Sheffield Teaching Hospitals NHS
NHS Foundation Trust

H

BOARD OF DIRECTORS

SERVICE IMPROVEMENT PROGRAMME UPDATES
SEPTEMBER 2011

1. INTRODUCTION

1.1 The Trust has three formal Improvement Programmes - Clinical Service Improvement, Workforce and Corporate, all designed to help drive and support delivery at directorate level.

1.2 This report provides the Board of Directors with:
- A summary of Directorate performance against the 2011/12 P&E Financial Targets at Month 4 (Appendix 1)
- An update on the three Improvement Programmes and related workstreams.

2. DIRECTORATE PERFORMANCE AT MONTH 4

2.1 The Trust target for the year is £25,457.3m for Productivity & Efficiency. The plans outline £31,427.9m and a recurrent plan for £35,466.4m.

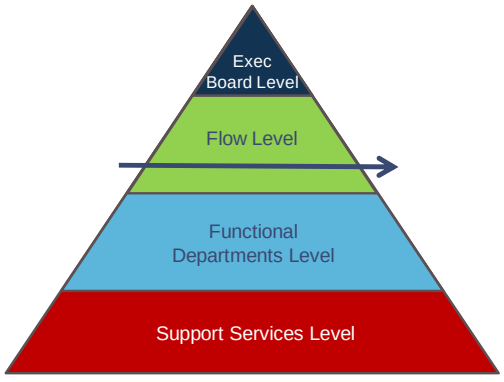
2.2 The month 4 results show financial delivery of £5,517.4m for P&E against a Trust plan of £8,576.1m. This represents a 36% shortfall against plan.

2.3 The Clinical Directorates report a deficit of £2,917.6m (38%) against their submitted plans. The Corporate Directorates report a deficit of £141.1k (15%) against plan. Examinations of the reasons for this under-delivery are being discussed through the directorate performance reviews and formal action plans have been submitted.

2.4 The forecast outturn position (at month 4) is £24.6m delivery against £25.5m target and £31.4m plan. This would represent a 3% shortfall against target and 22% shortfall against planned savings.

3. **CLINICAL SERVICE IMPROVEMENT**

This section relates to the improvement work underway in a number of clinical services particularly at the patient flow level; through changes at individual departmental level and at the support services level. The diagram below shows a schematic view of the different system levels.



3.1 Geriatric & Stroke Medicine Project

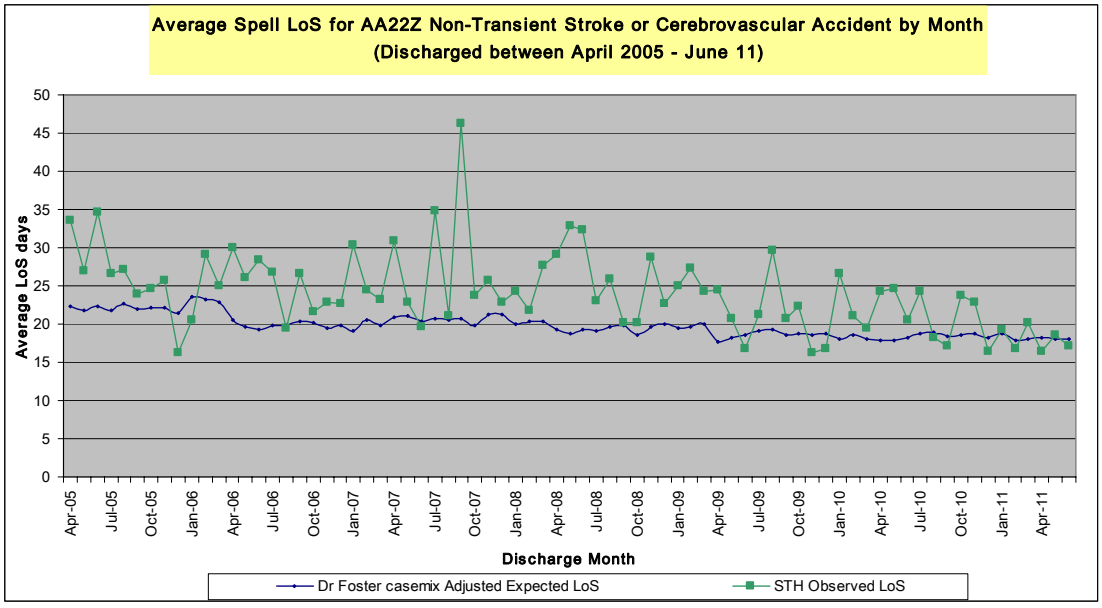
This is a major project to improve quality in the care of patients and deliver greater efficiency, with evidence that a major barrier to timely discharge is associated with the assessment processes which form part of the Continuing Health Care needs assessment. Data analysis suggests the equivalent of 5-6 GSM wards currently supporting patients who do not require acute care.

