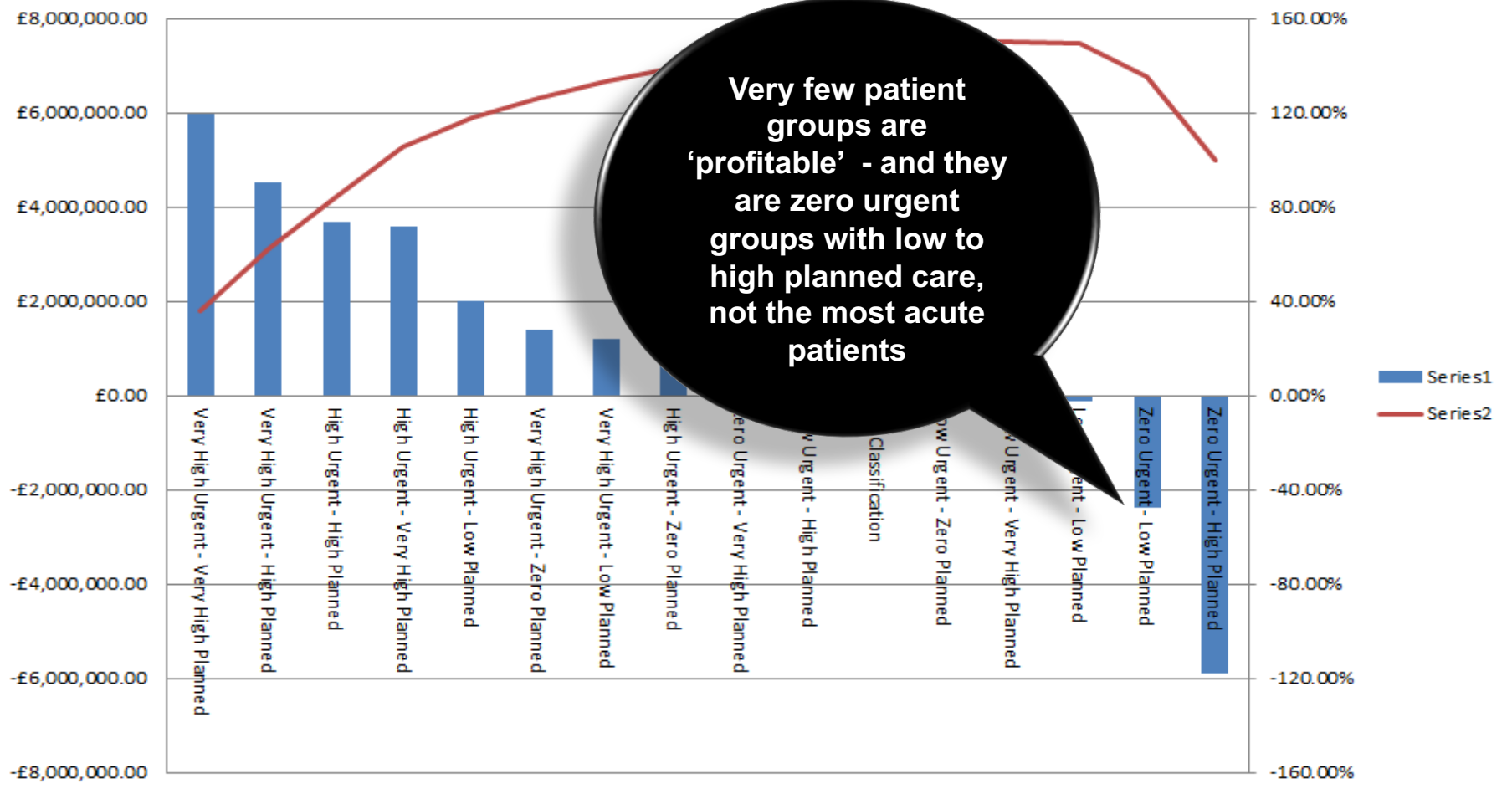
- ▶ Top 5% of patients
- ▶ **12,766 people**
- ▶ Trust makes 16.7M loss on these patients
- ▶ Equates to 99.5% of the deficit

# 'The Vital Few'



# The Perils of Patient Flow

**Pareto Chart of the Deficit By Cohort**



Very few patient groups are 'profitable' - and they are zero urgent groups with low to high planned care, not the most acute patients



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Health

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By Adam Brimelow  
Health correspondent, BBC News

14 April 2016 | Health

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# Intelligent Improvement

## Current

Analyse  
Activity

PMO

Standardise  
Pathways

## Approach

**CHECK**

**PLAN**

**DO**

## Better

Understand  
Patients

Prototype

Customise  
Care

# Intelligent Improvement

The problem is demand amplification of ‘vital few’ patients caused by poor system and service design. Improvement means redesigning services and systems to work for patient cohorts according to geographies, service functions, specialities and/or conditions in order to ‘learn to improve and improve to learn’.



