responsible

excellent

St George's Healthcare NHS

NHS Trust

Congestive Heart Failure Integrated Care Pathway

30 day Report Out

26th February 2014

kind

respectful

GE imagination at work

Let's remind ourselves why we're here...

Main objectives of today's report out

- What were we trying to achieve?
- What have we accomplished and how did we do it?
- What are the key lessons learned....so far?
- What do the next steps look like to embed and sustain the pathway and make it successful?

Let's remind ourselves why we're here…

The burning platform

HSJ MEDICAL PUBLICATION OF THE YEAR

HOME | NEWS | HSJ LOCAL | LEADERSHIP | RESOURCE CENTRE | OPINION | EVENTS | AWARDS | JOBS

Obama adviser to make 'zero harm in the NHS a reality', pledges PM

6 FEBRUARY, 2013 | BY JAMES ILLMAN

Don Berwick, the man who advised President Barack Obama on his health reforms, has been appointed to spearhead a "zero harm" agenda in the NHS, David Cameron has revealed.

President Obama

The eye-catching appointment is potentially a substantial coup for the prime minister, who announced the move to the House of Commons this afternoon.

Mr Berwick previously advised Bill Clinton and is regarded as one of the world's leading health advisers.

The "Burning Platform" for clinical quality and compliance to safe, evidence-based care is growing

Let's remind ourselves why we're here...

The case for Heart Failure...the size of the problem

900,000 people in the UK have heart failure

Almost as many have damaged hearts but no failure...yet!

25,000 new cases of heart failure in UK every year

2% of all in patient bed days

5% of all emergency medical admissions

2% of total NHS budget due to frequent community and hospital contact

70% of cost is inpatient care; Nationally 1 million bed days

Heart failure is more common than most cancers, including breast, testicular, cervical and bowel cancers

GE imagination at work

The case for a specialist HF Service

- STEMI and NSTEMI mortality dropped by 40% from 2005-2011…meaning **more people survive with damaged hearts**
- **18% ANNUAL increase in heart failure admissions** nationally
- **CHF population rising** (now 1% of UK population)
- In-patient **mortality rates better if admitted to cardiology** wards (8%) compared to general medical wards (14%) & other wards (17%)
- **UK hospital mortality rates** (11.6%) - **higher** than contemporary US and European registries
- **Mortality rates** after discharge are **significantly better if cardiology follow up** (18% vs. 31%) and referral to HF specialist nursing services (22% vs. 27%)

We're making progress...!

Improved prognosis in past 10 years (NICE 2010)

6 month mortality decreased from 26% in 1995 to 14% in 2005 (NICE 2010)

GE imagination at work

Don’t forget some of the key messages…

What should a gold standard service look like?

What the commissioner said…

- All inpatients reviewed on an acute HF unit by cardiologist
- Provision of ambulatory outpatient service for non-acute patients
- Tele-health solutions in place for select patients
- Agreed “evidence based care bundle” – “rubber stamped” for each patient
- Improve compliance to echocardiograms for all eligible patients
- Redesign services to enable primary care to deliver the plan
- Patient outcomes on end of life care (e.g. % dying out of hospital)

