The Shropshire Unscheduled Care Strategy 2011 – 2014

Operating Framework

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Contents

1 Executive Summary

The delivery of Unscheduled Care across Shropshire needs to improve. Patient journeys need to be simpler, shorter, safer and more effective. Service providers need to understand their roles and commissioning needs to be aligned within the context of the whole system. Everyone needs to share a collective responsibility for the whole patient journey.

The Shropshire Unscheduled Care Strategy (Shropshire County and Telford & Wrekin) started life with a series of patient focus groups about urgent care. They produced seven powerful patient statements around which this strategy is built:

- Be 'joined up' and responsible for my care
- Help me understand the Urgent Care service
- Let me access it appropriately
- Assess and treat me promptly and in the right place
- Admit me to hospital only when necessary
- Make my stay in hospital short, safe and effective
- Try to care for me at home, even when I am ill

Patient involvement from the beginning also shaped the strategy's values, process of change and intended outcomes.

These are articulated in the form of seven key principles and outcomes:

- The central role of attitude, behaviour and relationships
- Healthy Stakeholder Organisations capable of large scale change
- Full stakeholder involvement in strategy development
- Clinical engagement at the heart of the change process
- Working with the limitations of evidence
- Self directing project groups within a framework of shared governance, accountability and responsibility
- Developing metrics and quality standards that monitor behaviour and relationships

A series of stakeholder meetings have been held to develop and align patient, provider and commissioner priorities, from which project domains have been identified. These domains have then been populated with 19 specific projects.

Nineteen project groups with a clinical leader, project manager and members representing patients, providers and commissioners have been recruited. These groups are leading service re-design across unscheduled care and together, will deliver transformational change to the local health and social economy.

Every group has developed its own detailed Aims and Objectives, to which timelines, outcomes, metrics and financial modelling have been applied. These form the basis of this Operating Framework.

For the purposes of whole system financial modelling and QIPP plan development, the projects have been 'bundled' according to which domains of quality improvement and patient flow they will have maximum impact upon.

This format will allow decisions about targeted investment and rapid change to be made in the context of ongoing whole system changes.

Shared governance, accountability and responsibility for the whole of unscheduled care are required and structures are in place to deliver this.

There is full and continuing engagement from all stakeholders in this process at all levels.

The patients and their journeys remain the primary focus of this strategy.

2 Transformational change

Transformation: ‘A considerable change in the form, outward appearance, character and disposition of….’ *Oxford English Dictionary*

The need for transformational change in the NHS is repeatedly articulated in the NHS Operating Framework 2012/13 and in all other supporting guidance, particularly in relation to QIPP. This term therefore merits further examination to understand its meaning and mode of delivery since there is an expectation that transformational change will be the fundamental aim of every health and social care strategy and operating framework.

Traditional science assume that changes in form (structure, anatomy) and function (operation, processes, physiology) of an organism will determine its psychological (and spiritual) well being. However, there is increasing evidence that psychological distress causes physiological and anatomical disturbance or illness.

Traditional management principles make the same assumption; that changes in structure and operations can drive successful change and development of an organisation whilst maintaining or improving its well being. Again, there is increasing evidence that this is not the case.

The architects of the Health Bill and the authors of the accompanying guidance would, at first glance, appear to understand this, since many of the terms they use refer explicitly to the psychological status of employees and organisations and are expressed as being crucial ingredients of successful change management. They include: engagement, responsibility, motivation, morale, respect, attitude, behaviour, leadership, relationships, compassion and dignity. Where the guidance is less clear is in how to achieve these ‘inner’ changes in order to transform. Despite the inspirational language, without an accompanying clear methodology, there will be an inevitable retreat back to purely structural and operational change management.

We believe that transformation of a health and social economy may be stimulated by changing structures and operations, but is initiated, maintained and delivered through 'inner' changes in the people working in the stakeholder organisations which these terms attempt to describe.

We also believe that this Unscheduled Care Strategy has been developed using principles that place 'inner' transformation at the heart of the change process.

This operating framework now develops these principles and processes into a methodology to deliver transformational change to the health and social economy of Shropshire.

For the purposes of this strategy, transformational change is defined as:

'A major change in outer form and function which is largely dependant on inner changes in attitudes and beliefs.'

3 Shropshire Unscheduled Care Strategy Project List

Unscheduled Care Strategy. Projects Identified Sponsor: Bill Gowans. Lead: Carol McInnes			
No.	**Project Description**	**Project Sponsor**	**Project Lead**
1	**Education & Publicity**	A&E Patient Group	Karen Higgins
2 2a 2b 2c 2d 2e	**Primary Care Access** Demand & Capacity Management (Winter9) 111 – Local Implementation DOS including NHS Pathways Walk in Centres/MIU reconfiguration GP Surgery Urgent Care Audit	 Bill Gowans Peter Clowes Peter Clowes Steve James Bill Gowans	 Chris Morris Anna Char-Green Anna Char.-Green Carol McInnes Carol McInnes
3 3a	**Secondary Care Pathways & Outreach** Acute Frail and Elderly Pathways	Meena Srinivasan Meena Srinivasan	Fran Beck Helen Swindlehurst
4	**Mental Health Liaison**	Julie Lloyd-Roberts	Michael Bennett
5	**Pathways for Urgent Care Diagnostics**	Quentin Shaw	Lynne Breakell
6 6a 6b 6c	**Frail & Vulnerable** Virtual & Community Hospitals End of Life Care Clinical Support to Care Homes	Bill Gowans Bill Gowans Jeremy Johnson Maggie Bailey	Helen Swindlehurst Helen Swindlehurst David Whiting Karen George
7 7a	**Co-location of Services** Paramedics – MIU/WIC	Bill Gowans Nick Henry	Carol McInnes Carol McInnes
8 8a 8b 8c	**Hospital Systems** Emergency Ambulatory Care Case Management & Discharge Planning A&E	Kevin Eardley Kevin Eardley Mark Cheetham/ Kevin Eardley Rob Law	Elaine Hodson Rachael Redgrave Elaine Hodson Kerry Malpass
9	**Delayed Transfer of Care (DTOC)**	Peter Clowes	Chris Morris
10	**Re-ablement**	Fran Beck	SC: Sam Hill T&W: Chris Harrison
11 11a	**Admission Avoidance** Active Case Management	Colin Stanford Colin Stanford	Tracey Jones Tracey Jones

4 Developing the Operating Framework

Forming the Project Groups

Time and care has been spent on recruiting the members of the project groups, recognising that their success depends on the right mix of experience, skill and seniority. All the Project Sponsors are clinical and are each supported by a Project Lead who is either a manager or commissioner. The other members of the group have been carefully recruited to give the right balance of clinical, managerial, patient, provider and commissioner representation. The values and processes detailed in Key Principle 6 have been adopted by each group who have developed their aims, objectives, timeline and metrics which now form the basis of the Operating Framework of this Strategy.

Project group development and alignment

To minimise the risk of unintended consequences due to overlapping aims, objectives and delivery, the project group leads meet every 4 weeks to update, align, and troubleshoot. Where they identify the need for higher level challenge or alignment, the issue is referred to the Urgent Care Network which meets every 8 weeks. Stakeholder meetings, open to all group members, are held every 12 weeks.

Project 'bundling' to achieve whole system change and develop the QIPP plan

Although it is the primary task of the Unscheduled Care Strategy, and of every project group within it, to improve Quality of care and patient experience, there is a national requirement to develop a Quality, Innovation, Productivity and Prevention (QIPP) plan to demonstrate how this can be achieved whilst reducing overall expenditure. This strategy employs QIPP principles at the heart of its development and delivery, however there is a need to demonstrate whole system economies which individual project financial modelling may fail to describe. Precisely because

the strategy has developed a whole system plan, many of the projects have overlapping outcomes and metrics which could result in 'double counting' in respect of financial impact. To avoid this, and to provide the basis for financial modelling, the projects have been 'bundled' into groups according to which key areas of the unscheduled care system they will have the greatest impact in terms of efficiency savings and improved' patient flow'. Most will have impact in several areas and are therefore listed more than once:

Project Bundles	
Reducing the number of A&E attendances	• Education and Publicity • Demand and Capacity – Winter9 • Directory Of Services (DOS) development (including NHS pathways) • Walk in Centres / MIU re-configuration • GP Surgery Urgent Care Audit • 111 Implementation (future project)
Reducing the number of emergency medical admissions	• Demand and Capacity – Winter9 • Mental Health Liaison • Clinical Support to Care Homes • Active Case Management (including Risk Stratification and Tele-health) • Re-ablement • Community / Virtual Hospital Re-configuration • End of Life Care • GP Surgery Urgent Care Audit
Reducing emergency admissions by increasing Emergency Ambulatory Care	• Emergency Ambulatory Care • Pathways for Urgent Care Diagnostics
Increasing medical discharges within 72hrs (not including AEC	• Case Management and Discharge Planning • A&E • Acute Frail and Elderly Pathways
Reducing Length of Stay (LOS) and 'excess bed days' for frail elders	• Case management and discharge planning • Demand and Capacity – Winter9 • Delayed Transfers of Care (DTOC) • Acute Frail and Elderly Pathways • End of Life Care
Reducing LOS and 'excess bed days' for medical admissions	• Case Management and Discharge Planning • Delayed Discharges of Care

5 Project Descriptions

Education and Publicity

A patient led programme to help people understand the Urgent and Emergency Care Service, how to access it appropriately and thereby reduce A&E attendances.

There is no evidence that traditional publicity campaigns which try to reduce A&E attendances are effective. This patient led project, with a strong educational component and medium term objectives will rely on experience-based consensus and an evolving strategy for its success.

The Shrewsbury Patient Group, representing 15 practices, has formed an 'A&E group' which has achieved its short term goal of delivering a winter publicity campaign to encourage people to contact their GP surgeries when they have an urgent problem. They have also developed a medium term plan to design and lead an Education and Publicity campaign, initially in the Sundorne, Ditherington and Harlescott areas of Shrewsbury. Their work has begun with patient questionnaires to establish educational need and potential impact of different strategies. The preliminary results of this have been published. Similar activities will be undertaken in Telford.

Once a consensus is obtained, a county wide campaign will follow in conjunction with a re-branding of the Unscheduled Care Service. This is expected to have a significant positive impact on the understanding and appropriate access of unscheduled care.

