ITEM: 6

MEETING: **Trust Board – 19 September 2007**

TITLE: **Service Development Update**

SUMMARY:
This paper updates the Board on progress the Trust is making towards delivering the 18 week Referral to Treatment target, and reducing length of stay and bed day usage through the Making Best Use of Beds project.

The 18 week RTT project is moving into its second and most critical phase. In September an internal publicity campaign is planned to raise the profile of 18 weeks within the organisation and encourage widespread engagement. The attached report brings the HMB up to date with performance against trajectories, work that is underway across the organisation in respect to data collection, and within Divisions with regard to pathway mapping, as well as the specific objectives of the Diagnostic project. The immediate and medium term priorities of the project are highlighted, all of which require the support of Clinical Directors and other Board members. Discussion about the DNA policy would be welcomed as this needs to be address as a priority, but requires the support and agreement of clinicians.

The Making Best Use of Beds report provides an update of the surgical bed reconfiguration project and the impact this has had on a number of key indices including length of stay and infection control, as well as updating on project progress in other Divisions.

ACTION: For information & discussion

REPORT FROM: Adam Smith, General Manager, Diagnostics
David Emmerson, Assistant Director of IM&T

SPONSORED BY: Kate Slemeck, Director of Operations

Financial Validation Lead: Director of Finance	
Compliance with statute, directions, policy, guidance Lead: All directors	
Compliance with Healthcare Commission Core/Developmental Standards Lead: Director of Nursing & Clinical Development	**Reference:** Yes

Compliance with Auditors' Local Evaluation standards (ALE) Lead: Director of Finance	**Reference:**

Compliance with requirements of FT application and monitoring regime Lead: Director of Strategy & Performance	**Reference:**

1. Getting to 18 weeks

1.1 Trust Performance Against 18 Week Trajectory

1.1.1 Performance Summary

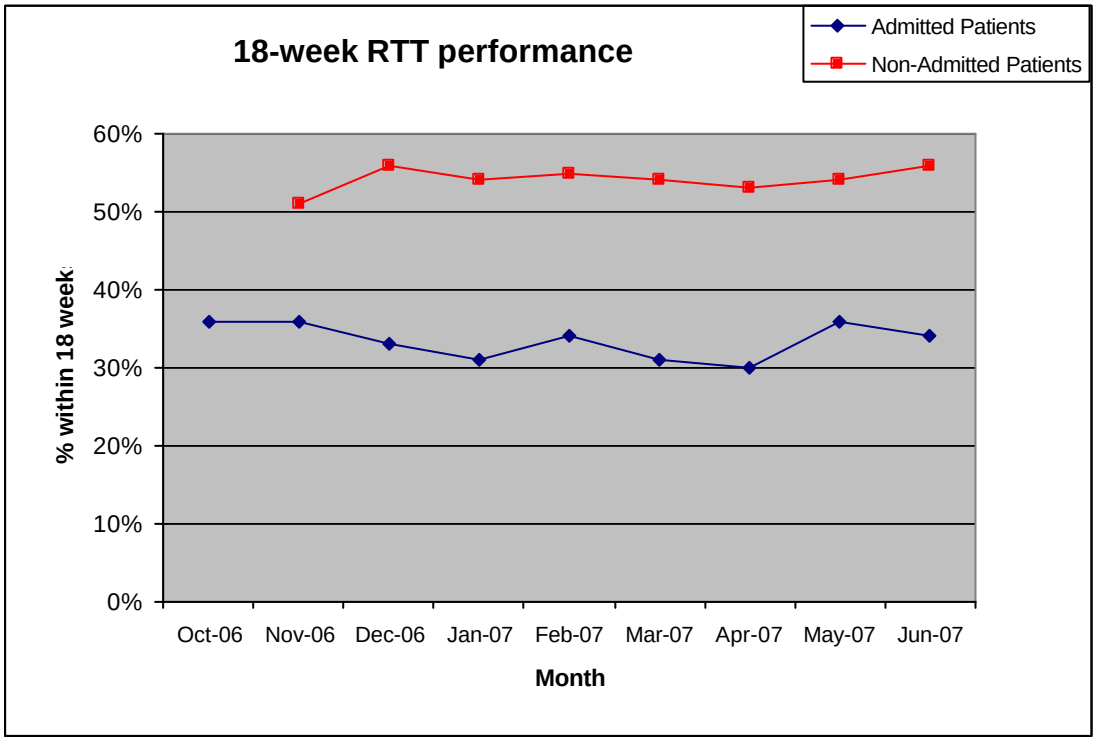
18-week RTT performance is measured using two indicators:

Admitted Patients	The national target for March 2008 is **85%**
Non-Admitted Patients	The national target for March 2008 is **90%**

The data below show the Trust position as reported to the Department of Health each since the start of monitoring.

Performance has been stable at **33% for Admitted Patients** and **55% for Non-Admitted Patients.** This provides a baseline to measure improvements as the actions listed is this report start to have an impact on the 18-week RTT performance.

