Surrey and Sussex NHS
Healthcare NHS Trust

TRUST BOARD IN PUBLIC	**Date: 29 September 2016** **Agenda Item: 4.2**	
REPORT TITLE:	SASH+ Progress Update (in partnership with the Virginia Mason Institute)	
EXECUTIVE SPONSOR:	Michael Wilson Chief Executive	
REPORT AUTHOR (s):	Sue Jenkins Director of Strategy & KPO Lead	
REPORT DISCUSSED PREVIOUSLY: (name of sub-committee/group & date)	Executive Committee	
Action Required:		
Approval ()	**Discussion ()**	**Assurance (√)**
Purpose of Report:		
This report provides the Board with assurance that the SaSH + work (in partnership with Virginia Mason) is progressing to plan.		
Summary of key issues		
This paper provides the Trust Board with an update on progress since July 2016 including details about:- • each of the value streams • training and development • stakeholder engagement • culture indicators and evaluation		
Recommendation:		
The Board is asked to consider this report and ensure that it provides assurance around delivery of the SaSH + work (in partnership with Virginia Mason).		
Relationship to Trust Strategic Objectives & Assurance Framework:		
SO1: Safe -Deliver safe services and be in the top 20% against our peers **SO2:** Effective - Deliver effective and sustainable clinical services within the local health economy **SO3:** Caring – Ensure patients are cared for and feel cared about **SO4:** Responsive – Become the secondary care provider and employer of choice our catchment population **SO5:** Well led: Become an employer of choice and deliver financial and clinical sustainability around a clinical leadership model		

Corporate Impact Assessment:	
Legal and regulatory implications	The Trust has a contractual commitment to participate fully in this programme for a five year period
Financial implications	The programme is being centrally funded by the Trust Development Authority (TDA) and the Department of Health. The programme is expected to achieve improvements in quality, performance and efficiency over the next five years
Patient Experience/Engagement	Patients will be involved in value stream work wherever possible
Risk & Performance Management	A Trust Guiding Team has been established to oversee this work. This group reports to a national Trust Guiding Board
NHS Constitution/Equality & Diversity/Communication	A national communications plan is being delivered to support the work and internally communications is being rolled out across the organisation
Attachment:	
SaSH + update	

TRUST BOARD REPORT –29 September 2016

SASH+ update – working in partnership with the Virginia Mason Institute

1. Introduction

1.1 The Board receives regular updates relating to the Trust's SASH+ work.

1.2 This paper provides the Trust Board with an update on progress since July 2016 including details about:-

- each of the value streams
- training and development
- stakeholder engagement
- culture indicators and evaluation

2. Value stream updates

2.1 The Trust has identified three value streams which will be the initial focus of improvement work.

2.2 They are:-

- Inpatient flow – cardiology
- Outpatients
- Management of diarrhoea

2.3 Each value stream has a suite of high level metrics that have been signed off by the Trust Guiding team. These confirm whether progress is being made to move from the current state high level value stream maps to the future state high level value stream map. Progress against the high level metrics will be reported to the Board for each of the value streams

2.4 **Update on cardiology value stream**

2.4.1 The first and second quarter results for the high level cardiology metrics are detailed below:-

	Baseline (October 2015— February 2016)	Target	1st Quarter April 2016	2nd Quarter July 2016	Comments
Quality Metric 1: Number of bed changes on Holmwood & CCU	H'wood- 12.5% CCU - 37.5%	0%	H'wood – 21% CCU - 44%	H'wood – 7% CCU - 25%	Both improved since baseline
Quality Metric 2: Number of outliers on other wards	n=3 8%	0%	n = 1 2.7%	n = 3 8%	No change