Project 1: Education & Publicity

Project Aim (linked to patient statements):	To raise patient and public awareness of the alternative urgent care services available across Shropshire and achieve a 2% reduction in self presentation at A&E for minor injuries.
Project Objectives (SMART)	1. Develop baseline of patient understanding of unscheduled care services that are available to deal with urgent medical needs by September 2011. 2. Develop and implement a public facing campaign to raise awareness of alternative unscheduled care services by October 2012.
Expected Outcomes:	• 2% reduction in self presentation at A&E (2009/10 & 2010/11 attendance as baseline & predict a monthly average for Oct – March inclusive). • Public demonstrates greater understanding of available alternative unscheduled care services (repeat baseline questionnaire March 2012).
Process Metrics:	• Patient survey developed and for patients to demonstrate greater understanding of available urgent care services
Balancing Metrics:	• Avoided increase in ambulance transfers from MIU's to A&E.
Data Source:	• Urgent care focus group reports • Urgent care patient survey – full data • Urgent care patient survey report • Incidental findings from patient volunteers • A&E self presentation data
Actions:	• Establish County wide patient led group • Group to develop action plan for patient led Marketing campaign • Develop draft baseline survey and pilot • Review results of pilot and amend survey accordingly • Perform baseline survey across chosen demographic • Liaise with clinical audit to evaluate data • Use data to inform development of patient facing marketing campaign • Implement public facing campaign (Oct 12 - March 2013) • Evaluate campaign and provide feedback report for Urgent Care Network
Task & Finish Group Membership:	**Project Sponsor:** A&E Focus Group **Project Manager:** Karen Higgins **Project Team:** • Sian • Transfer list •
Project Risks and Mitigating Actions:	**RISK**: Ineffective / inappropriate use of patient group feedback **ACTION:** Ensure recommendations are clear, evidence based. Obtain firm commitment for actions with named responsible person **RISK:** Marrying NHS deadlines with voluntary time **ACTION:** Establish firmly agreed timescales for patients and organisation
Interdependencies:	
Resource planning:	10k marketing budget required

Research evidence and background material

Education and Publicity.

Healthcare Commission Not Just a Matter of Time - A review of urgent and emergency care services in England 2008
Although most people understand the role of their local GP and of A&E departments, many are either less aware of, or less confident in using, the range of new services in between. In such an environment, our work with patients suggested that people's preference is often to stick with the services they are familiar with.

Adamson J et al Exploring the impact of patient views on 'appropriate' use of services and help seeking: a mixed method study British Journal of General Practice, July 2009, vol./is. 59/564(pp226-33) (available from xx)
Perceptions that individuals' use health services inappropriately are unlikely to explain differences in help-seeking behaviours. The findings suggest that people do not take the decision to consult health services lightly and rationalise why their behaviour is not time wasting.

Access to Health Care Reducing Attendances and Waits in Emergency Departments - A systematic review of present Innovations 2004
Key messages based on a literature review which investigated the organisational factors that influence attendance and waiting times in emergency departments, includes 'Patient education is of unproven advantage in reducing attendances'.

Department of Health Improving emergency care in England: sixteenth report of session 2004-05: report, together with formal minutes, oral and written evidence 2005
The Department should engage in a public education campaign, drawing on best practice from other organisations such as the UK Fire Service.

Dr Foster Intelligence A&E social marketing Quantitative research findings (December 2009) NHS Sutton and Merton
Includes the best messages that should be given to patients to encourage them to use emergency care appropriately.

Dr Foster Intelligence Reducing inappropriate use of A&E in Barnsley NHS Barnsley
Details of a local campaign to reduce A&E attendance.

NSMC Getting the Treatment Right
Details of a social marketing campaign to reduce inappropriate use of A&E in Tower Hamlets.

Knowsley Primary Care Trust 'Choose Well' initiative
This initiative has used communications and branding techniques, based on a thermometer brand, to help the public make more appropriate choices of service to meet their urgent care need.

Demand and Capacity Management – Winter9

A live, whole system demand and capacity management system for urgent and emergency care which is linked to active patient journey management is a key medium term goal in the development of a responsive, adaptable and 'joined up' system. With a small initial investment, the Winter9 project is providing a prototype unscheduled health and social care 'communications hub' which comprises an evolving demand and capacity 'dashboard', enhanced single point of access (SPA) care co-ordination and an acute frail elder service for 9 weeks of Winter. This 'gift' to the local health and social economy is testing the capacity of providers to 'do things differently' and detailing the challenges every stakeholder faces in delivering integrated care which is centred around the patient and not organisational boundaries. As well as providing the opportunity for a 'step change' in attitudes, relationships and working patterns, this project is providing rich data and stories to inform the further development and delivery of the entire Unscheduled Care Strategy. Because of this it has been designated a rapid change project to challenge the local health and social economy and to see 'how well we can do with what we already have'.

Project 2a: Demand & Capacity Management (Winter 9)

Project Aim (linked to patient statements):	To test and interrogate the ability of the local health and social economy to improve patient journeys and outcomes by providing an enhanced communications hub to 'join up' the system. (See Acute Frail and Elderly Pathways 3a for aim of frailty project embedded in Winter9)
Project Objectives (SMART)	1. To establish a communications hub for the local H&S economy 2. To establish a whole system Demand & Capacity dashboard 3. To establish provider communications personnel and protocols 4. To capture data and narrative arising from the interrogation 5. To use the project evaluation to develop a long term systems plan 6. To challenge providers to 'do better' with existing resources 7. To provide a forum for the delivery of the Acute Frail and Elderly project objectives (see Acute Frail and Elderly pathways 3a)
Expected Outcomes:	• A detailed understanding of the drivers and blocks in the system • The development of a detailed whole system comms. plan • 2% increase in alternative (to A&E) ambulance destinations • 1% increase in diversion rates achieved by enhanced CCC (see Acute Frail and Elderly Pathways 3a for Frailty Project Objectives embedded in Winter9)
Process Metrics:	No. of admissions via CCC against the total number of calls handled No. of ambulance calls diverted at scene against total number of responses Questionnaire to determine % of front line worker who used Winter9 for help and advice with their patient journeys
Balancing Metrics:	No. of onward journeys by ambulance after reaching first destination No. of admissions within 48hrs / 7 days after CCC alternative management plan implemented
Data Source:	CCC data and narrative
Actions:	• Establish project steering group • Agree model for centralised professional communications hub to be prototyped • Define, cost and work plans for increase in CCC capacity • Define work plans for additional senior clinical managers seconded from commissioners and providers • Engage providers via stakeholder event and promotional material • Identify operational and provider leads • Co-ordinate development and implementation of additional IT infrastructure to track appropriate patients through the system • Identify information needed for live demand and capacity dashboard and pilot • Agree metrics to be recorded for evaluation (quantitative & qualitative) • Develop and implement communication strategy – including capture of patient stories and project development • Engage 'resident story teller' and empower provider contacts to be 'pied pipers' for the project (see Acute Frail and Elderly Pathways 3a for Frailty Project actions embedded in Winter9)
Task & Finish Group Membership:	**Project Sponsor: Dr Bill Gowans** **Project Manager: Chris Morris** **Project Team:** Dr Gill Clements Carol McInnes Elaine Hodson Fran Beck Pete Gordon Anthony Stacey Tracey Jones

Research evidence and background material

Demand and Capacity Management

NHS Institute for Innovation and Improvement Demand and Capacity - A Comprehensive Guide
This comprehensive guide helps to get to the hub of the problem of why waiting lists and backlogs form and what you can do about it.

NHS East Midlands Transformation of the urgent care system 2011
Webinar looking at the current urgent care issues.

Walley, P et al Managing Variation in Demand: Lessons from the UK National Health Service Journal of Healthcare Management 51/5, Sep/Oct 2006, pp 309-20 (available from xx)
Lessons that have emerged focus on understanding and measurement of demand, capacity planning, reduction of introduced variation, segmentation and streaming of work, process design, capacity yield management, and measurement of variation.

Jack, E, Powers, T A review and synthesis of demand management and performance in health-care services. International Journal of Management Reviews, Vol. 11, Issue 2, pp. 149-174, June 2009 (available from xx - hardcopy)
Looks at the analysis and synthesis of research on demand management, capacity management and performance.

NHS 111

The implications to our local health economy and to a demand and capacity management system of the full implementation of a national 111 number by 2013 cannot be underestimated.

A Pan Shropshire group is in discussion with the Ambulance Service, the West Mercia Cluster Leads and Shropdoc with the aim of achieving cluster or regional level procurement, to reduce costs, and local commissioning of the agreed services to ensure it enhances Shropshire's co-ordination of services and a system wide unscheduled care strategy.

Research evidence and background material

NHS 111

NHS North East Procurement Service 111 Provider Engagement - Analysis of responses
A large proportion of providers suggested that the most attractive service model for the for commissioners would be a single contract provided by a consortium of providers with an identified lead provider

Department of Health Rolling out the NHS 111 Service 2011
We would now like to invite those areas that have not yet committed to go-live or procurement dates for NHS 111, to confirm their plans.

CMS DOS including NHS Pathways

NHS Pathways Capacity Management System Directory of Services is a suite of web-based tools which measures capacity and activity pressures in real time.

The aim of this project group is to explore the potential for NHS Pathways to be aligned with a Health Economy wide live demand and capacity system and to develop a plan for local development and implementation.

Research evidence and background information

CMS DOS including background material

NHS Connecting for Health NHS Pathways
NHS Pathways sets out to deliver a single clinical assessment tool that provides effective triage over the telephone in any setting taking calls from the public. This can include 999, NHS Direct, GP out-of-hours, NHS 111 and any other Single Point of Access (SPA) number in place.

4.1.1 Walk in Centre and Minor Injury Units re-configuration

Although Walk in Centres (WICs) are experiencing increasing demand, they remain strategically unconnected to the rest of the local health economy. Minor Injury Units, attached to the Community Hospitals, are underused and require review and re-configuration.

One option being considered is for a proportion of patients who are deemed to not require an ambulance but who require assessment following 999 triage using NHS pathways, and patients requiring assessment following 111 triage, to be offered appointments at MIUs and WICs using a live capacity management system.

This would begin a process for WICs of developing their services from entirely 'walk-in' to partly 'urgent care by appointment', thus integrating the service into an emerging whole system urgent care service.

