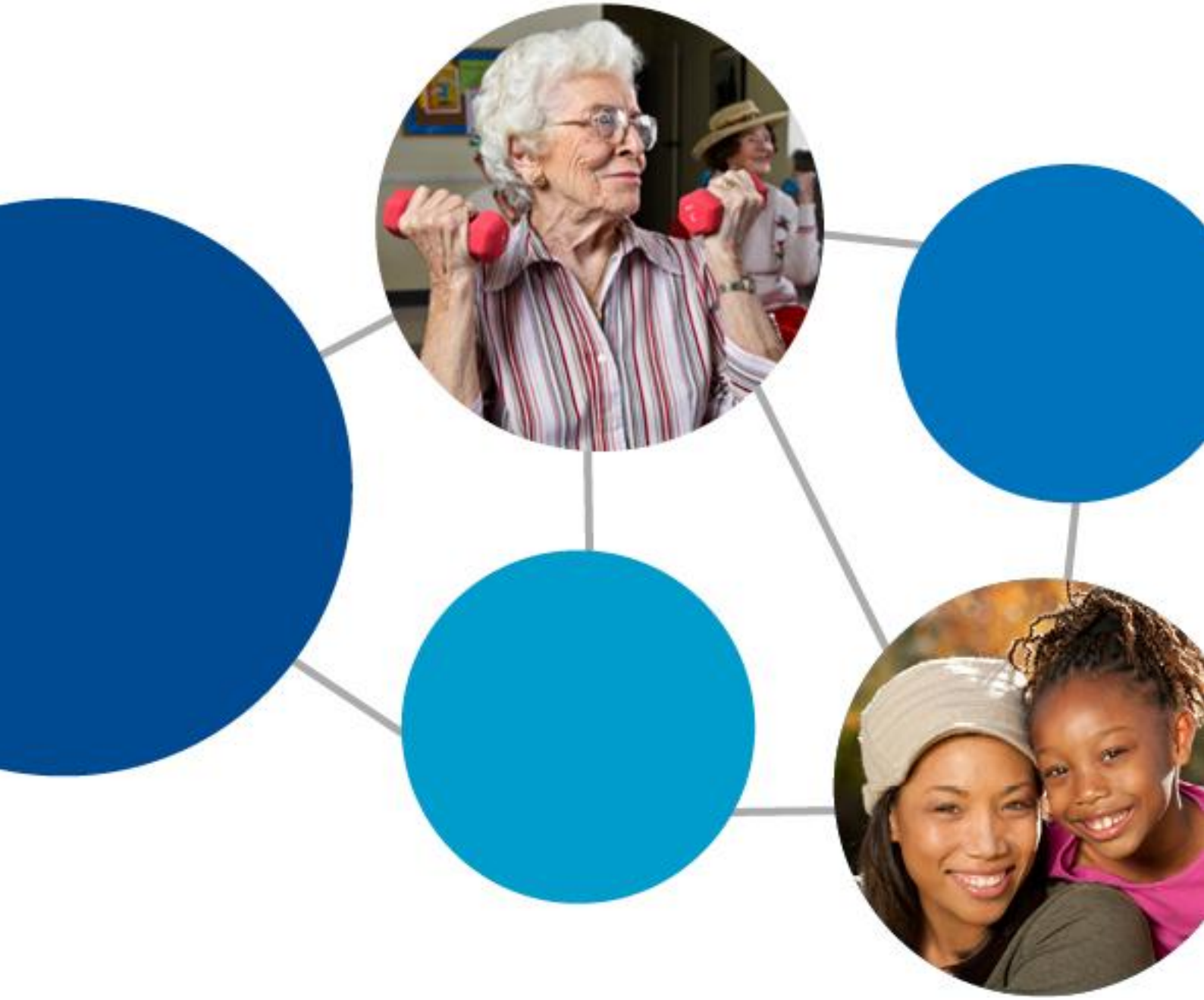
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NHS



