Reporting Month: JULY 2014

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Improvement Issue	Expected Outcome/ Benefit			Milestones (progress against last reported milestone and next upcoming milestone)	Owner (Milestone)	Delivery Date (Milestone)	BRAG Status
	Baseline	Actual	Target				
Critical Care:							
The General Intensive Care Unit (GICU) are lacking an appropriate and effective mechanism to book elective patients into the unit.	1271 GICU bed booked *(Dec 13 – Apr 14)* 738 admitted = uptake of **57%**	As baseline	• **80%** of booked patients arriving on the unit as planned	Stakeholder interviews completed Value Stream Mapping session delivered Electronic solution identified and piloted (Iclip/Theatre man)	Angela Cooke/Jenn Owen	Sept 2014 Sept 2014 Nov 2014	On schedule
The lack of mechanism prevents them from effectively utilising their elective capacity impact and this in turn negatively impacts on the various speciality teams and theatres; especially in terms of the 18 week patient pathway.	On the day elective canx due to no HDU/ITU bed - **50 patients** *(May 13- May 14)*	As baseline	• Reduction in the number of elective procedures cancelled due to unavailable GICU beds	Threshold for Critical Care elective capacity identified Two way communication strategy developed between Critical Care and Theatres	Angela Cooke/Jenn Owen/Monique Usher	Sept 2014 Aug 2014	On schedule
It also prohibits the possibility of generating additional income from increasing the number of elective patients cared for in the unit.	Mean weekly admission = **14 patients** *(Dec 13 – Apr 14)*	As baseline	• Increased income of £50k - based on one additional patient per week • 15 patients p/wk	Milestones above are linked to this target.	Angela Cooke/Jenn Owen	Sept 2014	On schedule

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The project aims to improve patient experience and reduce complaints.	Monthly data being compiled	As baseline	• Reduction in complaints • Increase in patients reporting a positive experience	Confirmation of baseline data Monthly reports to be circulated on P.Exp and complaints	Angela Cooke/ Annie Palmer	25 July 2014 Sept onwards	On schedule
Frailty Pathway: Acute Senior Health Unit & Acute Senior Health Assessment Service							
This workstream is looking at setting up an acute senior health unit, which will admit short stay senior health patients with an anticipated LoS of less than 10 days. This will be supported by an Acute Senior Health Assessment Service. This will aim to liaise with ED and AMU to avoid admissions, and will have links with the community.	Length of stay: >65 on medical wards = 18 days >65 on senior health wards = 24 days LoS for patients on ASHU = unit not open	As baseline As baseline Unit not open	14 days for all >65 on medical/senior health wards. 75% of patients on the Acute Senior Health Wards to be discharged by 10 days. 75% of patients on ASHU to have LoS of <10 days	½ ward (Amyand) opening Development of Acute Assessment Model and recruitment to posts	Dr Jane Evans Dr Jane Evans/ Bridget Kalber/ Emma Cooke	August 2014 October 2014	On schedule
	Admission Rates = 18%	As baseline	Admission Rates = 13.86%				

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Frailty Pathway: Acute Dementia & Frailty Unit							
This workstream is looking at working towards the development of an Acute Dementia & Frailty Unit providing the appropriate cohort of patients with the timely specialist care that they need.	Length of stay: >65 on medical wards = 18 days >65 on senior health wards = 24 days Emergency Readmission Rates: 28%	As baseline As baseline As baseline	14 days for all >80 on medical/senior health wards. 75% of patients on the Acute Senior Health Wards to be discharged by 10 days. 21%	Skill Mix Review Staff training in dementia and delirium. Improved provision of written information for staff and relatives. Implement ward environment improvements. Dalby & Heberden launched as Acute Dementia & Frailty Unit Set up operational group to feed into discharge workstream.	Dr Helen Jones/ Bridget K/ Mark Cottee	August 2014 October 2014 October 2014 October 2014 October 2014 August 2014	On schedule
	Agency spend to reduce by 10% based on baseline, linked to the reduced requirement for 1-1 care	TBC	10% reduction				

