

# Beyond projects

Case Studies from the  
*Care Closer to Home: Making the Shift*  
Programme



UNIVERSITY OF  
BIRMINGHAM

Health Services Management Centre



**Bringing  
care closer  
to you**

# Contents

1. Introduction	3
2. Methods	4
3. Birmingham back pain care	6
3.1 Project outline	6
3.2 Key success factors	9
4. Derbyshire COPD care	16
4.1 Project outline	16
4.2 Key success factors	21
5. Derbyshire end of life care	27
5.1 Project outline	27
5.2 Key success factors	31
6. Manchester gynaecology care	40
6.1 Project outline	40
6.2 Key success factors	43
7. Torbay diabetes care	47
6.1 Project outline	47
6.2 Key success factors	51
8. Conclusions	60
9. Acknowledgements	64



# 1.Introduction

The 2006 White Paper *Our Health, Our Care, Our Say*: a new direction for community services describes the Government's vision for shifting health and social care further into the community. The aim is to encourage people to live independently and to exercise greater personal choice by providing more flexibility, accessibility, timely interventions, and care closer to people's homes.

These changes require a significant 'shift' in the way care is delivered, away from care provided in specialist settings towards responsive community based services. The vision calls for more than simply changing the location where care is delivered; it is also about changing attitudes and behaviour among all stakeholders.

While these proposals may be widely supported, there are practical challenges in delivering care closer to home. Recognising these challenges, the NHS Institute for Innovation and Improvement (NHS Institute) established a programme to explore how such shifts can be implemented in practice; which approaches help accelerate change; and how to implement effective, evidence-based change across the NHS.

Starting in 2005, the Institute's *Care Closer to Home: Making the Shift* Programme worked with 14 projects in five healthcare communities to explore how to implement change over a six month period. Projects were implemented in the final half of 2006.

This report describes five case studies from the programme, prepared by the University of Birmingham's Health Services Management Centre (see page 64 for authors).

The report supplements a process evaluation of the key factors affecting implementation of projects of this nature, which included:

- receptive organisational and policy contexts
- a clearly defined focus for projects, with specified outcomes and success criteria
- organisational leadership and sponsorship of service improvement
- competent project management capacity within a skilled team
- analysis of appropriate stakeholders to involve in change initiatives
- engagement of and, where appropriate, leadership by clinicians
- action to overcome cultural barriers to change and improvement
- aligned incentives that demonstrate the benefits of participation to stakeholders
- training and support to develop skills and competencies among staff
- expertise in developing measures of progress and analysing data
- sufficient time to make shifts, particularly during periods of organisational change
- planning to sustain and scale up shifts, including developing business cases.

The sections overleaf describe how these factors manifest in five case study examples.

## 2. Methods

The case study projects were implemented between June and December 2006, including planning and development.

Information for the case studies was collected between June 2006 and April 2007 so the processes encountered during planning, implementing, and assessing the projects could be documented. A key aim was to understand what roles, relationships, and contextual factors might explain whether shifts in care do or do not occur, and to help 'tell the story' of how the projects were developed and implemented.

Information from all 14 projects in the programme was used to inform the final project evaluation report.<sup>1</sup> The NHS Institute then selected five projects on which more detailed case study material would be provided:

- a multidisciplinary clinic to support people with low back pain in Birmingham
- supporting people with chronic obstructive pulmonary disease (COPD) in Derbyshire
- improving end of life care in Derbyshire
- a review of gynaecology care in Manchester, and
- training primary care nurses to initiate insulin in Torbay.

Information for the case studies was collected using a variety of methods in each area, including:

- telephone and face to face interviews
- questionnaires with staff and users
- discussion groups
- feedback from internal meetings
- and review of relevant documents.

People who provided feedback included:

- SHA and PCT managers and leaders
- project champions and clinical leads
- consultants, GPs, nurses, and others
- data analysts and information managers
- stakeholders from the voluntary sector
- potential and current service users, and
- NHS Institute teams and consultants.

<sup>1</sup> Ham C, Parker H, Singh D, Wade E. *Getting the basics right: Final report on the Care Closer to Home: Making the Shift Programme*. University of Birmingham Health Services Management Centre and NHS Institute for Innovation and Improvement, February 2007.

In total, more than 70 people were interviewed. The majority were contacted a number of times over the project implementation period to provide feedback at different stages.

Participants provided feedback on the understanding that comments would not be attributable to individuals, but would be used to help understand themes within and between local healthcare communities and projects. In most instances, discussions were not tape recorded. Quotes have been used to illustrate key points throughout this report, but in the interests of maintaining anonymity, they have not been attributed to specific individuals, roles, or organisations.

Members of the University of Birmingham's Health Services Management Centre worked with the project teams to document the projects as they developed, and gave team members an opportunity to comment on written drafts.

## 3. Birmingham back pain care

This chapter outlines the development of a multidisciplinary clinic based in primary care for people with lower back pain. The first section describes the background and scope of the project. The second section outlines how each of the key factors put forward in the full evaluation report was important for this project.

### 3.1 Project outline

#### *Scope*

Birmingham East and North PCT is a recent merger of two PCTs with a population of 440,000 and 87 GP practices. The PCT is a Kaiser Permanente Beacon Site with an established clinical leadership structure to support shifts in care.

The need to establish an early intervention multi-disciplinary primary care back pain service was identified over five years ago. The PCT orthopaedic triage service identified that 95% of people referred with chronic low back pain did not require an orthopaedic intervention, but instead required chronic pain management. A 'whole system' clinical service redesign programme known as 'Working Together for Health' was set up by the PCT, Local Authority, and Heart of England Foundation Trust (HoEFT) to test new service models.

The project piloted a community-based, early intervention service shifting referrals for assessment from secondary care to primary care as an extension of the successful orthopaedic triage service. A multi-disciplinary team comprising a clinical psychologist, extended scope practitioner physiotherapist, pain consultant and a GP with special interests was established. One clinic per week was provided in a primary care centre.

The new service model simplifies the patient pathway by implementing a 'one-stop' approach to assessment and care planning, with participants seeing all members of the team as appropriate on the same day. An individually tailored treatment programme or discharge is then organised.

Table 3.1 provides a summary of the key aspects of the project.



**Table 3.1: Key components of the Birmingham back pain project**

<b>Key question tested</b>	Can integrated early care in a pain clinic improve management and satisfaction of people with low back pain?
<b>Issues addressed</b>	The current patient pathway includes long waiting times and multiple appointments. A 'one stop shop' enabling patients to see several health professionals in a single visit aims to reduce the need for multiple out patient appointments and reduce waiting times.
<b>Key shift levers</b>	<ul style="list-style-type: none"> <li>• Substituting location</li> <li>• Simplifying care pathway</li> <li>• Integration of professionals</li> </ul>
<b>Perceived long-term benefits</b>	<ul style="list-style-type: none"> <li>• Development of an agreed treatment plan early in the patient journey may help the patient see fewer and more appropriate secondary care specialists.</li> <li>• People not requiring high level intervention can be managed in primary care.</li> <li>• Consistent early advice / intervention could result in earlier return to work, impacting on unemployment and incapacity benefits and the high total cost of back pain.</li> <li>• Satisfaction with service provision should increase.</li> </ul>
<b>Key participants</b>	<ul style="list-style-type: none"> <li>• Pain consultant</li> <li>• GP with special interest</li> <li>• Clinical specialist</li> <li>• Physiotherapist</li> <li>• Consultant psychologist</li> <li>• People with a primary diagnosis of low back pain</li> </ul>
<b>Measures of success</b>	<ul style="list-style-type: none"> <li>• Reduction in number of visits, referrals and cross referrals</li> <li>• Earlier diagnosis and treatment</li> <li>• Decreased waiting times</li> <li>• Savings for the NHS</li> <li>• Patient satisfaction</li> </ul>

## ***Achievements***

The pilot project ran from September 2006 to March 2007. The outcomes of the project are positive (see Table 3.2).

GPs are now referring people earlier for assessment and it is felt that some of these patients will avoid developing a chronic condition.

A screening tool was used with everyone referred in order to assess the need for psychological support. Need was much higher than previously thought. Half of people using the new service saw the psychologist as part of their assessment. Before service redesign, the waiting time for psychology assessment was, on average, 12 months.

There is emerging evidence that people accessing the new service need fewer interventions compared to people who are seen much later in their condition, but this will need to be validated by longer term analysis.

**Table 3.2: Summary of outcomes**

<b>Objective</b>	<b>Baseline data</b>	<b>Outcome as at March 2007</b>
Reduce waiting times for appointments	The average waiting time at a pain clinic from September to November 2006 was 87 weeks.	The average waiting time for the new clinic was 22 days.
Reduce referrals to secondary care	Of 130 patients seen, 49% had previously been seen in secondary care (rheumatology and orthopaedics).	182 referrals were received. 136 new patients were seen. 18% were referred for secondary care intervention. 41% were given a follow up appointment with the consultant. 42% were referred to other primary care services. 18% were discharged with advice or medication.
Improve service users satisfaction with treatment	No data available.	95% of patients were satisfied or very satisfied with their experience at the clinic.
Analysis of costs	No baseline data was collected.	A full comparative cost analysis has been completed. The team estimate that it would cost £604 in sessional costs per 8 people seen at the clinic compared to £2492 in secondary care costs.

## 3.2 Key success factors

### *Receptive organisational and policy context*

High levels of receptiveness and commitment to achieving the objectives amongst lead clinicians and managers was felt to be a significant factor in the success of the project. This was attributed to the PCT's 'Working Together for Health' Programme, a history of effective partnership working between organisations, and positive clinical engagement that provided a good foundation for achieving success.

Early on in the project some concerns were expressed about the overall feasibility of shifting care.

*'Acute trust clinicians will need convincing that the work can be moved out of hospital.'*

This was partly in reference to the impact of Payment By Results policies, competing priorities for primary and secondary care, and the limited resources available to primary care to increase clinical activity. Some scepticism was initially expressed about the ability of organisations to implement changes that had been on the agenda for a long time, especially within the current financial climate. However, as the project proceeded, such concerns subsided.

*'Managers in the hospital have been instructed to provide the support we need to roll out this service.'*

At the start, team members felt that not all GP practices supported the project so there would be some work to do to increase the level of receptiveness and help the project be rolled out across the PCT. Suggested reasons included a lack of knowledge about the intended outcomes, and the project not being a high priority for GPs at the time of implementation.

*'The GPs are more focused on things like Choose and Book and commissioning at the moment.'*

However, the receptiveness of GPs increased when members of the team spent time with practices to explain the benefits of the service and the new referral process.

### *Clearly defined focus and outcomes*

Initially, the project was aimed at people with chronic pain. However, the final focus of the project was determined by the resources and the timescale of the NHS Institute's programme.

Factors which helped focus the project were largely practical. The team required a location that offered three consulting rooms. Facilities were found at a community health centre that enabled them to provide one clinic a week. The single clinic per week was also determined by the availability of the clinical psychologist.

As such, the team agreed to narrow the focus to low back pain as the most prevalent cause of chronic pain.

*'We began to realise early on that our initial plan was too ambitious for the timescale... it's been a useful process having to be very clear about what we were measuring and what we could realistically cope with.'*

The project planned to target high referring practices but because no data were available to identify these, it was decided to work with all of the practices from two localities.

As well as delivering the new service, the team identified a control group of people using the existing service to enable comparisons. The team were constrained by the resources required to manually analyse patients' notes from the control group to gather retrospective data on the number of interventions and referrals as a benchmark for the new service.

The team were able to identify planned project outcomes due to prior work reviewing the current service for a business case developing the pain management service. This early planning work was seen as a success factor in that a lot of the preparatory work in agreeing the service model and outcomes had already been completed.

*'We felt we came to this project with a good starting point as we already knew what we wanted to do and how, we just needed permission to get on and do it.'*

### ***Organisational leadership and sponsorship***

This project was one of ten service redesign projects running as part of the PCT's 'Working Together for Health' programme. This provided strong organisational leadership from primary and secondary care and ownership of the project at a strategic level that was seen by interviewees as being a key element to its success. The project had a high profile within the PCT and processes were in place to ensure that identified barriers and challenges were addressed in a timely manner. This included a monthly project update to the PCT Board and the support of a Programme Manager to facilitate organisational change.

### ***Dedicated project management and capacity***

Project management and team capacity created the greatest challenges. All interviewees agreed that a realistic analysis of the support required should be undertaken prior to any project beginning and the costs included in funding for the project.

Clinical members of the team had to find time within their existing commitments to devote to the project. This resulted in working overtime on a regular basis and the Consultant using allocated research time for the project.

