Whittington Health NHS

PERFORMANCE & QIPP DASHBOARD
December 2011

Surgery & Diagnostics Feedback

Indicator: 18 Weeks – Admitted Clock Stops

Specialty	< 18wks	> 18 wks	% within 18 wks	95th percentile (wk)
Ophthalmology	4	0	100%	1.0
Urology	84	5	94%	22.6
Dermatology	65	5	93%	18.8
General Surgery	102	8	93%	19.8
Orthopaedics	93	23	80%	35.1
ENT	9	3	75%	24.4

Target = 95th percentile wait to be less than 23 weeks

Commentary & Action plan

Additional lists have been provided to catch up with backlog of patients with aparticular focus on spinal patients in month. This resulted in a higher number of over 18 weeks being treated in month which resulted in a lower RTT performance.

Admitted performance has been >92% for January and on target for the planned trajectory for February and March respectively which will support achievment against the NHS London additional incentive money for over performance against 18 weeks

Indicator: Follow-Up Ratio (Median & Upper Quartile)

Target: to achieve median benchmark by March 2012 and upper quartile by March 2013

Exclusions: Oncology

	Follow-Up Ratio			
Specialty	**Median**	**Upper Quartile**	**Dec 11**	**Q3**
Dermatology	1.89	1.41	2.09	1.89
Ent	1.23	1.08	1.26	1.13
General Surgery	1.63	1.12	1.41	1.61
Medical Oncology	7.09	3.98	10.93	9.61
Ophthalmology	2.61	1.96	2.91	2.87
Plastic Surgery	1.36	1.05	0.33	0.42
Trauma & Orthopaedics	1.68	1.55	2.08	2.01
Urology	2.09	1.74	1.99	1.75

Commentary & Action plan

Ophthalmology and Trauma and Orthopaedics are particular target areas for surgical division. General surgery achieving target year to date although slipped currently in Q3.

Ophthalmology and orthopaedic coding being reviewed in conjunction with Performance and Planning as both include support staff run clinics (orthotics, optometrist).

In addition to reviewing the information and coding a clinical notes review is being undertaken by consultants in each of the service with aim of discharging patients with non-essential follow-up ratios.

Update on Progress

Ophthalmology

Clinic lists and patient level detail being reviewed for the next 6 weeks to identify patients suitable for discharge and agree protocol for frequency of follow up visits. As part of this it will include reviewing orthoptist and visual fields clinic codes, which are recorded as a f/up session. As part of this process the potential loss of income associated with the clinic switch is also being reviewed to ensure that it is not higher than the potential penalty.

Trauma and Orthopaedics

Clinic lists for orthotics to be reallocated to appropriate specialty which is increasing orthopaedic f/up rates significantly and artificially- currently all flagged to orthopaedic clinic and Mr Sweetnam f/up ratios. As above the potential loss of income associated with the clinic switch is also being reviewed to ensure that it is not higher than the potential penalty.

