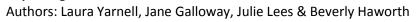




Improvement Issue	Ехр	ected Outcom	e/ Benefit	Milestones	Owner	Delivery	BRAG Status
	Baseline	Actual	Target	(progress against last reported milestone and next upcoming milestone)	(Milestone)	Date (Milestone)	
Critical Care:							
The General Intensive Care Unit (GICU) are lacking an appropriate and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

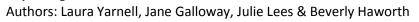
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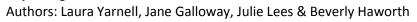
Improvement Issue	Ехр	ected Outcom	e/ Benefit	Milestones	Owner	Delivery	BRAG Status
	Baseline	Actual	Target	(progress against last reported milestone and next upcoming milestone)	(Milestone)	Date (Milestone)	
The project aims to improve patient experience and reduce complaints.	Monthly data being compiled	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 Se	enior Health Ur	it & Acute Se		nent 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	Length of stay: >65 on medical wards = 18 days >65 on senior	As baseline As baseline	14 days for all >65 on medical/senior health wards. 75% of patients on the Acute Senior Health Wards to be discharged by 10	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
Senior Health Assessment Service. This will aim to liaise with ED and AMU to avoid admissions, and will have links with the community.	health wards = 24 days LoS for patients on ASHU = unit not open Admission	Unit not open As baseline	75% of patients on ASHU to have LoS of <10 days Admission Rates =				
	Rates = 18%		13.86%				

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Improvement Issue	Ехр	ected Outcom	e/ Benefit	Milestones	Owner	Delivery	BRAG Status
	Baseline	Actual	Target	(progress against last reported milestone and next upcoming milestone)	(Milestone)	Date (Milestone)	
Frailty Pathway: Acute De	ementia & Frail	lty 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	Length of stay: >65 on medical wards = 18 days	As baseline	14 days for all >80on medical/seniorhealth wards.75% of patients onthe Acute SeniorHealth Wards to be	Skill Mix Review Staff training in dementia and delirium.	Dr Helen Jones/ Bridget K/ Mark Cottee	August 2014 October 2014	On schedule
they need.	>65 on senior health wards = 24 days Emergency	As baseline As baseline	discharged by 10 days.	Improved provision of written information for staff and relatives.		October 2014	
	Readmission Rates: 28%			Implement ward environment improvements. Dalby & Heberden		October 2014 October	
	Agency spend to reduce by 10% based	ТВС	10% reduction	launched as Acute Dementia & Frailty Unit		2014	
	on baseline, linked to the reduced requirement for 1-1 care			Set up operational group to feed into discharge workstream.		August 2014	





Improvement Issue	Ехр	ected Outcom	ne/ Benefit	Milestones	Owner	Delivery	BRAG Status
	Baseline	Actual	Target	(progress against last reported milestone and next upcoming milestone)	(Milestone)	Date (Milestone)	
	due to enhanced staff provisional						
Frailty Pathway & Surgica	al 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 orthogeriatri c beds in dalby ward by caring for patient in an	10	0				

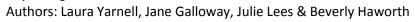
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Improvement Issue	Ехр	ected Outcom	ne/ Benefit	Milestones	Owner	Delivery	BRAG Status
	Baseline	Actual	Target	(progress against last reported milestone and next upcoming milestone)	(Milestone)	Date (Milestone)	
	offsite rehabilitation facility 10						
Frailty Pathway: Offsite E		d linked CAF	S function)		1	1	•
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 31 st 2014 October 2014	On schedule
0 115 11 24 1			,				
Overall Frailty Metrics (n "Achievement of the		1	•				On ask adult
Dementia CQUIN"	TBC	TBC	Achieving 90% of each element of the indicator				On schedule
1) Patients >75 admitted as emergency with a known dementia diagnosis or clinical diagnosis of				As p	oer workstreams		

