University Hospitals Bristol NHS

NHS Foundation Trust

Agenda for an Extraordinary Public Meeting of the Trust Board of Directors to be held on 14 April 2014 at 13:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item	Sponsor	Page
1. Chairman's Introduction and Apologies To **note** apologies for absence received.	Chairman	
2. Declarations of Interest In accordance with Trust Standing Orders, all members present are required to declare any conflicts of interest with items on the Meeting Agenda.	Chairman	
3. Chief Executive's Update To receive this verbal report from the Chief Executive to **note**.	Chief Executive	
Delivering Best Care		
4. Performance Overview and Recovery Plans Report To receive this report from the Chief Operating Officer for **approval**	Chief Operating Officer	
Information and Other		
5. Any Other Business To note any other relevant matters (not for decision).	Chairman	
6. Date of Next Meeting: Public Trust Board meeting, 28 April 2014 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU.	Chairman	

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**Cover Sheet for a Report for an Extraordinary Public Trust Board Meeting,
to be held on 14 April 2014 at 13:00pm
in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU**

4. Performance Overview and Recovery Plans Report
Purpose
The aim of this briefing is to provide assurance to the Board regarding performance recovery against the standards in Monitor's Risk Assessment Framework that are not currently being achieved.
Abstract
Four of the standards in Monitor's Risk Assessment Framework have been failed in quarter 4 2014/15, with a fifth still to be validated, but considered to be at high risk of failure (31-day first definitive cancer). The five standards are as follows: - A&E 4-hour standard   - Referral to Treatment Time (RTT) Non-admitted pathways standard   - Cancer 62-day GP standard   - Cancer 31-day First Definitive Treatment standard   - Clostridium difficile annual objective   This briefing includes a review of the causes of poor performance and sets-out the plans to recover performance in 2014/15.
Recommendations
The Trust Board is recommended to approve the Recovery Plan by the Chief Operating Officer.
Executive Report Sponsor or Other Author
• Sponsor – Chief Operating Officer
Appendices
• None

Access Standards Recovery Plan

Briefing to Extraordinary Board
14 April 2014

Briefing to Extraordinary Board

University Hospitals Bristol NHS
NHS Foundation Trust

CONTENTS

Objectives:

1. To provide assurance to the Board regarding performance recovery

2. To review the causes of poor performance that has lead to the governance concerns

3. To set out performance recovery plans and provide assurance about recovery for each of the failing / at risk access standards

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Board self-certification

- 2013/14 Annual Plan declaration:
  - FRR 3 / GRR AMBER-RED
  - Declared the following standards at risk:
    - A&E 4hr target
    - RTT Non-admitted
    - Clostridium difficile (C. diff)

- Internal Process
  - Risk assessment undertaken by Executive Directors
  - Senior Leadership Team review risk assessment and make quarterly recommendation to Trust Board
  - Trust Board consider risk assessment and recommended declaration

Governance Risk Rating	Declared	Actual	
Q3 2013/14	GREEN	GREEN	A&E 4-hour standard, C. diff and RTT Non-admitted standard not achieved.
Q2 2013/14	AMBER-RED	AMBER-RED	C. diff, 62-day GP cancer and RTT Non-admitted standard not achieved.
Q1 2013/14	AMBER-RED	AMBER-RED	A&E 4-hour standard and C. diff not achieved.
Q4 2012/13	AMBER-RED	AMBER-RED	A&E 4-hour standard, MRSA and 62-day GP cancer standard not achieved.
Q3 2012/13	AMBER-RED	RED	Red rating over-ride applied by Monitor for A&E + MRSA; 62-day cancer screening standard also not achieved.
Q2 2012/13	RED	AMBER-RED	C diff not achieved; CQC enforcement notice applied in the quarter; Monitor de-escalated to AMBER-RED once CQC actions implemented
Q1 2012/13	AMBER-GREEN	AMBER-RED	A&E not achieved; C diff subsequently confirmed as not achieved following updated advice from Monitor.

Assurance

- Internal Audit review of Trust processes against Monitor Compliance Code (April 2013). Outcome = *Green*

- Self-assessment against Monitor recommendations from independent self-certification reviews of FTs (January 2013):
  - Full compliance with 20 of 23 recommendations
 - *Amber-green* against 3 recommendations pending completion of internal review of Divisional governance

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4 hour Standard

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A&E 4-hour analysis

95% of patients to wait less than 4 hours in the Emergency Department, from arrival through to discharge, admission or transfer

Background:

- Flagged in Annual Plan as a risk due to increasing age profile of admissions, high levels of delayed discharges and increasing ambulance arrivals
- Recovery plan to Monitor showed failure in quarter 1, but recovery from then onwards, noting risks to achievement in quarter 4
- Similar pattern of performance in 2013/14 as the previous year, with failure against the 95% standard in quarters 1, 3 and 4

Trust AE Attendances with Mode of Arrival of 'Ambulance'
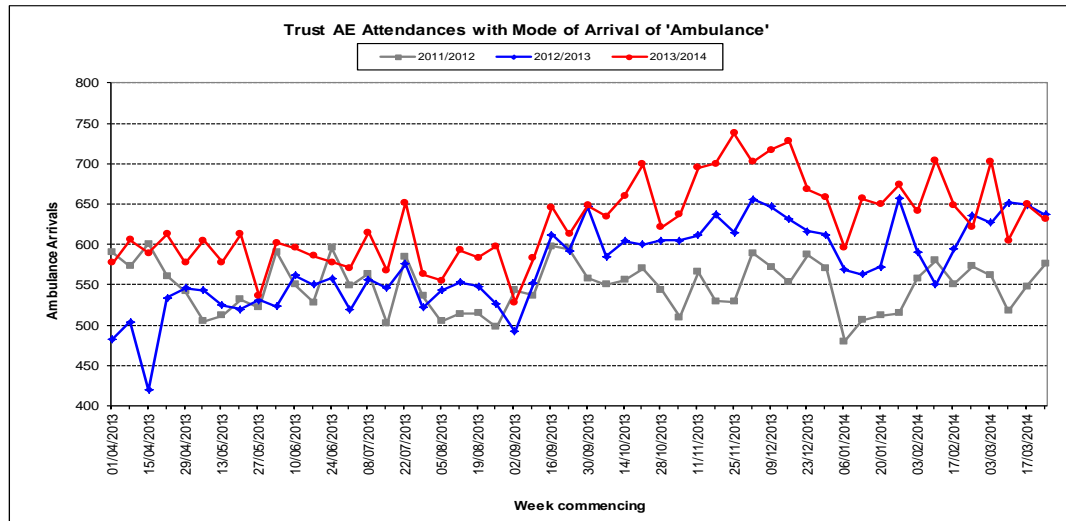
The number of emergency admission into the Bristol Children's Hospital (via the Emergency Department) each month during the last three years

Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2011/12	498	384	340	337	283	388	393	453	448	414	387	469
2012/13	398	568	546	621	401	492	516	514	574	479	460	578
2013/14	583	533	517	523	507	588	637	743	767	596	527	569

Root cause:

- 9% year-on-year increase in ambulance arrivals, translating into high levels of emergency admissions at the Bristol Children's Hospital, but not at the BRI
- 8% increase in levels of emergency admissions for patients aged 75 years and over, compared with same period last year, outstripping reductions in Length of Stay for this age-group
- Exceptional levels of emergency admissions into the Bristol Children's Hospital in quarter 3, due to respiratory illnesses (up 39% in Nov/Dec on previous year)

Progress to date:

- Achievement in quarter 2, as planned
- Significant improvement in measures of patient flow and quality, including ambulance hand-over delays , elective cancellations and outlier bed-days;
- Reduction in Length of Stay for patients aged 75 years and over, relative to the same period last year
- Improvements in measures of patient flow have not, however, translated into achievement of the 4-hour standard

Patient Flow Programme

Joint Project with KPMG

- In March 2013, the Trust appointed an external advisor (KPMG) to support the Trust in developing an integrated "Patient Flow" programme.

- The objective of this programme was to implement and embed those ideas which have the biggest impact on patient flow.

- Purposefully took a different approach in the design of the 2013/14 programme to focus on the causes of the problem, rather than the symptoms.

Causes identified included;
- discharges not being completed in the morning,
- poor planning for complex discharges,
- manual processes for bed management,
- pathways not established for ambulatory care conditions,
- complex older people not getting specialist input early enough in the pathway and
- access to full assessment in the Medical Assessment Unit.

Therefore, the Patient Flow programme for 2013/14 focussed on addressing these causes of poor patient flow. Further details are provided on the next slide.

The new 'fit for purpose' discharge lounge opened on 16th September 2013

Successes:
✓ reduction in the number of ambulance delays despite an increase in the total number of ambulances arriving year on year.
✓ reduction in the number of elective cancellations due to lack of ward beds
✓ increases in the use of ambulatory care to prevent admissions
✓ increased utilisation of community beds

Despite measurable improvements in performance between May 2013 and November 2013 (with the exception of July 2013), the trust has been challenged over the winter months with performance levels below the 95% standard.

