The Shropshire Unscheduled Care Strategy 2011 – 2014

Version Control	
Author:	Dr Bill Gowans
Version No.:	Version 1.4
Approval Date:	October 2011
Review Date:	

Document Control Sheet

<table>
<tr><td>Title:</td><td colspan="3">The Shropshire Unscheduled Care Strategy 2011-2014</td></tr>
<tr><td>Electronic File Name:</td><td colspan="3">The Shropshire Unscheduled Care Strategy 2011-2014</td></tr>
<tr><td>Placement in Organisational Structure:</td><td colspan="3">Document will be accessible via public facing PCT websites</td></tr>
<tr><td>Consultation with stakeholders:</td><td colspan="3">PCT Board Members, CCG members, Urgent Care Stakeholder Group, Urgent Care Network Group, Patient representatives via patient groups</td></tr>
<tr><td>Equality Impact Assessment:</td><td colspan="3">To be performed: confirmation and reference details of Equality impact assessment carried out e.g. Race, Equality, Gender, Equality, Health Inequalities, Mental Capacity</td></tr>
<tr><td>Approval Level:</td><td colspan="3">Clinical Advisory Panel, SCPCT/Professional Executive Committee, NHS T&W.</td></tr>
<tr><td>Dissemination Date:</td><td><<date document is disseminated>></td><td>Implementation Date:</td><td><<date document is implemented>></td></tr>
<tr><td>Method of Dissemination:</td><td colspan="3"><<Board members, appropriate managers, stakeholders, specialist staff, patient groups, website newsflash>></td></tr>
</table>

Document Amendment History

Version No.	Date	Brief Description
Version 1.1	09/09/11	Change to format: 09/09/11 Inclusion of Needs Analysis: 09/09/11 Inclusion of National Context: 09/09/11
Version 1.2	26/09/11	Table amended p16: 26/09/11
Version 1.3	28/11/11	Updated project list and amended description: 28/11/11
Version 1.4	12/12/11	Updated page numbering and table. Updated project list and descriptions.

Contents

	Page
1 Executive Summary	4
2 Introduction	6
The aim of the Shropshire Unscheduled Care Strategy	6
Why does Shropshire need an Unscheduled Care Strategy?	6
How will this strategy improve the delivery of healthcare in Shropshire?	6
The scope of this strategy	6
National context	7
3 Definitions	8
4 Key Principles and Outcomes	9
5 Project Development	22
Agreeing priorities	22
Aligning priorities	24
From priorities to project domains	25
From project domains to a project list	26
Forming the Project Groups	27
Project 'bundling' to develop the QIPP plan	27
6 Project Descriptions	29
7 Appendices	41
Appendix 1 - The need for a Shropshire Unscheduled Care Strategy	42
Appendix 2 - Shropshire Patient Groups (diagram)	54
Appendix 3 - Focus group sessions – example of completed group notes	55
Appendix 4 - Focus group collated notes	58
Appendix 5 - Ten providers of urgent care in Shropshire (diagram)	62
Appendix 6 - Collated notes from the first Urgent Care stakeholder meeting	63
Appendix 7 - Behavioural change proforma	66
Appendix 8 - Collated notes from GP focus groups	67
Appendix 9 - Terms of Reference for the Urgent Care Network	68
References	71

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
- 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, each 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.

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 Introduction

The aim of the Shropshire Unscheduled Care Strategy

Our aim is to provide, by 2014, comprehensive unscheduled, urgent and emergency care services, delivered by integrated teams of people who share a collective responsibility for every patient journey.

Why does Shropshire need an Unscheduled Care Strategy?

A combination of well described national and local demographic and healthcare factors have led to an ever increasing demand on the unscheduled, urgent and emergency care services. This demand is now over-stretching capacity to the point where quality of care is threatened *(see appendix 1 for a detailed discussion).*

How will this strategy improve the delivery of healthcare across Shropshire?

Patient journeys through unscheduled care will be simpler, shorter, safer and more effective. Service providers will better understand their roles within the context of the whole system and become more responsive and adaptive. Commissioning of individual services will be aligned with the intended outcomes of the whole system.

The scope of this strategy

This strategy covers all unscheduled care which includes urgent and emergency care.

It has been developed jointly between Shropshire County PCT, the Shropshire Clinical Commissioning Group (CCG), NHS Telford and Wrekin and the Telford and Wrekin Clinical Commissioning Group. As far as is possible, the Unscheduled, Urgent and Emergency Care services developed from this strategy will be implemented across both PCTs and CCGs. However, due to different demographic factors, some services will necessarily vary between the two PCT and CCG areas.

National Context

Nationally we know that the NHS has been protected from budget cuts, with a settlement that provides an annual inflation uplift on existing budgets for the next three years (in line with national whole economy inflation assumptions). In the current climate this is a comparatively good settlement.

We know however that there are a number of factors that make this financial equation very challenging, including:

- Rising demand from an aging population, from increased "lifestyle" disease and from increasing technological capability. This is estimated at as much as 2% per annum
- The actual cost of NHS inflation (driven by technological advance) running ahead of general inflation
- VAT and National Insurance increases
- Pay bill increase resulting from increments and Excellence Awards
- Transfer of NHS resources to Local Government
- Challenges to Local Government and other public sector partners resulting from real budget cuts. These may require actions that in turn have consequences for the efficiency and effectiveness of NHS operations or indeed for demand for services.

Nationally, it has been recognised that the combination of these factors leads to a potential gap between resources required and resources available of £15-20 billion cumulative by 2014/15 if the NHS carries on as it does now.

It will therefore be essential to undertake comprehensive financial modelling to assess the financial impact of the proposed projects.

3 Definitions

Strategy

'A plan, developed, articulated and owned by everyone involved in it, to create an integrated and comprehensive system that works, with agreed values, processes and outcomes incorporated into both its development and delivery.'

Unscheduled Care

'The provision of health care in response to a short term change in a patient's condition.' Urgent and Emergency care is part of unscheduled care.

Urgent Care

'The provision of health care that is required or requested on the same day as the contact with the patient is made.'

Emergency Care

'The provision of health care as fast as possible in response to a sudden and potentially life threatening change in a patient's health and well being.' This will usually, but not always involve a 999 ambulance call.

Transformational Change

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

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 change in attitudes and beliefs.'

4 Key Principles and Outcomes

The following key principles form the core of this strategy because they describe the values that underpin it, the ethical questions that arise from it, the change process employed and the intended outcomes and benefits of the plan. Each one is described in terms of values, processes and intended outcomes. The intended outcomes will be developed to form the enhanced metrics described in Key Principle 4.7.

4.1 The central role of attitude, behaviour and relationships

Values: We believe that it is our individual and collective attitudes, behaviours and relationships which frame our lives and our work and drive or obstruct change. To achieve transformational, large scale and cultural change, we must first identify the attitudes, behaviours and relationships we need in ourselves and others in order to succeed (including patients, providers and commissioners), decide how to develop these and only then make the organisational and structural changes that are required.

Evidence suggests that two thirds of all large scale change projects fail *(Ref.1).* The reasons are complex, but two of the most common are the failure to adequately engage stakeholders and employees in the change process and the imposition of structural change without taking account of attitudes, behaviour and relationships within the organisation(s).

Processes: Although strategic change documents often describe the necessity for transformational and cultural change, they do not usually articulate how to achieve this, and often assume that the sum of structural and organisational changes will reach a ‘tipping point’, beyond which transformation and cultural change occurs. Research evidence on large scale change suggests that this assumption is wrong *(Ref.1).*

As described above, we believe that explicit attention to attitudes, behaviours and relationships is required to deliver transformational change. To achieve this requires incorporation of specific methodologies and continuous reinforcement. To do this, we have developed a behavioural change proforma which has been used by every stakeholder prior to the third stakeholder meeting to help them articulate their views from a behavioural perspective in the first instance and to frame their proposed structural and organisational changes in the context of the desired attitudinal, behavioural and relationship changes needed to deliver a more successful service *(see appendix 6).*

The project groups will all continue to use a version of this proforma to define the development of the service for which they are responsible. Future stakeholder meetings and support activities will continue to champion the central role of this approach.

Intended outcomes: Outcomes that will demonstrate successful change in attitude, behaviours and relationships will be:

- *For every patient*, an experience that the urgent and emergency care system works in a 'joined up' way, with better communication between professionals who are caring for them who all have a 'can do' attitude to meeting their needs.
- *For every clinician*, a growing sense of collective responsibility for the whole patient journey, not just the specific part in which they are involved.
- *For every provider*, a high level of trust in the multi-disciplinary project groups and their members who are responsible for specific aspects of urgent care service development which allows these groups to 'drive' rather than just 'inform' the process of change which, in turn, then 'drives' the development of the provider organisation.
- *For every commissioner*, a more productive Unscheduled, Urgent and Emergency Care service that is more responsive to variation in demand and can maintain or improve high quality of care in the face of cost pressures.

4.2 Healthy Stakeholder Organisations capable of transformational change

Values: We believe that organisations involved in large scale, transformational change need to be robust and intrinsically healthy in order to be capable of successful change processes. We also believe that there are endemic problems in many NHS organisations which make them chronically unhealthy and potentially incapable of transformational change. Attempts to achieve systems changes within organisations frequently fail because the front line staff neither engage with the process nor 'buy into' the intended outcomes. Paying full and explicit attention to this is a crucial element of this strategy because its overall success is predicated on the capacity of the stakeholder organisations to change.

Processes: By emphasising the central role of attitudes, behaviours and relationships and ensuring full stakeholder involvement at every stage in the planning and implementation of the Unscheduled Care Strategy, the health status of the stakeholder organisations and their capacity to change will become steadily more apparent.

However, because successful transformational change is fundamentally dependant on healthy organisations, there is a need to apply a more rigorous 'diagnostic tool' so that problems identified can be addressed before they cause unintended consequences.

To this end, the Winter9 Demand and Capacity project is designed to 'test' the ability of all the providers of Unscheduled Care to communicate better and 'do things differently' by providing a whole system Communications Hub and access to senior Clinical Managers to help them with their patients' onward journey through unscheduled care. This in turn will test each organisation's ability to communicate and engage with its front line staff to inform and motivate them to make use of this service.

Early indications confirm that many of the providers have problems in this regard because there is a historic 'disconnect' between top managers who have committed their organisation to the project, and the front line staff who are neither championing nor even aware of their organisations change processes and plans. The launch and

publicity material for this project is specifically designed to both challenge and address this by being aimed at front line staff rather than managers.

Constructive ongoing challenge to all provider organisations concerning their ‘health status’ is also being made through the forum of the Urgent Care Network.

Intended outcomes: Outcomes that will suggest a healthy stakeholder organisation are:

- Strong clinical engagement and leadership within each organisation
- Excellent communication and a high level of trust within and across organisations
- Empowered staff who do not experience organisational or attitudinal obstructions to their ability to ‘do the right thing’ for their patients
- Recognition by all front line staff and managers of a personal and collective responsibility for the whole of every patients journey and the part they have to play in it.
- An individual and organisational commitment and capacity to make large scale changes to improve the way they deliver care.

