TELFORD & WREKIN HEALTH & WELLBEING BOARD JANUARY 2013

UPDATE ON THE UNSCHEDULED CARE PROGRAMME

DR MICHAEL INNES

1. PURPOSE

To inform HWB Board members on progress with the Unscheduled care programme of activity across all of Shropshire

2. RECOMMENDATIONS

That the Board:

- **Note the progress to date and focus on the main themes**
- **Note the next steps to deliver transformational change in Unscheduled care**

3. BACKGROUND

3.1. The Unscheduled care programme of work has been in progress for almost two years. It was formed as an early focus for the developing CCGs. The aim was for it to take a bottom up approach and to be collaborative across all of Shropshire involving population representatives, healthcare and social care from the outset.

3.2. The work has been driven by population needs especially derived from patient groups, articulated by a number of statements as follows:

- 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

3.3. Nineteen different streams of work were identified, which have been managed with a common framework (Table 1.). These have each had a dedicated group which has met regularly and reported to bimonthly unscheduled care network meetings and quarterly unscheduled care stakeholder meetings. Each Group has an identified project sponsor and lead manager. The project sponsor is largely a clinician from a provider organisation, Shropshire or Telford CCG.

4. SUMMARY OF ACTIVITY AND PROGRESS

4.1. Over time, with further work and discussion, it has been clear that the groups sit within clear themes. These are described in the table below.

Table 1. Workstreams in the Unscheduled care programme with associated themes

No.	Project Descriptions	Strategic Theme
2	Demand and Capacity Management (Winter 9)	**Demand and Capacity Communications Hub**
3	111 – Local Implementation	
4	DOS including NHS Pathways	
1	Education & Publicity	**Access**
5	Walk in Centres/MIUs Reconfiguration	
6	GP Surgery Urgent Care Audit -> Primary Care Access	
13	Paramedics & MIU's co-location -> Ambulance destinations	
16	A&E	
8	Mental Health Liaison	**Mental Health Liaison (RAID)**
14	Emergency Ambulatory Care	**Flow**
9	Pathways for Urgent Care Diagnostics	
15	Case Management & Discharge Planning	
17	Delayed Transfer of Care (DTOC)	
18	Reablement	**Reablement/Joint Commissioning**
7	Acute Frail & Vulnerable Pathways	**Frail and Complex Service**
10	Virtual and Community Hospitals	
19	Active Case Management	**Case Management**
11	End of Life Care	
12	Clinical Support to Care Homes	

4.2. Each group has made progress at a varying rate and not all groups were initiated at the start. Collaborative working across the boundaries between providers, commissioners, health and social care has been strongly encouraged.

4.3. It has become clear with time that it is important to focus on the large scale challenges and so much attention more latterly has been to develop work to address the themes.

4.4. The main areas of activity that are making significant progress are:

- Frail and complex care
- Demand and capacity management for unscheduled care
- Mental Health Liaison – Rapid Access to Intervention and Diagnosis (RAID)
- Flow – this is more difficult to tie down but the groups looking at the Walk in Centres and Emergency Departments (A&E) have been developing

Brief reports on the progress of each of these is detailed below.

