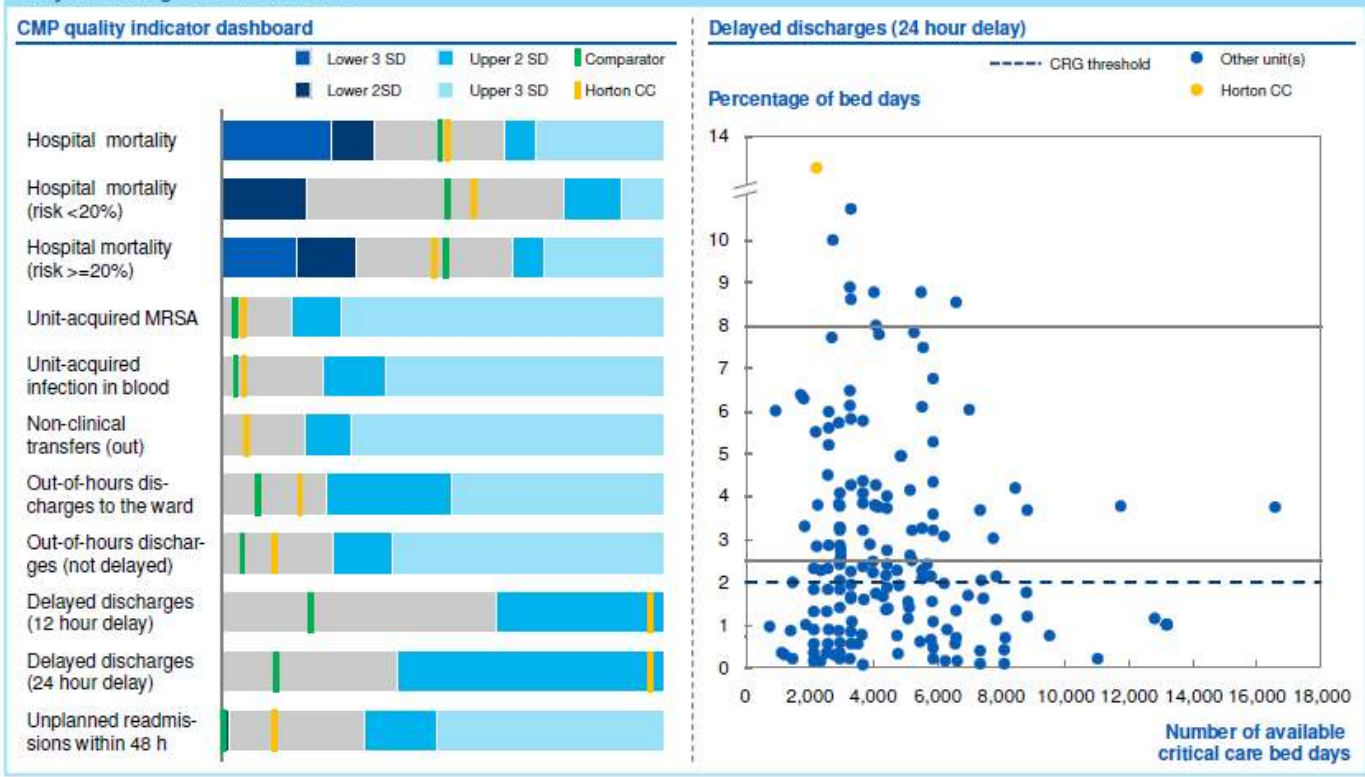
ICNARC Audit 13/14 Results

Elective, Diagnostic & Specialist

Although the Horton unit performed in line with most comparators in the ICNARC audit (2013/14), it is an outlier compared to benchmarked peers for delayed discharges from critical care