Month	Admitted Patients	Non-Admitted Patients
Oct-06	36%	
Nov-06	36%	51%
Dec-06	33%	56%
Jan-07	31%	54%
Feb-07	34%	55%
Mar-07	31%	54%
Apr-07	30%	53%
May-07	36%	54%
Jun-07	34%	56%



1.1.2 Trust Performance by Specialty

The tables below provide the RTT performance by Specialty. Note the discussion about data completeness below – this impacts on the Non-Admitted Patients category. The total of 2,330 RTT clock stops recorded in the month account for less than half the number of referrals the trust usually receives. It should also be remembered that purely diagnostic and follow up/planned procedures are excluded from the Admitted patient category so the number reported is significantly lower than reported for SLA purposes for example.

Non-Admitted Patients RTT performance – June 2007

Specialty	Number of RTT recorded	% less than 18w	% over 18w
General Surgery	152	67%	33%
Urology	53	36%	64%
Trauma & Orthopaedics	1024	59%	41%
ENT	113	68%	32%
Ophthalmology	50	46%	54%
Plastic Surgery	10	50%	50%
Pain Management	16	13%	88%
General Medicine	39	36%	64%
Gastroenterology	141	46%	54%
Endocrinology	20	45%	55%
Clinical Haematology	17	65%	35%
Diabetes	17	29%	71%
Cardiology	139	53%	47%
Dermatology	82	72%	28%
Chest Medicine	136	51%	49%
Nephrology	40	35%	65%
Medical Oncology	6	33%	67%
Neurology	69	65%	35%
Rheumatology	78	56%	44%
Paediatrics	1	0%	100%
Care of Older People	18	44%	56%
Maternity	2	50%	50%
Gynaecology	107	47%	53%
Total	**2330**	**56%**	**44%**

Admitted Patients RTT performance – June 2007

Specialty	Number of RTT recorded	% less than 18w	% over 18w
General Surgery	171	37%	63%
Urology	88	19%	81%
Trauma & Orthopaedics	120	28%	72%
ENT	8	25%	75%
Pain Management	50	2%	98%
Gastroenterology	73	44%	56%
Clinical Haematology	23	43%	57%
Cardiology	4	0%	100%

Specialty	Number of RTT recorded	% less than 18w	% over 18w
Chest Medicine	4	75%	25%
Nephrology	1	100%	0%
Medical Oncology	37	68%	32%
Rheumatology	4	25%	75%
Paediatrics	5	20%	80%
Gynaecology	107	44%	56%
Total	**695**	**34%**	**66%**

1.2. Project Structure, Communications and Data Collection

1.2.1 Project Structure

The project structure is now fully functioning based around a steering group headed by the lead Director, Kate Slemeck, that meets monthly and includes PCT representation and a project team, led by Adam Smith, that meets weekly and receives progress reports from General Managers on a weekly rotational basis.

1.2.2 Communications

The major Trust wide communication of the 18-week message has been delayed until September to avoid clashing with the communications roll out of the Foundation Trust consultation. The programme for September includes an article in the Link, Chief Executive briefing, formal launch of the web page and the project team systematically attending Trust wide meetings.

1.2.3 Organisational Development

Process mapping in now underway in all 4 divisions, and when complete will be posted on the intranet with the supporting data which will be open to ongoing validation. The process mapping will then lead directly onto organisational development and re-design linking with the General Managers (GMs) sub plans. However the project team do have concerns about the potential delays involved if any of the projects are such that they require a formal change process including consultation and review.

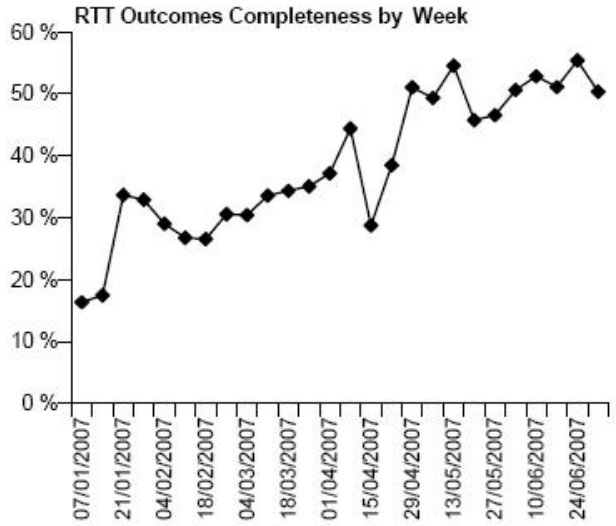
1.2.4 Data Collection/IT Support

A key focus of the project since the last update has been the improvement of data collection and the measurement of the 18-week wait 'clock' as it is referred to. A finalised version of the new outcome forms was agreed in early August and rolled out across all outpatient clinics, including for the first time paediatrics and maternity. The Trust is targeting 100% data completeness by October, against a July average of 40%. GMs are reviewing returns by clinic code on a weekly basis. Clinical engagement is key to accurate compilation of 18-week data via the outcome forms, without this it is impossible to identify correct clock stops.

