1. Introduction

This overview brings to the attention of members of the Board of Directors the key areas of Trust performance in February 2017. As has been the case for most months, the ED 4 Hour Access standard continues to be the Trust’s biggest performance challenge. In addition this month, the two week cancer standard experienced a significant drop in performance in Breast services and colorectal cancer. Diagnostic waits, however, returned to over 99% performance after two months of coming just under the operational standard.

2. ED 4 Hour Access Target

The Trust achieved 79.8% against the 95% ED 4 Hour Patient Access standard in February. This figure includes Urgent Care Centre (UCC) activity and was against a 90% trajectory figure. The Trust’s performance for Q4 to date, including UCC activity, was 81.1%, against a 90% trajectory for the Quarter.

February has been the most challenged month of the winter period. Although attendances and admissions actually reduced compared to both the previous month and the same month last year (for the first time for many months), operational performance was compromised by the acuity and dependency of the patients being admitted. A key characteristic of the month was a longer period required to get patients to a medically stable condition, and a significant increase in the number of medically fit patients in the hospital beds which again reduced operational bed capacity and led to protracted waits in the ED. The Trust experienced 13 breaches of the 12 Hour DTA standard as a result of this situation, in February.

March has seen a reduction in both numbers and acuity of patients for at least part of the month which has resulted in a slight improvement in performance against the 4 hour wait standard. At the time of writing, including UCC activity, the Trust has reached 84% against the standard in March, and Q4 to date has slightly improved to 82%. Regulators have asked the Trust to hit 85% in the month of March.

Board should note that the ED Improvement Plan was received and discussed at the March meeting of the Performance, People and Place (PPP) Committee and an update on the plan’s main features is summarised below.

- The transfer of Ambulatory Care from the AMU to the Clover building, adjacent to the UCC was successfully achieved on 23rd January. After an initial slow start, the unit continues to receive 26 patients per day on average, patients who would otherwise wait in ED. Committee will note that the numbers of patients going through the unit were 400 in February, compared to a figure of 167 in January. In another positive indicator, the percentage of direct admissions to Ambulatory Care (i.e. ED “push”) rose from less than 10% of the medical take in January to over 18% in February.

- The planned implementation of the conversion of the 11 beds vacated by Ambulatory Care into an acute triage area for GP referred admissions took place on 8th March. This area is equipped as a trolleyed bay and has been successfully maintained as such since the implementation date. The impact on the GP expected patient flow has been impressive: in the two months between 1st January and 7th March, the number of patients directly accessing the AMU was 29; between 7th and 17th March, the number of patients has been 107.

- A key supporting mechanism to obtain flow for the GP “Medically Expected Unit” (MEU) is for at least six inpatients to be discharged to the Discharge Lounge or ‘sat out’ on inpatient wards before 9 am to enable transfer of patients from the short stay unit on Kingfisher ward to base wards, and patients identified for admission on the MEU to then move from the that unit onto the short stay ward, creating two exit routes for ED. This process has generally been followed through proactive identification of suitable patients the night before by the Matrons and their teams.

- The Neurology “hot clinics” have been established and continued to work throughout February, having discharged 24 patients in February, compared to just three patients in
January. However, it has not been possible to recruit to the approved ‘proof of concept’ posts in Cardiology or Respiratory Medicine to introduce a similar model. In Respiratory Medicine, it is likely that the model will need to comprise part of the job plan of an additional substantive Consultant post, currently being considered within the medical workforce planning process. In Cardiology, the possibility of transferring the resource to a specialist nurse role is being actively considered.

- There continue to be focused discussions with the AMU Consultants to ensure the senior and junior workforce is fit for purpose in terms of managing the acute take, including senior coverage, medical education and clarity as to the decision to admit process.

- At the end of the month, the executive received an assessment of the impact of the package of measures authorised in January in order to make a judgement as to which aspects should receive recurrent funding in 2017/18. Executives agreed a sum of £1m recurrent funding, which would fund the majority, although not all, of the measures included in the January package.

- It is planned to incorporate the clinical and operational management of the Urgent Care Centre with that of ED, to facilitate streaming, improved ED led pathways and to relocate the Minors stream into the Clover building. It is anticipated that this change could be implemented by 1\textsuperscript{st} May.