5. Frail and Complex care

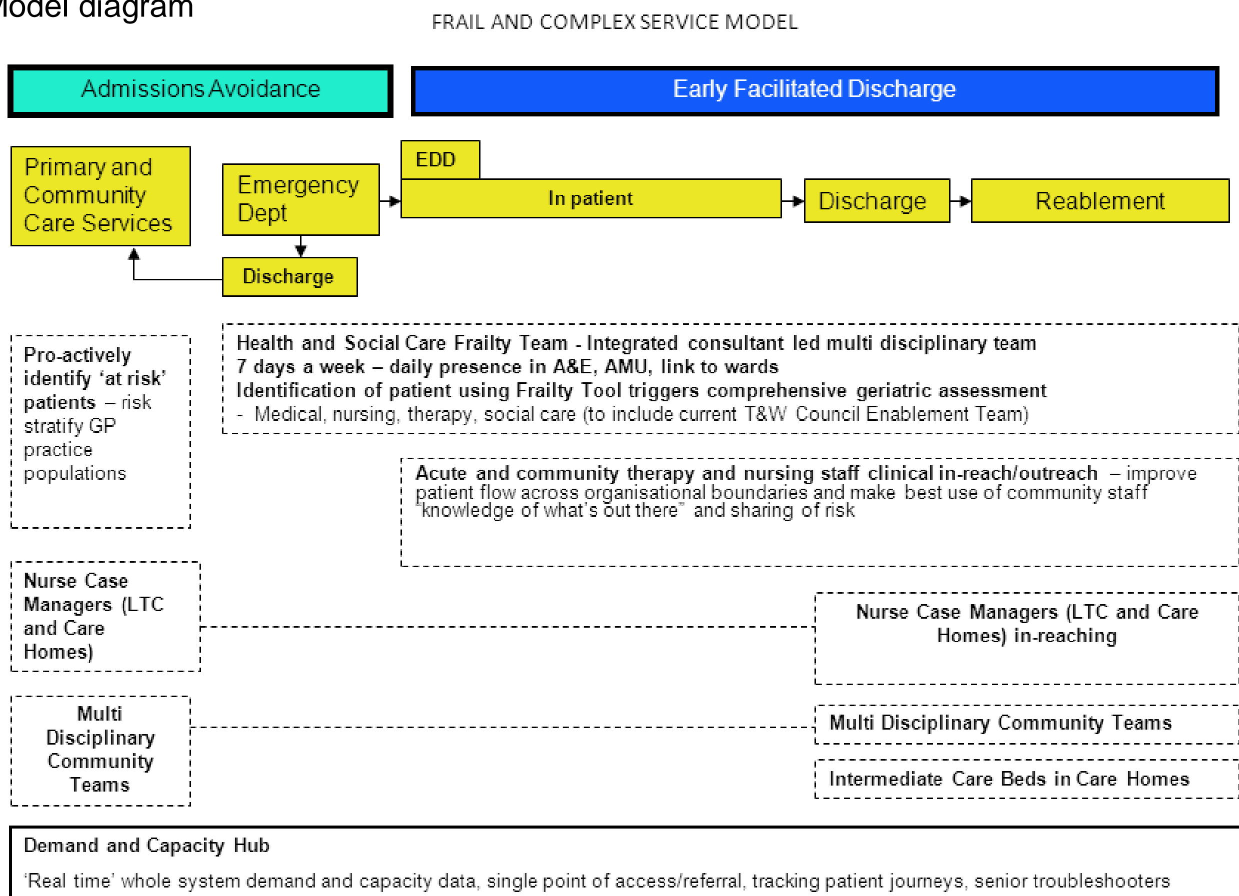
5.1. Driven by increasing numbers of elderly people with increasingly complex health and social care needs.

5.2. AIM: *to redesign working practices to deliver services that truly follow the patient journey across organisational boundaries to improve patient safety, quality, effectiveness and patient flow.*

5.3. Components agreed to be:

- Pro-active approach to early identification of 'at risk' patients;
- Community case management (including care homes);
- Dedicated integrated Frailty Team;
- Upskilled and increased acute and community therapy and nursing staff providing clinical in-reach/outreach.
- Demand and capacity management for unscheduled care

5.4. Model diagram



5.5. The model for Telford will develop over time as we are wanting to integrate Frail and complex with our enablement services as we have different arrangements to Shropshire.

5.6. For RSH and Shropshire , the senior medical support will come from clinicians who previously worked in DAART , the senior medical cover for the PRH site is still being arranged. Currently trying to recruit consultants in care of the elderly to staff the team, but it is proving hard.

5.7. Telford's approach to frail and Complex is one which sees both the medical / health and social components of care as being important. We have committed additional Winter funds monies to joint enablement team and for the purchase of bed based community assessment and treatment.

6. **Demand and capacity management for unscheduled care**

6.1. Driven by need to manage movement in and out of the acute trust in particular, with a need to know about all movements and all possible services that can be used as alternative pathways of care.

6.2. It will assist in the coordination of response to high level escalation pressures, and in proactively managing the system, to prevent, where possible, increasing levels of escalation occurring frequently.

