North East London Health & Care Partnership

2022/23 System Financial Recovery Summit

31 October 2022

Agenda

North East London Health & Care Partnership

	Item	Lead	Time
1	Introductions and scene setting:	Zina Etheridge	11.30
2	Current financial climate: • NHS M6 Results, FOT and benchmarked productivity • Local government summary	 Henry Black Ian Williams	 11.35 11.45
2	Drivers of the Financial Deficit • Introduction • Temporary Staff Controls	 Henry Black Nick Swift / Alan Wishart	 11.55 12.00
	Lunch break		12.20
4	Drivers of the Financial Deficit • Surgical Optimisation • WXH Improvement Programme	 Claire Hogg and Amalesh Thangadorai Neil Bourke, Hannah Evans and Eva Fiz	 12.30 12.55
3	Summary, agreed actions and next steps - Commitment for H2 delivery - Reporting - Governance	Zina / Henry	13.20

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NHS NEL Current Financial Climate

Henry Black

NEL Finance overview

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- NEL has been a financially distressed system for many years
- Pre-pandemic, 2019/20 system deficit of £54m

	2019/20 £'000
Barts	-73,119
BHRUT	-23,072
HUH	7,191
ELFT	9,391
NELFT	8,603
Provider Total	**-71,006**
CCGs/ ICB	16,775
ICS Total	**-54,231**

- 2020/21 deficit support rebased the system to financial balance
- However, cost pressures have continued to grow
- £86m further cost pressures in 2022/23 alone

- Underlying financial position- current MTFS modelling

	21/22 underlying deficit £'m	Conver-gence £'m	Inflation above 5.3% £'m	CNST pressure £'m	'Growth' above allocation £'m	LAS 999 and 111 above allocation £'m	CHC cost pressure £'m	Cost of capital £'m	22-23 underlying baseline £'m
Barts	**-52.3**	-3.0	-23.7	-3.3					**-82.3**
BHRUT	**-9.8**	-5.4	-1.8	1.5				-5.0	**-20.5**
HUH	**-11.4**	-1.5		-3.6				-1.5	**-18.0**
NELFT	**-14.0**	-1.7	0.0						**-15.7**
ELFT	**-7.5**	-1.5							**-9.0**
NEL ICB	**-36.8**				-17.6	-12.7	-5.3		**-72.3**
Total	**-131.8**	**-13.1**	**-25.5**	**-5.4**	**-17.6**	**-12.7**	**-5.3**	**-6.5**	**-217.8**

- The system has started the year, before efficiencies with a £217.8m financial deficit to cover to meet the statutory objective of break even
- The plan for the current year requires £186m of efficiencies and another £40m+ non-recurrent measures to break even

Finance performance year to date

NEL YTD Summary Month 6

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	Plan £000	Actuals £000	Variance £000
Barts	0	-29,652	-29,652
BHRUT	-3,097	-22,641	-19,544
ELFT	-1,294	-4,203	-2,909
HUH	-394	-4,976	-4,582
NELFT	0	-495	-495
Provider	**-4,785**	**-61,966**	**-57,181**
ICB	**0**	**7,498**	**7,498**
ICS Total	**-4,785**	**-54,468**	**-49,684**

- At M6 £54m in deficit, £50m off plan.
- YTD provider deficit of £62m excludes £18m of ERF, shown with the ICB – position would be worse by £18m if ERF returned
- We have not delivered £25m of our planned efficiencies (out of £82m target) and excess costs above funding (inflation) being main drivers of the YTD deficit in providers.
- ICB position of £7.5m surplus, includes £18m ERF, underlying deficit at M6 of £10.5m resulting mainly from CHC and prescribing cost pressures

Forecast Outturn

	Worst £'000	Best £'000	Likely £'000
Barts	-57,500	-18,500	-45,500
BHRUT	-40,200	-30,200	-35,200
HUH	-10,306	-7,138	-9,306
ELFT	-7,000	0	0
NELFT	-4,000	4,000	0
Provider Total	**-119,006**	**-51,838**	**-90,006**
ICB	0	0	0
ICS Total ex ERF	**-119,006**	**-51,838**	**-90,006**
22/23 ERF	40,238	40,238	40,238
ICS inc. full ERF	**-78,768**	**-11,600**	**-49,768**

- The initial 'likely' scenario with full ERF would be a system deficit of £49.8m
- £27m impact of excess inflation (energy, indexed contracts PFI etc.) included in Barts forecast
- Impact of winter pressures is an unquantified variable
- Actions already assumed within FOT:
  - Balance sheet support £30.8m (Barts £20m, BHRUT £8m, HUH £2.8m)
  - Deliver £30m of planned efficiencies of £50m +£8M NR (BHRUT)

NEL Workforce

Org Name	March 20	March 21	March 22	August 22	%increase 1920 to 2223
Barking, Havering and Redbridge University Hospitals NHS Trust	7,721	8,102	8,644	8,577	11%
Barts Health NHS Trust	17,323	18,637	19,656	19,693	14%
East London NHS Foundation Trust	6,539	7,331	7,615	7,665	17%
Homerton University Hospital NHS Foundation Trust	4,313	4,450	4,499	4,422	3%
North East London NHS Foundation Trust	6,101	6,881	7,272	7,316	20%
NHS North East London	41,996.4	45,400.7	47,686.0	47,673.6	14%
NHS North Central London	44,014.2	47,144.5	48,493.4	48,181.4	9%
NHS North West London	53,231.6	59,377.4	58,785.5	59,151.1	11%
NHS South East London	52,904.1	55,610.5	56,689.1	56,440.6	7%
NHS South West London	31,597.4	34,187.6	35,106.0	34,682.0	10%

- NEL highest increase in London at 14% by comparison to the other London ICS's which range from 7% to 11%
- Some of the increase will be for new services, SDF and MHIS, services understaffed or under provided in 19/20 such ICU beds
- The balance offers scope to reduce our unsustainable cost base

YTD

Organisation	Plan 20 Mar-23 WTE	M6 YTD Plan WTE	M6 YTD Actual WTE	YTD Variance WTE	M6 Plan Pay £'000	M6 Actual Pay £'000	M6 Variance £'000
Barts	19,635	19,514	17,892	1,622	587,417	611,674	-24,257
BHRUT	8,757	8,626	8,544	82	250,197	260,534	-10,337
ELFT	7,236	7,330	7,601	-271	195,909	209,973	-14,064
Homerton	4,680	4,657	4,391	266	130,657	134,668	-4,011
NELFT	7,414	7,233	7,531	-298	191,787	203,907	-12,120
Total	**47,722**	**47,360**	**45,959**	**1,401**	**1,355,967**	**1,420,756**	**-64,789**

- All provider overspending against pay plan YTD M6
- Barts, BHRUT and HUH below anticipated WTE utilisation – not translating into £ reduction

Agency and the cap

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Providers	2021-22	Planned Reduction	Planned Reduction	Cap 2022-23	M6 YTD Plan	M6 YTD Actual	M6 YTD Variance	M6 YTD Variance %	Projected Annual cost based on extrap M6 YTD	Projected Variance from CAP based on extrap M6 YTD	Projected Variance from CAP based on extrap M6 YTD %
Barts	47,087	-5,880	-12%	41,207	20,070	28,195	8,125	40%	56,390	15,183	37%
BHRUT	42,975	-12,709	-30%	30,266	16,741	18,860	2,119	13%	37,719	7,453	25%
ELFT	30,248	-5,244	-17%	25,004	12,915	14,174	1,259	10%	28,347	3,343	13%
Homerton	23,427	414	2%	23,841	11,922	12,200	278	2%	24,400	559	2%
NELFT	44,048	-9,227	-21%	34,821	20,631	23,797	3,166	15%	47,594	12,773	37%
Total	**187,785**	**-32,646**	**-17%**	**155,139**	**82,279**	**97,225**	**14,946**	**18%**	**194,451**	**39,312**	**25%**

- The agency cap equates to the annual plan for agency and by achieving the plan the system will achieve meet the cap, however, YTD M6, the system was £14.9m above plan and cap
- M6 annualised projection for agency is above plan and cap expenditure by £39.3m of which £15.2m at Barts and NELFT £12.7m. BHRUT trend has been decreasing month on month now £7.5m (£11.7m M3).
- Straight line of the YTD variance would indicate a £29.9m overshoot of the cap, however, this is in part explained by the back ended pay efficiencies and phasing of the agency plan.

Productivity overview

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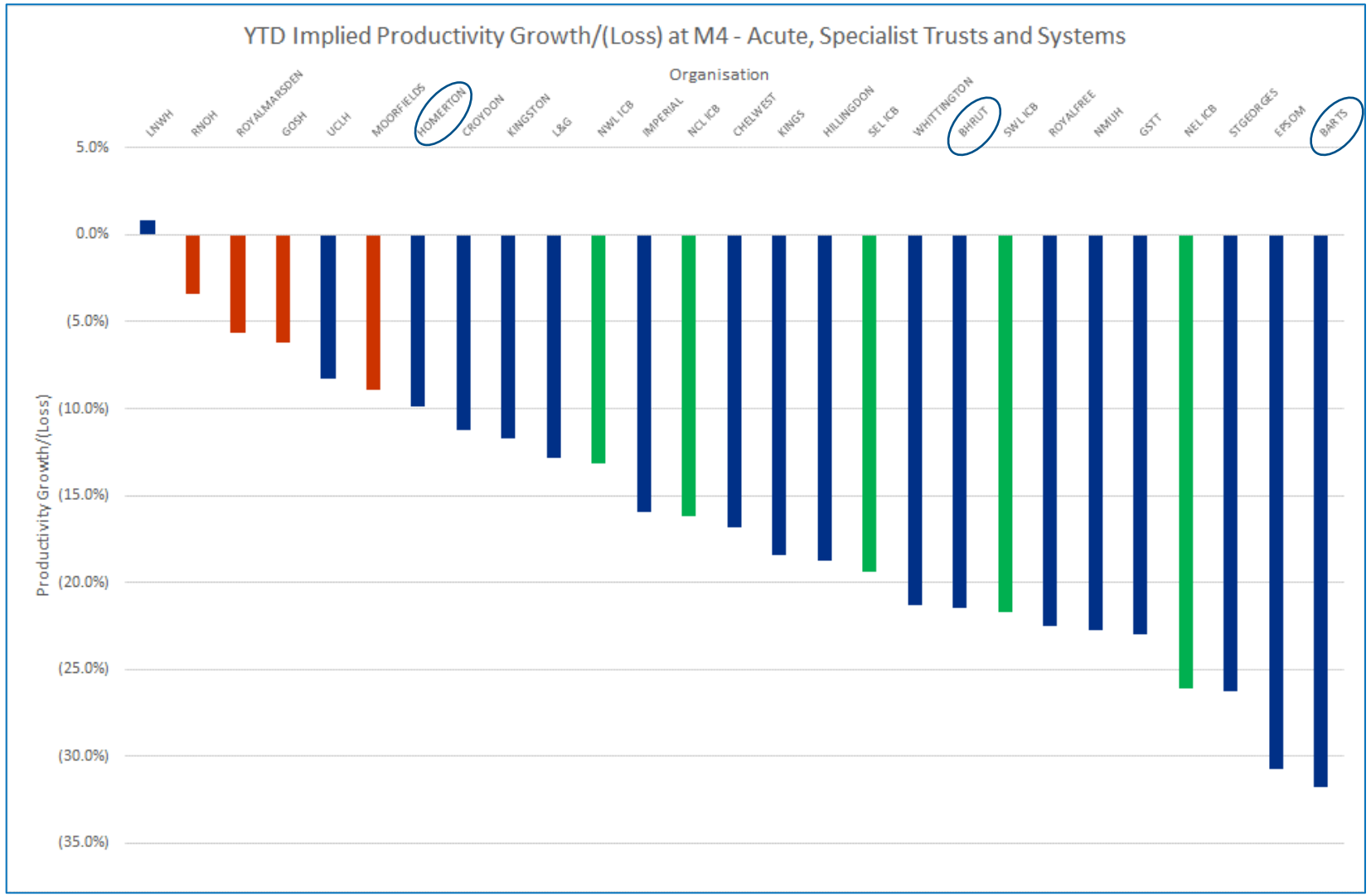
Org Name	YTD Real Term Cost Growth YTD Real Terms Cost Growth at M4	YTD Cost Weighted Activity Growth YTD CWA Growth at M4	YTD Implied Productivity Growth YTD Implied Productivity Growth at M4	 Change from previous month	YTD Activity Growth by POD APC Elective	 OP First	 OP Follow up	 AE Type 1&2	 APC Non Elective
NHS North East London CCG									
North East London ICB									
Barking, Havering and Redbridge University Hospitals NHS Trust	25.3%	-1.6%	-21.5%	-0.1%	-9.4%	-5.5%	-14.9%	-9.1%	5.5%
Barts Health NHS Trust	14.8%	-21.7%	-31.8%	-0.8%	-16.4%	-13.8%	-1.9%	-10.5%	-35.3%
East London NHS Foundation Trust	27.0%	-	-	-					
Homerton University Hospital NHS Foundation Trust	13.4%	2.1%	-9.9%	-0.8%	-8.6%	41.4%	4.8%	-0.9%	-4.2%
North East London NHS Foundation Trust	21.9%	-	-	-					
NHS North East London	17.0%	-13.5%	-26.1%	-0.6%	-13.1%	-2.8%	-3.9%	-8.2%	-19.8%
NHS North Central London	14.5%	-4.0%	-16.2%	-0.7%	2.7%	6.9%	6.5%	-3.3%	-24.6%
NHS North West London	8.5%	-5.8%	-13.1%	-0.8%	-6.7%	5.8%	-5.9%	-15.2%	-6.2%
NHS South East London	15.6%	-6.8%	-19.4%	-0.2%	-10.8%	3.7%	3.9%	-10.7%	-11.6%
NHS South West London	16.1%	-9.1%	-21.7%	-0.2%	-4.0%	8.5%	7.4%	12.5%	-30.2%

