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Making the Shift: A Review of NHS Experience

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Foreword

The White Paper 'Our Health, Our Care, Our Say: a new direction for community services' lays out the Government's vision of community-based care. In it, it builds upon the broader public sector reforms, allowing people to live more independently and to exercise greater personal choice. In order to achieve this, people will look for greater flexibility in service provision, improved accessibility, more timely interventions, a broader range of service providers from whom they can choose their care, and care closer to home with minimal disruption to their daily lives.

This all requires a significant 'shift' in the way care is delivered, away from what is often a 'one size fits all' approach, often delivered in a specialist setting to a community based, responsive, adaptable, flexible service. This is far more than simply changing the location from where care is delivered. It is also about changing mindsets and behaviour across the whole system.

The NHS Institute for Innovation and Improvement's Primary Care/Long Term Conditions Priority Programme is working with five local health and social care communities to establish how far this vision has been adopted already, to further develop the 'how to' deliver shift (across a range of themes) and how to accelerate this change across the NHS. The programme is aimed at showing how can we make shift happen in practice, quickly and broadly. This builds on, informs and supports other local and national strategies to execute the White Paper goals. This Experience Review was commissioned as a rapid piece of work to underpin the development of the programme and was undertaken at the same time as a review of the written evidence – Making the Shift: Key Success Factors also available from the NHS Institute.

This paper shows us that there are examples of exemplary practice. However, local shift projects are often piecemeal and isolated and there is an overall lack of systematic and strategic approaches to shift.

This review is being published to help NHS and social care organisations already planning and/or implementing shifts in care. It is hoped that the examples of current practice will be of real assistance. Early in 2007, we shall have the additional learning derived from the local communities we are working with. At that stage, we will launch a programme of tools and guidance on how to make a sustained shift that creates a real difference for patients.

Gary Lucking

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1. Introduction

'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 and provides the context for this review.

> [The] White Paper is an important new stage in building a world-class health and social care system. It meets the health challenges of the new century …These proposals, part of the Government's wider reform programme, will allow us to accelerate the move into a new era where the service is designed around the patient rather than the needs of the patient being forced to fit around the service already provided[1].

The White Paper also identifies six specialities; dermatology, ENT, general surgery, orthopaedics, urology and gynaecology that will lead the way as demonstration sites to redesign care pathways that offer effective care in a range of settings closer to home. Five areas of the secondary care pathway that have potential for a shift of care to the community have been suggested as

- simple diagnostics tests
- outpatient appointments
- day case surgery
- step down care
- outpatient follow up

The NHS Institute for Innovation and Improvement was set up in 2005 to help identify potential solutions to key challenges and to test innovative ideas, practices, and technologies to improve care, including the shift from hospital to community care.

> The mission of the NHS Institute for Innovation and Improvement is to improve health outcomes and raise the quality of delivery in the NHS by accelerating the uptake of proven innovation and improvements in healthcare delivery models and processes, medical products and devices and healthcare leadership.[2]

The Institute has set up a Primary Care/Long Term Conditions Priority Programme to examine the best strategies to support shifting care into the community. The Programme involves working with local NHS test sites to examine how shifting care works in practice, which approaches help encourage and increase shifts, and how to accelerate effective, evidence-based change across the NHS.

> The challenge is to make best practice in the NHS the norm, rather than the exception. Shifting care has to be evidence-based.[3]

The Institute recognises that good practice should be based on previous experience and research. Therefore the field tests are underpinned by rapid reviews of the literature and NHS experience about success factors for making the shift.

The literature review describes high quality studies from published research that have evaluated the impact of interventions designed to produce strategic shifts of care.[4] Key findings from this review identified a number of common features in those initiatives that have successfully supported a shift of care:

- empowering people to take responsibility,
- supporting people to manage their own care,
- involving users in planning and development,
- focussing on changing professional behaviour,
- training to support staff in new roles,
- increasing competencies not assuming proficiency,
- adequate investment in services,
- adequate timeframes in which to test services,
- realistic targets rather than unrealistic goals,
- involvement of all key stakeholders,
- whole system approaches,
- providing care based on levels of need,
- phased introduction of changes if needed,
- not running (competing) services in parallel,
- additional resources for primary care,
- acknowledging the impact of unmet need,
- not assuming that shifts will reduce costs.

This paper reviews current NHS experience in making shifts of care identifying to what extent progress has been made, examining areas of common experience and factors that are perceived as supporting or inhibiting successful change. It compares the findings from the review with those from the literature review and demonstrates that the NHS experience reflects much of the evidence from the literature.

