The Whittington Hospital NHS
NHS Trust

ITEM: 8

MEETING: **Trust Board**
DATE: **19 July 2006**

TITLE: **Service Development Projects – Review of 2005/06**

SUMMARY:
This report describes the Service Development achievements in 2005/06 and sets out the high level objectives for 2006/07.
All projects have made significant progress and in some areas, quite exceptional progress. Most projects span a number of years and are designed around achieving targets in 2008 (effectively the end of the current planning cycle in the NHS).
The **Day Case & Theatres** and **Making Best Use of Beds** projects have made the most progress with a majority of targets achieved. The **Changing Outpatients, Rapid Diagnostics** and **Modernising Secretarial Systems** projects have also achieved change but have taken longer to get going – partly because these projects are geared to the 18-week target in December 2008, and partly because of the staged project initiation approach taken through the year. These projects have also undergone significant revision through the year as requirements and new information changed the objectives and boundaries of the projects.
The momentum and progress made in 2006/07 needs to be sustained through 2007 and 2008. A Service Development event was held in May 2006 to help think through the objectives for the year ahead and two major change programmes have been initiated:

- **"Getting to 18 weeks"** - the planned patient journey integrating the component parts of the journey with radical redesign of pathways to hit the NHS Improvement Plan targets of 18 weeks from referral to treatment by December 2008.
- **"Making Best Use of Beds"** – the unplanned patient journey. Over 90% of the occupied bed days are used by this type of patient. The objectives of this programme are around the most effective (more appropriate care in the right setting) and efficient care (reduced number of bed days). This programme will cover a number of primary care developments – people with long-term conditions for example, as well as children and maternity care.

ACTION: **For Information**

REPORT FROM: **David Emmerson, Head of Service Development**

SPONSORED BY: **Kate Slemeck, acting Director of Operations**

Financial details supplied/checked by: **not applicable**
(Name of finance officer)

Recommendations contained within this paper have been checked for compliance with relevant statute and regulations/directions/policy as follows:

(Relevant law/direction etc.)
(Name)

None applicable

A: Review of the 2006/07 Service Development Projects

1. Summary

Project	Deliverables	Achievements at 31st March 2006
Day Surgery & Theatres	▪ Increase Surgical Day Case rate from 60% to 70% ▪ Convert 340 Elective IP to Day Cases (part year effect) ▪ Increase direct access service to day surgery ▪ Increase emergency day surgery ▪ Increase theatre utilisation – closure of a theatre	✓ Surgical Day Case Rate: 80% in Mar 06. ✓ 70% average over the April 2005-March 2006 period ✓ >450 IP converted to DC against plan of 340 ✓ 700 bed days saved against plan of 510 ✓ Direct access – extended to Orthopaedics ✓ One theatre closed – activity plans maintained × Emergency day surgery – more to do here
Changing Outpatients	▪ Achieve 13 maximum wait by December 2005 ▪ Environmental improvements ▪ Adapt booking systems ▪ Create capacity by reducing DNA rates (follow ups)	✓ Max 13-week wait achieved in December 2005 ✓ A number of environmental changes implemented and others currently underway ✓ Analysis of current booking systems completed × Improvements in follow up DNA – not yet achieved o Have had to modify plans to completely centralise processes because health records space will not be available; working through alternative plans and staff changes × Staff changes now planned for July 2006
Diagnostics	▪ Achieve max 26 week wait for MRI/CT scans by 03/2006 ▪ Adapt data collection systems ▪ Capacity & Demand/whole system model ▪ Change booking systems ▪ Develop plans for improving access to diagnostics as part of whole patient journey (reduction to 18 weeks)	✓ Max 26-week wait achieved for CT and MRI ✓ CT wait down to 3 weeks ✓ Ultrasound wait reduced × Data recording changes in progress (PARIS) × Whole system model/18-week plan – needed further clarity on 18 week implementation (just published May 2006) × Booking systems - plans revised and linked to the Clinical Administration Review Project ✓ Other achievements: email of results to GP practices and implementation of new mandatory reporting in Jan 2006.
Making Best Use of Beds	▪ 5% reduction in emergency bed day use by 03/2008 ▪ Temporary 20 bed ward closure in 2005/06 ▪ Permanent 20 bed closure from 2006/07 onwards (8,000 bed days required) ▪ Revised discharge planning processes ▪ Targeted length of stay reductions	✓ Temporary ward closure programme through summer Overall length of stay targets achieved but bed day use not reduced as far due to increased admissions ✓ Benchmarking of LOS by Healthcare Resource Group ✓ Top 25 selected & process mapping commenced –

Project	Deliverables	Achievements at 31st March 2006
	▪ Reduced number of DTOC patients ▪ Admission avoidance/long term health needs	significant reductions in targeted groups ✓ Discharge planning – process changes identified and in progress × Care Bundles– linking with the Saving Lives initiative and pilot of switch of IV to oral antibiotic - audit not yet completed ✓Monitoring arrangements in place to track PCT identified LTC patients (small numbers at the moment).
The Clinical Administration Review Project **Incorporating "Modernising Secretarial Systems"**	▪ New (single?) Booking Systems & Processes ▪ New Roles ▪ New Technology ▪ New Environment To change booking systems and support services and modernise the way secretarial systems work	✓ Major revision of project plan ✓ Modernising Secretaries project now part of wider project looking at Trust-wide booking systems ✓ Formal consultation with secretarial staff commenced in June 2006 ✓ Implementation phase taking place over the summer, plus outpatient and booking changes with revised structure in place from September 2006.

2. Project 1: Day Case & Theatres

2.1 The Day Case & Theatres project set out to improve the day case rate for elective surgery and improve the operational efficiencies of theatres.

Treating day surgery as the norm was the very first 10 High Impact Change. Patients prefer day surgery as opposed to an inpatient stay, and a number of bed days on general wards are no longer needed with the consequent saving in ward support costs and reduced clinical risks (MRSA for instance).

Historic data was analysed and the Modernisation Agency supplied data on the Audit Commission's "basket" and the British Association of Day Surgery's "trolley" of procedures in order to compare Trust rates against national and best practice benchmarks.

Actions included

- Day Surgery was agreed with clinicians as the norm for a range of surgical procedures.
- In periods where wards and/or theatres were shut for maintenance, a major initiative to concentrate on day case work was instigated.
- A review of elective activity was undertaken and resulted in (a) a revised theatre timetable using only 5 instead of 6 theatres, and (b) a seasonal profile of elective work adjusting explicitly for holiday and other quiet periods in the year.

2.2 Objectives

- 340 Elective inpatients treated as day cases with a saving of 510 bed days (assumes an average length of stay of 1.5 days)

- Increase the surgical day case rate (percentage of all elective surgery) from 60% to 70% by March 2006.

2.3 Achievements

The surgical day case rate was significantly increased. In March 2006 we achieved 80% with an average of 70% over the whole year. This is in excess of plan and partly due to a consistent counting of certain surgical procedures as day case (and not outpatients). However all specialties increased their day case and most noticeably and unequivocally in Gynaecology and Orthopaedics, which were unaffected by any data recording issues.

