

- Assignment:** Audit Report into Performance Recovery Programme at Oxford Radcliffe Hospitals NHS Trust
- Report Sponsor:** Trevor Campbell Davis, Chief Executive ORH
Oxford Radcliffe NHS Trust
Headley Way, Headington, Oxford, OX3 9DU
- Auditor:** Jane Ansell, Independent consultant & former Department of Health National Programme Manager for A&E 4 Hour Standard
- Assignment Period:** May 16th 2008- July 11th 2008
- Report Date:** July 16th 2008
- Project Brief:** To determine whether the activities conducted under the A&E Recovery Programme are a) sufficient to ensure that performance returns to a level of excellence formerly attained by the ORH and b) that performance at that level is sustainable for the foreseeable future.

Introduction and Context

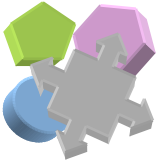
A spike of emergency admissions across the winter had coincided with the clearance of the 18-week elective backlog and a continuing high level of delayed discharges. Despite opening additional beds on a planned basis, reducing length of stay by 6% in 2006/7 and a further 5% in 2007/8, and significant management effort, the Trust had ended 2007/8 missing the 4-hour target by a margin of 0.8%. In addition, 2008/9 performance had started poorly and the Trust was regularly exceeding its maximum number of 30 breaches per week.

Andrew Murphy, the ORH Director of Performance was appointed as the lead for the recovery in early May, and subsequently engaged the support of Streamline Consultancy Services, Senior Consultant Jane Ansell to ensure that the strategy adopted for recovery would ensure that performance improved in line with the required trajectory and to recommend any additional steps that could deliver enhancement to the service in line with future aspirations for Acute Care at ORH.

The report is presented against the 5 key result areas (KRAs) needed to safeguard delivery of A&E 4 hour standard. These KRAs have been developed over the past 4 years based on extensive examples of similar recovery programmes conducted by this Consultancy in more than 15 NHS organisations:

- Information to Manage
- Discharge
- Proactive Pathway Management
- Leadership & Performance Management
- Trust wide service improvement

Audit Criteria for this review is based on the following hypotheses:



Hypotheses 1: All members of management & staff involved in the delivery of the A&E 4 hour standard has the necessary information available in a timely manner to ensure the standard can be delivered.

Hypotheses 2: The organisation has a detailed understanding of why patients breach the 4 hour standard in order that these causes can, wherever it is clinically safe and appropriate to do so, be eliminated

Hypotheses 3: That the flow of patients out of the ORH reflects the needs of the organisation in managing admissions, avoiding the need for patients to be cared for in less than ideal environments.

Hypotheses 4: Patients are not kept waiting inappropriately whilst undergoing an Emergency Care episode.

Hypotheses 5: The ORH organisation works together as a whole system to ensure that a patient flows seamlessly through its services to ensure that the right care is given, in the right place, by the right staff, at the right time.

Hypotheses 6: The leadership framework associated with the delivery of the A&E standard ensures that the values surrounding the standard are corporately owned and executed by all staff & directorates responsible.

Hypotheses 7: Blockages in care pathways are addressed by the application of service improvement techniques to ensure that the best possible patient care and patient experience is consistently delivered by the most effective utilisation of NHS resources

Hypotheses 8: Standard daily performance expectations for the delivery of the 4 hour standard are set at a high enough level to ensure that on days where there is 'special cause performance' (e.g. a major incident) that this does not significantly impact on overall monthly or quarterly performance.

The assignment commenced on the 16th May 2008 and it should be noted that full and open access to information, plans and resources were offered in support throughout.

Information to Manage

Daily Performance Information

Initial Findings-The organisation was failing to understand the root cause of why patient's breached. Back in 2003, the Emergency Services Collaborative identified 8 breach categories as being the most likely reasons why patients would exceed the 4 hour standard for being seen, treated, admitted or discharged. In all cases bar one, category 3- that of undergoing or waiting for treatment, all breaches are should be seen as **avoidable**. Many of the other causes of breaching are whole systems issues, not just the responsibility of the Emergency Departments (EDs) to address.

Action to Correct- The Trust needed to fully understand the true causes behind poor performance and it did this by introducing a mechanism for recording and disseminating the information around performance on a daily basis. In addition it developed a breach



recording mechanism ensuring that the reasons for breaching could be communicated to a broader audience. The Trust have developed management information that is now cascaded daily that clearly communicated the performance against the 4 hour standard, summary level information around breach causes and the impact of daily performance on Trust trajectories and milestones.

