West Hertfordshire Hospitals NHS
NHS Trust

Trust Board meeting
3 December 2015

Title of the paper:	**Operational update**
Agenda item:	**16/32**
Lead Executive:	**Lynn Hill, Deputy Chief Executive**
Author:	**Jane Shentall, Director of Operations, Elective Care** **Caroline Landon, Director of Operations for Unscheduled Care**
Trust objective:	Tick as appropriate: ☒Achieving continuous improvement in the quality of patient care that we provide and the delivery of service performance across all areas; ☐Setting out our future clinical strategy through clinical leadership in partnership and with whole system working; ☐Creating a clear and credible long term financial strategy.
Purpose:	The aim of this paper is to provide the Board with details of performance against national waiting times standards and an update on service improvements and developments within Elective Care.
Link to Board Assurance Framework (BAF)	**PR5** Inability to deliver and maintain performance standards

Previously discussed:

Committee	**Date**
N/A	

Benefits to patients and patient safety implications
Care delivered within national waiting times standards will ensure patients are not waiting excessive amounts of time for treatment and will deliver an improved patient experience.

Recommendations

To note

Agenda Item: 16/32

Trust Board meeting – 3 December 2015

Elective Care Update – RTT, Diagnostics & Cancer Performance

Presented by: Lynn Hill, Deputy Chief Executive

1. Purpose

1.1 This paper provides a summary of the Trust's performance against the relevant national waiting times standards. The main objectives are:

- to continue to reduce the number of patients that have waited over 18 weeks for their planned care and maintain compliance with national waiting times standards
- to deliver a compliant performance against all Cancer waiting times standards
- to maintain complaint performance against Diagnostic waiting times standards.

2. Background

2.1 In accordance with the Trust's Operational Recovery Plan (April 2015) the Trust achieved compliance against the following measures.

- Referral to Treatment Time (RTT) performance standards:
  92% incomplete/open pathways should be under 18 weeks
- Diagnostic waiting times performance standard for 15 key diagnostic tests:
  99% of should wait no longer than 6 weeks (month end)
- Cancer waiting times standards:
  96% 31 day decision to treat to first treatment
  85% 62 day decision to treat to first treatment.

2.2 Performance in terms of the diagnostic and cancer standards described above had been variable, both at Trust level and within specific tests/procedures and in Cancer, at specific tumour sites. RTT performance had been below the required target for many months.

2.3 Work continues with services where there are the most significant challenges, underpinned with recovery plans and regular discussion with the clinical teams to maximise the potential to achieve compliance. These services did not achieve compliance at the end of Q1, but performance in other areas compensated for this.

3. Progress Updates

Referral to Treatment (RTT)

3.1 In October 2015 the Trust achieved a fourth, consecutive compliant month in RTT waiting times, with 92.3% of open pathways under 18 weeks, slightly below the national average of 92.5%.

3.2 There were no patients waiting over 52 weeks at the end of the month (nationally, all Trusts – 799). The number of patients waiting for 40 weeks or more has continued to reduce and at month end there were no patients with a wait of this length or more. It should be noted however, that there will continue to be very small numbers of patients waiting in excess of 40 weeks. These will result from patient choice delays, complexity of pathways etc.

3.3 The new daily and weekly information reports have supported the development of a more proactive approach to managing RTT performance. Daily emails identify (at service level) the number of patients to be booked from the backlog, the changes in the waiting list, and also now a prompt to assist schedulers in giving reasonable (3 weeks') notice for offers of appointments and admissions. This is proving to be an effective tool, supporting PTL management.

The weekly booking summary tool, which demonstrates whether the backlog is increasing or decreasing at individual service level, clock stops and starts and reviews capacity over the ensuing 6 weeks, supporting further bookings and informing the decision to provide additional capacity.

3.4 The new clinic outcome form (COF) is being tailored to individual service requirements and a roll out programme has commenced. Work is currently underway with the Cardiology team, underpinned by general support and advice on RTT pathway management from the RTT Access team.

3.5 The new Patient Access Policy was presented to the members of the Operational Management Group and is to be discussed at November's extra-ordinary Policy Review Group Meeting (23/11/15).

3.6 The Trust is required to re-book all patients cancelled on the day of surgery for non-clinical reasons, within 28 days of the cancellation. There were 3 breaches of this rule in October (33 ytd). The Surgical Division have formed a cancellation task force which was formed in the summer of 2015 to address the rising rate of cancellations (clinical and non-clinical), many of which were considered avoidable. The group membership includes a Matron, Day Surgery Manager, Theatre Manager and the POA Manager.

The Cancelled Operations Task Force was tasked with identifying trends in all cancellation types, understanding the reasons for cancellations and agreeing actions to improve the rate of cancellation.

The group agreed a number of work streams including:

- Redesign of admission letters.
- Implementation of a missing notes escalation process.
- Identification of the "golden patient" – first on list.
- Consultant sign off of theatre lists.

Future projects include:

- Introduction of a pre-op phone call made by clinical staff to patients a week before admission (starts 1/11/15).
- Day Surgery to be responsible for all day case patients, including those without an allocated bed on admission (starts 1/11/15).
- Offer of same day pre-operative assessment (starts 19/11/15).
- Introduction of an electronic waiting list card.

The impact of these interventions will be measured with a review of cancellation rates pre and post implementation and will be included in a future paper.

Diagnostics

3.7 Compliance with diagnostic waiting times continues, with a performance of 99.8% against a national picture of 98.1%.

3.8 Plans to increase MRI and CT capacity at Watford are well developed and new scanners are on track to be installed in the spring of 2016.

Cancer

3.9 October's performance against all cancer waiting times standards is compliant (or expected to be compliant for those standards where there is a delay in reporting).

3.10 October's provisional performance against the 62 day referral to first treatment standard is provisionally compliant at 85.1% (standard is 85%), better than the national picture of 82.1%. Colorectal, Head & Neck, Lung and Urology all failed to achieve the standard. All of these services are now the focus of the Cancer Improvement Programme Group. However, the quarter is expected to be compliant and once confirmed, the Trust will have delivered two compliant quarters.

3.11 Performance against the 2 week wait breast symptomatic standard has improved significantly and was compliant at 98.4% (standard 93%), better than the national picture of 92.4% in October.

