West Hertfordshire Hospitals NHS
NHS Trust

Trust Board Meeting
1 October 2015

Title of the paper:	**Operational Recovery Plan – Progress Update**
Agenda Item:	**09a/30**
Lead Executive:	**Lynn Hill, Deputy Chief Executive**
Author:	**Jane Shentall, Director of Operations for 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 an update on progress against the Operational Recovery Plan

Please add which panel and/or group that the paper has been previously discussed at prior to TLEC

	Panel	**Group**
Name:	N/A	TLEC
Date:	N/A	18 June 2015

Benefits to patients and patient safety implications
Patients referred to the Trust for elective care should expect to receive their diagnostic investigation or elective care treatment within the relevant national standard. This is underpinned by the NHS Constitution which aims to ensure that patients are diagnosed and receive appropriate care as soon as possible.

Risk implications for the Trust	**Mitigating actions** (controls)
Delivery of safe, timely care	

Links to Board Assurance Framework, CQC outcomes, statutory requirements

Legal implications (if applicable)
N/A.

Financial implications (if applicable)

Recommendations
For information and assurance

West Hertfordshire Hospitals NHS
NHS Trust

Agenda Item: 09a/30

Trust Board meeting – 1 October 2015

Operational Recovery Update – RTT, Cancer & Diagnostics

Written by: Jane Shentall, Director of Operations for Elective Care

1. Purpose

1.1 This paper provides an update on the progress made in relation to operational recovery plans to achieve compliance against the relevant national waiting times standards. The main objectives are:

- to reduce the number of patients that have waited over 18 weeks for their planned care and achieve compliance with national waiting times standards
- to deliver a compliant performance against Cancer waiting times standards
- to improve performance against Diagnostic waiting times standards to a compliant position

2. Background

2.1 As planned, WHHT achieved organisational compliance in 3 key areas of performance by the end of Q1 2015/16, ie a compliant submission in July 2015, against the following national waiting times standards:

- 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 the services where there are the most significant challenges, supported with recovery plans and regular discussion with the clinical teams to maximise the potential to achieve compliance. It is recognised that these services will not be compliant at the end of Q1, but performance in other areas will mitigate for this.

2 Progress

Referral to Treatment (RTT)

3.1 The Trust achieved a second compliant month in RTT waiting times.

3.2 At the end of August there were no patients waiting over 52 weeks. The number of patients waiting for 40 weeks or more has continued to reduce as has the overall backlog.

3.3 Performance against the defunct 95% non-admitted and 90% admitted closed pathways measures remains under target, but it should be noted that these are no longer national requirements.

3.4 The review of the Trust's Access policy has been completed. It will be presented at the October OMG for ratification and then rolled out across the Trust.

3.5 After each outpatient attendance clinicians are expected to complete a clinic outcome form (COF) which should provide accurate information on the 18 week pathway events that may have taken place at that appointment. This is then handed to the receptionist as the patient leaves clinic and the receptionist enters the information on to PAS. The Trust's COF was complex and was not user friendly. A new, simple version has been drafted and is currently being piloted by a number of medical and surgical specialties. Initial feedback indicates that clinical teams are more easily able to select the correct outcome and indicate future plans. The RTT validation team are identifying significantly fewer errors on the new form and are therefore spending less team making corrections to patient pathways. The pilot finishes at the end of September when feedback will be collated and if successful, the new form will then be rolled out across the Trust.

Diagnostics

3.6 The improved diagnostic performance has been sustained with compliance in August.

3.7 Additional diagnostic equipment for Cardiology is operational and is contributing to a reduction in backlog and therefore a reduction in additional weekend sessions that had been required to meet demand and to manage the backlog of requests.

3.8 All DEXA requests continue to be outsourced to Mount Vernon Hospital. A business case for a replacement machine was approved at CPG and the machine has been ordered. This is expected to arrive 8 to 10 weeks later but negotiations with the supplier are underway to establish whether a loan machine could be made available during this time.

3.9 The monthly Diagnostic Performance group continues to oversee performance in all of the 15 areas reported in the monthly DM01 submission.

Cancer

3.10 The Trust returned a compliant performance submission against the 62 day referral to first treatment standard for July.

3.11 Weekly scrutiny of the Cancer PTLs (at patient level) is well embedded with patient pathway tracking from day 0.

3.12 Patient choice continues to be a significant challenge, particularly for 2ww and breast symptomatic. The national picture for breast symptomatic is similar. Progress has been made to bring the offer of a first appointment in to the 0-7 day period, where the majority of patents receive an offer of an appointment on day 5. Unfortunately many patients are choosing to wait longer. However, staff can then make a second offer before day 14, although many patients also reject this second offer. Work with the CCG and their lead clinician is underway in terms of patient education and information, using monthly newsletters and locality leads.