Understanding Actual Journey Time

Initial Findings-It was impossible to identify from the information being used originally, why many patient journeys took over 4 hours. This is important as it is clinically accepted that the actual journey time for all but exceptional conditions is far less than 4 hours.

Action to Correct-The Trust now undertakes to produce the DH 7 Day analysis that outlines performance curves in each of the 4 categories of patients Minors, Majors not Admitted, Medical Admissions & Surgical Admissions. From this information it was quickly identified that patient journeys did not start quickly enough on arrival at ED and that 4 hours was being treated as a target not a limit.

7 day Analysis information produced weekly has also shown that when a late 'Decision to Admit' is made, this makes it more challenging to ensure that a patient can get to the right bed in a timely manner. Overall -This analysis has enabled the organisation to understand where time was being unnecessarily lost, making the achievement of the standard much more difficult.

Conclusion

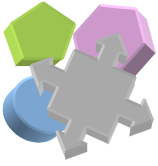
Good quality data & well structured management reports make excellent information to manage. They can feed the process improvement mechanism and ensure that the when changes are implemented that the necessary impact translates into performance. When utilised well they can act as a common communication between directorates and managers in order to stimulate creativity and develop local solutions.

Discharge

Timeliness of Simple Discharges- the 80/20 Rule

Initial Findings- The first breach cause that every organisation cites as the reason for failing the A&E target is 'beds'. Very few can justify exactly what they mean by that, but its always firmly, 'beds'. However, on analysing the true cause of breaching, it is more likely to be Category 1- Late Assessment in the ED, where the problem is often that there are too many waiting patients cluttering up the department. If trusts review their Midnight bed state analysis, it rarely shows that every bed in the hospital is full. The challenge is to get beds needed for the emergency take in ED to be available in a steady flow during the day rather than late in the evening.

Unfortunately, the energy that goes into the management of the elective admissions is not matched by the effort put into the management of the emergency admissions and



more predictably and less controllably that electives, emergency patients will come in and will need beds.

During the analysis phase of this programme there was an observation study conducted of the bed management meeting held at JR. The flow and content of the meeting indicated that there were issues that needed to be immediately addressed across the trust on the management of simple discharges-representing 80% of all discharges across the hospital-to ensure that beds were always available for the admission of the daily flow of emergency patients.

Action to Correct Position - It is critical to manage simple discharges rigorously as it can have a dramatic impact on lengths of stay, bed utilisation, 4 hour performance and patient experience. Most importantly in relation to the 4 hour standard, timely departures lead on to timely arrivals. Wards are to be encouraged to free up beds early in the day and under the direction of the admitting consultant pull patient from the ED's in a timely manner. Discharge is one of the most complex matters to tackle as there are many cultural issues tied up with improving the current approach.

Tighter operational grip can be applied to the bed management meetings ensuring specialties understand their commitment to their emergency patients and the need for early discharges enforced. The principles of timely discharge across the whole trust will need to be nurse lead and clinically championed and the difficulty of implementing this fully with all specialties, should not be underestimated.

Managing Complex Discharges

Initial Findings- Whilst delays in the transfer of complex patients to the community are of a significant concern to the ORH, this study has not needed to focus on this as a first line cause of poor performance in A&E. It is clearly a concern that beds are being tied up as a result of the delayed discharges waiting in acute beds, longer than is medically necessary and taking valuable resource out of the systems, but overall this is a small percentage of the total bed stock and was therefore not challenged as part of the immediate priorities. The management of Delayed Transfers of Care is covered by commissioning guidelines that allow reimbursement from the PCT for delays.

Action To Correct Position- As with any operational standard the Trust needs to ensure that it rigorously tracks the Medically Fit dates for patients transferring to the community and in addition ensure it has a documented audit trail of communication with its partners regarding transfer arrangements. When all reasonable attempts to transfer have been unsuccessful for what ever reason the mechanism reimbursement needs to be invoked to allow the Trust to capture the cost of housing patients that should be managed outside an acute care setting.

Conclusion

The vision day planned as part of the continuous improvement programme will need to address discharge and will probably result in a major programme of Discharge Management across both types of discharge groups, simple & complex.



Some acute providers are considering the use of redundant ward space for rehabilitation services and tendering for that service from Commissioners, as they feel that the lessons learned in the management of delayed discharges could be successfully applied to the provision of appropriate care packages of rehabilitation and prove to be an excellent opportunity for future income.