Quality Metric 3: **Non elective emergency readmission** **<7 days**	Oct 15 – 7.4%	7.0%	Apr 16 – 7.5%	Jul 16 – 7.3%	n=10/137
Quality metric 4: **Non elective emergency readmission** **< 30 days**	Sep 15 – 16.1%	14%	Mar 16 – 11.5%	Jul 16 – 19.7%	n=27/137
Quality metric 5: **Number of procedures cancelled**	Not plan/capacity 7.5% Not done/plan 13.5% Not done/capacity 20%	0% 0% 0%	63/120 = 52% 8/57 = 14% 71/120 = 59%	71/120 = 59% 3/49 = 6% 74/120 = 62%	Activity is profiled to focus on outpatient backlog
Quality metric 6: **Day care conversion**	Oct 16 - (32/114) 28.1%	18%	Apr 16 – (33/108) 30.6%	Jul 16 – (30/129) 23.3%	Improvement since 1st quarter and on baseline
Service Metric 1: **FFT for Holmwood**	Oct 15 – 93% 35.8% response rate	100% 35%	Apr 16 – 100% from 36.4% response rate	Jul 16 – 100% from 24.1% response rate	Target reached
Service Metric 2: **FFT for CCU**	Oct 15 – 100% 67.9% response rate	100% 35%	Apr 16 – 96% 50% response rate	Jul 16 – 100% from 40% response rate	100% maintained
Delivery metric 1: **LOS –non elective**	Oct 15 – 7.7 days	5.8 days	Apr 16 – 6.9 days	Jul 16 – 6.9 days	Improvement maintained from Q1
Delivery metric 2: **LOS—elective**	Oct 15 – 1.4 days	0.96 days 23 hours	Apr 16 – 1.5 days	Jul 16 – 1.4 days	No change
Delivery metric 3: **Time from referral to first seen by cardiologist**	15 hours and 30 minutes	2 hours	For in hours using new process 50 mins	For in hours using new process 2 hrs 38 mins	n = 3 patients out of 9 who presented during week For (14) OOH patients 8 hrs 35 mins For in hours not using process 16 hrs 30 mins
Delivery metric 4: **Time from referral to arriving in cardiology bed**	25 hours and 36 minutes	90 mins	For in hours using new process 33 mins	For in hours using new process 7 hrs 40 mins	n = 3 patients out of 9 who presented during week For (14) OOH patients 7 hrs 30 mins For in hours not using process 1 hr 40mins
Morale Metric 1: **Number of inliers on Holmwood, CCU and angio**	Angio 36% H'wood 14%	0% 0%	Angio 0% H'wood 3.5%	Angio 67% H'wood 27%	High bed capacity and use of angio as escalation continues

	CCU 0%	0%	CCU 0%	CCU 0%	
Morale metric 2: **Abbreviated Staff Survey**	Net score 256.5	>300	N/A	N/A	Currently being undertaken
Cost Metric 1: **Excess agency costs**	M1 -M7 Angio £32k Med £11k(excluding locum) ECG £22k Hwood/CCU £238k (£43,300 per month)	£21,600 per month	Apr 16 Angio £19k Med £0k ECG £1k Hwood £40k (£60,200 per month)	M1 – M4 Angio £62k Med £0k ECG £11k Hwood £134k (£52k per month)	
Cost Metric 2: **ADHs paid**	M1 – M7 £21,600 (£3,100 per month)	£1,500 per month	Apr - £13,200 per month	M1-M4 - £88 (£22k per month)	Additional outpatient clinics being undertaken

2.4.2 Our first rapid process improvement workshop (RPIW) for cardiology was held back in February 2016. It focused on improving the referral process for cardiology patients and reducing the lead time for a patient arriving at the hospital and being seen by a cardiologist and the patient arriving at the hospital and getting to a cardiology bed.

2.4.3 During the week the team also completed the following improvement work which is all embedded and in place:-

2.4.3.1 They undertook a 5S (sort, simplify, sweep, standardise, sustain) of the MDT room so that patient notes could be kept in a central location on the ward rather than in ad hoc places

2.4.3.2 They installed an electronic white board which is used to inform all of the clinical team of the status of the patient and is in real time. This is used at daily ward rounds

2.4.3.3 They identified a senior nurse from the team who would visit the patient in ED as soon as they have been identified by the ED team to assess them

2.4.3.4 They installed a cardiac nurse bleep to improve communications between the ED and cardiology team

2.4.3.5 They installed a cardiologist bleep to improve communication with cardiology consultant of the week

2.4.4 In addition the team have tried to implement a fast track bed but continued operational pressures, increasing numbers of inliers and use of angio as an escalation area has compromised this process. The cardiology team continue to work with the site team to implement the fast track basis when it can be and this has been acknowledged as a key contributor for improving the overall lead time further.

2.4.5 The monitoring for this RPIW will continue at 30 day intervals.

2.4.6 In April 2016 the Trust held its second RPIW for cardiology. This time the RPIW focused on the discharge process which was measured from the time the decision to discharge was made to when the patient left the cardiology bed.

2.4.7 The 90 day report out for this RPIW demonstrates that the work is in the main embedded and all metrics are either the same or better than the baseline or meeting the target.