Don’t forget some of the key messages…

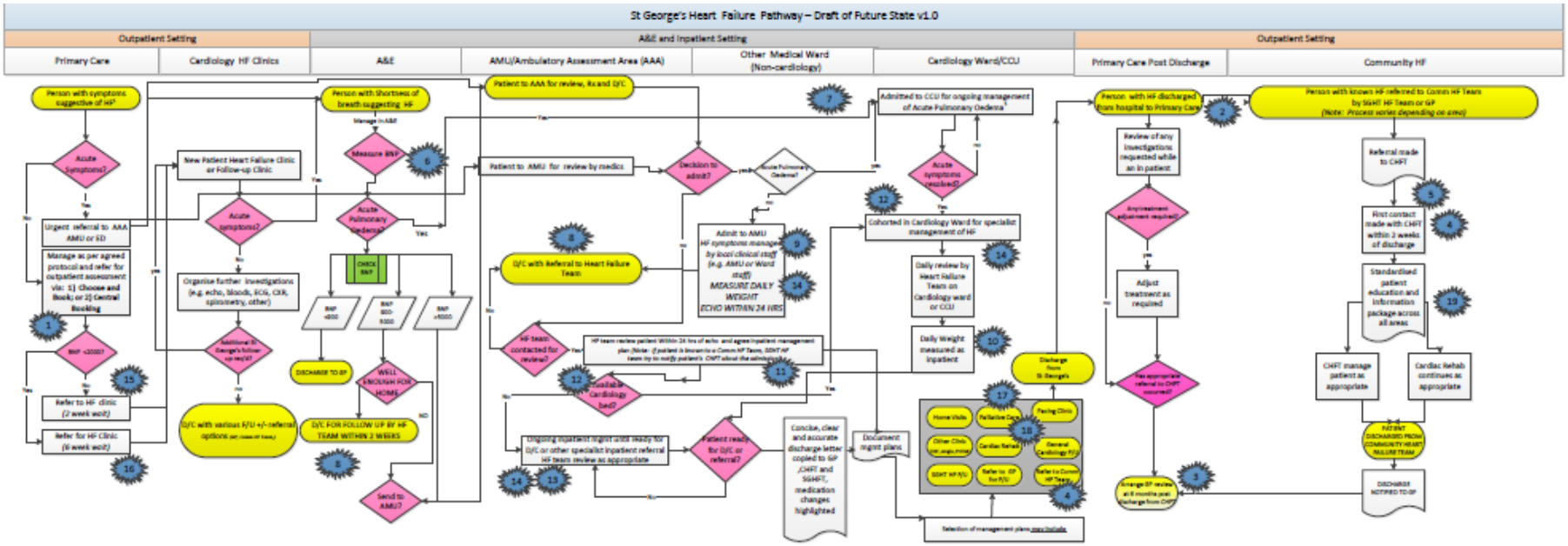
What did our patients ask for…

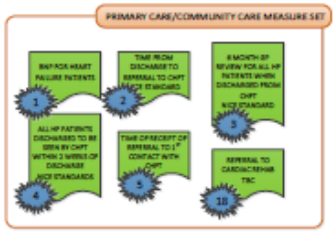
“Improved access to Cardiac Rehab”
“Improved education and awareness around self-medication and look for improved ways for the patient to administer drugs (blister packs, pill boxes, etc)”
“Improved patient information, especially explaining to family and carers symptoms to look out for at different stages of treatment, in addition to providing psychological support for the patient”

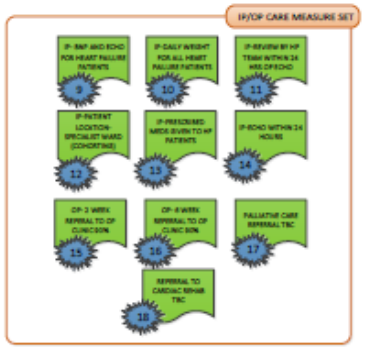
Heart Failure Pathway

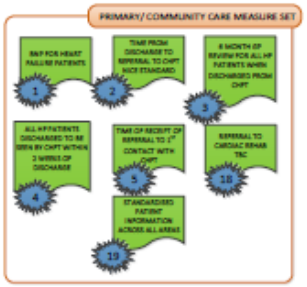
Heart Failure Pathway (future state)

Agreed Care Measures and changes to pathway









imagination at work

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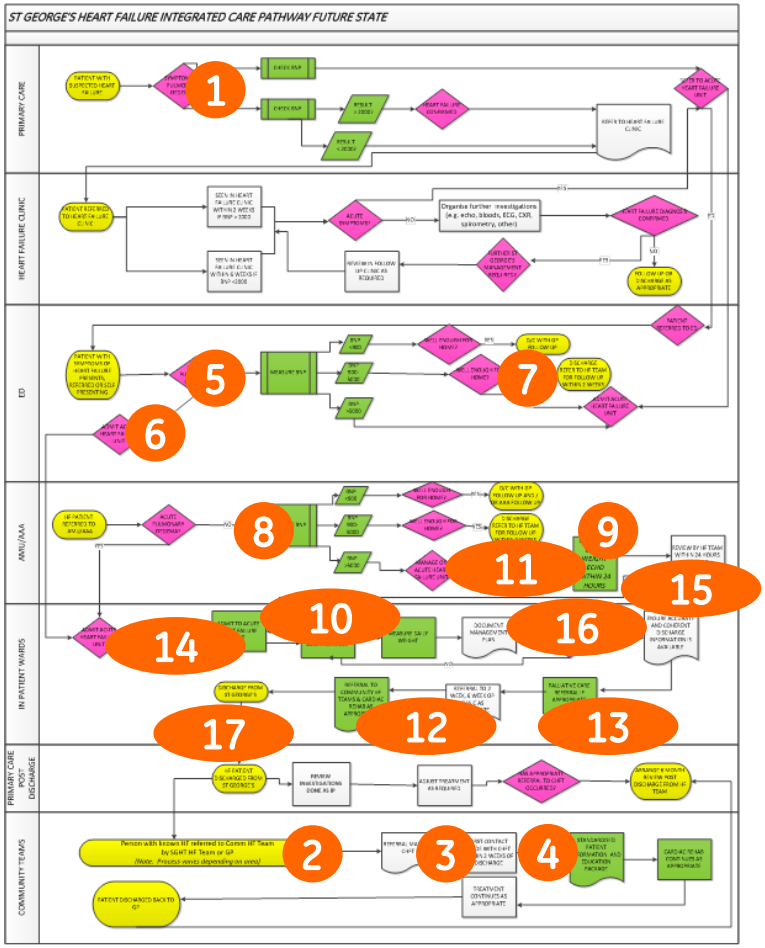
Heart Failure Pathway (future state)

Agreed Care Measures and changes to pathway



1. BNP for all Heart Failure Patients
2. All HF patients discharged to be seen within 2 weeks by CHFT (from receipt of referral)
3. Time from discharge to referral to CHFT
4. Time from receipt of referral to 1st contact by CHFT
5. BNP to be measured for all patients over 70 with shortness of breath
6. All acute pulmonary oedema patients to be admitted to CCU from ED
7. All heart failure patients discharged from ED to be captured for follow up by heart failure team
8. BNP requested for all HF patients
9. Echo requested for all HF patients
10. Prescribed meds given to HF patients
11. Echo within 1 working day from request
12. OP – x2 week referral to clinic (90%)
13. Palliative Care referral/assessment
14. Patient Location
15. Review by HF team within 1 day of Echo
16. Daily weight
17. HF Team concern over discharge