Proactive Pathway Management-No Delays

Initial Findings- Having established a need for improved information used to manage the A&E standard, the team started to analyse the delays in more detail. There were 2 initial areas of concern identified.

The first around Minors, (patients who present with Minor Illness and injury) that: patient journeys were taking too long; that an influx of Minors often meant there were Minors breaches (particularly unacceptable given the types of presenting complaint, and finally that there was a growing patient expectation in wanting reduced turnaround times in A&E i.e. no more than 2 hours. The Trust would be unlikely to meet given its current way of working. Figure 1 is an example of patient journey time in ED and clearly demonstrates a rush to the target line of 4 hours for Minors patients.

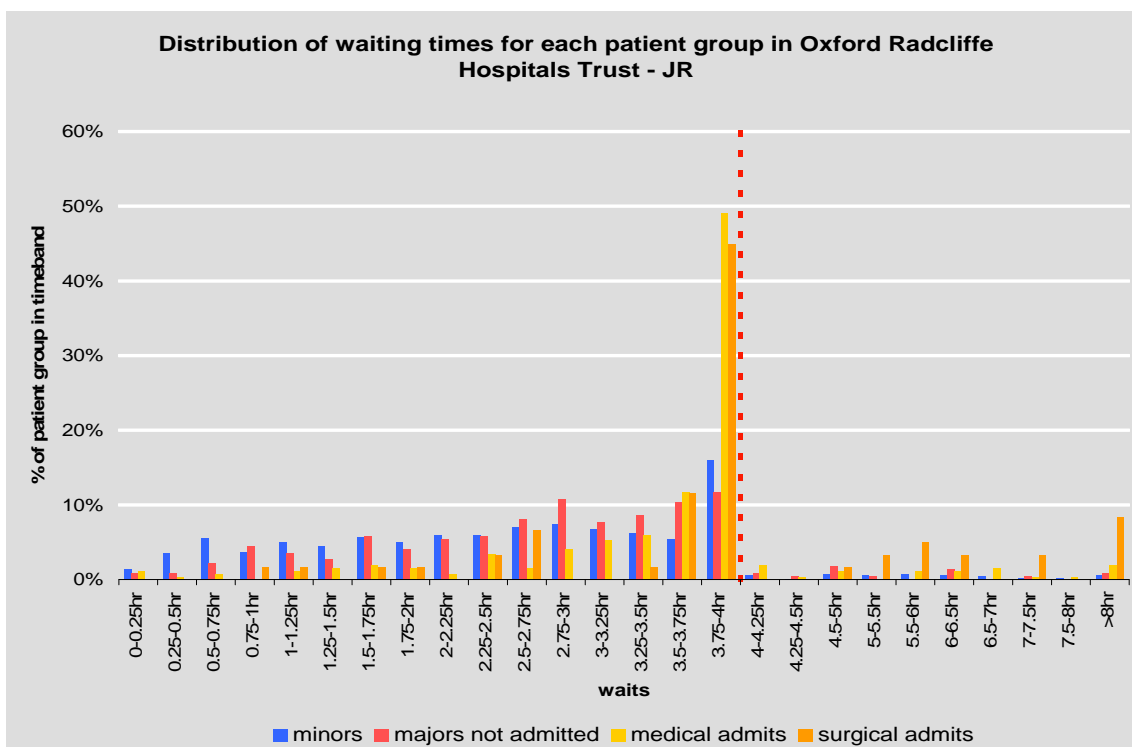
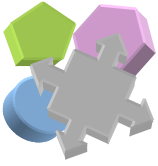


Figure 1- Distribution of Waiting times from 12th May 2008

Secondly, that patients waiting to be admitted, the 3rd & 4th categories shown on the above diagram, in were being left to maximum time in the Emergency Department before being managed into wards and the care of the appropriate specialties.

These conditions create poor outcomes including: cluttering the department; the patient experience waiting in EDs for ‘things to happen’ causing anxiety and frustration; potential for a relapse of a condition that has been previously stabilised; creation of



additional workload in a busy department , leading to additional breaches as staff have competing priorities; Patient not receiving the ward based care they need, as ED staff are busy dealing with new and now more urgent attenders; most impactively on the ED is that when the department is full this can lead to patient management issues with staff not knowing which patient needs their attention next.

Action To Correct Position- managing flow throughout a patient's journey needed to be improved. No patient should wait unnecessarily and the lack of flow co-ordination across the trust was apparent when examining the detailed breach analysis introduced as part of the Information to manage workstream.

