iCan

“The Story so far” Headlines
December 2022

3 Targeted Areas for Transformation

Our vision is to support more people to choose well, stay well and age well at home resulting in reduced unnecessary admissions to hospitals and better outcomes for people.

1. Community Resilience

- Maximise independence by helping more people remain at home
- Provide holistic planned care in community to help people age well
- Reduce unplanned primary and community care demand.

2. Frailty, escalation and front door

- Enable people with frailty to access the services they need
- Prevent avoidable admissions into the acute setting
- Give people input into the care they receive.

3. Flow and grip

- Reduce unnecessary time in hospital beds
- Maximise independence by helping more people return home
- Improve the experience of people in our care.

ICAN Improvements to date

Over 65 NEL Admissions are c. 183 per month lower than 2019, and 390 per month lower than 2019 Growth Forecast

New IV antibiotics review process and monitoring system – reducing length of course by 4 days

KGH frailty model delivering an 57 avoided admissions per month

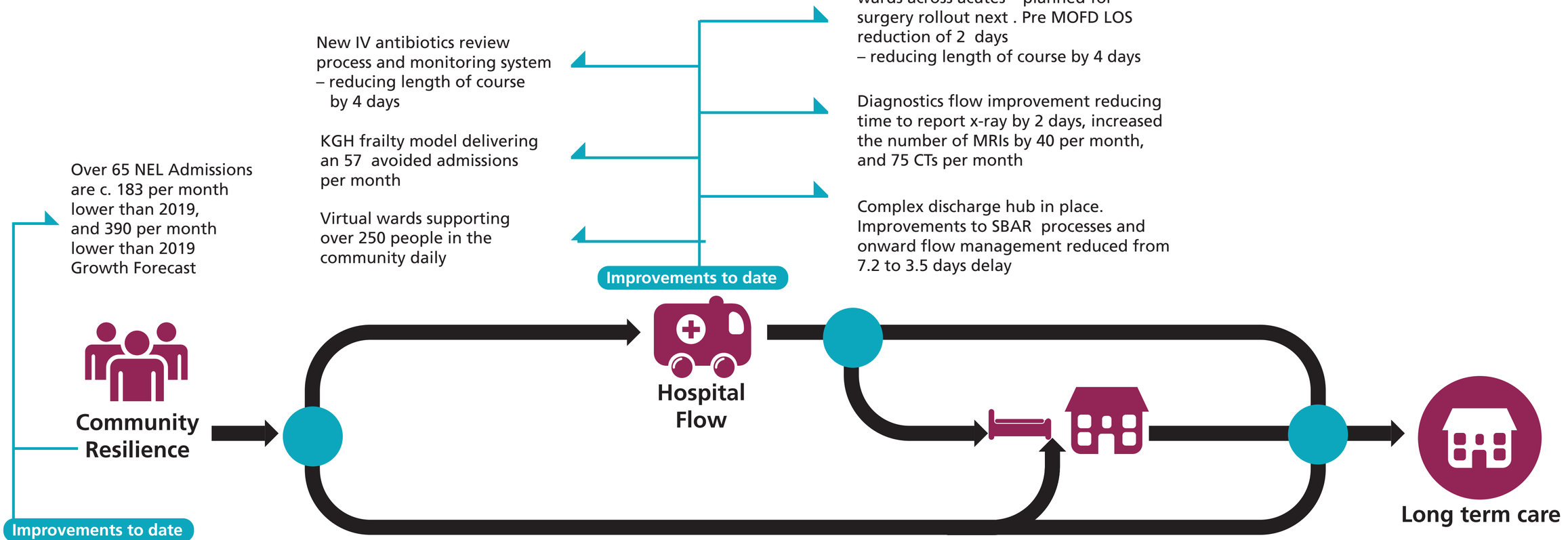
Virtual wards supporting over 250 people in the community daily

New IV antibiotics review Board round best practice rolled out to all medical wards across acutes – planned for surgery rollout next . Pre MOFD LOS reduction of 2 days – reducing length of course by 4 days