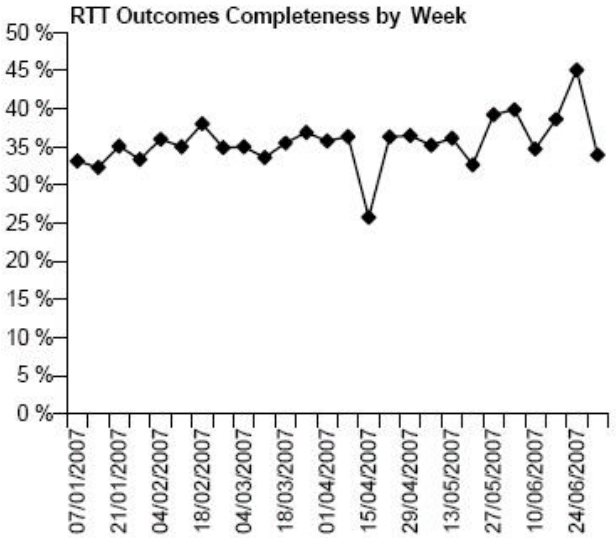
IT support is also being provided for capacity planning and developing validation systems for individual specialities to achieve 18 weeks.

July performance of outcome slip completeness by Division is outlined below. This will be reported by speciality in future reports.

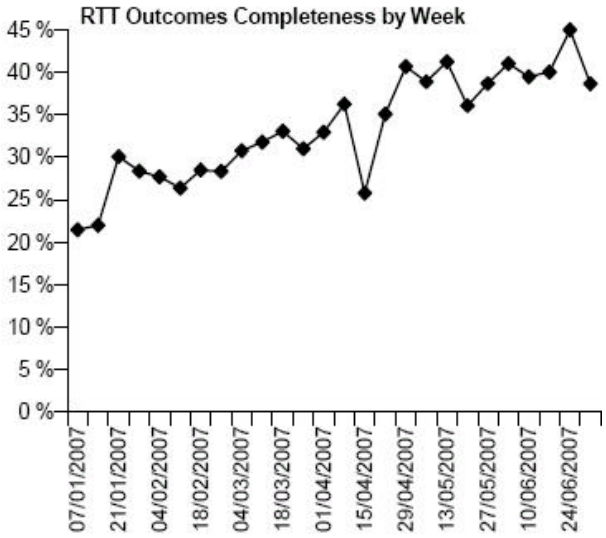
Trust



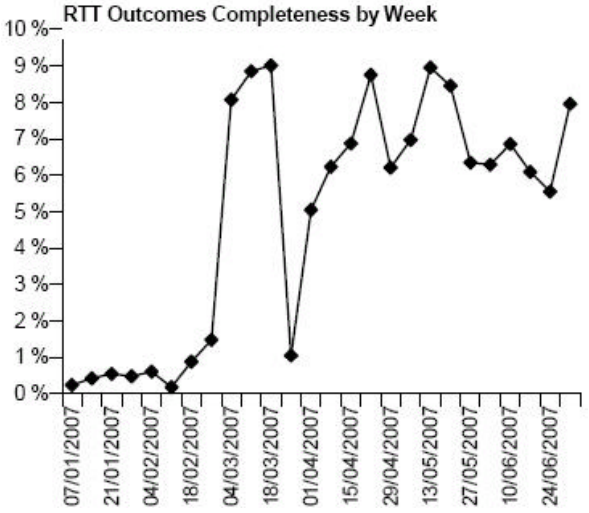
Medicine



Surgery



Women & Children



1.3 Project Progress

Each Division has been tasked with developing plans by speciality on how they will achieve 18 weeks in their particular area. The GMs, working with the clinical leads, are mapping each pathway and with the support of IM&T are also calculating the capacity requirements to reduce outpatient waits, mostly to 4 weeks, for both new and first follow ups. This work is also being used to inform the diagnostics project on the likely capacity requirements based around these 4 weeks wait and a total diagnostic turn around time of 4 weeks.

1.3.1 Diagnostics Improvement Project

Shortening Diagnostic waiting times is key to the delivery of the 18 week promise. Recognising this, the Trust has set up a diagnostics service improvement project, which will focus on the following:

- Reviewing and changing where necessary departmental systems that support the management and diagnosis of patients (Pathology, Imaging and Physiological Measurement)
- Achieving less than six weeks waiting times for diagnostic waits from initial GP referral by March 2008
- Contributing to 18 week target milestones for March 2008 (Admitted patients < 18/52 85%; Non-Admitted 90% and those to be set for December 2008)
- To contribute to achieving the Whittington promise

The project will ensure that each department works towards best practice implementation and cost efficiency, and will identify resource decisions that may have to be made in order to fully implement the service improvements outlined in this paper. The Clinical Director lead for the Project is David Grant, and the management lead Adam Smith.

Pathology

Lord Carter of Cole's national review of pathology services interim findings agrees with the Royal Collage of Pathologists recommendations, which are:

- That whilst there is some room for improved work flow through pathology departments, most opportunity for improvement lies with improving the systems and processes that lie outside the laboratory either in the process for requesting tests or the process of reviewing results and applying changes to patient management
- Significant improvements in the use of resources will only be made when pathology and pathology networks across the health economy start to take responsibility for "end to end" management of diagnostics, that is taking control of what is requested and when and what test will be done and why

It is hoped however that the Whittington will take the opportunity that this project provides to contribute to this debate.

