Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

COUNCIL OF GOVERNORS
7th September 2016

TITLE	**A&E Report (including Performance)**
EXECUTIVE SUMMARY	This report provides a performance update on A&E.
The Council is asked to:	Discuss the report
Submitted by:	Lorraine Knight, Interim Chief Operating Officer
Date:	September 2016
Decision	For discussion

Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

ASPH NHSI Performance
July 2016

Lorraine Knight – Interim Chief Operating Officer

ASPH NHSI Performance - July 2016

NHSI - 2016 JULY PERFORMANCE UPDATE

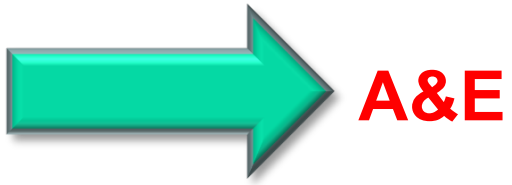
Domain	Standard		Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17	Monthly Sparkline	June	July
A&E	Maximum waiting time of **four hours** from arrival to admission/transfer/discharge		92.2% ☒	90.4% ☒	85.4% ☒	90.6% ☒		92.0% ☒	93.8% ☒
RTT	Maximum time of **18 weeks** from point of referral to treatment in aggregate **(INCOMPLETE PATHWAYS)**		96.0% ☑	95.8% ☑	94.6% ☑	94.1% ☑		93.9% ☑	94.2% ☑
CANCER	Cancer: two week wait from referral to date first seen	All urgent referrals	93.8% ☑	95.4% ☑	94.5% ☑	95.1% ☑		93.5% ☑	93.1% ☑
		Symptomatic breast patients	95.5% ☑	97.0% ☑	97.2% ☑	95.4% ☑		98.5% ☑	95.4% ☑
CANCER	All cancers: 31-day wait from diagnosis to first treatment		98.9% ☑	97.0% ☑	96.1% ☑	98.2% ☑		97.6% ☑	97.1% ☑
CANCER	All cancers: 31-day wait for second or subsequent treatment	Surgery	97.1% ☑	96.4% ☑	91.3% ☒	100% ☑		100% ☑	100% ☑
		Drug Treatment	100% ☑	100% ☑	100% ☑	100% ☑		100% ☑	100% ☑
		Radiotherapy	n/a	n/a	n/a	n/a	n/a	n/a	n/a
CANCER	All cancers: 62-day wait for first treatment	Urgent GP referral for suspected cancer	81.3% ☒	85.6% ☑	83.6% ☒	82.1% ☒		77.1% ☒	72.5% ☒
		NHS Cancer Screening Service referral	95.8% ☑	96.9% ☑	100% ☑	100% ☑		100% ☑	100% ☑