# Clinical Design Workstream

## A Report of Output
## November 2013 -March 2014

## Contents

1. Introduction
2. Scope of the clinical design workstream
3. Process
4. The Case for Change
    - 4.1 Background
    - 4.2 The Challenges
        - 4.2.1 Changes in our population profile
        - 4.2.2 Changing patterns of illness
        - 4.2.3 Higher expectations
        - 4.2.4 Clinical standards and developments in medical technology
        - 4.2.5 Economic challenges
        - 4.2.6 Opportunity costs in quality of service
        - 4.2.7 Impact on accessing services for populations living in two urban centres and much more sparsely populated rural communities
5. Acute and Episodic care
    - 5.1 Key principles
        - 5.1.1 Care closer to home
        - 5.1.2 Needs led services
        - 5.1.3 Integrated care
        - 5.1.4 Care by experts
        - 5.1.5 Consistent & consolidated services
        - 5.1.6 Sustainable systems
    - 5.2 Model of care
        - 5.2.1 Patient flows
        - 5.2.2 One emergency centre
        - 5.2.3 'Some' urgent care centres
        - 5.2.4 Partnership care
        - 5.2.5 Professional navigation
        - 5.2.6 Integrated community care
    - 5.3 Diagram of model of care

6. Long Term Conditions and Frailty
    6.1 Key principles
        6.1.1 Enabling patient responsibility
        6.1.2 Partnership care
        6.1.3 Shifting care into the community
        6.1.4 From reactive to proactive care
        6.1.9 Timely response, enhanced recovery & rapid reablement
        6.1.10The last year of life
    6.2 Model of care
        6.2.1 Prevention
        6.2.2 Partnership care
        6.2.3 Self management & care planning
        6.2.4 Integrated teams
        6.2.5 Increased levels of care
        6.2.6 Reablement and rehabilitation
    6.3 Diagram of model of care
7. Planned Care
    7.1Key principles
        7.1.1 Patient empowerment & navigation
        7.1.2 Pathways
        7.1.3 Partnership care
        7.1.4 Levels of care
    7.2 Model of care
        7.2.1 Patient portal
        7.2.2 Pathways
        7.2.3 Navigation
        7.2.4 Levels of care
    7.3 Diagram of model of care
8. Cross cutting themes
9. Whole system synergies
10. Next steps

## 1. Introduction

The Clinical Design workstream was established in November 2013 and used the results from the patients' and clinicians' Call to Action survey and meetings as a starting point for its work. From this, it has established an approach to ensure that the future of hospital and community services is considered within the context of the whole system. It has embedded a process which maximises patient and clinician engagement and co-creation, and agreed that there is a compelling case for change. It has also considered the clinical and design principles applicable to the whole system and key components within it, examined the national and international evidence base and formulated high level models of care across the whole system which have undergone some initial testing.

The output up to this point, together with a summary of next steps, is described fully in the following report.

## 2. Scope of the Clinical Design workstream

The design of high quality, safe, efficient and sustainable hospital services must be done within the context of a coherent and deliverable whole system plan. So, although the scope of the FutureFit programme is confined to the future of acute and community hospital services, the clinical design work stream is required to consider the health and social economy as a whole and establish models of care which fully integrate all services within it. The success of FutureFit is likely to depend on achieving whole system transformational change. This has significant implications for commissioners as well as the organisations, services and workforce that currently lie beyond the scope of this programme.

## 3. Process

Following the Call to Action surveys and events, a Clinical Reference Group comprising 50 senior clinicians from health and social care, along with patient representatives, met on November 20th 2013 to receive the results, from which a case for change was established and whole system design principles were debated and agreed.

The Clinical Reference Group met again on January 29th 2014, during which it confirmed the output from the first meeting, suggested what success would look like and how to measure it and discussed the clinical and design principles applicable to the three main areas of health care delivery:

- Acute and Episodic Care;
- Long Term Conditions / Frailty, and;
- Planned Care.

Three subgroups were formed to consider these areas further; each subgroup comprising approximately 30 clinicians from health and social care along with patient representatives. They each met for six hours during February 2014 to add more detail to the design and clinical principles, to establish high level models of care in each area and to begin a process of sense checking, testing and refinement of the models.

The core Clinical Design workstream, reporting to the Programme Team, has planned and overseen this process and will remain responsible for the next steps described at the conclusion of this report.

## 4. The Case for Change

### 4.1 Background

There are already some very good health services in Shropshire, Telford and Wrekin. They have developed over many years to try to best meet the needs and expectations of the populations served, including that of Mid-Wales. Nevertheless, when we look at the changing needs of the population now and that forecast for the coming years; when we look at the quality standards that we should aspire to for our population, as medicine becomes ever more sophisticated; and when we look at the economic environment that the NHS must live within; then it becomes obvious that the time has come to look again at how we design services so we can meet the needs of our population and provide excellent healthcare services for the next 20 years.