Patient Experience

Patient Experience

Capturing the voice of the patient/carer

- Recent funding received from NHS England to track patient experience across whole pathways – Heart Failure selected as one of 3 pathways.
- Plan to survey patients at each stage of the pathway; from GP services, to community nurses and inpatient/outpatient services.
- 3 ways a patient can take part:
  - By using tablet computers – each service will receive a tablet computers to capture patient feedback directly. These can be set up ask kiosks or brought with staff when visiting patients
  - Via online surveys - we can email, text or otherwise share a link to online surveys – patients can complete these in their own time
  - By paper/post - we'll hand out survey packs with Freepost return envelopes
- All data collected and made available to service managers in real time via the RaTE system.

Progress updates

Group 1: Community & Primary Care

Group 2: Inpatient / Outpatient

Group 3: ED

HEART FAILURE ICP ACTION PLAN **54%**

#	Status	Action	Group	Care Measure	Actionee	Progress Update	Target due date	Progress	Status
1		Collate Patient Education/Information given to patients by HF team in Sutton/Merton (Susan Brooker / Janet Oppong)	Community	Patient Education	Noyola				Closed
2		Collate Patient Education/Information given to patients by HF team in Croydon (Grace Williams)	Community	Patient Education	Noyola				Closed
3		Collate Patient Education/Information given to patients by HF team in Wandsworth (Junnet Barros)	Community	Patient Education	Noyola				Closed
4		Collate Patient Education/Information given to patients by HF team in Lambeth (Josh Sunkur)	Community	Patient Education	Noyola				Closed
5		Collate Patient Education/Information given to patients by HF	Community	Patient Education	Noyola				Closed
6		Confirm date for meeting at St Georges to discuss patient education (need representation from wandsworth, sutton/merton, lambeth, croydon, GP's and SGHT HF team)	Community	Patient Education	Noyola	Meeting confirmed for 7th Feb 9am Grosvenor Wing G2.3 Teaching.			Closed
7		Book a room at St Georges for Patient Education meeting (once meeting date/time is confirmed)	Community	Patient Education	Tom McCarthy				Closed
						Refer to comments from Mark O'Donnell and Janet			

106 Actions – 54% complete to date

imagination at work

Community & Primary Care

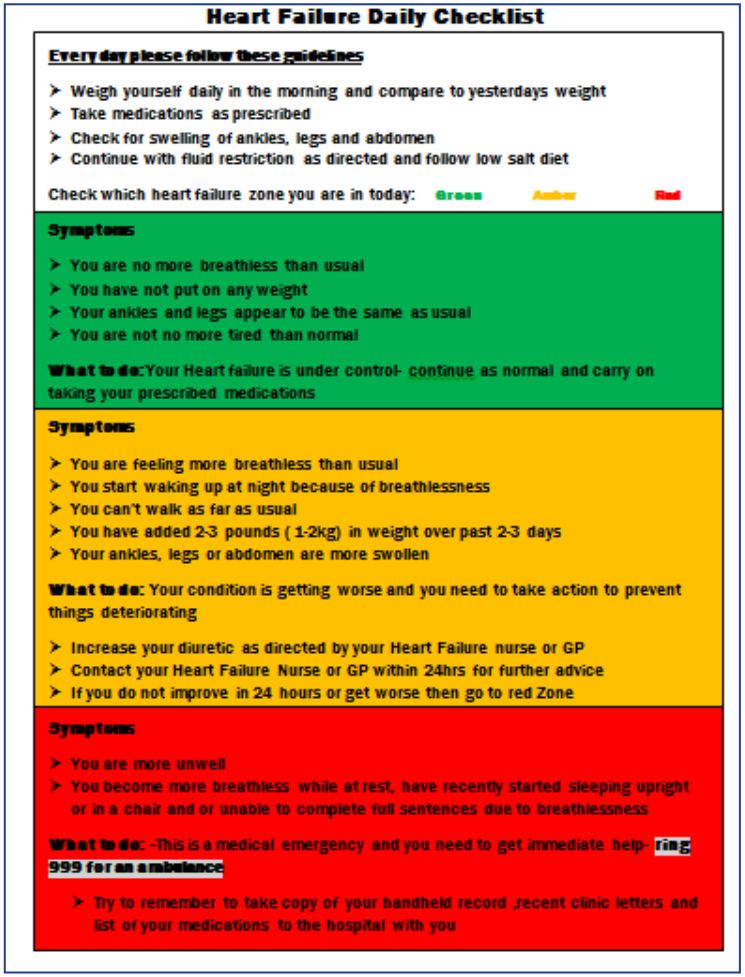
Community and Primary Care

Progress since implementation week

- All forms of patient information collated and reviewed by cross representation of all boroughs and SGH.
- Patient information packs agreed and standardised across all boroughs and SGH (large BHF packs).
- Basic patient education pack agreed and to be translated into different languages (Lithuanian and Russian done)
- Patient satisfaction survey reviewed to include patient education question.
- Investigation carried out to establish EPR access for community HF teams not employed by SGH.