A&E

Cancer
62 Day GP

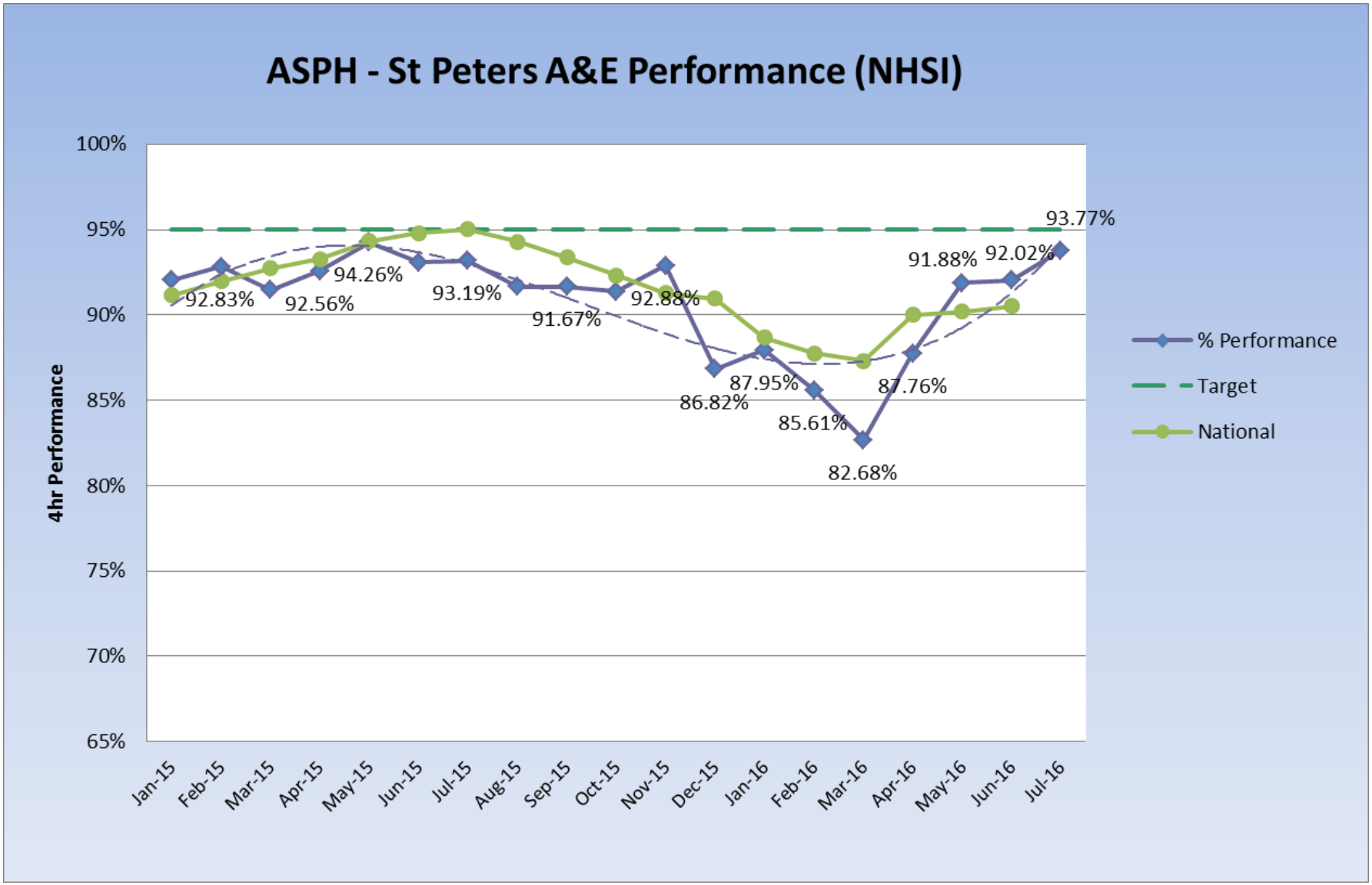
ASPH NHSI Performance - A&E

NHSI - 2016 JULY PERFORMANCE UPDATE								
Domain	Standard	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17	Monthly Sparkline	June	July
A&E	Maximum waiting time of **four hours** from arrival to admission/transfer/discharge	92.2% ☒	90.4% ☒	85.4% ☒	90.6% ☒		92.0% ☒	93.8% ☒



- *A&E NHSI Performance was recorded at 93.8% for July. This was a 1.7% further improvement on last month and 3.5% above the agreed recovery trajectory of 90.3%.*
- *Total attendances in July (at 8,631) were 5.1% higher than June's attendances (8,212) and 7.0% higher than July 2015 (8,064).*
- *Admissions during July (at 2,029) were 0.8% higher than June's admissions (2,013) and 9.4% higher than July 2015 (1,855).*
- *We have in place an **Urgent Care Improvement Programme** which includes changes to our governance and clinical engagement in order to provide an improvement trajectory delivering compliance from October onwards.*

A&E - ASPH NHSI Performance vs National



ASPH NHSI Performance - Cancer 62 Day Treatments

NHSI - 2016 JULY PERFORMANCE UPDATE									
Domain	Standard		Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17	Monthly Sparkline	June	July
CANCER	All cancers: 62-day wait for first treatment	Urgent GP referral for suspected cancer	81.3% ☒	85.6% ☑	83.6% ☒	82.1% ☒		77.1% ☒	72.5% ☒

Cancer
62 Day - GP

- *Cancer 62 Day GP Referral to Treatment for July was recorded at 72.5% (target = 85%)*
- *Delays were recorded due to complex pathways (9 patients), patient choice, fitness & thinking time (9 patients), & capacity (1 patient)*
- *The Trust continues to deliver its Cancer Improvement Action Plan although has requested the support of the NHSI Intensive Support Team to further augment the improvement activity to deliver sustainable performance.*
- *The IST team visited during July where we await their report.*

Urgent Care Programme - Objective 1 Update

❑ *Establishing the Urgent Care Centre (UCC)*

Objectives:

- *Establish the UCC processes and staffing model*
- *Launch the UCC and implement UCC pathways*

.REF	PROJECT	RAG
1.0	Establishing an Urgent Care Centre	
2.0	Implementing Ambulatory Care In AMU	
3.0	Improving the Medical Model	
4.0	Establishing and Implementing Core Clinical Standards	

