Ashford and St. Peter's Hospitals
NHS Foundation Trust

COUNCIL OF GOVERNORS			
Date of meeting	13 March 2025	**Agenda Item**	8.1
Author(s)	Mark Roland	**Confidential**	NO
Exec Sponsor	Mark Roland, Jay Dungeni, James Thomas	**Date submitted**	5 March 2025
Title of paper	Improving Flow Programme (non-elective pathway)		
Presented by	Mark Roland, Chief Medical Officer		
Committee(s) where paper has been discussed previously and outcome of discussion:			
Strategic Objective(s)			

Quality of Care	√	**People**	√	**Modern Healthcare**	√	**Digital**	√	**Collaborate**	√

Executive Summary
The Improving Flow Programme (adult non-elective pathway) builds on the work done through the past iterations of the Emergency Pathway Improvement Programme (EPIP) and continues with the ambition of eliminating corridor and escalation care whilst improving the experience and outcomes for our patients and for our staff. By taking a pathway-based, experience-based co-design approach, this programme will utilise the experience, knowledge and skills of those closest to care delivery to make sustainable improvements that will support the delivery of the Trust clinical strategy, contributing to the delivery of key operational, quality and financial targets.

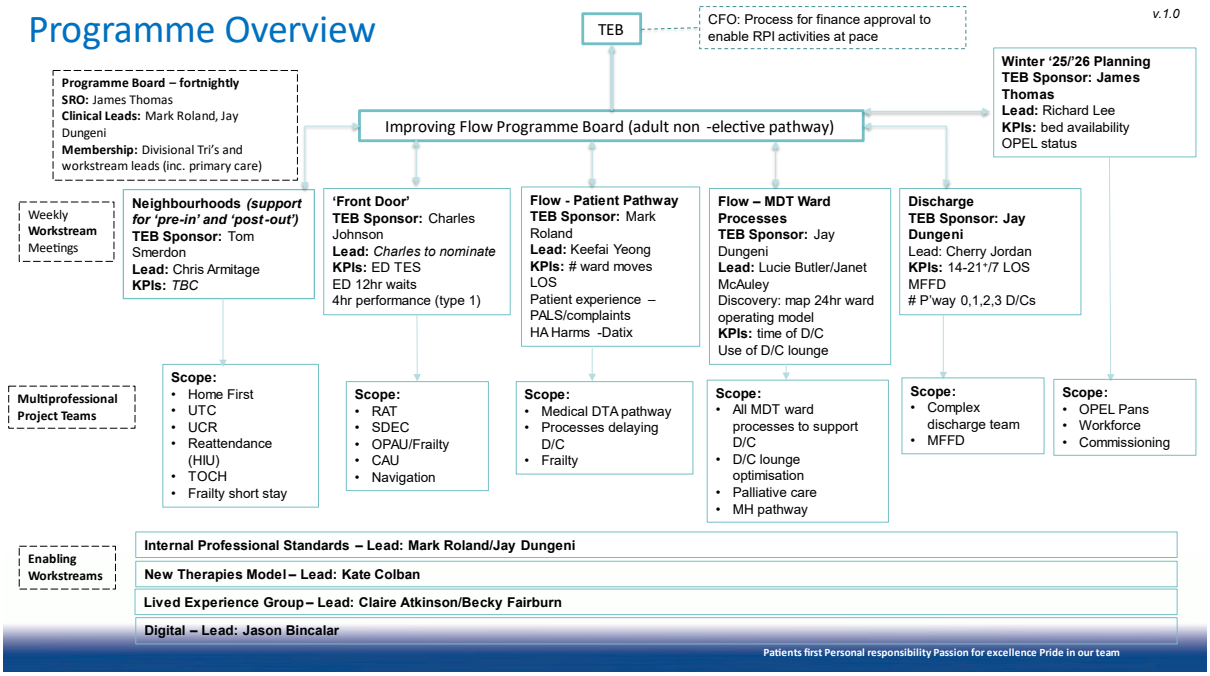
Recommendation	For: Decision ☐ Discussion ☐ Information ☒
Key issues: State impact/implications and mitigation	
Quality, safety & patient impact	Improving the flow of patients into, through and out of the ASPH substantive bed base will enhance the quality and safety of care and improve patient experience and outcomes.
Employee	Staff experience will be improved as roles and autonomy are clarified through the programme. Actions to minimise bed moves and eliminate corridor and escalation care will directly impact the staff experience.
Other stakeholder(s)	The programme will encourage collaborative working with community and lived experience partners.
Equality, diversity & inclusion	The programme eliminates unwarranted variation in experience and care by right sizing the organisation. The variation is evident along the lines of gender and age

	due to the nature and distribution of disease/conditions. Some patients may be affected more than others at times of sustained pressure and capacity constraints.
Finance	A key ambition for this programme is to significantly reduce or eliminate corridor and escalation care. This will reduce the requirement for temporary staff to cover areas outside of the substantial bed base, thus reducing costs.
Legal	The programme seeks to ensure we remain compliant with the Health and Social Care Act as regulated by the ICB, NHS England and the CQC. Non-compliance leaves the organisation open to litigation.
Risk(s) Identified (include link to Corporate Risk Register / Strategic (Board Assurance Framework) Risks:	
Finance – there is a risk that to deliver the benefits of the programme, at scale and pace, there will be additional resource required to support the teams in their delivery	

Programme Overview:

The 'Improving Flow (adult non-elective pathway) Programme' recognises and builds on the recent achievements of the Emergency Pathway Improvement Programme (EPIP). This programme will take a pathway-based, experience-based co-design approach to identify improvement opportunities and enable those closest to care delivery to test solutions.