Project 2c: Walk in Centres & MIU's Reconfiguration

Project Aim (linked to patient statements):	To review and reconfigure the unscheduled care services, currently provided by both the MIU's and the WIC's to ensure equitable access to safe and effective services across the LHE by March 2014.
Project Objectives (SMART)	• To Develop and agree a plan for reconfiguring the unscheduled care services, by the end of November 2011. • To agree an implementation plan for the reconfigured services by the end of December 2011. • To develop a system for managing live demand and capacity across both MIU's and WIC's. • To divert ?% of suitable patients from A&E to an appropriate unscheduled care service..
Expected Outcomes:	• 2% reduction in self presentation at A&E by x against agreed baseline (2009/10 & 2010/11 attendance as baseline & predict a monthly average for Oct – March inclusive) by x date
Process Metrics:	• 2% reduction in self presentation at A&E against agreed baseline by (2009/10 & 2010/11 attendance as baseline & predict an expected monthly average for Oct – March inclusive) by x date • X% increase in attendance at MIU/WIC's by x date • X% increase in ambulance going direct to MIU/WICs by x date
Balancing Metrics:	Increase in use of alternative sites without a decrease in A&E attendance
Data Source:	Monthly provider reports – activity & Performance,Monthly finance activity reports for both alternative services and A&E

Actions:	• Establish project group
	• Agree project aim and objectives
	• Agree timeline for implementation
	• Perform review of current state (data and processes)
	• Develop future state model and design implementation/reconfiguration
	• Develop implementation plan, including:
	  • Roles and structures
	  • Agreed standard operating procedures
	  • Agreed process for access to diagnostics
	  • Skill mix review of staff and training/development plan for staff as appropriate
	  • Draft revised service specification for affected services
	  • Perform cost analysis of proposed reconfiguration
	• Develop a live demand and capacity system for co-ordinated diversion of non-urgent patients to alternative services
	• Work with Education & Publicity group to raise public awareness of alternative unscheduled care services
	• Provide an update to GP's and other health care professionals regarding the revised services

Project Risks and Mitigating Actions:	**Risk:** Commitment of individual organizations to change **Action:** **Risk:** potential cost implications of aligning services across the County
Interdependencies:	Education & Publicity Demand & Capacity Management EAU Co-location of services
Resource planning:	

Research evidence and background material

02c Walk in Centre and Minor Injury Units re-configuration

Freeman JV et al The impact of the 4 h target on patient care and outcomes in the Emergency Department: an analysis of hospital incidence data. Emergency Medicine Journal, December 2010, vol./is. 27/12(921-7) (available from xx)
The introduction of a minor injuries unit (MIU) was associated with reductions in time to clinician and percentage not waiting, and increases in number of investigations, percentages admitted, admitted for 24 h and re-attendances within 7 days.

Sakr M et al Emergency nurse practitioners: a three part study in clinical and cost effectiveness Emergency Medicine Journal, March 2003, vol./is. 20/2(158-63) (available from xx)
A nurse practitioner minor injury service can provide a safe and effective service for the treatment of minor injury. However, the costs of such a service are greater and there seems to be an increased use of outpatient services.

NHS Sheffield Sheffield City Centre Walk-in Services – options evaluation framework 2010
This paper proposes an evaluation framework that will be used to assess each option in Sheffield

(see also evidence in section 07b – Co-location of Services - Paramedics and MIUs / WICs)

4.1.2 GP Surgery Urgent Care Audit

An externally facilitated systems audit of all the GP practices (the 45 in Shropshire County) is being carried out by the Primary Care Foundation to determine the efficiency, responsiveness and capacity of their urgent care service provision. All the Telford and Wrekin practices have already been offered the opportunity to carry out a similar audit.

The results of this audit will allow practices to review their provision of urgent care and, where indicated, make improvements based on examples of good practice in the county.

In addition, it will improve understanding of the way urgent care provided by Primary Care impacts on the other providers of urgent care, in particular A&E departments (and vice versa).

This audit will be completed by the end of 2011 and a process of practice, locality and county wide peer review will be augmented by individual practice visits from the Primary Care Foundation and potentially a re-audit 12 months later.

Project Aim (linked to patient statements):	To ensure that primary care provides a timely response for urgent care.
Project Objectives (SMART)	1. Lower response times for requests for urgent appointments and home visits to within 1 hour from time of request
Expected Outcomes:	• Less deterioration of 'at risk' patients, preventing emergency admissions (1% target per practice)
Process Metrics:	• 50% + of General Practices completed audit • Whole Health Economy report with themes identified produced
Balancing Metrics:	•
Data Source:	• Primary Care Foundation Tracker • Primary Care commissioning Reports
Actions:	• Identify Provider of primary care audit (already undertaken in T&W) • Agree Timescales • Contact Primary Care to introduce audit • Arrange Stakeholder/training events • Practices to implement audit over agreed 5 week period • Individual practice reports disseminated • GP Commissioning lead to attend locality meetings and provide general feedback/share best practice • Shropshire County Report to be developed and shared • Repeat audit at 12 month interval to assess impact and measure success
Task & Finish Group Membership:	**Project Sponsor:** Dr Bill Gowans **Project Manager:** Carol McInnes **Project Team:** GP Locality Leads
Project Risks and Mitigating Actions:	**Risk:** lack of primary care engagement **Action:** Project to be led and driven by CG Lead, detailed information provided to practice managers, administrative support provided to complete as required.
	Active Case Management Acute frail & vulnerable pathways Clinical Support to Nursing Homes Pathways for Urgent Care Diagnostics
Interdependencies:	Active Case Management
Resource planning:	Cost of Audit met by SHA

Research evidence and background material

02d GP Surgery Urgent Care Audit

Primary Care Foundation Urgent Care – A Practical Guide to Transforming Same-day Care in General Practice 2009
Urgent care in general practice matters. It matters to patients, who may be harmed or distressed if diagnosis and treatment is delayed. It matters to the NHS as a whole, because urgent care arrangements which have not kept pace with other operational changes within the NHS place pressure on the rest of the system, driving people towards A&E and avoidable hospital admissions. It matters to practices, where workloads can become unmanageable if urgent care is not handled well.

Acute Frail and Elderly Pathways

People who are frail and elderly and who become acutely unwell often have different and more complex care needs compared to the rest of the population leading up to, during and following an emergency hospital admission. They currently have longer hospital stays and poorer outcomes than the rest of the population.

Led by a consultant geriatrician, this project group will develop and implement acute Frail and Elderly pathways to guide the care of these patients during the hospital phase of their journey to ensure that their stay is as short, safe and effective as possible.

The Winter9 project has facilitated the rapid formation of prototype Frailty Teams working at the 'front door' of the two acute hospitals to improve the journeys of frail elders who will benefit from rapid assessment, treatment and discharge.

A short to medium term objective of this group is to assist commissioners in examining the potential of a county wide 'Frailty Service' which integrates all aspects of the care of the elderly. The potential enhancements achieved by risk stratification and tele-health will be included in this.

Project 3a: Acute Frail & Elderly Pathways

Project Aim (linked to patient statements):	To provide a seamless, integrated service with a multidimensional and multidisciplinary input for acutely ill frail elders
Project Objectives (SMART)	1. Develop, implement and evaluate frailty assessment tool, tracking and frailty team assessment within context and timescale of Winter9 project 2. Improve integration of acute and community services to improve the journeys of frail elders and to support timely discharge/transfers of care 3. Evaluate provision of care of the elderly specialists in local health economy 4. Assist in the integration of health and social care around acutely ill frail elders 5. Develop plans for a whole system Frailty Service
Expected Outcomes:	• Increase of 20% of frail elders discharged within 72hrs against baseline.
Process Metrics:	• Health Economy wide frailty tool developed, agreed and implemented. • Appropriate care pathways developed and implemented.
Balancing Metrics:	• Patient satisfaction with services not negatively affected. • Re-admission rates within 30 days of contact with hospital frailty team • Institutionalisation rates within 30 days of frailty team contact
Data Source:	Numbers of admissions Excess beds days of frail elders % of people admitted following attendance at A&E Care Home admissions of tracked frail elders
Actions:	**For Winter9 project**: 1. Agree and implement a Frailty Assessment Tool to be used to identify all frail elders as they enter the unscheduled care system 2. Design and apply an IT based Tracking tool to allow tracking of all identified Frail Elders as they move through unscheduled care. 3. Develop and trial a multidisciplinary frailty team to assess frail elders at acute presentation in SaTH 4. Agree work plans for seconded senior clinical managers to be active case managers for identified acutely ill frail elders anywhere in the system. **For December 11 / January 12** • Physio audit and 2 week in–reach model (11/2hrs per day) • Align current workstreams e.g. dementia care pathway work to reduce risk of duplication **For longer term development**: 1. Develop care pathways and delivery plans to improve the journeys of: a. Acutely ill frail elders assessed in MAU/A&E but not requiring admission • Acutely ill frail elders requiring short stay in-patient care (48-72hr LOS) • Acutely ill frail elder requiring in-patient care with LOS >3days 2. Develop case for whole system Frailty Team
Task & Finish Group Membership:	**Team Sponsor:** Dr Meena Srinivasan **Team Leader:** Helen Swindlehurst **Project Team:** Elaine Hodson, Rachel Redgrave Dr Gill Clements, Dr Peter Clowes Yvonne Rimmer, Dr Teresa Griffin Dr Rob Campbell, Jill Dale, Dr John Jones
Project Risks and Mitigating Actions:	**RISK**: Lack of support for frailty team from senior management **ACTION**: Highlight alignment of prototype with health economy demand/capacity model/projected efficiencies **RISK**: Lack of health economy support for frailty tool **ACTION**: Promote tool with other unscheduled care workstreams gain consensus for use **RISK**: Lack of support for acute frail elder workstreams/changes in practice **ACTION**: Align work with other workstreams e.g. acute dementia work to raise profile of requirements to change practices

Research evidence and background material

Acute Frail and Elderly Pathways

Audit Commission Supporting frail older people 2004
That report looks at what independence means for older people and concludes that, to be independent, older people need to feel they have choice and control over how they live their lives. It also reports the key factors that older people themselves said were important for keeping them independent.

Walsall Council Frail Elderly Pathway 2010
The aim of this pathway is to provide care in the person's own home to reduce the unnecessary use of acute hospital beds and care home placements, achieving as good or better outcomes in patients' health, well-being and quality of life. The pathway adopts the concept of a virtual ward whereby emergency, acute, primary care and community services, intermediate care, older people's mental health and social care services can work better together to deliver joined up care for frail elderly people with non specific, non life threatening conditions such as falls, immobility or confusion.