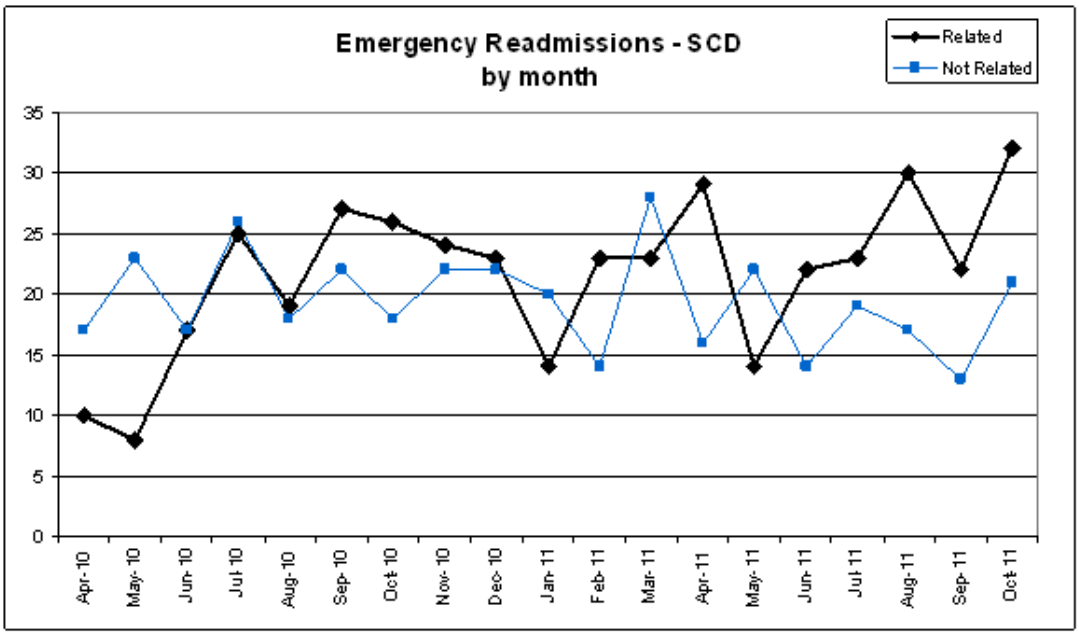
Dermatology

Clinic review is currently underway to benchmark the f/up rates associated with nurse led clinics and the specialist sessions (PDT, PUVA) against other dermatology units and the template and protocol will be adjusted accordingly.

Indicator: Emergency Readmissions

Target: 0 readmissions following elective discharge

Target: to achieve a 25% reduction on 2010/11 levels for readmissions following an emergency admission



General Surgery

Within General Surgery the department is currently submitting to the Executive Committee (20th December) proposals for expanding consultant general surgeon cover in line with emergency care standards in order to provide 12/7 consultant presence for Whittington Health. The Trust already has daily consultant input for the specialty but this will increase the coverage throughout the working week. This will enable 12/7 coverage to be provided when the 2 further posts are filled and will completely separate out elective and on-call commitment ensuring there is increased consultant presence throughout the week to manage emergency cases (highest readmitting group) and also to ensure that consultant that are on-call do not have clashes with elective commitments.

In terms of supporting readmissions this will ensure that there is increased consultant presence throughout the week and increased proportion of consultant led procedures (as opposed to consultant supervised) will be increased. It will also enable more rapid access to theatre for complex cases admitted non-electively that require consultant input. The increased presence will also enable a more complete ward round of patients to be taken throughout the week and enable emergency admissions to be reviewed by a consultant throughout the working day over a 12 hour period. It is envisaged that this increased level of consultant input will facilitate improved decision making, support discharge and help to potentially reduce complications.

Enhanced Recovery

The roll out of enhance recovery for elective procedure is being used to support improved efficiency (length of stay), patient experience and the quality of the pre-assessment, procedure and discharge process. This has already been introduced over the last year across elective knee surgery and some hip surgery and is well established for colorectal patients. The advantage of the pathway is that is standardises care and reduces variation in terms of both potential length of stay and outcome/readmission risks. As part of this years divisional QIPP programme the full roll out of enhanced recovery for all hip surgery and gynaecology surgery is currently being implemented, with the aim of all elective patients going through an ER pathway by the end of quarter 4.

Orthopaedics

In addition to the enhanced recovery work described above the other area of potential readmission relates to emergency trauma patients who arrive with fractured neck of femur. Readmissions can be due to a range of potential issues including post surgical complications through to inadequate discharge planning and support

The main divisional QIPP programmes this year covers the fractured neck of femur pathway. The aim of this particular programme of work is to improve the outcome, experience and quality of patients presenting with fractured neck of femur at Whittington Health and this should help to also support readmission work. The project is being led by Mary Jamal, Deputy Director of Operations and aims to deliver the following objectives.

- The pathway is co-ordinated and designed to reduce actual length of stay and to limit variation, reduce mortality and re-admissions
- Appropriate, medically fit patients receive surgery within 24 hours
- Patients are mobilised within 12-18 hours post op and receive therapy input over weekends Patients are discharged back to their usual address using a criteria based discharge process Health and social care multi agency teams are co-ordinated and integrated across the patient pathway
- LOS is reduced from average of 21days (current) to 6 days (national best practice)

Urology

Urology readmission rates are the lowest of the surgical specialties. However, when reviewing the admission pathway through ED as part of the recent NHS Intensive Support Team Emergency Department programme it became clear that some of the urology admissions (and potentially readmissions) could be avoided by implementing a more ambulatory based model of delivery.