A redesign of the pathways across the health-economy is crucial. It is also clear that delays to acute care are occurring due to the current medical take systems. Having invested time to understand the causes and engage a range of stakeholders in redesign, the internal GSM team is testing a range of improvements including changes to assessment and outpatient management. A recent example of this is Project Evie (Day Rehabilitation) which has delivered real improvements in patient experience and hard financial savings as well as re-engaging the staff.

The Chief Nurse/Chief Operating Officer has taken Executive Lead for the delivery of the formal change programme for Medicine/Unscheduled Care. The existing projects are being drawn into a single programme and the reporting arrangements are being clarified to ensure a consistent approach.

3.2 Stroke Medicine

The redesign of the stroke pathways is demonstrating clear improvement to the patient pathway and greater efficiency. The chart below shows the highest volume stroke-related Healthcare Resource Group (AA22Z) which consumes the highest number of bed nights. The blue line is the Dr Foster expected length of stay for this case mix and the green line is the Trust performance – this shows how the variation has been reduced, is in greater control and is getting closer to the Dr Foster expected level.

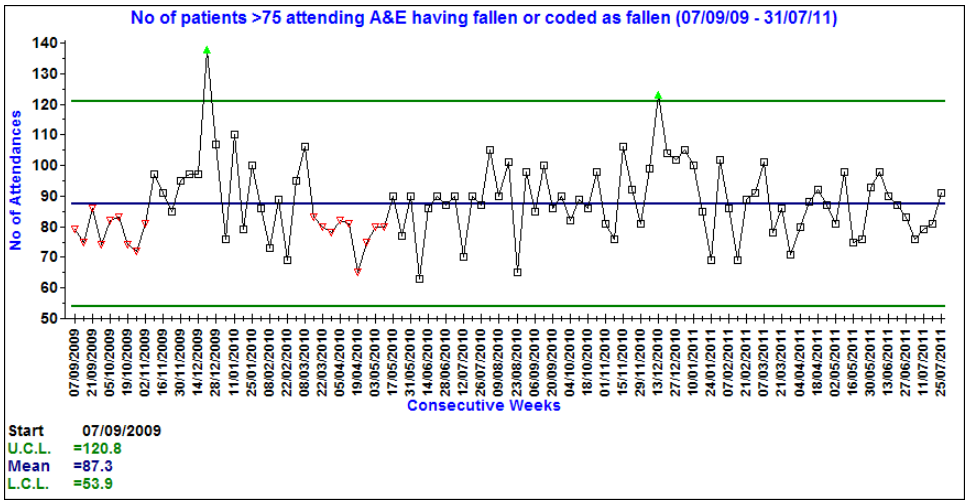


3.3 A & E / Falls

The project was initiated as a result of an audit of patients aged over 75 in 2010 who had attend A&E having fallen or were coded as falling. It was clear that demand for treatment via the A&E department was considerable, with approximately 90 patients per week - see

the graph below. In addition, the audit and subsequent analysis uncovered recurrent themes such as:

- Admissions to acute medical beds, despite patients being medically fit. This is because suitable services to manage the patient in the community are not available when required.
- The average length of stay for the 'social' admitted cohort described above was 13 days.
- Some admissions could also potentially have been avoided with input from a more senior clinician in A&E.
- Patients regularly returned to A&E with further falls within 28 days, many of patients had not been referred to specialist falls clinics.
- The average time in the A&E department for a falls patient is 251 minutes, increasing potential breaches, and consuming resources.



A series of sessions with key stakeholders have mapped the current system and highlighted disjointed and inconsistent working practices. The group has started the process of redesign with proposals for a community based hub and Falls Register. The first test of change has just commenced, to increase the referrals to a falls clinic; the intention is that by managing patients on an ambulatory basis. This is expected to improve patient experience and effect a reduction in repeat attendances.