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Improvement Issue	Ехр	ected Outcom	e/ Benefit	Milestones	nes Owner Delivery			
	Baseline	Actual	Target	(progress against last reported milestone and next upcoming milestone)	(Milestone)	Date (Milestone)		
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"	Lead clinician in place.	Lead clinician in place.	Lead clinician in place.				On schedule	
2) Named lead clinician for Dementia and appropriate training for staff"	Training TBC	Training TBC	All appropriate staff trained or booked onto training within a month of starting.	As p	oer workstreams			
"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 p	oer 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 p	oer workstreams		On schedule	

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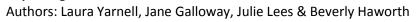


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Improvement Issue	Exp	ected Outcom	e/ Benefit	Milestones	Owner	Delivery	BRAG Status
	Baseline	Actual	Target	(progress against last reported milestone and next upcoming milestone)	(Milestone)	Date (Milestone)	
	(extremely or		worries & fears				
	likely)		addressed)				
	Worries &		Privacy: 90% or				
	Fears:		more				
	59.62%						
	Privacy:						
	85.56%						
	Average SH:						
	F&F: 91.05%						
	(extremely or						
	likely)						
	Worries &						
	Fears:						
	49.25%						
	Privacy:						
	73.55%						
Dischause Managament F)		and Dungane	NA/a ulsatu a a us			
Discharge Management F Inconsistent discharge	Togramme: Di	Scriarge iviar	Relevant SGH staff	1. Agree and	Beverley	December	Amber
management and lack of			attending	implement minimum	Haworth	2014	Alliber
control over patient flow.			discharge	standards for	Пажоги	2014	
Control over patient now.			management	discharge planning	Jennifer Hall		
Discharge planning does			training	(discharge	Jenninei Hall		
not happen early enough			i dilliig	menu/checklist)	Matrons.		
in patient pathway.			Discharge planning	2.Establish discharge	11.00101131		
patient patina,			begins pre-	management	All ward staff.		
			admission or day	training programme			

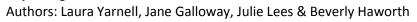
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Improvement Issue	Exp	ected Outcom	e/ Benefit	Milestones	Owner	Delivery	BRAG Status
	Baseline	Actual	Target	(progress against last reported milestone and next upcoming milestone)	(Milestone)	Date (Milestone)	
No systematic training programme in place 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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Improvement Issue	Ехро	ected Outcor	ne/ Benefit	Milestones	Owner	Delivery	BRAG Status
	Baseline	Actual	Target	(progress against last reported milestone and next upcoming milestone)	(Milestone)	Date (Milestone)	
				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 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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Improvement Issue	Ехр	ected Outcom	e/ Benefit	Milestones	Owner	Delivery	BRAG Status
	Baseline	Actual	Target	(progress against last reported milestone and next upcoming milestone)	(Milestone)	Date (Milestone)	
				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/department s	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 I	Programme: Ma	anagement I					
No systematic way to			- Daily feeds	1.Agree information	IT/iClip lead.	January 2015	Amber

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Improvement Issue	Ехр	ected Outcom	ne/ Benefit	Milestones	Owner	Delivery	BRAG Status
	Baseline	Actual	Target	(progress against last reported milestone and next upcoming milestone)	(Milestone)	Date (Milestone)	
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 coordinators 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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Improvement Issue	Ехр	ected Outcom	e/ Benefit	Milestones	Owner	Delivery	BRAG Status
	Baseline	Actual	Target	(progress against last reported milestone and next upcoming	(Milestone)	Date (Milestone)	
				milestone)			
				clear protocols 3. Clear process of detoc recording and protocols rolled out which all buy into	Project support.		
				and understand			
Discharge Management: \	Working with F	Partners Wor	kstream				
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 Coordinators. Mary White Project support.	January 2015	Amber
All discharge destinations			"Discharge menu"	1.Review existing	Executive lead	January 2015	Amber
not fully understood and vary across boroughs			developed – potentially	information on discharge	for work stream to be		