Monitoring Performance

3.12 Patient level waiting times are closely monitored at the following:

- weekly organisational level RTT and Cancer Performance meetings
- weekly divisional level Access meetings (RTT)
- Patient level detailed review of PTLs by Director of Operations for Elective Care.
- Monthly Diagnostic Performance meeting

3.13 Weekly updates of the RTT recovery plan trajectories ensure services are on track to deliver reduced waiting times, giving services opportunities to focus on areas which require additional input.

3.14 Progress against action plans is reviewed weekly with tumour site specialties at the Cancer Improvement Programme group.

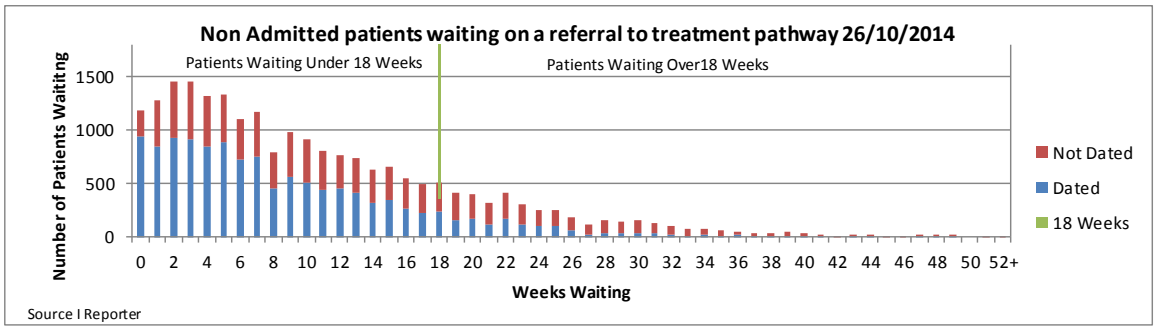
3.15 The following tables and charts demonstrate performance in all three areas.

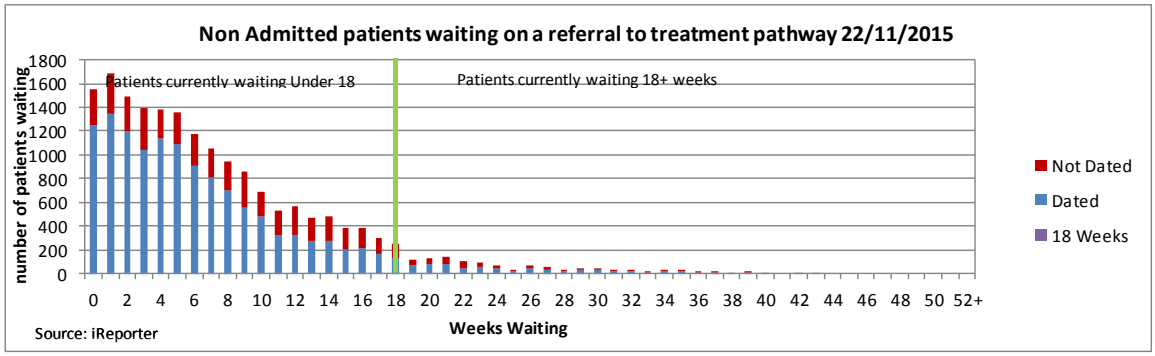
Waiting list profile (month end snapshots)

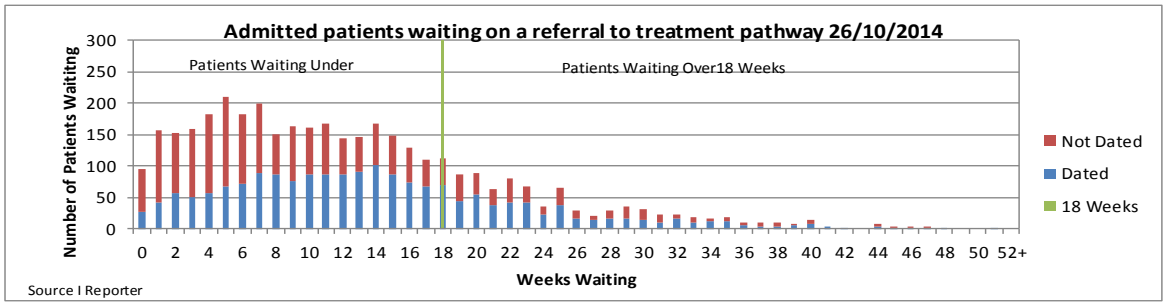
	Oct-14	Apr-15	May-15	June-15	July-15	Aug 15	Sep 15	Oct 15
Total pathways	26978	23087	23183	23497	21291	20531	19328	18921
Total backlog	5019	2327	2016	2014	1656	1589	1513	1456
Non-admitted pathways	22231	18336	18484	18719	17211	16569	15473	15212
Non-admitted backlog	4121	1609	1417	1415	1150	1104	1011	954
Admitted pathways	4747	4751	4699	4778	4080	3962	3855	3709
Admitted backlog	898	718	599	599	506	485	502	502
52 week waits	12	2	5	3	1	0	0	0
Long waits (40+ weeks)	156	84	54	32	15	9	5	1
Clock stops <18 weeks	21959	20760	21167	21483	18046	18942	17815	17465
Clock stops >18 weeks	5019	2327	2016	2014	1428	1589	1513	1456
Submitted performance against 92% target	81.4%	89.9%	91.3%	91.4%	92.2%	92.3%	92.17%	92.3%

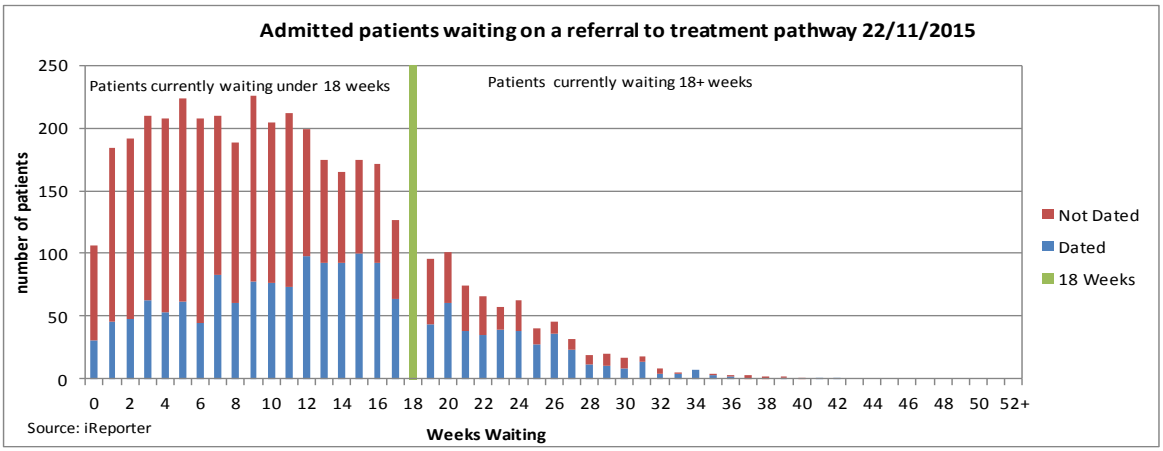
WHHT % incomplete pathways within 18 weeks

