Out Patient Transformation

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Executive Summary Trust Board paper J

Context

This paper provides the Trust Board with an update on UHL's Out-Patient Transformation Programme. ***Please note that the attached appendices are included for information only.***

Questions

1. Where are we currently?
2. What is the future vision for our out-patient services?
3. What approach will we take in beginning to transform our out-patient services?
4. What are the key risks and issues?
5. How will we measure performance?

Conclusion

1. This paper provides the Trust Board with a summary of the "current state "of our out-patient services which provides a compelling case as to why we need to change what we currently do. A vision for how we see out-patient services delivered in the future has been tested with stakeholders and now needs to be ratified by the Trust Board. This paper describes our approach to delivery to make sure that we do a few things well that we can sustain rather than try to do too many things, with limited impact, in what is a very large and complex project. The paper describes how we will use work undertaken in two chosen specialities (ENT and Cardiology) to deliver a rolling programme of change in further specialities next year. An overview of the key challenges to delivery is also provided.

The Current State

2. We currently see 875,000 outpatients per year (238,000 New patients and 500,000 Follow ups) in our out-patient services. In addition we offer 104,000 Outpatient Procedures. Numbers of referrals continue to rise in many specialities and clinics in many instances are full to capacity. In 2016/17 there were 386,522 hospital and patient appointment cancellations. This coupled with the numbers of patients who fail to attend for their appointment (69,452 patients) gives rise to wasted time and effort for clinic staff in preparing the clinics.

3. There are currently 27 steps in administering the average out-patient appointment. With opportunities such as a move to implementing an electronic GP referral system some of these steps can be eliminated.

4. Our patients and stakeholders have told us through the Family and Friends Test (FFT) Scores that the biggest things they are concerned about are waiting times in clinics, communication, medical care and staff attitude. The out-patient setting is for the majority of our patients the first

and often the only contact patients have with our services and therefore the experience they have of our services can be how they view UHL.

5. We have held a number of listening events with over 150 stakeholders and staff in recent weeks. Feedback from these events has pointed to many areas where there is significant room for improvement in our out-patient services. We provide out-patient services from 163 different locations and the "offer" to our patients is very variable depending on where they are seen.

6. In June 2016 the Trust underwent a Care Quality Commission (CQC) comprehensive inspection of its services. A number of failings in particular areas of our out-patient services were identified during the inspection leading to key actions within the CQC Compliance action plan. Not only is there are requirement to ensure that we achieve and sustain levels of compliance within these areas but this should be the standards that are expected in all out-patient areas.

7. A considerable number of patient complaints are associated with failings in our out-patient services. Added to this there a number of SUIs have occurred over the last few years which supports the view that systems and processes in OPs require improvement.

8. As part of our Sustainability and Transformation Plans (STP) across the Health Economy we know that growth in activity provided by UHL cannot continue to grow and that from an out-patient perspective we should only bring people for an appointment at our 3 hospitals if there is an absolute need to do so. Our patients and staff tell us that we bring some patients back for follow up appointments unnecessarily.

9. Good progress has been made over the past few weeks and we now have a clear view of the scale and complexity of the programme. Priorities have been identified for cross cutting themes and are being confirmed for the specialities ENT and Cardiology.

Vision for out-patient services

10. A clear vision for the future delivery of our out-patient services has been shared with a variety of stakeholders who are in agreement with the vision statement, There is a clear steer from all LiA events, our patients and stakeholders that we need to focus on ***"making every contact count"*** and only bring patients to our hospitals where face to face contact is necessary.

11. In the future we will be building a new Planned Ambulatory Care Hub (PACH) which will provide state of the art out-patient facilities in which staff will work very differently. We therefore need to get our out-patient model right before we invest in the new building. We know from our experience in delivering Phase 1 of the Emergency Floor Project that we should have invested time in changing the way staff worked and transforming services before the move into the new building and we need to learn from this..

12. As there is agreement that the vision for out-patient services describes this future state it is ready to be signed off by the Executive team and ratified by the Trust Board.

Our approach to transforming Out-Patient services

13. The scale and scope of the programme cannot be underestimated. As a consequence the approach will be to focus on doing a few things well in two specialities (ENT and Cardiology) and ensure that we have sustained changes that we implement before we roll out what we have achieved to other specialities. The approach will be twofold: "fixing the fundamentals" and getting the basics right is the first part. Redesigning processes, eliminating waste and focussing on sustainable demand and capacity management will form the second strand.

14. Five Listening into Action (LiA) events have been held to better understand the issues and engage over 150 staff in generating ideas to address areas for action and improvement. Main themes on which we will be concentrating our efforts in ENT and Cardiology will be:

- Improving our Customer Care Focus
- Improving the environment (facilities and way finding)
- Reducing unnecessary Follow up appointments
- Appointment letters
- Clinic processes – reducing unnecessary steps
- Investing in Information technology
- Communication and Team working
- Addressing cultural issues described by staff as barriers to change
- Developing the Interface with Primary care
- Appointment scheduling
- Reducing hospital cancellations
- Resources

“**Fixing the fundamentals”**

15. Getting the basics right will form a sound basis on which to deliver significant transformational change and to help win hearts and minds. Effort therefore will necessarily need to be put into the following areas:

16. **Customer Care Training:**
The creation of a customer care and franchise approach (consistency in look, feel and experience) across all our out-patient services modelled on best practice from other industries such as the John Lewis Partnership, McDonalds or the hotel industry. This will necessitate the development of a bespoke training package which promotes the behaviours and attitudes that we would expect, driven through empowering our frontline staff to become involved in developing such a programme.

17. **Addressing environmental factors that affect patient and staff experience:**
This will be based on setting some rules of engagement agreed across all out-patient departments no matter which CMG uses the space. Overcoming cultural attitudes and behaviours to ensure that no matter where patients are received the environment is conducive to their needs and that we promote consistency in our offer to patients. The cost impact of changes required is unknown at this stage but will need to be quantified in a business case where alternative sources of funding are not available.

18. **Improving out-patient correspondence:**
Building on work that has already been delivered with particular emphasis placed on 4 key areas: Ensuring all specialities adopt the outsourced method of sending out patient appointment letters, developing this process for 2WW appointments, improving quality and standardisation of information sent to patients and working towards clinic outcome letters being sent electronically to patients (linked to transcription project that is in progress).

19. **Improving functionality of IT equipment:**
Replacement of IT hardware in accordance with the Trust wide programme for rollout and resolution of day to day irritants will be an early priority for ENT and cardiology. It is also an aspiration for the project to have a completed a full baseline inventory of IT hardware requiring replacement across all out-patient areas by the end of the financial year.

20. Internally it is recognised, and there is a high level of support, for improving IT capability across our out-patient services. During this financial year there are some specific IT projects that will be delivered. Agreement to progress these is set in the context of the current capital constraints, project management resource availability and priorities for the Trust as a whole. The priority projects, identified as “must do’s” for this year, that will impact out patients are:

- **E-referrals** – By October 2018 all GP referrals need to be made electronically. UHL will not receive income for paper referrals accepted after this date.
- **Electronic ordering via ICE** (pilot currently underway in Haematology) – electronic requesting of tests and investigations.
- **E-referral training application –** Training version of the electronic referral system to allow staff to understand how to use the new electronic referral system.
- **Out-patient correspondence –** Procurement of a new supplier /transcription service for out-patient clinic letters.
- **ICE Hardware resilience/upgrade –** Upgrade of the hardware system

Redesigning processes and eliminating waste

This area of work will continue to focus on ENT and Cardiology in order to ***"make every contact count".*** Project plans will be developed focussed upon initiatives that will release significant capacity as well as reducing non-value added activities. Specifically we will look at:

21. **Clinic processes**
Staff have identified opportunities for streamlining clinic processes in order to reduce duplication and release precious administrative time. This is linked to work undertaken to implement electronic referrals for GP's, reducing follow up attendances and reducing hospital cancellations. An outcome of this work will not only be to reduce steps in the current clinic process but also to improve appointment scheduling.

22. Reducing follow up attendances
As part of the STP and work of the LLR Planned Care Board, to respond to patients wish to attend for a hospital appointment only if necessary and shift towards sustainable out-patient services there will be focussed work in ENT and Cardiology to look at ways to reduce follow up attendances. In both specialities there is significant opportunity. This will also help to release current capacity constraints felt by both specialities.

23. Reducing hospital cancellations
This area of work will look at the underlying reasons why we cancel so many appointments. It will seek to look at other processes that can be implemented such as use of open appointments to manage many patients who require long term follow up and to reduce the administrative time taken up cancelling and rebooking considerable numbers of appointments.

24. Developing the interface with Primary Care
GPs have identified opportunities to support out-patient transformation. These will be explored further in ENT and Cardiology. In ENT here are plans to use GPwSIs (GPs with a Specialist Interest in ENT) in clinics in order to release consultant capacity to see other patients.

25. Developing a framework for releasing capacity
As an integral part of this work a framework will need to be developed for releasing capacity once clinic processes have been redesigned and issues such as long term waiters addressed. The framework will be consistent with delivering system wide benefits and sustainability in service delivery. Links will be made to business planning principles and work undertaken by the contracts team to support contractual negotiations.

26. Programme of Work - Key milestones
At the start of the programme a high level milestone plan was provided within the Project Charter. Progress against the milestones is on track as planned in most areas. Timescales have been challenging in order to deliver the scale and scope of work required. Finalising and agreeing the specific project plans and KPI's with the ENT and Cardiology remains a high priority for the project. Plans are in place to manage this.

Progress against original milestones is on track with the exception of the development of key performance indicators which will be finalised in November 2017. The current milestone plan has been developed for the period July 21017 – March 2018 to ensure that we deliver and consolidate the transformation in ENT and Cardiology before we adopt changes in further specialities. We plan to start to develop out plans for roll out in the last quarter of the financial year in order that experience of delivery in ENT and Cardiology informs the transformation of future specialities.

The key milestone plan up until 31st March 2018 is provided below:

Key milestones	Accountable Officer	Expected outcome/Impact	Start date	Delivery date	RAG rating
Finalise the programme plan with	J Edyvean	Key milestones, accountable individuals, deadlines for delivery and clear outcomes	01/07/2017	~~01/09/2017~~ 30/11/17	(Scope/ complexity)
Develop, agree and sign off project plan- ENT & Cardiology	J Edyvean	Project plan is signed off and supported by Trust and relevant Speciality Boards/CMG Boards. People know where they are responsible for delivery of an action plan and can be held to account for delivery within agreed timescales.	01.10.17	17/11/2017	4
Develop and agree a future vision for Out Patient services	M Wightman	Vision clearly articulated that is consitent with clinical strategy and Reconfiguration Plans. Vision aligns with trsnsform,ation activities	06/09/2017	02/10/2017	4
Delivering quick wins in ENT & Cardiology	J Edyvean	Quick wins agreed and fully addressed	23/10/2017	31/12/2018	4
Addressing enviromnmental factors with focus on ENT & Cardiology	D Waters/R Karavadra	Improved environment. Increased staff and patient satisfaction	23/10/2017	31/03/2018	4
Customer Care Training	*TBC*	100% ENT&Cardiology Staff receive Customer Care Training	01/11/2017	31/03/2018	0
Clinic letters	S Priestnall	Improvements suggested by staff re appointment and clinic letters addressed initially in ENT & Cardiology	16/10/2017	31/03/2018	4
Reducing cancellations in ENT and Cardiology		Recorded cancellations reduce. Non value adding activities reduced. Clinic coordinator time released	01/11/2017	31/03/2018	0
IT Enablers	A Carruthers	Hardware replaced in ENT and Cardiology. Baseline assessment completed of all OP areas of herdware replacement requirements. Agreed IT developments implemented. Early move towards Paperless Out Patients 2020	20/10/2017	31/03/2018	0
Advice and guidance monitoring	H Cave	Reduce non admitted demand using advice and guidance service	01/04/2017	23/02/2018	4
Prism referrals	C Carr	Patients Referred into correct clinic at their first appointment	01/16/17	30/11/2017	3
Develop and agree a suite of outcome based KPI's for ENT and Cardiology	J Edyvean	Clear metrics for measuring improvement	29/09/2017	10/11/2017	4
Performance monitoring and evaluation	J Edyvean	Clear position on impact of changes and managing for improvement. Celebrating success	13/11/2017	31/03/2018	0
Develop communications and engagement plan	C Maddison	Staff and key stakeholders kept informed of progress. Toolkit available to ensure approach is flexible to needs of programme	29/09/2017	03/11/2017	4
Complete first cultural audits	T Rees/ A Assimacopoulos	Understanding of the systematic, cultural and behavioural aspects within two specific clinics of the wider Outpatients team- how do they perceive their service and what it is like to work for this service. A basis on which to ensure that the programme has the right people, with the right skills, attitudes and behaviours, working in the right place at the right time to support sustainable change.	05/10/2017	23/10/2017	4

27. Once we have completed the work in ENT and Cardiology we will review the outcome. Look at lessons learned in order that they can be incorporated into the future rollout in other specialities.

Measuring for success

28. It has been agreed that the overarching measurement for success will be using the Family and Friends Test (FFT) score. Our aspiration remains that a FFT of above 97% across all CMGs is only consistently achievable at the end of 2018/19. By comparison with our peers this would mean that we would be one of the top performers in terms of FFT for Out-patients.

29. In addition to the overarching metric an initial 11 further measures for improvement are proposed, subject to confirmation with relevant leads and based on areas for improvement . These sit alongside other measures that are regularly reviewed at the Out-Patient Quality Board and Trust Board.

Overcoming barriers to change – first steps (Cultural audit)

30. The time and investment in organisational development to change both patient behaviours as well as the culture of our staff will take considerable time and effort. This is likely to be the greatest area of challenge to the programme if true transformation is to occur. OD support is in place for the programme and this needs to be used to maximum benefit. In addition staff will require leadership development to manage conflict and to hold people to account where the desired behaviours and change are not being upheld.

31. Early cultural audits have been undertaken throughout October to obtain an initial baseline measurement for changing the culture amongst staff. Early feedback has highlighted the following high level positive and negative themes:

- Good teamwork/Support
- Understaffed
- Well organised
- Job satisfaction/patient focus
- Inefficient processes

- Stress
- Understaffed
- Poor facilities
- Clinics overrunning
- Lack of communication

Key risks and challenges

32. The scale of opportunity and the ability to realise this is a significant challenge for the organisation. This will take considerable medical leadership and commitment from clinical and administrative teams from across the Trust. Current high level risks and issues are summarised:

a) There is an issue that resources to deliver the programme are limited which may pose a risk to timescales for delivery.
b) The scale of ambition and expectations mean that we do not deliver transformation and the impact of change is underwhelming
c) Changes will not be sustained and services revert to current practice
d) Current contracting arrangements and CMG approach to achieving financial balance impacts on the willingness to achieve activity reductions that could materialise

Input Sought

33. Trust Board members are requested to:

- Note that we will concentrate on doing a few things well focussed on ENT and Cardiology this financial year.
- Provide comments and guidance on any areas prior to discussion at Trust Board in November.
- Sign off the vision and agree that we will work wards *“Making every contact count”.*
- Give assurance that the level of delivery that can be achieved in year is appropriate.
- Note the risks to delivery concerning resources, changing culture for sustained improvement and limited headroom within CMG’s to support delivery.

- Agree the frequency of formal updates outside the quality commitment reporting framework if required.
- Agree that this programme should be considered as an annual priority in 2018/19.

For Reference

Edit as appropriate:

1. The following objectives were considered when preparing this report:

Safe, high quality, patient centred healthcare [Yes]
Effective, integrated emergency care [No]
Consistently meeting national access standards [Yes]
Integrated care in partnership with others [Yes]
Enhanced delivery in research, innovation & ed' [Not applicable]
A caring, professional, engaged workforce [Yes]
Clinically sustainable services with excellent facilities [Yes]
Financially sustainable NHS organisation [Yes]
Enabled by excellent IM&T Yes]

2. This matter relates to the following governance initiatives:

Organisational Risk Register [Yes]
Board Assurance Framework [Yes]

BAF 17/18: Version	Sep-17											
Objective:	Safe, high quality, patient cantered, efficient healthcare											
Annual Priority 1.3.2	We will improve the patient experience in our current outpatient's service and begin work to transform our outpatient models of care in order to make them more effective and sustainable in the longer term. Trust QC Aim: outpatients tba											
Objective owner:	DCIE		**SRO:**	J Edyvean / D Mitchell		**Executive Board:**		EQB		**TB Sub Committee**		IFPIC
BAF Assurance Rating - Current position @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3	3	3	3	3	2						
BAF Assurance Rating - Year end Forecast @	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
	3	3	3	3	3	2						

3. Related Patient and Public Involvement actions taken, or to be taken: Patient Partners involved in LiA events held to date. Further advice awaited on continued involvement going forward. Patients and service users will be an integral part of delivery
4. Results of any Equality Impact Assessment, relating to this matter: [Not completed]

5. Scheduled date for the next paper on this topic: To be advised
6. Executive Summaries should not exceed 1page. [My paper does not comply]
7. Papers should not exceed 7 pages. [My paper does comply]

Transforming Out Patient Services across UHL – "*Making every contact count"*

Context

34. As an annual priority for 2017/18 UHL has committed to the transformation of our out- patient services as one of our annual priorities. Our quality commitment states that: *We will improve the patient experience in our current Out-patients service and begin work to transform our outpatient models of care in order to make them more effective and sustainable in the longer term.* This reflects an unmet need identified through feedback from our patients and stakeholders, as reflected in our Family and Friends Test (FFT) scores.

35. This paper provides the Trust Board with a summary of the "current state" of our out-patient services which provides a compelling case as to why we need to change what we currently do. A vision for how we see out-patient services delivered in the future has been tested with stakeholders and now needs to be ratified by the Trust Board. This paper describes our approach to delivery to make sure that we do a few things well that we can sustain rather than try to do too many things, with limited impact, in what is a very large and complex project. The paper describes how we will use work undertaken in two chosen specialities (ENT and Cardiology) to deliver a rolling programme of change in further specialities next year. An overview of the key challenges to delivery is also provided.