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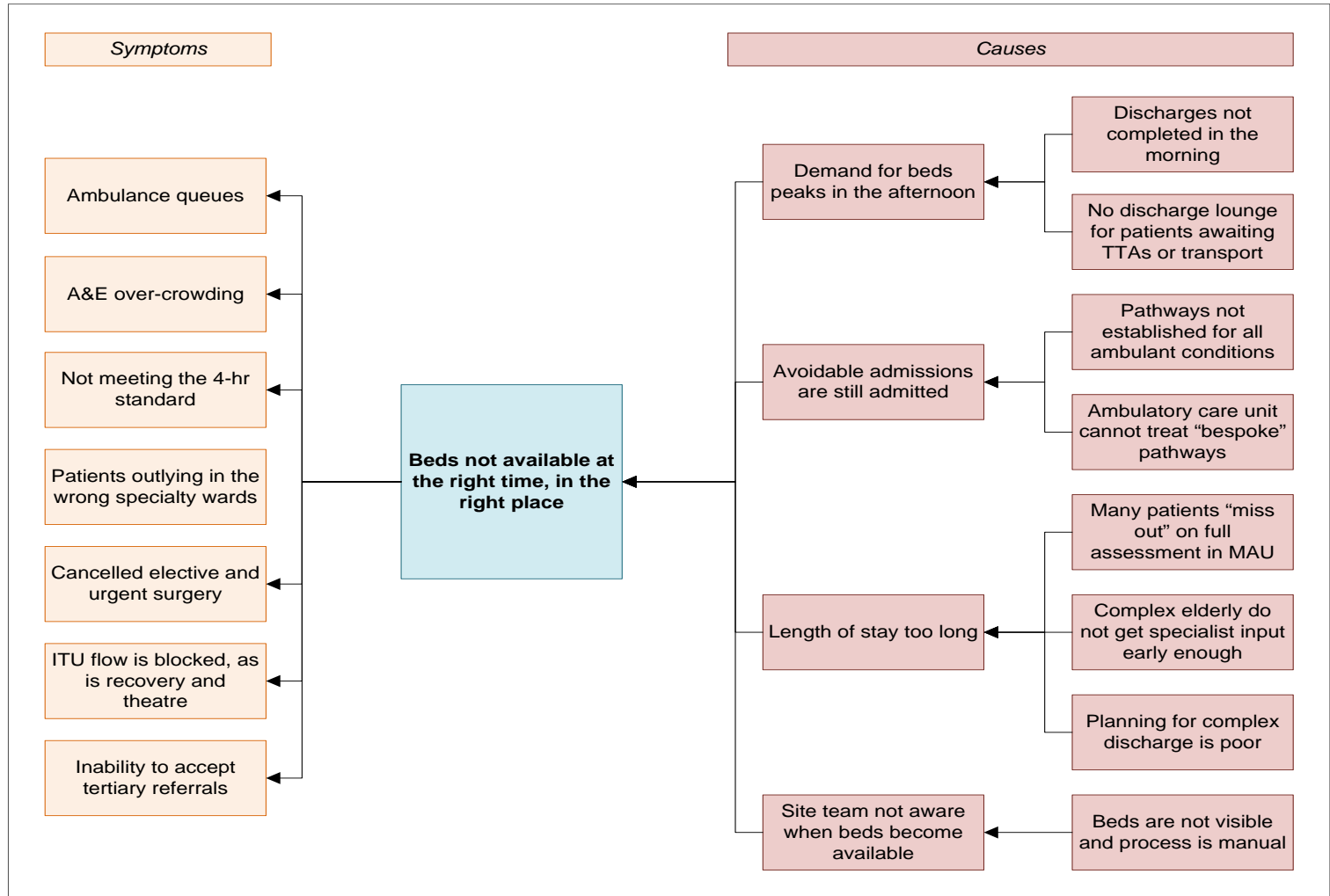**Working together**
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Patient Flow Programme

Symptoms and Causes

The diagram on the right shows the symptoms and primary and secondary causes behind the patient flow pressures that the Trust has experienced.

The symptoms on the left of the diagram are largely due to beds not being available for patients at the right place or the right time. This situation has arisen because of the root causes to the right of the diagram.

At times, the Trust's approach has been too focused on the symptoms of poor patient flow, whereas the Patient Flow projects focussed on a select number of root causes.

Symptoms

- Ambulance queues
- A&E over-crowding
- Not meeting the 4-hr standard
- Patients outlying in the wrong specialty wards
- Cancelled elective and urgent surgery
- ITU flow is blocked, as is recovery and theatre
- Inability to accept tertiary referrals

Beds not available at the right time, in the right place

Causes

- **Demand for beds peaks in the afternoon**
  - Discharges not completed in the morning
  - No discharge lounge for patients awaiting TTAs or transport
- **Avoidable admissions are still admitted**
  - Pathways not established for all ambulant conditions
  - Ambulatory care unit cannot treat "bespoke" pathways
- **Length of stay too long**
  - Many patients "miss out" on full assessment in MAU
  - Complex elderly do not get specialist input early enough
  - Planning for complex discharge is poor
- **Site team not aware when beds become available**
  - Beds are not visible and process is manual

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Patient Flow Programme – Phase I

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Phase I

There were 7 projects prioritised for phase I of the patient flow programme.

Each Project had an identified clinical lead, project team and Transformation support.

Delivery of the projects was overseen by a joint steering group which met weekly to ensure there was pace of delivery.

The overall project was lead by clinical leads, Andy Hollowood and Anne Frampton, who met with each project lead on a fortnightly basis throughout the period.

Project	Objectives	Outcomes
1. Ambulatory Care	• Implement key ambulatory protocols • Create capacity for 'bespoke' medically-led ambulatory care • Development of a dedicated unit with appropriate resources.	This project ran over phase I and II; see next page for outcomes. Directory of 34 pathways developed.
2. Complex discharge planning, including use of Medway	• Implement initiatives to avoid discharge delays • Electronic sharing of information with social care • Redesign interface with social services • Engagement of care homes • Move CHC assessment out of hospital.	Multi-professional logger implemented in Sept 2013. Improved engagement with care homes leading to Phase II project. This work-stream is now being taken forward as part of the Operating Model.
3. Embedding of reverse triage and discharge planning	• Improve on-the-day discharge times by extending current reverse triage system to all hospital wards • Includes linking the system to discharge planning action (TTA preparation, transport booking and EDIS completion)	Reverse triage now in place on all adult wards (July 2013), and children's wards (March 2014).
4. Criteria-led discharge and weekend planning	• Improve patient safety and weekend discharge rates.	Weekend plan stickers for patient notes implemented for all adult wards June 2013.
5. Real-time bed-state through use of Medway	• Improving the capture of data real-time • Generate experience improvements for patients and families • Assist in better outlier management by CSMs.	Real-time information is now consistently above 98%.
6. Fit for purpose discharge lounge	• Implement a fit-for-purpose discharge lounge with capacity for an average of 21 discharges per day	Discharge Lounge opened 16th September 2013. Percentage of discharges by midday improved from 19.4% in Q4 2012/13 to 31.1% in Q4 2013/14. March 2014 = 33.1%.
7. Older Persons Admissions Unit	• Improving access to elderly physician input at the front door will improve patient outcomes and reduce length of stay	Unit opened 19th June 2013; larger unit opened January 2014. Average length of stay has reduced by 1 day for this cohort of patients. There has also been an increased number of direct admits from the Emergency Dept.

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Patient Flow Programme – Phase II

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Phase II

Six projects were taken forward as part of phase II of the patient flow programme.
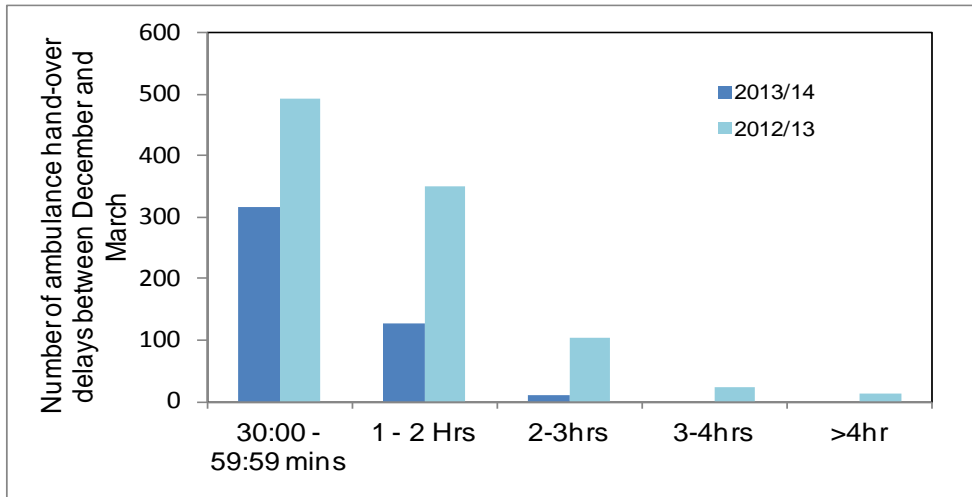
Whilst a number of the phase II projects continued to focus on internal improvements in our patient flow, there was a higher proportion of projects that focussed on improvements with partner organisations in the second phase.

These projects included leads from Bristol Community Health, Health & Social Care and Bristol Clinical Commissioning Group.