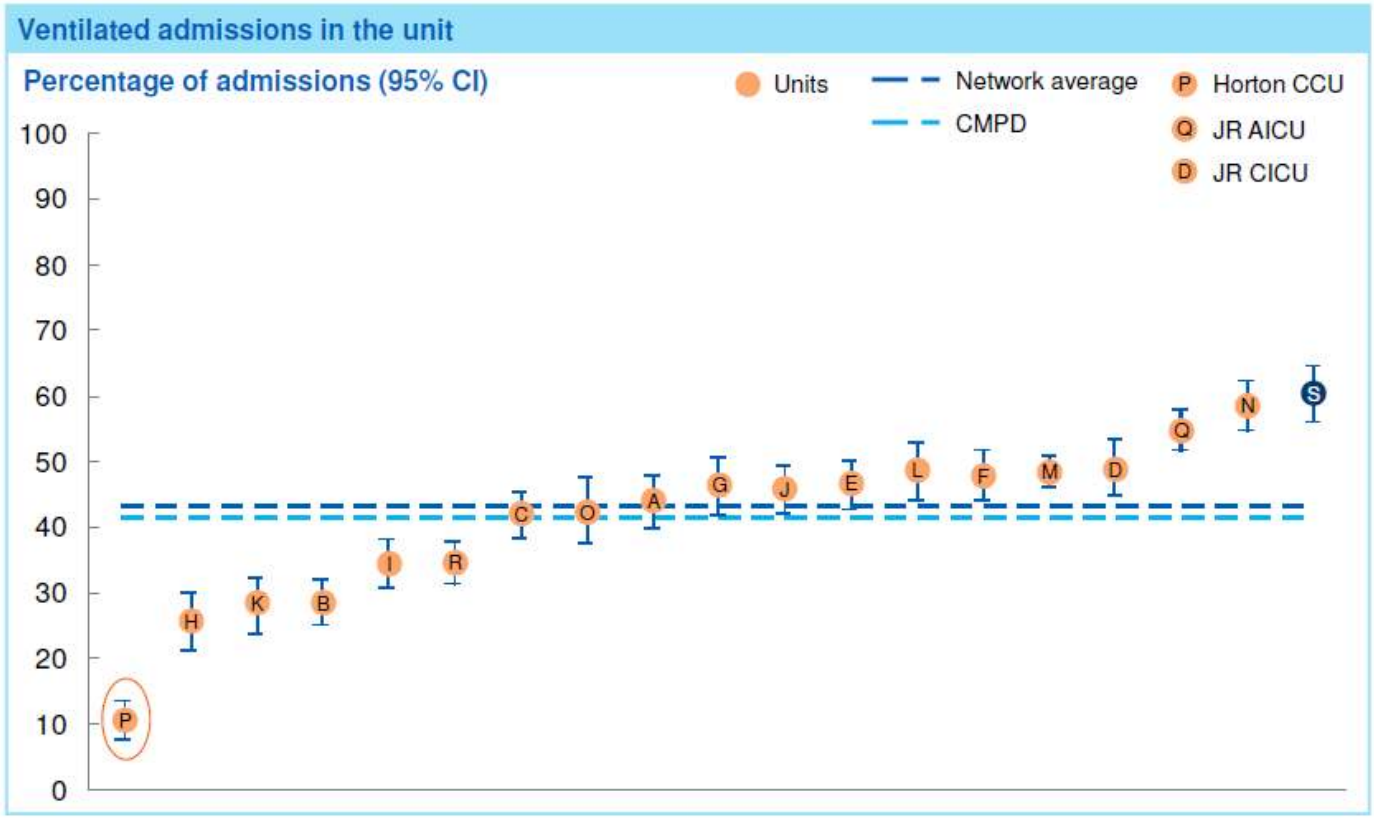


SOURCE: ICNARC 2013/14

Ventilated admissions by Unit

Elective, Diagnostic & Specialist

% of admissions

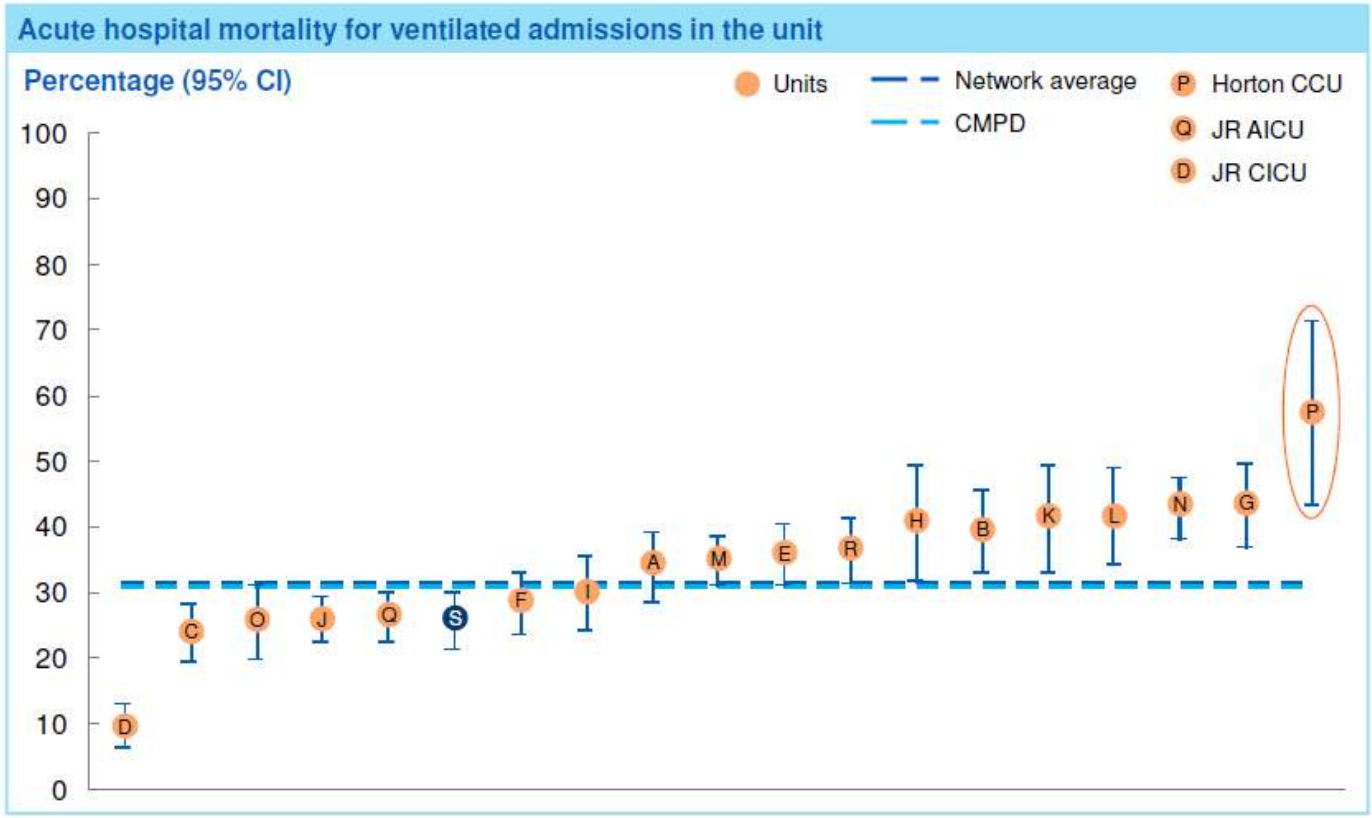


SOURCE: ICNARC 2016

Acute hospital mortality for ventilated admissions

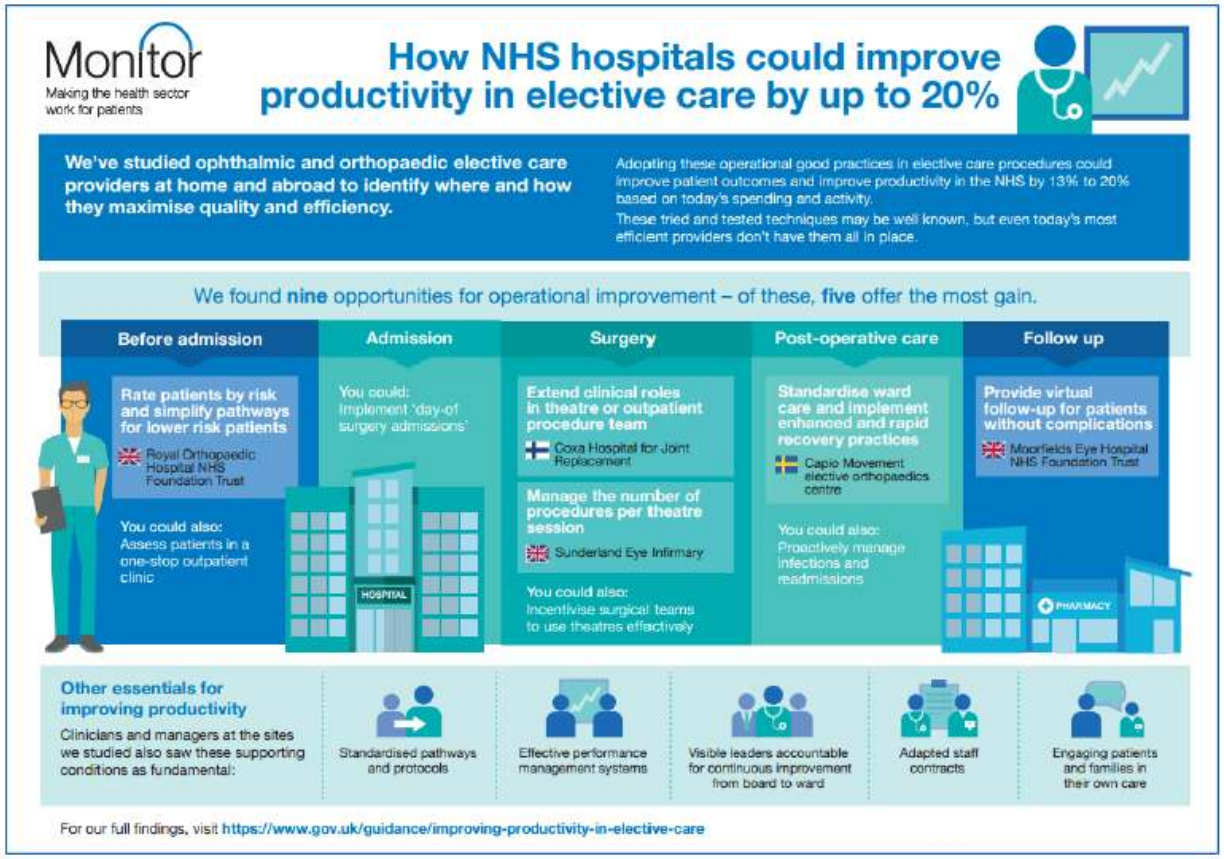
Elective, Diagnostic & Specialist

% of admissions



SOURCE: ICNARC 2016

Monitor report in 2015 on Elective Care highlighted opportunities to improve productivity



SOURCE: Source

External example: Elective Orthopaedic Centre (EOC), has significantly improved South West London's orthopaedic performance

- The EOC in South West London opened in 2004
- 4 trusts shared vision of creating single, world-class, NHS orthopedic elective centre
- Teamed up with a U.S. mentor organization who had done a similar project
- Increased capacity from 2,100 annual procedures in 2001 to estimated 5,200 (3,000 joints) in 2013. Now one of the largest orthopaedic centres in Europe.
- In 2013 SWLEOC was delivering a £3m surplus annually.

-54 inpatient and 17 PACU beds
-Offers major joint replacements, ligament reconstructions, arthroscopies to hip and knee, a full range of shoulder foot and ankle procedures and spinal work.
-Focus on flexibility and not 'cherry-picking' cases
-Uses intelligent procurement methods and leverages position with prosthetics manufacturers
-Full day operating lists