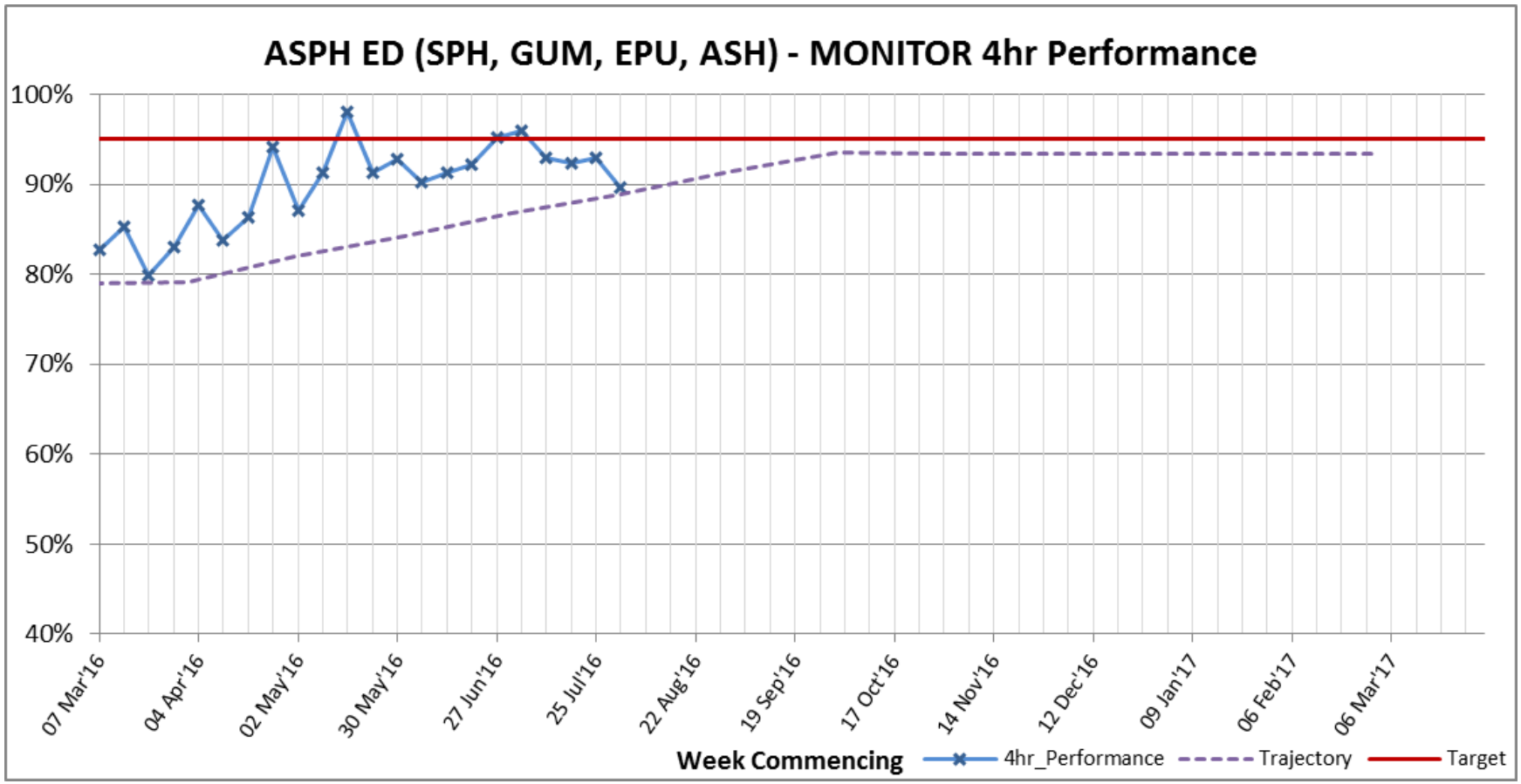
Urgent Care Programme - Objective 1 Update

	ESTABLISHING AN URGENT CARE CENTRE			
REF: 1.0	CLINICAL LEAD: JACOB ADDO		MANAGEMENT LEAD: RICK STRANG	
Overall	Milestones		Risks	Benefits
Patients walking into ED or arriving with a minor illness/ injury or a less urgent problem will be directed to the UCC during the hours of 0800-2000 hrs. The unit will be staffed by a combination of Emergency Department doctors, GPs and Emergency Nurse Practitioners. Patients will receive an improved patient experience and the initiative will support delivery of the ED 4 hour target by reducing overcrowding in ED and consequently time to assessment, treatment, discharge or transfer	The UCC is in place and milestones are on track. ASPH are working with the CCG to recruit GPs to further enhance the service. Building works to enlarge the reception area and CDU are awaiting planning approval and are on track to deliver in June 2016 The UCC is in place and seeing 55% of ED attendances between 0800-2000 hrs. GPs have been offered to the UCC and the commercials for this are currently being worked through. Possible start in September.		Ability to recruit GPs jeopardises the ability to deliver the benefits of the UCC long term.	The benefits of the UCC are to improve patient experience and support delivery of the ED 4 hours target by reducing overcrowding in ED.