Figure 1. Overall surgical day case rate

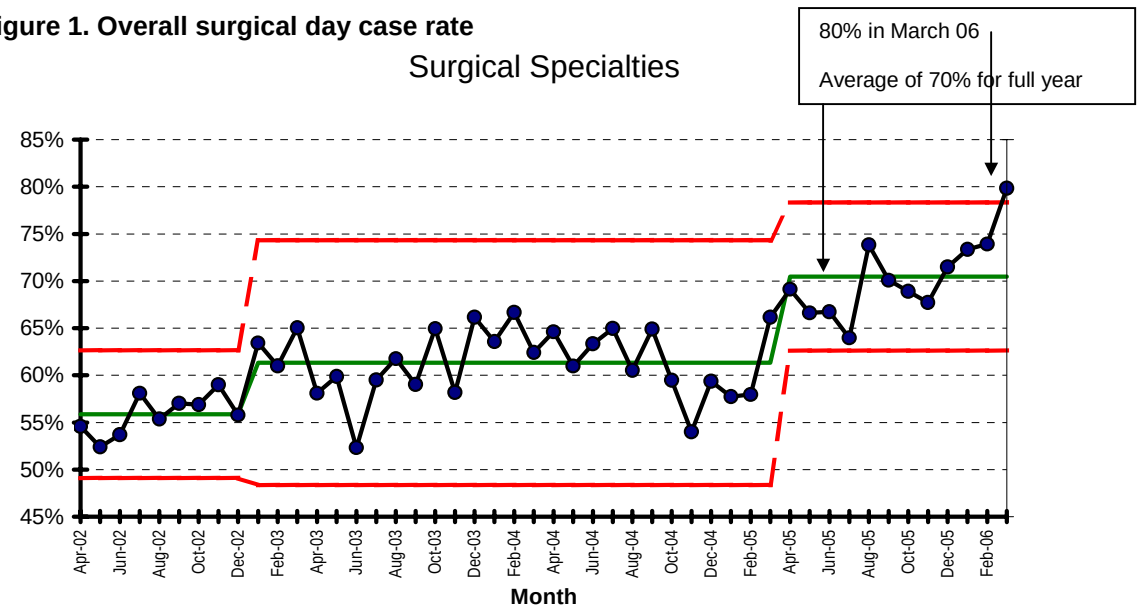


Table 1. Conversion of elective inpatients to day cases

	2004/05			2005/06						
	IP	DC	DC%	IP	DC	Reclassified Activity (est)	DC%	Expected DC	Actual DC	Number converted
General surgery	785	951	54.8%	829	1711	600	67.4%	1063	1111	48
Urology	374	463	55.3%	425	1209	500	74.0%	627	709	82
Gynaecology	587	838	58.8%	485	1072		68.9%	916	1072	156
Orthopaedics	685	653	48.8%	734	1054		58.9%	873	1054	181
										467

The 467 elective inpatients converted to day case (against a plan of 340) represent 700 bed days assuming a 1.5 day average length of stay. These bed days contributed to the Ward Closure programme in 2005/06.

The data recording changes of General Surgery and Urology activity masks their achievements, but nevertheless is a 12% and 19% increase respectively, even if the comparison is not on a like for like basis. Gynaecology and Orthopaedics were identified as potential areas for improvement in the comparison with the national data and have delivered significant increases.

Figure 2. Gynaecology day case rate

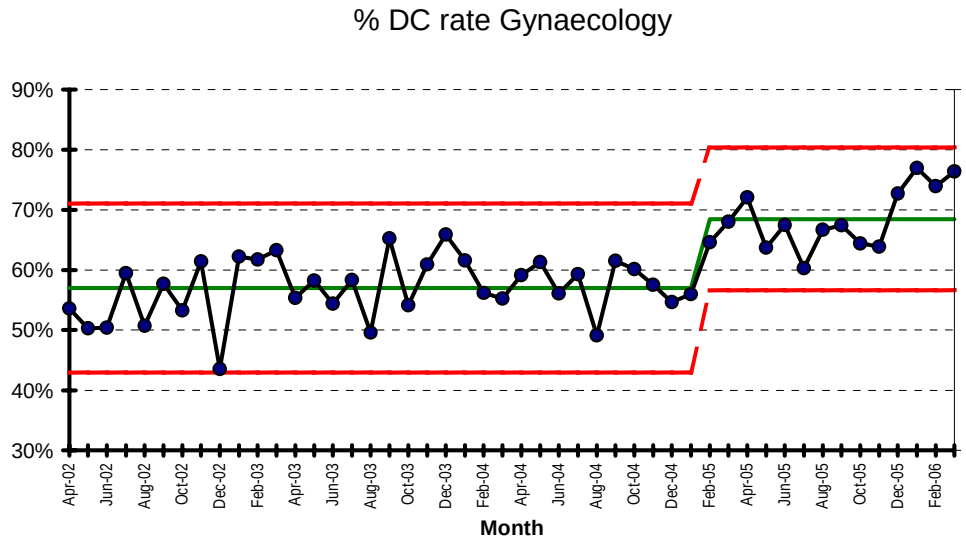


Figure 3. Orthopaedic day case rate

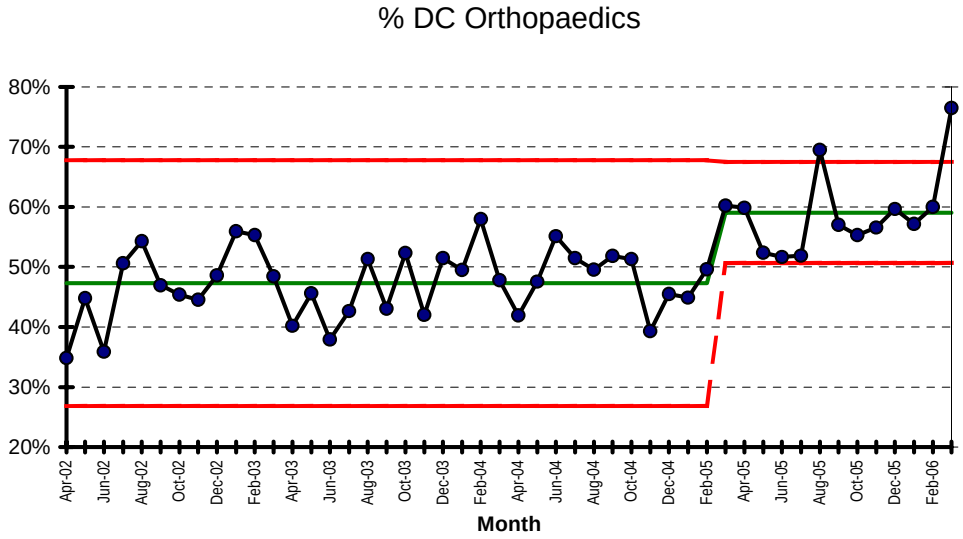


Figure 4. General Surgery

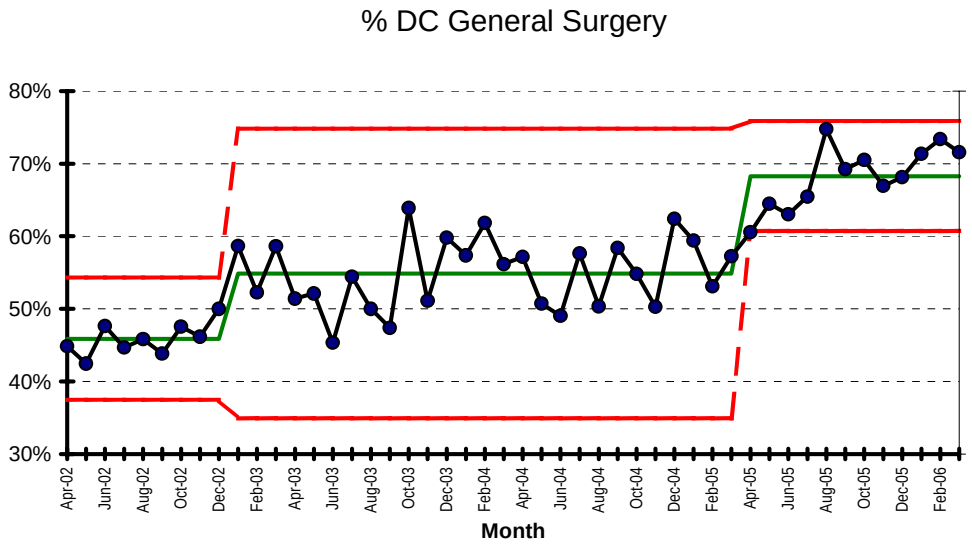
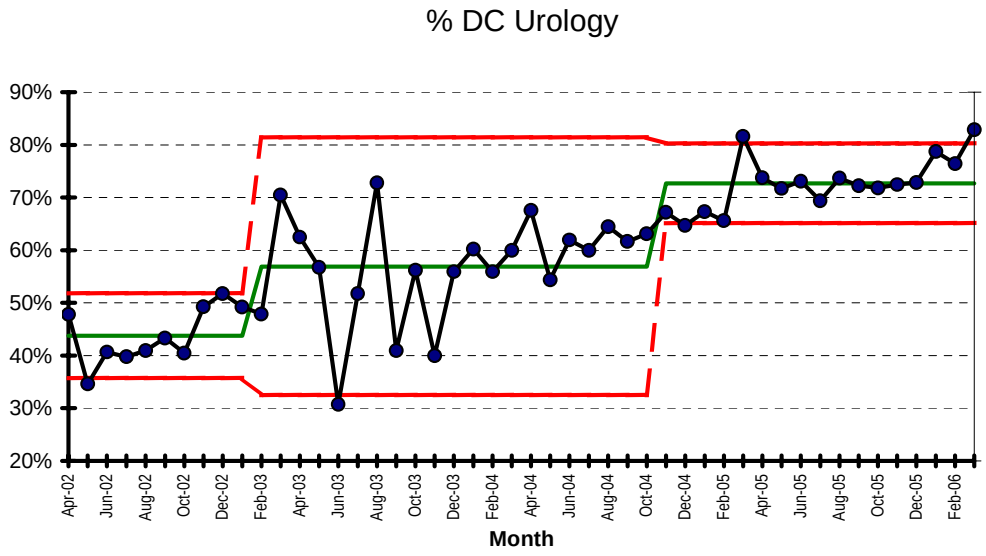