3.13 In Urology, additional MRI capacity has been sourced from Spire Bushey to support patients on the prostate pathway.

3.14 The eight key priorities (see table in Next Steps section) identified by Monitor, the TDA and NHS England (in a letter to CCGs, NHS Trusts and System Resilience Group Chairs, dated 14 July 2015) are intended to improve and sustain cancer performance. The Trust is compliant against 50% of these priorities and partially compliant against the rest.

4 Monitoring Performance

4.1 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

4.2 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.

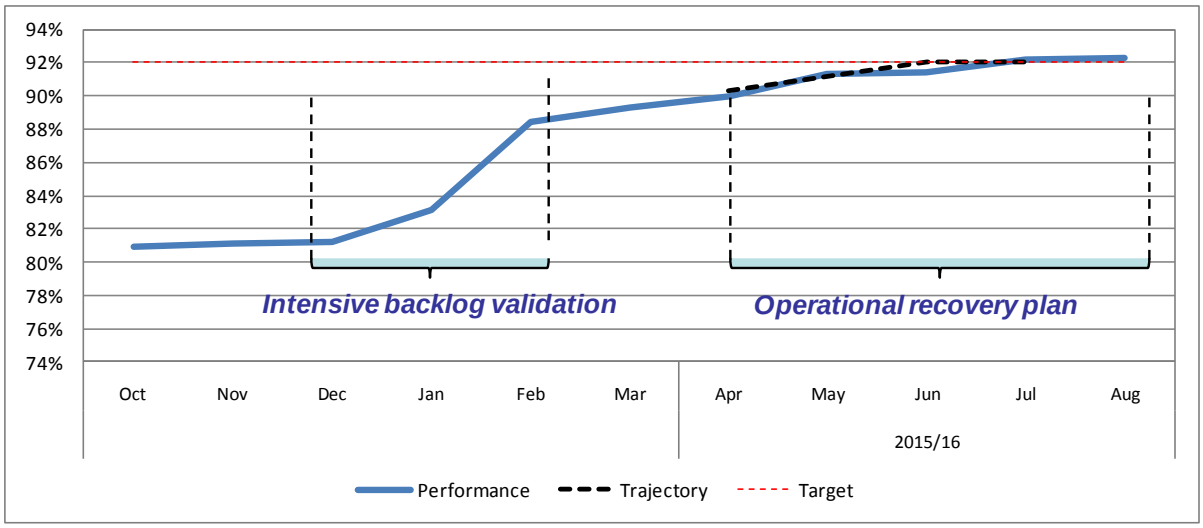
4.3 The following tables and charts demonstrate the improvements in performance in all three areas.

Waiting List Profile – 31 August 2015

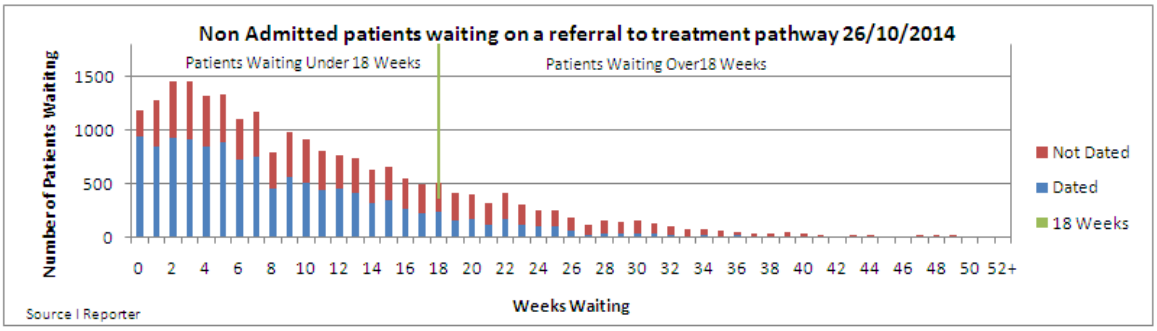
	Oct-14	Mar-15	Apr-15	May-15	June-15	July-15	Aug 15
Total pathways	26978	21817	23043	23576	23815	21345	23848
Total backlog	5019	2285	2340	2114	2171	1656	1591
Non-admitted pathways	22231	17459	18473	18780	19346	17265	16619
Non-admitted backlog	4121	1574	1633	1532	1603	1150	1106
Admitted pathways	4747	4358	4570	4451	4469	4080	3962
Admitted backlog	898	711	707	582	568	506	485
52 week waits	12	7	2	5	3	1	0
Long waits (40+ weeks)	156	90	84	54	32	15	9
Clock stops <18 weeks	21959	19532	20760	21167	21483	18046	18942
Clock stops >18 weeks	5019	2285	2327	2016	2014	1428	1589
Submitted performance* against 92% target	81.4%	89.5%	89.9%	91.3%	91.4%	92.2%	92.3%