Diagnostics flow improvement reducing time to report x-ray by 2 days, increased the number of MRIs by 40 per month, and 75 CTs per month

Complex discharge hub in place. Improvements to SBAR processes and onward flow management reduced from 7.2 to 3.5 days delay

Improvements to date



Improvements to date

Frailty reviews now held in 12 PCNs. ~110 frail patients stratified and reviewed each month with an MDT approach

EMAS & 111 stack shared directly with Rapid Response ~ 100 referrals per month resulting direct RR visit instead of an ambulance

Intermediate care, bedded and at home

Improvements to date

Community Hospital LOS improvement programme, including new equipment store (saving between 800 and 1200 days), MDT reviews and a flow dashboard

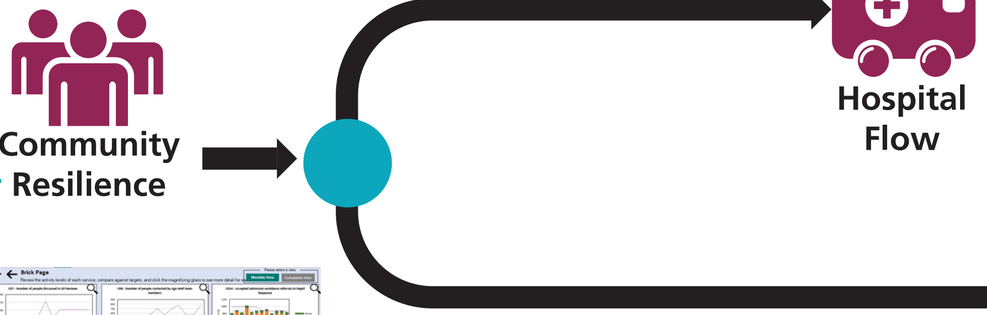
51 truly integrated 'Recovering Independence Beds' – model now live, and will be at full capacity in Jan. Expected to deliver a 10day LOS improvement

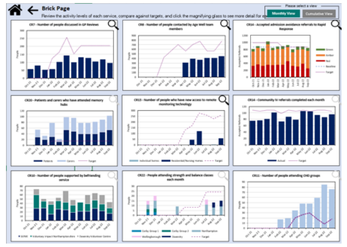
Redesigned Pathway 1 Services – with 1500 additional hours of provision planned to be in place by February

ICAN Phase 2
Digital Implementation

Patient Time Matters - acute stay patient flow PowerBI dashboards for all staff

System Flow dashboards to be accessible to all partners (currently live in both acutes)