*'If I had some dedicated time, the project would be further on by now, I couldn't keep this workload up for longer than 6 months.'*  
*'You just end up being reactive all the time... there is no thinking time.'*

One interviewee highlighted the problems with all the project information 'being tied up with one person'; the project lead. They felt that the project was at risk if that person had to be away from work for any reason as most of the information was 'inside their heads or on their computer' and there was no team back up that could take over and maintain continuity.

A lack of administrative support was also an issue.

Project team meetings were held when required. This was found to be a more effective use of time than scheduling regular meetings. However this technique also created challenges for clinicians who had to find time at short notice between clinical commitments.

Once the pilot was running, the team met after each clinic to review progress and make any necessary changes to the service model. Interviewees agreed that this was extremely beneficial and helped to sort out any issues quickly and with input from all team members. An example of this was the number of patients allocated to each clinic. Initially the team agreed that they would see 10 people per clinic. However, after a few clinics and an analysis of waiting times it was agreed that eight patients was more manageable. This allowed more time for clinicians to spend with individuals.

### ***Analysis of appropriate stakeholders***

To a large extent, the stakeholders for this project were already identified from previous service planning work. However, as the project progressed, the team identified a need for support from the PCT finance department. It was suggested that it would have been beneficial to have input from the finance team from the beginning to help understand the cost information needed to inform a business case for scaling up the project PCT-wide.

A success factor in the early stages of the project was the project leads meeting with information managers / data analysts. This enabled the project team to understand what information was already available and what could be collected easily using existing databases for the duration of the project. Information managers agreed that it was useful for them to be included in the project at the beginning as it helped them to understand the project aims and enabled them to provide the support necessary.

### ***Clinical engagement and leadership***

Due to the strategic framework of this project, the level of clinical engagement and leadership was high. Clinicians from primary and secondary care were jointly involved in leading and managing the project and all of the clinical staff interviewed were passionate about ensuring the project was sustainable and rolled out across the PCT.

It was acknowledged early on that co-operation between clinicians at the Heart of England Foundation Trust and the PCT to agree a new patient pathway would be a critical success factor. This would require a change in clinical behaviour to move away from silo working. With its multidisciplinary approach, the project has shown this can be achieved.

*'We had never worked together before but it has worked so well. We have all learnt much more about each other's roles and skills.'*

*'I've learnt an enormous amount from the psychologist. I can only do so much but have seen how many patients really need some specialist input if they are going to get better.'*

### ***Aligned incentives***

The strategic context of this project and joint ownership has meant that aligning incentives has not been problematic for the team. As stated above, there were some initial concerns about the impact of Payment By Results on ensuring incentives remained aligned but no problems emerged.

The next stage of scaling up the project requires buy-in from practice based commissioners. The team are confident that the positive outcomes from the pilot will provide the necessary incentive.

### *Training and support for project team*

Project leads stated that they had learnt a lot about project management tools and techniques from the management consultants commissioned by the NHS Institute. The gateway process used by the management consultants had helped the team to ensure they made best use of their time, kept the project on track, and were able to meet key milestones and timescales.

*'The gateway process was quite challenging but on the whole helpful. It provided real incentives to get things completed on time and I don't think we would have moved nearly as fast without it.'*

The gateway process is now being used by the PCT for all new redesign projects. The need for clerical support was identified early on but there were no resources available to provide dedicated administration time. To manage the workload the team 'used anyone we could' and some limited ad hoc support was found.

*'If I was doing another project I would make sure there was dedicated admin support before we started, it doesn't make sense to have clinicians stuffing envelopes, chasing x-rays and maintaining databases.'*

Towards the end of the project additional dedicated administrative support was found. This significantly improved capacity.

*'If I had had this support from the beginning I think we could have achieved much more; the other projects I am leading on would not have suffered in the way they have.'*

The 'Working Together for Health' Programme Manager was a key part of the team and was able to add extra capacity when required. Her strategic role within the PCT meant that her input was significant in understanding the organisational issues and contributing to finding and implementing solutions.

The PCT also identified a Project Facilitator to help with the overall co-ordination of the project. This was felt to be of real benefit in supporting the project lead especially as this worker came from a commissioning background. Identifying support at this level meant that the facilitator could act as a 'deputy' in meetings for the project lead when required and contribute to the overall development of the project design.

### ***Data analysis***

Data analysis was an area with a steep learning curve for the project team. The focus on developing robust measures of progress and analysing data effectively was a key element of the NHS Institute's programme and was outside the team's previous experience of project management. The team valued the expertise that the NHS Institute provided (via external groups) in defining realistic objectives that could be measured to identify progress and project success.

Data collection was a significant challenge. Collecting data for the control group to identify waiting times, number of consultations and interventions was difficult without a code for low back pain as a primary diagnosis. This meant that a manual search of patients' notes was required, but there was no resource to undertake the work. Initially a PCT manager began the work but this was not ideal as an understanding of clinical terminology was required. In the end, a research student worked with the Consultant to complete this task.

The team agreed that undertaking data collection and analysis before commencing the project would have helped them to scope the project more clearly and identified earlier on what was feasible in terms of measures.

*'It would have been helpful to have undertaken the data collection before the project started instead of it being founded on well-grounded supposition.'*

Due to the short timescale of the project, the team decided to adapt an existing database to collect data from the new service rather than create a new database. This worked well. Ideally, the service requires primary care IT systems to link to the secondary care intranet so that patients' secondary care records can be accessed at the time of the clinic. For the pilot, this issue was solved by a taxi transporting notes to the community clinic.



### *Sustaining change*

The pilot phase of the project is now complete and the next stage is working towards full roll-out across the PCT. This involves the project being assessed against a number of criteria:

**Cost:** Is the new service a full substitution of an old service or will there be some duplication in costs between community and hospital care?

**Demand:** A robust calculation of patient demand is undertaken to ensure that the new service is managed in a manner that will not create increased waiting times and reduce the quality of the patient experience. An accurate projection will also enable the appropriate staff and other resources to be costed and planned for within an agreed timescale.

**Acceptability:** The project will need to be validated by practice-based commissioners in order for it to proceed.

The beginning of this roll-out phase involved a 'Dragon's Den' in which the project team presented the outcomes of the pilot and were interviewed by a panel of senior PCT managers and clinicians. This highlighted the work that was required to satisfy the above areas for assessment.

It is expected that the project will move from the 'artisan to the industrial' later in 2007, assuming that the business case is approved. The timescale will also be determined by the ability to appoint a psychologist for the clinic and identifying appropriate facilities for additional clinics.

Overall, the project members felt that the initiative was a success and they and the hospital team fully support further roll-out.

## 4. Derbyshire COPD care

This section outlines the development of a project to improve care for people with chronic obstructive pulmonary disease (COPD) in Derbyshire.

### 4.1 Project outline

Derbyshire county, in the east Midlands, has a population of nearly one million people. It covers an area of 2625 square kilometres and encompasses both urban communities in Derby and Chesterfield and smaller towns and villages in the rural hinterland, including the Peak District National Park.

From an NHS perspective, Derbyshire is served by a county-wide mental health services trust and the East Midlands Ambulance Service. Acute hospital services are provided by the Chesterfield Royal Hospital NHS Foundation Trust in the north of the county and the Derby Hospitals NHS Foundation Trust in the south.

Service provision and NHS organisation tend to divide along north/south lines with the PCTs in the north looking mainly to the Chesterfield Royal Hospital NHS Foundation Trust and the PCTs in the south looking mainly to Derby Hospitals NHS Foundation Trust.

At the inception of the Care Closer to Home: Making the Shift Programme, there were three PCTs in the north, and five PCTs in the south. From October 2006, reorganisation resulted in these eight PCTs being replaced by two PCTs covering Derby City and Derbyshire County.

Contact between the NHS Institute and the former Trent SHA led to Derbyshire being selected for involvement in the Care Closer to Home: Making the Shift Programme. The area was thought to be more stable than some of the other health communities in the SHA area and had a track record of work on service improvement in general and long-term conditions in particular. This included experience as one of six national pilots for the Integrated Service Improvement Programme (ISIP).

## Scope

COPD is a chronic, slowly progressive disorder of the airways which is associated with significant morbidity and mortality and high costs to the NHS. Nearly 900,000 people in the UK have been diagnosed with COPD with around twice as many thought to be living with undiagnosed COPD. COPD is one of the leading causes of hospital admission, accounting for more than 10% of all acute admissions. Acute exacerbations of COPD are an important cause of attendance at Accident and Emergency Departments and unplanned hospital admission, with a peak in the winter months. The government has recently recognised the need to improve the prevention and treatment of COPD by appointing an expert reference group to prepare a national service framework for COPD.

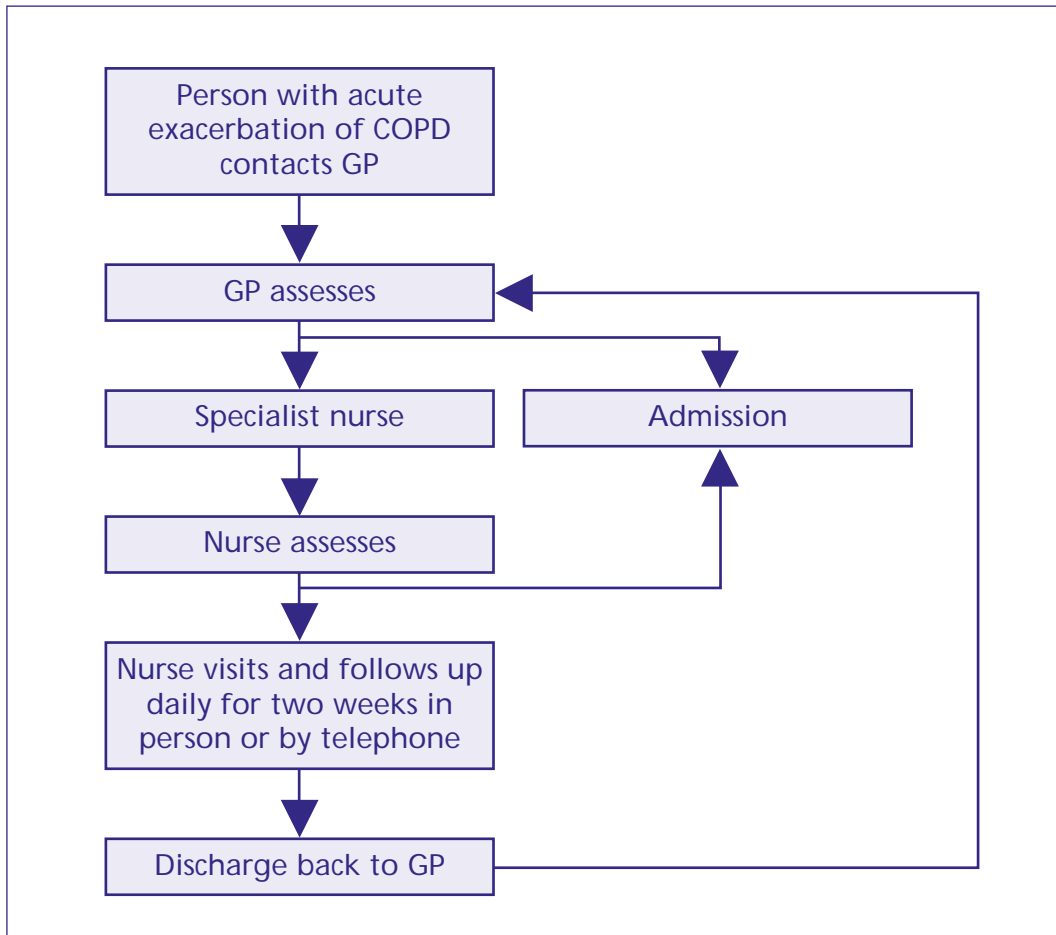
Prior to the inception of the Care Closer to Home: Making the Shift Programme, COPD had been identified as a priority area for improvement in Derbyshire through work on long-term conditions and unscheduled care developed as part of the Integrated Service Improvement Programme (ISIP). A group was set up to identify and recommend improvements to the care pathway for COPD, and had focussed on three areas of potential action including supporting people to self care more effectively; using 'hospital at home' services to avoid admissions; and strengthening primary care through the use of specialist nurses

An event held to launch the NHS Institute's programme in Derbyshire in early 2006 provided an opportunity for people working on different COPD-related projects across the region to meet and make connections between the various initiatives. North Derbyshire was considering developing a system through which GPs could refer people to the PCT's specialist COPD nurses for intensive home-based support and monitoring, as an alternative to an emergency hospital admission. Staff from Southern Derbyshire were interested in initiating a similar scheme, and it was agreed that this model of care would be piloted in both areas as one of Derbyshire's NHS Institute projects.