## Clarity of Purpose

- What matters?
- What needs to be solved?
- What needs to be better managed?

## Performance Metrics

- End-to-end time
- First-time resolution
- Representing demand
- PAC profiling

## Paper Prototype

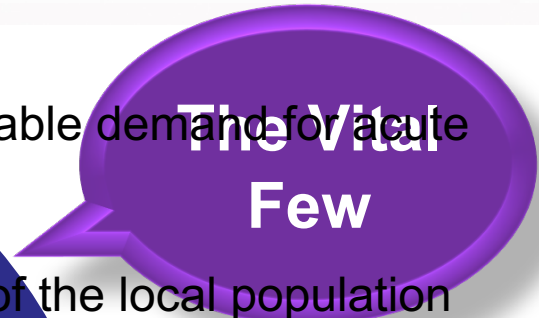
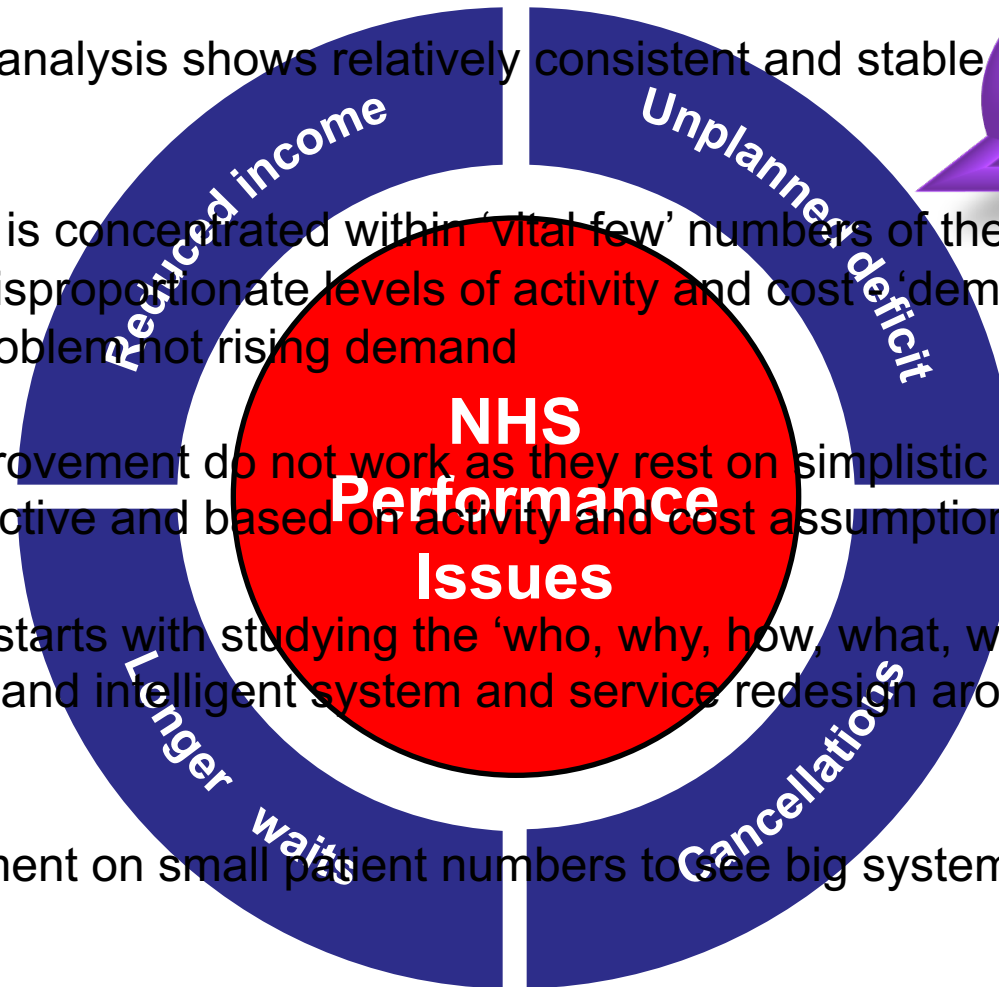
- Develop design
- Develop processes
- Anticipate economies
- Roles & resources

## Working Prototype

- Initiate with small cohorts
- Corresponding control groups
- Extend scope/volume

# Conclusions

- ❖ Patient-centred analysis shows relatively consistent and stable demand for acute care services
- ❖ Patient demand is concentrated within 'vital few' numbers of the local population who consume disproportionate levels of activity and cost 'demand amplification' is the greater problem not rising demand
- ❖ Attempts at improvement do not work as they rest on simplistic reductionist thinking: too reactive and based on activity and cost assumptions
- ❖ Transformation starts with studying the 'who, why, how, what, where, when' of patient demand and intelligent system and service redesign around patients, not pathways
- ❖ Focus improvement on small patient numbers to see big system benefits



# My Management Mentor

**Professor  
John  
Seddon**



Thank You



# Humanising HEALTHCARE