- Deep dive metrics provided by London (M5), illustrate a number of the issues NEL is facing
  - On average, cost growth is highest in London. Whilst the highest cost increases belong to providers in different systems, collectively, NEL has the unfortunate distinction of experiencing the highest (17%) YTD
  - By system cost weighted activity has fallen in all London systems and by a significant margin NEL has experienced the largest falls at 13.5%. This is driven by Barts, which are showing the largest fall (%) of all acute providers in London.
  - Implied productivity growth has fallen across London. However, the effect in NEL is almost double that experienced in NWL and has fallen further than all London ICS's. Barts, again, when viewed across London has experienced the greatest drop in implied productivity. All NEL providers deteriorated from prior month.
  - YTD activity growth is negative across all PODs monitored. Elective and OP first performance has suffered the worst deterioration across the London ICS's. OPFU, A&E and Non Elective have all fallen as well.
  - It is interesting to observe that some ICS's have managed to grow elective, OP First, OP FU and A&E activity.

Provider relative performance (m4) since 2019/20



- At M4 YTD, all NEL providers were experiencing decline in their productivity using the NHSE metric since 2019
- This chart illustrates the size of the problem in NEL, where Barts is the worst performer in London and BHRUT 9th from bottom.
- For context, London as a whole is slightly below the national average:

YTD productivity 22/23	YTD 22/23 vs 19/20		
	RT Cost Growth	CWA Growth	Productivity Growth
East of England	15.6%	(7.4%)	(19.9%)
London	14.3%	(7.7%)	(19.2%)
Midlands	17.9%	(5.9%)	(20.1%)
NE & Yorkshire	13.0%	(3.8%)	(14.9%)
North West	17.9%	(7.6%)	(21.6%)
South East	19.0%	(1.4%)	(17.2%)
South West	17.4%	(8.3%)	(21.9%)
All regions	**16.2%**	**(5.9%)**	**(19.0%)**

The formula used to calculated productivity growth/(loss) = **[(1 + CWA growth) / (1 + RT cost growth)]-1.** CWA calculation includes A&E type 1 and 2, elective inpatient (DC and EL IP combined), non-elective inpatient and outpatients new and follow up attendances including diagnostics and imaging outpatient activities.

Theatre Utilisation – Productivity Opportunity (Deloitte)

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Summary

Analysis of session and in session utilisation to establish the value of lost time against an 85% target for sessions going ahead and in session utilisation.

Data Sources

BHT:

- Internal theatres performance reporting: Theatre Sentinel Metrics v4 (1/04/22 – 24/07BHT/22)
- Model Hospital

BHRUT:

- Internal theatres driver report: Drivers of Financial Strategy V9 – Elective Improvement Programme

Data Methodology

85% utilisation target for theatres (sessions going ahead) and in session has been set by both organisations and this is consistent across the NHS.

For BHRUT the value has been provided based on income received for additional throughput. For BHT this has been calculated on a cos basis as outlined below:

Session opportunity:

$$((Total\ theatres \times number\ of\ BAU\ session\ minutes\ available\ each\ year \times 85\%\ utilisation\ target) - current\ actual\ session\ minutes) \times £14\ per\ minute$$

In session opportunity:

$$((Total\ session\ minutes\ per\ year \times 85\%\ utilisation\ target) - utilised\ session\ minutes\ per\ year) \times £14\ per\ minute$$

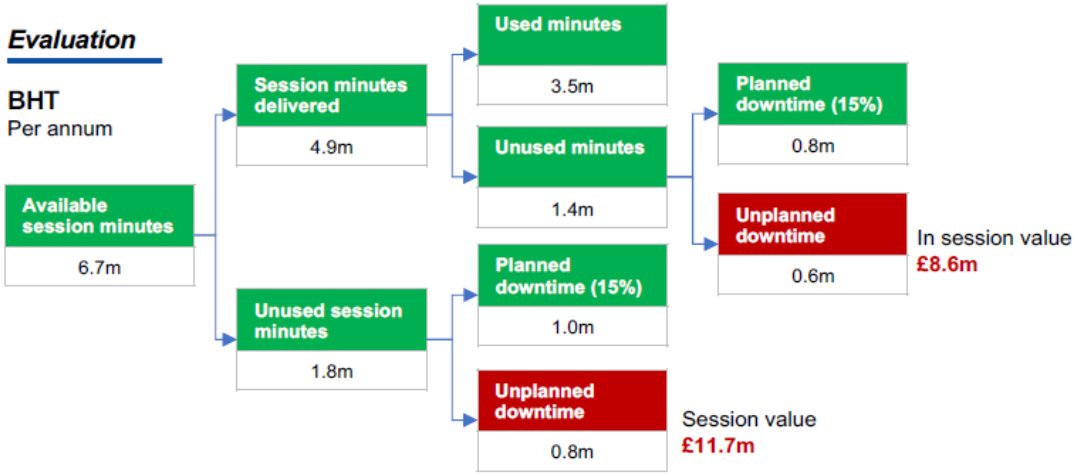
£14 per minute is the NHSE/I reported cost per minute of theatre time.

BAU refers to core capacity, excluding additional sessions such as WLI

The value that BHR calculated internally has been taken for the purposes of this report. The same methodology has then been applied to BHT to derive an amount under utilised theatre time.

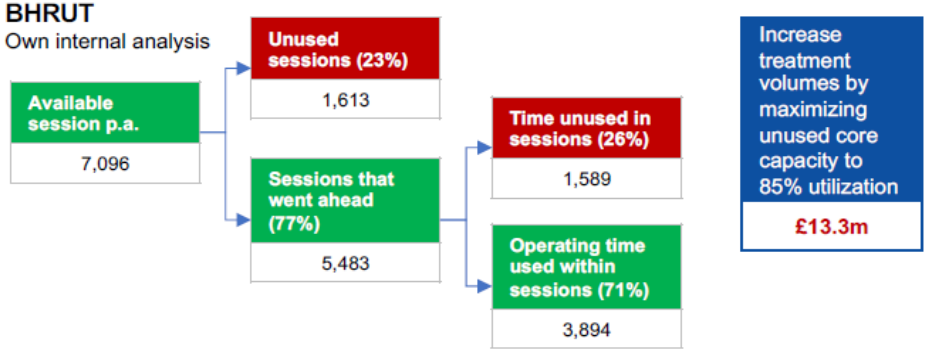
Evaluation

BHT
Per annum



The value of lost time compared to an 85% target for session utilisation and in session utilisation is £11.7m and £8.6m respectively. This equates to a total value of under utilised theatre capacity of **£20.3m**

BHRUT
Own internal analysis



BHR also identified 2 other areas which feature in the elective recovery plan. These have been excluded from the DOD calculation to avoid double-count with other drivers. These are; Eliminate use of premium cost capacity (£6.2m); Improve case-mix in theatres (£0.4m); Reduction in over-runs (£1.2m).

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Local Government Current Financial Climate

Ian Williams

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Drivers of the Deficit - NHS

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Temporary Staffing Controls

Nick Swift and Alan Wishart

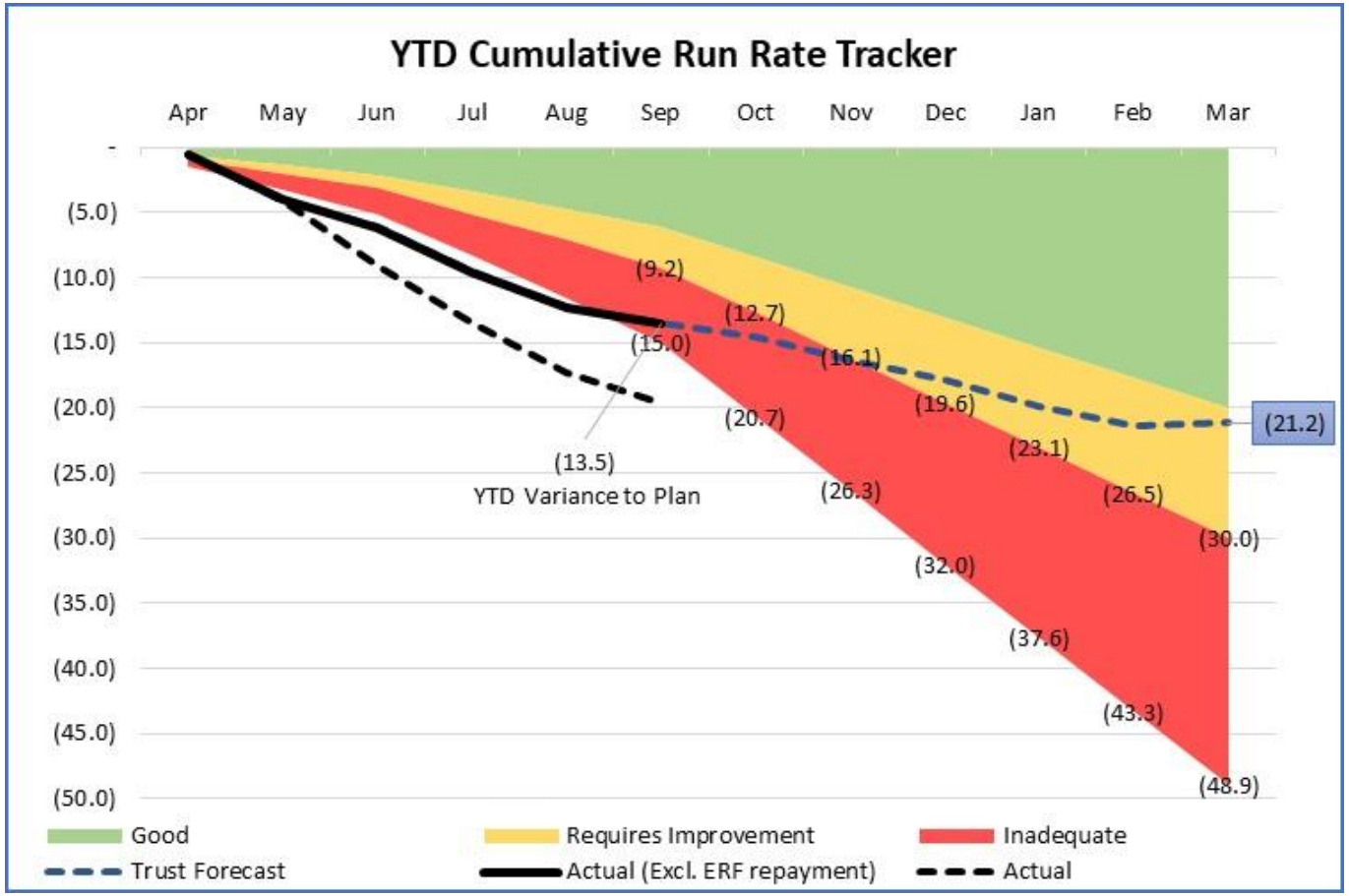
BHRUT ambitions and progress

Drivers of deficit work consistently shows financial waste of c£100m (ex COVID):

- £50m operational (primarily bank and agency, elective utilisation, some corporate)
- £50m strategic (CNST, system demand)
- Minimal structural

Deliberately set out ambition for full £50m of opportunity (6%), with c£20m risk

Starting to show progress, but plenty of risk



BHRUT – grip and control environment

Temporary staffing cost reduction opportunity

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Excess Rates Profile

Baseline Premium Summary

	Annual Opportunity	YTD achievement (annualized)
Bank Escalated Rates	Rates above approved: £6.4m	£1.2m
Agency Escalated Rates		
Medics Agency to Bank	Agency to Bank: £9.3m	£3.2m
Non-Medics Agency to Bank		
Bank to Perm	Bank to Perm: £11.6m	£3.3m
	£27.3m	£7.7m