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	due to enhanced staff provisional						
Frailty Pathway & Surgical Liaison							
This workstream is looking to provide geriatric support to the Surgical non elective pathways to ensure that patients are supported by the appropriate clinical team to support their recovery and facilitate timely discharge.	Non elective patients over age of 65 yrs in General Surgery . FY 2013/14 N=175*(7.63% of total)* Av LOS =14.57 days (*(overall LOS all ages 5.9 days)* Beds required =7 *(19% of total beds)*	TBC following clinical audit.	TBC	Scheduled for phase one/three. Initial data analysis complete. Retrospective clinical audit in progress to establish whether reduction in LOS and occupied bed days (Beds) could have been achieved with earlier Geriatric involvement.	Dr Mark Cottee/ Mick Sanders	August 2014	On schedule
	Removal of orthogeriatric beds in dalby ward by caring for patient in an	10	0				

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	offsite rehabilitation facility 10						
Frailty Pathway: Offsite Bed Facility (and linked CAHS function)							
This workstream is pursuing the option of offsite beds to ensure that patients are cared for in the appropriate environment when they are 'between' an acute bed and appropriate discharge to their place of residence. This will ensure links with the newly designed supported discharge pathway in the community	20 bed capacity SGH.	None as yet	15 step down beds. 3 NWB beds. 2 step up beds.	6 month short term award agreed. Business case written for 2 year contract. Procurement process in place for 2 year contract.	Alison Benincasa	August 2014 July 31st 2014 October 2014	On schedule
Overall Frailty Metrics (not included in workstreams)							
"Achievement of the Dementia CQUIN" 1) Patients >75 admitted as emergency with a known dementia diagnosis or clinical diagnosis of	TBC	TBC	Achieving 90% of each element of the indicator	As per workstreams			On schedule

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delirium who has been asked the dementia case finding question, and are then reported as having had a diagnostic investigation, and referred for further diagnostic advice"							
"Achievement of the Dementia CQUIN" 2) Named lead clinician for Dementia and appropriate training for staff"	Lead clinician in place. Training TBC	Lead clinician in place. Training TBC	Lead clinician in place. All appropriate staff trained or booked onto training within a month of starting.	As per workstreams			On schedule
"Achievement of the Dementia CQUIN" 3) Monthly audit of carers of people with dementia"	1/12/13 - 31/5/14 Actuals: Dalby: 1 Heberden: 2	As baseline	2 per week	As per workstreams			On schedule
Improvement in patient experience and satisfaction	1/12/13 - 31/5/14 **Average Med:** F&F: 95.06%	As baseline	**All wards:** F&F: 90% or more Worries & Fears: 85% (including no worries & fears or	As per workstreams			On schedule

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	(extremely or likely) Worries & Fears: 59.62% Privacy: 85.56% **Average SH:** F&F: 91.05% (extremely or likely) Worries & Fears: 49.25% Privacy: 73.55%		worries & fears addressed) Privacy: 90% or more				
Discharge Management Programme: Discharge Management Processes Workstream							
Inconsistent discharge management and lack of control over patient flow. Discharge planning does not happen early enough in patient pathway.			Relevant SGH staff attending discharge management training Discharge planning begins pre-admission or day	1. Agree and implement minimum standards for discharge planning (discharge menu/checklist) 2.Establish discharge management training programme	Beverley Haworth Jennifer Hall Matrons. All ward staff.	December 2014	**Amber**

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No systematic training programme in place for staff			one on-admission.	3.Roll out programme and monitor compliance against metrics as per agreed dashboards (see below) – potentially managed by ward/specialty	Management Information		
Discharge management plans not always agreed with patients and professionals.			No. of patients receiving specific information relating to discharge	1. Review patient information on discharge currently used 2.Revised patient information to made available – may be ward specific 3.Review trust website information concerning patient discharge arrangements 4.Build communication requirements with patients into rolling training programme	Beverley Haworth All ward staff. Patient Involvement Representative: Lesley Robertson	September 2014	**Green**

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	Baseline	Actual	Target				
				described above			
Inconsistent discharge management and lack of control over patient flow. Discharges happening too late in day to allow appropriate flow through Trust.	No. of patients with EDD recorded		All patients to have EDD recorded in 12 hours of admission 35% discharges before midday across all wards	1.Audit of whether patients do have EDDs recorded across all wards 2.Where gaps have been identified, develop system for recording EDDs (iClip) and activate 3.Training for ward staff and discharge co-ordinators on recording of EDDs and use of IClip (see below 4. Established mechanism for monitoring delays and monitoring of EDD record compliance is in place 5. Daily consultant led board rounds consistently in place.	Beverley Haworth Jennifer Hall Consultant lead. Matrons All ward staff Mary White IT lead	November 2014	**Amber**

