Newton

Delivering meaningful impact across health and care

CASE STUDIES


EMERGENCY
AMBULANCE
CREW

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FOREWORD

We are working with clients across the country to deliver on today's most critical challenges. We understand the significant pressures leaders are currently under, including as a result of the changes that the NHS and partners in the wider health and care system are facing.

As a strategic delivery partner to health and care systems, we deliver the complex transformative change required to tackle the intense pressures of today, while creating the headroom to start designing and building the much needed future models of health and care.

Our clients choose to work with us to deliver change at the complex interfaces of health and care, whether that involves transforming urgent and emergency care, designing and implementing integrated neighbourhood teams to deliver on the neighbourhood health strategy, or optimising the system overall including planned and unplanned care.

The team and I are delighted to welcome you here at NHS Providers Annual Conference and Exhibition. Since we were last here, we've continued working alongside trusts and systems across the country to deliver meaningful and measurable impact, always putting our fee at risk against achieving that. We've also invested in further developing the data and digital capabilities that we can offer to our clients. While Newton has an existing strength in the strategic use of data, digital, and AI to achieve greater value from public services, this focus is already creating a more powerful combination of capabilities to maximise and adopt digital assets and deliver structural, multi-year, digitally-enabled change.

The examples in this brochure showcase a range of our recent experience, each reflecting the unique context, challenges and ambitions of the different systems and localities that we work with.

However, all share a consistent outcome of achieving improved outcomes for individuals, a better experience for staff, and a more financially sustainable future for the health and care system.

Robin Vickers
Partner, Health and Integration

Improving Lives - launching a single point of access model in Coventry

The challenge

Coventry, one of four places within the Coventry and Warwickshire Integrated Care System, like much of the country, found its urgent health and care services under significant pressure meaning that the residents of Coventry were not always receiving an optimum service or the best possible outcome.

In response to this, in 2023 a place-based partnership consisting of Coventry City Council, University Hospital Coventry & Warwickshire, Coventry & Warwickshire Partnership Trust and other system partners including PCNs and the West Midland Ambulance Service began working on the Improving Lives programme with support from Newton.

The programme builds on the findings from an assessment of Coventry's urgent health and care services which found significant opportunities to improve along the entire pathway. The assessment, led by Newton, found that there was a tendency to make hospital conveyance the default option for people with urgent need. The drivers of this were identified as lack of awareness of services available in the community, paired with fragmented and unnavigable services in which frontline and clinical staff had low confidence. There was a clear opportunity to come together across Coventry to unlock organisational boundaries, improve relationships across the system, and create a more integrated model of care.

Impact

The Improving Lives programme is about fundamentally changing the way in which people with urgent need in Coventry are supported. By implementing a new model for the system, the programme has enhanced the visibility and awareness of available services in the community, enabling better decision-making and more effective use of resources across all system partners. Health and care is now tailored to a patient's specific needs rather than being constrained by the limitations of current service offerings.

A new, integrated model for the system

At the heart of the Improving Lives programme is a single, local integrated team which is fully equipped to respond in a coordinated way to urgent health and care needs across the city. This group is split into three locally integrated teams, with the capability to support all of its residents needs, ensuring that decisions are made based on individual need rather than the services available. This includes providing urgent response services which are tailored to the needs of each patient, proactive discharge planning for patients admitted to hospital, through to step-down, community-based services providing ongoing support in the community or at home. This team has one urgent health and care caseload, reducing duplication across multiple organisations, enabling the best use of skillsets and resources, and ensuring that a person's urgent needs are responded to in a tailored, coordinated way.