6.3. Locally, working between Health and Local Authority to maximise the opportunities that exist e.g. a 'joint localised hub' to link with the centralised one.

6.4. Activities to deliver this will encompass the following:

- locate Local Health Economy data within one data repository to enable aggregation, cross referencing and reporting
- develop links to enable the sharing of information with the Local Health Economy
- create a reporting framework across the Local Health Economy that provides timely and relevant data and information to furnish commissioners and management within provider organisations for the purposes of resource allocation and planning
- create data and information sources for health professional to direct patient care and treatment
- ensure continuity and sustainability is built into the long term solution

6.5. Funding has been secured to support this for the winter 12/13 at least. This includes provision of more appointments for walk in patients at the walk in centres this winter.

7. **Rapid Access to Intervention and Diagnosis (RAID)**

7.1. This comes as one of the schemes to deliver Quality, Innovation, Productivity and Prevention (QIPP).

7.2. It follows a model pioneered and proved in Birmingham and focuses on the Acute Trust (SATH)

7.3. It entails the use of an early intervention team to do two things. Firstly, to identify people who are at risk of dementia and mental health issues early and to intervene to prevent or manage these problems earlier than previously. Secondly to train all hospital staff to have a greater competence in this role.

7.4. It has been running since the early Autumn and progress so far has been good with cost efficiency already attributed to it.

7.5. Major activity so far has been as follows:

- Service started 9-5 6 days a week from end of October in PRH. Key feature of 1 hour response for referrals (95+ % success at that response time),
- Existing MH Liaison staff transferred to RAID, Consultant psychiatrist working full time across PRH and RSH from December, Clinical Psychologist in post full time,
- 12 hour/7 days a week from this week; moving to 16 hours and then full RAID provision 24 hours at end of the month across PRH and RSH
- 2 cohorts of training (40 SATH staff) completed. 2 more half way. One more planned before end of March. intention to ensure SATH staff from all key departments, CT and Social Care staff receive training
- Cascading document being devloped by Stafford Univ to support sharing RAID across SATH and other organisations. Will be available online to improve access
- Junior doctor to be taken forward. Challenge to recruit junior doctor identified
- RAID pathway agreed. Model includes 16+ and alcohol assessments so linking with Alcohol Liaison and CAMHS for 16-18 year olds. Developing protocols with other MH teams CT, SCC and TWC to ensure timely discharge
- Stafford Univ working with SATH to carry out evaluation from April 2013
- QIPP savings identified. At end of October (month 7) £209k savings (£43k ahead of target to date)

8. **Flow**

8.1. This has been harder to define and manage as one stream of work. A large element of this is about ‘the front door’ to the Acute Trust (SATH).

8.2. Work from two of the workstreams (Walk in centres and Emergency department groups) is coming to similar conclusions.

8.3. Put simply, this argues for a consistent ‘offer’ to the population across the whole of Shropshire and Telford and Wrekin.

8.4. Whilst not all sites will be offering all services (e.g. Community Hospitals will not offer Emergency Departments), it will be clear which ones they are offering and the service offered will be consistent everywhere.

8.5. The idea is to make a distinction between ‘Emergency Care’,’Urgent Care’ and ‘Ambulatory Care’. This will be embodied in the service offered, the labelling of that service and even the physical provision of each service.

8.6. It requires the separation of ‘Emergency’ from ‘Urgent’.

8.7. It also requires that provision by staff is based upon competence for to offer that service, not the provider, or even department where the member of staff sits.

For example, it may be that the Walk in centres can be used more effectively in a different way. The contract for the Walk in centres has two further years to run and there still needs to be some clarity about where that contract is held – the Local Area Team or The CCG. Until this is clarified, it is going to be difficult to make any changes.

9. ISSUES AND FUTURE PLANS

9.1. One of the issues that has arisen during this co-creation of a transformational change is the risks of transferring costs and burden of workload. This is especially sensitive between Health and Social Care because of the difference in funding (including differential cuts) between the two. This is a point of ongoing discussion.

9.2. Work on these and the other projects continues. The Unscheduled care programme has received a lot of praise from outside agencies who have appraised it.

9.3. It is going to be important to join this to the greater work of transformation that needs to happen across the whole health and social care landscape.