Oxford Radcliffe Hospitals NHS
NHS Trust

Performance Improvement and Cost Reduction Programme

June 2006

Part 1

Efficiency and Performance

Foreword

As the NHS receives increased funding, it is reasonable to ask why some parts of the country – including Oxfordshire – are in financial difficulty and faced with the need to cut costs by large amounts.

The extra resources made available to the Oxford Radcliffe Hospitals (ORH) in recent years have meant improvements in patient care, reduced waiting lists and waiting times, new hospital facilities, and the availability of new and often more expensive drugs. They have also meant better pay for our doctors, nurses and other staff – particularly important to us if we are to attract and retain staff in a part of the country with a high cost of living. In short, increased resources have enabled the ORH to deliver more, modernise its services, and build for the future of Oxfordshire's healthcare.

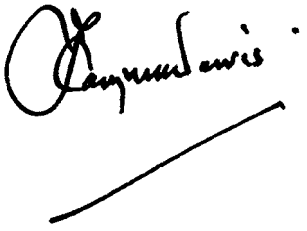
There is, however, a substantial gap between the money needed to run local services at their present cost and activity levels, and the funding currently available to the NHS in Oxfordshire. As a county, we receive 85% of the national average funding for NHS services, placing us among the lowest funded regions in the country. This is based on the relative health of the population, and means that (for example) inner city areas with higher levels of illness and deprivation receive higher levels of funding. At the same time, the NHS in Oxfordshire has to plan for a high cost of living, and has a population which is arguably more knowledgeable and demanding of its health services than some other areas of the country.

Oxfordshire's hospitals have greatly increased their efficiency in recent years, and are working hard to provide the most for the money available. According to official Department of Health figures, the ORH is now one of the most cost-efficient acute teaching trusts in England. In the future, under a system in which money follows the patient at an agreed national rate, there is no reason why the ORH should not be in a strong financial position each year.

For now, however, the gap remains. As the range of services and our efficiency has increased, so has demand. In 2002/03, for example, we treated 71,200 emergency inpatients – by 2005/06 this had risen to 91,500. Day cases and treatments have risen from 56,700 to 77,000 in the same time – an increase of 37%. Similar increases have occurred in most areas of our work.

Whilst the funding level for Oxfordshire will doubtless continue to be debated, the amount available is unlikely to change in the near future. We must therefore provide the best possible care for the local population within the present funding, which this year is £33 million less than required by current cost and activity levels.

This document therefore sets out proposals agreed by the ORH Board to reduce our costs by this amount. It is in two parts: **Part 1** deals with how we propose to improve our efficiency and performance and work with patient groups, key stakeholders and staff to implement these plans, and **Part 2** is the formal consultation document on options for changes in services at the Horton Hospital in Banbury. We hope that you will provide us with comments and feedback on both elements, but particularly in relation to **Part 2**. Further details of how you can contribute are included in both parts of the document.



Trevor Campbell Davis
Chief Executive

Part 1: Efficiency and Performance

The purpose of this document

The document gives an overview of our performance improvement and cost reduction programme and the impact on patient care. Actions which reduce costs without impact on patient care are well underway already.

The document will be widely available, using both electronic and paper media, and we will meet with key stakeholders to discuss our plans in more detail and seek feedback throughout. We will continue to work with the ORH Patient and Public Involvement Forum and Oxfordshire Joint Health Overview and Scrutiny Committee. Later, as we begin to implement our plans, we will work closely with patients, carers and other stakeholders in order to monitor the impact of these changes.

A set of options for service changes at the Horton Hospital in Banbury are included as **Part 2** of this document, and are the subject of full public consultation. This document includes the timetable for this process and invites comment and feedback.

Who we are

The ORH is one of the largest acute teaching hospital trusts in the UK, currently providing a wide range of general and specialist services from four hospitals: the Radcliffe Infirmary, the Churchill and John Radcliffe Hospitals in Oxford, and the Horton Hospital in Banbury. Services from the Radcliffe Infirmary will move to the John Radcliffe early next year. We currently employ 9,900 people, provide around 1,600 beds and, in 2005/06, had a turnover of £480 million. The Trust provides general hospital services to people in Oxfordshire and neighbouring counties, and specialist services on a regional and national basis. Our main commissioners are the Oxfordshire Primary Care Trusts (PCTs), PCTs from Buckinghamshire and Berkshire within Thames Valley, and the Wiltshire, Northamptonshire and Gloucestershire PCTs.

