Benefit Realisation Plans (22/09/2020)

This document presents the proposed benefits that are planned as a result of the proposed service changes in the Fit for the Future Programme (Phase 1). These plans will be developed through the business case process the baseline and outcome metrics are confirmed prior to implementation[1].

The identified benefits include:

- Improved patient outcomes
- Improved patient experience
- Improved staff experience
- Improved staff recruitment and retention
- Improved efficiency and effectives ness (cash releasing)
- Improved efficiency and effectives ness (non-cash releasing)

[1] It should be noted that Gastroenterology and T&O are currently pilots and therefore the benefits are those that have accrued as a result of their implementation.

Benefits Realisation- Emergency General Surgery (EGS) (C3)

Desired benefit pre change	Stakeholders impacted	Enablers required to realise benefit	Outcomes Displayed if benefit realised	Current (Pre-COVID) Baseline measure	Who is Responsible?	Target date	Learning / Indications from Temporary COVID 19 Changes
Improvement in staffing workload – Risk S2275- Risk of sub-optimal staffing caused by a combination of insufficient trainees and increased demand resulting in compromised trainee supervision, excessive work patterns and impacting on the ability to run safe and high quality surgical rotas	Patients Junior doctors Deanery Consultants	Reallocation of workload by centralising the emergency service. Rota redesign	Enhance training and support for staff. Retention and possible increase of trainee doctors Increasing registrar presence at GRH to 2 to enable better support and workload	Risk (S2275) Score: **Extreme Risk** 16- Workforce 12- Statutory 10- Finance In a 7 month period in 2019 15% of EGS shifts were not covered (390 out of 2599) Rota gaps increased by 46% over the past 3 years	Surgical Division	First quarter 2021/22	Rotas are still not optimal as covering CGH in a non-sustainable rota; however the new rota has shown marked improvement with significantly improved resilience and a reduction in locum shifts. Risk (S2275) has been reviewed following temporary co-location at GRH Score: **Moderate Risk** 6- Workforce 6- Statutory 6- Finance Opportunity to reduce locum spend but yet to be quantified.
Improvement in trainee environment- Risk S3035 to safe service provision caused by an ability to provide an appropriate training environment leading to poor trainee feedback which could result in a reduction of trainee allocation impacting further upon workforce and safety of care	Patients Junior doctors Deanery Consultants	Reallocation of workload by centralising the emergency service. Rota redesign	Retention and possible increase of trainee doctors	Risk (S3035) Score: **Extreme Risk** 15- Workforce Deanery feedback is poor.	Surgical Division	First quarter 2021/22	Rotas are still not optimal as covering CGH in a non-sustainable rota; however already there is a marked improvement with trainees now able to continue operating alongside consultants without being interrupted to review patients who require admission or escalation. Risk (S2275) has been reviewed following temporary co-location at GRH Score: **High Risk** 9- Workforce
Improved senior surgical review. Risk S2930-Insufficient senior surgical cover resulting in delayed senior assessment and delays to urgent treatment for patients- Risk to patient safety	Patients Junior doctors Deanery Consultants	Reallocation of workload by centralising the emergency service. Rota redesign	Ability to assess patients in a timely way resulting in faster assessment and treatment for patients	Risk (S2930) Score: **Extreme Risk** 15- Quality 12- Safety 10- Statutory	Surgical Division	First quarter 2021/22	Following the temporary centralisation of EGS, data collected by the Surgical Assessment unit has shown that the waiting time has reduced markedly with an increase of 81% to 93% of patients reviewed within 4 hours Score: **Moderate Risk** 4- Quality 4- Safety 4- Statutory