2.5 **Outpatients value stream update**

2.5.1 The high level metrics for outpatients are detailed below and Q1 measures are currently being colated:

	Baseline (April – end June 2016)	**Target**
Quality Metric 1: **Number of referrals in backlog, not admitted**	984	0
Quality Metric 2: **Number of cancellations by hospital:** **New appointments** **Follow ups** **Clinics cancelled <6/52**	 1351 4331 56	 0 0 0
Service Metric 1: **Number of patient complaints and concerns formally recorded about outpatient appointments. Count complaints**	8	0
Service Metric 2: **Friends and family results % r recommended**	89.3%	100%
Delivery Metric 1: **Time from receipt of referral to date of first appointment. (Lead time) for (a) Urgents and for (b) Routines**	2.5 weeks (u) 9 weeks (r)	0 weeks
Delivery metric 2: **% of DNAs** A. **for news** B. **For follow ups**	 6.9% 6.8%	 0% 0%
Morale Metric 1: **Staff survey results, taken from Management Standards for Outpatient Booking Office** **Domains:** · **Demand** · **Control** · **Managers support** · **Peer support** · **Relationships** · **Role** · **Change**	 2.87 3.24 3.00 3.50 4.17 3.60 3.11	 3.08 3.50 3.95 4.15 4.27 4.29 3.77

Morale Metric 2: **Staff vacancy rate outpatient booking office**	10	0
Morale Metric 3: **18 week RTT Breach fines per month**	£52600	£0
Cost Metric 2: **Cost of ad hoc clinics for outpatient appts**	Finance identifying	£0

2.5.2 The first RPIW for this value stream took place at the end of May 2016. The focus of this week was on the booking of new appointments for adult ophthalmology patients.

2.5.3 The 90 day report out has now been collated and the following are key points to note:-

2.5.3.1 The lead time for urgent referrals which is the time from the receipt of the referral by the outpatient booking office (OBO) to the date of the first appointment has improved from 28 days 2 hrs 59mins to 10 days.

2.5.3.2 The sub lead time for urgent referrals which is the time from receipt of referral by OBO to the date the booking is made for first appointment has improved from 14 days 2hrs 59 mins to 4 days.

2.5.3.3 The lead time for routine referrals which is the time from receipt of referral by OBO to the date of the first appointment has improved from 107 days 18hr 24mins to 32 days

2.5.3.4 The sub lead time for routine referrals which is the time from receipt of the referral by OBO to the date the booking is made for the first appointment has improved from 79 days 18hrs 24mins to 14 days

2.5.3.5 There has also been significant improvement around the work in progress (WIP) which came from the following categories:- post in pile; OBO awaiting consultant identification; OBO awaiting to be added to system; OBO awaiting to be taken for grading; outpatients / consultants trays & secretaries offices awaiting grading; awaiting return to OBO; partial booking letter sent; currently booking; awaiting firebreak clinics.

2.5.3.6 The WIP has improved from 1331 to 296.

2.5.3.7 There has been a WIP issue that has cropped up since the RPIW, around consultant availability to grade using their agreed standard work rota. This was due to both consultants, who had agreed to support the grading process when there was a gap in the rota, being on previously booked leave at the same time.

2.5.4 The next RPIW for outpatients is due to take place w/c 19 September 2016. It is focussing on attendance at breast clinic appointments starting from when the patient arrives at the hospital to the end of the consultation with the clinician.

2.5.5 Our baseline data collection has confirmed that

2.5.6 Some interesting points that were noted during the baseline data collection process are detailed below:-

2.5.6.1 The lead time for this process is 52 minutes and 31 seconds.

2.5.6.2 A member of the nursing staff leaves the consultation room during a consultation 48 times during one clinic. That number was associated with 16 patients who were being seen during a 3.5 hour clinic.

2.5.6.3 The number of steps walked by one nursing assistant during one clinic is 4563

2.5.6.4 The self check in kiosk at the front of outpatients department is a relatively new initiative. Although this has reduced the work of the reception staff, in order to encourage patients to use the kiosk it is 'manned' by a nursing assistant. This impacts on the capacity of nursing assistants to work in a true nursing assistant role in the clinic.

2.6 **Management of diarrhoea value stream update**

2.6.1 The high level metrics for this value stream are detailed below:

	Baseline (April – end June 2016)	**Target**
Quality Metric 1: Percentage of all patients without a stool chart present	57% N= 59/104	0%
Quality Metric 2: Percentage of samples received by the lab which are un-testable	23% N=14/60 Enteric pathogens 2% N= 1/59 C.diff	0%
Quality Metric 3: Number of lead consultant or ward changes per patient per admission (transfer of clinical care)	2.3 (mean) 2 (median) N=16	2 (mean)
Quality metric 4: The percentage of patients without an assessment of their baseline bowel function documented during initial clerking (ED/Medical)	100%	0%