Background and current state

36. Out-patient services are often the first point of contact and the first experience that majority of patients have of our services .First impressions are said to be the lasting impression. We currently deliver out-patient care to approximately 800,000 patients per annum across our 3 hospital sites in multiple locations (900,000 when services delivered in the Alliance are taken into consideration). In addition we offer 104,000 Outpatient Procedures across our 3 hospital sites. Numbers of referrals continue to rise in many specialities and clinics in many instances are full to capacity. In 2016/17 there were 386,522 hospital and patient appointment cancellations. This coupled with the numbers of patients who fail to attend for their appointment (69,452 patients) gives rise to wasted time and effort for clinic staff in preparing the clinics.

37. The "offer" to our patients, and how we tell our patients what to expect when they attend for an appointment is very variable. Often because we do not get things right first time we bring patients back for further appointments unnecessarily. Our out-patient clinics are often over-subscribed which leads to increased waiting times. Our patients, on average, can have up to 27 steps in their out-patient journey and our services are often designed around Trust requirements rather than the patient needs. This leads to a poor patient experience and does not value our patient's, their escort or staff time.

38. To date there has been a lack of investment in IT infrastructure in Out-patients. There is now a drive to make outpatient departments work digitally. The opportunity that could be realised are significant as this aligns with our priority to get the majority of key clinical documents in one application, by comparison with in patient service there is a relatively small amount of clinical notation and this would link with the outpatient letter project and communication with our GP partners.

39. The condition of many of our out-patient settings has had little investment over recent years. There is no standard governing how information is displayed which leads to a poor impression in some of our waiting areas. Information about the performance of a clinic in progress is displayed in different formats and due to reliance on manual updates the information is not displayed in real time.

40. Over time we have not invested in fixing the fundamentals or getting the basics right in our out-patient services. This creates a huge challenge to our staff when we are asking them to make significant changes in the way we deliver our services to make them affordable, fit for purpose and sustainable in the future.

41. A programme of work has been agreed via the LLR Better Care Together Planned Care Board that will impact how we deliver our out-patient services going forward. This is based on the agreements made within the Sustainability and Transformation (STP) Plans for LLR which makes the point that patients should only attend UHL if it is absolutely necessary to do so.

42. As part of the STP capital proposals UHL has submitted a bid for £397m capital funding to enable the delivery of its reconfiguration programme. A significant enabler of these plans is the development of a Planned Ambulatory Care Hub (PACH) based on the Glenfield Hospital site. A significant part of this facility will be for the provision of modern state of the art out-patient services. It is therefore critical that we start to transform our out-patient services now in order to inform the development of the business case and make sure that any such new facility is fit for purpose and embraces new ways of working.

The future Vision for our Out-Patient services

43. The future vision for our out-patient services in the next 5 years is:

    > To deliver "best in class" out-patient services, designed around the needs of our patients, from a dedicated environment with co-located diagnostics to facilitate one stop clinics. In making every contact count we will have a single standardised process for booking appointments and self-check in for patients on arrival. We will optimise the use of digital technology and wherever possible will provide out-patient consultations in a way that is most suited to patient needs, only bringing patients into our hospital sites where this is necessary. We will move to a paperless environment where clinicians have immediate access to all the information they require to be able to deliver todays work today.

    In summary we need to deliver this through ***"Making every contact count".***

44. This vision is aligned to the development of our Reconfiguration Programme and is in keeping with the philosophy for the PACH), where we will aspire to bring together all the required services into one location to deliver "best in class" out-patient services.

45. Our vision is consistent with work undertaken as part of the development of the LLR Sustainability and Transformation Plans (STP) and the work of the LLR Planned Care Board.

46. This vision has been shared with our patient partners, our staff and other key stakeholders during Listening into Action events over recent weeks. Feedback has been positive and comments have further illustrated that we need to change how we currently deliver our out-patient services.

The case for change

47. The need to change the way we deliver our out-patient services is driven by a number of compelling factors, some of which are explained in the background above. There are many other reasons why we need to change what we are currently doing.

48. In June 2016 the Trust underwent a Care Quality Commission (CQC) comprehensive inspection of its services. A number of failings in particular areas of our out-patient services were identified during the inspection leading to key actions within the CQC Compliance action plan. Not only is there are requirement to ensure that we achieve and sustain levels of

compliance within these areas but this should be the standards that are expected in all out-patient areas. Any out-patient transformation and improvement plan should therefore consider the requirements within the new CQC handbook.

49. A considerable number of patient complaints are associated with failings in our out-patient services. Added to this there have been a number of SUIs over the last few years which supports the view that systems and processes in OPs require improvement.

50. Very little time and attention has been given to reviewing how we deliver our out-patient services over the past decade. Recent changes have evolved and to date have largely focussed on the more transactional elements associated with achievement of referral to treatment times (RTT) and diagnostic and cancer waiting times targets.

51. Feedback from our patients tells us that the 4 biggest things that they are concerned about are:

    - Waiting times in out-patient clinics
    - Communication (including knowing who they will see when they attend for their appointment)
    - Medical Care
    - Staff attitude

52. A previous audit of waiting times in clinic illustrated that 23.4% of patients were seen on time or before there appointment slot. At the time of the audit the overall the average waiting time was 27 minutes with an average wait being recorded between 23 and 35 minutes. At the time compliance against the standard that patients should be seen within 15 minutes of their appointment time was 46%. The main reasons for waiting times in clinics was overbooking of clinics, doctors arriving late and late arrival of patients. Work has been undertaken to improve this position but it remains the main concern expressed by patients.

53. The triangulation of patient feedback in quarter four 2016/17 indicated that the main theme for improvement remained as waiting time in clinic (30% feedback). Waiting times, along with the other top three themes – communication, medical care and staff attitude, showed a significant increase when compared to the same quarter in the previous year. The top theme across demographic groups is also waiting times apart from patients with a disability which is medical care.

54. The outcomes from 5 recently held LiA events have provided compelling arguments from staff, GP's and out Patient Partners as to why we need to change. These are summarised in Appendix B.

55. Aligned with our aspirations to reconfigure our services across 2 hospital sites we also know that we need to change the way in which we deliver out-patient services as our current models of care will no longer be affordable and sustainable in the longer term. Out-patient services in other Trusts are being transformed and some now deliver more streamlined services in paperless environments that optimise the use of digital technology.

56. Demand for our out-patient services continues to rise. Whilst work is progressing through the adoption of advice and guidance, the implementation of triage systems, the shift to a fully electronic GP referral system by October 2018 to help manage some of this demand. Work is underway to reduce the number of follow up appointments in a number of specialities, however, there is still a lot more that can and needs to be done to manage demand and free up valuable clinic space for patients who essentially need to be seen in a secondary care setting.

57. In 21016/17 our out-patient income was £117m which is approximately 17% of the Trust's annual turnover. Improving out-patient efficiency remains an important priority for the Trust.

Given the workforce challenges that we face and the increasing pressure on staff to provide high quality and timely care consideration needs to be given to streamlining our services as effectively as we can.

58. IT systems are underutilised or are not used in our existing out-patient clinic settings. Over time standalone systems have been developed which do not integrate with other systems in the organisation. We do not have a single application where clinicians can access all key clinical documents in a single place. On a day to day basis staff still raise concerns that hardware needs replacement which results in delays in staff being able to deliver services efficiently. Investment in IT systems in our out-patient services would bring about large benefits for staff and patients as well as for the management of our patients across organisational boundaries. Other Trusts have been able to achieve this and move to paperless delivered out-patient services. Internally there is an appetite to drive these changes.

59. There is now a clear case for change and commitment directed towards improving patient experience. This will also make sure that we deliver benefits identified within UHL's Clinical Strategy, out IT strategy and our People Strategy. This will make sure that we are seen by service users as "best in class "and that our patients and staff would definitely recommend UHL as a place to receive treatment.

Framework for delivery

60. The UHL Better Change Methodology for developing, testing and implementing changes throughout the programme has already been adopted. Teams are beginning to access the necessary tools, techniques and development opportunities in order to realise the step changes required. The Project Charter (Appendix A)was formally signed off by the Executive Team in August 2017 and will be refreshed as the programme is delivered.

61. There are a number of projects that will enable us to deliver out out-patient transformation programme. These are illustrated as follows:

Out Patient Quality Board Initiatives

- Forget me not stickers
- Keeping patients informed of in-clinic wait time
- 14 day letter turnaround
- Ambulance issues
- Cancellation of rooms in central OPD services
- You said We did boards
- DNA management
- Clash reporting
- Bookwise
- Best Practice Checklist
- Future slot availability
- ASI's
- Roll out of advice and guidance
- Postal letters moving to electronic
- Review of information letters
- Translation services
- Management of 12+ month waiters
- Implementation of new transcription contract
- Eligibility criteria for ambulance transport
- Development and implement scorecards at speciality level
- SMS text reminder service
- Scope of booking Centre
- Development of advice and guidance
- Roll out of E referrals
- Action planning in response to F&F test feedback

CIP Schemes

- Standardise clinic templates
- Increase Booking Slots utilisation (BSU)
- Review DNA rates
- Improve the new follow up ratio
- Improve patient flow

62. As part of the scoping work we have looked at what other Trusts have delivered in transforming their out-patient services. Visits have taken place to Queen Elizabeth Hospital, (UHB) Birmingham , Circle in Nottingham, Nottingham University Hospitals and Derby Teaching Hospitals NHS Foundation Trust. As a consequence of these visits we are developing an active network of colleagues who are willing to share their experience going forwards. Lessons from these visits will be shared and used to inform the on-going development and delivery of the programme. Internally it is hoped that teams not only befit from this but they will be encouraged to adopt a “go see” approach in order to share best practice and learn from each other.

63. In order to avoid re-inventing the wheel we will endeavour to adopt best practice from elsewhere and use models that work effectively elsewhere where it is appropriate to do so.

Our approach to transforming Out-Patient services

64. The scale and scope of the programme cannot be underestimated. As a consequence the approach will be to focus on doing a few things well in two specialities (ENT and Cardiology) and ensure that we have sustained changes that we implement before we roll out what we have achieved to other specialities. The approach will be twofold: “fixing the fundamentals” and getting the basics right is the first part. Redesigning processes, eliminating waste and focussing on sustainable demand and capacity management will form the second strand.

65. Five Listening into Action (LiA) events have been held to better understand the issues and engage staff in generating ideas to address areas for action and improvement. Over 150 individuals have taken part in these events including Patient Partners, staff from a range of disciplines, and GP’s. Recurring themes were a common feature for each of the LiA sessions many of which focussed on sorting the fundamentals and getting the basics right whist others highlighted opportunities for transformation (Details are provided in Appendix B).

66. Participants were invited to identify what would get in the way of us delivering the changes they suggested. The outcome of this question has given a significant insight into some of the cultural barriers to change that will need to be addressed and the level of support that staff may require in order to hold each other to account to ensure changes are sustained . Outcomes have also been used to inform the cultural audits that have been undertaken, as described in sections 51 – 53 of this paper.

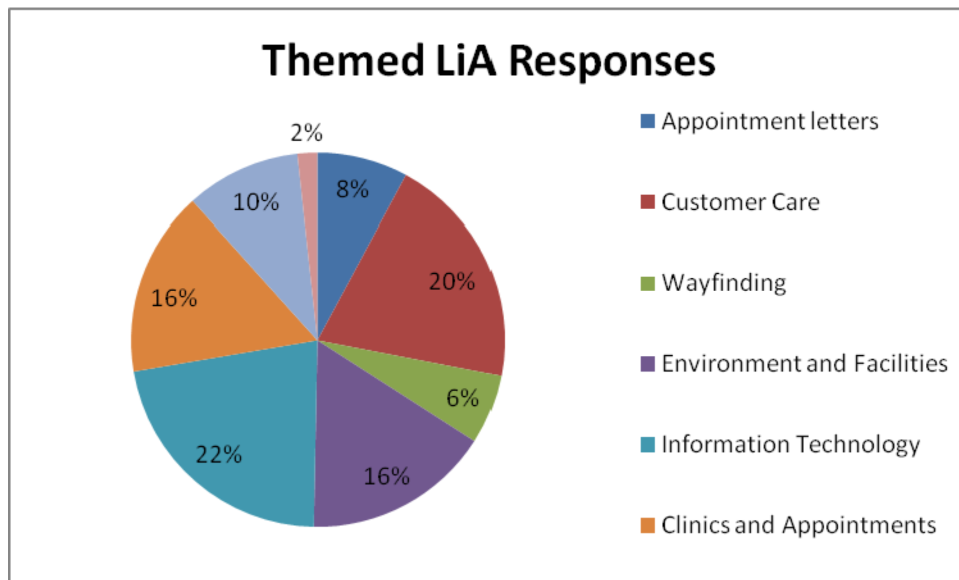
67. The main themes from the LiA events are summarised as follows:

- Lack of Customer Care Focus
- Information technology
- Environment/facilities/way finding
- Appointment letters
- Clinic processes
- Follow up appointments / cancellations
- Communication and Team working
- Culture
- Interface with Primary care
- Appointment scheduling
- Finance
- Resources

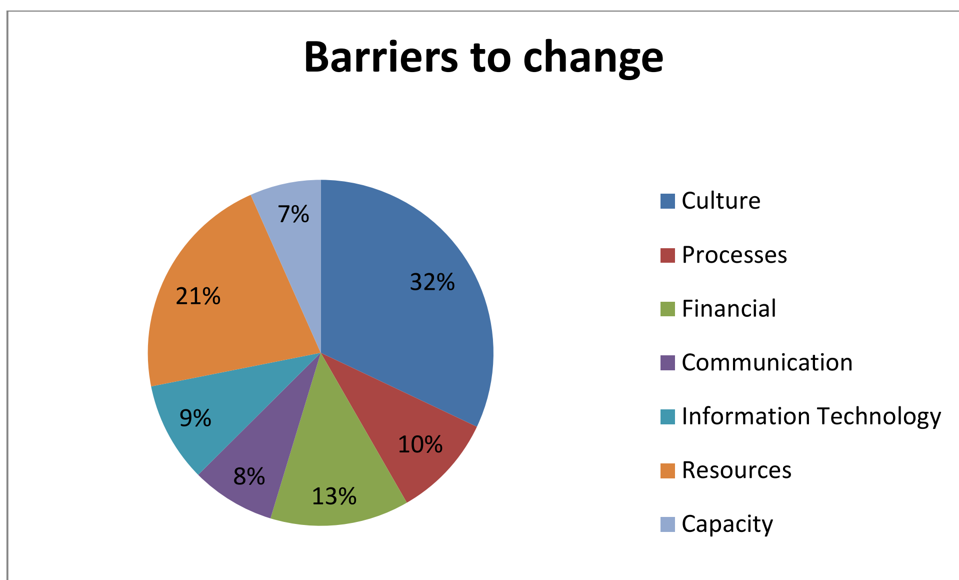
68. Key barriers to implementing and sustaining change were highlighted as:

- Organisation culture
- Historic processes
- Capacity
- Information Technology
- Resources
- Finance
- Communication

69. Further analysis of these common themes was undertaken following the two initial LiA sessions based on the frequency with which responses occurred. The theme recurring most frequently related to IT issues (179of all responses = 22%), followed by Customer Care (164 repeated responses = 20%).The full breakdown against all core themes is provided in the graph below:



The most significant barrier to change is seen as the organisational culture (106 repeated responses - 34%) and availability of resources as the next issue (21%).



Examples of barriers to change provided by staff are summarised in the following table:

Resistance to change/staff attitude
Fragmented working approach/work ethic depending on department
Leadership
Hierarchy, empowering everyone for change
Low morale as working under high pressure
Lack of training
Not viewing things from the patient's perspective

Lack of staff engagement across all professions
Lack of awareness of issues
Too many people wanting input
Perception that Out Patients is a lower priority
Lack of money for meaningful change
High admin staff turnover
Too many layers of bureaucracy to enact meaningful change

Fixing the fundamentals

70. As mentioned earlier there are issues that get in the way of staff delivering high standards of care on a day to day basis that undoubtedly has an impact on patient and staff experience. These issues we have called "fixing the fundamentals". Getting the basics right will form a sound basis on which to deliver significant transformational change and to help win hearts and minds. Effort therefore will necessarily need to be put into the following areas:

71. **Customer Care Training**:
The creation of a customer care and franchise approach (consistency in look, feel and experience) across all our out-patient services modelled on best practice from other industries such as the John Lewis Partnership, McDonalds or the hotel industry. This will necessitate the development of a bespoke training package which promotes the behaviours and attitudes that we would expect, driven through empowering our frontline staff to become involved in developing such a programme.

72. Addressing environmental factors that affect patient and staff experience:
This will be based on setting some rules of engagement agreed across all out-patient departments no matter which CMG uses the space. This will incorporate standard expectations Ain terms of how we treat the environment and agree standards for equipping generic space, including IT. Overcoming cultural attitudes and behaviours to ensure that no matter where patients are received the environment is conducive to their needs and that we promote consistency in our offer to patients. The formation of creative local partnerships may constitute part of this work to facilitate some of the environmental improvements required. The cost impact of changes required is unknown at present. Funding required will need to be quantified in a business case where alternative funds cannot be sourced.

73. Improving out-patient correspondence:
Building on work that has already been delivered with particular emphasis placed on 4 key areas: 1)Ensuring all specialities adopt the outsourced method of sending out patient appointment letters (minimum target 80%), 2) developing this process for 2WW appointments, 3) improving quality and standardisation of information sent to patients and 4) working towards clinic outcome letters being sent electronically to patients (linked to transcription project that is in progress).

74. Improving functionality of IT equipment:
Replacement of IT hardware in accordance with the Trust wide programme for rollout. This will also include resolving issues that have become day to day irritants to enable maximum functionality of existing IT equipment within out-patient clinic areas.

Speciality focus

75. As previously agreed ENT and cardiology are the first 2 specialities to receive support for a targeted out-patient transformation programme. Separate LiA events have been held in each speciality. Both services face significant capacity constraints therefore, in addition to making these areas a priority for addressing the fundamentals and exploiting existing IT capability, project plans will be developed focussed upon initiatives that will release significant capacity as

well as reducing non-value added activities. Whilst some of these actions will be common to both specialities there will be local differences owing to the different nature of the specialities.

