Sherwood Forest Hospitals
NHS Foundation Trust

Emergency Care Transformation

Ben Owens - Clinical Director

Roz Howie – Chief Operating Officer

Dedicated to Outstanding care

4h Emergency Standard

- November 2014 2nd worst in the country
  - 17 12h bed breeches in 1 day

- Flow work stream started in earnest Feb 2015

- We remain the best performer in the region and in the top 10 in the country for the 4h standard

Qtr 1 16/17	Qtr 2 16/17	Qtr 3 16/17
37487	37865	37325
2345	1831	1829
93.74%	**95.16%**	**95.10%**

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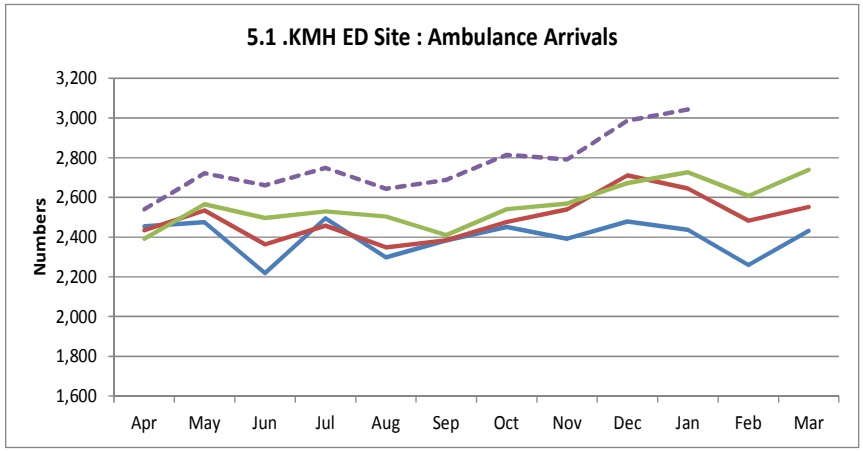
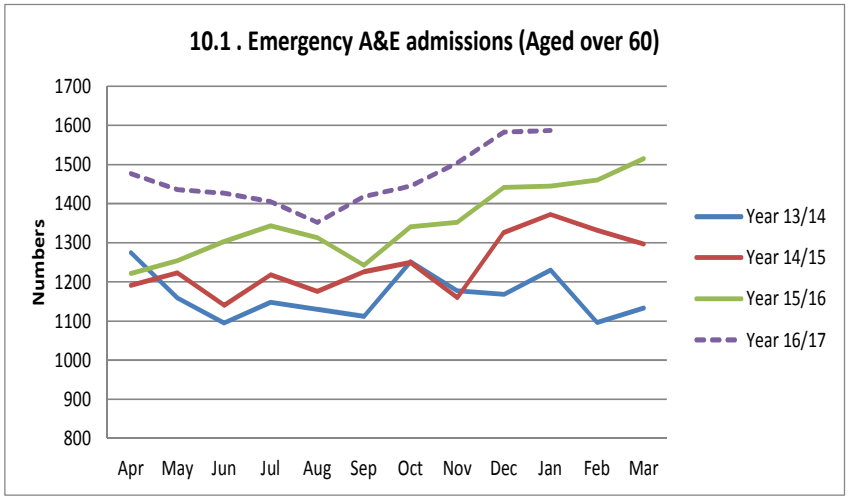
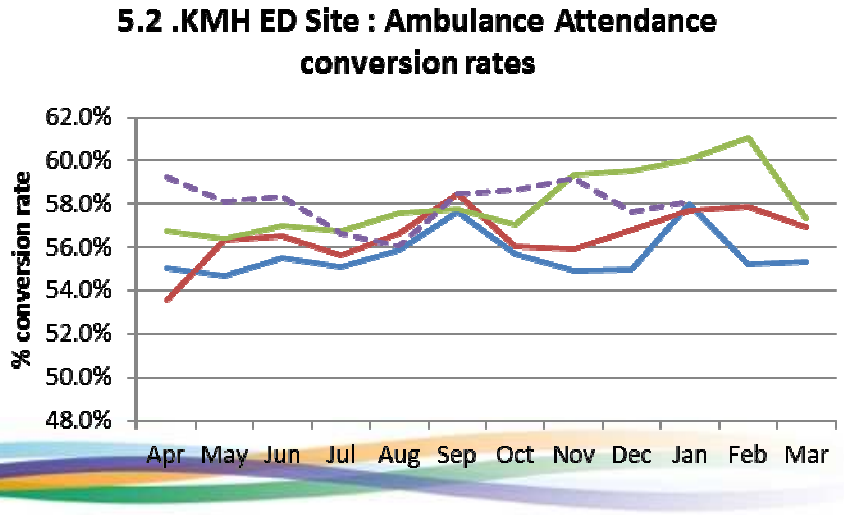
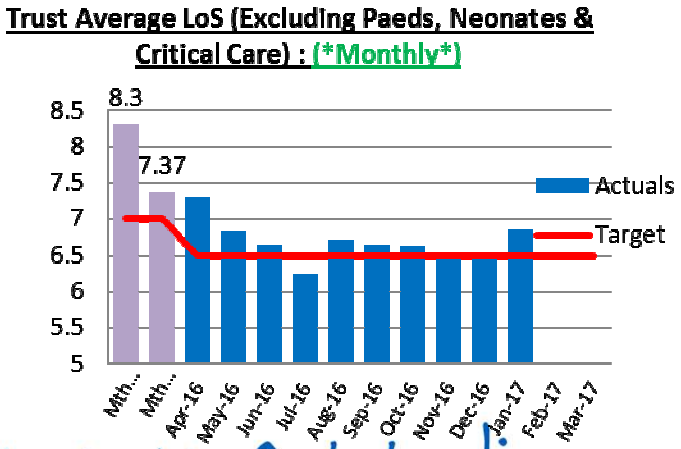
Demand and Capacity



