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Sandwell and West Birmingham Hospitals NHS Trust

Report Title	Mobilising diagnostic support: one set of promises		
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Meeting	Trust Board	**Date**	1st August 2019

1. Suggested discussion points *[two or three issues you consider the Trust Board should focus on]*

Consistency in clinical standards will improve time to test and diagnosis for our in patients. This aligns with the travel of direction for 7 day working. 3 clinical standards are recommended:

- 4 hour turnaround for rapid cardiology tests and chest drain insertions
- 24 hour turnaround from request for all inpatient tests and speciality opinions
- 48 hour turnaround from request for PEG and colonoscopy (to allow form clinical preparation time)

Alignment of in patient and planned care diagnostics and scheduling is necessary not to derail planned care pathways unintentionally.

Unity will enable us to measure what we do and inform our improvement focus.

2. Alignment to 2020 Vision *[indicate with an 'X' which Plan this paper supports]*

Safety Plan	x	Public Health Plan		People Plan & Education Plan	x
Quality Plan	x	Research and Development		Estates Plan	
Financial Plan	x	Digital Plan	x	Other *[specify in the paper]*	

3. Previous consideration *[where has this paper been previously discussed?]*

4. Recommendation(s)

The Trust Board is asked to:

a.	**SUPPORT** the approach and new standards as outlined
b.	**DISCUSS** the considerations and risks around implementation
c.	

5. Impact *[indicate with an 'X' which governance initiatives this matter relates to and where shown elaborate]*

Trust Risk Register							
Board Assurance Framework							
Equality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Report to the Trust Board: 1st August 2019

Mobilising diagnostic support: one set of promises

1. Introduction

1.1 There are many internal clinical standards that the Trust can ensure are in place to support a reduction in length of stay for inpatients. These include a range of diagnostics, procedures and speciality reviews for patients that will help facilitate the right treatment outcomes in a reduced amount of time. This paper outlines what we believe those standards to be in a formalised approach.

2. Background

2.1 We have always held clinical standards for access times for inpatient diagnostics; this paper outlines what the new standards are for radiology but also breaks down the clinical standards for all other clinical groups into a formalised agreement.

2.2 In essence there will be 3 standards:

- 4 hour turnaround for rapid cardiology tests and chest drain insertions
- 24 hour turnaround from request for all inpatient tests and speciality opinions
- 48 hour turnaround from request for PEG and colonoscopy (to allow form clinical preparation time)

2.3 The most significant changes will be delivered by September, but there are some standards in this paper that will need to increase physical capacity in order to complete the diagnostic / review within that timeframe. Where this is the case it has been approximated how long this would take to have in place. Ultimately, most of these standards are required by September to support the winter bed planning reduction in LOS.

3. Clinical standards

3.1 Table 1 below shows the current practice against the procedure or diagnostic, it outlines what the new clinical standard the Trust is setting in order to support a reduction in LOS.

Table 1 Clinical standards

Clinical Group	Procedure / diagnostic	Current observed practice	New clinical standard	Is service available 7 days a week	Implementation date
MEC	Chest Drain	24 hours	4 hours	Y	September 19/20
MEC	ECG and ETT	8 hours from request	4 hours from request	Y	September 19/20
MEC	Pacemaker/ICD Checks	8 hours from request	4 hours from request	Y	September 19/20
PCCT	Therapy Review	Within 4 hours of referral	4 hours of referral	Y	September 19/20
All groups	Specialist review	As soon as possible but generally no latter then 24 hours, sometimes 48 hours	24 hours*of referral	Y	September 19/20
MEC	Endobronchial Ultrasound – guided (EBUS)	Only 2 lists per week, could take up to 72 hours. Patient are discharged and brought back if EBUS is the only diagnostic required.	24 hours from request	N	Q4 of 19/20
MEC	Bronchoscopy	Completed when possible depending on the availability within endoscopy, can take up to 72 hours to complete	24 hours from request	N	Q4 of 19/20
MEC	Flexible sigmoidoscopy	Aim to complete with 48 hours	24 hours from request	N	Q4 of 19/20
MEC	Oesophago-gastroduodenoscopy (OGD)	Aim to complete with 48 hours	24 hours from request	N	Q4 of 19/20
MEC	Gastro Intestinal Bleeds – endoscopy	24 hours	24 hours from request	Y	August 19/20
PCCT	Think Glucose response	24 hours, Monday – Friday	24 hours of referral	N	September 19/20
MEC	Echocardiogram	48 hours	24 hours from request	Y	September 19/20
Imaging	All inpatient Imaging request to report	48 hours from request	24 hours from request	Y	September 19/20

Clinical Group	Procedure / diagnostic	Current observed practice	New clinical standard	Is service available 7 days a week	Implementation date
MEC	Colonoscopy	Dependant on availability	48 hours from request (inc of Preparation time)	N	September 19/20
MEC	Percutaneous endoscopic gastrostomy (PEG)	72 hours	48 hours from request (inc of assessment)	N	Longer term development required for workforce

3.2 *The requirement for a consultant or non-consultant specialty review within 24 hours is standard for the main admitting specialities. There are some specialities that do not have 7 day specialist rotas, where this is challenging eg; vascular, urology, dermatology, tissue viability. The expectation is that a review will be conducted the next working day but is not consistent. It is not be possible to track actual performance currently but should be available once Unity is live.

4. Measuring and meeting clinical standards

4.1 Some of the current standards performance are based on feedback or review of pathways as there is no dashboard or metric capture that outlines the above clinical standards performance.

4.2 Unity will give us capability to track speciality response times and many of the response standard response times. This will enable us to effectively benchmark current performance and build a dashboard to manage compliance and improvement.

4.3 The organisation will be going live with Unity in September, this has the risk to impact the timescales identified as much of the work for both will need to take place at the same time.

4.4 Project groups have already been set up for imaging and medicine to support the changes required to implement the standards. These feed into the Urgent Care Board for oversight. A review of the scope of these will be undertaken to ensure all standards are covered under a project group for accountability.

5. Risks

5.1 The biggest risk to ensuring these standards are delivered is the potential knock on effect to planned care diagnostics. To secure enough availability within sessions to ensure the clinical standards above we risk underutilising slots and therefore increasing wait times for routine diagnostics and potentially cancer patients. This risk will need to

be mitigated by good demand and capacity planning and where possible, through the using of intelligent scheduling and the introduction of stand by patients.

5.2 A full capacity review and utilisation study is being undertaken for both cardiac catheter labs and endoscopy to ensure that the current available capacity is sufficient to enable the clinical standards being met without impact onto other waiting times.

5.4 The list of clinical standards in this paper is not definitive and further work will go on over the next few months to ensure that all standards have been captured and are included within the dashboard.

6. Recommendations

6.1 The Trust Board is asked to:

a) Support the approach and new standards as outlined

b) Discuss the risks around implementing

Liam Kennedy
Deputy Chief Operating Officer
August 2019