76. Redesigning processes and eliminating waste
This area of work will continue to focus on ENT and Cardiology in order to ***"make every contact count".*** Project plans will be developed focussed upon initiatives that will release significant capacity as well as reducing non-value added activities. Specifically we will look at:

77. **Clinic processes**
Staff have identified opportunities for streamlining clinic processes in order to reduce duplication and release precious administrative time. This is linked to work undertaken to implement electronic referrals for GP's, reducing follow up attendances and reducing hospital cancellations. An outcome of this work will not only be to reduce steps in the current clinic process but also to improve appointment scheduling.

78. Reducing follow up attendances
As part of the STP and work of the LLR Planned Care Board, to respond to patients wish to attend for a hospital appointment only if necessary and shift towards sustainable out-patient services there will be focussed work in ENT and Cardiology to look at ways to reduce follow up attendances. In both specialities there is significant opportunity. This will also help to release current capacity constraints felt by both specialities.

79. Reducing hospital cancellations
This area of work will look at the underlying reasons why we cancel so many appointments. It will seek to look at other processes that can be implemented such as use of open appointments to manage many patients who require long term follow up and to reduce the administrative time taken up cancelling and rebooking considerable numbers of appointments.

80. Developing the interface with Primary Care
GPs have identified opportunities to support out-patient transformation. These will be explored further in ENT and Cardiology. In ENT here are plans to use GPwSIs (GPs with a Specialist Interest in ENT) in clinics in order to release consultant capacity to see other patients.

81. Developing a framework for releasing capacity
As an integral part of this work a framework will need to be developed for releasing capacity once clinic processes have been redesigned and issues such as long term waiters addressed. The framework will be consistent with delivering system wide benefits and sustainability in service delivery. Links will be made to business planning principles and work undertaken by the contracts team to support contractual negotiations.

Details of the themed outputs from each LiA event are provided in summary format in appendix B. The outputs from these sessions also identified some quick wins. Immediate action is already being taken to support staff in delivering some of these.

Programme of Work- Key milestones

Progress against original milestones is on track with the exception of the development of key performance indicators which will be finalised in November 2017. The key milestone plan up until 31st March 2018 is provided below:

Key milestones	Accountable Officer	Expected outcome/Impact	Start date	Delivery date	RAG rating
Finalise the programme plan with	J Edyvean	Key milestones, accountable individuals, deadlines for delivery and clear outcomes	01/07/2017	~~01/09/2017~~ 30/11/17	(Scope/ complexity)
Develop, agree and sign off project plan- ENT & Cardiology	J Edyvean	Project plan is signed off and supported by Trust and relevant Speciality Boards/CMG Boards. People know where they are responsible for delivery of an action plan and can be held to account for delivery within agreed timescales.	01.10.17	17/11/2017	4
Develop and agree a future vision for Out Patient services	M Wightman	Vision clearly articulated that is consitent with clinical strategy and Reconfiguration Plans. Vision aligns with trsnsform,ation activities	06/09/2017	02/10/2017	4
Delivering quick wins in ENT & Cardiology	J Edyvean	Quick wins agreed and fully addressed	23/10/2017	31/12/2018	4
Addressing enviromnmental factors with focus on ENT & Cardiology	D Waters/R Karavadra	Improved environment. Increased staff and patient satisfaction	23/10/2017	31/03/2018	4
Customer Care Training	*TBC*	100% ENT&Cardiology Staff receive Customer Care Training	01/11/2017	31/03/2018	0
Clinic letters	S Priestnall	Improvements suggested by staff re appointment and clinic letters addressed initially in ENT & Cardiology	16/10/2017	31/03/2018	4
Reducing cancellations in ENT and Cardiology		Recorded cancellations reduce. Non value adding activities reduced. Clinic coordinator time released	01/11/2017	31/03/2018	0
IT Enablers	A Carrruthers	Hardware replaced in ENT and Cardiology. Baseline assessment completed of all OP areas of herdware replacement requirements. Agreed IT developments implemented. Early move towards Paperless Out Patients 2020	20/10/2017	31/03/2018	0
Advice and guidance monitoring	H Cave	Reduce non admitted demand using advice and guidance service	01/04/2017	23/02/2018	4
Prism referrals	C Carr	Patients Referred into correct clinic at their first appointment	01/16/17	30/11/2017	3
Develop and agree a suite of outcome based KPI's for ENT and Cardiology	J Edyvean	Clear metrics for measuring improvement	29/09/2017	10/11/2017	4
Performance monitoring and evaluation	J Edyvean	Clear position on impact of changes and managing for improvement. Celebrating success	13/11/2017	31/03/2018	0
Develop communications and engagement plan	C Maddison	Staff and key stakeholders kept informed of progress. Toolkit available to ensure approach is flexible to needs of programme	29/09/2017	03/11/2017	4
Complete first cultural audits	T Rees/ A Assimacopoulos	Understanding of the systematic, cultural and behavioural aspects within two specific clinics of the wider Outpatients team- how do they perceive their service and what it is like to work for this service. A basis on which to ensure that the programme has the right people, with the right skills, attitudes and behaviours, working in the right place at the right time to support sustainable change.	05/10/2017	23/10/2017	4

82. The current milestone plan has been developed for the period July 21017 – March 2018 to ensure that we deliver and consolidate the transformation in ENT and Cardiology before we adopt changes in further specialities. We plan to start to develop out plans for roll out in the last quarter of the financial year in order that experience of delivery in ENT and Cardiology informs the transformation of future specialities.

83. At the start of the programme a high level milestone plan was provided within the Project Charter. Progress against the milestones is on track as planned in most areas. Timescales have been challenging in order to deliver the scale and scope of work required. Finalising and agreeing the specific project plans and KPI's with the ENT and Cardiology remains a high priority for the project. Plans are in place to manage this. The key milestones for ENT and Cardiology are provided within Appendix C. These projects are expected to deliver the required outcomes and benefits by the end of the financial year.

84. Plans to deliver wider cross cutting projects as listed under "fixing the fundamentals" are being confirmed with respective leads. The headlines and key milestones for each of the key areas of work are provided in Appendices C and E.

85. As noted above part of the OP Transformation Programme there will be a requirement to develop a framework to guarantee the release of capacity/efficiencies and resources at given points in the programme which will need to be negotiated at an individual speciality level. This will need to sit alongside discussions within the contracts team so that there is alignment with commissioning intentions. Without such a framework in place there is a risk that growth continues to be absorbed and waiting times reduce with capacity remaining the same and sustainable models of care not being realised. Timelines for delivery of such a framework will be by the end of the financial year.

86. Prior to the commencement of this programme some work was being progressed through the Out Patient Programme Board. These activities have been reviewed and where appropriate arrangements have been agreed for these to be included as part of the overall monitoring of out-patient improvement activities. Ownership of the plans for delivery remains with the original owners. Details are provided at Appendix D.

87. Engagement and input with colleagues from the wider Health Economy continues to ensure our plans are continuously aligned with the work of the LLR Planned Care Board. There is a high level of assurance that the programmes of work continue to complement each other. Arrangements are in place for relevant projects to continue to be managed in partnership with LLR Planned Care Project Managers.

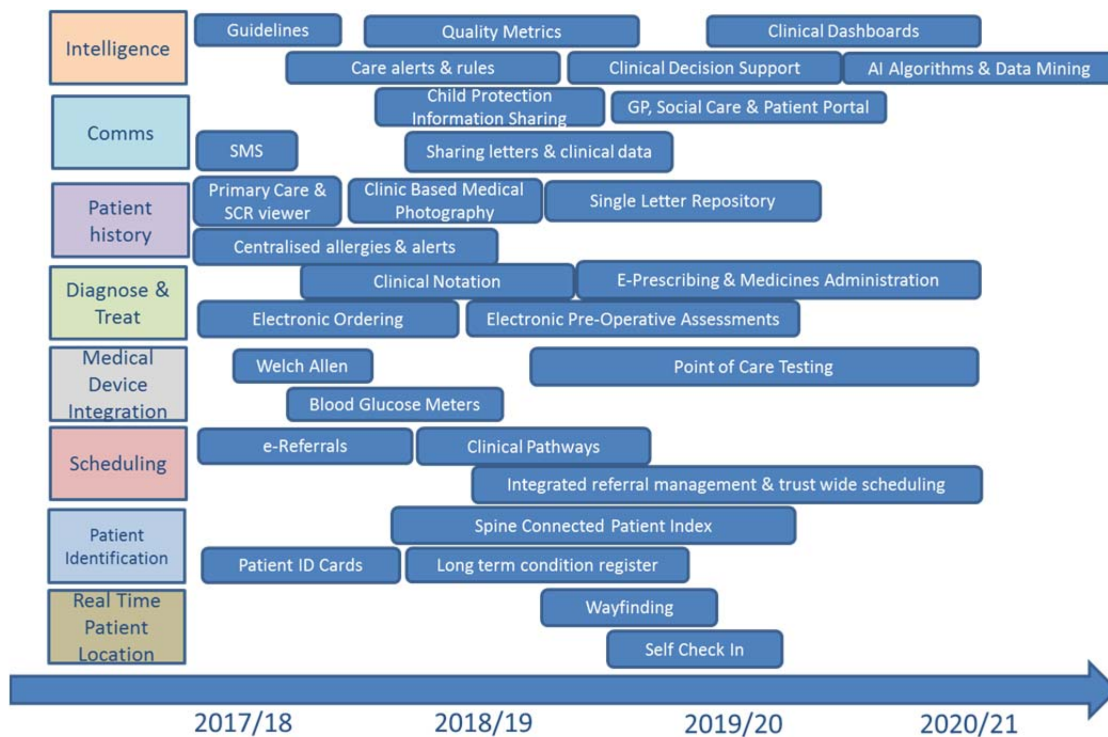
Programme Interdependencies

88. There are a number of project interdependencies that will need to be managed throughout the programme. These are summarised as follows:

Element of work stream	Dependent on	Interdependency description
Quality of Care	Inspection Framework	CQC Compliance
Paperless clinic 2020	IT	Prioritisation of IT Developments Capital availability to support IT investment Paperless Out-Patient 2020 strategy
IT Quick wins	IT Capital resources Trust wide priorities	The extent to which hardware in OPD can be replaced/refreshed will be dependent upon the approach to hardware refresh programme
Models of care/F/U reductions	STP & Finances	Consideration of any in year or 2018/19 contractual impact
Environment	Capital availability	Pressures on the capital programme may result in an inability to address some of the environmental factors that affect patient and staff experience

IT as an enabler

89. Internally it is recognised, and there is a high level of support, for improving IT capability across our out-patient services. During a visit to Queen Elizabeth Hospital Birmingham, to look at their Digital "Fast followers" IT programme, opportunity was taken to explore how they had moved to implement a paperless fully digital run out patient service. There is wide support for this direction of travel across the organisation and this will form part of the Trusts Digital by 2020 Strategy. The key pillars of work to achieve this are shown in the following diagram:



90. During this financial year there are some specific IT projects that will be delivered. Agreement to progress these is set in the context of the current capital constraints, project management resource availability and priorities for the Trust as a whole. The priority projects , identified as “must do’s” for this year, that will impact out patients are:

- **E-referrals** – By October 2018 all GP referrals need to be made electronically. UHL will not receive income for paper referrals accepted after this date.
- **Electronic ordering via ICE** (pilot currently underway in Haematology) – electronic requesting of tests and investigations.
- **E-referral training application –** Training version of the electronic referral system to allow staff to understand how to use the new electronic referral system.
- **Out-patient correspondence –** Procurement of a new supplier /transcription service for out-patient clinic letters.
- **ICE Hardware resilience/upgrade –** Upgrade of the hardware system

91. There is currently a repository in place that will enable to Trust to store electronic referrals from GP’s which will support the national imperative to eliminate paper referrals by October 2018.

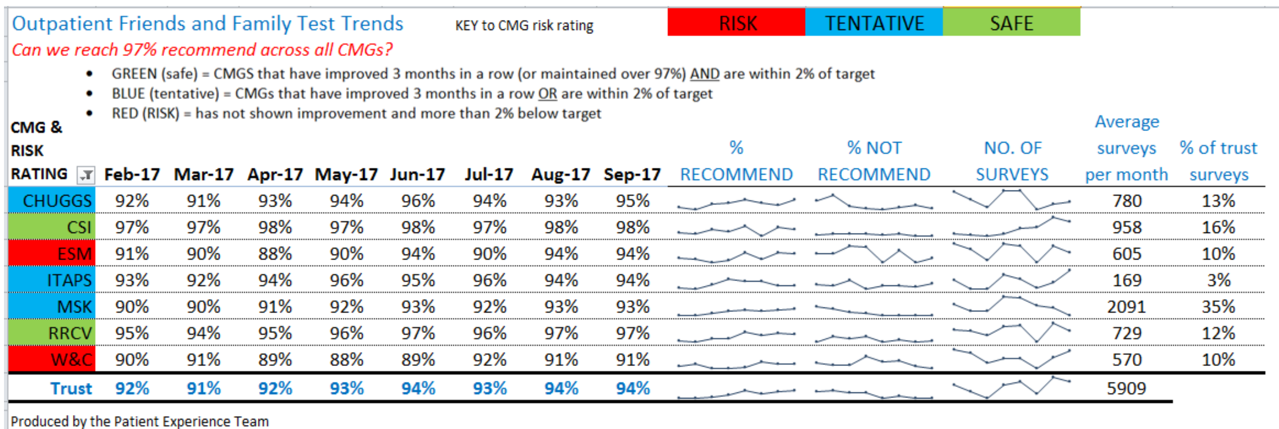
92. There are a number if IT issues that have been raised as recurring themes at all LiA events. They broadly fall into 2 categories: “fixing the fundamentals” and sorting hardware issues and longer term investment in infrastructure and developments that will deliver the paperless clinic 2020 as described above. Details of things that can be delivered in year are provided in appendix E.

Measuring for success

93. It has been agreed that the overarching measurement for success will be using the Family and Friends Test (FFT) score. Current data captured for Out-patients show how each CMG has performed since December 2016. December 2016 was the point at which the Trust started to get enough feedback at clinic level to enable staff to start to improve patient experience in real time.

94. Consideration has been given to the level of achievement over the lifetime of the programme. Our aspiration remains that a FFT of above 97% across all CMGs is only consistently

achievable at the end of 2018/19. By comparison with our peers this would mean that we would be one of the top performers in terms of FFT for Out-patients. We intend to use the FFT score for each CMG outpatients in accordance with the role out of changes for each CMG. The information below shows that the Trust still has a long way to go to achieve 97% in outpatients but this should be achievable with the changes planned for delivery by the end of Q4 2018/19



Outpatient Friends and Family Test Trends — KEY to CMG risk rating: RISK | TENTATIVE | SAFE

Can we reach 97% recommend across all CMGs?

- GREEN (safe) = CMGS that have improved 3 months in a row (or maintained over 97%) AND are within 2% of target
- BLUE (tentative) = CMGs that have improved 3 months in a row OR are within 2% of target
- RED (RISK) = has not shown improvement and more than 2% below target

CMG & RISK RATING	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	% RECOMMEND	% NOT RECOMMEND	NO. OF SURVEYS	Average surveys per month	% of trust surveys
CHUGGS	92%	91%	93%	94%	96%	94%	93%	95%				780	13%
CSI	97%	97%	98%	97%	98%	97%	98%	98%				958	16%
ESM	91%	90%	88%	90%	94%	90%	94%	94%				605	10%
ITAPS	93%	92%	94%	96%	95%	96%	94%	94%				169	3%
MSK	90%	90%	91%	92%	93%	92%	93%	93%				2091	35%
RRCV	95%	94%	95%	96%	97%	96%	97%	97%				729	12%
W&C	90%	91%	89%	88%	89%	92%	91%	91%				570	10%
Trust	**92%**	**91%**	**92%**	**93%**	**94%**	**93%**	**94%**	**94%**				5909	

Produced by the Patient Experience Team

95. In addition to the overarching metric the following initial range of measures are proposed subject to confirmation with relevant leads:

Area of improvement	Metric	Baseline	Target	Target Date
Environment	PLACE Environmental audits		TBC	31/3/2018
	Turnaround times for estates and facilities requests	Audit baseline	TBC	31/3/2018
Clinic correspondence	% Appointment letters sent via out sourced provider (excluding 2WW)	74% ENT 88-90% Cardiology XX% Trust	100% ENT 100% Cardiology 85% Trust	31/3/18 31/3/18 31/3/18
	% 2 WW Letters sent via out sourced provider	TBC	TBC	TBC
	% Clinic letters sent to patients electronically to patients in ENT and Cardiology	0% ENT 0% Cardiology	TBC	TBC
Customer care	% Front line staff trained	Audit baseline	TBC	TBC
Demand& Capacity management	PRISM Pathways	PM's to provide 6/15 ENT Complete 3 Pathways complete Cardiology	100% Complete	31/12/17
	% Electronic GP Referrals		100% Trust	09/04/18
	Follow up reductions – New to follow up ratios	1:1.51 ENT 1:1.7 Cardiology	TBC TBC	31/3/18
	Patients waiting in excess of 12 months for follow up	2,322 ENT TBC Cardiology	0	01/04/18
Information Technology	Baseline/inventory of all hardware issues	Minimal ENT (TBC) Cardiology (TBC)	C Carr to provide	31.12/17 30/11/17 30/11/17

96. Further KPI's will be agreed with ENT and Cardiology in accordance with completion of local project plans during November.

97. Once agreed the KPI's will be translated into a scorecard for measuring and reporting performance improvement. The framework for this is in the early stages of development. It is anticipated that this will be completed by the end of November 2017, populated with the KPI's and the current baseline. Many specialities already have an out-patient scorecard for managing performance. This will be taken into consideration in developing the out-patient transformation scorecard.

Overcoming barriers to change – first steps (Cultural audit)

98. The time and investment in organisational development to change both patient behaviours as well as the culture of our staff will take considerable time and effort. This is likely to be the greatest area of challenge to the programme if true transformation is to occur. OD support is in place for the programme and this need to be used to maximum benefit. In addition staff will require leadership development to manage conflict and to hold people to account where the desired behaviours and change are not being upheld.

99. Early cultural audits have been undertaken throughout October to obtain an initial baseline measurement for changing the culture amongst staff. The results of this initial audit will be formally collated on 23rd October 2017. A verbal update will therefore be provided to the Trust Board with a formal written report to follow. Early feedback has highlighted the following high level themes:

- Good teamwork/Support
- Understaffed
- Well organised
- Job satisfaction/patient focus
- Inefficient processes
- Stress
- Understaffed
- Poor facilities
- Clinics overrunning
- Lack of communication

100. Shaping both team behaviours as well as behaviours amongst our longer term patient populations we know will be a significant challenge in delivering the programme.