When considering the pattern of services currently provided, our local clinicians and indeed many of those members of the public who have responded to the recent Call to Action consultation, accept that there is a case for making significant change provided there is no predetermination and that there is full engagement in thinking through the options. They see the opportunity for:

- Better clinical outcomes through bringing specialists together, treating a higher volume of cases routinely so as to maintain and grow skills
- Reduced morbidity and mortality through ensuring a greater degree of consultant-delivered clinical decision-making more hours of the day and more days of the week through bringing teams together to spread the load
- A pattern of services that by better meeting population needs, by delivering quality comparable with the best anywhere, by working through resilient clinical teams, can become highly attractive to the best workforce and can allow the rebuilding of staff morale
- Better adjacencies between services through redesign and bringing them together
- Improved environments for care
- A better match between need and levels of care through a systematic shift towards greater care in the community and in the home
- A reduced dependence on hospitals as a fall-back for inadequate provision elsewhere and instead hospitals doing to the highest standards what they are really there to do (higher dependency care and technological care)

- A far more coordinated and integrated pattern of care, across the NHS and across other sectors such as social care and the voluntary sector, with reduced duplication and better placing of the patient at the centre of care

They see the need and the potential to do this in ways which recognise absolutely the differing needs and issues facing our most dispersed rural populations and our urban populations too.

This then is the positive case for change - the opportunity to improve the quality of care we provide to our changing population.

### 4.2 The Challenges

Our local clinicians and respondents to the Call to Action also see this opportunity to systematically improve care as being a necessary response to how we address the many challenges faced by the service as it moves forward into the second and third decades of the 21st century.

These challenges are set out below - they are largely outside our control and we have to adapt our services to meet them:

#### 4.2.1 Changes in our population profile

The remarkable and welcome improvement in the life expectancy of older people that has been experienced across the UK in recent years is particularly pronounced in Shropshire where the population over 65 has increased by 25% in just 10 years. This growth is forecast to continue over the next decade and more. As a result the pattern of demand for services has shifted with greater need for the type of services that can support frailer people, often with multiple long-term conditions, to continue to live with dignity and independence at home and in the community.

#### 4.2.2 Changing patterns of illness

Long-term conditions are on the rise as well, due to changing lifestyles. The means we need to move the emphasis away from services that support short-term, episodic illness and infections towards services that support earlier interventions to improve health and deliver sustained continuing support, again in the community.

#### 4.2.3 Higher expectations

Quite rightly, the population demands the highest quality of care and also a greater convenience of care, designed around the realities of their daily lives. For both reasons, there is a push towards 7-day provision or extended hours of some services, and both of these require a redesign of how we work given the inevitability of resource constraints.

#### 4.2.4 Clinical standards and developments in medical technology

Specialisation in medical and other clinical training has brought with it significant advances as medical technology and capability have increased over the years. But it also brings challenges. It is no longer acceptable nor possible to staff services with generalists or juniors and the evidence shows, that for particularly serious conditions, to do so risks poorer outcomes. Staff are, of course, aware of this. If they are working in services that, for whatever reason, cannot meet accepted professional standards, morale falls and staff may seek to move somewhere that can offer these standards. It is also far more difficult

to attract new staff to work in such a service. Clinicians are a scarce and valuable resource. We must seek to deploy them to greatest effect.

**4.2.5 Economic challenges**

The NHS budget has grown year on year for the first 60 years of its life ……in one decade across the turn of the 21st century its budget doubled in real terms. But now the world economy, and the UK economy within that, is in a different place. The NHS will at best have a static budget going forward. And yet the changing patterns of population and resultant need, the increasing costs of ever improving medical technology, the difficulties in simply driving constant productivity improvements in a service that is 75% staff costs and that works to deliver care to people through people, mean that without changing the basic pattern of services then costs will rapidly outstrip available resources and services will face the chaos that always arises from deficit crises.

**4.2.6 Opportunity costs in quality of service**

In Shropshire and Telford and Wrekin the inherited pattern of services, especially hospital services, across multiple sites means that services are struggling to avoid fragmentation and are incurring additional costs of duplication and additional pressures in funding. The clinical and financial sustainability of acute hospital services has been a concern for more than a decade. Shropshire has a large enough population to support a full range of acute general hospital services, but splitting these services over two sites is increasingly difficult to maintain without compromising the quality and safety of the service.