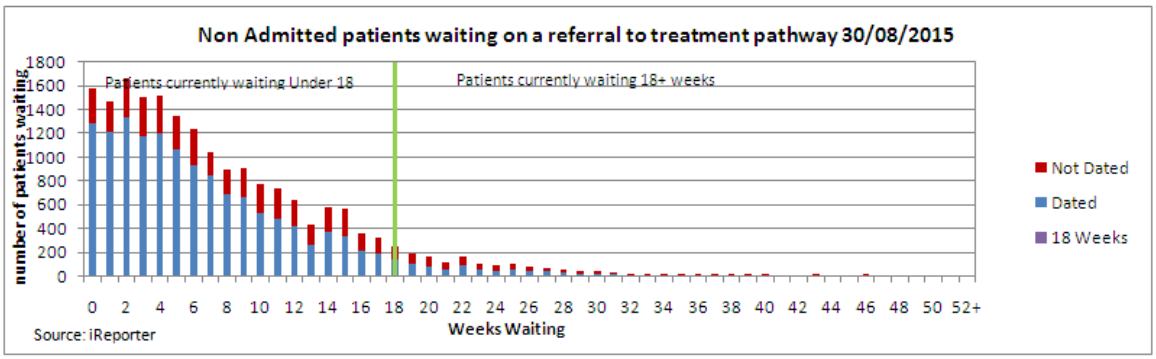
*The final month end position may differ from the submitted position as validation continues beyond the submission date.

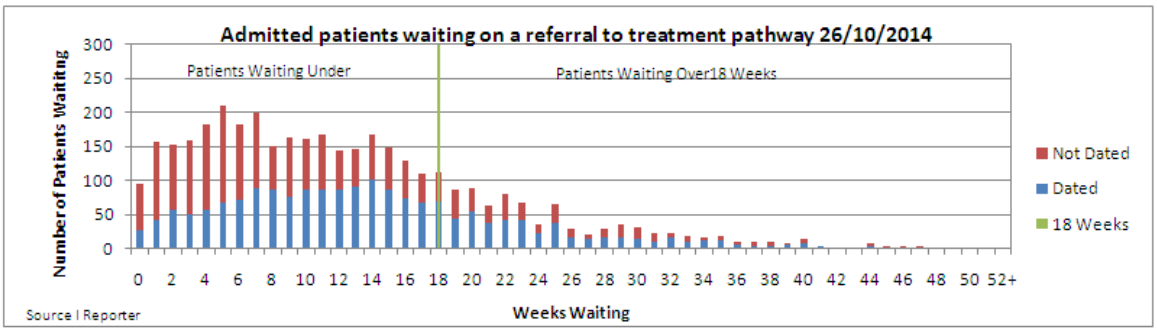
WHHT % incomplete pathways within 18 weeks

