NHS Trusts and Provider Collaborative Engagement Session

18th of July 2024

Agenda

Item No	Item	Time	Presenter
1.	Introductions and scene setting	10:00 - 10:10	**Jason Bloomfield** Customer Account Director
2.	Integrated Resource Management • Challenges & Opportunities	10.10 - 10.30	**Alison Tonge** Executive Director of Strategy/Planning and Innovation
3.	Prioritisation of Current Challenges #1 – Group Input • What are the challenges for better resource management & driving-out efficiencies	10.30 - 10.45	**Terry Huff** Productivity Lead
4.	West Yorkshire Association of Acute Trusts • Harnessing efficiencies through provider collaboratives- pathology procurement	10:45 - 11.05	**Ben Roberts** Associate Director of Finance
5.	NUH- Financial Transformation using Nottingham's Wave programme • Reducing waste and improving the quality of services of services provided	11:05 - 11:25	**Kim Fletcher** (Transformation Programme Lead NUH WAVE) **Scott Hodgson** (Head of Clinical Accounting and Costing Transformation)
6.	NHS Supply Chain • Value in Procurement	11.25 - 11:40	**Hamish Makanji** Head of Hospital Care
7.	Comfort Break	11:40 - 11:50	
8.	Opportunities for Specialised Services Delegation using the Power of new flexibilities: The Provider Selection Regime (PSR)	11.50 - 12.05	**Collette Palmer** Associate Director of Procurement (Specialised Commissioning)
9.	Prioritisation of Current Challenges #2 – Group Input • A review of Item 2 in light of knowledge shared	12.05 - 12:20	**Terry Huff** Productivity Lead
10	Summary / Outcomes / Next Steps / Close	12:20 - 12:30	**Chair**

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Health and social care systems support

Introduction

Jason Bloomfield, Customer Account Director
NHS Arden & GEM CSU

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Welcome!

1. **Purpose of this morning**
2. **A quick overview of CSU’s and NHS Arden & GEM**
3. **Challenge brings opportunity**
4. **Key messages from Month 2**

Purpose of this morning

- How can Finance and Procurement work together to drive substantial improvements and waste reduction across our health and care systems?

- What are the tools and support needed?

What are CSUs?

A little bit about Arden & GEM

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Health and social care systems support

CUSTOMERS AND SYSTEMS

90+

Working with a customer base of 90+ organisations across health systems

- NHS England
- ICSs/ICBs
- Providers
- Primary Care
- Local Authorities
- Department of Health and Social Care

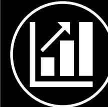
Our customer satisfaction score remains at 4.1 out of 5

Quality assurance

Certificate Number 13096

Certificate Number 13096

FINANCE



£103m
Forecast turnover for 2023/24

WORKFORCE

1200+
Multidisciplinary staff

WRES compliant
BME representation comparable to local population

Accreditation

INVESTORS IN PEOPLE®
We invest in people Gold

SERVICES AND INNOVATION

- Business intelligence and data
- IT and digital
- Healthcare consultancy
- Procurement
- Finance
- Human resources and OD
- Engagement, communications and marketing
- Clinical support

3 National award wins + 4 shortlisting's

Data-Driven Transformation for a project which improved care for people with frailty and dementia.

Service Desk of the Year in the large enterprise category

Digital solution for social care for the Adult Social Care Client Level Directions project

Challenge brings opportunity

The No.1 challenge for NHS Leaders

"How do they balance their books while protecting patient safety given many organisations are having to achieve significant efficiency savings?"

NHS Confederation – The state of NHS finances 2024/25

Challenge brings opportunity

So, what can we collectively achieve?

1. NHS Leaders plan to reduce spending on agency, locums, bank staff and freezing vacancies
2. Deliver services more efficiently
3. Redesign how care is delivered

Short term versus the longer term

- Efficiency targets need to be delivered now [5% – 11%]
- How do we address productivity in a strategic way?
- The role of social care and community settings

Key messages from Month 2

- Not where we need to be
- What do we need to do?
- Credibility

Arden&GEM

Integrated Resource Planning Network

HELPING SYSTEMS TO IMPROVE VALUE

Connected Resource Management

Benefits of connected planning across Healthcare Providers

The Triple Aim: Goals and Complex Decisions

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The Triple Aim in the NHS: The Triple Aim framework aims to improve health outcomes, improve quality of care and access and demonstrate greater efficiency and value from the investment. We have a legal duty to make good decisions

Key Decisions :

1. Reallocating Funding to the Right Care

- **Invest in Prevention and Community Services**: Shifting funds from high-cost, acute interventions to preventative and community-based care to improve overall health outcomes.

2. Releasing Funding for Reinvestment

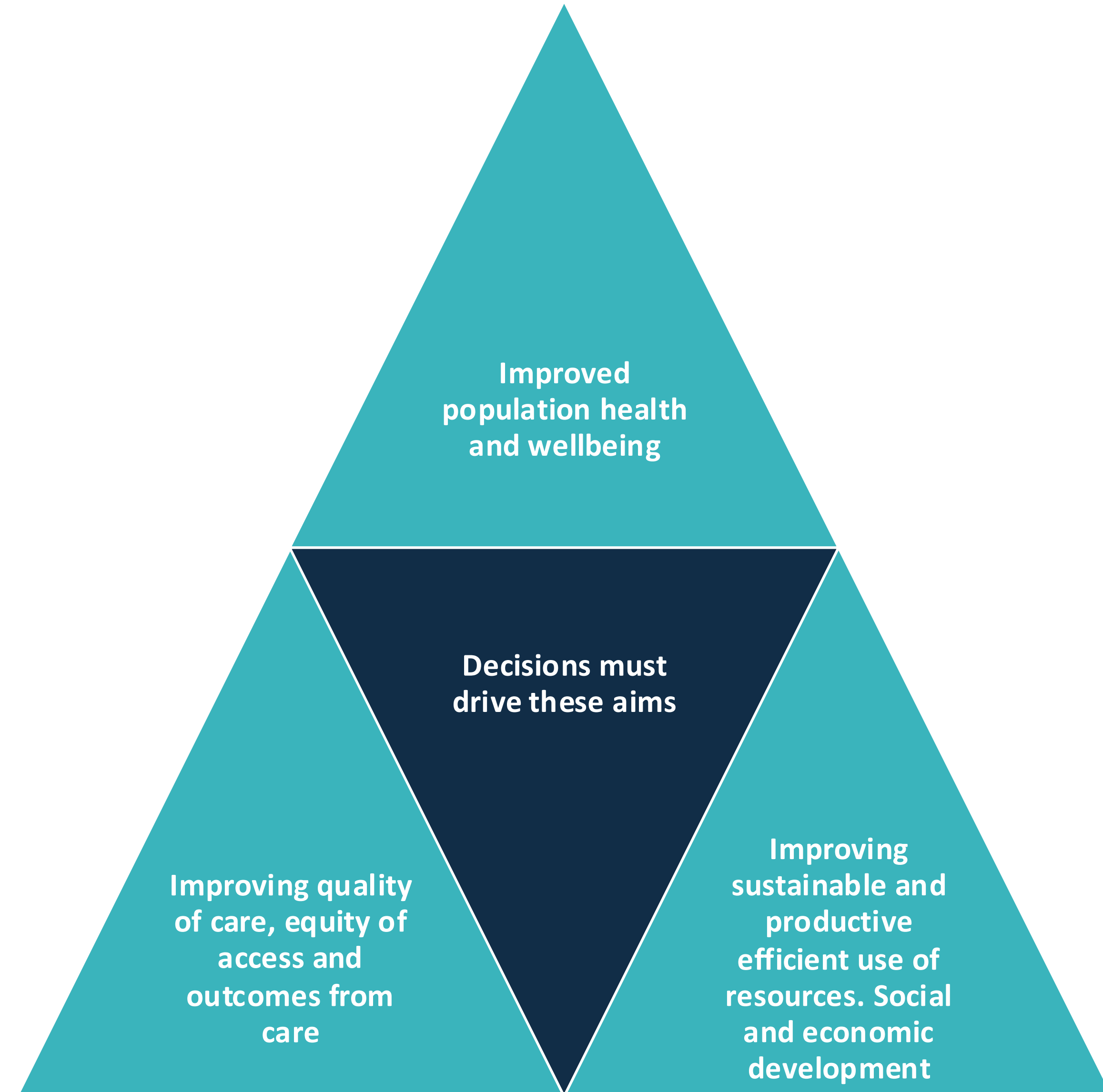
- **Focus on Productivity and Reducing Waste**: Implementing best practices, digital-first approaches, workforce efficiency, optimal utilisation, and commercial efficiencies to maximize value.

3. Delivering Care Centred Around Patients' Needs

- **Patient and Population-Focused Care**: Ensuring care is designed to meet the needs of patients and populations rather than organisational convenience.

Assurance to Stakeholders:

- **Transparency and Accountability**: Demonstrating the best use of resources to patients, taxpayers, and stakeholders through continuous improvement and measurable outcomes.



What does good decision making look like?

- Research in social sciences, economics and psychology highlights the importance of improving decision-making across four main areas.

Quality of decisions

- Decisions are framed against clear objectives, with benefit criteria and measures for impact
- Relevant and reliable information is provided across multiple measures to enable the decision.

Impact of decisions

- Outcomes from each decision choice are clear, as are trade-offs between factors such as money, capacity, workforce, performance, outcomes, quality
- Decisions are made at the right level for the impact required, at an operational or strategic level.

Action orientated

- Decisions can be acted on within a timeframe that enables the benefits to be delivered.

Productive

- Decisions are made efficiently – the organisation sets out how and where decisions are made
- Increasing the percentage of available management time for making decisions.

Improving decision-making processes alone won't enhance the value delivered by these decisions to achieve optimal results we need to have enterprise- wide resource management decisions **connected together.**

How can we connect better?

A highly connected organisation focuses on ensuring resources are managed optimally through interconnectivity of data, intelligence, processes, governance, and systems aligned across three dimensions:

Vertically – from board to operations, strategic to operational

Horizontally – across functions or delivery units working together to deliver end results, such as a pathway of care

Externally – serving populations and places to deliver value for specific population groups, e.g. frail elderly or young black males with mental illness in a neighbourhood

Connected dimensions

Dimension	Resource management capability	Best practice
Vertical	Strategic connected to operational	Roll up and roll down of operational to strategic, from monthly, quarterly and annual to three yearly.
	Connect many bottom-line measures	Each unit has a clear set of measures for triple value. Connect these unit measures across the value chain to the overall objective.
	Real-time monitoring and manage performance to deliver results	Dynamically changing plans to deliver the results required, influencing resource decisions, operational delivery.
Horizontal	Aligned roles, processes and practices	Effective and efficient cross-functional collaboration, between finance, workforce, capacity and demand.
		Cross business unit collaboration to plan the end results for a pathway of care.
	Connected data, intelligence and resource systems	A single source of intelligence across key results [triple value performance], workforce, finance, demand and capacity
External	Connect with patients, populations and places	Integrating triple value measures from target areas for biggest impact and acting on performance variation.
	Connect with suppliers, life sciences and innovators	Align supplier product value (price, quality, social value) to key pathways and business units. Align life science drugs, devices and technologies adoption decisions with consistent value framework.

Why does industry adopt enterprise wide resource management systems?

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Industry has long recognised the importance of integrating - resource management, advanced intelligence and decision functions within their organisations.
Indeed, research papers abound with empirical evidence which demonstrates the significant impact of integrating real-time operational information systems and business planning on key results such as market share, sales, efficiency and satisfaction. However there is little if any evidence in the NHS of integrated resource management and the impact on benefits for patients and populations.

Key improvements observed include:

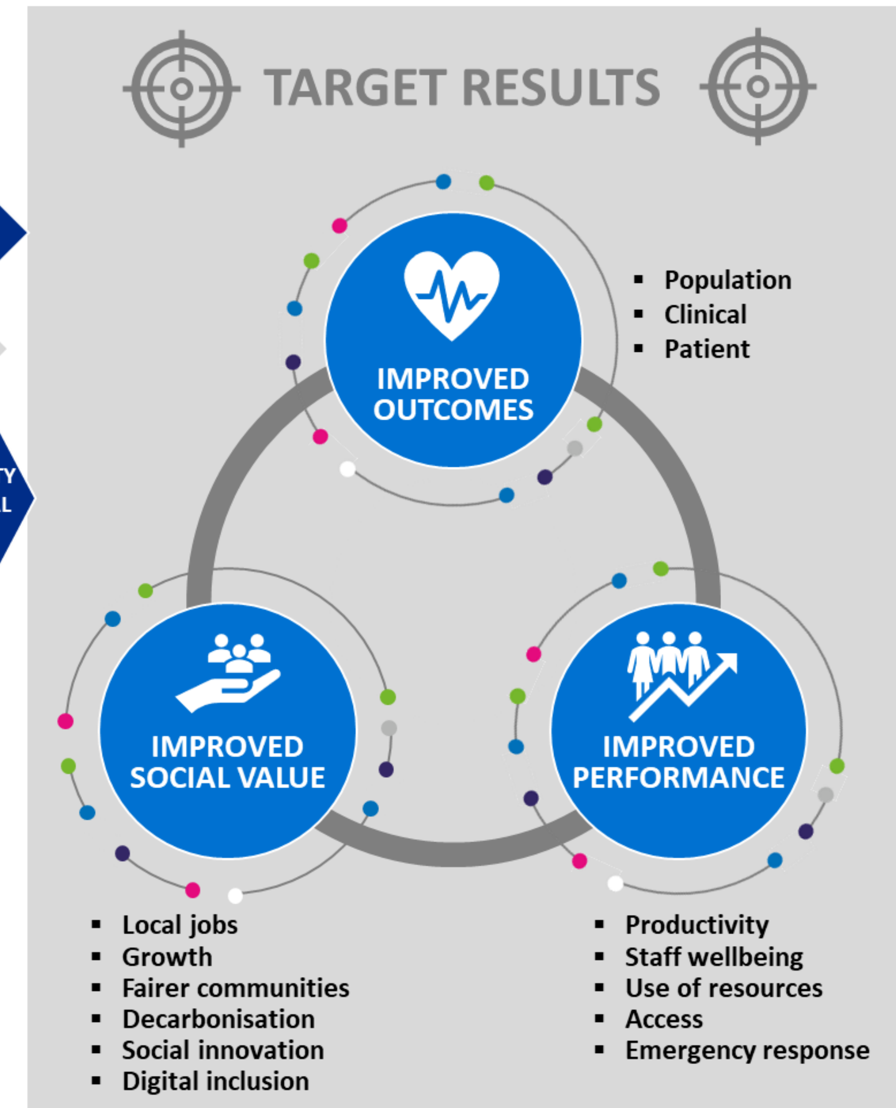
- **Increasing revenue by 52%**
- **Improving forecast accuracy by 31%**
- **Enhancing perfect order and customer service by 31%**
- **Better supply planning and schedule adherence by 31%**
- **Improving new product launch by 28%**
- **Reducing inventory by 27%**
- **Better translation of demand into procurement requirements by 21%**
- **Improved capital planning and asset management by 21%**
- **Developing and executing demand-shaping programs by 20%**
- **Enhancing logistics planning by 19%**
- **Improving asset utilisation by 17% (Palmatier & Crum, 201**

Our Approach to Connected Planning

KEY PRODUCTIVITY AND EFFICIENCY STANDARDS AGREED

Models

TRANSFORMATION INITIATIVES



Our Service - the Centre of Integrated Planning-driving performance through connected planning

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Anaplan

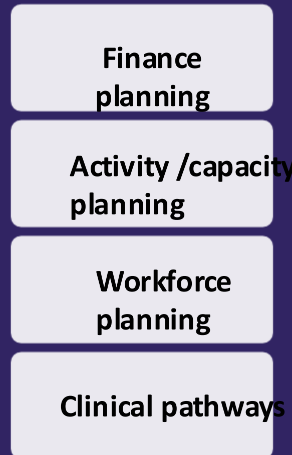
- *The centre enables members to benefit from development of integrated planning models for the NHS.*
- *Shared learning and best practice on achieving high performance in resource management methodologies, interventions, modelling scenarios, forecasting and governance controls.*
- *Utilising an industry best practice technology solution to facilitate integrated planning through a suite of models*
- *Services delivered to the NHS by the NHS*

The Centre of Integrated Planning includes a Data Hub for centralised decision-making, a Design Authority for quality design processes, structured Model Development Process, a Community of Practice for sharing best practices, and a Standard Business Case and ROI framework for evaluating investments.