Most pressingly, the Acute Trust currently runs two full A&E departments and does not have a consultant delivered service 16 hours/day 7 days a week. Even without achieving Royal College standards the Trust currently has particular medical workforce recruitment issues around A&E services, stroke, critical care and anaesthetic cover. All of these services are currently delivered on two sites though stroke services have recently been brought together on an interim basis. This latter move has delivered measurable improvements in clinical outcomes.

**4.2.7 Impact on accessing services for populations living in two urban centres and much more sparsely populated rural communities**

In Shropshire, Telford and Wrekin there are distinctive populations. Particular factors include our responsibility for meeting the health needs of sparsely populated rural areas in the county, and that services provided in our geography can also be essential to people in parts of Wales. Improved and timely access to services is a very real issue and one which the public sees as a high priority. We have a network of provision across Community Hospitals that can be part of the redesign of services to increase local care.

## 5. Acute and Episodic Care

### 5.1 Key Principles

#### 5.1.1 Care close to home

An enhanced and integrated education and prevention programme, driven by a commitment to wellbeing as a primary health, social, economic, political and cultural aim, without which the sustainability and quality of services in the future will be seriously threatened. This is discussed further in the LTC section.

Easy access to understandable and trustworthy information about self care options and local services, combined with clear signposting to points of access appropriate for the level of urgent or emergency care required.

A single point of access for professionals to navigate patients to a wider range of integrated and community based services.

Urgent (not emergency) care delivered by expert community generalists as a default, with prompt access to specialist advice and opinion when required.

#### 5.1 2 A needs led service

Patient access to urgent and emergency care should be dependant on the level of care they require. Quality, safety and achieving the best outcomes will come before choice. Services will be rationalised so they are more consistent in their quality and the services they offer. This will make it easier to effectively triage, signpost and brand to ensure more appropriate attendances at the right point of care, which should be the least intensive level required to fully meet every patient's needs in order to maximise efficiency and reduce iatrogenic harm.

#### 5.1.3 Integrated care

Integrated care records are a necessary component of an integrated health and social care system and their development should be of the highest priority. Patients regard them as a reasonable proxy for continuity of care.

Agreed pathways of care should run seamlessly across the whole system and span whole patient journeys. They should be consistent across all localities, 7 days a week. Local variation due to rurality should not obstruct integration.

There should be smooth transitions between levels of care. Providers should define their transitions as carefully as their core business.

Holistic assessments should be the default in all care settings.

#### 5.1.4 Care by experts

An early expert opinion should be available from senior clinicians in all settings. A principle of right care first time: 'triage – diagnose – treat / palliate' should be the default.

An education, training and workforce review will be required and new roles developed in order to provide expert opinions in all settings 7 days a week.

### 5.1.5 Consistent and consolidated services

A single high acuity emergency centre, providing expert specialist and generalist led services, will provide multiple clinical benefits. It will consolidate resources, improve teamwork and integration, improve quality and safety, allow more effective generalist support in lower acuity settings and provide an economy of scale and high volumes of care to maximise expertise and improve outcomes.

'Some' community based urgent care centres, staffed by expert generalists with easy access to specialist support, will provide services closer to home but at a sufficient scale to ensure consistent, effective and sustainable 'modular' services.

### 5.1.6 Sustainable systems

The 'critical mass' of urgent and emergency care delivered by one emergency centre and 'some' urgent care centres will enhance recruitment and retention of staff.

Continuous monitoring and learning should be embedded to allow service evolution and improvements and to develop predictive forward planning.

Commitment to this model of care should be long term.

## 5.2 Model of Care for Acute and Episodic Care

### 5.2.1 Patient Flows

An internet 'patient portal', available on all platforms, will provide easy, trustworthy and localised information regarding self help, advice and signposting. This will include and integrate health, social and voluntary sector information.

A 'Smart' Single point of telephone access (111) will intelligently triage all requests for urgent care (defined as requests for same day assessment) and signpost patients to the right point of care, including the capacity to make appointments at their GP practice if less urgent, or at one of the urgent care centres. This service will be linked to a live demand and capacity management system to improve patient flow.

As a default, LTC urgent care should be 'planned' as active case management will detect exacerbation at an early stage.

There will be increased signposting to local pharmacies for low level urgent care advice and treatment. Pharmacies will 'cluster' with GP practices and develop closer working relationships.