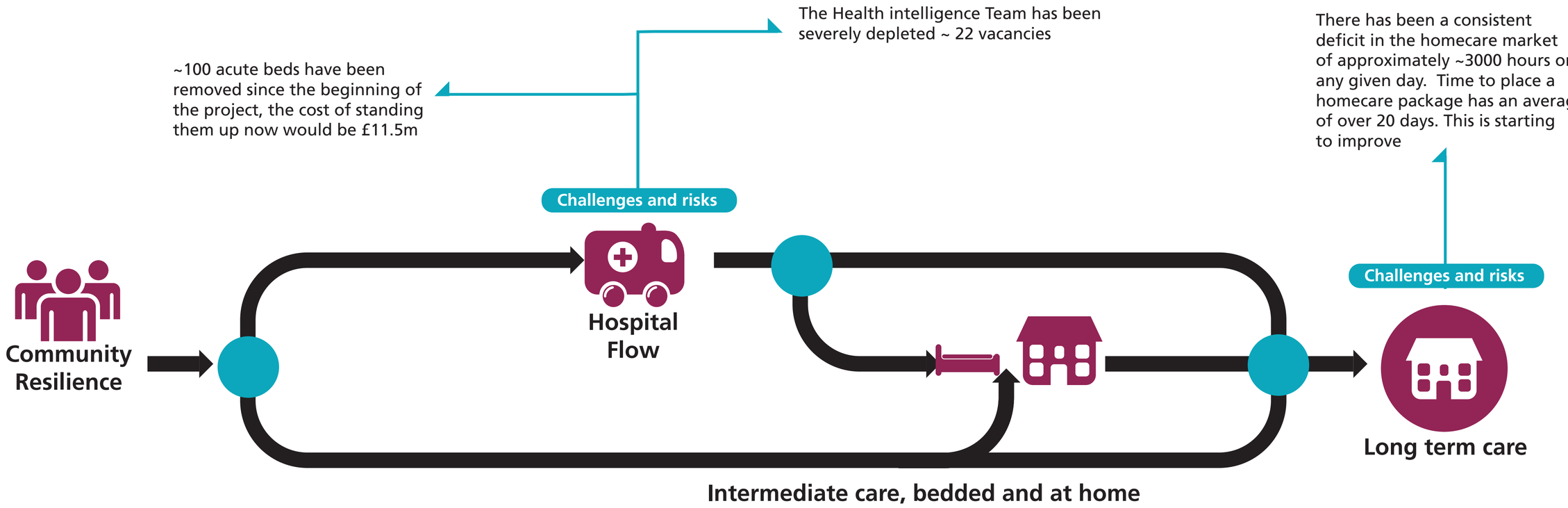




Community Resilience 'helicopter metrics' dashboard in place

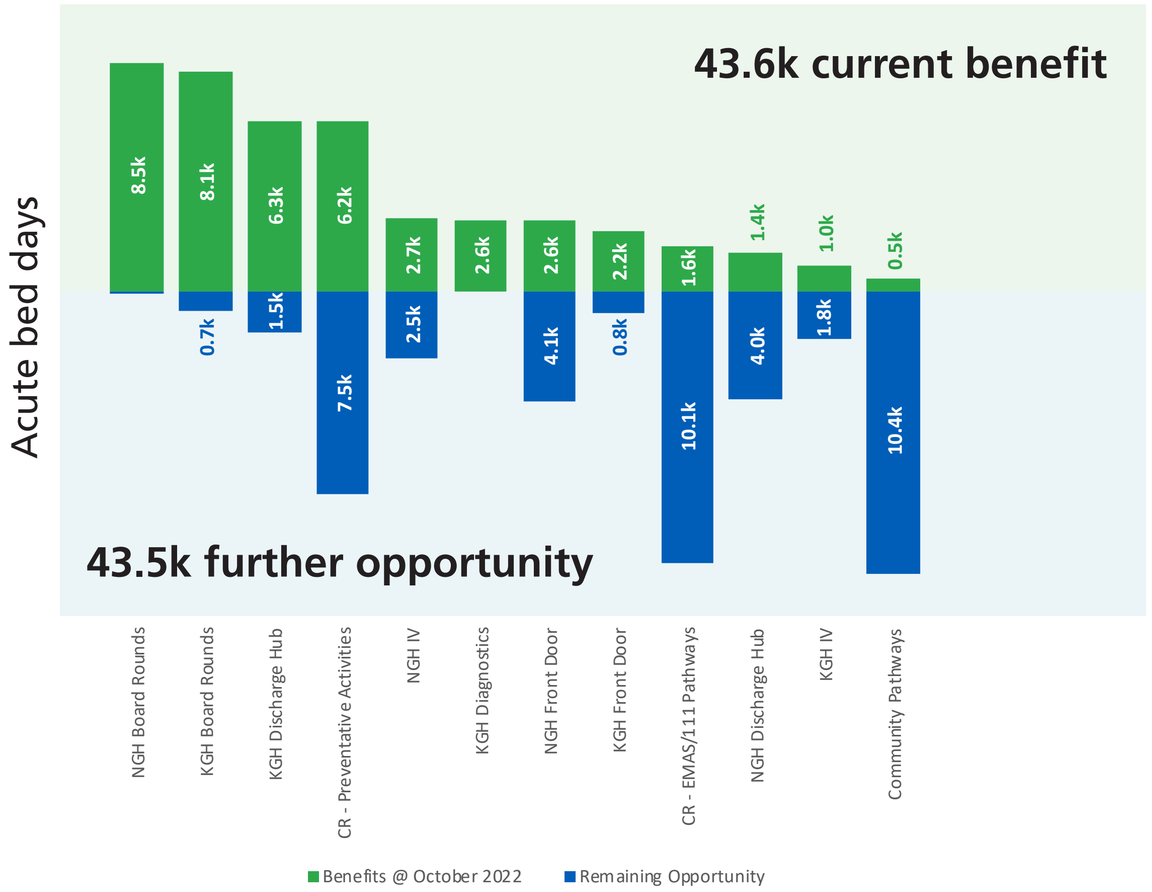
Pathway 2 Bed flow Dashboards live and covering CH and RIB beds