4.3 Full Stakeholder Involvement

Values: We believe that a successful strategy must be framed around the different perspectives of the stakeholders involved in its development and delivery. The three perspectives articulated in this strategy are:

- **Patients** (Local Community – Civil Society)
- **Providers** (Business – Economics)
- **Commissioners** (The State – Government)

Each of these should influence the other two in a balanced and responsive way in the planning and delivery of care.

Processes: To achieve full stakeholder involvement in the development and delivery of this strategy, we have adopted a range of processes, described below, to ensure full and balanced engagement from patients, providers and commissioners.

4.2.1 Patient Involvement

The approach we have adopted places the patient at the centre of the change process and is in line with government policy to promote patient involvement at every stage of service development and review. The initial patient engagement activities were in Shropshire, due to the well-developed network of active, enthusiastic and engaged patient groups attached to GP surgeries *(see appendix 2).* Following an approach from the Urgent Care lead, patient groups expressed an interest in engaging in focus group work looking at urgent care *(see appendix 3).* After running the first session with a group comprising representatives from 15 local patient groups, they then took the work back to their own groups and repeated the sessions, thus generating a large volume of views and opinions. This work was then repeated by other patient groups across the county. Additional sessions were run with more targeted groups, such as mums with toddlers.

The views expressed were then collated and summarised, fed back to the patient groups, shared with health professionals and incorporated into this unscheduled care strategy *(see appendix 4).* Regular updates and feedback are given to and received from patient groups to ensure their continued inclusion in the planning cycle.

There is a patient representative present at all stakeholder meetings and the different project groups either have a patient representative in them or have direct access to patient views through the stakeholder meetings and patient group meetings.

The views of patients obtained from focus groups and their full engagement in the planning cycle have produced eloquent and powerful statements about their ideas, concerns and expectations of unscheduled health and social care in Shropshire. These statements have formed one of the guiding principles of this strategy. Going forward, similar patient engagement activities are progressing in Telford.

4.2.2 Provider Involvement

Evidence from change management research strongly suggests that the views of the professionals who work in provider organisations, the 'wisdom in the room', should be incorporated into all large scale change strategies. The ten providers of unscheduled care in Shropshire *(see appendix 5)* are all led by experienced health professionals and managers with views shaped by many years of 'coal face' activity. Collectively they have important views on the way unscheduled, urgent and emergency care should be delivered in the future; views which are almost always synchronous with patient attitudes because they are shaped by their interaction with patients over professional lifetimes.

To capture these views and aspirations, a series of urgent care stakeholder meetings have been held, along with one-to-one meetings between one of the two urgent care leads for the Shropshire County Commissioning Group and provider representatives. The first stakeholder meeting established agreement on the need to change and generated a wealth of (as yet unconnected) ideas on service developments *(see appendix 6).* The second meeting provided a forum for discussion and sign up to a 'framework for change' (now incorporated into the Key Principles and Outcomes). At the end of this meeting, every provider organisation was asked to prepare for the next meeting by completing a behavioural and relationship change proforma which tasked them to decide how they wanted to improve their delivery of urgent care starting from a behavioural perspective, leading to actions required to achieve the attitudes, behaviours and relationships needed to succeed *(see appendix 7).* This work then formed the basis for the third stakeholder meeting in which each provider gave a presentation detailing their aspirations, plans and commitment to the changes they had identified as needed to improve the delivery of urgent care in Shropshire. The meeting was ended with a collation of patient, provider and commissioner views and intentions to form an emergent urgent care strategy.

Additional supportive information and engagement was obtained by holding focus groups on urgent care with the GP members of the Shrewsbury Locality Group (previously commissioning group), representing 15 practices *(see appendix 9).*

The fourth stakeholder meeting presented the Shropshire Unscheduled Care Strategy and detailed the methods, principles, operational expectations and challenges which will be used and encountered by every project group. Also detailed was the strategic support available to every group as well as the overall command, control and governance processes which have been put in place to support the different project leads and their groups in achieving their individual objectives, to ensure that the key principles of this strategy continue to be employed, and to help strengthen the connection and responsiveness of the groups to all the other projects within the Unscheduled Care Strategy. Stakeholder meetings will continue to be held every three months.

4.2.3 Commissioner Involvement

This is the first strategy developed since the creation of Clinical Commissioning Groups, with the clinical engagement that this brings with it. Even at this early stage, experience suggests that this has had a significant impact on the way this strategy has been developed using the key principles described here.

Due to external constraints and deadlines, the first drafts of the urgent care component of the QIPP plan for Shropshire were written before the other components of this strategy had begun. However, the second articulation of the QIPP plan in 2011 has taken account of this process and its preliminary outcomes and it now accurately maps the majority of the content. Future revisions of the (cluster) QIPP plan will be completely aligned to this strategy.

Regular updates have been presented to the QIPP board throughout the process described here, and there has been full commissioner representation at the urgent care stakeholder meetings. In addition, there has been involvement of other commissioner, consultancy and advisory organisations in this process, namely the Strategic Health Authority, the Urgent Care Intensive Support Team and Deloitte.

The Shropshire County Clinical Advisory Panel (formerly PEC) and the Telford and Wrekin PEC have both approved this strategy.

Intended Outcomes: Outcomes which will demonstrate success in achieving full stakeholder involvement will be:

- Patients will understand how to access the Urgent and Emergency Care services and be confident in its ability to meet their needs.
- Professionals working within the Urgent and Emergency Care services will understand his or her specific role and the part this plays in the context of the whole system.
- Every service within the Urgent and Emergency Care system will be responsive and adaptive to the other services that make up the whole system.
- Service development will become progressively more embedded within the commissioning process.
- The commissioning process will be completely aligned with the whole system development plan.
- The health economy prioritisation process will be embedded in the Urgent Care Strategy and be demonstrable in its delivery.
- The winter planning process, along with the demand and capacity management systems it requires to be successful, will be incorporated into this strategy and its delivery.

4.4 Clinical Engagement and Leadership at the heart of the Change Process

Values: We believe that true clinical engagement in the development and delivery of the Shropshire Unscheduled Care Strategy is a key component to its success. The clinical leads for Urgent Care across Shropshire are all GPs and members of their respective Clinical Commissioning Groups. Their own clinical experience and their relationships with colleagues and other clinicians working for provider organisations must ensure that service re-design and change is 'driven', rather than just 'informed' by the combined clinical intelligence of the practitioners involved.

Processes: The project groups responsible for the development of individual services within the Urgent Care system are all composed of a mixture of clinicians,

managers and commissioners who represent the local health economy and are mandated by their own organisations to make decisions on their behalf.

At the core of every group's activity will be a 'clinical conversation', running in parallel with, and giving a lead to a 'management and commissioning conversation' around service development. The two 'conversations' must keep pace with each other and eventually integrate to shape the resulting service.

For these 'conversations' to lead to successful outcomes, the project groups must have the right membership, with a clear mandate and robust governance and accountability.

Every effort has been made to ensure that the members of the project groups are at a senior enough level in their respective organisations to allow the 'clinical conversation' to truly lead service re-design.

Intended Outcomes: Outcomes that will demonstrate successful clinical engagement are:

- Powerful and effective Urgent Care project groups which lead service re-design across the local health economy.
- The development of clinically intelligent services around robust care pathways which promote efficient, effective and risk managed care.
- A final structure and organisation of the Clinical Commissioning Group, provider organisations, the Cluster and the Department of Health, that promotes clinical engagement as the driver for service development.

4.5 Working with the limitations of evidence

Values: We believe that, where possible, service re-design should be guided and led by current research evidence. However, we recognise that the evidence base to inform the development and delivery of an integrated system of unscheduled care across the local health economy is very limited and, in many cases, non-existent. This

is in part due to the fact that, within a complex adaptive system such as unscheduled care, evidence based changes to one part of the system often lead to illogical and unpredictable outcomes elsewhere in the system.

In order to develop and deliver a system wide strategy, there is a necessity to develop services beyond the available evidence of best practice.

To do this, and to maximise the likelihood of success, requires a collective recognition of the limitation of evidence, an understanding of the characteristics of complex adaptive systems and a collective commitment to adopt processes that unite and align opinions and views from patients, experienced professionals, other stakeholders and commissioners to develop a robust experience-based consensus to lead the change process where an evidence base is lacking.

Processes: The project manager and clinical leads for the Urgent Care Strategy have compiled the evidence base for large scale, cultural and transformational change (*Ref. 1*). They are also responsible for providing the evidence base for the work streams of individual projects within the Urgent Care Strategy (*Ref. 2*).

A 'change forum' is planned to examine projects in their early planning stages from multiple perspectives using the key principles described here.

An open and ongoing debate around the available evidence and its limitations and the strengths and weaknesses of experience-based consensus will continue within the Urgent Care stakeholder meetings.

Intended outcomes: Outcomes that will suggest success in working with the limitations of evidence will be:

- Adoption of evidence-based best practice where there is clear evidence to follow.
- The development of a rigorous experience-based consensus to inform development where there is no evidence base available.

- A pragmatic but rigorous design and collection of metrics to monitor and establish the success of every component of the Unscheduled Care Strategy, the implementation of which can then contribute to the national emerging evidence base.
- A collective recognition of the need to work with uncertainty and complexity and a collective commitment to manage it by employing the key principles described here.
- Robust assurance that unintended consequences of the reconfiguration of services and pathways are being minimised.
- An increase in the quality of services and improved patient experience.

4.6 Self-directing project groups working within a framework of shared Governance, Accountability and Responsibility

Values: We believe that every unscheduled care project group must determine their own aims and objectives and be responsible for delivering them. This level of self-direction is necessary in order to embed the key principles of full stakeholder involvement, putting clinical engagement at the heart of the change process and recognising the need to change attitudes, behaviours and relationships to achieve successful and sustainable services. For this way of working to be successful in delivering transformational whole system change, a system of shared governance and accountability is required which allows and promotes all stakeholders to develop a robust collective responsibility for the whole urgent care system whilst, at the same time, working in project groups that determine their own intended outcomes.

Shared accountability will necessarily include shared risk and defined methods for managing conflict.

This represents a significant change from previous models and its implications and methodology require close scrutiny and careful development.

Processes: During the third Urgent Care Stakeholder meeting, it was agreed that the Urgent Care Network, previously disbanded, should be re-formed with the aim of

becoming the body directly and fully accountable for the delivery of the Unscheduled Care Strategy.

This group, now fully constituted and with new terms of reference, comprises a patient representative and the CEOs, or designated deputies, of every provider and commissioning organisation involved in unscheduled care.

The revised terms of reference are explicit in placing full accountability and responsibility for the urgent care system in the hands of the Urgent Care Network (*see appendix 9).*

Intended outcomes: Outcomes that will suggest successful shared governance and accountability are:

- An efficient and consequent Urgent Care Network.
- Consistent CEO or equivalent representation at the Urgent Care Network.
- The development of new attitudes, behaviours and relationships between patients, providers and commissioners.
- The promotion of a vigorous debate on the implications for the NHS of shared accountability within a service developed around these key principles.

4.7 Developing Metrics and Quality Standards that monitor behaviour and relationships

Values: We believe that the development, collection and analysis of robust metrics and quality standards are crucial in achieving and maintaining a sustainable and successful urgent care system.
Alongside this, we also acknowledge the necessity of moving beyond the evidence base to include experience-based consensus as a driver for change.