- Exceeded activity targets
- Have achieved 18-weeks from March 2008 (96% Admitted, 98% non-Admitted)
- Reduced same day cancellations to 1% for clinical reasons and 0.5% for non-clinical reasons (all admitted within 28 days). (Nat. average 4.3%)
- Reduced average LOS to 3.4 days (5.5 for knees, 4.9 for hips, 6 for revisions)
- Reduced post-op infection to 0.02% (national average 1.0% to 1.4% dependent on study)
- Reduced blood transfusions to well below national average.
- Increased theatre utilization from 87% in 05/06 to 97% in 08/09, consistently at 95% in 12/13
- Now largest joint-procedure provider in U.K. and possibly Europe

SOURCE: SWLEOC, Updated based on 2013 report https://www.nhsproviders.org/media/1823/swleoc-final-m.pdf

External example: Elective Orthopaedic Centre (EOC), has significantly improved South West London's orthopaedic performance

- The EOC in South West London opened in 2004
- 4 trusts shared vision of creating single, world-class, NHS orthopedic elective centre
- Teamed up with a U.S. mentor organization who had done a similar project
- Increased capacity from 2,100 annual procedures in 2001 to estimated 5,200 (3,000 joints) in 2013. Now one of the largest orthopaedic centres in Europe.
- In 2013 SWLEOC was delivering a £3m surplus annually.

-54 inpatient and 17 PACU beds

-Offers major joint replacements, ligament reconstructions, arthroscopies to hip and knee, a full range of shoulder foot and ankle procedures and spinal work.

-Focus on flexibility and not 'cherry-picking' cases

-Uses intelligent procurement methods and leverages position with prosthetics manufacturers

-Full day operating lists

- Exceeded activity targets
- Have achieved 18-weeks from March 2008 (96% Admitted, 98% non-Admitted)
- Reduced same day cancellations to 1% for clinical reasons and 0.5% for non-clinical reasons (all admitted within 28 days). (Nat. average 4.3%)
- Reduced average LOS to 3.4 days (5.5 for knees, 4.9 for hips, 6 for revisions)
- Reduced post-op infection to 0.02% (national average 1.0% to 1.4% dependent on study)
- Reduced blood transfusions to well below national average.
- Increased theatre utilization from 87% in 05/06 to 97% in 08/09, consistently at 95% in 12/13
- Now largest joint-procedure provider in U.K. and possibly Europe

SOURCE: SWLEOC, Updated based on 2013 report https://www.nhsproviders.org/media/1823/swleoc-final-m.pdf

External example: Alfred Health (1/2)

AlfredHealth

Executive summary

- New model of delivery of elective surgical services designed specifically to provide consistent quality of care and good operational performance
- The model is based on a high degree of standardization:
  - Clarity of complexity/case mix which the centre can accommodate – with higher complexity patients treated at the tertiary hospital (separate managerial structure but single financial entity)
  - 168 protocols for all major pathways
  - Defined expected length of stay for all major pathways (usually 3 days maximum)
  - Peri-operative coordinators responsible for theatre scheduling (rather than individual surgeons) with suite of theatre scheduling tools and analytics
  - Streamlined pre-admission assessment process
  - Fully ring-fenced resources (theatres, beds, teams) which cannot be requisitioned by emergency patients
  - Defined cultural norms including a "no hospital-initiated cancellations" policy

Delivery model

- A public sector multi-specialty elective only centre with fully dedicated management and resources, co-located with a large teaching hospital providing emergency and specialist elective care
- Surgeons work across both organisations (the elective centre and the teaching hospital)