The Programme includes the full spectrum of projects required to deliver sustainable change for the population we serve, including a Community/Neighbourhoods group which will now report into this structure rather than the NW Surrey Alliance ODG. This is to ensure that all partners are sighted on the totality of work in this domain to encourage further collaboration and innovation.



Programme Scope:
Included – any non-elective adult admission, all relevant pathways and professional roles
Excluded – paediatric or elective admission, although insights and benefits will be delivered through the programme.

Programme Aim:
To eliminate care in areas not designated for admitted care (corridor and escalation areas) with <5 medical DTAs in the ASPH ED at 0830 on any day by November 2025.

KPIs:

- Temporary Escalation Space (TES) - ED and Trust
- 4hr admitted performance (Type 1)
- 12hr, 24 and 48hr ED stays
- # medical DTAs in ED @ 0830 daily
- LOS for adult medical non-elective pathways
- Elective cancellations (surgery and cardiology)

Governance:

- Fortnightly programme board, chaired by James Thomas, COO. Checkpoint reporting from workstream leads and review of progress against programme KPIs.
- Weekly MDT workstream meetings to identify improvement opportunities within their scope, support improvement cycles and learning using local KPI data.
- The programme board will report to TEB at a pre-agreed frequency.

Workstreams:

1. **Neighbourhoods**
   TEB Sponsor: Tom Smerdon
   Lead: Christine Armitage, NWS Director of Transformation
   KPIs: TBA
   Scope: UCR capacity improvement, UCR/SECAMB and SPOA, WIC to UTC, Neighbourhood team development and flow, virtual wards and frailty pilot, TOCH improvement, workforce redesign for out of hospital surge planning

   Incorporating this NW Surrey workstream now provides a more cohesive view for all partners of the totality of system work in the non-elective space. This is integral to the 'left shift' ambition and its presence in this overarching will synergise the relationships and discussions required to allow these resources to be enhanced over time.

2. **'Front Door'**
   TEB Sponsor: Charles Johnson
   Lead: TBA
   KPIs: ED TES, 4hr performance (type 1), 12hr waits
   Scope: RAT, SDEC, CAU, OPAU/frailty, navigation/streaming/redirection

   A seamless continuation of the transformation work already underway within UEC applying a working group structure and rhythm with the requirement to report into the programme board to provide updates and assurance.

3. Flow - Patient Pathway

TEB Sponsor: Mark Roland
Lead: Keefai Yeong
KPIs: number of ward moves per stay, number of senior decision maker contacts and changes during stay, LOS, patient experience, hospital acquired harms
Scope: all aspects of the adult non-elective admitted pathway

This group follows the evidence provided by our 4-hour wait admitted pathway performance (see table below) and medical DTAs in ED every morning with medical patients frequently held in ED or the corridor for more than 12 hours before being admitted, and some waiting more than 36 hours at times. The existing pathway has been designed with patient safety as its goal, but exceptional waits of this nature have been proven to drive poor outcomes and increased mortality. Continuity of care and decision making improves quality of care, patient outcomes and reduces length of stay. Every time we move a patient between wards, or change their decision maker, we break that continuity and increase their length of stay.

The multiprofessional project group, which will include patient representatives, will work through a discovery phase, analysing patient pathways quantitatively and qualitatively, to understand the experience of our patients. We will then come together for a 5-day Rapid Process Improvement Workshop to analyse the output from that discovery phase and work to design potential new pathways for our patients. From this we will develop a series of Tests of Change which we will conduct over subsequent weeks, utilising PDSA methodology to work towards recommendations for new ways of working and delivering care to this cohort of patients.

The Case for Change – ED Trolley Waits (exc. Mental Health)

A&E Attendances : 12+hrs waits	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
A&E - Admitted - Medical	319	396	320	345	518	444	626	605	700	701	674	659	570	753	688	636	521	690	754	678	809	794
A&E - Admitted - Other	41	98	93	93	108	102	124	129	113	137	128	74	90	111	79	74	65	80	77	63	76	49
A&E - Admitted - T&O	43	51	81	58	72	67	39	148	130	124	97	72	99	103	52	57	39	61	60	60	55	31
A&E - Major (Not Admitted)	101	91	97	68	95	119	146	193	168	174	132	133	88	170	163	134	103	155	164	153	157	188
A&E - Minor (Not Admitted)	46	19	24	23	26	26	38	63	64	50	40	33	40	57	37	26	25	40	50	40	37	27
A&E - Other (Not Admitted)	3	3	2	2	9	7	5	2	4	5	9	4	2	3	5	4	2	4	2	8	4	4
Total	553	658	617	589	828	765	978	1140	1179	1191	1080	975	889	1197	1024	931	755	1030	1107	1002	1138	1093