Community and Primary Care

HF Daily Checklist self-assessment



Heart Failure Daily Checklist

Every day please follow these guidelines

- Weigh yourself daily in the morning and compare to yesterdays weight
- Take medications as prescribed
- Check for swelling of ankles, legs and abdomen
- Continue with fluid restriction as directed and follow low salt diet

Check which heart failure zone you are in today: Green Amber Red

Symptoms

- You are no more breathless than usual
- You have not put on any weight
- Your ankles and legs appear to be the same as usual
- You are not no more tired than normal

What to do: Your Heart failure is under control- continue as normal and carry on taking your prescribed medications

Symptoms

- You are feeling more breathless than usual
- You start waking up at night because of breathlessness
- You can't walk as far as usual
- You have added 2-3 pounds (1-2kg) in weight over past 2-3 days
- Your ankles, legs or abdomen are more swollen

What to do: Your condition is getting worse and you need to take action to prevent things deteriorating

- Increase your diuretic as directed by your Heart Failure nurse or GP
- Contact your Heart Failure Nurse or GP within 24hrs for further advice
- If you do not improve in 24 hours or get worse then go to red Zone

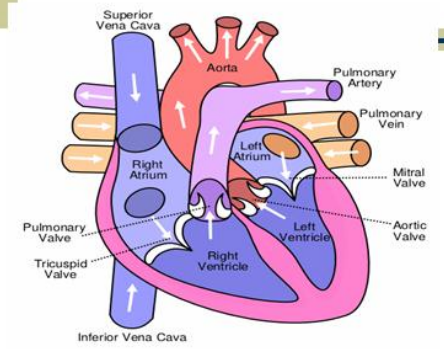
Symptoms

- You are more unwell
- You become more breathless while at rest, have recently started sleeping upright or in a chair and or unable to complete full sentences due to breathlessness

What to do: -This is a medical emergency and you need to get immediate help- **ring 999 for an ambulance**

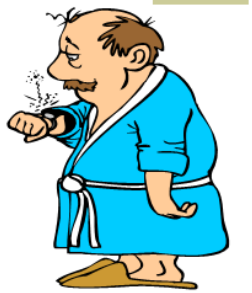
- Try to remember to take copy of your handheld record ,recent clinic letters and list of your medications to the hospital with you

The Heart



Symptoms of Heart Failure

- Shortness of Breath
- Tiredness/ fatigue
- Swollen ankles/legs
- Reduced ability to exercise



Helping yourself

- Daily Weights
- Fluid Allowance of 1.5L
- Seek help early if unwell
- Vaccinations

Diet

- Healthy eating
- Try to lose weight if necessary.
- Low salt
- Potassium
- Alcohol

Smoking

- Increases severity of most of the causes of Heart failure.
- Increases shortness of breath
- Increases likelihood of other illnesses

Physical Activity

- Keep moving when you are well
- Try to build up activity
- Rest when you are unwell
- Energy Conservation

Medication

- What do your medications do?
- Always take medication as prescribed and don't allow yourself to run short
- Over the counter medicines

Stress and anxiety

- Do you need help with managing stress?
- Identify the causes of your stress
- Practice relaxation techniques

St

Don't suffer in silence……..

- Your GP
- Heart failure nurse
- Practice nurse
- District nurses
- Smoking cessation
- Palliative care
- Dietician
- Physiotherapy
- Social services
- Intermediate care
- Occupational therapy
- Pharmacy

…..are all there to help you!

Community and Primary Care
Challenges faced

- Disperse group – difficult to meet face to face, so reliant on teleconference and email communication
- Time pressures on individual team members.
- Access to identified resources
- RiO / iClip interface
- Information governance restrictions
- Conflicting commissioning intentions

Community and Primary Care

Next Steps

- Patient Reference group to be formed and have first meeting
- Access to EPR for community HF teams (this will considerably reduce the amount of admin time)
- Establish reporting system out of RiO
- Stakeholder discussion on up-titrating and 6 month assessment at CVD Clinical Reference Group – 27th March
- Meeting with CAHS working group to feedback identified needs for service (inc. psychology support)

IP/OP

IP/OP

Progress since implementation week

- Regular Echo rounds now established
- Improved process for referring patients from AMU to HF Team
- IT working session held to look at iClip functionality
- 50% of care measures identified as possible within existing iClip functionality
- Missed doses audit underway
- Engagement with palliative care
- Adherence to 2 week rule for outpatients

IP/OP
Challenges faced

- Certain care measures with no immediate electronic solution (manual spreadsheet required)
- Time constraints and clinical commitments
- Multiple IT systems
- Capacity within Cardiac Rehab

IP/OP
Next Steps

- Second Cohorting meeting scheduled for 7th March
- Patient experience (RaTE) system to be implemented across whole pathway
- Follow up with IT to implement electronic data capture

