TRUST BOARD IN PUBLIC	**Date: 30 March 2017** **Agenda Item:**	
REPORT TITLE:	SASH+ (in partnership with the Virginia Mason Institute) update	
EXECUTIVE SPONSOR:	Michael Wilson	
REPORT AUTHOR (s):	Sue Jenkins	
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 December 2016 including details about:-

- each of the value streams
- training and development

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:

- **Safe** - Deliver safe, high quality care and improving services which pursue perfection and be in the top 25% of our peers
- **Effective** - As a teaching hospital, deliver effective and improving sustainable clinical services within the local health economy
- **Caring** - Work with compassion in partnership with patients, staff, families, carers and community partners
- **Responsive** - To continue to be the secondary care provider of choice for the people of our community
- **Well led** - To be a high quality employer of choice and deliver financial and clinical sustainability around a patient centred, clinically led 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 NHS Improvement (NHSI) 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 –30 March 2017

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 December 2016 including details about:-

- each of the value streams
- training and development

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

2.2.1 Eight rapid process improvement workshops (RPIWs) across the three value streams have now been completed. Two in cardiology, three in management of diarrhoea and three in outpatients.

2.2.2 The emerging results for the value streams are as follows:-

3. Cardiology

3.1 The cardiology value stream was the first to start but the work agreed in the Rapid Process Improvement Workshops (RPIWs) carried out in February and April 2016 has not been well embedded or sustained. This is due to a number of factors including the inexperience of the KPO team and resistance to change from some of the team involved.

3.2 In response to this a review and refresh event was held on 28 February 2017. This was attended by those that had been involved in the initial improvement work and a revised implementation plan was agreed which went live on 20 March 2017.

3.3 The initial metrics from the RPIWs will be re-measured at 30, 60 and 90 days post go live and the high level metrics will continue to be reported and monitored.

3.2 The quarterly high level metrics for cardiology are detailed below

	Baseline (October 2015— February 2016)	Target	1st Quarter April 2016	2nd Quarter July 2016	3rd Quarter October 2016	4th Quarter January 2016	% Change	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%	H'wood—7% CCU—25%	H'wood—25% CCU—62%	-100% -65%	
Quality Metric 2: Number of outliers on other wards	n = 3 8%	0%	n = 1 2.7%	n = 3 8%	n = 3 8%	n = 3 8%	0%	No change
Quality Metric 3: Non elective emergency readmission <7 days	Oct 15 – 7.4%	7.0%	Apr 16 – 7.5%	July—7.3%	Oct 6.8%	Jan 5.7%	22%	Now below target
Quality metric 4: Non elective emergency readmission < 30 days	Sep 15 – 16.1%	14%	Mar 16 – 11.5%	July—19.7%	Oct 13%	Dec 12.9%	20%	Now below target
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%	Metric being reviewed	Metric being reviewed	-800% 56% -300%	Metric being reviewed by VSST
Quality metric 6: Day case conversion	Oct 16 - (32/114) 28.1%	18%	(33/108) 30.6%	(30/129) 23.3%	(33/106) 33.1%	(25/84) 29.8%	-6%	

Service Metric 1: **FFT for Holmwood**	Oct 15 – 93% 35.8% response rate	100% 35%	100% from 36.4% response rate	100% from 24.1% response rate	100% 12.5% response rate	100% 14% response rate	7% points	Target maintained
Service Metric 2: **FFT for CCU**	Oct 15 – 100% 67.9% response rate	100% 35%	96% 50% response rate	100% from 40% response rate	96.2% 47% response rate	100% 38.8% response rate	0%	Target maintained
Delivery metric 1: **LOS –non elective**	Oct 15 – 7.7 days	5.8 days	Apr 16 – 6.9 days	6.9 days	7 days	Jan 6.6 days	14%	Improvement maintained from Q1
Delivery metric 2: **LOS—elective**	Oct 15 – 1.4 days	0.96 days 23 hours	Apr 16 – 1.5 days	1.4 days	2 days	Jan 2.7 days	-93%	Links with conversion rate which has also worsened
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	No patients used new referral process	No patients used new referral process	N/A	21 patients referred None used rapid assessment process 4 used old process 19hrs 5 mins 17 were out of hours 10hrs 35 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	No patients used new referral process	No patients used new referral process	N/A	21 patients referred None used rapid assessment process 4 used old process 15 hrs 6 mins 16 were out of hours 12hrs 45mins
Morale Metric 1: **Number of inliers on Holmwood, CCU and angio**	Angio 36% H'wood 14% CCU 0%	0% 0% 0%	Angio 0% H'wood 3.5% CCU 0%	Angio 67% H'wood 27% CCU 0%	Angio 38% H'wood 14% CCU 0%	Angio 77% H'wood 18% CCU 0%	-100% -28%% 0%	High bed capacity and use of angio as escalation continues
Morale metric 2: **Abbreviated Staff Survey**	Net score 292.5	>300	324	To be collected annually	To be collected annually	240	-18%	
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/CCU £40k (£60,200 per month)	M1—M4 Angio £62k Med £0k ECG £11k H'wood/CCU £134k (£52k per month)	M5—M7 Angio £65k Med £0k ECG £25k Hwood/CCU £45k (45K per month)	M8—M10 Angio £61k Med £0k ECG £30k Hwood/CCU £73k (£54k per month)	-26%	
Cost Metric 2: **ADHs paid**	M1 – M7 £21,600 (£3,100 per month)	£1,500 per month	Apr - £13,200 per month	M1—M4 £31K (£8k per month)	M5—M7 £41k (£13K per month)	M8—M10 £18k (£6k per month)	-100%	Improvement on all previous quarters