Project	Objectives	Outcomes
1. Ambulatory care	• Maximise the use of ambulatory care pathways for ambulatory care conditions to reduce emergency admissions (building on the work in phase I)	• Three new ambulatory care pathways introduced. • Number of ambulatory care patients treated increased by 10 per week.
2.Ward Processes – Including Reverse Triage, eHandover Criteria Led discharge, EDIs/ TTAs	• Proactive approach to discharge planning • Increase in number of patients discharged before midday • Increase TTAs and discharge summaries prepared day before discharge • Increase number of discharges at weekend	• New IT system due for completion end July 2014 • This is being taken forward as part of the Operating Model.
3. ITU - pathways	• Reduced the number of patients transferred to wards out of hours • Reduce the number of Elective operation cancellations due to ITU availability • Tertiary referrals are repatriated to referring location within agreed timeframes	• Repatriation policy implemented Jan 2014 • Work to continue as part of the Operating Model.
4. Care homes	• 7 day transfers to care homes • Improved timeliness from referral to transfer to care homes (including assessment	• Pilot transfer of care documentation with five care homes completed March 2014 • Roll-out to all local care homes being taken forward as part of the Medicine Division work programme.
5. Out of hospital care	• Improve information sharing and joint working to smooth pathways for patients across partner organisations • Reduce the amount of time patients are delayed in an acute hospital setting • Better utilisation of community beds available for rehabilitation	• Utilisation of community beds increased from 65% to consistently running at 97% to 98%. • Green to Go List reduced to 40 in December, increased numbers during quarter 4, but back down to 48 following Breaking the Cycle week. • Work to continue as part of the Operating Model.
6. Medical Assessment Unit (MAU)	• Ensure specialty ownership of management of patients within MAU • Early supported discharge from MAU either via outpatients or Ambulatory Care.	• New interim model for the management of MAU established January 2014.

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Patient Flow Programme: Benefits realised

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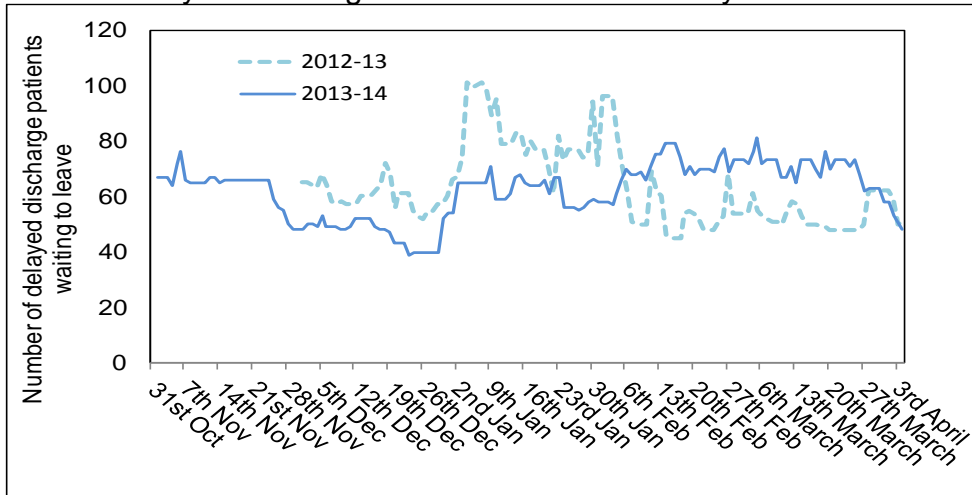**NHS Foundation Trust**

Fewer delayed ambulance hand-overs
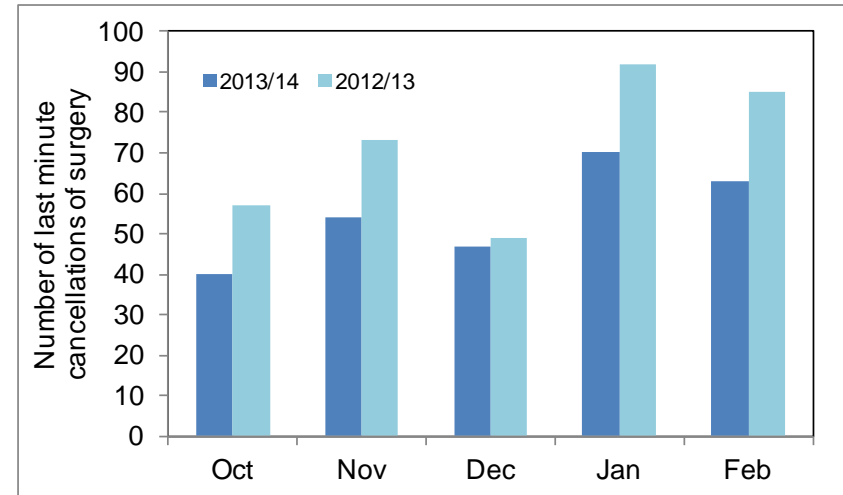

Patients spending less time on the wrong wards
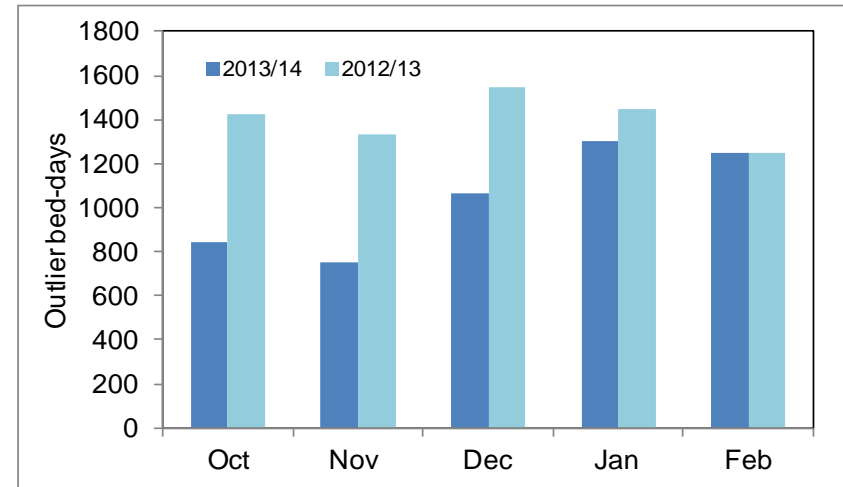
Fewer delayed discharges – December to January

Fewer operations cancelled

Breaking the Cycle Together took place on the week commencing 31st March 2014. and was run over seven days, covering all adult inpatient wards.

It was run using a Major Incident approach to rapidly address barriers to adherence with standards of care.

The initiative was based on the Perfect Week methodology recommended by the Emergency Care Intensive Support Team (ECIST)

The key aim of the week was to break the cycle of repeated escalation measures and end the continuing disruption to normal clinical business which disadvantages patients and frustrates clinical staff.

Breaking the Cycle Together was run by the Trust with the full involvement of Bristol Health and Social Care, and Bristol Community Health (BCH).

The process provided a great opportunity for us and our partner organisations to gain a better understanding of the day to day issues causing delays across the system. The next slide details the issues that have been resolved and the plans to address outstanding issues.

Initial results from the week:
Whilst there is still a great deal of analysis to be completed on the information gathered during the week, there are a number of key results that are worth celebrating.

✓ **Outliers** reduced from around 30 to 3 by Sunday
✓ **Green to go** list reduced from circa 70 to 48 by Friday
✓ Regularly coming in to **empty beds** at 8.30am each morning
✓ **Occupancy** reduced to 92.0% by Friday
✓ The number of **extra capacity beds** opened reduced
✓ **4-hour Performance** for the week in the BRI / BHI was **95.6%**
(Trust level performance = 95.5%)

BRI 4 hour Performance
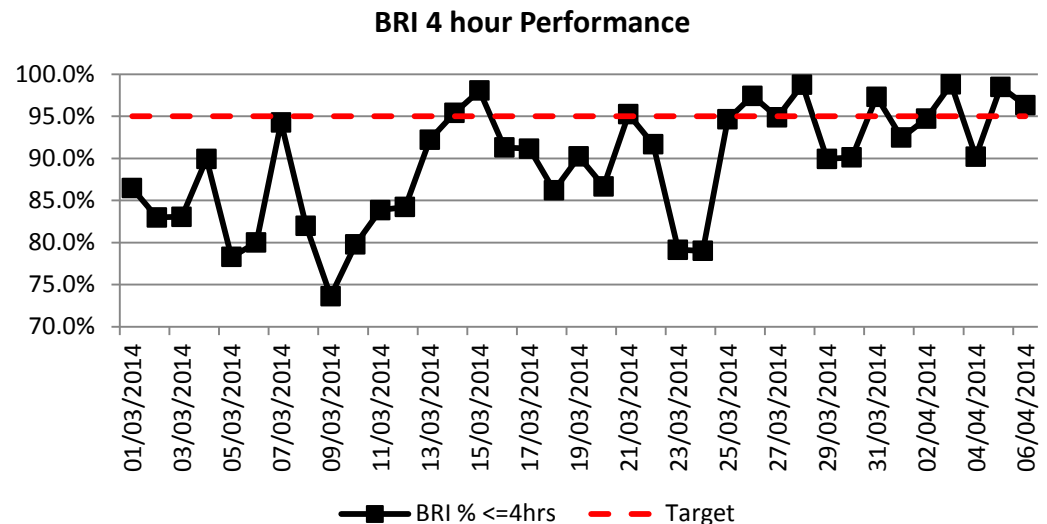
Breaking the Cycle Together

Following the Breaking the Cycle Together week, this summarises the key issues that have been addressed and the plans to resolve the remaining issues.