This, in turn, leads us to recognise the importance of developing and adopting metrics and quality standards that capture change in behaviour, relationships and quality of leadership in addition to the standard metrics around need, cost and outcomes.

Processes: Every project within the urgent care strategy will have well established metrics applied that assess quality in terms of need, outcome and cost.

In addition, newer assessment tools will be applied that monitor change in behaviour and relationships between all stakeholders involved in the project and the way they relate to and interact with the urgent care system as a whole.

Intended outcomes: Outcomes that will suggest success in applying metrics that capture changes in behaviour and relationships will be:

- Wider recognition that successful large scale changes depend on change in attitudes, behaviour and relationships.
- The development of more sophisticated tools to improve the quality of services through explicit attention to the attitude, behaviour and relationships of the professionals and users of the system.
- A better understanding of the power of experience-based consensus, alongside available evidence of best practice, in driving large scale, transformational and ‘cultural’ change.
- The ability to manage complex change in a more structured and predictable way.

5 Project Development

5.1 Agreeing Priorities

The principles and processes outlined above (and discussed in detail in the appendix) have been applied in a variety of settings during 2011 to develop a set of agreed patient, provider and commissioner priorities. This has included extensive focus group work using existing patient participation groups across the county, urgent care stakeholder meetings, focus group work and discussion at GP locality meetings and many small group and one to one meetings.

Patient Priorities: Collation of the views expressed in the patient focus groups (appendices 3, 4 and 5) revealed seven powerful and consistent messages:

- Be ‘joined up’ and collectively 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’m ill

Provider Priorities: The priorities expressed and refined by the clinicians, managers and other professionals working for the ten provider organisations that deliver urgent care in Shropshire are:

- Education and publicity
- Patient navigation
- Reduce A&E attendance
- Professional navigation
- Networked or integrated assessment and treatment
- Reduce hospital admissions

- Improve hospital systems
- Better discharge processes
- Develop and integrate community services

Commissioner Priorities: The priorities defined in the QIPP plan that correspond to those expressed by patients and providers and which include an over-arching commitment to reducing bed numbers and increasing the productivity of community services, are:

- Improve understanding of available services
- Alternative urgent care services commissioned
- Enhance rapid access to assessment and diagnosis
- Improve Long Term Condition (LTC) management
- Improve dementia care
- End of life care
- Reduce non elective stay
- More effective discharge
- Provision of re-ablement
- Extended community teams
- Risk stratification
- Self management

5.2 Aligning priorities

The change process used to develop this strategy allowed the agreed patient, provider and commissioner priorities to be easily aligned during stakeholder meetings:

SHROPSHIRE UNSCHEDULED CARE STRATEGY Stakeholder Alignment			
Perspective:	**PATIENTS**	**PROVIDERS**	**COMMISSIONERS**
Based On:	**Experience and Values**	**Process, Organisation and Leadership**	**Need, Outcome and Cost**
Key Themes:	**Be 'joined up' and responsible for my care**	**Always network, but integrate where possible**	**Quality, Innovation, Productivity and Prevention**
Priorities	**Help me understand the urgent care service**	**Education & Publicity**	**Improve understanding of available services**
	Let me access it appropriately	**Patient Navigation**	**Alternative urgent care services commissioned**
	Assess and treat me promptly and in the right place	**Reduce A&E attendance**	**Enhance rapid access to assessment and diagnostics**
	Admit me to hospital only when necessary	**Professional navigation**	**Improve LTC management**
	Make my stay in hospital short, safe and effective	**Networked or integrated assessment & treatment** **Reduce hospital admissions** **Improve hospital systems** **Better discharge processes**	**Improve dementia care** **End of life care** **Reduce non elective stay** **More effective discharge**
	Try to care for me at home, even when I'm ill	**Develop and integrate community services**	**Provision of re-ablement** **Extended community teams** **Risk stratification** **Self management**

5.3 From Priorities to Project Domains

Following the key principles and processes described above, the aligned patient, provider and commissioner priorities were then used as a basis for creating project domains:

SHROPSHIRE UNSCHEDULED CARE STRATEGY Project Domains		
PATIENT PRIORITIES	**PROVIDER PRIORITIES**	**PROJECT DOMAINS**
Help me understand the urgent care service	Education and Publicity	Publicity, Education and Branding
Let me access it appropriately	Patient Navigation Reduce A&E attendance	Co-ordinating Functions Primary Care Access
Assess and treat me promptly and in the right place	Professional navigation Networked or integrated assessment & treatment	Pathways and direct access diagnostics Co-location of services
Admit me to hospital only when necessary	Reduce hospital admissions	Pathways for urgent care diagnostics Frail and Vulnerable (acute) Mental Health Liaison
Make my stay in hospital short, safe and effective	Improve hospital systems Better discharge processes	Hospital systems Delayed discharge of care Secondary care pathways & outreach
Try to care for me at home, even when I'm ill	Develop and integrate community services	Re-ablement Frail and Vulnerable Clinical Tools Development & Application

5.4 From Project Domains to a Project List

From these project domains, a full Urgent Care Strategy project list has been derived and is detailed below:

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

5.5 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.

5.6 Project 'bundling' to 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

6 Project Descriptions

6.1 Education and Publicity (Project no. 1)

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.

6.2 Primary Care Access

6.2.1 Demand and Capacity Management – Winter9 (Project no. 2a)

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’.

6.2.2 111 (Project no. 2b)

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.

6.2.3 CMS DOS Including NHS Pathways (Project no. 2c)

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.

6.2.4 Walk in Centre and Minor Injury Units re-configuration (Project no. 2d)

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.

6.2.5 GP Surgery Urgent Care Audit (Project no. 2e)

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.

6.3 Secondary Care Pathways and Outreach

6.3.1 Acute Frail and Elderly Pathways (Project no. 3a)

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.

6.4 Mental Health Liaison (Project no.4)

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.

6.5 Pathways for Urgent Care Diagnostics (Project no. 5)

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.

6.6 Frail and Vulnerable

6.6.1 Virtual and Community Hospitals (Project no. 6a)

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.

6.6.2 End of Life Care (Project no. 6b)

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.

6.6.3 Clinical Support to Nursing Homes (Project no. 6c)

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'.

6.7 Co-location of Services

6.7.1 Paramedics and MIUs / WICs (Project no. 7a)

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.

6.8 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.

6.8.1 Emergency Ambulatory Care (Project no. 8a)

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.

6.8.2 Case Management and Discharge Planning (Project no. 8b)

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.

6.8.3 Accident and Emergency (Project no. 8c)

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.

6.9 Delayed Transfer of Care (DTOC) (Project no. 9)

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.

6.10 Re-ablement (Project no. 10)

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.

6.11 Admission Avoidance

6.11.1 Active Case Management (Project no. 11a)

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.

7 Appendices

Appendix 1 - The need for a Shropshire Unscheduled Care Strategy

Appendix 2 - Shropshire Patient Groups (diagram)

Appendix 3 - Focus group sessions – example of completed group notes

Appendix 4 - Focus group collated notes

Appendix 5 - Ten providers of urgent care in Shropshire (diagram)

Appendix 6 - Collated notes from the first Urgent Care stakeholder meeting

Appendix 7 - Behavioural change proforma

Appendix 8 - Collated notes from GP focus groups

Appendix 9 - Terms of Reference for the Urgent Care Network

Appendix 1

The need for a Shropshire Unscheduled Care Strategy

In common with many other parts of the country, unscheduled care in Shropshire has evolved through many NHS policy changes and, as a result, comprises many largely unrelated services, each with different names and access points which both patients and healthcare professionals find hard to navigate. This has created a complicated, difficult to understand and inefficient system with poor connections and patient flows

Patient journeys through unscheduled care need to be simpler, shorter, safer and more effective. Service providers need to better understand their roles within the context of the whole system and become more responsive and adaptive. Commissioning of individual services needs to be aligned with the intended outcomes of the whole system.

In planning unscheduled care services for Shropshire residents it is essential to consider the expressed needs of patients in their request for a more accessible service. It is also necessary to ensure a full analysis of the health needs for the population is considered to ensure services are planned effectively.

Pen portrait of Shropshire County

- Overall Shropshire County is a relatively affluent area. In England there are 32,482 ‘super output areas’ (SOA) of these only three SOAs in Shropshire fall within the most deprived fifth of SOAs in England.
- Shropshire is a diverse, large, predominantly rural, inland County, situated in the West Midlands. With a population of just 289,300 and at only 0.9 persons per hectare, the county is one of the most sparsely populated in England. Shropshire has a very low population density.
- Approximately 36% of the population live in rural areas. South Shropshire has the lowest population density.

- Shrewsbury is home to around a quarter of the population and is a key employment, shopping and cultural centre for Shropshire, and a popular destination for tourists and visitors. The county's economy is based mainly on agriculture, tourism, food industries, healthcare and other public services. The profile of Shropshire County, its history, geography and population distribution makes delivering services effectively and efficiently more difficult.
- Shropshire covers 1235 square miles of which only approximately 6% comprises suburban and rural development and continuous urban land.
- With an estimated 289,000 residents, Shropshire has the smallest population of any of the remaining 2 tier shire counties in England, and with a population density of 0.9 persons per hectare, or about 234 persons per square mile, it is also one of the most sparsely populated counties in England.
- The 2001 Census shows that whilst 6% of the county’s land area is urban it is occupied by 64% of the county’s population. The remaining 102,850 people (36%) live in rural Shropshire in villages, hamlets and in the countryside.

Key Demographic Messages for Shropshire County

- Shropshire is a diverse, large, predominately rural inland county with a wide range of land use, economic activities, employment and social conditions
- Shropshire’s population has been increasing at a faster rate (7%) than England (5.3%) as a whole since 1991. Much of that has been due to migration.
- Shropshire has a relatively high concentration of people in the older age groups. In 2005 about 47% of the county’s residents are aged 45 or over, compared to only 40% nationally. 26% are over the age of 60 compared to 21% in England.
- In contrast the number of people aged 16-29 has fallen by 18%, compared to a fall of 12% nationally. This age group accounts for 14% of the county’s population compared to 19% for England.

- The population of Shropshire has grown by 7.7% (20,600 people) from 1991 to 2006, compared to a national figure of 6.0%. Shropshire, like most parts of the country, has an ageing population.
- Shropshire has a relatively high concentration of people in the older age groups. In 2006, about 47.4% of the County's residents were aged 45 or over, compared to only 40.5% nationally.
- 1.2% of the population identified themselves as being from black, mixed or other minority ethnic groups, significantly lower than the national figure of 9% and the West Midlands regional figure of 11%.

Pen portrait of Telford & Wrekin

Population growth in Telford and Wrekin has been and will continue to be driven in the future, in the main, through the planned expansion of housing by the local Council. There are also issues arising from previous migration of people to Telford and Wrekin in the late 1960's and 1970's, now approaching retirement, and many of the housing estates built by the then Telford Development Corporation are areas suffering from the worst deprivation.

The Council's future plans are for a significant expansion in private housing and associated inward investment of businesses to the area, raising the population of Telford and Wrekin by almost 40,000 between now and 2026.