Communication and engagement

101. One of the key principles of the out-patient transformation programme will be to implement an engagement and communications strategy that will provide assurances that our approach is inclusive and representative of the populations we serve. Further to this we will make sure that this is a continuous theme throughout the programme and is seen as a way in which we maintain patients and service users at the heart of the programme.

102. Our communications and engagement team have been involved in developing the communications plan for the programme. A variety of approaches will be adopted therefore the plan will offer a range of tools that can be used

103. An analysis of the key stakeholders who will play a part in the design and delivery of the out-patient transformation programme was developed at the beginning of the programme. Their needs and the necessity to involve different stakeholders will be reviewed as the programme develops

104. Meetings have been held with our PPI and Membership manager to seek his support in reaching out to service users. Meetings have been held with our patient partners who have participated in the LiA events. There are now on-going discussions to agree how we will make sure our continued involvement of our patient partners is inclusive. A response from our PPI and Membership manager is expected at the end of October. In the meantime we continue to involve those who have participated to date.

105. It is recognised that on-going dialogue with our GP's colleagues is an important factor in changing our models for out-patient care. A bespoke engagement session was held with a representative group of GP's from all CCG's in September. We aim to continue to secure their input going forward.

Governance

106. Governance arrangements are being established in accordance with the agreed arrangement set out within the Project Charter (Appendix A). These will be enhanced by the development of operational delivery groups which are being established. Formal reporting arrangements are in place through the Quality Commitment with highlight reports now being submitted on a monthly basis. This incorporates reporting of risks and issues, described in the next section.

Key risks and challenges

107. The scale of opportunity and the ability to realise this is a significant challenge for the organisation. This will take considerable medical leadership and commitment from clinical and administrative teams from across the Trust. Current high level risks and issues are summarised:

Risk	Current controls	Current score (LxI)	Mitigations	Target score (LxI)
There is a risk that the scale of ambition and expectations mean that we do not deliver transformation and the impact of change is underwhelming	Oversight group in place. Monthly updates to EQB. Project plan to EPB October and Trust Board November. Highlight reporting via Quality Commitment reports	16	Develop few but clear metrics. Chunk up programme to a few things we will do well this year. Networking with other Trusts on approach to sustainable delivery	9
There is a risk that changes will not be sustained and services revert to current practice	Monthly reports against quality commitment. Monthly reports to EQB and LLR Planned Care Board. Support from Exec Sponsor in place	20	Develop OD Programme. Agree methods for holding people to account. Reporting against metrics once changes underway. Local ownership	9
There is a risk that current contracting arrangements and CMG approach to achieving financial balance impacts on the willingness to achieve activity reductions that could materialise	ESB and TRUST BOARD providing oversight	20	Understand future demand and capacity and agree model for realigning clinic capacity and resources in line with activity changes. Develop framework for future contractual discussions	12

Issue	Current controls	Mitigations
There is an issue that resources to deliver the programme are limited which may pose a risk to timescales for delivery.	Monthly reports against quality commitment. Monthly reports to EQB and LLR Planned Care Board. Support from Exec Sponsor	Continued liaison with CD's HOO. Focus on 2 specialities in first instance. Review resources beyond CMGs a an enabler

	in place	
There is a risk that attitudes and cultural barriers to change impact on the ability to deliver sustainable change	Issues identified at LiA events. OD Team support in place. Cultural audit to commence October 2017	Develop OD plan to respond to outcome of cultural audit. Application/use of UHL way toolkit Up-skill leaders in managing change, conflict resolution and holding to account.

Next steps

108. In the next month we plan to:

- Finalise the key performance indicators (KPI's) for the programme, completing the baseline where this information is not available and agreeing a scorecard for monitoring purposes ;
- Finalise how we will continue the active involvement of our patient partners;
- Start to deliver some of the quick wins;
- Start to regularly communicate with staff using "you said…we did" approach;
- Agree what can be delivered this year for IT in the context of Trust agreed priorities and communicate expectations with clinical teams ;
- Analyse the outcome of cultural audits and agree a set of OD interventions to help staff deliver early changes.

Conclusion

109. Good progress has been made over the past few weeks and we now have a clear view of the scale and complexity of the programme. Priorities have been identified for cross cutting themes and within the specialities of ENT and Cardiology.

110. There is a clear framework in place for managing the delivery of this programme of work which will be overseen by the Quality Out-Patient Programme Board. Governance arrangements also take account of wider programmes of work managed via the LLR Planned Care Board and relevant project plans have been incorporated into the UHL OP Transformation programme.

111. A clear vision for the future delivery of our out-patient services has been shared with a variety of stakeholders who are in agreement with the vision statement, There is a clear steer from all LiA events that we need to focus on *"making every contact count"* and only bring patients to our hospitals where face to face contact is necessary.

112. Our patient partners, service users, staff and colleagues from the wider health community are actively engaged in starting to deliver the challenging programme of work over forthcoming months.

113. There are a number of inherent risks and issues that the Executive Team will need to lend their support in overcoming. One of the biggest challenges is the cultural and behavioural shift required in order that we implement changes that are embedded as business as usual and we consistently deliver customer focussed out-patient services.

Input Sought

114. The Trust Board are requested to:

- Note that we will concentrate on doing a few things well focussed on ENT and Cardiology this financial year.
- Provide comments and guidance on any areas prior to discussion at Trust Board in November.
- Sign off the vision and agree that we will work wards *"Making every contact count".*
- Give assurance that the level of delivery that can be achieved in year is appropriate.
- Note the risks to delivery concerning resources, changing culture for sustained improvement and limited headroom within CMG's to support delivery.
- Agree the frequency of formal updates outside the quality commitment reporting framework if required.
- Agree that this programme should be considered as an annual priority in 2018/19.

APPENDIX A

Project Charter Template

Project Title: Out Patient Transformation

Project Lead	Project Sponsor	Date completed and agreed
Debra Mitchell/Jane Edyvean	Mark Wightman	Initial: August 2017 Revised: October 2017
Project Rationale		

Over the past years actions to improve out-patient services have largely focussed in transactional changes aimed at improving operational performance and CIP delivery. Nothing transformational has been delivered over many years and this needs to change recognising that UHL still has too many patients ,there is insufficient space to deliver all that we are trying to do and the "offer" to our patients and GP's is inconsistent. All of this results in a varied and often poor experience for patients and service users. There is now agreement that this should be one of UHL's top priorities.

Patient Experience
Our Quality Commitment for 2017/18 sets out our quality improvement plan for the coming year. As part of this UHL has committed to "improve the patient experience in our current out-patients service and begin work to transform out-patient models of care in order to make them more effective and sustainable in the longer term". Currently the top 2 themes of concern repeatedly raised by our patients are around waiting times in clinic and poor communication as to who they will be seen by when they attend for an appointment.
Patient experience and valuing the time of patients and our staff should absolutely remain the driving principle.

STP Capital Scheme Submission – May 2017

UHL's wider vision to reconfigure the current Estate and services from 3 to 2 sites was submitted to NHS Improvement and NHS England on 24th May 2016. This included opportunities to develop a Planned Ambulatory Care Hub (PACH) as well as the desire to rationalise the footprint of our estate. Our Out Patient services occupy significant footprint across all 3 of our hospital sites. In order to reduce this requirement and design facilities that reflect modern day practice new models care of care will need to be introduced.
Out-patient transformation is also a key enabler for the delivery of many of our major capital business cases. This is both in terms of "right sizing" as well as releasing space for other services to occupy.
The out patient-transformation programme will, over time, also support the delivery of system wide transformation programmes. This will help mitigate growth in demand and ensure that patients are only referred to UHL where the intervention of the acute sector is required, making sure that every contact counts. .

Developing our vision
Other than work undertaken through the PACH Programme Board UHL has yet to confirm it's future vision for a modern out-patient delivered

	service fit for the future. Through the Project we will need to develop and agree our purpose and vision which will set out a clear set of expectations for service users and our staff. This will extend to the inclusion of pre-operative assessment which is delivered as an out-patient function within our out patient settings. **Making best use of technology** The delivery of modern out-patient services will include the delivery of IT solutions that will benefit patients and staff solutions. This will be two fold: in the immediate foreseeable future maximising use of what is already available (where this adds value and improves patient experience) and in the short/medium term adopting IT solutions as part of UHL's "Best of Breed (large scale" post EPR solution. Out-patient services will need to be made a priority in the order of roll out for the Trust. **Interfaces / Interdependencies** The Out Patient Transformation Project will report internally to the Executive Quality Board (EPB) via a proposed strategic OP Transformation oversight group. Key links will also be with the current Outpatient Performance Board and the Organisation of Care Board. As the Project seeks to close the gap between demand and capacity (amongst other things), there is a key interdependency with the overall reconfiguration projects. There needs therefore to be alignment with the PACH Project Board, the wider Reconfiguration Programme Board and other Project Boards overseeing the development of our Major Reconfiguration business cases. A further interface needs to be managed with the system wide STP and hence up-dates will be provided to the LLR Planned Care Board, as one of the workstreams of the STP and the Alliance Project Board. • This project seeks to inform the development of our major reconfiguration business cases, including the opportunity to rationalise space to make way for other services. • This project will transform the way our staff work which will inform future workforce planning which will form an integral part of our major business cases. • Support delivery of the requirements within the STP and local CQUIN targets through the reduction in the number of patients attending out-patient settings across UHL.

Project Objectives *(summarised from the 'Objectives Setting' process)*
1. Identify what matters most to our patients and address the top 3 issues of concern in order to improve the out-patient experience for patients, service users and staff
2. To deliver a consistent "offer " to all patients (children and adults) in the fundamentals of care no matter where they are treated in UHL.
3. To identify KPI's that are meaningful to patients and members of the public in demonstrating how we have improved our services
4.To develop and agree the future state and vision for out-patient services across UHL (purpose, expectation, outcome i.e. every contact counts)

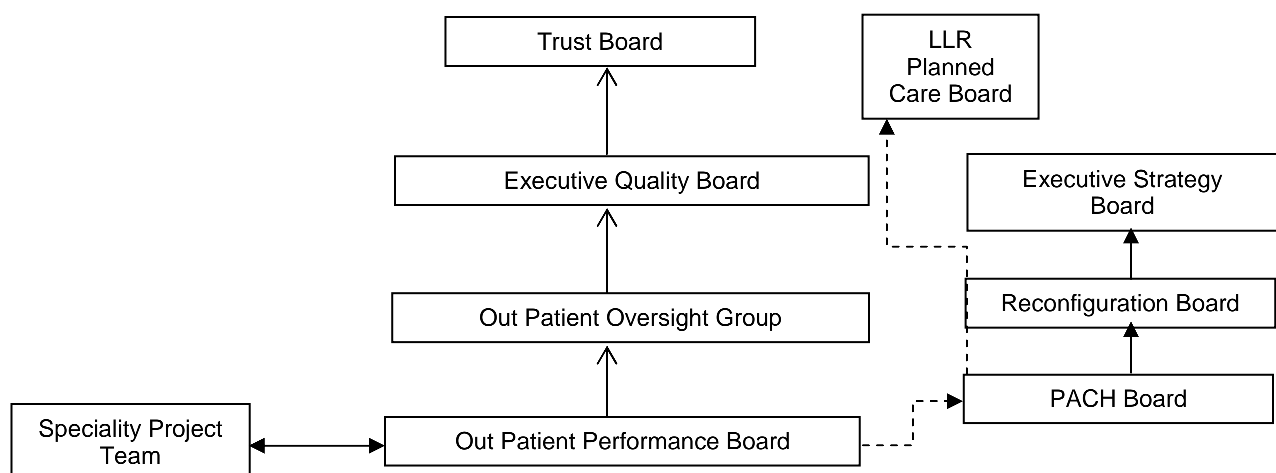
5.To identify the programmes of work that will deliver the necessary step changes in the first year of the Project			
6. To make the optimum use of available technology to improve out patient service delivery.			
Main Benefits *(summarised from the project's 'Benefits Realisation Plan')*			
Internal processes – More streamlined process where every contact counts with fewer steps in the process, quicker turnaround of results, earlier decision making and patients leaving with a clear outcome			
Patient experience – Improved patient experience to achieve improved levels of satisfaction measured using the Friends and family test score through addressing what matters to most patients (e.g: waiting times in clinics and communication about who patients see in clinic).			
Patient experience – Patients have the same "offer" no matter which out-patient services manage their care (getting the basics right and embedding the fundamentals of care on a sustainable basis)			
Output benefit – Delivery of an overall reduction in OP attendances/footfall to ensure "every contact counts", that we can better align capacity to demand and that we are able to inform the future right sizing of our out-patient accommodation over the first 2 years of the programme.			
Quality of Care – Improved quality of consultation resulting in improved decision making and clinical outcomes			
Input benefit – affordable workforce model fit for the future aligned to new ways of working and the supply market			
Financial - A more cost effective sustainable model of providing out-patient care.			
Learning and growth – Patients and service users in journey of discovery, diagnosis and design throughout the whole programme			
Learning and growth – Up-skilling UHL teams to make a shift from transactional change to sustainable transformation through the application of the UHL Way toolkit			
Learning and growth – Development of a library of information on exemplars of best practice in out patient delivery (network of hospitals/other providers, new ways of working, innovations in IT, models of care etc)			
Has a 'Stakeholder Analysis' been undertaken? *('Yes' or 'No')*			**Yes**
Were Patient & Public Involvement (PPI) consulted? *('Yes' or 'No')*			**5 LiA Events held**
Has a 'Sustainability' assessment been undertaken? *('Yes' or 'No')*			**No**
Has a project 'Action Plan' been produced? *('Yes' or 'No')*			**Yes**
Key Milestones (the second, third and fourth stages of the Better Change approach)			
Milestone	Stage 2 - **'Diagnose'**	Stage 3 - **'Trial'**	Stage 4 - **'Implement'**
Target Completion Date	October 2017	October - December 2017	January – March 2017 (Phase 1)
Project Board			
The Project Board, chaired by the Senior Responsible Officer (SRO), will oversee the delivery of the project through the identified work streams from conception to completion. The Project Manager will			

provide a consistent approach to delivering the project objectives and will work with the relevant work streams leads to deliver the expected outcomes on time and within budget. Accountability for the outputs of the individual work streams sits with the respective work stream leads.

The key roles of the Project Board will be:

- Confirm the scope of the project.
- Sign off the Project Initiation Document and project plans.
- Deliver the project within the parameters set:
- Agree all major plans
- Authorise deviation from agreed project scope
- Sign off completion of each stage and deliverables & ensure relevant trust approvals are met
- Ensure that required resources are available
- Respond to any escalated issues from work streams
- Monitor risks associated with the project and review risk register
- Sense check and quality assure work stream outputs
- Provide high level direction on stakeholder involvement & support and monitoring project level management of stakeholders.
- Provide strategic direction for the project.
- Ensure the requirements for any essential business case approval are met.
- Ensure the governance process and key milestones are agreed and communicated with all stakeholders.
- Hold teams to account to ensure change in our out-patient services is transformational and is sustained.

The following diagram demonstrates the governance arrangements for the Out-Patient Transformation Project as an interim measure until such time it is clear what the project will deliver and therefore the governance to support delivery:



Membership of the Strategic Oversight Group is as follows:

Name & Position	Project Role	Time Commitment
Mark Wightman - Director of Communications, Integration and Engagement	Executive Lead	As required
Debra Mitchell - Integrated Services Programme Lead	SRO	Time limitations due to other portfolio priorities
Vacant – Deputy Medical Director	Corporate Medical Lead/ QA and oversight of action plan	**NIL**
Heather Leatham – Assistant Chief Nurse	Corporate Nursing lead/ QA and oversight of action plan	
Jane Edyvean – Out Patient Transformation and Reconfiguration Programme lead	Programme Management	4 Days per week
Will Monaghan – Director of Performance and Information	Operational performance delivery	
TBC	IT Lead	
TBC	Head of Operations Lead	
Carol Yassein – HR Business partner	OD and HR Lead	
Andrew Riddick – Graduate Trainee	Project Management Support	5 days per week

Work-Stream Groups

As the project develops, there may be a requirement for separate work-streams to meet in order to progress their deliverables. Membership, terms of reference and meeting frequency will be determined and agreed by the Out Patient Programme Board and endorsed by the Oversight Group prior to the commencement of any work-stream groups.

In establishing the governance arrangements the role and remit of the Out-Patient Programme Board has been reviewed and the activities of the group aligned with the requirements of the Out-Patient Transformation Programme.

Estimated Resource Requirements

Current resources: Debra Mitchell (limitations on time owing to other priorities), Jane Edyvean (Project Lead - 4 days per week), Carol Yassein (OD support part time)
Resources that will be accessed over forthcoming months: LiA team (support for LiA events), core OD team (support initially for cultural audit support), IT, CMG improvement teams, CMG nominated leads, Patient partners, Central OP team, Business intelligence support, PPI and Membership Manager, Service Equality Manager
Future resource requirements to support outcome of diagnostic work, planning and implementation: TBC

Project Costs

Has project funding been identified and secured? *('Yes' or 'No')*	**No - TBC**

Additional Information *(including development/support required to use the 'Better Change' method)*

OD support offered through HR Business partner and OD Lead for ED Project to deliver first cultural audit
Future requirement to support teams involved in design and delivery in the use of the UHL Way , Better Change toolkit , training in conflict resolution and holding to account and influencing for change.
Customer care training isendified as a need at all LiA events

Specific Project Issues / Challenges

A number of project issues and challenges are likely to be faced. Early issues and challenges are:

- Ability to release clinicians and others time to deliver the required transformational change.
- Influencing culture, attitudes and behaviours to achieve the step change required as UHL is used to more transactional approaches to changes in out-patients.
- Risk appetite with respect to managing patient through different pathways and long term patients being managed away from UHL.
- Maintaining the out-patient transformation programme as a top priority for the Trust.
- The ability to make changes to the environment where essential to do so as there is a lack of capital funding.
- Making best use of existing IT solutions available to us in out-patients.
- Lack of investment in an alternative to the EPR and or competing with other Trust wide priorities.