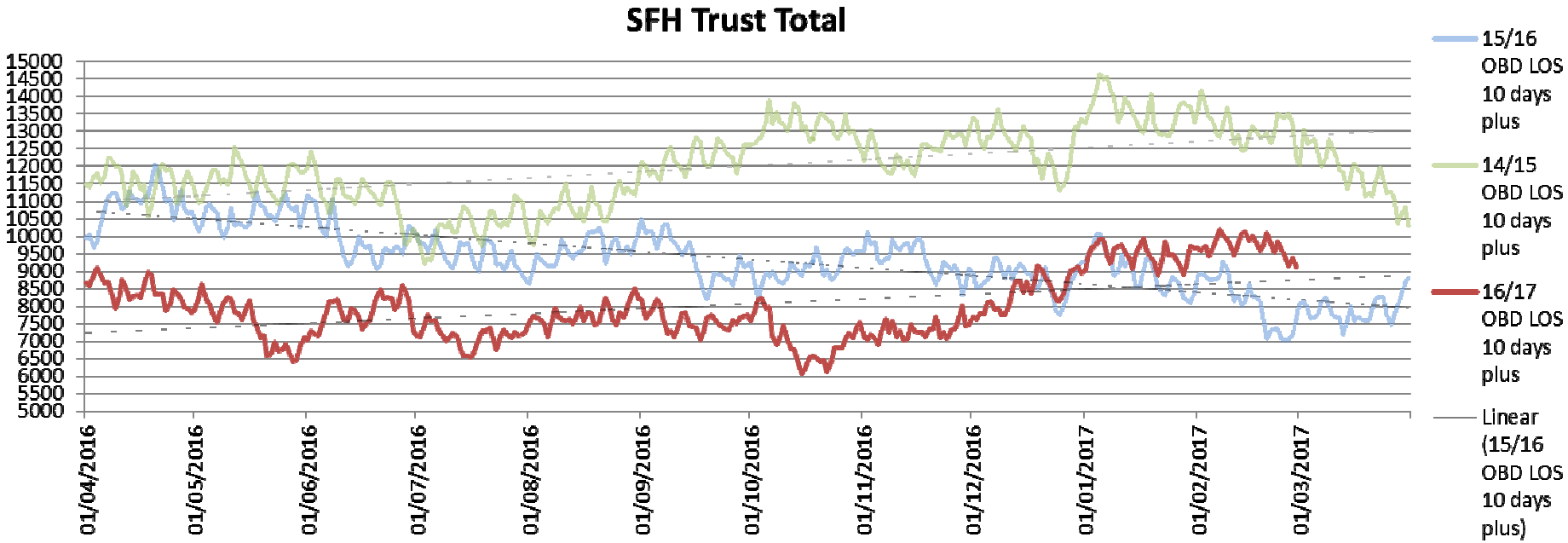






Dedicated to Outstanding care

Occupied Bed Days for Pts >10/7 LOS



Align Goals across the organisation

- 3 goals for all staff – In this order
    - Flow
    - Emergency system
    - RTT
- get this right and
    - most efficient and sustainable
    - finance should sort itself
- safety, governance and training are our job