### 5.2.2 One Emergency Centre

A single, fully equipped and staffed high acuity emergency centre with consolidated technical and professional resources delivering high quality emergency medical care 24hrs 7 days a week. A combination of expert generalists (Acute physicians, COE consultants and new roles etc) and specialists (ED consultants and specialists) will provide early expert opinions at all times. It will serve as a trauma centre with a co-

located critical care unit. Other adjacencies include facilities for ambulatory care and assessment units with multi-disciplinary teams (including mental health) specifically dealing with patients suitable for 0 day length of stay (LOS) pathways (ambulatory care) and <3 day length of stay (LTC and frailty syndromes). There will be also be full and immediately accessible diagnostic facilities, blood bank and pharmacy.

Access will be via 999 ambulance or co-located urgent care centre.

A single emergency centre will improve safety and quality of care and focus resources to improve teamwork. Integration and consolidation of the workforce will promote better working practices both within the unit and in providing support to generalists in lower acuity settings. Improved trust and relationships across different care settings will be embedded through partnership care and rotating / posts, some in new roles designed to promote integrated care and whole system pathways.

### 5.2.3 'Some' Urgent Care Centres

Multiple units provided at 'cluster' GP practice level of 'modular' and consistent design to provide low and medium levels of urgent medical and care input. Some diagnostic facilities and a pharmacy will be available on site. Co-located with a range of mental health, community and voluntary sector services, GP Out of Hours, and in some centres medium acuity beds. Timely expert generalist opinion available 7 days. One Urgent Care Centre (UCC) will be co-located with the Emergency Centre and receive all the 'walk in' patients who will not be able to access the Emergency Centre unless transferred by a clinician from the UCC. Urgent Care Centres will be staffed by a combination of advanced practitioners and GPs from the 'cluster' of practices surrounding it. From a GP practice perspective, urgent care will be provided at cluster level, whilst LTC management and other non urgent work will remain at practice level. Continuity of care at urgent care centres will be achieved through integrated care records, whilst continuity of care for patients with LTCs will be through a named clinician or keyworker (in addition to integrated care records).

### 5.2.4 Partnership Care

Specialist support will be easily and quickly available to support generalists in lower acuity care settings, including urgent care centres. This will be in the context of the development of partnership care across all care settings with a re-definition of generalist and specialist roles to include a greater teaching and learning component to increase generic skills and improve the consistency of care. Communication between professionals will be frequent and direct (not via a third party) which will improve working relationships, feedback and learning. This model is described in more detail in the LTC section.