The teams treating Minors patients are now committed to starting journeys closer to the start of 4 hours avoiding the need to rush to the finish line and this has resulted in the total elimination of Minors breaches from the system.

Teams treating patients with likely admission needed to adopt a simple approach, that of the application of a methodology that is driven by a plan for each patient at 2 hours and an escalation at 3 hours. If specialties fail to respond in a timely manner to their emergency patients, these instances are escalated to the senior management team for immediate attention. Again there has been a significant reduction in the number of patients awaiting admission that fail to reach an appropriate destination within 4 hours and therefore this action is said to be working well.

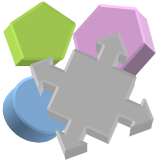
Conclusion

This work has been particularly successful to date but it is not yet fully embedded and owned by all specialties and all staff. It still needs significant management attention in times of pressure. It is recommended that the ORH do further work on communicating the importance of the management and 'pulling' of emergency patients by specialties to ensure sustainability. Over the past 2 years, financial balance and 18 Weeks Referral to Treatment ambitions have distracted organisations from making progress on its emergency patient management, leaving emergency departments to fend for themselves and care for patients in their own downstairs environments.

Whilst the John Radcliffe has an excellent facility to support patients in ED, it must always be questioned as to whether keeping a patient on an observation bed in a clinical decision unit or holding an elderly patient on a Medical Assessment Unit bed is the right care for that patient. Whenever possible patients should be moved to the most appropriate environment, this will be especially poignant in the management of Stroke patients as per the direction of the National Stroke strategy which can be found at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandguidance/dh_081062.

Leadership & Performance Management

Initial Findings & Observations-This workstream is the focus on ensuring that the organisation places equal priority on all operational standards regardless of the 'flavour of the month'. As discussed in the previous section the focus on other priorities has meant that A&E had lost some profile and performance had suffered as a result.



This is disappointing as the ORH enjoyed national recognition for its early work on the 4 hour standard during 2004 being an early achiever through the implementation of the Jonah system and excellent Emergency Services Collaborative service improvement leadership.

At the start of this process the Trust did not have adequate mechanisms in place to control all breaches, and there was no consequence for the specialty or department that contributed to breaches occurring. Senior management were therefore unable to pinpoint the actions needed to bring about improvement.

Action to Correct- The trust has made an appropriate switch for the management of A&E performance to the Director of Performance, Andrew Murphy. Breaches and their root cause(s) are now openly discussed and actioned at senior level. Specialties are now being held to account for their emergency patients and will now take responsibility for ensuring that any admitted patient is brought into the hospital well before the 4 hour limit and that non-admitted patients have proactively managed & timely journeys through the Emergency departments.

Conclusion

The mechanisms and awareness are now in place but this needs careful monitoring. The Executive & the Trust Board should be made aware of the key issues remaining and should routinely seek clarity that risk around potential non delivery of the standard is minimised. In addition to minimising risk, it is important that everything is done to achieve service excellence to run world class acute services for patients, ahead of any new guidance that is likely to be recommended or mandated.

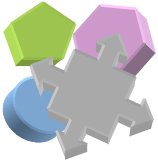
Trust Wide Service Improvement

During the Breach analysis it became apparent that some systems and pathways currently in operation within the Trust were prohibiting the consistent delivery of the 4 hour standard. Many of these were linked to Discharge & patient pathway management and have already been discussed in detail but there are other matters to address such as staffing levels both in EDs and in specialties that need to respond to emergency patients.

The Stroke strategy implementation will need a Trust wide approach as access to CT within 30 minutes is not consistently being achieved, nor is the guidance that 90% of a patient's journey on a Stroke pathway should be managed on a Stroke Ward.

Training and induction is also critical to ensure that patient waits are a thing of the past. It should be the responsibility of the trust to ensure that every junior doctor understands what it is like for a patient or indeed an anxious relative to wait for 4 hours in ED not knowing what is happening.

These and other issues identified and their solutions, need to be extrapolated in the Vision day and be built into the long term plans for sustainability and improvement. This is a matter for both current operational and strategic consideration.



Summing Up

The Trust has made exceptional progress in the last 2 months in order to regain its performance against the 4 hour standard, delivering not only whole community performance but also Trust only cumulative performance for Q1 at 98.01%.

The Trust continues to improve but for the purposes of this Audit it is essential to see where work undertaken is complete and where ORH are undertaking further improvement to meet more stretching deliverables outlined in the various hypotheses in the introduction.