The next stage of development nationally lies with the release of national benchmarked cost per test data from Lord Carter of Cole's 12 pilot sites. This data will give commissioners information necessary to begin to discuss with GPs, trusts and the independent sector, "NHS" commissioning of pathology diagnostic services across the health economy and to demand that prices and value are competitive. It is essential that we engage early with GPs and commissioners and continue to work with other trusts in order to inform our prospects for future commissioning and business planning.

Pathology Work streams have been identified as follows:

- Benefits realisation resulting from the pathology system implementation (including administrative and clerical support staff review)
- Consultant job plan review and strategic recruitment to vacant posts
- IT projects (including voice recognition and Order Comms – electronic test ordering)
- Joint pathology review with the Royal Free including: on-call and staff share; joint tendering; joint training officer; mortuary services review; individual speciality review and response to the National Pathology Review best practice (including the unbundling of tariffs and cost per test benchmarking)

Imaging

The imaging department has established its individual priorities within the overall 18-week target strategy, which are to better understand the needs of our customers and the contribution imaging diagnostics play in the trusts achievement of the 18-week standard.

Additionally the imaging department is working to build upon its improvements in report turnaround time, electronic transfer of results, waiting times and the managed equipment service to improve its position with respect to other trust and independent sector competition.

Update on Imaging Workstreams

The project launched with a department away day on 12th July 2007. The agreed outcomes of that day included the following:

- to challenge current ways of working
- to develop administration and management team and support changes in systems to improve customer care and new ways of working
- to look at models to improve workflow to reduce patient waits using clinically sound best practice
- To appoint a representative steering group and sub groups to agree work programme
- To hold weekly meetings and open staff forums and to monitor progress from August 2007

Planned Work:

- Reviewing and implementing National Imaging 18 week Team best practice including:
  - Changes in working patterns/hours (National Imaging 18-week team best practice)
  - Modality review e.g. radiology leads for barium enemas, head CT, Cardiac Imaging, CT colonoscopy.
- Linked appointments with new and follow-up outpatient appointments, to eliminate OP appointments without diagnostic reports (driven by 18-week project)
- Meeting with PCT/GP commissioners in order to manage expectations of direct access and develop diagnostic business models for sustainable services (through the 18-week steering group)
- IT/PACS projects (including Order Comms – electronic test ordering)

- Information modelling essential to change management, including linking RIS data to outcomes
- Take the opportunity that ASTERAL have offered to provide Six Sigma service redesign expertise to assist the project (at no cost)
- Unbundling of tariffs to identify the true cost of imaging to GPs and other specialities within the trust
- MAU re-location to ED and the operation of an acute core satellite imaging facility
- Install new services for DEXA, CT, Nuclear Medicine
- Introduce 'Choose and Book' services for imaging

Physiological Measurement

Improvements to the physiological measurement pathways are not currently included in the overall diagnostics service improvement plan. Physiological measurement services are managed within the other divisions and improvements to these services are being managed by the respective general manager and will follow the same principles as the imaging service development plan. There will be discussion at a later date as to whether these areas should be managed in a different way in the trust structure. (e.g. Cardio physiology, Respiratory physiology, Neurophysiology and Audiology as part of Diagnostics Division)

1.4 Other Issues for Consideration and Discussion

1.4.1 Finance

A finance resource has now been added to the project team however until the implications of the capacity planning and pathway redesign are more fully understood it is not possible to fully cost the 18 weeks project. Whilst the SLA agreement has additional activity within it to reduce new outpatient appointment waiting times and reduce the waiting lists, it is likely this may not fully cover the requirement, as the waits may have to be shorter in some specialities. The SLA is not funded for reduced follow up waiting times and these are believed to be a more significant problem than new appointments. There is now PCT representation on the project steering group, and these issues, alongside primary care engagement are picked up there.

1.4.2 DNA Policy Review

18 week measurement will require the Trust to review the current DNA policy. The current policy does not cover diagnostic DNAs, and will need to be systematically applied across the organisation.

As part of the project plan, discussions will need to take place with the Consultant body to agree and implement a DNA policy that is robust and clinically appropriate. This will involve discharging patients who DNA back to the care of their GP.

1.4.3 The Department of Health Intensive Support Team

The DoH 18 week intensive support team have been invited in by the Trust to externally validate our work to date, and to validate our plans and data and provide advice. This will assist us in our planning and assure our progress to date.

1.5 Immediate and Medium Term Support Required

The following areas require clinical and managerial support and engagement in order to ensure that progress towards delivering the 18 week target is being made:

Immediate Priorities

Outcome Slip Completion - Medical Staff:

Completion of the OP outcome slip is the only way the trust is able to monitor its compliance with the target. It is essential that all Consultant staff ensure 95% completion of outpatient outcome forms following all patient appointments. Reports on completion rates by outpatient clinic are being developed and will be shared with individual consultants and the Medical Director.

Patient Pathway Mapping

General Managers and their teams in conjunction with clinical colleagues are currently mapping specialty patient pathways and identify the risks in achieving the 18–week standard associated with capacity gaps either in specialty service provision, support services such as diagnostics or staff

Data/Information Support

The IM&T department continue to resource and develop information and data management systems to support improved monitoring of patient pathways

Medium Term Priorities

Market assessment and competitor analysis:

It is essential that we quickly engage with GPs and Commissioners to manage expectations of direct access and to understand future commissioning intentions. It is also important that we continue to work with other trusts to maximise efficiencies and understand their service strategies and to develop diagnostic business models for sustainable services.