NHS Hampshire Overall vision for the Frail Elderly 2009
It is our intention to commission appropriate interventions that reduce hospital attendances, particularly inappropriate admissions, prevent entry to long-term care institutions and provide support at home, or as near to home as possible. We will also develop robust and clear plans for disinvestment from inappropriate unscheduled services, mainly with actue providers.

NHS East of England Getting it right for frail elderly people 2011
This workshop focused on different elements of how we can engage with frail elderly people in a way that embraces "no decision about me, without me". The presentations covered a range of topics - potential pathways, dementia management in care homes, case finding, fragility fracture and falls, risk stratification and assistive technology.

Michael YL et al Primary care-relevant interventions to prevent falling in older adults: a systematic evidence review for the U.S. Preventive Services Task Force Annals of Internal Medicine, December 2010, vol./is. 153/12(815-25)
Primary care-relevant interventions exist that can reduce falling among community-dwelling older adults.

Logan P et al Community falls prevention for people who call an emergency ambulance after a fall: randomised controlled trial BMJ 2010;340:c2102
A service to prevent falls in the community reduced the fall rate and improved clinical outcome in the high risk group of older people who call an emergency ambulance after a fall but are not taken to hospital.

Department of Health How Can We Help Older People not Fall Again? 2003
The resource cost to health and social care systems of falls (and fractures) is large – in direct costs and in lost opportunity costs.

Scanailla C et al Technology Innovation Enabling Falls Risk Assessment in a Community Setting Ageing International, 36(2), June 2011, pp.217-213 (available from xx)
Advances in technology may enabling community-based practitioners to perform tests that previously required expensive technology or expert interpretation. Gait and balance impairment is one of the most common risk factors for falls.

NICE Clinical practice guideline for the assessment and prevention of falls in older people 2004
The main areas examined by the guideline were: The evidence for factors that increase the risk of falling; The most effective methods of assessment and identification of older people at risk of falling; The most clinically and cost effective interventions and preventative strategies for the prevention of falls; The clinical effectiveness of hip protectors for the prevention of hip fracture; The most clinically and cost effective interventions and rehabilitation programmes for the prevention of further falls; Older peoples' views and experiences of falls prevention strategies and programmes.

Mental Health Liaison

30% of all adults admitted to hospital as an emergency have a mental health (MH) co-morbidity.

There is potential for MH liaison services to be utilised and managed more efficiently which could in turn support the development of effective discharge systems and improve patient outcomes.

There are three aspects to MH liaison services which have been identified for improvement:

- The MH assessment of acutely disturbed and often violent patients presenting to A&E departments.
- The MH assessment of patients admitted to the Medical Assessment Unit with physical problems whose care is made more complex because they have a MH co-morbidity.
- The physical assessment of patients with a MH diagnosis who are admitted to a psychiatric bed and who have physical co-morbidities which require assessment and treatment as part of their overall care.

This project group will help develop strategies and work streams to improve all three aspects of MH liaison. The evidence provided by the RAID project in Birmingham will be incorporated into the development of a whole system approach to Mental Health Liaison.

Research evidence and background material

Mental Health Liaison

Malone D, et al Community mental health teams (CMHTs) for people with severe mental illnesses and disordered personality Cochrane Database of Systematic Reviews 2007, Issue 3.
Community mental health team management is not inferior to non-team standard care in any important respects and is superior in promoting greater acceptance of treatment. It may also be superior in reducing hospital admission and avoiding death by suicide.

NHS Confederation A future vision for mental health 2009
This report sets out a new vision for the future of mental health and well-being in England. Based on four principles, it outlines the priorites that the Future Vision Coalition believes should underpin mental health policy for the next decade.

National Audit Office Helping people through mental health crisis: The role of Crisis Resolution and Home Treatment services 2007
The NHS in England spent over 8 billion on mental health in 2006-07, more than on any other category of health problem. Most people with mental health problems receive treatment in the community, for example from their GP or a Community Mental Health Team.

Zolnierek C Non-psychiatric hospitalization of people with mental illness: systematic review Journal of Advanced Nursing 2009; 65(8): 1570-1583 (available from xx)
The author concluded that in-patients in medical-surgical settings with severe mental illness had poorer clinical outcomes compared to patients without mental illness and that nursing staff require support in working with this population. Given the unclear quality of the included studies and potential for error and bias in the review process, the author's conclusions should be treated with caution.

Pathways for Urgent Care Diagnostics

This local health economy project group is currently responsible for the prioritisation, development, approval, implementation and governance of pathways for Urgent Care Diagnostics which are necessary for the rapid and efficient development of Emergency Ambulatory Care (EAC) within the two SaTH hospitals. In the near future it will also ensure that these EAC pathways are aligned with, and developed alongside, primary care urgent care diagnostic pathways currently provided via the Care Co-ordination Centre (CCC) and the DAART unit at SaTH.

Project 5: Pathways for Urgent Care Diagnostics

Project Aim (linked to patient statements):	To design, develop and implement pathways to provide equitable access to timely urgent care diagnostics for patients, to facilitate prompt assessment, treatment and care in the most appropriate place, admitting patients to hospital only when necessary
Project Objectives (SMART)	• To develop integrated pathways for urgent care diagnostic investigation whether in primary or secondary care • To develop and implement integrated care pathways for ambulatory emergency care conditions which have been identified and agreed by working group • To increase primary care and outpatient access to secondary care based urgent diagnostics reducing the need for in-patient admission
Expected Outcomes:	• 20% decrease in medical patients who present with potential ambulatory conditions with LOS that exceeds 3 days LOS
Process Metrics:	• AEC pathways developed and implemented. • Integrated pathways for urgent care diagnostics developed.
Balancing Metrics:	
Data Source:	**Weekly:-** • Unscheduled admissions activity for identified conditions against activity for 2010/11 • Urgent outpatient diagnostic requests • GP urgent diagnostic activity
Actions:	**November 2011 – March 2012** • Ensure all existing pathway groups are identified and reformed into the 'refreshed' pathways group • Analysis of current unscheduled admissions 0-1 day and 2-3 day LOS, for the potential ambulatory emergency care conditions • Agree expected outcomes • Implement and evaluate the Pulmonary Embolism pathway • Prioritise pathways for development and implementation, based on the 2010/11 potential ambulatory emergency care conditions activity, with timescales • Agree model and process for pathway design • Establish governance framework for implementation
Task & Finish Group Membership:	**Project Sponsor**: Quentin Shaw **Project Manager:** Lynne Breakell **Group members:** Kevin Eardley, Rachel Redgrave, Elaine Hodson, Bill Gowans, Emily Peer, David Hinwood, Gill Clements, Kumar Bhamidamarri, Shukri Ramandan, other members co-opted for specialty knowledge on ad hoc basis **A&E consultant, Community Trust Manager, Finance, Informatics representation (to be agreed at inaugural meeting 1st November**
Project Risks and Mitigating Actions:	• **Duplication–** need to identify all groups that are currently working on patient pathways, and reform as one 'refreshed' pathways group • **Protected time** for clinicians will need advanced notice of meetings, nominated deputies and accountable actions with robust timescales
	Education & publicity NHS Pathways Walk in Centres/MIU reconfiguration AEC Active Case management
Resource planning:	

Research evidence and background material

Pathways for Urgent Care Diagnostics

NHS Scotland Long Term Conditions Collaborative - Improving Care Pathways 2010
Tools include Plan Do Study Act (PDSA) cycles/Model for Improvement; lean-thinking; Value Stream Mapping (process mapping, 6S and 7 Wastes that identify steps and activities that don't add value); DCAQ (Demand, Capacity, Activity, Queue) addressing capacity and flow to streamline pathways and reduce delays, and Poke Yoke to prevent errors thereby increasing reliability, productivity, safety and value across the whole system.

NHS Interim Management and Support Planning for predictable flows of patients into unscheduled care pathways beyond the Emergency Department: Meeting Demand and Delivering Quality 2010
This short paper, which was commissioned by the Urgent and Emergency Care Intensive Support Team, describes an approach to managing urgent and emergency patient flow in acute hospitals that can significantly reduce length of stay. The principles described in this paper have been successfully implemented across the NHS.

Virtual and Community Hospitals

It is a government and commissioner priority to reduce the total number of beds required in the local health service by improving the productivity of community services.

The bed based model of care also requires a fundamental review in the context of a whole system plan to deliver more effective unscheduled, urgent and emergency care.

However, the provision of efficiently managed step-up and step-down community beds is regarded as having an important role to play in improving the patient journey and their outcomes by facilitating the rapid flow of patients through secondary care beds.

The Virtual Ward service in Shrewsbury, identified as a Rapid Change project, already provides actively managed step-up and step-down beds, commissioned from local nursing homes together with the provision of enhanced medical care to the patients admitted to those beds.

The Virtual Ward project is linked to the development of Frail and Vulnerable registers within the local GP Practices. This is with a view to aligning and integrating the development of community beds with Active Case Management of people identified as frail and vulnerable who might require a bed during an acute exacerbation of their condition.

This project group, led by one of the Urgent Care GP leads, will perform a full review and, where appropriate, a re-design of all community beds provided in the county.

Project 6a: Virtual & Community Hospitals

Project Aim (linked to patient statements):	To use the correct number and correct mix of community beds in the most efficient, therapeutic way to provide patients with high quality, sustainable care.
Project Objectives (SMART)	1. To understand the current community bed provision in the context of local need 2. To develop a clear picture of current best practice, need, future needs and gaps in provision 3. To identify possible directions of travel to providing modern, safe, high quality care
Expected Outcomes:	• Provision of appropriate numbers of beds in each locality according to identified need (capacity to meet demand).
Process Metrics:	• Baseline of current services produced. • Future state mapped.
Balancing Metrics:	
Data Source:	Community Provider reports
Actions:	October 2011 to March 2012 • Agree longer term membership of group • Current state analysis • Agree bed numbers/mix S&A • Agree bed numbers/mix Northwest Shropshire • Resource planning • Develop metrics/measure interventions • Redefine criteria for admission • Redefine service specifications
Task & Finish Group Membership:	» **Team Sponsor**: Dr Bill Gowans/Dr Mary Goodge » **Project Lead:** Helen Swindlehurst Dr Emily Peer, Andrea Davies, Dr Teresa Griffin, Medical advisor rep, Community hospital nurse rep, ?therapy rep
Project Risks and Mitigating Actions:	CHR1 Lack of engagement from clinicians/teams in medium term planning for redesign CHM1 Engage with clinicians/teams from outset with regard to involvement in developing new models of care CHR2 Shortfall in available funding when mapped against need for Shrewsbury & Atcham community beds CHM2 Identify all available funding streams/ensure tender includes affordable pricing structure to match bed requirements
Interdependencies:	Active case management Delayed transfers of care Acute frail and vulnerable
Resource planning:	Identify resources for S&A community beds – HS to lead. Current resource for 15 beds recurrent. To identify possible Resources for extra beds e.g. EMI rehab beds

Research evidence and background material

Virtual and Community Hospitals

King's Fund Case study: Virtual wards at Croydon Primary Care Trust
Croydon Primary Care Trust (PCT) has been piloting the practical use of the Combined Model on behalf of the King's Fund and Health Dialog since May 2006. It has developed a package of care called virtual wards that it offers solely to people at highest predicted risk.