> **"With an aligned workforce and collaborative leadership we can unblock things that have previously been unfathomable. This programme has a voice and allows us to do things that the workforce have been wanting to do for years."**
>
> Integration Lead, Coventry and Warwickshire Partnership Trust

Enablers of the new model

This is an ambitious, complex model which requires robust supporting mechanisms and tools to be in place in order to realise its potential and become sustainable. The partnership has embedded the following key enablers:

- **Hospital visibility and accountability:** really embedding the basics through well-defined roles, responsibilities and accountabilities across the hospital pathway, and providing front-line staff and leaders with live visibility of data to drive the right behaviour and evidence-based decision-making.
- **Pull model:** commencing the discharge process as soon as someone is admitted to hospital, led by the local integrated team which has deep knowledge of and connections with services in the community and is able to actively pull residents out of hospital.
- **Workforce and leadership**: integration at all levels across the three main organisations, with a single leadership structure to help hundreds of staff work collectively in the new model.
- **Digital and data:** building a single intermediate care record system with shared access to holistic care plans for patients and enabling effective resource planning. Creating a suite of dashboards providing live visibility of activity across the urgent care pathway to enable evidence-based decisions, both at a patient level by frontline staff, as well as at a system level by executive leadership.

The new model has been designed, trialled and iterated, with involvement from across the health and care system, including PCNs and the ambulance trust, in the design of interfaces with the local integrated team, ensuring a more streamlined service for residents.

OUTCOMES

The Improving Lives programme has seen many positive outcomes, from the creation of a locally integrated model that effectively supports residents, the introduction of a pull model which allows patients who are being discharged from hospital to have their care plan before they're medically optimised, and improvements to the visibility of the services within the system. Most importantly, the experience of the residents in Coventry has improved significantly with a personalised approach to health and care supporting them in achieving the best outcomes.

As of January 2025, the programme is having the following impact on outcomes across the UEC pathway in Coventry:

- **18%** reduction in older adult admissions to base wards with people being better supported by primary care or the urgent community services
- **20%** reduction in P0 patient length of stay
- **50%** reduction in the number of people moving to a long-term bedded setting
- Reduced demand for short-term bedded care from **85** beds to **39** beds, with this group having more independent outcomes in their own homes
- Successfully moved **158** members of staff from eight different services into one new organisation
- Built a care record that hosts a case load of **700+** people and connects community, adult social care, and acute data
- This performance translates to ~**£17m** annual financial benefit for Coventry.

Integrated Neighbourhood Teams in Birmingham

Understanding the challenge

Like much of the country, Birmingham's health and care services were under significant pressure from rising demand. As a result, residents were not always achieving their best outcomes whilst the financial position of the health and care system was becoming increasingly unsustainable.

The scale of this challenge nationally has received a great deal of focus in recent years, with widespread agreement that the shift towards more preventative health and care services is essential in helping people live longer, healthier lives and in ensuring the performance and sustainability of the health and care system.

The publication of the Fuller Stocktake Report in 2022 provided an early vision for the reorientation of health and care towards more proactive, personalised services by building 'Integrated Neighbourhood Teams' (INTs). It also highlighted the need for local systems to drive the change themselves, requiring primary, secondary, social care and voluntary services to work together to design and deliver an impactful new model of care for their population. The challenges presented by integrated ways of working are well known, alongside the difficulty with proving the impact of preventative services within a timeframe that supports significant and recurrent investment. However, the approach taken by Birmingham has led to hugely positive results in a relatively short space of time, generating significant national interest and providing a proven model for other systems to adapt and adopt for their own contexts.

What did we do?

Birmingham's journey towards impactful INTs began with detailed analysis of service use across the system. By combining patient-level data from all partners in Birmingham and Solihull Integrated Care System, it found that 57% of services were being used by the top 5% of service users. Having identified this high frequency user cohort, further analysis, including multi-disciplinary case reviews, enabled system partners to further understand the impact of delivering preventative interventions to these individuals.

This evidence was then used to co-design a new operating model for Birmingham's INTs, including the membership of the team, the services they would provide and new ways of working. Four interventions were found to match 75% of the needs of the target cohort, including community mental health, social prescribing, structured medication reviews and social care assessments. This understanding of the specific needs and volume of the target cohort was central to the design of the new team.

> **This genuinely gives us the chance to make a fundamental difference to people for the long term."**
>
> CEO, Birmingham Community Healthcare NHS Foundation Trust

A single Primary Care Network (PCN) INT consists of:

1. **INT Coordinator:** A skilled admin who ensures appropriate information gathering and smooth running of INT meetings, remaining action-focussed.
2. **Neighbourhood Expert:** A social prescriber or voluntary sector representative who supports the whole team in building knowledge of available interventions and links into, for example, social care community coordinators.
3. **GP:** A named GP from the PCN, who attends both weekly meetings and has delegated responsibility for any clinical decision-making by the INT.
4. **Four Key Workers (Occupational Therapist, Social Worker, Community Trust Rep, Mental Health Trust Rep):** Contribute their professional perspective about cases discussed. Act as the key point of contact for specific residents supported by the INT.