We are continuing to work with a range of external partners to accelerate our development of this centre of excellence.

Communities of practice- Adopt and Learn

Pre-Built Models



Centre for integrated resource planning team

Results from Connected Decisions

- These examples illustrate the tangible benefits of connected decision-making in the NHS, highlighting the potential for improved productivity, efficiency, and collaboration across health and care systems.
- ***Example 1: Financial planning and productivity gains***
- By integrating financial planning metrics, NHS Trusts have demonstrated significant productivity gains. For instance, one Trust's approach to financial planning has resulted in each full-time equivalent (FTE) employee saving 3-4 days per month previously spent on manually aggregating and adjusting data for resubmission into their general ledger. This translates to a 20% productivity gain each month, regardless of the organisation's size. Furthermore, by connecting finance with workforce data, budget holders are saving 20% of their time previously spent on spreadsheets, allowing them more time to advise operational staff effectively.
- ***Example 2: System demand and capacity planning***
- An Integrated Care System (ICS) has implemented an integrated business planning platform. This platform replicates NHS England planning submissions with connected assumptions and scenarios, consolidating ICS-wide reporting. The pilot project demonstrated several benefits:
- A system-wide view of demand and capacity on beds and services for acute, community, local authority, and hospice services
- Dynamic reports viewed across different dimensions and levels of detail to improve operational efficiency
- Forecasting capabilities allowing users to adjust factors like admissions and capacity to understand their impact on demand and capacity shortfall
- Improved collaboration between system partners, creating a shared understanding and facilitating targeted actions to improve patient/service user flow through the system.

Projected Financial Savings

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The Ambulance Trust is on the brink of a significant overhaul, poised to replicate the successful ICS digital transformation. By implementing a series of IT enablers, the Trust is expected to realise substantial financial and operational benefits. This case study outlines the projected potential benefits, extrapolated from the achievements witnessed by the ICS in the same region.

Initiatives for Transformation:

The proposed IT enablers for include:

- **Integrated Planning** - Creating robust forecasting mechanisms for demand-driven workforce planning.
- **PAS/Bank/Agency Integration** - Enhancing resource allocation and management to align with actual service demand.
- **GRS – Time & Attendance** - Implementing automated timesheet systems to ensure accurate payroll processing.
- **Virtualised Scheduling** - Developing a trust-wide rostering system for improved staff and bed management, operational 7 days a week.

Anticipated Financial Benefits with extrapolated data from the achievements witnessed by Mids & South Essex FT implementing the same enablers:

Financial Benefit Areas	Description	ICS Quantitative Achievement	Potential Annual Savings for the ICS
Reduced Readmissions	By analysing complex discharges and using shared information systems, the ICS achieved a 5% reduction in emergency readmissions post-discharge.	5% reduction on 1176 potential readmissions = 58.8 fewer readmissions	**£94,980.80** (at **£1,616** per readmission)
Improved Patient Flow	The ICS targeted delays in care and improved patient flow by 5%.	5% improvement on 23,725 lost bed days = 1,186.25 recovered bed days	**£296,562.50** (at **£250** per bed day)
Virtual Wards	The ICS utilised the excess capacity of 31 beds in virtual wards.	Savings from 31 virtual ward beds	**£582,800.00** (at **£18,800** per virtual ward bed annually)
Total Annual Savings	Projected Total Annual Savings	--	**£974,343.30**

Note: total annual saving of approximately **£974,343.30** by adopting the strategies that have proved successful in the ICS.

Integrated Business Planning (IBP)

The IBP is a **dynamic planning platform**, that is informed by actual performance and reforecasting. It provides analysis across 5 integrated elements to allow for **dynamic planning decisions**, preventing a static annual process.

OLD WORLD

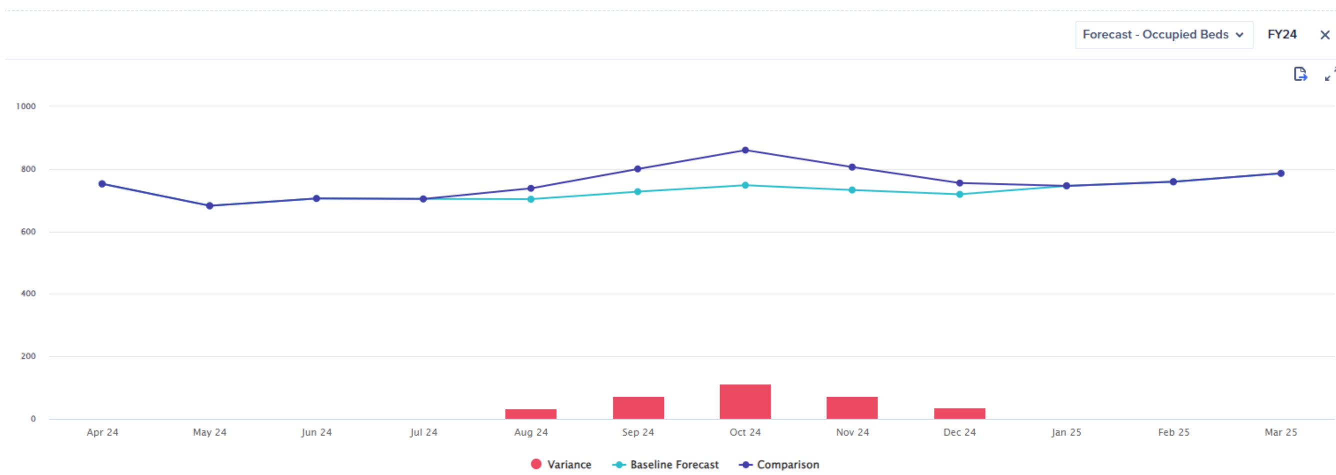
- Disjointed
- For the few
- Target driven
- Subjective
- Excel by default
- Plan only
- Static
- Negative

NEW WORLD

- Connected
- Collaborative
- Decision driven
- Optimised
- Purpose built
- Executable
- Agile
- Positive

Forecast and plan variations with optimiser calculation

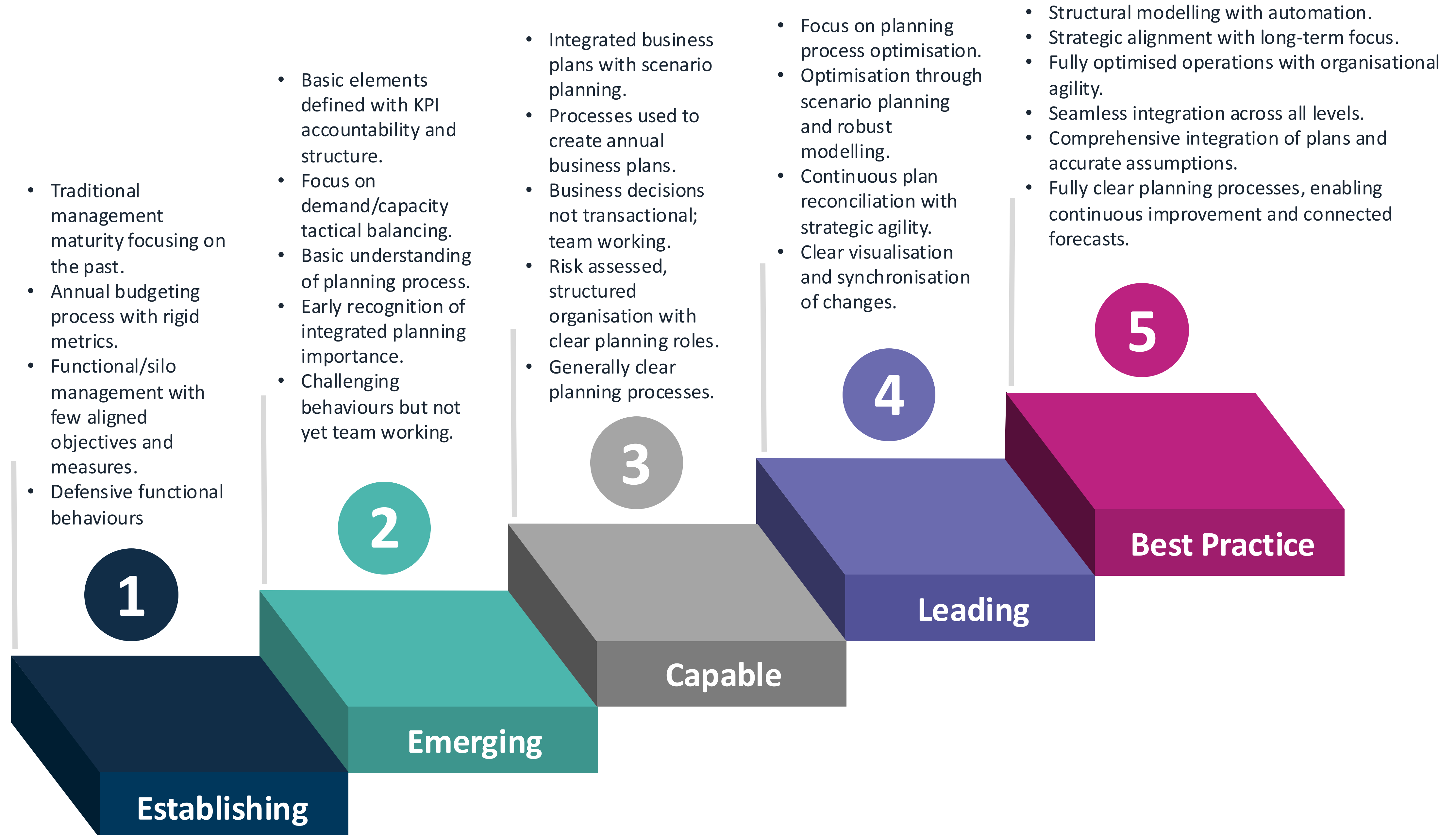
	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Forecast- Admission	3,707	4,577	3,724	3,712	4,900	4,155	4,508	5,360	4,197	3,994	5,020	4,157
Forecast - AVG LoS	5.7	5.7	5.7	5.7	5.7	5.7	5.7	5.7	5.7	5.7	5.7	5.7
Forecast - Discharges	3,631	4,647	3,701	3,713	4,866	4,093	4,448	5,414	4,248	4,002	5,008	4,130
Forecast - Occupied Beds	752	682	706	704	738	800	860	806	755	746	759	786
Forecast Bed Capacity	707	707	707	707	707	679	679	679	650	650	650	650
Forecast - Occupancy	97%	98%	98%	98%	103%	113%	123%	119%	122%	115%	115%	119%
Forecast - Surplus/(Deficit)	-45	25	1	3	-31	-121	-182	-127	-104	-96	-109	-136



	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Occupancy %	96.6%	98.1%	98.1%	98.3%	103.3%	113.3%	123.1%	119.2%	122.0%	115.2%	115.4%	119.0%
Input Target Ocupancy %	-	-	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%
**												
Adjust Admission by			-7.70%	-7.91%	-13.42%	-26.67%	-38.92%	-32.45%	-37.53%	-29.01%	-27.91%	-33.87%
Adjust LoS by			-0.35	-0.36	-0.64	-1.20	-1.76	-1.54	-1.69	-1.31	-1.32	-1.53

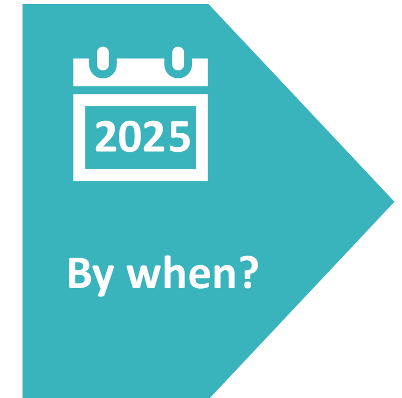
- **Multi-year multi-site demand and capacity planning model linking in hospital and out of hospital activity**
- **Machine learning** provides a baseline forecast of future expected demand, allowing for weekend and seasonal variations
- **Data and forecasts** are refreshed on a weekly basis through a managed service and users can compare current forecasts to historic to measure impact of any interventions introduced.
- End user can **test scenarios** to understand the impact of varying capacity, admissions, and length of stay on demand. These scenario impacts can then easily be compared to the baseline
- Tool further supports strategic planning through an **optimiser calculation**. If a user wants to achieve a target level of occupancy, e.g. 92%, they receive an indication of either the change in admissions or length of stay required to achieve this target.

Taking the temperature of connected planning in the NHS



A diagnostic support

Level	Maturity Characteristics
Level 1: Establishing	- Traditional management maturity focusing on the past. - Annual budgeting process with rigid metrics. - Functional/silo management with few aligned objectives and measures. - Defensive functional behaviours.
Level 2: Emerging	- Basic elements defined with KPI accountability and structure. - Focus on demand/capacity tactical balancing. - Basic understanding of planning process. - Early recognition of integrated planning importance. - Challenging behaviours but not yet team working.
Level 3: Capable	- Integrated business plans with scenario planning. - Processes used to create annual business plans. - Business decisions not transactional; team working. - Risk assessed, structured organisation with clear planning roles. - Generally clear planning processes.
Level 4: Leading	- Focus on planning process optimisation. - Optimisation through scenario planning and robust modelling. - Continuous plan reconciliation with strategic agility. - Clear visualisation and synchronisation of changes.
Level 5: Best Practice	- Structural modelling with automation. - Strategic alignment with long-term focus. - Fully optimised operations with organisational agility. - Seamless integration across all levels. - Comprehensive integration of plans and accurate assumptions. - Fully clear planning processes, enabling continuous improvement and connected forecasts.



Q&A

Open Discussion:

- We invite the audience to ask questions and share their thoughts.

Thank you. We are dedicated to supporting your journey towards higher levels of integrated business planning maturity.

For further information and next steps, please contact: agem.integrated-planning@nhs.net

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NHS Arden & GEM CSU IBP Maturity Self Assessment Tool

NHS Arden & GEM CSU IBP
Maturity Self Assessment Tool

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HELPING SYSTEMS TO IMPROVE VALUE

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www.ardengemcsu.nhs.uk

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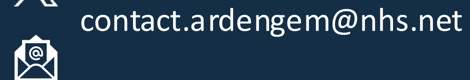
contact.ardengem@nhs.net

Prioritisation of Current Challenges – Group Input

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- Urgency – How Immediate is the need to address the challenge ?
- Impact – How significantly does the challenge impact on the health & care system ?
- Strategic Alignment – Does solving the challenge align with our strategic objectives ?
- Connected Planning – How will connected planning help address this challenge ?

Prioritisation of Current Challenges #2 – Group Input

- What challenges are highest priority - to address in next 6-12 months?

- What would be your measures of success a year from now ?

(savings , enhanced productivity, reduced waiting lists etc)

- Key next steps ?

- Identified leads to take forward ?

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West Yorkshire Association of Acute Trusts (WYAAT)

Ben Roberts

Associate Director of Finance

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@WYAAT_Hospitals

West Yorkshire
Association of Acute Trusts

What is WYAAT and why does it exist?