Key outcomes	Residual issues and themes
Key operating standards agreed across wards and other clinical areas.	Ensure operating standards become better embedded into wards and clinical areas as "Business as Usual" at all times.
Rapid escalation of non-compliance with standards to resolve issues quickly.	Embedding processes for escalation and response into daily routines.
Significant improvement in patient flow and a reduction in our escalation levels during a busy week.	Learn from data captured during the week and how this can better inform daily operational flow.
Joint planning and daily feedback to Social Care and Bristol Community Health has strengthened the working relationship and led to progress against the Key Performance Indicators agreed for the week	Working together to speed-up the discharging of patients with complex care needs.
Staff from support areas have been given the opportunity to understand front-line patient care delivery first hand.	Building upon staff feeling that the hospital is 'smaller' and more cohesive.
Rapid response from IM&T, Facilities and Estates fixed numerous equipment and buildings issues.	To link support teams with individual areas so issues are proactively identified and addressed.

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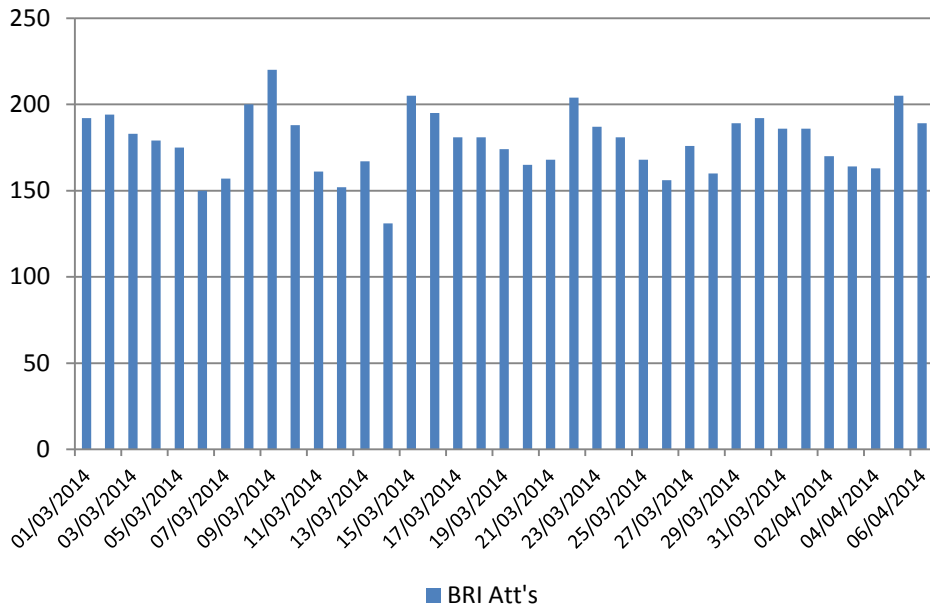Working together
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Breaking the Cycle Together

There has been an improvement in performance against the 4-hour standard. The graphs below show that this is not due to fewer attendances or admissions in the period.

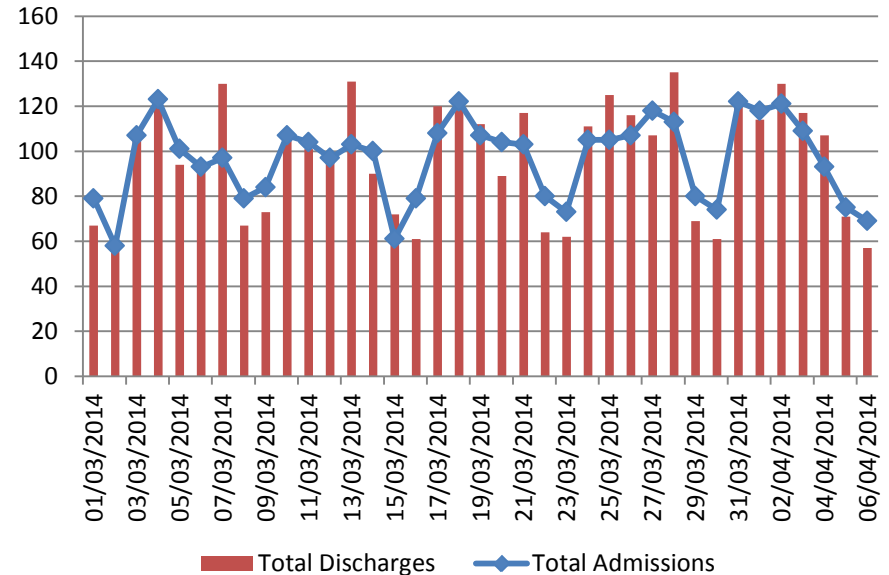There was similar levels of attendances during the week compared to numbers of attendances during March 2014

Admissions and discharges were both high at the beginning of the week and followed a similar weekend pattern to previous weeks.

BRI Attendances

BRI Admissions and Discharges - Total

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Operating Model for 2014/15

By resetting our operational processes through **Breaking the Cycle Together**, it has provided us with some headroom to enable the other six projects identified as part of the new operating model to progress in the coming months.

Project plans for the remaining projects are being worked up but clear delivery plans are not yet in place therefore the impact of the remaining projects cannot yet be quantified.

Project	Project Aims	Progress on delivery
Integrated discharge hub and supporting discharge processes	To co-locate staff from the three key Organisations responsible for managing patients with complex care needs; Bristol City Council, Bristol Community Health and University Hospitals Bristol; to improve efficiency of discharge processes; improve communication, reduce duplication and create an integrated discharge policy and process.	Area for co-location of teams identified, conversion costs being assessed. Joint workshop to develop integrated processes, taking learnings from Breaking the Cycle Together, planned for later in April 2014.
Out of hospital solution	To commission further out of hospital transitional care beds to reduce the number of bed days consumed by 'Green to Go' (delayed discharge) patients, thereby reducing Length of Stay (LOS) and bed occupancy to improve patient flow.	Potential beds identified. Proposal prepared for the Better Care Fund programme board to agree funding arrangements (completed). Criteria and Standard Operating Procedures for Discharge team are under development (April 2014).
Early Supported Discharge	Effective early supported discharge pathways in place for patients which are provided by either a community partner or UH Bristol, or a combination of both which leads to better patient outcomes, better patient experience and a reduced LOS	Success models exist locally (e.g. Stroke). Currently prioritising areas which will benefit most from the approach and scoping the right work (ongoing).
Trust wide review of Critical Care	The project is still being scoped but will address issues of flow and capacity in adult critical care facilities.	Long term capacity review planned alongside short term interventions to improve flow between critical care and other areas (is in planning stage).
Weekend discharge – diagnostic and solution	To understand the issues needed to even out patient flow across the seven days of the week and increase the number of discharges that take place at the weekend.	Valuable evidence gathered during Breaking the Cycle Together being evaluated now to better understand root causes (in progress, April 2014).
Protected Beds	To develop an operating model that will support elective and urgent tertiary activity to proceed unhindered by periods of high demand for acute medical care through the Emergency Department. This will ensure that all our patient flows are supported, both planned and unplanned care.	Team is developing a planning and bed management tool to allow us to manage protected beds with high occupancy. Aim to commence pilot operating at end April 2014.

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4-hour Standard Trajectory

Recovery trajectory

- Based on the position at the time of writing, we are unable to provide a percentage improvement for performance for each of the six action plans as plans are still being worked up.
- However, with the work that has already been completed through Breaking the Cycle Together plus the operating model plans for the coming year, we are projecting overall improvement in performance.
- Quarter 1 performance remains at risk due to the projects needing to start up and take effect
- Quarter 2 and 3 are predicted as achieving.
- Quarter 4 performance is at risk due to the likelihood of system wide issues remaining ongoing linked to winter pressures i.e. quarter 4 has not been achieved previously so is therefore a risk.

Next steps

- Detailed analysis of the improvements seen through the week of Breaking the Cycle Together is currently being undertaken and there is a plan to hold a series of lessons learnt sessions with all staff involved during the week to identify what worked well and should become part of business as usual.
- The six operating model projects are being progressed as further details of the expected benefits of the projects are confirmed, these will be fed into the trajectory modelling for 4 hour performance and Cancer standards.
- BCH programme on patient flow to add robustness to Q3 delivery

Impact of actions: current and projected	Q1 RAG	Q2 RAG	Q3 RAG	Q4 RAG
• Quarter 1 and Quarter 4 are at risk	🟥	🟩	🟩	🟥

Failure again in quarter 4 will potentially trigger a further governance concern under the rules of Monitor's Risk Assessment Framework.