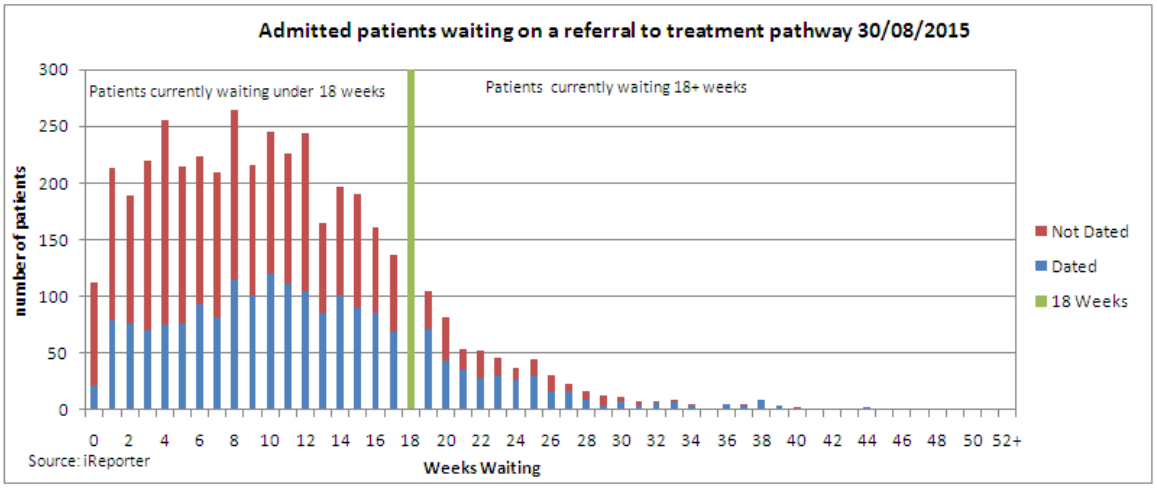


WAITING LIST PROFILES









DIAGNOSTIC WAITING TIMES PERFORMANCE

Diagnostic Performance – August 2015

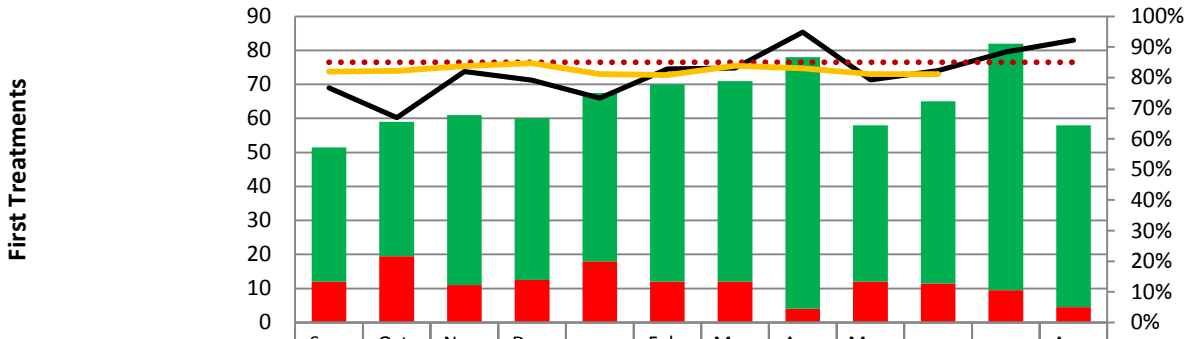
Description	6+ weeks	% compliance
Magnetic Resonance Imaging	0	100.0%
Computed Tomography	0	100.0%
Non-obstetric ultrasound	0	100.0%
Barium Enema	0	100.0%
DEXA Scan	0	100.0%
Audiology - Audiology Assessments	0	100.0%
Cardiology - electrophysiology	-	
Cardiology - echocardiography	11	93.7%
Respiratory physiology - sleep studies	-	
Neurophysiology - peripheral neurophysiology	0	100.0%
Urodynamics - pressures & flows	2	96.2%
Colonoscopy	0	100.0%
Flexi sigmoidoscopy	0	100.0%
Cystoscopy	0	100.0%
Gastroscopy	0	100.0%
TOTALS	**13**	**99.7%**

CANCER WAITING TIMES PERFORMANCE

62 day performance	Jul-15			Aug-15		
	OE			Provisional		
Tumour sites under threshold	Total pathways	Breach	%	Total pathways	Breach	%
Breast	22	0	100.0%	12	0	100.0%
Colorectal	9	1.5	83.3%	5	1.5	70.0%
Haematology	6	0	100.0%	2	0	100.0%
Gynae	4	0	100.0%	6	0	100.0%
Head and Neck	2.5	0.5	80.0%	1.5	0	100.0%
Skin	15	3	80.0%	11	0	100.0%
Lung	4	1	75.0%	3	1	66.7%
Upper GI	2.5	1	60.0%	1.5	0	100.0%
Urological (Excluding Testicular)	17	2.5	85.3%	16	2	87.5%
Total	**82**	**9.5**	88.4%	**58**	**4.5**	92.2%

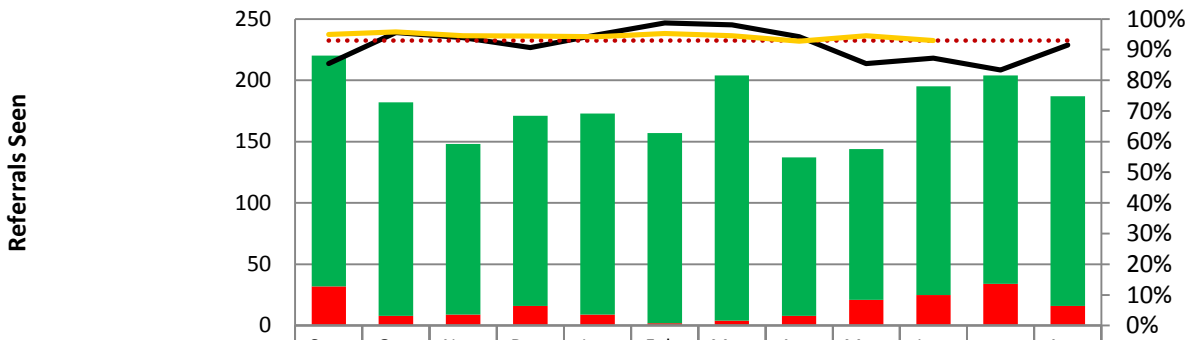
Breach analysis (August)					
Month	**Target**	**Tumour type**	**Days wait**	**Allocation**	**Reason**
August	62d	Lung	78	0.5	21 day wait for EBUS
August	62d	Lung	97	0.5	Multiple diagnostic tests
August	62d	Urology	77	0.5	Delay to Joint Oncology Clinic
August	62d	Colorectal	75	0.5	Complex pathway
August	62d	Colorectal	98	0.5	Patient choice and histo delays
August	62d	Urology	79	0.5	Patient choice and histo delays
August	62d	Urology	98	1	Delay in MRI and complex
August	62d	Urology	109	0.5	Delay to JOC and patient unwell
August	62d	Urology	185	1	Complex pathway
August	62d	Colorectal	101	0.5	1st histo benign, repeated
August	62d	Urology	82	0.5	Complex pathway
August	31d	Colorectal	41	1	Complex procedure between teams