The project was identified as a priority because work was already underway and the project was therefore thought to have scope to demonstrate shifts in care within the six month pilot period. The other content areas within the Derbyshire COPD Pathway would progress, but over a longer timescale.

The overarching objective was to reduce unnecessary admissions to hospital by providing an alternative place of care. Substitution of location was the key lever for shift (see Figure 4.1).

**Figure 4.1: Service pathway**



People targeted for the service were those with mild or moderate COPD who, in the absence of support from a specialist nurse, GPs said they would admit to hospital.

As detailed planning got underway, the project steering group decided to keep the focus narrow and work with just a small number of GP practices. This was partly in order to concentrate on those practices where there seemed to be most potential to bring about improvements, and due to the limited capacity of staff to take on additional work.

The system required daily visits to each patient so, given existing clinical commitments, the maximum case-load for each nurse-specialist was four patients.

The pilot began in North Derbyshire in June 2006. Three practices in Chesterfield with a total population of 25,500 were involved. The project was initially led by two nurse specialists but was subsequently managed by one nurse (due to the second leaving the PCT for a new job). In Southern Derbyshire, the project was initiated in November 2006, and involved one practice with a total population of 15,000.

**Table 4.1: Key components of the Derbyshire COPD project**

<b>Key question tested</b>	Can home visits by a specialist nurse reduce unplanned admissions for acute exacerbations of COPD?
<b>Issues addressed</b>	GPs admit people with acute COPD exacerbations, so the project tested whether providing two weeks worth of nurse home visits would reduce the need for such admissions. The nurse visits focussed on self management education as well as clinical monitoring.
<b>Key shift levers</b>	<ul style="list-style-type: none"> <li>• Substituting location</li> </ul>
<b>Perceived long-term benefits</b>	<ul style="list-style-type: none"> <li>• Increase confidence in and satisfaction with services among people with COPD</li> <li>• Increase the number of people with COPD receiving self-management plans</li> <li>• Reduce hospital admissions among people with COPD.</li> <li>• Provide services for people with COPD more cost effectively</li> </ul>
<b>Key participants</b>	<ul style="list-style-type: none"> <li>• People with COPD</li> <li>• GPs</li> <li>• Specialist nurses</li> </ul>
<b>Measures of success</b>	<ul style="list-style-type: none"> <li>• Number of participants</li> <li>• Admissions to hospital within one month of seeing specialist nurse</li> </ul>

## ***Achievements***

Between June 2006 and the end of the pilot period in December 2006, there had been nine referrals to nurses in North Derbyshire. Between November 2006 and April 2007 there had been one referral in Southern Derbyshire. Of these referrals, no service user was admitted to hospital within one month of their referral to the specialist nurse.

All patients using the service were asked to complete a questionnaire providing feedback about their experience. Only two questionnaires had been returned by the end of the evaluation period (20%), but within these all of the comments made were positive. Both respondents emphasised that the service had worked well for them because they had not wanted to go into hospital.

Participants highlighted some unintended, but potentially beneficial, consequences of the initiative. First is the realisation that there is scope for making savings on nebulisers, thus releasing funding that could be reinvested in the nursing service.

Second was identifying service users' unmet needs, including social service input. Although not a specific criteria for referral to the service, the majority of the people seen by the nurse specialists were house-bound and receiving support from carers. In several instances, the initial contact with a COPD nurse resulted in social services input being obtained; in one case this had been repeatedly refused in the past. Better links between the nurse specialists, district nurses and community matrons were also developing through carrying out joint visits to participants.

It was not possible to systematically evaluate the direct impact of the project on costs, or on overall hospital admission or patient satisfaction rates. However, indicators suggest that a nurse-run home-based system of caring for people with COPD can provide an effective alternative to a hospital admission for some people, and that this appears to be acceptable to service users.

While the numbers involved were small, the nine people referred in North Derbyshire equated to about 20% of people with COPD admitted as emergencies from the three practices involved in an equivalent historical period. If scaled up and rolled out across the whole PCT with a similar success rate, the total number of admissions avoided could be significant.

The project team used a 15% to 20% reduction in the number of people requiring admission to calculate the potential costs and savings involved if the programme was extended to cover all practices in the PCT. This information has been used in developing a business plan.

## 4.2 Key Success Factors

### *Receptive organisational and policy contexts*

As noted above, improved management of COPD was identified as a priority at both a national and regional (SHA) level prior to the commencement of this project. Correspondingly, those involved in the project perceived the policy context to be mainly supportive of their work throughout. This included an opportunity to shift resources from acute hospitals under Payment By Results, the priority attached to long term conditions, and the emphasis on self care.

At an operational level, the willingness and ability of nurse specialists to take on a new role and to balance this against their existing commitments was of critical importance, as was the cooperation of the GP practices involved. Recognising this, when approaching practices to participate the nurses in North Derbyshire specifically targeted those where they knew the GPs to have an existing interest in COPD. As a result, the nurses found that all three practices were 'very up to speed' with the project, and willing to amend practice processes for the purposes of the pilot.

The South Derbyshire practice was originally selected for a different reason: as a large practice, it was felt to have great scope for identifying suitable participants and demonstrating shift. Despite its size, from the outset this practice also demonstrated a genuine interest in developing an integrated programme of care for people with COPD.

A fit between 'top-down' strategic objectives, and 'bottom-up' interest from individual clinical leads created a context that, for the purposes of the pilot, was receptive to trying new ways of working. However, when it came to considering rolling out the initiative, it was felt that Practice Based Commissioning would have a significant role.

*'Unless you can get PBC engagement, you are unlikely to get past the first hurdle.'*

It was noted that Practice Based Commissioning had generally led to an increased interest in COPD amongst PBC groups (due to the high consultation and admission rates associated with the condition), and that the project was likely to benefit as a result.

### *Clearly defined focus and outcomes*

The focus for this project was narrowed considerably from the original long-term conditions / unscheduled care strategy, to concentrate on one specific aspect of the COPD pathway in a small number of GP practices.

By the end of the evaluation period, views on this approach were mixed. On the one hand, team members acknowledged the value of the gateway review process in helping to identify whether a project objective is achievable, measurable and properly resourced, and in making refinements if not.

On the other hand, it was suggested that future projects might 'be braver from the start' rather than focussing on small scale changes. Emphasising the time it can take for projects to deliver outcomes, it was felt that sometimes it is necessary to go for a 'big bang' rather than constantly narrowing the focus. This project found that a very small pilot can take a year to develop and evaluate before planning for any wide-scale implementation is even considered. Therefore, one participant suggested that if major shifts are to be achieved rapidly, the approach should be "if you think it is going to deliver, commission it from the start."

As with the project scope, after much discussion it was agreed to simplify the outcome measures considerably. For the purposes of the pilot, the key measures were the number of service users involved and whether or not these people were admitted to hospital within one month of referral to specialist nurses.

Members of the project team felt this focus and simplicity had been useful, because "there is a tendency to say you will measure everything" when this is not always possible or constructive. The desired outcome was ultimately to reduce avoidable admissions, thereby improving patient experience and reducing costs. The steering group was inevitably interested in analysing data about hospital admissions but recognised that the impact of the initiative on overall admission rates was likely to be negligible, and that the significance of any changes in COPD admissions could not be tested statistically due to the small numbers involved. Therefore it made sense to focus on a tangible measure, and to extrapolate from this the potential impact on higher-order objectives.

### *Organisational leadership and sponsorship*

PCT reconfiguration during the implementation period meant that CEO-level engagement in this project was not continuous. The CEO of the pre-reconfiguration PCT endorsed the initiative and demonstrated the organisation's commitment to it. Board-level involvement was subsequently maintained through the director of commissioning of the new PCT.

The pilot itself did not appear to be significantly disrupted by organisational changes. The project lead retained oversight of the initiative within the new organisational structure. The practice-level focus of the project and relatively small number of stakeholders also meant that the project could maintain its own momentum once established.



### ***Dedicated project management and capacity***

The project lead had previously been involved in managing numerous projects and programmes, including ISIP. Consequently, project management systems were already in place, including the process of 'signing off' project milestones. The project lead recognised that more could be done to apply programme management approaches systematically and rigorously. Overall though, the main barrier to effective project management was the capacity and workload of managers, particularly in the context of organisational change. In the early stages, the project lead spent about half a day per week on the project, but this became increasingly difficult over time. Additional management capacity was brought in when the need for such resources was highlighted at a project review meeting.

### ***Analysis of appropriate stakeholders***

The project steering group did not explicitly undertake a stakeholder analysis to identify who should be involved in the project. Beyond the project manager and specialist nurses, the key stakeholders engaged were GPs in participating practices. Practices in North Derbyshire were identified and approached by a nurse-specialist on the basis of her knowledge of potentially interested parties. In Southern Derbyshire, the practice was selected due to its size, and then approached by a nurse specialist to explain the nature and purpose of the project. It is not clear what, if any, impact this approach had on the project during the pilot phase.

One team member acknowledged that while the GP leads in each practice were supportive, they primarily saw their role as promoting the idea behind the pilot within their own practice rather than championing it externally. A number of GPs were approached at the start of the project to seek their involvement on the project group, but it was difficult to engage them due to other work pressures.

More recently, one of the GPs has begun to take a 'champion' role in the context of Practice Based Commissioning, by bringing the initiative to the attention the local PBC consortia.

### ***Clinical engagement and leadership***

Although GPs were involved in the Steering Group considering the whole COPD pathway, the clinical leadership of this project came, in the main, from the nurse specialists. Although this had not been a barrier to progress within the pilot, team members recognised that in the context of Practice Based Commissioning, further GP involvement would be beneficial if the project were to be rolled-out.

Having a GP champion has been instrumental to the project lead and nurse specialist gaining access to a PBC consortium meeting to present their business-case.

### ***Overcoming cultural barriers***

The project team reported that the local context was very receptive to change, and so they did not set up specific processes to change attitudes among PCT staff, specialist nurses, or GP practices.

### ***Aligned incentives***

To date, the clinical teams involved in the pilot have been those with an existing interest in COPD, or an identified interest in developing an holistic programme of care for people with this condition. Interviewees suggested that while reducing costs would be an important long-term priority for any GP practice, the primary incentive for those involved in the pilot was an opportunity to improve patient care.

The team acknowledged that a more explicit exposition of clinical and financial benefits will be required if Derby City PCT and Derbyshire County PCT are to extend the service.

One interviewee noted the importance of 'selling' projects and initiatives in different ways to meet the needs and spark the interests of specific stakeholders. While some practices will be interested in the potential to make savings on their secondary care budget, others may be primarily interested in this type of project due to the potential to improve holistic care, and others due to the scope to reduce the workload of practice staff themselves.

### ***Training and support for project team***

Interviewees did not feel that training and support for the project team was a significant factor in this project. No additional clinical training was required, and although project leads reported that they had learned more about project management approaches as a result of participating in the programme, they did not identify a need for further training in this area. Time and capacity were seen to have been the key issues for this team, rather than skills and competency.

### *Data analysis*

The overarching objectives of shifting care from hospital to home visits were to increase confidence in and satisfaction with services among people with COPD; increase the number of people with COPD receiving self-management plans; reduce hospital admissions among people with COPD; and provide services for people with COPD more cost effectively. However, due to the timescale and small numbers of people involved in the pilot, the team did not anticipate being able to demonstrate significant changes in any of these factors during the project period.

The number of people who could be managed at home was limited by the capacity of the nursing teams involved, and so no specific target was set. Instead, the team focused on testing the principles and processes behind the initiative. They did not place a strong emphasis on measurement and data analysis during the pilot phase. However, the figures derived from the pilot have been used to inform a business case for rolling out the initiative.

### *Sufficient time*

A number of interviewees stressed that it takes a long time to implement change. The history of work on COPD was seen as an enabler of progress within a relatively rapid timeframe. It was noted that the NHS Institute's timescales had been very challenging, but "probably necessary" to maintain the momentum and push teams to maintain focus. However, all involved were managing this project on top of existing commitments, and felt that "if you push too hard, you can put people's backs up."

In Southern Derbyshire the pilot started later than anticipated, but this was not necessarily seen as detrimental by all stakeholders.

*'we wanted to put the brakes on to get it right, to put it on a sound footing.'*

The delay was seen as necessary in order to involve all key stakeholders in discussions.

### *Sustaining change*

The project team have presented a business case to the local PBC consortia. The business case is based on a 15% to 20% reduction in emergency COPD admissions across Derbyshire County PCT and Derby City PCT inserted into a cost model adapted from another PCT. The model compares the costs associated with rolling out the project with the funding saved from the tariffs associated with admissions, and demonstrates the potential savings across the PCTs. The business case also summarises the clinical rationale for a community-based service.

