Sherwood Forest Hospitals NHS
NHS Foundation Trust

NHS
Newark and Sherwood
Clinical Commissioning Group

NHS
Mansfield and Ashfield
Clinical Commissioning Group

ED Performance at Sherwood Forest Hospitals

Briefing for Escalation Meeting 2.12.14

Issues Impacting on ED Performance

Activity and demand

Hospital flow

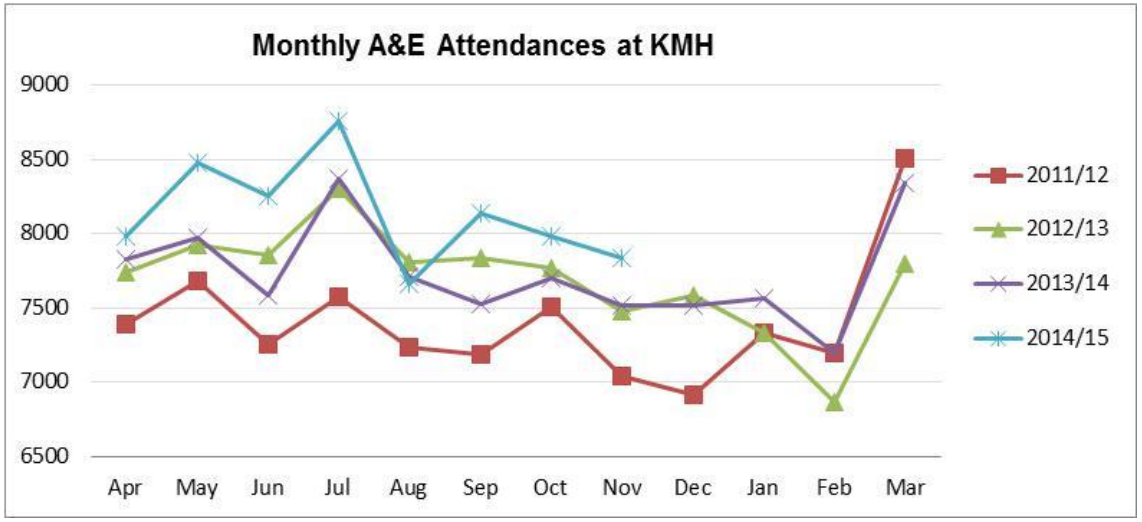
DTOCs

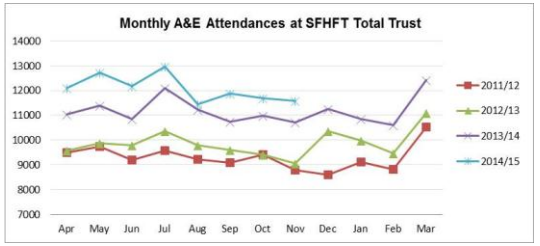
Key points

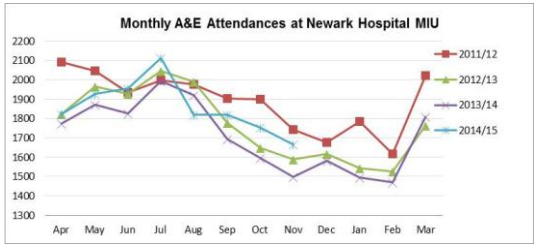
- For SFHFT as a whole, ED attendances have risen by **+8.44%** on the previous year (November YTD) , but are on plan for **Total Trust**. Notable increases occurred in Q1, indicating that demand was considerably higher than expected following the 13/14 winter season.
- The volume of ambulance conveyances to KMH has not changed significantly in recent months (Q1 showed an increase, resulting in a 4.9% increase YTD), but admission conversion rates have fallen and more people leave ED without further treatment or investigation.
- ED attendances have risen later in the day and department occupancy is now higher during the evening. This results in more overnight admissions and diagnostic delays.
- Bed days are lost through delays in flow and discharge - waiting for a bed accounts for 30-50% of ED breaches (analysis of previous 6 weeks).
- Length of stay is above average for the trust and variable against expected baseline by ward. Achievement of best practice benchmark length of stay for 0, 1, 2, 4-14 and 15+ day length of stay would confer considerable benefits for bed utilisation, patient flow and ED breaches.
- There is a consistent net demand for beds, but discharges do not occur in time to match demand for admission beds early in the day.
- These factors all have an impact on breach rates. Breaches are associated with ED occupancy, bed occupancy and availability of clinical decision makers across the clinical areas.
- The recovery plan and trajectory reflects actions to mitigate these factors and improve flow within ED, EAU, the wards and discharge
- A maximum of 18 breaches per day is required in order to meet the 95% target. The improvement trajectory shows improvement towards this, with ≤ 9 breaches per day resulting from ED delays and ≤ 9 breaches per day resulting from lack of bed availability.
- A 95% weekly run rate will be achieved from the beginning of January 2015
- Joint team working and problem solving across community and acute settings is now much stronger. The expansion of community in-reach and Transfer to Assess will enable practitioners to build confidence for more rapid discharge after an acute episode and will increase understanding of clinical risk thresholds / normal functional capacity of patients in primary and community services.

Key Impact Actions	To reduce
Transfer to Assess and Pulling Schemes	Bed breaches
Daily Board Rounds	Bed breaches
SAFER Bundle	Bed breaches
Medical In-Reach	ED breaches
Developing the plan for streaming to reduce majors	ED breaches
Extend Discharge Lounge to allow CDU to be used as originally intended	ED & Bed breaches

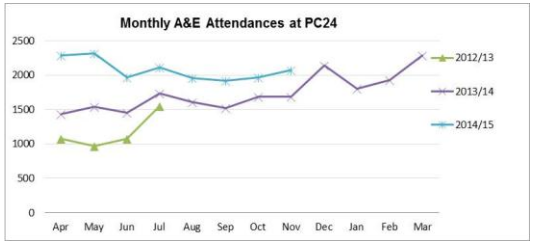
As a Total Trust, ED attendances have increased by +8.44% on the previous year (November YTD) – although the Trust is within plan for 14/15. Notable increases occurred in Q1, indicating that demand was considerably higher than expected following the 13/14 winter season





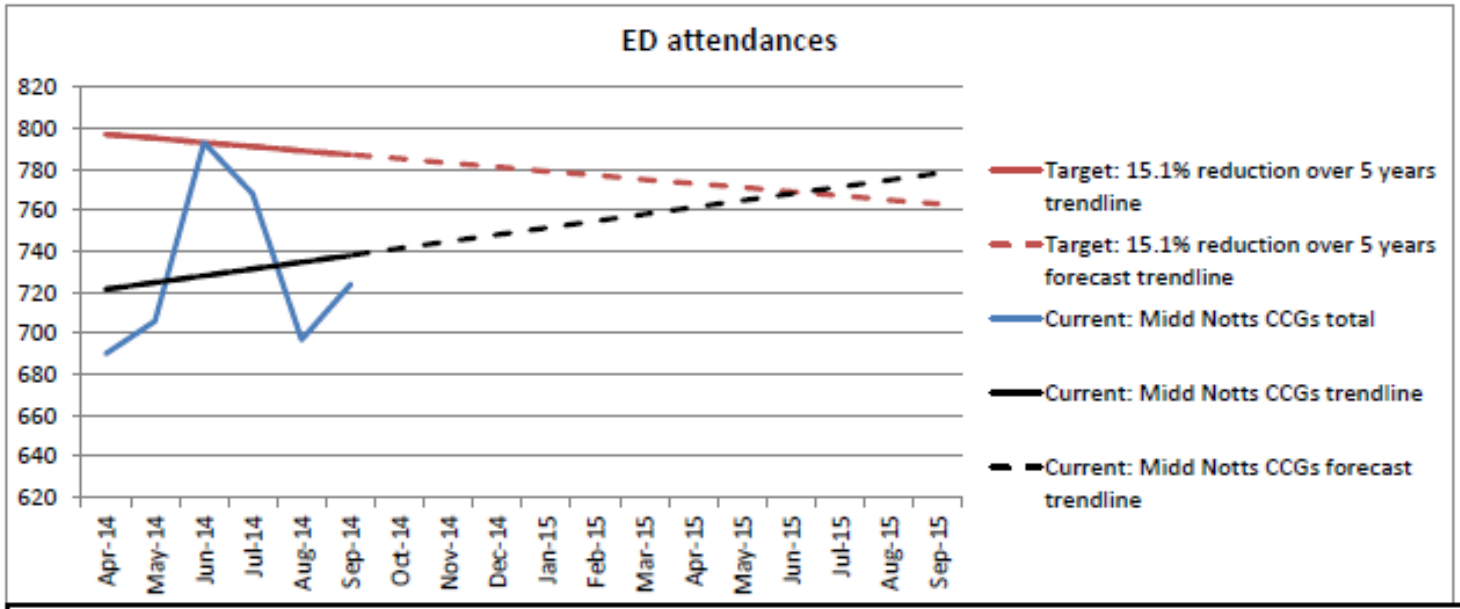


Hospital Site	Apr-Nov YTD		
	13/14	14/15	% Diff
SFHFT Total	89047	96564	8.44%
KMH	62214	65104	4.65%
Newark MIU	14180	14879	4.93%
PC24	12653	16581	31.04%



Kings Mill ED is adjacent to a primary care facility (PC24). Primary care presentations are streamed to this facility from ED. PC24 also provides a primary care walk in facility and OOH appointment service. Work is underway to develop a single front door. Building work has been commissioned and a more comprehensive clinical streaming protocol is also under development.

ED attendance targets for Mid-Nottinghamshire CCGs' five year strategic plan (system level KPI)



Attendances at any ED by patients registered to a Mid Notts CCG GP. (not including self referrals)

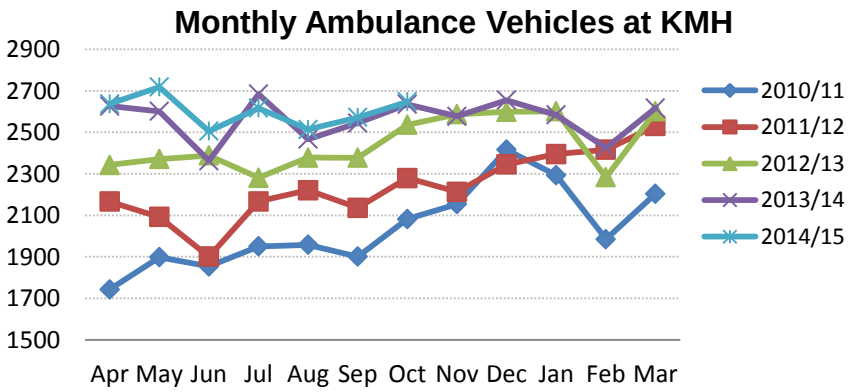
ED attendences observations:

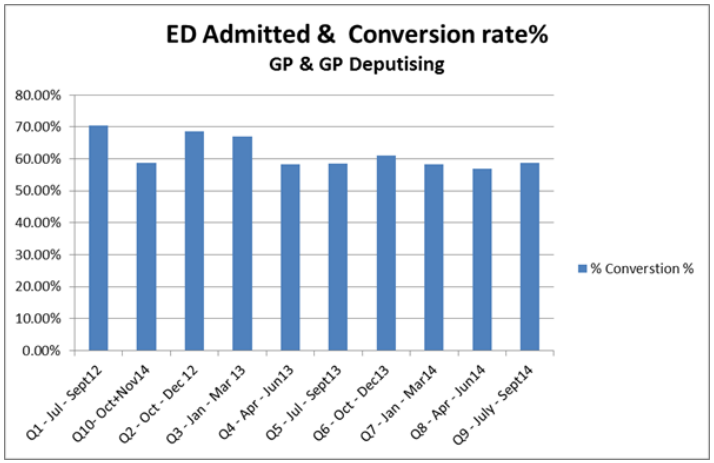
The chart above shows the detail of current ED attendances data for the Mid Notts CCGs from April 2014 to September 2015 with a current and forecast trendline, showing the current trend and future trajectory if this trend was to continue.

The red trendline indicates the trajectory of a fall in ED attendances needed to achieve a 15.1% reduction over 5 years from the current ED attendances as of June 2014.