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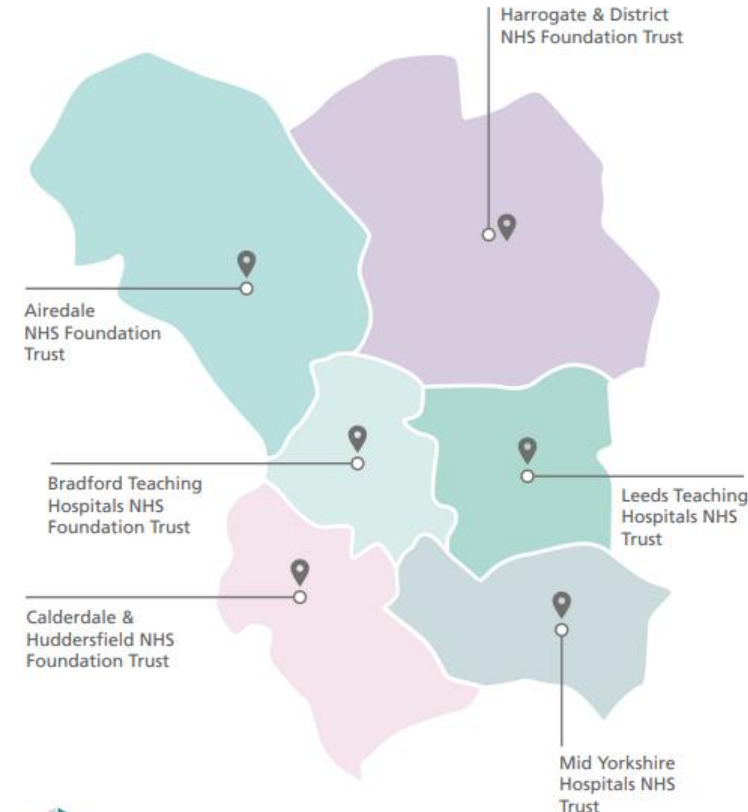
- Collaboration of the **six acute trusts** in West Yorkshire & Harrogate
- **Self-funded** by the trusts
- Forum for acute trusts; a **single voice** into the HCP
- Providing a mechanism to **share best practice** and **learn from each other** to tackle **unwarranted variation or inequalities in access, outcomes and experience**
- Delivery of **acute trust focused change programmes**
- Leadership of wider programmes **on behalf of the ICS**
- Facilitates **clinical, operational collaboration** & mutual aid
- **Prioritising** and planning **system investments** in acute services
- **Only** what the trusts do together and the decisions they take together
- **Not** an organisation
- **Not** "doing things to" the trusts



The West Yorkshire Association of Acute Trusts is made up of six trusts working closely together to plan health and care services across the area.

West Yorkshire Association of Acute Trusts

WYAAT Collaborative Programmes

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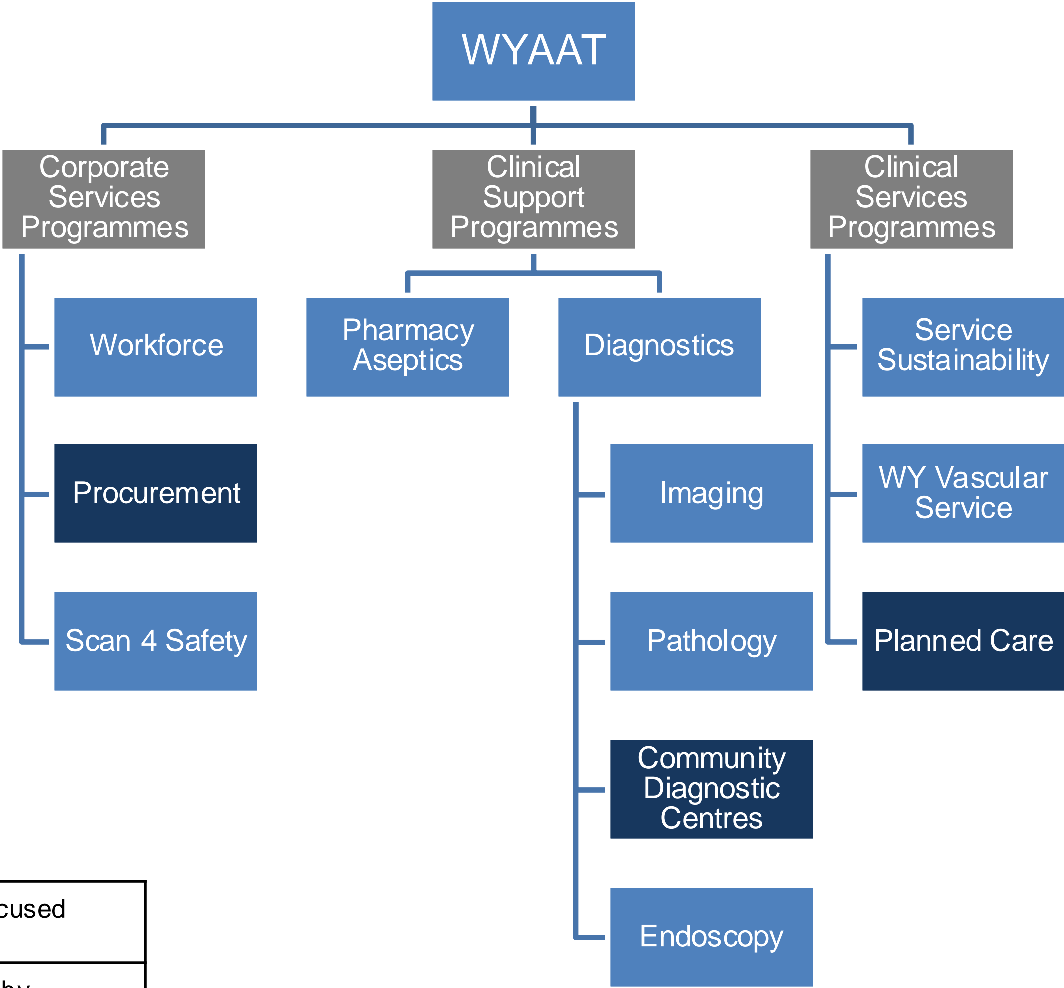
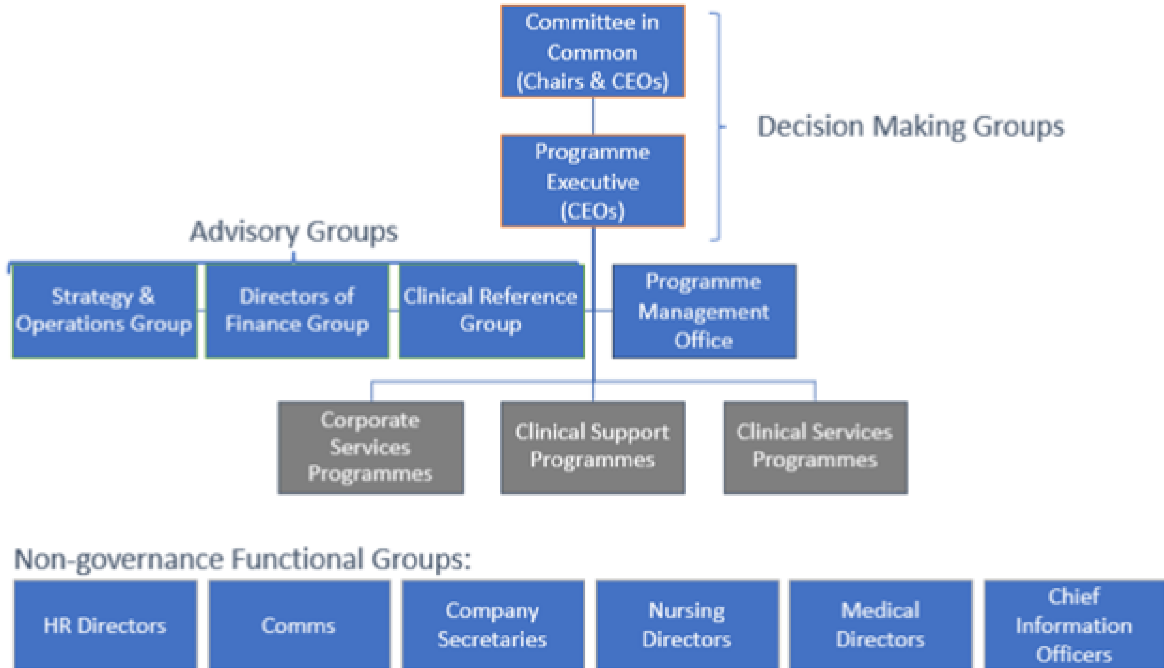


(light blue)	WYAAT acute focused programmes
(dark blue)	Programmes led by WYAAT on behalf of the WY ICB

West Yorkshire Association of Acute Trusts

Governance



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Change is going to happen

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Background

- Carter Report 2016 identified the need to consolidate Pathology services
- From 112 units to 29 hub & spoke networks
- Consolidating LTHT, CHFT & MYTT = “The Collaborative”
- Key enabler, procuring a single MSC covering:
  - 80% of testing volume of the 4th biggest ICS
  - For 7 years + 7 years
  - Including growth
  - Regional Genomics wet lab
  - Covid?
- £475m contract, in the one of the most litigious markets

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Competing Priorities

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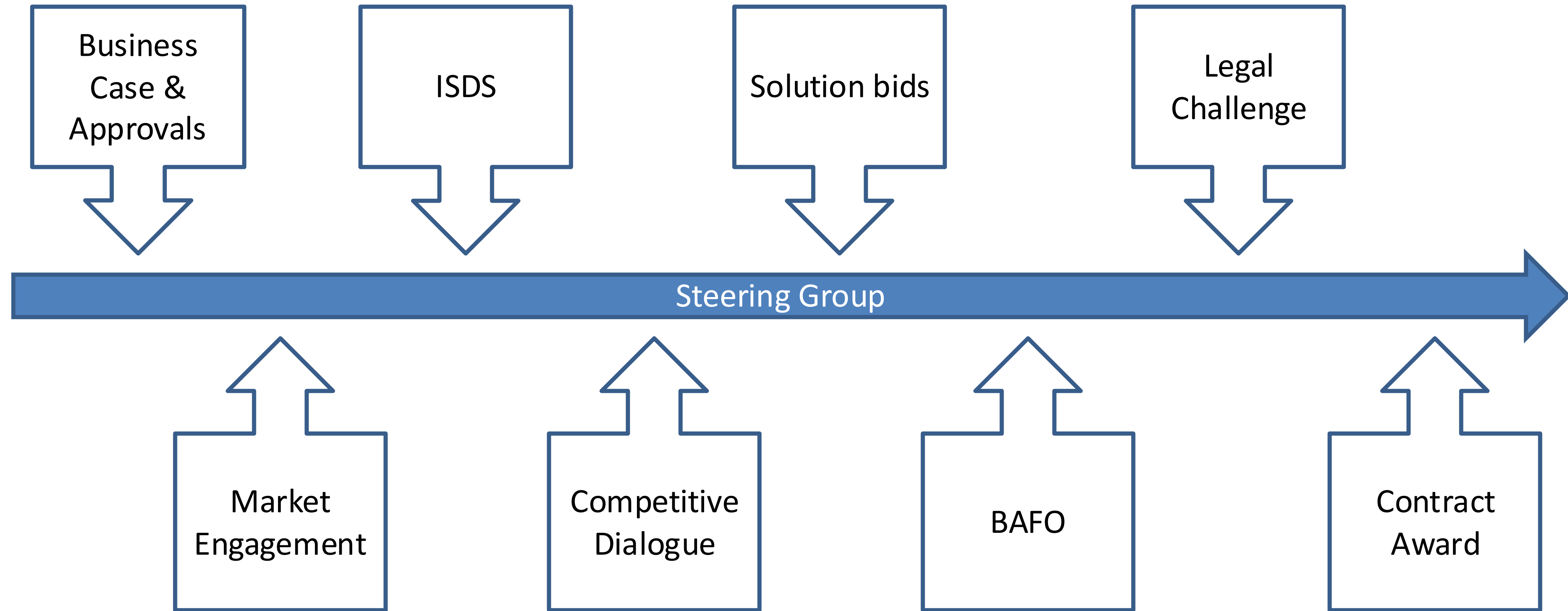
The Plan



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The Plan

Business Case & Approvals

ISDS

Solution bids

Legal Challenge

Steering Group

Market Engagement

Competitive Dialogue

BAFO

Contract Award

3.5 Years

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The market says….

- No one will bid without committed volumes
- No one will bid with inflation controls
- No one will bid with our KPIs
- No one will accept our T&Cs

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The market says....

- No one will bid for no committed volumes
- No one will bid with inflation controls
- No one will bid with our KPIs
- No one will accept our T&Cs
- **We had multiple bidders at every stage!**

Legal Requirement

Fair, transparent & proportionate

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The Challenge

FOR HEALTHCARE LEADERS
HSJ
Part of Wilmington Intelligence

EMILY TOWNSEND
Why stalling of reforms could hit service improvement

SECTORS TOPICS LOCAL COMMENT INTERACTIVE EVENTS JOBS PRODUCTS &

FINANCE AND EFFICIENCY

Three trusts taken to High Court in £475m contract row

By Jack Serle | 21 June 2023

14 Comments

- Provider accuses trusts of breaking procurement rules when awarding pathology deal
- The three Yorkshire trusts deny the allegations made against them
- The case, which is being heard by the High Court, is on-going

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Good News Story

FOR HEALTHCARE LEADERS
HSJ
Part of Wilmington Intelligence

EMILY TOWNSEND
Why stalling of reforms could hit service improvement

SECTORS | TOPICS | LOCAL | COMMENT | INTERACTIVE | EVENTS | JOBS | PRODUCTS &

FINANCE AND EFFICIENCY

Trusts to award £500m pathology contract after legal challenge dropped

By Jack Serle | 5 July 2023

4 Comments

- Supplier withdraws effort to overturn award of £475m, 14-year contract for pathology services
- Decision to halt legal process clears way for Yorkshire acute trusts to award contract to their preferred bidder

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The Good News cont.

- Individual procurements = £12m of savings
- As a collaborative = £30m of savings
- Enabling a further £39m from consolidation
- 1st time versus 4th time
- Sharing the learning

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We’ve Changed the Game

*“And we can infer from the fact that late last month, it decided to drop the challenge, freeing up the trusts to continue with awarding the contract to Siemens, **that the original calculations had changed**.”*

HSJ Daily Insight: 6th July 2023

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Got a few dinners out of it....

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Critical to Success

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Questions

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East Midlands HFMA Conference

NUH WAVE & GIRFT

Kim Fletcher – Transformation Programme Lead – WAVE

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Scott Hodgson – Head of Clinical Accounting & Costing Transformation

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Concentrate on….

- Improvement Methodology WAVE (Working to Achieve Value & Excellence)
- Evolution of GIRFT (Getting It Right First Time)
- How we use data to improve

Working to Achieve Value & Excellence (WAVE)

The purpose of WAVE is to facilitate Specialties in identifying and scoping for delivery projects which contribute to NUH Strategic goals covering operational, financial and patient risk.