The Trust has a national reputation for the quality of its clinical care, teaching and research in many areas, including in particular neurosciences, cancer services and gastroenterology. The ORH works closely with the University of Oxford's Medical Sciences Division and Oxford Brookes University's School of Health and Social Care, and is a renowned teaching and education base for doctors and nurses. (See also www.oxfordradcliffe.nhs.uk)

How we are performing now

Over the past four years, the Trust has moved from being a 'no star' to a 'two star' Trust, and in the last year, has met all of its key waiting time and other performance targets. More than 98% of patients attending the emergency departments were diagnosed, treated, discharged or admitted within the required four hours. Patients waiting for planned surgery are treated within six months, and no patient waited over 13 weeks for an outpatient appointment. These targets were achieved despite the fact that the demand for services increased in all areas of our work. In particular, outpatient attendances rose by 10,000 over the past financial year, and the number of emergency inpatients increased by over seven thousand.

The Trust achieved Practice Plus last year, the highest award possible within 'Improving Working Lives', the Department of Health's scheme aimed at ensuring that staff are supported in the workplace.

A new performance rating system has now been introduced by the Healthcare Commission – the Annual Health Check – which looks at a much broader range of indicators than the targets used previously. For example it looks at the amenities and care environment, patient privacy and dignity, safety systems and policies, as well as taking account of the financial performance of trusts and the meeting of targets such as waiting times and the time to be seen as an outpatient or being treated in the emergency department. The first part of this new method of rating performance is a self assessment against 43 core standards. The ORH has declared compliance against 41 of these standards, with plans in place to achieve compliance on the final two by July this year. Further details and the declaration of compliance can be found on our website at http://www.oxfordradcliffe.nhs.uk/news/performance.aspx

The strategic context

The ORH Strategic Review was launched in July 2004, with publication of the document ***Fit for the Future,*** which described our services and set down the way in which the Review would work. The aim of the Review was to recommend the way in which our services should be organised and delivered in the future and how a financially stable future could be achieved. In September 2005, following twelve months of work and discussions with staff and partners, including patient groups, we published ***Emerging Themes*** for discussion and debate across the county and internally. We outlined the approach for our clinical services (providing a framework for grouping and describing these services), discussed how high quality and effective services could be provided at the Horton Hospital in Banbury, and set out the key emerging themes under five headings:

- Customer-focused patient care
- Marketing the Trust and its services
- Our place in the healthcare system
- The relationship with Oxford's universities
- Organising for strategic advantage

The Review is now finalising its work and further reports on clinical and corporate strategies for the future will be published after discussions with the Trust Board on its recommendations. The work done as part of the Review has provided a strong and evidence-based framework on which the current performance improvement and cost reduction programme can be based. A number of ways to achieve financial stability were identified through the work of the Review and as part of the modernisation work already underway. As a result, we have been in a good position to take work forward quickly, building on this experience and knowledge, and the involvement and commitment of staff.

Achieving significant performance improvements such as reducing lengths of stay and bed use, changes to the way in which clinical services are provided, workforce remodelling, and initiatives to boost income have always been part of the ORH's strategic objectives.

In the new health environment, and given Oxfordshire's overall funding position, it is clear that this approach will be essential to ensuring that money is available for service development.

The current programme will be very challenging but will stand us in good stead in future years, allowing the ORH to fund improvements in services, facilities, equipment and buildings, in more customer-focused patient care, and in leading-edge treatments and training.