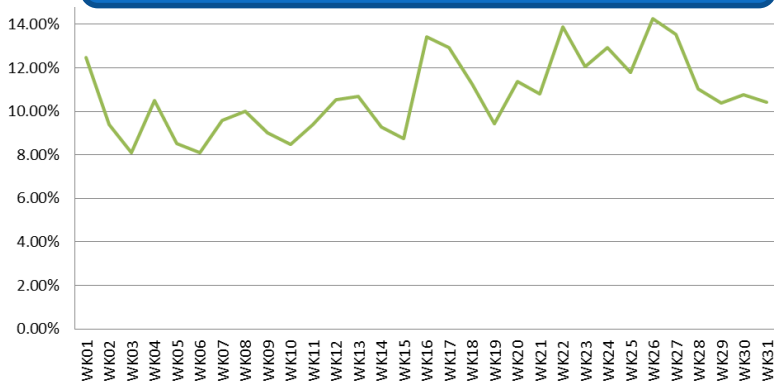
As can be seen from the graph, the Midd Notts CCGs currently have a lower level of ED attendances (724) , in September, tha n they had in June 2014 (793) and so are currently well below the trendline needed to meet the reduction in A&E attendances percentage t arget. However at the current trajectory, the level of attendances of the CCGs are likely to cross , in June 2015, and increase abov e, the target trendline set to make the reduction over 5 years.

The volume of ambulance transfers to KMH has not changed significantly in recent months (YTD 4.86%, showing a rise in Q1) but the activity case mix and admission conversion rate has changed

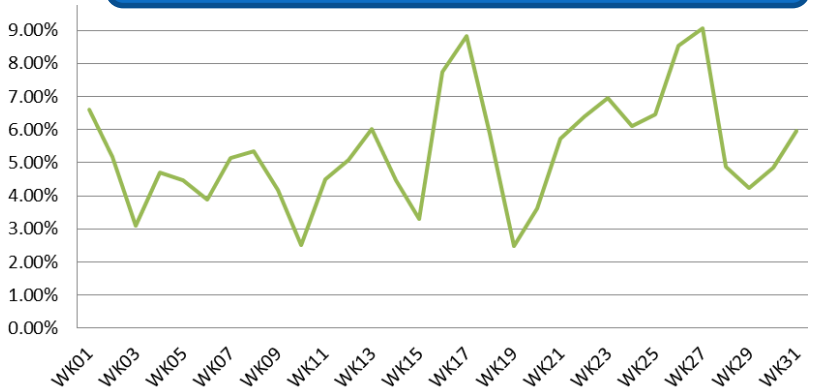




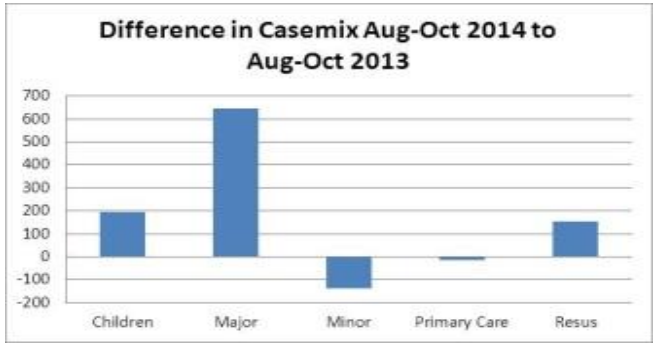
Increasing number of patients attending ED with no investigation or significant treatment

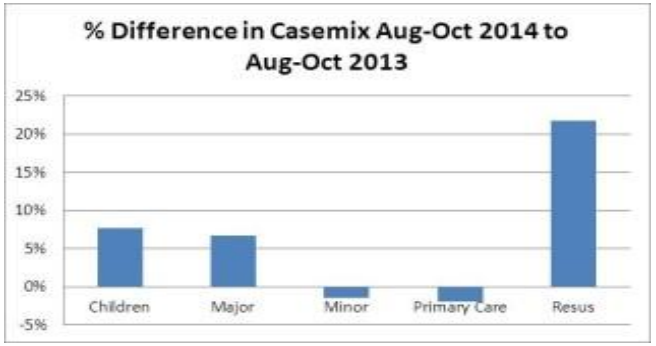


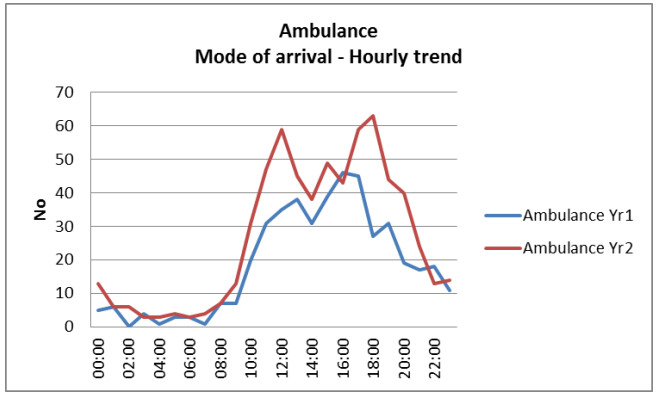
Increasing number of patients conveyed to ED by EMAS where no investigation or significant treatment

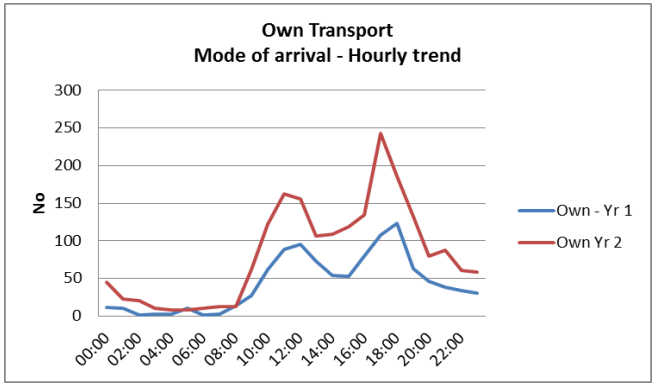


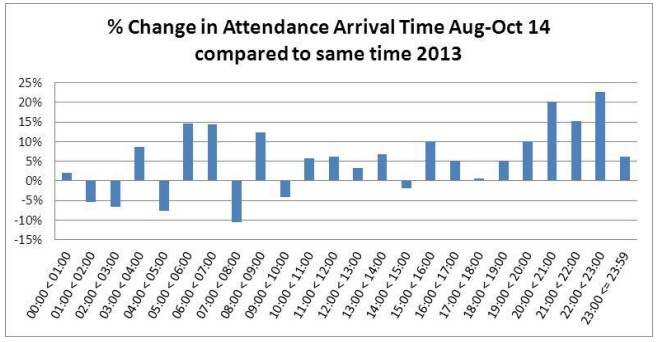
Case mix and arrival times appear to have changed, with later arrival times and more patients classified as majors under the current streaming system

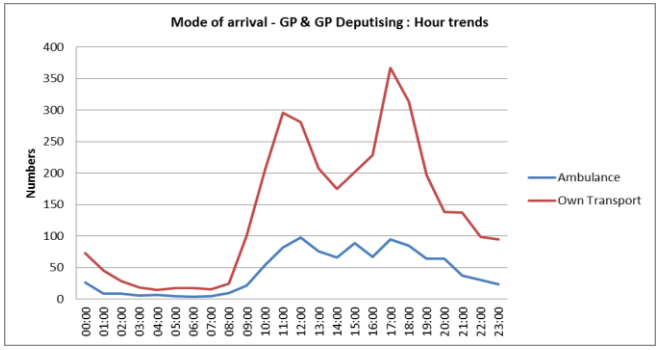




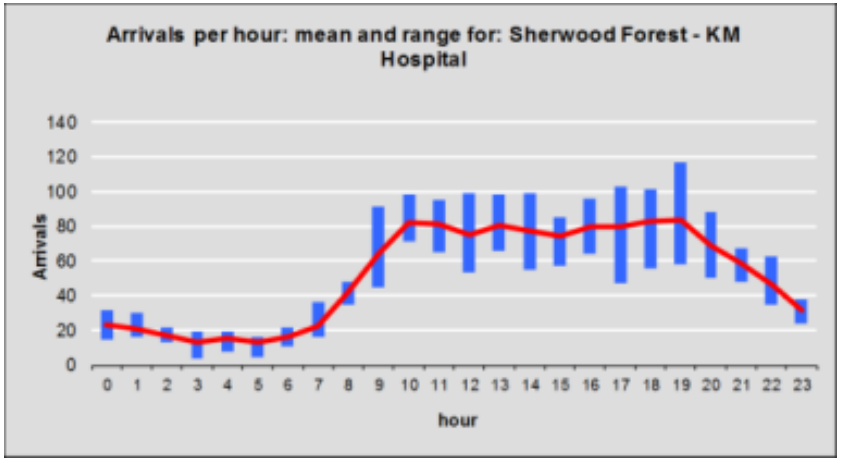


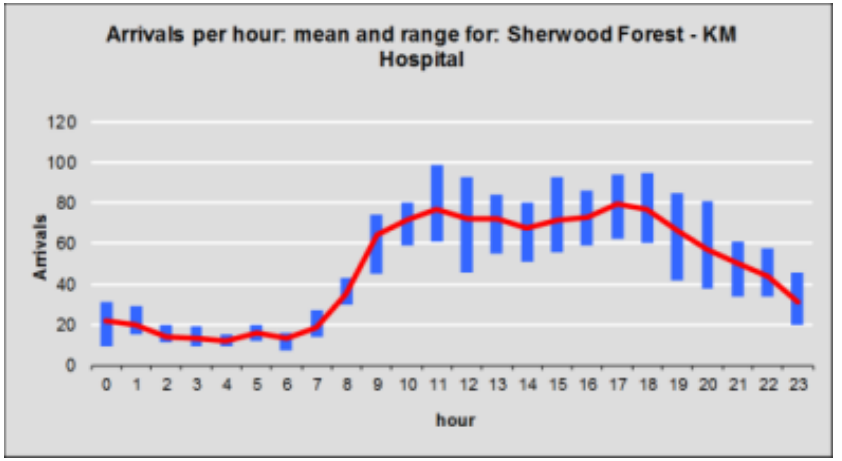


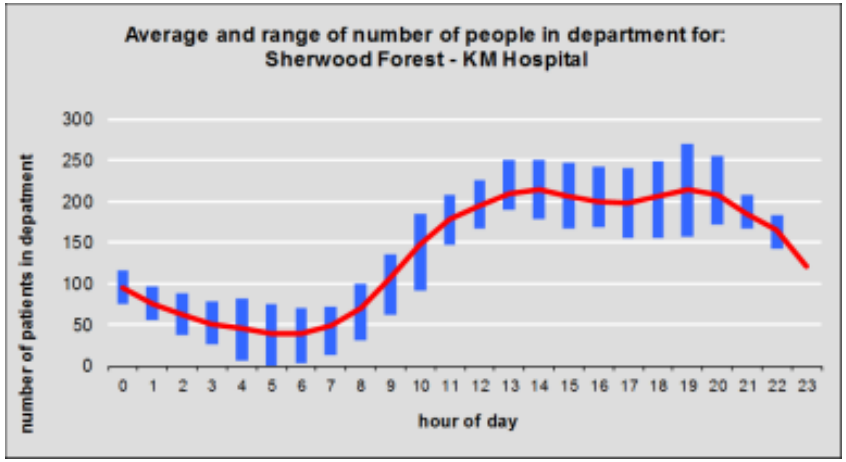


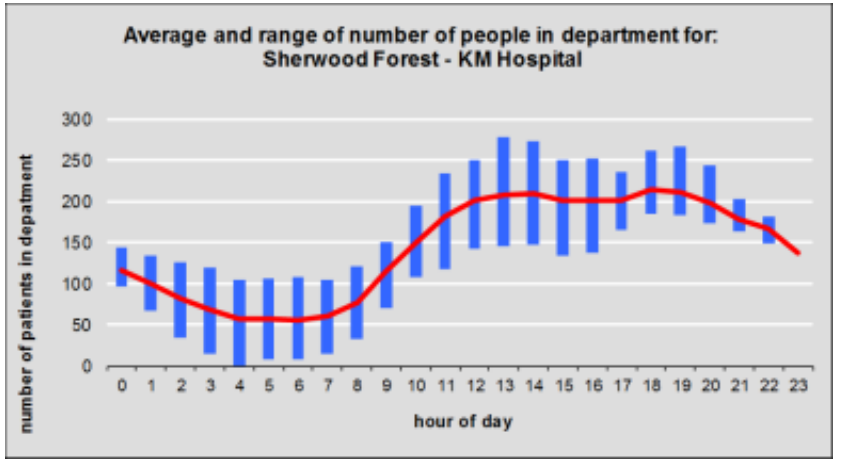


Arrival times have an impact on ED occupancy and this is now higher until later in the evening