Waiting list Profiles

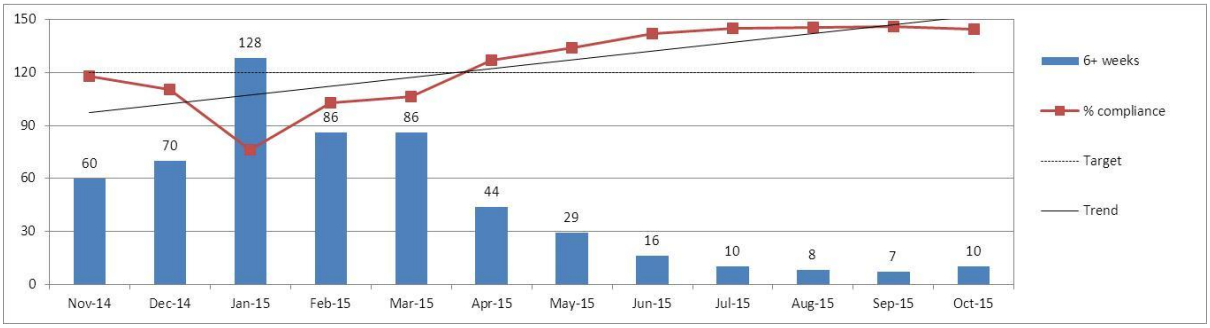








DIAGNOSTIC WAITING TIMES PERFORMANCE



Diagnostic Performance – October 2015

Diagnostic Test	Under 6 Weeks	Over 6 Weeks	Total WL	%
Magnetic Resonance Imaging	1210	0	1210	100.0%
Computed Tomography	510	0	510	100.0%
Non-obstetric ultrasound	2114	0	2114	100.0%
Barium Enema	14	0	14	100.0%
DEXA Scan	275	0	275	100.0%
Audiology - Audiology Assessments	392	3	395	99.2%
Cardiology - echocardiography	141	2	143	98.6%
Cardiology - electrophysiology				
Neurophysiology - peripheral neurophysiology	100	0	100	100.0%
Respiratory physiology - sleep studies				
Urodynamics - pressures & flows	52	3	55	94.5%
Colonoscopy	220	1	221	99.5%
Flexi sigmoidoscopy	113	0	113	100.0%
Cystoscopy	138	1	139	99.3%
Gastroscopy	330	0	330	100.0%
Total	5609	10	5619	99.8%

CANCER WAITING TIMES PERFORMANCE

April – September submitted performance

Targets	Apr-15	May-15	June	Q1 2015/16	Jul-15	Aug-15	Sep-15	Q2 2015/16	Operating Standard	England average
2WW	95.50%	96.90%	94.40%	95.50%	94.10%	95.50%	96.60%	95.30%	93%	93.60%
2WW Breast	94.20%	85.40%	87.60%	88.80%	83.30%	92.20%	98.80%	90.90%	93%	93.40%
31-Day	97.10%	100.00%	98.60%	98.50%	99.30%	99.40%	97.40%	98.70%	96%	97.50%
31-day Subsequent drugs	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	98%	99.60%
31-day Subsequent surgery	100.00%	100.00%	100.00%	100.00%	90.50%	90.50%	100.00%	93.90%	94%	95.00%
31-Day Rare Cancers	100.00%			100.00%	100.00%			100.00%	96%	85.80%
62-Day	94.90%	79.30%	82.30%	86.30%	89.60%	93.50%	85.50%	89.30%	85%	81.80%
62-Day Screening	94.70%	100.00%	92.90%	95.80%	100.00%	100.00%	100.00%	100.00%	90%	93.10%
62-Day Cons Upgrade	100.00%	100.00%	100.00%	90.00%	83.30%	0.00%	57.14%	66.67%	None	89.50%

October 62 day referral to first - provisional

62 day performance	Oct-15			Nov-15			Q3*		
	Provisional			Provisional			Provisional		
Tumour sites under threshold	Total pathways	Breach	%	Total pathways	Breach	%	Total pathways	Breach	%
Breast	15.5	1	93.5%	9	0	100.0%	24.5	1	95.9%
Colorectal	4	2	50.0%	1.5	1	33.3%	5.5	3	45.5%
Haematology	0	0		0	0		0	0	
Gynae	2	0	100.0%	0.5	0	100.0%	2.5	0	100.0%
Head and Neck	0	0		0	0		0	0	
Skin	6	0	100.0%	3	0	100.0%	9	0	100.0%
Lung	3	2	33.3%	1	0	100.0%	4	2	50.0%
Upper GI	4	0.5	87.5%	0.5	0	100.0%	4.5	0.5	88.9%
Urological (Excluding Testicular)	21	4	81.0%	7	2	71.4%	28	6	78.6%
Unnown	0	0		0	0		0	0	
Total	**55.5**	**9.5**	82.9%	**22.5**	**3**	86.7%	78	12.5	84.0%