Maximum 62 day - Urgent GP Referral to First Treatment



	Sep-14 OE Final	Oct-14 OE Final	Nov-14 OE Final	Dec-14 OE Final	Jan-15 OE Prov	Feb-15 OE Final	Mar-15 OE Final	Apr-15 OE Final	May-15 OE Final	Jun-15 OE Final	Jul-15 WHHT Prov	Aug-15 WHHT Prov
Compliant	39.5	39.5	50	47.5	49.5	58	59	74	46	53.5	72.5	53.5
Breached	12	19.5	11	12.5	18	12	12	4	12	11.5	9.5	4.5
Total	51.5	59	61	60	67.5	70	71	78	58	65	82	58
Performance	76.7%	66.9%	82.0%	79.2%	73.3%	82.9%	83.1%	94.9%	79.3%	82.3%	88.4%	92.2%
Standard	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%
National Performance	82.0%	82.2%	83.8%	84.7%	81.1%	80.8%	83.9%	83.0%	81.1%	81.2%		

Referrals Seen



	Sep-14 OE Final	Oct-14 OE Final	Nov-14 OE Final	Dec-14 OE Final	Jan-15 OE Prov	Feb-15 OE Final	Mar-15 OE Final	Apr-15 OE Final	May-15 OE Final	Jun-15 OE Final	Jul-15 WHHT Prov	Aug-15 WHHT Prov
Compliant	188	174	139	155	164	155	200	129	123	170	170	171
Breached	32	8	9	16	9	2	4	8	21	25	34	16
Total	220	182	148	171	173	157	204	137	144	195	204	187
Performance	85.5%	95.6%	93.9%	90.6%	94.8%	98.7%	98.0%	94.2%	85.4%	87.2%	83.3%	91.4%
Standard	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%
National Performance	94.9%	95.8%	94.5%	94.4%	94.2%	95.3%	94.5%	92.7%	94.5%	93.0%		

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	To be presented at OMG on 5 October 2015 for ratification.	↑
Pilot of simplified clinic outcome form in September 2015.	Lynne McGrory	01/09/2015	Pilot underway in a number of medical and surgical specialties. Feedback to be collated by mid-October. Trust wide roll out will depend on the outcome of the pilot but there are early indications of success.	↑
Development of GOO PTL (patients without an outcome following a first appointment)	Mark Currie	30/09/15	Draft PTL completed. Modifications required to enable simple filtering from main PTL	↑
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.	↑

Diagnostics

Services who are currently not able to achieve the diagnostic waiting times standard (Cardiology, Urodynamics) continue to demonstrate improvement, albeit slowly. In Cardiology a number of processes (centralisation of the administrative team which required a management of change) have adversely affected the service's ability to deliver improvements at pace. Additional equipment has been procured for both services which is expected to contribute to improved waiting times for patients referred for these investigations.#

Early review is underway to assess the benefits of amalgamating the surgical and gynaecological urodynamics services. This is dependent on the centralisation of Urology services at SACH.

Cancer

Actions to improve performance against the breast symptomatic 2 week wait target have been jointly agreed with the CCG. The main reason for the Trust's inability to meet the standard has been patient choice and therefore the key priority has been to improve the information and advice given to patients at the point of referral. This is being managed through the CCG's lead clinician for cancer, monthly newsletters and GP locality leads.

An action plan to ensure achievement of the 8 key priorities to improve cancer performance has been submitted to the TDA (see below).

Priority	Is this priority in place? Please answer 'Yes', 'No', or 'Partially' If no, or partially, please confirm timeframe for completion in the commentary section	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.	A stand alone, more detailed policy needs to be developed. To be completed by the end of Q2.
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.	Partial	In development as part of the Cancer Improvement Plan.	1st draft to be published by 31 August 2015 with final draft with Clinical lead sign off by 30 September 2015.
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.	Partial	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 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.
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.	Partial	Partial C&D completed for 1st OPA and diagnostics.	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.
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.