- Work to develop the frailty pathway in agreement with the Consultant Geriatricians, the GPs supporting SwIClCC, and the wider MDTs to enable patient exit routes from the Elderly Care bed base to step down accommodation within SwIClCC is also underway, with initial meetings taking place in early April. Elderly Care inreach to ED and ‘pull’ of patients to the Elderly Care Assessment unit on Teal Ward continues to operate.

- The Home To Assess service, which has struggled with workforce deficits ever since it opened in November, is now fully staffed. A full review of its effectiveness November 2016 – February 2017 has been carried out and has been submitted to Swindon CCG to support a case for recurrent funding. In this period, the service has discharged 130 patients and is estimated to have saved 384 bed days as a result. With substantive funding and more successful recruitment and retention, the service can achieve much more. In principle at least, commissioners recognise that H2A needs to be a permanent part of the system’s urgent care portfolio of services.

- Shalbourne Ward continued to provide the previously agreed 8 beds to the NHS, but NHS usage increased to 70\% in February. The Trust is gearing up to return to full ringfencing of Shalbourne for private patients from April.

- The new Improvement Team, working under the leadership of Linda Power, continues to work on avoiding unnecessary 4 hour breaches and improved operational grip, including reviews of reasons for breaches; has reviewed the 4 hour and 12 hour SOPs and Internal Professional Standards in ED and the AMU; seeks to maximise utilisation of the Ambulatory Care Unit, and actively supports the planned changes to the medical take and review of the medical workforce. The new regular thrice daily ward demand/capacity meetings to project and deliver the required number of patient discharges per day is now fully embedded and supported by a redesigned site report and escalation triggers.

It is envisaged that the above actions will contribute to improved performance in forthcoming months, as the winter disease profile begins to recede.

*Right Patient, Right Bed* metrics showed a fall back in each indicator in February, with particular reference to streaming to the UCC (down to 11.3\% of the take in February from 12.8\% in January); patient discharges before 12 (down to 24.9\% of total discharges from 27.9\% in January); and use of the Discharge Lounge (down to 17.2\% of total discharges from 21.8\% in January). The discharge metrics should receive a significant uplift from March with the implementation of the MEU and supporting early discharges. The plans to integrate UCC with ED with an explicit intention to maximise both streaming from ED and into primary care, should ensure improvement against this metric from April.
I am also pleased to report that bed state information is now derived from the ibox information tool, after being inputted at ward level, rather than from ring rounds or walkrounds by the site team or other managers. This has been a significant support to the regular daily site meetings.

Despite all the above actions, operational performance is only showing marginal gain against the 4 hour target. Board will note that the fundamental problem remains system wide. Although DTOCs did come down in February, the total number of medically fit patients is now reliably reported as over 90 most days. Unless concerted effort is made by partners to achieve the target of 20 partner discharges per day, set by the CCG, GWH will continue to run an overcrowded hospital. Efforts to turn the system “Gold Calls” into a genuine escalation mechanism in terms of capacity, are being worked up, to operate from next month.

3. **Stroke Services**

Performance against the Stroke standards saw mixed performance in February, with improvements in some standards against an improved baseline in January (Direct admission within 4 hours; brain imaging within 1 hour; and thrombolysis on admission) and deterioration against others (Direct admission; length of stay). The stroke improvement action plan, designed to secure sustained performance improvement, and working to a July–October 2017 implementation timeframe, is focused on the following:-

- Ringfencing at least one acute stroke bed at all times to address the length of stay standard: there are sufficient stroke admissions each day to justify this change to bed management protocol;
- A review of existing community stroke team provision to see if an Early Supported Discharge Service can be developed. It is acknowledged that investment will probably be required to meet the national specification;
- Integration of the data recording inputter with the wider clinical service to improve clinical knowledge, accuracy of the Trust returns and timeliness. Board should note that February data is available to this report.
- Development of the integrated stroke pathway between the acute unit on Falcon Ward and the rehabilitation unit on Forest Ward in SwiCC, which will be facilitated by ensuring *Right Patient Right Bed* principles also apply to stroke;
- A review of workforce gaps in therapy services, stroke nursing and dietetics; and
- Full review of the status of the Stroke Rehabilitation Unit, and the possible designation of hyper acute beds on Falcon ward.