Based on these reviews and the field test sites, the Institute aims to provide practical and evidence-based guidance about how to implement and accelerate changes in the system.

2. Scope of the review

As a rapid review, this paper does not attempt to provide a complete national picture of all the programmes and projects that have been implemented, or are in progress, within hospital and community settings. It is acknowledged that there is much more work being undertaken to shift care that we have not been able to include due to time constraints. However, in capturing a range of examples across the NHS and the experiences of those staff leading them, the paper adds to the body of literature already available that describes new initiatives and evaluates best practice within the NHS in redesigning care that is coherent with the aims of the White Paper.

Examples of this literature include the Modernisation Agency's Good Practice Guides that emerged from the *Action On Programme* across a range of specialities and the White Paper itself that outlines a number of case studies highlighting best practice and innovative approaches to shifting care. The Good Practice Guides share the learning from the *Action On* pilot sites and outline some common features of successful change that support shifting care. These are summarised as:

- developing the role of practitioners with a specialist interest
- a shared vision between all providers
- time for clinicians to meet regularly to plan and review
- agreed outcomes and pathways across providers
- use of proven tools and techniques such as process mapping, capacity and demand analysis
- establishing baseline data to measure impact of change
- direct referral options
- use of technology such as helplines
- development of community 'teach and treat' clinics

The experience review had three key elements: a survey of Strategic Health Authorities (SHAs) using an electronic questionnaire to identify progress to date, two workshops to explore the experience of managing the change process and a survey of professional networks through the NHS Alliance, NHS Confederation and HSMC.

Survey of SHAs

The questionnaire was sent to all 28 SHAs with two follow up reminders to those who had not responded. Each SHA was asked to provide information relating to the following three areas:

- Current initiatives happening in the SHA relevant to shifting care
- Impact on services and patients
- Evaluation approaches and metrics used

Responses to the questionnaires varied from very brief responses to submission of service proposal papers and evaluation data. Responses were followed up, where possible, with a telephone interview to gain more understanding of the underlying approach and experience.

18 SHAs responded to the questionnaire, 10 directly and 8 via one or more of their Primary Care Trusts (PCTs); a response rate of 64%. 12 completed questionnaires were received and 16 PCTs responded to the questionnaire with specific examples of relevant initiatives but not all answered the questions directly. A summary of SHA and PCT responses is provided in Table 1.

Workshops

54 people were invited to attend the workshops with a choice of either Birmingham or London venues. Those invited were drawn from HSMC and NHS Institute databases of initiatives related to shifting care. A total of 15 clinicians and managers participated (Appendix One) and shared their own experiences of developing initiatives to shift care to a community setting relating to the topic areas within the questionnaire. The two groups shared their experience of the challenges encountered, solutions where found and the enablers within their local economy that had supported making the shift.

Network survey

32 email responses were received via the professional networks. Where appropriate these were followed up with a telephone call or requests for supporting papers that were available.

Evidence Analysis

Overall, the detailed information relating to the projects or initiatives required to make robust conclusions was not available. However, there was sufficient information to draw some conclusions and identify common experiences that make a valuable contribution to the overall learning process.

The material gathered was analysed for its relevance to making shifts of care. Approximately 10% of the projects identified were disregarded for not meeting this criterion. These were good examples of innovative service developments such as redesigning district nursing services to increase efficiency but did not directly focus on shifting care from hospital to community settings. Where there was project duplication (some responses from the SHAs and networks referred to the same project) the information from both sources was pooled.

The evidence was grouped into four key themes to illustrate the range of activity in progress, but recognising most projects cut across one or more themes. The four themes have been identified by the Institute's Primary Care/ Long Term Conditions Priority Programme to consider when shifting services from hospital:

1. Integration of services
2. Substitution
    - of location
    - of skills
    - of technology
    - from clinical to self management of organisations
3. Segmentation (including sectors and targeting)
4. Simplification (reducing structures and pathways)

The evidence was also analysed for common characteristics across all the projects. This identified the organisational approaches and frameworks that were underpinning a shift care, key enablers that contributed to successful change and factors that were inhibiting or preventing change from taking place.

3. Making the shift: Common features

The review demonstrated some common features in the approach to shifting care providing a useful overall picture of current activity. Overwhelmingly, the review highlighted that progress in developing services to achieve a sustainable shift in care is very much embryonic and therefore robust conclusions or assumptions about sustainability and outcomes are not feasible.

Strategic frameworks

The literature review suggests that a common feature of successful shifts in care involves a whole system approach. Reference to project development and implementation within an agreed strategic framework was not universal. Many projects had been established in isolation from other developments driven by the enthusiasm and clinical interest of individual practitioners in response to demands on their service.