Williams, R Virtually at home Nursing Management UK, June 2007, vol./is. 14/3(8-13) (available from xx)
Report on a case management model developed at Croydon PCT that enables community care staff to carry out home-based treatment of patients with long-term conditions at risk of unplanned admission. The development of the model, which includes the use of predictive risk tools and virtual ward systems, is discussed.

NHS Warwickshire Consultation for North Warwickshire Intermediate Care and Bramcote Hospital 2011
Preferred option - Close Bramcote Hospital and re provide the current service by the purchase of up to 8 beds providing 24 hour care and enhancing the intermediate care service. In addition, opening an additional 100 places on the virtual ward in North Warwickshire, available to all General Practitioners (GP) Practices

End of Life Care

The principles and practice of palliative care already provide a high standard of care to people dying of cancer in Shropshire.

These practices need to be extended to everyone who is in a terminal stage of their illness no matter what the diagnosis.

Everyone who is nearing the end of life should be involved in making choices about where they die and be given more opportunity for this to be at home when this is their choice.

This county wide project, led by the Medical Director of the Severn Hospice, will champion the changes in attitude, behaviour and relationships required to deliver excellent end of life care.

The work of the project group will build on the work already done over a number of years by the Palliative Care Forum across Shropshire and the End of Life Group in SaTH.

A potential rapid change element of this project is to reduce the number of people dying, against their wishes, in hospital.

Project 6B: End of Life Care

Project Aim (linked to patient statements):	To have systems in place across the Shropshire health economy that allow everyone to have excellent care at the end of life and wherever possible to die in the place of their choosing, by April 2013
Project Objectives (SMART)	• Services across the health economy are coordinated and configured to give patients the best possible care at the end of life, including to die wherever possible in the place of their choosing, in place by April 2013 • All 'hands-on' health and social care staff to have the skills to give the best possible care to patients (and support for their relatives) at the end of life, by April 2013
Expected Outcomes:	• Quality standards identified for care in EOL; incentives for organisations to adhere to quality standards; monitoring of performance • EOL related skills and competencies identified for relevant staff; training available; organisations train their staff • EOL pathway easy to navigate; care coordinated centrally; shared database ('locality register') of EOL patients • Relatives 'PROM' to measure quality of services
Process Metrics:	
Balancing Metrics:	
Data Source:	
Actions:	• Agree core group, terms of reference, project plan, future worksteams/meetings • Approach – follow the patient pathway to identify gaps in provision and improvements • Areas to consider; o Out of hours care, care coordination, data sharing, key worker role o Impact of the elderly o Psychological support, clinical supervision, education o Resources – financial, personnel, managerial, bidding for funds, LES (local enhanced service) agreement for GPs o Monitoring systems, quality standards
Task & Finish Group Membership:	**Team Sponsor:** Jeremy Johnson **Team Leader:** David Whiting **Project Team**: Paul Cronin Lynda Randle Karen Stringer Mandy Thorn Saskia Jones-Perrott Paul Taylor Di Beasley Fiona Hay
Project Risks and Mitigating Actions:	
Interdependencies:	Unscheduled Care Frail & Vulnerable projects Shropshire Palliative Care Forum PCT clinical commissioning groups
Resource planning:	PCTs End of Life budget and hospice grants LA, CHC, hospital, etc. budgets Training budgets for relevant organisations Voluntary sector charitable funding CQUINS with local providers Hypothecated savings

Research evidence and background material

End of Life Care

Imison C et al Improving primary care management of end-of-life care from 'Transforming our health care system – 10 priorities for commissioners' King's Fund, 2010
Within primary care, improving the systematic identification of patients who are at the end of life, and then providing the appropriate support; in particular, improving the co-ordination of care, continuity, quality of communication, and the provision of bereavement care.

National Audit Office End of Life Care 2008
Given the potential to redistribute resources identified in our work, there is scope for PCTs to improve services in all settings by deploying existing and future resources more efficiently and effectively in supporting people in their preferred place of care.

Department of Health End of Life Care Strategy - promoting high quality care for all adults at the end of life 2008
Around half a million people die in England each year, of whom almost two thirds are aged over 75. The large majority of deaths at the start of the 21st century follow a period of chronic illness such as heart disease, cancer, stroke, chronic respiratory disease, neurological disease or dementia. Most deaths (58%) occur in NHS hospitals, with around 18% occurring at home, 17% in care homes, 4% in hospices and 3% elsewhere.

Hughes-Hallett T et al Palliative Care Funding Review 2011
We want to ensure everyone is able to live well until they die. Like birth, death is a part of life - something no one can avoid. But, unlike the beginning of life where it is clear what the state will provide, the evolution of palliative care has led to a lack of transparency about how the state funds a good, safe death.

Ipsos MORI End of Life Locality Registers evaluation 2011
This report presents the findings from an evaluation of eight locality register pilot sites across England. This incorporates the findings from the interim report, and includes a detailed case study report for each of the sites. They began operating in October 2009 and have been evaluated since September 2010 so that key learning points and good practice from the pilots can be shared.

Marie Curie Delivering Choice programme
The Marie Curie Delivering Choice Programme aims to double the number of people with a terminal illness who are cared for and spend their final days at home. Since its inception, the programme has helped push palliative care up the political agenda.

Clinical Support to Nursing Homes

There is good evidence nationally that the quality of primary and community care provided to people who live in care homes is inferior to that offered to people still living in their own homes.

There is also good evidence that the provision of enhanced clinical support to people in care homes reduces 999 calls and emergency hospital admissions, especially those at risk of multiple re-admissions (*Ref.2*).

There is a clear need for a more pro-active approach to the medical care, in and out of hours, of people living in care homes. The principles and practice of Active Case Management can and should be applied. This group will champion these methods by adopting an educational and inclusive approach with all stakeholders with the aim of delivering higher quality care and reducing emergency hospital admissions over the next three years.

This project will take account of a successful pilot project in Telford which provided education of care home staff to improve their recognition of common acute medical conditions and a review of care home policies to modify their tendency to be overly 'risk averse'.

Project 6C: Clinical Support to Care Homes

Project Aim (linked to patient statements):	**Project aim (linked to patient statements):** To review current care provision across all care homes in Shropshire and implement a proactive enhanced clinical support model. This will provide targeted care for people within the care home setting even when they are ill, by understanding and anticipating all of their care needs. To reduce emergency admissions and readmissions by x% by March 2014.
Project Objectives (SMART)	1. Develop a draft tool to map current clinical support for care homes to help to identify interdependencies relating to service provision and admissions and test model by the end of January 2012. 2. Utilise agreed tool to perform a review of the current level of clinical support to residential and nursing homes across Shropshire by February 2012. 3. Perform analysis of acute and MH Trust provider admission prevalence for nursing/residential home residents (by place of residence, reason for admission and LOS) by February 2012. 4. Use baseline data to agree next steps.
Expected Outcomes:	• To reduce the number of emergency medical admissions for nursing/residential nursing homes to acute provider by 5% from April 2012- April 2013.
Process Metrics:	• % or residents in nursing homes which have agree input • % residents dying in nursing home vs acute hospital
Balancing Metrics:	• No increase in 999 calls from nursing homes
Data Source:	Provider Informatics Dept – admissions data
Actions:	Establish steering group with appropriate representatives from lead organisations. KG to provide working group with key details of current nursing/residential home provision to group (name/location/type of care provision) Produce draft tool for data capture , test model,amend accordingly and implement review. Source admissions data , analyse trends and share with group. Project group to use baseline report to identify potential areas for admission avoidance and plan phase 2.
Task & Finish Group /Membership:	**Project Sponsor**: Maggie Bayley **Project Manager:** Karen George **Group members:** Helen Swindlehurst Fran Beck Susan Spence Ceri Wright Gill Foster Ejaz Nazir Debbie Price Kim Hollamby Teresa Griffin
Project Risks and Mitigating Actions:	CICH 4 - Robustness of Admissions Data Mitigation: Gain support of providers via the UCN. CICH 3 - Some providers may not engage in providing information to project team. Mitigation: Gain support of providers via the UCN
Interdependencies:	End Of Life Virtual Ward Frail and Vulnerable Active Case Management
Resource planning:	

Research evidence and background material

Clinical Support to Nursing Homes

British Geriatrics Society A Quest for Quality in Care Homes 2011
This report marks the start of a process of partnership to develop impetus, resources and clinical guidance that will support the NHS to play part in improving the experience and the quality of life of residents in care homes. The report describes current NHS support for care homes. It tells a story of unmet need, unacceptable variation and often poor quality of care provided by the NHS to the estimated 400,000 older people resident in UK care homes.

Ward D et al Care home versus hospital and own home environments for rehabilitation of older people (Review) Cochrane Database of Systematic Reviews 2008, Issue 4.
To determine and compare the effects of the different places for rehab on elderly people, a review was conducted. After searching for all possible relevant studies, no studies were found.

University of Warwick Models for providing improved care in residential care homes: A thematic literature review 2008
The review identified extremely little published evidence on residential care homes; the research base is almost exclusively related to provision of care in nursing homes. Considerable evidence points to a need for better management of medication in nursing homes. Pharmacist medication reviews have shown a positive effect in nursing homes. It is unclear how this evidence might relate to residential care. There is evidence that medical cover for nursing and residential care home residents is suboptimal. Care could be restructured to give a greater scope for proactive and preventive interventions.

Donald IP et al Care home medicine in the UK - in from the cold Age & Ageing, November 2008, vol./is. 37/6(618-20) (available from xx)
A range of innovative models of medical care are emerging across the UK which have the potential to improve the standard of care in homes, and reduce inappropriate use of secondary care admissions. These models are described, and the need for them to be subjected to evaluation.