Desired benefit pre change	Stakeholders impacted	Enablers required to realise benefit	Outcomes Displayed if benefit realised	Current (Pre-COVID) Baseline measure	Who is Responsible?	Target date	Learning / Indications from Temporary COVID 19 Changes
Improved access to sub specialty treatment and equity of care. Risk S3036 shows sub-optimal care for patients with conditions requiring specific care (upper or lower GI) caused by inability to provide sub-specialty rotas and resulting in inequitable are and different clinical outcomes	Patients	In the proposals there are plans to have two consultants on call one upper and one lower GI	The on call arrangements described would ensure that patients requiring subspecialty expertise receive it in a timely way	Risk (S3036) Score: **Extreme Risk** 15- Quality	Surgical Division	First quarter 2021/22	Following the temporary centralisation of EGS the new on call arrangements have been trialled enabling a reduction in delay to theatre and better continuity of care. Score: **Moderate Risk** 6- Quality
Better access to emergency theatre. Risk S3038- A risk of sub-optimal care with delays for patients requiring surgical treatment caused by limited day time access to emergency theatres resulting in increased length of stay and poor patient experience	Patients Junior doctors Consultants	To increase emergency theatre provision to one 24 hrs a day and a second 08.00-18.00	To allow more timely surgery and avoid working after 20.00hrs on patients who should receive surgery during normal working hours (national guidance)	Pre COVID baseline- During February 2020; 42 operations were carried out between the hours of 20.00 to 08.00 Risk (S2930) Score: **Extreme Risk** 16- Quality 9- Safety	Surgical Division	First quarter 2021/22	April- August 2020; 152 operations were carried out between the hours of 20.00 to 08.00 (an average of 30 a month) This shows a reduction of 40%. It is anticipated that this would further improve if the vascular surgical team are not sharing the emergency theatre as they have during the COVID period Risk (S2930) Score: **High Risk** 12- Quality 9- Safety
The provision of a protected dedicated Surgical Unit. If the wards are not ring-fenced other patients' sometimes medical patients are accommodated on the surgical ward and in turn surgical patients are then outliers in other wards. This makes the care more difficult for the on-call team.	Patients Junior doctors Consultants	To ring-fence wards 5A and 5B.	This will create a dedicated area for General Surgery including a Surgical assessment Unit which will improve patient care.	Pre COVID baseline- There were 41.9 beds used for emergency surgical outliers in the 4 months prior to COVID November 2019-Feb 2020. An average of 10.5 beds a month	Surgical Division	First quarter 2021/22	During the COVID changes from April-August 2020 there were 33 outliers. An average of 6.6 a month

Desired benefit pre change	**Stakeholders impacted**	**Enablers required to realise benefit**	**Outcomes Displayed if benefit realised**	**Current (Pre-COVID) Baseline measure**	**Who is Responsible?**	**Target date**	**Learning / Indications from Temporary COVID 19 Changes**
To Reduce the admission rate. By providing improved senior review for emergency patients in ED or the Surgical Assessment Unit. Currently in theatre whilst the other is available to support junior staff in the assessment of emergency patients. This will avoid unnecessary admission. The rate of emergency Admission is 9.7% higher than peer groups.	Patients Hospital capacity	By having two consultants on call, one will be in theatre whilst the other is available to support junior staff in the assessment of emergency patients.	Improved patient pathway and patient experience The plan is to reduce the admission rate by 20%- 455 admissions but this is non-cash releasing (~£314,000)	Pre COVID baseline- To reduce the number of admissions. In the year prior to COVID March 2019 to Feb 2020 there were 6895 admissions. An average of 574.6 a month	Surgical Division	First quarter 2021/22	Emergency Surgery admissions from April to August 2020 were 2277 An average of 455.4 a month. Indicating a drop in admissions of 21%
Achieve compliance with Regulatory Bodies. Currently emergency theatre provision at CGH does not comply with NCEPOD regulations as there is not dedicated emergency theatre provision 24/7	Patients All Staff Trustwide	Patients	Compliance with NCEPOD recommendations	Emergency theatre provision at CGH does not comply with NCEPOD regulations as there is not dedicated emergency theatre provision 24/7	Surgical Division	First quarter 2021/22	Proposed Theatres provision at GRH is compliant with NCEPOD recommendations

Benefits Realisation- Centralisation of elective colorectal (lower GI) services to one site (C5 & C6).