Figure 5. Urology



2.4 **Other Achievements**

- A new theatre timetable was introduced in October 2005 based on a model of activity that predicted a need for 4 theatres for elective work and 1 theatre for emergency surgery. While there are still operational difficulties due to the occasional increased variation in demand, the concept appears to be sound. One theatre was therefore closed from October 2005 onwards as a major cost saving benefit from the project. This and related surgical ward changes saved £570,000 in 2005/6, while achieving an increased volume of operations on the previous year.

- The direct access day case service was extended to carpal tunnel procedures in Orthopaedics in additional to the well-established inguinal hernia protocol.

- There were proposals to extend the use of the emergency day case service (patients diverted from an emergency admission into a day case procedure a day or so later depending upon clinical urgency). However no real inroads have been made on this and we have reviewed

where it sits as it appears to be in wrong project and is more related to the emergency pathway, which is where it has now been placed for 2006/7.

3. Project 2: Changing Outpatients

3.1 Objectives

- Achieve maximum 13 wait by December 2005
- Environmental improvements
- Adapt booking systems (Choose & Book plus an internal reorganisation of booking teams)
- Create capacity by reducing DNA rates (focus on reducing the follow up DNA rate as well as First)
- Review follow up/reattendance ratios – reduce to national benchmarks

3.2 Achievements

The key deliverables are shown below in figures 6–8. The main target was the number of patients over 13 weeks. Progress on some of the other indicators was delayed through external factors (part of wider projects, failures in technology relating to reminder texts, delay in extending partial booking to follow up appointments because of staffing issues).

Both the Outpatients and Diagnostics projects continue into 2006/07 as key parts of the "Getting to 18 Weeks" programme. The key efficiencies or benefits from this project were the reduced number of transactions (fewer DNA and cancellations plus increased number of electronic referrals means fewer appointments to be cancelled and rebooked by the hospital), however as noted below a number of the major benefits have yet to be realised.

Figure 6.

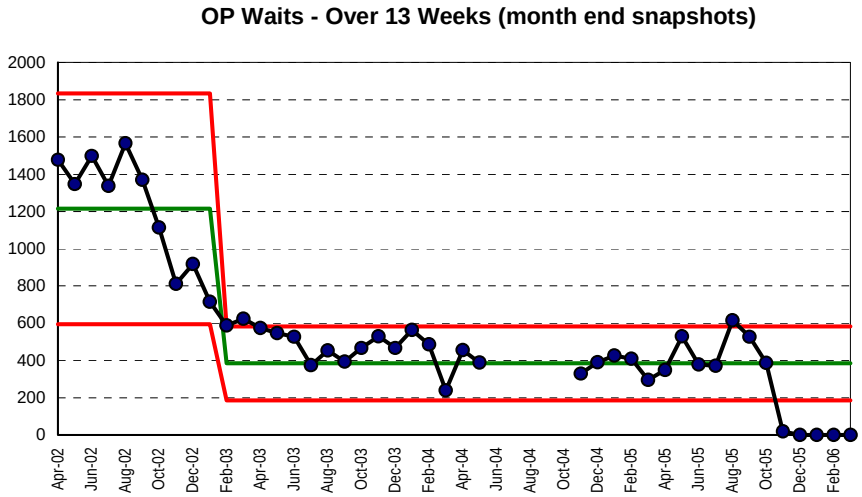


Figure 7.

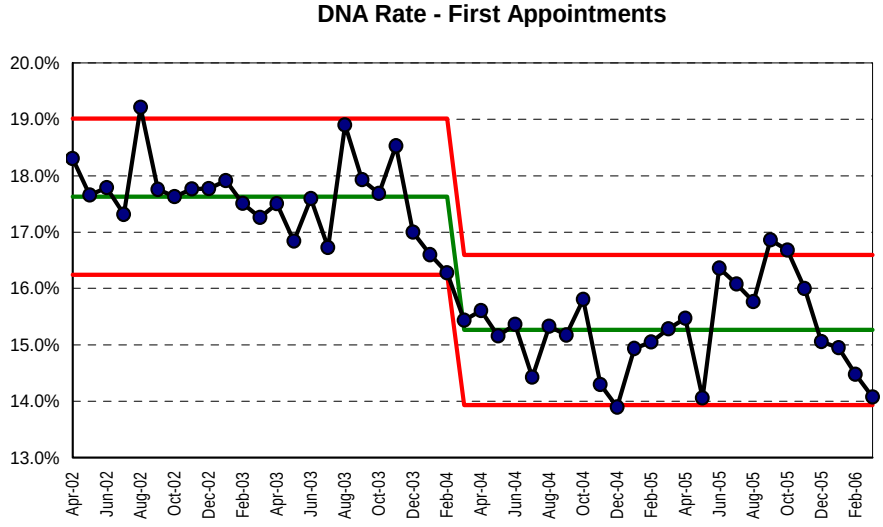
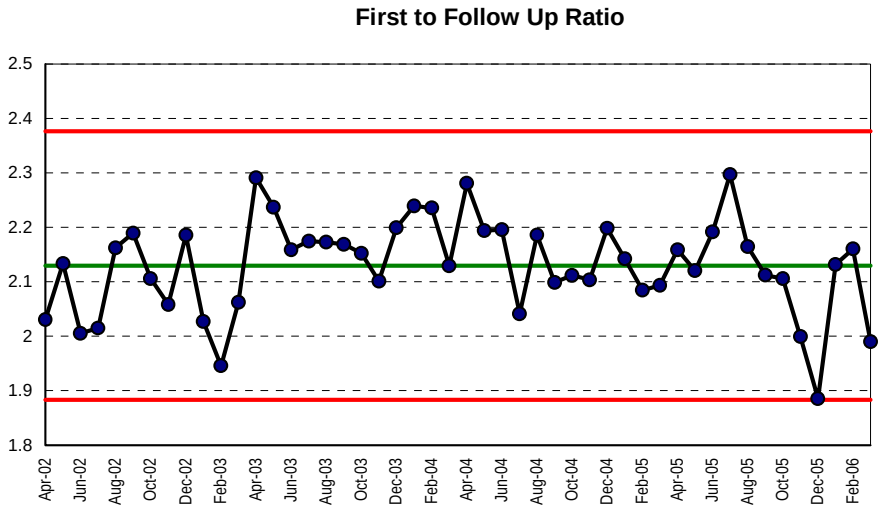


Figure 8.



3.3 **Other achievements in Outpatients:**

- ✓ Customer service training undertaken by outpatient staff - nurses, team leaders and clinic co-ordinators
- ✓ Redesign of appointment letters, designed with patient input, greatly improved and now rolled out across the Trust
- ✓ Environmental improvements – Rheumatology and ENT clinics complete
- ✓ Analysis of telephone calls to Main Appointments and Partial Booking points – volumes by day of week, by outcome – to assist in the planning of new booking systems and processes
- ✓ Text messaging reminders – now rolled out across the Trust
- ✓ Detailed patient flow analysis undertaken to calculate patient volumes to revised numbers of reception points and assist in options appraisal
- ✓ Choose and Book advances this year have placed us very well in a Choice environment and a key supporting strategy to our “hospital of choice” campaign

4. Project 3: Rapid Diagnostics

4.1 This project focuses on achieving the 2008 18 week wait target. Outcomes in the form of significant improvements were not scheduled for 2005/06 with the exception of the maximum 26-week wait for MRI/CT scans.