This list is not exhaustive and it is likely that issues and challenges will develop during the course of the project. These will be managed and mitigated via the risks and issues register for the project , linked to CMG risk registers, with escalation to the Oversight group

Initial Project Plan Milestones

Initial programme and critical deadlines, including a table of project milestones is detailed below. These will be confirmed as greater clarity emerges for the project.

Milestone	Date	Status
Agree Governance arrangements	June 2017	5 Complete
Agree a set of process KPI's and one high level metric designed to sit in the patient experience pillar of the QC 'house'	July 2017	High level metric - complete
Undertake external diagnostic work, benchmarking and field visits (I literature review completed, at least 2 visits to other providers completed, peers for benchmarking identified and agreed)	August 2017	Complete
Complete first cultural audits	August 2017	Delivery October 2017
Hold 3 LiA events (1 cross cutting and 2 speciality specific)	September 2017	5 Complete
Identify transformation priorities and target areas from LiA events	September 2017	5 Complete
Scope IT Priorities (including exploiting current systems)	October 2017	4

Finalise the programme plan with key milestones, accountable individuals, deadlines for delivery and clear outcomes	~~September 2017~~ November 2017	3 (Scope/ complexity)
Develop and agree a future vision for Out Patient services	November 2017	4
Develop and agree a suite of outcome based KPI's	October 2017	4
Initiate Trust wide initiatives	October 2017	4
Deliver quick wins	December 2017	4
Initiate Speciality based plans (ENT & Cardiology)	November 2017	0
Deliver outcomes from speciality based plans	March 2018	0
Deliver agreed in year IT solutions	March 2018	0

Scheme Success

The project will be considered a success when the objectives identified within this document are delivered on time and results from patient experience surveys and the staff cultural survey show improvement against agreed trajectories.

Definition of Success

Process KPI's identified at the start of the programme as an early measure of success were:

- **Diagnosis:**
  - I literature review completed (Achieved)
  - at least 2 visits to other providers completed (Achieved)
  - peers for benchmarking identified and agreed with specialities (Achieved)
  - Confirmation of 2 specialities where OP transformation will begin (?Ophthalmology and Cardiology) (Achieved) – ENT and Cardiology confirmed
  - I cultural audit completed in areas selected for Transformation(Achieved)
  - 3 LiA events completed (1 generic cross cutting, 1 Cardiology, 1 Ophthalmology) (Achieved) – 5 delivered

- Patient experience
  In the first year to show an improvement in patient's satisfaction levels of their experience within outpatients as measured using the Friends and Family test score This is predicated on the assumption that we are able to act on improvements identified during early LiA engagement events and within the 2 specialities agreed (cardiology and ENT) is your project milestones going to include implementation of agreed improvement initiatives Depending upon these a possible improvement trajectory for FFT can be identified.
  A further suite of outcome base KPI's will be developed and agreed by November 2017 based on the outcome of the LiA events held during September and early October 2017. These will be based upon delivery of project objectives – quality, impact of any changes to the models of care and addressing some of the fundamentals of care.

Post Project Evaluation

Lessons learned will be captured over the lifetime of the project and will be used to inform future projects
Risks and issues will be captured, managed and reviewed through a risk and issues register maintained by the project lead.

Please Remember: Sending a copy of your Project Charter to the Clinical Audit team will help UHL keep track of all improvement initiatives and helps everyone to know what wonderful work you are doing.

Out Patient Transformation - ENT LiA Themed responses

12th October 2017

Ref	Theme	Comment	Frequency	Further Comment
	Themed responses			
1	Out Patient Appointment letters	Clearer information on letters about clinics	7	Managing expectations about wait times, what to expect from appointment, e.g. Letters for Obs and Gynae using hospital numbers
2		Patients need to be called to arrange tests after first hospital appointment	1	Letters arranging tests take too long - extends patient journey
3		Giving patients choice for which hopsital consultant to see?	1	Subject to demand?
4		Locations for patients to be specific on clinic letters	1	
5		Too many options on letter templates	1	Easier to use, more efficient/user friendly
6	Customer Care	More notice for patients regarding appointment cancellations	5	Cancelled patients to be called and immediately booked over phone, cancellation letters needing clearer information and what happens next - currently confusing
7		Paeds only clinics	2	Currently mixed adults/paeds - segragated = better privacy+dignity and better overall patient care
8		Specific clinics for more complex patients	1	with right provision for patients in clinics
9		Cancellations currently pass costs onto patients due to transport etc…	1	
10	Information Technology	IT hardware needs upgrading before software	4	e.g. some clinic rooms running Windows XP, removal of Skype on automatic startup as it makes slow PCs even slower on startup
11		Better online Choose and book function/provision	3	More interlinking between HISS and C&B - reduce manual admin process (e.g. manual inputting), patients don't know which clinic/clinician they are booking onto - results in appointment chan
12		ICE in OPs	3	Investigate who and what jobs are on ICE e.g. needing templates for grommet clinics
13		?SystmOne as system of choice for OP and community clinics	3	Currently used by LPT/LOROS, linking EMRAD and SystmOne?
14		Unified referral system	2	part electronic/part paper system too time consuming, risk of patients being lost in 'system'?
15		PRISM, including advice and guidance	2	How does this link to current community provision?
16		Self check in	2	
17		Upgrading of network infastructure	2	
18		Single Sign On	2	Avoid issues such as ICRIS logging out fequently - wasting clinic time
19		Provision for better phone systems	1	Patients ringing department about appointments/test/changes are not getting through - increasing DNA rate?
20		Virtual clinics for appropriate referrals	1	
21		Ambition for 100% hit rate for UBRN numbers	1	
22		Electronic notes	1	
23		EMRADS reporting	1	Slow, low quality images, impacting on flow, issues with networks
24		TrackIt system needs to be reliable	1	Currently unreliable, cannot obtain notes for clinics which creates delays in clinic preparation and long waits or cancellations,
25		Hearing service software	1	Practice navigator software, Noah 4, Windows 7. Siemans won't support further so fitting bone anchored hearing aids starting to become problem.
26		Agreed for consultant lead to complete development of PRISM pathways	1	
27	Process	Follow ups	3	Only by exception, use phone/virtual FU?, need good safety net system if this is norm - as used in community
28		Better test booking process	2	Patient calling to book test appoint? Quicker than being sent letters, avoids being given a date patient can't attend, scan dates currently up to 6/52 if non-urgent
29		Hospitals being able to issue 6/52 sick notes	2	
30		Referral and triage process streamline	2	e.g. GPs booking tests at same time as referral? Patients with demenia/OTAS/MSK pathways
31		One stop shops	2	
32		Not enough time for clinicians to effectively triage all referrals	1	High volume and low time = missing referrals that can be turned back to primary care?
33		DNA F/Us	1	Currently automatically rebooking DNA F/Us?
34		Efficient filtering of GP referrals by urgent/non-urgent	1	
35		Need shorter wait times to see specialist for first time	1	
36		7 day working	1	Including clinical teams
37		Longer appointment times to stop clinic overunning	1	Clinic slots appropriate for patient needs/appointment requirements/tests needed
38		Greater overall capacity	1	More appointments to meet growing demand
39		Tests happening at same time on first appointment	1	Reduce overall patient journey
40		One single OP process across clinics	1	
41		Adult pre-assessment capacity	1	Currently if no capacity patient given access to ad hoc lists within next 7 days
42		RTT Waiting list pressures	1	Some mitigation currently through WLI lists, activity returns analysis, amendments to clinic templates
43		Mixed adults/paeds clinics listing same patients together	1	e.g. putting adults at start, paeds at end to reduce mixing of patients in waiting rooms
44		Consultants leave to be better communicated when planning clinics	1	
45	Primary Care	Consistant balance of primary care provision	4	What coverage can be realistically achieved in primary care? What is currently offered/provided?, What diagnostics would be regularly expect primary care to do? Any diagnostics easy to offe
46		GP test result call back	2	GP appointments for test results should be by exception only - if all okay don't need face to face, direct referral if specialist intervention needed
47		Shorter waiting times for booking GP appointments	1	Currently too long, can wait longer than 1 week to get first GP appointment - extended patient journey
48		More reception staff to answer calls/book appointments	1	
49		More appointment slots	1	To compliment actual demand
50		Bloods/other suitable tests to be done same day	1	Results seen by GP, patient informed of results and further plans
51		GP referral - electronic	1	
52		GP walk in appointments	1	
53		ENT to sign up city GP lead	1	
54		All practices currently do things differently	1	Role of GPR and online booking?
55		More access for online GP booking	1	Including for groups like overseas students
56		Pharmacy currently need to request another GP appointment if prescription issues	1	Not safe to issue without - any other solutions?
57		UHL to manage finances as whole and look at how GPs approach this	1	LLR £ following the patient
58	Communication and teamworking	Dedicated people/teams to train staff	2	Not staff training staff, standardised training across OPs
59		MDT meetings	2	Including pre-assessment, paediatrics, notes/admin/clinical/radiology
60		Clinic co-ordinators specific to consultants	1	Create working relations, admins staff to know patients
61		Communication between team members currently good	1	Including ENT-Pre-assessment, management

Barriers to change

No.	Category	Barrier	Score	Comment
62	Culture	Willingness to get tests/scans/results done?	1	Currently no KPIs 6/52 for this
63	Process	Note tracking	4	Notes being tracked to department but not turning up, often no notes for late additions to clinics, notes needed at least 15 mins before clinic start
64		Choose and book allowing patients to book onto wrong clinics	3	Patients then have to be cancelled and rebooked by admin, different wait times can mean a rebook being a significantly later date
65		Consultants receiving referrals suitable for reg level	1	
66	Communication	Communication re directions for patients	1	Patients can be late if sat in wrong clinic
67	Capacity	Unrealistic workload	1	
68	Information Technology	Not enough overall resource	1	
69	Resources	Greater staffing provision	2	To equal demand
70	Environment and Facilities	More physical space	3	Including office space
71		Lack of overall room to see and pre-assess patients in clinics	2	Particularly Paeds, as current paeds pre-assessment process fragmented due to no dedicated space to see in clinics
72		Mixing of adults and paeds in one clinic	1	

Out Patient Transformation - LiA Themed responses

5th October 2017

Ref	Theme	Comment	Frequency	Further Comment
	Themed responses			
1	Out Patient Appointment letters	Make sure that every patient knows what to expect - understanding patient journey	23	Including managing expectations, e.g. what to bring, what tests they may need beforehand, how long they will be there, who they will see and why, what happens next, understanding whole joune
2		prioritising cancelled clinic patients to avoid further cancellation	11	e.g.: on text messages/letters about clinician/clinic/site/what will happen, more patient friendly comms, info about appt on arrival, reduce 'threatening' wording about DNAs
3		Standardise letters, with specific clinic information	10	Currently too many letter templates, creating errors?, straight to the point layout and information
4		Easier access for patients	6	Directions on letters that are relevant to signage, parking
5		Prioritising cancelled clinic patients to avoid further cancellation	3	Re-booking immediately instead of goin back on the waiting list?
6		Follow up booked for patients at end of appointment before departure	3	Reduce need for further calls/letters
7		Better communication about changes/short notice appointments	2	e.g. cancellations, date change, clinic location change, Communication via text or email if not answering phone and too late to send letter
8		Appointment letters contain easy to understand maps	2	
9		DNAs to be informed in text and by letter	2	Instead of automatic rebook
10		Appointment letter sent from within UHL so you 'know' it's been sent	1	Decreasing DNAs?
11		Asking patients about preferred method of communication re appointment/appointment reminders	1	Text, email, letter
12	Customer Care	Staff attitude - customer care training - seeing from a patients perspective	60	Team ethic/team working, Not rushing patients, meet and greet with a smile, not having staff sit around doing nothing, Staff not having audible social/personal conversation etc…
13		Communication/information to patients	34	Information boards - Waiting times/delays/changes in clinics, Staff communication directly with patients, Process map of patient journey?, educational material to prepare for consultation, clear ne
14		Timely running of clinics	27	Staff ready to start working when clinic starts, test results on time, clinic appointment times reflect accurately treatment expected/needed, accountability for staff not arriving on time
15		Corporate identity, Universal OP standard/policy	21	Competant service, Trust values, Staff being visible, approachable, holding staff to account re standards/expectations, consistent structure of staff across clinics?, universal clinic uniform
16		Patient feedback/involvement reviewed	7	F&F feedback, share feedback with staff monthly, share feedback as changes enacted?, Patient partner involvement
17		Opportunity for patients to immediately feedback	3	About consultation or clinic experience
18		Patient choice as to how they have their consultation	3	Phone, Skype, face to face, in community etc…
19		Increased volunteering provision	2	For meet and greet, buggy service, to direct to other supporting services e.g. x-ray
20		Indentified staff who can assist with non-english speaking patients	1	
48		Arranging 'Walk in my Shoes' sessions	2	Experiencing patient journey first hand
21		Allowing patients to leave Out-Patient area whilst waiting to see hcp/clinician	1	?Relies on accurate and real time waiting times?
22		Each OP speciality to have lead clinician as part of MDT to review/meet patients	1	Including nursing, admin, diagnostics
23		Knowing patient's background before meeting family/patient	1	
24		Portering taking patients out to drop off areas after clinics	1	
25	Way Finding	Standardised and up to date site signage	18	Including maps, correct/relevant details on texts/letters, etc…
26		Wheelchair provision	7	More, having them available in right place when needed
27		Distinct colours for clinics/hospital areas	6	For patients to differentiate areas
28		Visible information on arrival/central areas e.g. Information kiosks	4	use of IT wayfinder, guides patients from arrival through to clinic wait area
29		Co-residing locations for treatments for easier way finding	4	Cohorting relevant pathway treatment locations
30		Disabled/frail friendly access	3	Disabled parking close to point of clinic or buggy service, Portering/buggy service available for out of hours/late clinics
31		Car park signage LGH	3	Patients able to locate car again when leaving, clear parking concessions
32		More engagement from staff in directing patients	2	When patients look lost/confused
33		Patients to bring own wheelchairs	2	Publicity campaign
34	Environment and Facilities	Clean and bright environment, universal throughout OPs	32	Fresh paint, Furnishings, office environments included, area looks cared for (e.g. waste management, tidy desks/clinic rooms), Remove clutter - have localised universal information points/boards
35		Drinks machines/refreshment facilities	20	Food/drink vending, water dispensers, staff offering teas/coffees?
36		Waiting environment suitable for clinic specific patients	16	old/young/disabled/bariatric - suitable seating, info relevant to condition/clinic/speciality, disabled toilets, access to walking aids, breast feeding space, access for wheelchairs/stretchers?
37		Space for correct privacy/dignity	7	weighing/measuring/testing/bereavement -?Privacy screens where space limited and appropriate to use
38		Suitable footprint, fit for purpose	7	e.g. to manage current capacity, having space to manage children with specific needs, for Physiotherapy to see more patients
39		Asking patients when they want/how they feel about environment/process	7	"You said… We did" engagement, patient focus groups
40		Pay after appointment Car Parking	7	To implement at LGH and GH, as already operated at LRI
41		Facilities/estates portal - repair job tracking	6	Lots of time taken phoning and chasing job progress
42		Information boards for clinics/teambuilding	4	Including health promotion? E.g. smoking, alcohol, weight etc…
43		Assess current equipment provision	4	e.g. scales/height sticks, improved availablility to allow nutritional screening in OP, Examination couches in all rooms, removing unecessary equipment blocking doors/corridors
44		Interpreting service	4	More/right provision when needed, face to face service?
45		Comfortable air temperature	3	Heating in winter, fans/ventilation during summer
46		Better patient movement through physical space in OP	3	Operational flow
47		Hard of hearing provision	3	Do staff know about hearing loops, Hard of hearing 'alert system' whilst patients waiting for appointment
48		TVs/radios	2	
49		Ensure rooms that are booked are used	2	
50		Single sex clinics	2	Improved privacy and dignity
51		Staff clothing - shared linen in clinic rooms	1	
52		Ambulance liaison	1	Sited within OP facility?
53		Relaxing stimuli	1	Music/fish tanks/pictures/projections (e.g. as on Vascular wards)
54	Information Technology	One paperless IT system so clinicians can see all referrals (ERS) and records/information/tests - PRISM	43	Including paperless assessment/note taking, electronic requests, tests, intergrated acute and primary care?, filtering appts/referrals, empowering appropriate rejection of refs
55		More efficient and effective IT systems	26	Investment into IT hardware + IT contracts, ipads/notebooks/chromebooks to supplement clinic work?, IT in place to support more nurse-led clinics, Simplified IT
56		Better prepared for clinics so notes/results/staff/IT in place beforehand	16	r/v prep process - can it be simplified?, all medical records available to clinics the day before - EPR system?, tagging notes with results and last clinic appointment
57		Book in Kiosk/electronic booking in	14	Check in system to prompt patient for tests first if needed e.g. x-ray, bloods etc…, support for those that are not IT literate?
58		Online self-booking appointment system	12	Including directions to correct OP clinic, being able to see other bookings/tests to avoid clashes, appointment choice
59		All services to use 'Advice and Guidance' on ERS systems to GPs, to avoid unecessary referrals	12	Engaging GPs directly, including GPs checking community provision (e.g. alliance - slot sharing?), patients are fit for proceedures before referral made e.g. BPs, ECGs, anti coag, diabetic, etc…
60		Electronic notes	11	
61		Real time screens on time to appointment/waiting times and delays	9	
62		One phone number for booking appointments/queries with extended 'opening hours'	5	Including better provision to accommodate current demand on phone systems