The business case was well received by the PBC consortium and will now be considered by the PCTs' PBC subcommittees. The intention is to bid for funding from the 'Invest to Save' scheme that the PCTs have established to pump-prime PBC initiatives.

Overall, the project team are happy with what they achieved during the pilot, and are hopeful that the service will be expanded.

## 5. Derbyshire end of life care

This section outlines the development of a project to improve care at the end of life for people in Derbyshire. The context of projects in Derbyshire is outlined in Section 4, and is not repeated here.

### 5.1 Project outline

#### *Scope*

Work on improving care at the end of life pre dated the NHS Institute programme. The foundation work was led by a group focussed on end of life care and another focussed on palliative care. The groups identified the scope for improving services in North Derbyshire by adopting best practices developed elsewhere and prepared an 'end of life strategy' in 2005. One of the issues that emerged was the potential to enable more people to die in the place of their choice. Analysis indicated that a relatively high proportion of deaths occurred in hospital and that, with support, it may be possible to increase the number of people dying at home. The North Derbyshire district took forward this work as part of the Care Closer to Home: Making the Shift Programme.

The project focused on 16 GP practices in Chesterfield which are working together in a Practice Based Commissioning consortium. A number of the practices had expressed an interest in improving care at the end of life. Practice Based Commissioning created an opportunity for care to be provided differently. Interviewees suggested that targeting a topic of widespread interest and working through a Practice Based Commissioning group enabled the work to progress quickly.

**Table 5.1: Key components of the Derbyshire end of life project**

<b>Key question tested</b>	Can more people be supported to die in their place of choice, ultimately reducing hospital admissions?
<b>Key shift levers</b>	<ul style="list-style-type: none"> <li>• Integration of staff and services</li> </ul>
<b>Perceived long-term benefits</b>	<ul style="list-style-type: none"> <li>• Understand why people are admitted to hospital</li> <li>• Increase proportion of people dying in their place of choice</li> <li>• Reduce admissions</li> </ul>
<b>Key participants</b>	<ul style="list-style-type: none"> <li>• People at end of life</li> <li>• GPs</li> <li>• Specialist nurses</li> <li>• Other agencies</li> </ul>
<b>Measures of success</b>	<ul style="list-style-type: none"> <li>• Practices using Gold Standards Framework</li> <li>• Number dying at home</li> </ul>

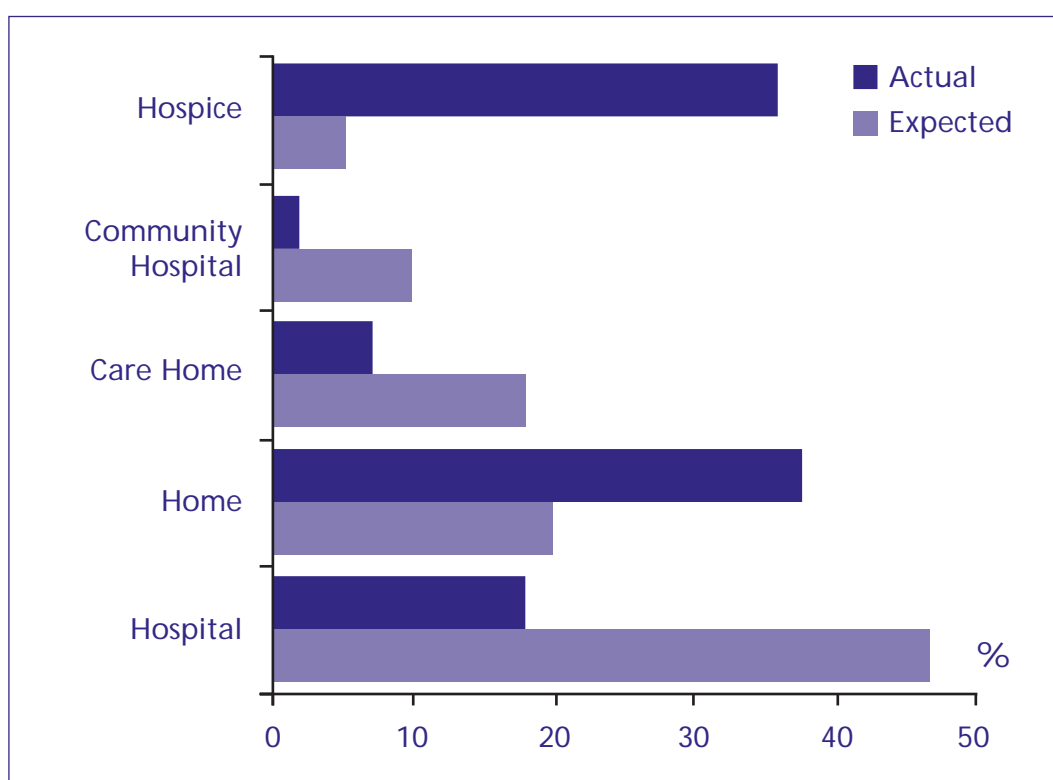
The project aimed to develop primary care services within Chesterfield by improving the identification of people at the end of life and by asking practices to sign up to the Gold Standards Framework, the North Derbyshire end of life pathway (akin to the Liverpool pathway), and the Right Care project – the local out of hours service. Staff involved in end of life issues wanted to strengthen palliative care for people with a wide range of conditions, to complement existing specialist provision for people with cancer. Among other things, this entailed providing case management support to a small cohort of people at the end of life.

## Achievements

The project identified that a significant number of people were not dying in their place of choice, and as such there may be scope to intervene. A cohort of people was identified to receive case management and care mapping. Table 5.2 outlines progress towards monitoring achievements.

Analysis of information received for the first small cohort of people involved in the project (n=45) suggested some better than 'predicted' outcomes regarding enabling people to die away from hospital, in the place of their choice (see Figure 5.1).

**Figure 5.1: Changes in expected place of death for 45 people case managed**



Note: Expected figures are based on predictions from 2005 data from Chesterfield practices

**Table 5.2: Preliminary outcomes**

Objective	Baseline data	Preliminary follow up data
Increase the proportion of people dying in their place of choice and as such reduce emergency admissions.	The project team used national figures to estimate the proportion of people who want to die in different places: 56% home, 11% hospital, 24% hospice, 4% care home, 5% elsewhere.	All practices have signed up to the GSF and are at different stages of implementation.
	In North Derbyshire in 2005, 50% of deaths were in an acute Hospital, 7% in a community hospital, 5% in a hospice, 18% in a care home, and 20% at home. Almost 1.4% of all emergency admissions to Chesterfield Royal in 2005 resulted in an inpatient death of a person identifiable as at the end of life, most occurring within the first two days of admission.	2006 figures will not be available until the second quarter of 2007.
Understand why people at the end of life are admitted to hospital and what happens to them there.	The team have conducted an audit to help understand the reasons for arrival at hospital, reasons for admission, and pathways after admission and written analyses of local needs.	The team are analysing data collated up to March 2007.



## 5.2 Key success factors

### *Receptive organisational and policy contexts*

The end of life project benefited from a supportive organisational context. The local PCT was committed to the project objectives and the previous work about end of life care gave the project a 'head start.' The staff leading the project had established positive relationships with a number of clinicians in Chesterfield, and it was not difficult to persuade local practices to become involved in improving care at the end of life.

The national policy context was also supportive in a number of ways. Factors mentioned by interviewees as being helpful included the White Paper, Our Health, Our Care, Our Say, the Department of Health's end of life programme, and Building on the Best, the government's policy document setting out plans to offer people an increasing range of choices. In the case of primary care, the Gold Standards Framework was seen as especially helpful (see Box 5.1).

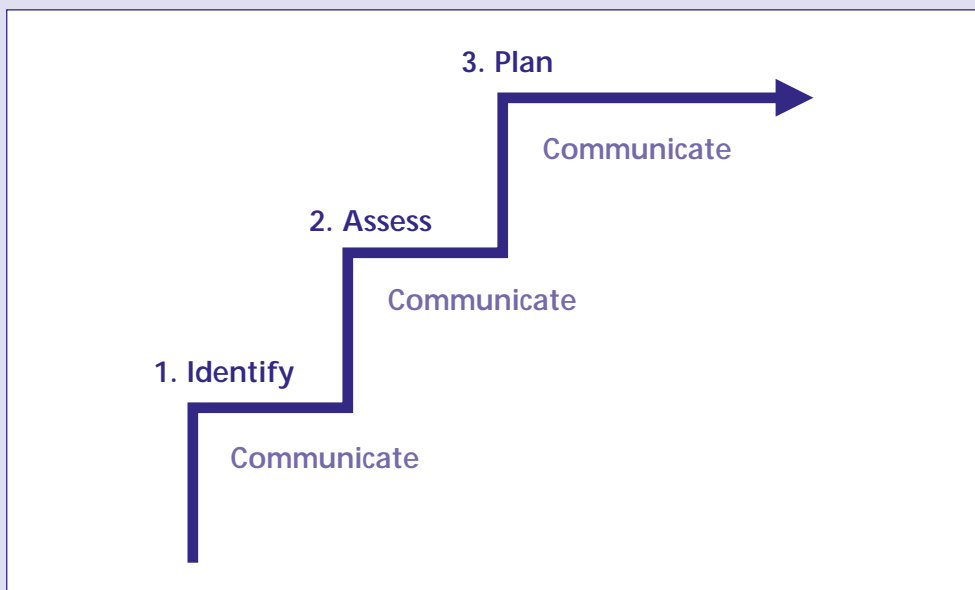
It was felt that some NHS funding policies supported the project while others were a potential hindrance. For example, the new GMS contract was helpful in rewarding practices for improving end of life care, and Practice Based Commissioning was also helpful in creating opportunities to use resources differently if more people were cared for at home rather than in hospital.

In contrast, Payment By Results was reported to be a potential hindrance in so far as the local Foundation Trust may discourage clinicians from carrying out work that did not attract income, or work that helped to prevent admissions to hospital and the income associated with these admissions. The Payment By Results guidance introduced in the 2006/7 contracting round applied a differential rate of payment (50%) above and below a set threshold for emergency spells. This differential rate restricted commissioners' ability to redistribute funding associated with reducing unnecessary emergency admissions to secondary care as only 50% of the tariff could be withdrawn from the contract payment.

### Box 5.1: Gold Standards Framework

The Gold Standards Framework (GSF) is a strategy to promote a 'gold standard' of care for everyone nearing the end of their lives. The GSF was developed from clinical experience in primary care, as a grass roots initiative to improve primary palliative care and collaboration with specialists. Since 2000 it has been adopted by over a third of practices across the UK, improving care for thousands of people. The aim of the GSF is to develop a locally-based system to improve the organisation and quality of care for patients and their carers in the last year of life.

Key processes of the GSF involve identifying people in need of supportive care towards the end of life; assessing their needs, symptoms, preferences and any issues important to them; and planning care around the patient's preferences and enable these to be fulfilled, including supporting people to live and die where they choose.



Seven key tasks or standards to aim for are (the seven Cs):

- C1 - Communication
- C2 - Co-ordination
- C3 - Control of symptoms
- C4 - Continuity including out of hours
- C5 - Continued learning
- C6 - Carer support
- C7 - Care in the dying phase

Source: adapted from the Gold Standards Framework website

### ***Clearly defined focus and outcomes***

A key challenge in the early stage of the project was to determine an approach that could be implemented and evaluated within the NHS Institute's timeframe. It was decided to focus on the implementation of the Gold Standards Framework and the North Derbyshire Care Pathway in the 16 practices in Chesterfield.

At the heart of the project was a desire to use case management to enable a small cohort of people at the end of life to be cared for and eventually die in the place of their choosing. This involved practices identifying one patient for every 1000 registered with them who stood to benefit from case management. People selected for inclusion were given support by practice staff (usually a district nurse or community matron). In addition, individual care plans were prepared and lodged with Right Care as part of the out of hours provision to ensure patients' preferences were known to staff.

The main outcomes and success criteria for the project followed from this approach. It was agreed that progress would be assessed in terms of implementation of the Gold Standards Framework and the North Derbyshire Care Pathway. Alongside these intermediate outcomes, arrangements were put in place to gather data on the care provided for participants.

Project staff emphasised that their principal aim was to improve the provision of primary care rather than to shift care from hospitals to the community. They recognised that care was likely to be provided in different places but this was seen as a consequence of strengthened primary care rather than the project's *raison d'être*.

### ***Organisational leadership and sponsorship***

Organisational sponsorship of the project was provided by a PCT chief executive who was closely involved from the outset. Project leadership was provided by a public health specialist who had been leading on end of life work and the palliative care strategy before the inception of the programme. The commitment of these two individuals was seen as critical in enabling the project to make progress and in ensuring that additional staff and resources were secured to take forward the work.