Desired benefit pre change	**Stakeholders impacted**	**Enablers required to realise benefit**	**Outcomes Displayed if benefit realised**	**Current (Pre-COVID) Baseline measure**	**Who is Responsible?**	**Target date**
The provision of a protected dedicated Surgical Unit. If the wards are not ring-fenced other patients' sometimes medical patients are accommodated on the surgical ward and in turn surgical patients are then outliers in other wards. This makes the care more difficult for the on-call team.	Patients Junior doctors Consultants	To ring-fence ward	This will create a dedicated area for colorectal surgery which will improve patient care.	Pre COVID outlier baseline- There were 7.9 bed days with outlying colorectal patients in the 6 months prior to COVID Sept 2019-Feb 2020. An average of 1.3 a month	Surgical Division	First quarter 2021/22
Greater capacity to cope with higher levels of demand. Demand for healthcare is increasing due to population growth	Patients Regulatory targets-18 week pathway	To centralise elective colorectal surgery	A centralised service will provide more capacity and increased levels of efficiency to support higher levels of demand Additional 16 Inpatient cases PA x £4,159 per average PbR income. Total increased income of £43,254 Non-cash releasing	Number of elective inpatient episodes. From March 2019 to Feb 2020 were 166, an average of 14 a month.	Surgical Division	First quarter 2021/22
To implement ERAS (enhanced recovery after surgery) programme	Patients Consultants Nursing Staff	To centralise elective colorectal surgery	A single site will facilitate the standardisation of practice which will give clear pathways resulting in better patient, nursing and junior doctor experience LoS reduction of one day per case; 166 cases PA x cost of a day in hospital £300 gives a total saving of £49,800. However this is already included in the SSDP (Surg 05)	Length of stay and patient feedback	Surgical Division	First quarter 2021/22
Workforce benefits	Consultants Nursing Staff Junior Doctors	To centralise elective colorectal surgery	It is anticipated that centralisation will enhance the training and support offered to staff. It will also form closer working relationships and peer support.	Deanery feedback is currently poor. Nursing feedback to be recorded	Surgical Division	First quarter 2021/22

Benefits Realisation- Centralisation of General Surgery (upper and lower GI) day cases to CGH (C11)

Desired benefit pre change	**Stakeholders impacted**	**Enablers required to realise benefit**	**Outcomes Displayed if benefit realised**	**Current (Pre-COVID) Baseline measure**	**Who is Responsible?**	**Target date**
Reduction in cancellations due to bed pressures. Currently approximately 55% of upper and lower GI day surgery cases are performed at GRH. As GRH hosts more emergency work, peak pressures on beds can result in the cancellation of non-urgent day cases.	Patients	To move elective day cases for both upper & lower GI to CGH.	Improved patient experience Each cancellation means that theatre is not utilised. A theatre sessions costs approx. £2,000 to staff and there are approximately 4 cases in each session (£500 per case and there is an assumption 300 cancellations in GS can be prevented. There will be a saving of £150K PA	Over 400 cancellations for non-clinical reason were recorded in the past year the majority of these were day cases.	Surgical Division	First quarter 2021/22
Greater capacity to cope with higher levels of demand. Demand for healthcare is increasing due to population growth	Patients Regulatory targets- 18 week pathway	To centralise elective general surgery day cases	A centralised service will provide more capacity and increased levels of efficiency to support higher levels of demand If there is an increase of 10% there will be an additional 62 cases PA x the average cost of a day case £4,159. (£167,000)	Number of elective day case episodes. In the year from February 2019 to January 2020 were 622, an average of 52 per month.	Surgical Division	Second quarter 2021/22
Reduction in length of stay. Day surgery principles are fundamental to modern patient care	Patients	To centralise elective general surgery day cases	Shortened length of stays improves outcomes and earlier mobilisation reduces the risk of hospital acquired infections and venous thromboembolism If an hour is removed from every procedure, this will give 30 bed days. A reduction of £9,000 (assuming that the cost of a bed day is £300). However this is already included in the SSDP business case (Surg 05)	The British Association of Day Surgery (BADS) has listed an index of listed procedures that are optimally done as a day case. The BADS target is to undertake 95% of these cases as day surgery. The target for general surgery at Gloucestershire Hospitals is currently 75%	Surgical Division	Fourth quarter 2021/22
Standardisation of pathways. High volume, non-complex cases are particularly suited to geographical separation	Patients Consultants Nursing Staff	To centralise elective general surgery day cases	A single site will facilitate the standardisation of practice which will give clear pathways resulting in better patient, nursing and junior doctor experience	Patient feedback via FFT	Surgical Division	Second quarter 2021/22

Workforce benefits	Consultants Nursing Staff Junior Doctors	To centralise elective general surgery day cases	It is anticipated that centralisation will enhance the training and support offered to staff. It will also form closer working relationships and peer support.	Deanery feedback is currently poor. Nursing feedback to be recorded	Surgical Division	First quarter 2021/22

Benefits realisation – Centralising Acute Medicine (A3)