4. Outpatients

4.1 There have been three RPIWs so far supporting the outpatients value stream

4.2 These have been focussed on:-

4.2.1 The referral process for ophthalmology patients

4.2.2 The attendance at clinic for breast patients

4.2.3 The preparation of medical records

4.3 Some of the key benefits and improvements have been

4.3.1 Time from the patient arriving at the hospital to the end of their consultation with the breast clinician reduced more than half from 52 mins to 25 mins. This impacts positively on the experience for patients.

4.3.2 The number of breast patients seen after their allocated appointment time has reduced from 94% to 0%. This means patients get seen on time and clinics don't over run meaning that staff can finish their working day on time too.

4.3.3 Time from receipt of urgent ophthalmology referrals to date of first appointment has gone from 28 days and 3 hrs to 10 days (64% improvement). This means that urgent patients who were having to wait over a month for their first appointment are now being seen in less than two weeks.

4.3.4 Time from receipt of routine referrals to date of first appointment has improved from 107 days 18 hrs to 32 days (67% improvement). This will contribute enormously to delivering the 18 week access standard reducing the time between referral and first appointment by two months.

4.3.5 Number of referral letters in the system waiting to be processed has reduced from 1331 to 296. This not only means that patients get offered an appointment sooner but also means that staff don't have piles of work waiting to be processed at any one time helping them feel in more control of the work that they do.

4.3.6 The reduction of processing time for medical records to prepare clinic lists for the day from 41 minutes to 9 minutes (78% improvement). This has enabled the medical records team to focus on the quality of notes that they are preparing for clinics i.e splitting large volumes of clinical records so that clinicians have only the most recent and relevant information to hand in their clinic rather than months, and sometimes years, worth of previous records.

4.3.7 The quarterly high level metrics for outpatients are detailed below. One of the challenges of these metrics is that they are measured across all of the outpatient specialties. The RPIW work has however only been focussed around single specialties so the positive impact that has been experienced in each of these specialties is not showing at the overall metric level yet. The Trust Guiding Team have discussed this and accept that the impact will not show in the high level metrics until roll out of the work starts to be shared across as many of the other specialties as possible.

	Baseline (April – end June 2016)	Target	1st Quarter (1st Aug – end Oct 2016)	2nd Quarter (1st Nov – end Jan 2017)	3rd Quarter (1st Feb – end Apr 2017)	4th Quarter (May – end July 2017)	% Change
Quality Metric 1: **Number of referrals in backlog, not admitted**	984	492	1620	1754			44%
Quality Metric 2: **Number of cancellations by hospital:** **New appointments** **Follow ups** **Clinics cancelled <6/52**	1635 5032 56	817 2516 28	1575 5021 61	1448 5076 47			12% 1.8% 9%
Service Metric 1: **Number of patient complaints and concerns formally recorded about outpatient appointments. Count complaints**	8	4	8	1			92%
Service Metric 2: **Friends and family results % recommended**	89.3%	>90%	91.1%	89.7%			0
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)	2weeks 6 weeks	4.3 weeks (urgent) 9 weeks (routine)	5.2 weeks (urgent) 7.6 weeks (routine)			-100% 75%
Delivery metric 2: **% of DNAs** A. **for news** B. **For follow ups**	6.9 6.8	5% 5%	7.1% 7.5%	7.3% 7.6%			0% 5%
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	2.87 3.24 3.00 3.50 4.17 3.60 3.11	2.87 3.24 3.00 3.50 4.17 3.60 3.11			
Morale Metric 2: **Staff vacancy rate outpatient booking office**	10	0	No data a/v	No data a/v			
Cost Metric 1: **18 week RTT Breach fines per month**	£52600	0	£126600	£154500			-150%

5. Management of diarrhoea

5.1 The management of diarrhoea value stream has been our most successful so far. There have been three RPIWs to date. The first focussing on the initial diagnosis of patients experiencing diarrhoea, the second focussing on the implementation of the treatment plan for patients with diarrhoea and the third focussing on how patients access isolation rooms if it is required.