Improving bank and agency controls

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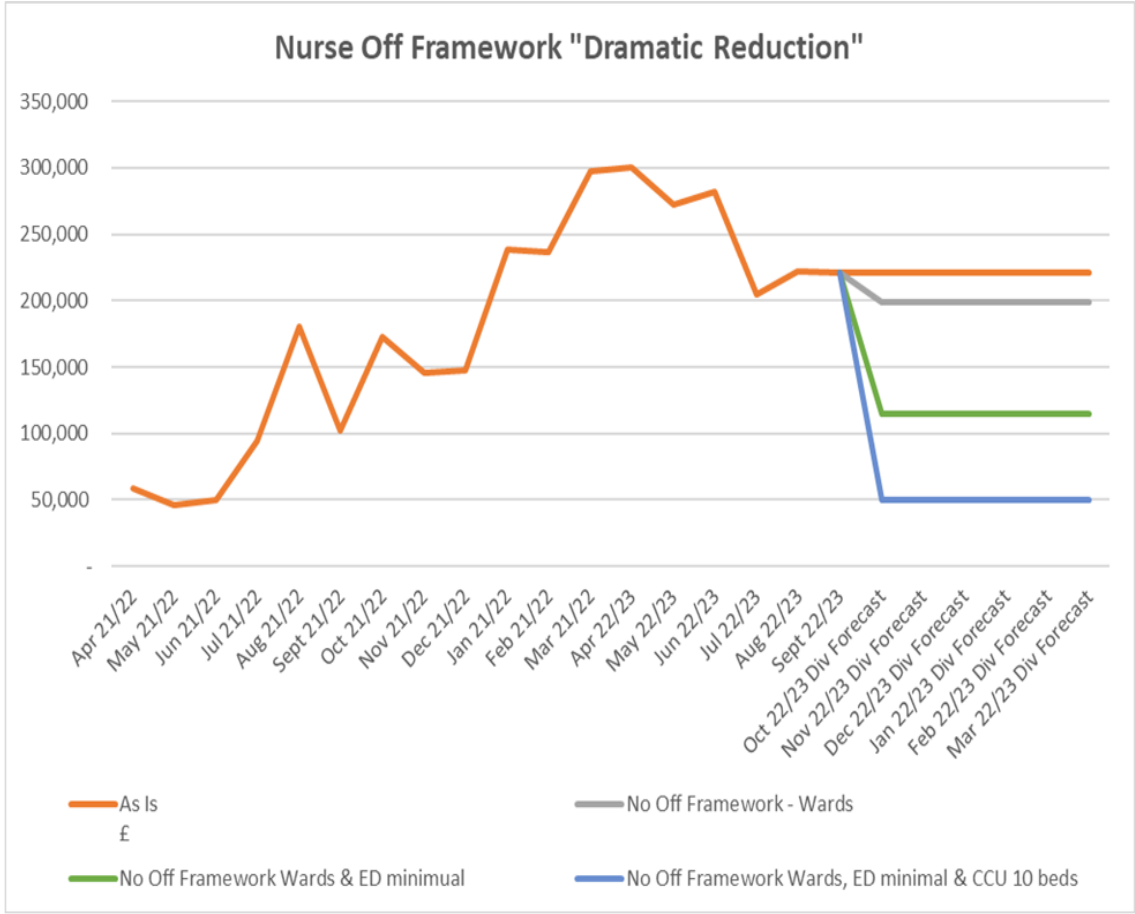
	Approval	Last minute
Bank and agency usage		
Rostering compliance	Divisions, reviewed by hub with compliance reporting in perf meetings	
Additional shift request		HUB, following escalation checklist
Claims (to avoid current retro issues)	New process required to ease on time claims	
Bank and agency rates		
Standard rates set	TEC, recommended by HUB	
Request for enhanced rates	IRG – benefits and affordability	HUB
Off framework agency	Stopped from 30 Sep – need to use on framework agencies (roughly half the cost)	

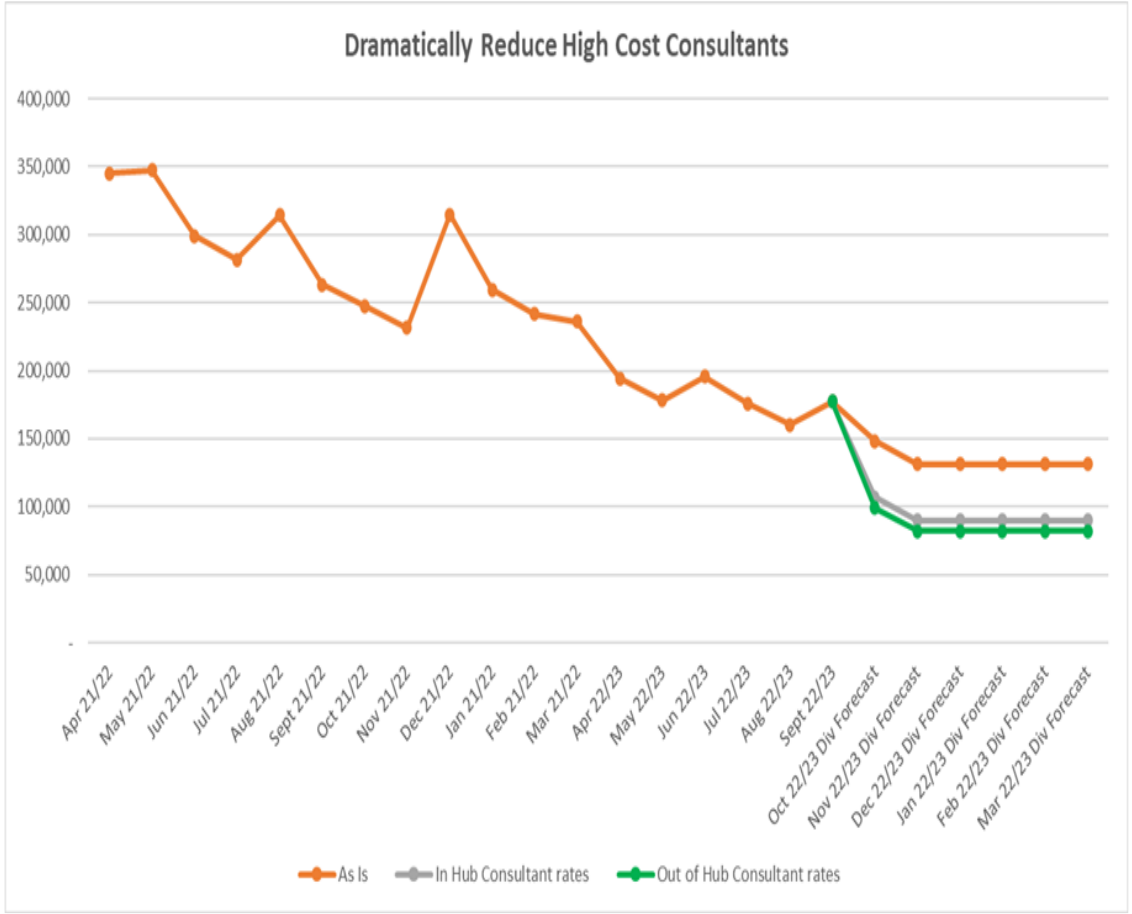
Nurse off framework

- Stopped nurse agency off framework 30 September
- Improving finance visibility and literacy for wards
- Developing winter plans using bank not agency and build into forecast
- Graph shows off framework spend significantly increased since April 2021
- But reduced dramatically over last few months
- If controls work in all areas spend will be back in line April 2021



Medical escalated rates

- BHRUT has reduced number of hourly paid consultants and other high cost doctors
- Graphs shows dramatic reduction in high cost consultants spend from c£350k in April/May 2021 to c£170k in September 2022
- Working through challenges of job planning with complexities of legacy and cultural issues
- Developing programme to improve experience of junior doctors
- Medical workforce hub still reports between 130-150 consultant shifts worked at escalated rates each week
- Work ongoing with most affected specialties to bring shifts in line with published rates
- If controls work then run rate forecasted at below £100k per month from £350k



Rolling 12 week temporary staffing KPIs

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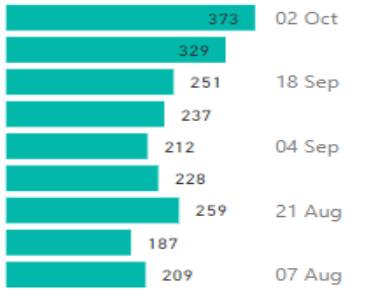
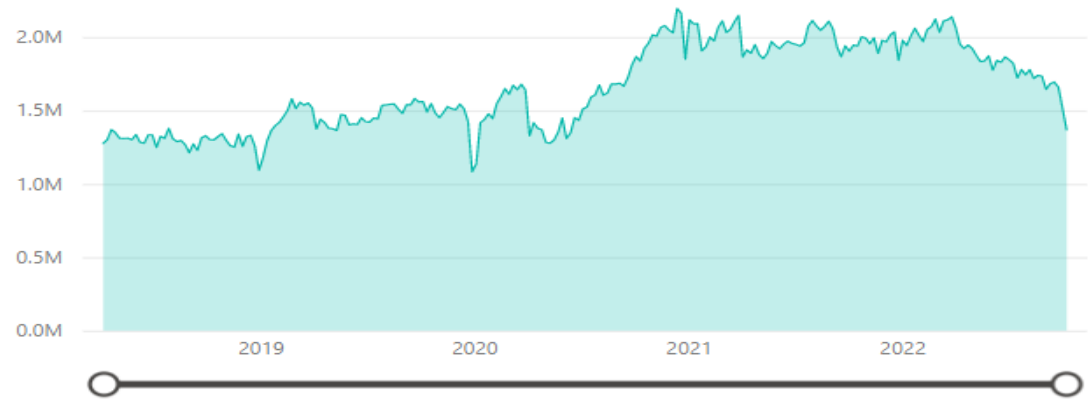
Rolling 12 Week KPI's

	07/08/2022	14/08/2022	21/08/2022	28/08/2022	04/09/2022	11/09/2022	18/09/2022	25/09/2022	02/10/2022	09/10/2022	16/10/2022	23/10/2022
Bank Cost	1,142,997	1,091,796	1,102,805	1,102,327	1,092,956	1,091,278	1,088,178	1,050,972	914,173	814,973	675,072	458,850
Agency Cost	634,875	626,064	636,347	630,824	550,551	589,834	605,306	607,393	602,125	553,529	478,549	286,078
Total Cost	1,777,872	1,717,860	1,739,152	1,733,151	1,643,507	1,681,111	1,693,484	1,658,364	1,516,298	1,368,501	1,153,621	744,928
Total WTE	1,322.8	1,278.1	1,274.9	1,297.0	1,246.2	1,278.8	1,289.5	1,231.3	1,169.6	1,119.9	1,027.2	694.9
Fill Rate %	80.0%	79.4%	80.9%	80.0%	80.6%	82.3%	82.0%	80.1%	77.4%	75.0%	71.0%	63.0%
All Rate Breaches	688	654	693	713	678	705	716	639	611	499	347	148
Medic Rate Breaches	366	373	362	320	309	363	337	324	295	130	43	34
Medics Rate Compliance	70.7%	67.0%	68.9%	72.0%	70.9%	67.9%	70.0%	70.6%	71.5%	84.5%	93.7%	93.0%
Medic DE Compliance	66.2%	63.1%	70.8%	68.6%	72.5%	67.9%	72.4%	69.7%	72.8%	75.5%	76.4%	79.0%
Unclaimed Shifts	209	187	259	228	212	237	251	329	373	598	3,361	2,605
Retrospective Booking	1,634	1,546	1,422	1,426	1,303	1,440	1,441	1,251	1,142	1,045	116	