4.2 **Objectives**

- Achieve maximum 26 week wait for CT and MRI by March 2006 ✓
- Adapt data collection systems
- Capacity & Demand/whole system model
- Change booking systems

- Develop plans for improving access to diagnostics as part of whole patient journey (reduction to 18 weeks)

Data on the queue of CT and MRI patients has only been measured from September 2005 onwards, therefore insufficient data for SPC charts at this stage.

The main focus of the project in 2005/06 is to switch data recording from the existing system onto the Patient Administration System (also known as the PARIS project). This will allow a more robust measurement of waiting times and increased control over the process and this work is currently underway for CT, MRI and ultrasound tests. Until we have a more robust measurement system a number of improvements cannot be made and the new equipment in the PFI building will radically change the demand/capacity model and assumptions.

4.3 Other achievements in Diagnostics

✓ New national reporting of diagnostic waiting times from January 2006 – The Trust is submitting data to the national system and meeting targets for "Choice of Scan" so are not having to move patients to other providers at cost

✓ Significantly improved waits for GP direct access ultrasound (waits now down to 4-8 weeks from 18-20 weeks)

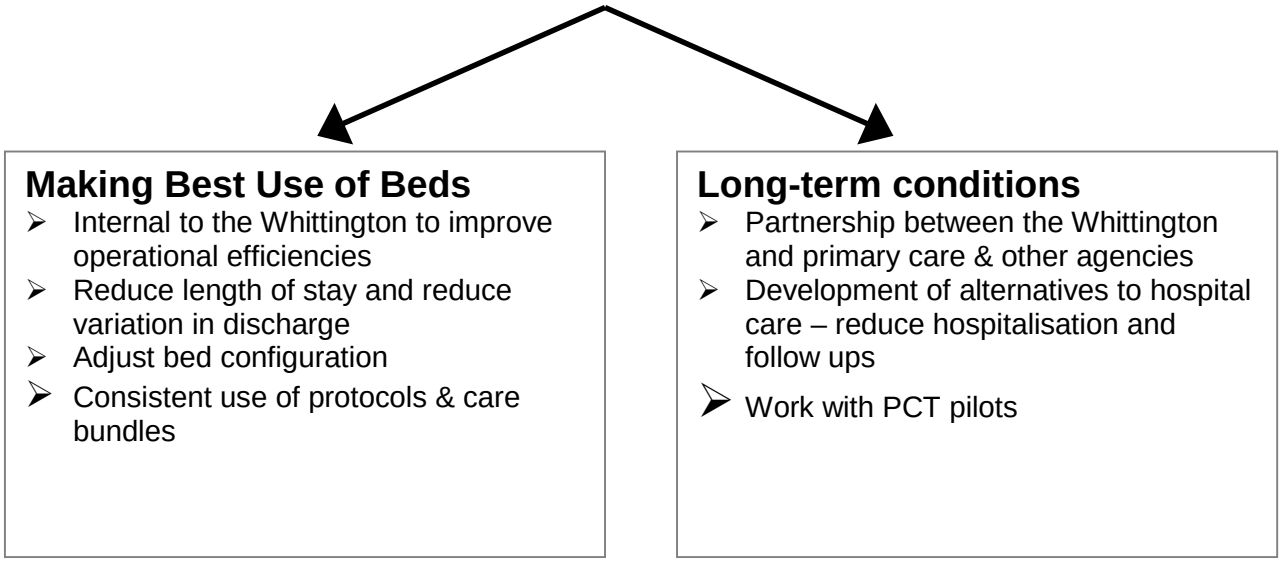
✓ Wait for CT scan is now less than 3 weeks

✓ Improvements to reporting times have been maintained (from 3 weeks to 2 days)

✓ Improved links with GPs (electronic reporting of direct access test results now going out to 45 practices)

5. Project 4: Making Best Use of Beds

The Making Best Use of Beds project was split into two sub-projects.



Most of the achievements have been in the first project as it is under the direct control of the Trust. The pace of progress on long-term conditions is largely governed by the speed of developments in primary care.

5.1 **Objectives for 2006/07**

- **Achieve national and/or locally agreed benchmarks for Length Of Stay**
  - Minimum requirement – 1 day off current medical emergency ALOS of 12 days and 0.5 days off the surgical emergency LOS of 6 days
  - Bed day saving – 8,800 bed days (a 20 bed ward) – 8% of total
- **Ensure timely admission every time**
  - ED target – 4 hour wait for a bed via ED admission. Only 90% in 2004/05.
  - Plan for 05/06: 98%-100%
- **No patient is admitted who does not require acute inpatient care**
  - Identify alternatives to admission such as next day emergency Outpatient clinics
- **Adjust Bed configuration – temporary and permanent ward closure programme.**
  - Flexible plan to match beds/wards to demand

5.2 **Achievements**

(a) Length of Stay

Length of stay was tackled in two ways – one was generic looking at standard processes (such as discharging patients) and the other was patient specific by HRG. Length of stay by Healthcare Resource Group (HRG) was benchmarked against the national Hospital Episode Statistics (HES) data. The HRGs that were furthest away from the national average LOS for the HRG **and** would generate the most bed days if we reduced to that national HRG average were identified for further analysis and action.

Appendix A contains the top 25 HRGs from the 2004/05 baseline data used in the project. The HRG that would generate the most bed days was A22 Non Transient Stroke or CVA >69 or with complications. This HRG was the focus for much of the year as the bed days to be saved potentially by this one HRG is close to 4 beds.

Appendix B contains a repeat of the benchmarking analysis but using 2005/06 Trust data (national data is still only 2004/05). It should be noted that A22 has slipped down the list of top 25 HRGs (to position number 22) as the length of stay for this type of stroke patient was reduced by 8 days.

Table 2. Average Length of stay

	Medicine			Surgery		
	Activity	Bed Days	AvLOS	Activity	Bed Days	AvLOS
2004/2005	7,347	88,050	11.98	3,658	22,017	6.02
2005/2006	7,527	82,121	10.91	4,216	23,109	5.48
Reduction	180	-5,929	-1.07	558	1,092	-0.54
% change	2.4%	-6.7%	-9.0%	15.3%	5.0%	-8.9%

- Length of Stay Targets were achieved for both Medicine and Surgery
- However the increased admissions reduced the bed day effect – the LOS reductions on last years activity would have resulted in 9,000+ bed days (last year's activity x this year's LOS)

- Key message is that variation in both activity and in LOS need to be managed
- Improvements to whole system are ongoing as well as to individual patient pathways
- Ward Closure programme – wards were closed on a temporary basis through the summer months (for 6 months of the year – see cost improvement reports for full details).

Figures 9 and 10 below show the average length of stay for emergency patients in Medicine and Surgery. The main focus of the project was reducing excess bed days for emergency medical patients, and Medicine was noticeably effective in reducing in LOS although recent variability highlights the potential problems of seasonal effects or increased variation/volatility.

The pattern in Surgery is less clear cut – although the target LOS reduction was achieved on a year to date basis, no SPC test has been satisfied to statistically prove the reduction and more analysis is needed to understand recent data. Opening the PAU in December and admitting patients directly to it on the day of surgery seems to have had an effect on pre-operative length of stay, see figure 11, December, January and March being below the median, although like Medicine there was a peak in February, and there are opportunities to use the PAU more extensively.