Why? – Poor flow is our greatest risk

- Lack of discharge = too many patients
  - Higher mortality
  - Patients in the wrong place
  - More outliers
  - Distracted from the truly sick patients
  - More bed moves
  - Higher stress
  - Inability to do our jobs efficiently
  - Higher risk
  - Higher cost – 2 million pounds a ward
  - Failed targets – lack of credibility and increased work

Finance and Quality

- Closing a ward saves £1.2-2 million (Whole Year Effect)
- Reduced SI and complaints
- Almost no medical outliers
- Empty beds daily on EAU
- Readmissions static
- HSMR from 118 to 90

Emergency care is Easy

- Stop them coming at all
- See them quickly
- Admission Avoidance
- Early Senior Review
- Early Investigations
- See them daily
- Plan for discharge with all other agencies

Emergency Flow Steering Group

- Clinical lead in the group
- To enable flow across the hospital
- Admission avoidance
- Quick decisions about pathways, funding.
- All specialities can be called
- CIP is about being more efficient with length of stay not cutting services
- Governance

Front Door

- Co-locate Primary Care and maximise it
- Streaming/early senior input
- Plan workforce to patients
- Do the right thing for the patient
- Admission is not the safer option
- Only admit those who cannot be treated at home
- Do not admit for investigation
- No social admissions
- Agree Emergency Care Standards

Admission Avoidance

- FIT team
- Physio/OT
- PRISM Team
- Call for Care
- Ambulatory care
- Hot Clinics
- Cannot cancel care packages

Acute Medicine

- Speciality In reach
- Short Stay ward – 25 to 90 patients a week
- Ambulatory Care
- 7/7 social care
- Frailty Intervention Team

Ward Length of Stay

- Daily consultant Review
- Board rounds
- Weekend working
  - Cardiology, Gastro, Diabetes, Acute Medicine
  - ED, HCOP, Respiratory
  - Increased juniors on the weekend
- All Investigations ordered before 8 pm will be done that day – radiology
- All inpatient specialty opinions within 24h

Principals

- No Social Admissions in the day
- Stop silo working
- Admission is not the safer option
- Make it easy to do the right thing
- We are all responsible for all patients
- Always do the right thing for patients even if its hard
- All opinions before 5pm same
- Escalate when things aren't done

Interesting facts to share

- If you are admitted through an overcrowded ED you have a 43% mortality increase if admitted for 10 days or more

- If you are 77 you have a mean of 1000 days of life left – How many would you choose to have in hospital?

- Bed rest – 10-20% muscle strength lost per week – admission for > 3 days can convert an independent frail person to a dependant one

Demand

- A number of actions have been put in place:
  - Daily calls set up as required with partners to resolve any key blockages on a daily basis.
  - Attendance and admission avoidance strategies identified at the Better Together Alliance meeting.
  - EMAS conveyance rates discussed with CCG.
  - As part of the winter planning, staffing increased in CDU to reduce admissions into the main organization.
  - Extra capacity is being utilised at Newark and at KMH to sustain flow.

Summary

- In the last 2 years we have:
  - Gone from the 5th worst to one of the top 4h performers in the country of 136 acute trusts against a backdrop of a 15% rise in ED attendances
  - taken out 60 beds saving approximately 6 million pounds a year and reduced risk by targeting challenging ward areas
  - reduced length of stay by almost 2 days
  - cancelled very few elective procedures
  - taken mortality (HSMR) from 118 to 90
  - gone from a CQC safety rating for ED of inadequate to good and come out of special measures