Referral to Treatment (RTT) Non-admitted analysis

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95% of patients on a non-admitted pathway to be treated within 18 weeks of referral

Background:

- Flagged in Annual Plan as a risk for two quarters of 2013/14, due to the size of backlogs arising from the planned Head & Neck service transfer from North Bristol Trust (NBT)
- Current failure of 3 quarters, with a further 2 quarters at risk

RTT Non-admitted backlogs

Legend: Backlog > 18 weeks — RTT Non-admitted ongoing pathways (% < 18 weeks)
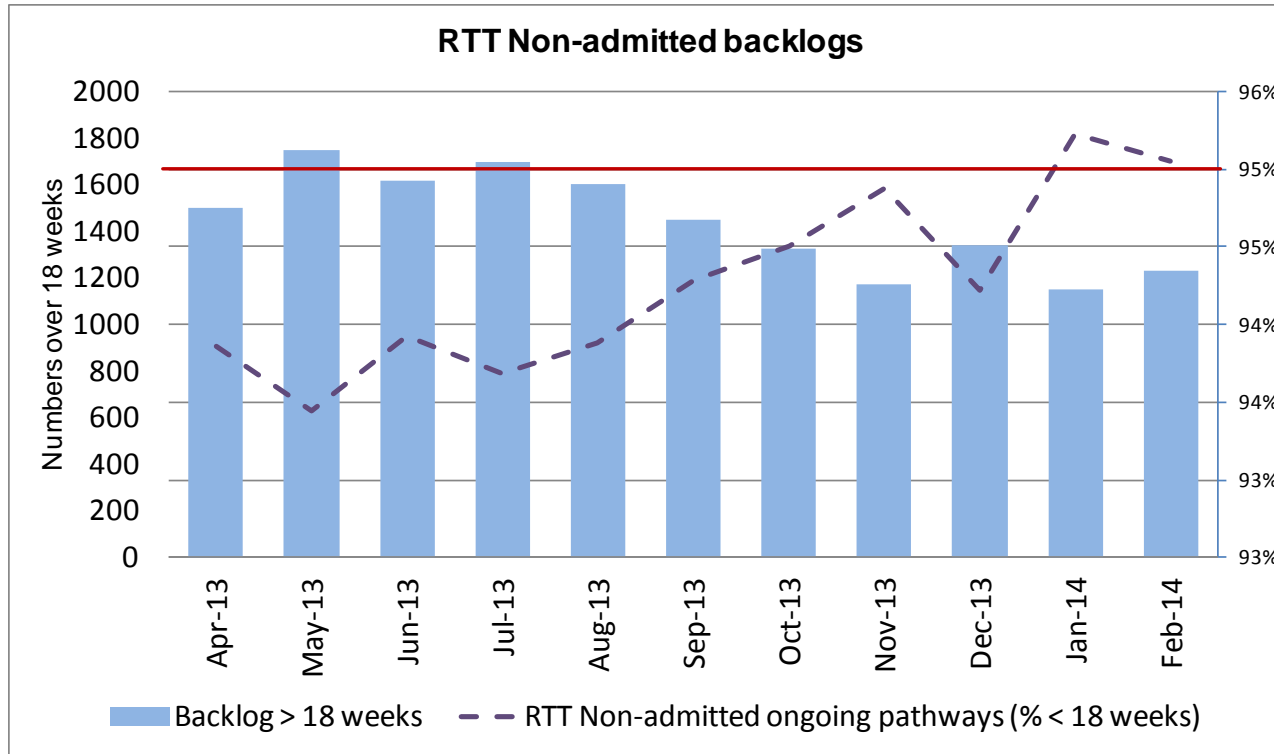
Root cause:

- High volumes of long waiting patients transferring from NBT as part of the Head & neck service transfer
- GUM (Genito Urinary Medicine) service no longer contributing to RTT Non-admitted performance (approx. 1% reduction in performance)
- Increase in GP referrals (4% overall, significantly higher in transferring specialties, and those with capacity constraints); significantly above Office of National Statistic (ONS) growth rates
- Pre-existing referral and booking management process issues were highlighted following the Head & Neck service transfer

Progress to date:

- Significant reduction in Non-admitted RTT ongoing backlogs from peak post transfer
- RTT Non-admitted ongoing performance reached 95% in January and February, but this has not translated into an equivalent reduction in clock stops (i.e. achievement of the RTT Non-admitted standard)

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Referral to Treatment (RTT)
First Outpatient Waits Recovery Plans

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- Recovery plans have been developed to reduce the wait to first outpatient appointment for each specialty that has been assessed as high risk or has a high volume of activity.
- The list of specialties and key summary information used as part of the modelling is set out below.

- The high level 'combined' plan is shown on the next slide
- We have also included the summary report for ENT to illustrate the detailed trajectories available at specialty level.
- Progress against these plans will be monitored weekly and any deviations from plan investigated and mitigated as appropriate

Summary of plans by Specialty

Division	Specialty Name	Target wait in weeks	Baseline Period (for modelling)	Backlog cleared from	Additional recurrent activity identified	Non-recurrent activity required	No. over target wait (end Feb)	Ave mth WL change	Ave mth b/log change	Key action underpinning plans
Specialised Services	Cardiology - Other	13	Last 6 months	Oct-14	Yes	Yes	288	31	16	Additional clinics recurring and non-recurring
Diagnostics & Therapies	Chemical Pathology	13	Last 6 months	Jul-14	Yes	Yes	22	-2	-3	New consultant joins service in July 2014
Surgery, Head & Neck	ENT	11	Last 3 months	Aug-14	Yes	Yes	346	67	48	Recruitment of consultant and specialty doctor
Surgery, Head & Neck	Ophthalmology - Other	13	Last 6 months	Jan-15		No	554	-15	10	Review booking prioritises and clinic templates
Surgery, Head & Neck	Oral Surgery	11	Last 6 months	Jul-14	Yes	No	251	29	-26	Recruitment of 1x Specialty dentist
Surgery, Head & Neck	Orthodontics	11	Last 6 months	Aug-14	Yes	No	198	-41	-43	Recruitment of consultant after 18 month gap
Surgery, Head & Neck	Trauma & Orthopaedics	6	Last 6 months	Mar-13		No	109	-3	-109	Target wait delivered. Review of diagnostics and follow up pathway
Surgery, Head & Neck	Restorative Dentistry	11	Last 6 months	Oct-14	Yes	No	529	9	8	Recruitment of consultant after 10 month gap
Medicine	Rheumatology	13	Last 6 months	Jun-14	Yes	Yes	52	-19	-2	Business case to make locum post substantive
Medicine	Dermatology	11	Last 3 months	May-14		Yes	107	10	-14	Locum in place to provide non-recurrent activity
Women's & Children's	Paediatric ENT	13	Last 6 months	May-14		Yes	67	-26	-12	Waiting list initiatives March and April
Women's & Children's	Paediatric Cardiology	13	Last 6 months	Jan-15	Yes	Yes	206	-3	-3	Business case x2 new Cardiology posts
Women's & Children's	Paediatric Neurology	13	Last 6 months	Jul-14		Yes	41	-6	-5	Waiting list initiatives May and June
Women's & Children's	Paediatric Surgery	13	Last 6 months	Aug-14		Yes	105	-8	-4	Clinic utilisation increased
Women's & Children's	Paediatric Trauma & Orthopaedics	10	Last 6 months	Jul-14		Yes	121	-4	2	Waiting list initiatives until CSP Transfer
Women's & Children's	Paediatric Urology	13	Last 6 months	Oct-14	Yes	Yes	78	10	3	Additional 1 clinic per week (as per OPP)
							3,074	29	-134	

The next slide shows the modelling methodology with the aggregated Trust level data, and also shows the capacity plans and assumptions for a worked example (i.e. Adult Ear, Nose, & Throat - ENT)

Referral to Treatment (RTT)
First Outpatient Wait Recovery Trajectory

Referral to Treatment (RTT) Non-admitted Recovery Plan

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First outpatient versus Non-admitted waits

- Whilst the waiting times from referral to first outpatient appointment form only a part of the non-admitted pathways, for many specialties, the non-admitted clock stop will take place as part of the first outpatient appointment.
- For other specialties, there will be an element of diagnostics and follow up waiting times before a clock is stopped
- For other pathways, patients will have a decision to admit and move onto an Admitted pathway.
- By reducing the wait to the first outpatient appointment, this will have both a positive impact both on non-admitted and admitted waiting times
- However, it is difficult to correlate exactly between the planned reductions in first outpatients and the overall performance for non-admitted waiting times.

Non-admitted improvement trajectory

- Based on the reductions in backlog waiting times for first outpatients, we have modelled the trajectory for achievement on non-admitted performance at trust level.