62 day referral to 1st treatment breach Analysis – October 2015

Tumour Site Description	Delay Reason Comment (Referral To Treatment)	Breach allocation
01 : Suspected breast cancer	**Patient choice** . Pt cancelled x2 OPA's Due to Holiday. First seen in Clinic on day 42 of pathway	1
03 : Suspected lung cancer	**Patient changed treatment plan**, also need time to stop smoking in order for surgery to take place.	0.5
03 : Suspected lung cancer	Needed Cardiac review before surgery @ harefield	0.5
03 : Suspected lung cancer	29 days until first diagnostic test. This patient was referred prior to implementation of new CT amber alert pathway	0.5
03 : Suspected lung cancer	Initially referred for surgery to Harefield, **patient unfit** -Harefield referred for Oncology treatment.	0.5
06 : Suspected upper gastrointestinal cancers	**Patient Choice**- Delay treatment plan.	0.5
07 : Suspected lower gastrointestinal cancers	delay in reporting of ct scan - scanned 03/09 - reported 21/09	1
07 : Suspected lower gastrointestinal cancers	Thought to be benign, **patient was MRSA+,** needed clear swabs before treatment could commence.	1
11 : Suspected urological cancers (excluding testicular)	PSA FU pathway and several cancellations due to **patient choice**	0.5
11 : Suspected urological cancers (excluding testicular)	**Patient Choice** . Patient was away 4 months	1
11 : Suspected urological cancers (excluding testicular)	**Patient Choice** and complex pathway	1
11 : Suspected urological cancers (excluding testicular)	Admin Delay: TCI card not tracked in the absence of CNS.	0.5
		8.5

Next steps

Referral to Treatment (RTT)

Action	Lead	Due by	Update	Progress
Access Policy to be updated and ratified, then rolled out across the Trust.	Jane Shentall	31/10/2015	Delayed to incorporate new national guidance, published October 2015. Updated draft presented to the Policy Review Group on 23 November 2015	↑
Pilot of simplified clinic outcome form in September 2015.	Lynne McGrory	01/09/2015	Pilot completed. Programme to roll form out across Trust to commence in November.	**Completed**
Roll out of new COF across organisation, in a phased programme	Lynne McGrory	30/11/2015	Phased programme to be agreed with divisions. Roll out to commence by end of November.	↑
Development of GOO PTL (patients without an outcome following a first appointment)	Mark Currie	31/10/15	Further modifications required to simply access to and identification of relevant pathways.	→
Development of demand & capacity tool in partnership with NHSE & CCG	Mark Currie		The model has been developed and built but now requires populating and validation. Within the Information team leads have been identified for the theatre model (Alan Osman, James Chan) and the outpatient and inpatient models (Jeremy Lowe)	↑
Develop suite of reports to support management of PTLs	Mark Currie / Jeremy Lowe / Jane Shentall	Ongoing as will be responsive to service needs.	Daily RTT performance tracker emailed to Service Managers. Future months' performance available on i-Reporter.	**Completed**

Cancer

The action plan to ensure achievement of the 8 key priorities to improve cancer performance has been further updated and shared with the CCG, TDA and NHSE. Actions 4 and 7 are now achieved.

Priority	Is this priority in place?	Current Position	Action required to implement
1 The Trust Board must have a named Executive Director responsible for delivering the national cancer waiting time standards.	Yes	Lynn Hill is the Executive Director	None
2 Boards should receive 62 day cancer wait performance reports for each individual cancer tumour pathway, not an all pathway average.	Yes	Included in the board report with immediate effect	None
3 Every Trust should have a cancer operational policy in place and approved by the Trust Board. This should include the approach to auditing data quality and accuracy, the Trust approach to ensure MDT coordinators are effectively supported, and have sufficient dedicated capacity to fulfil the function effectively.	Partial	Cancer waiting times policy embedded within the Trust Access Policy. New policy in development. Will be completed for Trust sign off by the end of November 15.	A stand alone, more detailed policy needs to be developed. To be completed by the end of Q2. **Action delayed due to staff shortages but SOPs in post for MDT, intertrust referrals, imaging, PTL and tracking, note pulling and tracking, amber alerts, training, 2ww audit, histology audit, datix, storage and filing, reporting, other audits, breach reporting, VTC, pathways, consultant upgrades, 2ww pathways, screening programmes and escalation.**
4 Every Trust must maintain and publish a timed pathway, agreed with the local commissioners and any other Providers involved in the pathway, taking advice from the Clinical Network for the following cancer sites: lung, colorectal, prostate and breast. These should specify the point within the 62 day pathway by which key activities such as OP assessment, key diagnostics, inter-Provider transfer and TCI dates need to be completed. Assurance will be provided by regional tripartite groups.	Yes	In development as part of the Cancer Improvement Plan. Lung, Urology and Lower GI timed pathways complete and signed off by the clinical lead. To be sent to the CCG for sign off at the next cancer action group. Breast timed pathway to be discussed at the Unit meeting on 27th October.	1st draft to be published by 31 August 2015 with final draft with Clinical lead sign off by 30 September 2015. **Awaiting timed pathways from the network. Awaiting clinical sign off of the breast timed pathways.**
5 Each Trust should maintain a valid cancer specific PTL and carry out a weekly review for all cancer tumour pathways to track patients and review data for accuracy and performance. The Trust to identify individual patient deviation from the published pathway standards and agree corrective action.	Yes	Weekly Cancer Access Meeting in place.	None
6 A root cause breach analysis should be carried out for each pathway not meeting current standards, reviewing the last ten patient breaches and near misses (defined as patients who came within 48hours of breaching). These should be reviewed in the weekly PTL meetings.	Yes	RCA completed and signed off by the Clinical lead for 31/62 and 100+ day breaches. All are reveiwed weekly by the Cancer Programme Lead. All breaches are reviewed at cancer access and performance with reasons and actions identified by the service managers.	All relevant Service Managers to attend weekly PTL meetings with the MDT Coordinators. RCA to be completed for all patient 60+ and presented for discussion at the Cancer Access Meetings by the relevant Service Manager. To be implemented for all patients identified as breaches as of beginning of August 2015.

Priority	Is this priority in place?	Current Position	Action required to implement
7 Alongside the above, a capacity and demand analysis for key elements of the pathway not meeting the standard (1st OP appointment; treatment by modality) should be carried out. There should also be an assessment of sustainable list size at this point.	Yesl	Partial C&D completed for 1st OPA and diagnostics. Awaiting conversation with IST regarding C&D assistance. Endoscopy and theatre capacity likely to require C&D. Internal theatre capacity work being undertaken currently.	Identify key elements (from timed pathways) not meeting standard, provide capacity and demand anaylsis and ensure adequate resources available. To be completed by the end of Q2. **Team attending capacity and demand workshop on 1 December. Capacity and demand for Urology subspecialty first appointment completed and templates amended. Theatre capacity and demand carried out and redesign of theatres in process of being signed off. Additional theatre capacity for colorectal in the pipeline to give them an additional 2 sessions every fortnight for cancer workload. Business case in progress for additional oncology sessions to include more joint oncology urology sessions.**
8 An Improvement Plan should then be prepared for each pathway not meeting the standard, based on breach analysis, and capacity and demand modelling, describing a timetabled recovery trajectory for the relevant pathway to achieve the national standard. This should be agreed by local commissioners and any other providers involved in the pathway, taking advice from the local Cancer Clinical Network. Regional tripartite groups will carry out escalation reviews in the event of non-delivery of an agreed Improvement Plan.	Yes	Improvement Plan in place and individual recovery plans for specialties not achieving the standard.	Capacity and Demand data to inform Improvement Plan in place. To be amended by end of Q2.