Mr Maneesh Ghei and Mr Barry Maraj, Consultant Urologists, are now leading on a piece of work of the back of this with Dr Carmichael, Consultant Emergency Department, to establish an ambulatory model for patients admitted for potential urological condition. This will enable a proportion of current admitted patients to be seen in fast track urology clinic slots preventing the need for any admission via the Emergency Department and ensuring the provision of a fast track clinic to ensure that there is a safe clinical model in place. The protocols should be completed by the

end of January with the aim of going live with the model in March 2012. The model should lead to a reduction in emergency admissions for urology input and in turn will potentially reduce readmissions for the patients that are frequent re-attenders with urological problems.

Update on Progress

Update as above- in addition patient information leaflets for common procedures, including follow up procedures and support will be completed by the clinical nurse specialist forum and disctributed at the end of the month onwards.

Within ICAM additional suport is also being put in place to support the management of the emergency pathway and support the readmission pathway, which will include the relatively high group of patients with urological problems reattending.

- Ambulatory care clinic commences Feb 22nd
- Additional ED Consultant sessions provides more access to senior clinical input
- Community nursing to be part of 12 ED board round

Indicator: % Complaints responded to on time	
Target: 85% November 2011: 10 out of 13 complaints responded to on time	
Commentary & Action plan Overdue complaints within the division were all due to delayed clinical statements for clinically complex cases during the month - multiple clinicians, inquests and claims. All complaints involving consultants are escalated immediately to both clinical director and divisional director and a single nominated clinician is identified for multiple department complaints. Delayed responses are escalated on a daily basis tracked against the expected response date by the Director of Operations.	
Update on Progress Performance has improved significantly in month compared to previous performance report and complaints continue to be escalated to the Director of Operations and Divisional Director on a daily basis to both allocate and chase responses. Complaint management remains a standing agenda item at the weekly DMT meeting.	

Indicator: Consultant 7 day ward rounds

Commentary & Action plan

Business case taken to EC in December 2011. Approval gained for two additional general surgeons to support the split of emergency and elective work in general surgery. This recruitment will enable the general surgery consultant on-call to be free of elective commitments and undertake twice daily ward rounds.

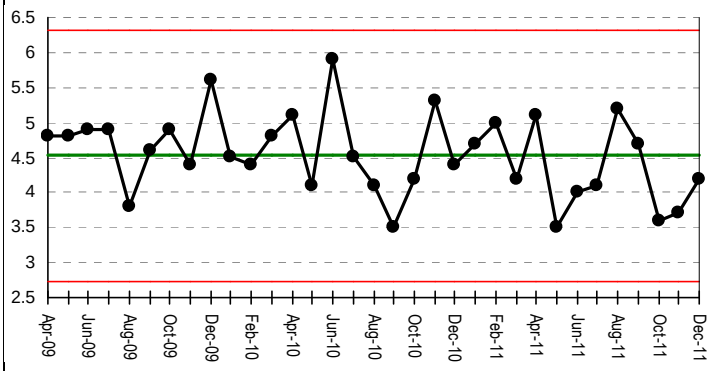
Indicator: Consultants on call with no elective commitment

Commentary & Action plan

Plan is detailed above- Job descriptions have been completed and fully approved by the Royal College of Surgeons and going out to advert.

Indicator: Average Length of Stay reduction

Target: 1 day by March 2013



Commentary & Action plan

Length of stay has reduced as shown above.

A number of initiatives are underway to support the achievement of the reduction in length of stay by 1 day by March 2013. The recruitment of two additional general surgery consultants will play an integral part in ensuring consultant-led emergency service provision within the surgical directorate. Ensuring that there is always a general surgery consultant who is free of elective commitments will result in a senior decision maker being more involved in care of all general surgery inpatients.

The roll out of enhanced recovery for all surgical patients is underway. A reduction in length of stay has already been demonstrated in colorectal and joint replacement

patients using the principles of enhanced recovery and this has delivered significant length of stay reductions- now being rolled out for remainder of elective surgery.