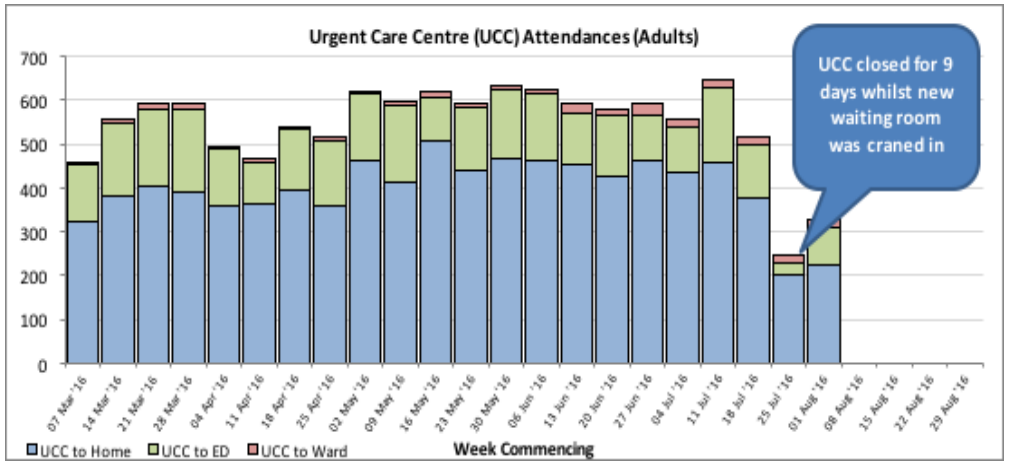
Urgent Care Programme - Objective 1 Update

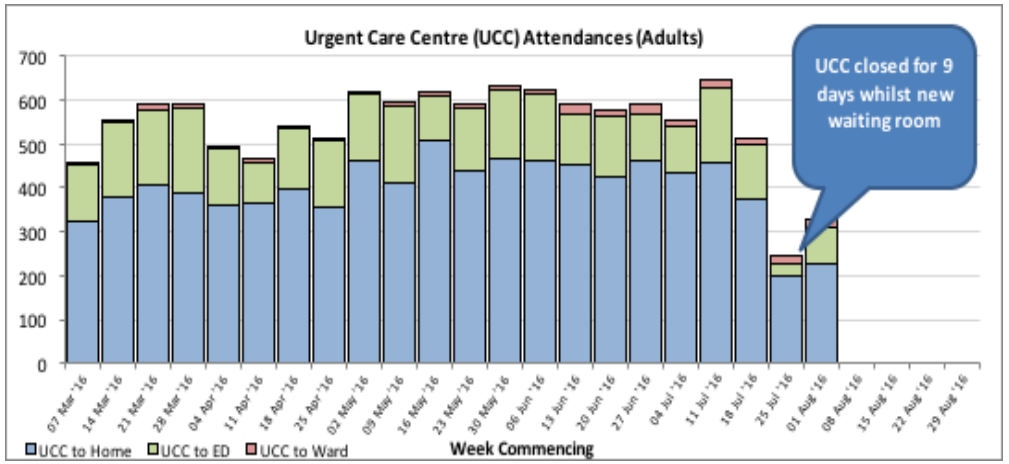
Actions completed this period	Actions to be completed next period
Urgent Care Centre is in place using ED staff	GP commercials to be reviewed
Extend the UCC waiting room	

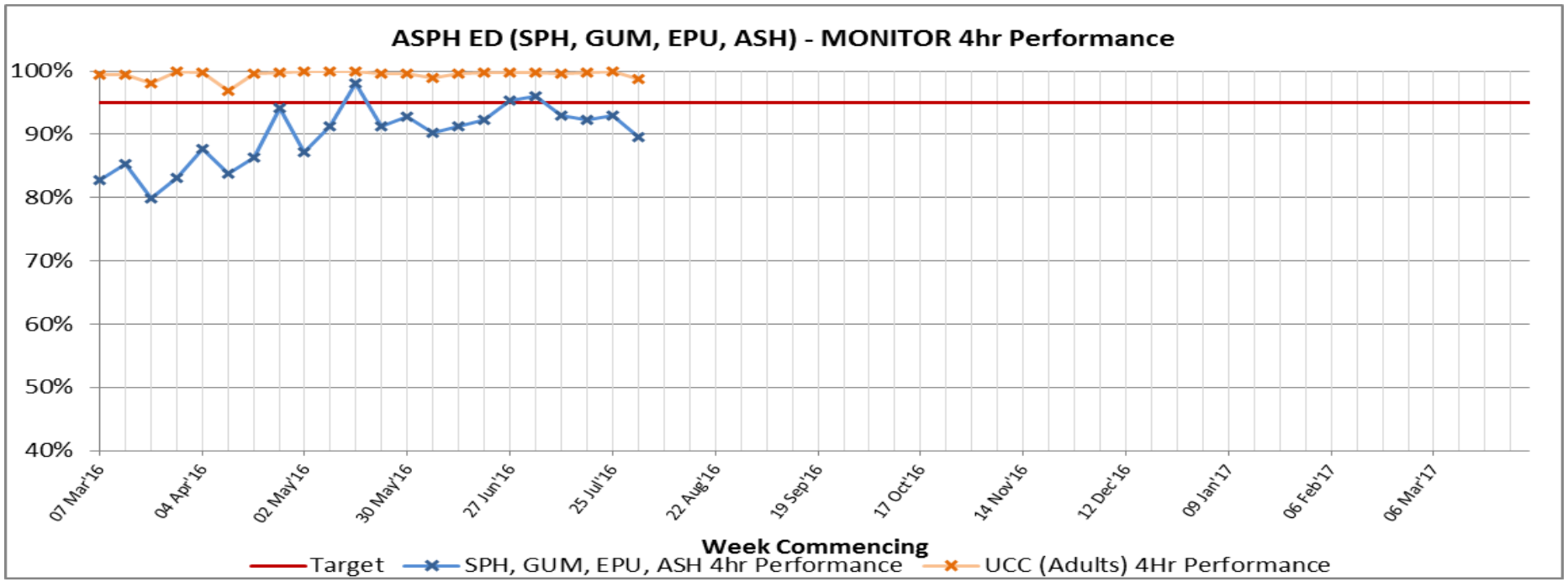
Urgent Care Programme - Objective 1 Update