6 Risks scoring 15 or above relating to the provision of elective care

There is only one risk on the Corporate Risk Register relating to principal risk five – inability to deliver and maintain performance standards – detailed below.

ID	Principle Risk	Division	Speciality	Risk Lead/Exec Lead	Opened	Description	Consequence (initial)	Likelihood (initial)	Rating (current)
3483	PR 5	Medicine	Care of the Elderly	Lynn Hill	11/06/2015	**Patient Flow, delayed transfers and medical outliers (medicine)** Due to the high number of DTOC patients in the hospital, beds are blocked, causing bottlenecks at the front door and queues in A&E leading to long trolley waits, patients not placed on the best ward for their care etc, and the DTOC patients themselves may deteriorate in hospital waiting for onward services. There appears to be a significant lack of capacity in external organisations to be able to manage the flow of patients out of hospital causing the whole process to become slow and congested.	4	4	**16**

Other risks of note on the Corporate Risk register 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 (initial)	Likelihood (initial)	Rating (current)
3120	PR 4	Medicine	Outpatient Nursing Services	Lynn Hill	09/07/2014	**Patient Medical Notes missing, Delayed or poor condition**. There are a number of issues with the storage, transportation and management of health records in the Trust, which are cumulatively resulting in notes not always being delivered in a timely manner or being available for appointments. The issues are detailed below: a) Space - the Trust has 2 Health Records Libraries, one at WGH and one at HHGH. Due to limited storage space only the records of patients who have attended within the past year are kept on site, with the remainder having to be stored off-site within the secure archive. There is also a significant space issue in Clinic Prep at WGH, as the working environment is overcrowded with insufficent storage, which results in inefficiencies. b) Logistics - notes have to be transported between the 3 sites, which is inefficient and coupled with the existing space issues, often means that the notes for the most acute patients who attend WGH cannot always be stored at WGH Library due to their size (HHGH's Library is larger). c) IG - compliance with the tracking process is poor across the Trust, leading to notes being reported as 'lost' and then being found after intensive searches by the Health Records team. d) Resource - Outpatient activity (which directly impacts the Clinic Prep team) has increased 24% over the past 5 years, with limited review of the Clinic Prep staffing establishment, meaning that the team are having to utlise a high number of bank and agency staff to maintain service which results in instability and decreased efficiency. e) Technology - the Trust does not currently have a strategy for Electronic Patient Records, therefore is not currently harnessing technology that could resolve some of these inefficiencies and therefore improve the patient and clinician experience.	4	5	**20**

ID	Principle Risk	Division	Speciality	Risk Lead/Exec Lead	Opened	Description	Consequence (initial)	Likelihood (initial)	Rating (current)
3421	PR 2	Corporate	Human Resources	Paul Da Gama	08/04/2015	**Recruitment and Retention** Cause: There is a nationwide shortage of key trainned clinical staff including nurses, A&E consultants, etc. Effect: The Trust is finding it exteremly 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**
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 expansion plan will result in: -Endoscopy unit not achieving Level A for timeliness of waiting national targets for 3 consecutive months resulting in change to JAG status; -Loss of JAG accreditation leading to loss of reputation, ability to train endoscopists and will lead to loss of our current bowel screening programme (worth £800,000) -Bowel Scope screening unable to expand to running 10 lists by March 2018 (1 list currently running, 1 due to start in Oct 2015 and 1 more to commence in Mar 2016) -Loss of income to the Trust (Income loss calculated to be -Bowel Scope lists on full roll out is £1.8M PA and Symptomatic list income is £2.26M PA) -Inability to meet national targets for symptomatic and suspected cancer patients within national standards -Surveillance cases being pushed out beyond 3 months	4	5	**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
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
3122	Medicine	Failure of HHGH & WGH OPD ventilation systems	8

7 Recommendation

7.1 The Committee is asked to note:

- The achievement of the 92% incomplete pathway standard in August.
- The sustained performance in Diagnostics.
- The achievement of the 62 day referral to first treatment cancer waiting times standard.
- The 8 key priorities for cancer performance improvement.
- The risks scoring 15 and above relevant to the provision of elective care at the Trust and other related risks within the divisional risk registers.

Jane Shentall
Director of Operations for Elective Care

21 September 2015

Operational Recovery Update – Unscheduled Care

Presented by: Caroline Landon, Director of Operations, Unscheduled Care

1. Overview

1.1 A&E performance dipped by 0.5% in August with a Trust position of 93.6%, however the core performance metrics are showing positive improvement, most notably and consistently in Medicine Length of Stay (23% reduction since April), Ambulance Turnaround, and AAU length of stay.