Finance

The relationship of income to expenditure in imaging is critical to the continued success of the current service. We need to unbundle the tariffs to clarify the true cost of imaging in order to determine what efficiencies are required and how the service makes a financial contribution to the trust

Human Resources:

As there may be changes to the additionality clause for ISTCs, recruitment and retention of key staff becomes vital to the continued success of the service. Efficient recruitment processes, supportive organisational changes and careful job planning will be required for the departments to continue to be employers of choice

IM&T:

PACs and PAS development, order comms, information modelling, improved communications and implementation of choose and book systems will improve our competition rating with GPs

Facilities:

Project planning for new equipment implementation will be required.

2. Making Best Use of Beds

2.1. Surgical Bed Reconfiguration – Update on Progress and Performance

The new surgical bed base of 91 beds was discussed and approved at the HMB of June 2007. At that board, a framework of key performance indicators (KPIs) were proposed and it was agreed that regular reports would be incorporated into this paper and presented to HMB on a regular basis to demonstrate performance against these.

The data contained in the table below monitors the performance against the KPIs from April – June 2007. Full July data was not available at the time of writing this report.

The reconfiguration of the surgical bed base commenced on the 14/05/07 and was fully implemented by 05/06/07. The key drivers of the change were to deliver sustained financial savings, to improve the quality of patient care and to address concerns over the size of the wards.

2.1.1 Key Points to date

- ✓ The planned financial savings as set out in the business plan have been maintained.
- ✓ A reduced ALOS for joint replacement surgery and breast surgery against previous years performance has been delivered.
- ✓ Pre operative length of stay for elective admissions has been reduced.
- ✓ There have been significant reductions in pressure ulcer indices on Coyle and Victoria Wards
- ✓ Lower levels of patient complaints

During June, a 6-week closure programme was undertaken in the operating theatres, with one theatre closed per week. This resulted in a reduced demand for elective surgical beds. This had a significant impact on both Thorogood Ward bed occupancy (55%0 and Highgate Hill Treatment Centre bed occupancy (57%). Bed Occupancy on Coyle and Victoria Wards was maintained 87% and 86% respectively. This will be closely monitored over the next period now elective activity is running to plan.

2.1.2 Further Action

New arrangements have been implemented with the Bed Management Team to monitor the numbers of medical outliers on to the Surgical Unit and also to identify the surgical patients who cannot be admitted to the Surgical Unit.

Nurse led discharge was to be introduced on the surgical unit as a follow on from the site practitioners discharging out of hours but as yet this process has not been formalised. Therefore the surgical Matron with the Sister for HHTC and Thorogood are

developing a nurse led discharge guideline for specific use within their area. This guideline will be piloted in the autumn, initially on HHTC with the aim of rolling out to all other surgical areas early in the New Year.

Monitoring Framework for Surgical Bed Project

Target Objective	Performance Indicator	Current 06/07	Nat. Avg	April	May	June
Achieve a reduction in the surgical length of stay	Elective	3.25		3.56	2.83	3.35
	Emergency	6.01		4.54	4.92	5.05
	Total	9.26		4.3	4.3	4.4
Reduce Elective ALOS of four key HRG's (data based on discharges)	Hip Surgery (primary)	8.7	7.7	6.88	7.7	4.8
	Knee Surgery (primary)	9.5	8.1	6.45	4.9	6
	Lower GI Surgery	15		43.6	7.1	5.5
	Upper GI surgery	6		1.33	3.1	31.6
	Breast Surgery (all mastectomies)	3.3		1.75	0.6	1.8
Non Elective ALOS	Hip replacement			14	17	9.0
	Lower GI Surgery			4	16.2	40.1
	Upper GI Surgery			42	30.7	14.2
Pre-operative LOS	Elective	0.38		0.48	0.32	0.21
	Emergency	1.59		0.93	1.6	1.4
	# NOF	1.86		1.29	1.4	1
	Total					
% Readmission Rates (of elective patients within 28 days of discharge)	ENT	N/a	-	1	0	0
	Gen Surg	4%	-	5	3	4
	Gynae	2%	-	3	1	3
	Trauma & Ortho	1%	-	1	2	2
	Urology	3%	-	7	3	3
Day case/ inpatient percentages	Day Case	68		71	69	76
	Elective in patient	32		29	31	24
Bed Utilisation	Victoria		-	-	-	86%
	Coyle		-	-	-	87%
	Betty Mansell		-	-	-	68%
	HHTC		-	-	-	57%
	Thorogood		-	-	-	55%
Deliver a reduction in levels of hospital acquired infection	Incidences of C Diff	59	-	0	4	4
	Incidences of MRSA	8	-	0	0	0
Deliver Robust bed management	Surgical Outliers (days)		-			
	Non-surgical patients(days)		-			