Non-admitted Trajectory
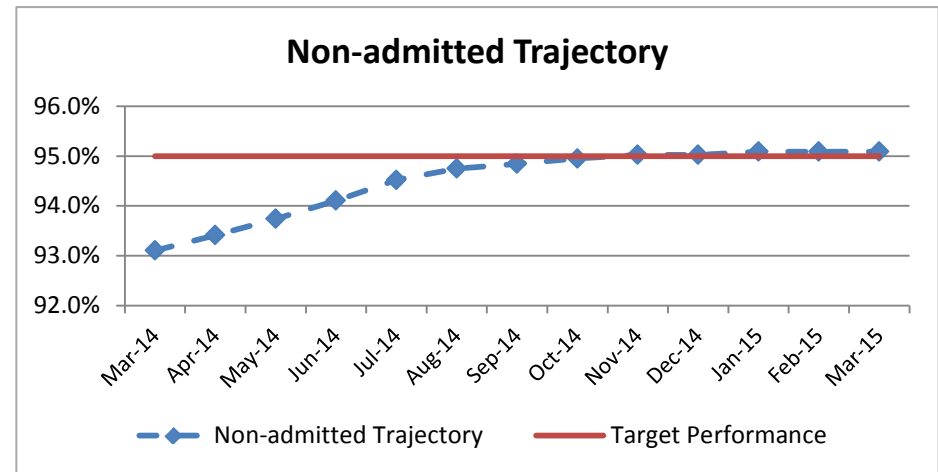
Non-admitted Trajectory	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Long 1st outpatient wait backlog	2,940	2,483	1,998	1,454	844	505	364	207	98	98	0	0	0
Percentage	93.1%	93.4%	93.7%	94.1%	94.5%	94.7%	94.8%	95.0%	95.0%	95.0%	95.1%	95.1%	95.1%

Impact of actions: current and projected	Q1 RAG	Q2 RAG	Q3 RAG	Q4 RAG
Expected to achieve at Trust level from Quarter 3 onwards but delivery at specialty level in some areas remains a risk				

Cancer Standards

Cancer 62-day GP analysis

University Hospitals Bristol NHS
NHS Foundation Trust

85% of patients referred by their GP with a suspected cancer to be treated within 62 days

Background:

- Breast and Urology cancer services transferred to North Bristol Trust (NBT) at the end of quarter 4 2012/13, with Head & Neck services transferring into the Trust
- Over 80% of cancer patients treated are now treated for tumour sites that nationally perform below the 85% standard
- Tertiary referrals for the more complex pathways and patients have increased
- 69% of breaches now due to unavoidable causes, including late tertiary referrals, medical deferrals and patient choice

62-day GP performance in quarter 2 and quarter 3 2013/14

Tumour site	Quarter 2 2013/14		Quarter 3 2013/14		Total treated in quarter 3
	UH Bristol	National average	UH Bristol	National average	
Brain/Central Nervous System	N/A	N/A	100	83.9	0.5
Breast	100	97.4	100	97	10
Gynaecological	88.5	82.7	93.5	83.6	31
Haematological	72.2	83.1	87.5	81.8	24
Head & Neck	69.6	74.5	83	76.8	23.5
Lower Gastrointestinal	61.5	78.8	81.5	78.7	27
Lung	79.8	79	75.8	77.8	45.5
Other	0	74.3	60	79.3	2.5
Sarcoma	66.7	76.2	100	78.1	4
Skin	97.6	97.3	100	95.8	31.5
Upper Gastrointestinal	78.9	78.9	68.6	79.1	25.5
Urological	0	83.4	66.7	81.5	3
All Cancers	**78.9**	**86.7**	**84.6**	**85.6**	**228**

Please note: The 62-day GP standard was achieved in Q3 2013/14, with breach reallocation; in order to make a direct comparison the above figures do not include reallocations

Root cause:

- Portfolio of cancer services now biased towards most complex pathways and tertiary services (e.g. lung and upper GI)
- Higher levels of late tertiary referrals, medical deferrals and patient choice in Q4, which the Trust has limited influence over
- Capacity constraints in thoracic surgery and upper GI (hepatobiliary) services
- Increasing demand for critical care beds, translating into cancellations of surgery due to lack of beds

Progress to date:

- Breaches due to avoidable causes have reduced significantly, both in number and percentage terms
- Significant improvements realised in tumour-site level performance between quarter 2 and 3, with performance above national average in many tumour sites
- Performance above average of peer group of 12 similar trusts in quarter 3

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Breach reasons	Average Q4 breaches per month	
Late referral	5.2	31%
Medical deferral/Clinical complexity	3.8	23%
Patient choice	1.2	7%
Histology delay	0.3	2%
Outpatient delay	1.2	7%
Delayed admitted diagnostic	1.5	9%
Admin delay/pathway planning issue	1.0	6%
Delayed pathway other provider	1.0	6%
Elective cancellation	0.5	3%
Insufficient capacity	0.8	5%
Total breaches	16.5	

Summary of actions referenced in table below

1. New management for tertiary thoracic surgery referrals (impact from Q4 onwards)
2. Reduce maximum wait for 2-week wait step to 7 days for 90% patients (July onwards)
3. Reduction in histology delays realised in March, with further improvements expected with recruitment later in 2014/15
4. New approach to escalation of pathway delays to be enacted from April onwards, involving the Divisional Management teams
5. 2.5 additional ENT theatre sessions per week from October 2014 onwards, which will reduce the majority of panendoscopy delays
6. Reduction in cancellations already seen following opening of 20th critical care bed
7. New approach to critical care cancellations and booking of cases should minimise impact of residual cancellations
8. Additional thoracic and HPB theatre sessions timetabled from October 2014, when Vascular service moves to NBT
9. Additional activity to be scheduled in December, when activity levels are low and breaches can result in Q4

Breach reasons	Action reference	Apr-14	May-14	Jun-14	Q1	Jul-14	Aug-14	Sep-14	Q2	Oct-14	Nov-14	Dec-14	Q3	Jan-15	Feb-15	Mar-15	Q4
		Improvement trajectory (percentage reduction in breaches)															
Late referral	1	0%	0%	0%		0%	0%	0%		0%	0%	0%		10%	10%	10%	
Medical deferral/Clinical complexity	2	0%	0%	10%		15%	30%	30%		30%	30%	30%		30%	30%	30%	
Patient choice	2	0%	0%	10%		15%	20%	20%		20%	20%	20%		20%	20%	20%	
Histology delay	3	50%	50%	50%		50%	50%	50%		50%	50%	50%		50%	50%	50%	
Outpatient delay	4	25%	25%	25%		50%	50%	50%		75%	75%	75%		75%	75%	75%	
Delayed admitted diagnostic	5	0%	0%	0%		0%	0%	0%		80%	80%	80%		80%	80%	80%	
Admin delay/pathway planning issue	4	30%	30%	50%		50%	50%	75%		75%	75%	75%		75%	75%	75%	
Delayed pathway other provider	N/A	0%	0%	0%		0%	0%	0%		0%	0%	0%		0%	0%	0%	
Elective cancellation	6,7	25%	25%	25%		25%	25%	25%		75%	75%	75%		75%	75%	75%	
Insufficient elective capacity	8,9	25%	25%	25%		25%	25%	25%		75%	75%	75%		75%	75%	75%	
Total estimated breaches		15.4	15.4	14.7	45.5	14.2	13.5	13.3	41.0	11.1	11.1	11.1	33.4	10.6	10.6	10.6	31.8
Total estimated activity		63.5	79	42	184.5	70.5	75.5	73	219.0	82	74.5	70	226.5	70	72.5	81.5	224.0
		75.7%	80.5%	65.0%	75.3%	79.9%	82.1%	81.8%	81.3%	86.4%	85.1%	84.1%	85.3%	84.8%	85.4%	87.0%	85.8%

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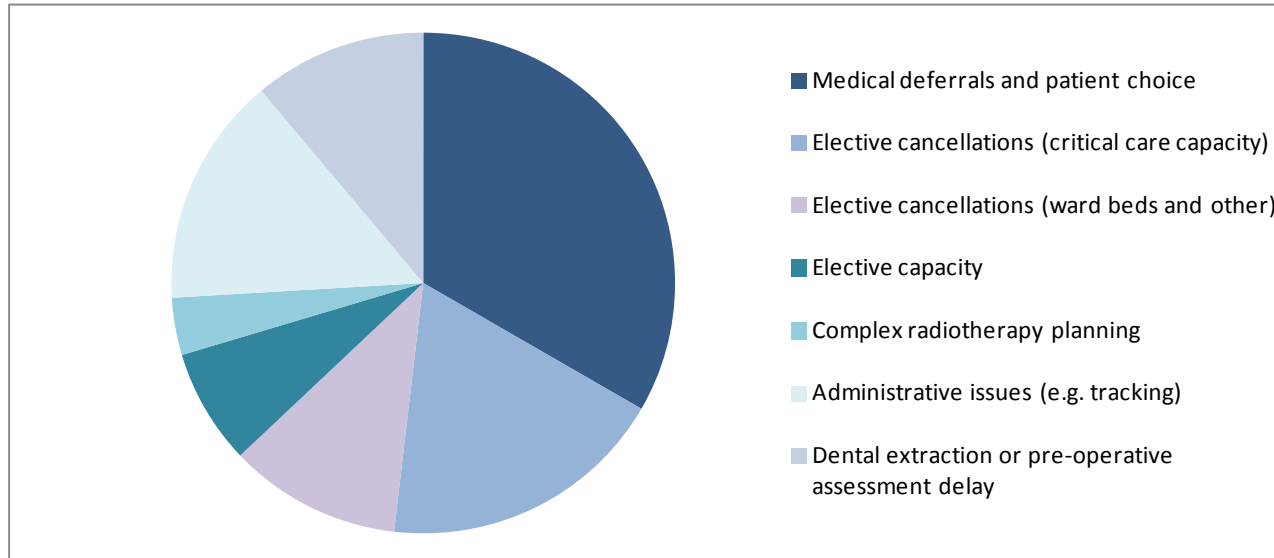Working together
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Cancer 31-day first definitive analysis

96% of cancer patients to be treated within 31 days of the decision to treat

Background:

- 31-day first definitive cancer standard achieved since quarter 2 2009/10
- Critical care capacity has previously been a pressure-point, and led to a deterioration in performance in Q2 2013/14 (although standard still achieved); business case for additional intensive therapy unit bed written and approved early in quarter 3
- Cancer portfolio now biased towards the more complex/tertiary pathways, following the transfer-out of the breast and urology service