3.4 **Day Case Rates**

Work continues to maximise the surgical activity that can be managed as a day case. The chart on the next page shows the Trust performance to May 2011 against the basket of 25 procedures. There are a number of specialties making considerable progress including General Surgery who have improved Laproscopic cholecystectomy rates to performance nearing the top 5% of all Trusts.

Healthcare Commission Basket of 25	May-11	2011/12	2010/11	National Rates 2009/10				Bed days 2011/12
Procedure	Month	YTD	Year	Median	P75	P25	P5	YTD
ALL	82.1%	83.3%	81.9%	82.8%	77.1%	87.3%	93.4%	0%
Anal fissure dilation or excision	100%	100%	89.7%	0%	0%	0%	0%	0%
Arthroscopy	91.7%	93%	82%	81.5%	73.7%	86.5%	93.7%	0%
Bunion operations	66.7%	45.8%	44.5%	52.8%	31.2%	67.5%	97.6%	0%
Carpal tunnel decompression	97.7%	96.3%	91.8%	96.8%	94.4%	98.4%	99.7%	0%
Circumcision	69.6%	81%	37.6%	88.1%	81.1%	92.3%	95%	0%
Correction of squint	50%	52.9%	80.8%	94.9%	92%	97.5%	99.2%	0%
Dilation and curettage/hysteroscopy	100%	92.5%	95.6%	87.8%	82.1%	91.3%	95.9%	0%
Excision of breast lump	100%	92.3%	83.9%	76.9%	65.6%	86%	94.5%	0%
Excision of Dupuytren's contracture	88.9%	92.3%	92.9%	72.4%	60.8%	81.9%	94.2%	0%
Excision of ganglion	100%	94.7%	86%	94.7%	89.9%	96.6%	100%	0%
Extraction of cataract with/without implant	91.8%	94.9%	97%	98.8%	97.4%	99.5%	99.9%	0%
Haemorrhoidectomy	71.4%	75%	76%	61.1%	47%	73.8%	92.5%	0%
Inguinal hernia	75.5%	71.3%	59%	61.9%	53.1%	70.5%	81.6%	0%
Laparascopic cholecystectomy	50%	56.8%	27.1%	21.9%	8.9%	36.8%	58.2%	0%
Laparoscopy	74.2%	71.3%	69.2%	75.3%	69.3%	81%	89.5%	0%
Myringotomy with/without grommets	71.4%	81.8%	93.2%	93.9%	89.1%	96.1%	98.5%	0%
Operation for bat ears	100%	100%	76.9%	17.5%	17.5%	17.5%	17.5%	0%
Orchidopexy	50%	50%	0%	86.4%	76.7%	89.1%	95.4%	0%
Reduction of nasal fracture	66.7%	90%	93.5%	93.4%	88.9%	97.1%	99.3%	0%
Removal of metalware	64%	70%	72.2%	66.9%	58.1%	75%	85.4%	0%
Submucous resection (septum or turbinate of nose)	41.7%	57.7%	70.2%	47.9%	21.2%	69.1%	92.1%	0%
Termination of pregnancy (normal abortion)	90.1%	90.2%	92.7%	95.4%	91.9%	97.7%	100%	0%
Tonsillectomy	57.1%	54.5%	23.7%	20.8%	1.7%	46.5%	85.6%	0%
Transurethral resection of bladder tumour (TURBT)	16.1%	19.1%	18.4%	24.2%	14.9%	33.8%	51.3%	0%
Varicose vein stripping or ligation	100%	96.9%	96%	84.2%	72.6%	89.4%	97.5%	0%