Target Objective	Performance Indicator	Current 06/07	Nat. Avg	April	May	June
Monitor Closure of HHTC at weekends	**HHTC closures - No. of hours**		-	N/A	124	198
Monitor Number of preventable complications	**Number of visits from Outreach Team**		-	16	24	33
	Pressure Ulcer Indices	4.65		0.7	1.6	N/A
Improve the efficiency of the Surgical bed compliment	**No. of nurse led discharges**	0		0	0	0
Improve the experience of surgical patients	**No. of complaints received**	37 (06/07)		5	0	1
Ensure the delivery of Financial savings plan	**Additional financial efficiencies in year**			3557	-16692	2788
	Cost versus income analysis					
Improve the staff experience	**Undertake regular internal Trust surveys**					
	Review staffing models					
	Access to personal development and extended roles					

2.2 **Medical beds**

Many of the work streams that form the MBUOB programme have now become every day practice in the Division of Medicine and continue to deliver efficiencies.

The Division has had 30 beds on JKU closed in August to enable deep cleaning of each of the JKU wards on a rolling programme.

Once deep cleaning is complete Cloudsley ward will open to a reduced bed base as each of the bays is reduced from six to four beds creating an overall reduction in beds of four beds.

MAU will move to the 15 bedded 'Mary Seacole' Acute Admissions Unit in the PFI on 24 September. This will reduce medical bed base by a further 11 beds. With the opening of Mary Seacole there will be an implementation of a new clinical management pathway for acute medical admissions and it is anticipated that this different model of non-elective medical admission will see further length of stay reductions for this type of patient.

To ensure its efficient operation it is recognised by the General Physicians that work must continue on reducing medical in-patient length of stay and the Divisions aim is to now reduce bed occupancy to 85%. In order to achieve this, work streams will now concentrate on the implementation of nurse lead discharge. Pilot work undertaken by the clinical site practitioners has seen some early success however a project team is being brought together to formally start this programme of work from September.

Bringing together the delayed discharge team and the clinical site practitioners to improve early discharge planning will be the main focus of this work.

2.3 Division of Women and Children's

The Division is working to maintain the gains, which were made in 2006/07. In 2007/08 work will focus on the following areas:

- Increasing the conversion of cases from in-patient to day case
- Improving data capture – this may be masking true performance
- Considering undertaking more ambulatory/ 23 hour care
- Review into extending roles within Maternity with a view to reducing length of stay
- Development of Birth Centre to facilitate a reduction in length of stay

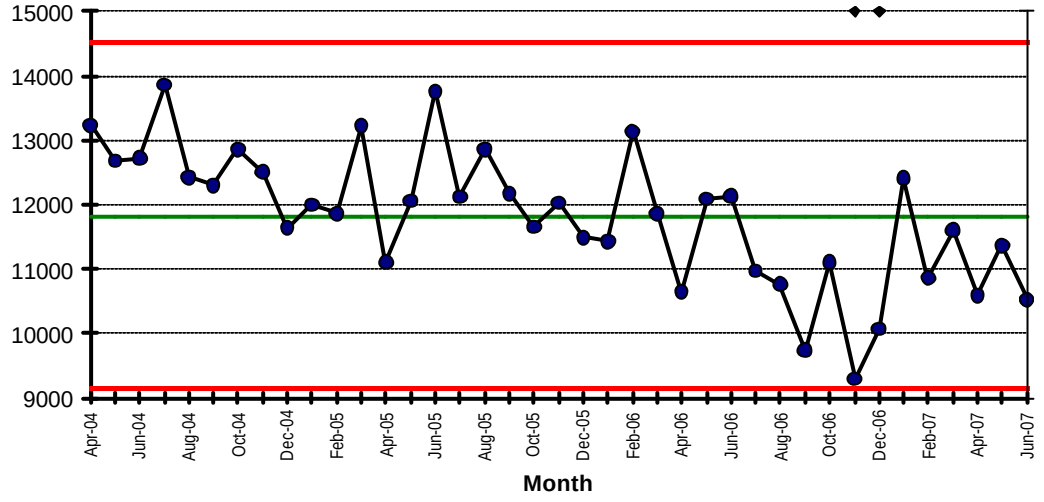
2.4 Analysis of Length of Stay and Bed Day Use

The Making Best Use of Beds programme continues to monitor overall bed day use and average length of stay.

The improvements to emergency Medicine length of stay continue to be maintained. The average length of stay for medicine is now 9.5 days compared to 11.5 day two years ago.

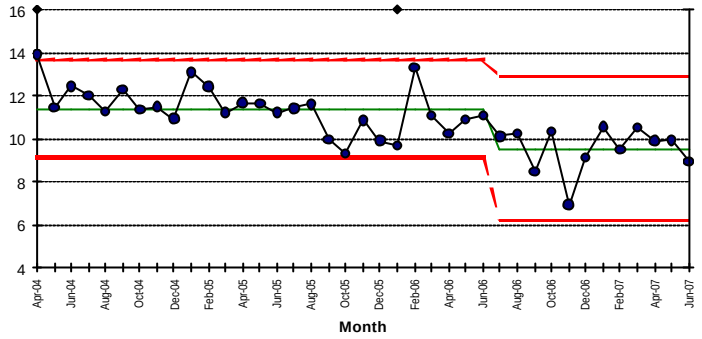
The SPC charts below demonstrate this significant improvement and provide additional information on surgical specialties to show the impact of the Surgical Bed project.