### 5.2.5 Professional Navigation

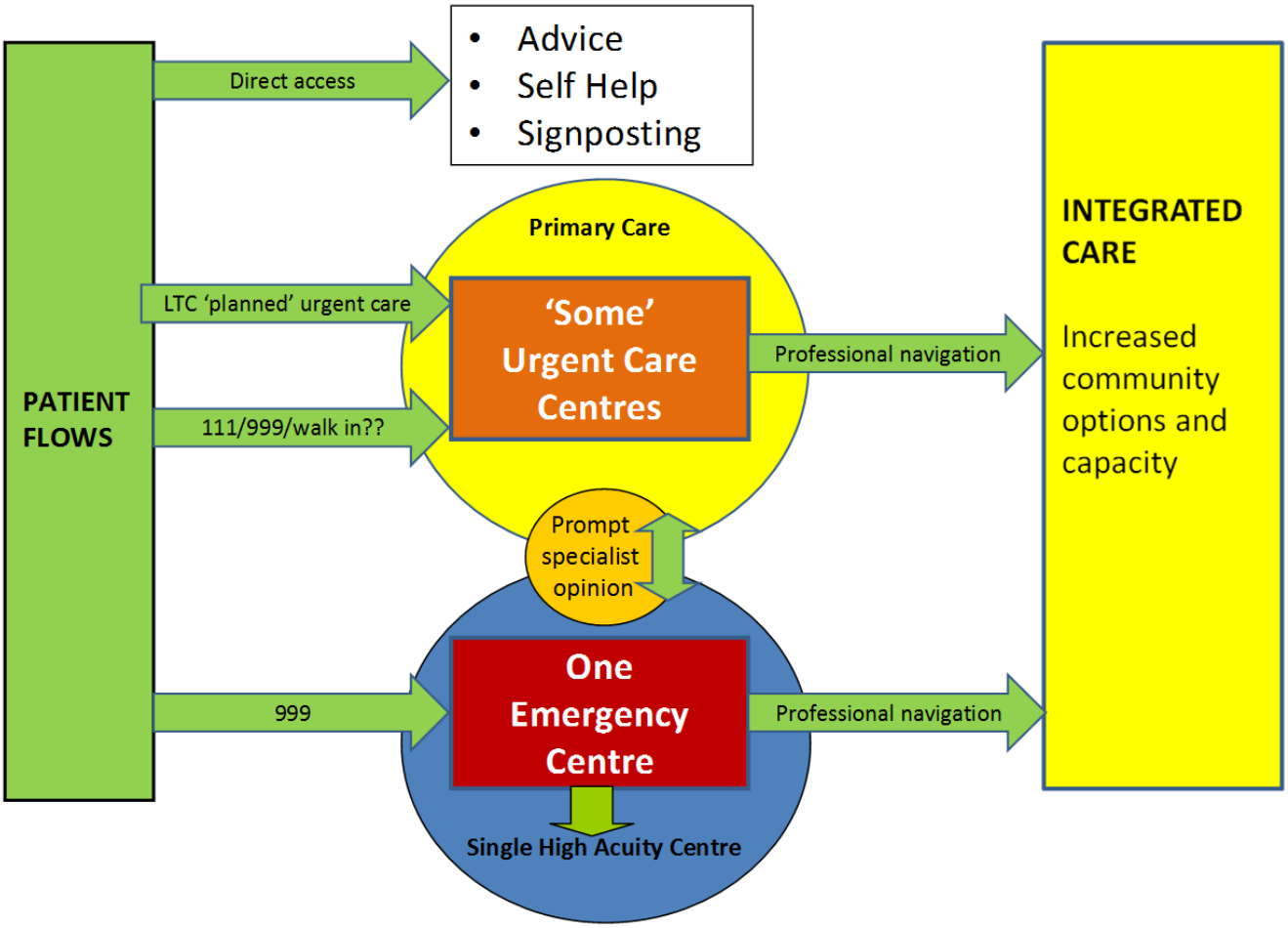
There will be a single point of access (SPA) for professionals to arrange further care and support for patients following their urgent or emergency care contact. This SPA will act as a portal to a wide range of community based integrated care options. For complex care issues, the SPA will initiate contact but care planning will then be finalised through direct conversation between professionals. For simple care issues,

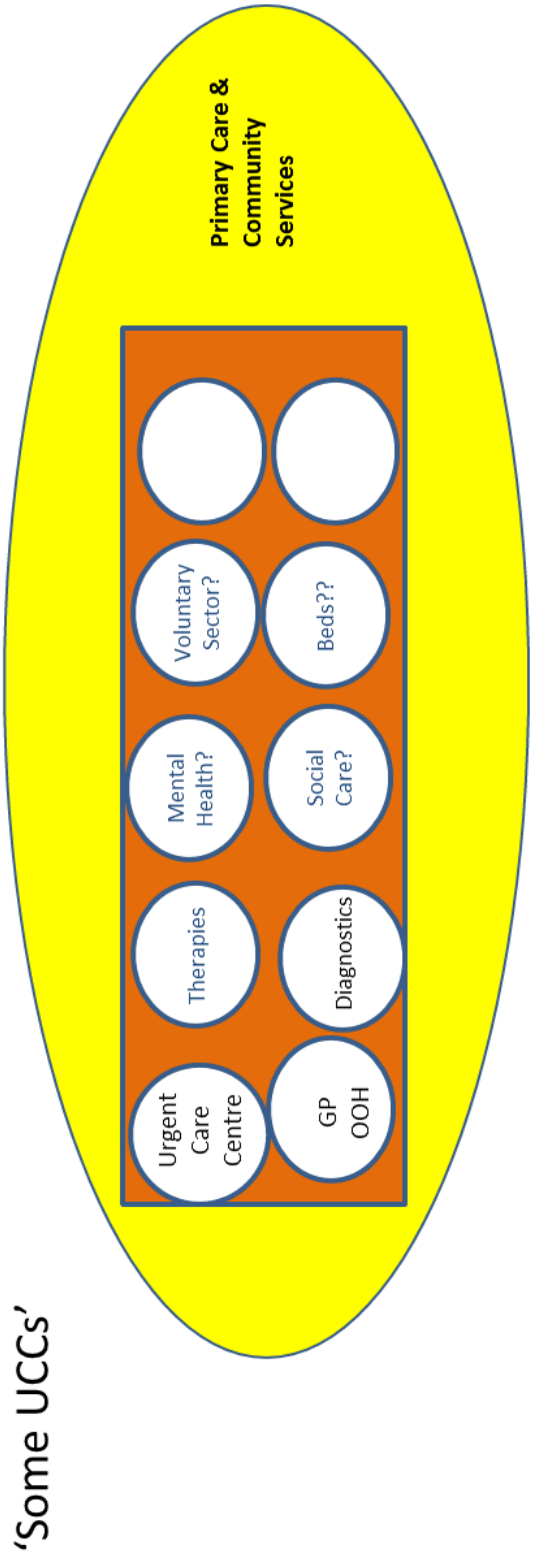
a 'handover' will be managed through the SPA service with integrated care records serving as a valid proxy for continuity of care.