Some examples were given that did demonstrate a whole system approach to project development. These typically involved large scale reviews of existing services such as acute service reviews (West Midlands South SHA) and NHS Integrated Service Improvement Plans (North East London SHA, Trent SHA). Two SHAs made reference to using the 10 High Impact Changes as an underpinning framework for developments (North East London SHA, West Midlands SHA).

South Warwickshire PCT and General Hospitals have set up a series of meetings across all specialties between consultants and GPs to agree appropriate care for hospital and community settings. Outcomes of this work are informing Local Delivery Plans.

There was also evidence to demonstrate that *'function was following form'* in that a number of projects had identified the 'solution', such as a disease-specific multi-disciplinary team, but had not yet worked through the detail of how that team would function in relation to a whole system of change or well defined outcomes.

Segmentation

Of the four key themes, reference to a robust process of segmentation as defined below was least in evidence. However, there were several references to the 'targeting of complex cases' related to the community matron role to reduce inappropriate admissions to hospital.

Segmentation identifies patients with similar needs and/or preferences, and groups them together so that a specific pathway can be designed for them and specific resources can be allocated to them. An example is a strategy for people with long term conditions such as diabetes and asthma. Rather than having a "one size fits all" support strategy for people with long term conditions, we can group or segment patients by their level of risk. So a person with mild disease could be offered a disease specific education programme or expert patient programme to help with self care. A patient with more severe disease or multiple diseases might be offered one to one support in the community to avoid crisis and prevent hospital admission.[5]

There was evidence that risk stratification models were useful tools for segmentation. Birmingham and Black Country SHA is using United Health Europe's risk stratification model across their PCTs to support service development and patient care. Early results also show that it is useful for commissioners and case managers in identifying patients who are attending multiple outpatient appointments for procedures that could be undertaken in primary care e.g. haematology. Other risk stratification models are also being explored.

Clinical engagement

Almost universally, the projects or initiatives were driven by clinicians or had a high level of clinical input and engagement. These mainly involved GPs, nurses and therapists with extended roles in specialist areas.

Substitution and simplification

There was evidence to demonstrate that much of the activity in shifting care was through a process of substitution of roles and location and simplification of the patient pathway: The most common examples given of shifting care were:

Development of multi-disciplinary teams lead by a practitioner with a specialist interest (PwSI). and mostly GPwSI as part of an enhanced service such as dermatology, chronic obstructive pulmonary disease (COPD) and diabetes was most commonly described. This typically presented as a clinical assessment and treatment service to reduce hospital activity and resulted in a reduction of new to follow-up ratios of outpatient activity.

The on-going development of community nursing and therapy services to provide intermediate step-up and step-down care for older people within their own homes or as part of community hospital developments.

The least common approaches identified were the integration of services and substitution of technology. Additionally, there was minimal evidence to demonstrate a development of shifting diagnostic care into the community although a number of areas highlighted proposals to do so.

Where stated, there was universal agreement that referral, or demand, management was most successful as part of a clinical assessment and treatment service. Those areas that had established referral management centres using an administrative model of referral screening had ceased, or were planning to cease, the service. The service was seen to be adding complexity to the pathway and that simplification occurred through the use of community specialists to assess and treat where possible.

Evaluation and performance management

The evidence from this review suggests that this is the weakest area of current project development. For projects that were underway, identification of key performance metrics were largely under-developed and in most cases explicit outcomes were undefined. There was no reference to productivity and efficiency measures[6] but this may reflect the embryonic nature of developments. In response to the request for information on the impact change was having on services and patients typical replies were that *'it was too early to tell'*. Aspirational outcomes were defined as:

- Improving the patient pathway
- Patients now seen in the most appropriate setting
- Reduction in waiting times
- Reduced length of stay
- Reduction in outpatient attendance
- Reduction in unscheduled care admissions

Individual responses to evaluation progress by SHA are summarised in Table 1.

4. Making the shift by integrating services

The literature review found inconsistent evidence about whether integrated care, or shared care, really does make a difference to shifting the focus from hospital care. This applied to shared care between GPs and hospitals and attaching hospital specialists to community-based teams. Whilst this was the least common approach provided in the review there were a number of examples of integrated care given. The most common example provided was the development of COPD teams that integrated specialists from acute and primary care.

The literature review found some evidence that joint working between health and social care can help shift the focus to care in the community and this featured predominantly in examples of intermediate nursing and therapy services. The community matron role was also commonly cited as means for facilitating the integration of health and social care services as part of a case management approach to reducing hospital admissions.