### *Dedicated project management and capacity*

When the Care Closer to Home: Making the Shift Programme was launched in June 2006, no dedicated project management was in place. This was a serious concern because the project leader did not have the additional capacity needed to take on this role. With the arrival of an experienced PCT manager in August 2006 additional staff were made available. All interviewees suggested that this was probably the single most important factor that enabled the project to progress.

Also important was the contribution made by a public health trainee who undertook a detailed needs assessment regarding end of life care in North Derbyshire. This included helping to analyse local data about end of life care and working with the NHS Institute and GP practices to gather information about the care received by the cohort enrolled in the project.

By late summer 2006, the end of life project was staffed by a project leader, a project manager giving around three days a week to the work, and the public health trainee. The complementary skills and experience of members of the project team, and the time they were able to devote to the work, provided the resources needed to accelerate implementation. Additional contributions were made by a PCT manager involved in Practice Based Commissioning and primary and secondary care clinicians who took a particular interest in end of life care.

### *Analysis of appropriate stakeholders*

The development of the project from an existing work programme meant that most of the appropriate stakeholders were already involved. Further work was done to ensure that all GP practices in Chesterfield were aware of the project and were engaged in its implementation. The project manager discussed the aims of the end of life project with practices to secure their commitment. Despite this, uptake and engagement by the practices was variable. As one of the GPs involved in the work explained, practices were faced with competing demands, including their new contract, Practice Based Commissioning, and the implementation of Choose and Book. For some, involvement in the end of life project was not the highest priority.

Also important was the involvement of the out of hours service and social care. With the benefit of hindsight, project staff recognised that more could have been done to involve social care. Although social care was represented on the wider end of life group, they were not involved in the NHS Institute's programme.

### *Clinical engagement and leadership*

Three aspects of clinical engagement were important in this project. First, there was active involvement and support from the palliative care specialist and the nurse specialist at the Chesterfield Royal Hospital NHS Foundation Trust. These specialists were already closely engaged with the work and continued to lend their support, even at a time when managers in the Trust were seeking to give higher priority to work that brought the Trust income. The support of Accident and Emergency staff in conducting and completing the audit was also vital for obtaining data.

Second, there was sponsorship from leading GPs in Chesterfield who saw the project as an opportunity to improve the quality of care offered at the end of life.

Third, and in some ways most important of all, there was support from district nurses and community matrons. Project staff saw the involvement of nurses as being important because they took on the role of case managers for people at the end of life, and without their commitment progress would have been slower.

### *Overcoming cultural barriers*

An important part of the project was overcoming the fears of some GPs about taking on a bigger role in end of life care. As one of the GPs involved in the project emphasised

*'most of us find it difficult to have conversations with patients at the end of life about where they want to die.'*

The project built the confidence of GPs to become more involved in an aspect of patient care that has increasingly been undertaken in hospital. Project staff felt that some GPs had 'lost their nerve' and needed reassurance that they could provide the care that people wanted. The team also addressed the concerns of GPs and nurses in primary care, post Shipman, that they might be investigated if there were to be an increase in the numbers of their patients dying at home.

Similar concerns affected the ambulance service. Ambulance staff were worried about the consequences of not transferring people to hospital, even if they expressed a preference in their care plans to be supported at home.

The project team began work to overcome these cultural barriers and concerns and recognised that more needs to be done.

### *Aligned incentives*

Practice Based Commissioning and the new GMS contract helped to ensure that the incentives in primary care were aligned with the aims of the project in the initial stages. However, as time went on, Practice Based Commissioning was felt to have become less salient, with the GPs involved in the project reporting declining engagement and enthusiasm in commissioning by some practices.

Interviewees emphasised that the main incentive for practices to become involved was not financial. Rather it was the desire of GPs and nurses in primary care to provide a good service that reflected patients' preferences. As one team member explained, "if you get it right you feel very good as a clinician."

The opportunity offered by the project to 'get it right' for people at the end of life was seen as a powerful motivator, and the most important factor in explaining the willingness of clinicians to become involved.

### *Training and support*

The project team arranged a number of educational sessions to support implementation. These sessions were aimed at district nurses and community matrons. A psychologist helped nurses learn how to initiate conversations with people about their preferences for care at the end of life.

The project also secured funding to employ a GP Macmillan facilitator who will work with practices to take forward the work they have started and support continuing implementation of the Gold Standards Framework. As the project continues to develop, the facilitator will examine how GPs can work hand in hand with district nurses and community matrons to case manage patients. In addition, the facilitator will help GPs develop the confidence and skills that may be lacking in end of life care. One of the GPs involved in the project reported that lack of training had been a significant obstacle to progress, and the facilitator will help to address this.

## **Data analysis**

Comprehensive analysis of readily available data was a key success factor for this project. The team analysed where people currently die, potentially avoidable hospital admissions, and the services required to support people to die in the place of their choice. Analysis of place of death in North Derbyshire found that in 2005 57% of people died in hospital, 5% in a hospice, 18% in a nursing, residential or care home, and 20% in their own homes.

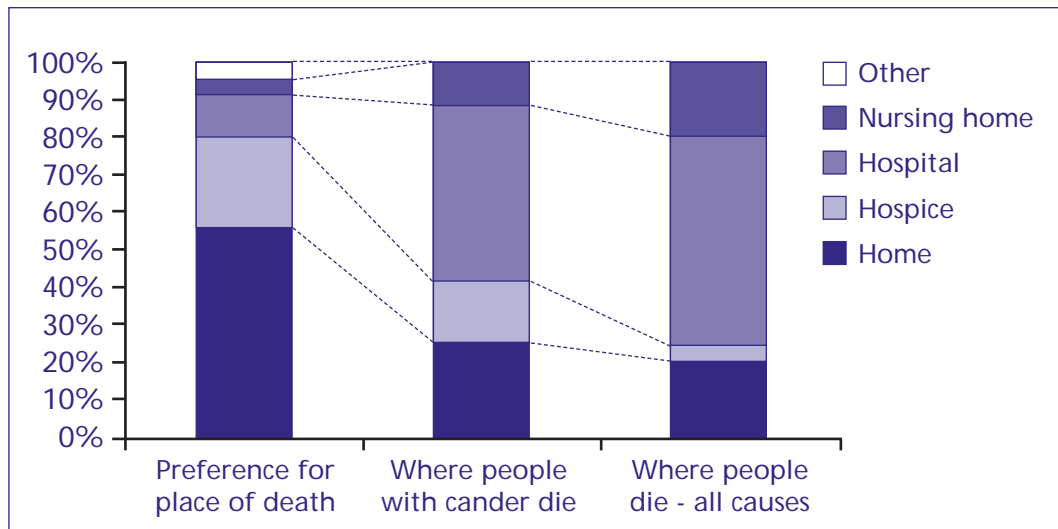
A study of inpatient deaths following emergency admission to Chesterfield Royal Hospital in 2005 found that roughly half of deaths were in terminally ill people, with most deaths occurring in the first few days after admission. The main category of disease among those dying was organ failure (47%) followed by cancer (39%) and frailty/dementia (14%). The data highlighted discrepancies between the preferred and actual place of death, and suggested that there was potential for some of these people to be supported to die outside hospital. Figure 5.2 summarises some similar national data about differences in people's preferred and actual place of death.

A prospective audit of 33 patients admitted to hospital who had been identified as being in the last year of their life was undertaken between July and October 2006. The palliative care team was known to be involved with 10 of the 33 patients, and none of the patients was known to have a North Derbyshire end of life pathway. Twenty of these people were discharged from hospital and 13 died as inpatients. Sixteen of the admissions were considered by hospital clinicians to have been unavoidable.

In the later stages of the project, data collection and analysis was centred on outcomes for the cohort of people receiving case management. One of the challenges here was securing staff and expertise within the practices to submit forms about the care provided to service users and their families both before and after the end of life.

In one practice, a staff member returning from maternity leave was able to take on this work. Other practices found it harder to do the necessary work within existing staffing levels. By the end of 2006, around 70% of the Chesterfield practices were reported to be submitting data (11 out of 16).

**Figure 5.2: National findings about preferred and actual place of death**



### **Sufficient time**

Interviewees felt that the time available within the NHS Institute's programme was too short because the project involved system and pathway redesign across different organisations. While recognising that there was value in having to demonstrate results within a predetermined period, the team suggested that the project required 12 months rather than six months to become established. Ideally, this would have entailed three months to plan the work, six months to secure implementation, and three months to collect and analyse data on impact. Project staff emphasised the challenges involved in gathering and analysing data provided by the practices and the difficulty of doing this within a tight deadline.

More time for project design and implementation was seen as important, not least because of the reorganisation of PCTs. It was suggested that the reduction in the number of PCTs in the county had some benefits for implementing the end of life strategy (see below), but restructuring was a hindrance during the pilot implementation period because of the uncertainty for staff about their own positions and the distractions of reorganisation.

The fact that clinical staff were not directly involved in the reorganisation was reported to have helped in maintaining progress and momentum, but for managers the effects of PCT restructuring were negative. This was starkly evident at one point when project staff suggested that all roles and responsibilities within the new PCT were being reviewed, and as a result they might not be able to continue the project work.



## *Sustaining change*

Looking back on the project in April 2007, the project team offered the following reflections on their experience:

- the need to be clear at the outset about the problem you are trying to solve and your objectives,
- the value of applying project management principles;
- the value of having regular reviews of progress, as undertaken by NHS Institute's gateway process,
- the importance of having good information about current services and data on the impact of new interventions;
- the need to plan to mainstream changes into routine practice.

Sustainability and scaling up in this project were dependent on demonstrating positive outcomes, and working through the PCT to ensure that other practices and areas were aware of these outcomes and could implement new ways of working.

At the time of writing, project staff are analysing data provided by the 16 practices in Chesterfield on the impact of the work. The aim is to use these data to build up a business case for continuing support from the Practice Based Commissioning consortium and the PCT. Persuading practices to sustain and extend the project depends in part on demonstrating improvements in the quality of care, and in part on showing that resources can be saved and redeployed by improving care at the end of life.

As far as scaling up is concerned, the main benefit of the reorganisation of PCTs has been establishing a provider arm in Derbyshire County PCT with the capability to take forward projects of this kind and lead their implementation in other areas. Project staff reported that scaling up would have been more complex and uncertain under the previous structure in which there were more organisations and where PCTs lacked staff with the seniority and credibility to take forward work of this nature. At the same time, staff acknowledged that Chesterfield was a relatively compact and homogeneous community, with other areas posing a more significant challenge because they were more fragmented and dispersed.

The team will report on project outcomes, with a view to extending the service, later in 2007.

## 6. Manchester gynaecology care

This chapter outlines a project to improve gynaecology care in Central Manchester.

### 6.1 Project outline

#### *Scope*

The project was initiated by Central Manchester PCT, which merged with two neighbouring PCTs in October 2006 to become Manchester PCT. The project focus remained on the former PCT's population of 190,000 people registered with 41 general practices. The main acute care provider is Central Manchester and Manchester Children's University Hospitals NHS Trust (CMMCUHT).

The PCT worked with practices to develop a cluster model for commissioning locally agreed services from October 2006. This included establishing a Practice-Based Commissioning Board that has identified priority services for development, such as emergency care and outpatient services. This process, together with a strong history of whole system working for reform, was a factor in the project being included in the NHS Institute's programme.

The Practice-Based Commissioning Board identified the need to review and improve gynaecology care, with a particular focus on shifting inappropriate outpatient activity to primary care. The purpose of the project was to define the activities currently undertaken within secondary care that could reasonably be delivered within primary care, identify the obstacles preventing primary care from undertaking this work, and test the impact of a redesigned care pathway.

The first phase focused on infertility. Further phases looking at dysfunctional bleeding and polycystic ovarian syndrome are planned.

An infertility clinical pathway with referral protocols was agreed to ensure consistency in the management of people in primary care. The pathway reinforces current good practice and sets out appropriate primary care management, including investigations to be undertaken prior to referral to secondary care.

Data collection was undertaken to identify the interventions received by 30 infertile people in November / December 2005 together with referrals to secondary care. These data will act as a baseline for measuring a shift in care against the same data in November / December 2007. It is hoped that the project will create a sustainable shift in care, increasing access to local services by reducing the current waiting time, shifting resources into primary care, and enabling secondary care to focus on more complex patients.

Table 6.1 provides a summary of key aspects of the project.