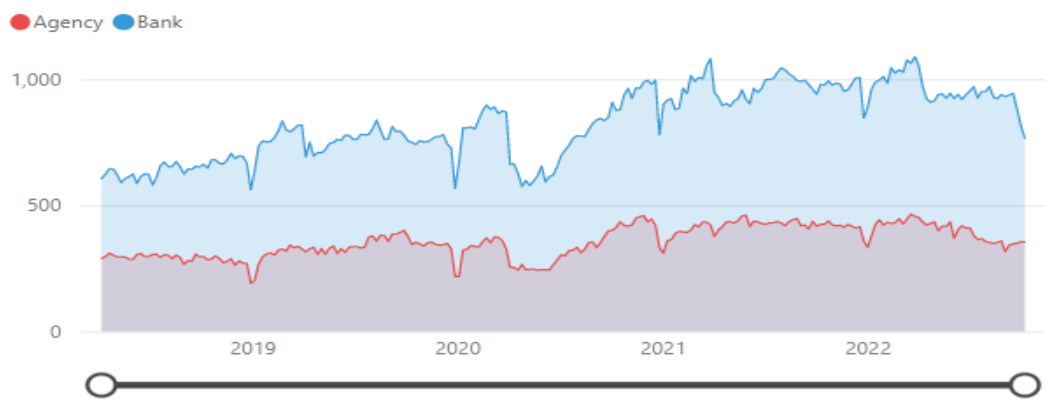
Unclaimed Shifts



Weekly Cost Profile



Weekly WTE Profile



Other actions/measures

- Recruitment 1 in 1 out replacement of temporary staffing to minimise growth in establishment
- Recruitment drive to build workforce which is 90% substantive, 7% bank and 3% agency
- Previous business cases increasing headcount by 1,200 reviewed and RAG rated to remove 300 WTEs (from 8,640 WTEs to 8,340)
- Improved monitoring and reporting on roster compliance e.g. additional duties, unapproved rosters
- Working with Divisions and Bank Partners to review of retrospective and unclaimed B&A shifts
- Working with planned care and UEC programmes to create sustainable solutions to vacancies and use of temporary staffing
- Working collaboratively to improve workforce productivity to narrow workforce gap across APC

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Surgical Optimisation

Claire Hogg and Amalesh Thangadorai

Planned Care Programme Aim & Activities

An integrated system programme to improve equity of access to planned care for the people of North East London

North East London Health & Care Partnership

Programme Aim	Key Drivers	Activities & Interventions	Commentary
To reduce waiting times for elective care in line with the national recovery plan so that no one is waiting more than 52 weeks by March 2025	Manage Demand	Waiting list management	Clinical prioritisation; validation; scheduling across the whole pathway (non admitted, diagnostic & admitted); Access policy
		Outpatient & out of hospital services	Virtual OP appt; A&G; PIFU; SPA; Primary/Secondary Care interface; community triage; community provision and supporting people to 'wait well'
	Optimise existing capacity	Mutual Aid	Using mutual aid to reduce variation in access times across NEL – diagnostics; endoscopy, surgical procedures (not LTC).
		Independent Sector	Are we making the most of available IS capacity to support non-admitted, diagnostic & admitted recovery? How do we reduce variation in access?
		Productivity & Efficiency	Theatre efficiency & productivity; Diagnostic efficiency & productivity, GIRFT;
		Workforce	Identifying & addressing workforce gaps that limit are ability to optimise existing capacity e.g. anaesthetics; ODP; theatre nurses; radiographer; radiologists are required for new capacity
	Create new capacity	Community Diagnostic Centres	Implementing early adopter sites and developing plans for additional CDHs
		High volume surgical hubs	Creating surgical hub strategy and implementation plan across NEL linked to TIF schemes
		Digital Transformation	Using new technology to transform how we use our capacity and support transformation in the way in which we provide services

Planned Care Programme - Governance & Oversight in 22-23

North East London Health & Care Partnership

Integrated Care Board

Acute Provider Collaborative

NEL Planned Care Recovery and Transformation Board

- NEL Surgical Optimisation Group
- NEL Outpatient & Out of Hospital Group
- Diagnostic Programme Group
- Elective Recovery Leads Group

Peri-operative CLG

- **General surgery CLG**
- **Orthopaedic CLG**
- **Gynaecology CLG**
- **Ophthalmology CLG**
- **ENT CLG**
- **Urology CLG**
- **Imaging network**
- **Endoscopy network**

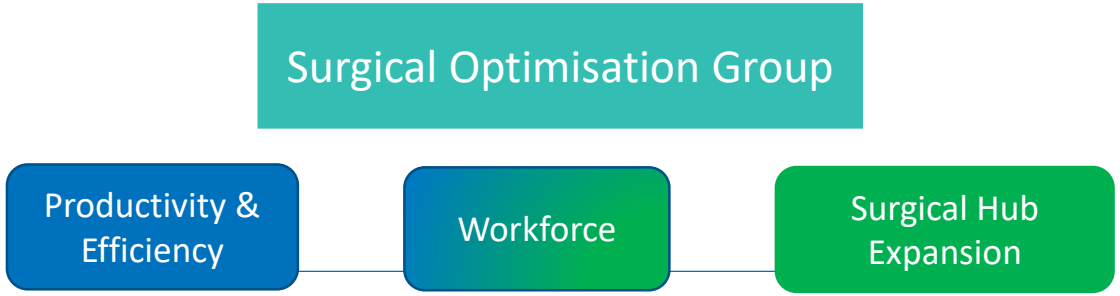
** CLG = clinical leadership group*

Supporting system infrastructure

- **Planned Care Programme Management Team**
- **Health Inequalities Group**
- **Data Group**

Surgical Optimisation Group

North East London Health & Care Partnership



TERMS OR REFERENCE	
Membership of Group	**Purpose of Group**
CORE MEMBERS:- • Chair – Thangadorai Amalesh, Lead for Surgical Optimisation/HVLC Sites • Co-chair – Claire Hogg, Director of Planned Care • Surgical Divisional Leadership - BHRUT, HUH, WXH, RLH & NUH • SRO/Programme Director – Productivity & Efficiency Workstream OTHER INVITEES Trust Elective Recovery Lead Barts Health Director of Clinical Transformation NEL Performance Team Admitted Pathway Lead SRO/Programme Director – Workforce Lead HVLC Clinical Leadership Group Chairs	This group will provide leadership, oversight and assurance of the following streams of work in 22-23 • Improving productivity & efficiency of existing theatre capacity with a particular focus on optimising HVLC sites • Planning for new surgical capacity (TIF theatres) • Workforce engagement, development & expansion associated with productivity & efficiency and TIF theatre implementation HVLC clinical leadership groups will report work on productivity, efficiency & GIRFT metrics into this group.
Frequency	**Reports to**
Meeting monthly	Planned Care Recovery & Transformation Board

SURGICAL OPTIMISATION PRORITIES FOR 22-23

North East London Health & Care Partnership

- **Theatre productivity improvements** - We must improve theatre productivity across all sites focusing activities that will improve the following key metrics
  - Late starts
  - Early finishes
  - Capped theatre utilisation
  - Fallow lists
  - Cancellations (on the day & up to 3 days before)

- **Theatre scheduling & on-the-day improvements** - We must ensure all of site have robust 6-4-2 planning, patient contact and optimisation pre surgery and criteria-led discharge in place. We need to share good practice and learning across all sites and agree a NEL standard.

SURGICAL OPTIMISATION PRORITIES FOR 22-23

North East London Health & Care Partnership

- **Theatre capacity utilisation across NEL** – targeting available capacity to treat longest waiting patients and maximise throughput. This requires mobilisation of NEL hub model
  - **Homerton & KGH**
    - Provide 'mutual aid' across NEL to support reduction in long waiters. Mutual aid means accepting patients from other hospitals within NEL across all 6 HVLC specialities i.e. patients transfer to these sites and are treated by BHRUT and Homerton surgeons
    - Additional capacity (e.g. weekend list) can be made available for Barts Health surgeons to operate on Barts patients (This has already happened at Homerton for ENT)
  - **Whipps Cross**
    - Plane Tree elective surgical centre provides capacity for high volume, low complexity ENT and urology surgery across the Barts Health Group. Eye Treatment Centre provides capacity for high volume, low complexity ophthalmology surgery across the Barts Health Group. This means surgeons move with their patients to Whipps Cross
  - **Newham**
    - Surgical centre on main sites provides capacity for high volume, low complexity Gynae & General surgery across the Barts Health Group. This means surgeons move with their patients to Newham.
    - BHOC provides high volume, low complexity capacity for high volume, low complexity orthopaedic surgery for Barts Health Group & Homerton. Surgeons at Barts and Homerton already have job planned sessions at BHOC. BHOC has capacity to provide mutual aid to NEL for HVLC e.g. upper limb This means patients moving and being treated by BHOC surgeons

- **Planning implementation of 6 additional theatres for NEL funded by TIF** – oversight of implementation & mobilisation plan. Agreeing what we need to do collectively rather across NEL rather than individually

APC/BH-BHRUT Collaboration - Sharing good practice on theatre productivity and delivering BAU activity

North East London Health & Care Partnership

Workstream Objective

To improve theatre productivity and efficiency across Model Hospital metrics.

To reduce variation in theatre productivity & efficiency between sites.

To deliver/exceed BAU levels of elective activity.

Rationale for collaboration

- To reduce variation in theatre productivity & efficiency by sharing good practice across the Group

Governance:

NEL Surgical Optimisation Group
NEL Planned Care Board

Expected benefits (including impact on EDI)

Increased levels of activity through same capacity

Key dependencies and enablers

- All sites to have theatre efficiency & improvement programme of work established
- Data on theatre productivity & efficiency must be recorded in the same way across all sites
- Ability to maximise theatre utilisation dependent upon workforce capacity i.e. vacancies, use of temporary workforce, job plan capacity

Key Milestones & owners

Milestone	Due Date	Owner	Actions needed
Site based theatre productivity & efficiency programmes to be confirmed	Dec 22	Trust COO & Site CEOs	• Review theatre productivity & efficiency metrics at site level to identify opportunities for improvement & areas of good practice • Identify drivers of theatre productivity & efficiency at site level • Identify & track improvement actions • Site representation at NEL Surgical Optimisation Group to share good practice
Improve theatre productivity metrics (capped utilisation; late starts & early finishes)	April 23	Trust COO & Site CEOs	• Identify high performing sites and contributing factor including areas of good practice • Clinical lead visits to sites to share good practice • Programme Manager attendance at 6-4-2 meeting to identify practice across sites; understand variation and create best practice SOP • Surgical Optimisation to facilitate sharing good practice between sites
Reduce number of fallow lists	April 23	Trust COO & Site CEOs	• Ensure all sites have tracking in place to capture fallow list activity • Identify drivers of fallow list capacity • Identify variation between sites and drivers of variation to understand good practice • Identify & track improvement action

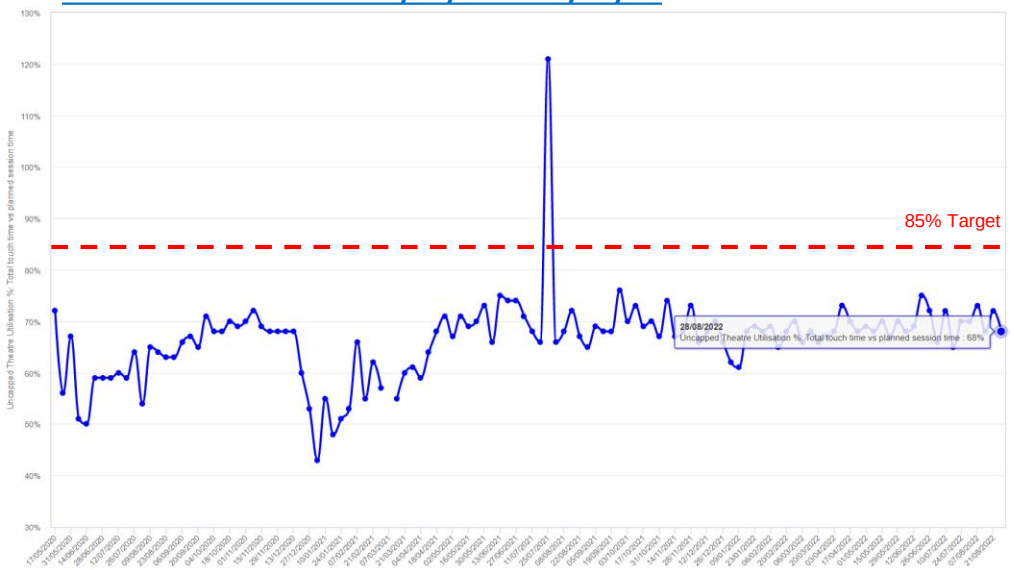
Key risks & mitigations

Risk	RAG	Mitigation
Inability to implement good practice and improve theatre utilisation metrics due to workforce shortages		Work with 'workforce programme' to create sustainable solutions to vacancies and use of temporary staffing.