ICAN Phase 2
the Challenges and Risks to Continued Improvement



Benefits position is half way to Total Opportunity, and 2/3rds of the way to Programme Target

Bed days impact by workstream: current achieved vs further opportunity



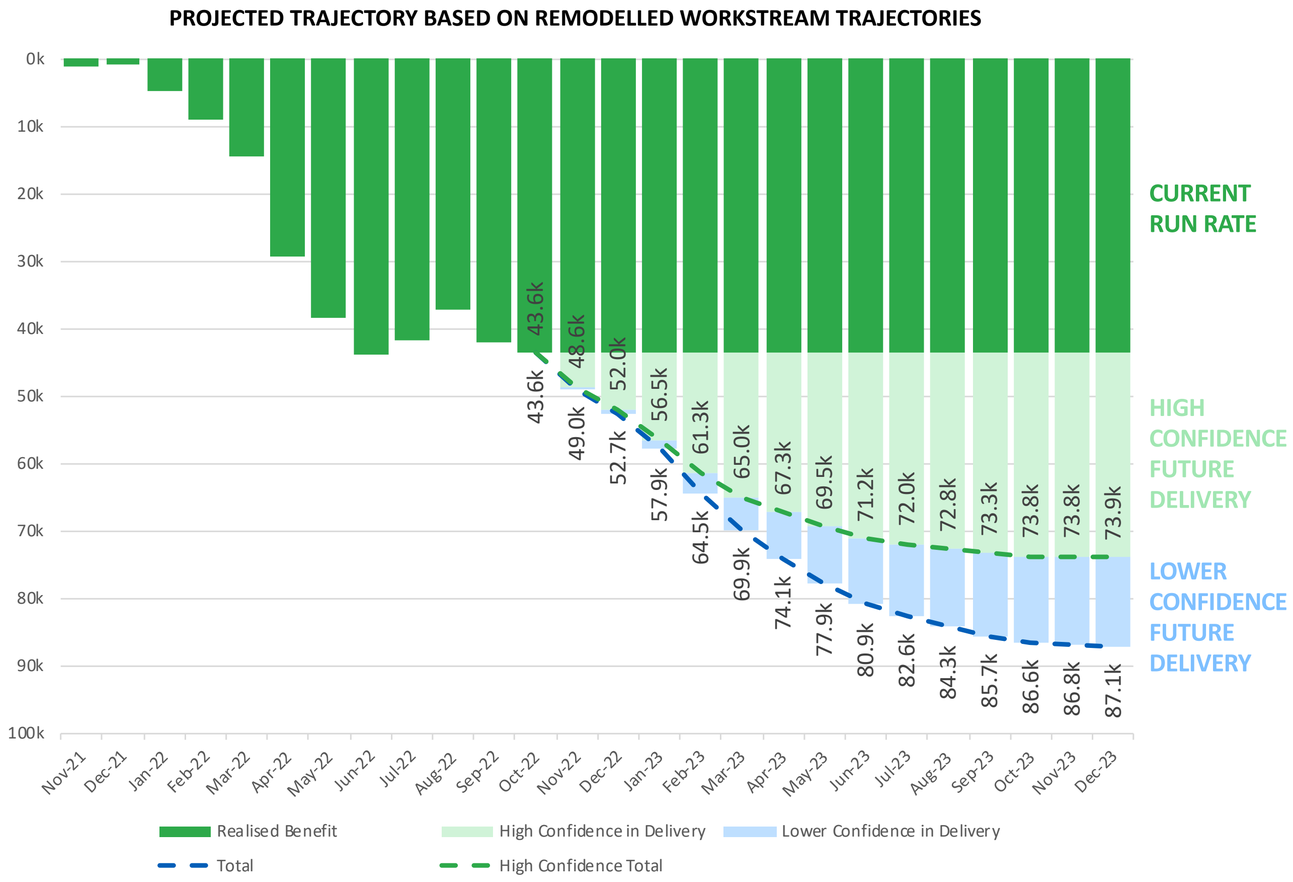
- The acute productivity and frailty improvements make up c. 80% of the benefits to date, are well embedded in BAU and well monitored.
- The community-based work still has significant further opportunity, which is based on a combination of rolling change out countywide, and the new work on new Pathways and EMAS/111 Referral routes which started later and is expecting to realise benefits over the coming months.
- There is also further opportunity to be realised by the hospitals – particularly in NGH Frailty service and Discharge Hub.
- Realising all of these would far exceed the targeted iCAN benefit of 62.5k.