Validated 31-day first definitive breach reasons in quarter 4 2013/14 to date

Legend:
- Medical deferrals and patient choice
- Elective cancellations (critical care capacity)
- Elective cancellations (ward beds and other)
- Elective capacity
- Complex radiotherapy planning
- Administrative issues (e.g. tracking)
- Dental extraction or pre-operative assessment delay

Validation of Q4 31-day position continuing and current position is therefore subject to final reporting,

Root cause:

- Unusually high levels of medical deferrals post decision to treat in Q4 (33% of breaches)
- Increasing emergency and non-elective demand for critical care beds over 2013/14, resulting in an increase in occupancy (86.3% in quarter 2 to 91.7% for quarter 4 to date) and higher levels of cancellations of elective surgery
- High levels of cancellations on the day of surgery for other reasons, including ward bed availability during periods of emergency pressures and black escalation

Progress to date:

- Twentieth intensive therapy unit bed opened at the end of February 2014
- Escalation protocol revised and zero tolerance to cancellation of cancer surgery due to ward bed availability
- Additional thoracic surgery capacity planned from Q3 2014/15
- Performance in April to date 95% pre-validation, with the forecast for quarter as a whole 97.4% based upon historical trajectories

Cancer 31-day first definitive

Breach reasons	Average Q4 breaches per month	
Medical deferrals and patient choice	3.00	33%
Elective cancellations (critical care capacity)	1.67	19%
Elective cancellations (ward beds and other)	1.00	11%
Elective capacity	0.67	7%
Complex radiotherapy planning	0.33	4%
Administrative issues (e.g. tracking)	1.33	15%
Dental extraction or pre-operative assessment delay	1.00	11%
Total breaches	9	

Summary of actions referenced in table below

1. Implementation of pathway improvements to thoracic, following practice of best performing providers
2. Reduction in cancellations already seen following opening of 20th critical care bed; Critical Care Review
3. Cancellation escalation protcol implementation
4. Additional thoracic and HPB theatre sessions timetabled from October 2014, when Vascular service moves to NBT
5. New approach to escalation of pathway delays to be enacted from April onwards, involving the Divisional Management teams
6. Escalation process for cancer patients being managed via pre-op; additional capacity to address dental extractions (full impact of both Q3)

Improvement trajectory (percentage reduction in breaches)

Breach reasons	Action reference	Apr-14	May-14	Jun-14	Q1	Jul-14	Aug-14	Sep-14	Q2	Oct-14	Nov-14	Dec-14	Q3	Jan-15	Feb-15	Mar-15	Q4
Medical deferrals and patient choice	1	0%	10%	10%		15%	15%	15%		20%	20%	20%		20%	20%	20%	
Elective cancellations (critical care capacity)	2	33%	33%	33%		33%	33%	33%		33%	33%	33%		33%	33%	33%	
Elective cancellations (ward beds and other)	3	50%	50%	50%		50%	50%	50%		50%	50%	50%		50%	50%	50%	
Elective capacity	4	0%	0%	0%		0%	0%	0%		33%	33%	33%		33%	33%	33%	
Complex radiotherapy planning	N/A	0%	0%	0%		0%	0%	0%		0%	0%	0%		0%	0%	0%	
Administrative issues (e.g. tracking)	5	50%	75%	75%		100%	100%	100%		100%	100%	100%		100%	100%	100%	
Dental extraction or pre-operative assessmer	6	0%	33%	50%		75%	75%	75%		100%	100%	100%		100%	100%	100%	
Total estimated breaches		6.3	5.7	5.7	17.6	5.2	5.2	5.2	15.5	4.8	4.8	4.8	14.4	4.8	4.8	4.8	14.4
Total estimated activity		155	155	170	480	160	155	160	475	170	170	145	485	170	155	170	495
		95.9%	96.4%	96.7%	96.3%	96.8%	96.7%	96.8%	96.7%	97.2%	97.2%	96.7%	97.0%	97.2%	96.9%	97.2%	97.1%

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Clostridium difficile

Clostridium difficile (C. diff)

The number of Trust attributed C. diff cases against the limit set for the quarter/year

Good assurance that there are no systemic issues at the Trust

- C Diff trend reduction (see graph)
- 21% reduction in C. diff cases in 2013/14 relative to 2012/13
- Limit for 2014/15 (40) higher than 2013/14 out-turn (38)
- Antibiotic prescribing compliance at Trust target (90%)
- Working with Care Homes and GPs to reduce community cases
- Norovirus outbreak management
- Results of monthly audits of key clinical quality indicators - see table below.

Clostridium difficile trend

	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Trust cases	364	286	99	94	54	48	38

Key clinical quality indicators – latest audit results

Indicator	Jan-13	Feb-13
Hand hygiene: Trust score	98.3%	98.3%
Toilet & Bathroom checklist	97.4%	97.9%
Cleanliness audits: Trust score (high risk areas)	95%	95%
Cleanliness audits: Trust score (very high risk areas)	95%	96%
Antibiotic compliance	88.6%	90.1%

Infection prevention & control leadership 2013/14

i.   Medical DIPC (up to 4 PA Consultant Microbiologist)

ii.   F/T Senior Infection Control nurse / deputy DIPC

iii. Chief Nurse & Medical Director executive leadership, with fortnightly meetings held with Medical DIPC/Deputy DIPC

iv.   IC reporting to Medical Director-chaired Clinical Quality Group

v.   1 PA Consultant decontamination lead

vi.   Matron personal objectives linked to IC Plan

vii. Supervisory ward sister KPIs include IC targets

Quarter 1 to Quarter 3 2013/14
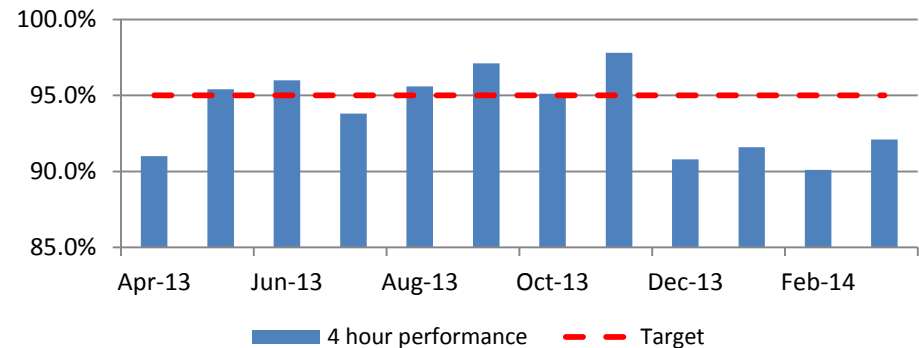
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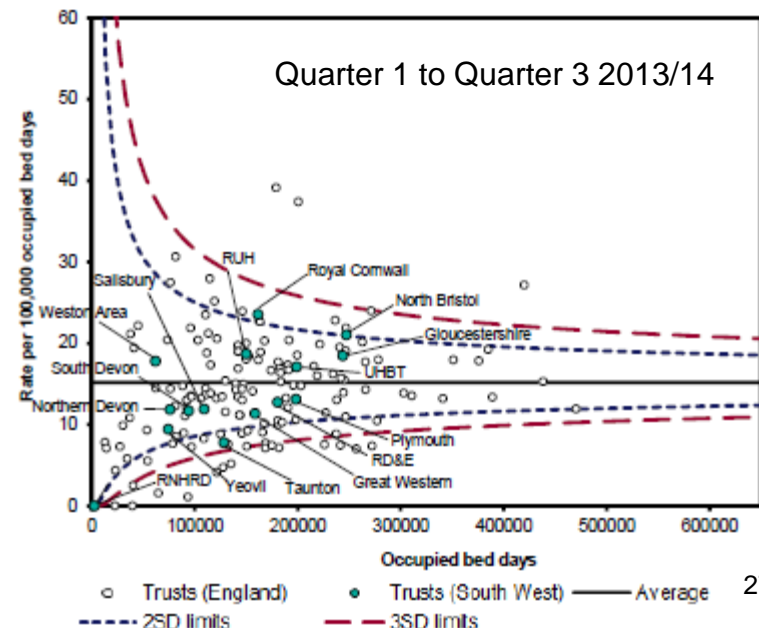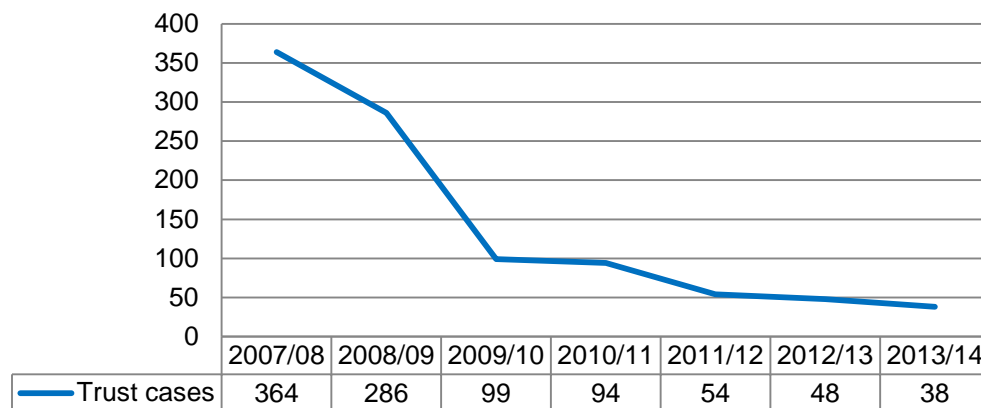
Risks to delivery