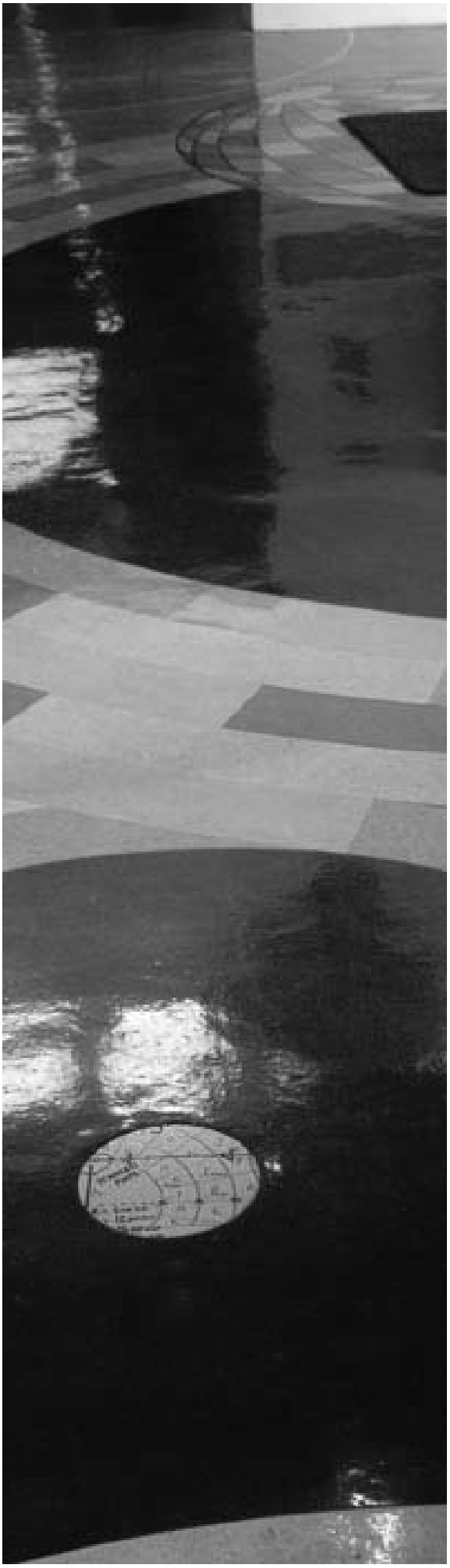
The ORH has used its strategic objectives to make sure that its plans for a stable financial future are not compromised by the short-term pressures. In addition, the need to deliver the financial savings during 2006/07 has resulted in the reassessment of the consultation timetable for the work of the Strategic Review. Hence, options for changes in services at the Horton Hospital, that might otherwise have been consulted on separately, are included for consultation as **Part 2** of this document.

The financial context

The Department of Health national reference cost index[1], published in April 2006, shows the average cost of hospital services. The ORH is now one of the most cost-efficient acute teaching trusts in England and, with a reference cost of 94, the most efficient of all large acute trusts with a turnover of more than £300m. It is now looking to become the most cost-effective teaching hospital in the UK.

However, Oxfordshire only receives 85% of the national average funding for NHS services, and is one of the lowest funded counties in the country. This funding is based on the relative health of the population, and reflects the fact that inner city areas with higher levels of illness and deprivation receive higher levels of funding. At the same time, the NHS in Oxfordshire has to plan for a high cost of living, which we do not feel is not adequately compensated for in the funding formula.

This year, we estimate that we will receive £33 million less than needed to run services at current levels (and current costs). In order to tackle the shortfall, and to become more efficient and cost-effective, we are planning a further performance improvement and cost reduction programme, building on the work already done over the last three years.



1 Reference costs are the average cost to the NHS of providing a defined service in a given financial year. NHS Trusts are paid at 100 regardless of their reference cost.

Our approach

As soon as the financial position for 2006/07 became clear, a team was set up to generate ideas to reduce running costs and identify performance improvements in services across the organisation. This team includes doctors, nurses, managers, and other healthcare professionals throughout the Trust. The work is being supported by an external project manager with experience in the commercial sector. The plans have been discussed with our staff and the staff-side organisations.

Some of the projects build on existing work and others look at new areas for efficiency and cost-saving. But, in all aspects of this programme, the following principles underpin our approach:

- Patient safety remains of paramount importance.
- We will do everything we can to minimise the impact on patient care.
- We will do everything we can to minimise the impact on staff, and avoid compulsory redundancy.
- We will discuss plans with staff before they are announced externally.
- We will discuss plans for service changes with staff, patients and the public.
- We will as far as possible avoid action which damages the long-term strategic interests and objectives of the Trust.

The cost reductions fall broadly in the following areas, shown in the table below with an indication of the levels of savings:

	Workstream	approx target value £000s
1	**Performance improvement, service re-modelling and reduction in activity[1]**	**11,600**
2	**Remodelling and reduction in non-clinical support services**	**4,900**
3	**Non-pay savings**	**9,000**
4	**Pay costs and staff-related savings**	**5,150**
5	**Increasing non-patient income**	**1,450**
6	**Other service changes**	**900**
	Total	**33,000**

1 The Oxfordshire PCTs have notified the ORH that they plan to commission fewer elective services in 2006/07 than in 2005/06

The Trust-wide programme is being driven by a Performance Improvement Team (PIT), which meets regularly to ensure that all gaps are covered and that any impacts from one project on another can be managed. In addition, meetings are held with the clinical divisions and corporate directorates to ensure the robust management and smooth implementation once the details have been agreed.