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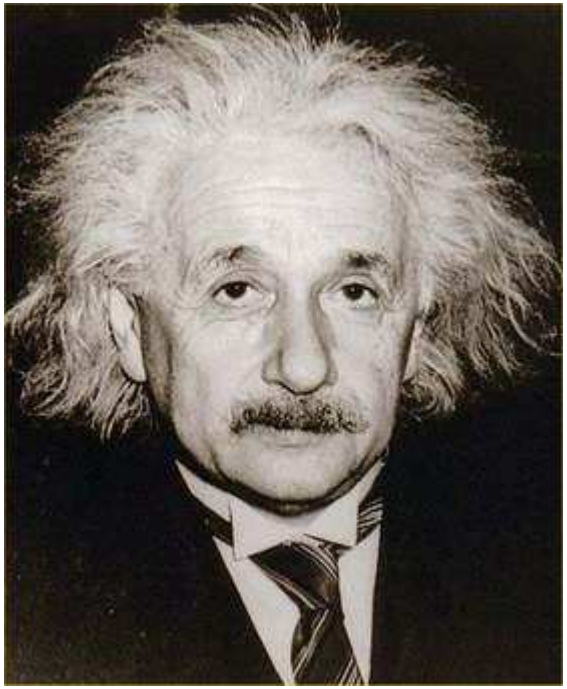
Flow and admission avoidance is everybody's job because it saves lives and we all have a duty to constantly modify our practice for the safety of our trust and our patients

We all have to change together!

- “Insanity: doing the same thing over and over again and expecting different results”
- Albert Einstein