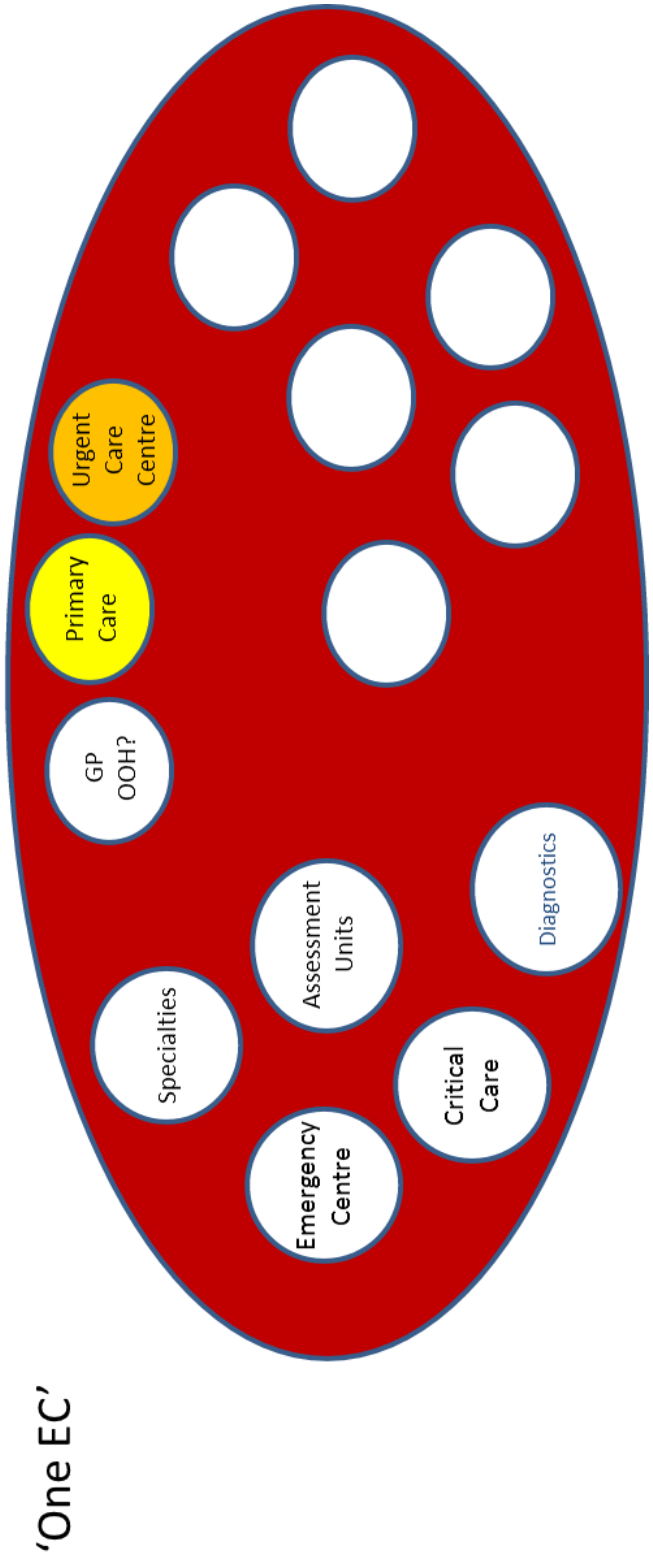
### 5.2.6 Integrated Community Care

Urgent and emergency care will be delivered in the context of whole system integration. Services will be provided by teams around the patient, not by a series of independent professionals working within their own organisations and professional boundaries. Community capacity will be built to keep people at home and out of hospital, deliver reablement in the community, enhance the role and involvement of primary care and consistently deliver the right care in the right place by the right staff. Access to these services will be available from all points of patient contact via the SPA. This is further discussed in the LTC section.