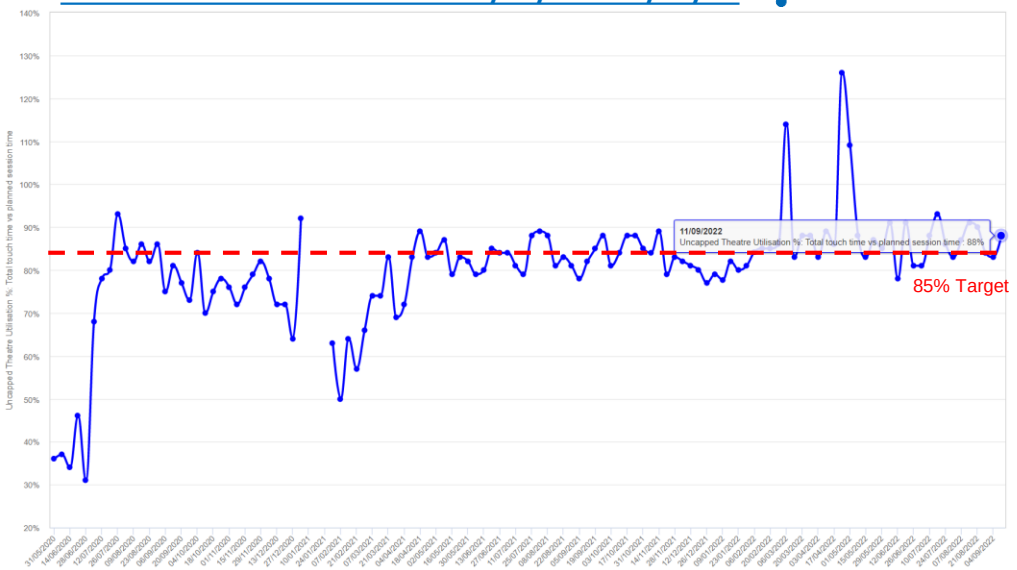
Theatre Productivity – Capped Utilisation

North East London Health & Care Partnership

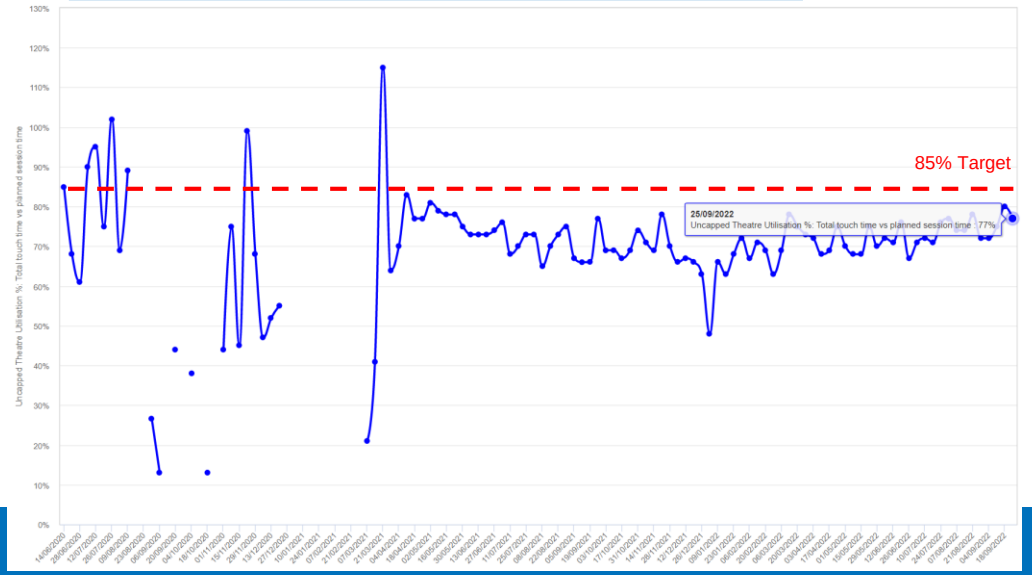
Barts – MH trend from 17/05/20 to 21/08/22



BHRUT – MH trend data from 31/05/20 – 11/09/22



Homerton – MH trend data from 14/06/20 to 25/09/22

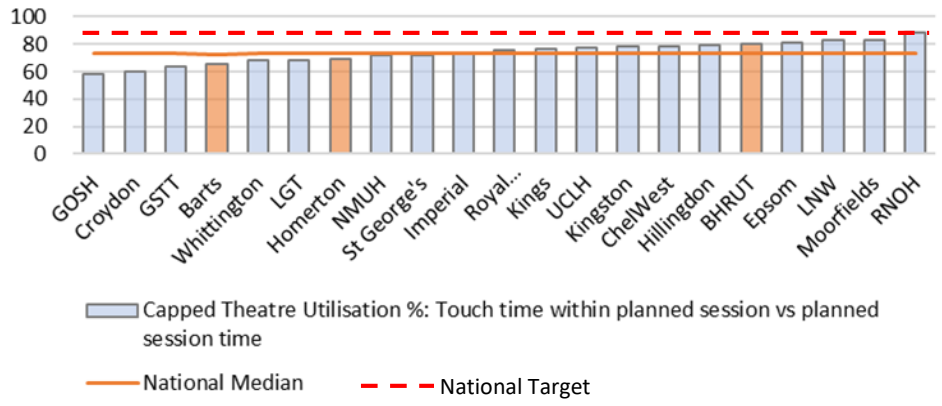


- Further opportunities exist to improve theatre utilisation across NEL sites, particularly at Barts Health.
- All Trusts have site level reports on theatre utilisation and productivity including cases per list, start and finish times, fallow lists and cancellations.
- Theatre productivity & efficiency programmes in place at each Trust/site.
- Surgical Optimisation Group is identifying and sharing good practice across NEL.

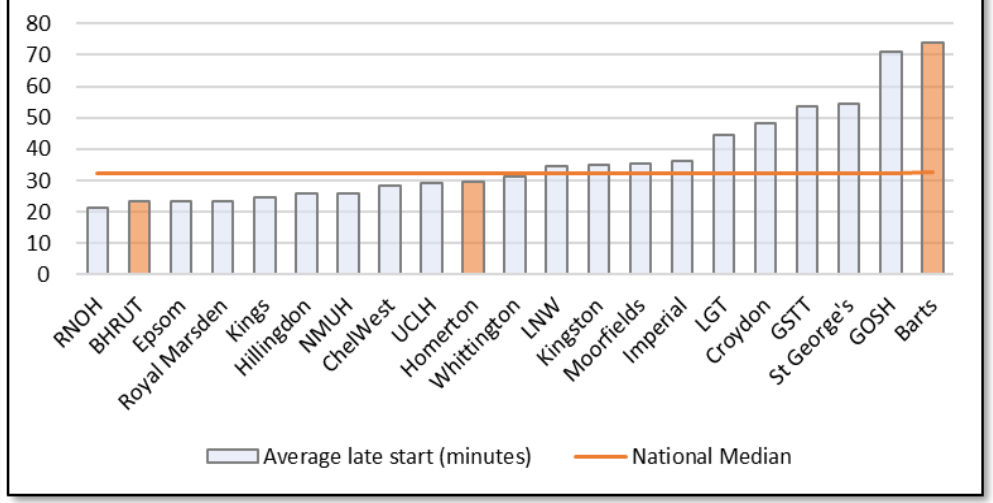
From London Region – NEL Theatre Productivity

North East London Health & Care Partnership

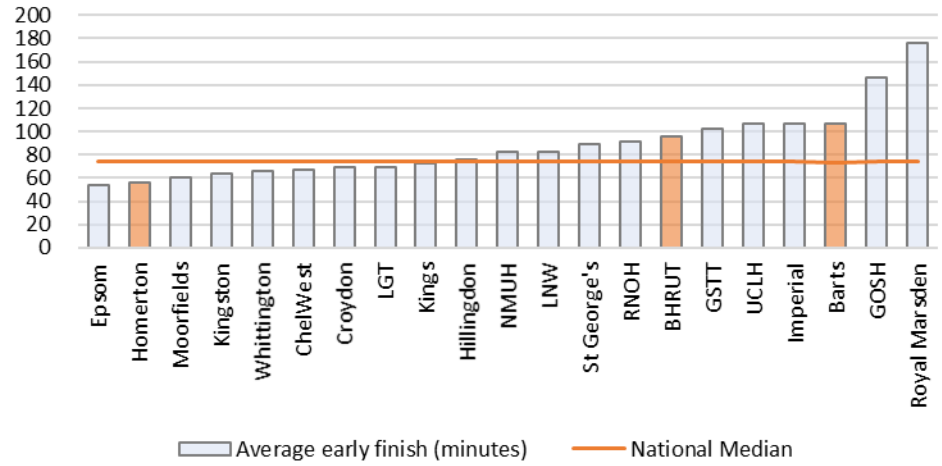
Capped Theatre Utilisation %: Touch time within planned session vs planned session time in Theatre Utilisation by provider (last 4 weeks from w/e 11/09/2022)



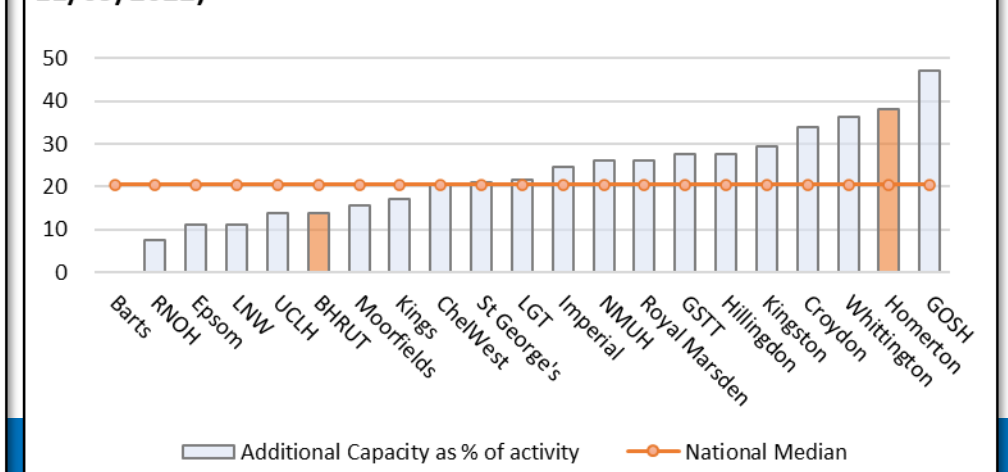
Average late start (minutes) in Theatre Utilisation by provider (last 4 weeks from w/e 11/09/2022)



Average early finish (minutes) in Theatre Utilisation by provider (last 4 weeks from w/e 11/09/2022)



Additional capacity as a % of current activity in Theatre Utilisation by provider (last 4 weeks from w/e 11/09/2022)

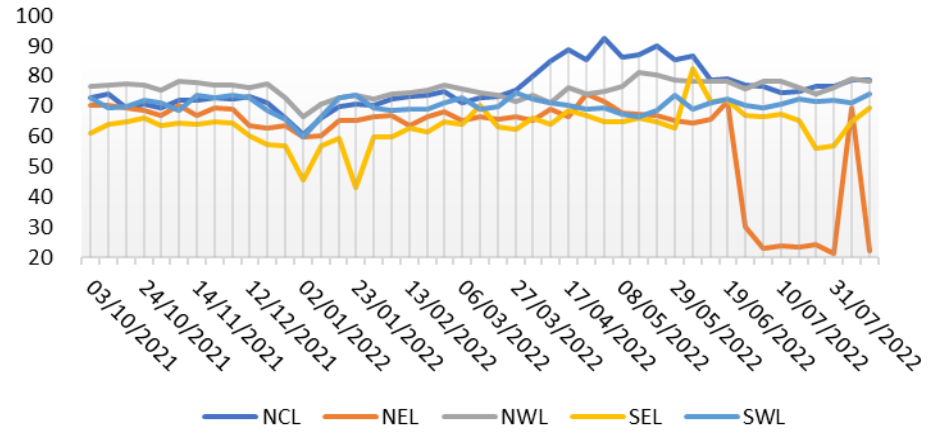


- All NEL trusts are below the national target for capped utilisation. Barts has the 4th lowest capped utilisation in London
- Barts has the highest average late starts in London
- Barts has the 3rd highest average early finishes in London
- Homerton has the 2nd highest opportunity for additional activity in London. While Barts is stated as 0% this is clearly a DQ issue due to their low capped utilisation and high average late starts

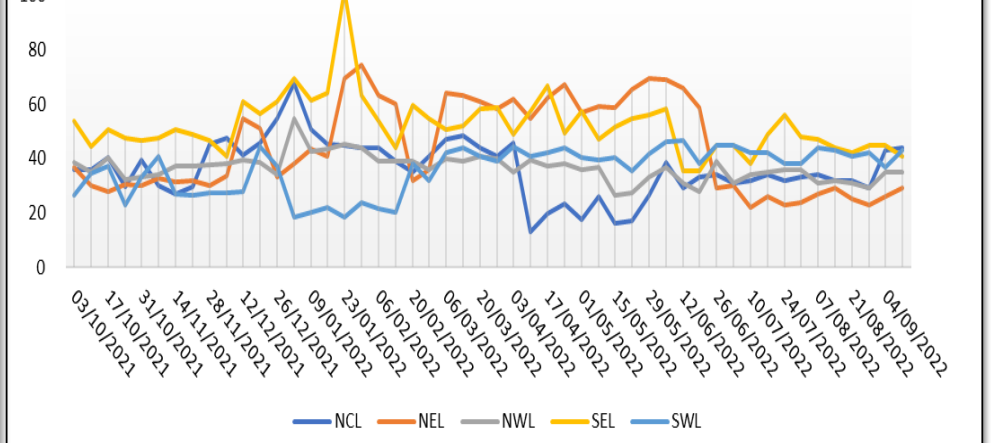
From London Region - Theatre Productivity – NEL ICS Comparison