**Table 6.1: Key components of the Manchester gynaecology project**

<b>Key question tested</b>	Can less complex gynaecology outpatient appointments in secondary care be reduced by extending primary care services?
<b>Issues addressed</b>	Local evidence suggests that there is scope to standardise the work undertaken in primary care prior to referral on to secondary care for common infertility conditions.
<b>Key shift levers</b>	<ul style="list-style-type: none"> <li>• Standardisation: from an unclear patient journey that can involve duplication and excessive outpatient attendances to a single agreed work-up prior to referral.</li> <li>• Substitution of services in secondary care by primary care.</li> </ul>
<b>Perceived long-term benefits</b>	<p>The reduction in gynaecology outpatient appointments in secondary care and the provision of more care within GP practices should:</p> <ul style="list-style-type: none"> <li>• reduce secondary care waiting times,</li> <li>• allow secondary care to focus on the more complex conditions that can only be treated in secondary care,</li> <li>• allow the transfer of resources from secondary to primary care,</li> <li>• improve the patient/carer experience through the provision of care closer to home.</li> </ul>
<b>Key participants</b>	<ul style="list-style-type: none"> <li>• Programme lead</li> <li>• PCT Project lead</li> <li>• GP lead</li> <li>• PBC Scheduled Care lead</li> <li>• Consultant Gynaecologist</li> <li>• Directorate Manager</li> <li>• Clinical Nurse Specialist</li> </ul>
<b>Measures of success</b>	<ul style="list-style-type: none"> <li>• Reduction in gynaecology outpatient appointments per referral / reduction in referrals</li> <li>• Change in the level of services offered by GP practices</li> <li>• Cost benefit analysis</li> <li>• Patient/carer satisfaction</li> </ul>

### ***Achievements***

The final outcome of the project cannot be determined until the follow up audit in November / December 2007. However, the baseline audit identified potential cost savings of £14,292 from a reduction in secondary care activity. This figure was calculated by analysing what secondary care activity could have been avoided and costing this at national tariff rates. If a whole episode could have been avoided, then all the attendances were costed; new and review. If it was a single appointment, then one review attendance was costed. Out of the 30 patients audited, 17 would not have needed a consultant referral if the new pathway was followed and investigations undertaken in primary care.

***Table 2: Summary of outcomes***

<b>Objective</b>	<b>Baseline data</b>	<b>Project outcome</b>
Change in the level of service offered by GP practices	Audit of referrals showed inconsistency in undertaking investigative tests within primary care	A new care pathway has been designed and an audit of care is planned for Nov/Dec 2007
Satisfaction of service users		A questionnaire has been developed
Analysis of costs		The team have developed a comparative cost model which suggests that annual savings of £14, 282 are possible

## 6.2 Key success factors

### ***Receptive organisational and policy contexts***

Everyone interviewed stated that the health economy generally was very receptive to making appropriate shifts of care where it was identified that there was a benefit to patients.

It was also felt that receptiveness at a general practice level was higher than for previous projects initiated by the PCT given the drivers of Practice Based Commissioning and Payment By Results. It was important that the focus of the project had been identified by the GPs through the Practice Based Commissioning Board. A sub-board structure of Project Groups focused on service improvement and led by GPs has helped to develop productive partnership working between organisations to shift care where appropriate.

CMMCUHT have been very receptive and involved in the project, seeing a positive outcome as enabling them to focus their resources on developing secondary and tertiary care services.

The PCT reconfiguration was seen to have some impact on project progress because it took up staff's time and energy, but it was not thought to have affected the outcomes of the project in any way.

### ***Clearly defined focus and outcomes***

This project has faced significant challenges in scoping and defining project objectives and boundaries. The parallel development of an SHA wide Integrated Clinical and Treatment Service (ICATS) impacted on the scoping of the project. ICATS impacted on which services, and elements of services, could be included in the project. The project was delayed due to a lack of information about what would be included in ICATS.

The initial suggestion was to focus on early pregnancy care, providing an increased level of primary care for early pregnancy complications and ultrasound scans. In working through this option, the project group concluded that proposed new pathways were not clinically appropriate. There were also significant issues regarding sustainability and feasibility due to staff recruitment and training. A data analysis also showed that the financial savings first anticipated would not be realised.

*'We spent a lot of time at meetings discussing something that was never going to work – it's important to have accurate data and information rather than relying on gut instinct.'*

This is a good example of the value in undertaking some early data analysis to inform priority setting and to determine what change is required before spending a lot of time setting up a project.

A successful element of the project was undertaking a 'scoping meeting' for the project team and other stakeholders to agree terms of reference for the project group and to establish the outcomes. This process helped to achieve ownership of the project and the analysis work that would need to be done.

### ***Organisational leadership and sponsorship***

In principle, there was clear sponsorship for the project at PCT senior management level. Due to the PCT reconfiguration, senior management involvement in the project was limited and this caused some delays in decision making. As described above, the development of Practice Based Commissioning in scoping the project ensured the project had a high level of clinical sponsorship.

### ***Dedicated project management and capacity***

Initially the project lacked dedicated project management due to staff sickness. This impacted on the pace and progress of the project. This was compounded by limited clinical leadership. The project was 'minded' by another project manager who also had limited time available. Once a management lead and clinical lead were identified the project began to make progress much more quickly.

*'You need someone leading who is committed to the project and has time to sort out all the issues and speak to everyone. If it's just added onto someone else's job and they are already busy you are never going to get anywhere.'*

*'Things are now moving, the last nine months have been a waste of time and money... meetings without progress, not thought through.'*

Identifying a clinical lead to work alongside the project lead was suggested as a key success factor. This helped to pool skills and expertise and to develop a joint commitment to service improvement between the PCT and general practice.

All clinicians involved in the project had difficulty in committing time to the project.

*'If people could be taken away from their day to day jobs just to focus on something like this I think we could have achieved much more in half the time.'*

Initially, fortnightly project meetings were planned but this became difficult to achieve alongside clinical commitments. A solution to this was to use telephone and email communication and only hold face to face meetings when necessary.

### ***Analysis of appropriate stakeholders***

The initial scoping exercise allowed for an analysis of appropriate stakeholders. As the project involved redesign of a pathway across primary and secondary care, the team included the representatives from general practice, CMMCUHT and the PCT, with a balance of clinical and management expertise.

An audit facilitator joined the team when the need for audit was identified. It was recognised that it would be useful in future projects to include this level of expertise during the initial scoping.

### ***Clinical engagement and leadership***

The embryonic nature of the Practice Based Commissioning structure caused early delays in identifying a clinical lead, but then provided a clear leadership forum and decision-making process to support clinical engagement. The PCT funded the clinical lead time on a sessional basis and this was agreed to have worked well in maintaining a high level of engagement and commitment to the project. The model of primary care and secondary care clinicians working together on developing redesigned pathways was recognised as very productive. Although the project was led by primary care, the involvement and leadership from senior hospital clinicians was seen as a factor in agreeing a pathway within the timescale.

It is recognised that there is still a lot of work to do to engage with all 41 practices. Where relationships are already established between the PCT and GPs, the level of engagement is much higher.

Clinical engagement was also enhanced by meetings held between GPs and the project clinical leads. The lead GP and consultant met with GPs on two occasions to discuss the management of fertility, present a proposed pathway and referral criteria and answer any queries.

*'The feedback was very positive and helped us to develop good relationships.'*

Monthly Practice Based Commissioning Group meetings of all practices were a useful forum for ongoing feedback and checking back on decisions made. This increased the level of engagement in the project and created joint ownership of the agreed developments.

### ***Aligned incentives***

Aligning incentives was not an issue for this project. The Trust, PCT, and commissioners had non-conflicting incentives to ensure the project was a success. All organisations were committed to improving services for patients and making more effective use of funding and secondary care resources.

### *Training and support*

The project team did not have any additional resources for project management apart from the funded clinical lead time. The input of additional capacity from the NHS Institute between June and December 2006 was seen as adding significant benefits.

The gateway process introduced by the NHS Institute enabled the team to remain on track and provided a framework for ongoing review.

The PCT recognised that project management experience and skills amongst GPs was limited and therefore organised a day to explore their training needs. This is seen as crucial to sustain ongoing service improvement.

### *Data analysis*

Data analysis proved to be one of the main challenges for the project team in terms of capacity and availability of data. Data collection to establish a service baseline of primary care interventions before referral was difficult due to the way patients are coded on GP and hospital systems. Therefore information was gathered manually from patient notes and referral letters by the audit facilitator. To identify potential cost savings and reduced waiting times, the same audit will be carried out on 30 patients in November / December 2007.

A patient questionnaire has been developed and is being circulated to patients accessing services prior to and after the introduction of the pathway.

### *Sustaining change*

The new pathway was launched more widely in April. The PCT are developing a referral template to facilitate effective communication between primary and secondary care and support future data analysis. An electronic version of the pathway will also be available to GPs to enable quick reference during patient consultation.

Due to the nature of the project, no additional resources are required to sustain the expected shift of care as it is an agreed element of GPs' current responsibility. There is not expected to be any significant increase in GP workload, rather the basis of the consultation will change. An assessment of GP training needs was undertaken with no issues identified.

A patient information pack is being developed to ensure people understand the pathway and associated interventions.



## 7. Torbay diabetes care

This chapter describes a project to increase confidence to initiate insulin in primary care for people with diabetes in Torbay, South Devon. The first section outlines the project scope and outcomes. The second section focuses on the extent to which selected factors helped or hindered success.

### 7.1 Project outline

#### *Scope*

Torbay Care Trust has a remit to commission both health and social care. It is the smallest Trust by population in England, with an estimated resident population of about 132,500 people. There are larger proportions of elderly people and those with a long-term condition compared to national averages.

As part of the NHS Institute programme, Torbay Care Trust aimed to increase confidence in primary care to begin insulin rather than referring people with diabetes to secondary care specialist teams. The key levers being tested were a shift in location from outpatient visits to primary care and simplification of the care pathway.

The project involved a specialist diabetes nurse working with nurses from five out of Torbay's 22 GP practices to assess competencies and confidence to initiate insulin in primary care. The aim was to identify the training and development needs of nurses in primary care, and ultimately to increase confidence to initiate and maintain insulin. Needs identification and training took place over a 2-3 month period.

Table 7.1 provides a summary of the key aspects of the project.

**Table 7.1: Key components of the Torbay diabetes project**

<b>Key question tested</b>	Can we increase practice nurses' confidence to shift insulin initiation and management from outpatients to primary care?
<b>Issues addressed</b>	GPs refer people with diabetes who require insulin initiation to outpatients appointments with specialist nurses. With training and support for GP practices, these people could be managed in primary care.
<b>Key shift levers</b>	<ul style="list-style-type: none"> <li>• Substituting primary care for outpatients</li> <li>• Simplifying care pathway</li> </ul>
<b>Perceived long-term benefits</b>	<ul style="list-style-type: none"> <li>• Improved general diabetes skills in primary care</li> <li>• Increased initiation of insulin in primary care</li> <li>• Reduced referral to secondary care</li> <li>• Less time spent on initiation by secondary care</li> <li>• Convenience and better continuity of care for people with diabetes</li> <li>• Financial savings</li> </ul>
<b>Key participants</b>	<ul style="list-style-type: none"> <li>• Secondary care specialist nurses</li> <li>• Practice nurse from five primary care practices (out of 22)</li> <li>• People requiring insulin</li> </ul>
<b>Measures of success</b>	<ul style="list-style-type: none"> <li>• Increased confidence among practice nurses</li> <li>• Reduction of referrals to initiate insulin as a proportion of all diabetes referrals</li> <li>• Reduced hours spent by specialist nurses on initiation</li> <li>• Cost analysis</li> </ul>

## ***Achievements***

The project team felt that it would be unrealistic to make significant impacts on insulin initiation rates during a short period, therefore the focus was on increasing the confidence of practice nurses to initiate insulin and on identifying whether there was scope to increase insulin initiation in primary care.

Project data suggests there is significant scope to initiate insulin in primary care. When the specialist team assessed records from one practice, about one fifth of people with diabetes were identified as needing insulin initiation and about one third may need a change in dose.

*'Diabetes is high on QoF points so primary care might think they are already doing a lot in this area. But this project shows that we could be doing better.'*

Five practice nurses took part in competency assessments in September 2006. Six months later, nurses received a one page questionnaire asking them to consider whether their confidence or behaviour had changed as a result of working with a specialist diabetes nurse. A specialist nurse also discussed learning points from the project with each practice nurse. Follow up data suggested that primary care nurses felt their confidence and knowledge had improved significantly.

Interviewees believed that the project had helped to set up a support network of practice nurses who could communicate with each other at meetings or via email or telephone, thus maintaining confidence and skills. This was particularly important for practice nurses working in isolation or those working with a number of different GPs who may provide conflicting advice and management planning.