3.5 Enhanced Recovery

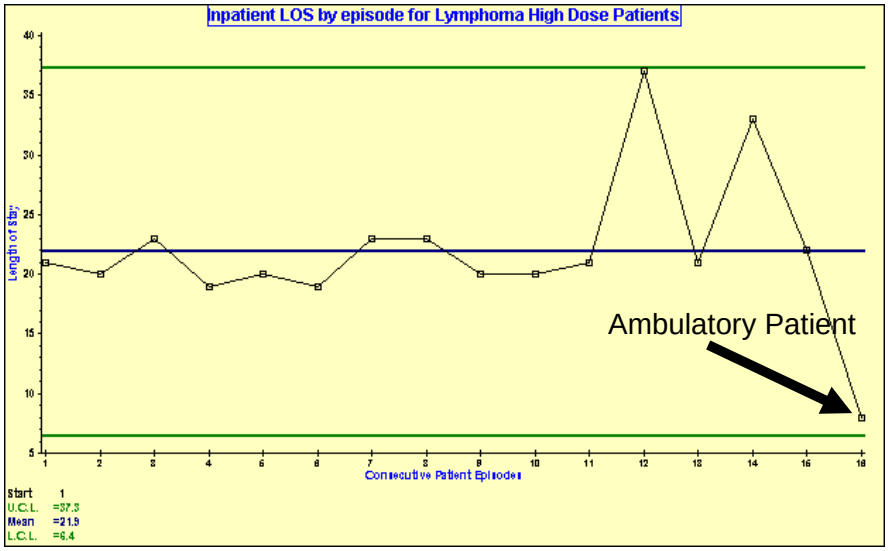
- **Orthopaedic Hips and Knees** - A pilot commenced in October 2010 to introduce the enhanced recovery model of care to elective primary arthroplasty patients at STH. Prior to the project starting, the average LoS for primary arthroplasty patients treated at STH on the NGH site was 8 days. By May 2011, 116 patients had progressed through the enhanced recovery pathway at NGH, with a LoS of approx 4 days, see the graphs below. There is further potential for the speciality to extend this model to all elective primary arthroplasty patients to ensure an effective flow of elective orthopaedic surgery and ensure maximum benefits from the delivery of services at the RHH site.

- **Renal transplantation enhanced recovery** - Enhanced recovery following living donor renal transplantation commenced with a single surgeon in April 2010. Further improvement work has now been undertaken. The mean length of stay for patients receiving a living donor transplantation fell from 10.5 days to 7.3 days and the variation in the length of stay is also reduced.

Cardiac surgery is now reviewing where ER could be applied and a project will commence in September 2011.

- **SHINE Ambulatory Haematology Project** - Patients with haematological cancers (leukaemia, lymphoma and myeloma) often need to stay in hospital for up to 4-5 weeks because they need intensive chemotherapy and/or a bone marrow transplant and supportive care. The Haematology team are currently implementing a project which is delivering a significant phase of cancer therapy for patients using ambulatory

(outpatient) treatment pathways whilst maintaining clinical efficacy and safety. Patients stay with their carers in an upgraded flat at Beech Hill Road or at home for defined phases of the patient's treatment, whilst visiting the day ward for their chemotherapy and supportive care.



The team have redesigned the pathway and the reduction in LOS for the first Lymphoma patient is shown on the run chart - a reduction from a median of **21 days to 8 days**. A second patient is has recently received care and has spent 17 days in ambulatory care rather than as an inpatient, with a LOS of only 3 days. Similarly Acute Myeloid Leukaemia patients have experienced reduced LOS from **23 days down to 9**. This delivery of this project is being supported by the Service Improvement Team and a successful bid to the Health Foundation (SHINE scheme).

3.6 Hospital @ Night at the Northern General

National evidence shows that Hospital at Night improves safety, reduces serious untoward incidents and improves efficiency whilst contributing to reductions in length of stay. It also helps with European Working Time compliance and with medical workforce development. Hospital at Night was successfully introduced at the RHH in December 2010. The project at the Northern General site is complex and has required substantial redesign of current systems. The Medical model went live at NGH on 3 August 2011 and the surgical areas are planned to follow with the new system on 31st October 2011.

3.7 Outpatients

A new strategy for *Quality Improvement in Outpatient Services* was approved by TEG in June 2011. This aims to:

- Ensure Outpatient services reflect patients needs
- Match capacity and demand by reducing the follow up load and standardise where clinically possible;
- Drive system wide changes through active ownership and participation of the front line clinical teams.

A major programme to support the delivery of this Strategy is currently being scoped.