A detailed risk assessment of the schemes has been carried out, and the identified risks will be closely monitored by the Board and the management team, throughout the implementation phase.

Our plans

Since the financial position within the Trust, Oxfordshire and across the Thames Valley became clear in the latter part of 2005/06, work has been underway to ensure that plans are put in place to meet the financial challenge. Two key approaches have been adopted:

- Improving efficiency, economy and productivity
- Performance improvements

Improving efficiency, economy and productivity

We are targeting the maximum possible contribution from improved efficiency, economies of scale and productivity measures, as these should have the least impact on patient services and our workforce. In many areas, work is already underway and being discussed within the services and with our staff.

The opportunity has also been taken to streamline the Trust's corporate and business support directorates including Human Resources, Estates and Facilities, Finance and Procurement, and Information Technology. Savings have been made by looking at how these areas can work more effectively, perhaps with improved technological support.

Budgets have been reduced and changes in the number of posts made as a consequence. The impact on staff will, as far as possible, be kept to a minimum by filling existing vacancies and cutting back on the use of temporary staff. The same principles have been applied across the three clinical divisions. These are large and complex areas, but take account of the same need to minimise the impact on clinical services and the workforce. A number of the projects impact across all areas of the Trust and include the following:

- **The agency project.**
  The contribution of agency and temporary staff across a number of areas have been much valued and, in many situations, such staff have allowed critical services to be maintained. However, in the current financial situation and with the need to reduce the impact on permanent employees, we are looking even more carefully at how we use temporary staff. There has already been successful work to reduce the use of high-cost agency staff within the Trust. This is being accelerated, with the focus continuing in nursing and midwifery and now on administrative and clerical staff. Last year, we spent £10 million on medical, dental and administrative temporary staff and £10 million on agency nurses. Some of these temporary staff are essential – for example, to cover nursing shortages. We are closely examining the use of all agency staff, and will only allow it when it is absolutely necessary.

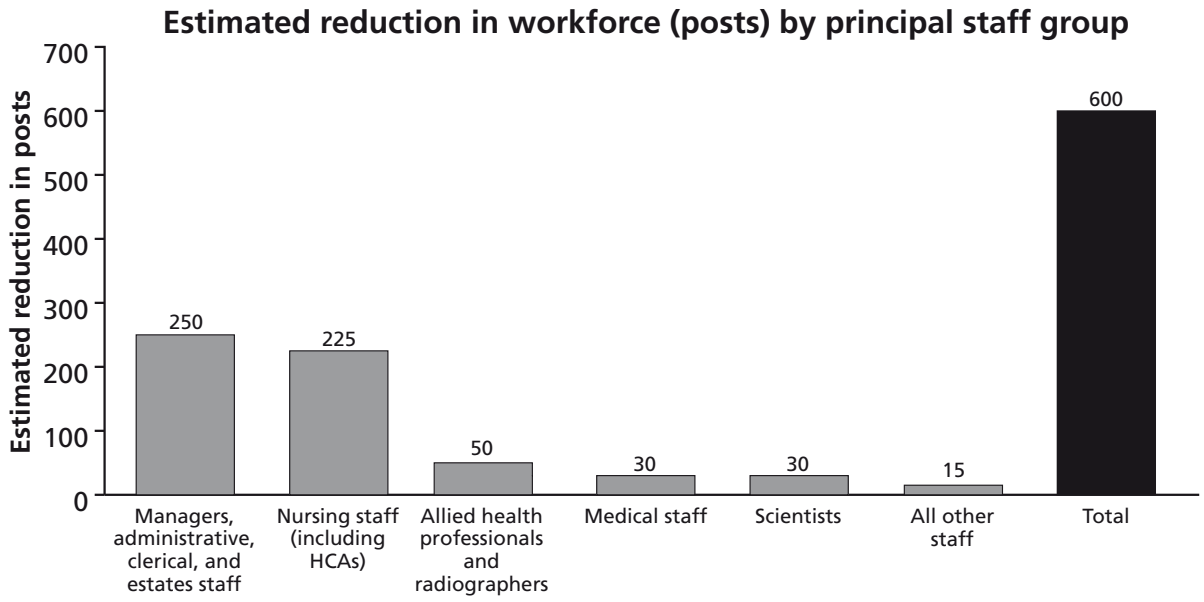
- **Review of administrative and clerical services.**
  We are now looking at how administrative, secretarial and clerical services can be provided differently and more effectively, perhaps with the use of new technologies. This work will link with the National Programme for Information Technology (Connecting for Health). Significant savings can be made in all areas.