Desired benefit	Stakeholders impacted	Enablers required to realise benefit	Outcomes displayed if benefits realised	Current baseline measure	Who is responsible?	Target date
Increased number of ED attendances managed by SDEC on both sites– avoiding admission	Patients attending ED	Redistribution of medical registrars across sites Extended use of CINAPSIS Extending opening hours of SDEC in CGH (from 6pm to 8pm Mon-Fri)	CGH - Reduction in AEC associated admissions with a LOS of <24hrs, reducing number of admissions by 1,416 GRH – 40% of acute medical take managed by SDEC Non-cash releasing benefits included in SSDP (£1.3m)	CGH - AEC associated admissions with LOS of <24hrs is 1416 GRH – 29% of acute medical take managed by SDEC	Medical Division	First quarter after implementation
Consistent **provision of consultant review within 14 hours of arrival**	Acute Medical admissions	Centralised acute medical take rota	90 % of inpatients reviewed within 14 hours of arrival. Reduction in ALOS on AMU to 1.4 days Non-cash releasing benefits included in SSDP (£1.56m), potential additional £144,000	% patients assessed within 14 hours on weekdays 67% and 48% at weekends 25660 admissions to ACUC and AMU LOS – current baseline shows for AMU 0.86. SSDP assumptions – ACUC baseline 1.3, AMU baseline 1.2	Medical Division	First quarter after implementation
Earlier access to 'in reach' advice from other specialties	Acute medical patients, acute medical team	Acute medical take centralised at GRH, improving co-location with other specialties	Earlier assessment of acute medical patients, leading to: Reduction in admissions Reduction in LOS on AMU to 1.4 days	See above	Medical Division	First quarter after implementation

Desired benefit	Stakeholders impacted	Enablers required to realise benefit	Outcomes displayed if benefits realised	Current baseline measure	Who is responsible?	Target date
Enhanced **staff training and support**	All staff of all professional groups	Where specialities are centralised this will enhance the training and support offered to staff	Forges closer working relationship and peer support. Mentors affords easier access to those they are mentoring and vice versa Avoids forced duplication of training provision Management support more accessible Improved staff morale Natural progression to meet demands of a developing service new roles/ways of working Positive impact on patient care Reduction in staff turnover by 2% Reduction in agency / locum costs Cash and non-cash releasing benefits included in GSSD (£913,000)	Medical Division turnover is 13.31%	Medical Division	Assess success 6 & 12 months post implementation National NHS Staff Survey
Improved recruitment and retention – medical and nursing staff and overall staff satisfaction	Medical and Nursing Staff	New rotas to support a centralised acute take. Creation of more attractive job roles and training opportunities Overall impact of improved morale health and we being	Improved staff satisfaction/morale will make Acute Medicine a more attractive place to work. Not only improve retention of staff thus reducing number of vacancies but act as a magnet to attract new staff thus reducing reliance upon agency. Better able to support staff in terms of flexible working Reduction in number of vacancies Reduction in staff turnover by 2% by the end of the second year following implementation Maintain GMC NTS GIM overall scores using GRH scores as baseline Staff Survey – improvement to staff motivation to England Average Reduction in workforce risk register scores (M, 2434, Emer, - The risk of reduced safety, patient experience and quality of care due to inability to recruit and retain qualified nursing staff across Unscheduled Care – scored 8-12)	43% vacancy rate for acute medical consultant physicians Medical Division turnover is 13.31% Workforce risks reduced to 4-6	Medical Division	Third quarter post implementation Turnover – at end of 2nd year 2%

Desired benefit	Stakeholders impacted	Enablers required to realise benefit	Outcomes displayed if benefits realised	Current baseline measure	Who is responsible?	Target date
Workforce efficiencies through centralising acute medical beds	Nursing staff	Creation of a centralised acute medical unit	Reduction in 5.8 wtes (inclusive of additional costs to extend SDEC at CGH)			Third quarter from date of implementation
Improved patient pathway and patient experience	Patients	All of the above plus direct admission protocols	Increased number of direct admissions to CGH avoiding the need for admission via the ED. Improved Family and Friends scores % who would recommend the service to England Average	Currently 2120 direct admissions to CGH	Medical Division	Second quarter from implementation