The WAVE cycle is 17 weeks in total with weekly cadence – aim for 12 specialties p/a

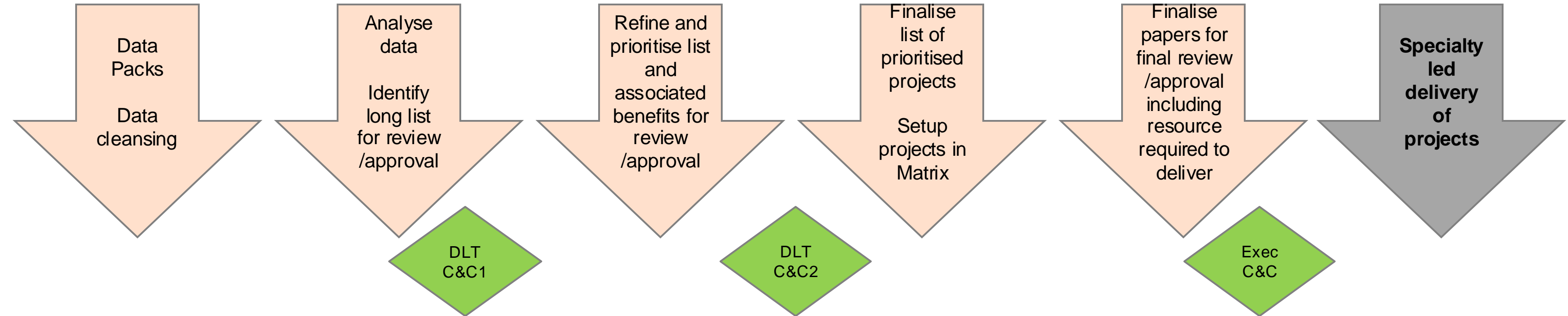
Core Specialty Representation - Head of Service, Matron, SGM/AGM

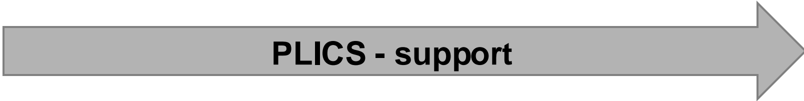
Core Corporate Representation – Programme Lead, PLICS, Finance, Data Analyst

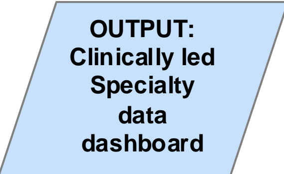
3 stage process - Data Cleanse, QI/Waste and Planning with gateway approvals by the DLT and Exec approval of the prioritised projects which have been shaped for delivery at the end of the WAVE

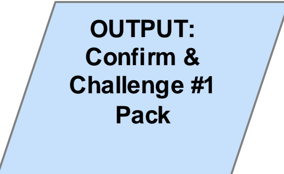
Exec supported process

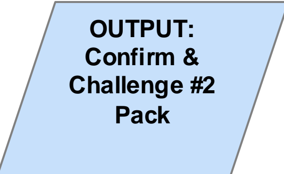
Overview of key activities, expectations & outputs

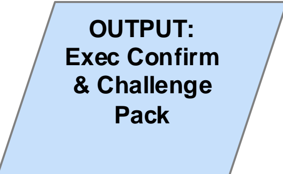


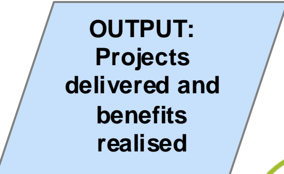


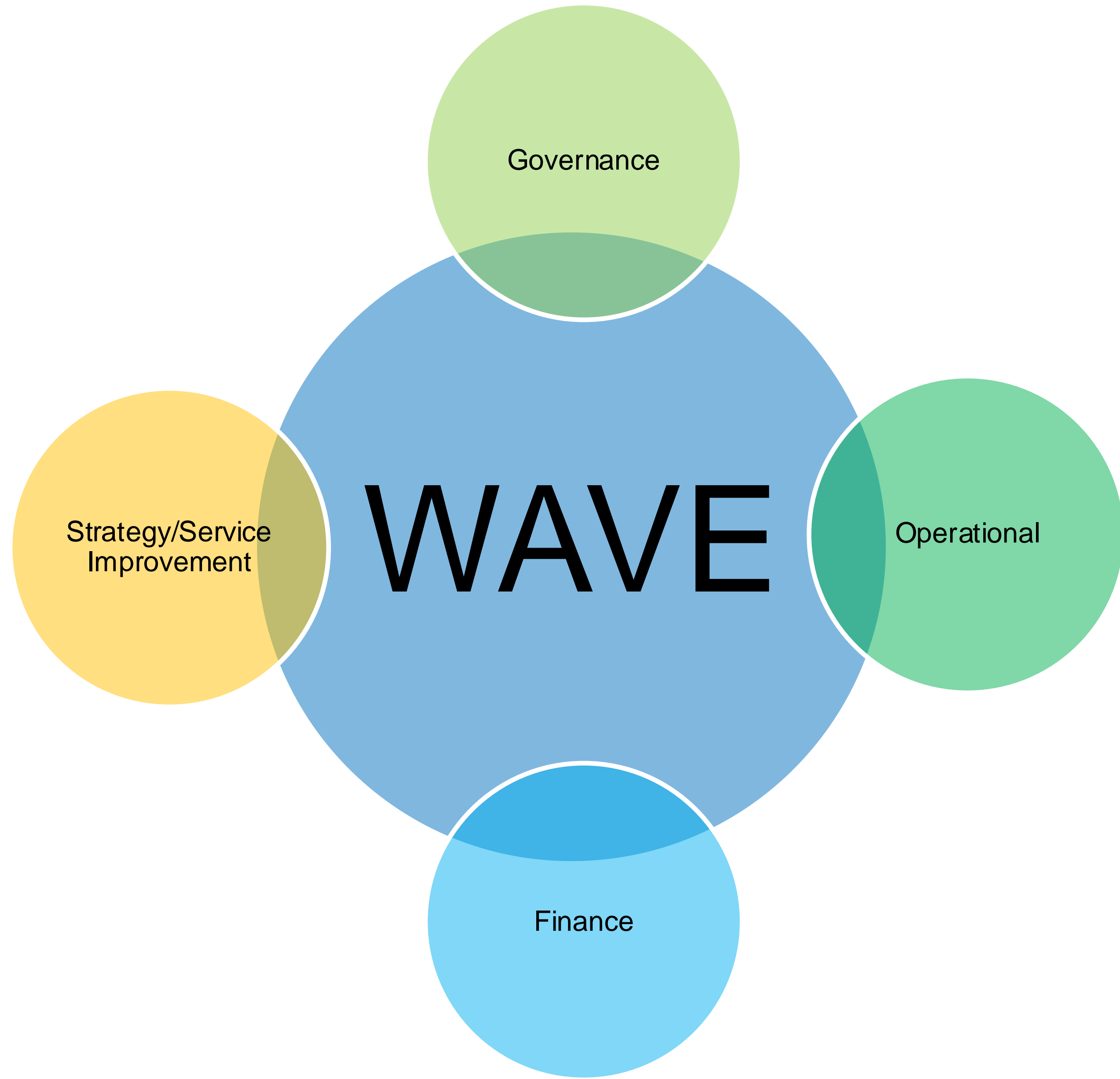











Governance
Strategy/Service Improvement
WAVE
Operational
Finance

What’s Working Well…

- Nationally Recognised as Best Practice (EVO One NHS Finance, HFMA Costing Awards, ICB Value for Money, Projects national/international awards)
- Articles within HFMA – Spines & Paediatric WAVES
- Financial Opportunities 6 years to 19/20 - £51m identified, £29.5m achieved (56%)
- QI/Waste Opportunities 20/21 to current
  - 236 projects
  - £23m identified (129 prioritised projects)
- Huge Clinical buy-in
- Link into wider system for improvements across the ICB – Mobile Stroke Unit & Palliative Care Virtual Ward plus Breast/Urology WAVE across the ICB inc Sherwood Forest Trust
- Creating sustainable continuous improvement – long list of opportunities, training, skills, medium term strategic plans formulated for services
- Delivery Resources

Programmes/Projects Outcomes – last 12 months

- Development of Business cases and funding approved for
  - Paediatric Medical Day Case Unit
  - Renal Home Therapies rightsizing
  - Breast 2ww pathway
- Design and development of new MRI Express pathway
- Funding for play specialist intervention in GA MRI
- Development of new nurse led discharge protocol & training within Paeds Day Case surgery
- SDEC both Adults & Paeds
- Genomics Nanopore Technology
- Mobile Stroke Unit
- Virtual Wards
- Reducing Health Inequalities for 'Was Not Bought' in Paeds OP
- 'Trigger Tool' for Palliative Care Patients
- Combined Hand Surgery Service (T&O & Plastics)

WAVE Evaluations (last 15 services)

- **Q1** – How would you rate your current understanding of your financial position/performance?
  - Pre Wave: 1 2 3 4 **(5)** 6 7 8 9 10
  - Post Wave: 1 2 3 4 5 6 7 **(8)** 9 10

- **Q2** – How would you rate your current understanding of the PLICS system?
  - Pre Wave: 1 2 **(3)** 4 5 6 7 8 9 10
  - Post Wave: 1 2 3 4 5 6 **(7)** 8 9 10

- **Q3** - How would you rate your current understanding of Waste and Quality Improvement?
  - Pre Wave: 1 2 3 4 **(5)** 6 7 8 9 10
  - Post Wave: 1 2 3 4 5 6 7 **(8)** 9 10

- **Q4** - How likely are you to use the PLICS system to identify Waste & Quality Improvement opportunities?
  - Pre Wave: 1 2 **(3)** 4 5 6 7 8 9 10
  - Post Wave: 1 2 3 4 5 **(6)** 7 8 9 10

- **Q5** - How would you rate your current understanding of the Trust PMO system (Matrix)?
  - Pre Wave: 1 2 **(3)** 4 5 6 7 8 9 10
  - Post Wave: 1 2 3 4 5 6 7 **(8)** 9 10

- **Q6** - How useful do you think the WAVE programme has been to your service?
  - Pre Wave: 1 2 3 **(4)** 5 6 7 8 9 10
  - Post Wave: 1 2 3 4 5 6 7 8 **(9)** 10

NUH WAVE
Working to Achieve Value and Excellence

Evolution of GIRFT

2021

Specialty Focus

2022

High Volume Low Complexity

Right Procedure Right Place

Theatres Productivity

Transforming OP's

2023

Further Faster

Cancer Reporting

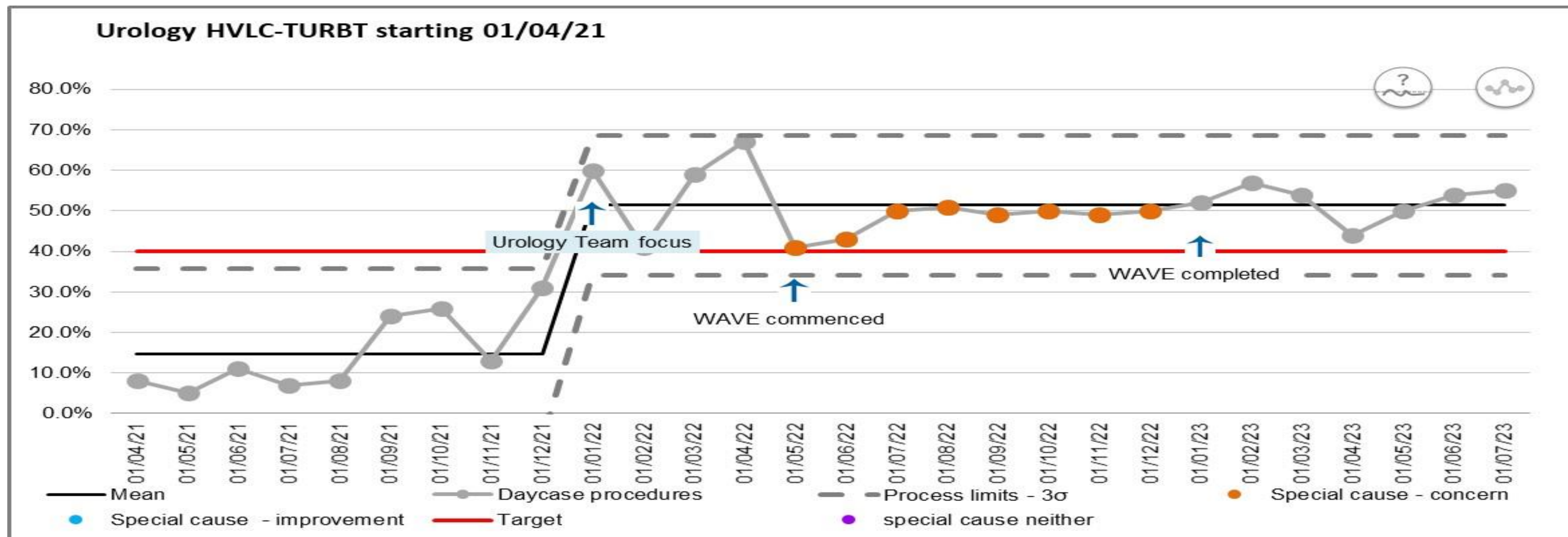
ICB Reporting

- NUH is an exemplar Trust for GIRFT
- HVLC – from lower quartile to upper quartile nationally - £2.1m efficiency
- RPRP – ENT - Transfer 1,400 procedures from Theatres to Outpatient Procedure Room
- GIRFT Innovation Board

NUH WAVE
Working to Achieve Value and Excellence

Outcomes – HVLC Urology

	21/22	22/23	M6 actual 23/24	M6 ADJ actual 23/24	M6 cum 23/24	M6 ADJ cum 23/24	Peer	Benchmark
TURBT	24%	54%	53%	53%	51%	54%	46%	43%
Ureteroscopy	39%	62%	57%	61%	55%	61%	76%	80%
Cystoscopy	62%	69%	77%	77%	71%	81%	84%	80%
Minor Peno Scrotal	93%	92%	100%	100%	97%	98%	89%	96%
Bladder Outflow Obstruction	13%	10%	47%	47%	42%	46%	28%	25%



NUH WAVE
Working to Achieve Value and Excellence

GIRFT

GETTING IT RIGHT FIRST TIME

NHS
Nottingham University Hospitals
NHS Trust

National requirements

Litigation

GIRFT litigation data packs for medical and surgical specialties are shared with trusts to encourage the triangulation of learning from claims, incidents, complaints and inquests.

HVLC

The High Volume Low Complexity (HVLC) programme is a priority data-led transformation programme supporting the recovery of elective care services post COVID-19 pandemic. It aims to reduce the backlog of patients waiting for planned operations, improve clinical outcomes and access to services through standardised clinical pathways.

RPRP

Supporting providers in moving procedures to the most appropriate setting, from traditional theatres to outpatient and community settings

Theatres productivity

To support elective recovery, GIRFT is helping to lead a national theatre programme which aims to draw together all key national workstreams engaged in improving theatre productivity, efficiency and workforce.

Further faster

'Further Faster' programme has is planned to deliver rapid clinical transformation with the aim of reducing 52-week waits.

Clinical transformation groups have been established across16 specialties, involving clinical leads from across the trusts as well as national speciality leads, and other key stakeholders.

Transforming outpatients

Guidance has been produced which pulls together concise summaries of condition-specific advice for 17 specialties with high numbers of +78 week waits, as well as a support focus on common themes and challenges in the outpatient department, such as remote consultation, reducing DNAs, and driving patient initiated follow-up (PIFU).

Deep dives / National speciality reports

GIRFT's drive to identify and reduce unwarranted variation and learn from top-performing trusts continues through the publication of national specialty reports and clinical guidelines, and regular engagement with trusts to help gain insight and a true understanding of care delivery across England.

NUH

Litigation

Report 2023 not received yet

HVLC

TIM Paeds

6 focus services:

Urology
EO
Ophthalmology
Gen surg
ENT
Gynae

RPRP

Paper to agree utilisation of free space

ENT procedure room business case

Mini c arm case

Theatres productivity

Standby patient

Golden patient

Emergency theatre demand and capacity - NEGGS list

Further faster

Governance TBC

Funding potential for Lap chole list

Data mining opportunity

Virtual wards

Trauma TBC

Paeds surgery TBC

Work with Heather to determine further GIRFT opportunities

Transforming outpatients

Clinic template cleanse

Text reminder policy

12 week text

PIFU

Deep dives / National speciality

Governance TBC

Meeting coordination to be overseen by GIRFT lead

Representation TBC

Pathology stewardship

Led by chief reg - Planned to start 15th of Jan.