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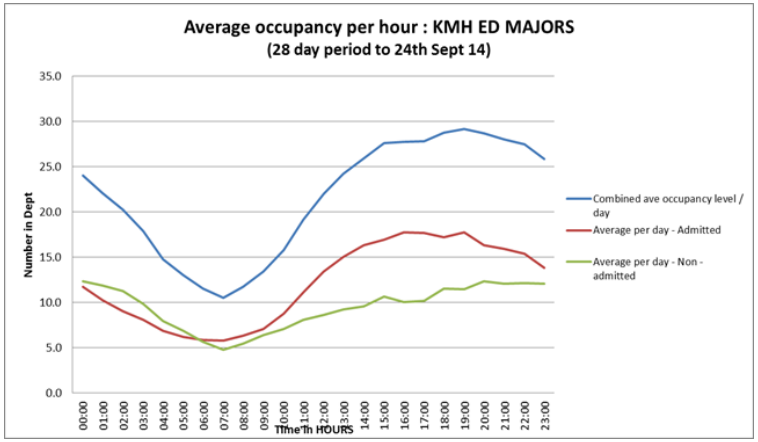
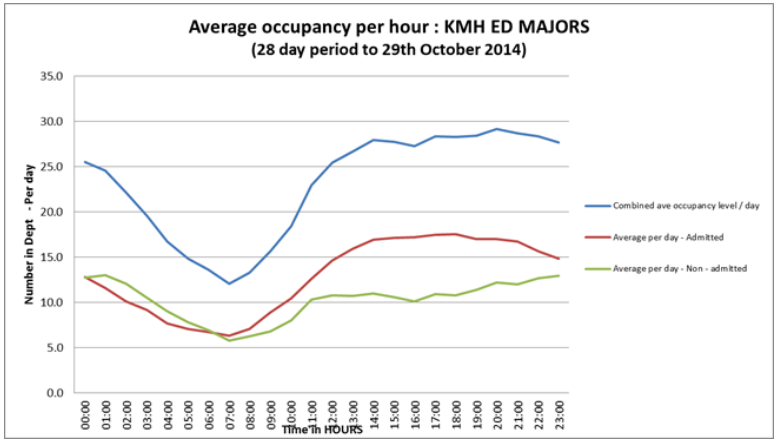
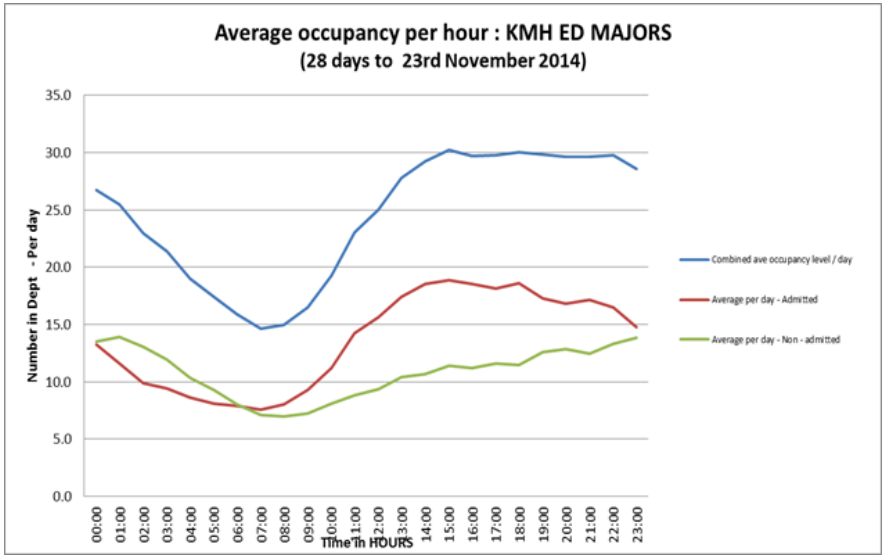
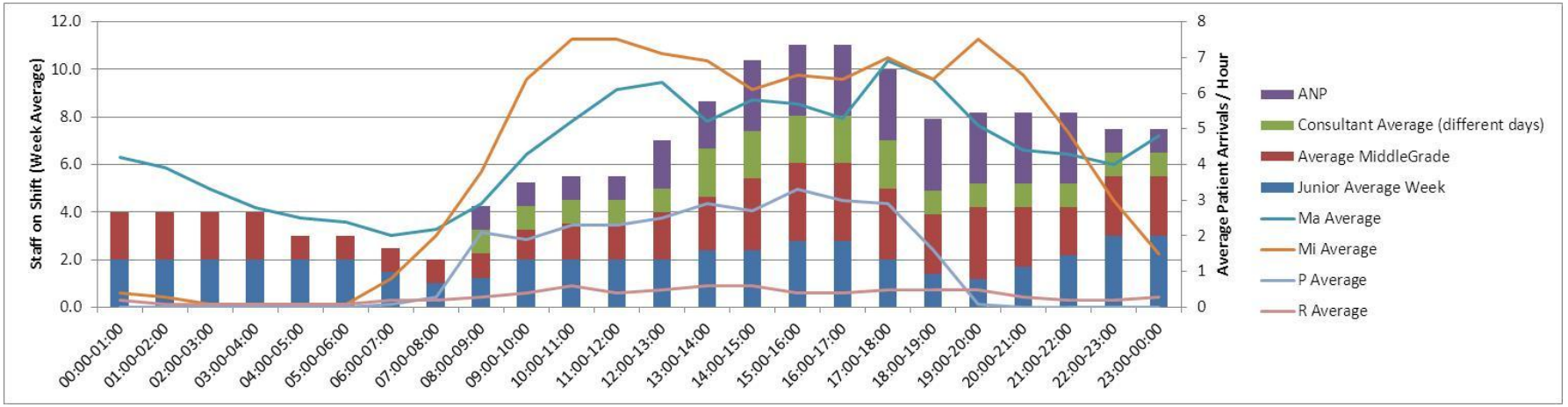


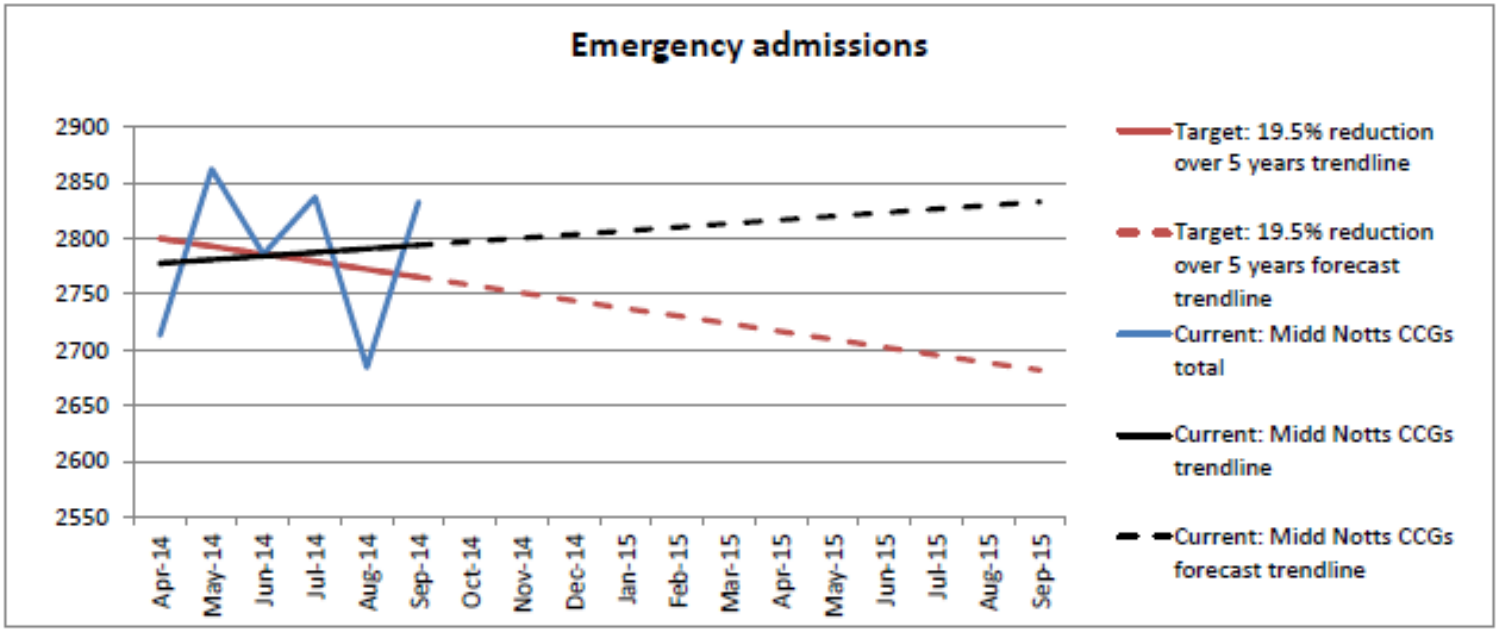




There are recruitment challenges and clinical staffing levels in ED do not match patterns of demand



Emergency admissions are increasing for Mid-Nottinghamshire CCGs and are above plan (system level KPI)



Emergency admissions data for Mid Notts CCGs: all providers.

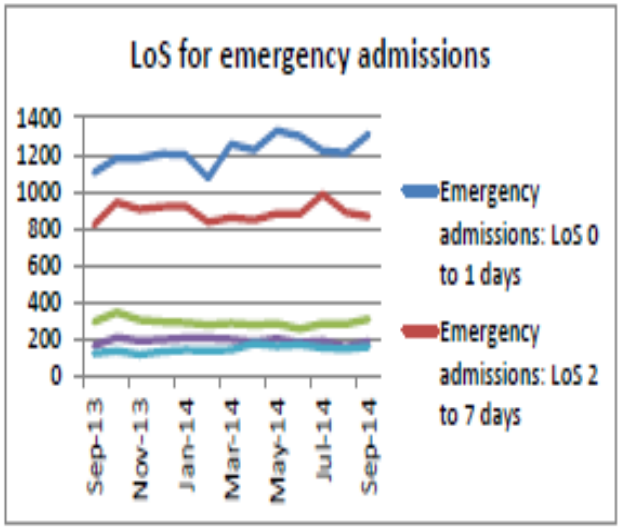
Emergency Admissions observations:

The chart above shows the detail of current Emergency Admissions data for the Mid Notts CCGs from April 2014 to September 2015 with a current and forecast trendline, showing the current trend and future trajectory if this trend was to continue.

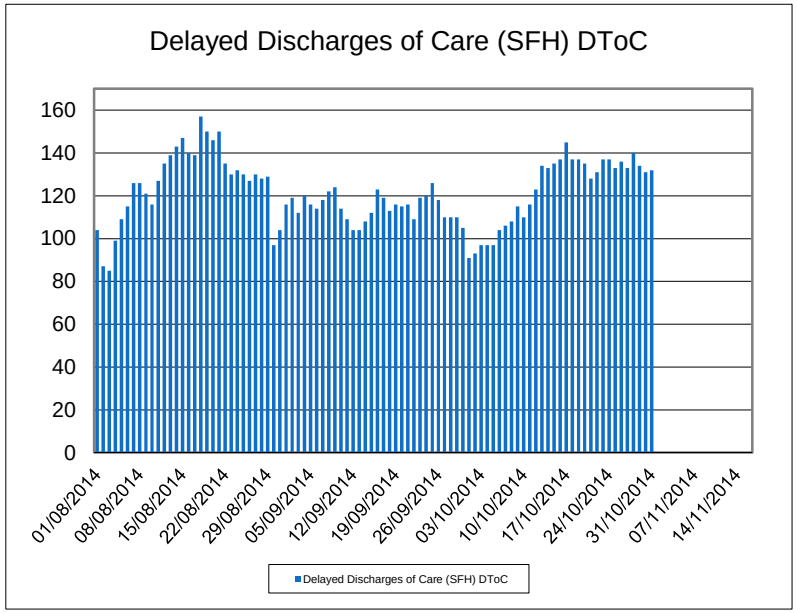
The red trendline indicates the trajectory of a fall in emergency admissions needed to achieve a 19.5% reduction over 5 years from the current emergency admissions as of June 2014.