No.	Category	Item	Count	Comments
63		Skype/virtual Clinics	5	
64		Use text for more communication/improve detail in messages	4	e.g. use as opposed to 2nd/3rd appointment letter, when/where/how to contact department is vital
65		One log in system	2	Avoiding multiple log ins, Logging out after short inactivity time etc…
66		ICE in OPs	2	
67		In house help service - IM&T help desk	2	
68		IT education and support forums for staff	2	As systems change, for staff to deal with change, raise concerns/learn new systems/pathways etc…
69		Telephone assessments	1	
70		Forward facing screens to check patient details for every attendance	1	
71		Better room booking system	1	
72		Central OP mailbox/Twitter for more universal communication	1	
73		Linked up OP booking system	1	e.g. cancellation automatically cancels the appointment
74		Managed Print at LGH	1	
75		Voice recoginition to help with OP letters	1	
76		Bookwise	1	
77		Coordinator training/access to HISS	1	
78		Online information portal for patients	1	Log on, with info on appointment, car parking, what to bring, what's a CT scan, etc…
79		Electronic patient information booklets	1	
80		Phone services to identify outgoing calls as NHS in caller ID	1	Increase liklihood of patients picking up phone - not cold calling
81		Recording calls for evidence of patient abuse to staff	1	
82		LGH wifi support	1	Limited wifi access (OPD 1&2) to infoflex on desktops
83	Clinics and Appointments	One stop Clinics	17	e.g. OPD to pre-assessment to surgery - including pharmacy, high risk clinic (anaesthetic), Phlebotomy, anaesthetic review if for surgery, expanding current nurse skills to do some of these?, spec
84		Reducing degree of overbooking in clinics	15	Including double booking on single clinic slot, staggering appointment slot times, strict review of clinic templates to stop double booking at source
85		Better joined up services	10	Imaging/Pathology/Phlebotomy e.g. service knowing ahead of time how many patients are on clinic needing service, improving service provision to meet needs/improve wait times, better flow from
86		All admin staff to be managed by OPs with clear leadership	10	Including standard proceedures across all OPs, one model will not fit all however there are common themes
87		Adequate clinic time slots/flexible/realistic appointment options	8	Meeting all patient needs (e.g. Full time workers/school children), Including evening and weekend clinics?
88		Stricter DNA policy	8	Reducing DNAs, Charging for DNAs?
89		Nurse/Advanced practitioner led clinics	7	Support e.g. Nurses work with junior doctors first before doing clinics on their own, employ more ANPs to take more clinics?, have redesigned user friendly clinic templates for nurses/ANPs
90		Referrals triaged timely	7	Including better criteria between primary/secondary to ensure appriopriate referrals - why are they being referred?
91		Same admin staff/team to prep and then sit clinic for consistency	7	Dedicated co-ordinators per consultant - ownership, smaller teams with greater support
92		Follow up reduction	6	F/U clinics running in GPs, community hospitals? Follow up phone calls instead?, telephone results instead of face to face meet, defined criteria for what needs hosp follow up
93		Pre-testing prior to appointments	5	streamline appointment process
94		Appropriate use of appointments	5	reviewing capacity vs acuity e.g. Seen by exception only, or where condition requires (As norm) - appointment of value with clear purpose/outcomes, leaving appointments open as rebook is not a
95		Easy to use, flexible clinic templates	5	Ease of setting up new clinics/clinic codes/ad hoc clinics, altering templates to be sure clinician is available at said time
96		Better agreed mandatory pathways	3	e.g. Introduction of National Optimum Lung pathway for cancer
97		Reduce cancellation of clinics	3	Communicate in better time to wider teams when clinics are cancelled - waste less staff time
98		Community based management of long term care	3	Community based clinics?, community based care teams
99		Reducing other clinic activity when consultant on call, to avoid long waiting times	2	
100		Include consultant annual leave into clinic planning	2	
101		Extra clinics	2	
102		Joint speciality clinics so patients see multiple people in one visit	1	
103		Increase co-ordinators from band 2 to band 3	1	Improve staff retention?
104		Better utilisation of cinical staff	1	Appropriate training for role, additional skills for additional responsibilities?
105		Additional Emergency clinics/pathways	1	To reduce pressure on active lists
106		Seeing the right doctor for the right referreal	1	
107	Communication and teamworking	Engagement from clinic leadership	27	Clear/defined visible leadership and increased communication/engagement with rest of team, e.g pre-clinic briefing - team understanding of targets/shared vision, recognising and rewarding good
108		Communication across teams	16	Communications training?, Full communication across teams e.g. admin/nursing/clinical, including other departments with OPs, less e-mail culture communication?
109		More available/better communication regarding training, career progression	15	Including nursing and A&C, ?increased enthusiasm, engagement and staff retention, in depth training face to face?, time release to do training
110		Taking vision and communicating specific objectives for change to everyone	10	OP leadership engagement, identifying necessary support for staff for change, all stakeholders, including agreed quality/progress measures
111		OPD change higher and more visible on UHL agenda	6	With communicated planning going forward
112		Teambuilding days	4	
113		OP newsletter	2	To all OP teams/clinicians informing of improvements/changes in areas - benchmarking?
114		Speciality based catchups	1	
115	Culture	Recognition of staff/teams who are improving/making changes	5	Taskforce on the ground?, staff engagement in decision-making and change, sharing best practice
116		OP 'September surge' initiative to enact change	2	Senior 'buy-in'
117		Involve external third partner for change input/consultation	2	Company with excellent customer service e.g. Virgin - providing some of the training?
118		Conflict training between different team groups	2	Understanding challenges in different job roles
119		Changing culture/attitude about room usage/provision	1	From 'there will always be a room' and a nurse -> to asking if this is available
120		Working party to go to other OPD to learn from them	1	
121		Training so everyone included understands vision	1	e.g. RTT training
	Barriers to change			
122	Culture	Resistance to change/staff attitude	36	Staff motivation, enagaging shared vision, the perception that change is extra work when already under significant pressure, 'It's always been done this way', fear of change,
123		Fragmented working approach/work ethic depending on department	14	Separate services have evolved differently to suit staff rather than patients?, physical fragmentation/location of close working specialties/teams, centralised OPD no jurisdiction over CMGs clinics
124		Leadership, the right top down ethos	13	Lack of clear joint up OP leadership, lack of support for change/training, lack of role expectations, awareness of empowering change 'are we allowed to..?'
125		Hierarchy, empowering everyone for change	8	Currently not empowering everyone to make change, 'higher grades/levels know best', individuals with influence with the incorrect attitudes
126		Low morale as working under high pressure	7	Low ambition, 'what's the point' - so many obstacles staff give up trying, no opportunity to 'pause' the day to day to enact change
127		Lack of training	7	Training opportunity, customer service, RTT training, work ethic/universal practice/expectations,
128		Not viewing from the patient's perspective	6	being innovative with solutions/resources
129		Lack of staff engagement across all professions	4	e.g. needing more of the clinical workforce engaged, unproactive colleagues, consultants not wanting to do virtual clinics to prevent hospital attendance etc…
130		Lack of awareness of issues	3	Communicating issues with all staff/management, communicating benefits of change, unhelpful perceptions how how useful change will be
131		Too many people wanting input	2	Including interference from outside sources

132		Perception that OPs is a lower priority	2	
133		Paper system	1	Causing issues such as ?inappropriate referrals from GP
134		Lack of money for meaningful change	1	
135		High admin staff turnover	1	Skills leave with admin staff - starting over
136		Too many layers of bureaucracy to enact meaningful change	1	
137	Processes	Processes/pathways not clear	9	No support from management in this, need clear OP pathway with plan of action, non flexible pathway doesn't allow for ad hoc clinic work
138		GP referral system inefficient	9	Inappropriate referrals waste admin time or even appointment time, feels like triage service directing to other services, ability to reject more referrals?, referral criteria
139		Delayed start times	3	Staffing covering multiple areas so arrive late, missing notes etc…
140		Consistency	2	Too much change confusing staff,
141		Triage	2	Do all patients need to be seen?
142		Patients have multiple visits before all investigations done	2	tests that are not factored into appointment times
143		Difficult to change process	2	Often find going back that nothing has changed, too much buraeucracy to enact meaningful change
144		Outpatients not given equal priority for beds and theatres	1	
145		Poor medical rostering systems	1	
146		OPD pathways written for Junior Doctors etc…	1	
147	Financial	Lack of funding	15	Prioritising most important areas/aspects to change?
148		Effective/right use of funds/resources	7	What is wasted? E.g. reallocation of staff
149		Lack of physical space	2	
150		Funding process makes it difficult to have anything approved	2	Levels of complexity for any change requiring money
151		Funding for refurbishment	2	
152		No view on the cost of things that we don't improve/change/invest	2	Some ideas cost neutral for overall benefit?
153		Funding for IT	2	
154		Funding for medical equipment/kit	2	
155		Not enough money to provide 'ideal', so left with 'best fit'	2	
156		Ever rising costs to improve/change	2	Value of healthcare, costly?
157		Financial/money training for staff	1	
158		Capital investment?	1	
159		Realistic plans considering the lack available money currently	1	
160		Funding resource to meet current capacity demands	1	
161		UHL DNA charging policy?	1	
162	Communication	Poor patient communication	6	OP letters, Patient expectations, staff attitude, lack of patient co-operation e.g. DNAs/not always needing face to face appointment (Patient choice is still important though!)
163		Patient participation/feedback	6	More contribution/involvment of patients in change, surveying patient wants/needs, F&F tests, how well are we doing?, not losing sight of the individual
164		Poor internal communication	4	Between staff, different specialties, clear OP leadership communication needed
165		Better signage and directions	3	Maps with 'you are here' stickers?
166		Benchmarking	3	Against other OPDs, against previous F&F/patient+staff surveys, regular updates for staff on change progress?
167		Poor external communication	2	Lack of adequate communication process between primary and secondary care, which patients are coming in via ambulance on stretcher?
168		OP letters with specific directions to clinics	1	
169		Interpreting assistance - no PEARL	1	
170	Information Technology	Fragmented IT system, not joined up	11	ERS, UHL/Alliance, One system used across all specliaties, electronic records, current limitations of systems e.g. HISS
171		Available provision/infrastructure too slow	10	Linked to finances, including phone systems, currently inadequate to support vision
172		Outdated booking system	4	e.g. system not encouraging patients to phone in, cannot pick own time/date, cumbersome
173		IT support	3	More extensive if going paperless, backup plans if system/network/power goes down?
174		Training in new/relevant software	2	The right people using the right systems correctly
175		IT team not given time to find solutions, having to rely on 'quick fixes'	1	
176		Right staffing resource at the right time	22	e.g. skilled staff, staffing levels/shortages creating over-stretched staff, annual leave means clinics not covered/being cancelled, reduced admin support, staff retention, Children's Hospital staff
177	Resources	Capacity and equipment	20	Overall footprint, office space, needs to be adequate for one stop shop clinics, current lack of space hindering access to diagnostics for e.g., not appropriate for all patients e.g. stretchers
178		Buildings not fit for purpose	11	Does not reflect capacity needs/service growth, poor environment for patients (space, tired, old), old buildings not adaptable
179		Right training	8	e.g. for Nurse led clinics,customer service skills for clinic co-ordinators/admin/clinic staff, training to support culture change
180		Availability of rooms	3	Including efficiency of use, not always used
181		Resources not being available outside M-F 9-5	2	
182		Car Parking system	2	People running out of time on tickets
183		Not enough hours in a day to accommodate all patients	2	
184		Portering	1	Not enough, so patients can't get to diagnostics
185	Capacity	Time	10	More OP sessions in clinical timetables, clinic cancellations put additional pressure on times, high volume of work because patients squeezed onto lists/clinics
186		Competing pressures/interests/priorities	5	Short term 'fire fighting' taken as a priority over long term gains to deal with what needs doing now
187		Too many referrals	4	Not all appropriate, current demand outstrips capacity
188		Not enough overall capacity to see all patients	3	Consultants, space, nursing, admin staff
	KPIs			
189	Patient and staff satisfaction	Patient feedback	3	F&F scores, patient satisfaction surveys, M2M feedback
190		Clinic performance metrics	3	Length of wait in clinics, No. of patients seen, DNAs
191		Reduction in complaints	2	
192		Increased staff retention	1	
193		Happier staff	1	
194		Reduced sickness	1	
195		Datix incidents	1	
196	Environment	Environmental audits	1	

197	PLACE	1
198	Response times from facilities portal	1
199	IP metrics	1

APPENDIX B(ii)

"Making Every Contact Count"

CARDIOLOGY OUT- PATIENT TRANSFORMATION LiA

11th October 2017

Themed responses

UHL's Out Patient Transformation Programme 2017 – 2019
"Making every contact count"

1. It is 12 months from now - What are the headlines?
2. What obstacles or issues might get in the way of us reaching our goals?
3. What do we need to do together to achieve our vision?
4. PRISM, A&G, F/U reduction current focus

Question 1

"It is 12 months from now. We are being held up as a shining example for the changes we have made to Cardiology Outpatients, and teams are feeling proud, valued and fully involved in making this happen. What are the headlines?"

- Theme: IM&T

- GPs use ERS correctly – i.e. referral letter available straight away, not weeks later as waiting for it to be typed
- Electronic referrals
- IT provision
- IT - Electronic referrals
- Virtual clinics
- Electronic referrals
- IM&T – able to access all information required
- Virtual clinics to ensure patients are not brought in inappropriately and poorly patients are seen in correct clinic
- Junior doctors who come to clinic to have the clinic logins to be able to access all the IT needed to sure clinic flows
- IM&T to be up to standard in order to view scans
- Improved IT systems – getting WINSCRIBE to work as currently using tapes
- PCs that load quickly and have the correct software/programmes

Question 1

"It is 12 months from now. We are being held up as a shining example for the changes we have made to Cardiology Outpatients, and teams are feeling proud, valued and fully involved in making this happen. What are the headlines?"

- Theme: IM&T

- Virtual clinics run by pharmacists to discuss and address medicines
- Prescriptions – can these be FP/Os or details communicated electronically to GPs to generate them dispensed via community pharmacists?
- Electronic system of communicating information between all specialities so it's available to support decision making
- Consultants must have all the data available for a decision – EMRAD, previous procedures, medication (SystmOne?), tests
- Virtual clinics for results – bring for F/U only those who might need further tests/decisions
- Functional IT equipment (QW?)
- Improved IT systems 'state of the art'?
- More dictophones (Getting pinched)
- No IT issues
- All consultants and ANP have virtual clinics for results review
- Dedicated email service/telephone service for patients to contact
- Better IT

Question 1

"It is 12 months from now. We are being held up as a shining example for the changes we have made to Cardiology Outpatients, and teams are feeling proud, valued and fully involved in making this happen. What are the headlines?"

- Theme: IM&T

- Reducing F/U appointments in clinics – having more virtual clinics instead?
- IT provision
- IT (QW?)
- Virtual clinics (QW?)
- Electronic referrals
- Virtual clinics run by ANPs and all doctors
- Clinic (HISS) set up to enable ad hoc clinics – i.e. cover for A/L, cancelled clinics so rooms can be utilised appropriately
- Hotline for patients in the area

Question 1

"It is 12 months from now. We are being held up as a shining example for the changes we have made to Cardiology Outpatients, and teams are feeling proud, valued and fully involved in making this happen. What are the headlines?"

- Theme: Process

- DNA policy adhered to
- Cancellation policy adhered to
- Correct clinics for patients i.e. CDU only for CDU consultants
- Clinic planning – no EP doctors, should not happen – 3 news for 1 doctor per week is not enough
- Slot capacity needs to be looked at
- Urgent slots for urgent/soon
- Cancellation lists for slot utilisation
- All ward follow ups currently sent for follow up – who decides this is necessary?
- Appropriate referrals
- Test results available
- Slick check in
- Time for each patient appointment appropriate
- Patients that arrive are expected
- Right people stay in hospital
- More people seen in primary care

Question 1

"It is 12 months from now. We are being held up as a shining example for the changes we have made to Cardiology Outpatients, and teams are feeling proud, valued and fully involved in making this happen. What are the headlines?"

- Theme: Process

- Point of referral screened – appropriate referral?
- Clinic templates fit the session times
- No overbooking
- Templates match the consultation time needed by clinician and patient
- Templates to be allocated accordingly for new and F/U patients
- Clinics prepped and all results present/notes ready for clinic
- Communication between speciality and generic outpatients regarding changes e.g. templates, clinic codes etc…
- No overbooking clinic
- Repeat of clinics?
- Patient pathway reviewed before attendance
- Changing consultant templates rather than constantly overbooking
- Shorter wait times
- No delays
- Waiting times reduced in clinics

Question 1

"It is 12 months from now. We are being held up as a shining example for the changes we have made to Cardiology Outpatients, and teams are feeling proud, valued and fully involved in making this happen. What are the headlines?"

- Theme: Process

- Less follow ups – appropriate management flow
- Robust review of ward F/Us before F/U booked
- Desk clerks fully prepared for clinics so signposting through notes is easier for clinicians
- Same/standardised admin processes across all specialities
- Refer the right patient to the right clinic in the right time with the right results
- Rapid FU clinic – AF
- Less cancelled clinics
- 3 month follow up in 3 months, not 6-8 months
- Quick turnaround for test and results
- Waiting times for patients in clinics reduced
- More people seen in primary care
- GPs do tests – ECGs, 24/48w tapes etc…
- Waiting times
- Some tests to be done by GP services before being seen
- Waiting times reduced in clinics

Question 1

"It is 12 months from now. We are being held up as a shining example for the changes we have made to Cardiology Outpatients, and teams are feeling proud, valued and fully involved in making this happen. What are the headlines?"

- Theme: Process

- Reduce waiting times for patients
- Waiting time 3 months max for appointments
- Timely appointments/reduced waiting times – i.e. seen within 30 mins
- No long waits in clinics
- No long waits for an appointment date
- No 45 min wait for patients at start of clinic waiting for pt to have ECG (This regularly puts clinics behind)
- Waiting times
- Follow up clinics – telephone pharmacist rather than attending if need advice on medication only e.g. supply issues
- Patients are seen quicker – not having to wait 12 weeks for their 1st appointment – this will reduce complaints

Question 1

"It is 12 months from now. We are being held up as a shining example for the changes we have made to Cardiology Outpatients, and teams are feeling proud, valued and fully involved in making this happen. What are the headlines?"

- Theme: Resource

- Correct staffing levels e.g. Doctors know 6 weeks in advance – rotas
- Access to test results for patients on returning FUs
- Imaging provision
- Management issues – free up other specialists time to focus on their specialist areas and patient management
- ?Prepacks of routine newly initiated medicines in clinics
- New HCA staff in clinics (QW?)
- Access to investigations on day, or access to results prior to appointment i.e. echo, CT, angio…
- Access to all patients records/results
- Support for RACPC – by HCAs
- Diagnostics/tests all available
- Consultant led clinics – minimal reg only clinics
- More access to investigations either UHL or primary care, or same day access

Question 1

“It is 12 months from now. We are being held up as a shining example for the changes we have made to Cardiology Outpatients, and teams are feeling proud, valued and fully involved in making this happen. What are the headlines?”