Other examples were also given that covered a range of integrated approaches:

- Dudley Beacon and Castle PCT has taken a whole system approach to integrating services between primary and secondary care, health and social care and generalists and specialists. Working with hospital colleagues, the PCT has developed a wide range of community services, reducing admissions and outpatient referrals to hospital. Primary care teams are supported by specialist practitioners to manage complex care. Specialists, including case managers, do not hold their own caseloads to avoid patients transferring back and forth between teams. All tertiary referrals are managed through practice-based commissioners to avoid unnecessary ongoing care.

- As one of three main workstreams, Surrey and Sussex SHA is supporting the integration of A&E, Minor Injury services and GP Out of Hours services to create emergency care centres for better patient access and appropriate treatment by the right professional.

- East Lincolnshire have developed a COPD programme involving establishing community clinics within practices and referring to

acute care for specialised treatment only. A COPD intermediate multi-disciplinary specialist team, employed by the PCT, works across the patient pathway in community and hospital settings. Evaluations demonstrate a reduction in admissions and readmissions.

- Eastleigh & Test Valley PCT has developed services in primary care attaching specialists to the community team. This includes a pain service, rheumatology and COPD service. All new care pathway design is done in collaboration with consultants to agree protocols, roles and responsibilities.

5. Making the shift by changing locations

There was good evidence from the literature review that providing care at home may have positive clinical outcomes and potentially reduce costs but less evidence to suggest this was true if care was relocated to other residential or community settings. Whilst intermediate care services to prevent hospital admission or support early discharges using community beds or enhanced home care packages was a common approach in this review, the evidence from the literature does not identify a positive impact on the use of hospital services.

Other examples given of relocating non-acute care currently taking place in acute hospitals in community settings involved developing community hospital provision. Formal evaluations are still to be undertaken although the literature points to evidence that shows just a change in the location of care is not sufficient to support sustainable shifts of care.

Examples provided that were perceived as being successful in shifting care by changing locations included:

- Somerset Coastal PCT who developed a nurse-led clinical assessment unit within a community hospital. Patients who can be managed within a community setting but would have otherwise been admitted to hospital for assessment are assessed by district nurses, social workers and case managers. With a 48 hour turn around time, packages of care are put in place to avoid admission.
- An alternative imaging service to hospital departments for GPs established within Thetford Cottage Hospital by Southern Norfolk PCT. An advanced practitioner radiographer provides a plain film service. Currently reporting is done by radiologists but proposals are being made for this to be done by the practitioner.
- Supported by practice-based commissioners, South West Hampshire PCT has withdrawn funding for beds at two local acute trusts and used the funding for the management of long term conditions to increase its community teams and contract with nursing homes for in-patient care.

6. Making the shift by substituting skills

There was no evidence from the literature review that skill substitution contributed to a tangible shift of care. Examples provided within the experience review were embryonic in nature and few had evaluation data available to measure the extent to which the services supported sustainable change.

All SHA areas provided examples of redesigning and extending existing primary care roles to develop locally sensitive services. These predominantly involved the use of PwSIs who were undertaking roles that had been traditionally performed by hospital specialists.

Typical examples include:

- West Gloucestershire PCT has developed an orthopaedic triage service. This involves an extended scope practitioner (podiatrist) triaging electronic referrals to secondary care and diverting those patients who can be managed non-invasively into her clinic or referred to a podiatric surgeon in the community hospital.
- A number of PCTs (e.g. Croydon, Eastern Birmingham, Dudley Beacon and Castle, Tower Hamlets) were using physiotherapists with advanced skills to provide orthopaedic assessment and treatment services reducing outpatient referrals, admissions and surgery interventions.
- Ashfield and Mansfield PCTs have enhanced service agreements with 11 practices to undertake rheumatology monitoring. This has reduced hospital attendances for these patients. Similarly practices will undertake insulin initiation in primary care alongside education and review of diabetic patients.
- South Gloucestershire PCT is using a GPwSI in dermatology. The PCT has developed a primary care tariff for this work and has seen a 21% reduction in hospital referrals. The ratio of new to follow up appointments has reduced from 1:7 to 1:1.
- Nottingham Traumatic Brain Injury Team have established a chronic back pain service using extended scope physiotherapists as part of a team delivered from leisure centres across Nottingham. This has reduced significantly the referrals to the spinal orthopaedic consultants, reduced the DNA rate and increased patient compliance. A measure of its success has been demonstrated by the ability to close a service in one leisure centre as patients improved and transfer it to another area of greater need.