The new model was trialled across two PCNs in east and west Birmingham, where activities and an agreed set of KPIs were closely monitored to allow the model to be iterated and optimised.

Scaled up, there is an opportunity for 20,000 people in the city to be supported by INTs, preventing at least 15% of the 850,000 contacts with health and care services each year.

OUTCOMES

Impact and legacy

Results from the two pilots showed a significant stabilisation in service use for individuals receiving an intervention from the INTs. This included:

- A **32%** reduction in primary care appointments
- A **15%** reduction in A&E attendances.

Residents supported by the pilot reported an overwhelmingly positive experience – with an average feedback rating of **4.3** out of 5.

The work and its early impact has generated significant national attention, with visits from senior leaders from NHS England and health sector membership bodies such as NHS Providers and NHS Confederation, and is helping to inform other health and care systems around the country looking to mobilise their own INTs.

Our role

Newton played a central role in the diagnostic, design and set up of the two INT pilots. At the heart of this was the alignment of leaders across health and care system partners, using the data and evidence to enable them to proceed with confidence in realising their joint vision for the residents of Birmingham.

Over 200 members of staff across the system were involved in the design process from social care, primary care, the acute, community and mental health providers, the voluntary sector and the Integrated Care Board. Not only did this ensure that the design of the new teams and services benefited from the full breadth and depth of clinical and operational experience within the system, but also helped to build the belief, commitment and new integrated ways of working that would ensure the effectiveness and sustainability of the new model.

Working as One - UEC transformation in Gloucestershire

The challenge

Like much of the country, Gloucestershire's hospitals are under significant pressure, with demand forecast to continue increasing due to an ageing population. Delivering urgent and emergency care (UEC) services which are equipped to deal with the demands of today and the future is critical.

Committed to evidence-based improvement of UEC services, One Gloucestershire commissioned Newton to undertake a detailed pathway review, covering delivery of care in the community, hospital arrivals, during hospital stays, and intermediate care journeys post discharge. The review found a number of challenges including lengthy ambulance handovers, long waits for acute beds, and challenges in discharging residents resulting in lengthy stays. Disconnected services and lack of awareness of referral pathways meant that residents often were not supported to stay in their homes and communities.

Fundamentally, there was mismatch between demand for care and capacity in the system. Aligning around a vision for citizens and clear evidence of where the most impactful change would be, the Working as One programme was conceived to advance integrated ways of working and enable more citizens to lead healthier lives, getting the care they need, in the right place, at the right time.

The impact

Working as One is an example of a system-wide partnership aligning around a vision for its population. It works in a truly joined-up way across a hugely complex change programme to deliver improved outcomes for the individuals in its care.

The improvements in flow have seen the hospital occupancy reduce from over 105% to the low 90s. This has been achieved in a period where demand has been rising, and the system has undergone some significant reconfigurations of its bed base, as well as consolidating most ambulance conveyances at a single site. Improvements to discharge have seen the NCTR queue reduce, without using additional beds in the community, and the system is now using fewer beds than before.

This is enabling better outcomes for patients, and the acute trust has seen impact on their delay related harm and mortality outcomes. Ultimately, people are spending fewer nights in a bed that isn't their own, and are achieving more independent outcomes than they were previously.

The Working as One approach

In the programme there has been a deliberate effort to start small, for example with one ward or team, before scaling more widely – with the hospital flow improvements now spreading across both medicine and surgery specialities, and the intermediate care improvements rolling out across all community hospitals and locality-based reablement teams.