North East London Health & Care Partnership

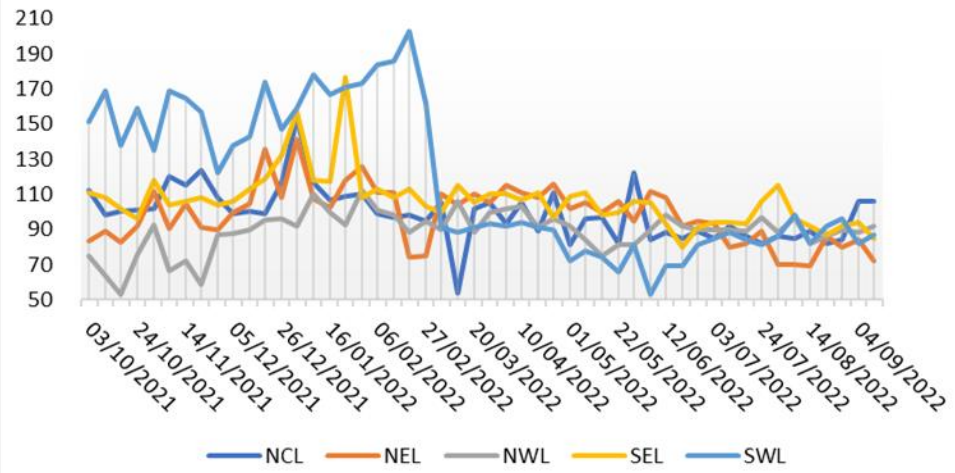
Capped Theatre Utilisation %: Touch time within planned session vs planned session time in Theatre Utilisation by ICS (last 12 months)



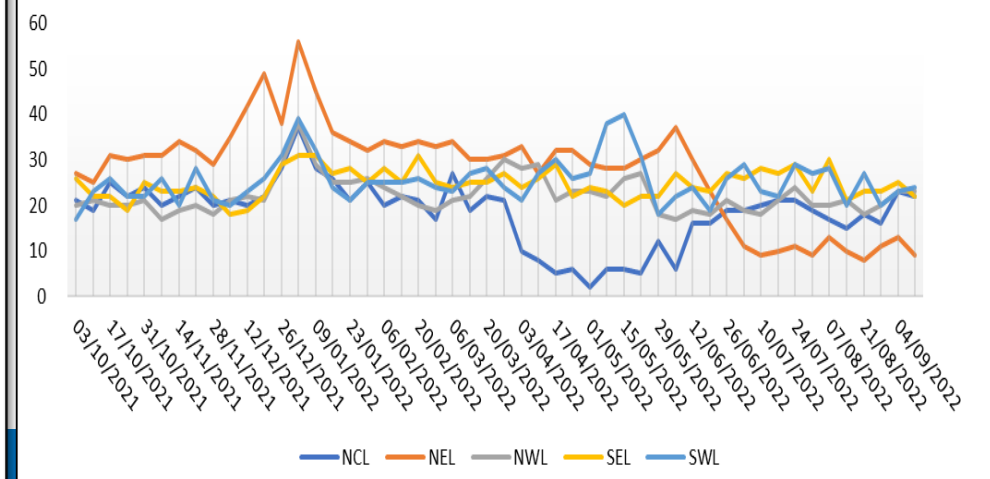
Average late start (minutes) in Theatre Utilisation by ICS (last 12 months)



Average early finish (minutes) in Theatre Utilisation by ICS (last 12 months)



Additional capacity as a % of current activity in Theatre Utilisation by ICS (last 12 months)



- NEL has very low capped utilisation, however, this does not match data submitted by NEL trusts, therefore this is likely a DQ issue.
- Historically NELs capped utilisation has been below the national target
- From June 2022 NEL's average late starts, average early finishes, and additional capacity as a % of current activity has dropped dramatically. This aligns with the drop in capped utilisation
- Historically NEL's average late starts and additional capacity as % of activity have been the highest in London

Whipps Cross Theatre Experience Program

Neil Bourke, Hannah Evans and Eva Fiz

North East London Health & Care Partnership

Theatre Experience Programme at WXH

Presentation for NEL Finance Summit

31st October 2022

1. Our journey so far
2. Using WeImprove to support recovery and transformation

Neil Bourke, *Divisional Manager, Surgery, Peri-Operative Medicine and Critical Care, Whipps Cross Hospital*

Hannah Evans, *Senior Improvement Advisor, Barts Health*

Eva Fiz, *Deputy Director of Improvement and Transformation, Barts Health*

WXH Theatres Experience Programme: our journey at a glance

North East London Health & Care Partnership

1 Group/Site sponsorship and support: Sept 2021

Group push: Maximise the use of existing theatre capacity and bring back focus post Covid
Reflected in both: BH Elective recovery plan and Clinical Transformation Programmes

2 Agreed aim and priorities: Oct-Dec 2021

QI facilitated session with surgery leads to:

- Understand the current system
- Agree our aim
- Identify priorities

3 Staff engaged and involved through

We worked with ops and clinical leads to share the aim and worked with staff across site to understand their issues and gather ideas.

4 Governance in place: Nov 2021

Set up TEG (**Theatres Experience Group**) as a place to oversee implementation, share progress and raise concerns. TEG is co-chaired by Divisional Manager and Clinical Lead for Surgery. Reports into WXH Quality Improvement Board.

5 Projects in action: Dec 2021 onwards

Focusing on: Wellbeing and communication, operating theatres processess and list planning

6 Quality management system: July 2022 onwards

Quality planning, improvement and control for sustainable long term change

Theatres programme aim and priorities

North East London Health & Care Partnership

We aim to achieve 70% of our green zone lists starting on time by October 22

In 2020/21, 20% of our lists started on time*

Development of a theatres recovery programme aimed at <u>improving starting times through:</u>

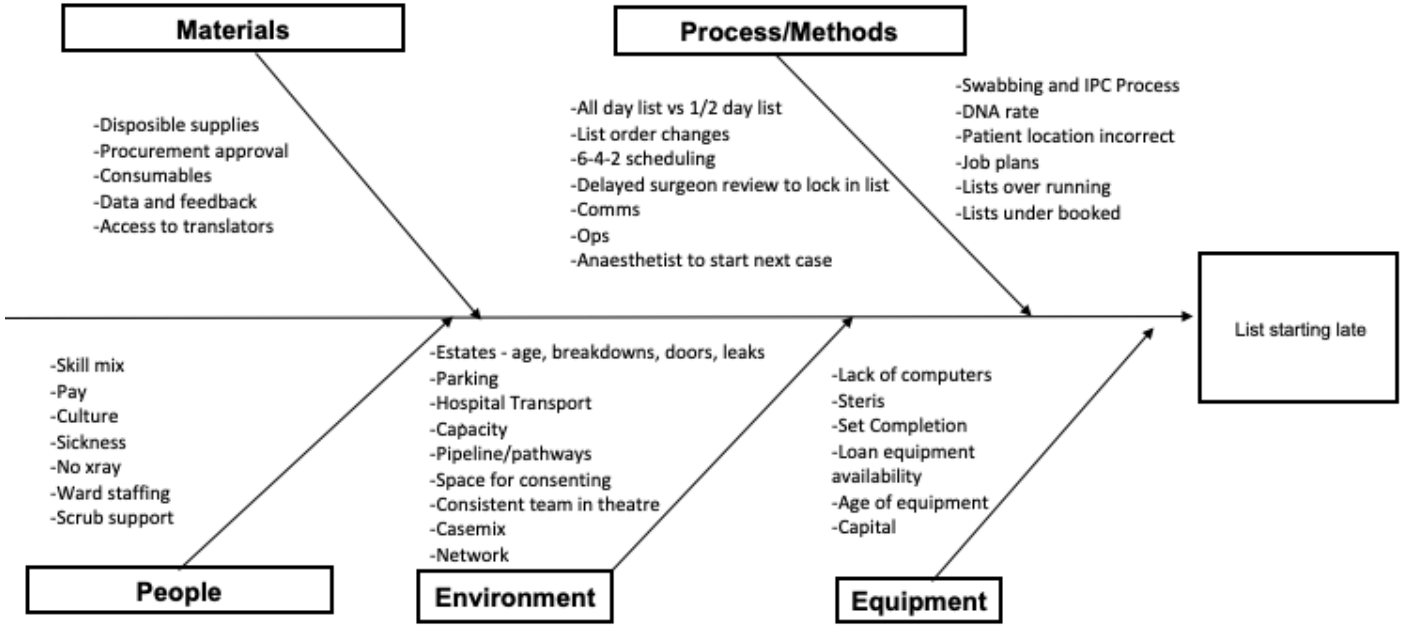
- Starting a Theatres <u>Experience</u> Group (TEG) to support and drive changes; and
- Staff-led initiatives supported by our improvement and transformation teams

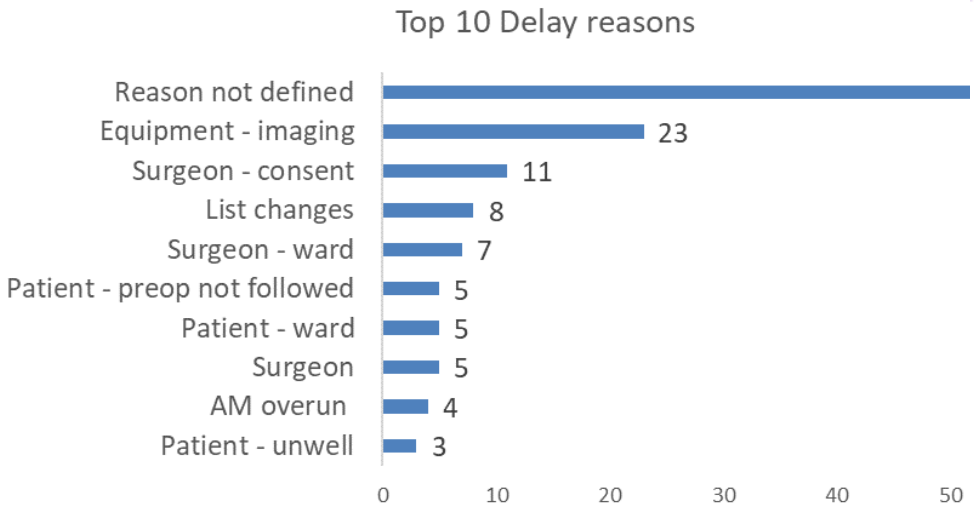
**Definition of starting on time; needle to skin at 8.30 /13:30*

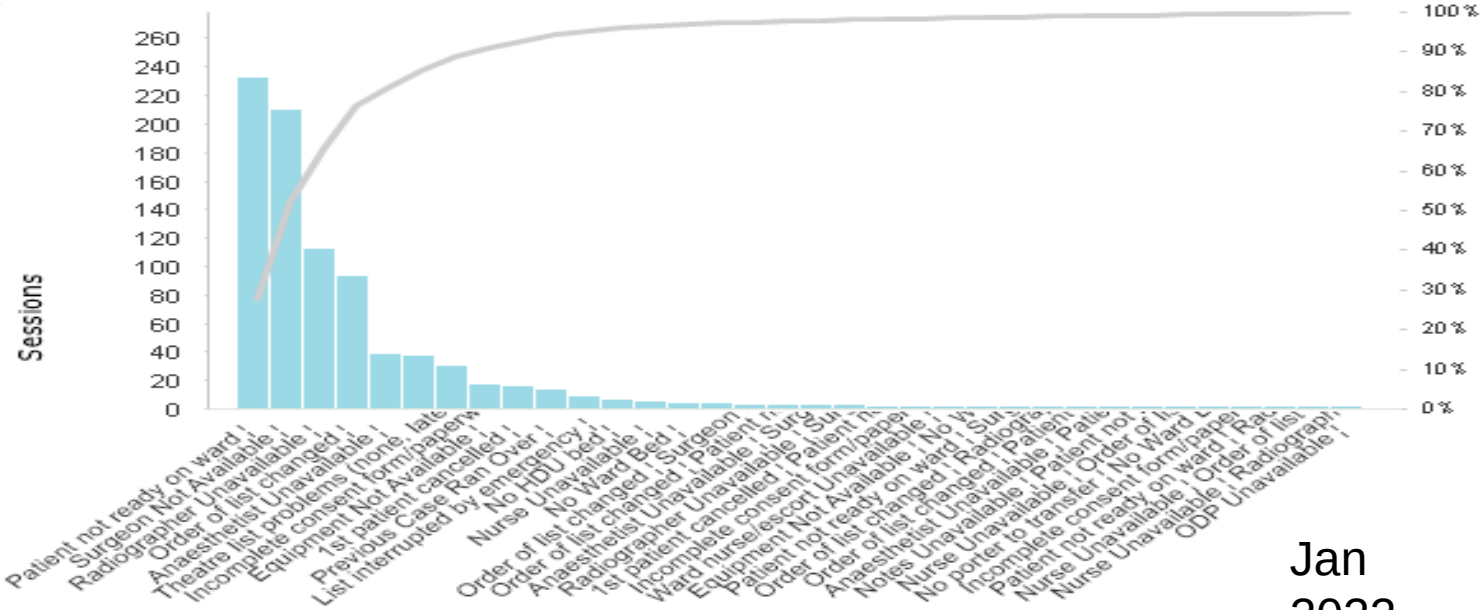
Our aim and priorities were agreed through an engagement session with representatives of each group on the 7th October 2021 and have been refreshed to reflect changes in the system