There is also a project specifically focused on fractured neck of femur patients. This project involves all relevant stakeholders across the Trust with a key KPI of reducing the length of stay of this cohort of patients to upper quartile. The aim of this particular programme of work is to improve the outcome, experience and quality of patients presenting with fractured neck of femur at Whittington Health. The project is being led by Mary Jamal, Deputy Director of Operations and aims to deliver the following objectives.

- The pathway is co-ordinated and designed to reduce actual length of stay and to limit variation, reduce mortality and re-admissions
- Appropriate, medically fit patients receive surgery within 24 hours
- Patients requiring returns to theatre/washouts do not get delayed or cancelled
- Patients are mobilised within 12-18 hours post op and receive therapy input over weekends
- Patients are discharged back to their usual address using a criteria based discharge process Health and social care multi agency teams are co-ordinated and integrated across the patient pathway
- LOS is reduced from average of 21days (current) to 6 days (national best practice)

Update on Progress:

As above plus links to Estimated Date of Discharge action plan that has been developed by the Divisional Head of Nursing. This incorporate a number of key elements.

- Setting EDD at point of admission and one that is clinically owned and recorded on Bed Web
- Reviewing TTA process with Pharmacy team and ward managers
- Nurse-led protocol based discharge for weekends.
- Implementing revised transport requisition process to support effective discharge planning
- Ensure patients are informed of pre-11 discharge process at pre-assessment stage for elective patients
- Patient admission information booklets to include information for families and relatives on pre-11 process

Indicator: Discharges before 11am	

Target: 50% by April 2012

December 2011 Surgical Wards: 19.6% before 11am

Commentary & Action plan

Weekly monitoring of target.

Ward mangers and Matrons have provided a list of issues that inhibit the discharge of patients by 11am and include:

- Delay in TTA prescribing by FY1. Generally due to workload.
- Delays from pharmacy supplying TTA
- Patients who require results from investigations before being discharged
- Patients admitted to the ward post op from recovery who make a quicker than expected recovery and are discharged late in the evening. This is also applicable for the elective joint patients
- Patients requiring trial without catheter –i.e. cannot be discharged until they have passed urine post removal of catheter. Patients need to void satisfactorily on a number of occasions and have a bladder scan. These are usually post op patients.
- Patients with high care needs at home requiring discharge after care package is activated. In many cases this can be after 4pm.
- Residential of nursing home request.

Kara Blackwell has devised a weekly “discharge breach” that WMs are completing weekly to help identify target areas and reasons for breaches.

Update on Progress:

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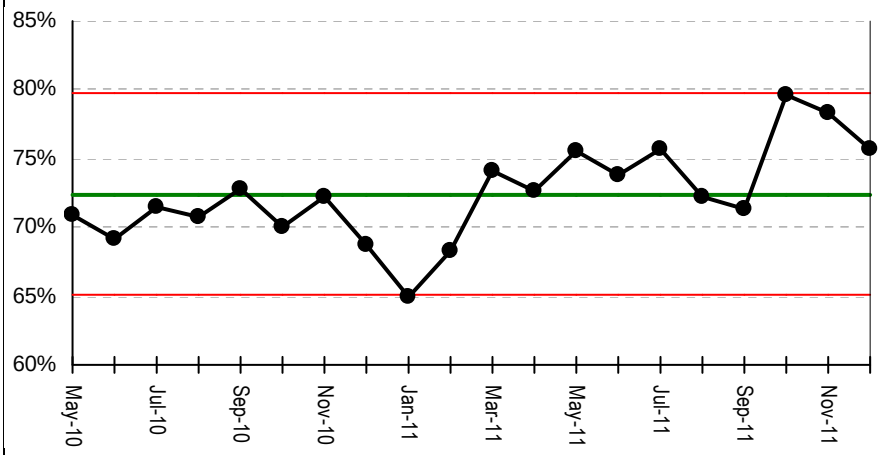
Indicator: Theatre Utilisation

Target: TBC



Commentary & Action plan

The target for the first phase of the theatre utilisation project is 85% - this includes elective and emergency theatre utilisation. Importantly this is against funded sessional time.