Working as One focused on transforming three areas around UEC which together would lead to improved outcomes for people, better experience for staff, and financial system benefit:

- **Community urgent response and front door:** Better use of services in the community – with effective referral routes to support the right people to stay at home and improved ways of working at the hospital front door that help more people return home that day.
- **Hospital flow and decision making:** Reduced time for people in hospital through better co-ordination of health and care teams and a collaborative discharge hub supporting the most complex patients quickly to their ideal next step.
- **Intermediate care and access to care packages:** Improved availability, flow and outcomes through rehabilitative care in the community. Increased intermediate care capacity to smooth discharge from hospital (or step-up from community) into care in the most suitable location. Better availability of long-term care packages reducing delays in onward progression.

OUTCOMES

To date, the programme has achieved the following:

- **21%** reduction in emergency length of stay
- **50%** reduction in length of stay in short stay units
- Acute medical unit now supports as many people with **40** beds as it did with 60
- Hospital occupancy reduced from over 105% to the low **90s**
- The improvements on discharge have seen the NCTR queue reduce by **80** people

This performance translates to **£27m** operational value for the system. As well as investing in the occupancy improvement, operational savings have allowed the system to sustain a planned **40** bed reduction via acute reconfiguration and using **50** fewer P2 beds than previous years, all while absorbing increased front door pressure.

HomeFirst - a new model of intermediate care in Leeds

The challenge

Across the country, health and care systems are facing a range of challenges in the delivery of intermediate care due to rising demand, driven in part by an aging population with increasingly complex health conditions.

In Autumn 2022, the Leeds Health and Care Partnership, which brings together health and care organisations in the city, commissioned Newton to conduct an initial review to help identify how the system could improve the delivery of intermediate care for the residents of Leeds. The review showed that whilst thousands of people from across Leeds were receiving great health and care, there were a number of challenges in the system related to patient flow and the transfer of people into intermediate care, which meant that individuals were not always achieving their best outcome.

Impact

Based on this evidence, the Leeds Health and Care Partnership, supported by Newton, set out to transform the way that intermediate care is delivered in Leeds through the HomeFirst programme, which aims to achieve a person-centred, home-first model of intermediate care that is joined up and promotes independence.

By working together in a true partnership, system partners have delivered a new model of intermediate care within existing workforce, funding and organisational arrangements. Fundamental to the success of the HomeFirst programme has been building on the culture and relationships across partners in the system, embedding a culture of collaborative decision making and service delivery.

As a result of the changes made, the HomeFirst programme sees more residents achieving their best outcome whilst simultaneously relieving seasonal pressures on the acute and unlocking significant financial benefit within the system.

The HomeFirst programme

The HomeFirst programme consists of five interrelated projects which focus on maximising independence and ensure that residents always achieve their best outcome.

The five projects are:

- **Active Recovery at Home:** redesigning the home-based intermediate care offer to maximise capacity and deliver the best outcomes for people accessing these services.
- **Enhanced Care at Home:** transforming preventive services to avoid escalations in need with a specific focus on avoidable acute hospital admissions.
- **Rehab & Recovery Beds:** transforming bed-based intermediate care to improve outcomes and minimise length of stay in short-term beds.
- **System Visibility & Active Leadership:** making use of the wealth of data in the system to produce system and service level dashboards, while establishing the right cross-partner governance to use these for effective decision-making.
- **Transfers of Care:** redesigning the discharge model to minimise discharge delays and ensure the system achieves the most independent outcomes for people leaving hospital.

The new ways of working have been designed, trialled, iterated and scaled by experts including frontline staff and operational managers from across the system.

The benefits have been huge, both for staff and for the patients. For the patients, it means that they're seen in a more timely manner and prioritised, appropriately. The referrals are triaged immediately, so there's no delay, and from a staff perspective it means that we're receiving the right patients who are right for our service."

Occupational Therapy Clinical Lead

OUTCOMES

The HomeFirst programme has seen many positive outcomes, from seasonal pressures on the acute hospital being relieved, to a reduction of the system's reliance on long-term care. Most importantly, residents of Leeds are receiving highly effective services and are supported in achieving significantly improved outcomes.