4. Risks

4.1 Risks scoring 15 and above are detailed in the Corporate Risk register. Those with relevance to the provision of elective care at the Trust are as follows:

ID	Principle Risk	Division	Speciality	Risk Lead/Exec Lead	Opened	Description	Consequence (current)	Likelihood (current)	Rating (current)
3120	PR 4	Medicine	Outpatient Nursing Services	Lisa Emery	09/07/2014	**Patient Medical Notes missing, Delayed or poor condition**. Cause: limited medical records storage across all sites, poor adherence to tracking processes and variability / insufficient administrative resource in clinical prep and health records teams to match increased demand Effect: lack of availability of notes for clinical episodes of care, IG risk related to lost notes not securely stored, inefficient and resource intensive processes. Impact: safety and quality, patient experience, financial.	4	5	20
2145	4	Clinical Informatics	Data Quality	Lisa Emery	13/02/2009	**Loss of the Hemel or Watford Data Centres** Risk: Data centres damaged or links to data centres severed. Cause: Physical data centre housing is not fit for purpose therefore risk of damage through fire, water, temperature, humidity, sabotage (physical, virtual), power. Consequences: Prolonged and material loss of IT services hosted from the data centres will seriously hinder WHHT's ability to support he delivery of safe patient care. These services include key clinical and operational IT systems.	4	4	16
3448	4	Clinical Support	Radiology	Lisa Emery	13/04/2015	**PACS Data Storage** Cause: The Trust is required to localise the PACS images currently stored at the Accenture Data centre by June 2015. HSCIC has put in place a national process / slot plan to allow for data to be migrated to locally hosted solutions. WHHT "slot" was allocated for August 2015. The plan had been to transfer the data to the trust's Outsourced IT partner however they have not been able to provide an appropriate solution within the agreed timeframe. HSCIC require trust to confirm its plan for data migration by 23.09.15 and for transfer to be effected by 1st November 2015. Effect: If the trust is not able to conform to this requirement there is a risk that migration is not able to be completed within the national timescale resulting in potential for significant loss of patient level clinical data. Impact: Loss of this data will result in potential delays in diagnosis for some patients by preventing review of past imaging, preventing comparison of current and past imaging. This was affect patient care and safety and also presents a medico-legal and financial risk to the trust.	4	4	16
421	PR 2	Corporate	Human Resources	Paul Da Gama	08/04/2015	**Recruitment and Retention** Cause: There is a nationwide shortage of key trained clinical staff including nurses, A&E consultants, etc. Effect: The Trust is finding it extremely difficult to recruit to its existing staffing establishment. Impact: The Trust is running with significant levels of vacancies which is impacting on staff morale, leading to even higher levels of turnover, which in turn has the potential to negatively impact patient care and is creating major financial pressures due to increase agency and locum costs.	4	5	20

ID	Principle Risk	Division	Speciality	Risk Lead/Exec Lead	Opened	Description	Consequence (current)	Likelihood (current)	Rating (current)
3155	PR 3	Medicine	Gastroenterology	Kevin Howell	28/07/2014	**Failure to deliver the planned expansion of the Endoscopy Unit** Failure to deliver the Endoscopy Unit expansion according to plan will put the following at risk: 1. Achievement of Level A JAG Accreditation (timeliness of national waiting targets for 3 consecutive months must be demonstrated to achieve accreditation). 2. This will have an adverse impact on the trust's reputation and could lead to: 3. Inability to provide recognised endoscopist training, leading to 3a. Inability to recruit and retain staff 3b. Loss of hte national bowel screening programme and associated income 4. Inability to meet national waiting times targets (RTT & Cancer) 5. Increased waiting times for surveillance patients, putting JAG accreditation (see point 1) at further risk. 6.	4	4	**16**
3583	PR 2	Womens and Children	Gynaecology	Paul Da Gama	05/08/2015	**High nursing vacancies on Elizabeth Ward leading to poor patient experience, safety risk and financial costs** Cause: national workforce shortage, poor staff morale, workload pressures and staff concerns about patient mix, maternity leave Effect: high turnover / poor retention / high vacancy rate (40% vacancy at Band 5) Impact: high usage of bank and agency, risk that not all shifts meet planned nursing workforce levels, adverse impact on quality, safety and patient experience.	4	5	**16**

Review of divisional risk registers has identified the following estate/equipment issues which might compromise the provision of elective care services as follows:

Risk ID	Division	Risk Description	Current Rating
2937	Surgery	Inadequate ventilation in SACH theatres	9
3444	Surgery	WGH Day Surgery – single sex non-compliance	10
2939	Surgery	Theatre Recovery – paediatric NSF non-compliant	10
3189	Clinical Support	Failure of the WGH MRI scanner	12
2755	Clinical Support	Failure of the HHGH MRI scanner	12
2920	Clinical Support	Computerised radiography equipment at end of life	12
3062	Medicine	Severe shortage of endoscopy nurses	12
3122	Medicine	Failure of HHGH & WGH OPD ventilation systems	8
3119	Medicine	WGH OPD environment (plumbing, roofing) issues	9

5. Recommendation

5.1 The Board is asked to note the Trust's performance against national waiting times standards and the progress detailed within RTT, Diagnostics and Cancer Services.

Jane Shentall
Director of Operations, Elective Care
20 November 2015

Trust Board meeting – 3 December 2015

Operational update - unscheduled care

Presented by: Lynn Hill, Deputy Chief Executive

1. Overview

1.1 A&E performance dipped in October with a Trust position of 86.6%, performance re ambulance handover delays also dipped. The Trust had an average of 50 DTOC's in October which compromised capacity and flow.

