

2010 update

April 2008

the best staff, working together, to give excellent care



Plans for One-Stop Services

There are plans in place for one-stop services for elective orthopaedics: general orthopaedic imaging/x-ray. Steve Hart explains:

“The situation now is that patients are referred by their GP to an orthopaedic consultant, and will be seen as a new patient in an outpatient clinic. Generally, patients will need one or more x-rays on the day of this first appointment and a fairly high proportion will need to be referred to radiology, to return another day for other radiological procedures such as MRI.

“The patient will then come back for a follow-up appointment with the consultant once the results are ready and a decision will be made as to whether surgery is required, based on both an examination and the diagnostic results. If the patient does need surgery, they will be listed for this and will come back for a pre-operative assessment and, after that, for the surgery itself.

“In the autumn we are aiming to introduce a system whereby the patient comes for their first outpatient appointment and receives everything that they need on the same day – including MRI, x-rays, pre-operative assessment and any other tests - which might include neuro-physiology test, blood tests, echo-cardiogram, etc. The patient will also be listed for surgery on this day so that they leave with a firm appointment. This means that instead of coming for a few hours or less, patients would probably remain in the RUH throughout the day, cutting out the need for at least two appointments.

“We will soon be carrying out a survey of the views of around 200 patients to ensure that the one-stop service is what they actually want.

“The current challenge to the plan lies in the MRI because at this stage we only have one MRI scanner which is capable of providing a full range of MRI imaging and there are existing capacity issues with that. There are obvious inefficiencies which would arise from allocating dedicated time on the MRI scanner for patients who may or may not require a scan. However, the business case for a new scanner, which was put together at the end of 2007, is now being progressed and, if we are able to source another scanner, these necessary inefficiencies become far less of an issue.”

Evaluation of RUH 2010

Teresa Hemingway is working with Patricia Mills to circulate a proposal plan to undertake an evaluation of RUH 2010 from May 2007 to May 2008. This will be divided into three parts. The first part is a questionnaire which has been sent to the programme's project leads, clinical leads, sub-project leads, sponsors and supportive roles. The second part of the evaluation involves engaging with the wider organisation in terms of finding out their views on the extent and manner of impact which RUH 2010 has had on the day-to-day working life of the Trust. The third stage is an event for project and sub-project leads, sponsors, etc. designed to feed back these findings so that we can move forward with the next stage of 2010 and develop our capabilities as a learning organisation. In doing so, we need to determine future planning and how 2010 can most usefully be carried forward to improve the way we care for patients, the working lives of staff and the way we spend our money.

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Medlock: Productive Ward



Sharon Preston

November issue of the RUH 2010 Update outlined the pending start of a project called Productive Ward. We are now several months into Productive Ward and are revisiting to catch up on progress. Just to recap: Productive Ward is about releasing more nursing time to care. The think-

ing behind it is that releasing more time to spend on patient care will improve the overall patient experience and will have many benefits, including reducing our patients' length of stay, rates of infection and complaints. Sharon Preston, Deputy Director of Nursing, tells us more...

Productive Ward looks at how an individual ward is run and how it delivers care. It is this point which is key because one of the reasons why Productive Ward does work is that the ward team are deciding how their ward will run and what they want to change or what needs

to be changed. By wanting to change something it is more likely to be sustained.

On Medlock we measured 12 hours' of nursing activity on a continuous basis minute by minute, looking at what the registered nurse was doing and what they intended to do. This showed us that 42% of nursing time on Medlock is spent delivering direct patient care. Interestingly, the highest intended and actual activity was the medicine round, so this is one of the first modules within the Productive Ward programme that the ward will be implementing.

I am now looking at the roll-out plan and think that we will follow Productive Ward on a matron-by-matron basis with one matron heading up the project per ward. It is far more powerful for people as opposed to places to own a project like this.

Medlock Discharge Liaison Nurse Project

Alex Massey, Patient Access Manager

“The aim of the intensive Discharge Liaison Nurse project was to reduce length of stay by expediting complex discharge on Medlock. It is difficult to establish cause and effect, but length of stay has dropped significantly on Medlock since the pilot started. This level

of support is very expensive, but the reduction in occupancy, plus associated benefits, will have made savings. Does this equal the cost of the intensive Discharge Liaison Nurse support? Probably not, and even if it did, we don't have enough Discharge Liaison Nurses to provide this level of support for all wards - hence our interest in the Ward Administrator post. Jennie Russell, who has been working as a Discharge Liaison Nurse on Medlock, could endow this person with the knowledge to succeed her in managing complex discharge on the ward, and this person could link with the Discharge Liaison Nurse team as a whole for updates/advice. Jennie could then repeat the process on another ward.

“Our vision is of a ‘superclerk’ who does some of the higher level ward management work currently undertaken by the senior ward nurses. As well as freeing up the nursing staff to concentrate on patient care, this role would provide a link for both the Patient Access team (bed management, performance against targets) and the Discharge Team (complex discharge). This person would be the ‘owner’ of the specialist knowledge currently held for the ward by Jennie and the Discharge Liaison Team. A proposal for the role is being put together at the moment and should be circulated in May for consideration.”



Sharon Preston's Update

How Do the Modules Work?

The programme begins with three 'foundation modules', which are based on the ward itself:

- knowing what we are doing
- patient status at a glance (having a whiteboard with patient status will help avoid unnecessary interruptions, for example)
- well organised ward (lean thinking and looking at the systems and processes in place on a specific ward)

The well-organised ward is a continuous process which should never be finished as staff should always be looking at working methods and making improvements. On Medlock, in the first phase of this baseline module, staff looked at the organisation of the ward from every angle.