As of September 2024, the programme is having the following impact on outcomes across intermediate care in Leeds:

- **169** more people able to go home after their time in intermediate care rather than a long-term bedded setting each year
- **8.2** day reduction in the average length of stay in short-term beds
- **421** more people going directly home after their stay in hospital each year
- **786** fewer adults admitted to hospital each year
- **31%** reduction in length of stay for complex patients with no current reason to reside
- **522** additional people benefitting from reablement each year
- The effectiveness of the home-based reablement offer has increased by **8%** (in terms of long-term home care hours following the service), with a **19%** increase in the proportion of people leaving the service fully independent
- **33%** decrease in readmission rates after receiving home-based reablement
- This performance translates to **£23.7m** per annum of equivalent financial benefit to the system. These benefits are spread across system partners and are a combination of cost-out, future cost avoidance, or investment in quality.

Embedding and sustaining the changes is an important component of the work allowing for long term change that can be maintained by teams. There is more to do to deliver the full vision of the programme and ensure that Leeds Health and Care Partnership is able to support the changing needs of the population in years to come, but the impact and approach of HomeFirst delivers a strong foundation to build from.

The beauty of HomeFirst is that it has brought people together through a partnership and *TeamLeeds* approach to look at all the key transitional points where people move from the community to hospital, from hospital to home, and from hospital to community care beds. It feels so much more joined-up now because we have had so much commitment to doing this as a system rather than individual organisations."

Sam Prince, Executive Director of Operations, Leeds Community Healthcare NHS Trust

System Visibility

Before the HomeFirst programme, system partners in Leeds regularly met to discuss system performance, but the lack of a unified data source meant these meetings were often inefficient and unfocused. Each partner organisation produced a lot of data, but without a single version of the truth, efforts were duplicated, and trust was eroded. Leeds needed a way to consolidate their data and a leadership model to ensure decisions were evidence-based at every stage.

The introduction of the system visibility dashboard addressed this need by bringing existing data into a single, regularly updated platform. This dashboard supports decision-making at all levels, providing patient-identifiable data for joint case management at the team level and highlighting areas needing additional support at the service and system levels. This tool, combined with the Active Leadership framework, enables partner organisations to review data collectively and take coordinated action to resolve issues.

For the first time, heads of service from all health and care organisations in Leeds can effectively review system pressures and delays, allowing for timely, cross-organisational actions to relieve pressure before it escalates. The team has been able to identify the hidden delays further down the system which were often driving some of the delays to discharge, which would otherwise go unnoticed. The System Visibility tool and Active Leadership approach has transformed how Leeds manages system performance, fostering collaboration and enabling more effective, data-driven decision-making.

“What the dashboard has given us is one version of the truth so we can actually focus on what we need to do for the people of Leeds to improve their outcomes and we’re doing it together. So rather than having a culture where we don’t necessarily trust each other, and we don’t necessarily trust each other’s data, we’ve not got real agreement and consensus and can move forward, taking actions together collaboratively.”

Nicola Nicholson, Associate Director of Strategies and Programmes, West Yorkshire ICB

Delivering a programme with the scale and complexity of HomeFirst is never an easy task, and requires a high level of dedication, commitment and hard work, day-in, day-out from everyone involved. It has been fantastic therefore to see how through a collaborative and a real TeamLeeds approach with partners, we have seen leaders and staff across each of the projects really embrace the challenge and deliver some extremely positive results to improve and further support the delivery of intermediate care services across the city."

Caroline Baria, Director of Adults and Health, Leeds City Council

I need to get back my mobility because I used to go out quite a lot before I were ill. They've been great, really great. I've picked up now, and I'm doing alright."

Person being supported at home by Active Recovery

Providing insight to the elective challenge

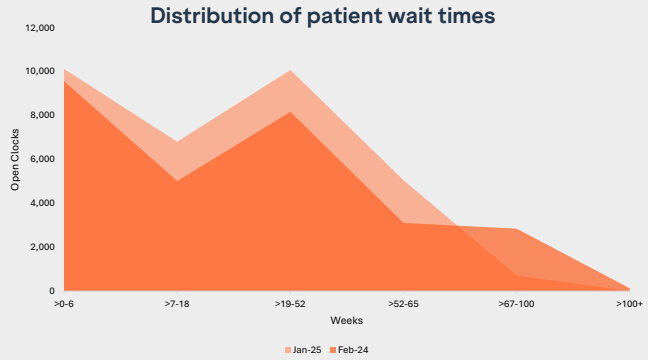
The elective challenge

Waiting times for elective care have been under pressure for a long time, but COVID-19 caused a dramatic escalation. At the height of the pandemic, many routine and elective procedures were paused to prioritise emergency care and respond to the urgent needs of patients with COVID-19. As a result, a substantial backlog accumulated. By 2024, the elective waiting list in England had grown to over 7.5 million with nearly 1 in 8 of the UK population on an elective waiting list.