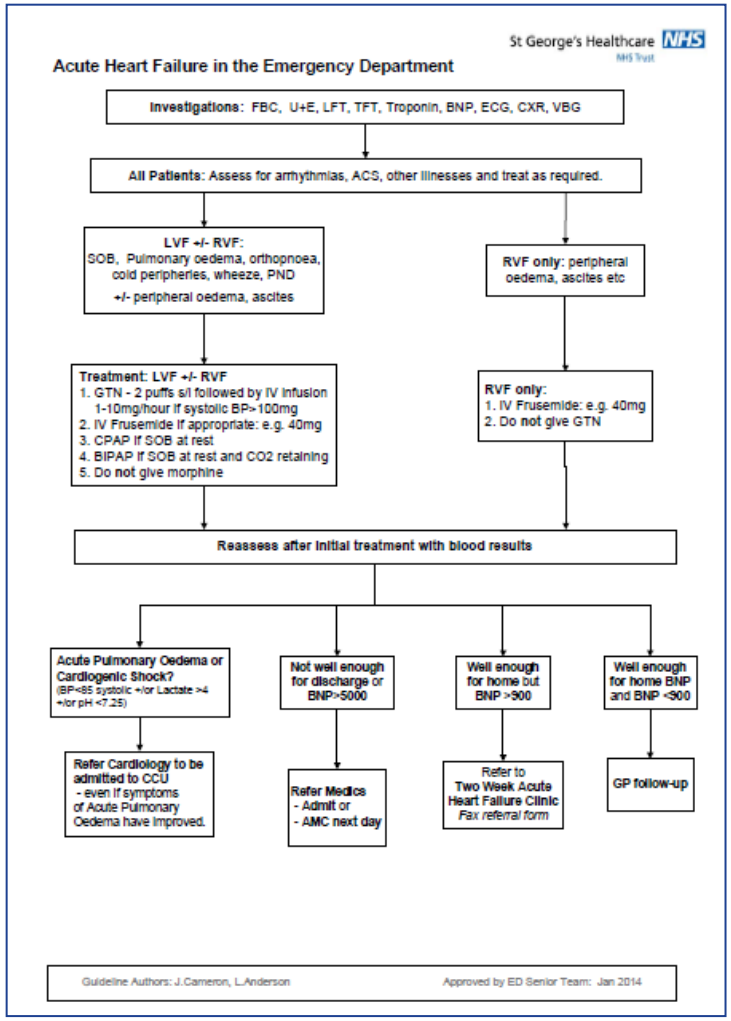
ED

ED

Progress since implementation week

- Referral process agreed and flowchart on intranet
- Referrals received by HFT from both AAA and ED
- Patients in ED who have BNP measured are generally admitted
- Better understanding of numbers, flows
- Improved communication between departments

ED
Interim Paper Referral



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Acute Heart Failure in the Emergency Department

Investigations: FBC, U+E, LFT, TFT, Troponin, BNP, ECG, CXR, VBG

All Patients: Assess for arrhythmias, ACS, other illnesses and treat as required.

LVF +/- RVF:
SOB, Pulmonary oedema, orthopnoea, cold peripheries, wheeze, PND
+/- peripheral oedema, ascites

RVF only: peripheral oedema, ascites etc

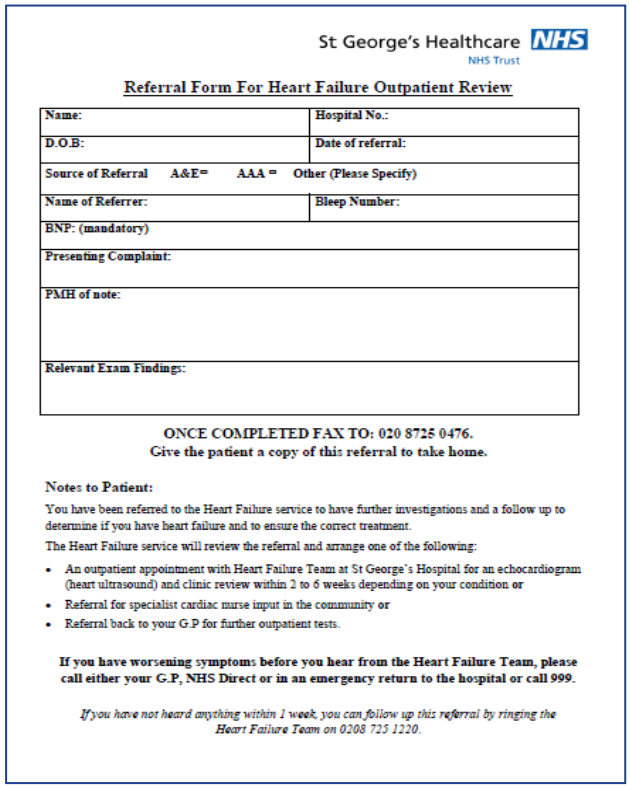
Treatment: LVF +/- RVF
1. GTN - 2 puffs s/l followed by IV infusion 1-10mg/hour if systolic BP>100mg
2. IV Frusemide if appropriate: e.g. 40mg
3. CPAP if SOB at rest
4. BIPAP if SOB at rest and CO2 retaining
5. Do not give morphine

RVF only:
1. IV Frusemide: e.g. 40mg
2. Do not give GTN

Reassess after initial treatment with blood results

Acute Pulmonary Oedema or Cardiogenic Shock? (BP<85 systolic +/or Lactate >4 +/or pH <7.25)	Not well enough for discharge or BNP>5000	Well enough for home but BNP >900	Well enough for home BNP and BNP <900
Refer Cardiology to be admitted to CCU - even if symptoms of Acute Pulmonary Oedema have improved.	Refer Medics - Admit or - AMC next day	Refer to Two Week Acute Heart Failure Clinic *Fax referral form*	GP follow-up

Guideline Authors: J.Cameron, L.Anderson — Approved by ED Senior Team: Jan 2014



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Referral Form For Heart Failure Outpatient Review

Name:	**Hospital No.:**
D.O.B:	**Date of referral:**
Source of Referral A&E= AAA = **Other (Please Specify)**	
Name of Referrer:	**Bleep Number:**
BNP: (mandatory)	
Presenting Complaint:	
PMH of note:	
Relevant Exam Findings:	

ONCE COMPLETED FAX TO: 020 8725 0476.
Give the patient a copy of this referral to take home.