Urgent Care Programme - Objective 1 Update







Urgent Care Programme - Objective 2 Update

❑ *Implementing Ambulatory Care in the medical assessment area*

Objectives:

- *Implement ambulatory pathway in order that all patients presenting with a GP letter attend the AMU & not ED*
- *Complete analysis of 0 to 1-day LoS patients to establish additional pathways/services required in ambulatory care*
- *Convert one bay on AMU to an ambulatory area, closing at night*

.REF	PROJECT	RAG
1.0	Establishing an Urgent Care Centre	
2.0	Implementing Ambulatory Care In AMU	
3.0	Improving the Medical Model	
4.0	Establishing and Implementing Core Clinical Standards	

Urgent Care Programme - Objective 2 Update

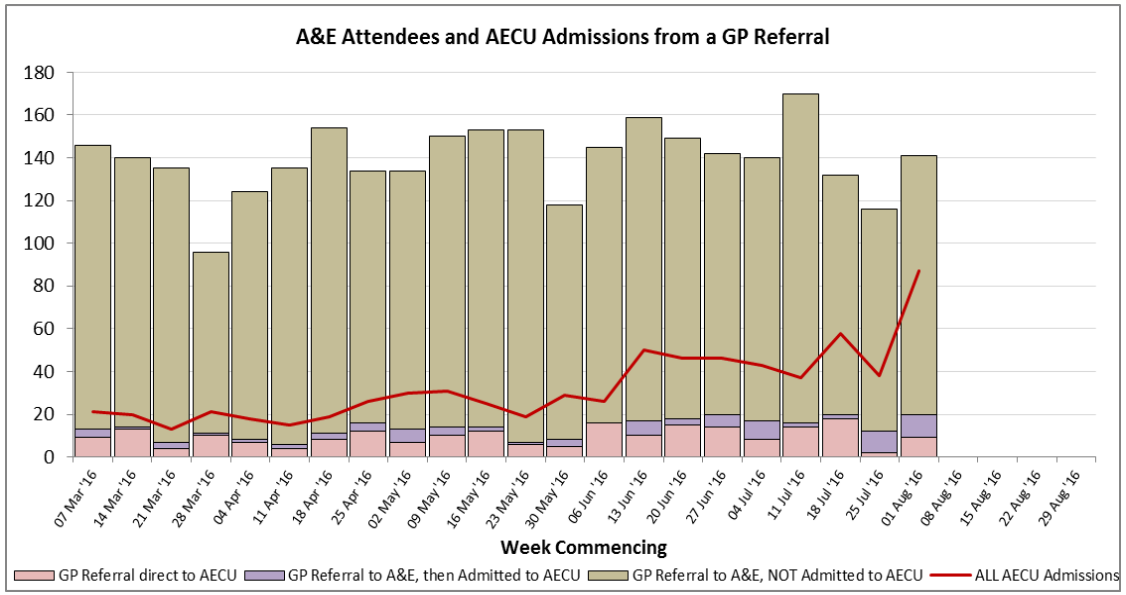
	IMPLEMENTING AMBULATORY CARE IN AMU		
REF: Priority 3.0	CLINICAL LEAD:	JONATHAN ROBIN	
	MANAGEMENT SUPPORT:	RICK STRANG	