This in turn creates issues for NHS Telford and Wrekin in that the Office for National Statistics has consistently under-estimated the local population of Telford and Wrekin, and these are the figures on which central funding for the NHS and the local Council is based. NHS Telford and Wrekin will continue to press the case for the local estimation of population figures to be used for funding, which if not recognised will mean that we continue to be funded for fewer patients living in Telford and Wrekin than is the case, putting extra pressures on scarce resources.

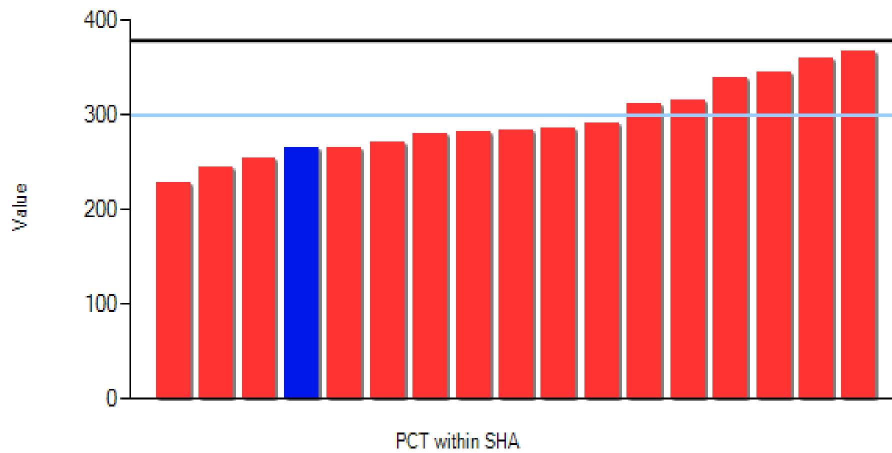
According to the Department of Health's own figures, as at 2010/11, NHS Telford and Wrekin stands at 6.2% below its 'fair shares' of NHS resources (equivalent to £16 million per year).

Key Demographic Messages for Telford and Wrekin

- The population will grow from 167,200 to 206,600 people by 2026.
- The 65+ population will rise by 14,300 (61%)
- The 85+ population will increase to 4,400 people (69%).
    - Men aged 85+ will grow from 800 to 1700 (113% increase).
    - Women will significantly out number men in this cohort (1,700 men to 2,800 women)
- The 0 to 15 population will rise by 5,900 (17.4%)
    - This cohort will account for 19.3% of the population compared to 20.3% in 2008
- The Black and Minority Ethnic population is forecast to increase from 5% to 6.5% of the overall population by 2026
    - the number of BME residents aged 60+ will increase to 2,100

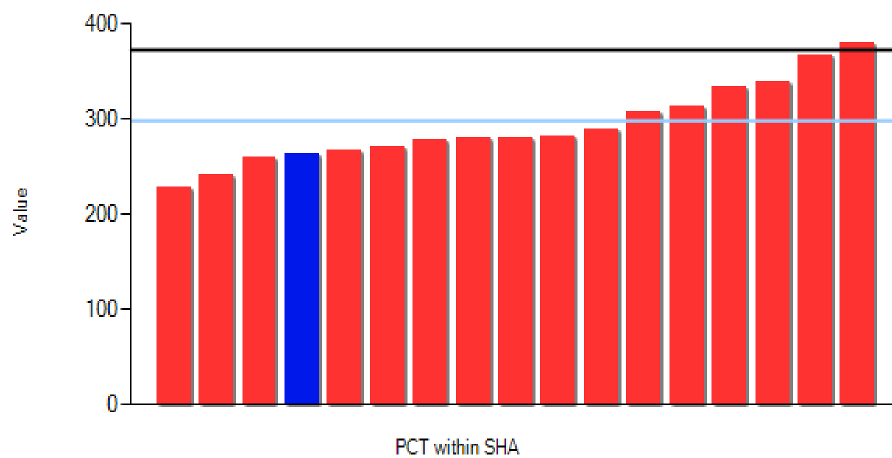
A&E Activity data:

Graph 1: Telford & Wrekin A&E Attendances per 1000 population - Q1 and Q2 10/11 SHA Comparison



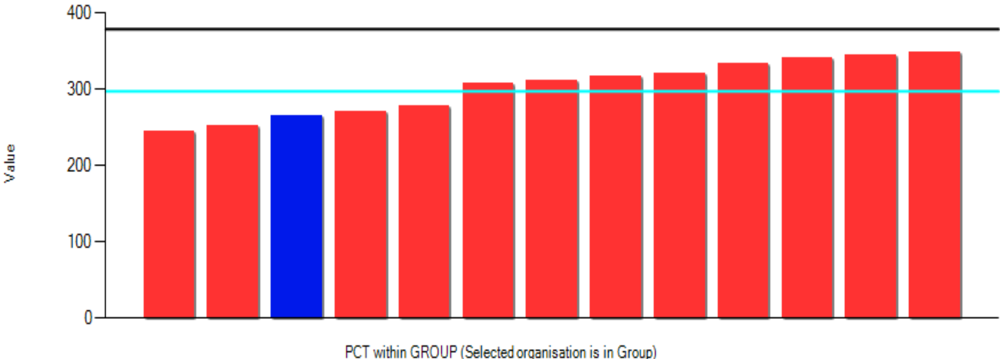
Source: NHS Comparators (2011)

Graph 2: Telford & Wrekin A&E Attendances per 1000 population - 09/10 SHA Comparison



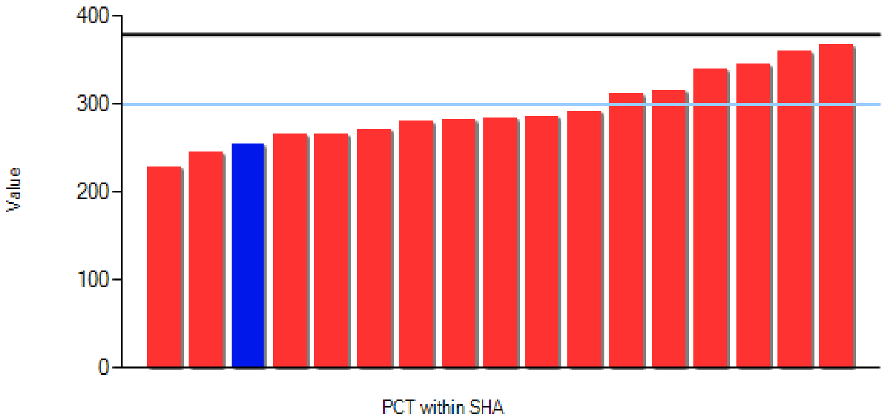
Source: NHS Comparators (2011)

Graph 3: Telford and Wrekin PCT - Accident and emergency attendances per 1000 population Period/Year: Rolling Year - 2010/2011; Activity; Applied Group: Manufacturing Towns



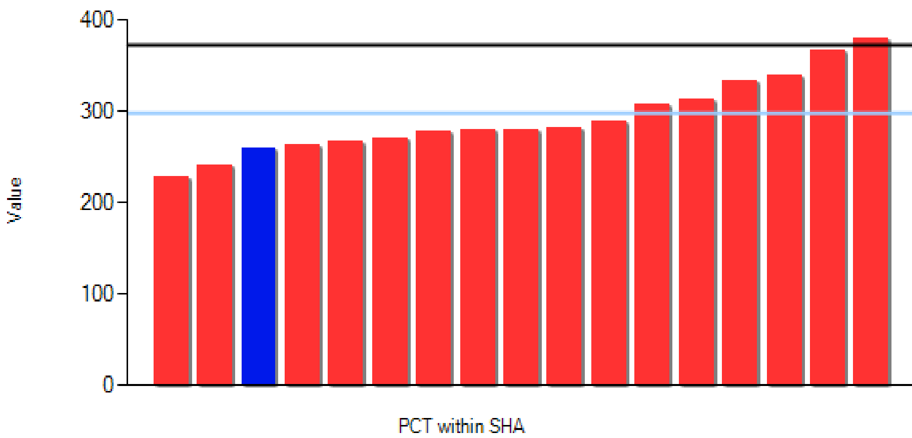
Source: NHS Comparators (2011)

Graph 4: Shropshire County PCT A&E Attendances per 1000 population - Q1 and Q2 10/11 SHA Comparison



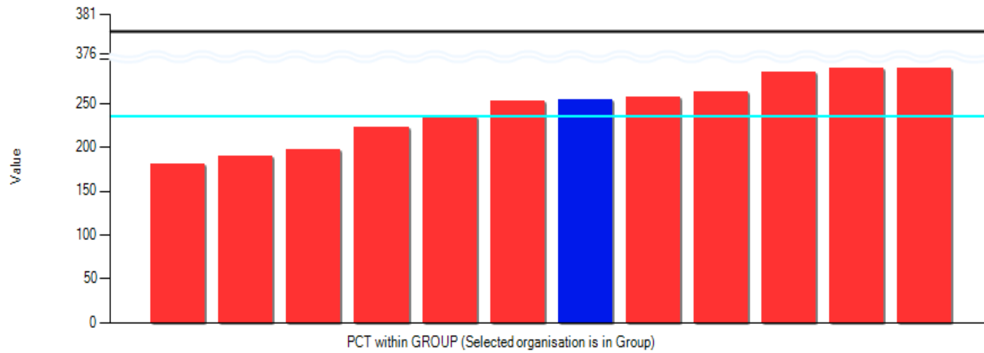
Source: NHS Comparators (2011)

Graph 5: Shropshire County PCT A&E Attendances per 1000 population - 09/10 SHA Comparison



Source: NHS Comparators (2011)

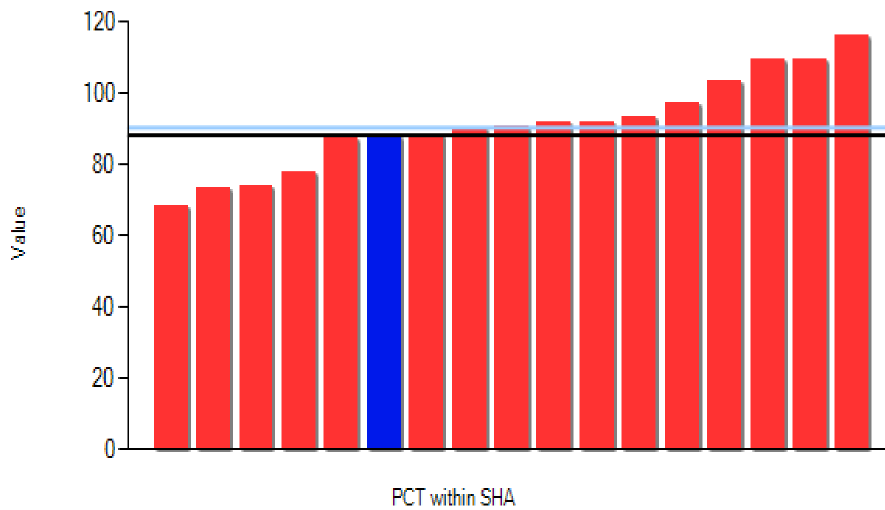
Graph 6: Shropshire County PCT - Accident and emergency attendances per 1000 population Period/Year: Rolling Year - 2010/2011; Activity; Applied Group: Prospering Smaller Towns - B