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				6. Daily discharge challenge meetings consistently in place across wards.			
No. of pts discharged at weekends drops. Requirement to ensure 7 day discharge in place			No. of recorded patient discharges at weekends Weekend discharge arrangements and protocols in place for all wards/departments	1.Review and refine existing weekend discharge protocols 2.Build into discharge management training programme as described above (Reference 7 day working)	Acute medical lead. TBC	January 2015	**Amber**
Unnecessary delays caused by patients awaiting completion of TTos and transport booking			Zero patients delayed awaiting TTos and transport	1.Review previous work and ensure action plan in place. 2.Clear protocols to be developed where these may be required 3.Roll out changes as part of training programme	Mary Prior Pharmacy leads. Matrons All ward staff.	September 2014	**Amber**
Discharge Management Programme: Management Information Workstream							
No systematic way to			- Daily feeds	1.Agree information	IT/iClip lead.	January 2015	**Amber**

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measure performance in discharge management. Information management system required to do this			on predictions : - EDDs - Discharge destination - Completed discharges from wards - Electronic escalation - Internal delays outliers	requirements for dashboard 2. Electronic dashboard of key performance indicators to be developed 3.Roll out use of this on daily/weekly basis by site team and other colleagues as required	Management Information Brendan McDermott Mary White All ward staff.		
All partners currently do not understand rules of detoc reporting and full submission is not made on weekly basis as required	8 recorded w/c 13/07/14.		Number of detocs reported through relevant system.	1.Existing detoc information numbers and collation systems reviewed with discharge co-ordinators 2.New system of reporting established underpinned by	Jennifer Hall Matrons All ward staff. DC Co-ordinators. Mary White	September 2014	**Amber**

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	Baseline	Actual	Target				
				clear protocols 3. Clear process of detoc recording and protocols rolled out which all buy into and understand	Project support.		
Discharge Management: Working with Partners Workstream							
Multiple versions of documentation required to facilitate discharge depending on borough. Complexity of system leads to confusion and delay in paperwork being completed to support timely discharge			Number of forms in place Number of electronic submissions as systems automated	1.Review documentation across all partners 2.Agree standardised versions where possible 3.Implement roll out of revised versions and monitor compliance through discharge management forum	Executive lead for work stream to be appointed. Matrons All ward staff. DC Co-ordinators. Mary White Project support.	January 2015	**Amber**
All discharge destinations not fully understood and vary across boroughs			"Discharge menu" developed – potentially	1.Review existing information on discharge	Executive lead for work stream to be	January 2015	**Amber**

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			electronic DoS	destinations and community and social care services available 2.Develop "discharge menu" 3.Roll out training on menu through discharge management forum	appointed. Matrons All ward staff. DC Co-ordinators. Mary White Project support.		

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Improvement Issue		**Expected Outcome/ Benefit**			**Milestones (progress against last reported milestone and next upcoming milestone)**	**Owner (Milestone)**	**Delivery Date (Milestone)**	**BRAG Status**
	Metric	**Baseline 2013/14**	**Actual (from Mar 15)**	**Target**				
Emergency Surgical Pathways: • 30% ↓ in 1 day LOS to 0 day • 10% ↓ in 2 days LOS to 1 day • 10% ↓ in 3 days LOS to 2 days; • 100% patients with a 0 day LOS not requiring inpatient bed • 50% of all 1, 2 ,and 3 day LOS patients will spend their first night on SAU								
• No clear separation of emergency & elective admissions. • Surgical patients being admitted to wards not designated for their care. • Some procedures being cancelled. • Delayed discharges. • SAU is a mandatory requirement of the Acute Emergency	Bed days	7300	-	2592	<u>Progress in Month</u> • Floor plans signed off • Application of target savings (bed days; beds) to baseline data in accordance with business plan • ED data sourced <u>Upcoming Milestones</u> • Business case sign off at Trust Board • Modelling of pathways • Confirm use for saved beds e.g. 2 beds for repatriated bariatric patients • Collection of baseline data: no. of elective cancellations; no. of outliers commenced • Determine baseline % patients via various pathways	Rob Hagger Mick Sanders / Kathryn Lennon Chloe Cox / Drew Fleming MS KL MS MS/KL	07.07.14 14.07.14 15.07.14 16.07.14 16.07.14 18.07.14 21.07.14	On schedule
	Bed days @ 90% occupancy	6570	-	2332				
	Total beds	20.02	-	7.12				
	No. of on the day elective cancellations (bed availability)	TBC	-	TBC				
	No. of outliers	TBC	-	TBC				
	% (n) home (no bed required)	0% (0)	-	26.33% (1776)				
	% (n) 0 day LOS	14.5% (982)	-	0% (0)				
	% (n) 1 day LOS	23.4% (1576)	-	13.2% (891)				
	% (n) 2 days LOS	16.3% (1100)	-	15.6% (1052)				
	% (n) 3 Days LOS	9.2% (621)	-	8.3% (559)				