Notes to Patient:

You have been referred to the Heart Failure service to have further investigations and a follow up to determine if you have heart failure and to ensure the correct treatment.

The Heart Failure service will review the referral and arrange one of the following:

- An outpatient appointment with Heart Failure Team at St George's Hospital for an echocardiogram (heart ultrasound) and clinic review within 2 to 6 weeks depending on your condition **or**
- Referral for specialist cardiac nurse input in the community **or**
- Referral back to your G.P for further outpatient tests.

If you have worsening symptoms before you hear from the Heart Failure Team, please call either your G.P, NHS Direct or in an emergency return to the hospital or call 999.

If you have not heard anything within 1 week, you can follow up this referral by ringing the Heart Failure Team on 0208 725 1220.

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ED

Retrospective audit of BNP requested from ED

Patients with BNP >900	N= 83
Admitted	N=80
General Medicine	56
Cardiology	9
Geriatric Medicine	5
Rheumatology	4
Nephrology	1
Neurology	1
Accident & Emergency	2
Clinical Haematology	1
Trauma and Ortho	1
Total	80

Discharges
N = 3
2 readmitted within 4 days

ED
Challenges faced

- Data, coding, reporting
- Devising method of electronic referral
- Clinical availability
- Translating paper referral in e-referral

ED
Next Steps

- Build recording into electronic pathway
- Expand measurement of BNP to identify unmet need – need to agree parameters
- Review the discharges from ED who are readmissions to identify root cause
- Develop and implement e-referral from ED to HF team

Building for the future…

Building for the future…

Feedback from the team

What went well…

- Patient surveys showed high levels of satisfaction with current service models and gave a clear indication of areas to improve
- New referral pathway has gone live for patients whom are discharged from A&E with a suspected diagnosis of heart failure to ensure rapid follow-up in heart failure clinic
- Mechanism to transfer care from AAA to Heart Failure clinics where a heart failure diagnosis is suspected
    - Ensure patients see the Right Person, in the Right place, at the right time with the right investigations
- More communication between community heart failure teams to aid a more standardised approach to education and support and information
- Better access to Echo for MAU – Dedicated echo round
- More conversations around Heart Failure across the organisation leading to better collaboration

Feedback from the team

What went well…

- Good will of clinicians to work together to address the needs of heart failure patients
- Allowed time to discuss the future state of heart failure services
- Opportunities to work with other teams across the organisation with the aim to piece together the complex ‘jigsaw puzzle’ that is heart failure

Feedback from the team

What could be improved…

- Delays to implementation of Trust wide IT systems
  - E-Prescribing
  - Elements of nursing documentation
- Scope of the project has been too large to accommodate in this process meaning large change areas still to be addressed
  - Cardiac rehabilitation for Heart Failure
  - Cohorting to improve patient experience and team efficiency
  - Bespoke palliative care
- Lots of data collected through multiple surveys but not all results or outcomes collated for future use
- Project yet to deliver the perceived benefits we can provide to patients through more effective care

Lessons learned

Building for the future…

- IT involvement is critical to success
- Clinical commitment sometimes take priority (as it should be the case)
- Strong (full time) project management is needed
- The goodwill is there but sometimes the commitment is lost in the complexities of the organisational structure and multiple tiers of decision making
- Heart failure team remains under resourced and the time dedicated to this project has had a temporary impact upon service delivery
- How does this align with the Trust's strategy?
- Clinical engagement hasn't been a problem – although resources are limited, executive leadership and commitment is required to drive projects through
- The realisation that data is critical…!

Key components of a successful ICP

Let's recap…it's all about the data data data

Advance Clinical Leadership & Governance

- Build **governance model** that aligns clinicians around the patient pathway
- Develop **organisational capabilities** to lead transformational change
- Establish rigorous **data governance** for reliable, actionable data

Redesign Care Delivery

- Analyze current state of pathway; redesign care models to ensure **delivery of evidence-based care**
- Implement **rapid cycle change** and testing of new care delivery models
- Adopt, embed and **measure the impact of change;** iterate models to continually improve

Enable with Technology

- Embed evidence based pathway into **electronic system**
- Collect data on **clinical performance** and outcomes
- Leverage clinical analytics to **identify, stratify & manage** patients
- **Automate care coordination** along the pathway for improved outcomes and efficiency

Our Vision: Improved outcomes + Lower cost = IMPROVED VALUE

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Key components of a successful ICP

What data do we still need…

- Refined ICD-10 discharge diagnosis code set to ensure all HF patients are captured and mapped correctly to HRG codes
- Identify sub-set of Snomed codes applicable to HF patients
- Expand understanding of demand posed by HF patients by including secondary diagnosis codes
- Link data sets (iClip, RiO, MedCon, etc.)
- Individual care measure data captured electronically
- 30% of outstanding actions relate to the above!!!