- Theme: Resource

- More nurse led clinics
- More professional staff on shop floor willing to support all clinics
- More support for RACPC – e.g. HCA support with tasks such as finding a wheelchair for a patient, help with translating etc…
- Same time reporting - CxR report
- Access to ‘guidance’ for Junior staff

Question 1

"It is 12 months from now. We are being held up as a shining example for the changes we have made to Cardiology Outpatients, and teams are feeling proud, valued and fully involved in making this happen. What are the headlines?"

- Theme: Communication

- ? Partial booking – patient choice
- Correct letters with details and time
- Friends and family feedback results increased with positive feedback
- Positive feedback from staff on UHL staff survey
- Pathway for patient – blood, Xray, ECG etc… clear signs/who to book in with
- OPD letters explain the patient journey – i.e. length of stay, what tests they need, what they need to bring with them
- When leaving patient knows what the plan is i.e. follow up etc…
- Communications between all services users i.e. Doctors rota, clinics cancelled/reduced
- Doctor rota being communicated so need to know who is attending clinic (clinician)
- Outpatient letters to be more specific – to have clinic name, speciality and consultant listed
- Patients are fully informed of their next steps following their 1st clinic appointment
- Patients know what to expect of their appointment and what is going to happen to them

Question 1

"It is 12 months from now. We are being held up as a shining example for the changes we have made to Cardiology Outpatients, and teams are feeling proud, valued and fully involved in making this happen. What are the headlines?"

- Theme: Culture

- Doctors attend on time
- Doctors arrive in clinic on time and when they are supposed to be there
- Rota staff to increase friendliness and support – one team (QW?)
- Clinicians arriving on time
- Clinicians turning up on time to start clinic
- 'supportive' and friendly clinic staff – eager to help
- All staff working to the same goals/visions
- Cohesive team – nursing/admin/medical
- Strong direct leadership
- Change culture in clinics – more helpful (QW?)
- 100% patient satisfaction

Question 1

"It is 12 months from now. We are being held up as a shining example for the changes we have made to Cardiology Outpatients, and teams are feeling proud, valued and fully involved in making this happen. What are the headlines?"

- Theme: Environment

- Clinics correct for cardiology i.e. diabetic 3 rooms, DVT 3 rooms etc…
- Enough space for each doctor/ANP
- Imaging suite
- One stop clinics
- Overall space
- Too many consultants in OP at same time
- One stop shops
- Space
- Investigations hub within the same area – e.g. MRI, Xray, Echo, Bloods, ECG etc…
- One stop shop
- Patients can park
- One stop clinic – Pt has tests whist in clinic waiting areas
- Environment that is fit for purpose – e.g. space for stretchers/wheelchairs
- Drinks/food facilities/entertainment (TVs, radios) for all OPD areas

Question 1

"It is 12 months from now. We are being held up as a shining example for the changes we have made to Cardiology Outpatients, and teams are feeling proud, valued and fully involved in making this happen. What are the headlines?"

- Theme: Environment

- Rearrange clinic rooms to create more space (QW?)
- More available rooms for increased clinics
- Adequate rooms and facilities
- Rooms kept topped up with all clinical/patient info
- One stop stops – access to echo, ETT, tape etc on the day before appointment
- Facilities for patients drink/food vending/TVs and radios
- One stop clinics – all observations, ECG done by OPD nurses, bloods, cardiac investigations etc…
- Utilise bookwise
- Cancel clinic rooms when not using them in order for others to utilise the rooms

Question 1

"It is 12 months from now. We are being held up as a shining example for the changes we have made to Cardiology Outpatients, and teams are feeling proud, valued and fully involved in making this happen. What are the headlines?"

- Theme: Top points

1. One stop clinics – all investigations take place there and then patients know what will happen to them next
2. IM&T services – access to working PCs and software, electronic notes, WINSCRIBE instead of tapes
3. Consistent process of all specialities – e.g. admin steps, appointment booking, investigations etc…

1. Space
2. IT/electronic referrals
3. Co-located diagnostic suite

1. Right patient in the right clinic with appropriate investigations/results e.g. EP/Arrhythmia -> EP clinic etc…
2. Virtual clinics for all consultations or ANPs
3. Electronic notes access – for results etc…

1. No overbooking
2. Right patients seen in correct hospital setting – including more people seen in primary care
3. Doctors rota's six weeks in advance – less cancellations + less complaints

Question 2

“What obstacles or issues might get in the way of us reaching our goals?”

- Theme: IM&T

- Unable to get timely IT support
- IM&T not adequate for clinic – not up to date enough
- IM&T equipment
- Old computers in OPDE
- Poor IM&T
- EMRAD
- ICRIS too slow or doesn’t work
- IT provision
- Too many systems – why can’t we just have one?
- GPs not using ERS correctly
- Incorrect phone numbers
- IT slow, old, broken
- Online self-booking?
- EMRAD not fit for purpose

Question 2

"What obstacles or issues might get in the way of us reaching our goals?"

- Theme: IM&T

- IT systems
- Consultant doesn't have access to all data/information needed
  - -EMRAD
  - -Patients medications
  - -previous tests
  - -e.g. OGD – bleeding risk – Gastroenterology results are not available electronically
  - -One stop shop (ECG, CxR, Bloods etc...) not available yet
- IT systems
- IT
- IT Shared system?
- EMRAD not fit for purpose
- Choose and book – Online booking??
- Patient choosing appointments – how? – online booking?

Question 2

"What obstacles or issues might get in the way of us reaching our goals?"

- Theme: Process

- Patient notes not prepped accordingly
- Overbooking clinics – patients on the same time slots
- Not having all the tests ready for clinics
- All clinics to run the same no matter which clinic manages them – e.g. ECG, bloods etc… to be done by OPD nurses already happens in generic OP clinics A,B,C,D,F!
- Poor admin processes
- Lack of standardised processes/SOPs
- Overbooking of clinics
- Cancelling clinics for audit and clinicians not present so all cancelled
- Long term follow ups?
- Outpatient waiting lists
- Hospitals cancelling appointments
- Doctors not seeing extra patients

Question 2

“What obstacles or issues might get in the way of us reaching our goals?”

- Theme: Process

- Rapid access AF – but no ECGs attached
- Pts admitted before referrals - No referral letters, no clinical details
- Appointment times do not allow enough time for doctors to speak to patients
- Doctors expected but do not turn up
- Time to think and implement change – PRISM/advice and guidance/FUs
- Duplicate appointments between sub specialities
- Waiting times
- Appointments – need flexibility
- Patient is booked to clinic of different/random sub-specialty – then needs re-referral and new waiting time
- Increased GP direct referral for diagnostics = less capacity for clinic patients
- Investigations – waiting time for test due to capacity/service demand

Question 2

"What obstacles or issues might get in the way of us reaching our goals?"

- Theme: Process

- Better time effectiveness
- FU appointments booked for no obvious clinical reason
- No flexibility in system - e.g. nowhere to put patients if clinics cancelled without overbooking
- Long wait times for consultants – time can vary greater for consultant, up to a year!
- Patient experience – some patients attend on ghost appointments and are then frustrated. Some don't receive appointment via post and then DNA
- CDU follow up every patient – Who decides appoint is necessary?
- Clinics overrun
- Longer wait times on day if ECG needed, pushing whole clinic back
- Waiting times
- 45 min wait for patient in ECG pre clinic appointment

Question 2

"What obstacles or issues might get in the way of us reaching our goals?"

- Theme: Resource

- Money
- Resource limitations – Funding, adequately trained staff (particularly if staff redeployed), clinic space/rooms
- HR recruitment process delays if new staff employed
- Finance
- Training for clinical staff
- Space, environment, design area
- Lack of space
- Lack of finance
- All staff to be bloods/ECG trained as a basic need for clinic
- Capacity
- Parking
- Transport
- Cost
- Transport
- Weekend clinics?

Question 2

"What obstacles or issues might get in the way of us reaching our goals?"

- Theme: Resource

- How to get to hospital – Ambulance service?
- 7 day working?
- Recruitment restraints
- Lack staff – including skill mix
- Lack of budget
- Staffing – recruitment issues
- Expanding of services – 7 days?
- Funding
- Resource and money
- Staffing issues
- Admin capacity
- Knowledge of pathway structures – education?
- No access to 'advice'
- Insufficient clerical team to facilitate virtual clinics
- Inexperienced/unsupported medical staff in clinic
- Issues with transport, particularly ambulance

Question 2

"What obstacles or issues might get in the way of us reaching our goals?"

- Theme: Communication

- Communication between specialities
- No communication within/between all service users
- Letters not having clinic title on it – needs more explanation
- Letters to have the pathway for patients so they know where they are going, what happens next etc…
- Patient choice – limited in what they can do, when
- Doctors expected but do not turn up
- Cancelled clinics – patients still arrive
- Customer service from clinic co-ordinators
- Better customer care from clinic coordinators – i.e. introduce themselves to patients

Question 2

"What obstacles or issues might get in the way of us reaching our goals?"

- Theme: Culture

- Being resistant to change
- "Consultant is God" mentality – changing culture and challenging practice
- "It's the UHL way" - changing mindset
- "Not my job! Attitude
- Dealing with consultants that display "attitude" towards the nursing staff and have demands that don't matter e.g. notes trolley not wanting to be shared with another consultant
- Consultants not going into allocated room according to bookwise
- "Not my job" – Every member of staff needs to work the same
- Culture – people not wanting to change
- More enthusiastic/motivated clinic staff – a need to challenge self and improve patient experience

Question 2

"What obstacles or issues might get in the way of us reaching our goals?"

- Theme: Environment

- Space
- Pay on exit parking
- Parking space
- Paying for parking
- Parking costs
- Capacity of diagnostic departments
- One stop shops – increase impact?
- Room capacity

Question 2

"What obstacles or issues might get in the way of us reaching our goals?"

- Theme: Top points

1. Inflexible choice of booking process – need online/phone/letter, text confirmation system
2. Need 7 day working and extended hours – dependant on staffing, recruitment, funding
3. Clinic co-ordinators having access to book patients into next diagnostics/procedures
4. IT shared systems

1. Funding
2. Unable to get timely IT support/working technology
3. We don't work as one – fragmented investigations, x-ray, OPs…

1. Log jam in ECG at beginning of clinic as all have same clinic templates – new/follow – specifically in clinic D
2. Admin capacity – to support virtual clinics
3. Access to all information – e.g. cath lab images, EMRAD, gastroenterology

1. Lack of forward planning
2. Correct clinics i.e. lipids, DVT, diabetes, rheumatology – 155 slots per week = 15 rooms
3. Available time to make changes and implement e.g. Advice and guidance, PRISM, follow up reduction

Question 3

"What do we need to do together to achieve our vision?"

- Theme: IM&T

- Contact IT to have auto shutdown removed from clinical PCs
- Bookwise system – will it work in cardiology? – availability of rooms/which clinics are cancelled
- Computers that don't turn off at 6pm
- Setup Virtual/telephone clinics to reduce face to face contacts and free up time
- Stop using EMRAD and go back to PACS until problems are fixed
- Access to Gastroenterology letters/procedures
- Access to SystmOne to see medications
- ERS – HISS one system? As they are very different.
- Booking system for clinic D? bookwise
- More reliable IT
- New PCs – faster (QW?)
- All areas to use bookwise
- New PCs – IM&T to be faster, update to be able to view scans accordingly
- IT, get EMRAD working
- Slow PCs
- Self-check in

Question 3

"What do we need to do together to achieve our vision?"
- Theme: IM&T

- Plain film GH
- Old PCs with out of date software
- Replace EMRAD!
- Too much IT downtime (software/hardware)
- Self-check in – avoid queues at reception
- Electronic requests
- Self-check in
- EMRAD – not fit for purpose
- CRIS – too much downtime
- Slow computers
- Electronic requests
- Set up virtual clinics for all consultants and ANPs to have pt FUs booked into
- Central room booking viewable electronically consultants A/L - ?being used in other GH clinics?
- More telephone/virtual clinics
- One stop clinics (QW?)
- More virtual clinic follow ups

Question 3

"What do we need to do together to achieve our vision?"

- Theme: Process

- 'Fire breaks' – e.g gaps in clinic planning for patients from cancelled clinics to be booked into
- System for review of ward FUs before being booked (if needed) or discharged
- GP requests to be done elsewhere
- Diagnostics prior to clinic to help reduce wait for 'one shop'
- Triage F/Us
- More MDT clinics
- Virtual clinics by pharmacists for medicine optimisation – frees up coordinated pre-assessment clinics /appointments with patients seeing all relevant specialists
- Specialist pharmacy prescribers running high cost and high risk med clinics – responsible for monitoring, follow up, pre-treatment checks
- Long term/chronically ill patients – Pharmacy to manage the prescribing, dispensing, delivery of long term high cost/high risk medicines including follow up and communication with primary care
  -patients don't have to wait for meds to be dispensed after waiting a long time in clinic
- Patient counselling in clinic by pharmacist for newly initiated medicines
- <u>ECG performed before the clinic time appointment (QW?)</u>

Question 3

"What do we need to do together to achieve our vision?"

- Theme: Process

- <u>Review clinic templates to match need (QW?)</u>
- <u>All ECGs to be performed in clinic ready for clinician to see patient (QW?)</u>
- Clinicians to see patients on the wards, not bring inpatients to outpatients
- Baseline observations to be performed on all patients in clinic
  -already done in clinic A, B, D, E, F and BCC
- Confidentiality of medical notes in clinic coordinator trolley? Leaving desk unattended
- Improving patient pathways
- GP referrals for ECGs – still patients take time and room space
- Optimise patient flow, bottlenecks – look at appointment slots?
- ECGs done on clinics
- New patients to come at different times – not all at once?
- EP patients done in practice/community
- Plan OPs to optimise flow and reduce bottlenecks for diagnostics
- Don't overbook clinics
- Staff to work together to plan/schedule clinics better to reduce queues for diagnostics

Question 3

"What do we need to do together to achieve our vision?"

- Theme: Process

- Rapid FU clinic for AF patients from CDU (to be set up)
- Review clinic template timings of New to ease pressure on ECG
- Audit of patients who had ward F/Us and if they needed it – Dr. Andy Ladwiniek
- Before booking any patient to a clinic, consider if symptoms do require any subspeciality input or general cardiology
- Discharged patients are not just routinely given appointments – assess if they want/need to come
- Need to agree dates for working through PRISM & advice and guidance and follow up reductions
- Reduce duplicate patient episodes where not needed
- Specialist anticoagulation pharmacist prescribers within the cardiology team to manage the patients (newly started and maintenance) on NOACS DOACS warfarin including follow-up and virtual clinic slots run by the pharmacists
- 1st Follow up clinic appointment with pharmacists on all patients initiated on new treatments – free up ANP and cons time to see more patients

Question 3

"What do we need to do together to achieve our vision?"
- Theme: Process

- Allocated time to liaise with GPs, SpRs, offer advice and a management plan regarding referral – may prevent inappropriate referrals?
- Hotline for patients to phone with regard to matters relating to their cardiology care. They'll get directed to the appropriate specialist, they have a contact point at any given time e.g. medicine supply issues in primary care can be directed to a dedicated cardiology pharmacist prescriber who's part of the team
- More ANP clinics – use ANPs to fill follow up slots and release New slots for consultants
- Investigations requested prior to appointment if possible and results available on the day?
- Access to on the day investigations so patients can be reviewed and possibly discharged off the system?
- Better appointment system? – more streamlined, text reminders?
- All patient notes and patient information available on the day
- More slots for ECHO on the day
- ?possible better utilisation of cardiac investigations

Question 3

"What do we need to do together to achieve our vision?"

- Theme: Resource

- <u>All outpatient nurses can perform ECG/bloods – working to same standards (QW?)</u>
- <u>Outpatient nurses, qualified and unqualified to be ECG trained (QW?)</u>
- Funding equipment e.g. ECG machines in a charitable funds
- Use stats forms on all clinics to capture utilisation of rooms and clinics running over
- Having staff available who can perform bloods so when blood room is closed patients can still get bloods done
- Have enough staff with the right skills at the right time
- More ANP clinics to support system

Question 3

"What do we need to do together to achieve our vision?"

- Theme: Communication

- Advice booklets for Registrars,/ANP regarding patient management – e.g. EP patients, risks of procedures, who to bring back and how often etc…
- Managing patients expectations if we cannot resolve these issues quickly i.e. let patients know that there could/will be a wait
- Communicate between cardiology, CSI and specialities to ensure one stop clinics – have tests on the day and go away with next steps
- Knowing which receptionist to book in with
- Patients knowing how long they are going to wait
- Communicating times to GP – We have open access 08:30-4:30

Question 3

"What do we need to do together to achieve our vision?"

- Theme: Culture

- Reduce waiting times by Dr's turning up on time to clinic
- Time out day/hours of clinic D staff and cardiac investigations to challenge ideas and allocate tasks, develop champions within different projects for change, to take forward and implement in own areas

Question 3

"What do we need to do together to achieve our vision?"

- Theme: Environment

- Create more capacity in clinics
- Clinics in their right speciality/site
- Separate ECG area for cardiology clinic D
- Space – audit utilisation to see room usage? (QW?)
- Audit utilisation of rooms and space used appropriately?
- Performing ECGs within clinic - ?rooms available
- More room for patients to wait
- Better signage
- Generator testing at inconvenient times

Question 3

"What do we need to do together to achieve our vision?"
- Theme: Top points

1. Planning – Dr rostering
2. Agreed implementation of advice and guidance/PRISM
3. Fewer follow ups – Triage F/U ward requests, do all need to come? – Virtual appointments?

1. Electronic booking for clinic space, including consultant A/L
2. Patients booked for appropriate specialist – e.g. clinics identified for GPs (clinic directory? – referral process), list of available subspecialty e.g. syncope, EP, intervention etc…
3. Stop using EMRAD, using PACS until EMRAD provision by company improves
4. Cardiology outpatient handbook – referral process (how to), how to manage patients in clinic who need F/U, DNA and cancellation policies (Sue Armstrong happy to be involved)

1. Quick wins – All OP nurses (Qualified and unqualified) to be ECG trained. All ECGs to be performed on new patients in clinic, not to be sent to cardiac investigations before being seen by clinicians – already happening in clinics A, B, C, E, F and BCC.
2. Quick Win – Review templates regarding when new patients arrive
3. One stop clinics
4. PC upgrades and software
5. Audit utilisation of space and rooms (Main OPD already has bookwise for e.g.)