Total Occupied bed days

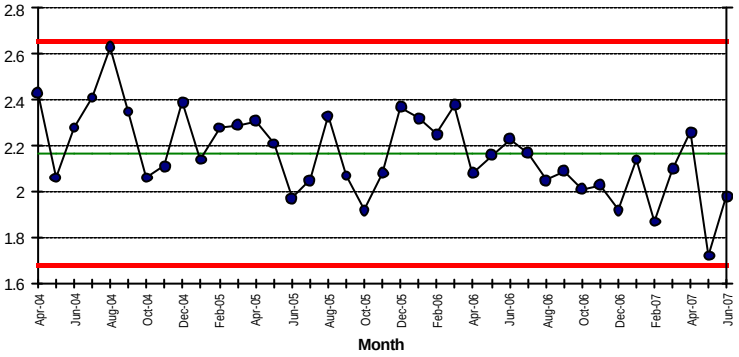


The downward trend in bed day use continues after the seasonal increase over the winter period.

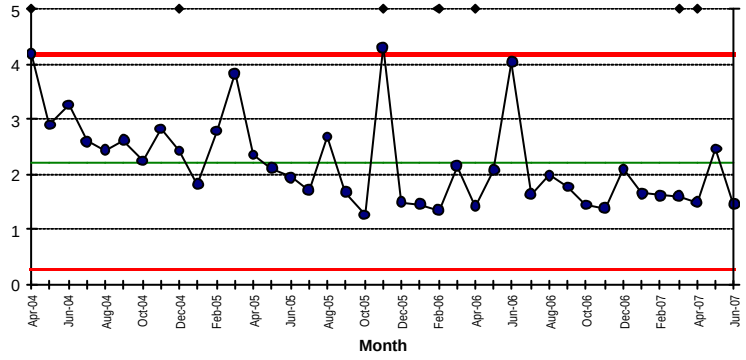
Medical Non Elective AvLOS (days)