Figure 9. Emergency Length of Stay in Medicine

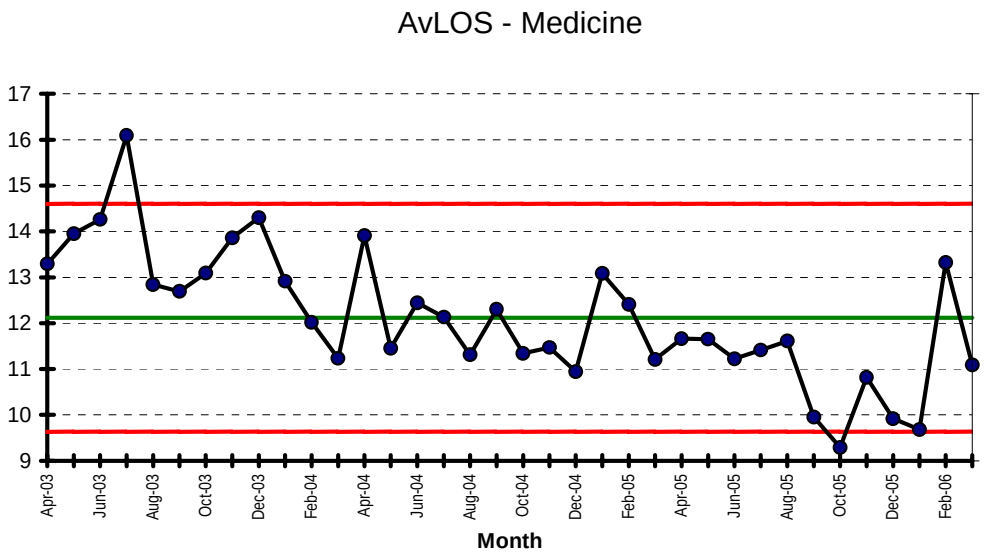


Figure 10. Emergency Length of Stay in Surgery

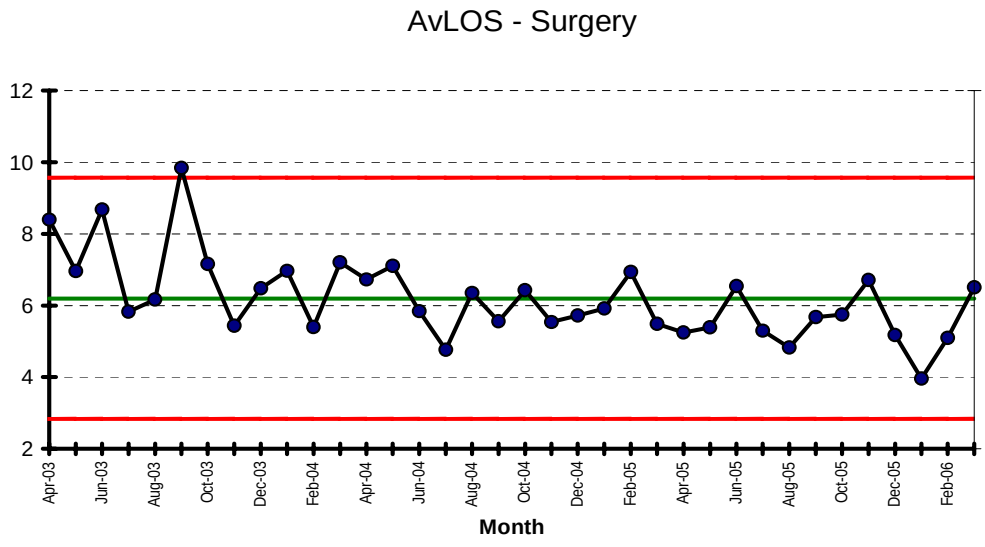
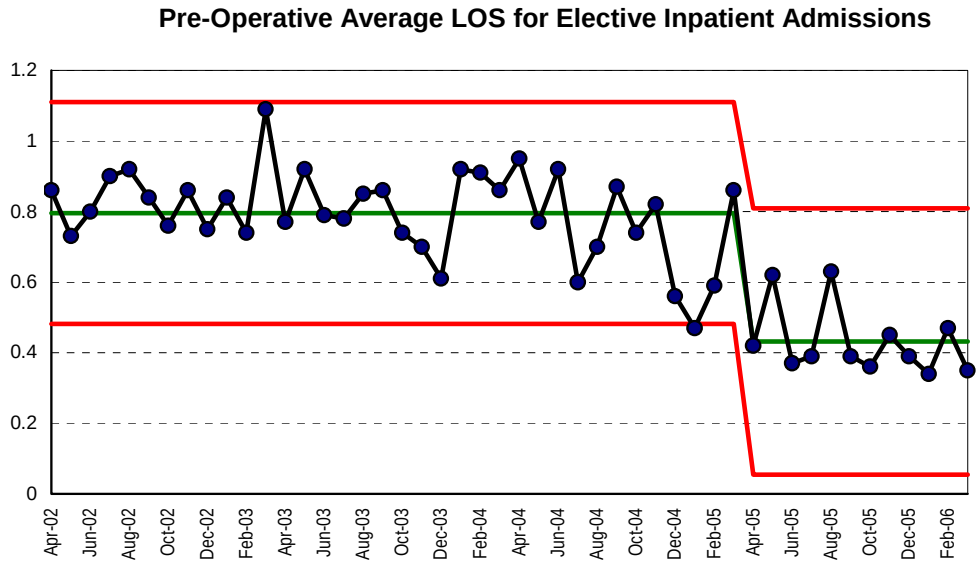


Figure 11



Patient Specific Length of Stay Reductions – A22 Non Transient Stroke or CVA >69 or w cc

As noted above the length of stay for this HRG was reduced by 8 days in 2005/06.

Figures 12 and 13 show the change in length of stay for patients in the A22 HRG. Figure 12 is a SPC chart showing the average LOS month by month and the improvement can be seen clearly (one more point for a significant run of 8 points – April data is still awaited).

Figure 13 is a frequency distribution graph of LOS with 2004 and 2005 data presented as overlays. The 2005 data shows improvement as both ends of the distribution – fewer outliers or very long stay patients, more patients discharged earlier and a smoother distribution (fewer intermediate peaks).

Figure 12. Average LOS over time for HRG A22

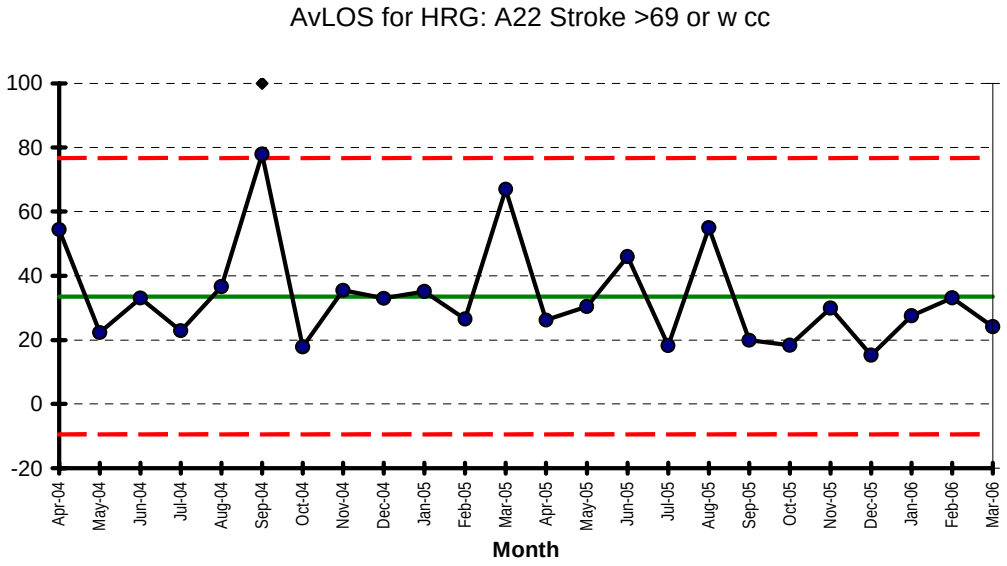
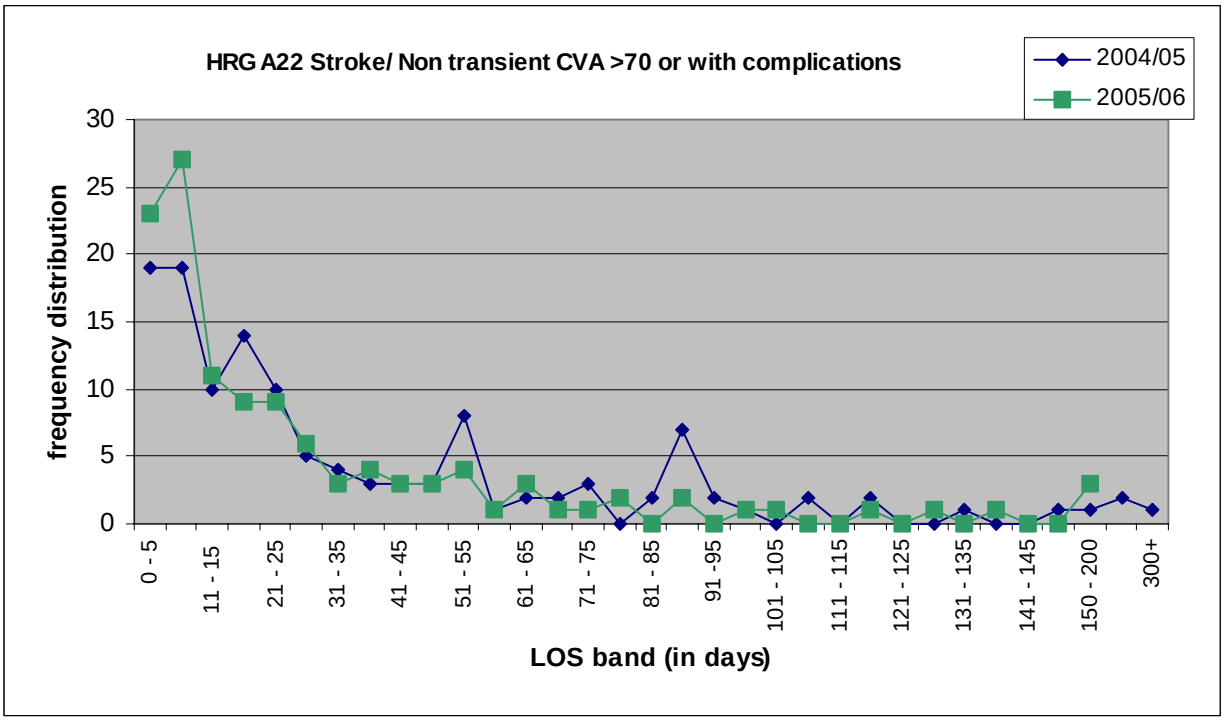