Key components of a successful ICP

It can be done…we just need to make it happen!

Care Measure					
6 month GP review for all Heart Failure Patients	Time from discharge to referral to CHFT	All acute pulmonary oedema patients to be admitted to CCU from ED	Echo requested for all HF patients	OP – x2 week referral to clinic (90%)	Review by HF team within 1 day of Echo
BNP for all Heart Failure Patients	Time from receipt of referral to 1st contact by CHFT	All heart failure patients discharged from ED to be captured for follow up by heart failure team	Prescribed meds given to HF patients	Palliative Care referral/assessment	Daily weight
All HF patients discharged to be seen within 2 weeks by CHFT (from receipt of referral)	BNP to be measuredfor all patients over 70 with shortness of breath	BNP requested for all HF patients	Echo within 1 working day from request	Patient Location	HF Team concern over discharge

50% of the care measures can be captured in iClip

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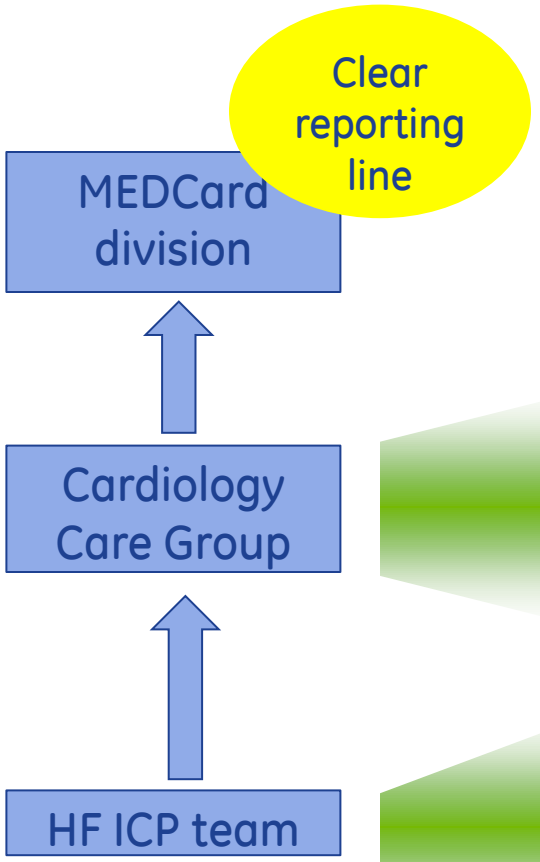
Taking the first steps - recommendations for piloting within MEDCARD / the cardiology service



ICP projects will not succeed unless **driven by clinicians** – needs to be embedded into "the way we do things around here"

- Care Group MD lead
- Nurse manager
- Business manager
- Information specialist
- Research lead
- ICP MD leads

- ICP MD lead
- MD ICP experts
- Frontline MD, nursing, AHP staff
- Improvement Team PM
- Information specialist
- IT specialist (central team)

Reporting

Divisional Report
- Existing report

+
- ICP section in cardiology

Cardiology Care Group Report
- Existing report

+
- HF ICP

HF Dashboard
- Compliance with care measures

What's next…?


HIGH VALUE
CQUIN

The Vision

The Vision

Future vision for Heart Failure services at St Georges

- First established dedicated Acute Heart Failure Unit in the UK
- Capacity for participation in leading edge cardiovascular research attracting financial reward
- Beacon site for best practice in heart failure management
- Potential to become 1st patient choice for heart failure management

The Vision

Success depends on a 'smart' pathway specific model

5-year Financial Model – Under Development

Patient groups:

- Inpatients (1° & 2° HF-related diagnosis)
- Outpatients
- Ambulatory referrals from A&E and AAA

Features to include:

- Introduction of Heart Failure unit
- Refined allocation of EB03I/H tariff
- CQUIN's
- Length of Stay Targets
- Ultrafiltration Therapy
- Readmission penalties
- Ambulatory Patient Referrals