The specialty service delivery group now reports into the overall economy project group and a full improvement plan has been submitted and accepted. Although on a relatively long time frame, it is anticipated considerable improvements can be made within the existing resource envelope and secure sustained performance improvement against the national stroke standards.

4. **RTT**

The RTT Incomplete standard was not achieved in January at 91.1%, a marginal underachievement, that reflected a level of elective inpatient and outpatient activity cancellations to free up consultant staff to manage acute medical pressure. This estimate was shared in advance with commissioners and regulators. At the time of writing, the projection is that, for these same reasons, the performance standard was not achieved again in February, although it slightly improved to 91.14%, despite a higher number of elective cancellations than in the previous month. This was acceptable to both regulators and commissioners. The aim is to secure 92% in March.

Board should be assured that management processes for RTT remain robust: waiting list shape remains good and there were no over 52 week waiters in February – the second month in succession that the Trust has met this standard.

5. **Diagnostic Waits**

The standard was marginally not met January, with 98.6% achieved against the 99% target. This was entirely due again to pressure on Ultrasound capacity. A recent business case was successfully submitted to the Trust Investment Group, where approval to recruit two additional Ultrasonographers was given and the D&O Division have secured locum staff against these new posts. The impact has been immediate: the target was achieved in February at 99.1%.
6. Cancer Services

All Cancer service targets were met in January, with the significant exception of the 2 week wait standard in Breast services and colorectal cancer, with 82.1% achieved against the 93% target. This position is anticipated to continue into February and March and has arisen from a significant capacity deficit in General Surgery’s acute on call rota in January and February, necessitating a reprioritisation of work from non emergency capacity on the part of consultants and Registrars towards on call. The situation has been eased by the start in post of a new Consultant surgeon and remedial action taken this month. The action plans estimate that the services will be back in balance by early April. Close scrutiny of other tumour sites is underway to ensure the 31 and 62 Day position is not compromised in March.

7. Theatres

Board should note a revised presentation of performance against the Theatre metrics, which is more concise, presenting the performance position in an integrated grid format, with the most up to date information available, backed up with a narrative summarising actions undertaken in February and planned actions this month. It is hoped by the new theatres management team that this will provide the quantitative and narrative detail to summarise progress in this important improvement programme to the satisfaction of Non Executive Directors.

This format was presented for full discussion to the PPP Committee in March, where Non Executive comments and feedback was received.

8. Electronic Discharge Summaries

The ‘EDS lite’ for the Surgical Assessment Unit (SAU) was implemented in January and a significant improvement in Planned Care’s performance can be noted, sustained into February. Roll out of this format to other specialties is being considered. Women’s and Children’s Services improvement in performance in January was not sustained in February, with Children’s services pulling the rest of the Division down. At the Divisional Performance Review meeting in March, this was made a top priority, and work with specialty Registrars to improve the position is underway.

Unscheduled Care fell back in February, due to significant service stretch and are currently refreshing their action plan. Diagnostic and Therapeutic Services continue to perform extremely well, with a much smaller ward base than the other Divisions.

9. Clinic Letters

Performance was poor in all Divisions in February. The improvement project, led by Teresa Harding, and seeking to extend best practice and achieve economies of scale across the Divisions has been launched, but delayed due to Teresa’s unavoidable period of absence. A brief progress report on this project will be provided in a future OPR, once the leadership of the project is restored.

10. Private Patients

NHS utilisation rose to 70% in February, causing significant challenges. The unit has managed to maintain some PP activity, but patient experience has not been good over the winter. The beds provided to the NHS are to be handed back in April, and ringfenced. Providing this is maintained, the unit remains confident it will meet its business and financial targets.

11. Conclusion

As in previous months, Urgent Care remains the Trust’s greatest challenge. It is hoped the actions taken in March will see some improvement in performance and less congestion in ED as acute pressure begins to recede. An unwelcome drop in performance has also been incurred in 2 week cancer waits, which will continue into March at least.

Adrian Griffiths
Chief Operating Officer
28th March 2017