Figure 13: Frequency Distribution graphs of LOS for HRG A22



(b) People with long term conditions

Progress as been limited as PCTs continue to recruit and develop the community matron role. The Trust has been actively involved in a number of ways:

- Helping PCTs identify "very high intensity user" – the potential caseload for community matrons
- Develop alert systems when a patient being managed by a community matron has an emergency admission or an ED attendance (use of the auto-email functionality for the following morning to alert the PCT).
- Collaborating with Islington PCT on the development of the Integrated Service Improvement Plan (ISIP), which will concentrate on long term conditions.

6. Project 5: Modernising Secretarial Systems/Clinical Administration Review (CARE project)

6.1 The Modernising Secretaries project has been incorporated as a workstream of a wider review of all clinical administration systems.

6.2 Two proposals are to go out to formal consultation that change the roles and functions of secretaries and booking staff across the Trust.

6.3 The first, for medical secretaries is currently underway having been launched on 20th June. The second which looks at bringing together booking functions will be undertaken in July. Implementation will be over the summer with the new structures in place by the autumn. Physical works to bring the booking teams together and create one larger reception per floor/area (5 instead of 12) are also underway.

6.4 As this is more of a staff change than a service development, we will not repeat the detail from the consultation papers here, although these are available on request. However, update reports will provide more information about the changes following the implementation phase.

B: Programme for 2006/07

7. The service development plans for 2006/07 and 2007/08 will focus on two major change programmes.

- **Getting to 18 weeks** – covers the Planned patient journey from referral to treatment
- **Making Best Use of Beds** – covers the Emergency or unplanned patient journey

The use of the word programme is deliberate, as each programme will have a suite of linked projects. For example in the Getting to 18 Weeks programme there will be projects covering the component parts of the journey – outpatients, diagnostics and the waiting list.

All existing national targets have been mapped to these two programmes (see Appendix C) although in a number of cases the link is indirect or tangential.

7.2 Getting to 18 weeks

"By 2008, no one will wait longer than 18 weeks from GP referral to hospital treatment"
NHS Improvement Plan (June 2004)

This target will become the prime focus of service development work around the elective or scheduled services in the Trust. There are intermediate targets for component parts of the journey but a more radical redesign of patient flows may be needed to meet the 18 week target.

The high level objectives for 2006/07 are to

(a) Meet the intermediate waiting time access standards for OP, Diagnostics and Elective inpatients.

By March 2007	Outpatients	12 weeks
	Diagnostics	13 weeks
	Elective	23 weeks

(b) Collect and analyse baseline information.

At the moment, **we cannot measure the 18 week journey**.

The guidance material on the 18 week journey was only published on 10th May 2006. No current hospital information system collects the required data items to identify what the waits are and to measure progress against an improvement plan.

Reporting will be mandatory from January 2007.

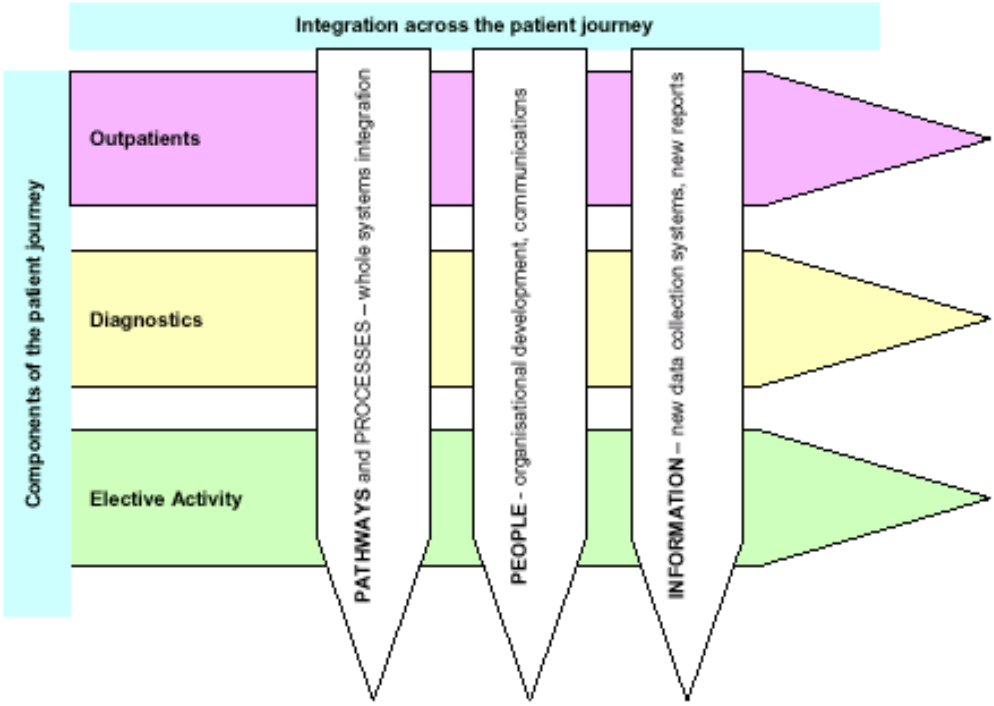
Baseline information will be essential to inform the final strand of work – redesign of patient pathways.

(c) Patient Pathways. Using the baseline information (paragraph 2 above) to segment and prioritise the work in designing patient pathways. It is difficult at this stage to be precise about the exact objectives for March 2007 until further project planning is completed. This strand of work may also cross over into long term conditions and other demand management initiatives where appropriate.

7.3 Proposed Programme Structure for Getting to 18 Weeks

We need to continue to make progress within the individual parts of the journey but also start the integration or whole systems work covering processes (or pathway redesigns), people (not just new roles but new communications strategies) and information/technology (new data collection systems, new operational systems to provide feedback information to managers and staff).

Figure 14. Project or workstream structure for Getting to 18 Weeks



7.4 Making Best Use of Beds

This programme will build on the achievements and the learning from 2005/06. One of the key messages is that variation in admissions as well as variation in discharges needs to be managed in order to make most effective use of our beds. Although we achieved the length of stay targets last year, the resultant bed day savings were less than planned because of the admission increases.