1.2 In the past month, the Unscheduled Care programme has been updated and refreshed in preparation for Winter 2015/16.

1.3 The programme continues to monitor the original work streams, in relation to Front Door and Hospital Patient Flow, but now also focusses 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
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	▶ ALOS ▶ Discharges before 12 and weekend discharges ▶ Complaints, SIs and Incidents ▶ A&E standards

Project	Divisional Lead	Corporate Support	Objectives	KPIs impacted
			• Implement a discharge planning culture on the wards	
Front Door Flow: AAU	Debbie Foster	-	• 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	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

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.

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 walk around of the AAU department has been undertaken to identify options for creating ring fenced assessment capacity, in order to maintain flow through the department through winter, and tackling the delays often seen for GP heralded arrivals. No decision has yet been made as to the options available

2.7 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.

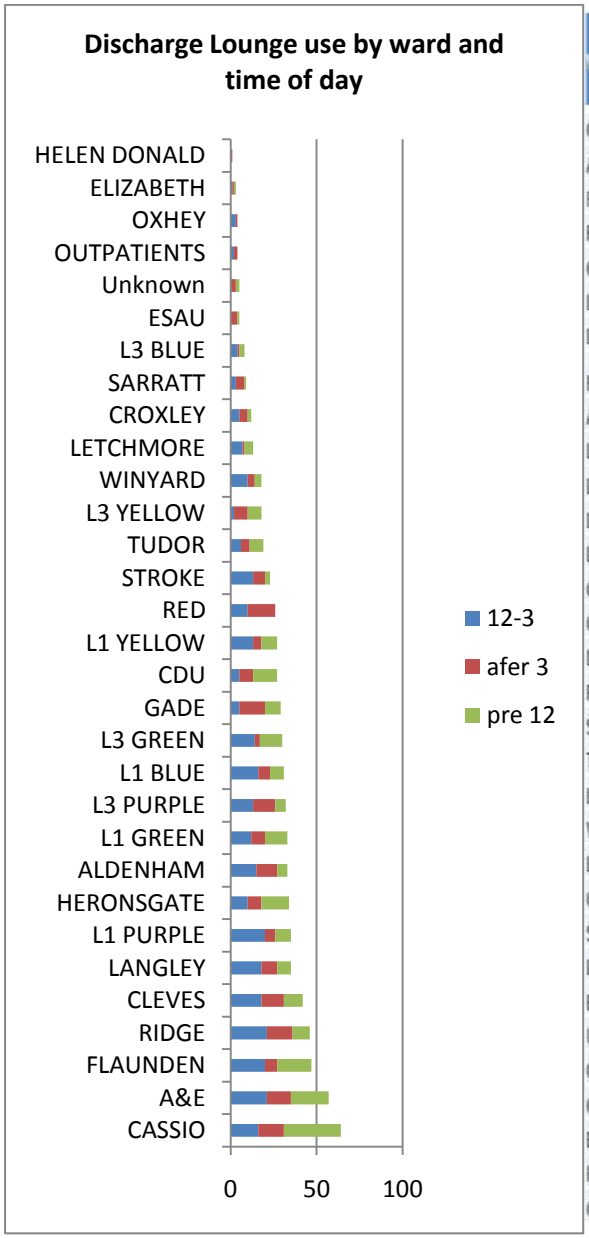
Hospital Patient Flow

2.8 The perfect ward concept has been refreshed and re-launched as the “Efficient” ward project, to tackle the broader issues across all wards. Additional corporate nursing support has been identified to increase the pace of progress and mitigate the risks highlighted previously regarding lack of capacity to deliver improvements.

2.9 An initial assessment of the 6 wards identified for the roll out has been completed with areas of focus for each ward agreed. The challenge to deliver the improvements identified remains a concern as the root cause of many issues is directly linked to workforce capacity and capability. A revised plan for band 6 and band 7 nursing development is needed in order to build managerial capability at ward level.

2.10 The discharge lounge move to incorporate stretcher patients saw an average increase of 2 patients per day using the lounge over the course of the 6 week evaluation.

2.11 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	

2.12 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.

2.13 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

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

2.15 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.

2.16 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.

2.17 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.

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

A&E Reconfiguration

2.19 The scenario outputs are now being finalised with sign off planned for September. The business case is due for completion by the end of the month with the simulation model outputs, and the final presentation of these is planned for the unscheduled care panel on 13th October. This will then be presented to TLEC and Trust board.

2.20 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 (ie discharge profile matched to admission profile/removal of DTOCs from the bed base).

3. Performance Monitoring

3.1 A&E performance dipped by 0.5% in August with a Trust position of 93.6%, however the core performance metrics are showing positive improvement, most notably and consistently in Medicine Length of Stay, Ambulance Turnaround, and AAU length of stay.