7. Making the shift using technology

The literature review focused on two areas of technological advances; telemedicine consultations and telecare involving monitoring or supporting patients in their homes using telecommunications technology and provided inconclusive evidence as to its effect on shifting care. The experience review did not identify any examples of the former although two SHAs identified proposals to explore the potential of telemedicine to reduce outpatient referrals in dermatology.

However, this review did identify examples of new services that provided telephone information and support, including the use of video phones for patients with complex needs and long term conditions. These had been evaluated by PCTs and initial evaluations were demonstrating some evidence of success.

- Eastern Birmingham and North Birmingham PCTs have developed a model for self-care in collaboration with Pfizer and NHS Direct called Birmingham OwnHealth. A telephone-based active care management service for 2000 patients it promotes effective care management for those with long term conditions who have been identified as low users of health services. Under the guidance of 10 nurse case managers, patients set their own goals receiving telephone support and signposting to other services when needed. Software provides decision support and captures ongoing progress. Whilst evaluation is ongoing, early indicators demonstrate an effective service.
- Dudley Beacon and Castle PCT case managers and their patients can also now talk via video phones. This has enhanced communication and encouraged patients to seek telephone advice when

needed. Evaluation has demonstrated a significant correlation between increased patient contact with case managers and reduction in admissions and A&E attendance.

Examples were also given where the use of mobile phones to improve communication between providers was supporting shifts of care:

- Case managers at Eastern Birmingham PCT are alerted by mobile phones by A&E if their patients arrive in the department. This enables them to redirect patients back to primary care services if possible. Similarly, case managers at Dudley Beacon and Castle PCT are alerted by ambulance control if they have a non-emergency call for their patients. The case manager then attends the patient to prevent admission if appropriate.

Local solutions to information technology constraints had been developed and early evaluations were demonstrating some evidence of success:

- Eastern Birmingham PCT has installed the 'Insight' system for all GPs. All GPs now log every referral enabling the PCT to review and compare patterns. It also enables peer review of referrals and has helped to promote best practice and reduce referrals.
- Dudley Beacon and Castle PCT has installed a web-based tracking system for all its GPs. This system allows them to track, in real time, patients who are in hospital, including location and length of stay. In this way, patients who are in for longer than the 'norm' are immediately flagged and followed up.

8. Making the shift by supporting self care

The Institute suggests that moving from clinical to self management is a key ingredient in shifting reliance from acute hospital care. The literature review suggests there is little evidence about whether involving people in making decisions about their care will help shift more care into the community.

However, there is evidence that providing structured self-management education may help to facilitate shifts in the focus of care. The experience review identified a common approach to this aspect of care with the continued development of Expert Patient Programmes to shift care from community services to the patient although there was no formal evaluation data of its impact available.

The literature review also suggests that developing self-monitoring services may be a promising area to deliver to support a shift of care. The area of developing simple diagnostic testing services within community settings or patients home was one of the least common approaches to shifting care within the experience review. One example identified was

- Bewdley Medical Centre who have developed home monitoring of blood pressure giving patients an increased control over their own treatment. Over 300 self selected patients have bought their own machine and are monitoring their blood pressure at home. It has reduced the workload of GPs and practice nurses and reduced prescribing costs.

Other examples included:

- Kingston hospital that is using a Respiratory Therapy Practitioner to deliver a supported discharge scheme. Patients are screened on admission to ensure early discharges where possible and care is continued at home for a period of one to four weeks including supporting a model of self care. Patients can self refer back to the service for information and support to facilitate early intervention and prevent admission to hospital.
- West Midlands SHA that is supporting a meteorological project for COPD patients. Each patient on the scheme receives forecasts of weather conditions and education material to enable them to plan and manage their care more effectively.

The literature review suggests open access clinics for outpatient follow up may help to support self management and warrants further study. There was no evidence in the experience review that this was an area of development.

9. Making the shift by substituting organisations

The literature review examines two examples of partnership working with organisations outside of the NHS such as private sector treatment centres and community groups. Examples of these were not given by organisations as part of the experience review, however, examples were given of using organisations in different ways and working in partnership to support shifts of care:

- Surrey is piloting a directory of intermediate care services that has been included on Ambulance Trust information systems. This is enabling patients, where appropriate, to be redirected to community services. It has also developed into a tool to support early discharge as the system can be accessed by ward staff to identify capacity within community and nursing home services.
- Kent Ambulance Trust has established an unscheduled care desk in partnership with PCTs and the LA. Using a series of clinical algorithms, paramedics give medical advice and arrange for community based services for those 999 calls that are not immediately life threatening or serious. This has reduced admissions to A&E. The partnership approach has developed 'treat and leave' and 'treat and refer' policies to develop alternative options to hospital care.
- Pathway redesign by the Central Nottinghamshire Ophthalmology Service Review group has resulted in the introduction of a cataract direct assessment and referral pathway involving 50 local optometrists. This has reduced outpatient referrals to ophthalmologists.
- South West Dorset PCT has established an orthopaedic assessment and triage service that includes procurement of a MRI service from a local private provider. This service has enabled practitioners to make decisions more quickly about packages of care and reduced secondary care referrals.