Source: NHS Comparators (2011)

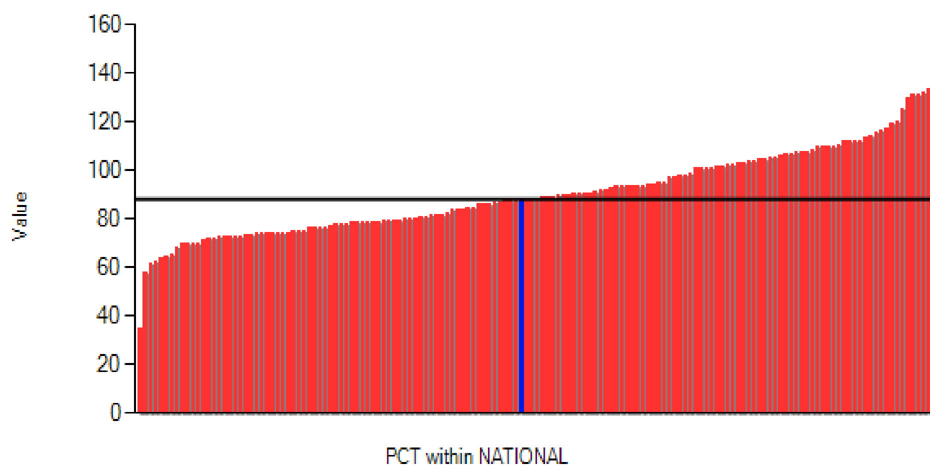
Emergency Admissions

Graph 7: NHS Telford & Wrekin Emergency Admissions per 1000 population - Q1 and Q2 10/11 SHA Comparison



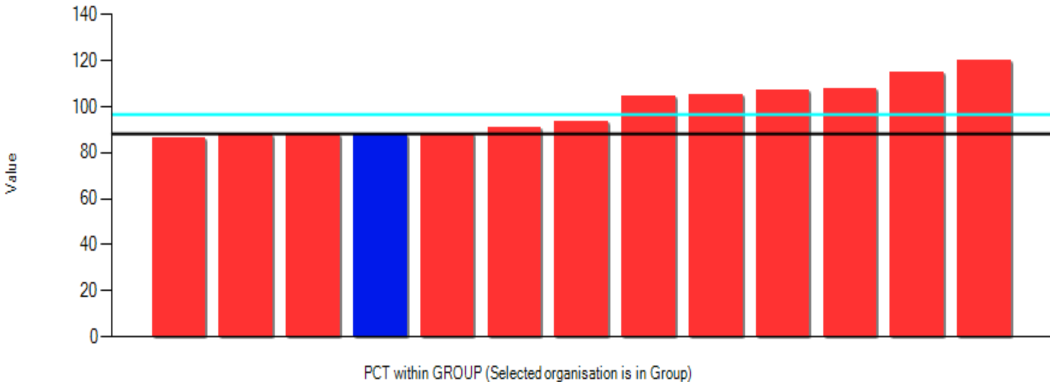
Source: NHS Comparators (2011)

Graph 8: NHS Telford & Wrekin Emergency Admissions per 1000 population - Q1 and Q2 10/11 National Comparison



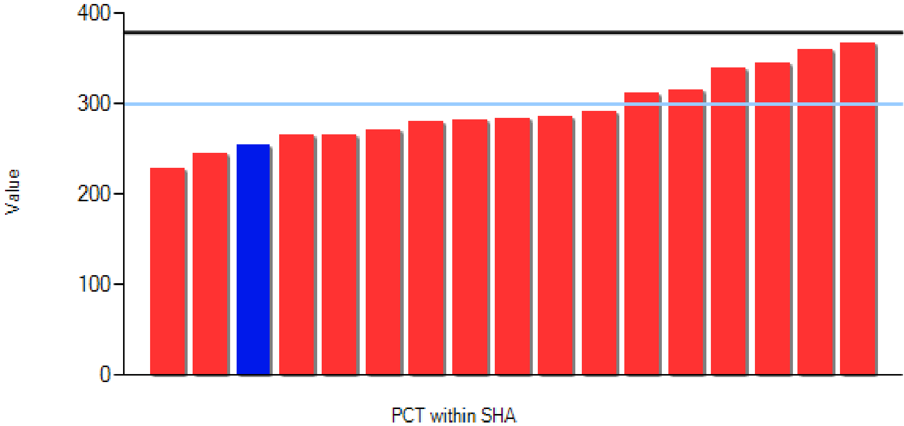
Source: NHS Comparators (2011)

Graph 9: Telford and Wrekin PCT - Emergency Admissions per 1000 Population Period/Year: Rolling Year - 2010/2011; Activity; Applied Group: Manufacturing Towns



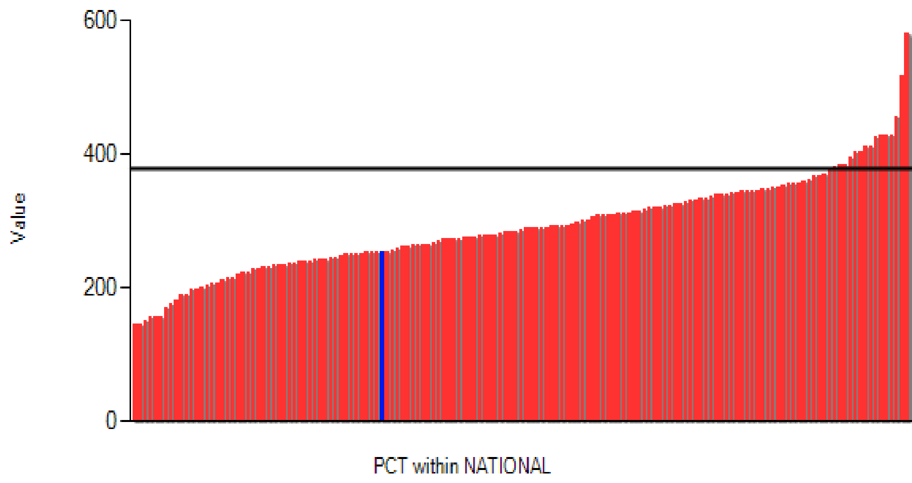
Source: NHS Comparators (2011)

Graph 10: Shropshire County PCT Emergency Admissions per 1000 population - Q1 and Q2 10/11 SHA Comparison



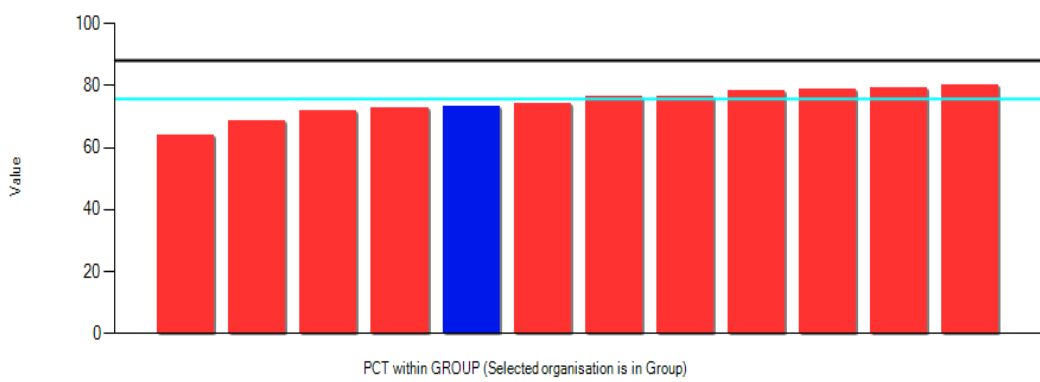
Source: NHS Comparators (2011)

Graph 11: Shropshire County PCT A&E Attendances per 1000 population - Q1 and Q2 10/11 National Comparison



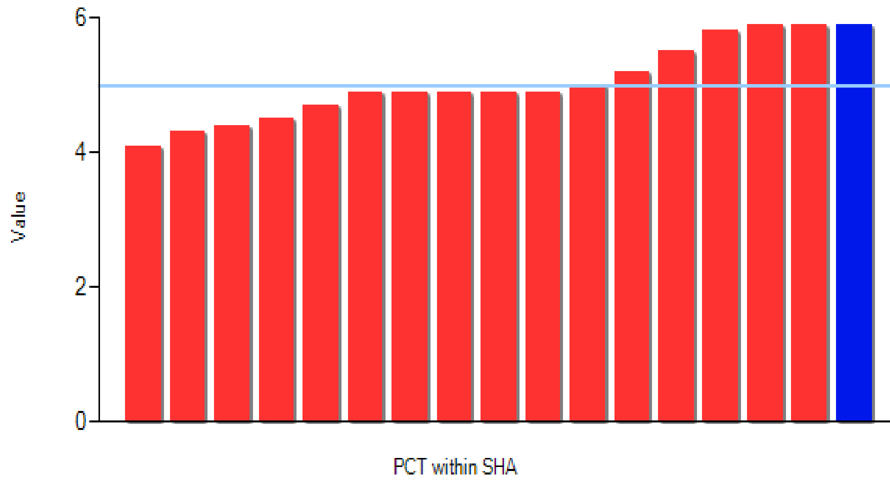
Source: NHS Comparators (2011)

Graph 12: Shropshire County PCT - Emergency Admissions per 1000 Population Period/Year: Rolling Year - 2010/2011; Activity; Applied Group: Prospering Smaller Towns – B



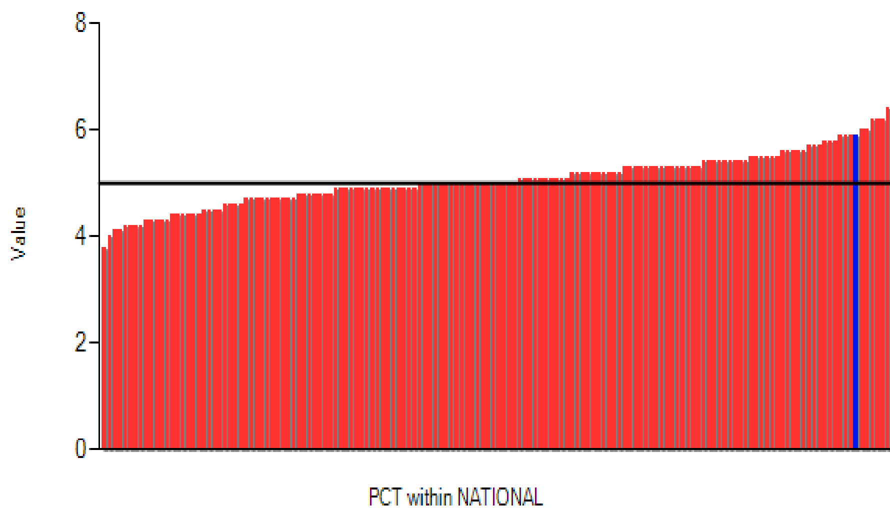
Emergency Admissions: Average Length of stay (LOS)

Graph 13: NHS Telford & Wrekin Emergency Admissions Mean Length of Stay - Q1 and Q2 10/11 SHA Comparison