Trust wide roll out TBC

Digital enablers

E-meet and greet

Awaiting funding - requirements to be met

Patient portals - Statement of intent Nerve Centre

Day case surgery

B floor opportunity - WIWO

Increase utilisation of DSU at City

Day case digital admission

Group job planning

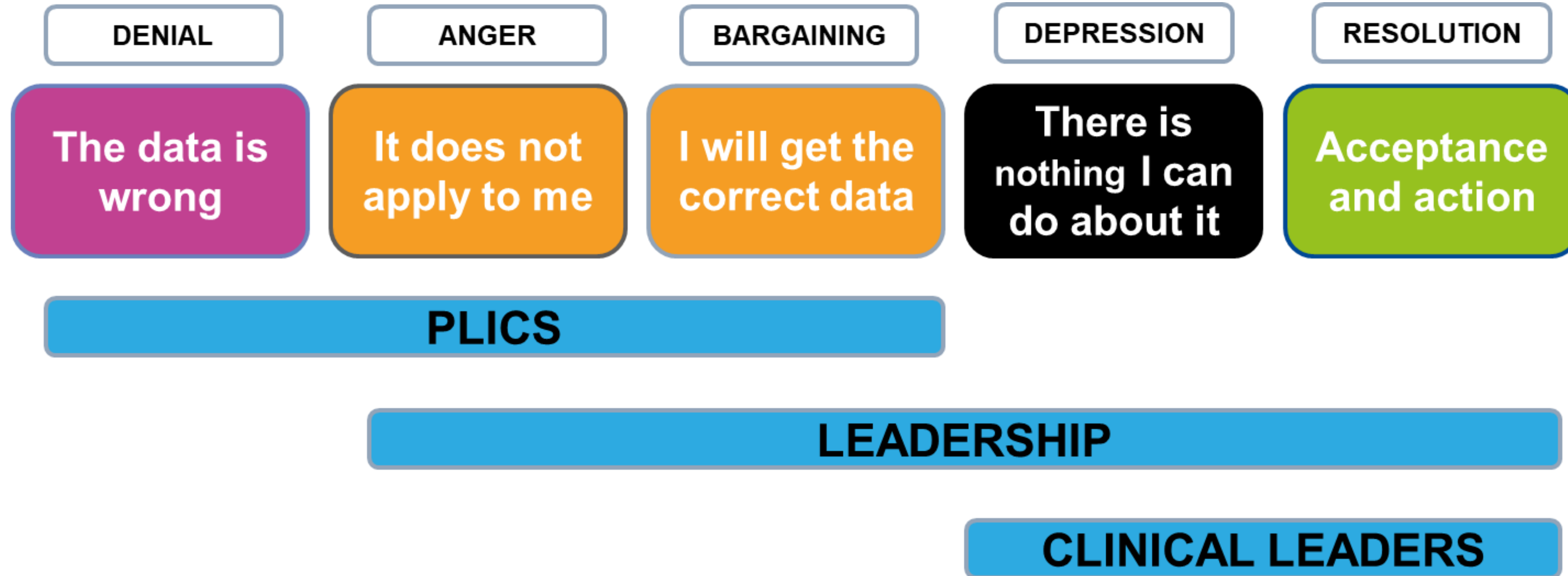
ENT Ongoing

Explore opportunity with Helen W

You seldom improve quality by cutting costs, but you can often cut costs by improving quality.
Karl Albrecht
quotefancy

NUH WAVE
Working to Achieve Value and Excellence

The Data Grief Cycle

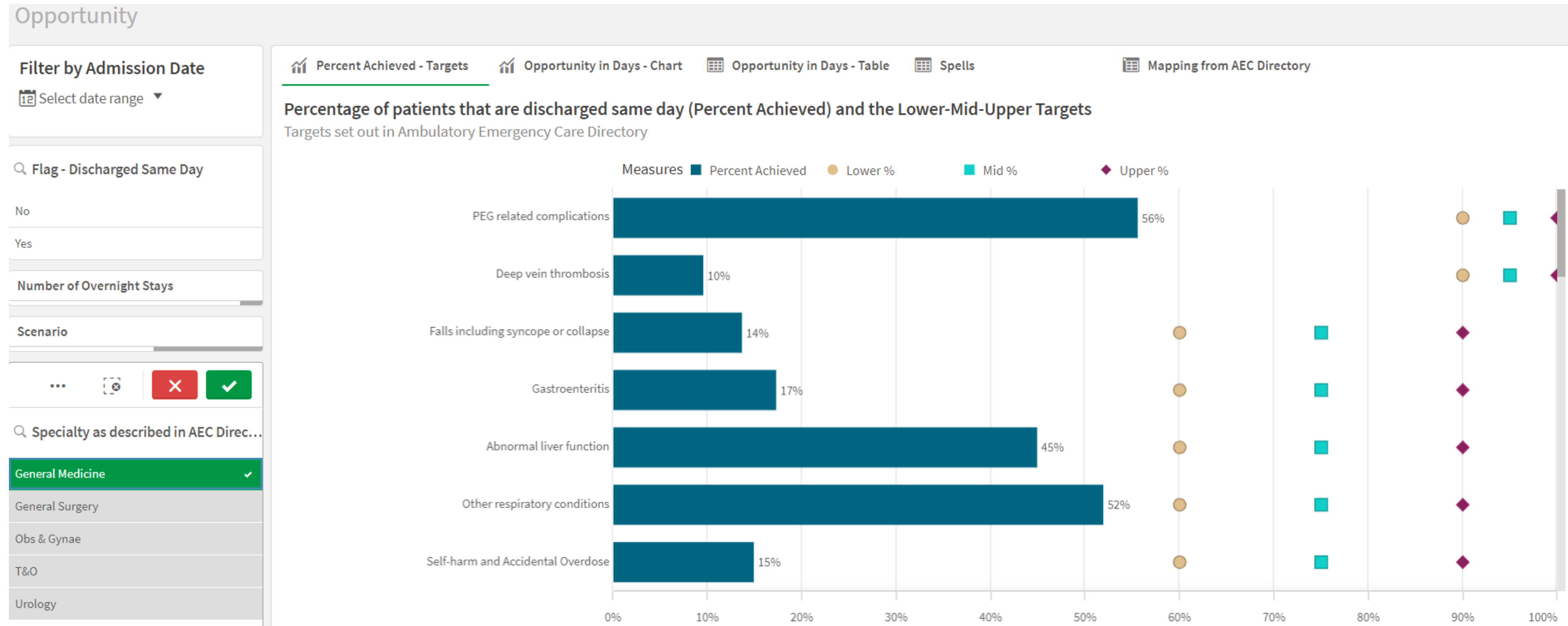


Linus's Law "given enough eyeballs, all **bugs** are shallow"

i.e. Let's jump into the "sandpit" and explore our Data!!

NUH WAVE Working to Achieve Value and Excellence

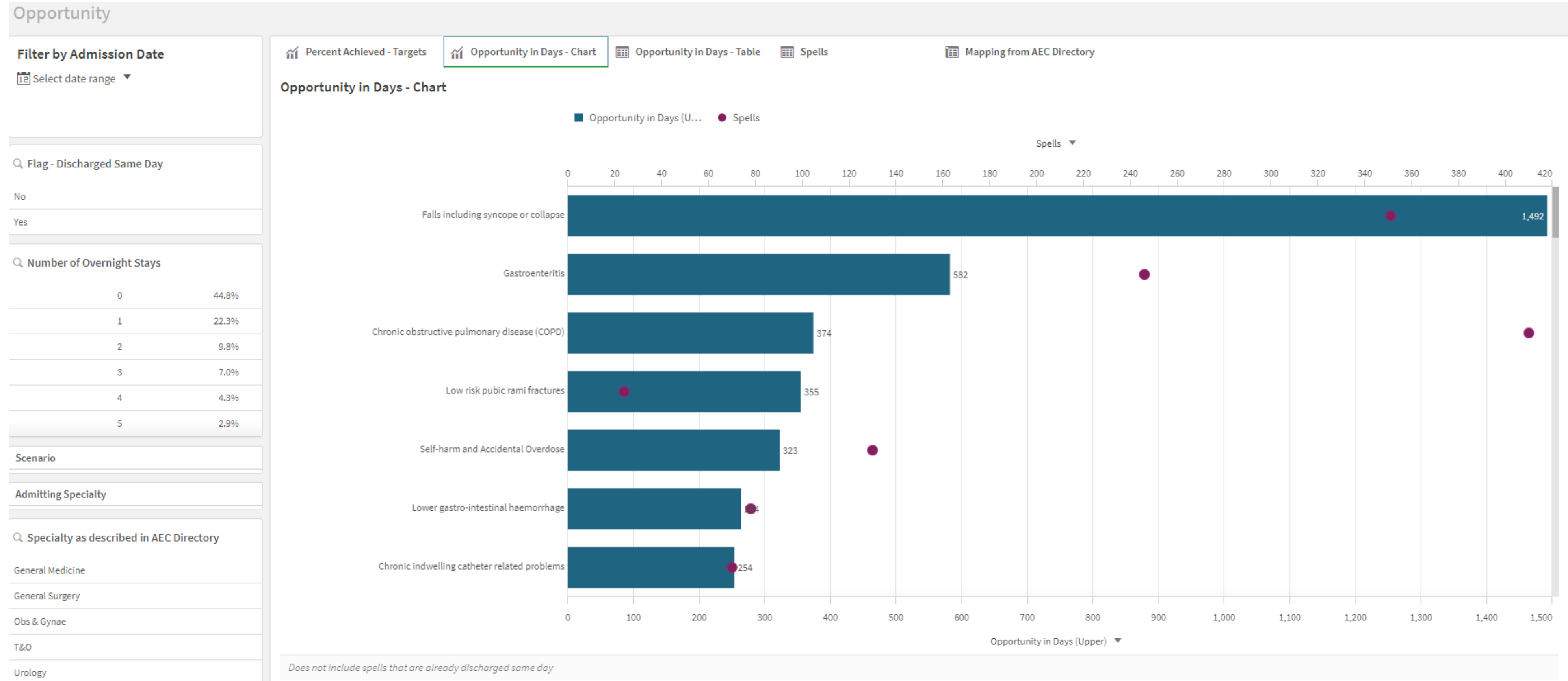
PLICS – SDEC (1)



- Highlights where specialties are performing against SDEC targets
- Shows data by the Ambulatory Emergency Care Scenarios
- Full drill down to patient detail – Sankey charts showing flow

NUH WAVE
Working to Achieve Value and Excellence

PLICS – SDEC (2)



- Show opportunity in days against each scenario
- Full drill down to patient detail

NUH WAVE
Working to Achieve Value and Excellence

PLICS – High Volume Low Complexity

Endo sinus surgery

Metadata

Procedure code (first position): E133 or E142 or E081 or E148 or E132 or E143 AND Procedure code in any position Y761
Age>= 17 years
Main specialty: 120 or Treatment function code: 120 or 215

Excluding all patients with head and neck cancer

girft Pathway EndoSinus

Activity YEAR	MONTH	POD DC	EL	Grand To	%
21/22	Apr	3	2	5	60%
	May	3	2	5	60%
	Jun	11	1	12	92%
	Jul	5	2	7	71%
	Aug	1	1	2	50%
	Sep	3	1	4	75%
	Oct	5		5	100%
	Nov	4		4	100%
	Dec	4		4	100%
	Jan	3		3	100%
	Feb	6		6	100%
	Mar	2	1	3	67%
21/22 Total		**50**	**10**	**60**	**83%**
22/23	Apr	2	1	3	67%
	May	5	1	6	83%
	Jun	3	2	5	60%
	Jul	3	1	4	75%
	Aug	4	1	5	80%
	Sep	8	2	10	80%
	Oct	4	2	6	67%
	Nov	4	2	6	67%
	Dec	3		3	100%
	Jan	1	2	3	33%
	Feb	4		4	100%
	Mar		2	2	0%
22/23 Total		**41**	**16**	**57**	**72%**
23/24	Apr	4	1	5	80%
	May	3		3	100%
	Jun		2	2	0%
	Jul	1	2	3	33%
23/24 Total		**8**	**5**	**13**	**62%**

Peer value = 81%
Benchmark = 95%

Tonsillectomy

Metadata

Procedure code (first position): F341 or F342 or F343 or F344 or F345 or F347 or F348 or F349
Age>= 17 years
Main specialty: 120 or Treatment function code: 120 or 215
Excluding all spells with procedure codes D345 or F346
Excluding all patients with head and neck cancer

girft Pathway Tonsil

Activity YEAR	MONTH	POD DC	EL	Grand To	%
21/22	Apr	7	2	9	78%
	May	7	2	9	78%
	Jun	6	2	8	75%
	Jul	8	1	9	89%
	Aug	2	2	4	50%
	Sep	6	2	8	75%
	Oct	4	1	5	80%
	Nov	7	2	9	78%
	Dec	4	1	5	80%
	Jan	5	1	6	83%
	Feb	12	3	15	80%
	Mar	2	2	4	50%
21/22 Total		**70**	**21**	**91**	**77%**
22/23	Apr	8		8	100%
	May	9	1	10	90%
	Jun	7	2	9	78%
	Jul	2	2	4	50%
	Aug	5	2	7	71%
	Sep	2		2	100%
	Oct	12	3	15	80%
	Nov	3	2	5	60%
	Dec	5	3	8	63%
	Jan	6	2	8	75%
	Feb	14	3	17	82%
	Mar	11	2	13	85%
22/23 Total		**84**	**22**	**106**	**79%**
23/24	Apr	3	4	7	43%
	May	7	1	8	88%
	Jun	8	4	12	67%
	Jul	19	5	24	79%
23/24 Total		**37**	**14**	**51**	**73%**

Peer value = 82%
Benchmark = 90%

Myringoplasty

Metadata

Procedure code (first position): D141 or D142 or D148 or D149
Age>= 17 years
Main specialty: 120 or Treatment function code: 120 or 215

Excluding all patients with head and neck cancer

girft Pathway Myringoplasty

Activity YEAR	MONTH	POD DC	EL	Grand To	%
21/22	May	1		1	100%
	Jun	3		3	100%
	Jul	5		5	100%
	Aug	1		1	100%
	Sep	4		4	100%
	Oct	3	1	4	75%
	Nov	8	1	9	89%
	Dec	6		6	100%
	Feb	9	1	10	90%
	Mar	2		2	100%
21/22 Total		**42**	**3**	**45**	**93%**
22/23	Apr	4		4	100%
	May	4		4	100%
	Jun	3	2	5	60%
	Jul	3		3	100%
	Aug		1	1	0%
	Sep	1	1	2	50%
	Oct	4		4	100%
	Nov	2		2	100%
	Dec	3		3	100%
	Jan	2		2	100%
	Feb	1		1	100%
	Mar	3	1	4	75%
22/23 Total		**30**	**5**	**35**	**86%**
23/24	Apr	4		4	100%
	May	5		5	100%
	Jun	3		3	100%
	Jul	3		3	100%
	Aug	1		1	100%
23/24 Total		**16**		**16**	**100%**

Peer value = 91%
Benchmark = 95%

- Highlights where specialties are performing against GIRFT targets and Peer Benchmarked Trusts
- Shows data by the GIRFT HVLC Scenarios

PLICS – HVLC Dashboard (1)