Benefits Realisation – IGIS

Desired benefit	Stakeholders impacted	Enablers required to realise benefit	Outcomes displayed if benefits realised	Current baseline measure	Who is responsible?	Target date
Improved access to interventional radiology for patients on an emergency pathway	Acute medicine, Interventional Radiology	Establishment of 24/7 IGIS Hub, Centralisation of the acute take to GRH	Improved patient outcomes - Reduction in mortality - Reduction in morbidity - Reduced LoS	- Trustwide mortality rate for patients admitted on emergency pathway - Unable to baseline morbidity rate - Trustwide average LoS for patients admitted on emergency pathway = 5.6 days	Radiology	2024 (following full establishment of the 24/7 IGIS hub
Improved access to adjacent specialty advice for second opinion / clinical advice	Interventional Radiology, Vascular Surgery, Cardiology	Establishment of 24/7 IGIS Hub, relocation of cath labs, relocation of hybrid theatre	Improved patient outcomes - Reduction in mortality - Reduction in morbidity Not expected to be a statistically measurable difference	- Trustwide mortality rate for patients admitted on emergency pathway - Unable to baseline morbidity rate	Radiology, Cardiology, Vascular Surgery	2024 (following full establishment of the 24/7 IGIS hub
Improved recruitment and retention – medical and nursing staff	Radiographers, Radiologists, cardiologists, surgeons, nursing	Establishment of the 24/7 IGIS Hub	Reduction in agency spend Reduction in staff vacancies Reduction in staff turnover Reduction in risk rating for D&S2051Rad Datix (Risk of a reduced radiology service due to increase in vacancy and turnover rate of skilled Radiographic staff) = target score of 8 or below	D&S2051Rad Datix current score = consequence 4 x Likelihood 3 = 12	Radiology, Cardiology, Vascular Surgery	2024 (following full establishment of the 24/7 IGIS hub

Desired benefit	Stakeholders impacted	Enablers required to realise benefit	Outcomes displayed if benefits realised	Current baseline measure	Who is responsible?	Target date
Workforce deployment efficiencies through consolidation of radiology locations	Radiographers	Co-location of hybrid theatre and IGIS Hub	Reduction in radiographic equipment downtime resulting from staff shortages Non-cash releasing benefit 20 x £2,077 (£54,000)	IR suites have been closed on approximately 20 occasions a year as a result of radiographers being unavailable. Had facilities not have been out of action on occasion because of breakdowns this figure would be much higher.	Radiology	2024 (following full establishment of the 24/7 IGIS hub
Improved patient pathway and patient experience for emergency patients requiring cardiac input	Cardiology inpatients, emergency admissions, E-zec	Relocation of the cath labs	Reduction in inter-site transfers for emergency cardiac interventions. Estimate reduction of 62% inter-site transfer (NCRB ~£25,000) Average LoS reduction of 0.5 days for each inter-site transfer avoided (NCRB £39,000) Resulting in improved patient experience	Between Feb19-Jan20 678 Patients were admitted at GRH on an emergency pathway and required inter-site transfer to CGH to access the cath labs	Cardiology	2021 (following relocation of cath labs)
Improved patient pathway for patients requiring urgent vascular input	Emergency admissions	Relocation of Vascular surgery, Centralisation of the acute take to GRH	Undifferentiated emergency admissions will have access to vascular care without the need to transfer to CGH Thereby improving the patient experience and reducing time to intervention Reduction in inter-site transfers for vascular inpatients admitted via the other site (NCRB ~£3,400)	Vascular patients admitted via GRH (this will need to offset by the number of vascular patients admitted via CGH) – Between Feb19-Jan20 64 patients were admitted as vascular inpatients via GRH ED. Unable to effectively measure expected change in patient experience	Vascular Surgery	2024 (following full establishment of the 24/7 IGIS hub
LoS reduction resulting from new IR procedures replacing open surgery	Patients, Surgical division, Interventional radiologists	Commissioned to undertake new activity / agreement to undertake activity under the QE MDT	See bed impact detail NCRB - 62 beds days @ £276 (£11,000)	As detailed in bed impact	Interventional Radiology	Subject to commissioner approval

Desired benefit	Stakeholders impacted	Enablers required to realise benefit	Outcomes displayed if benefits realised	Current baseline measure	Who is responsible?	Target date
Reduction in expired IR inventory resulting from consolidated IR locations	Interventional Radiology	Co-location of hybrid theatre and IGIS Hub	Reduction in expired stock. Target of 33% reduction (moving from 3 sites to 2) = dispose of less than £53k CRB £27,000	During 2017/18 £80k of IGIS consumable stock had to be disposed of	Radiology	2024 (following full establishment of the 24/7 IGIS hub
Increased revenue resulting from repatriated activity	Interventional Radiology	Commissioned to undertake new activity / agreement to undertake activity under the QE B'Ham MDT	£463,590 in potential additional revenue (as detailed in financial modelling)	£0	Radiology	Subject to commissioner approval
Reduction in patient travel resulting from repatriated activity	Gloucestershire patients	Commissioned to undertake new activity / agreement to undertake activity under the QE B'Ham MDT	Improved patient experience Avoided requirement for Gloucestershire patients to travel out of County to receive their care.	N/A	Radiology	Subject to commissioner approval
Reduction in inter-site transfers resulting from same site location of vascular and dialysis services	Vascular inpatients, E-zec	Relocation of vascular surgery to GRH	Improved patient experience No inter-site transfers required for vascular inpatients requiring dialysis. NCRB 146 x £60 (£8,760)	During the six month period of July 2019 – December 2019 72 site transfer-and-return journeys were undertaken for vascular inpatients requiring dialysis = 146 transfer and return journeys / annum	Vascular Surgery	2024 (following full establishment of the 24/7 IGIS hub