In 2006/07 the target will be expressed in bed days or more properly in beds. The levers of change may still be around LOS reductions and the discharge process, but there will be a clearer focus on what is to be achieved as an outcome.

The high level objective for the Making Best Use of Beds programme is:

- **Close 24 beds by March 2007**

Associated objectives will the most appropriate ward/bed configuration as clinical services move into the new PFI building.

The proposed programme structure will continue the projects currently underway but with a clearer focus and a new (more ambitious) set of objectives:

- Identify bottlenecks and remove them – and extend the project to Women and Childrens Services. The repeat exercise in benchmarking length of stay by HRG in Appendix B shows an

increased number of maternity HRGs in the top 25 HRGs identified for improvement (4 of the top 5 HRGs!).

- Improve decision making supported by protocols – introduce Nurse Led discharging and consider how else wards can support the process.

- Closer partnership working with primary & social care to identify services that will support earlier discharging (including redesign of clinical pathways – for example there was a trial of a change from IV to oral antibiotics to speed up discharge)

- Link in to Demand Management programmes including Community matrons & other primary care developments that could change the pattern of hospitalisation and number of beds needed.

- Increase use of alternatives such as Emergency day surgery.

C. Programme & Project Management, Improved Reporting & Monitoring

The project structure used in 2005/06 has been reviewed and a number of improvements will be implemented.

In 2005/06 in recognition that the senior operations team is small and that 50% of Divisional Managers had more than one project to lead, there was a phased start to projects over the course of the year.

The disadvantage was that projects operated for a time without a project plan, and the project planning stage was lengthy. This both limits the progress that can be expected by the end of the year, and limits monthly reporting as objectives are not set. This year all projects will commence (or continue) from the start of the year.

Project plans and setting of objectives are key, not least because these formed the measures of success. It is proposed that all project plans be completed by the end of June 2006 with the Head of Service Development acting as Programme Manager and leading the development of the programme mandates and project plans.

The programme mandates, project plans and benefit realisation plans (including a mapping to cost improvement plans) will be brought to HMB in July/August. The Service Development Board will be the Programme Board for Modernisation projects in the year ahead.

Last year our reporting structure was to alternate hospital management boards and Trust boards, this year periodicity of reports will be monthly. Each month HMB will have an activity & performance report, a service development and demand management report that will start to dovetail and integrate information in a coherent fashion.

Last year our communications plan included using the Whittington forum, which was used well and will continue. There were some features in the Link and this will increase in the year ahead so that all staff know about what the programmes are achieving. We also want to increase our external exposure in terms of publications.

The year ahead is likely to have greater focus on staff and cultural change issues, major changes in organisational behaviour. The service development team has some extra resource with the addition of some of Ruth Pattison's time to help support this work following the completion of the AfC project.

Last year there was strong buy-in from all members of the executive and non-executive team, and fellow directors structured their own work objectives around our plans, which assisted the delivery of our service development objectives. In the following year this support will be needed again.

D. Summary

The **Trust Board** is requested to:

- Note the review of 2005/06 service development projects presented above
- Comment on the proposed workstreams for 2006/7
- Comment on the proposal that brief updates for 2006/07 projects are brought to each future meeting of the Trust Board (6 rather than 3 times per year)
- All directors are thanked for their active participation in the 2005/06 service development projects and are asked to continue to support the Operations Directorate in the delivery of these key service developments in the year ahead

Appendix A

Non Elective Activity – Comparison of 2004/05 Trust data to national data

Top 25 HRGs with the highest potential bed day "saving"

NON ELECTIVE		Trust Data (04/05)			National comparators - All spells 04/05			
HRG3.5 Code	HRG3.5 Description	Number of Spells	Bed days	Mean	Mean	Median	LOS difference	Potential BD saving
A22	Non-Transient Stroke Or Cerebrovascular Accident >69 Or W Cc	122	4,589	37.61	26.7	13	10.91	1331.6
N12	Antenatal Admissions Not Related To Delivery Event	2779	3,174	1.14	0.7	0	0.44	1228.7
A12	Disorder Of Balance Aetiology Unknown W Cc	74	2,114	28.57	13.6	6	14.97	1107.6
N04	Neonates With Multiple Major Diagnoses	169	5,041	29.83	24.1	16	5.73	968.1
A19	Haemorrhagic Cerebrovascular Disorders	55	1,938	35.24	21.2	7	14.04	772
D25	Respiratory Neoplasms	113	2,012	17.81	11.9	8	5.91	667.3
N05	Neonates With One Major Diagnosis	71	1,356	19.1	9.8	5	9.3	660.2
G15	Therapeutic Pancreatic Or Biliary Procedures	25	868	34.72	9.6	6	25.12	628
E99	Complex Elderly With A Cardiac Primary Diagnosis	112	2,534	22.63	17.1	10	5.53	618.8
N10	Caesarean Section W Cc	122	1,439	11.8	7	5	4.8	585
E18	Heart Failure Or Shock >69 Or W Cc	172	2,696	15.67	12.3	8	3.37	580.4
L09	Kidney Or Urinary Tract Infections >69 Or W Cc	181	2,986	16.5	13.5	7	3	542.5
Q15	Amputations	19	1,156	60.84	34.3	24	26.54	504.3
H86	Neck Of Femur Fracture With Hip Replacement W Cc	21	908	43.24	20.5	16	22.74	477.5
D99	Complex Elderly With A Respiratory System Primary Diagnosis	159	3,189	20.06	17.1	10	2.96	470.1
J12	Drainage Of Ascites	71	1,463	20.61	14.5	9	6.11	433.5
A99	Complex Elderly With A Nervous System Primary Diagnosis	66	2,796	42.36	35.8	20	6.56	433.2
N06	Normal Delivery W Cc	66	664	10.06	3.7	2	6.36	419.8
N02	Neonates With Multiple Minor Diagnoses	131	776	5.92	2.8	2	3.12	409.2
E22	Ischaemic Heart Disease Without Intervention >69 Or W Cc	213	1,735	8.15	6.3	3	1.85	393.1
C07	Minor Medical Head, Neck Or Ear Diagnoses <70 W/O Cc	17	387	22.76	1.6	1	21.16	359.8
S06	Red Blood Cell Disorders <70 W/O Cc	230	1,024	4.45	2.9	1	1.55	357
F32	Large Intestine - Very Major Procedures	33	888	26.91	16.2	12	10.71	353.4
J99	Complex Elderly With A Skin, Breast Or Burn Primary Diagnosis	12	673	56.08	27.5	16	28.58	343
D16	Bronchiectasis	24	566	23.58	10.7	8	12.88	309.2

Appendix B

Non Elective Activity – Comparison of 2005/06 Trust data to national data

Top 25 HRGs with the highest potential bed day “saving”