Understanding the reasons behind late starts

North East London Health & Care Partnership







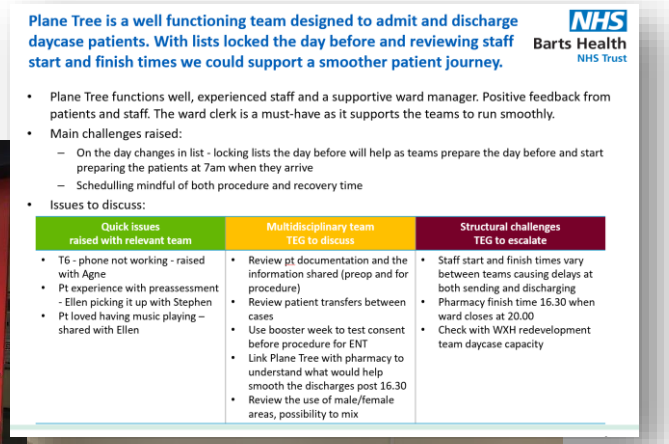
October 2021

Jan 2022

Understanding the reasons behind late starts

1. Ward observations to better understand patient flow through day case and inpatient wards and identify how can we support staff getting patients into theatres

2. Visits to every surgical specialty on their audit day to hear their thoughts and ideas



Plane Tree is a well functioning team designed to admit and discharge daycase patients. With lists locked the day before and reviewing staff start and finish times we could support a smoother patient journey.

NHS Barts Health NHS Trust

- Plane Tree functions well, experienced staff and a supportive ward manager. Positive feedback from patients and staff. The ward clerk is a must-have as it supports the teams to run smoothly.
- Main challenges raised:
  - On the day changes in list - locking lists the day before will help as teams prepare the day before and start preparing the patients at 7am when they arrive
  - Schedulling mindful of both procedure and recovery time
- Issues to discuss:

Quick issues raised with relevant team	Multidisciplinary team TEG to discuss	Structural challenges TEG to escalate
• T6 - phone not working - raised with Agne • Pt experience with preassessment - Ellen picking it up with Stephen • Pt loved having music playing – shared with Ellen	• Review pt documentation and the information shared (preop and for procedure) • Review patient transfers between cases • Use booster week to test consent before procedure for ENT • Link Plane Tree with pharmacy to understand what would help smooth the discharges post 16.30 • Review the use of male/female areas, possibility to mix	• Staff start and finish times vary between teams causing delays at both sending and discharging • Pharmacy finish time 16.30 when ward closes at 20.00 • Check with WXH redevelopment team daycase capacity

WXH Theatres Drivers for Change

North East London Health & Care Partnership

Aim
We aim to achieve 70% of our elective lists starting on time by October 22

Measures:
% lists starting w/ 15';
% lists starting w/ 30'

Primary drivers	Secondary drivers	Change ideas
1. Theatres team experience	1.1 Recognition and communication 1.2 Team ways of working 1.4 Team development	• Theatres of the month • Visibility of the data: theatres scorecard • Theatres Experience Group • Posters on start times for AM+PM lists • Run theatres-focused audit session • Newsletter • Induction for new starters, locums, visiting • Review career opportunities
2. Operating theatre process	2.1 Processes and protocols 2.2 Pre-op 2.3 Equipment / supplies / tools 2.4 Imaging	• Patient getting ready on the day leaflet • Review ITU/HDU capacity • Review holding bay use • Auto populate anesthetic chart • Update loan policy, service contracts, maintenance of checklist • Review sterilisation process • TTA packs on plane tree • Availability of medicines in theatres eg. Botox • Adjusted start times for radiographers • Don't consent on the day, just confirm
3. List planning	3.1 Capacity 3.2 List allocation 3.3 Schedulling 3.4 Communications	• Booking based on average procedure times • Job plan gap analysis • Review list structure for WXH: 3 session days 6-7 day lists • List order done based on scoring system • Checklist for booking • 642 process • Update scheduling with new IPC guidelines • Staffing planning 8w ahead (instead of 6) • Access to theatre scheduling information
4. Cancellations	4.1 Patient-led cancellations 4.2 Hospital-led cancellations 4.3 Short-notice cancellations	• Patient feedback on reasons for cancellations • Deep dive on specialty-led reasons

WXH Theatres: progress

North East London Health & Care Partnership

Priorities September 22 – March 23	Description	Impact
Theatres experience	• Theatres Experience Group • Monthly newsletter with Theatres of the month • Theatres dashboard • Posters on start times for AM+PM lists • Theatres-focused audit session	• Improved staff engagement and experience • Data driven improvement • Improved start times
Operating theatre processes	• Patient getting ready on the day leaflet • Adjusted start times for radiographers (now start at 8am rather than 9am) • TTA packs on Day Surgery Unit • Booster weeks in ENT + Urology • Reopening of our acorn paediatric day case unit • Using frailty scoring to plan day case lists that would have otherwise been inpatient stays	• Significant reduction in the cause of late starts due to radiographer availability • Improved flow • Improved patient experience
List Planning	• Booking based on average procedure times • Checklist for booking • 642 process	• Improved list planning • Improved activity/ utilisation

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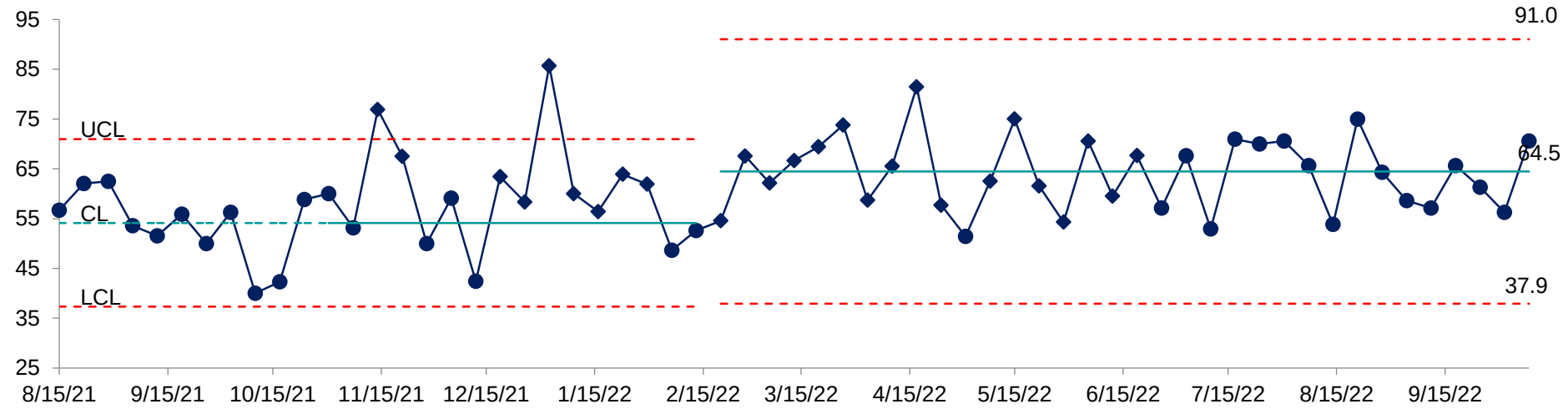
Impact

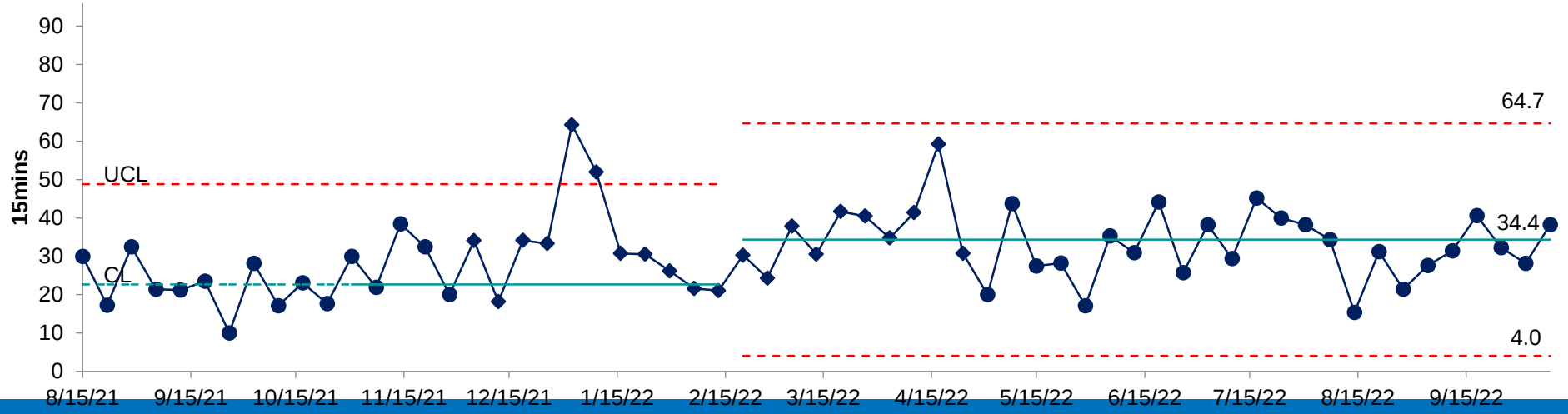
North East London Health & Care Partnership