Service Metric 1: **Time between identification of symptoms to return to normal bowel habit (last documented type 5-7 if normal bowel habit not documented)**	73 hours (median) N=9/16	72 hours 100% of patients with normal stools documented
Service Metric 2: **Length of time (duration) of isolation (for diarrhoea)**	5.5 days (mean) N = 11/16 (Number of patients isolated)	1 day
Service Metric 3: **Patient experience of care relating to management of diarrhoea**	9% N=1/11	100% of patients agree/strongly agree (*for bundled questions*)
Delivery Metric 1: **Time between printing of stool sample label to receipt by lab**	15 hours 11 minutes (median) N= 66 samples	1 hour
Delivery metric 2: **Time between identification of symptoms and isolation in side room.**	53 hours (mode) N=10/16	2 hours to transfer to side room
Delivery metric 3: **Time between identification of symptoms and stool sample collection**	15 hours (median) N= 12/16	0 hours
Delivery metric 4: **Time between identification of symptoms and documented differential diagnosis**	57.5hours (Median) N=5/10	14 hours 100% of patients with documentation
Morale Metric 1: **Staff survey (staff experience - caring for patients with diarrhoea)**	23% N=3/13	100% agree/strongly agree *(bundled question responses)*
Cost Metric 1: **Cost of closed beds**	252 bed days x £256 (mean cost of 1 bed per day) £64,512	£32,216 per quarter
Cost Metric 2: **Cost of untestable samples being sent to the lab**	15 X £19.11= £286.65 (M,C&S + C.diff)	0

2.6.2 The first RPIW for this value stream took place from 18 – 22 July 2016. The focus of this week was on the identification of patients with type 5-7 stools, personal care and differential diagnosis. The genba (where the work is done) for this RPIW was the Acute Medical Unit.

2.6.3 The baseline lead time from identification of symptoms (first episode of type 5-7 stools in hospital) to a documented differential diagnosis in the medical notes was 2 days 9 hours and 36 minutes.

2.6.4 During the RPIW week this lead time was reduced to 4 hours and 20 minutes, this exceeded the target set by the sponsor of 24 hours. At 30 days this was reported by the process owner as 6 hours 20 minutes.

2.6.5 Some of the other key successes, actions and learning from the RPIW are detailed below: -

2.6.5.1 Our baseline data collection identified that nursing staff were leaving the ward at least once per day to collect linen from the main hospital linen store, a return journey of 348 steps. During the RPIW week a 5S activity was undertaken to create a second linen cupboard on the ward and the par levels for the linen delivery were modified. The number of daily trips made to the linen store have now reduced to zero.

2.6.5.2 Prior to the RPIW 89% of patients on the ward did not have a stool chart in their notes. It is now standard work for all patients to have a completed stool chart as part of their admission to the ward which includes their baseline bowel function and is updated as part of the nurses observation round. At 30 days the number of patients without a completed stool chart has reduced to 3%.

2.6.5.3 The number of patients without an assessment of their baseline bowel function has reduced from 100% to 60% at 30 days, further embedding of this standard work is ongoing.

2.6.5.4 Only 50% of patients with more than one episode of type 5-7 stools had a differential diagnosis related to their diarrhoea prior to the RPIW. Introduction of posters in the toilets to encourage patients to report their symptoms, stickers to alert the medical team when patients are experiencing a change in their bowel habits and whiteboard magnets which alert all members of the MDT have increased the number of patients receiving a diagnosis to 100% at 30 days.

2.6.5.5 A personal care pack has been developed to reduce the set up time from 7 minutes 36 seconds to 1 minute 20 seconds at 30 days for nursing staff caring for patients with type 5-7 stools.

2.6.5.6 The number of staff wearing gloves inappropriately prior to the RPIW was 60%, a poster has been created ‘ to glove or not to glove’ and quizzes now take place at handovers to raise awareness. At 30 days inappropriate glove use has reduced to 20% and the risk of cross contamination has remained the same. Further focus is required on these metrics to achieve the targets of 0% set by the sponsor.

2.6.6 The report out made to the Trust by the staff involved in the RPIW at the end of the week is available on the Trust intranet for all staff to access.

2.6.7 The next RPIW for this value stream is planned for the week commencing the 21st of November 2016 and will focus on treatment of patients with diarrhoea. The sponsor for this RPIW is Dr Matthew Cowan and the genbas identified are Hazelwood and Bletchingley ward.

2.6.8 The first quarter high level metrics for this value stream are due to be reported at the end of October 2016.

3 Training and development

3.1 In June the Trust launched the first module of its Lean for Leaders programme. This is an eight month development programme which consists of:

- Six taught days delivered in partnership by colleagues from the Virginia Mason Institute and our own Kaizen Promotion Office team
- On-site coaching and mentoring for all candidates
- An opportunity to apply the learning from the taught days to undertake marked improvement assignments in your own work areas
- Compulsory pre-reading of various books and articles

3.2 It is aimed at staff in key leadership roles and 37 candidates have attended the first and second modules. In between each module the candidates apply the tools and techniques that they have learnt and start undertaking improvement in their own areas of work.