- **Vacancies.**
  With a workforce of nearly 10,000, there are commonly a large number of vacancies and a relatively high turnover of staff. We have reviewed all vacancies and taken out those posts which are not absolutely essential, and we have now 'frozen' the majority of the vacancies. Other vacancies will be filled by staff moving from other posts as part of reducing the impact of these measures on the workforce.

- **Procurement.**
  We are talking to our major suppliers and examining how we can make our relationships with them more cost-effective. Much has already been done in this area, but there is the potential for further savings to be made. Particular work focuses on making the best use of our considerable buying power and making sure that we try to standardise the equipment and supplies we purchase.

Changes to and impact on the workforce

More than 60% of the ORH's expenditure is on staff. It is inevitable that a significant part of any savings programme will lead to a reduction in the number of posts; we anticipate that we will need to reduce the number by around 600. Staff whose posts are 'at risk' will receive full support from our Human Resources and management teams during the 90 day consultation period, and every effort will be made to avoid compulsory redundancy. The process for dealing with post reductions has been fully discussed with staff-side organisations (unions).



Performance improvements

Every year the ORH sees, treats and admits more patients than the year before. Between 2002 and 2005, the number attending A&E rose by nearly 10%, and emergency admissions rose by 18%. This rise in activity also resulted in increased workload in the clinical support services such as laboratories, diagnostic services, including X-ray, and in such services as occupational therapy, pharmacy and physiotherapy.

The table below shows how activity across our key areas of work has changed in the last five years.

	2002/03	2003/04	2004/05	2005/06
Emergency activity	71,240	76,707	84,227	91,482
Elective inpatients	21,915	22,010	22,811	23,180
Day cases	56,746	59,460	61,437	77,673
Total FCEs*	149,901	158,177	168,475	192,335
A&E attendances	114,538	116,791	125,482	123,852
Outpatients	486,900	510,320	514,613	525,710

*FCE = finished consultant episodes

Over the past few years, we have accommodated the rise in demand for services in a number of different ways, such as

- making more use of day surgery, so that fewer surgical patients have to be admitted overnight,
- developing new community services, so that patients who previously had to come into hospital can be treated in their own homes, and
- by reducing the average length of stay for patients.

We know that compared with other hospitals, we have made some significant achievements in these areas. Our average length of stay for patients is shorter than the national average, and we also make more use of day surgery than many other hospitals.

Through the Strategic Review, we looked in detail at all of our clinical services. Particular areas of focus have included our elective general and specialist surgical services and acute general medicine and the care of the older person. Much of the performance improvement work is focused in these areas.

The programme

A Performance Improvement Team has been brought together from experienced clinicians and managers to deliver the changes. The programmes being worked on include:

- eliminating unnecessary delays in laboratory tests, x-rays and other examinations, thereby reducing lengths of stay for all patients;
- using our operating theatres and diagnostic services more efficiently;
- extending the use of day surgery and making better use of our outpatient services;
- looking at how we best use the administrative and clerical support services.

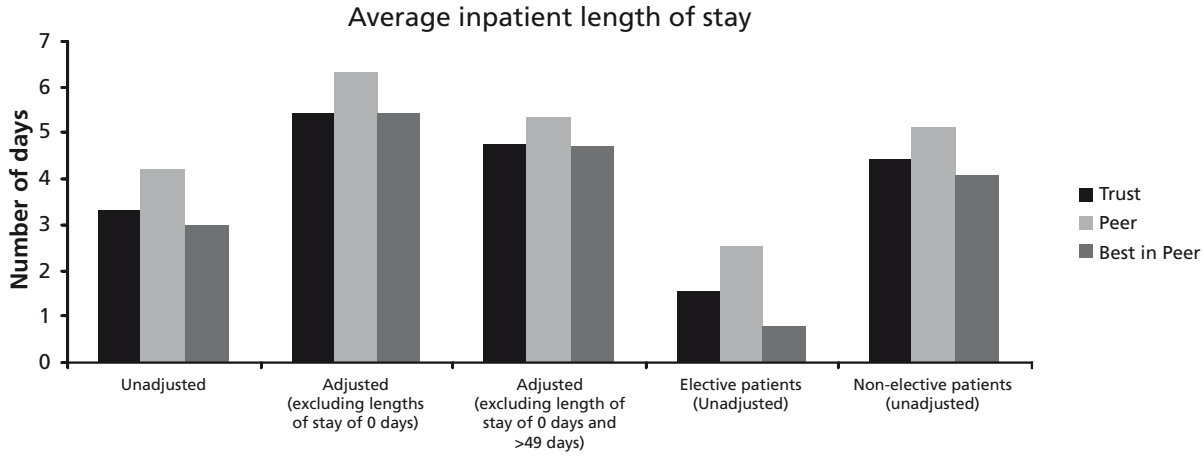
We are drawing on work already in progress, and are also looking at examples of good practice and improved patient services from across the country. In particular, the NHS Modernisation Agency's '10 High Impact Changes', including:

- making sure that patient discharges are properly organised;
- managing variation in patient admission;
- applying a systematic approach for people with long-term conditions;
- improving patient access by reducing queues;
- improving patient flows by tackling bottlenecks.

The table below shows how efficient we are currently in a number of areas, and our target for improvements:

Extract from performance improvement programme				
Measure	**Current position**	**Planned position**	**Planned improvement or reduction**	**Percentage change**
Average length of stay	6.16 days	5.5 days	-0.66 days	-10.7%
Number of beds	1,600	1,470	-130	-8.1%
Outpatient clinic utilisation	85%	95%	+10%	+11.8%
Number of outpatient clinics	698	628	-70	-10.0%
Theatre utilisation	83%	90%	+7%	+7.8%
Number of theatre lists	292	261	-31	-10.6%

The following table shows our length of stay performance in comparison with other similar trusts:



We estimate that by implementing these changes, we will be able to reduce our bed capacity (and hence our costs) by some 130 beds in the medical and surgical adult services (roughly four fewer wards), across all of our hospital sites.

Improving our surgical services

Much of the improvement in our Reference Cost Index has come from the ways in which our surgical services have improved their effectiveness and focused on the convenience of services for individual patients and their families. Particular work has looked at the admission of patients on the same day as their operation and increasing the numbers of day case operations – that is, employing surgical methods that allow patients to go home on the same day and experience quicker recovery times. Surveys across the country have shown that both these approaches are much preferred by patients and their families. The increased use of, for example, preoperative and preadmission clinics, can make sure that all the necessary tests are done on an outpatient basis, meaning that the same day admission can take place with the patient and their family being fully aware of all aspects of the procedure and the way in which the discharge will be planned.

In addition, we can be much more efficient in the ways in which we use our theatres by redesigning the areas for direct admissions, for postoperative care, and in the way we use technology to plan our theatre lists and the use of staff.

We shall increase the number of procedures done for patients as day cases. Again, experience across the UK has shown that patients prefer this approach. The changes in the delivery of these aspects of our service will meet our objective to improve our customer-focused care. Improvements in how we deliver these services will also help keep waiting times down and reduce the cancellations that are so disruptive for patients and indeed for the clinical teams.

The work currently being done with doctors, nurses, theatre and ward staff and the supporting services is expected to lead to improvements in performance (fewer operating lists, increased number of day cases, and increased number of same day admissions).

We are also proposing that a group of staff be brought together to act as an operations centre to bring about the maximum improvements in performance and productivity – it will:

- support the management of all beds across all sites to ensure best use;
- act as a single point for the booking of beds for admissions and theatre lists;
- oversee both emergency and elective, or planned, work;
- use a case management approach to reduce lengths of stay (this focuses on the individual patient and the way in which their care and treatment are planned from before their admission).

Service improvements in outpatients

It is important that we provide the best possible outpatient services for our patients. The clinical teams see more than 500,000 people each year in outpatient clinics on referral from GPs and at follow-up appointments. Our commissioners are asking for a 10% reduction in the number of appointments and hence we shall be making sure that the available clinics are used properly.

The Clinical Advice and Liaison Service will be developed in partnership with the PCTs, supported by joint work with GPs to develop protocols for referrals and follow-ups and on a range of clinical pathways for patients. This will both manage demand and make sure that patients who need to be seen are referred quickly.

We will also try to make sure that when patients do come for an appointment, everything they need, such as blood tests, X-ray, and ECGs can be done at the same time.