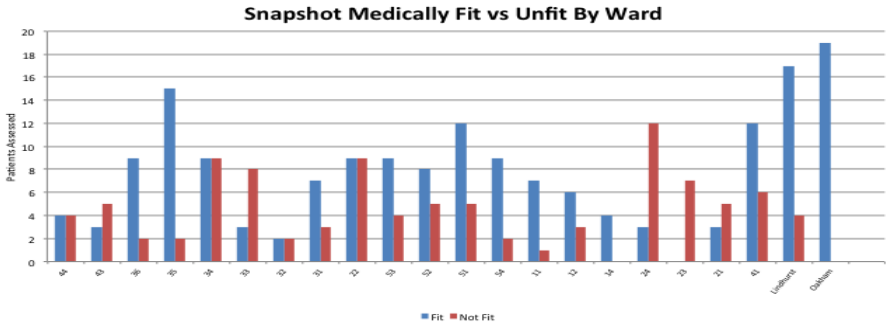
As we can see the Midd Notts CCGs have a increasing trajectory of emergency admissions compared to the decreasing trajectory of the trendline needed in order to meet the reduction target and so are likely to be well above the target reduction in emergency admissions at the end of 5 years.

Bed days are lost through delays in flow and discharge - Waiting for a bed accounts for 30-50% of ED breaches

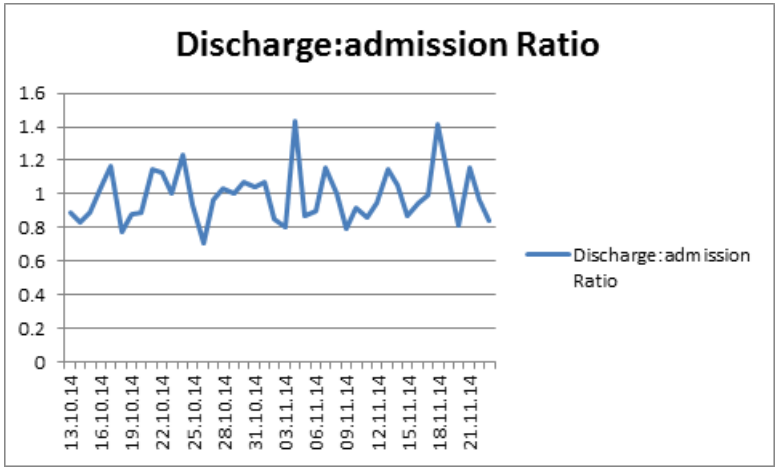


Lengths of stay for Emergency admissions measured in total bed days according to total length of stay





ECIST Review covered 268 total patients reviewed 170 were deemed as medically fit to leave hospital. Only 98 were considered to require more acute clinical care.



Current length of stay and occupied bed days versus remodelled length of stay based on best practice benchmarks. This indicates opportunities along the pathway to reduce bed occupancy and improve flow

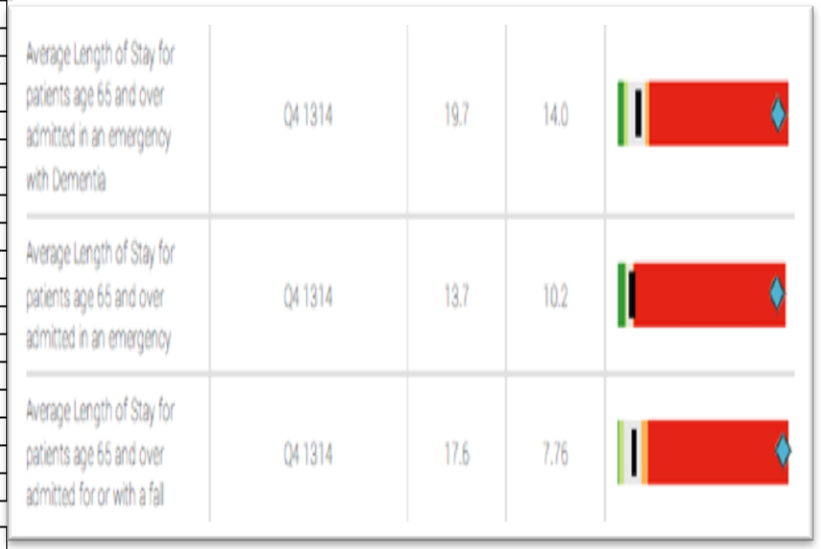
Current length of stay	Current occupied bed days	Current %	Best practice occupied bed days	Best practice %
0		18%		25%
1	3486	19%	3678	20%
2	3136	8%	7356	20%
4-14	49988	40%	29887	25%
15+	81197	15%	51492	10%
Total	137807		92413	

Analysis based on non-elective medical and elderly admissions April 13-March 14. Occupancy modelled at 95%

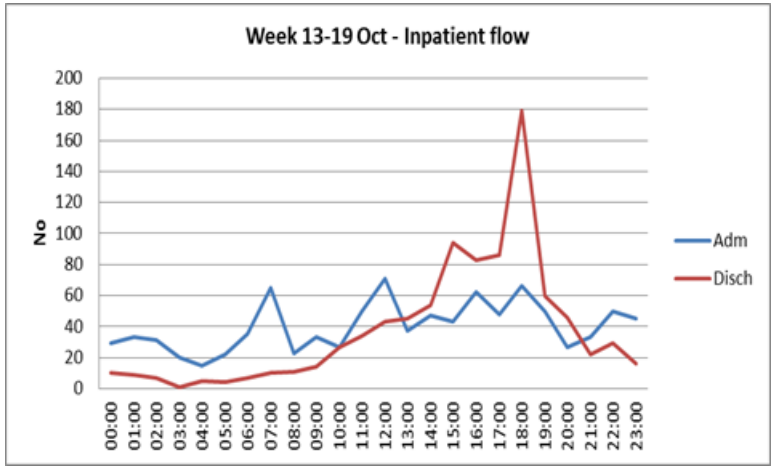
Length of stay is above average for the trust and variable against expected baseline by ward

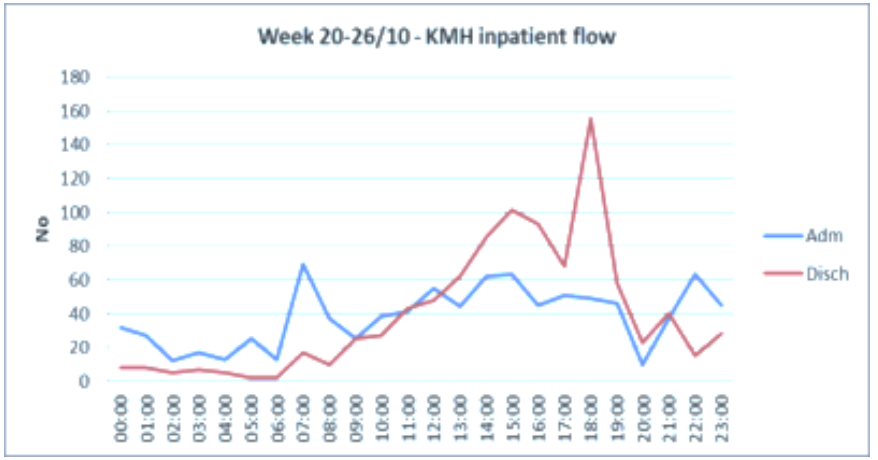
	Inpatient Wards	Ward Description (Medway)	No discharged wk : compared to baseline	% Discharge pre noon : compared to baseline	% of Discharges at Weekend	Av ward LoS compared to expected baseline	Max Stay of patient (discharged in mth)	Use of Discharge Lounge
KMH	KM11	11 Ward Orthopaedic Elective	4	-23.4%	10.3%	0.33	14	1
	KM12	12 Ward Trauma	-11	-41.4%	37.5%	-2.17	25	
	KM14	14 Ward Gynae & Breast	21	-1.7%	21.1%	0.52	22	
	KM21	21 Ward Surgery	-1	-4.6%	20.0%	-0.10	25	2
	KM22	22 Ward Geriatrics, ortho-geriatrics, rheumatology	-8	-22.3%	10.0%	-3.87	43	
	KM23	23 Ward Cardiology	-7	1.2%	14.3%	-0.31	25	3
	KM24	24 Ward Cardiology & Haematology	1	-23.6%	33.3%	-2.33	43	
	KM31	31 Ward Surgery	7	5.4%	21.4%	2.69	8	1
	KM32	32 Ward Surgery & Urology	11	4.0%	14.3%	0.11	34	
	KM33	33 Ward Gastroenterology	10	0.4%	14.8%	2.07	20	1
	KM34	34 Ward Endocrinology	-5	-13.2%	8.3%	-0.32	27	
	KM35	35 Ward Delayed Transfer of Care	-3	6.0%	0.0%	2.47	19	
	KM36	36 Ward General Medicine	0	-13.4%	14.3%	-5.63	101	
	KM41	41 Ward Geriatrics	-4	-20.0%	0.0%	0.64	42	
	KM42	42 Ward Respiratory	-3	-11.2%	8.3%	-3.73	70	
	KM43	43 Ward Respiratory	-2	-19.3%	21.7%	-1.50	32	4
	KM44	44 Ward Respiratory	-2	4.7%	22.2%	-5.35	47	
	KM51	51 Ward Geriatrics & Neurology	0	-18.1%	0.0%	3.19	28	1
	KM52	52 Ward Geriatrics & Dementia	-8	-14.5%	0.0%	3.05	18	
	KM53	53 Ward Acute Stroke	6	-10.8%	13.0%	-3.04	41	
	KM 54	54 Ward Stroke Rehab	3	-38.8%	14.3%	10.04	62	
	EAU	EAU Emergency Assessment Unit	-14	0.8%	28.8%	-0.02	7	17
	DCU	Day Case Ward	27	20.1%	22.0%	0.21	2	
	SAU	SAU Surgical Assessment Ward	5	-6.7%	26.9%	0.24	1	
NH	Minster	Minster Ward	-7	38.7%	16.7%	2.42	1	
	Sconce	Sconce Ward	-4	-20.2%	0.0%	1.02	20	
MCH	Lindhurst	Lindhurst Ward Rehabilitation	0	22.8%	0.0%	-0.94	47	
	Oakham	Oakham Ward Rehabilitation	-3	-22.2%	0.0%	-7.80	63	

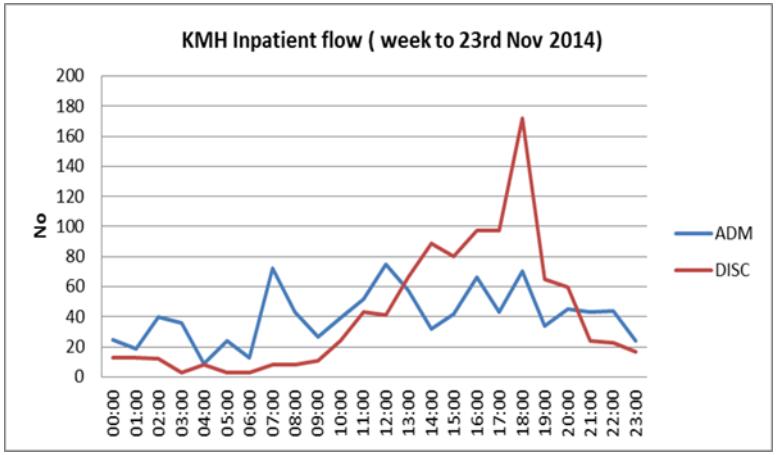
Dashboard | 1. Ed Breach performance | 2. Discharges | 3. Adm _ Dis Flows | 4. Ward stays | 5 Discharge Lounge | 6. Trend Graphs | 7. Base ward pull from EAU