The revised theatre timetable has been established by the project group and is implemented from January 2012 onwards to support the utilisation programme and the target reduction of 1 IP theatre.

Update on Progress

One inpatient theatre has now been closed since January 2012- supporting obstetric work- with no impact or current reduction in total operating workload carried out per work. The same volume of activity is running through one less inpatient theatre, which is supporting the efficiency programme and links to the CIP scheme on theatre utilisation for 2012/13.

A significant amount of work has been undertaken by the transformation team supporting the theatre programme to validate ORMIS theatre data and ensure accurate data capture of correct theatre utilisation times and down times.

Indicator: Outpatient Slot Utilisation

Target: TBC

December 2011:

	Unused Slots	Utilisation
Dermatology	466	66%
General Surgery	164	87%
ENT	38	92%
Trauma & Orthopaedics	476	81%
Ophthalmology	227	84%
Urology	85	90%
Plastic Surgery	10	33%
Oncology	105	63%

Commentary & Action plan

Review of all clinic template across surgery underway to ensure that slot utilisation is being measured correctly. Review of data also being undertaken to ensure that utilisation statistics are accurate.

Clinic team leaders leading work to ensure that slots that are available as a result of patient cancellations are re-used to avoid a slot being wasted.

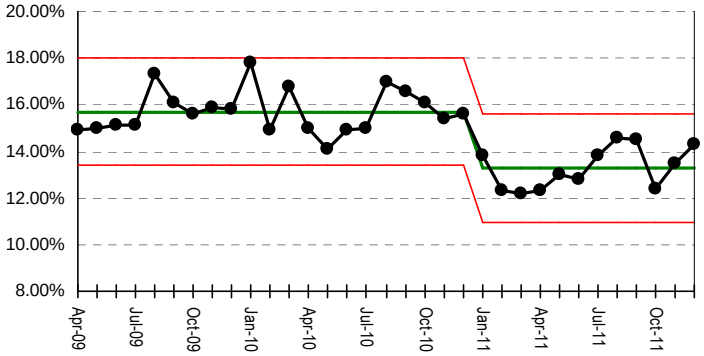
Update on Progress

Clinic data has been reviewed in detail with IM&T team and the reported utilisation data needs refining as it is not incorporating clinic overbooking's and therefore utilisation figures are inaccurate for all specialties in the divisions. On the sample reviewed the average utilisation rate was over 100% i.e. most clinics had over-bookings against the standard template number.

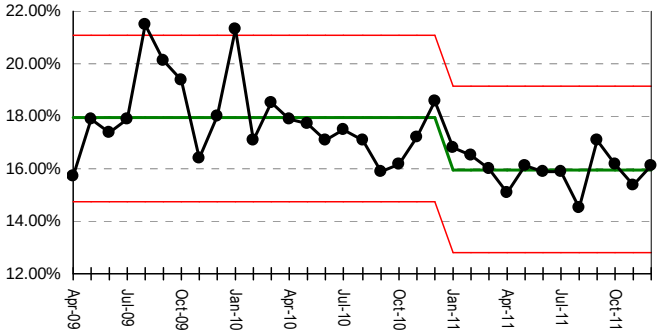
Indicator: DNA Rates - Acute

Target: <8%

First Appointments:



Follow-Up Appointments:



	Total Appointments		
Month	Atts	DNAs	DNA %
Dermatology	703	119	14.5%
Ear, Nose & Throat	388	62	13.8%
General Surgery	1016	158	13.5%
Oncology (Medical)	150	17	10.2%
Ophthalmology	789	237	23.1%
Plastic Surgery	4	1	20.0%
Trauma & Orthopaedic	1781	279	13.5%
Urology	596	140	19.0%

Commentary & Action plan

Roll out of partial bookings is underway within surgery. Ophthalmology, which has the highest DNA rate, is now using the partial booking system for patients who have a follow-up of more than 3 months away.

Improvement in the call handling of our hospital booking system also means that patients calling to cancel or change appointments are answered or now able to leave a message.

Work with the company who run Remind+ has also started to maximise the use and effectiveness of the system and review its current implementation.