Home | Clear All Selections | Show detail

HVLC Monitoring by GIRFT Pathway

GIRFT pathway	YEAR	MONTH	DC Acitivity	EL Activity	Total Activity	NUH % DC	GIRFT Suggested %	Peer %
			4,429	4,656	9,085	48.8%	-	-
CYSTOSCOPY PLUS	21/22	Apr	18	7	25	72.0%	80%	81%
CYSTOSCOPY PLUS	21/22	May	25	22	47	53.2%	80%	81%
CYSTOSCOPY PLUS	21/22	Jun	5	13	18	27.8%	80%	81%
CYSTOSCOPY PLUS	21/22	Jul	17	13	30	56.7%	80%	81%
CYSTOSCOPY PLUS	21/22	Aug	13	6	19	68.4%	80%	81%
CYSTOSCOPY PLUS	21/22	Sep	12	17	29	41.4%	80%	81%
CYSTOSCOPY PLUS	21/22	Oct	10	7	17	58.8%	80%	81%
CYSTOSCOPY PLUS	21/22	Nov	34	11	45	75.6%	80%	81%
CYSTOSCOPY PLUS	21/22	Dec	17	9	26	65.4%	80%	81%
CYSTOSCOPY PLUS	21/22	Jan	22	4	26	84.6%	80%	81%
CYSTOSCOPY PLUS	21/22	Feb	16	6	22	72.7%	80%	81%
CYSTOSCOPY PLUS	21/22	Mar	12	10	22	54.5%	80%	81%
CYSTOSCOPY PLUS	22/23	Apr	12	8	20	60.0%	80%	81%
CYSTOSCOPY PLUS	22/23	May	18	7	25	72.0%	80%	81%
CYSTOSCOPY PLUS	22/23	Jun	18	8	26	69.2%	80%	81%
CYSTOSCOPY PLUS	22/23	Jul	21	13	34	61.8%	80%	81%
CYSTOSCOPY PLUS	22/23	Aug	13	10	23	56.5%	80%	81%
CYSTOSCOPY PLUS	22/23	Sep	18	13	31	58.1%	80%	81%
CYSTOSCOPY PLUS	22/23	Oct	20	13	33	60.6%	80%	81%
CYSTOSCOPY PLUS	22/23	Nov	18	10	28	64.3%	80%	81%
CYSTOSCOPY PLUS	22/23	Dec	25	5	30	83.3%	80%	81%
CYSTOSCOPY PLUS	22/23	Jan	32	6	38	84.2%	80%	81%
CYSTOSCOPY PLUS	22/23	Feb	25	12	37	67.6%	80%	81%
CYSTOSCOPY PLUS	22/23	Mar	8	4	12	66.7%	80%	81%
EndoAb	21/22	Apr	1	1	2	50.0%	98%	10%
EndoAb	21/22	May	3	0	3	100.0%	98%	10%
EndoAb	21/22	Jun	2	0	2	100.0%	98%	10%
EndoAb	21/22	Jul	1	0	1	100.0%	98%	10%
EndoAb	21/22	Aug	3	0	3	100.0%	98%	10%
EndoAb	21/22	Oct	4	0	4	100.0%	98%	10%
EndoAb	21/22	Nov	3	1	4	75.0%	98%	10%
EndoAb	21/22	Dec	2	0	2	100.0%	98%	10%
EndoAb	21/22	Jan	1	0	1	100.0%	98%	10%
EndoAb	21/22	Feb	2	0	2	100.0%	98%	10%
EndoAb	21/22	Mar	2	0	2	100.0%	98%	10%
EndoAb	22/23	Apr	2	0	2	100.0%	98%	10%
EndoAb	22/23	May	0	1	1	0.0%	98%	10%

Scenario | Dominant Procedure | HRG

Specialty
ELECTIVE ORTHOPAEDICS
ENT
GENERAL SURGERY
GYNAECOLOGY
UROLOGY

Location
BARCLAY THORACIC UNIT
CARREL WARD
CHILDRENS AMBULATORY (
CRITICAL CARE DIRECTORA
CSDC
DAY SURGERY UNIT

POD
DC
EL

SELECT YEAR
21/22
22/23

SELECT MONTH
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar

- Shows GIRFT pathway by month and %DC achieved against target and Peers
- Filters for Specialty, Location, POD, Year and Month
- Full drill down to patient detail

PLICS – HVLC Dashboard (2)

Home | Clear All Selections | Show detail

HVLC Information by Procedure and Scenario

PROC_DESC	girft Pathway	YEAR	MONTH	DC Activity	EL Activity	Total Activity	NUH % DC
				429	234	663	65%
Unspecified diagnostic endoscopic examination of bladder	CYSTOSCOPY PLUS	21/22	Apr	5	2	7	71%
Diagnostic endoscopic examination of bladder using rigid cystoscope	CYSTOSCOPY PLUS	21/22	Apr	3	1	4	75%
Dilation of meatus of urethra	CYSTOSCOPY PLUS	21/22	Apr	3	1	4	75%
Dilation of urethra NEC	CYSTOSCOPY PLUS	21/22	Apr	4	0	4	100%
Diagnostic endoscopic examination of bladder and biopsy of lesion o...	CYSTOSCOPY PLUS	21/22	Apr	1	1	2	50%
Endoscopic dilation of urethra	CYSTOSCOPY PLUS	21/22	Apr	1	1	2	50%
Endoscopic lithopaxy	CYSTOSCOPY PLUS	21/22	Apr	0	1	1	0%
Optical urethrotomy	CYSTOSCOPY PLUS	21/22	Apr	1	0	1	100%
Dilation of urethra NEC	CYSTOSCOPY PLUS	21/22	May	8	2	10	80%
Diagnostic endoscopic examination of bladder using rigid cystoscope	CYSTOSCOPY PLUS	21/22	May	3	5	8	38%
Unspecified diagnostic endoscopic examination of bladder	CYSTOSCOPY PLUS	21/22	May	4	3	7	57%
Dilation of meatus of urethra	CYSTOSCOPY PLUS	21/22	May	5	2	7	71%
Endoscopic lithopaxy	CYSTOSCOPY PLUS	21/22	May	0	5	5	0%
Optical urethrotomy	CYSTOSCOPY PLUS	21/22	May	4	1	5	80%
Endoscopic dilation of urethra	CYSTOSCOPY PLUS	21/22	May	1	3	4	25%
Diagnostic endoscopic examination of bladder and biopsy of lesion o...	CYSTOSCOPY PLUS	21/22	May	0	1	1	0%
Unspecified diagnostic endoscopic examination of bladder	CYSTOSCOPY PLUS	21/22	Jun	1	6	7	14%
Diagnostic endoscopic examination of bladder and biopsy of lesion o...	CYSTOSCOPY PLUS	21/22	Jun	0	2	2	0%
Endoscopic extraction of calculus of bladder NEC	CYSTOSCOPY PLUS	21/22	Jun	0	2	2	0%
Diagnostic endoscopic examination of bladder using rigid cystoscope	CYSTOSCOPY PLUS	21/22	Jun	1	1	2	50%
Dilation of urethra NEC	CYSTOSCOPY PLUS	21/22	Jun	0	1	1	0%
Endoscopic lithopaxy	CYSTOSCOPY PLUS	21/22	Jun	0	1	1	0%
Dilation of meatus of urethra	CYSTOSCOPY PLUS	21/22	Jun	1	0	1	100%
Endoscopic dilation of urethra	CYSTOSCOPY PLUS	21/22	Jun	1	0	1	100%
Optical urethrotomy	CYSTOSCOPY PLUS	21/22	Jun	1	0	1	100%
Dilation of urethra NEC	CYSTOSCOPY PLUS	21/22	Jul	8	2	10	80%
Diagnostic endoscopic examination of bladder and biopsy of lesion o...	CYSTOSCOPY PLUS	21/22	Jul	1	3	4	25%
Endoscopic lithopaxy	CYSTOSCOPY PLUS	21/22	Jul	1	3	4	25%
Dilation of meatus of urethra	CYSTOSCOPY PLUS	21/22	Jul	3	0	3	100%
Diagnostic endoscopic examination of bladder using rigid cystoscope	CYSTOSCOPY PLUS	21/22	Jul	1	1	2	50%
Endoscopic dilation of urethra	CYSTOSCOPY PLUS	21/22	Jul	1	1	2	50%
Unspecified diagnostic endoscopic examination of bladder	CYSTOSCOPY PLUS	21/22	Jul	1	1	2	50%
Endoscopic extraction of calculus of bladder NEC	CYSTOSCOPY PLUS	21/22	Jul	0	1	1	0%

Scenario | Dominant Procedure | HRG

Specialty
ELECTIVE ORTHOPAEDICS
ENT
GENERAL SURGERY
GYNAECOLOGY
UROLOGY

Location
BARCLAY THORACIC UNIT
CARREL WARD
CHILDRENS AMBULATORY (
DAY SURGERY UNIT
ELECTIVE ADMISSIONS LOU
HARVEY TWO WARD

POD
DC
EL

SELECT YEAR
21/22
22/23

SELECT MONTH
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar

- Dashboard showing GIRFT pathway by procedure
- Filters for Location, Year and Month
- Full drill down to patient detail

PLICS – BADS Dashboard (1)

BADs - Opportunity

Tabular View - For Export

Specialty	Patients	Avg LoS	LOS <24HRS (Daycase)	LOS <24HRS (Elective)	LOS <24HRS (Combined)	LOS 24-48HRS	LOS 48-72HRS	0 Night Stay Target	1 Night Stay Target	2 Night Stay Target
Breast Surgery										
Axillary dissection / clearance	29	1.14	41 %	45 %	86 %	14 %	0 %	95 %	5 %	0
Incision of breast	3	1.67		67 %	67 %	0 %	33 %	100 %	0 %	0
Insertion, revision, removal, renewel of breast prothesis	21	1.05	86 %	10 %	95 %	5 %	0 %	99 %	1 %	0
Mammoplasty (reduction, augmentation, revision)	13	1.15	54 %	38 %	92 %	0 %	8 %	75 %	25 %	0
Mastectomy without axillary surgery	88	1.20	41 %	47 %	88 %	5 %	8 %	75 %	25 %	0
Mastopexy	4	1.00	50 %	50 %	100 %	0 %	0 %	75 %	25 %	0
Microdochotomy + other operations on duct of breast	4	1.00	100 %		100 %	0 %	0 %	100 %	0 %	0
Operations on nipple	24	1.00	88 %	13 %	100 %	0 %	0 %	100 %	0 %	0
Re-excision of margins	18	1.00	83 %	17 %	100 %	0 %	0 %	100 %	0 %	0
Sentinel lymph node biopsy	1	1.00		100 %	100 %	0 %	0 %	100 %	0 %	0
Wide local excision of breast including wire guided	219	1.02	68 %	31 %	99 %	1 %	0 %	99 %	1 %	0
Emergency Surgery										
Appendicectomy, including laparoscopic	111	2.09		19 %	19 %	53 %	28 %	15 %	80 %	5
Evacuation of retained products of conception	2	1.00	100 %		100 %	0 %	0 %	95 %	5 %	0
Incision and drainage of perianal abscess	77	1.16	27 %	61 %	88 %	8 %	4 %	95 %	5 %	0
Incision and drainage of skin abscess	306	1.24	20 %	63 %	83 %	10 %	7 %	100 %	0 %	0
Laparoscopic cholecystectomy	174	1.11	52 %	40 %	92 %	5 %	3 %	25 %	25 %	0
MUA fracture and application of plaster cast	249	1.04	8 %	89 %	97 %	2 %	1 %	100 %	0 %	0
Primary reduction and open fixation of ankle	6	1.17		83 %	83 %	17 %	0 %	25 %	50 %	25
Reduction of fractured mandible	52	1.96		35 %	35 %	35 %	31 %	20 %	70 %	10
Removal of foreign body from skin	46	1.09	57 %	35 %	91 %	9 %	0 %	100 %	0 %	0
Removal of products of conception from fallopian tube (ectopic pregnancy), including laparoscopically	1	2.00				100 %	0 %	55 %	40 %	5
Repair of hand or wrist tendon	110	1.11	72 %	20 %	92 %	5 %	3 %	95 %	5 %	0
Suture of skin wound	138	1.21	37 %	49 %	86 %	8 %	7 %	75 %	25 %	0

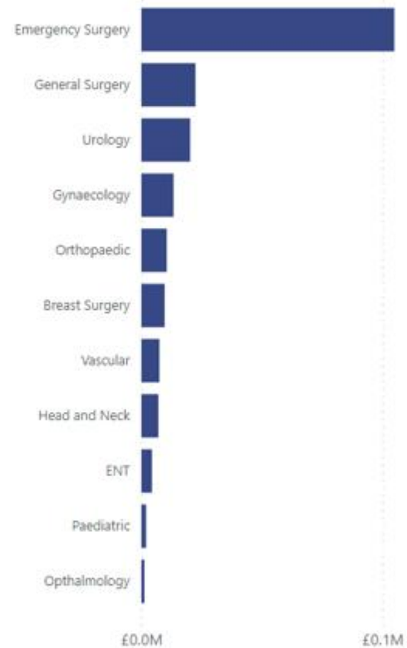
- Dashboard showing Specialty and procedure highlighting areas for improvement
- Full drill down to patient detail

PLICS – BADS Dashboard (2)

BADs - Opportunity

Opportunity for savings if procedures are moved away from Inpatient setting to Day Case Setting

Specialty	Patients	Avg LoS	PatExpense	Unit Cost	Bed Cost Saving
Emergency Surgery	**703**	**1.39**	**2,071,911.37**	**£583,553.98**	**£73,597**
Incision and drainage of skin abscess	306	1.24	606,858.31	£101,143.05	£33,033
Appendicectomy, including laparoscopic	111	2.09	500,349.10	£380,671.01	£29,240
Incision and drainage of perianal abscess	77	1.16	204,915.38	£23,951.15	£6,048
Repair of hand or wrist tendon	110	1.11	358,044.38	£29,294.54	£2,657
Reduction of fractured mandible	52	1.96	280,372.99	£155,283.50	£1,359
Removal of foreign body from skin	46	1.09	116,507.32	£10,131.07	£1,180
Removal of products of conception from fallopian tube (ectopic pregnancy), including laparoscopically	1	2.00	4,863.89	£4,620.69	£80
General Surgery	**489**	**1.22**	**1,461,838.45**	**£230,187.24**	**£13,636**
Closure iliostomy	5	2.40	27,204.17	£8,161.25	£7,246
Primary repair of inguinal hernia	171	1.08	506,843.32	£29,639.96	£2,415
Excision biopsy of lymph node for diagnosis (cervical, inguinal, axillary)	58	1.12	165,701.13	£17,141.50	£1,142
Diagnostic laparoscopy	43	1.05	100,168.28	£4,658.99	£754
Repair of umbilical hernia, adult	99	1.14	285,003.65	£28,788.25	£611
Laparoscopic repair of hiatus hernia with anti-reflux procedure	3	1.33	15,816.14	£3,690.43	£417
Repair of recurrent inguinal hernia	22	1.14	64,700.63	£8,822.81	£305
Treatment of anal fistula including seaton suture	30	1.13	66,152.22	£6,615.22	£238
Repair of rectal mucosal prolapse	6	1.33	17,089.81	£2,848.30	£221
Appendicectomy, including laparoscopic	41	2.20	169,202.03	£135,980.65	£198
Primary repair of femoral hernia	11	1.36	43,957.06	£7,992.19	£89
Urology	**452**	**1.23**	**1,556,870.67**	**£275,552.33**	**£13,218**
Endoscopic resection/destruction of lesion of bladder	218	1.13	652,196.32	£36,199.89	£6,988
Endoscopic insertion of prosthesis into ureter	106	1.30	354,662.28	£86,992.63	£2,238
Endoscopic laser fragmentation of calculus of kidney	23	1.35	137,782.36	£35,943.23	£1,193
Ureteroscopic extraction of calculus of ureter	57	1.26	220,395.47	£38,665.87	£1,130
Total	**5372**	**1.25**	**17,740,490.32**	**£3,180,210.76**	**£141,550**



- Dashboard showing potential bed cost savings by specialty and procedure
- Full drill down to patient detail

NUH WAVE Working to Achieve Value and Excellence

Audiology - Is the current patient journey optimised?