Desired benefit	Stakeholders impacted	Enablers required to realise benefit	Outcomes displayed if benefits realised	Current baseline measure	Who is responsible?	Target date
Improved robustness of OOH interventional radiology service resulting from radiologist vacancies	Radiology	Establishment of 24/7 IGIS Hub	Reduction in score of datix risk D&S1636Rad (Risk of non-availability of OOHs interventional radiology service) Target score of 9 or less	D&S1636Rad datix score = consequence 3 x likelihood 4 = 12	Radiology	2024 (following full establishment of the 24/7 IGIS hub
Improved mortality and morbidity rates within interventional cardiology	Cardiology	Relocation of the cath labs to GRH and centralisation of the acute take	Reduction in morbidity and mortality for the PPCI 24/7 programme and ACS treatment	Tbc	Cardiology	2024 (following relocation of the cath labs and centralisation of the acute take
Improved access to renal ward for vascular opinion	Renal inpatients	Relocation of vascular AC to GRH	Better access to fistula patients by vascular consultants. Improved access to a vascular opinion. Quicker review of patients. Not expected to produce measureable benefit	N/A	Vascular / Renal	Following relocation of vascular service

NB: These Pilots have been implemented therefore benefits realised are in the Baseline

Benefits Realisation- Centralisation of Gastrointestinal Medicine

Desired benefit pre change	**Stakeholders impacted**	**Enablers required to realise benefit**	**Outcomes Displayed if benefit realised**	**Current (Pre-COVID) Baseline measure**	**Who is Responsible?**	**Target date**
Greater capacity to cope with higher levels of demand. Demand for healthcare is increasing due to population growth	Patients Regulatory targets- 18 week pathway	To centralise patients from two sites to one dedicated unit	A centralised service is more efficient freeing clinicians to provide more clinic and endoscopy capacity	Additional endoscopy lists a week. Post pilot the service is regularly achieving 5.6 additional endoscopy lists a week	Medical Division	Fourth quarter 2018/19
Reduction in spend by no longer outsourcing private services. Before the pilot the service was unable to keep up with demand necessitating the use of private providers to undertake endoscopy procedures	Patients Regulatory targets- 18 week pathway	To centralise patients from two sites to one dedicated unit	By becoming more efficient (as described above) the service would no longer need to 'outsource' to private providers	The annual cost to GHNHSFT before the pilot was £660K. Since the pilot it has not been necessary to 'outsource' endoscopy services.	Medical Division	Fourth quarter 2018/19
Achieve the 6 week wait diagnostic target. Before the pilot the service was unable to achieve the target of 6 weeks for endoscopy even with the use of private providers to undertake endoscopy procedures	Patients Regulatory targets- 18 week pathway	To centralise patients from two sites to one dedicated unit	By becoming more efficient (as described above) the service would no longer need to 'outsource' to private providers	To achieve the 6 week diagnostic target. Pre pilot the service was unable to achieve the target of 6 weeks for endoscopy even with the use of private providers to undertake endoscopy procedures Post pilot the trust has achieved the 6 week target	Medical Division	Fourth quarter 2018/19
Reduced time to 'be seen' by a gastroenterologist. This refers to a request via e-referral	Patients	A 'consultant of the day' rota to be established	A 'consultant of the day' rota to be established to provide support for two 'high acuity beds' at GRH and provide referrals in a more timely way	Pilot target was that all patients should be seen within 24 hours. Pre pilot results 24-48 hours Post pilot results 6-12 hours	Medical Division	Fourth quarter 2018/19
Decrease in the number of violence and aggression incidents within the service.	Patients All Staff	Improvement of the time taken to assess patients	The system described above will enable patients to be reviewed earlier and prevent delays which lead to agitation	A decrease in reported incidents involving violence and aggression within the service. Before pilot there were an average of 8.5 a month After the pilot there were an average of 1.6 a month	Medical Division	Fourth quarter 2018/19