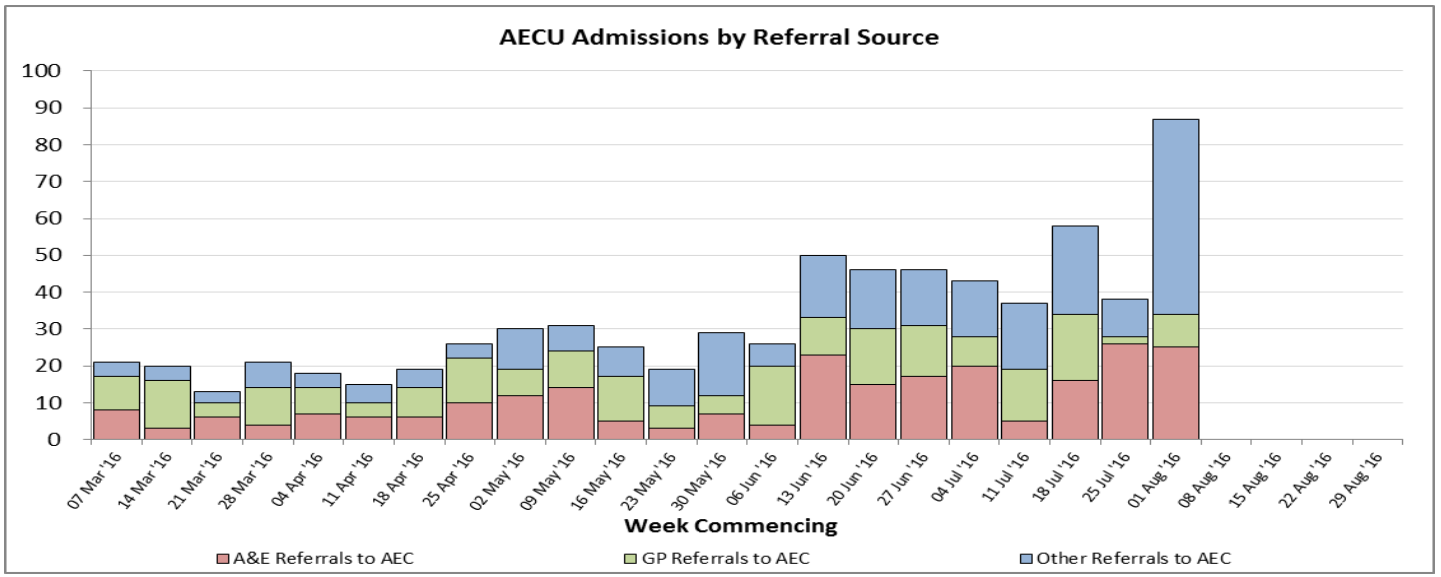
Overall	Milestones	Risks	Benefits
All patients will be treated as ambulatory unless proven otherwise. Patients referred by a GP practice or walking into ED/UCC with an ambulatory condition will go directly to the AECU to be assessed, diagnosed, treated, discharged or transferred. Ambulatory pathways are in place.	Lead Nurse now in post to reinforce pathways and develop "pull through" model from ED. New SHO rota provides medical cover each day. There has been a significant increase in the numbers of patients seen in the ambulatory care service.	Current flow will be too large for unit. Exit block in MAU will delay admissions from AECU and block it.	The benefits of the Ambulatory Emergency Care Unit will be to improve patient experience and support achievement of the ED 4 hour target

Urgent Care Programme - Objective 2 Update

Actions completed this period	Actions to be completed next period
Ambulatory pathways are in place	The nursing workforce model is agreed with Lead Nurse in post and recruitment strategy in progress.
Data review of patients staying 0-1 days	Medical workforce only temporarily in place as HDU resource supporting ambulatory care.
Workshop held with AEC and Lead clinician (JR) – established baseline data set.	
Discharge lounge now relocated and trolleyed area available for use by ambulatory care	
Communication of pathways to staff and GPs	
Actions completed this period	Actions to be completed next period
Ambulatory pathways are in place	The nursing workforce model is agreed with Lead Nurse in post and recruitment strategy in progress. Medical workforce only temporarily in place as HDU resource supporting ambulatory care.

Urgent Care Programme - Objective 2 Update





Urgent Care Programme - Objective 3 Update

- ***Improving the medical model and input to Cherry Annex and the medical inpatient wards***

Objectives:

- *Agree and implement a medical model for Cherry Annex ward*
- *Review and improve the acute medical continuity model as required*
- *Work with the medical specialty teams to agree and implement consultant-continuity models for the inpatient wards*

.REF	PROJECT	RAG
1.0	Establishing an Urgent Care Centre	
2.0	Implementing Ambulatory Care In AMU	
3.0	Improving the Medical Model	
4.0	Establishing and Implementing Core Clinical Standards	