KPI / standard	14/15 baseline	Apr-15	May-15	Jun-15	Jul-15	Aug -15	TREND	Q1	Target
A&E 4hr waits (Type 1, 2 & 3)	91.3%	86.2%	90.8%	91.9%	94.1%	93.6%	↓	89.7%	95.0%
A&E 12hr trolley waits	3	0	0	0	0	0	⇔	0	0
Ambulance turnaround time between 30 and 60 mins	13.7%	22.1%	12.7%	13.6%	10.4%	10.1%	↓	22.1%	15%
Ambulance turnaround time > 60 mins	4.0%	12.2%	4.9%	2.3%	0.3%	0.2%	↓	8.7%	0%
50% of NEL discharges occur between 8am and 12pm (main adult wards excl AAU)	18.1%	19.4%	16.6%	14.3%	20.9%	17.9%	↓	16.7%	50%
Achieve Peer group Average LOS Non Elective Medicine (Spell, case mix adjusted)	7.2	8.4	7.6	7.4	7.1	6.4	↓	7.8	3.9
Achieve Peer group Average LOS Non Elective Surgery (spell, case mix adjusted)	5.9	7.4	5.8	6.4	5.7	6.0	↑	6.5	2.7
30% of total NEL (medical & surgical) discharges occur at the weekend	16.0%	17.7%	20.4%	14.8%	15.0%	16.7%	↑	17.6%	30%
Cancelled Operations within 24hrs due to lack of beds (per month)	21.4	21	13	22	33	20	↓	89	0
Delayed Transfers of Care (DToC)	2.7%	3.7%	8.8%	8.3%	5.7%	not available	↓	6.9%	3.5%
Medical Ambulatory Care Admissions % of all NEL Medical admissions	34.4%	33.2%	32.9%	35.0%	33.2%	34.3%	↑	33.7%	30%
Surgical Ambulatory Care Admissions % of all NEL Surgical admissions	15.4%	26.2%	30.0%	28.5%	28.7%	30.0%	↑	28.3%	30%
NEL Admissions to ED attendance ratio	34%	34.3%	33.7%	33.2%	33.8%	25.9%	↓	33.7%	38%
% of patients with a LOS on AAU1 >72 hours	8.1%	11.2%	12.2%	7.3%	7.1%	5.6%	↓	10.6%	0%
Number patients (per month) with >3 ward transfers within one week's stay	674	62	55	61	58	33	↓	178	0

4. Next Steps

Front Door Flow

4.1 Feedback consultant survey results
4.2 Evaluate options for ring fenced assessment space & implement interim solution

Winter Resilience

4.3 Initiate monthly reporting and delivery of scheme action plans

Hospital Patient Flow

4.4 Review board round training presentation at COE consultant meeting & agree plan to move to early board rounds
4.5 Agree band 6/7 ward nursing development plan

Integrated Discharge Team

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

A&E reconfiguration

4.7 Scenario modelling to be completed, strategic outline case to be refreshed and presented to the Panel and key stakeholders

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

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

ID	Principle Risk	Division	Speciality	Risk Lead/Exec Lead	Opened	Description	Consequence (initial)	Likelihood (initial)	Rating (current)
3480	PR 3	Unscheduled Care	Emergency Care	Caroline Landon	11/06/2015	**A&E Estates** Due to the layout / size of A&E department and increase in activity, the A&E dept: 1. lacks space to offload ambulances leading to queues in the corridor; 2. Isolate infectious patients 3. Non-compliant with Royal Society of Psychiatrists for a suitable/safe mental health room 4. Lack of space for triage (initial assessment for clinicians) 5. May possibly breach single sex accommodation in CDU This has an adverse impact on the quality and safety of the service, working environment for staff and efficiency/ability to meet key performance targets	4	5	20

3483	PR 5	Medicine	Care of the Elderly	Lynn Hill	11/06/2015	**Patient Flow, delayed transfers and medical outliers (medicine)** Due to the high number of DTOC patients in the hospital, beds are blocked, causing bottlenecks at the front door and queues in A&E leading to long trolley waits, patients not placed on the best ward for their care etc, and the DTOC patients themselves may deteriorate in hospital waiting for onward services. There appears to be a significant lack of capacity in external organisations to be able to manage the flow of patients out of hospital causing the whole process to become slow and congested.	4	4	**16**

Review of divisional risk registers has identified the following risks which might compromise the provision of unscheduled care as follows:

Risk ID	Division	Risk Description	Current Rating
3841	Unscheduled Care	ED nursing vacancy	20
3227	Unscheduled Care	A&E Medical Staffing	20
2965	Unscheduled Care	Inability to offload ambulances due to bed capacity leading to possible breaches in waiting times and patient harm	16
3224	Unscheduled Care	Shortage of nursing staff in AAU	15
3183	Medicine	Lack of medical cover to surge areas	12

6. Recommendations

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

Caroline Landon
Director of Operations, Unscheduled Care