5.2 The high level metrics demonstrate that there has been a positive impact on the metrics that have a direct link to the RPIWs.

	Baseline (April – end June 2016)	Target	1st Quarter (1st Aug – end Oct 2016)	2nd Quarter (1st Nov – end Jan 2017)	3rd Quarter (1st Feb – end Apr 2017)	4th Quarter (May – end July 2017)	% Change
Quality Metric 1: **Percentage of all patients without a stool chart present**	57% N= 59/104	0%	AMU 0/ 39 0% at 90 days N= 13/98 13%	N = 7/105 7%			50%
Quality Metric 2: **Percentage of samples received by the lab which are un-testable**	23% N=14/60 Enteric pathogens	0%	27% N= 12/44 Enteric pathogens	44% N= 22/50 Enteric pathogens			- 21%
	2% N= 1/59 C.diff		2% N= 1/48 C diff	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 (mode) N=16	2 (mean)	2.4 (mean) **2 (mode)** N= 15	2.6 (mean) **2 (mode)** N= 16			13%
Quality metric 4: **The percentage of patients without an assessment of their baseline bowel function documented**	N = 15/ 15 100%	0%	AMU 2/10 20% at 90 days N= 12/15 80%	N= 14/16 88%			12%
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	231 hours (median) N= 6/15	50hrs 10 mins (median) N= 3/16			32%
Service Metric 2: **Length of time (duration) of isolation (for diarrhoea)**	5.5 days (mean) N = 11/16 (Number of patients isolated)	1 day	5.8 days N= 9/15	7.1 days N= 3/16			- 27%
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*)	N= 2/7 29%	N= 7/15 47%			38%
Delivery Metric 1: **Time between printing of stool sample label to receipt by lab**	15 hours 11 minutes (median) N= 66 samples	1 hour	14 hours (median) N = 58 samples	14 hours 40 mins(median) N = 63 samples			3%
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	18 hrs 50 mins(median) N= 9/16 2 patients isolated prior to sx	18 hrs 30 mins (median) N =13/16 2 patients isolated prior to symptoms			65%
Delivery metric 3: **Time between identification of symptoms and stool sample**	15 hours (median) N= 12/16	0 hours	21 hours (median) N = 11/15	6hrs 40 (mean of median) N= 10/16			60%

collection							
Delivery metric 4: **Time between identification of symptoms and documented differential diagnosis**	57.5hours (Median) N=5/10 50%	14 hours	AMU - 6 hrs (median) at 90 days	1hr 10 mins (mode) N = 12/16 (75%) 12hrs 30 mins (median) N = 12/16			78%
			19 hrs 45 mins (median) N =12/15				
Morale Metric 1: **Staff survey (staff experience -caring for patients with diarrhoea)**	23% N= 3/13	100% agree/strongly agree *(bundled question responses)*	100% N=10/10	60% N= 6/10			37%
Cost Metric 1: **Cost of closed beds**	252 bed days x £256 (mean cost of 1 bed per day) £64,512	£32256	71 bed days x £256 £18,176	187 bed days x £256 £47,872			26%
Cost Metric 2: **Cost of untestable samples being sent to the lab (week)**	15 X £19.11 = £286.65 (M,C&S + C.diff)	£0	13 X £19.11 = £248.43 (M,C&S + C.diff)	23 X £19.11 = £439.53 (MC&S + C.diff)			- 53%

6. Training and development

6.1 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

6.2. It is aimed at staff in key leadership roles and 31 candidates have now completed all six 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.

6.3. 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.

6.4. 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.

6.5. The KPO and Trust Guiding Team have now recruited 59 more leaders to the Lean for Leaders cohort which started in February 2017. An additional 60 leaders are also being recruited for the next cohorts that start in September 2017.

6.6 A short video will be shown at the Board meeting which reflects the learning and experience from several of the lean for leaders candidates

7. Recommendation

7.1 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
March 2017