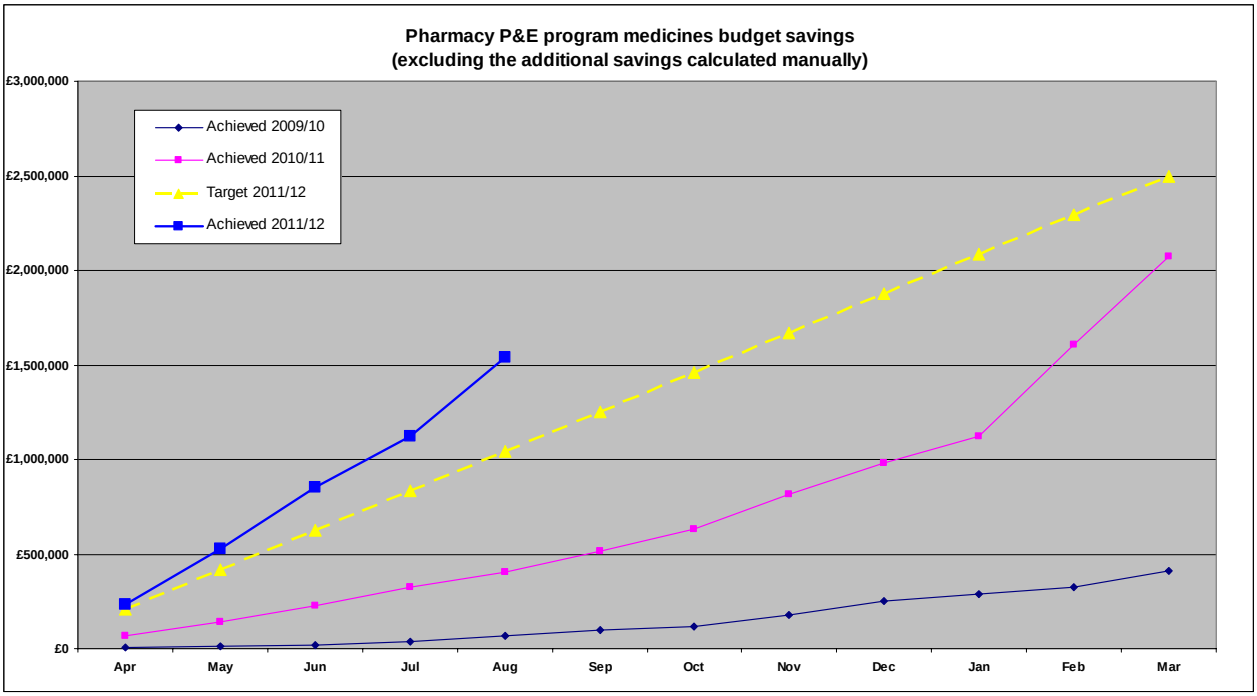
- **Check-in Technology** In addition to the development of the new Strategy, the workstream has implemented a successful electronic check-in pilot in Rheumatology. The pilot system went live in Q1 within the Rheumatology department. The system has had a dramatic effect on the flow in clinic where patients are now spending on

average 19 mins less time in clinic. Feedback from patients has been very positive and many reported they are used to similar systems at their local GP surgery. The system has allowed the release of one Support Worker from the department, and released 1 nurse to undertake an additional clinic.

- **Cystic Fibrosis Outpatients – Project Brandon**. Cystic Fibrosis is a life long condition that requires multiple repeat outpatient attendances and consultations with a broad multi disciplinary team. A key aim has been to shorten clinic visit times as these patients visit the unit frequently. Examining the clinic flow has allowed the clinical team to redesign the clinic and reduce the time patients spend in clinic by 28 minutes. Adherence to treatment by patients has also been identified as an area for improvement. A working group is now established to improve monitoring (using innovative telehealth) and standardise the approach. The aim is to improve patient outcome and experience and reduce unnecessary admissions and 'rescue' treatments.