The Evaluation Table in Appendix 1 highlights where the Trust have fully met their goals and where there is still further on-going operational work to develop. All areas are either Green or Amber identifying that there are no points needing escalation at this stage.

The ORH Trust Board can be assured that the right mechanisms and processes are in place in order to safeguard delivery utilising existing management arrangements. The management team do recognise, in the light of the Darzi Review, that there are further improvements to be made to Acute Care access that will benefit both patients and the trust in terms of sustainability and the provision of service excellence and they should be actively supported to continue to strive for these ambitions.

Jane Ansell
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16th July 2008



Appendix 1-Evaluation against Hypotheses

Hypotheses	Evidence to support status	Trust Lead (To be agreed)	Escalation Status Green= complete or nearing completion Amber = On-going development Red= Requiring escalation as insufficient evidence available or progress on delivery
<p>Hypotheses 1: All members of management & staff involved in the delivery of the A&E 4 hour standard has the necessary information available in a timely manner to ensure the standard can be delivered.</p>	<ul style="list-style-type: none"> ➤ Development of the A&E performance report cascaded to all relevant departments. ➤ Production of 7 day analysis on a weekly basis to understand where improvements in Journey times can be made 	Alyn Still	Green
<p>Hypotheses 2: The organisation has a detailed understanding of why patients breach the 4 hour standard in order that these causes can, wherever it is clinically safe and appropriate to do so, be eliminated</p>	<ul style="list-style-type: none"> ➤ Breach reporting to identify true breach causes ➤ Attribution to specialties and departments ➤ Action to address recurring issues ➤ Whilst Breaches for non clinical reasons occur this should be constantly on-going 	Fiona Barnes	Amber
<p>Hypotheses 3: That the flow of patients out of the ORH (discharges) reflects the needs of the organisation in managing admissions, avoiding the need for patients to be cared for in less than ideal environments.</p>	<ul style="list-style-type: none"> ➤ Greater understanding of the need to improve simple discharges as a matter of routine 	Rosemary Dooley / senior nursing team & clinical leads	Amber
<p>Hypotheses 4: Patients are not kept waiting inappropriately whilst undergoing an Emergency Care episode.</p>	<ul style="list-style-type: none"> ➤ Significant reduction in breaches of the 4 hour standard 	Melanie Darwent Supporting Management	Green



Hypotheses	Evidence to support status	Trust Lead (To be agreed)	Escalation Status Green= complete or nearing completion Amber = On-going development Red= Requiring escalation as insufficient evidence available or progress on delivery
		teams	
Hypotheses 5: The ORH organisation works together as a whole system to ensure that a patient flows seamlessly through its services to ensure that the right care is given, in the right place, by the right staff, at the right time.	<ul style="list-style-type: none"> ➤ This may need further engagement by Clinical Directors to further reduced the last minute admission performance ➤ Breach reporting can inform clinical service improvement as the information can be used to identify where clinical pathways & protocols can substantially benefit patients without unnecessary clinical risk i.e chest pain, stroke, manipulations etc 	Caroline Landon/ Rosemary Dooley	Amber
Hypotheses 6: The leadership framework associated with the delivery of the A&E standard ensures that the values surrounding the standard are corporately owned and executed by all staff & directorates responsible.	<ul style="list-style-type: none"> ➤ Robust escalation process in place ➤ Use of daily reporting to promote understanding across the trust ➤ Further details around performance to forma part of trust wide communication 	Andrew Murphy	Green
Hypotheses 7: Blockages in care pathways are addressed by the application of Service Improvement techniques to ensure that the best possible patient care and patient experience is consistently delivered by the most effective utilisation of NHS resources	<ul style="list-style-type: none"> ➤ Information from breach reporting informing the Vision day ➤ Information from complements & complaint letters and customer surveys to understand what is needed by customers from the ORH emergency access service 	Fiona Barnes/ Caroline Landon	Amber



Hypotheses	Evidence to support status	Trust Lead (To be agreed)	Escalation Status Green= complete or nearing completion Amber = On-going development Red= Requiring escalation as insufficient evidence available or progress on delivery
<p>Hypotheses 8: Standard performance expectations for the delivery of the 4 hour standard are set at a high enough level to ensure that on days where there is 'special cause performance' (e.g. a major incident) this does not significantly impact on monthly or quarterly performance.</p>	<ul style="list-style-type: none"> ➤ Zero tolerance of breaches by ED & management team ➤ Escalation process in place to support the 'Plan at 2 hours and escalation at 3' philosophy 	<p>Andrew Murphy</p>	<p>Green</p>