% lists starting within 30mins - X Chart



We have improved from an average of 51% of lists starting within 30 mins to 65%

% of lists starting within 15mins - X Chart

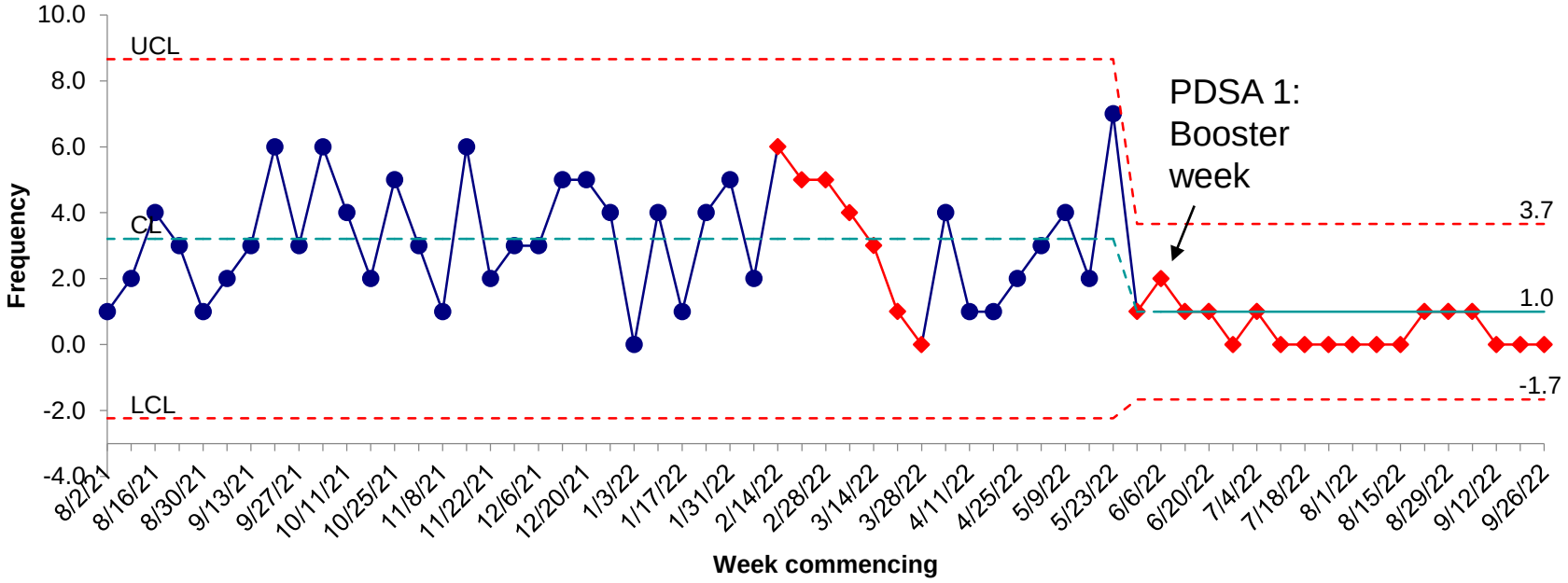


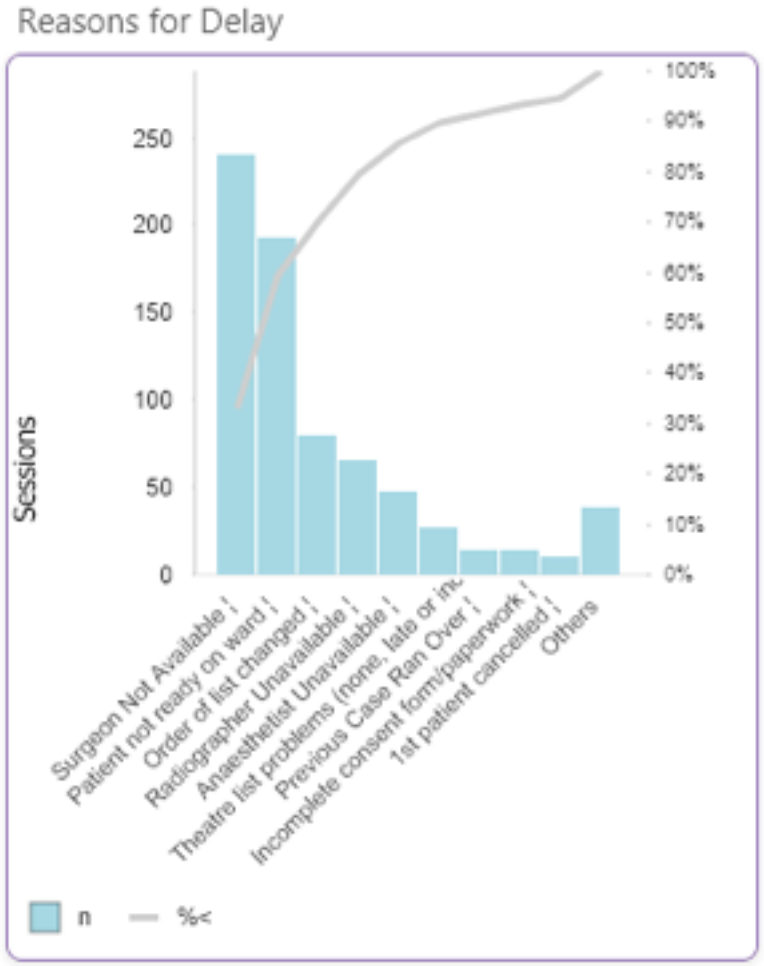
We have improved from an average of 22% of lists starting within 15 mins to 34 %

Impact

North East London Health & Care Partnership

Radiographer not available causing late start frequency



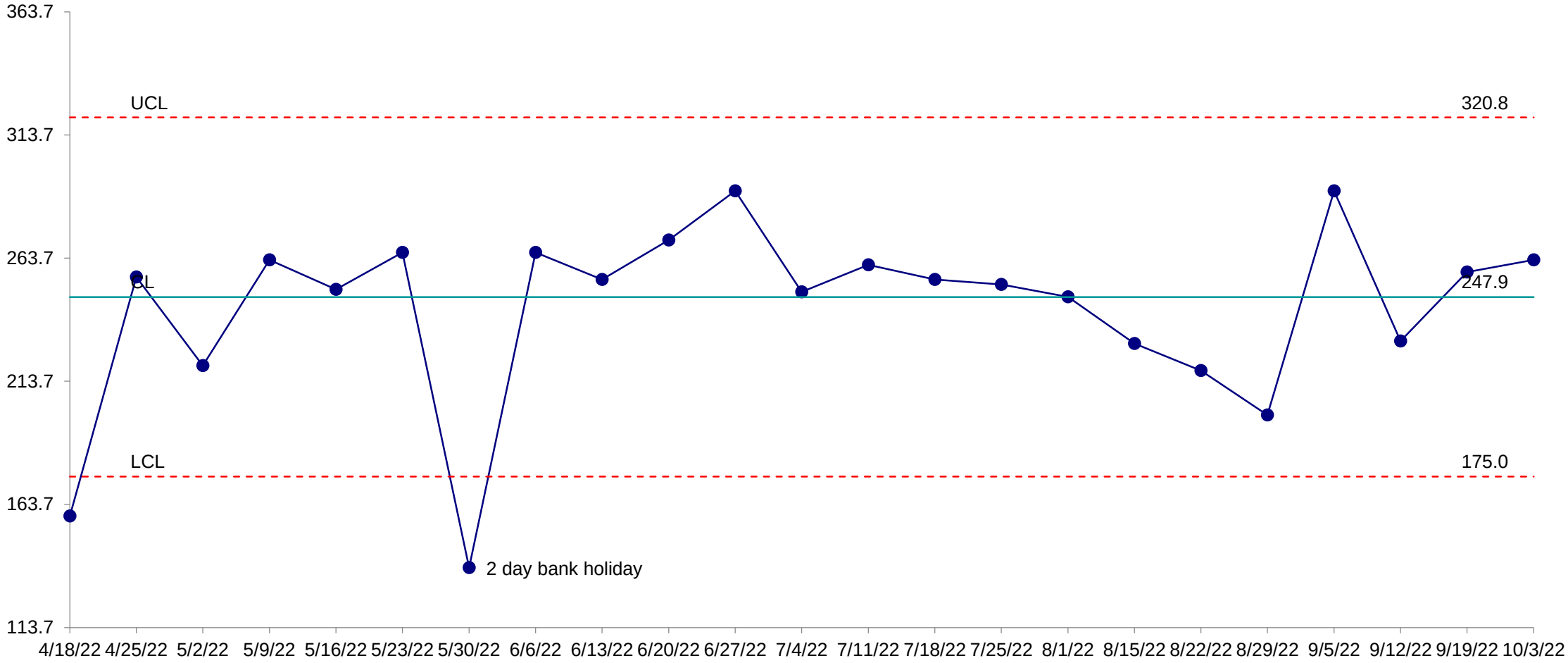


We have seen a significant reduction in our delayed start times being attributed to radiographer availability since Urology Booster week when their start time was adjusted from 9am to 8am

Impact

North East London Health & Care Partnership

Number of Patients scheduled per week



Average bookings per week = 247 (adjusted to account for bank holiday week)

WXH Theatres: priorities

Priorities September 22 – March 23	Description	Impact
Cancellations	• Specialty deep dive on the reasons for cancellations • Develop guidance for time between surgical review and day of surgery for subspecialties • Use of ENVOY messaging service to improve patient communication	• Reduction in cancellations • Improved activity/utilisation • Improved patient experience
Day case to inpatient conversion	• Audit review, root cause analysis on day surgery unit and development of change ideas from there	• Reduction in last minute inpatient bed requests • Increase day case rates
Increase average case per list from 2.6 to 3	• Specialty deep dives to identify opportunities for improvement	• Improved activity/utilisation

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BAU – activity opportunity

North East London Health & Care Partnership

ENT

Period	28-Aug	04-Sep	11-Sep	18-Sep	25-Sep	02-Oct	09-Oct	6 Wk Avg.	% Diff
Actual	31	22	31	15	28	24	14	24	52.8%
BAU	11	18	22	7	15	13	22	15	

General Surgery

Period	28-Aug	04-Sep	11-Sep	18-Sep	25-Sep	02-Oct	09-Oct	6 Wk Avg.	% Diff
Actual	10	11	12	19	10	15	10	12	-11.2%
BAU	17	9	20	17	6	13	16	14	

Gynaecology

Period	28-Aug	04-Sep	11-Sep	18-Sep	25-Sep	02-Oct	09-Oct	6 Wk Avg.	% Diff
Actual	32	23	29	17	30	32	36	28	41.1%
BAU	17	16	19	24	21	27	17	20	

Ophthalmology

Period	28-Aug	04-Sep	11-Sep	18-Sep	25-Sep	02-Oct	09-Oct	6 Wk Avg.	% Diff
Actual	47	22	66	52	52	65	57	52	-13.8%
BAU	39	49	55	73	55	83	65	60	

Urology

Period	28-Aug	04-Sep	11-Sep	18-Sep	25-Sep	02-Oct	09-Oct	6 Wk Avg.	% Diff
Actual	26	31	43	31	41	29	24	32	29.3%
BAU	13	34	28	25	31	22	21	25	

- Case mix
- Pre operative flow
- High volume cataract
- Network job planning / annualization

Activity Trajectory

North East London Health & Care Partnership

November – December

Assumption	comment
case per list average	stretch range of 3.3 per list in November
case per list average	11/12 - 01/01 adjusted case per list to reflect period 2.85 per list. Historic BAU used as guide
cancellation rate Lower Limit %	reduce to 7 from 8
cancellation rate upper limit %	reduce to 12 from 14
fallows	structural deficit = 10
elective trauma	signigicant varience in activity in this area. Needs more monitoring (3 to 22 range)
Audit	10th November, 5th December
Annual leave	checked for 6 weeks and assumed 1 session impacted per consultant and an aim to improve previous run rate of sessions lost to leave
sentinel metric report	sense check of weekly activity. This trajectory is at, or above 2019 levels of activity

	31-Oct	07-Nov	14-Nov	21-Nov	28-Nov	05-Dec	12-Dec	19-Dec	26-Dec	02-Jan	09-Jan
No. Consultants on annual leave	3	13	13	14	3	5	7	10	12	8	2
Bank holdiay or audit sessions lost		10				10			40	20	
Fallows	5	10	13	10	3	5	7	25	42	0	5
Open sessions	95	80	87	90	97	85	93	75	20	60	95
Booked activity	**285**	**264**	**287**	**297**	**320**	**281**	**279**	**210**	**54**	**162**	**285**
cancellation rate lower	22	18	18	18	18	18	18	18	18	18	18
cancellation rate upper	~~39~~	~~24~~	~~24~~	~~24~~	~~24~~	~~24~~	~~24~~	~~24~~	~~24~~	~~24~~	~~24~~
total	**263**	**246**	**269**	**279**	**302**	**263**	**261**	**192**	**36**	**144**	**267**
note			Audit			Audit		School Holiday	2 x xmas	1 x NY	

historic BAU 2.8 per list over this period

2019 BAU	11-Dec	18-Dec	25-Dec	01-Jan
Activity	230	198	47	139
case per list	3.03	2.91	2.61	2.84

Summary

North East London Health & Care Partnership

Highlights

- Staff engaged and committed to improving start times
- Staff having protected time to engage in improvement work across the MDT
- Clear understanding of current performance and barriers, enabling development of drivers for change that will result in sustainable change
- Robust improvement approach
- A number of changes tested to support delivery of wider recovery programme, being replicated at RLH now
- Unintended improvements as a result of aim for start times eg. paeds day units re-opening, booster weeks
- Improvements against BAU trajectories
- In a state of quality control for start times, that has identified wider system change need. Eg. Consent processes
- TEG has enabled further improvements beyond start times and development of cohesive winter pressures plan

Next Steps

- Formal system-wide recovery plan to be devised as a matter of urgency, using the Drivers of the Deficit waste reduction approach:
  - Agency reduction, including elimination of off framework
  - Workforce productivity
  - Mental Health & Community Services
  - Primary Care, Prescribing, CHC, joint commissioning
  - Further opportunities tbc
- Headline commitment for H2 delivery – return to breakeven runrate in H2
- Reporting of delivery across ICS
  - Consistent metrics (where possible) tracked through Planned Care Board
  - Temporary Staffing and establishment controls tracked through workforce productivity group – HR, Finance, MD, CN and COOs
- Collaborative governance through ICS Financial Recovery Group

Plan for H2 delivery

	H1 Actuals	H2 on Plan BE except ERF	BE	Total
	£000	£000	£000	£001
Barts	-29,652	-9,250		-38,902
BHRUT	-22,641	-7,000		-29,641
ELFT	-4,203	0	4,203	0
HUH	-4,976	-3,569		-8,545
NELFT	-495	0	495	0
SC ERF	1,683	1,683		3,365
NEL ERF	18,136	18,136		36,272
Provider	**-42,148**	**0**	**4,698**	**-37,450**
ICB	**-10,638**	**0**	**10,638**	**0**
ICS Total	**-52,786**	**0**	**15,336**	**-37,450**

- ELFT, NELFT and ICB - deliver full year breakeven, thus recover H1 deficits
- Other providers deliver runrate balance to plan in H2 (exc ERF)
- The system would then need to find £12.5m of non recurrent flexibility to meet the challenge target set by London and discussed with national colleagues