What Next

Our journey continues in 2022-23 …

- Expansion Virtual Health Environments
- Continued Co-production
- Expansion Age Well teams & GP led Reviews
- Northamptonshire Analytics and Repository Platform live
- Frailty Unit – Acute Front Door with community support
- Real Time – all Pathway System Dashboards live
- Integrated Same Day Access Development

Programme Trajectory



- The programme trajectory has been remodelled, taking into account workstream plans, with a confidence weighting taking into account some of the challenges of delivering in full
- The additional Community Pathways and EMAS/111 Referral Pathways work are both key to achieving the targeted 62.5k bed day efficiency within the original programme timescales of 62.5k bed days by June 2023
- Total delivery would be forecast to land somewhere between 73k and 87k bed days depending on the success of the delivery which has been weighted as lower confidence

What Staff Say

“At the beginning I thought this was going to be a huge mountain to climb but now I’m quite excited. And I’m getting a massive kick out of it because the patients are getting the benefit.”

Acute Divisional Director

“This is the first time in my career that we have had the whole county engaged in one initiative that combines multiple services into one. There has been nothing like it before.”

– Dr John Harrison GP - Clinical lead for ICAN Community Resillience

Partner Staff Testimonials

EMAS Medical Director stated that the implementation of the pathway was “Fantastic news” and “Really positive progress”

“If our board rounds were 30% good before, I’d say we’re 95% good now”– Therapist

“I’m loving the Daily Hub metrics that I have got. It is really clear now if we are on track and what I need to do to drive the team’s performance”
– Complex Discharge Lead

“This visibility allows us to make sure we are challenging the right wards, but also gives them the tools to take their own responsibility”
– Deputy Chief of Pharmacy

“I’ve noticed a massive improvement, I went to a board round this week and it ran so smoothly! Everyone knew what they were doing, I was so impressed” – Louise, Medicine Matron

“we have never seen so many inpatients in one afternoon session before!” – CT scanner team member

What People Say

“I remember the fact that it was multidisciplinary team meeting. And if I remember right it was the first time it had happened and so it was refreshing and helpful… My mum could be at home so she was comfortable in her own space, it was relaxed, the people felt professional, yet warm and we were together as family and could have a discussion together.”

– Daughter of a woman who was supported at one of our first GP-led MDTs

Patient Testimonials

“My mum would have ended up in a care home if it wasn’t for her extended GP review”
– Daughter of person who had a GP-led review

“I feel confident to go out in my garden on my own” & ”I feel like I am learning new things each week and I can understand why I need to do the exercises to keep me healthy”
– Attendees at a strength and balance class

“Dad is usually a quiet man but he is really enjoying the group and talking about you by name at home”
– Attendee at a memory hub meeting