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Improvement Issue	Ехр	ected Outcom	e/ Benefit	Milestones	Owner	Delivery	BRAG Status
	Baseline	Actual	Target	(progress against last reported milestone and next upcoming milestone)	(Milestone)	Date (Milestone)	
			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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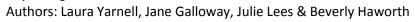


Improvement Issue		Expected	d Outcome/	Benefit	Milestones (progress against last reported milestone and next upcoming milestone)	Owner (Milestone)	Delivery Date (Milestone)	BRAG Statu s
Improvement Issue	Expected Outcome/ Benefit			Milestones (progress against last reported	Owner (Milestone)	Delivery Date	BRAG Statu	
	Metric	Baseline 2013/14	Actual (from Mar 15)	Target	milestone and next upcoming milestone)		(Milestone)	S

Emergency Surgical Pathways:

- 30% ↓ in 1 day LOS to 0 day
- 10% \downarrow 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	Bed days	7300	-	2592	Progress in Month			On
	separation of emergency &	Bed days @ 90% occupancy	6570	-	2332	Floor plans signed offApplication of target savings (bed	Rob Hagger Mick	07.07.14 14.07.14	schedule
	elective	Total beds	20.02	-	7.12	days; beds) to baseline data in	Sanders /		
•	admissions. Surgical patients being admitted to	No. of on the day elective cancellations (bed availability)	TBC	-	TBC	accordance with business planED data sourced	Kathryn Lennon		
	wards not	No. of outliers	TBC	-	TBC	Upcoming Milestones		45.05.44	
	designated for their care.	% (n) home (no bed required)	0% (0)	-	26.33% (1776)	Business case sign off at Trust Board	Chloe Cox / Drew	15.07.14	
•	Some procedures being cancelled.	% (n) 0 day LOS	14.5% (982)	-	0% (0)	Modelling of pathways	Fleming	16.07.14	
•	Delayed discharges.	% (n) 1 day LOS	23.4% (1576)	-	13.2% (891)	Confirm use for saved beds e.g. 2 beds for repatriated bariatric patients	KL	16.07.14	
•	SAU is a mandatory requirement of	% (n) 2 days LOS	16.3% (1100)	-	15.6% (1052)	Collection of baseline data: no. of elective cancellations; no. of outliers commenced	MS	18.07.14	
	the Acute Emergency	% (n) 3 Days LOS	9.2% (621)	-	8.3% (559)	Determine baseline % patients via various pathways	MS/KL	21.07.14	





Standards.					Establish number of patients discharged from ED with an OPA that	RH/KL/MS	01.08.14	
	% (n) >4 days LOS	36.6% (2468)		36.6% (2468)		MS	01/08/14	
	% home to OPA / 'hot clinic'	TBC	-	ТВС				
	% 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)				
				•		•		

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Medical Amb	oulatory Car	e:						
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 Statu s
Ambulatory care model					Progress in Month			Amber
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.	% admissions 0 day LOS (AMU/AAA)	26%	25%	35%	 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 	Acute medical model & process for collecting data currently established. Phil Moss / Jane Evans / Alison	11.07.14 11.07.14	
	% admissions 1 – 3 day LOS (AMU/AAA)	36%	32%	30%		Harvey McEnroe / Julie Lees / Coreen Eastes	EEnroe / ie Lees oreen 11.07.14	
	% admissions 0 – 3 day LOS (AMU/AAA)	62%	57%	65%			11.07.14	
	Referrals from ED to AAA	Mean/month/ Quarter Q1 = 17 Q2 = 44 Q3 = 101 Q4 = 95 2013/14 64	Data needs validating	TBC – dependent on agreed model going forward		Orlagh Flynn	w/c 21.07.14	
	Referrals from GP to AAA	Mean/month/ <u>Quarter</u> Q1 = 62 Q2 = 60 Q3 = 31 Q4 = 38	Data needs validating	TBC	 Identify week to pilot Consultant to take all referrals for acute medicine from GPs & ED Consultants. Gain agreement to backfill Consultant post. 	JE AW	ТВС	





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