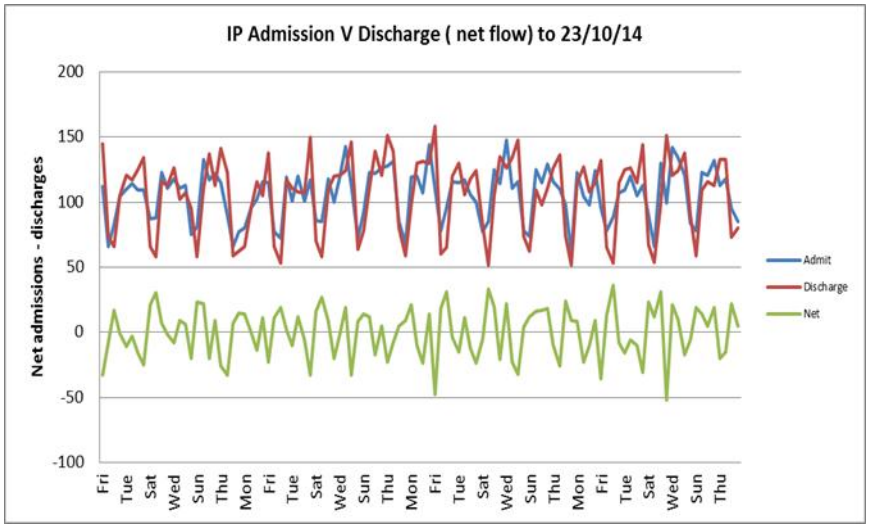


There is a consistent net demand for beds, but discharges do not occur in time to match demand for admission beds early in the day

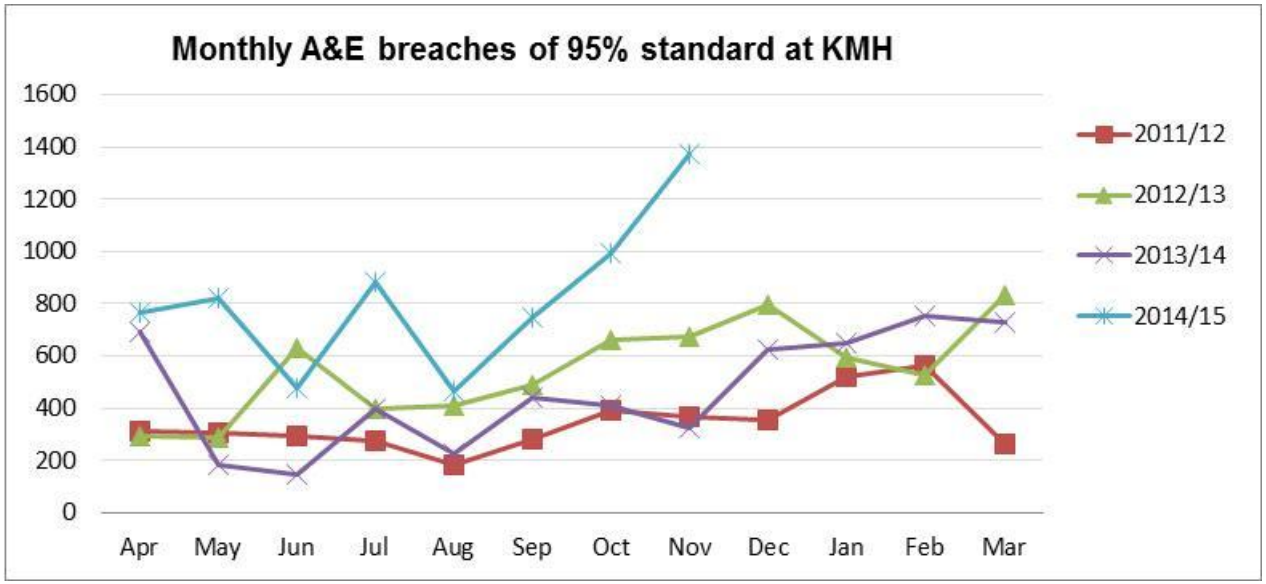








These factors all have an impact on breach rates. Breach rates are associated with ED occupancy, bed occupancy and availability of clinical decision makers in ED, EAU and the wards



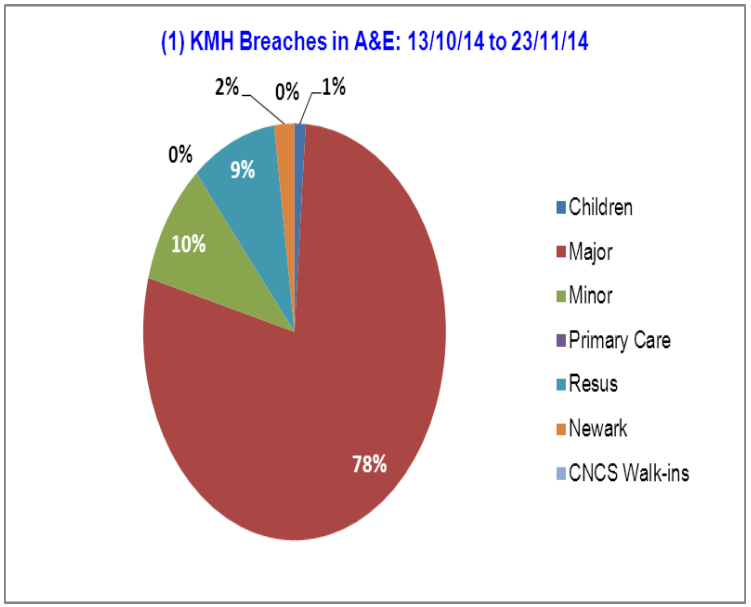
Breach Analysis and Actions to Improve Flow

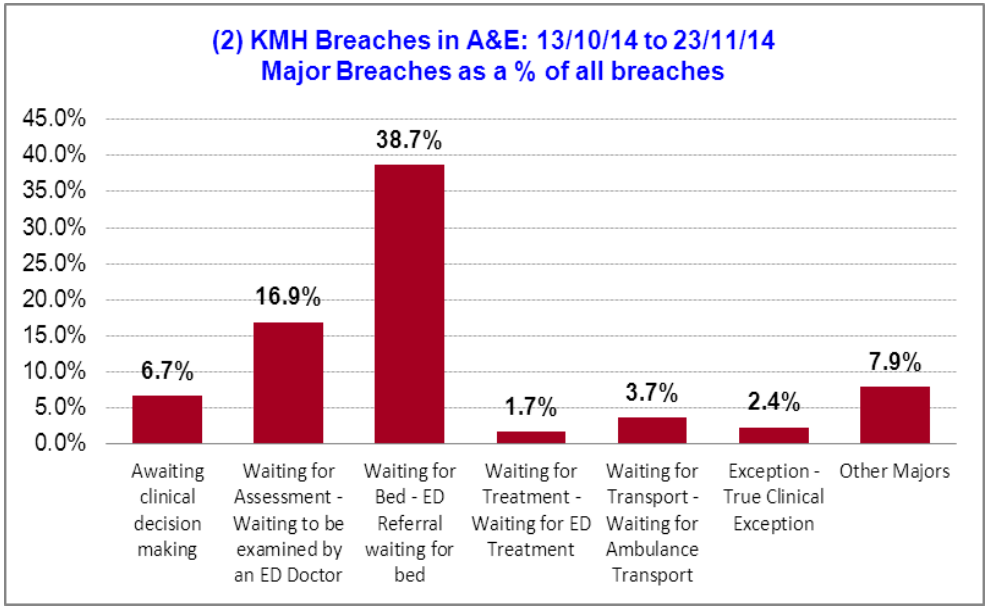
Breach analysis by category

Plans to reduce breaches

Target numbers of breaches by category

Breach analysis





Summary of breaches at KMH

Breaches at King's Mill Hospital

Week Ending	19/10/14		26/10/2014		02/11/14		09/11/14		16/11/14		23/11/14		YTD from 13/10/14	
	Number	% of total breaches	Number	% of total breaches	Number	% of total breaches	Number	% of total breaches	Number	% of total breaches	Number	% of total breaches	Number	% of total breaches
Total Attendances	**2669**		**2736**		**2566**		**2629**		**2724**		**2706**		**16030**	
Over 4 hours	**424**		**269**		**198**		**189**		**436**		**337**		**1853**	
% within 4 hours	**84%**		**90.17%**		**92%**		**93%**		**84%**		**88%**		**88%**	
Breaches by Patient Category	Total				Total		Total		Total		Total		Total	
Children	1	0.2%	3	1.1%	2	1.0%	5	2.6%	4	0.9%	7	2.1%	22	1.2%
Major	336	79.2%	210	78.1%	159	80.3%	140	74.1%	332	76.1%	268	79.5%	1445	78.0%
Minor	43	10.1%	29	10.8%	10	5.1%	22	11.6%	37	8.5%	37	11.0%	178	9.6%
Primary Care	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Resus	39	9.2%	19	7.1%	18	9.1%	19	10.1%	51	11.7%	22	6.5%	168	9.1%
Newark	5	1.2%	8	3.0%	9	4.5%	3	1.6%	12	2.8%	3	0.9%	40	2.2%
CNCS Walk-ins	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Grand Total	**424**	100.0%	**269**	100.0%	**198**	100%	**189**	100.0%	**436**	100%	**337**	100.0%	**1853**	100.0%
Majors @ KMH														
Awaiting clinical decision making	25	5.9%	16	5.9%	18	9.1%	16	8.5%	27	6.2%	23	6.8%	125	6.7%
Waiting for Assessment - Waiting to be examined by an ED Doctor	74	17.5%	41	15.2%	58	29.3%	52	27.5%	21	4.8%	67	19.9%	313	16.9%
Waiting for Bed - ED Referral waiting for bed	193	45.5%	92	34.2%	51	25.8%	41	21.7%	214	49.1%	126	37.4%	717	38.7%
Waiting for Treatment - Waiting for ED Treatment	3	0.7%	2	0.7%	6	3.0%	4	2.1%	7	1.6%	9	2.7%	31	1.7%
Waiting for Transport - Waiting for Ambulance Transport	9	2.1%	9	3.3%	5	2.5%	5	2.6%	21	4.8%	19	5.6%	68	3.7%
Exception - True Clinical Exception	1	0.2%	11	4.1%	8	4.0%	7	3.7%	9	2.1%	8	2.4%	44	2.4%
Other Majors	31	7.3%	39	14.5%	13	6.6%	15	7.9%	33	7.6%	16	4.7%	147	7.9%
Minors @ KMH														
Waiting for Assessment - Waiting to be examined by an ED Doctor	8	1.9%	8	3.0%	3	1.5%	9	4.8%	6	1.4%	15	4.5%	49	2.6%
Waiting for Bed - ED Referral waiting for bed	6	1.4%	5	1.9%	2	1.0%	2	1.1%	12	2.8%	7	2.1%	34	1.8%
Other Minors	29	6.8%	16	5.9%	5	2.5%	11	5.8%	19	4.4%	15	4.5%	95	5.1%

Breach component factors

Actions taken and planned

To be read in conjunction with ED recovery plan and trajectory

Breach reason: ED process delays (awaiting clinical decision making, waiting for assessment, waiting to be examined by an ED doctor, waiting for ED treatment)

Actions taken and in place	Actions planned in 14/15
Additional capacity in ED: • **Increase middle grades in ED to 2 overnight** • Nurse assessors and IDAT to facilitate discharge and MDT assessment • 1 additional acute physician working within in ED at key times • ANPs working in the department at peak times • **Increased twilight nursing shifts**	• 3 additional acute physicians have been recruited and will come into post January – March • **On-going recruitment to replace remaining locum and agency staff and vacancies**
Improved processes to improve flow through ED: • Standardised investigation protocols at assessment • Escalation protocols for overcrowding • Review of trauma protocols • Review of transfer protocols • Community nurse assessors and IDAT to facilitate discharge • RAT senior assessment, investigation and treatment	**- Monitoring and escalation against internal professional standards (reducing variation and delays in diagnostic/specialty input and flow within the department)**