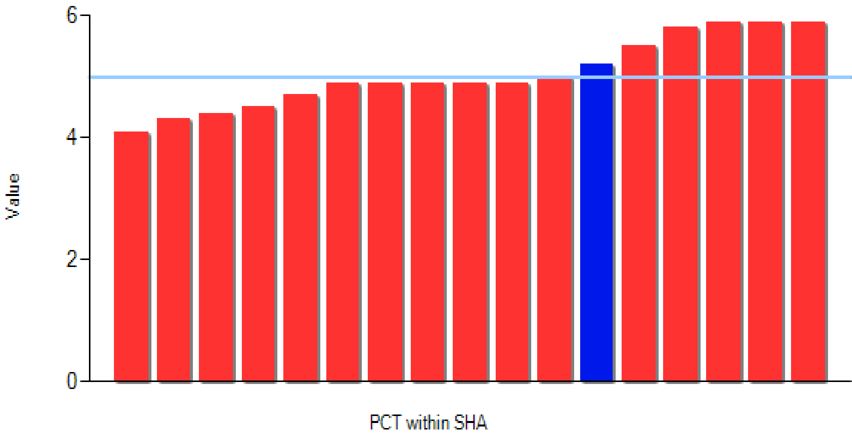
Source: NHS Comparators (2011)

Graph 14: NHS Telford and Wrekin Emergency Admissions Mean Length of Stay - Q1 and Q2 10/11 National Comparison



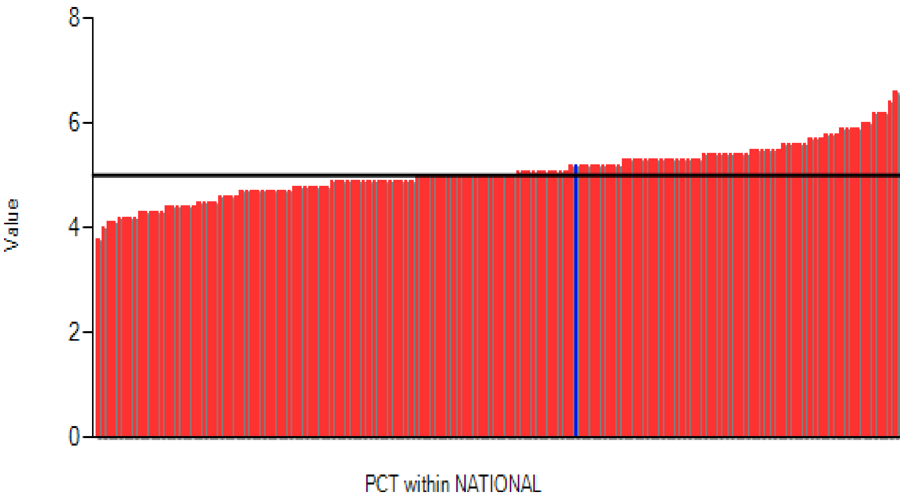
Source: NHS Comparators (2011)

Graph 15: Shropshire County PCT Emergency Admissions Mean Length of Stay - Q1 and Q2 10/11 SHA Comparison



Source: NHS Comparators (2011)

Graph 16: Shropshire County PCT Emergency Admissions Mean Length of Stay - Q1 and Q2 10/11 National Comparison



Source: NHS Comparators (2011)

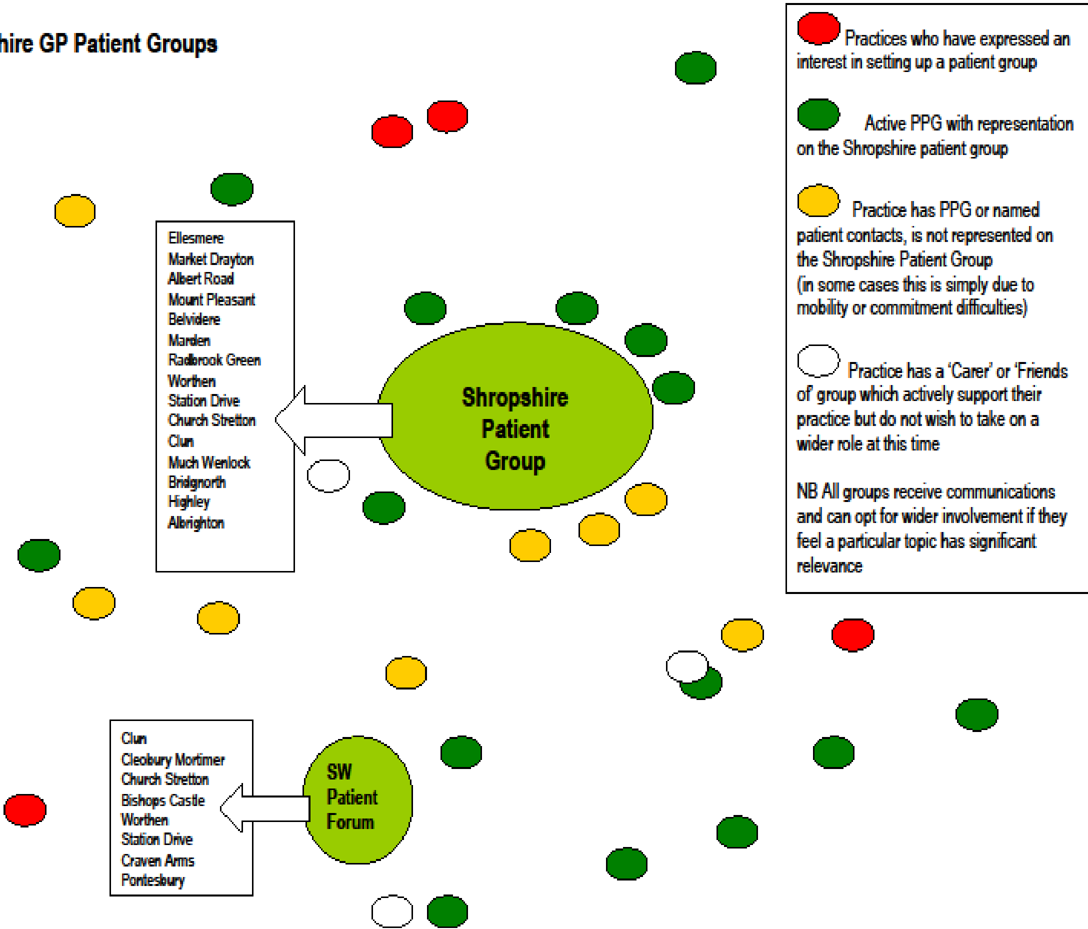
Summary

It is clear from NHS benchmarking data that both Shropshire County PCT and NHS Telford and Wrekin perform relatively well against expected A&E Attendances per 1000 population and Emergency Admissions per 1000 population. There are significantly fewer A&E attendances and emergency admissions in Shropshire compared to both national and regional averages.

However, mean length of stay for both Shropshire County and NHS Telford and Wrekin is an area of concern, particularly for Telford which is the lowest performing PCT in the Strategic Health Authority (SHA) and in the bottom quartile nationally.

Appendix 2

Shropshire Patient Groups



Appendix 3

Patient Focus Group Sessions – Example of Completed Notes

Urgent Care Focus Group Session

K2, William Farr House
Lead: Dr Bill Gowans
Facilitators: Bernie Jones, Graham Shepherd, Karen Higgins
Tuesday 8th March 2011 5.15 pm
Male & female - age range 55 +
Discussion time: 45 minutes

Does your Surgery deal with your urgent medical needs?

Unanimous opinion was yes, practices do deal with urgent medical needs and that an appointment can be obtained same day if necessary. (Does the question need to be asked, what makes a person feel they need to be seen that day)

What does your Surgery do well?

Home visits if requested
Good at referring on if need further investigation
Triage nurse ensures quick call back from GP if identified as urgent
Dedicated duty doctor for urgent cases
Telephone appointments are useful and can work but the standard does appear consistent across practices

What could it do better?

Surgery is not open long enough; particularly, there is no service at weekends. Providing extended cover would be useful. Surgery not open at lunchtimes, not even phone contact at lunchtimes
Could be more open / flexible
Provide a drop in service
Shropdoc out of hours service is poor (query, whether perception of service is related to location, access to service, this needs to be qualified)
Records need to be accessible by Shropdoc to provide any sort of confidence
Shropdoc and GPs are not joined up
Problems persuading receptionist or triage nurse that your case is urgent

What would make you go to A&E?

At weekends and evenings especially if A&E is nearer than Shropdoc base, proximity can determine visit to A&E. Shropshire is a vast County and this has a bearing on decisions
Feel A&E are better equipped to diagnose problem, access to specialist diagnostics
Suspected broken bones / stroke / heart attack i.e. perceived seriousness

Responsible for another person / helping someone vulnerable, older person child
Shropdoc advise you to go to A&E
'GP can't fix me so I'll go to A&E!'

What does it do well?

Triage
Investigation & diagnosis

What could it do better?

Waiting times
Need to get a grip of drinking problems, need a separate area for drunk and disorderly
Need to deal with elderly and frail patients quicker
'Improve waiting rooms!'

What would make you decide to call an ambulance?

Perceived life threatening condition

- Unconscious
- Excessive bleeding
- Breathing difficulties
- Stroke
- Heart attack
- Head injury
- Car accident
- Fire

Calling an ambulance will bring calmness to a situation at speed and expertise can reach you quicker than travelling to A&E.
We assume there will be a paramedic on every ambulance.
Will be dealt with quicker than turning up at A&E.
Told to dial 999 by Shropdoc or GP.
Would feel safer in an ambulance e.g. accompanying a woman in labour.

What do they do well?

Staff are excellent. Reassuring, calm, dignified, supportive – Highly trained
Staff take charge of situation and keep talking to you
Air ambulance is excellent and vital for County. Floating ambulance also a necessity.

What could they do better?

Should be a paramedic on every ambulance

Response times can always be better, some rural areas and some not so rural areas struggle. Two examples cited of ambulance unable to locate GP practice. Better knowledge of area is needed by controllers.

What would make you feel that you needed to be in hospital?

The doctor said so! Medical opinion
Social issues - being on your own, lack of support, no one to administer care.
Thinking I was critical
Feeling of uncertainty
Require further diagnostics / tests
Junior doctors can appear uncertain and reluctant or unable to access higher opinion, this can lead to 'worried well'.

What do they do well?

A&E – brilliant, Wards – ok, Discharge – (this was quite a strong, zealous statement reinforced by 2 others with recent experiences)
Handle bereavement well
Outpatients follow up appointments are generally good
Orthopaedics are very good

What could they do better?