Standards. .					• Determine target % patients via various pathways • Establish number of patients discharged from ED with an OPA that could attend a hot clinic	RH/KL/MS MS	01.08.14 01/08/14	
	% (n) >4 days LOS	36.6% (2468)		36.6% (2468)				
	% home to OPA / 'hot clinic'	TBC	-	TBC				
	% no treatment home same day	0%		13.75% (928)				
	% minor procedures and home same day	0%	-	12.6% (889)				
	% ED (SAU) to short stay	0%	-	37% (2502)				
	% ED (SAU) to long stay ward	100% (6747)	-	36.6% (2468)				

Medical Ambulatory Care:								
Improvement Issue	**Metric**	**Baseline Apr 13 - Feb14**	**Actual Feb 14**	**Target**	**Milestones (progress against last reported milestone and next upcoming milestone)**	**Owner (Milestone)**	**Delivery Date (Milestone)**	**BRAG Status**
Ambulatory care model introduced at St. George's Healthcare Trust during 2013. Ambulatory care score tool to identify patients suitable for ambulatory care was model chosen for rolling out the programme across the trust (in preference to a pathway or process approach. The latter makes the assumption all patients are eligible for ambulatory care until indicated otherwise). However, tool currently not being used routinely for all patients. Potential for patients amenable to ambulatory care management not being treated via this route & thus leading to unnecessary admissions and extended LOS.					<u>Progress in Month</u> • Acute medical model & process for collecting data currently established. • Confirmed that pathways onto Richmond unit & AAA both have zero LOS . Recorded activity may not reflect level of actual ambulatory care. • Best practice standards for ambulatory care identified. • Agreement to pilot Consultant to take all medical referrals subject to provision of backfill. (This is system in place in other trusts where ambulatory care is embedded, however, Consultants do not have additional clinical commitments). <u>Upcoming Milestones</u> • Conduct AMB score audit (requested by ED Lead). • Identify week to pilot Consultant to take all referrals for acute medicine from GPs & ED Consultants. • Gain agreement to backfill Consultant post.	Phil Moss / Jane Evans / Alison Watson / Harvey McEnroe / Julie Lees / Coreen Eastes Orlagh Flynn JE AW	11.07.14 11.07.14 11.07.14 11.07.14 w/c 21.07.14 TBC TBC	Amber
	% admissions 0 day LOS (AMU/AAA)	26%	25%	35%				
	% admissions 1 – 3 day LOS (AMU/AAA)	36%	32%	30%				
	% admissions 0 – 3 day LOS (AMU/AAA)	62%	57%	65%				
	Referrals from ED to AAA	Mean/month/ <u>Quarter</u> Q1 = 17 Q2 = 44 Q3 = 101 Q4 = 95 <u>2013/14</u> 64	Data needs validating	TBC – dependent on agreed model going forward				
	Referrals from GP to AAA	Mean/month/ <u>Quarter</u> Q1 = 62 Q2 = 60 Q3 = 31 Q4 = 38	Data needs validating	TBC				

Data may not be reflecting current actual activity since both AAA & Richmond Unit have 0 day LOS which could all be AEC coded (currently only AAA is being coded as ambulatory activity)		2013/14 48						
	AAA clinic activity	Mean/month/ Quarter Q1 = 167 Q2 = 180 Q3 = 158 Q4 = 228 2013/14 183	2014 Q1 = 192	TBC				
	Discharge & Partnership: Workstream One							
	Discharge & Partnership: Workstream Two							
	Discharge & Partnership: Workstream Three							

BRAG STATUS CODE

- BLUE – Action complete with evidence to demonstrate impact
- RED – Actions not delivered in agreed time line or significant risks identified to prevent expected outcome
- AMBER – Actions behind time frame but mitigation identified to support achieving
- GREEN – Action complete but evidence not yet available to demonstrate that a process has been embedded or impact achieved