An unanticipated outcome of the project was building trust and rapport between practice nurses and the specialist diabetes team. Practice nurses reported that they did not feel threatened by the specialist nurse who helped them assess their competencies and development needs. Instead, they saw the project as an opportunity to work together and to develop their skills.

*'[The specialist nurse] put forward a joint working model. She reinforced that practice nurses were doing a good job and discussed ways to improve.'*

The specialist team also said that they learnt a lot from the project, particularly in terms of how things work at practice level. This includes how and why practices make referrals for insulin initiation and what support practice nurses need in order to feel more confident in initiating and maintaining insulin for people with diabetes.

*'The project was a success because we found out what else we need to do. It was about identifying gaps in support and building relationships. We know what the blocks are now and why people might be referred to secondary care.'*

Of the five practices that took part, two were initiating insulin at the beginning of the project. By the end, four out of five practices were initiating insulin. However, we cannot suggest that this was a result of the project, because all four of these practices had received training about insulin initiation prior to the project and, in theory, were ready to begin initiation at the outset.

## 7.2 Key success factors

### *Receptive organisational and policy contexts*

A receptive organisational context appears to have been important in this project. Representatives from primary and secondary care suggested that Torbay was very receptive to change and service development.

On a receptiveness scale of 0-10, with 10 being the highest, interviewees rated the South Devon community as 7, 8, or 9. This was not specific to the diabetes project, but rather a reflection of the local context in which it was implemented.

Interviewees reported that engagement and partnership working was reflected at the highest management levels as well as at the frontline. Chief Executives and finance teams from the Care Trust, other local PCTs, and the acute sector meet regularly to discuss progress and work as a team.

The Care Trust is relatively new and there is some organisational instability, however overall Care Trust staff and those in secondary care reported a relatively stable base of organisations and personnel to work with. The fact that local Strategic Health Authorities and Trusts were not reorganised in 2006 as in most other parts of England was seen to be positive, leading to more stability and more chance for pilot projects to succeed.

From the outset of the project, interviewees felt that having good relationships, including relationships with GPs and other clinicians, would make a significant difference to project achievements.

*'It may be easier for us to make a shift because our GPs are more easy going and up for change compared to other areas.'*

It was secondary care staff who originally suggested the scope of the project, so there were few concerns about secondary care specialists feeling threatened by a 'withdrawal' of services. The secondary care specialist diabetes team helped to plan and implement the project at each stage, and worked with primary care practices to identify and respond to development needs.

Interestingly, the role of integrated health and social services was not mentioned as a key facilitator. Although the Care Trust combines health and social care, the budgets of each remain distinct. No-one that we spoke to felt that the combined health and social care focus had influenced the progress of the diabetes project.

The diabetes project focused on building on existing successes, and showing how the project fitted in with things that were already planned or underway.

This helped situate the project in a context that was already receptive to change.

*'We already do a lot in primary care, and we already do insulin initiation, so this project was about making it even better. We wanted to find out how well we were already doing it, and what else could make it better.'*

The impact of the policy context on this project was less clear. The diabetes project team were aware of the importance of local drivers for change, including policy drivers.

*'Other areas who want to shift care should think about local drivers. How can you use PBR [Payment By Results], PBC [practice based commissioning], and local strategic priorities to support your project?'*

But they were also clear that financial policies could be a challenge. Secondary care staff as well as those from the Care Trust suggested that Payment By Results may have a negative impact on the general principle of providing more care in the community, because hospital trusts could lose money if services are shifted from the acute sector. South Devon Healthcare Trust is moving towards Foundation Trust status. Interviewees suggested that this move, coupled with Payment By Results, had made everyone more aware of finances and more focussed on costs per case. However while interviewees acknowledged that in theory Payment By Results could hinder the process, they stated that locally there was a commitment to ensure that these types of policies did not 'get in the way' of providing better care for local people.

*'We have good relationships between GPs, the Acute Trust and the Care Trust. Patients do come first in Torbay and payments get sorted out in the background. Initiatives such as Practice Based Commissioning and Payment by Results 'come and go.' While we will work with these initiatives, they are not necessarily important drivers in ways to make the shift.'*

### ***Clearly defined focus and outcomes***

Having a clearly defined focus was important for the diabetes project. Preliminary ideas about scope involved increasing initiation of insulin in primary care, both in terms of the number of practices initiating insulin and the overall number of cases initiated. However, as the project began, the team realised that this was not realistic within a short timeframe. The focus shifted to identifying what practice nurses needed to increase their confidence to initiate insulin. Having realistic targets was important for the success of the project and the morale of the team. The project outcomes and use of data could have been more precisely defined, as described later in this section.

### ***Organisational leadership and sponsorship***

Having strong multi-organisational leadership was an important factor in the success of this project. The project team and stakeholders were drawn from numerous settings. The project was led on a day to day basis by the Diabetes Lead for Torbay Care Trust, championed by leaders within the Care Trust, and supported by the Trust's Service Improvement Team. Secondary care staff were key to the development and initiation of the project, including a diabetes facilitator, specialist nurses, consultants, and a diabetes dietician. The project was discussed and signed off at Board level and by the PEC. The Diabetes Local Implementation Group, made up of partners from primary and secondary care, had an overseeing role.

Interviewees suggested that support from senior management was of importance.

*'Having someone with clout and someone with authority to buy services supporting the project made a huge difference. It showed everyone that the partners were all serious about taking this forward.'*

### ***Dedicated project management and capacity***

The Torbay team acknowledged that management and staffing capacity was important, and could have been developed further in this project. The project was largely resourced from existing budgets and staff capacities. Care Trust managers and primary care nurses worked on the project as part of their usual role, on top of other routine activities.

Interviewees said that having people with good project management and organisational skills involved kept the project on track and ensured that there was a long-term view about the sustainability and roll out of the project.

But staff involved in managing and implementing the project said it was a challenge to prioritise this work in addition to their usual workload. They suggested that future projects would benefit from additional management time and staff capacity, so that service delivery redesign projects could be given the priority they deserve.

*'If other areas want to do something similar they must create capacity so there is enough time to focus on making change.'*

The Care Trust reimbursed a secondary care nurse for an additional five hours per week for two months during the main implementation phase. This allowed the specialist team to undertake visits to primary care practices and provide telephone support on an ongoing basis, in addition to their usual roles. Having the specialist staff capacity to devote extra time to the project, and a budget to allow payment by the Care Trust, were key to progressing the project within the NHS Institute's six month timeframe.

### ***Analysis of appropriate stakeholders***

The diabetes team did not undertake detailed analysis of appropriate stakeholders to involve in project planning and initiation, but they did acknowledge this may be an important part of future projects.

Gaining input from primary and secondary care practitioners and identifying key champions within primary care were seen as priorities. The diabetes project team identified interested people from primary and secondary care and the Care Trust. Monthly meetings were held to maintain momentum. From the outset, the Hospital Trust's specialist diabetes team reported that they were positive about shifting more insulin initiation into primary care, and there were no perceived issues of 'safeguarding territory.'

However, although primary care practices were to be key recipients of training and development within this project, they were not involved heavily during initial planning stages. Some GPs did contribute to brainstorming and planning sessions, but in general, the Torbay team suggested that further involvement of primary care practitioners at an early stage may have been beneficial.

*'To be honest, I think we would all acknowledge that communication and relationships with general practices were challenging in this project. We needed more input and acceptance from GPs early on.'*

### ***Clinical engagement and leadership***

The project had good clinical engagement from secondary care teams, but there were some challenges in engaging primary care. Enhancing clinical engagement is a focus for Torbay Care Trust. Interviewees felt that this may set them apart from other areas.

*'Torbay is different because we have a long culture of integration. We've been engaging people and working together for more than ten years. Even right back when the Primary Care Group was first set up we put C2C (clinician to clinician) groups in place to give primary care and secondary care an opportunity to talk to one another.'*

Clinicians from primary and secondary care were involved in scoping the diabetes project, and from the outset GPs emphasised the importance of general practitioner involvement in and 'ownership' of the NHS Institute projects. However, the diabetes project team encountered some difficulties in identifying practices that wanted to participate - and GPs had little involvement in the project overall. In hindsight, the project team suggested that having a little longer to engage with primary care would be helpful, as would involving GPs and practice nurses in planning meetings from the outset.



*'It took a while to get GPs and practice nurses involved. Getting practices on board was one of the biggest challenges. We had to put a lot of time in to overcome this.'*

Care Trust staff emailed, wrote to and visited practices to tell them about the project and to invite them to become involved. Key lessons include not underestimating the amount of time and hands-on contact it may take to encourage participation by practices, and that visiting practices can often be the most effective means of communication.

The Care Trust found that they received no response to letters written to practices and that each practice does things differently. A learning point was to acknowledge that diabetes is only one component of the work done by practices, and may not be a priority. The Care Trust asked practices to nominate one person to lead on liaising about diabetes issues, so they could maintain contact with practices at the same time as acknowledging that practice staff were busy with other priorities. They also found that the wording and tone of invitation letters can be important, so time needs to be spent developing these.

Some interviewees suggested that gaining support from local champions, such as someone within each practice, was an important way to promote projects to primary care.

*'You need to engage with champions - this is how you need to get buy-in in primary care. Projects should allow enough time to identify and schmooze with champions.'*

It was also important to ensure that primary care practices did not feel they were being 'forced' to do anything by secondary care teams. There was a danger of this because secondary care teams had been instrumental in developing the project and secondary care nurses were helping to assess the competencies and development needs of primary care nurses. The diabetes team were aware of this issue from the outset, and team members were careful to emphasise a partnership approach between primary and secondary care.

*'[The specialist nurse] was very careful not to tread on any toes. She made it clear that she was not 'assessing' us in a bad way or trying to point out our faults. It was about making the whole service better and finding out what needs primary care nurses had. It was not about making anyone feel bad. There was a lot of trust developed.'*

A learning point for future projects is the potential to develop service level agreements or other documents to support project implementation. Some staff suggested that it would have been helpful to have documents so everyone was clear about their roles within the project and what was expected of them. While one individual per practice was nominated as a liaison person, the Care Trust still expected practices to be fully aware of and engaged in the project. Interviewees suggested that not all practices were aware of the expected level of engagement.

### ***Overcoming cultural barriers to change***

Taking steps to overcome cultural barriers to change was not a key success factor for this project. As outlined above, Torbay managers and practitioners feel they work in a receptive context for service redesign. The diabetes project team did not report any cultural barriers to change or steps to overcome perceived barriers.

### ***Aligned incentives***

Aligning incentives and suggesting the benefits of change was not considered as part of the diabetes project. These issues will likely be considered as part of sustainability planning, as described below.

That said, the fact the Torbay Care Trust could resource extra staff time from specialist nurses for the diabetes project did smooth the way. Questions were asked about how specialist nurses were being reimbursed for the time they were spending on the project, and these questions may not have been at the forefront if Payment By Results was not a priority. In considering roll out, some general practices have also questioned the merits of allocating practice nurse time to initiate insulin if this activity is time consuming and not associated with any additional reimbursement.

### ***Training and support***

Training and support was a key component of the diabetes project because practice nurses were encouraged individually to further develop their skills. Managers did not receive specific additional training, but external support was available from the NHS Institute team.

In general, interviewees did not feel that extra project management support from the NHS Institute was a key success factor in motivating change. However, some felt that the structured approach used by the NHS Institute was helpful and that it was useful to have the extra capacity offered through the management consultants the Institute commissioned.

*'It is having the time and capacity that is worthwhile ... The benefits of having consultants is that they can be more impartial, can draw on other examples, and can help you to think about things differently.'*

Managers said that they valued having someone to speak to about the projects, especially if people could visit when they wanted to talk.

*'It is good to have someone from outside to overview what you are doing. We could get stuck in the detail or dwell on little things. Having someone coming in to remind us of the big picture was good.'*

However, the number of processes, forms, and tools provided was overwhelming.

*'Having a project plan and a strategy for next steps is fine, but project teams do not need to overburden themselves with a huge number of reports, spreadsheets, diagrams, and tools. Tools should be just that - tools to help you along, not just more things to do or get caught up in.'*

Thus, it was the expertise and facilitation of external support that was more important than the written documentation or tools provided.

Another perceived benefit of being involved in the NHS Institute's Care Closer to Home: Making the Shift Programme was to encourage staff to access resources and information from other sites, academic institutions, and personnel that they might not otherwise have come into contact with. Some people said that this had helped to alter the way they think about their role and NHS services.