10. Making the shift by simplifying pathways

The literature review suggests there is little evidence about whether care pathways help shift care from hospital into the community although some studies suggested that pathways can reduce hospital use for specific populations such as asthmatics and diabetics. Activity in this area identified in the experience review was directly related to the development of clinical assessment and treatment services and community services using PwSIs. Early indicators suggest there is an impact on hospital use, reducing referrals and outpatient follow-ups. These developments had all involved simplifying the pathway although there was little evidence to demonstrate the development of simple diagnostic tests to support the pathway redesign. The literature review suggests that these services have little impact in reducing diag-

nostic hospital activity and may increase diagnostic activity but no evaluation data was available from the projects to help inform this view.

A number of these examples have already been illustrated. Other examples include:

- Cumbria and Lancashire SHA who is establishing an SHA wide Capture, Assess, Treatment and Support (CATS) system. A primary care assessment and treatment service will provide appropriate alternative services to secondary care. Only patients requiring acute hospital care will be referred on, based on locally agreed clinical criteria.

- Oldham PCT has supported the development of Pennine MSK Partnership. This Integrated CATS, via a Specialist PMS Practice, delivers a community rheumatology service with a multi-disciplinary team. The pathway is now predominantly primary care focused with patients except for when hospital-based treatment is required. Waiting times have reduced significantly from 17 weeks to 2 weeks and the number of referrals for surgical intervention has also reduced with the team using alternative treatments such as joint injections.

11. Key success factors

The workshops and telephone interviews helped develop a picture of the current NHS experience in relation to the factors that are perceived as supporting or inhibiting successful change. The experience of those involved in leading transformational projects largely reflected the success factors identified in the literature review but also identified others that had specific relevance to the current structural reorganisation within the NHS.

- **Strong clinical leadership** was identified as a key enabler and had been a factor in all the successful projects. Effective clinical leaders were seen as an essential requisite for driving forward initiatives and influencing a change in professional behaviours. As such investment in developing leadership skills was considered to be cost-effective and essential for sustainable change.

  Resistance to clinical change in some areas was inhibiting the ability to make shifts of care, particularly with regard to referral management. A successful solution to this had been GP peer review of referrals. The process of peer review had identified variations in clinical practice that had resulted in agreement of best practice between practices and a reduction in hospital referrals.

- **Training to support staff in new roles** was identified as a significant enabler for service change. There was concern about the lack of clinical skills within primary care to manage a successful pace of change and that organisations needed to see this training as an important element of workforce development plans. Further investment in education and training for identified key roles was agreed to be a high priority.

- **Empowering people to take responsibility** supports successful change and this required an element of risk taking and 'bravery' amongst senior managers and clinicians. It was agreed that this needed to be supported by SHAs within agreed frameworks. This was particularly relevant in the present financial climate that could potentially lead to a halt on some very cost effective developments.

- **Professional attitudes and behaviours** have a direct influence on the pace of transformational change. Cultural differences between primary and secondary care were still seen as a significant barrier to change. PCTs that had been successful stated that investing time in developing relationships between GPs and Consultants through facilitated redesign workstreams had made a significant impact on the speed of progress in managing change. The development of 'clinical contracts' between primary and secondary care had underpinned success in some areas.

- **Organisational stability** is needed to support the development of relationships between managers and clinicians across organisations. Recent and impending changes to organisations had hindered progress in agreeing service improvements and created 'bureaucratic paralysis'. Strong relationships had been key to successful change and there was a concern that any changes in personnel would slow progress again.

- **High quality information management and technology** is identified as a key enabler, but a delay in national implementation was identified as slowing progress. However, where local solutions had been found these had worked well and proved to be cost effective.

- **Increasing competencies and not assuming proficiency** is essential for sustainable change. Specifically, this applied to project management skills and information management expertise. There were concerns that these skills were lacking in the management workforce and were hindering effective progress. Projects that were proving successful in implementing a shift of care identified these as a success factor but there was also concern they may be lost locally as a result of structural reconfigurations.