3.8 Pharmacy/Medicines Management

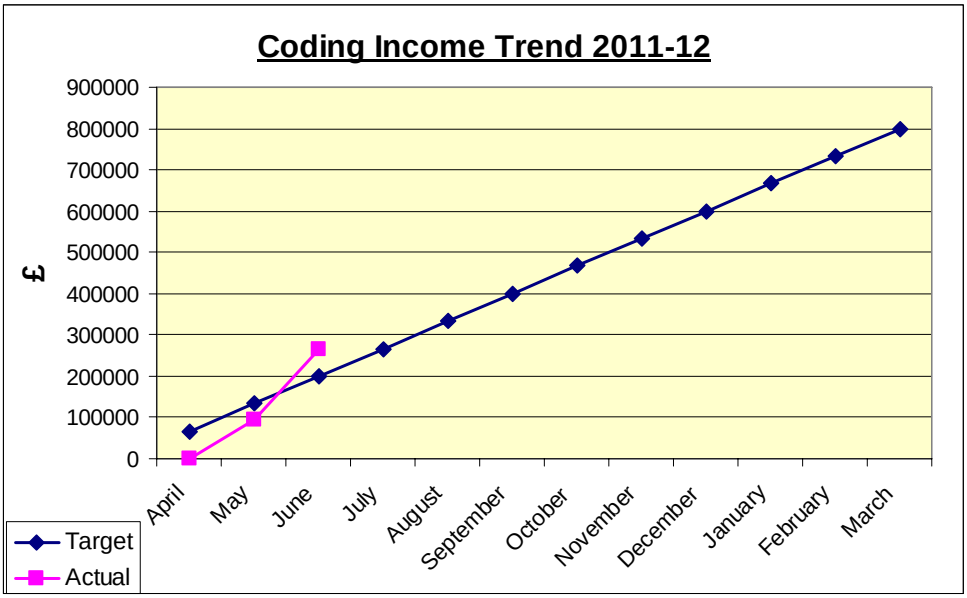
There are a range of P&E schemes supported and delivered by the Pharmacy Directorate. To Month 5, the projects have delivered in excess of £1.5m against a full year target of £2.5m. There are some additional schemes which have a delayed start (for example homecare chemo, outsourcing OPD dispensing) which will deliver further savings in-year and result in a full year effect saving circa £500k. The Outsourcing Outpatient Dispensary project is currently underway with a projected go-live date of September 2012.



3.9 Coding

The Coding Workstream is focussed on projects with specific specialties. A detailed action plan (with a nominated coding lead) maps this coding improvement work across the year by care group and speciality. The Workstream has an overall target to deliver £800k for the year. At the end of Q1, the workstream is ahead of target (£265.7k against a target of £200k). Coding Audits have been undertaken in Haematology, Neurology and

Neurosurgery, and Bronchoscopy. Affirmative action taken to ensure the correct income by speciality is responsible for much of the additional income.



3.10 **Additional projects at the Support Services Level:**

- ***Rationalisation of Laboratory Services***

The Trust has made a major capital investment to build and equip a new centralised laboratory on the NGH site. In order to achieve the in-use date Laboratory Medicine (LM) have initiated a number of projects. For two of these, transport and specimen reception, the SI Team are supporting the directorate with systems training. The initial work has been to try and get a full-system overview of how specimens move from their initial request to result received. Whilst the project is still at an early stage the following challenges are starting to appear;

- the new facility will be required to handle around 10,000 specimens per day (roughly one every 6 seconds)
- the current 9 different reception pathways will need to be merged in a single one
- the current arrival pattern suggests that the automated equipment may not be able to handle the volume & there are major challenges associated with the arrival patterns of requests (e.g. very high volume arriving from Primary Care around 1600)
- A high level of automation within the laboratory does not necessarily have any impact on the overall patient-perceived lead time for results to be delivered.

3.11 ***Therapies – Dietetic & Therapy 7 day Working***

Within physiotherapy and occupational therapy an extended project has been undertaken to test the hypothesis that 7-day working can reduce length of stay. An analysis of time to initial therapy assessment does show an improvement and time to completion of therapy with a 2-day reduction. Work is now being started within Dietetic services to see how systems design can be used to improve the delivery of OP dietetic clinics and to understand the service demand and ensure the correct capacity is deployed.

4. Building Capability & Capacity for Improvement

Working across the organisation, the Service Improvement Team have supported and delivered a series of “improvement sessions” to engage directorate teams in quality improvement and service redesign. This has included considerable work with specialities within the Emergency Medicine and Surgical Services Care Groups.

In addition, the SI Team held a half day course *"Quality Care for Less"* on the 21st July as an introduction to quality improvement methodology. Using presentations, patient stories and interactive techniques the course covered –

- Transforming Complex Systems
- Value Based Design in Healthcare
- Ethics and Quality Improvement
- Capacity and Demand Modelling
- Microsystem Redesign

The session was well attended by delegates from the Trust, from other Hospitals and across the wider healthcare sector including GPs and community services. Feedback following the day from delegates was collected using an online survey, with excellent feedback and a unanimous view that participants would be interested in coming to future events. The team are currently planning a follow up event for November.

5. Management Consultancy Support

KM&T have been appointed by TEG to provide external support to the drive for further productivity & efficiency savings. This support is focussed on providing practical help at directorate level to improve delivery. KM&T will be supporting the development of the 2012/13 Financial Plan through an Opportunities Search and support to five workstreams identified as priority areas: Medicine Length of Stay; Outpatients; Workforce; Medical & Surgical Spend and General Surgery. The project initiation documents and resources implications will be assessed by TEG at the beginning of October 2011.