3.3 Lean for leaders is a key tipping point for building both capacity and capability of the tools, techniques and culture of improvement across the organisation.

3.4 VMI are co-teaching our first lean for leaders course and certifying our KPO lead to be able to deliver this course in the future.

3.5 The KPO team are currently recruiting 40 more leaders to the Lean for Leaders cohort which will start in February 2017.

4 Stakeholder engagement

4.1 As part of the national stakeholder engagement plan we have received a positive response to our invites to three key national stakeholders to visit SASH and to hear about our SASH+ work and achievements to date. Visits are arranged for:

Stakeholder	Date	Time
Roy Lilley Health commentator	1 December 2016	9am-1pm
Chris Wormald Permanent Secretary, Department of Health	2 December 2016	10am-1pm
Jane Cummings Chief nursing officer NHS England	6 January 2017	1-4pm

4.2 The visits will give an overview of the NHS Improvement and Virginia Mason Institute partnership and our SASH+ transformation work and value stream progress. Roy Lilley and Chris Wormald have also expressed an interest in meeting frontline staff and visiting the hospital. A programme for the visits is being finalised with the Trust Guiding Team.

4.3 A national stakeholder e-newsletter is also being finalised and will be issued in early October to both national and local stakeholders. The content includes articles and videos from across the five partnership trusts and will have a SASH video feature on our Trust Guiding Team.

4.4 The stakeholder engagement plan aims to encourage an interest in the partnership, the transformation work and outcomes as part of a broader aim to create greater awareness and understanding of the programme and the difference the developments make to the provision of high quality safe care for patients

5 Culture Indicators and Evaluation

5.1 A key element of the SASH+ programme is for each trust to review and consider its own culture and how this supports, or otherwise, the introduction, implementation and embedding of improvement methodology.

5.2 The "VMI Trust" HR Directors (HRDs) agreed to develop a set of indicators that would be used to measure culture across the five years of the partnership. These metrics have been developed in collaboration with the HRDs, the Kings Fund and NHSi.

5.3 To ensure the culture assessments highlight trends in a meaningful manner, it has been agreed that these would be run at years one, three and five of the partnership. The year one assessments have been completed for each Trust and are attached as Appendix 1.

5.4 It is acknowledged that each Trust has a unique culture and therefore different requirements from the programme. As such, benchmarking across the five organisations using these metrics has limited value.

5.5 The Culture Indicators have been developed using three data sets:

- Culture Assessment Tool (CAT) (run by the Kings Fund)
- Relevant key findings from the annual National Staff Survey
- GMC Trainee Survey

5.6 The CAT was developed by the Kings Fund to specifically review culture in the five organisations over the duration of the programme.

5.7 It highlights the impact the work has had on those staff who have been involved in SASH+ value streams, learning or are aware of local initiatives as opposed to those staff who have not. Given this assessment is directly linked to the SASH+ work it should provide a detailed assessment of the impact across each Trust.

5.8 The HRDs and NHSi agreed a number of Key Findings from the annual National Staff Survey which measures, amongst other indicators, culture within trusts.

5.9 Whilst the Staff Survey is not directly related to SASH+ work-streams, and local initiatives will be developed by each trust to address issues raised in the survey year-on-year, it will provide an overview of changes to culture in the organisations during the five year period.

5.10 The GMC metrics are a sub-set of the wider GMC Survey and have been developed by Dr Kathy McLean and the Medical Directors from the Trust. As with Staff Survey data, these will provide a guide to changes in culture in each organisation rather than a direct comparison of the effect of the improvement work. However, as with the Staff Survey, positive and negative trends will be reviewed in line with the CAT

Survey to understand where correlations exist and actions plans will be developed to support and address these.

5.11 It is planned that future Culture Assessments will be undertaken in years three and five of the partnership and this should highlight key trends and the impact that the methodology has had on each organisation.

5.12 The HRDs are continuing to work collaboratively, communicating regularly and sharing 'best practice' where applicable.

6 Recommendation

6.1 The Board is asked to consider this report and ensure that it provides assurance around delivery of the SaSH + work

Sue Jenkins
Director of Strategy & Kaizen Promotion Office (KPO) Lead
September 2016

Appendix 1 – Year one culture assessment for SASH+

SaSH+Culture Indicators - Year 1 - 1