- **Support of professional organisations** such as the Royal Colleges was important in ensuring acceptability in some areas of service redesign. Some PCTs had experienced resistance from professional groups to changes in clinical roles and responsibilities and this had hindered progress.

- **Creating the right incentives** to encourage shifting care is also a key success factor. Robust information management systems that provided clinicians with accurate and 'real time' data to support service development and demonstrate effective change were seen as an important incentive for change. In PCTs where payment to GPs had been 'up front' as part of a practice-based commissioning agreement, this had stimulated an enthusiasm to implement change.

  There was some concern that payment by results was beginning to affect progress in the ability to reduce hospital activity. Examples were given where the number of hospital admissions had increased following the establishment of Foundation Trusts in areas of care that had previously seen sustainable reductions.

- **Shared boundaries** between health and social care had been a factor in successful change that required joint working between health and social care. As such, the new configurations of PCTs were seen to be a step forward in developing relationships and joint service provision.

12. Summary of activity by SHA

Table 1.

Table excludes intermediate care projects, case managers/community matrons and PwSI services as these were common to all areas.

SHA area	Current Projects	Outcomes
Kent and Medway	Refocusing work of **community hospitals** away from bed based services into centres of community healthcare. Expanded rehabilitative health and social care. Developed **unscheduled care desk** with ambulance trust and LA to divert patients from hospital referral to community services. Establishment of Neurorehabilitation assessment and evaluation team (Asset) manages patients collaboratively within the community reducing hospital admissions. Dartford, Gravesend and Swanley PCT has opened new community hospital that will transfer outpatient work to the community.	Evaluations in progress. Reduced admissions for case managed patients. 63% of those patients who had been frequent flyers had not had an admission in the last year. (DGS PCT).
Cumbria and Lancashire	Procuring **Capture, Assess Treatment and Support systems** to reduce unnecessary referrals to secondary care.	Evaluation in progress. Anticipating 150,000 + reduction. Orthopaedics pilot demonstrating deflection to alternative community services leading to reduction in OPD slots and surgeon providing more theatre sessions. Evaluation of systems will consist of 'double running' to assess effectiveness against assessments generated by traditional methods.
South West Peninsula	Increase in **diagnostics** at community hospitals. **Orthopaedic** triage in progress. **Extended practice** nurses supporting LTC care. **General surgery** provided by GP surgery (Probus) **GPwSI** in a range of specialties,	Evaluations in progress.
North West London	Piloting a **new pathway for fractured NOF** patients to reduce LOS in hospital. Community rehabilitation team take on care to facilitate early discharge either to home or PCT in-patient beds.	Pilot one month old – collecting LOS data.
Hampshire and Isle of Wight	Established a multi-disciplinary **COPD service** to reduce hospital admissions. South West Hampshire PCT developing a business case for **24 hour nursing** service.	Evaluation in progress.
South-East London	**Sexual and reproductive health service** established in community clinics.	Referral to GUM providers has decreased from average of 28 per month to 17. Uptake in numbers using the service has increased.
West Midlands South	Two large scale **acute service reviews** e.g. South Warwickshire – series of facilitated meetings between GPs and Consultants across all specialties to review care and care settings. Review of **pathology service provision** is underway to develop a common approach across Birmingham and Black Country, enhancing choice of access using pharmacies and independent sector. A **meteorological project** for patients with COPD is in progress. **Preoperative assessments** taking place to reduce unnecessary hospital visits.	Evaluations form part of the regular performance monitoring systems.