The following 'layer' of modules are the eight care modules which are based on activity on the ward. These are: medicines; meals; shift handovers; admissions and planned discharge; patient observations; patient hygiene; nursing procedures and ward rounds. The NHS Institute is still working with pilot sites to develop more modules which will be introduced in time.

On Medlock we have completed the foundation modules and are now ready to start the medicine module. This will involve some process mapping, videoing of staff undertaking a medicine round and involving as many people as possible in working out a way to complete the medicine round more effectively.

Measuring Success

Productive Ward is an NHS Institute initiative. The Institute recommends that 11 key measures should be used in order to demonstrate that Productive Ward is making a difference. These measures include the proportion of time spent on direct care, length of stay and infection rates, as well as the volume of factors such as complaints, falls, staff absence and agency and bank usage.

“ Small things have really saved substantial amounts of time each day and it is amazing how these measures can make such a difference to the ward's efficiency. ”

Challenges to Productive Ward

Ward closures due to D&V outbreaks during December and January posed challenges to the continuing work of Productive Ward, as did staff shortages due to sickness/vacancies. Having enough capacity to release staff for training was tricky and so we engaged the help of the matron for the area and the nurse consultant as well as members of the practice development team – they either provided training or relieved staff doing clinical duties.

At the end of the process and once we had managed to release a group of staff on one occasion, they were able to get on with the work and could do it at times to suit them, making the most of weekends and nights and so on. Dionne Wilkinson, the sister on the ward, and the ward sister and members of the nursing team, were absolutely determined to make it work - which has proved well worthwhile.

Data has been collected for the period before Productive Ward began and for the first few months of the process and we now have a good range of information from which to begin measuring our success. We know, for example, that at the start of the project nursing time spent on direct care stood at 42%.

Early evidence of success is promising. Since we completed the work on the foundation module, 'well organised ward', people are taking greater care in putting things where they should be and it has been noticed that the ward already looks tidier.

Small things - such as reorganising the ward keys and cupboards - have really saved substantial amounts of time each day and it is amazing how these measures can make such a difference to the ward's efficiency.

Project 5 - Strategic Suppliers

Each day the Trust depends on a number of strategic suppliers who deliver the goods and services which make the hospital function; without their service levels the hospital would not operate effectively. On the surgical side, for example, this includes the major providers of orthopaedic implants and consumables, and on the facilities side, our laundry supplier who delivers six days per week to ensure we have the theatre drapes and flat linen to maintain our service levels.

To ensure that the extended supply chain operates more effectively, it is important that we keep our strategic suppliers updated as to our plans, so that they are able to adjust their plans to meet our changing requirements. For example, if we have accepted more commissioning work from the PCT, which means that we have to extend the theatre operating hours to undertake more procedures, then there is a strong possibility that we are likely to consume more goods; this needs to be planned and factored into the joint planning activity with our suppliers so that we have the right products at the right time.

Once we have agreed our requirements, we also need to work with our suppliers to monitor and measure their performance in terms of price, quality, quantity and timeliness. To do this in future, we shall be using more commercial techniques, such as key performance indicators, to measure supplier performance so that we know that the service levels which we contracted for and are paying for are being routinely met. If they are not, we have several options to rectify the problem, from finding a new supplier to working with them to resolve the difficulties.

Over the last few weeks we have negotiated early payment discounts with six of our strategic suppliers which will deliver financial benefits to both parties over the next few months. During 2008 and beyond we will be further improving and strengthening our commercial relationships with our strategic suppliers to ensure that both parties are clear as to what our plans and priorities are and the performance management standards required to assist in making RUH the first-choice hospital for patients.

Project 6: Radiology Sub-Project Top 10 Efficiency Gains

The radiology sub-project has been looking at efficiency of existing rotas; use of PTL to drive down waiting lists; use of equipment and space; skill mix and other staff issues; recognition and celebration of good practice. With radiology activity rising by over 21% over the year, and referrals increasing by over 10% over the past three months, reviewing the radiology service whilst trying to drive down waiting times has been difficult. Despite this, however, the following efficiencies have been achieved:

- radiologists have become more adaptable with their lists;
- more flexible rotas have improved co-ordination between the staff groups, particularly radiographers and radiologists;
- Patient Targeted List management and reduced waits have improved list efficiency/patient throughout and reduced DNAs and cancellations;
- CRIS lists are fully booked and start promptly due to closer bookings monitoring;
- inpatient services have moved upstairs which has improved the service offered to orthopaedic inpatients in particular. (We have ownership over when we see these patients and fit them in around our capacity. This was not possible when they were seen downstairs in between the walk-in patients where activity fluctuates.)
- we have moved administrative/clerical staff upstairs which means a better, quieter, more efficient working environment and fewer distractions for the secretaries who are now downstairs in a quiet room;
- a higher number of advanced practitioners carry out reporting, undertake barium enemas, Hysterosalpinograms and place Hickman lines;
- we have altered the staff mix between radiology department assistants and porters to increase porter numbers in support of CT in particular but also main department inpatient flows;
- working in partnership with Bath Imaging Partnership has given good income streams for the Trust which has enabled us to employ a Band 6 Radiographer to run the second (old) MRI scanner three days per week at no cost to the Trust;
- PACS has improved reporting rates and CR has reduced the number of repeat images taken due to greater exposure latitude. This has also increased patient throughput.

For more information on any of the projects included in RUH 2010 please email: RUH2010@ruh.nhs.uk