Audiology Sankey Chart

U-S27DY

U-S27FT
No attendance
U-S27DV
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U-S27R3
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U-S27FI
U-S27DW
U-S27FS
U-S27R2
U-S27YP
U-S27KE
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No attendance
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U-S27FI
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U-S27PR
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U-S27OA
U-S27R1
U-S27FS
U-S27DT
U-S27LV
U-S27VM
U-S27FT
U-S27DU
U-S27AT
U-S27R3
U-S27VA
U-S27BA
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U-S27DQ
U-S27DA

No attendance
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No attendance
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No attendance
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No attendance
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U-S27DW
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U-S27VM

Audiology - Is the current patient journey optimised?

Discovery

- Multiple patient pathways
- Lost patients
- Interaction with ENT not efficient

Solutions

- Audiologists Transformation into Primary Care Model – ICB
- Optimisation of Best Practice Pathways
    - Within NUH
    - New Nationally Commissioned Services
- Improved Systems & Processes
    - Online ordering of spare parts & Online hearing tests
    - Patient initiated Follow-ups
    - Skill mix improvements

HCOP – Right Patient, Right Pathway (Bed)

Comparison between HCOP and Cardiology on the top four cardiac type conditions that present in HCOP:

FrailtyScore	
0. Not Populated	256
1. Very fit	6
2. Well	43
3. Managing well	168
4. Vulnerable	160
5. Mildly frail	237
6. Moderately frail	511
7. Severely frail	245
8. Very severely frail	16
9. Terminally ill	3

Discharge Year
2019
2020
2021

Age Groups	
56-60	1
61-65	3
66-70	29
71-75	95
76-80	287
81-85	391
86-90	455
91-95	315
96-100	67
100+	5
0-5	0

Spells with a Frailty Score or cared for by HCOP

HRG Root	Discharging Ward Specialty	Activity (Spells)	Average LOS	Readmissions within 7 Days	Readmissions from 8 - 30 Days	Red Days (% of LOS)	Average Red Days	Average Cost	Med Safe (% of LOS)	Average Medically Safe Days
Heart Failure or Shock	Healthcare of Older People	583	11	6%	13%	15%	2	-£5,226	10%	15
	Cardiology	166	9	5%	14%	5%	1	-£4,961	4%	30
Syncope or Collapse	Healthcare of Older People	497	6	11%	12%	14%	1	-£3,214	15%	17
	Cardiology	28	2	4%	11%	3%	0	-£1,345	0%	-
Arrhythmia or Conduction Disorders	Healthcare of Older People	114	6	11%	7%	9%	1	-£3,315	4%	14
	Cardiology	146	3	5%	10%	0%	0	-£1,546	0%	-
Unspecified Chest Pain	Healthcare of Older People	91	4	9%	19%	16%	1	-£2,201	5%	18
	Cardiology	20	2	10%	5%	0%	0	-£1,130	0%	-

Initial findings show elderly patients currently in HCOP beds with a frailty score 1-5 with the same primary condition but in a Cardiology bed have a lower length of stay, lower readmission rates & lower mortality.

A solution being explored, to optimise patient care is to create a Cardio-Geriatrician service or a HCOP in-reach program to support treatment of higher frailty patients with cardiac conditions.

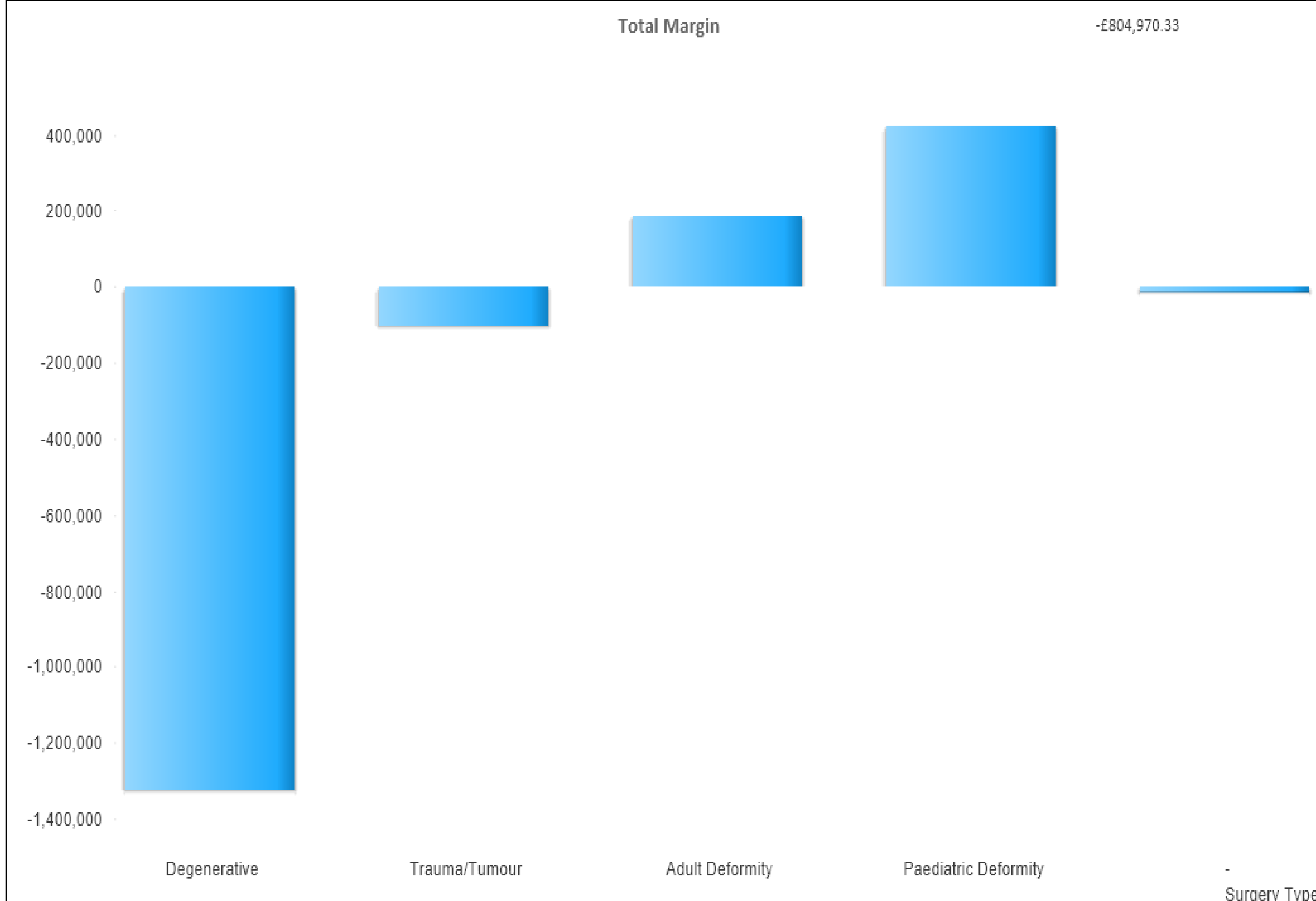
HCOP – Right Patient, Right Pathway (Bed)

- Patient journey
- Frailty Scores
- Is the patient in the right place
- Hypothesis – inpatients admitted to HCOP
  a) Outside of their definition for the service (being over 74 and having a frailty score of at least '6. Moderately frail')
  b) Presenting with a primary condition which would be better treated with the associated specialty. For example, Heart Failure patients to be better managed in Cardiology. Primary condition, not age.
- Exploring the data to support the three ideas to optimise inpatients in HCOP
  1) Getting patients to the right place, first time
  2) Variation in outcomes, by discharging specialty, primary condition, age and frailty score
  3) Variation in HCOP wards

Spines – Where do I start?

Back to Main | Clear All Selections | Show HRG analysis | Show episode detail

Elective Spines Margin by Surgery Type



Consultant | Diagnosis | Procedure

Age Flag
- Adult
- Paeds

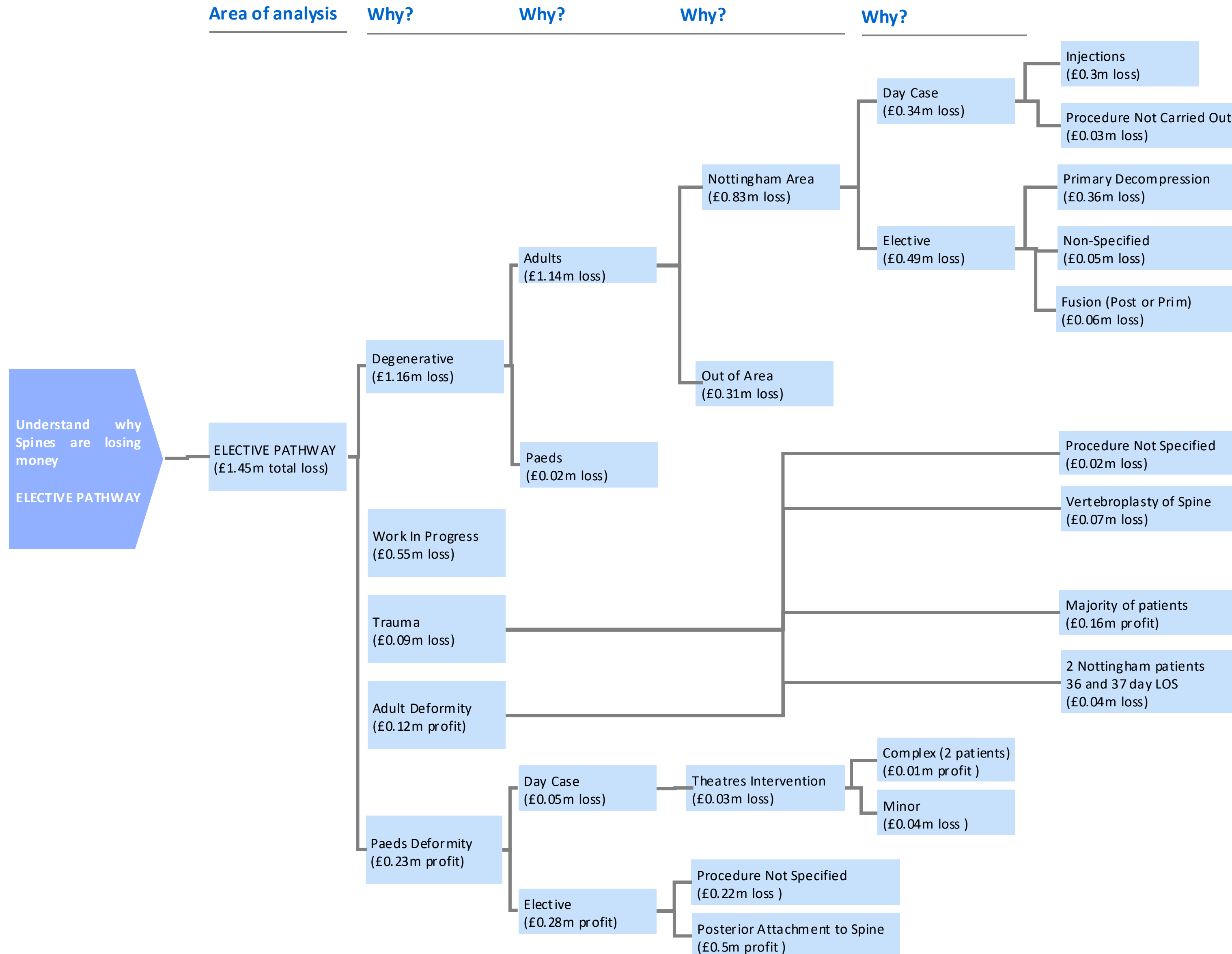
Intervention
- Diagnostic Test
- Injection
- No Intervention
- Theatre intervention
- None Listed
- Work in Progress - IGNORE

Area

Birmingham	Colchester
Coventry	Croydon
Derby	Dartford
Doncaster	Dudley
Huddersfield	Gloucester
Kingston upon Thames	Guildford
Leicester	Hull
Lincoln	Lancaster
Northampton	Liverpool
Nottingham	Milton Keynes
Peterborough	Newcastle upon Tyne
Sheffield	Norwich
Stoke-on-Trent	Plymouth
Walsall	Salisbury
York	Shrewsbury
Blackburn	South East London
Blackpool	Southampton
Bradford	Swansea
Brighton	Truro
Bristol	Unknown
Cardiff	Wakefield

Point Of Delivery
- DC
- EL
- NEL
- OPFA

Spines – Understanding my finances



NHS
Supply Chain

NHS Supply Chain

Hamish Makanji: Head of Hospital Care

Chris Morris: National Lead for Out of Hospital Care Service Development

Leanne Wareing: Care Pathway Specialist (Specialised Commissioning)

Agenda

NHS
Supply Chain

- Introductions
- Overview of NHS Supply Chain
- Functional overviews
  - Hospital Care
  - Out of Hospital Care
  - Care Pathway Team
- Opportunities to Work Better Together
- Questions

NHS Supply Chain Strategy

NHS Supply Chain

Our long-term Strategy guides our multi-year delivery programme to ensure we are delivering our vision of making it easier for the NHS to put patients first:

One NHS Supply Chain

We are one organisation in the eyes of our teams and stakeholders, operating efficiently as a single organisation within the NHS family.

Strengthen Resilience

We ensure availability of critical products, supporting the NHS to deliver excellent patient care.

£1 Billion of Value

We will create £1 billion of recurrent value to return to the NHS from 2030.

Our Role

NHS Supply Chain

We are part of the NHS and deliver a **resilient** supply chain of **clinically assured** goods and services to **health and care providers**.

What we do	
Consolidate Purchasing, Deliveries and Invoices	Aggregate NHS spend for a range of medical devices and clinical consumables. Provide consolidated deliveries, picked to requisition point, to agreed delivery times.
Clinical and Quality Assured	Provide clinical and quality assurance across all our frameworks.
Targeted Resilience	Provide resilience for a core list of products (stockholding, alternatives, supply chain mapping).
Safety	Work with regulators and suppliers to ensure product safety issues are dealt with swiftly.
Sustainability and Social Value	Deliver sustainability solutions and social value across our global supply chain.
Innovation	Collaborate with suppliers and trusts to introduce MedTech and novel innovations that deliver value-based benefits.