To meet this challenge the government and NHS England have launched several initiatives.

- **Elective recovery plans:** targeted investment in staff, facilities, and technology, including surgical hubs and community diagnostic centres, to increase capacity and efficiency.
- **Use of the independent sector:** collaborations with private healthcare providers to increase the volume of elective procedures.
- **Prioritisation and triage:** systems to ensure those in greatest clinical need or who have been waiting longest are treated first.
- **Digital innovation:** expansion of virtual consultations and digital tools to streamline patient pathways and reduce administrative delays.

However, the situation remains challenging. Although the number of people waiting the longest has reduced, the profile of people waiting has shifted and the overall list size remains largely unchanged.



In January 2025, the NHS published a new ambition to reform elective services and increase the percentage of patients treated within 18 weeks to 65% by March 2026, with a further increase to 92% by March 2029.

To meet this challenge, one large multi-site acute teaching trust asked Newton to help by bringing an innovative dynamic flow-based approach to the development of their recovery plan; a task they knew would be incredibly challenging. Newton's rigorous, data-led approach has provided the trust with the insight they need to meet the challenge.

Working together to understand the challenge

Newton, alongside the trust's operational, clinical and BI teams, were able to provide a level of insight that enabled the trust to understand:

- the areas with the greatest opportunity to improve and how to access them – by speciality, point in the pathway, operational planning guidance, and operational delivery lever;
- the relative potential for each opportunity to impact performance for prioritisation;
- the requirement for dynamic solutions and to recognise the knock-on impact of improvements across the pathway;

and to forecast the required performance trajectory, including clock start / stop requirements to meet targets, and highlighting delivery risks for further consideration.

Bringing a flow-based approach to elective recovery

The Newton team were able to bring the sophisticated, dynamic flow-based approaches that have been so critical to solving Urgent and Emergency Care (UEC) flow across systems and apply the same technology, processes and predictive based thinking to elective recovery.

This involved:

Pathway Deep Dives - operational

With agreed speciality and Points of Delivery (POD) areas, Newton worked alongside data validators to review cases and processes to further understand patient pathways and the opportunities to improve elective care performance.

Static Data Analysis

Combining publicly available and trust-provided data to analyse how the trust's performance compared nationally and identified focus areas within the trust.

Dynamic Analysis

With the basis of data analysis and case studies examined, a dive further into the data to identify the specific improvements that could be implemented, creating a dynamic view of how the waitlist is changing over time.

Scenario Modelling

Utilising the patient pathways identified from the case studies and the dynamic analysis, modelling how the suggested improvements would drive better 18-week performance and simulating how this would impact waiting lists at different parts of the patient pathway.

We showed that:

Over **55%** of people with open clocks were waiting for a first outpatient appointment, and over **75%** of patients have their clocks stopped in their first outpatient appointment.

Up to **40%** patients would have benefitted from a 'straight to test' pathway, improving patient experience and RTT performance.

Providing actionable insights

Through the deployment of technology and approaches that have been so critical to solving complex UEC flow optimisations and applying them alongside a deep understanding of elective care, Newton was able to surface actionable insight for the clinical, operational and leadership teams. This allowed the trust to build an optimised recovery plan that will dramatically reduce the numbers waiting for care over the next three years and contribute to achieving the 65% target by 2026, and 92% targets by 2029.

We are really excited to be able to wrap this insight alongside Newton's fee guarantee model to make a meaningful contribution to helping NHS trusts reduce the numbers of people waiting for care, enabling them to deliver better outcomes at a lower cost.

Improving theatre productivity in West Hertfordshire

The challenge

Across the country there are over 7 million patients on waiting lists for elective care; the backlogs existed before the COVID-19 pandemic, but the impact of the pandemic has compounded the problem and more people than ever are waiting for surgery.