Paramedics and MIUs / WICs

As part of the ambulance service re-configuration, there are well advanced plans to place ambulances and their crew at MIUs and WICs. This will improve communication between health professionals and increase the effectiveness with which the ambulance crews direct and transport patients to a range of urgent care services other than A&E.

Research evidence and background material

Co-location of services - Paramedics and MIUs / WICs

NHS Confederation Critical care paramedics 2011
This report outlines the key findings and lessons from an evaluation of the CCP programme. It looks at the achievements and challenges of this clinical innovation to treat high-risk patients.

College of Emergency Medicine The Way Ahead 2008-2012 - Strategy and guidance for Emergency Medicine in the United Kingdom and the Republic of Ireland 2008
The aim of The Way Ahead 2008 is to inform strategy in delivering emergency care and provide detailed guidance for all involved in the planning of such services.

National Insitute for Health Research Service A Multi-Centre Community Intervention Trial to Evaluate the Clinical and Cost Effectiveness of Emergency Care Practitioners 2009
This study has successfully evaluated the impact of a new role in healthcare taking the example of Emergency Care Practitioners operating through a variety of healthcare settings.

(see also evidence in section 02c - Walk in Centre and Minor Injury Units re-configuration)

Hospital systems

The Chief Executive of SaTH and consultant clinicians have identified an urgent need to improve the Urgent and Emergency Care services they provide.

This programme of improvements, already underway, is not only critical to the provision of efficient and high quality services in the SaTH hospitals, but it is a key component of the successful implementation of the Unscheduled Care Strategy for the whole county.

The component projects are being co-ordinated and progressed as part of a Reform of Medicine programme which is being led by the Chief Executive of SaTH. This has the aim of supporting the clinicians tasked with delivering the projects by addressing the attitudes, behaviour and relationships of hospital staff to ensure the full ownership of, and a collective responsibility for, the changes being made to hospital systems and care pathways.

It is crucial that any changes to the delivery of Urgent and Emergency Care within SaTH must be made in the context of the county wide Unscheduled Care Strategy. To ensure that this happens, both Urgent Care GP leads are participating in the design and delivery of the Reform of Medicine programme.

Emergency Ambulatory Care

Developing an EAC service which streams patients who require urgent or emergency care, using senior decision making at an early stage to identify assessment and treatment pathways and likely length of stay, is shown nationally to reduce admissions, improve efficiency and reduce cost.

A Rapid Change project to develop this service is underway at SaTH.

The assessment unit component of this is currently being provided by the co-location of DAART and RACAM but a site closer to A&E would be preferable in the long term.

Project 8a: Emergency Ambulatory Care

Project Aim (linked to patient statements):	The vision of the ED and Ambulatory Care is to provide the best possible care for patients who should be seen as quickly as possible, assessed by a senior decision maker, given the correct treatment and either admitted or discharged without delay.
Project Objectives (SMART)	• To create Ambulatory Care Units (ACU) at PRH and RSH and treat more patients with a medical emergency on a 'day case' basis by March 2012 • To implement the ambulatory care pathways developed by the pathways project group (in line with national guidance) • To improve and sustain patient flow through the MAU
Expected Outcomes:	• To increase the number of patients treated on an ambulatory care pathway (metrics dependant upon individual pathways) • To reduce length of stay (Target - 65% of medical emergency patients will be discharged within 72 hours by March 31st 2012) • To improve quality (Target - achieve a sustainable 95% 4 hourly A&E target by March 31st 2012)
Process Metrics:	• Ambulatory care units in situ on both acute provider sites
Balancing Metrics:	
Data Source:	• SaTH medical admissions with Los <3 days • 95% A&E target data • Individual pathways modelled by HRG coding as per priority pathways
Actions:	• Set up pathway group • Nominate physicians to work up draft pathways as identified as priority area for development by the pathways group • Staff visit to Huddersfield / Blackburn ACU's • Undertake options appraisal to site ACU at RSH and PRH • Identify resource for Estates work and staffing to establish ACU at RSH • Undertake Estates work at RSH • Pilot ACU at PRH in MAU thro' Oct • Share evaluation of pilot with key stakeholders • Work with commissioners to agree ambulatory care tariff • Monitor demand and capacity for future planning
Task & Finish Group Membership:	» **Team Sponsor:** Kevin Eardley » **Team Leader:** Rachel Redgrave » Kerrie Malpass » Rob Law » Shukri Ramadan Kumar Bhamidimarri » Vanessa Roberts Caroline Brierley » Jim Winnal » Steve Williams / Sam Cook » Rachel Pearson » Graham Shepherd
Project Risks and Mitigating Actions:	Skill mix of staffing at RSH – await new appointments and book additional training Align with 9 week Demand and Capacity project – feed issues into project group Agree tariff that is financially viable – collect and share information from pilot
Interdependencies:	Demand & Capacity Frail and Elderly Mental Health Pathways

Research evidence and background material

Emergency Ambulatory Care

NHS Institute for Innovation and Improvement Ambulatory emergency care - manage your emergencies as day cases
It has been identified that admissions to hospital beds could be reduced significantly through introducing Ambulatory Emergency care models, which would avoid unnecessary overnight stays for emergency patients. This has informed the best practice tariff for Ambulatory Care (starting in 2012), which also makes this the perfect time to develop your emergency services.

NHS Institute for Innovation and Improvement How To Implement Ambulatory Emergency Ambulatory Care 2010 (requires password or available from xx)
This guide offers practical guides and case study evidence on how to implement Ambulatory Emergency Care.

NHS Institute for Innovation and Improvement The Directory of Ambulatory Emergency Care for Adults (2007, updated 2010) (requires password or available from xx)
Identifies 49 emergency conditions and clinical scenarios (e.g. cellulitis) that have the potential to be managed on an ambulatory basis. The underlying principle is that admission to a hospital bed should only take place in the context of an acute illness that requires inpatient care.

Imison C et al Managing ambulatory care sensitive conditions from 'Transforming our health care system – 10 priorities for commissioners' King's Fund, 2010
Ambulatory care sensitive (ACS) conditions are chronic conditions that include congestive heart failure, diabetes, asthma, angina, epilepsy and hypertension. Actively managing patients with ACS conditions – through vaccination; better self-management, disease-management or case-management; or lifestyle interventions – prevents acute exacerbations and reduces the need for emergency hospital admission.

(also see evidence in '08c - Accident and Emergency' section)

Case Management and Discharge Planning

The SaTH unscheduled care programme aims to ensure that the right patient is in the right place at the right time, with no delays. Working with GPs it also aims to ensure that only patients who need our specialist care are admitted to hospital, and that patients are able to leave hospital promptly and safely.

One aspect to achieving this is to ensure the multidisciplinary team on the wards work effectively. Directed by the clinician's expectations of when the patients will be suitable for discharge (the Expected Date of Discharge – EDD), the multidisciplinary team will be more effective in achieving a timely and safe discharge.

For many wards this necessitates changes in the way the multidisciplinary team work. To support them in this process a number of tools have been provided and a culture of debate and sharing of ideas and experiences has been generated. Publication of performance indicators has been useful in providing feedback and will continue to be used to stimulate ongoing improvements. One such performance indicator is a measure of how well we achieve discharges early in the day. We know that achieving this will really help patients because:

- Patients get to the next step in their journey more quickly.
- They are more likely to be placed on an appropriate ward more quickly (e.g. not as medical outliers on a surgical ward).
- They are less likely to have to wait to be transferred to an inpatient bed - currently many of our patients are transferred between departments and wards too late at night.
- They will have fewer transfers between wards - some patients are transferred up to seven times during their stay in hospital.
- Also, less time in hospital means less risk of harm, which in turn means less time in hospital.

Project 8b: Case Management & Discharge Planning

Project Aim (linked to patient statements):	To facilitate high quality, safe and timely discharge from SaTH into the appropriate setting.
Project Objectives (SMART)	1. To ensure that every patient has a clear management and discharge plan that the patient, carers and MDT play about in planning 2. To reduce LOS and improve patient flow though SaTH 3. To contribute to the overall reduction in occupied bed days
Expected Outcomes:	• 65% of medical patients discharged within 72 hours • ? % reduction in the number of hospital acquired infections/falls within an acute setting/SUI's/???< in mortality
Process Metrics:	
Balancing Metrics:	
Data Source:	
Actions:	**<u>Implementation of the Bed Bundle</u>** • To implement daily board rounds on every ward to prioritise the MDT's activity for the day focusing on high early warning scores and potential patients for discharge (known as the Bed Bundle) • To increase the number of patients discharged before midday and distribute discharges across the 7 day week • To ensure that all patients are aware of their up to date EDD which will be displayed on the whiteboard and above the bed • Develop the role of integrated case management teams
Task & Finish Group Membership:	» **Team Sponsor:** Kevin Eardley » **Team Leader:** Elaine Hodson » David Ladd » Liz Hook » Pete Gordon Currently using Health and Social care economy DTOC group which reports to Urgent Care Network
Project Risks and Mitigating Actions:	Information systems not compatible Alignment of Re-ablement Strategy and social care funding Partnership working & different systems and processes with Powys Lack of operational leadership for ICMT Reconfiguration of beds in SaTH Reinforcing accountability of nurse leadership regarding all to take responsibility for discharge planning
Interdependencies:	Ambulatory Care, Demand & Capacity; Frail & Elderly, DTOC
Resource planning:	Build capability of Integrated Case Management Team Hospital Status at a Glance (HSAG)

Research evidence and background material

Case Management and Discharge Planning

NHS Institute for Innovation and Improvement Discharge Planning
Planning for discharge with clear dates and times reduces: Patient's length of stay; Emergency readmissions; Pressure on hospital beds. This is true for all patients, both day surgery and patients who have more complex needs.

Sheppard S et al Discharge planning from hospital to home Cochrane Database of Systematic Reviews 2010, Issue 1.
The evidence suggests that a structured discharge plan tailored to the individual patient probably brings about small reductions in hospital length of stay and readmission rates for older people admitted to hospital with a medical condition. The impact of discharge planning on mortality, health outcomes and cost remains uncertain.