1.2 In the past month, the Trust hosted a visit from ECIP (Emergency Care Improvement Project) who are working with challenged unscheduled care systems nationally to help improve performance. ECIP raised challenges re process in ED and AAU and the location and size of key services. A Manager from ECIP has been assigned to work with the Trust and will be on site weekly to help address some of the process challenges faced by the Trust. ECIP also spent some time with the IDT team and identified that process was too sequential; resulting in unnecessary delays for patients, a social care advisor from ECIP will be working with the IDT team to help move these issues forward.

1.3 The programme continues to monitor the original work streams, in relation to Front Door and Hospital Patient Flow however these work streams are now owned by the divisions and it is the responsibility of the divisional Tri's to embed. The programme is now focussed on delivery of the Winter Plan, as well as the IDT transformation plan. As a reminder, the objectives of these are set out below:

Project	Divisional Lead	Corporate Support	Objectives	KPIs impacted
Winter Resilience	Karen Bailey	Caroline Landon	• Deliver schemes funded by CCG and ensure monthly reporting, completion of all actions and monitoring impact • Implement local actions to prepare for increase demand over winter • Ensure organisational resilience is robust and closely managed	▶ A&E standards ▶ Discharges before 12 and weekend discharges ▶ DTOCs ▶ Readmissions ▶ ALOS
Integrated Discharge Team (IDT)	Jane Waite	Caroline Landon	• Work with system partners to reduce DTOCs • Improve case management of complex patients to reduce LOS and improve early discharges • Streamline assessment and transfer processes out of hospital • Improve data accuracy and reporting, with close monitoring of delays and clear escalation routes • Implement robust management of the IDT to ensure optimal performance of staff, systems and processes	▶ DTOCs ▶ ALOS ▶ Discharges before 12 and weekend discharges ▶ A&E standards

Project	Divisional Lead	Corporate Support	Objectives	KPIs impacted
Hospital Flow: Efficient Wards	Elaine Odlum / Phil Downing	Maxine McVey	• Tackle capacity and capability issues at ward level, improving ward level performance across all indicators • Improve and standardise board rounds across medical wards to increase daily, early discharges • Implement a discharge planning culture on the wards	▶ ALOS ▶ Discharges before 12 and weekend discharges ▶ Complaints, SIs and Incidents ▶ A&E standards
Front Door Flow: AAU	Debbie Foster	Karen Bailey	• Improve the GP heralded patient flow by implementing single point of access and clear admission protocols, as well as ring fenced assessment capacity • Enhance the ambulatory care provision through greater access / number of services and reviewing exclusion criteria • Reduce the LOS on AAU though improved post take ward rounds, board rounds and operational processes	▶ Admission & readmission rates ▶ A&E standards ▶ ALOS ▶ Discharges before 12 and weekend discharges
ED Reconfiguration	Ruth Connelly/ Helen Galloway	Caroline Landon	• Complete the ED reconfiguration business case to develop the department and tackle fundamental issues with the estate and environment which are not conducive to optimal patient care	▶ A&E standards ▶ Estates & Environmental standards

2. Progress Updates

Winter Resilience

2.1 There are 5 schemes funded for winter resilience by the CCG:

- Discharge consultant sessions over the weekend
- Therapy team to support surge wards
- Additional Discharge Ambulance
- Acute Coronary Syndrome Nurse
- Discharge Planning Nurse (Joint with HCT)

2.2 A weekly winter planning group has been established, led by the head of operations, which includes representatives from all divisions. The project team have developed a broader action plan to implement schemes without significant cost implication, in order to further boost the resilience plan for 15/16. Other key projects which are being explored include:

- Identify areas to expand Emergency Surgical Assessment Unit
- Identify areas to expand ambulance off-load space
- Locate equipment stores on site to facilitate early discharge
- Review of the porter allocation in departments

The organisation is currently in discussion with the CCG re the re prioritisation of winter schemes across the system as the current allocation does not allow for

funding to cover unfunded posts in WHHT that are still in place from last winter. The resilience monies also do not take into account the unfunded capacity in Shrodells. This issue is being managed by the CFO. The organisation has gone ahead at risk with three of the approved schemes, albeit in a reduced provision, these schemes are:

- Discharge consultant sessions over the weekend
- Therapy team to support surge wards
- Additional Discharge ambulance

Front Door Flow

2.3 Through the first month of the new single point of access service, the team audited Care of the Elderly calls which identified 26% of calls were directed to the COE team. This is now being reviewed by the COE team to decide whether a full single access point would be appropriate. A proposal has been put forward by the COE team to provide geriatric support in ED to help avoid unnecessary admissions. It is proposed that this front door frailty service will be a joint initiative between WHHT and HCT, a scoping exercise to assess potential benefit is scheduled to take place in November.

2.4 The consultant sessions which were previously providing cover for the admissions phone calls have been reallocated, with over 750 additional outpatient appointments created and more than 70 Endoscopy procedure slots opened up.

2.5 The coding audit completed by the consultants whilst their sessions were being re-instated identified some issues which now need to be actioned by the medical teams, including:

- Coding changes made by the consultants across 236 inpatient spells only equated £2600 worth of income improvements
- 27 HRG codes changed
- 51% of notes did not have a definitive diagnosis
- Main reasons for coding corrections/changes were down to
  a) Interpretation of test results - Coders must not interpret test results to arrive at a diagnosis; this is the role of the Clinician,
  b) The consultants were able to identify co-morbidities by drugs on list and
  c) Main diagnosis not clear in the notes

2.6 A Junior Doctor feedback survey was sent out in July & August to identify any issues or concerns with the post take ward or board rounds. The feedback from this survey is now being reviewed by the Clinical Directors and will be disseminated to the consultants for further actions where appropriate.

2.7 Following agreement at CAG there is to be a 2 week trial of locating a medical consultant in ED to review patients in ED to facilitate quicker decision making and admission avoidance – if the trial demonstrates impact then a business case will be presented to the CCG. The CCG are supportive of the endeavour – due to commence November

2.8 An expanded ESAU has been reprovisioned on Letchmore, the surgical division has agreed that all ortho and surgical patients with non life threatening injuries will go straight to ESAU. This commenced in October and is having a positive impact on surgical throughput and capacity on AAU.