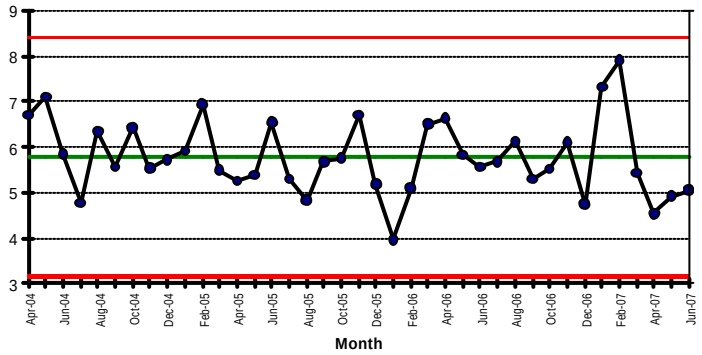
Maternity AvLOS

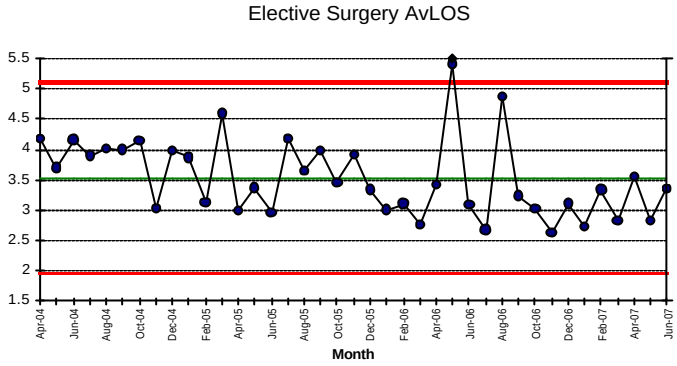


Paediatric Non-Elective AvLOS



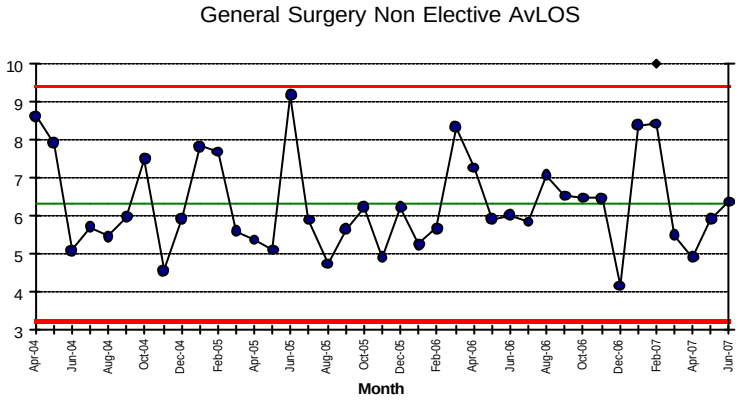
Surgery Non Elective AvLOS

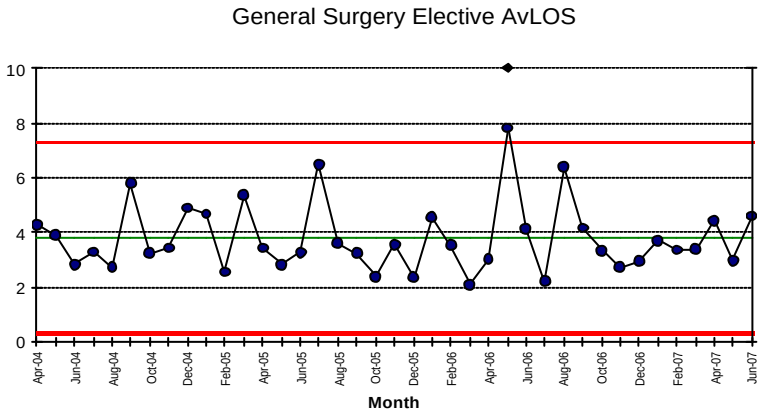




The elective surgery average length of stay is lower than last year – the April 2007 data point breaks the significant trend, however it can be seen that there is more consistency now. It is too soon to see an impact on non-elective surgery. For information the average length of stay by admission type for the four main surgical specialties is presented below.

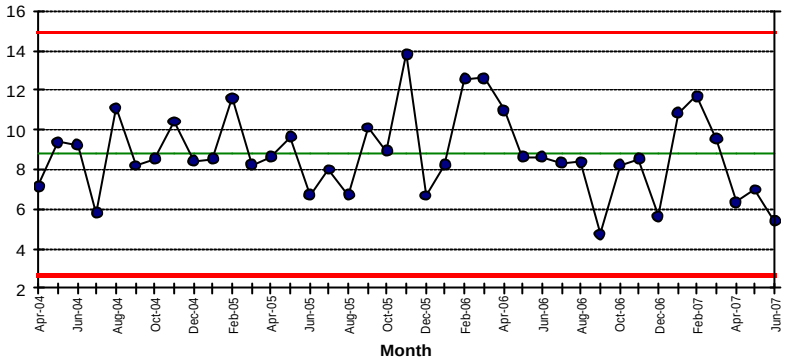
General Surgery



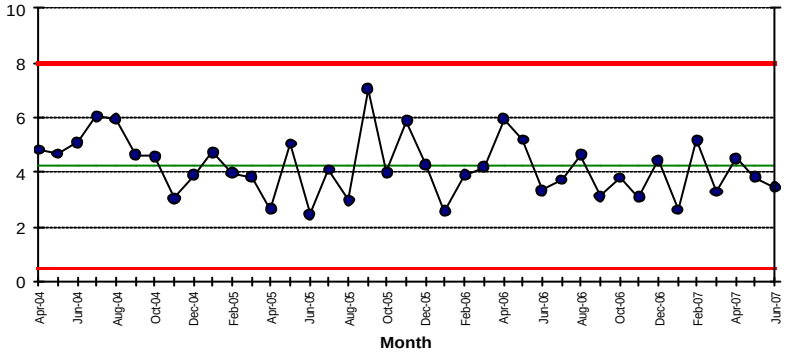


Trauma & Orthopaedics

Orthopaedic Non Elective ALOS AvLOS

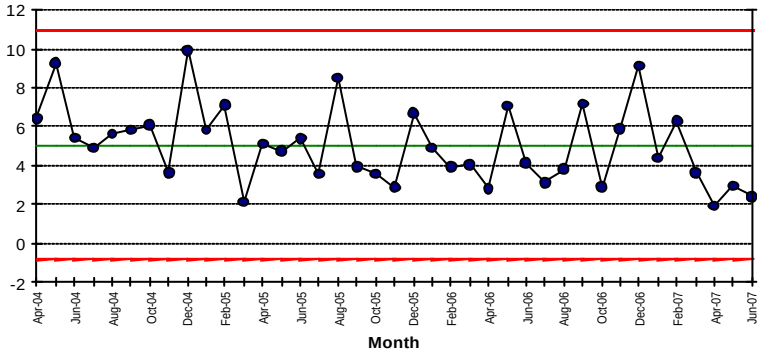


Orthopaedic Elective ALOS AvLOS

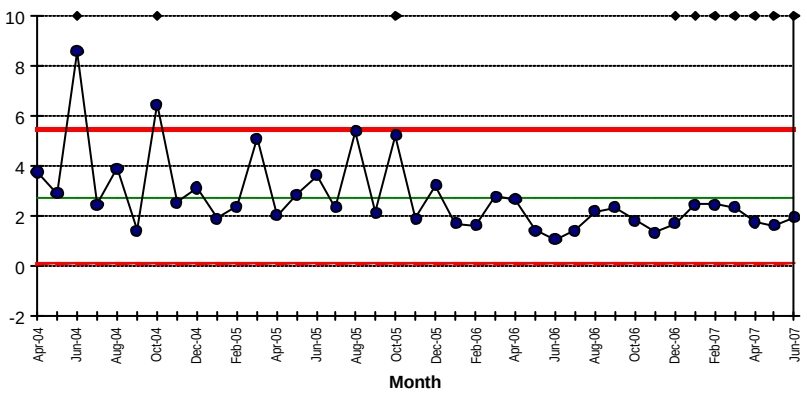


Urology

Urology Non Elective AvLOS



Urology Elective IP AvLOS



Gynaecology