NON ELECTIVE		Trust Data (05/06)			National Comparator (04/05)			
HRG3.5	HRG3.5 Description	Number of Spells	Bed days	Mean	Mean	Median	LOS difference	Potential BD saving
N12	Antenatal Admissions Not Related To Delivery Event	3060	3063	1	0.7	0	0.3	921
A12	Disorder Of Balance Aetiology Unknown W Cc	75	1780	23.73	13.6	6	10.13	760
N02	Neonates With Multiple Minor Diagnoses	389	1793	4.61	2.8	2	1.81	704
N10	Caesarean Section W Cc	110	1263	11.48	7	5	4.48	493
N07	Normal Delivery W/O Cc	1916	3920	2.05	1.8	1	0.25	471
E18	Heart Failure Or Shock >69 Or W Cc	200	2922	14.61	12.3	8	2.31	462
D25	Respiratory Neoplasms	88	1471	16.72	11.9	8	4.82	424
A99	Complex Elderly With A Nervous System Primary Diagnosis	57	2455	43.07	35.8	20	7.27	414
D33	Other Respiratory Diagnoses >69 Or W Cc	45	674	14.98	5.9	3	9.08	409
A16	Cerebral Degenerations >69 Or W Cc	25	1083	43.32	27.2	13	16.12	403
C59	Exteriorisation Of Trachea	19	985	51.84	31.2	20	20.64	392
J12	Drainage Of Ascites	54	1156	21.41	14.5	9	6.91	373
N06	Normal Delivery W Cc	68	610	8.97	3.7	2	5.27	358
A29	Epilepsy >69 Or W Cc	71	911	12.83	7.9	3	4.93	350
H99	Complex Elderly With A Musculoskeletal System Primary Diagnosis	58	2127	36.67	31	20	5.67	329
E32	Syncope Or Collapse <70 W/O Cc	80	457	5.71	1.8	1	3.91	313
S12	Septicaemia	58	1157	19.95	14.7	8	5.25	304
F21	Small Intestine - Very Major Procedures	13	550	42.31	18.9	12	23.41	304
Q13	Diagnostic Radiology - Arteries Or Lymphatics W Cc	28	577	20.61	10.2	4	10.41	291
N04	Neonates With Multiple Major Diagnoses	175	4504	25.74	24.1	16	1.64	287
D39	Chronic Obstructive Pulmonary Disease Or Bronchitis W Cc	125	1632	13.06	10.9	7	2.16	270
A22	Non-Transient Stroke Or Cerebrovascular Accident >69 Or W Cc	118	3407	28.87	26.7	13	2.17	256
H84	Intracapsular Neck Of Femur Fracture With Fixation W Cc	16	558	34.88	20.5	15	14.38	230
K99	Complex Elderly With An Endocrine Or Metabolic System Primary Diag	10	462	46.2	23.4	13	22.8	228
F45	General Abdominal - Diagnostic Procedures	21	403	19.19	8.6	5	10.59	222

Appendix C

Mapping of Healthcare Commission national targets to Objectives/Service Development Programme

EXISTING NATIONAL INDICATORS - 2005/2006					
Existing National Target		Performance Indicator		Improvement target for 06/07	Linked to objective/project
1	Achieve a maximum wait of six months for inpatients by December 2005	1	Number of inpatients waiting longer than the standard	National trajectory to 20 weeks? PCTs unwilling to fund	Getting to 18 weeks
2	Achieve a maximum wait of three months for an outpatient Appointment by December 2005	2	Number of outpatients waiting longer than the standard	National trajectory to 11 weeks? PCTs unwilling to fund	Getting to 18 weeks
3	Achieve a maximum waiting time of two months from urgent referral to treatment for all cancers by December 2005.	3	All cancers: two month GP urgent referral to treatment	Maintenance of current performance	Achieved – maintenance Getting to 18 weeks
4	Delayed transfers of care to reduce to a minimal level by 2006	4	Delayed transfers of care	Further reductions: minimal level is not defined	Making Best Use of Beds
5	Deliver a ten percentage point increase per year in the proportion of people suffering from a heart attack who receive thrombolysis within 60 minutes of calling for professional help.	5	Thrombolysis - 60 minute call to needle time	Not applicable	Achieved – maintenance Getting to 18 weeks
6	Ensure a maximum waiting time of one month from diagnosis to treatment for all cancers by December 2005.	6	All cancers: one month diagnosis (decision to treat) to treatment	Maintenance of current performance	Achieved – maintenance Getting to 18 weeks
7	Ensure that by the end of 2005 every hospital appointment will be booked for the convenience of the patient, making it easier for patients and their GPs to choose a hospital and consultant that best meets their needs. By December 2005, patients will be able to choose from at least four or five different health care providers for planned hospital care, paid for by the NHS.	7	Convenience and choice - elective (inpatient and daycase) and outpatient booking	tbc	Getting to 18 weeks
		8	Convenience and choice - provider information in place to support choice.	Likely to change in 06/07	Getting to 18 weeks
8	From April 2002 all patients who have operations cancelled for nonclinical reasons to be offered another binding date within 28 days or fund the patient at the time and hospital of the choice.	9	Cancelled operations and those not admitted within 28 days treatment	Local improvement target: all hospital cancellations?	Getting to 18 weeks
9	Maintain a maximum two-week wait standard for Rapid Access Chest Pain Clinics	10	Waiting times for rapid access chest pain clinic	Maintenance of current performance	Achieved – maintenance Getting to 18 weeks
10	Maintain a two week maximum wait from urgent GP referral to first outpatient appointment for all urgent suspected cancer referrals.	11	All cancers: two week wait	Maintenance of current performance	Achieved – maintenance Getting to 18 weeks
11	Maintain the four hour maximum wait in A&E from arrival to admission, transfer or discharge.	12	Total time in A&E: four hours or less	Maintenance of current performance	Making Best Use of Beds
12	Three month maximum wait for revascularisation by March 2005.	13	Patients waiting longer than three months for revascularisation	Not applicable	Not applicable

New National Targets

New National Target		Performance Indicator		Improvement target for 06/07	Linked to objective/project
1	Achieve year on year reductions in methicillin resistant Staphylococcus aureus (MRSA) levels, expanding to cover other health care associated infections as data from mandatory surveillance becomes available.	1	MRSA Bacteraemia	LDP trajectory	Trust wide project Lead: DW
2	Increase the participation of problem drug users in drug treatment programmes by 100% by 2008 (from a 1998 baseline); and increase year on year the proportion of users successfully sustaining or completing treatment programmes.	2	Drug misusers: information, screening and referral	Indicator likely to change for March 2007. Currently measuring a process	Tbc Making Best Use of Beds
3	Reduce health inequalities by 10% by 2010 (from a 1997 - 1999 baseline) as measured by infant mortality and life expectancy at birth.	3	Data quality on ethnic group	? Indicator likely to change for March 2007	Information QA Operations (TD) and IM&T (GW)
		4	Infant health: data completeness	? Indicator likely to change for March 2007	Information QA Operations (TD) and IM&T (GW)
4	Reducing adult smoking rates (from 26% in 2002) to 21% or less by 2010, with a reduction in prevalence among routine and manual groups (from 31% in 2002) to 26%	5	Smoke- free NHS, recording of smoking status and reducing smoking	? Indicator likely to change for March 2007 Currently measuring a process	Trust wide
5	Reducing the under- 18 conception rate by 50% by 2010 (from the 1998 baseline), as part of a broader strategy to improve sexual health	6	Access to genito- urinary medicine (GUM) clinics	Not applicable	Not applicable
6	Secure sustained national improvements in NHS patient experience by 2008, ensuring that individuals are fully involved in decisions about their health care, including choice of provider, as measured by independently validated surveys. The experience of black and minority ethnic groups will be specifically monitored as part of these surveys.	7	Experience of patients	tbc	Trust wide projects linked to improving patient experience Lead: DW Making Best Use of Beds Getting to 18 weeks Both programmes will Contribute to improving the Patient experience of the Trust

New National Target		Performance Indicator		Improvement target for 06/07	Linked to objective/project
7	Substantially reduce mortality rates by 2010 from heart disease and stroke and related diseases by at least 40% in people under 75, with a 40% reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole.	8	Participation in audits	Clinical audit participation	Clinical Governance programme, Saving Lives Lead: DW
8	Substantially reduce mortality rates by 2010 from suicide and undetermined injury by at least 20%.	9	Processes in place to ensure compliance with National Institute for Health and Clinical Excellence guidelines for the treatment and management of self-harm in emergency departments.	? Indicator likely to change for March 2007	Making Best Use of Beds
9	Tackle the underlying determinants of ill health and health inequalities by halting the year on year rise in obesity among children under 11 by 2010 (from the 2002/ 2004 baseline) in the context of a broader strategy to tackle obesity in the population as a whole.	10	Obesity: identification and management in secondary care	? Indicator likely to change for March 2007	Making Best Use of Beds
10	To ensure that by 2008 no body waits more than 18 weeks from GP referral to hospital treatment.	11	Waiting times for MRI and CT scans	National trajectory to 13 weeks Indicator likely to be extended in 06/07	Getting to 18 weeks
11	To improve health outcomes for people with long term conditions by offering a personalised care plan for vulnerable people most at risk; and to reduce emergency bed days by 5% by 2008 (from the expected 2003/ 2004 baseline) through improved care in primary care and community settings for people with long term conditions.	12	Emergency bed days	National target 5% Local target 8%? Sufficient to close a medical ward on a permanent basis 4% achieved in 05/06	Making Best Use of Beds