In January 2023, Newton and West Hertfordshire Teaching Hospital NHS Foundation Trust (WHTH) started a programme of work to improve the effectiveness of their operating theatres. At the start of the programme the Trust had 5,500 patients waiting for surgery, with many of these people having been waiting for well over a year. The Trust had limited visibility over how theatres were operating, meaning that surgeries were often being cancelled on the day and it was difficult to have grip on the situation.

WHTH needed to improve their theatre effectiveness to ensure that they were providing the best standard of care for their patients.

A clinically and data-led approach to improving theatre productivity

The programme, co-designed by Newton and WHTH, has embraced a clinically-led change approach from the outset, empowering clinicians and the teams around them to design and own the solutions to improve theatre performance. To kickstart this, 105 staff across the division (clinicians, theatre staff, waiting list coordinators, divisional management and more) took part in workshops to set a clear vision for the programme.

Key principles underpinning this vision were:

- Calm, efficient surgeries with smooth patient flow minimising delays. Multi-disciplinary teams working together to create a fantastic patient experience.
- Every operating list is at full capacity, to ensure prompt finishes without finishing early.
- Prompt starts and smooth turnarounds, with a standardised process to call for the next patient and lists reviewed ahead of the day to prevent order changes.

An on-the-day process for theatres has been agreed by all involved in the process, from those booking the surgeries to the surgeons, to prevent delays, ensuring that surgeries start sooner and turnarounds between surgeries are efficient. A separate booking process ensures that the lists created will have the right number of patients, helping them to run to time and enabling full utilisation of valuable theatre time.

These changes have been enabled by a newly implemented theatre performance tool.

With this clinically led approach, this time I really think we will be able to make a change together."

Clinician, West Hertfordshire Teaching Hospitals Trust

We've seen what worked: Clinical engagement, visibility of data, commitment to action - we need to do more of this."

CEO, West Hertfordshire Teaching Hospitals Trust

The theatre performance tool

The theatre performance tool which has been implemented as part of this programme of work is providing WHTH with greater visibility than ever before. The theatre management software provides two main views:

- **Booking view –** enabling improved forward-looking visibility of how full lists are and providing confidence that a list will be well utilised. This is encouraging ownership of lists, and allows for flexibility in booking.
- **Reporting view –** showing how theatres have been utilised and where cancellations have occurred, allowing clinicians, theatre staff and management to continuously identify blockages and ensure they are addressed going forwards.

The tool also provides easy use of surgeon-specific median operation times to ensure lists can be optimally used.

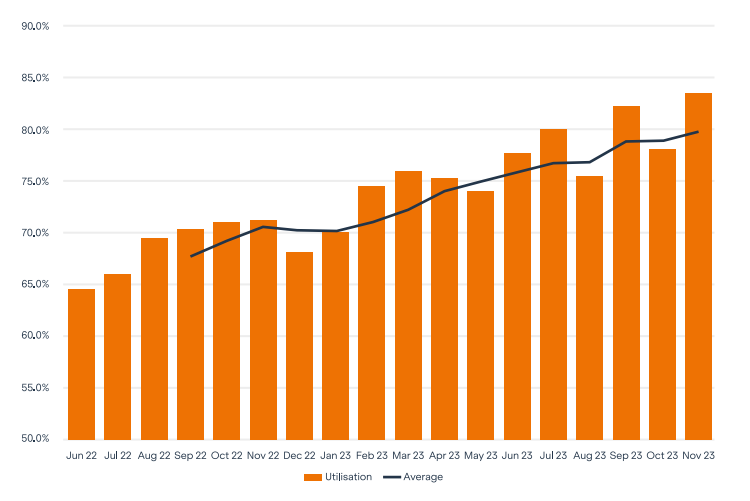
Since implementing the tool, lists are better planned, theatres are more utilised and patients are not waiting so long for surgery. In addition, staff are enabled to have better grip on services and can work proactively to ensure that the new processes are being followed.

THE IMPACT

- **40%** reduction in late starts
- **20%** reduction in time to turnaround between cases
- An additional **3,000** cases per year, reducing the impact of industrial action.

Operating theatre utilisation

- A **22%** increase in trust-wide utilisation across all elective activity.



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