Service improvements in diagnostics

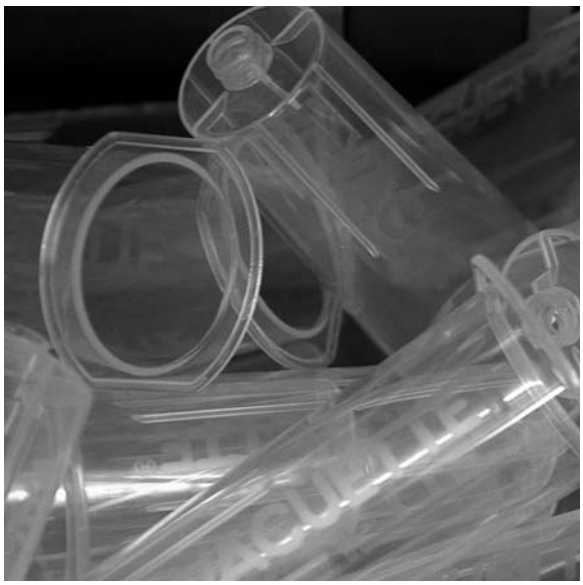
Diagnostic services such as CT scans, x-rays, blood tests and MRI scans are essential for the smooth and efficient running of the front-line clinical services, and are often crucial to the clinical pathway and delivery of national targets. For example, diagnostic investigations are vital for meeting cancer waiting targets and for ensuring the start of the right treatments and care pathways as quickly as possible.

Good management of diagnostic services can make the difference between admission or treatment on an outpatient basis, and can ensure the smooth running of a patient's stay in hospital.

Inefficient services cause delays for patients, for clinicians and can result in more time spent in hospital and delays in crucial treatments. Reducing the inappropriate use of diagnostic services will help us improve all our services service, while at the same time reducing our costs.

A number of specific initiatives are now underway to make sure that these services can be provided in support of really efficient and effective front line services:

- looking at what tests can be done at the bedside to support the clinical teams and avoid the need for out-of-hours services;
- working with GPs and PCTs on changes to direct access phlebotomy and aspects of outpatient phlebotomy which GPs are able to provide, and in many cases already do.
- better prioritisation of radiology tests and x-rays, supported by improved technology and digital imaging;
- stronger controls to make sure that only necessary tests are asked for.



Improving our medical services

As part of the work described above, we are currently looking at how we use our beds for medical patients, a very significant proportion of our total inpatient activity. We know that measures being used to improve the effectiveness of our surgical services, for example, length of stay and the management of both elective and emergency work, will also benefit the medical patients. We are planning ways to use these beds more efficiently, including tackling delays for patients in hospital, and improving the way in which they are discharged. We believe that these measures will ensure that we can reduce bed use, whilst maintaining high quality patient care.

Some of the changes being considered include:

- Having all of a consultant's patients in one 'home' ward, rather than placed in different wards across the hospital.
- Ensuring that patients and carers are aware, from the time that they are admitted, when they might expect to be discharged, so that they can plan for this (for example, by helping them to organise transport home).
- Ensuring that patients and carers are aware at an earlier stage about the options available to them for nursing and care in the community.
- Ensuring that drugs which patients need to take home with them are available when they are ready to leave.
- Discharging patients earlier in the day so that beds can be freed up for incoming patients.

Many of our patients are older people and, in acute general medicine, the mean age of those patients admitted in 2004 was 84. We are all living longer, and 14.5% of the population of Oxfordshire is currently over 65; this figure will grow by a further 14% in the next five years. 2% of the Oxfordshire population (almost 14,000 people) will be over 85 by 2011. This growth, and the fall in the numbers of people under 16, will have a major impact on our services in the future.

The Trust is working hard to meet the challenges of this ageing population, and to develop services which are in the best interests of patients, and which also make most efficient use of resources. Working with our primary and social care partners, our aim is to make sure that patients are treated in the right place at the right time, that they stay in hospital no longer than they need, and that they move on to appropriate care when they leave.