4-hour Standard - Risks to delivery

University Hospitals Bristol NHS
NHS Foundation Trust

Current status
• Pressures experienced across the system ("black escalation") resulting from high level of bed occupancy, outliers and 'green to go' (delayed discharge) patients has meant the measurable benefits in terms of 4 hour performance have not materialised • 'Breaking the Cycle Together' has provided a good foundation for performance improvement but the other six projects identified as part of the new Operating Model will need to be developed to ensure delivery for Q4

4 hour performance - Trust Level

Legend: 4 hour performance (bars), Target (dashed line)

Y-axis: 85.0%, 90.0%, 95.0%, 100.0%
X-axis: Apr-13, Jun-13, Aug-13, Oct-13, Dec-13, Feb-14

Operational/clinical - mitigating actions

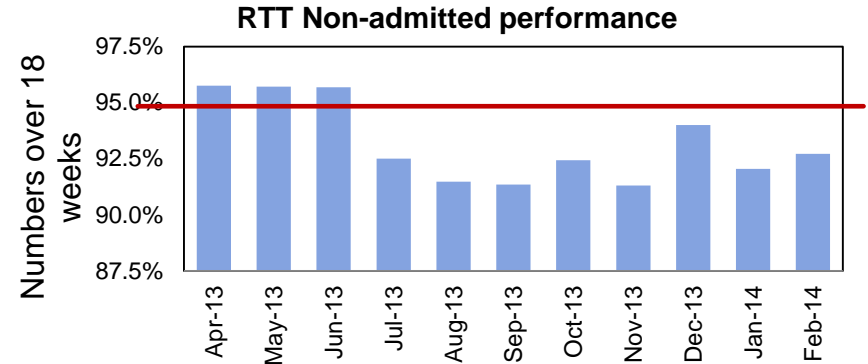| Risk	Action
Increasing age profile of emergency patients continues to put pressure on flow	Health system wide Emergency Care Intensive Support Team (ECIST) review to be commissioned
'Green to go 'list does not reduce and occupancy & outliers remain high	Continued partnership working with Health & Social Care and Bristol Community Health Operating Model projects

Governance - mitigating actions

Risk	Action
Six further projects do not deliver the required improvements to ensure Q4 achievement	Project plans including trajectories are being developed. Progress monitored via Senior Leadership Team
Frenchay flows in excess of that forecast and planned for	Work with ambulance trust and commissioners in the use of the Capacity Management System (CMS) to dictate flows

Referral to Treatment (RTT) Non-admitted

| Current status |
|---|
| Residual backlogs of patients transferring as part of the Head & Neck service transfer, at the start of 2013/14; GUM (Genito Urinary Medicine) service no longer contributing to RTT performance according to national rules (used to contribute 1% to performance); increased levels of GP referrals cross a range of services which has resulted in long first waits for outpatient specialties. |

RTT Non-admitted performance

A bar chart titled "RTT Non-admitted performance" with y-axis labelled "Numbers over 18 weeks" ranging from 87.5% to 97.5%, a red horizontal target line at 95.0%, and monthly bars from Apr-13 to Feb-14.

Operational/clinical - mitigating actions	
Risk	**Action**
Achievement of non-admitted performance in ENT and Orthopaedics	Detailed pathway reviews to include diagnostic and follow ups to ensure 18 weeks delivered
Recovery plans for reducing first outpatient waits do not deliver required improvements for non-admitted	Weekly monitoring of performance to ensure actions taken are delivering improvements in both non-admitted and admitted pathways

Governance - mitigating actions	
Risk	**Action**
Booking processes and governance impact on pathway management	System wide Elective Care Intensive Support Team review scheduled for April 2014 – will assess recover plans and RTT governance structure
Dermatology service at Weston closed to Choose & Book resulting in a higher than expected transfer of referrals to the Trust	Trust working with Weston to support the service until an agreed transfer can take place; commissioners actively involved; planned reduction in waits in addition to that necessary for achievement of RTT standard.

62 day Cancer – GP Referral

University Hospitals Bristol **NHS**
NHS Foundation Trust

| Current status |
| --- |
| High levels of late referrals from other providers, patient choice, medical deferrals, in addition to elective cancellations due to significant bed pressures and capacity constraints within the thoracic (lung cancer) and HPB (hepato-biliary – upper GI cancer) service continue to contributed to poor performance. |

Cancer 62 Day Urgent GP Referral
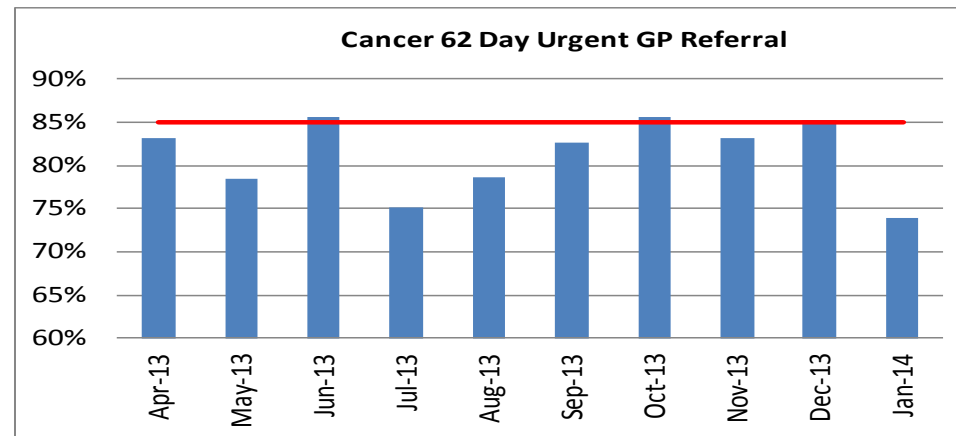
Operational/clinical	
Risk	**Action**
Elective cancellations due to bed pressures, particularly critical care	Protected Beds and Critical Care review as part of the new Operating Model for 2014/15
Capacity constraints within the thoracic (lung cancer) and HPB service	Business cases for additional consultant capacity being developed
Late referrals from other organisations	Working with other local trusts to improve timeliness of referrals
Medical deferrals + patient choice delay diagnostics	Reduce wait for 2-week wait step to 7 days, to provide more opportunity to reduce delays

Governance - mitigating actions	
Risk	**Action**
Elective patients cancelled due to non-elective demand	Protection of cancer and other clinical y urgent patients is a standard part of the escalation policy since January 2014
Change in Division of Surgery leadership	Clinical Chair fully signed-up to plans; recruitment to Divisional Director post initiated

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31 day Cancer – First Definitive

Current status
Elective cancellations due to significant bed pressures, particularly for critical care, have reduced but still impacting on performance. High levels of medical deferrals, capacity constraints within the thoracic (lung cancer) service and timeliness of dental extractions prior to radiotherapy planning and treatment contributing to poor performance.

Cancer - 31 Day First definitive
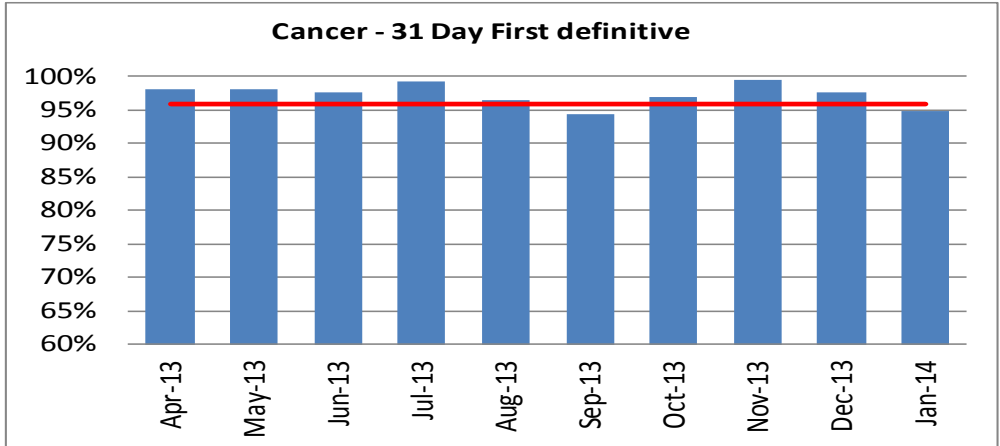
Operational/clinical - mitigating actions	
Risks	**Action**
Elective cancellations due to bed pressures, particularly critical care	Protected Beds and Critical Care review as part of the new Operating Model for 2014/15
Delays in pathways for dental extraction prior to operation	Review of pathway to ensure all unnecessary delays are prevented
Capacity constraints within the thoracic (lung cancer) service	Business cases for additional consultant capacity being developed

Governance - mitigating actions	
Risk	**Action**
Cancer booking processes and governance impact on pathway management	Elective Care Intensive Support Team (ECIST) review will assess governance and management practices for both Referral to Treatment and Cancer services

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