Urgent Care Programme - Objective 3 Update

	IMPROVING THE MEDICAL MODEL			
REF: 3.0	CLINICAL LEAD: PETER WILKINSON		MANAGEMENT LEAD: TOM SMERDON	
Overall	Milestones	Risks	Benefits	
Investing in all specialty IP teams to ensure all patients receive daily consultant care and consultant continuity. Strengthening medical leadership within the Medicine Division to ensure clinical engagement. Improving patient flow management to ensure minimal outlying and access to the right bed. Overarching bed modelling work complete and identifies that there is insufficient bed base to meet demand working at an 90-95% occupancy level.	A fifth respiratory consultant has been recruited. Unable to fill 6th post at present. Unable to recruit to gastroenterology Consultant posts in July but hope to appoint a current Registrar into a Consultant post when eligible (November 2016). New specialty lead for gastroenterology has been appointed and will introduce consultant of the week model as a priority. Recruitment to CoE Consultant posts successful, with 2 new Consultants starting in Sept/Oct 2016. Trust grade SHOs also appointed to fill junior gaps. Fully functioning older persons short stay service now operational.	Recruitment challenges at all levels of medical and nursing staff remain. Bed modelling (April 16) suggests medical bed base c. 30 beds short to achieve target occupancy levels. System-wide stroke reconfiguration will move all IP stroke activity to SPH requiring a further c. 30 beds.	Continuity of care of all patients will lead to improved discharges and flow in the hospital supporting the delivery of the 4 hour target and Keogh Standards Reduced variance between weekend and weekday discharge numbers to match increasing weekend admissions.	

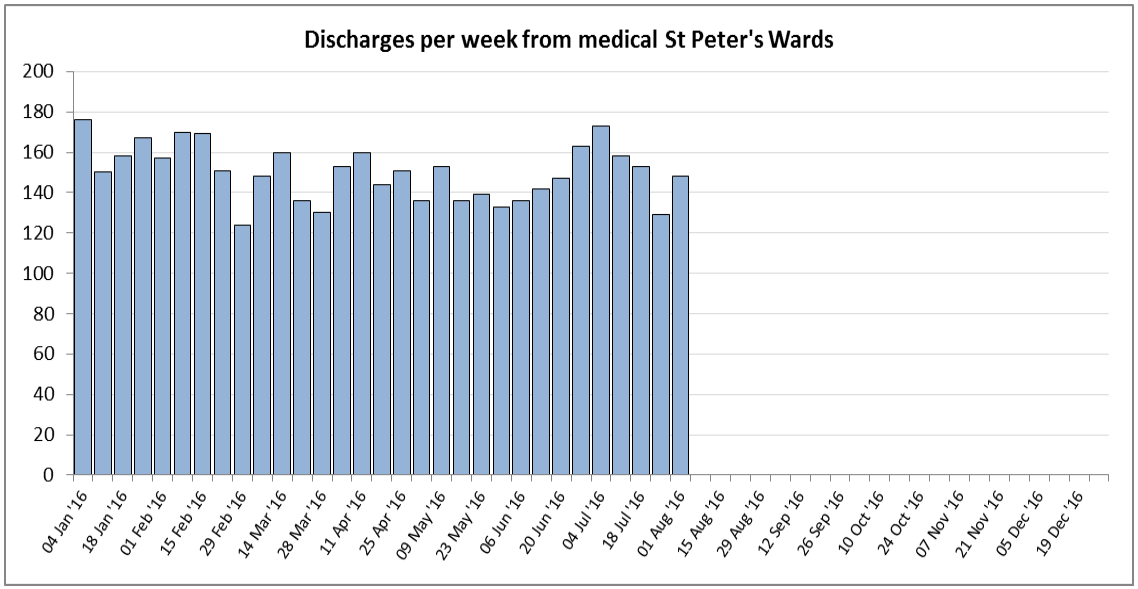
Urgent Care Programme - Objective 3 Update

