Surrey and Sussex NHS
Healthcare NHS Trust

TRUST BOARD IN PUBLIC	**Date: 28 July 2016** **Agenda Item: 4.3**
REPORT TITLE:	SASH+ (in partnership with the Virginia Mason Institute) update
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 & Trust Guiding Team

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 May 2016 including details about:-

- each of the value streams
- training and development
- the communications plans
- the compacts

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 –28 July 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 May 2016 including details about:-

- each of the value streams
- training and development
- the communications plan
- the compact work

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 diarrhea

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 quarter results for the high level cardiology metrics are detailed below. The second quarter data is currently being colated:-

	Baseline (October 2015—February 2016)	Target	1st Quarter April 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%	Increase from 3.4/28 to 6/28 Increase from 3/8 to 3.4/8
Quality Metric 2: Number of outliers on other wards	n=3 8%	0%	n = 1 1/36 = 2.7%	

Quality Metric 3: **Non elective emergency readmission <7 days**	Oct 15 – 7.4%	7.0%	Apr 16 – 7.5%	
Quality metric 4: **Non elective emergency readmission < 30 days**	Sep 15 – 16.1%	14%	Mar 16 – 11.5%	
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%	
Quality metric 6: **Day care conversion**	Oct 16 - (32/114) 28.1%	18%	Apr 16 – (33/108) 30.6%	
Service Metric 1: **FFT for Holmwood**	Oct 15 – 93% 35.8% response rate	100% 35%	Apr 16 – 100% from 36.4% response rate	
Service Metric 2: **FFT for CCU**	Oct 15 – 100% 67.9% response rate	100% 35%	Apr 16 – 96% 50% response rate	
Delivery metric 1: **LOS –non elective**	Oct 15 – 7.7 days	5.8 days	Apr 16 – 6.9 days	
Delivery metric 2: **LOS—elective**	Oct 15 – 1.4 days	0.96 days 23 hours	Apr 16 – 1.5 days	
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	n = 9 patients out of 13 who presented during week For OOH patients 9 hrs 38 mins For in hours not using process 13 hrs 05mins

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	n = 9 patients out of 13 who presented during week For OOH patients 6 hrs 5 mins For in hours not using process 4 hrs 20mins
Morale Metric 1: **Number of inliers on Holmwood, CCU and angio**	Angio 36% H'wood 14% CCU 0%	0% 0% 0%	Angio (0/14) 0% H'wood (1/28) 3.5% CCU (0/8) 0%	
Morale metric 2: **Abbreviated Staff Survey**	Net score 256.5	>300	N/A	To be reported at 120 days
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)	
Cost Metric 2: **ADHs paid**	M1 – M7 £21,600 (£3,100 per month)	£1,500 per month	Apr - £13,200 per month	

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 The challenge in embedding the new referral process for the cardiology team has continued. The value stream sponsorship team have continued to meet and at 90 days when the reporting out would normally be ceased it was recognised that the process was neither embedded nor sustainable.

2.4.4 The monitoring has continued and this RPIW is continuing to report out to at least 150 days at 30 day intervals. Key staff working in the cardiology team have been involved in addressing the issues around embedding the new process and the chief of medicine has been invited to join the sponsorship team and been actively involved in developing the solutions.

2.4.5 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.

2.4.6 The 60 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. The data for the 90 day report out is currently being collated.

2.5 **Outpatients value stream update**

2.5.1 The high level metrics for outpatients have now been agreed and are detailed below:

	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. There were 6 weeks of data collection, including timed observations of each operator in the process, as preparation for the RPIW.

2.5.3 Baseline metrics showed a lead time of:

- Urgent Referrals

Time from the receipt of the referral by outpatient booking office (OBO) to the date of the first appointment
= 28 days 2 hrs 59mins

During the RPIW week this lead time was reduced to 19 days and on the 30 day report out this reduced again to 18 days. The team are still aiming to achieve a target of 10 days

- Sub-lead Time

Time from receipt of referral by OBO to the date the booking is made for first appointment = 14 days 2hrs 59 mins

During the RPIW week this lead time reduced to 5 days and at the 30 day report out increased slightly to 7 days. The target for this lead time is 5 days.

- Routine Referrals

Time from the receipt of the referral by OBO to the date of the first appointment = 107 days 18hrs 24mins

During the RPIW week this lead time reduced to 33 days and at the 30 day report out this improved further to 25 days. This exceeded the target that was set for this lead time of 89 days.

- Sub-lead Time

Time from receipt of the referral by OBO to the date the booking is made for the first appointment = 79 days 18hrs 24mins

During the RPIW week this lead time reduced to 5 days and at the 30 day report out increased slightly to 7 days. This exceeded the target that was set for this lead time of 61 days.

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

- Our baseline data collection identified 1331 referrals that were in various offices awaiting grading and an appointment. In the first 30 days of improvement this work in progress has been reduced to 361
- A fax machine has been moved from the first floor to the ground floor where outpatient booking office staff sit and reduced the number of steps taken each day to retrieve the referral faxes from 726 to 0 for each person. The outpatient booking office staff describe this work as having "transformed their working day"
- A number of duplicate and incomplete referrals were identified during the data collection process and these have been removed which has reduced the demand that was originally required for ophthalmology patients
- There has been set up reduction implemented where medical secretaries are preparing the referrals for grading by the consultants. This process now happens on a daily basis
- The booking process has been moved from partial booking to "live" booking and fire break clinics have been implemented to accommodate any rescheduling due to leave or sickness of clinicians
- At our 30 day report out two key actions that were still outstanding included liaising with the post room to ensure that only ophthalmology referrals go to the ophthalmology team and that the switchboard passed calls relating to outpatients to the correct team.