Breach reason: waiting for a bed

Actions taken and in place	Actions planned in 14/15
Improved processes and flow in EAU: • Morning, afternoon and evening board rounds • CDU open 8-9: mental health / self-harm, DVT, cellulitis, EDASS, chest pain, PE, pyelonephritis low risk overdoes, post manipulation, anaphylaxis, anaemia • Nurse assessors and IDAT to facilitate discharge and MDT assessment • 1 additional acute physician (same as per previous slide – this affects ED process and waiting for a bed)	• Embedding new ambulatory care pathways and increased signposting to these pathways from ED • Develop short stay stream LOS <48 hours • Develop specialty pull with LOS <15 hours • 3 additional acute physicians in post Jan – March 2015 (same as per previous slide – this affects ED process and waiting for a bed) • In-reach to ED to pull medical admits and ensure all have a plan agreed 08.00 – 22.00hrs • Reduce re-clerking • Agreement regarding intensive monitoring beds • Reduce EAU beds as flow improves with escalation plan until achieved

Ward discharge planning and pull from wards to release beds:
• Discharge lounge established and operational, enabling earlier discharge from the wards
• SAFER Bundle (being implemented but not embedded)
  • Daily board round in all acute areas
  • EDD on all patient boards
  • Optimise discharge lounge
  • Increase discharges by midday
  • Daily review of all LOS >14 days
• Weekly capacity meeting
• Discharge process myth busting
	• Review bed management and Jonah live meetings
	• Prioritise TTOs
	• Develop trust urgent care pathways for 80% acute medical conditions in order to standardise processes
	• Daily consultant review, commencing 1.12.14 and incrementally increasing across specialties

Breach reason: waiting for a bed

Actions taken and in place	Actions planned in 14/15
Back door pull and discharge from hospital: • 7 day IDAT / social worker / EDASS • Ward 35 interim pull team, social worker, community nurse (pending phase 2 roll out of Transfer to Assess)	• Transfer to Assess on wards 51 and 52, commencing 3.12.14 • Non weight-bearing beds spot purchases, commencing 1.12.14 • Joint team working to build confidence that patients are able to be discharged and increase understanding of clinical risk thresholds / normal functional capacity of patients in community services

System Sustainability: system actions to reduce demand and overcrowding in ED

Actions taken and in place	Actions planned in 14/15

Capacity outside of hospital to reduce reliance on ED:
• Community integrated health and social care teams are in place, with 8 localities across Mid-Nottinghamshire, now 7 day extended service (PRISM)
• GP 10 minute protocol
• 111 dispositions to 999 and ED @8%
• Expanded nursing support for care homes (from October 2014)
• Urgent Care Programme Director transferred from CCG (Better Together Programme) into trust transformation programme
	• Front door build to co-locate PC24 and ED, single registration with dual triage (April 2015)
	• Expansion of 7 day working as PRISM teams reach full capacity:
	  • N&S extending to 8:00-23:00 by 8th December 2014
	  • M&A extending to 8:00-23:00 by end of Q4.
	  Pace of expansion of services is based on recruitment plan & availability of new starters.
	• Integration of community response team with PRISM and expanded intermediate care:
	  • N&S from w/c 8th December 2014
	  • M&A to be developed.
	• ECP pilot to support home visits and stagger ED arrival times (from 8.12.14)
	• Integration of MIU and OOH (single front door at Newark Hospital)

Calculation of maximum breach targets, based on average ED attendance rates

	System	KMH Only
Lowest Att	316	211
	15	10
	95.25%	95.26%
Average	396	267
	19	13
	95.20%	95.13%
Highest Att	484	347
	24	17
	95.04%	95.10%

The attendance data suggest that >18 breaches per day are likely to result in failure to achieve the 95% 4 hour ED target. It is therefore proposed that breach targets are established as follows:

≤ 9 breaches per day resulting from ED delays

≤ 9 breaches per day resulting from lack of bed availability

SRG Governance

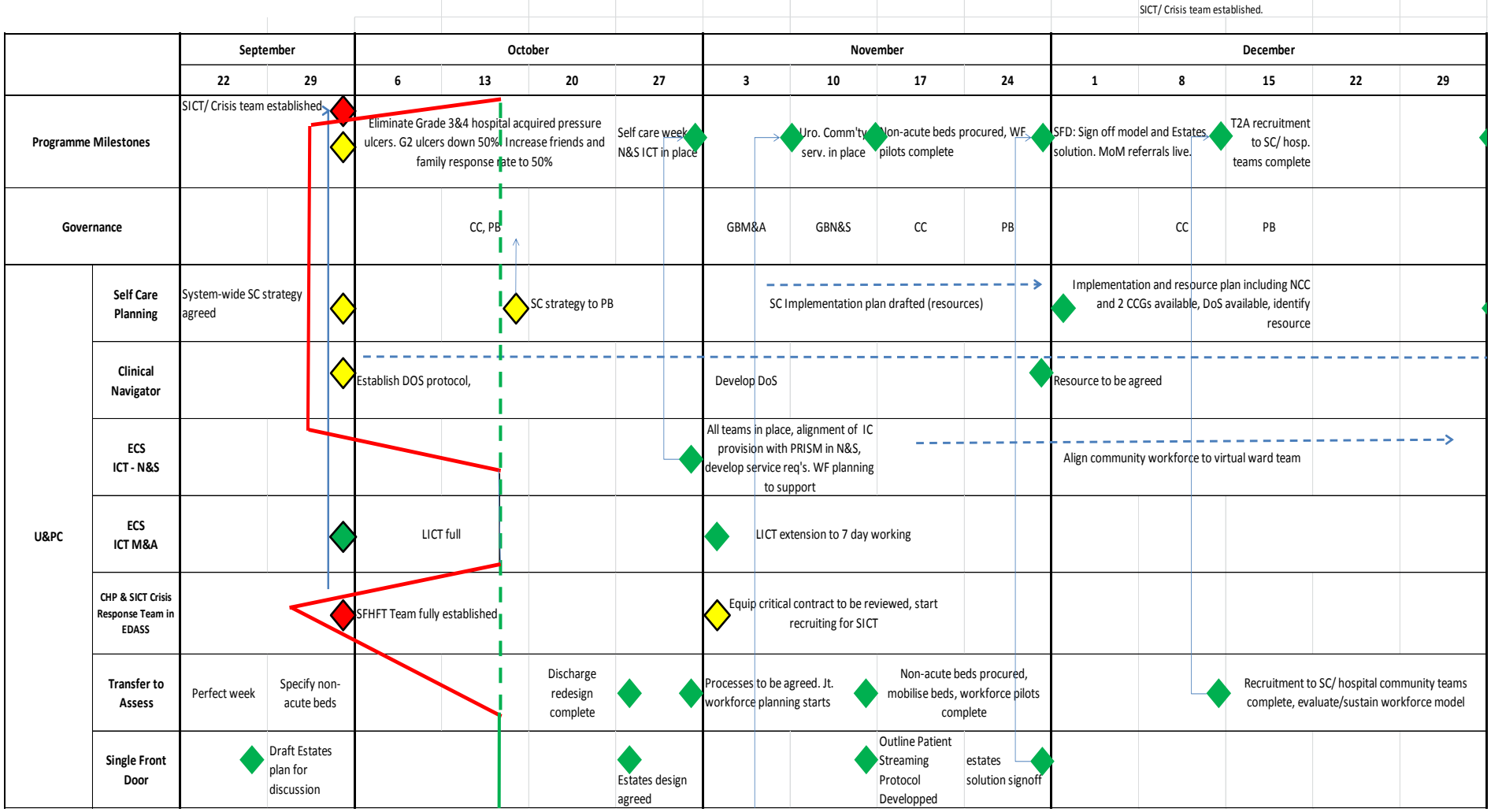
- Governance arrangements
- Link between operational delivery / performance management and transformation (system sustainability and planning)
- System level milestones and inter-dependencies

The System Resilience Group (SRG) oversees delivery of the ED improvement trajectory and deployment of resilience funding

- The SRG is an executive level meeting (Terms of Reference are included as supporting information in the appendix).
- The system has retained the Urgent Care Working Group as an operational liaison / tactical problem solving meeting. This reports and escalated issues to SRG.
- Tactical actions are aligned to longer-term transformational plans.
- Resilience funding has enabled some schemes to be brought forward (e.g. development of specialist intermediate care and community therapy resource).
- A sample of the system transformation milestone plan is included for information. The Programme PMO is well established and supported by financial planning and allocations.

Extract from Better Together Programme Milestone Plan with programme interdependencies

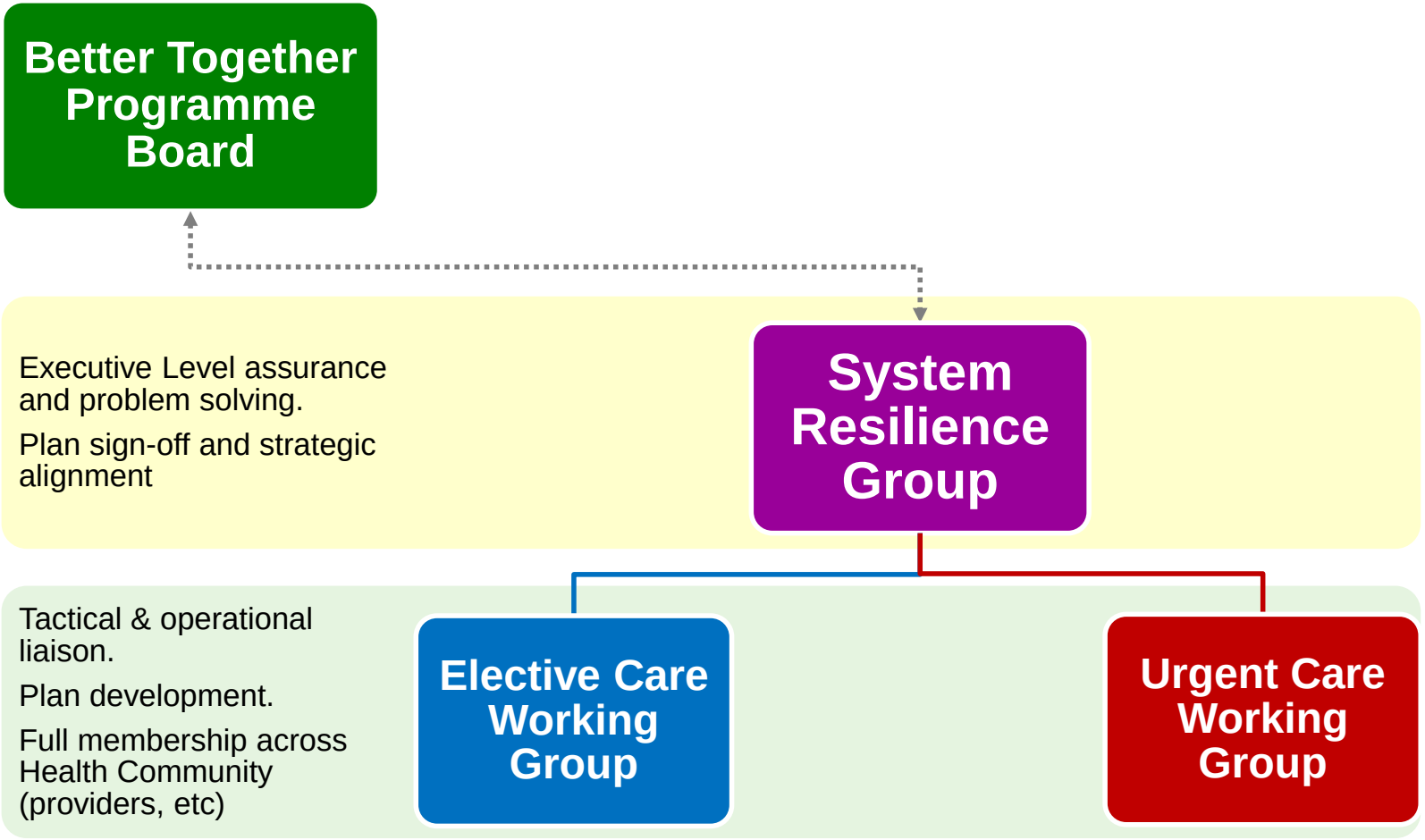
Better Together Programme - 6mth plan



Appendix (supporting information)

- NHSE, Monitor, Trust, CCG roundtable presentation regarding urgent care sustainability, transformational change
- System Resilience Group Terms of Reference

Mid-Nottinghamshire System Resilience Group



System Resilience Group (SRG) Terms of Reference

NORTH NOTTINGHAMSHIRE SYSTEM RESILIENCE GROUP

TERMS OF REFERENCE

Background

- On June 13th 2014 NHS England, NHS TDA, Monitor and ADASS informed Urgent Care Working Groups (UCWG) of the operational resilience and capacity planning requirements for 2014/15.
- UCWGs have been asked to expand to include elective as well as urgent care with a new title of System Resilience Groups (SRG). The focus is intended to be on year round resilience and capacity planning across the system. Locally the UCWG will remain in place as a task and finish group for urgent care and a new SRG will be created to oversee achievement of the operational resilience and capacity plan submitted to the Area Team on the 30th July.