There is no joined up working, no consistency in staff, making it impossible to draw up discharge letters. On the wards there is a general lack of 'care'. 'Staff couldn't cope, they were overworked and thin on the ground'
A lack of doctors able to make decisions at weekends – 'people don't get sick Monday to Friday!'
Outpatients follow-up appointments are generally good
Numerous separate appointments lead to worry over diagnosis

Other general comments

More needs to be done in the community. Joined up working is needed to provide local care.
Cottage hospitals needed for those who need constant care but not acute treatment
Long delays in getting results of tests / x-rays lead to concern.
Operations cancelled at very short notice even up to the point of nil by mouth.
Better out of hours service is needed – speedier responses especially by Shropdoc
Cut down on paperwork – use IT & phones
MIU should be in GP surgeries
No one takes ownership
Feeling of not being told information unless you ask and not everyone is able or confident to ask.
Better communication is needed between areas of healthcare

Appendix 4

Patient Focus Groups – Collated Notes

Urgent Care – Focus Group Report 2011

Objective

- To explore current provision of particular health issues, their suitability and/or potential for improvement in the future provision.
- To trial a focus group process which presents a series of issues to members of the Shropshire Patient Group and then asks them to take the process back into their own communities and report back. Enabling the opportunity to capture a wider demographic of views.

Aim

- To contribute to health service re-design in a "bottom up" and inclusive way. Patient input from the start of the process.

Progress to Date

Initial focus group lead by Dr Bill Gowans on 8th March with members of the Shropshire Patient Group. The session involved three groups of six and each had a facilitator.

The briefing document for the focus group is attached.

Focus groups have now been held in several areas around the County and are planned to take place in others. Some areas have held more than one focus group with different group profiles:

- Albrighton
- Market Drayton
- Station Drive
- Worthen
- Marden
- Pontesbury
- Much Wenlock

Different groups have been approached to take part including Walking 4 Health, Mother and Toddler, 30/40 some-things and existing patient groups.

The focus group session asked what would prompt an individual to use various providers of urgent care and what each of these services does well and what they could do better.

Themes

GP surgery

The answers provided in this section were the most contradictory. To start out it appears most were generally happy and yet this response was frequently contradicted by later answers and discussion.

Eg. ‘Does your GP surgery deal with your urgent medical problems?’
‘Yes….’

Then later, ‘What might make you go to your MIU, Shropdoc or a Walk-in centre?’

‘*…………it is quicker to go to a walk in centre than to see a doctor which may take days’*

However very few actually spoke of their Practice in terms of an urgent care service and one group in particular (‘independent thirty some-things’) had never even considered the GP practice as a source of treatment for a minor injury.

Shropdoc/Walk-in Centre

Shropdoc received critical response due to waiting times but also due to circumstances beyond its control, lack of access to patient information / records. However Shropdoc was notably viewed very favourably by mums of young children*, ‘don’t think service needs changes’*.

The views on the walk-in centres were widely varied. They are very popular with busy working people who like the convenience of being able to attend after work or, as was highlighted by one participant, being able to access a service near their place of work. (walk-in centre hosted by Boots on Birmingham New Street)

Specifically in terms of urgent care, the walk-in centres had been used by participants who felt they would be wasting A&Es time.

In complete contrast, in three public sessions held in Albrighton there was little if any knowledge of walk-in centres and the services they provide, the same was also said of MIU.

A&E Department

Many comments in this section were as might be expected, a trip to A&E is determined by perceived seriousness.

Many of the comments focused on quality; lack of dignity, unpleasant waiting rooms, long waiting times. Despite the concerns over the quality of the service delivery there is a sense that A&E provides a degree of confidence in diagnosis.

- *‘all tests can be carried out’*
- *‘feel A&E are better equipped to diagnose problem, access to specialist diagnostics’*
- *‘they are backed up by hospital facilities’*
- *‘where you go when your GP can’t fix you’*

Ambulance

Patients perceptions of ambulance services are that they can bring a sense of calm to a situation swiftly. Although many believe they are there only to deal with the most serious of incidents, ‘heart attack’, ‘road traffic accident’; others clearly thought they might be used out of hours if there was a ‘lack of a prompt response from Shropdoc’ or to bring a sense of confidence to a situation eg ‘a woman in labour’

Hospital

Along with expected answers to why a person might feel the need to be in hospital, ‘unstable condition’, ‘doctor told me I needed to be there’; many of the participants were concerned that hospital was being used because a person is simply unable to cope at home.

Comment on Discussions

Views are very different when non-patient group members are taking part. This has generally highlighted an education issue. Many people simply don’t know what options are available let alone which is the most appropriate.

With all the focus group reports in the comment in the interim progress report still stands.
‘Any changes to improve the efficiency of urgent care and reduce the strain on the service would benefit greatly from an inventive and successful education campaign. It is very easy for those of us in the NHS or closely linked to it to believe that all the information that a patient needs is available but:

- No one cares about the information until the point of need – how do we influence this behaviour?
- As one participant responded when informed that her local GP’s services were listed in her practice book / leaflet, ‘*A what? Why on earth would I have a practice book?!’*

In addition supporting this view from other focus groups:

- ‘*Decide how to reach those infrequent users of the medical centre to tell them about the triage system and prescription ordering….’*
- *‘Among the participants there was a wide variation in what could be deemed as “being in need of urgent care”!’*

Two other major considerations arising from the focus groups are geography and confidence in diagnosis.

It was very notable that Shropdoc received very favourable comments from the mothers of young children and this is supported with comments:

- *'Call you back quickly'*
- *'After giving advice always say "call us back if you are worried"*

And the same group when asked, 'What would make you go to A&E?', the response was, '*advised to go by Shropdoc'*.

This could pose the question, does Shropdoc deliver a degree of confidence and trust with a specific approach for parents of young children or is this purely incidental?

In all the Groups there was a strong sense that the degree of confidence a patient has in the service received, massively influences their decision making and choices.

It is no great revelation that the geography of Shropshire is very varied. However it shouldn't be accepted as an excuse and needs to be addressed in relation to access to urgent care:

- 'What would make you go to A&E?'
  'At weekends and evenings especially if A&E is nearer than Shropdoc base'

Comment on the Process

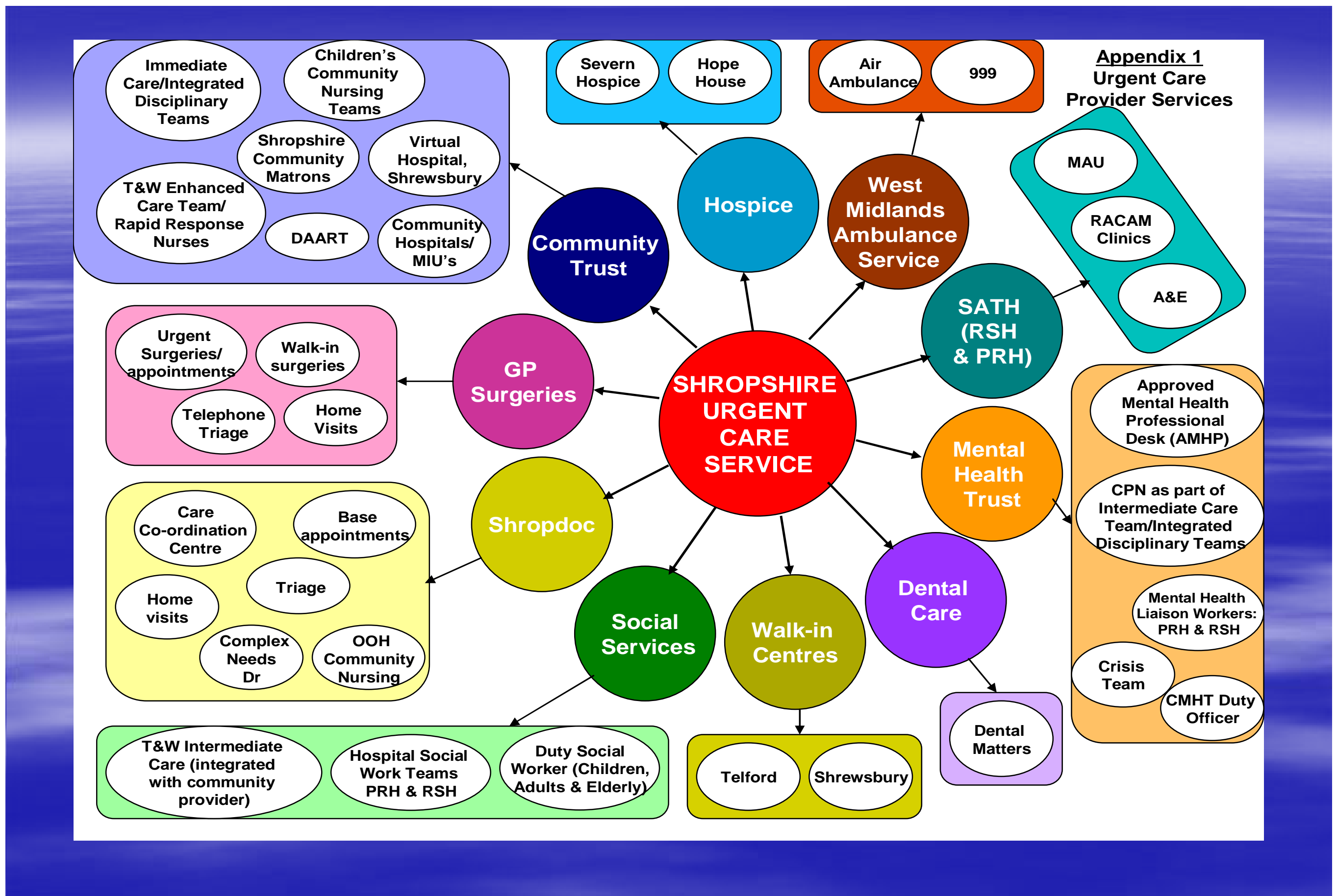
This has delivered some useful insight into the choices and reasons for those choices made by patients when accessing treatment for an urgent medical problem. This was experimental and in some respects was quite crude but the process has a definite value and could be repeated. Recommendations for the future would be:

- The degree of success varied around the County and this could be made more consistent if patient groups wishing to take part were offered training
- Patient groups should be supported by commissioners in identifying members of their communities whose views would be most beneficial to the topic and supported by their practice to contact these groups
- Patient representatives running focus groups must be aware that they need to report all opinions even where they conflict with their own
- Need to be aware of timescales required to complete the process – needs to begin at least 12 weeks prior to results being required.

This whole project has only been possible due to the commitment and time given generously by patient group members from around Shropshire County, all of who have stated that they and their groups would be willing to repeat the focus groups in the future for this or other topics.

Appendix 5

The Ten Providers of Urgent Care in Shropshire



Appendix 6

Collated Notes from 1st Urgent Care Stakeholder Meeting

Urgent Care Strategy Meeting 9th March 2011
'Collated minutes'

Present at the meeting: Cath Molineux-Consultant Nurse Primary Care T&W, Dr Bill Gowans GP and vice chair of the SCCC(Shropshire County Commissioning Consortium), Graham Shepherd Patient representative, Dr Robert Law SaTH Centre Chief for Emergency and Critical Care (consultant anaesthetist), Dr Julian Povey, GP and member of the SCCC, Dr Peter Clowes GP and Innovation Team Lead SCCC, Dr Mark Prescott, SaTH Value Stream Lead Telehealthcare (A&E consultant), Dr Wendy Jane Walton, Medical Director Telford Walk-In Centre, Dr Nick King, GP and urgent care lead for T&W consortium, Dr Kevin Eardley, SaTH Value Stream Lead Unscheduled Care (consultant physician), Pete Gordon - Head Of Service Improvement (SaTH), Tina Cookson- Chief Operating Officer (SaTH) , Elaine Edwards-Nursing Director Shropdoc, Tracey Jones- T&W Lead Commissioner Service Transformation, Hilary Adams-Team Manager Intermediate Care

We agreed that, before next winter, we will develop and implement a functioning emergency ambulatory care system with rapid access, rapid investigation and rapid specialist opinion which is available 7 days a week.
We agreed that, before next winter, we will develop community care strategies which allow early supported discharge from hospital.
We agreed to meet again in six weeks to develop our plans further and hold each other to account for progress made.