Background and history

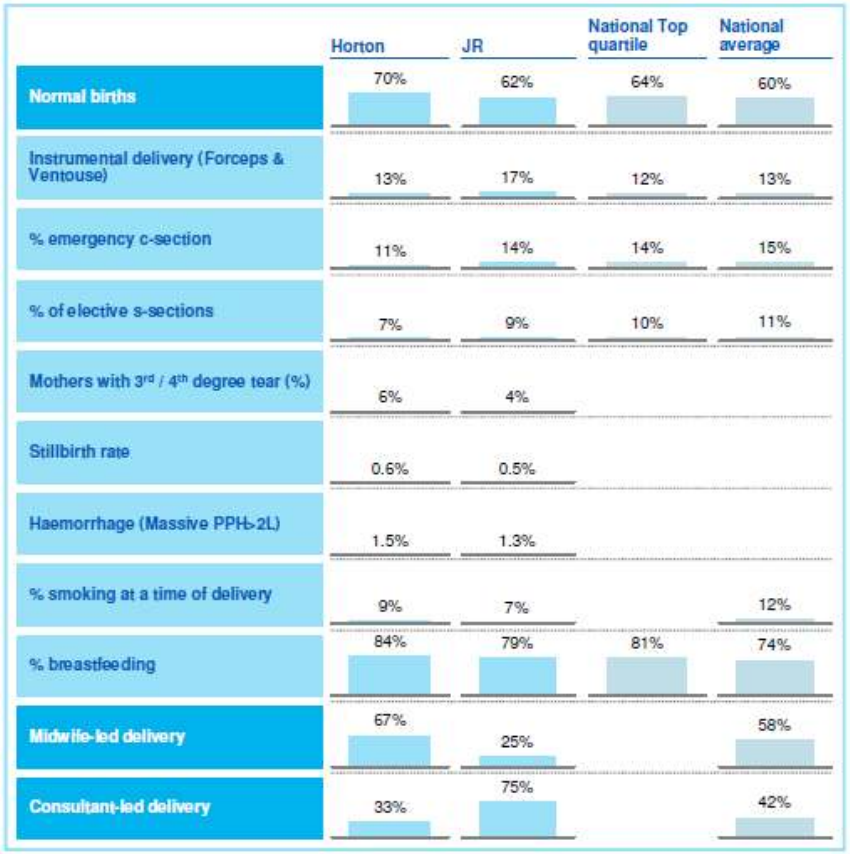
- Opened in 2007 in order to address issues at the tertiary centre (The Alfred) including:
  - Long waiting times for elective surgery
  - Frequent cancellations or postponements of elective surgery due to prioritisation of time-critical emergency surgery

Health system context

- Australian national public health insurance scheme, Medicare, provides universal health coverage but private insurance is encourage through taxation and subsidies
- Mix of public and private hospitals serving all insurance groups
- State governments have relatively high degree of autonomy in administration of health services

SOURCE: Alfred Health interviews; MJA (2011) Streamlining elective surgery care in a public hospital: the Alfred experience (https://www.mja.com.au/journal/2011/194/9/streamlining-elective-surgery-care-public-hospital-alfred-experience

Risk indicators for both Horton and Headington (JR) Obstetric Unit sites



SOURCE: HES for Horton and JR – provided by client. Cumulative for 11 months of 2015/16; for national benchmarks: Maternity Statistics 2014/15 and Maternity CQC Patient Survey, 2013

RCPCH – Standards for Paediatric Services (2015)

Documents

Facing the Future: Standards for Acute General Paediatric Services

RCPCH, 2015

10 standards for acute general paediatric care

1. A consultant paediatrician or an equivalent is present and available in the hospital during peak times seven days a week
2. Every child admitted is seen by a healthcare professional competent to work on the tier two (middle grade) paediatric rota within four hours of admission
3. Every child admitted is seen by a consultant paediatrician or an equivalent within 14 hours of admission, or sooner according to illness severity or staff concerns
4. At least two medical handovers every 24 hours are led by a consultant paediatrician or an equivalent
5. Before they are discharged, every child referred for a paediatric opinion is seen by, or has their case discussed with: a consultant paediatrician, a middle grade paediatrician, or an advanced children's nurse practitioner
6. Throughout opening hours, paediatric assessment units must have access to the opinion of a consultant paediatrician
7. All general paediatric inpatient units adopt an attending consultant system, most often 'consultant of the week'
8. All general paediatric training rotas are made up of at least ten whole time equivalent posts, in compliance with UK and EU law
9. Specialist paediatricians are available for immediate telephone advice for acute problems for all specialties and paediatricians
10. All children, social care, police and health teams have access to a paediatrician with child protection experience and skills (of level 3+ safeguarding competencies) who can provide immediate advice and assessment, if necessary, for children <18 years of age where there are child protection concerns – written report required