Proudlove NC et al Can good bed management solve the overcrowding in accident and emergency departments? Emergency Medicine Journal, March 2003, vol./is. 20/2(149-55) (available from xx)
Operational capacity management is very poorly developed in most acute hospitals and faces many major cultural and political barriers, particularly in relation to the interaction between the surgical and medical side. Despite this there is great potential though to move to anticipatory and coordinated planning, and current initiatives may hold the key to achieving the reduced levels of occupancy necessary for the efficiency gains required to enable the hospital system to be meet the responsiveness demanded of it in the NHS Plan.

eHealth Services Research Group University of Tasmania Discharge, Referral and Admission: A Structured Evidence-based Literature Review 2010
This document provides three structured evidence-based literature reviews on the benefits, enablers, barriers and challenges related to the processes of discharge, referral and admission.

Imison C et al Managing elective activity-referral quality from 'Transforming our health care system – 10 priorities for commissioners' King's Fund, 2010
Managing elective (planned) hospital activity by systematically reviewing and auditing referrals with a view to benchmarking against other practices and improving referral quality and by ensuring patients are fully involved in decision-making.

Audit Commission Bed Management – review of national findings 2003
Many trusts could improve patient outcomes without the provision of more beds if they managed their existing beds better. This includes ensuring that only the right patients are admitted and that unnecessary delays in diagnosis, treatment and discharge are avoided. Some delays to discharge, though, stem from a shortage of 'intermediate' or of other care in the community. This is beyond the power of acute trusts to remedy and requires input from the whole local health economy. In some trusts it can affect a considerable proportion of the available beds. This review though, focuses on the factors that acute trusts themselves can influence.

Accident and Emergency

A complete review of A&E services and their place in an integrated county wide unscheduled, urgent and emergency care service is required. This has been delayed by SaTH re-configuration issues, but is now possible and a Local Health Economy project group has been formed to urgently undertake this work.

Research evidence and background material

08c Accident and Emergency

NHS East of England Evidence Adoption Centre Accident and Emergency Services – a rapid review of research literature 2011
This report found that the core services that should be commissioned in any 24hr A&E department in a local hospital are: Acute medicine; Level two critical care; Non-interventional coronary care units; Essential services laboratory (ESL) and Diagnostic radiology.

Primary Care Foundation Primary Care and Emergency Departments 2010
Successful schemes are the product of sustained attempts to test out new ideas, learn from each other and improve patient care, based on clear recognition of the skills of each group of clinicians and mutual respect. However, in practice there can be a clash of cultures, with staff divided by different training, approaches to managing risk, governance systems, language and their experience of different case mixes.

Squires JP, Mason S Developing alternative ambulance response schemes: analysis of attitudes, barriers, and change Emergency Medicine Journal, November 2004, vol./is. 21/6(724-7) (available from xx)
Flexibility of AMPDS and dispatch targets will need to be reviewed to permit the successful implementation of alternative responses to 999 calls. Careful consideration needs to be given to communicating the aims and value of such schemes to all staff and ensuring a common understanding of, and commitment to, a shared vision. The effect of implementation on the remaining service function must be well planned.

Deasy C et al The impact of a pre-hospital medical response unit on patient care and emergency department attendances Irish Medical Journal, February 2008, vol./is. 101/2(44-6) (available from xx – hardcopy)
It was possible to safely discharge 31% of patients on scene. In our experience skilled Emergency Medicine doctors attending at scene could provide advanced care and reduce ambulance transportation and patient attendance.

Healthcare Commission Not just a matter of time - A review of urgent and emergency care services in England 2009
This review looked at out-of-hours GP services, A&E services and urgent care centres, emergency ambulance services and, to a lesser extent, urgent GP services delivered during usual surgery opening hours and NHS Direct.

Royal College of Physicians Acute medical care - The right person, in the right setting – first time 2007
The report makes a number of recommendations, at the heart of which is the need to ensure that the first assessment of acutely ill patients is by competent clinical decision makers, supported when necessary by ready access to senior clinical decision makers. Competent decision making also requires diagnostic support, and the availability of these services must be improved and better aligned to when and where they are needed.

4.2 Delayed Discharge of Care (DTOC)

This is a Rapid Change project, led by a project group who have developed an Integrated Case Management Team (ICMT) whose aim is to reduce DTOC levels to 3.5% by the end of Q2 2011/12. DTOC levels have already fallen significantly, although a full understanding of cause and effect is elusive at this early stage.

The ICMT works across both RSH and PRH hospital sites and operates at ward level, targeting patients whose discharge is already delayed or where the discharge process is complex and likely to lead to a delay,

The team also aims to contribute to the attitudinal, behavioural and relationship changes required at ward level to achieve a hospital wide cultural change in implementing Early Facilitated Discharge processes and more efficient ward and admission processes.

Although the DTOC project group, which is led by an experienced nurse/ commissioner, is responsible for delivering some rapid changes, it also has a medium term goal of achieving a consistently low level of DTOCs and a long term goal of achieving a change of ward culture and practice that renders the multi-disciplinary case management team obsolete.

Research evidence and background material

09 Delayed Discharge of Care (DTOC)

Scottish School of Primary Care A research review on tackling delayed discharge (2004)
A whole systems approach that follows four key inter-connected stages may contribute towards tackling delayed discharges: Find out the main causes for delayed discharges in the local care system; Develop initiatives to tackle these causes; Evaluate the impact of these initiatives; Monitor the extent to which the delayed discharges are being successfully tackled.

Health Services Management Research From bed-blocking to delayed discharges: precursors and interpretations of a contested concept (2011) (copy available from xx)
Three key features of the bed-blocking concept are also analysed: the reduction of patients' length of stay to improve efficiency, the intrinsic methodological difficulties of measuring hospital delays and the most common reasons for delayed discharges.

Jasinarachchi et al Delayed transfer of care from NHS secondary care to primary care in England: its determinants, effect on hospital bed days, prevalence of acute medical conditions and deaths during delay, in older adults aged 65 years and over. BMC Geriatrics 9/4 2009 (copy available from xx)
Awaiting therapy and domiciliary care input were significant contributing factors in delayed transfer of care. Similar local assessments could provide valuable information in identifying areas for improvement. Based on available current evidence, efficacy driven changes to the organisation and provision of support, for example rapid response delayed discharge services at the time of "fit to discharge" may help to improve the situation.

Godden S et al A Policy on the rebound: trends and causes of delayed discharges in the NHS Journal of the Royal Society of Medicine, January 2009, vol./is. 102/1(22-8)
The focus on reducing delays should be set in the context of the wider health economy. There are a number of pressures to reduce the time patients spend in hospital including fewer beds and increasing numbers of admissions, plus a rise in emergency readmission rates is noted.

Department of Health Achieving Timely 'Simple' Discharge from Hospital - a toolkit for the multi-disciplinary team 2004 (available from xx)
The toolkit focuses on the practical steps that health and social care professionals can take to improve discharge. At least 80% of patients discharged from hospital can be classified as simple discharges. Changing the way in which discharge occurs for this large group of patients will have a major impact on effective use of bed capacity and improve patient experience.

(see also evidence in section 8b Case Management and Discharge Planning)

4.3 Re-ablement

Effective, targeted and timely short term re-ablement has a critical role to play in the provision of good care to people who are discharged from hospital and will significantly contribute to achieving a reduced average length of stay and fewer re-admissions.

The aim of this project is to undertake a review of the current re-ablement work streams that have been implemented following the DoH funding allocation to PCTs/social care across the Health Economy.

Following a service review, this project group, which is led by the Director for Integrated Care for both PCTs, will identify best practice and consider the potential for the development of integrated re-ablement services across the whole county.

A key issue to be addressed is the current exclusion of 'self-funders' from receiving short term re-ablement monies.

Project 10: Reablement

Project Aim (linked to patient statements):	To work together to improve reablement services to maximise the opportunities to deliver care closer to home.
Project Objectives (SMART)	1. To understand health and care *needs* and quantify potential demand for reablement services, particularly for F&V and LTC 2. To *map* current service provision 3. To establish what reablement *capacity* (particularly non-bed capacity) should be available to meet need/demand, 4. To *design* and *streamline* reablement services so they play an integral part in the delivery of the urgent care strategy 5. To ensure *outcomes* and *value for money* are consistent across the range of providers of reablement services.
Expected Outcomes:	• Greater *productivity* and *consistency* of care from redesign/decommissioning of existing services • Greater understanding of *needs* and *'what works'* to inform *redesign* and/or *expansion* of services • Clarity on *pathways/processes* so right care, right time, place and cost is delivered • Fewer hospital admissions as alternative provision provided in the community closer to home *(step up)* • Length of stay in hospital will decrease as more patients discharged earlier to community services *(step down)* • Reduced number of people admitted to *long term care* – individuals retain *independence* for longer • User feedback demonstrates higher levels of *satisfaction* • *Audit* arrangements established so measurements of consistent good *outcomes* through different services are routine • Production of an *informed reablement plan* summarising the above and including *costed proposals*
Process Metrics:	
Balancing Metrics:	
Data Source:	
Actions:	• assessments and service mapping • To engage with patients/users to understand how best to improve their experience/outcomes • To provide opportunities for clinical staff to inform redesign • To understand the range of current provision and relative costs to allow comparisons • To establish future demand and capacity needed and use to inform development of an integrated pathway • To explore potential for use of a centralised demand and capacity management system to streamline that pathway • To inform commissioning intensions for sustainable services
Task & Finish Group Membership:	Team Sponsor: Fran Beck Team Leader: Sam Ruthven-Hill (Shropshire) & Chris Harrison (T&W) Group members: B. Gowans, K. Allwood, T Wilson, T. Jones, L. Breakell, C Morris, E Hudson
Project Risks and Mitigating Actions:	**Time and capacity to do the work – mitigated by keeping group small, focused and avoiding duplication** **Commitment of all partners – mitigated by all agencies signed up to UC strategy**
Interdependencies:	Key project for Urgent Care Strategy, QIPP and Winter Plan 2011/12 Specifically admissions avoidance, DTOC and telehealthcare
Resource planning:	

Research evidence and background material

10 Re-ablement

Social Policy Research Unit Home Care Re-ablement Services: Investigating the longer-term impacts (prospective longitudinal study) 2010
The study found that re-ablement was associated with a significant decrease in subsequent costs of social care service use. However, this reduction in costs was almost entirely offset by the initial cost of the reablement intervention. The average cost of a reablement episode was £380 lower than the mean cost of the comparison group. Reablement had positive impacts on users' health-related quality of life and social care-related quality of life. Using the National Institute for Health and Clinical Excellence cost-effectiveness threshold, reablement was found to be cost effective.