1. EMRAD – Not fit for purpose
2. Currently regular IT downtime/old PCs

PRISM, A&G, F/U reduction

Current focus

- PRISM: Deb working with Elved and cons team. Pathways identified and allocated. Aim to be live during December.

- Advice and Guidance: One service currently live. CCGs asking additional cardiology services as priority. Advice already being given to GPs but not through A&G framework – formally via A&G will attract small tariff for UHL

- F/U reduction: 2 areas identified as a start for investigation:
  1. Post CDU F/Us discharged at weekends where junior doctors are making these decisions, not all need F/U? Audit being undertaken to understand scale.
  2. Maz identified cohort of post investigation patients that can be followed up by non-cons team. Previous work on this not taken up as potential need for 'Invest to save'. To revisit and take to CCGs if decided viable.

APPENDIX C

OUT PATIENT TRANSFORMATION KEY MILESTONES

PROGRAMME MILESTONES

Key Intervention No:	Key milestones	Accountable Officer	Expected outcome/Impact	Start date	Delivery date	RAG rating	Comments
1	Finalise the programme plan with	J Edyvean	Key milestones, accountable individuals, deadlines for delivery and clear outcomes	01/07/2017	~~01/09/2017~~ 30/11/17	(Scope/ complexity)	
2	Develop, agree and sign off project plan- ENT & Cardiology	J Edyvean	Project plan is signed off and supported by Trust and relevant Speciality Boards/CMG Boards. People know where they are responsible for delivery of an action plan and can be held to account for delivery within agreed timescales.	01.10.17	17/11/2017	4	
3	Develop and agree a future vision for Out Patient services	M Wightman	Vision clearly articulated that is consitent with clinical strategy and Reconfiguration Plans. Vision aligns with trsnsform,ation activities	06/09/2017	02/10/2017	4	
4	Delivering quick wins in ENT & Cardiology	J Edyvean	Quick wins agreed and fully addressed	23/10/2017	31/12/2018	4	
5	Addressing enviromnmental factors with focus on ENT & Cardiology	D Waters/R Karavadra	Improved environment. Increased staff and patient satisfaction	23/10/2017	31/03/2018	4	
6	Customer Care Training	*TBC*	100% ENT&Cardiology Staff receive Customer Care Training	01/11/2017	31/03/2018	0	
7	Clinic letters	S Priestnall	Improvements suggested by staff re appointment and clinic letters addressed initially in ENT & Cardiology	16/10/2017	31/03/2018	4	
8	Reducing cancellations in ENT and Cardiology		Recorded cancellations reduce. Non value adding activities reduced. Clinic coordinator time released	01/11/2017	31/03/2018	0	
9	IT Enablers	A Carruthers	Hardware replaced in ENT and Cardiology. Baseline assessment completed of all OP areas of herdware replacement requirements. Agreed IT developments implemented. Early move towards Paperless Out Patients 2020	20/10/2017	31/03/2018	0	
10	Advice and guidance monitoring	H Cave	Reduce non admitted demand using advice and guidance service	01/04/2017	23/02/2018	4	
11	Prism referrals	C Carr	Patients Referred into correct clinic at their first appointment	01/16/17	30/11/2017	3	
12	Develop and agree a suite of outcome based KPI's for ENT and Cardiology	J Edyvean	Clear metrics for measuring improvement	29/09/2017	10/11/2017	4	
13	Performance monitoring and evaluation	J Edyvean	Clear position on impact of changes and managing for improvement. Celebrating success	13/11/2017	31/03/2018	0	
14	Develop communications and engagement plan	C Maddison	Staff and key stakeholders kept informed of progress. Toolkit available to ensure approach is flexible to needs of programme	29/09/2017	03/11/2017	4	
15	Complete first cultural audits	T Rees/ A Assimacopoulos	Understanding of the systematic, cultural and behavioural aspects within two specific clinics of the wider Outpatients team- how do they perceive their service and what it is like to work for this service. A basis on which to ensure that the programme has the right people, with the right skills, attitudes and behaviours, working in the right place at the right time to support sustainable change.	05/10/2017	23/10/2017	4	

ENT MILESTONES

Key Intervention No:	Key milestones	Accountable Officer	Expected outcome/Impact	Start date	Delivery date	RAG rating	Comments
1	Develop, agree and sign off project plan(s)	J Edyvean	Project plan is signed off and supported by MSS CMG Board and owned by ENT. People know where they are responsible for delivery of an action plan and can be held to account for delivery within agreed timescales.	01.10.17	17/11/2017	4	
2	Delivering quick wins	A Riddick	Quick wins agreed and fully addressed	23/10/2017	31/12/2018	0	
3	Addressing enviromnmental factors	*TBC*		23/10/2017	31/03/2018	4	
4	Customer Care Training	*TBC*	100% Staff receive Customer Care Training	01/11/2017	31/03/2018	0	
5	Improving clinic processes	*TBC*		01/11/2017	31/03/2017	0	
6	Clinic letters	S Priestnall	Improvements suggested by staff in clinic letters addressed	16/10/2017	31/03/2018	4	
7	Reducing follow ups	S Turner	Every contact counts enacted. Patients who do not need to come to UHL for face to face follow up seen elsewhere or managed through different pathways. Follow up attendances reduce. Clinic capacity improved	12/09/2017	31/03/2018	4	
8	Reducing cancellations	S Turner	Recorded cancellations reduce. Non value adding activities reduced. Clinic coordinator time released	01/11/2017	31/03/2018	0	
9	IT Enablers	A Carruthers	Order communications implemented in ENT. *Improved use of existing technology(TBC)*	20/10/2017	31/03/2018	0	
10	Advice and guidance monitoring	Linsey Ellis	Reduce non admitted demand using advice and guidance service	01/04/2017	23/02/2018	4	
11	Prism referrals	D Cakmak	Patients Referred into correct clinic at their first appointment	01/16/17	30/11/2017	3	
12	Developing alternative pathways	D Cakmak	Reduced NR & FU outpatients referrals. Enhance community shift, increase consultant & nursing clinic capacity.	01/05/2017	01/01/2018	4	
13	New ways of working	D Cakmak	Implementation of new pathways for telephone FU for OSA to reduce FU rates and enhance flow and support RTT position	01/05/2017	01/10/2017	3	
14	GPwSI Implementation	C Carr	Optimisation of opportunities to use GPwSI to support the ENT Service	01/05/2017	01/01/2018	4	
15	Develop KPI's	J Edyvean	Clear metrics for measuring improvement	29/09/2017	10/11/2017	4	
16	Performance monitoring and evaluation	I Morgan	Clear position on impact of changes and managing for improvement. Celebrating success	13/11/2017	31/03/2018	0	

CARDIOLOGY MILESTONES

Key Intervention No:	Key milestones	Accountable Officer	Expected outcome/Impact	Start date	Delivery date	RAG rating	Comments
1	Develop, agree and sign off project plan(s)	D Turner & M Patel	Project plan is signed off and supported by RRCV CMG Board and owned by Cardiology. People know where they are responsible for delivery of an action plan and can be held to account for delivery within agreed timescales.	01.10.17	17/11/2017	4	
2	Delivering quick wins	A Riddick	Quick wins agreed and fully addressed	23/10/2017	31/12/2018	0	
3	Addressing enviromnmental factors	*Resource to be identified*	Improved patient and staff experience	23/10/2017	31/03/2018	4	
4	Customer Care Training	*Resource to be identified*	100% Staff receive Customer Care Training	01/11/2017	31/03/2018	0	
5	Improving clinic processes	D Turner & M Patel	Non value added steps reduced, duplication reduced clinic capacity increased	01/11/2017	31/03/2017	0	
6	Clinic letters	S Priestnall	Quality of Patient correspondance improved	16/10/2017	31/03/2018	4	

7	Reducing follow ups	D Turner & M Patel	Every contact counts enacted. Patients who do not need to come to UHL for face to face follow up seen elsewhere or managed through differenct pathways. Follow up attendances reduce. Clinic capacity improved	12/09/2017	31/03/2018	4	
8	Reducing cancellations	D Turner & M Patel	Recorded cancellations reduce. Non value adding activities reduced. Clinic coordinator time released	01/11/2017	31/03/2018	0	
9	IT Enablers	A Carruthers	Order communications implemented in ENT. *Improved use of existing technology(TBC)*	20/10/2017	31/03/2018	0	
10	Advice and guidance monitoring	Linsey Ellis	Reduce non admitted demand using advice and guidance service	01/04/2017	23/02/2018	4	
11	Prism referrals	C Carr	Patients Referred into correct clinic at their first appointment	01/16/17	30/11/2017	3	
12	Developing alternative pathways	C Carr	Reduced NR & FU outpatients referrals. Enhance community shift, increase consultant & nursing clinic capacity.	01/05/2017	01/01/2018	4	
13	New ways of working	C Carr	Implementation of new pathways for telephone FU for OSA to reduce FU rates and enhance flow and support RTT position	01/05/2017	01/10/2017	3	
15	Develop KPI's	J Edyvean/M Patel	Clear metrics for measuring improvement	29/09/2017	10/11/2017	4	
16	Performance monitoring and evaluation	M Cheung	Clear position on impact of changes and managing for improvement. Celebrating success	13/11/2017	31/03/2018	0	

APPENDIX D

Assignment of Out Patient Programme Board Initiatives

Action	Lead	Include in BAU	Include in OP Transformation	Comment/update
All to consider whether they receive referrals for diagnostics within their own areas, so that they can be set up on ICE as a "service receiving department". To liaise with Ann Hall directly.	Ann Hall		Yes	
Keeping patients informed of in-clinic wait time: Processes to be put in place to ensure the outpatient nursing staff keep the clinic co-ordinators informed of waiting times, and for clinic co-ordinators to inform patients who they are due to see, and what the expected waiting time is.	CMGs		Yes	
Ambulance Issues	CMGs		Yes	
You said we did boards (Have these been uniformally implemented in standardised way?	CMG's		Yes	
Patients attending for multiple appointments on the same day/clash reporting	Debbie Waters	Yes	Yes	
OP Clinic Template management policy	Helen Cave	Yes		In place since 2013. Compliance variable. For review 2020
Best Practice Checklist to baseline specialties	Helen Cave		Yes	
Roll out of advice and guidance	Helen Cave	Yes	Yes	linked to a CQUIN target that runs through to Q4 18/19. This is also reported through the Planned Care Board.
OP Transformation LIA events	Jane Edyvean		Yes	
Achievement of CQC reuirements (not just Ophthalmology and Imaging)	Justine Allen		Yes	
Postal letters moving to electronic	NIL		Yes	
Review of information leaflets	Shirley Priestnall		Yes	

Translation Services	Stacey Thrower/Colin Bray	Yes	Yes	
Review of hardware across OPDs	Taff Webb		Yes	
Implementation of new transcription contract	Will Monaghan	Yes	Yes	Tender award pending. Roll out plan to be developed as an important part of the tender
Eligibility criteria for ambulance transport			?	
Development and implement scorecards at speciality level	Helen Cave	Yes		Completed with focus on 9 KPIs for outpatients. Updated monthly ad sent out automatically to CMG's .
SMS Text reminder service	Justine Allen		?	
Scope of Booking Centre and how the specialties across the Trust could use them	Debbie Waters		Yes	
Develoment of advice and guidance	Helen Cave		Yes	On Track
Roll out of e referrals	Helen Cave	Yes	Yes	The roll out of e-referrals links with the national Paper Switch Off project, whereby from 9th April 2018 we will no longer accept paper referrals, and from October 2018 we will not be funded for paper referrals (from GP into consultant led outpatient services). This is also reported through the Planned Care Board.
Action planning in response to F&F test feedback	CMGs		Yes	Reviewed monthly

Out Patient Transformation - Information Technology Priorities 2017/18

APPENDIX E

##

Ref	Theme	No	Comment	2017/18	2020 plan	Comments
	Themed responses					
	Paperless clinic 2020	N/A	Hardware refresh programme	√		Baseline assessment to be undertaken of all areas and plan/quantum/approach agreed
		N/A	Patient ID Cards - Pilot in Oncology/Haematology (need to test if applicable to ENT/Cardiology)	√		Only in Haematology/Oncology. Need to see if this is relevant to ENT or cardiology
		N/A	E-Referrals	√		In Progress. National requirement October 2018. Internal deadline April 2018
		N/A	Welch Allen - specific to monitored areas	?		Very specific to monitored areas. Not high priority in OP currently
		N/A	ICE Electrinic ordering	√		Pilot in progress. ENT and Cardiology to be put forward as next priorities depending on outcome of pilot
		N/A	Centralised allergies and alerts	**Baseline**	√	Baseline assessment only for 2017/18 - do we collect this in other software applications?
		N/A	Primary Care SCR viewer - System1	√	√	Already available via systmone So could be rolled out now - needs comms & engagement and RA cards issued
		N/A	SMS	**In place**	√	SMS Texting in place. Future extended use part of 2020 work
		N/A	Guidelines	**In place**		
		N/A	MSK DMS - Interim solution	**Review**		Explore as an interim solution for starting DMS system and for ?Consultant to consultant referrals
	LiA IT Actions	43	One paperless IT system so clinicians can see all referrals (ERS) and records/information/tests - PRISM		√	Speciality Plans and dates for delivery in place. Suppoerted by LLR Project Managers
		26	More efficient and effective IT systems	√	√	
		14	Book in Kiosk/electronic booking in		√	Limitations of current systems. Forms part of Paperless Clinic 2020 work
		12	Online self-booking appointment system		√	Limitations of current systems. Patient portal needs to be in place. Forms part of Paperless Clinic 2020 work
		12	All services to use 'Advice and Guidance' on ERS systems to GPs, to avoid uncessary referrals	√		Pilot in progress. ENT and Cardiology to be put forward as next priorities depending on outcome of pilot
		11	Electronic notes		√	Paperless Clinic 2020 Work Stream
		9	Real time screens on time to appointment/waiting times and delays	√		In place in Oncology - assessment to be undertaken for adoption in other clininc areas
		5	Skype/virtual Clinics		√	Work required on video links for the Trust. Explore - Business case required. Part of Paperless clinic 2020
		4	Use text for more communication/improve detail in messages		√	Limited sope of Patient Centre - no room to store e mail or other correspondance. Patient portal will resolve this
		2	One log in system	√		Licence to roll out as required. Full assessment to be undertaken and implement as far as possible
		2	ICE in OPs	√		Pilot in progress. ENT and Cardiology to be put forward as next priorities depending on outcome of pilot
		2	In house help service - IM&T help desk	**In place**		In place - educate staff -Help desk off shore - desktop/networks local
		2	IT education and support forums for staff	√		
		1	Forward facing screens to check patient details for every attendance		√	Paperless Clinic 2020 Work Stream. Note this has not been used in ED - needs engagement and change
		1	Better room booking system	**In place**		Educate staff re Bookwise
		1	Linked up OP booking system		√	Paperless Clinic 2020 Work Stream
		1	Managed Print at LGH	**Under review**		Awaiting quote from IBM - business case & funding dependant
		1	Voice recoginition to help with OP letters	√		Part of transcription project
		1	Coordinator training/access to HISS	**In place**		
		1	Online information portal for patients		√	Paperless Clinic 2020 Work Stream
		1	Electronic patient information booklets	√	√	Clinical librarian in place responsible for standardising patient information. Focus on consolidation and use of SharePoint
		?	EMRAD improvements			East Midlands wide issue - John Clarke engaging with partners
		1	LGH wifi support	√		Additional points being installed. Further improvements capital funding dependant
	ENT LiA actions	4	IT hardware needs upgrading before software	√		Baseline assessment to be undertaken of all areas and refresh as far as possible
		3	Better online Choose and book function/provision	?		
		3	ICE in OPs	√		Pilot in progress. ENT and Cardiology to be put forward as next priorities depending on outcome of pilot
		3	SystmOne as system of choice for OP and community clinics	Not being progressed		
		2	Unified referral system	√		
		2	PRISM, including advice and guidance	√		Advice and guidance in place. 15 PRISM pathways being developed . Clinical lead identified to do this (nov 17)
		2	Self check in		√	Paperless Clinic 2020 Work Stream
		2	Upgrading of network infastructure		√	Paperless Clinic 2020 Work Stream
		2	Single Sign On	√		Assess where there are gaps and suystems that staff need access to. Implement
		1	Ambition for 100% hit rate for UBRN numbers	√		
		1	Electronic notes		√	Paperless Clinic 2020 Work Stream
		1	EMRADS reporting		√	See note above
		1	TrackIt system needs to be reliable	System to remain as is		
		1	Hearing service software	√		Local issue escalated to A Carruthers. J Edyvean to follow up
		1	Junior doctor clinical log in	√		Locally resolved issue to be sorted in walk around - Examples to be provided if this is an on-going issue
		1	Turn off skype	√		Identify PC's and IT to turn off from PC start up
		1	Ensure the right software is on PC's	√		Baseline audit. Identify what soptware is missing and address
		1	Agreed for consultant lead to complete development of PRISM pathways	√		Lead identified
	Cardiology LiA Actions		Remove auto shutdown from clinical PCs	√		Identify PC's where this happens and rectify -
			Look to use Bookwise system – availability of rooms/which clinics are cancelled	√		
			Remove automatic turn off at 6pm on computers	√		Audit PC's where the notifications need to be changed (need to message system centrally to change)
			Address issues with EMRAD? go back to PACS until problems are fixed		√	See note above
			Access to Gastroenterology letters/procedures	?	√	Paperless Clinic 2020 Work Stream
			Access to SystmOne to see medications		√	SJ to be asked to explore with Tony Bentley
			ERS – HISS one system?		?	
			Booking system for clinic D - bookwise	√		Implement/roll out as system currently available
			More reliable IT	√	√	Initiate through hardware audit and refresh
			New PCs – faster with up to date software	√		Baseline assessment to be undertaken of all areas and plan/quantum/approach agreed
			Address IT downtime (software/hardware)		√	
			Self-check in		√	Paperless Clinic 2020 Work Stream
			CRIS – too much downtime		√	
			Electronic requests - ICE Rollout	√		Implemented by April 2018
			Central room booking viewable electronically consultants A/L as used in other GH clinics	√		Implement/roll out as system currently available