SHA area	Current Projects	Outcomes
Trent	From March 2009 **Ashfield and Mansfield Community Hospitals** will have 80 nurse/AHP led rehabilitation and end of life care beds, 16 stroke beds and 16 specialist physically disabled beds for community based care reducing current acute admissions. **Ophthalmology** pathway redesign establishing cataract direct access assessment and referral pathway involving 50 local Optometrists. A MDT triage team now reviews all **orthopaedic** routine referrals Enhanced Services SLA for a locally agreed **hip and knee care pathway** and scoring tool. There has also been an increase in 'OA School' places - advice & exercise groups for patients with Osteo-Arthritis. 11 practices now undertaking **Rheumatology** monitoring in Primary Care under and Enhanced Service SLA, thus reducing hospital attendances for this cohort of patients. Community group education classes introduced for Rheumatology. A co-ordinated **COPD** care pathway has been developed across Primary and Secondary Care and community-based Specialist COPD nurses and pulmonary rehabilitation staff recruited to cover Ashfield, Mansfield District and Newark. Introducing **diabetes insulin initiation** in primary care from 2006 as an enhanced service.	Evaluations are integral to performance management framework. Reduction in OPD follow ups. 2005/2006 has seen a significant reduction of more than 12% in referrals to Orthopaedics in secondary care. Reduction in OPD follow up.
North and East Yorkshire and North Lincolnshire	**COPD programme** establishing screening, MDT intermediate care team. **Self car**e strategies in place. Joint approach with LA to establish **telecare**. Pilots in place for home monitoring and **video consultations.**	23% decrease in COPD admissions from 2000 – 03. Outcome on track to reduce admissions by 50%. Readmission rates are 7.8% compared to national average of 30%.
Dorset and Somerset	**Community hospital** investment programme to expand inpatient and day services.	Two year evaluation of commenced in April 06 – first report due Autumn 06. Agreed targets have been set for reduction of delayed transfers, unscheduled admissions, number of people supported at home, numbers of people entering long term care.
Birmingham and Black Country	Whole system **Integrated model of care** within Dudley Beacon and Castle PCT reducing admissions to secondary care. Using United Health Europe **risk stratification model** successfully to identify complex needs. Case managers alerted on Blackberrys that patients are in A&E for timely turn around. **Orthopaedic assessment service** led by physiotherapists to see and treat patients in community setting instead of referral to acute care. A nurse consultant in **urgent care** triages patients in A&E and redirects to community services where appropriate. Developing a telephone based outreach service to support **self care.** **Partners in Health Centre** promoting self care and education for long term conditions.	Dudley - Evaluation data available. Other evaluation in progress and reports published soon. SHA analysing comparison between case managed and non-case managed patients. Too early to report. Planning to use standard patient satisfaction questionnaires across most projects to ensure consistency of output.
Norfolk, Suffolk and Cambridgeshire	Community-based **imaging** service (Southern Norfolk PCT).	In progress.

SHA area	Current Projects	Outcomes
South West London	Kingston Hospital **COPD outreach team** supporting early discharge and self care to prevent readmission.	No information available.
Shropshire and Staffordshire	Maximise skills and technology within the **ambulance service.** Developing **care pathways including direct diagnostic access**. Increased use of **telemedicine**. Independent sector provision of **diagnostics. Falls** prevention, development of **urgent call centre**.	Delivered through ISIPs with clear outcome framework. Evidence of success not yet available.
Greater Manchester	New **Rheumatology** service within Oldham PCT delivered by SPMS practice. **Integrated Care, Assessment, Treatment and Support services** across the SHA in all specialities. Pilots in progress for **MRI** services, **point of care testing** at pharmacies and in patient's homes using ambulance staff.	In progress.
North East London	**Integrated Service Improvement Plans** being developed in all 5 health economies. These include proposals to establish **clinical assessment centres** in primary care, develop and **orthopaedic triage** service, develop **additional building capacity** through LIFT, extend GP opening hours, support the training of **ECPs** in the ambulance service. Tower Hamlets PCT pilot **Physiotherapy self referral service** in two practices.	Evaluation in progress by individual PCTs and via quarterly performance review processes. Reduction of 10 referrals per month per surgery and in DNA rates.
South West London SHA	Kingston Hospital providing outreach service to **COPD** patients to support early discharge and self care.	
Surrey and Sussex SHA	Integrating A&E, MIU and Out of Hours to create **emergency care** centres. Developing community based **diagnostic services**.	All evaluations in progress as part of performance management process.

APPENDIX ONE: Workshop attendees

Andy Bacon	Director of Diagnostics, South Manchester PCT
David Balfour	PEC Chair, Eastleigh & Test Valley Primary Care Trust
Andrew Donald	Director of Policy and Redesign, Eastern Birmingham PCT
Peter Colclough	Chief Executive, Torbay Care Trust
Leslie Eddowes	Advanced Practitioner Radiographer, Southern Norfolk PCT
Simon James	Primary Care Commissioning Manager, Barking & Dagenham PCT
Sandra Mellors	Head of Physiotherapy Services, Mile End Hospital, London
Hilary Watkins	Associate Director, Service Improvement, SW Dorset PCT
Ruth Lemiech	Long Term Conditions Project Manager, Birmingham & the Black Country St HA
Claire Old	Director of Commissioning Nursing & Quality, Dudley PCTs
Dr Nitti Pall	Oldbury & Smethwick PCT
Emma Savage	Primary Care Development Manager, South Gloucestershire PCT
John South	Director of Primary Care, Birkenhead & Wallasey PCT
Penny Spreadbury	Head of Service, Nottingham Traumatic Brain Injury Team
Steve Cartwright	PEC Chair, Dudley PCTs

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