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Pharmacy

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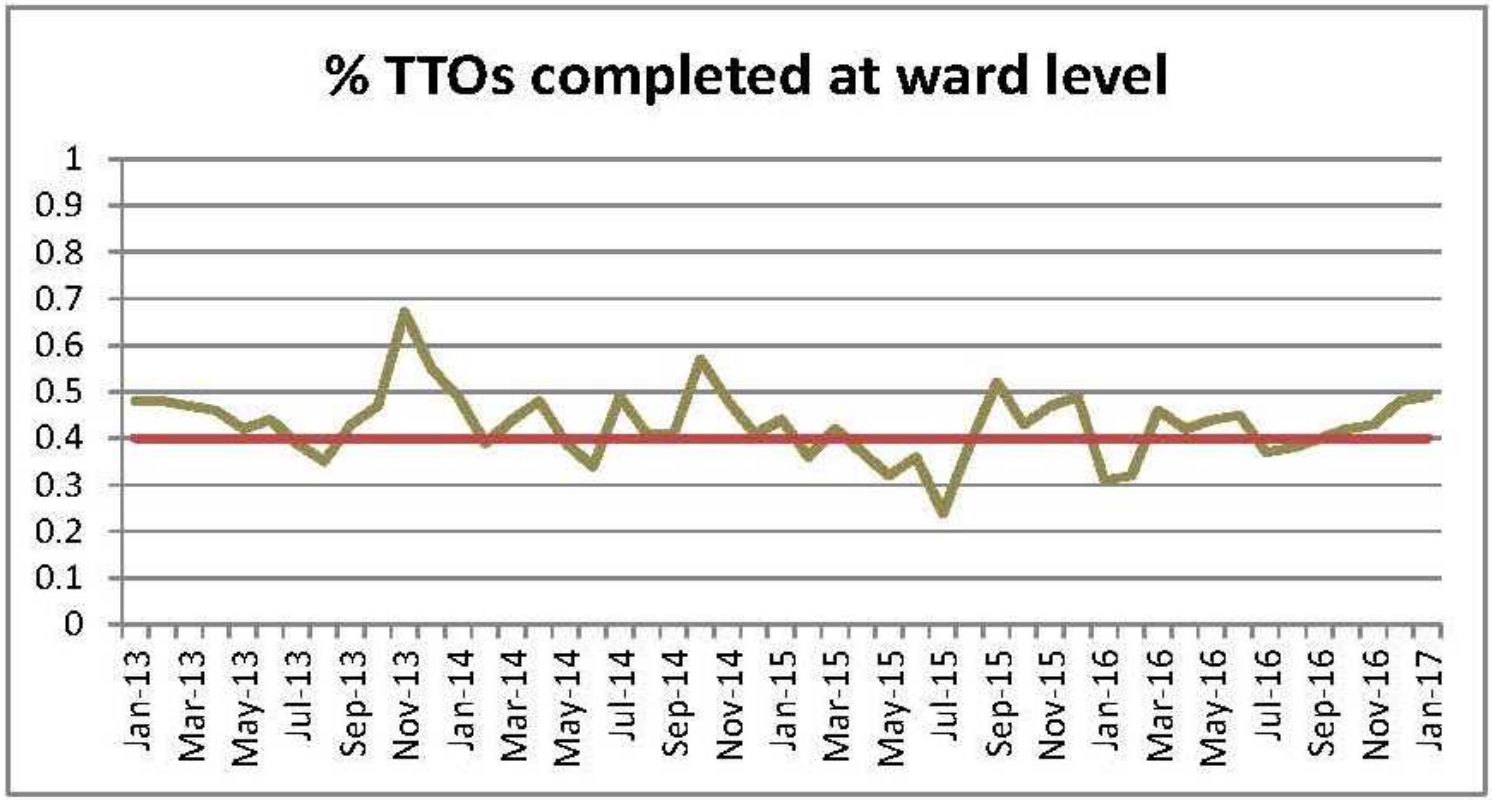
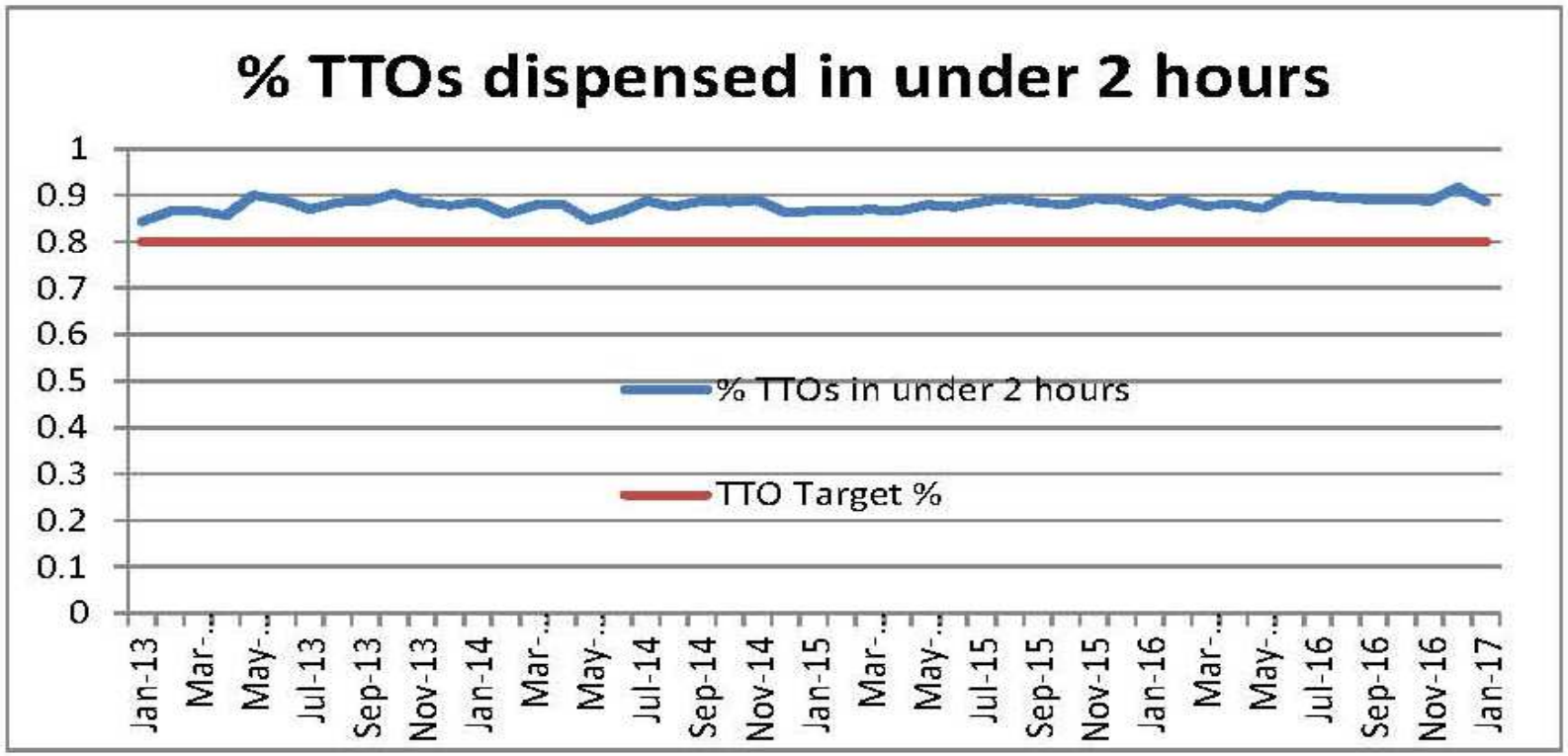
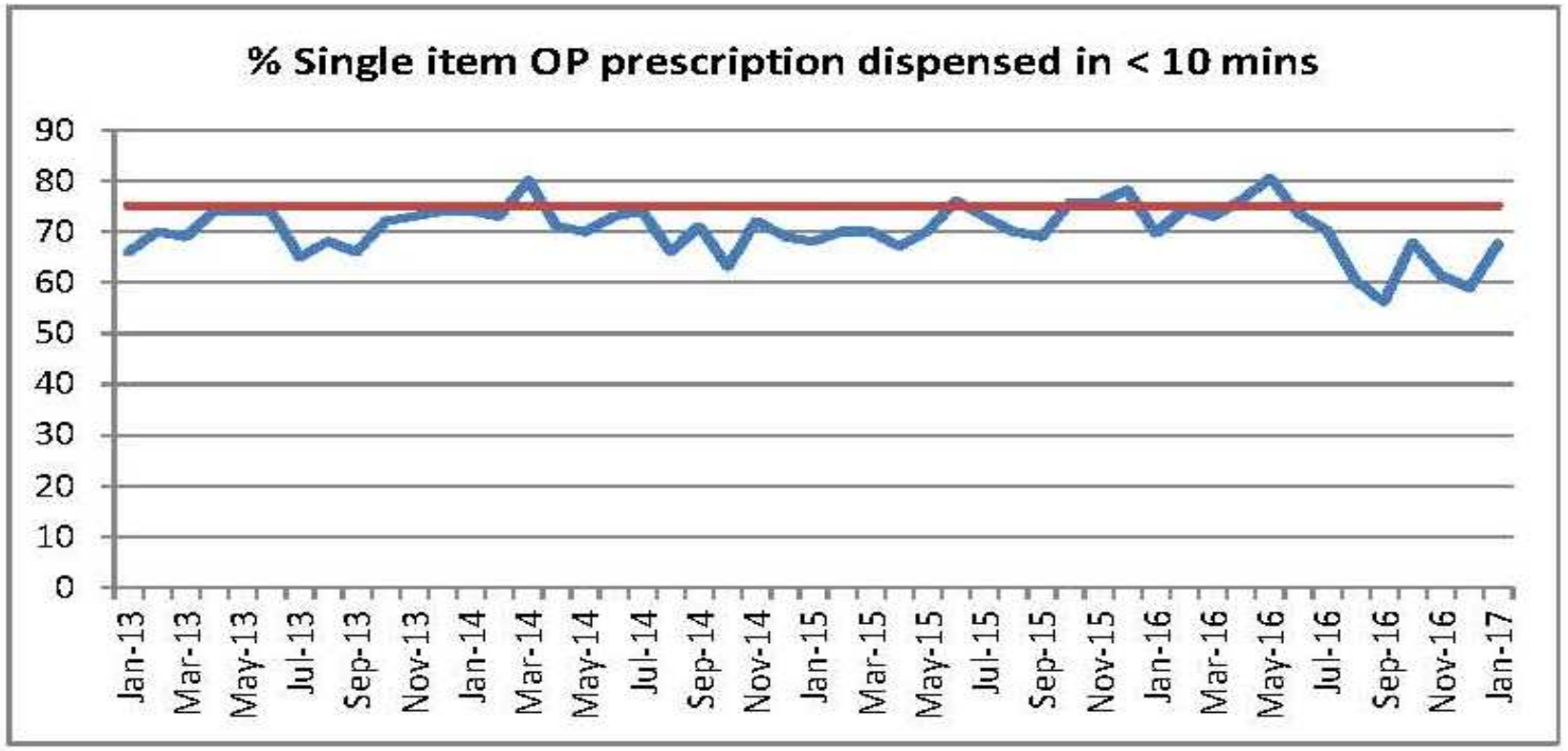
TTOs – completed at ward level