A&E attendance 24+hr waits Row Labels	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
A&E - Admitted - Medical	3	27	18	8	31	21	46	60	121	166	166	132	93	150	128	118	105	257	315	181	294	335	220
A&E - Admitted - Other	1	6	8	6	10	11	4	11	9	11	12	7	5	8	7	22	16	26	24	15	15	17	9
A&E - Admitted - T&O		4	3	1	3	6	4	8	7	18	21	5	23	25	7	10	3	16	11	15	6	8	9
A&E - Major (Not Admitted)	18	15	14	5	13	19	15	22	20	33	22	24	14	26	31	26	17	40	54	32	39	53	27
A&E - Minor (Not Admitted)	11	4	4	6	6	4	9	7	6	4	7	6	9	10	8	3	2	14	14	5	5	6	7
A&E - Other (Not Admitted)													1										
Admitted - Medical	9									1												1	
Admitted - Other	8																						
Admitted - T&O	3																						
Total	53	56	47	26	63	61	78	108	163	233	228	174	145	219	181	179	143	353	418	248	359	420	272

A&E attendance 36+hr waits	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
A&E - Admitted - Medical		2	4	1	7		4	4	7	7	13	4	1	7	2	4	9	41	66	23	38	37	30
A&E - Admitted - Other		6	6	5	4	7	1	4	3	6	1	2		1	3	16	10	14	14	10	6	9	7
A&E - Admitted - T&O		1	1		1		1		4		2		2	5	2	1		2		3			
A&E - Major (Not Admitted)	4	7	4	2	7	8	6	8	9	10	8	10	5	11	6	8	9	12	10	10	13	12	5
A&E - Minor (Not Admitted)	3	2		3	4	1	1	2	2	1		1	2	3	1	1	1	3	2	2	1	1	
Admitted - Medical	5																					1	
Admitted - Other	1																						
Admitted - T&O	1																						
Total	14	18	15	11	23	16	13	18	25	24	24	17	10	27	14	30	29	72	92	48	58	60	42

4. Flow – MDT Ward Processes

TEB Sponsor: Jay Dungeni
Lead: Lucie Butler/ Janet McAuley/ *AHP Lead TBC*
KPIs: time of D/C, use of D/C lounge; (Watch metrics include: Red Flags, Safer Staffing Census data)
Scope: all MDT processes and practices contributing to daily ward functions to facilitate a safe and timely patient journey, D/C optimisation

(Mental Health and Palliative Care are noted here although may require separate working groups post discovery phase)

Variability in ward processes with a reactive approach to P0 discharges contribute to increased LOS, detriment to patient experience and safety. Often this as a major contributor to discharges occurring late in the day or to be avoidably delayed. Embedding consistent ward processes ('the way we work together here') will bring benefits to patients and staff through: a SAFER rhythm; MDT Board Rounds working towards shared and communicated discharge goals; Red to Green actions adding value to each patient's days and a strong focus on preventing deconditioning.

5. **Discharge**
   TEB Sponsor: Jay Dungeni
   Lead: Cherry Jordan
   KPIs: 14- 21+day LOS, number of Medically Fit For Discharge (MFFD), number of pathway 0, 1, 2 and 3 discharges
   Scope: Complex discharges, MFFD cohort

   The majority of our planned daily discharges are P 1-3 due to the consistent work of our integrated discharge team. The team has made huge progress through EPIP with a strong educational programme for staff. They will maintain and go further with this work, bringing a transformational lens to Long Length of Stay patients, daily temporal discharge profile and use of the discharge lounge amongst other areas. This workstream will work closely wit the MDT Ward Processes in ensuring that critical steps are carried out early in the patients' journeys to ensure timely discharge once MFFD status is reached. Additionally, this also brings in to sharp focus the review and utilisation of capacity and expertise in the community as outlined in the Neighbourhood workstream.

6. **Winter '25/'26 Planning**
   TEB Sponsor: James Thomas
   Lead: Richard Lee
   KPIs: TES (ED and Trust), bed availability, OPEL status
   Scope: OPEL plans, workforce, commissioning

   A supporting workstream looking at supporting planning and resource allocation for Winter 25/26.

Enabling Workstreams

Internal Professional Standards – to go beyond ED into wards and describing aspects of the care we provide such as IPC, deteriorating patients and end of life care. Very much striving to provide a shared articulation of 'the way we work together here.'

New Therapies Model – will overlap and have interface with all other working groups. This recognises the contribution of therapies in the care environment and seeks to optimise the provision to enable the best outcomes.

Lived Experience Group – complementing the patient representative input into the pathway redesign group.

Digital – a key enabler for all the workstreams described, seeking to optimise care processes and interventions with supportive digital tools including ePR; robotic processes and analytics/intelligence reporting.