Where we support

Inventory Management
Support the roll out of inventory management; generating efficiencies and supporting patient safety

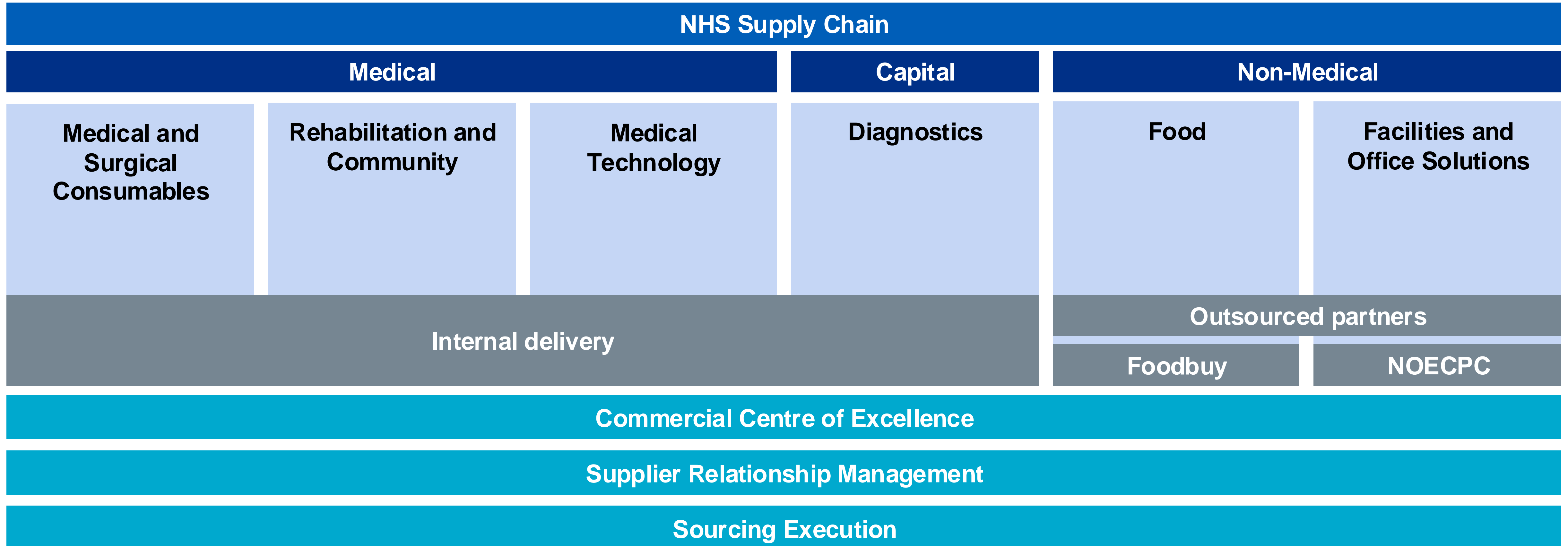
Demand Management
Implement demand management control requirements on behalf of NHS England

Insights and Account Management
Provide data and intelligence on savings opportunities for the NHS

A New Commercial Model to Support the NHS

NHS Supply Chain

We operate across a wide product range: our products are grouped into **four medical** and **two non-medical categories**, covering **134 awarded product and service categories**.



Being Easier to Work With

NHS Supply Chain

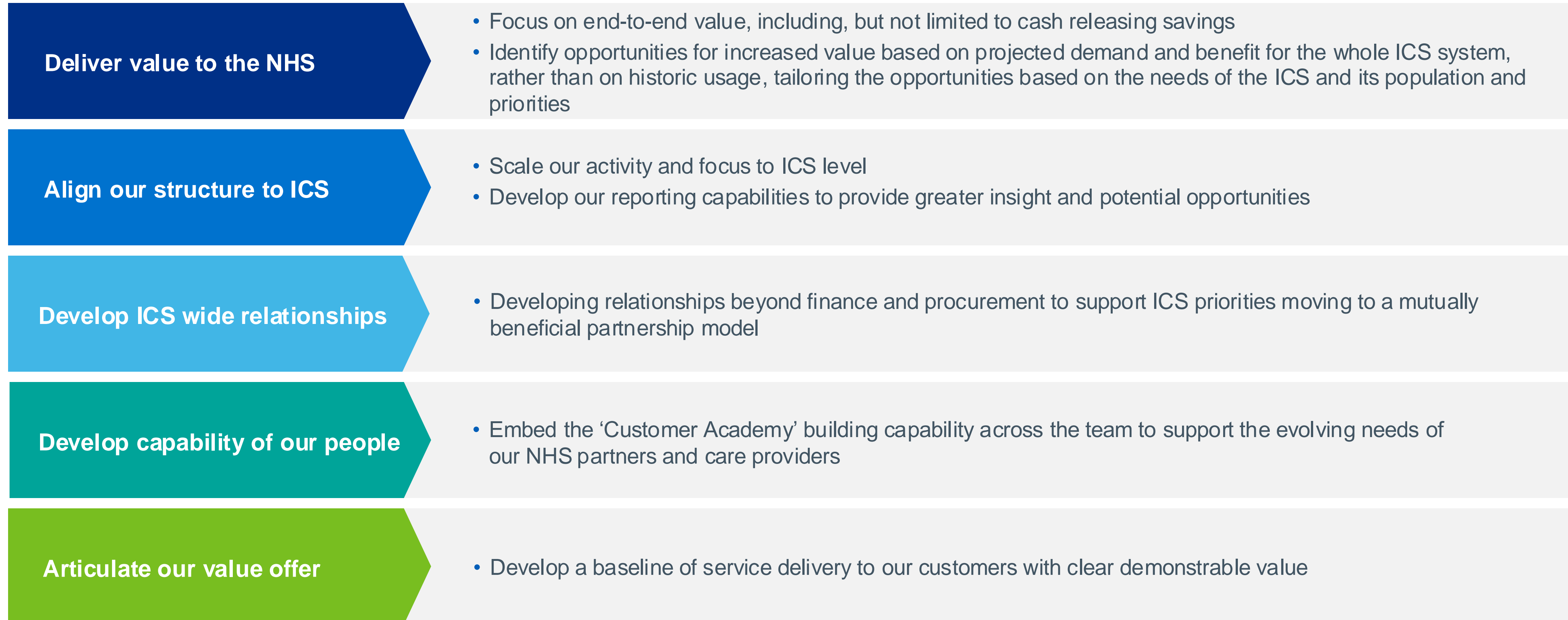
We are investing in an ambitious **transformation programme** and **evolving how we work** to ensure **customer needs** are at the core of our decision making.

- **Technology modernisation**
- **Aligning to ICS working**
- **Focus on NHS needs through engagement**
- **Working as One NHS Supply Chain**
- **Focus on end-to-end patient pathways**

Hospital Care Strategy

NHS Supply Chain

Partner expertly with our customer - holding influence and key relationships internally to source expert support



Out of Hospital Care: How We Are Organised To Deliver

NHS
Supply Chain

Natalie Royston
Head of Out of Hospital Care

Stuart Milhench
Home Delivery Service (HDS) Manager

Will Gilbert
Out of Hospital Care Service Manager

Deane Bridges
Out of Hospital Care Data Manager

Chris Morris
National Lead for Out of Hospital Care Service Development

Existing Out of Hospital Care Services

NHS Supply Chain

Current Service Offer

- Wound care
- Continence (HDS)

Direct-to-Healthcare Professional:

- NHS Supply Chain can expand our service where there is an existing delivery footprint, for example increasing the range of products delivered to GP Surgeries, District Nurse bases and Clinics.

Direct-to-Patient:

- Opportunity to optimise continence product ranges system-wide generating cost savings
- Further savings and sustainability potential in washable products

Developing New Services

- Nutrition and Enteral Feeding
- Bladder, Bowl and Stoma
- Respiratory
- Rehabilitation and Frailty
- Renal (Dialysis)

The Out of Hospital Care team has a dedicated Service Development function to explore new services with NHS customers and better understand priority categories and services to **help the NHS save lives and improve health.**

Care Pathway Team

NHS Supply Chain

Partner Expertly with Integrated Care Systems to:

- Support delivery of the **NHS Quadruple Aim**:

- Support delivery of objectives set out in the **2024 / 2025 priorities and operational planning guidance**:
    - Deliver a balanced net system financial position
    - Eliminate 65-week waiters
    - Deliver 107% elective activity target
    - 95% of patients to receive a diagnostics test within 6 weeks

Care Pathway Team 2024 / 2025 Priorities

NHS Supply Chain

To Partner Expertly with Integrated Care Systems to:

- Drive the adoption of clinical practice featured in our Value Based Procurement (VBP) Case Studies within identified care pathways
- Drive the adoption of Innovative Products, Devices and Services, including those featuring on the MedTech Funding Mandate Policy within identified care pathways
- Develop Integrated Care System-led activities that address care pathway clinical pain points and / or operational challenges creating future VBP Case Studies

Efficiency and Productivity Methodology

NHS Supply Chain

- Hospital Episode Data from 23/24
- Dependency: quality of NHS provider organisation clinical coding
- Applies efficiency / financial values signed off in VBP case studies
- Applies principles from NHS procurement value and savings methodology (NHSE)
- Assumes GIRFT best practice, NICE recommendations and MedTech Funding Mandate (MTFM) policy adoption

Recent Developments

Developing our data strategy to help identify clinical pain points

Partnering with the Health Innovation Network e.g Apos and MTFM programme

2024 VBP Case Study Publications – Transnasal Endoscopy

Partnerships established with multiple systems nationally

Productivity and Efficiency Savings - Example

NHS Supply Chain

System Financial Modelling- Example				
VBP Opportunity Name	**Assumed Productivity and Efficiency (P&E) Saving Per Procedure / Patient / NHS Provider**	**Estimated Annual P&E Savings Based On Financial Modelling and Assumptions**	**Assumed Number of Procedures / Patients / NHS Providers**	**Comments**
Transnasal Endoscopy	£30.57 per procedure	£0.3m	11,520	Using HES (code G45) for 23/24. Weighted at 85% as per case study. Excludes reported values from Case Study Site Royal United Hospitals Bath NHS Foundation Trust
BARD tray / CAUTI Reduction	£1,968 per procedure	£0.2m	785	Using updated HES Data (Code M47) for 23/24. Weighted at 50% reduction Excludes reported values from Case Study Site Case Study Site - University Hospitals of North Midlands NHS Trust
Disposable Elastomeric Pump (IV)	£500,000 per acute provider	£2m	4	Based on number of NHS Providers per ICS Excludes reported values from Case Study Site Case Study Site - Oxford University Hospitals NHS Foundation Trust
Artiss skin sealant	£38,571 per acute provider for LoS <2.4 days or £805 per patient for LoS >2.5 days	£0.1m	70	Based on the number of relevant acute providers in ICB undertaking the procedures (codes F44) Excludes reported values from Case Study Site Case Study Site - Manchester University NHS Foundation Trust
APOS	£4,700 per patient	£0.9m	186	Applies £4,700 per patient saving over a 3-year period based upon NICE MTG-76 Resource Impact Assessment No case study published as yet.
Remote Monitoring	£424 per patient	£0.5m	1,085	Using HES (codes K60 & K61) for 23/ 24. Excludes reported values from Case Study site Case Study Site - University Hospitals of Leicester NHS Trust. Excludes modelling for Barts Health NHS Trust and Dorset County Hospital NHS Foundation Trust.
Pacenet	£150,000 per acute provider	£0.6m	4	Based on number of in-scope NHS Acute Provider Providers (not all NHS Providers will have a need for Pacenet) Case Study to be published - to exclude modelling for Royal Free London NHS Foundation Trust and London North West University Healthcare NHS Trust
Total opportunity		**£4.6m**		

Opportunities to Work Better Together

NHS Supply Chain

Work in partnership with NHS Supply Chain to unlock value:-

- Encourage your teams to continue to share data, implement workplans, and understand new opportunities
- Engage with us to deliver value opportunities in all care settings for wound care and continence
- Partner with us to develop new services that drive operational efficiency, improve the patient experience and deliver system savings
- Champion the implementation of VBP opportunities to support the delivery of the 2024 / 2025 priorities and operational planning guidance objectives

NHS Supply Chain

Thank you

@NHSSupplyChain
NHS Supply Chain
www.supplychain.nhs.uk

Supply Chain Coordination Limited (SCCL) is the Management Function of the NHS Supply Chain

Comfort Break: 10 Minutes

NHS Arden and Greater East Midlands Commissioning Support Unit

NHS Trusts and Provider Collaborative Engagement Session

Provider Selection Regime (PSR)

Collette Palmer - Associate Director of Procurement (Specialised Commissioning)

Arden&GEM
Health and social care systems support

Provider Selection Regime (PSR) – Background and Overview

NHS
Arden and
Greater East Midlands
Commissioning Support Unit

PSR - regulations came into force on **01st January 2024** and replaced:

The National Health Service (Procurement, Patient Choice and Competition) (No 2) Regulations 2013 (PPCCR 2013) and,

The Public Contracts Regulations 2015 (PCR 2015).

PSR has been designed to **support greater integration**, **wider collaboration** across systems, offer **flexible and proportionate processes** for selecting providers of **health care services**.

Organisations referred to as '**Relevant Authorities**' are required to follow PSR:

Integrated Care Boards (ICBs),
NHS England (NHSE),
NHS Trusts and Foundation Trusts,
Local Authorities,
Combined authorities.

Very important to note that these new regulations only apply to **Clinical Healthcare Services** Procurement unless it is construed as a mixed procurement.

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Health and social care systems support

Key points - updates

- **New Contracts** can only be awarded using the **Most Suitable Provider** or **Competitive Process**. Commissioners cannot directly award new contracts except for reasons of urgency (maximum 12 months).
- **Direct Award Process A** – existing service / existing provider is only capable provider – i.e.Emergency Services (Blue Light etc.)
- **Direct Award Process B** – i.e. - elective services led by a consultant or mental health care professional where patients have a legal right to Choice. Cannot limit number of providers. Have to allow providers to express an interest and be advised of outcome within 6 weeks.
- **Direct Award Process C -** is proving to be resource intensive for Commissioners. All DAPC processes need to utilise all 5 Key Criteria within Annex D of the Statutory Guidance (examples of sufficient evidence are also provided).
- Demands greater transparency. Commissioners **MUST** place a notice when **ANY** contract is awarded. Dependent on the process followed this can vary from 2 notices to 4 notices.
- As part of the transparency requirements there are a number of requirements placed on Relevant Authorities in terms of **record keeping**. These are considerably more onerous than previous requirements.
- The **Independent Patient Choice & Procurement Panel** referral form is now live, and providers can now access and complete to submit their **representations**.

Key points - updates

NHS
Arden and
Greater East Midlands
Commissioning Support Unit

- For the majority of processes, including DAP C, Commissioners must apply five "**key criteria**" and be able to **demonstrate** how they have done this. The key criteria are:
  - Quality and innovation
  - Value
  - Integration, collaboration and service sustainability
  - Improving access, reducing health inequalities and facilitating choice
  - Social Value
- Thresholds for **contract modification** have been amended so that the modification is considered material if:
  - The changes render the contract **materially different** in character; or
  - The changes are **OVER £500K AND represent OVER 25%** of the original contract value (where the modification is attributable to a decision of the Relevant Authority as opposed to being made in response to external factors beyond the control of the Relevant Authority).
- A system whereby relevant authorities must consider "**representations**" bought by providers must be in place. These:
  - Must **adhere** to certain **timescales** (in terms of a "standstill period")
  - Can be escalated to an **advisory NHSE panel** who will scrutinise process but will only **"advise"** relevant authorities on the correct course of action
  - If still disgruntled, ultimate remedy is **Judicial Review.**

Arden&GEM
Health and social care systems support

PSR – what we provide our customers/partners

- Experts in the delivery of PSR – already undertaking numerous processes under the regime on a daily basis
- Advice and guidance on best approach
- Support in governance and record-keeping
- Represented on the ‘Representation review panel’
- Training and development
- As results of panel investigations (from across the country) are published we will share and commence lessons learned sessions to ensure continued learning

Prioritisation of Current Challenges – Group Input

NHS

- Urgency – How Immediate is the need to address the challenge ?
- Impact – How significantly does the challenge impact on the health & care system ?
- Strategic Alignment – Does solving the challenge align with our strategic objectives ?
- Connected Planning – How will connected planning help address this challenge ?

Prioritisation of Current Challenges #2 – Group Input

- What challenges are highest priority - to address in next 6-12 months?

- What would be your measures of success a year from now ?

(savings , enhanced productivity, reduced waiting lists etc)

- Key next steps ?

- Identified leads to take forward ?

Close: Chairs Summary