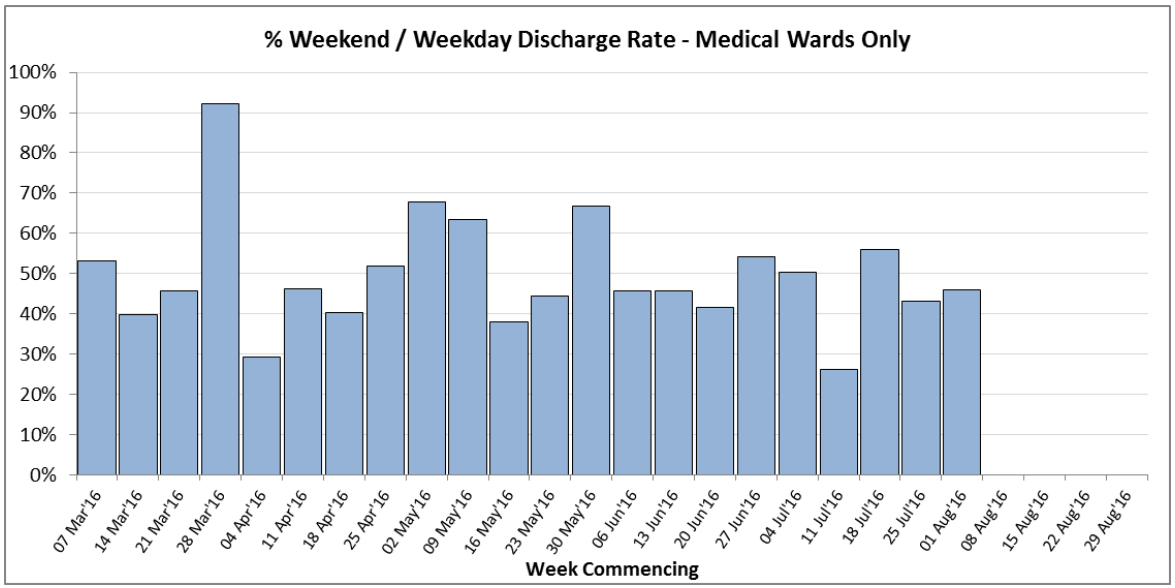
	IMPROVING THE MEDICAL MODEL		
REF: 3.0	CLINICAL LEAD: PETER WILKINSON	MANAGEMENT LEAD: TOM SMERDON	
Overall	Milestones	Risks	Benefits
	New junior doctor (F1/2) rotas providing improved ward continuity commenced in August 2016. Outline plan for Consultant of the week model on Maple ward has been agreed and will be implemented during September.		

Urgent Care Programme - Objective 3 Update

Actions completed this period	Actions to be completed next period
Recruitment of a number of key medical posts at Consultant and junior level	Completion of RMO tender for Ashford, releasing further junior doctor resource
Appointment of new specialty lead for Gastroenterology	Implementation of Consultant of the week model for May ward
Commenced new junior doctor rota (F1 and F2/CMT), providing greater continuity on-call and for ward cover.	Agree changes in junior doctor cover related to HDU collocation with ICU in November. Improve medical workforce planning and short notice absence response, to ensure minimal gaps in rotas.
Agreed to merge acute and general medicine services to improve governance and workforce management	Introduce new governance arrangements. Agree and implement options for resolution of Maple ward cover (general medicine).
Reported on NHSE 7 day services audit.	Develop plan to remedy areas of weakness.
Developed 20 bed OPSSU service on Cherry Ward	Extend to 29 beds, with direct access from A&E. Monitor impact on CoE LOS and readmission rate.

Urgent Care Programme - Objective 3 Update





Urgent Care Programme - Objective 4 Update

❑ *Establishing and implementing core clinical standards*

Objectives:

- *Engage with clinical teams to identify and agree the core clinical standards*
- *Agree standards with Exec and clinical leadership*
- *Cascade sign-up to the standards through the clinical teams and communicate through the organisation*

.REF	PROJECT	RAG
1.0	Establishing an Urgent Care Centre	
2.0	Implementing Ambulatory Care In AMU	
3.0	Improving the Medical Model	
4.0	Establishing and Implementing Core Clinical Standards	

Urgent Care Programme - Objective 4 Update

	ESTABLISH AND IMPLEMENT CORE CLINICAL STANDARDS			
REF: 4.0	CLINICAL LEAD: DAVID FLUCK	MANAGEMENT LEAD: RICK STRANG		
Overall	Milestones	Risks	Benefits	
Actions in place to engage with clinicians from each Division to agree the philosophy of care, developing a set of '10 golden rules' for emergency care (core clinical standards) by which our team will operate. In addition, determining routes for escalation when non-compliant. The standards will outline the guiding principles for the appropriate admission of emergency patients to the correct clinical team preventing delays in patient assessment, transfer or admission to a specialty, and improving patient experience	Engage with clinicians from each division to agree the philosophy of care, developing a set of core clinical standards and determining routes for escalation when non-compliant. Launch the philosophy of care and clinical standards at a Trust wide event led by the Chief Executive and Medical Director.	Lack of clinical engagement across the Trust to develop clinical standards and maintain compliance.	Improved management and transfer of patient care to the right person at the right time, in the right place will lead to early diagnosis, treatment, discharge, transfer or admission and will reduce overcrowding in ED thereby supporting delivery of the 4 hour target and achievement of the Keogh standards. Improved patient experience due to a reduction in delays to assess, transfer or admit a patient.	

Urgent Care Programme - Objective 4 Update

Actions completed this period	Actions to be completed next period
Met with representatives from the Orthopedic division to consider core clinical standards	Further clinical engagement with Surgery and Gynaecology with Trust Executive support
Meet with clinical representatives from Surgery and Medicine Divisions	Final agreement to a core set of Trust clinical standards – wider consultation exercise undertaken and final workshop to provide clinical sign off to be completed by end of July 2016 (Lorraine Knight to convene)
	CEO, Medical Director and COO to launch Trust wide clinical standards