Improving our geratology service

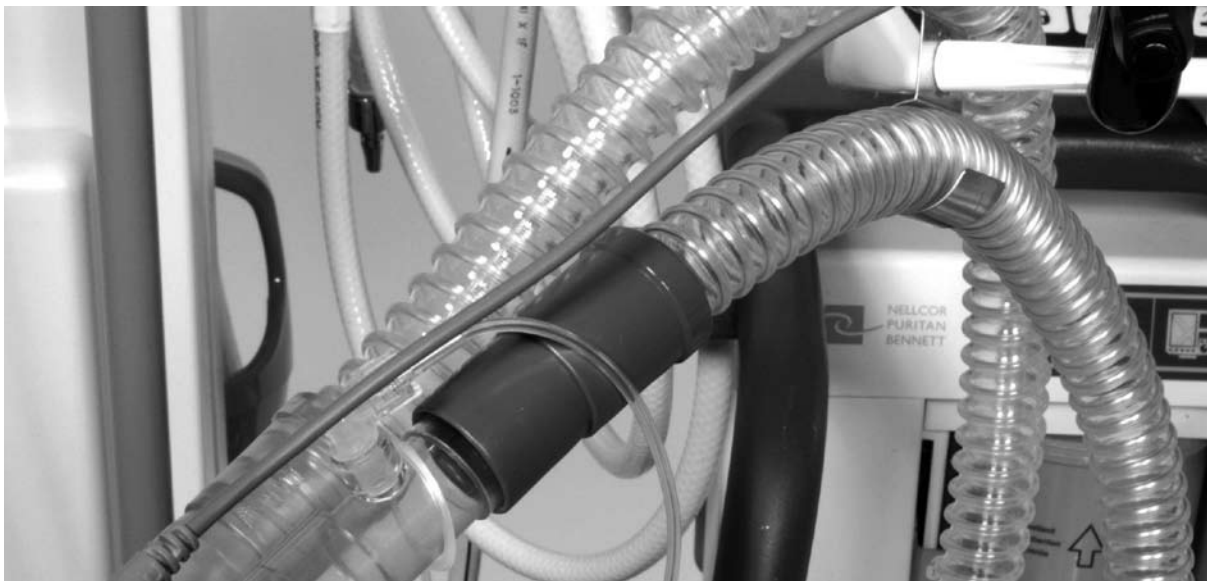
The Strategic Review highlighted ways in which services for the older person might be taken forward. Our long-term aspiration is to develop these services significantly and to become a national leader in the provision of care for older people. We will continue to develop this longer-term vision, working in close co-operation with patient groups and primary and social care colleagues.

In the short-term, we have a particular issue that needs to be tackled now. We need to move our geratology beds from the Radcliffe Infirmary, before it closes in January 2007. Over the past few months we have been planning how we do this, working with colleagues in both primary care and in social care. Our plans now need to take account of financial pressures within the NHS in Oxfordshire.

The medium-term plan is to create specialist geratology wards on level four of the John Radcliffe Hospital, using the space to be vacated when the children's wards move into the new Children's Hospital. This element of the overall plan has not yet been finalised with commissioners. We also plan to introduce rapid assessment and diagnosis services in both Oxford and Banbury, so that GPs can refer older people who are unwell for assessment, testing and diagnosis. The service will enable some patients to be treated on the spot and sent home or referred directly to community hospitals. Admission via the emergency department could also be avoided.

While we will continue to develop our longer-term plans, we need to make short-term arrangements, in order to protect our services for older people. In the short-term, we propose to locate the geratology beds within our acute general medical wards at the John Radcliffe Hospital on level seven, using the space which will become free when we implement the measures to reduce length of stay.

The length of stay for geratology patients is considerably longer than that of general medical patients (between seven and eight weeks, on average, but with some patients staying considerably longer). So we will also be tackling delays for these patients, using the same measures we are using tackle delays for all medical patients. It is vitally important that we work in close co-operation with our primary and social care colleagues, to ensure that our services are integrated, and that we have a shared vision of how we want to develop in the future.



Other service improvements

The Performance Improvement Team will be reviewing all the work on a regular basis to make sure that when new opportunities arise, these can be seized.

This paper sets out the main changes we are planning which will have an impact on the delivery of patient care. There are other projects which will help us make more efficient use of our resources. The majority of these will have no impact on the way in which we manage patient care. There are, however, one or two plans under consideration which we may wish to discuss with patient groups in the future. For example, we are considering reducing a number of under-used outpatient clinics, currently held in the community. When we have firm proposals relating to this, we will discuss them with GPs and patient groups and take account of views and concerns, before making any changes.

We are looking at our non-emergency patient transport services, to make sure that these are provided to patients who really need them. As part of income generation measures, car parking charges for patients, visitors and staff will be increasing. We will keep an overview of transport issues as they affect patients and their families, and will be discussing them with patient groups. We will also be working with the local authorities to increase public transport to our hospital sites.

How you can contribute to this debate and provide us with feedback

Comments on these plans are welcomed. These can be sent in writing to:

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Headley Way
Headington
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or emailed to: megan.turmezei@orh.nhs.uk

We will acknowledge all comments and, in addition, are happy to come and talk to patient/carer groups and any other interested parties. If you are interested in this, please contact Megan Turmezei. In addition, this document is published on our website, and other information, including Trust Board papers, is available at: www.oxfordradcliffe.nhs.uk