Role and Remit

- The SRG is a forum where all partners across the health and social care system meet to assess and manage the local capacity and resilience plans for elective and urgent care. The group will oversee the coordination and integration of services to support the delivery of effective, high quality accessible services which are good value for taxpayers.

Responsibilities

- To cover elective and urgent care services in line with constitutional pledges
- To determine service needs on a geographical footprint
- To initiate the local changes required
- To address the issues that have historically hindered whole system improvements
- To plan for the capacity required to ensure delivery and oversee the coordination and integration of services to support the delivery of effective, high quality, accessible services
- To agree and sign off relevant and specific KPIs for each scheme that will increase the capacity to deliver
- To sign off the local operational and capacity plans
- To publish the local operational resilience and capacity plans on the CCG websites
- Rigorous and analytical review of the drivers of system pressures so that solutions can be developed
- To support all members to hold each other to account for improving system delivery using a clear set of KPIs and a dashboard
- To build consensus across members and stakeholders and advise on the use of non-recurrent funds and marginal tariff

Goals

- To ensure achievement and maintenance of the 18 week RTT target at SFHFT
- To ensure achievement and maintenance of the four hour ED target at SFHFT

Sub Groups

- The UCWG and 18week RTT performance group will continue to deliver the time limited pieces of work, reporting to the SRG on progress made.

System Resilience Group (SRG) Terms of Reference

Key Linkages

- Neighbouring SRGs (e.g. Greater Nottingham & Derbyshire)
- NHS England Area Team - Nottinghamshire & Derbyshire Area Team
- NHS Trust Development Authority (NHS TDA)
- Monitor
- Mid Nottinghamshire Transformation Board
- CCG Governing Bodies
- Constituent Member Boards/Governing Bodies

Reporting and Accountability

- The SRG will be accountable to the Governing Bodies of its constituent members for the delivery of the operational resilience and capacity plans. The minutes of the SRG will be formally received by those Governing Bodies.
- There will also be a formal link, through cross-membership and updating at meetings, with the Mid Nottinghamshire Transformation Board. This will ensure there is strategic alignment for medium / longer-term developments.

Membership

- The SRG is chaired by the CCGs Chief Officer. Members include a senior representative (executive level) from all local provider, commissioner and social care organisations. The group also includes clinical representation from both urgent and elective care.
- The membership of the group and attendance will be reviewed regularly to ensure that constituent organisations are being represented by a Senior Clinical and Senior Management lead, with delegated authority to make decisions on behalf of their organisations. The current membership list is included at the end of this document.
  - Group members are expected to:
  - Send apologies and delegate a suitable representative;
  - Send agenda items to the SRG administrator;
  - Share group papers, progress and information as appropriate within their organisations;
  - Facilitate the implementation of actions agreed by the Group, within their own organisations; and
  - Participate in group work programmes and task focussed groups as appropriate.

Quorum

- A quorum will be 8 members and 75% of attendance is required over the period of a year.

Meetings

- Meetings will be held monthly

Administration

- Administration for the group will be provided by NHS Mansfield & Ashfield CCG

Review

- The Terms of reference will be reviewed annually.

System Resilience Group (SRG) Terms of Reference Membership

MEMBERSHIP LIST Organisation	Role	Name
Mansfield & Ashfield and Newark & Sherwood CCGs	Chief Officer (Chair)	Amanda Sullivan
Mansfield & Ashfield and Newark & Sherwood CCGs	Director of Contracting & Urgent Care	Ian Ellis
Nottinghamshire County Social Services	Corporate Director – Adult Social Care, Health and Public Protection	Jon Wilson
Nottinghamshire & Derbyshire Area Team	Director of Commissioning	Vikki Taylor
Sherwood Forest Hospitals NHS Foundation Trust	Medical Director	Andrew Haynes
Sherwood Forest Hospitals NHS Foundation Trust	Director of Operations	Jacqui Tuffnell
Nottinghamshire Healthcare NHS Trust	Executive Director Local Services	Simon Smith
Nottinghamshire Healthcare NHS Trust	Deputy Chief Operating Executive Health Partnerships	Liz Hallam
East Midlands Ambulance Trust	Director of Operations	Richard Henderson
Central Notts Clinical Services	Chief Executive	Richard Carroll
Derbyshire Health United	Programme and Operations Director	Pauline Hand

better+together

Shaping health and care in Mid-Nottinghamshire

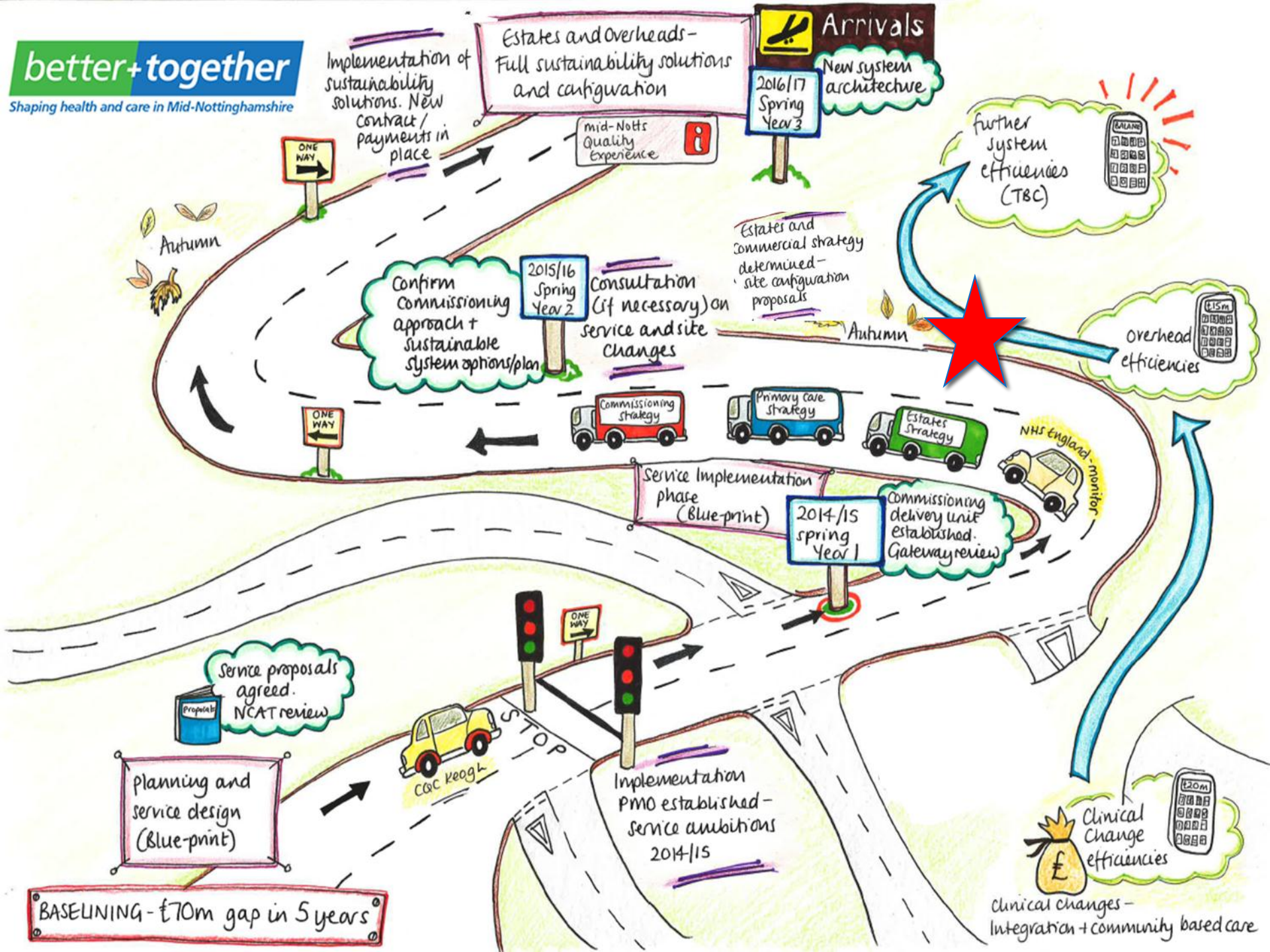
Mid-Nottinghamshire

Integrated Care Transformation Programme

ROUNDTABLE DISCUSSION

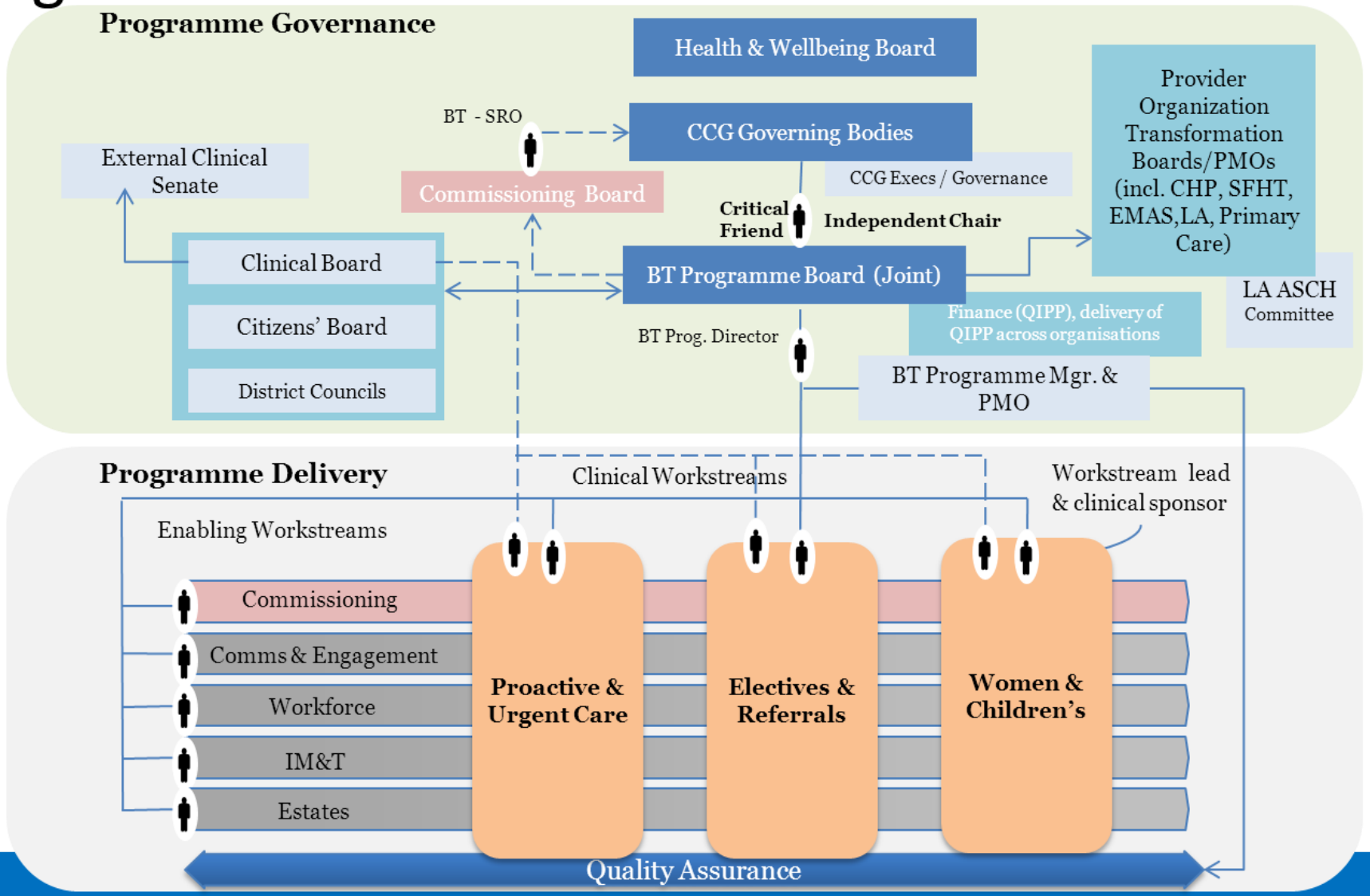
MONITOR / NHS ENGLAND / TRUST / CCGS

24TH SEPTEMBER 2014


better+together
Shaping health and care in Mid-Nottinghamshire
Implementation of sustainability solutions. New contract / payments in place
Estates and Overheads - Full sustainability solutions and configuration
Arrivals
New system architecture
2016/17 Spring Year 3
mid-Notts Quality Experience
ONE WAY
Autumn
Confirm Commissioning approach + Sustainable system options/plan
2015/16 Spring Year 2
Consultation (if necessary) on service and site changes
Estates and Commercial strategy determined - site configuration proposals
Autumn
further system efficiencies (TBC)
£15m
Overhead efficiencies
Commissioning Strategy
Primary Care Strategy
Estates Strategy
NHS England - monitor
ONE WAY
Service Implementation phase (Blue-print)
2014/15 spring Year 1
Commissioning delivery unit established. Gateway review
ONE WAY
Service proposals agreed. NCAT review
Proposals
STOP
CQC keogh
Planning and service design (Blue-print)
Implementation PMO established - service ambitions 2014/15
£20m
Clinical Change efficiencies
£
BASELINING - £70m gap in 5 years
Clinical changes - Integration + community based care