2.9 A clinical team led by Sue Catnach has committed to reviewing the DTA process in ED and process mapping the patient journey through unscheduled care – support for this imitative is being sought from the CCG. This work stream will also review the revision and efficacy of the ward rounds provided in AAU

Hospital Patient Flow

2.10 The perfect ward concept has been absorbed into the ward validation project to tackle the broader issues across all wards. The perfect ward programme now sits within medicine and is the responsibility of the medical Tri to rollout and sustain.

2.11 The medical matrons are to attend ED when there are 5 or more medical patients waiting for beds and remain in the department liaising with the medical wards to support ED and facilitate safe transfer of patients as quickly as possible – to commence in November.

2.12 Pharmacy has committed to reviewing the TTA process and committed to reducing the pathway by at least 2 steps.

2.13 Operational services are currently reviewing the provision of transport out of hospital and process mapping to identify efficiencies – the CCG have committed to assisting with this piece of work.

2.14 The discharge lounge move to incorporate stretcher patients has been agreed and commencing in November 2 bays will consistently be used for discharge and an additional 6 beds committed to surge.

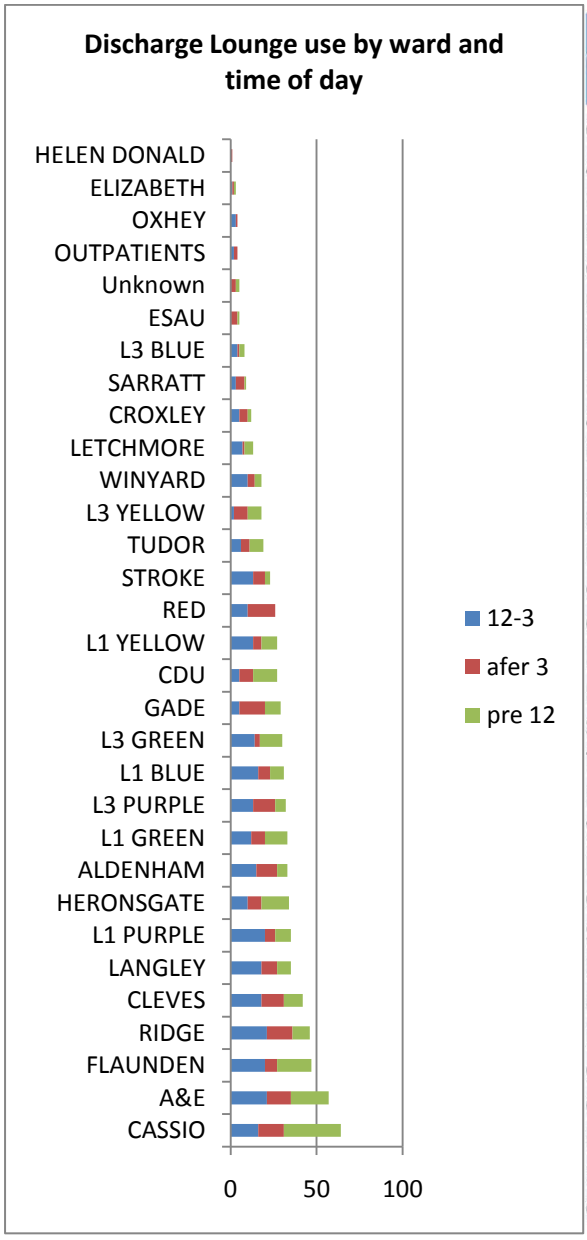
2.15 The medical division are reviewing the provision of OPAL and pulling together a plan to reinvigorate the provision of this service.

2.16 Commencing November the discharge coordinators are to move management lines and sit under the medical division under the line management of the Medical Discharge manager – this will be for a trial period over winter.

2.17 Sue Catnach is leading on the scoping of a project to provide a 'twilight hospital' a significant proportion of activity takes place outside working hours therefore the proposal is to measure and analyse this activity and understand the gap. The initial report will be available in December

2.18 The Trust admits a significant number of patients with a LOS less than 2 days. A clinical team led by Sue Catnach and Tammy Angel have committed to reviewing the current pathways to better understand presenting and management – report due December

2.19 The analysis completed during the discharge lounge trial also demonstrated a strong link between morning discharges and early board rounds, as shown below:



WARD	Pre 12pm	12pm -3pm	After 3	Total discharges	Board Round Time
CASSIO	51.56%	25.00%	23.44%	64	08:30
A&E	38.60%	36.84%	24.56%	57	na
FLAUNDEN	42.55%	42.55%	14.89%	47	11.00
RIDGE	21.74%	45.65%	32.61%	46	08:30
CLEVES	26.19%	42.86%	30.95%	42	08:00
LANGLEY	22.86%	51.43%	25.71%	35	09:00
L1 PURPLE	25.71%	57.14%	17.14%	35	09:00
HERONSGATE	47.06%	29.41%	23.53%	34	09:00
ALDENHAM	18.18%	45.45%	36.36%	33	09:00
L1 GREEN	39.39%	36.36%	24.24%	33	09:00
L3 PURPLE	18.75%	40.63%	40.63%	32	Tbc
L1 BLUE	25.81%	51.61%	22.58%	31	09:00
L3 GREEN	43.33%	46.67%	10.00%	30	Tbc
GADE	31.03%	17.24%	51.72%	29	08:30
CDU	51.85%	18.52%	29.63%	27	Tbc
L1 YELLOW	33.33%	48.15%	18.52%	27	Tbc
RED	0.00%	38.46%	61.54%	26	12:15
STROKE	13.04%	56.52%	30.43%	23	09:00
TUDOR	42.11%	31.58%	26.32%	19	12:00
L3 YELLOW	44.44%	11.11%	44.44%	18	Tbc
WINYARD	22.22%	55.56%	22.22%	18	11:30
LETCHMORE	38.46%	53.85%	7.69%	13	09:30
CROXLEY	16.67%	41.67%	41.67%	12	12:00
SARRATT	11.11%	33.33%	55.56%	9	12:00
L3 BLUE	37.50%	50.00%	12.50%	8	tbc
ESAU	20.00%	0.00%	80.00%	5	na
Unknown	40.00%	0.00%	60.00%	5	na
OUTPATIENTS	0.00%	50.00%	50.00%	4	na
OXHEY	0.00%	75.00%	25.00%	4	na
ELIZABETH	33.33%	33.33%	33.33%	3	tbc
HELEN DONALD	0.00%	0.00%	100.00%	1	tbc
Grand Total	31.82%	39.35%	28.83%	770	

2.20 This is particularly relevant to the COE team who have struggled to develop an efficient way of working which facilitates morning board rounds. This is now being taken to the consultant team at their next monthly meeting in September for discussion and further review.