Update on Progress

The surgical team are now piloting some additional work in ENT, Ophthalmology and Urology- all previous DNA patients that needed rebooking (clinically requested and not suitable for discharge at appt no 1) are being telephone a week in advance to provide to a direct phone reminder of their forthcoming appointments and also informing them of the policy should they DNA for a second time. This is in addition to the Remind + text message system.

The outpatient lead for surgery has set up a weekly meeting with clinic staff to action to review DNA patients and monitor compliancy with applying the DNA policy.

Partial booking is in place in ophthalmology and now being rolled out across ENT and Urology from February onwards.

Indicator: Waiting times in outpatient clinics

Target: 90% of patients seen within 15 mins (TBC)

December 2011:

Specialty	Atts	% with valid times entered	% seen within 15 mins (apts with valid times)
Plastic Surgery	4	25.0 %	100.0 %
Dermatology	718	46.9 %	81.0 %
Trauma & Orthopaedic	1,762	99.9 %	70.6 %
Ophthalmology	789	99.2 %	52.7 %
Urology	595	96.1 %	40.9 %
General Surgery	929	92.5 %	27.9 %
Ear, Nose & Throat	387	98.7 %	20.4 %

Commentary & Action plan

Outpatient teams are now working towards ensuring that 100% of patients have valid times seen entered. This will include agreeing methodologies for entering and capturing data across divisions- for example outpatient support is run by the IC&M division for dermatology.

Review of data has identified the specific clinics to be targeted with long waiting times and service manager has produced specific action plans for these clinics. Review of clinic templates also underway for all specialities in conjunction with clinical lead to ensure that current capacity is being maximised and that template times aim to reduce waiting.

Capacity problems are being flagged and capacity shortfall being reviewed by speciality. Business case approved for additional breast capacity which has a current shortfall of capacity. Breast clinics will be spread throughout the week and additional slots introduced following recruitment of new breast surgeon and extra sessions through agreement with Royal Free Hospital.

Delays in clinic are being escalated by the OP lead manager for surgery to the General Manager and Director of Operations in real time to ensure early resolution.

Update on Progress

Overall data capture rates have improved since previous report and waiting times are now being captured for 91% of surgical outpatient appointments during the month.

Total performance against 30 minute wait is now currently 78% and 53% against the 15 minutes standard. Urology, ENT and General surgery are the three worst specialties for waiting times by performance.

The ENT service is provided via an SLA arrangement and the provider has changed to UCLH recently- the SLA is being reviewed and this will aim to include non-payment performance penalties for late consultant clinic/starts for services provided by UCLH.

In General Surgery capacity shortfalls are being address following the approved breast, bariatric and colorectal business cases that were approved and out to advert/ due to start in post. The use of pagers is in place across clinic 4a.

Urology templates are being reviewed for the oncology clinics, which are main delayed clinic sessions. Non-cancer patients are being identified and redistributed to other clinic sessions. Urology CNS post has also now started and will provide additional clinical capacity for urology OP sessions.

Indicator: Consultant to consultant activity

Target: Upper quartile by March 2013

Specialty	Upper Quartile	Dec-11	Q3
Dermatology	4%	9%	7%
Ent	12%	15%	11%
General Surgery	14%	14%	15%
Medical Oncology	60%	71%	65%
Ophthalmology	16%	16%	17%
Plastic Surgery	27%	67%	65%
Trauma & Orthopaedics	42%	15%	16%
Urology	20%	18%	21%

Exclusions: Plastic Surgery

Commentary & Action plan

Surgical division have worked with IT department to mandate entry of referrer on PAS system to enable targeting of source of consultant to consultant referrals. Review of PAS data entry undergoing to ensure that high rates are not due to incorrect entering of data.

Ophthalmology and urology are target areas; consultants have been reminded to reject inappropriate referrals and raise to service manager to ensure that these are prevented.

Reduction in consultant to consultant referrals across surgery has reached median and majority of specialities have also reached upper quartile.

Update on Progress

Mandated from January 2012 the source of referrer, which is the prime driver for c to c referrals. This data is being reviewed in order to target source of referrals and identify appropriateness of the referral by specialty.

Specialties are on trajectory to achieve this March 2013 upper quartile target.