To achieve these objectives:

As part of the **planning process** we need to:

- have patients more involved
- design pathways around the patient journey
- have a safe, effective and shortened patient journey
- keep the current level of care as a minimum standard
- develop a plan now! – so we know what we are going to do
- develop an overall strategy with one plan and key tasks (captured in a visual way)
- develop a process map (alongside a structural map)
- have actionable projects
- have some quick wins
- be committed to a longer term plan designed through a combination of bottom up and top down processes.
- make the complex simple and use what is already there better and more efficiently

- have a consistency of approach (in hours is not the same as ooh)
- have governance built in from the beginning
- show value for money
- not be scared of ‘punitive’ tariffs
- describe the problems, process and outcomes precisely, using appropriate language
- not start with ‘the solution’
- use data to guide us
- let examples of good practice guide us
- include social care in the map (and ? the solutions) and encourage new ways of working
- evolve through a combination of bottom up and top down activity
- have clear goals with a sense of urgency resulting in tangible change
- reinvest savings from secondary care in primary and community care in a way that strengthens the solution
- break down boundaries

To have an effective **Front door** to the hospital, we need to :

- not have too many doors for patients to access urgent care
- clarify the role of DAART assessment for the acutely ill elderly patient – this might be duplication and one too many doors
- recognise perhaps that there is little we can do to change peoples ‘ behaviour in the short term
- understand why patients make the choices they do to inform longer term solutions
- regard the front door issue as part of a longer term project and not attempt to change it as part of our short term ‘quick win’

To have an effective **Back Door** to the hospital, we need to:

- make ‘invisible’ community care visible to secondary care staff
- have joined up community care with increased capacity, including more community hospital beds
- have reactive support mechanisms in place in the community
- develop and make accessible enhanced care in the community – and especially for patients to continue to live in their own homes
- up skill community nurses (?with rotating posts)
- achieve a consistency / standardisation of care and service in the community across the county
- commission the community trust in a tailored way to meet these objectives
- develop a ‘can do’ and ‘will do’ culture in community teams.

- have a co-ordinated ‘pull’ out of hospital without too many people involved
- allow CCC to achieve it’s full potential
- develop a CCC ‘in reverse’?
- know that whoever talks to ‘CCC in reverse’ or equivalent from the hospital about discharge has the appropriate skills (? Long term training needs)
- use Telemedicine to support early discharge
- have a clear discharge process

To develop **an effective Emergency Ambulatory Care system in the hospital**, we need to:

- resolve issues with estates in the hospital
- meet the needs of the elderly acutely ill patient
- get patients to specialists early in the day and in a smoother distribution throughout the day
- have effective communication between primary and secondary care and between clinicians and patients
- Clarify the role of primary care input to assessment – GPwSI or community clinician
- Stream patients according to estimated length of stay (can we identify what sort of patients these are and ‘prevent’ their admission)
- have an appointments system in A and E?
- have good access to high level decisions resulting in the rapid turnaround of patients
- have an efficient early supported discharge process
- have an ‘almoner’ involved in the discharge process?

Bill Gowans (collated from flipchart records made during the meeting)

Appendix 7

Behavioural Change Proforma

1. Who are you?
Who are you or what organisation or team do you work in?
2. What do you want to do?
Think of one broad behavioural outcome which you would like to achieve in your role or which you would like your tem to achieve. The outcome you choose must be behavioural though; doing something more cheaply, or doing it better is not directly behavioural.
3. What attitudes, behaviours and relationships do you need to achieve this?
Think of attitudes, behaviours and relationships which you or everyone on the team will need to have or demonstrate in order to achieve the behavioural outcome you have chosen in 2.
4. How will you meet the needs you have identified? (in 3.)
These will be specific processes, structures or tasks which you or everyone in the team will implement or do to achieve your desired attitudes, behaviours and relationships.
5. What are you going to do?
This is a list of things to do. It will require 'project managing' with frequent reference back to 4,3 and 2 to check you are on track.

Appendix 8

GP Locality Focus Group. Collated Notes

Urgent Care Focus Groups – Shrewsbury Practices

Collated notes from three focus groups held during the Shrewsbury Locality Board meeting on 17th March 2011

Within the practices:

- There is a variation in urgent care provision across practices. This is, in part, list size dependent. Nurse triage and telephone appointments were used by some larger practices, telephone triage and open surgeries worked for smaller practices and visit triage worked for all sizes.
- Urgent care demand is met, but in hours only. Patients liked continuity of care and were willing to wait for it.
- Clinician and patient views on what is urgent / appropriate are not aligned
- Patient flow in the day is a problem which affects primary and secondary care. E.g. late calls and visiting late morning.

Beyond the practices:

- Ambulance response for real emergencies, Shropdoc, Acute referral centres, Fracture clinic and outstanding clinicians all worked well.
- Other services worked but had access / capacity problems. E.g. community matrons, rapid access investigations, immediate care
- There are too many options / doors for patients to access urgent care. This causes fragmented care and lack of continuity.

Recommendations:

- Increase practice based urgent care provision but provide more resources to do it. E.g. physician's assistants, better access to investigations and urgent specialist opinion.
- Provide a 'single point' of access for patients with better publicity and education
- Increase access / capacity of community nursing
- Develop hospital 'front door' for 'fit to sit' patients
- Get rid of NHS direct and re-examine the role of the Walk in Centre.

Appendix 9

URGENT CARE NETWORK

Terms of Reference

Purpose

To oversee the development of an integrated and whole system urgent care strategy and ensure the delivery of the resulting urgent care plan to provide a sustainable and high quality urgent care system for the local health economy of Shropshire County and Telford and Wrekin.

Responsibilities

To be responsible for the development and implementation of the Pan Shropshire Unscheduled Care Strategy .

To receive reports and proposals from Urgent Care Strategy programme and project leads and groups – to include stakeholders from primary care, secondary care, local authority, community services, and patient representatives.

To receive clinical assurance from Urgent Care Strategy Group, Shropshire County PCT Clinical Assurance Panel and Telford and Wrekin Professional Executive Committee on each service change, or new pathway development.

To receive on behalf of the individual organisations proposals of service changes and pathway amendments and share the proposals with their respective organisations.

To champion the agreed mandate of developing increasingly integrated models of urgent care.

To ensure financial sustainability of models of care proposed.

To consider opportunities for full involvement of patients and public in all service specification reviews.

For members to be accountable to their individual organisation boards and to be held responsible for informing their boards of agreed changes and gaining ratification of each proposal.

Proposed Membership

To fulfil it's purpose, including full accountability and decision making functions, each organisation should ensure that their representative at the Urgent Care Network, if that person is not the Chief Executive or equivalent, should be sufficiently senior to be able to carry out the duties described on behalf of their organisations.

Directors from following organisations are invited to attend:-

Name	**Organisation**
Dr Bill Gowans **Joint Chair**	Shropshire County Clinical Commissioning Group
Dr Mike Innes **Joint Chair**	Telford & Wrekin Clinical Commissioning Group
Adam Cairns	Chief Executive, SaTH
Leigh Griffin	Managing Director, SCPCT & NHS T&W
Jo Chambers	Chief Executive, Shropshire Community Health Trust
Paul Cronin	Chief Executive, Severn Hospice
Kym Riley	Chief Executive, Shropshire County Local Authority
	Chief Executive, Telford & Wrekin Local Authority
	South Staffordshire & Shropshire Mental Health Foundation Trust
Nick Henry	West Midlands Ambulance Trust
Dr Gill Clements	Shropdoc
Wendy Farrington Child	Robert Jones & Agnus Hunt
Dr Peter Clowes	Shropshire County Clinical Commissioning Group
Fran Beck	Director of Integrated Services, SCPCT/NHS T&W
Tracey Jones	NHS T&W Lead Commissioner Service Transformation
Carol McInnes	Shropshire County PCT Commissioning Manager for Unscheduled Care
Muriel Fellows	Patient Representative, Telford & Wrekin
Graham Shepherd	Patient Representative, Shropshire County
Helen Herrity	Chair, Shropshire County PCT
Andrew Mason	Chair, NHS T&W

On occasion when the identified representative cannot attend, he/she will be responsible for identifying an appropriate representative to attend on their behalf.

The Chair will be rotational between designated member of Shropshire County and T&W CCG's

The Deputy Chair will be the CCG representative who is not scheduled to act as Chair.

Quoracy (minimum needed)

1 member from either PCT
1 member from either CCG (with prior approval to act on behalf of both CCG)
1 member from SATH
1 member from Shropshire Community Health Services
1 member from each Local Authority unless pre-agreed cross representation obtained.
West Midlands Ambulance Service

Reporting

Each organisation represented will report to their respective Boards and appropriate Sub-committee's.

Meetings

Formal minuted meetings
Proposed changes with attached governance document seven days prior to meeting

Frequency of Meetings

Every 8 weeks

Review

Terms of Reference to be reviewed annually.

Frequency of Meetings

Every 8 weeks

Review

Terms of Reference to be reviewed annually.

References

Ref. 1 – Evidence for large scale change

1. Leading Change: Why Transformation Efforts Fail. John P. Kotter. Harvard Business Review 29/4/09
2. The Inconvenient Truth About Change Management. Scott Keller & Carolyn Aiken. McKinsey & Company
3. The 5 Myths of Innovation. Julian Birkinshaw, Cyril Bouquet & J-L. Barsouz. 16.12.10
4. What Are the Measures That Matter? Art Kleiner. Culture & Change. Reprint 02101.
5. Inspiring Change in the NHS. Introducing the Five Frames. NHS Institute for Innovation and Improvement.
6. An Introduction to the Theory and Practice of Large-Scale Change, and its Relevance to the NHS. Paul Plesk. Academy for Large Scale Change. 11.10.08.
7. What Can We Learn from Each Other? ‘Wisdom in the Room’ Sharing Session. Paul Plesk. Academy for Large Scale Change.

Ref. 2 – Research evidence for effective Urgent Care

1. How to Implement Ambulatory Emergency Care. NHS Institute for Innovation and Improvement. October 2010
2. Directory of Ambulatory Care for Adults. NHS Institute for Innovation and Improvement. March 2010.
3. Avoiding Hospital Admissions. Lessons from evidence and experience. Chris Ham, Candace Imison, Mark Jennings. The Kings Fund. 2010
4. Avoiding Hospital Admissions. What does the research evidence say? Sarah Purdy. The Kings Fund. December 2010
5. Transforming our health care system. Ten priorities for commissioners. Candace Imison, Chris Naylor et al. The Kings Fund. 2011.
6. Urgent and Emergency Care Clinical Audit Toolkit. RCGP, RCPCH & CEM. 2011