2.21 A revised staffing structure for the discharge lounge is now being considered as well as different ways to promote discharge lounge usage. The long term plan to redevelop the existing discharge lounge area to include beds is still ongoing.

Integrated Discharge Team

2.22 The IDT improvement plan is integral to the delivery of ward improvements, with a number of work streams which overlap between teams.

2.23 The development of the discharge coordinators, including discharge planning books, standardised checklists and appropriate allocation of resource have all been

identified as issues through the perfect ward projects which are now being owned by the IDT to implement.

2.24 Streamlined processes for data monitoring and reported have been introduced, as well as daily “live” patient monitoring with board briefings with the discharge planning nurses held daily.

2.25 Lead roles have been introduced in relation to self-funders, and continuing healthcare (CHC) assessments, and a number of staff have been re-allocated to different areas to tackle issues of bottle necked referrals.

2.26 The longer term development of the IDT and the links with Social Care and Community services is still being reviewed.

A&E Reconfiguration

2.27 The scenario outputs have now been presented with final sign off. The business case is due for completion by the end of November with the simulation model outputs; this will then be presented to TLEC and Trust board.

2.28 Scenario outputs indicate that:

- Increasing CDU bed capacity by 1-3 beds can enable performance improvement of 1.2 – 2.6% respectively against baseline
- Consolidating the walk in triage process into one area with 3 bays staffed at all times, 4 hour performance can improve by 2.7%
- The combined impact of the above 2 scenarios could improve performance by 5-6%
- Streaming all GP heralded patients through A&E would negatively impact performance
- Expanding ESAU capacity could improve performance by 2.5%-5% dependent on the number of additional trolleys and impact on the surgical bed base
- In all scenarios, reconfiguring the department is not sufficient in and of itself to support sustained achievement of the 95% performance target. This can only be achieved through the creation of meaningful flow (i.e. discharge profile matched to admission profile/removal of DTOCs from the bed base).

3. Performance Monitoring

3.1 A&E performance dipped in October with a Trust position of 86.6%.

KPI / standard	2014/5 Baseline	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	TREND	Q1	Q2	Target
A&E 4hr waits (Type 1, 2 & 3)	91.3%	86.2%	90.8%	91.9%	94.1%	93.6%	87.7%	86.6%	↓	89.7%	91.8%	95.0%
A&E 12hr trolley waits	3	0	0	0	0	0	0	0	↔	0	0	0
Ambulance turnaround time between 30 and 60 mins	13.7%	22.1%	12.7%	13.6%	10.3%	9.7%	14.8%	22.6%	↑	15.9%	6.3%	15%
Ambulance turnaround time > 60 mins	4.0%	12.2%	4.9%	2.3%	0.3%	0.6%	2.2%	5.7%	↑	11.4%	1.0%	0%
50% of NEL discharges occur between 8am and 12pm (main adult wards excl AAU1)	18.1%	17.6%	16.3%	14.7%	18.3%	16.0%	14.6%	15.2%	↑	16.1%	16.3%	50%
Average LOS Non Elective Medicine (Spell)	7.2	8.4	7.6	7.4	7.1	6.5	7.5	7.5	↔	7.8	7.1	3.9
Average LOS Non Elective Surgery (Spell)	5.9	7.4	5.8	6.3	5.7	5.9	6.3	5.5	↓	6.5	5.9	2.7
30% of total NEL (medical & surgical) discharges occur at the weekend	16.0%	17.7%	20.4%	14.8%	15.1%	16.8%	13.6%	14.7%	↑	17.6%	15.1%	30%
Cancelled Operations within 24hrs due to lack of beds (per month)	21.4	21	13	22	33	20	20	22	↑	56	73	0
Delayed Transfers of Care (DToC)	2.7%	3.7%	8.8%	8.3%	5.7%	6.9%	5.7%	6.4%	↑	6.9%	6.1%	3.5%
Medical Ambulatory Care Admissions % of all NEL Medical admissions	34.4%	33.2%	32.9%	35.0%	33.2%	34.4%	33.9%	32.6%	↓	33.7%	33.9%	30%
Surgical Ambulatory Care Admissions % of all NEL Surgical admissions	15.4%	26.2%	30.0%	28.5%	28.6%	29.6%	23.6%	28.2%	↑	28.3%	27.4%	30%
NEL Admissions to ED attendance ratio	34%	34.3%	33.7%	33.2%	33.8%	35.6%	34.6%	29.2%	↓	33.7%	34.6%	38%
% of patients with a LOS on AAU1 >72 hours	8.1%	11.2%	12.2%	7.3%	7.1%	5.6%	10.4%	11.7%	↑	10.6%	8.5%	0%
Number patients (per month) with >3 ward transfers within one week's stay	674	62	55	62	61	57	66	82		179	184	0

4. Next Steps

Front Door Flow

4.1 Implement medical consultant in ED trial
4.2 Support continued utilisation of ESAU
4.3 Review DTA process and AP ward rounds
4.4 Evaluate options for ring fenced assessment space & implement interim solution
4.5 Implement COE Frailty Service scoping exercise

Winter Resilience

4.6 Initiate monthly reporting and delivery of scheme action plans

Hospital Patient Flow

4.7 Review board round training presentation at COE consultant meeting & agree plan to move to early board rounds
4.8 Agree band 6/7 ward nursing development plan
4.9 Instigate medical matron support in ED
4.10 Review transport capability
4.11 Commence review of OPA provision
4.12 Commence review of TTA process
4.13 Scope 'twilight hospital' project

Integrated Discharge Team

4.14 Roll out MDT discharge planning book and refresh Discharge Coordinators training programme

A&E reconfiguration

4.15 Scenario modelling to be incorporated in strategic outline case and to be presented to TLEC and Board in December.

4.16 UCC pilot in A&E to initiate in October 2015

5. Risks scoring 15 or above relating to the provision of unscheduled care

Risks are currently being reviewed and refreshed in accordance with the refreshed governance process.

6. Recommendations

6.1 The Board is asked to note the progress against plan.

Caroline Landon
Director of Operations, Unscheduled Care