	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017
HEART FAILURE ACTIVITY	388	400	412	424	437
Cardiology Coded Spells	51	79	81	84	86
General Medicine Coded Spells	298	284	292	301	310
Other Speciality Coded Spells	39	37	38	39	41
HF Patient Average Length of Stay (days)	8.0	8.0	8.0	8.0	8.0
HF Readmissions	54	55.6	57.3	59.0	60.8
INCOME	£1,180,848.98	£1,205,350.11	£1,222,918.99	£1,240,743.96	£1,258,828.73
Cardiology Coded Spells	£167,695.24	£255,209.29	£258,929.15	£262,703.24	£266,532.34
General Medicine Coded Spells	£950,826.99	£891,690.48	£904,687.54	£917,874.03	£931,252.74
Other Speciality Coded Spells	£62,326.75	£58,450.35	£59,302.31	£60,166.68	£61,043.66
COSTS	£1,611,082.03	£1,659,309.15	£1,708,982.10	£1,760,144.24	£1,812,840.24
Cardiology Coded Spells	£183,531.28	£189,025.22	£194,683.86	£200,512.15	£206,515.18
General Medicine Coded Spells	£1,157,827.07	£1,192,486.18	£1,228,184.35	£1,264,952.75	£1,302,823.48
Other Speciality Coded Spells	£269,723.68	£277,797.76	£286,113.89	£294,679.34	£303,501.58
Non-core costs (targeted for reduction):	£1,388,939.52	£1,430,502.37	£1,473,311.11	£1,517,403.12	£1,562,816.89
WARD COSTS	£1,104,089.90	£1,137,212.60	£1,171,328.97	£1,206,468.84	£1,242,662.91
HIGH ACUITY WARD COSTS	£0.00	£0.00	£0.00	£0.00	£0.00
ADMITTED A&E COSTS	£58,713.21	£60,474.61	£62,288.84	£64,157.51	£66,082.24
A&E COSTS	£3,372.53	£3,473.71	£3,577.92	£3,685.25	£3,795.81
THEATRES	£362.14	£373.00	£384.19	£395.72	£407.59
DAY SURGERY	£617.36	£635.88	£654.96	£674.61	£694.84
CRITICAL CARE	£32,805.27	£33,789.43	£34,803.11	£35,847.20	£36,922.62
BLOOD PRODUCTS	£7,908.42	£8,145.67	£8,390.04	£8,641.74	£8,901.00
DRUGS	£45,444.93	£46,808.28	£48,212.53	£49,658.90	£51,148.67
DRUGS (HIGH COST)	£0.00	£0.00	£0.00	£0.00	£0.00
PHARMACY	£32,315.80	£33,285.27	£34,283.83	£35,312.35	£36,371.72
XS BED DAYS	£0.00	£0.00	£0.00	£0.00	£0.00
MED STAFF	£207,889.45	£214,126.14	£220,549.92	£227,166.42	£233,981.41
ENDOSCOPY	£8,976.33	£9,245.62	£9,522.99	£9,808.68	£10,102.94
THERAPISTS	£41,444.24	£42,687.57	£43,968.19	£45,287.24	£46,645.86
OUTPATIENT COSTS	£0.00	£0.00	£0.00	£0.00	£0.00
SPECIALISTS	£2,450.87	£2,524.40	£2,600.13	£2,678.13	£2,758.48
SECONDARY COMMIS	£0.00	£0.00	£0.00	£0.00	£0.00
CNST	£5,113.32	£5,161.39	£5,209.91	£5,258.88	£5,308.31
LEVY INCOME	-£162,564.26	-£167,441.19	-£172,464.42	-£177,638.36	-£182,967.51
Core Costs (not targeted for reduction)	**£222,142.51**	**£228,806.79**	**£235,670.99**	**£242,741.12**	**£250,023.35**
PATHOLOGY	£15,777.65	£16,250.98	£16,738.51	£17,240.66	£17,757.88
BIOCHEM	£13,167.19	£13,562.21	£13,969.07	£14,388.14	£14,819.79
HAEM	£15,650.72	£16,120.24	£16,603.85	£17,101.96	£17,615.02
IMMUNOLOGY	£1,858.07	£1,913.81	£1,971.23	£2,030.36	£2,091.27
MICRO BIO	£13,613.70	£14,022.11	£14,442.77	£14,876.06	£15,322.34
HISTO / CRYPTO	£2,249.27	£2,316.75	£2,386.25	£2,457.84	£2,531.57
RADIOLOGY	£36,631.83	£37,730.78	£38,862.71	£40,028.59	£41,229.45
NEURORADIOLOGY	£459.49	£473.27	£487.47	£502.10	£517.16
CATHLAB	£181.06	£186.49	£192.09	£197.85	£203.78
What else from non-core can be moved to core?		£0.00	£0.00	£0.00	£0.00
		£0.00	£0.00	£0.00	£0.00
OTHER DIRECT	£122,531.92	£126,207.88	£129,994.11	£133,893.94	£137,910.76
OTHER COSTS	£21.61	£22.26	£22.93	£23.61	£24.32
Net activity-level financials	-£430,233.05	-£453,959.04	-£486,063.11	-£519,400.29	-£554,011.51
Cardiology Episodes	-£15,836.04	£66,184.07	£64,245.29	£62,191.09	£60,017.16
General Medicine Episodes	-£207,000.08	-£300,795.70	-£323,496.82	-£347,078.72	-£371,570.74
Other Specialty Episodes	-£207,396.93	-£219,347.41	-£226,811.58	-£234,512.65	-£242,457.92
Net financials	-£430,233.05	-£453,959.04	-£486,063.11	-£519,400.29	-£554,011.51
% variation vs. 2012-2013		-1%	-3%	-5%	-8%

imagination at work

St George's NHS Trust Acute Heart Failure Unit

1-3 months

- Build project team
- Identify physical footprint
- Develop project, capacity & resource plan
- Develop business plan
- Refine future state pathway
- Sustainability plan

3-6 months

- Business case approval
- Commence recruitment
- Prepare physical footprint
- Commence communication
- Define and establish measures of quality, financial model and performance

6-9 months

- Agree SOP's for Unit
- Agree leadership & governance
- **Go live for Acute Heart Failure Unit**
- Report out for month 1 performance
- Review the sustainability plan

9 months - 1 year

- Develop research plan
- Report performance, quality and financial metrics at monthly intervals
- Capacity review
- Celebrate success! ☺

Thanks for your attention!

Event	When	Where
60 day Report Out	26th March 2014 10am – 12pm	Education Centre Room 1, Perimeter Road


imagination at work