- Programme well established – significant pace for implementation phase
- System resilience plan assured and closely monitored (14/15 delivery); System Resilience Group established
- Relationships continue to develop - joint solution focussed
- Re-commissioning process enables development of relationships across the system, whilst maintaining delivery focus
- CRS process underway for contingency planning – general alignment, further analysis / public call for evidence in Q3/4

Programme Governance



Links between Better Together and Operational Performance

- All transformation initiatives support operational and clinical sustainability as demand is rebalanced and the system becomes more cost effective
- Year 1 of the 5 year plan is built into 14/15 contracts, although some room for flexibility as schemes are further developed / evaluated
- Significant system-wide resources in place as part of the Programme infrastructure – additional capacity for providers and commissioners
- Shared sponsorship of work streams across the system
- PMO and programme plan / milestones in place
- Work now underway to align with CIP milestones in more detail
- Additional tactical responses in place through System Resilience Group, Urgent Care Working Group

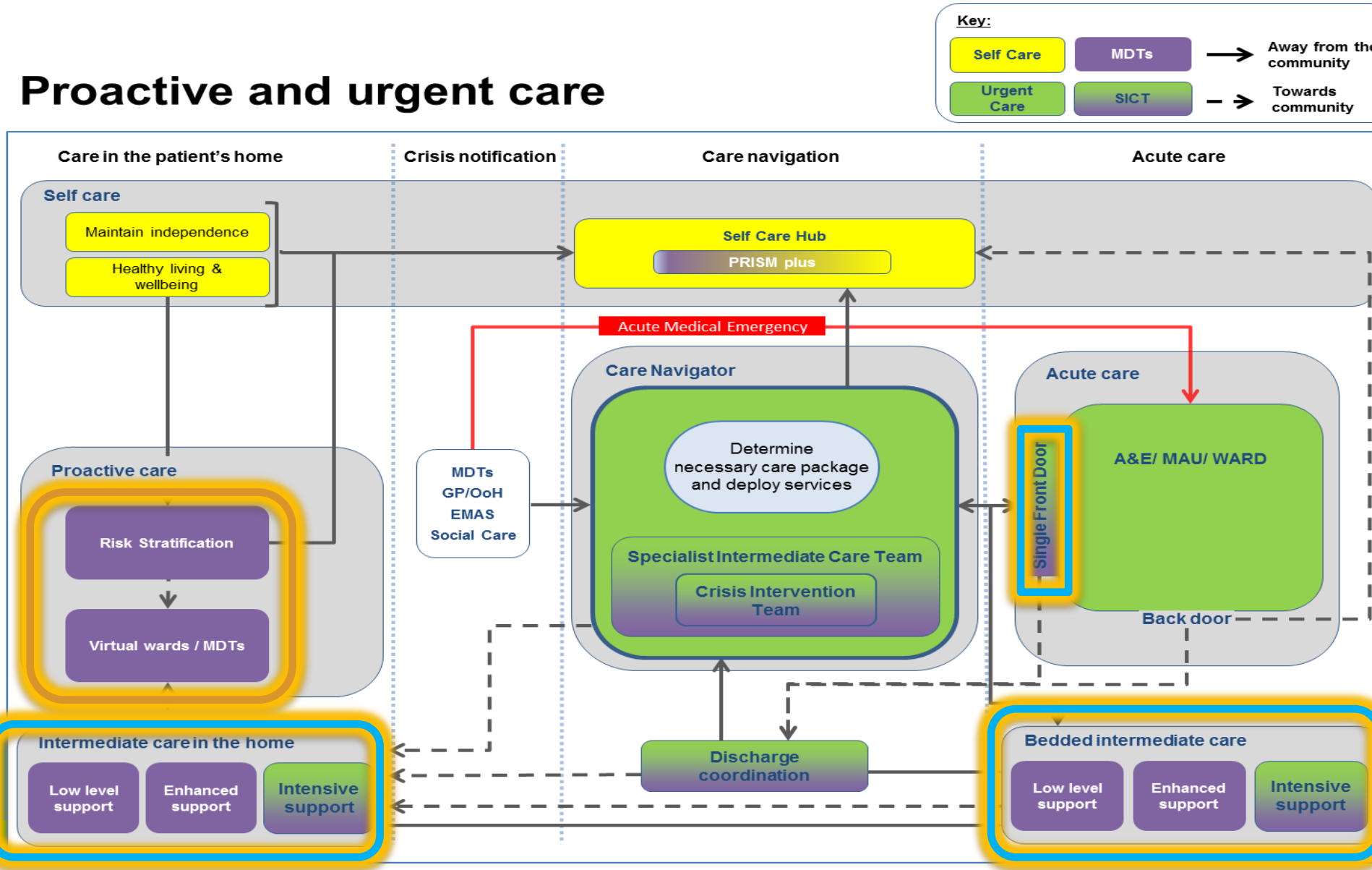
Impacts to date – urgent and proactive care

- Integrated community teams in place in Newark and Sherwood in 13/14, implemented in Mansfield and Ashfield during Q1/2 14/15
- Population risk stratification, MDT care planning and proactive care for LTC in place as part of first phase
- Next phases are front door interventions (clinical streaming), transfer to assess / proactive discharge process, development of intermediate care provision, self care
- All are interdependent – single interventions won't have desired impact

In place

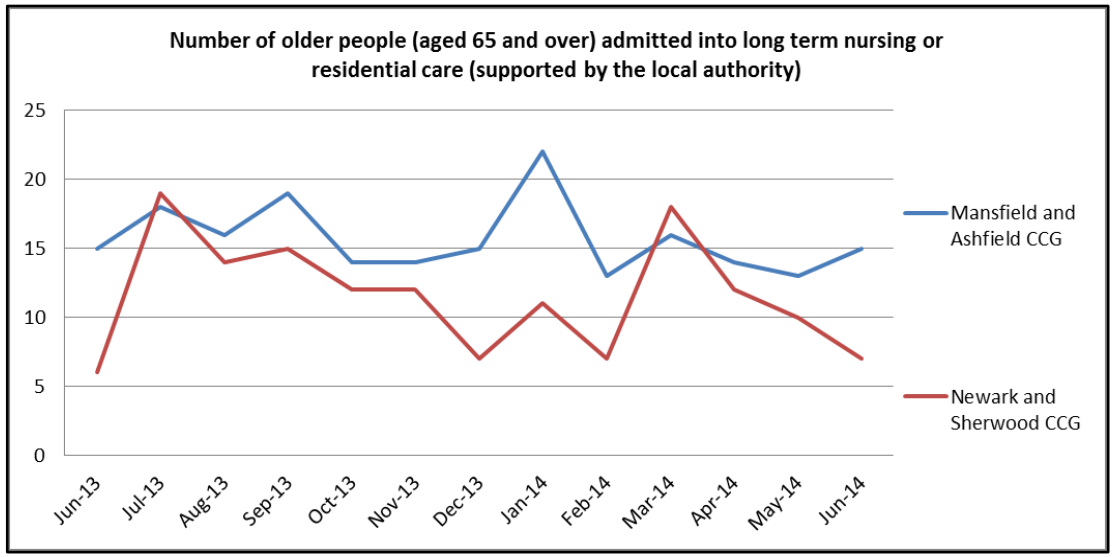
Further tactical responses in 14/15 to support long-term vision

Proactive and urgent care

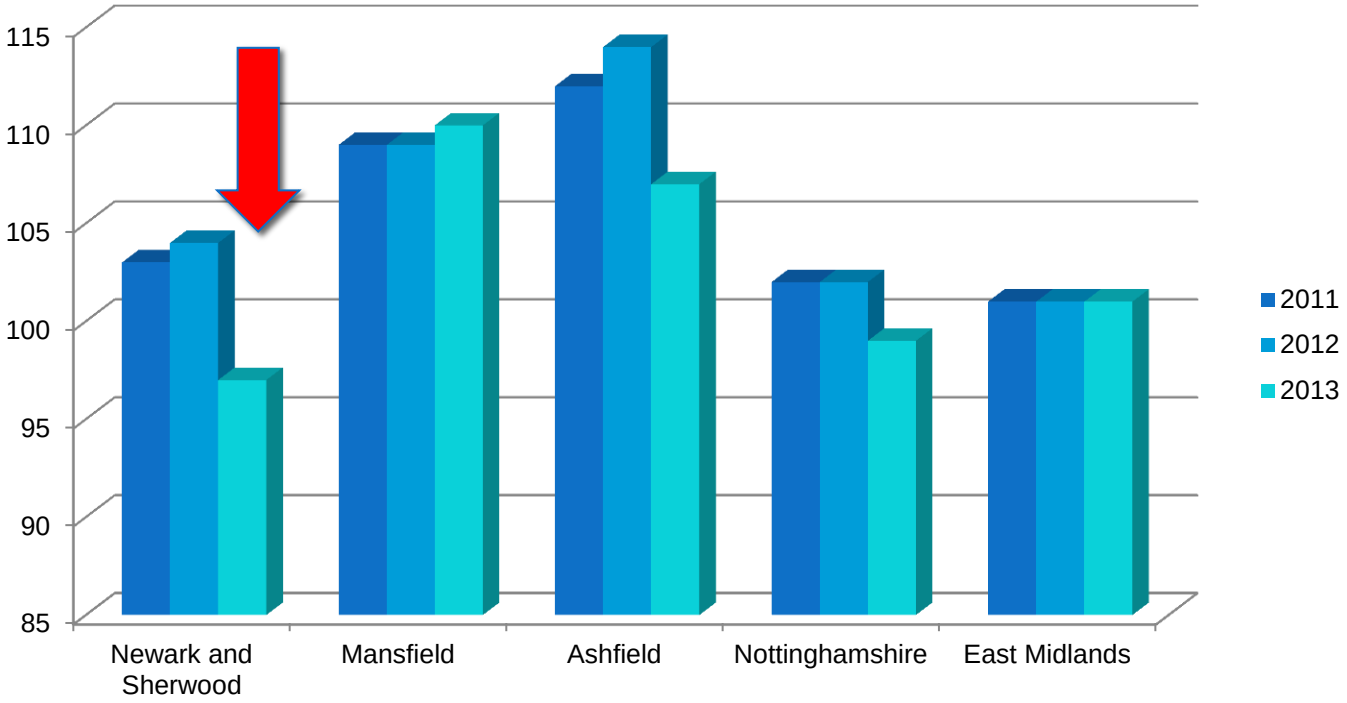


Impacts to date – urgent and proactive care

- Evidence of real terms admissions avoidance, but against increasing demand
- Some unmet need probably being picked up / addressed more comprehensively
- Significant reductions in mortality and residential care admissions in Newark and Sherwood



The number and proportion of people who were still at home 91 days after discharge from hospital into reablement / rehabilitation services



- Standardised mortality ratios 2011-2013, based on ONS data