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

2.6 **Management of diarrhoea value stream update**

2.6.1 The high level metrics for outpatients have now been agreed and 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**		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)**		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	
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 is planned for the week commencing the 18 July 2016 and will focus on 'Identification of symptoms and initial care'. Examples of kaizen bursts that the teams will be looking to improve in the RPIW are:

- 'First mention of diarrhoea differs between nursing and medical notes (inconsistency)'
- 'Patients often embarrassed and reluctant to inform others of symptoms, resulting in delays to identifying symptoms'
- 'There is variability in responding to patients with diarrhoea, depending on level of professional experience'
- 'Patients with communication difficulties, cognitive deficiency are unable to use call bell for help'

2.6.3 The baseline data collection work necessary to prepare for the RPIW is complete. This involved identifying patients with diarrhoea when presenting with symptoms in AMU and following their care in real time (where possible). The RPIW process owner and sponsor meet weekly in the lead up to the RPIW to ensure the appropriate preparation and planning is carried out before the event.

2.6.4 Some of the key initial baseline metrics for the RPIW include:-

- The lead time from identification of symptoms to a documented differential diagnosis is 2 days 9 hrs and 36 minutes. The target that has been set to improve to is 24 hours.
- The number of steps staff take to collect additional linen supplies from main stores is 348 steps. The target that has been set to improve to is 0 steps
- The percentage of patients without a stool chart is 89% and the target that has been set to improve to is 0%
- The time spent gathering supplies to attend to patients personal care needs is 10 minutes and 6 seconds. The target that has been set to improve to is 5 minutes.

3 Training and development

3.1 Local SASH+ training and development in accordance with the plan previously circulated to the Board continues.

3.2 The taster sessions continue on a monthly basis. This is a 2.5 hour session giving an overview of the Virginia Mason story and how the SASH+ work has come about. It covers a couple of lean tools and techniques including understanding what waste is and what it looks like and 5S – sort, simplify, sweep, standardise and sustain or self-discipline. These tools are simple and quick to learn and can be taken away by participants to use in their own work areas and with their teams.

3.3 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

3.4 It is aimed at staff in key leadership roles and 42 candidates attended the first module. 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.

3.5 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.

3.6 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

3.7 The national team have also offered the opportunity for newly recruited Trust Guiding Team members to undertake the executive leadership development session in Seattle later this year. Three leaders including our Chief Operating Officer, our director of OD and people and our Head of Communications will be taking up this opportunity in early September.

4 Communication

4.1 The KPO and communications teams meet on a regular basis and have developed a communications plan to ensure that internal and external communications and stakeholder management is focused and that staff, external audiences, stakeholders and the media are engaged throughout and their views are listened to. This is aligned to the national NHSI VMI Communications Strategy. The Head of Communications and the KPO lead meet their counterparts from the participating Trusts on a monthly basis to ensure that there is alignment, consistency of messages and open communication at a national and local level.

4.2 At a local level the Trust has developed a communications plan which includes:-

- Stakeholder engagement – both locally and as part of the national programme of stakeholder engagement
- Regular Kaizen bulletins sharing the improvement story as it unfolds
- Regular updates at TeamTalk meetings
- Tailored SASH+ TeamTalk meetings for RPIW report outs and updates on value streams
- Specific reference to the work in the CEO's weekly message

- A KPO wall which will visually depict the value stream progress
- A web page sharing information and the stories from the SASH+ work as it progresses
- Updates in Staff News and Yammer
- Updates shared through our social media platforms
- Media engagement – in-line with national partnership timeframes
- Regular board reports which provides updates of the work undertaken along with delivery against key metrics as this progresses
- A series of videos displayed on the trust information screens and the web page sharing progress, updates successes and learning
- A visual identity for SASH+ and branded templates for all materials and corporate communications messages

5 Compact development

5.1 Underpinning the improvement work at both a national and trust wide level is the development of a compact which details reciprocal commitments and an explicit set of responsibilities from all parties engaging in this development work.

5.2 At a national level a compact has been developed between the TDA and the five participating NHS Trusts.

5.3 In order to support the improvement work at a SASH level a draft compact has been developed between the organisation and clinicians. This work has been led by Amicus, who are specialist experts in compact development, working in partnership with VMI.

5.4 Our local draft compact is being shared and considered across the organisation for feedback. A further development and refining session with clinical leads, divisional chief nurses, chiefs, associate directors, the executive team and heads of department took place on 23 June to take this work forward.

5.5 A small sub group of the TGT including the medical director, chief of clinical education, director of OD and people and the KPO lead will be set up to oversee this work.

5.6 As part of the contract with VMI NHSI have identified up to 5 days that can be used by the Trust with Amicus providing support and expertise for this work during 2016/17.

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
July 2016