Desired benefit pre change	**Stakeholders impacted**	**Enablers required to realise benefit**	**Outcomes Displayed if benefit realised**	**Current (Pre-COVID) Baseline measure**	**Who is Responsible?**	**Target date**
Reduction in length of stay.	Patients	To centralise patients from two sites to one dedicated unit	Shortened length of stays improves outcomes and earlier mobilisation reduces the risk of hospital acquired infections and venous thromboembolism	Monitor Length of stay. Reports show fluctuation in length of stay. However because there are more patients being seen quickly on admission and discharged home straight from the Acute Medical Ward the previous shorter stay admissions are no longer required.	Medical Division	Fourth quarter 2018/19
More responsive to GP requests	Patients GPs Consultants	Provide an 'Advice and Guidance' service to GPs	Direct communication between GPs and consultants enables best care for patients which can either result in the prevention of an Inpatient admission or a more streamlined admission where the patient is admitted directly to the gastro ward	Monitor the number of requests. Since the start of the pilot the gastroenterology service receives between 120 and 150 GP requests for help in managing this patient group.	Medical Division	Fourth quarter 2018/19
Improvement of patient experience.	Patients	To centralise patients from two sites to one dedicated unit	A single dedicated unit will provide timely admission to a ward staffed by an expert team of nurses and doctors	Patient feedback via FFT (Friends and Family Test) Prior to pilot results: Positive 79%, Negative 6.98% After pilot results: Positive 91.49%, Negative 2.13%	Medical Division	Fourth quarter 2018/19
Improved Junior Doctor training	Junior Doctors	To centralise patients from two sites to one dedicated unit	Improved access to teaching ward rounds. Manageable workload. Increase opportunities to attend endoscopy sessions and clinics.	Monitor deanery feedback	Medical Division	Fourth quarter 2018/19
Workforce benefits	Consultants Nursing Staff	To centralise patients from two sites to one dedicated unit	It is anticipated that centralisation will enhance the training and support offered to staff. It will also form closer working relationships and peer support.	Monitor Feedback: Consultant feedback overwhelmingly positive, able to concentrate on their own specialty. Nursing feedback agreed that the changes gave patients the correct environment with the right expertise.	Medical Division	Fourth quarter 2018/19

Benefits Realisation- Trauma & Orthopaedics

Desired benefit pre change	**Stakeholders impacted**	**Enablers required to realise benefit**	**Outcomes Displayed if benefit realised**	**Current (Pre-COVID) Baseline measure**	**Who is Responsible?**	**Target date**
Improved senior surgical review. Prior to the changes there were often prolonged waits for senior Orthopaedic Opinion because the on-call team might be undertaking other duties, for example working in clinic or theatre.	Patients Junior doctors Consultants	Re-allocation of service by centralising the trauma service and rota redesign to have a designated on-call Consultant and registrar without other commitments	Ability to assess patients within 30mins of being contacted by ED; resulting in faster assessment and treatment for patients	Number of patients seen within 30 mins of ED request.	Surgical Division	Third quarter 2017/18
Reduction in trauma admissions. Delays in getting a senior orthopaedic opinion in ED (as above) could also lead to a higher number of patients being admitted than necessary.	Patients Junior doctors Consultants	Re-allocation of service by centralising the trauma service and rota redesign to have a designated on-call Consultant and registrar without other commitments	Reduce trauma admissions as patients will no longer be admitted unnecessarily due to delayed senior opinion.	Number of trauma admissions; bed days for trauma patients have been difficult to calculate accurately however we believe that bed days are reduced as we are able to prevent unnecessary admissions from ED. Trauma beds have been reduced by 5.	Surgical Division	Fourth quarter 2017/18
Daily Ward/Board Round for Trauma patients. Prior to the changes post op follow up was variable as clinicians who were responsible for patients may be timetabled elsewhere making daily consultant review impossible	Patients Junior doctors Deanery Consultants	Re-allocation of service by centralising the trauma service and altering the on call rotas. There is now one designated on-call Consultant and registrar who will undertake a daily ward and board round	All trauma patients to receive a **daily senior review** by the on-call consultant 7 days a week	100% of patients reviewed daily by a Consultant, every day.	Surgical Division	Third quarter 2017/18
Improved access to sub specialty treatment Sometimes there was inability to provide timely sub-specialty surgery for complex trauma. This was because timetables for complex subspecialty trauma surgery were not evenly rostered.	Patients	There are two all day trauma theatres 7 days a week. Every day a surgeon who is able to undertake hip arthroplasty is allocated to one theatre and there is a rota for other specialist surgery i.e. upper limb, and foot and ankle in the other theatre	Reduced waits for complex surgery	Reduced delays for complex surgery	Surgical Division	Third quarter 2017/18