Department of Health LAC (DH) (2010) 6: The Personal Care at Home Act 2010 and charging for reablement (2010)
PCTs should use the plans developed for this year as a basis for co-ordinated activity on post-discharge support in 2011/12 and 2012/13 when changes to the tariffs will take effect. In 2011/12, non payment to Trusts for emergency readmissions will create savings for commissioners to reinvest in reablement and post-discharge support in year, whilst the intention is that from 2012/13 the tariffs are increased to cover the cost of post-discharge support, including reablement

Department of Health Homecare Reablement discussion document 2007
This document aims to share knowledge and emerging findings from Councils with Social Service Responsibility (CSSRs) who have implemented, or have started to implement, a home care reablement scheme. We hope that by describing the steps taken, and the lessons learned from the CSSRs profiled here, that others will be enabled to broaden their understanding and progress their planning and implementation phases.

Ambrey Associates The New Reablement Journey 2011
This paper aims to stimulate discussion and thinking about a different way of offering reablement. It doesn't contradict the current approach, but builds on it, suggesting that we can take reablement to a new level in order to maximise its benefits. This involves re-defining reablement, challenging our thinking about who should be able to benefit from it and for how long; and how much the person is involved in owning and steering the process.

Bury PCT A Business Case for the Reablement Pathway 2011
This Business Case aims to show the level of resources that are currently committed to care services for vulnerable adults experiencing either a sudden or steady deterioration in their ability to live independently. The Reablement Model is a proposed model of care that integrates Health and Social teams together under one pathway. This has been proven to work elsewhere in the country and has seen significant savings made in adult social care and hospital admissions.

4.3.1 Active Case Management

This is project with major long term goals, led by an experienced GP, whose aim is to re-integrate General Practitioners with Community Teams by adopting Active Case Management across the county.

Active Case Management shifts the focus of care from reactive diagnosis and treatment to include the proactive detection and prevention of acute exacerbation and illness.

The methods used to deliver this service include the further development of Frail and Vulnerable registers, the use of Risk Stratification tools, Telehealth and regular multi-disciplinary team meetings between primary care and community teams.

There is good evidence that Active Case Management can significantly reduce the number of emergency hospital admissions

The project is complex and will require alignment and co-development with several other projects including Secondary Care Pathways and Outreach, End of Life Care, the Falls Service, Virtual and Community Hospital re-design, Clinical Support to Care Homes, Delayed Transfer of Care and Re-ablement.

Project 11: Active Case Management

Project Aim (linked to patient statements):	To review current provison and implement a model of active case management with the outcome of ensuring patients are facilitated to understand their care; to work in partnership with the MDT and wider communities to ensure the provison of care at home where possible
Project Objectives (SMART)	• Proactive identification of adults who are at risk / have emerging risk of avoidable acute hospital admissions • Targeting of available resources to patient needs in an integrated way that views individual within a combined psychosocial and medical model • Adoption of an outcome focused interaction whereby patients , family members (where applicable) and relevant health ,social and non statutory staff are clear of the issues and agreed actions relating to those issues • Promotion of a cultural shift which places individuals at the centre of their care and enables them to be active partners with support from health and social care organisations and communities
Expected Outcomes:	
Process Metrics:	TBA once new model agreed. Note: Informatics Team Member Lee Osbourne
Balancing Metrics:	
Data Source:	
Actions:	• ACM1 Design Audit to collect baseline data re active case management activity Pan Shropshire (CS) • ACM2 Ensure all relevant services known to stakeholder complete audit (TEAM) • ACM3 Promote awareness of 4D Risk Stratification through workshop (TJ) • ACM4 Collate audit data and prepare gap analysis report (CS, TJ and HS) • ACM5 Review of gap analysis report (TEAM) • ACM6 Audit of current service specifications against gap analysis (TEAM) • ACM7 Scope proposed model (TEAM) • ACM8 Refinement of proposed model (CS, TJ and HS) • ACM9 Promote awareness of personalised care planning process and self management (TJ)
Task & Finish Group Membership:	**Project Sponsor: Dr Colin Stanford** **Project Manager: Tracey Jones** **Group Members:** Helen Swindlehurst, Cath Molineux, Lee Osbourne, Andy Matthews, Di Beasley, Paul Cronin T&W Council Rep
Project Risks and Mitigating Actions:	Lack of engagement in risk stratification Pan Shropshire - a) Team to champion benefits; b) Awareness raising events; c) Inclusion within service specifications Failure to achieve cultural change necessary to deliver active case management - a) Team to lead change; b) Deliver education sessions on personalised care planning; c) monitoring of patient level outcomes Failure to deliver to QIPP Agenda - a) Ensure cost modelling and outcome metrics are defined within new service model
Interdependencies:	Community Hospitals Project; Delayed transfers of care; Acute frail & vulnerable; Ambulatory Emergency Care Project; End of Life Care
Resource planning:	Activity and Cost Data LO to lead on activity with nominated finance team lead; Assumption of project alignmentto QIPP; No allocated budget to project; Additional resources to deliver project actions to be submitted to programme board

Research evidence and background material

11a Active Case Management

PSSRU Evaluating Active Case management in Greater Manchester 2008
The evidence sheds relatively little light on the impact of different approaches to case management on outcomes.

McEvoy, P, Laxade, S Patient registries: a central component of the chronic care model British Journal of Community Nursing, Vol. 13, Iss. 3, 07 Mar 2008, pp 127 - 133 (available from xx)
The use of patient registries to collect clinical data about a defined group of patients and issues needs to be considered when setting up a registry. The Chronic Care Model, items included in a patient registry and a case study examining the impact of a patient registry in an active case management service are described.

Elwyn G et al Case management by nurses in primary care: analysis of 73 'success stories' Quality in Primary Care, 2008, vol./is. 16/2 (75-82)
The case managers describe having the time and the skills to assess a mix of clinical and social problems, and then accessing the correct networks to help elderly people with multiple illnesses navigate a complex system of providers. More weight should be given to the ability of this intervention to result in improved quality of life for patients, and to the investigation of costs and benefits.

Shepperd S et al Hospital at home admission avoidance Cochrane Database of Systematic Reviews 2008, Issue 4
We performed meta-analyses where there was sufficient similarity among the trials and where common outcomes had been measured. There is no evidence from the analysis to suggest that admission avoidance hospital at home leads to outcomes that differ from inpatient hospital care.

Ham C, et al Avoiding hospital admissions - Lessons from evidence and experience King's Fund 2010
One of the main messages of this paper is that the NHS needs to move beyond projects and adopt comprehensive admission avoidance programmes. These programmes need to involve the full spectrum of care providers and should look across the whole system of care. The challenge will be to ensure that the coalition government's emphasis on choice and competition does not 'crowd out' collaboration, integration and whole system working in the next stage of reform.

Purdy, S Avoiding hospital admissions. What does the research evidence say? King's Fund 2010
In this paper, we aim to address the following questions: What interventions work in reducing avoidable admissions? Who is at risk, and how do we identify them? Which admissions are potentially avoidable? Which interventions work in: primary care, social care, emergency care, discharge from hospital.

HSMC Reducing Unplanned Hospital Admissions – what does the literature tell us? 2006

This rapid review of 186 studies collated evidence about these and other initiatives to reduce unscheduled hospitalisations and the number of unplanned days in hospital.

Warwick Business School Reducing Attendances and Waits in Emergency Departments A systematic review of present innovations 2004
There is evidence that attendance rates among the chronically ill, older people and high users may be amenable to reduction via a number of educational, social and medical interventions, including the use of community based admission avoidance schemes.

Telehealth Care

King's Fund E. Technology in the NHS: Transforming the patient's experience of care 2008
This report analyses the principal factors, both positive and negative, that influence decisions to adopt technology.

WSDAN Evidence Database (Click here for the WSDAN Evidence Database)
This online database brings together published materials related to the impact and evidence of telehealth and telecare. It has been specifically designed to enable people to reach and understand appropriate and relevant evidence at the touch of a button. The database is updated on a quarterly basis.

NHS West Kent et al Promoting and Sustaining Independence in a Community Setting – Kent TeleHealth Evaluative Development Pilot 2010
The study concluded that telehealth brought peace of mind and improved quality of life for patients and carers. It supported independence, empowerment and self-management of conditions, and both patients and carers embraced the technology and valued it. People who used telehealth had fewer hospital admissions, shorter lengths of stay, reduced GP contacts and, in some cases, fewer nursing visits. Financial savings were possible through fewer unplanned admissions, A&E visits and clinician home visits.

Good Governance Institute Better care for people with long-term conditions: the quality and good governance of telehealth services 2011
The report, which says that focussing on the perceived economic benefits will not be enough to encourage wide-spread implementation, makes 17 recommendations to guide trusts in implementing and mainstreaming telehealth services. Please see the links below for further information.

Doughty, K SPAs (smart phone applications) - a new form of assistive technology Journal of Assistive Technologies Vol. 5 Iss: 2, pp.88 – 94, 2011 (available from xx - hardcopy)
Demonstrates how smart phone applications are capable of transforming a high-performance mobile phone into a number of different assistive devices that can improve the lives of millions of people with and without disability.

Risk Stratification

NHS West Midlands Investing for Health Innovation Centre Feedback and Recommendations for Improvement to the Partnership Board
The Innovation Centres appreciate the value of the tool's future application within NHS West Midlands and are keen that as much benefit as possible is extracted from the tool's potential. The Innovation Centres have derived a number of challenges to the toolset and its developers to respond to in order to make the NHS West Midlands Toolset and any future iteration as useful as possible. This report outlines the key feedback, queries and recommendations derived from the Innovation Centres, agreed by their Project Boards for submission to the Implementation Group.

Department of Health Risk Stratification and next steps with DH Risk Prediction tools – Patients at Risk of Re-hospitalisation and the Combined Predictive Model 2011
The continued uptake and usage of risk stratification tools are fundamental to the success of the LTC QIPP workstream and the delivery of good LTC management. It is vital that commissioners understand the needs of their population in order for cost effective interventions to be targeted and prioritised.

Nuffield Trust Predictive risk and health care: an overview 2011
Predictive risk adjustment tools are becoming increasingly important in the NHS, with primary care trusts (PCTs) and GP consortia expected to make greater use of such tools to stratify the health risk of the populations they serve. This research summary explores how these techniques are currently being used in the NHS and identifies some of the challenges involved in applying the techniques in practice.