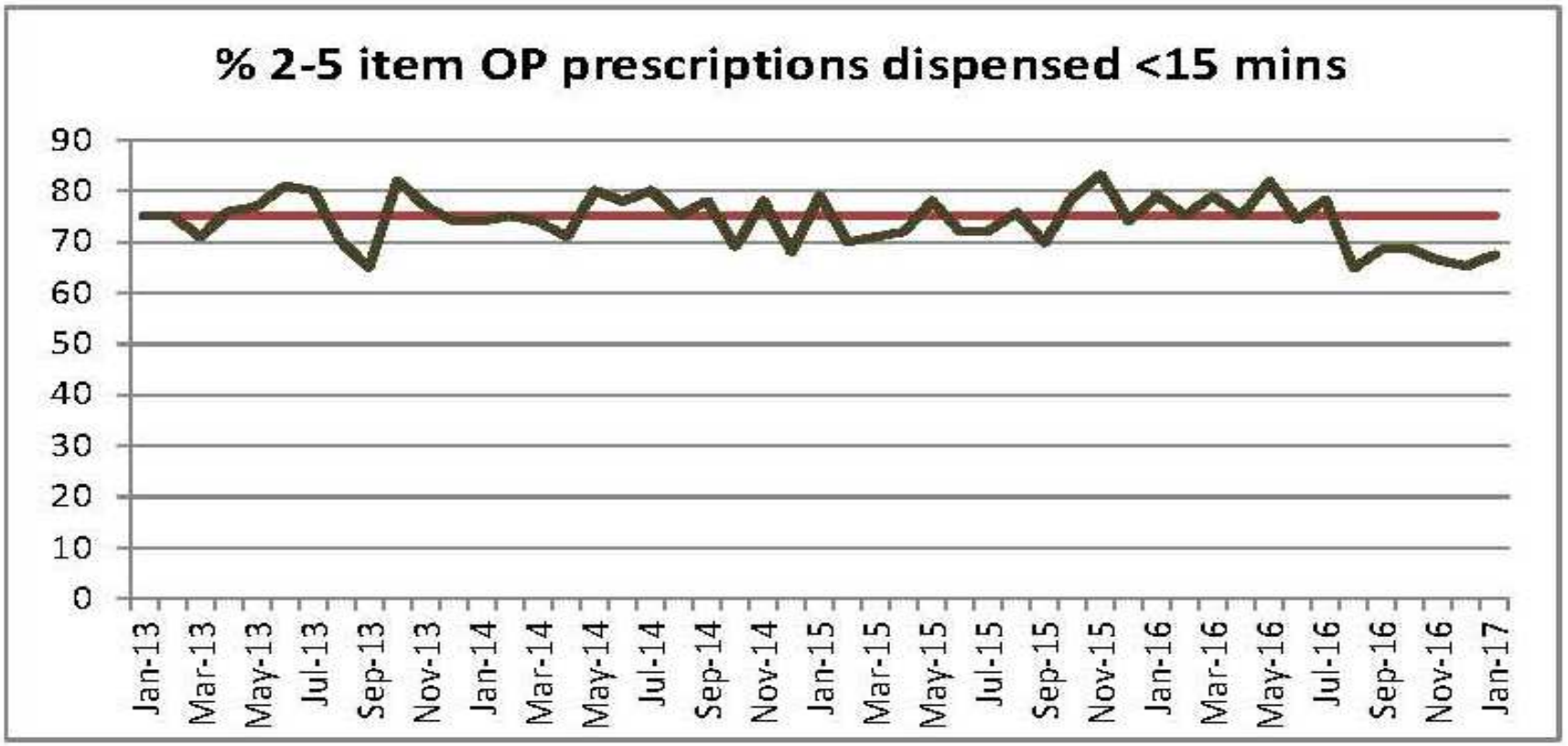
TTOs - dispensed in under 2 hours



% Single item OP Prescriptions dispensed in <10 mins



% 2-5 item OP prescriptions dispensed <15 mins



Pharmacy

To expedite discharge we have the following systems:

- Pre-packed medications as stock on the ward to allow dispensing at the patients bedside.
- 9am – 5.30pm ward based service, 11am-1pm and 2pm-5pm there is a dedicated TTO service available via Vocera.
- Orion has a work list showing all completed TTOs which all pharmacy staff check first when attending a ward.
- We work closely with community pharmacies to ensure continuation of medication after discharge and we won't supply items if they are not required. Patients and their carers are consulted during their stay to see what they already have at home to prevent duplication and unnecessary waits for items they already have. The current medication chart has a tick box for 'supply at home' so we know not to supply this at the point of discharge.