### **Data analysis**

The use of data and analysis processes was not a significant factor in this project, though team members suggested that this was a gap and something that they would have done differently if implementing the project again. In particular, there may have been a clearer scoping of the project and more effective use of data. During the project, the specialist diabetes team was able to work with practices to examine their records and identify people who might benefit from insulin initiation. The specialist team suggested that this might most usefully have been done at the start of the project to provide a framework for action.

*'We should have started with practice data about how many are on insulin and how many are not. We're doing this at the end, but using data more smartly would have been good from the start.'*

*'You need to allow enough time to think about what to collect in terms of baseline data and also enough time to get it, analyse it, and put it to use.'*

If the team was clearer about the focus from the outset, they could have taken steps to collate before and after measures of confidence and competencies. While competency assessments were conducted during implementation, follow up assessments were not built into the project plan. Confidence was assessed after the project, using retrospective questioning rather than a before and after design.

The team also omitted to examine what service users thought about initiating insulin in primary care. Initially there were plans to survey service users about satisfaction with practice nurse appointments, but due to time constraints and the limited focus on initiation of insulin during the short implementation period, this was not achieved.

### ***Sufficient time***

The project team felt that there was insufficient time available to shift services from secondary to primary care. The project was initiated in mid 2006, with planning and recruitment spanning a two to three month period.

Interviewees suggested that one of the most significant challenges was implementing the project within a six month timeframe, beginning during the summer holiday period. It took time to scope the project fully, decide how to implement it, and make contact with general practices. As such, the implementation phase was only two to three months long. The project team have suggested that future initiatives of this nature might benefit from a nine month timeframe. This would allow three months for planning and gaining stakeholder buy-in, and a full six months for implementation.

*'We need to be realistic about what we can achieve. If we want to make a real shift, we have to plan well and get people motivated and this requires time. Having a set timeframe is good, because it gets people moving - but you have to balance speed with thoroughness.'*

Most people involved in the project agreed that it was helpful to have a bounded timeframe, such as a six month implementation period. Without this, they suggested that there was a danger that projects would not be a priority or would not be implemented. However, they thought that it was important to consider the most appropriate start time of projects.

## *Sustaining change*

Continuation planning was an important factor for this project. Care Trust and Hospital Trust managers and practitioners, as well as primary care practices suggested that the project has helped build links between primary and secondary care and may have longer term benefits for improving the quality of care. There have been enquiries from other primary care practices wanting to be involved in the scheme. Therefore, the Care Trust is considering rolling out the programme, using a local extended services agreement as a bridge to support Practice Based Commissioning in this area.

Importantly, sustainability was discussed throughout the project, and was a particular focus of the review day held at the end of the pilot period. Here key stakeholders discussed what they had learnt from the project and whether it would be worthwhile to extend the project further. Senior managers from the Care Trust attended, as well as those who had been involved in implementing and participating in the project.

*'Having a review meeting gave us time to reflect on what we'd achieved and where we wanted to take it in future. It was a really important step in the project. The fact that [senior people] came made a difference. It showed that the project was being taken seriously.'*

Some Care Trust representatives suggested that the context of Practice Based Commissioning will be helpful for shifting care more generally because this policy can be used as a lever to help promote new initiatives to GPs, showing them how they can save or make money. However, it was acknowledged that GPs may have different ideas about what works well compared to the Care Trust, and therefore Practice Based Commissioning would mean that more negotiation and 'selling' of ideas was needed.

Most noted that GPs in Torbay have not yet fully embraced Practice Based Commissioning so the consequences remain uncertain. For these reasons, a local extended services agreement (LES) has been suggested as a way to support practices who wish to gain more training in insulin initiation. The LES would offer some financial reimbursement for participating practices, and help to build evidence that the service may be useful in the context of practice based commissioning.

The team hoped that the LES would be operational from the beginning of the 2007-8 financial year. This will provide one year of pump priming to support good practice models and include a focus on quality assurance. It will also ensure that that Trust continues to learn from the project, and to build on the successes of the pilot period.

## 8. Conclusions

Reviews conducted by the Health Services Management Centre in the early stages of the Care Closer to Home: Making the Shift Programme suggested that whilst initiatives to shift care away from hospital settings are not new, there was little evidence of systematic and sustained shifts taking place in England.<sup>2,3</sup> The Care Closer to Home: Making the Shift Programme was set up to help NHS organisations respond to this challenge, by encouraging the development and implementation of change management projects at an accelerated pace.

The five case studies described herein suggest that change was delivered with varying levels of success. All five of the case studies implemented a project. While not all were able to demonstrate measurable shifts in providing care closer to home within a six month timeframe, each project did have some positive outcomes, including increasing the project management skills and confidence of staff and facilitating joint working between a wide variety of stakeholders. Despite their differences, and the wide range of clinical areas covered, the case studies and the fuller evaluation report found that each project faced similar challenges.

The twelve themes identified in our evaluation of the Care Closer to Home: Making the Shift Programme, and applied to the case studies presented in this report, help to explain the factors that facilitated change. These factors must be interlinked and managed simultaneously to enable sustainable shifts in care.

### *Change management*

A recurring theme in the case studies is the importance of time, resources, and expertise in project management and change management.

Initially, a number of projects made slow progress because the staff involved were expected to take them forward alongside existing responsibilities. Only when other staff with relevant skills were identified to support projects, or project staff were relieved of some of their responsibilities, was it possible to generate the focus and momentum required.

Finding time to work on projects was a particular challenge for clinicians, especially when meetings were called at short notice. Also, the six month period over which the programme ran placed heavy demands on clinicians and managers at a time of considerable organisational change.

The need to engage with stakeholders added to the pressures facing project staff, especially where there was little or no history of work on the services chosen for inclusion in the programme.

2 Parker H. *Making the Shift: A Review of NHS Experience*. HSMC and NHSI, 2006.

3 Singh D. *Making the Shift: Key Success Factors*. HSMC and NHSI, 2006.

As in other service improvement initiatives, the engagement of clinicians and the identification of clinicians to take on leadership roles contributed to the progress made. Yet even where clinicians were involved in this way, the case studies suggest that it was often necessary for project staff to spend time with clinical teams explaining the purpose of projects and securing support for their implementation.

In the case of primary care, this entailed approaching each practice to negotiate its commitment to projects, and seeking to ensure that GPs and practice staff were 'signed up' to the changes being pursued. This was slow and often sensitive work that could not be rushed, even in the face of the demanding timescales of the NHS Institute.

Change management also needs to be underpinned by strong project management skills. In the case studies, projects and individuals benefited from the structured 'gateway' process implemented as part of the NHS Institute programme. This was a relatively simple intervention to help refine projects which seems to have had a large impact on both the projects within the programme, and on the way individuals and organisations have approached projects since.

### ***Strategic context***

Equally important is the need for projects to be implemented as part of a local strategy for service improvement. The history of quality improvement is littered with examples of initiatives that result in pockets of innovation rather than organisation-wide change. This will continue to be the case in the absence of a strategic approach to improvement.

The evidence presented here and in the full process evaluation report<sup>4</sup> underlines the challenge of linking change at the level of individual projects with improvement across a whole organisation or system of care.

This challenge is particularly important in healthcare because of the need to engage clinicians and other staff at the front line in bringing about service improvements while simultaneously moving beyond disconnected and relatively isolated pockets of innovation.

In the Care Closer to Home: Making the Shift Programme, efforts were made to link the work of individual projects to the broader strategic context through the involvement of chief executives as project champions, and by selecting areas for involvement on the basis of their track record in this field of activity. In practice, changes in personnel as a consequence of NHS restructuring, and variations in local arrangements for connecting the work of the projects and the learning they generated to wider developments in the participating health communities, made it difficult in most cases to keep the strategic context in sight.



Many of the findings of the case studies are reinforced by Kotter's work on change management.<sup>5</sup> The lesson that follows from our findings, in Kotter's terms, is to ensure that a guiding coalition is in place to support the work of individual projects and to lead major changes in service delivery. In emphasising the role of a guiding coalition, we are highlighting the importance of going beyond the leadership of energetic chief executives to create a large group of people who are committed to change and are working together to make it happen. This is especially important and challenging in a programme such as this because of the need to draw members of the coalition from different organisations into a cohesive team.

In developing the guiding coalition, it is essential to develop a vision to clarify the direction of change and to motivate members of the coalition and their followers to take the necessary actions. Such a vision provides the context for strategies that set out in detail how the vision will be realised and the resources and plans that will be put in place to achieve it. In the absence of a guiding coalition linked by a shared vision, change efforts are always likely to result in improvements that are focused on projects rather than improvement in an organisation or a system of care. This is not to suggest that project-level changes are not worthwhile, but rather to emphasise that such projects are more likely to be sustainable and to make significant changes if they are based within a wider strategic vision.

In short, the case studies and evaluation of the Care Closer to Home: Making the Shift Programme suggests that the NHS needs to think 'beyond projects' towards more systemic shifts in processes and attitudinal and behavioural change.

### *Linking factors in change processes*

The case studies presented here illustrate how the interplay between the factors affecting implementation identified in our process evaluation report shaped the outcomes of the projects we studied. As research into previous quality improvement initiatives has shown,<sup>6</sup> individual factors such as organisational leadership and project management are less important in explaining outcomes than the interaction of several factors over time, and the context in which improvement initiatives are introduced. One of the consequences for those promoting change is the need to understand the complexity of quality improvement in health care and to avoid seeking simple or mechanical solutions.

4 Ham C, Parker H, Singh D, Wade E. Getting the basics right: *Final report on the Care Closer to Home: Making the Shift Programme*. HSMC and NHSI, 2007.

5 Kotter JP. *Leading change*. Boston: Harvard Business School Press, 1996.

6 Walston S, Kimberley J. Reengineering hospitals: experience and analysis from the field. *Hospital and Health Services Administration* 1997; 42(2): 143-63.



In previous work, we have shown how a major NHS change programme, the introduction of booked hospital appointments, went through a period in which progress was made in implementing the programme's goals, only for this to be followed by a period in which some of the pilot sites back tracked and found it difficult to sustain the advances they had made.<sup>7</sup> To make this point is to be reminded of the fragile and contingent nature of change in healthcare organisations, and the importance of different factors being aligned behind the change being made.

The stories of the projects we selected for analysis illustrate the impact of these factors and their interplay in the time covered by the programme, underscoring once again the need to be sensitive to the dynamics of change.

In emphasising the importance of process as well as variables, our aim is to avoid giving the impression that quality improvement can be reduced to a cookbook approach in which change can be guaranteed if the factors that affect improvement are all in place. The reality of the projects we focused on was necessarily more complex and their impact dependent on local circumstances (hence our emphasis on the context of change), and on relationships between leaders and stakeholders. Working with this complex reality is the challenge facing managers and clinicians in the next phase of work to provide care closer to home.

## **Conclusion**

The case studies described in this report have outlined how five teams strove to 'get the basics right' in providing care closer to home. The key success factors are often well known to NHS staff and have been repeatedly documented in the literature. Yet there is a gap between knowing what needs to be done, and actually doing it. In short, in order to get the basics right organisations must invest time, commitment, and resources.

Providing more care closer to home cannot be seen as a panacea for all of the issues facing health and social services. However, given that this is such an important policy focus, it is crucial to invest in the people and projects that can help implement and sustain such changes. It is also essential to ensure that project management, change management and the strategic context are aligned to enable service and quality improvement to progress to the next level – beyond projects and to widespread change in practice.

The NHS Institute will build on these case studies and other evaluation material in developing tools to help organisations plan, manage, and systematically implement service improvement programmes.

<sup>7</sup> Ham C et al. Redesigning work processes in health care: lessons from the national health service. *Milbank Quarterly* 2003; 81(3): 415-39.

## 9. Acknowledgements

This report was written by a team from the University of Birmingham Health Services Management Centre. The Derbyshire COPD case study was written by Chris Ham and Elizabeth Wade and the Derbyshire end of life case study was written by Chris Ham. The Birmingham and Manchester case studies were written by Helen Parker and the Torbay case study was written by Debbie Singh. Chris Ham and Debbie Singh wrote the Conclusions and Debbie Singh wrote the introductory sections and edited the final version of the report.

We would like to thank all of the people who took part in interviews and discussion groups throughout the evaluation period.





If you require further copies of this document please quote:  
*NHSI/COH/CStudies* and contact:

Prolog Phase 3,  
Bureau Services,  
Sherwood Business Park,  
Annesley,  
Nottingham NG15 0YU

Tel: 0870 066 2071  
Fax: 01623 724 524  
Email: [dh@prolog.uk.com](mailto:dh@prolog.uk.com)

To find out more about the NHS Institute email: [enquiries@institute.nhs.uk](mailto:enquiries@institute.nhs.uk)  
You can also visit our website at [www.institute.nhs.uk](http://www.institute.nhs.uk)