Desired benefit pre change	Stakeholders impacted	Enablers required to realise benefit	Outcomes Displayed if benefit realised	Current (Pre-COVID) Baseline measure	Who is Responsible?	Target date
Improvement in trainee environment- to provide an appropriate training environment leading to poor trainee feedback which could result in a reduction of trainee allocation impacting further upon workforce and safety of care	Patients Junior doctors Deanery	Reallocation of workload by centralising the trauma service and redesigning the rotas.	Retention and possible increase of trainee doctors	Deanery feedback: Foundation Year 2 Feedback was 'requires' improvement prior to the pilot and 'good' post changes. Registrar feedback remains good and it has been easier to recruit Trust Doctors.	Surgical Division	Third quarter 2017/18
Improved access to specialist trauma and orthopaedic clinicians for advice. By providing a trauma triage service	Patients ED & MIU Clinicians Consultants Junior Doctors	Set up an advice service where referrals and X-rays are reviewed.	This enables the expedition of prioritised urgent cases and those who do not need further face to face appointments can be contacted by extended scope practitioners to give advice. Therefore avoiding unnecessary visits.	**Every GP and MIIU trauma referral** now triaged by a senior decision maker, patients are prioritised with urgent cases seen sooner		Third quarter 2017/18
The provision of a protected dedicated Elective Unit. It is essential that elective orthopaedic wards are ring-fenced to prevent deep joint infection	Patients Junior doctors Consultants	To ring-fence elective orthopaedic wards: Alstone, Dixton, Hazelton and 2A Annex	This will create a dedicated area for elective orthopaedic patients which is essential to provide the best environment to achieve low rates of infection and best post-operative care	Surgical Site infection rates are to be monitored.	Surgical Division	Third quarter 2017/18
Greater capacity to cope with higher levels of demand. Demand for healthcare is increasing due to population growth	Patients Regulatory targets- 18 week pathway	To centralise elective orthopaedic arthroplasty surgery	A centralised service will provide more capacity and increased levels of efficiency to support higher levels of demand	Monitor the number of procedures: In comparison with the year prior to the pilot and first year afterwards. The overall number of elective procedures went up by 310, 10% representing an additional £1.656 M income. Of these higher proportions were joint replacements. Hip replacement increased by 20% and Knee replacement by 19%. In the following year the number reduced slightly as one of the theatres was refurbished and out of action for 6 months.	Surgical Division	Third quarter 2018/19

Desired benefit pre change	Stakeholders impacted	Enablers required to realise benefit	Outcomes Displayed if benefit realised	Current (Pre-COVID) Baseline measure	Who is Responsible?	Target date
Reduction in surgical cancellations. Previously elective cases were cancelled for trauma, in particular complex trauma.	Patients	To separate the elective orthopaedics and trauma services	Previously elective cases were cancelled for trauma, in particular complex trauma. With allocated sub-specialty trauma sessions this should be markedly reduced.	Monitor Cancellations. In the first 14 months post pilot cancellations on the day were reduced by 55% and cancellations for urgent trauma were reduced by 80%	Surgical Division	Third quarter 2018/19
Increase Efficiency (ERAS- enhanced recovery after surgery programme**)** A single site will facilitate the standardisation of practice which will give clear pathways resulting in better patient, nursing and junior doctor experience	Patients	Patients Consultants Nursing Staff	To centralise elective orthopaedic (arthroplasty) surgery	Monitor length of stay. In the past year length of stay for hip replacement has reduced by 20%	Surgical Division	Third quarter 2018/19
Standardisation of Theatre Equipment. Theatre staff can be familiar with all equipment used which increases safety and there are financial savings associated with buying in larger quantities	Patient safety and Financial benefit	To centralise both trauma and elective orthopaedic surgery	A single site will facilitate the standardisation of equipment which will enable a more streamlined and efficient Theatres experience and may result in reduction in purchase costs.	Monitor spends on equipment particularly high cost items like hip and knee prostheses. Work has been undertaken to standardise implants used resulting in a reduction in spend of £750K	Surgical Division	Fourth quarter 2017/18