6. WORKFORCE PROGRAMME

An update is provided below on each of the 13 schemes within the Workforce Programme. Please refer to Appendix 2.

6.1 Enforced Retirements

Retirement Case Progress:
173 Retiring
113 require redeployment
24 Posts given up
36 Other

Of which:
70 requests to continue working beyond retirement age
Of these 35 were rejected, 35 had an extension granted.
17 Staff have appealed against decisions made.

This continues to be a very contentious issue with external publicity and interest from members of parliament challenging / questioning the Trusts policy in relation to individual cases.

6.2 Fixed Term Contracts

Of the 57 fixed term posts reported previously it has been confirmed that 44 of the posts are to be offered permanent contracts of employment. The 57 post were fixed term appointments within nursing and included a number of newly qualified nursing staff.

The HR Department are developing a detailed administrative process linking in with managers to identify fixed term posts that are coming to an end. Working with managers to deal appropriately with the contractual obligations in place relating to each individual case, identifying whether the posts are to be given up or whether the contracts are to be

extended. This process will also identify potential suitable candidates for inclusion on the redeployment register who then could be transferred across to cover the duties. Throughout the first quarter a total of 45 contracts were due to end, 7 of these contracts were ended with 38 contracts being extended.

NB: This scheme is an enabler of other initiatives and was intended to provide a source of vacancies should staff requiring these posts be displaced from elsewhere across the Trust. These posts have not thus far been required for this purpose.

6.3 **Agency Posts**

50 posts identified as suitable for redeployment as and when required, however to date none have been required, this work is ongoing. Agency posts continue to be monitored with a view to being removed to facilitate the appointment of displaced staff through organisational change. Throughout the first quarter of the financial year there have not been large numbers of staff available through redeployment therefore the majority of agency posts remain within the Trust. A second audit of Agency staff is currently underway within the HR Departments Resourcing Team.

6.4 **MARS**

107 MARS applications received
11 applicants have withdrawn
90 Compromise Agreements have been produced
88 Compromise Agreements have been signed off returned
59 staff left under the scheme in the first quarter

Of the 6 outstanding comprise agreements 5 are dependent upon the successful redeployment of candidates to backfill the roles – redeployment candidates have been provisionally identified for 2 of these posts and the HR department are working to find candidates for the other three posts. The remaining compromise agreement is with the employee to be signed off.

Financial validation of the cost and savings associated with completion of the MARS process shows and in year saving of 1.4m against a projected saving of 500k, and a recurrent saving for 12/13 of 2.1m against a projected saving of 1.5m. Investigation is underway to determine whether a second MARS scheme should run in the third quarter of 11/12 to bring further full year effect savings in 12/13).

6.5 **MAFS**

This scheme has been approved through Staff Side. The document has been updated based upon TEG comment and is ready for launch. The HR team are in the process of drafting the communication information for launch of the scheme which will be launched in September (two months later than planned).

6.6 **Voluntary Purchase of Annual Leave**

This policy has now been launched across the organisation. Throughout the first quarter of the year 9 members of staff have made an application under the scheme and been accepted. This has generated a FYE saving of £36k.

6.7 **Stop Weekly Pay**

The Finance and Payroll Department are scoping the financial savings available from this scheme, this will be finalised following completion of an external service review. The

employee relations team are forming a plan for the implementation of this scheme based on the required consultation and notice periods.

6.8 **Contact Centre**

Business Case was submitted to BPT in June and funding for the project approved. A project plan is in place and the pilot is scheduled to commence in October 2011, with a view to developing the pilot sites further.

6.9 **E-Rostering**

A Project Manager has now been appointed and a pilot in General surgery commenced on 5th September with staff working to the first electronic roster from this date. An IT provider has been identified and is working on development of the system with the Trust

6.10 **Removal Of Paid Breaks**

Discussions are ongoing to establish areas within the Trust where paid breaks are common practice. Once the evaluation is completed we will be able to verify the savings against this scheme and in turn be able to define timescales for the removal of the paid breaks. A key part of this scheme relates to the feasibility of removal of paid breaks through discussions with Trust managers ensuring that there is no further financial impact if the breaks are to be removed. It is also important that we understand the benefits of this process versus the potential impact upon staff morale and engagement.

6.11 **Reduction Of Sickness**

A target of 3.5% has been set for the forthcoming financial year 2011-12. The sickness absent rate will be monitored through HR as part of the KPI monthly reporting process. The implementation of the new Sickness policy has been delayed due to TCS project which means that the Trust will not gain a full year effect of benefit from the introduction of the amended policy. Consequently this is likely to impact on the Trusts ability to meet the 3.5% sickness absence target.

6.12 **Reduction Of Bank & Agency**

Confirmed targets for financial year 2011/12 are based upon actual monthly spend in both areas for 2010/11. The target has been set through the performance management framework as a spend no greater than 1% of the pay bill. This target is also being monitored through the Trust performance management framework. At present data shows that both Bank and Agency are above this target at 1.12% and 1.8% spend respectively. Based upon last years spend this shows a decrease in bank spend but an increase in agency spend in the first quarter of the year.

6.13 **Travel Expenses**

A small working party has been set up to undertake some initial cost based analysis with a view to producing suggested amendments to current policy. This work will need further support as changes will need to be tabled at JNC & LNC.

7. CORPORATE PROGRAMME

The table below summarises the financial savings at end Qtr 1.

Corporate Programme Qtr 1					
		Target Saving (£k)	Saving achieved to date (low or no risk) £k	Forecast Outturn Saving £k	Forecast Under/ Over achievement against target £k
	All projects	**9,166**	**2,912**	**5,851**	**-3,315**

A brief update is provided below on the main schemes within the Corporate Programme.

7.1 *Travel expense reduction:* - Work will commence shortly to review the travel expense policy including rail travel, cross city travel allowance and other travel allowances. This will include the use and assessment of the current travel agency arrangement.

7.2 *Reducing governance team pay costs* (£20k) – achieved

7.3 *Reducing STH Insurance premium* (£100k) – achieved

7.4 *Achieving NHS LA level 2* – Currently reviewing the possibility of moving away from NHSLA for insurance. Evaluation underway that if implemented could achieve significant savings in 2013/14.

7.5 *Reduce Estates Footprint* – a decision is due to take place in September regarding disposal of 3 properties and the release of a lease. If approved likely to take 6 months therefore no saving in FY 2011/12 A strategic review of estate use, including a review of the Hallamshire tower options is currently being undertaken.

7.6 *Carbon Footprint reduction* –delivered £250k to date, currently ahead of target.

7.7 *Reduction of Minor new works (<£5k)* - On target

7.8 *Rationalisation of Provider Arm management costs* Work nearing completion for PA senior management. A review of middle management costs is now underway.

7.9 *Sheffield NHS wide back office rationalisation* - With recent management changes that have occurred in Sheffield, none of the NHS organisations have been able to progress this project and have withdrawn. Therefore there will be no savings arising from this project.

7.10 *IT Benefits Realisation* PACS, ICE & Single PAS. Patient Centre delays mean no savings in 2011/12. Further investigation on PACS and ICE confirm that these will not deliver savings in 2011/12.

7.11 *STH/Provider Arm ICT shared services* - progress has been limited to date. The new Informatics Director will now review the feasibility and options.

7.12 *Case note tracking*– this project has been delayed and will not deliver any savings in 2011/12 although is likely to deliver savings in 2012/13. Savings are currently being quantified.

7.13 *Single Switchboard* – this Project is scheduled for implementation in September, once Estates developments are complete. Service development savings in 2011/12 estimated to be £75k with further savings on 2012/13 of £150k.

7.14 *Managed print services* – this project has been delayed and a proposal to support its completion is to be reviewed by the Trust Executive Group in September. Unlikely to achieve direct savings in 2011/12.

7.15 *Procurement Savings:*

- *Central STH large scale projects* £1,950 savings to date.
- *Commissioning Hub benefits* – no savings identified to date.
- *Central STH small scale projects* - £150k savings to date – on target

8. <u>The Board of Directors is asked to note:</u>

8.1 The month 4 results which show financial delivery of £5,517.4m for P&E against a Trust plan of £8,576.1m. This represents a shortfall against target and a shortfall against plan. The under performance is being addressed through the Performance Management Framework.

8.2 The range of improvement activities across the three programmes to support, enable and challenge Directorates to deliver service improvements.

8.3 The additional consultancy support which has been commissioned by TEG and the opportunities search to inform the 2012/13 Financial Plan.

Mike Richmond
Medical Director

Mark Gwilliam
Director of Human Resources & Organisational Development

Andrew Riley
Corporate Development Director

September 2011