### 5.3 Diagrams of the Acute and Episodic model of care




'Some UCCs'
Primary Care & Community Services
Urgent Care Centre
GP OOH
Therapies
Diagnostics
Mental Health?
Social Care?
Voluntary Sector?
Beds??


'One EC'
Urgent Care Centre
Primary Care
GP OOH?
Specialties
Assessment Units
Diagnostics
Emergency Centre
Critical Care

# 6. Long Term Conditions and Frailty

## 6.1 Key Principles

### 6.1.1 Enable patient responsibility for prevention, self care, maintenance and accessing appropriate care

Enabling patient responsibility should be embedded in all models of care. Although there is mixed evidence of short term impact on admissions and cost, there is an overwhelming case for empowering citizens and communities to be co-responsible for managing their lives and social environment, whatever their health status.

Many long term conditions are preventable and systematic secondary prevention shows improved outcomes. The medium and long term potential for reduction in health and social care demand is great.

Targeted prevention activities in social care have demonstrated impact although there is currently no statutory obligation for Local Authorities to invest in prevention.

Public Health and all other stakeholders must be involved and particular focus is required for hard to reach groups. The prevention agenda should form part of the school curriculum.

Behaviour change, education and support will often be more effective and sustainable if delivered by peers rather than professionals.

Self management of Long Term Conditions is at an early stage of development with little hard evidence as yet to support significant investment. It is the view of the clinicians locally however that it is aligned with the principles of citizen empowerment and community mobilisation as well as the emergence of assistive technology, self care should be a central component of LTC management.

People with co-morbidities and who are frail have less capacity for self management and require a different approach, especially when they are ill. Frailty syndromes are now recognised as an independent risk of worse outcomes and do not fit well into pathway driven care which the patient can be co-responsible for. They require a named key worker or responsible clinician with whom they can share decisions and who can act as their advocate. This is also the case for other vulnerable groups such as people with learning difficulties.

### 6.1.2 Generalist care as a default, with partnership care between generalists and specialists and clearly defined indications for specialist care

Generalists perform holistic assessments as a default and should be available in all care settings. Workforce planning and redesign will increase the number of generalists, many of whom will also develop specialist skills. This includes GPs, community health professionals and acute care clinicians. They will be responsible for initial assessment as well as the co-ordination and continuity of care for the majority of patients.

Specialists will offer timely response to support generalist care. They will assume greater responsibility for education and learning to improve the generic skills of generalists in all care settings. They will continue to be responsible for the care of the most complex patients.

Partnership care between generalists and specialists will become the norm with a more dynamic and greater range of options to share the care of patients through meaningful and direct conversation, interaction and information flow. This will allow the care of a greater proportion of patients to be managed by generalists in a community setting with targeted specialist input when required. Resources must shift to support this.

Partnership care will be developed across the whole health and social economy. The integrated health and social care of a patient will be provided 'in parallel' (not 'in series' as is currently the case) with shared risk management.

Better relationships will allow 'honest feedback' and more effective mutual and case based learning.

Age transitions, especially in mental health and paediatric care are currently a problem which will be resolved when continuity of care is managed by a community generalist working across all age groups.

Integrated care records are a key requirement for partnership care.

### 6.1.3 Provide a better match between needs and levels of care through a systematic shift towards greater care in the community

People prefer to be cared for in their own home whenever possible, even when they are ill.

Too much care is currently provided at levels of care which are higher than patients require to meet their needs. This is not only resource inefficient, but also increases the risk of iatrogenic harm. Up to 30% (?) of people admitted to acute hospitals could be managed safely and effectively in a different care setting and at a lower level of care.

Patients cared for at home remain connected to their family and carers. Community support remains continuous and the patient is less likely to 'decompensate' by being cared for in a bed based acute environment which is also much more stressful. Individualised care can be delivered more easily by integrated teams. The potentially difficult and harmful transitions from home to hospital and back again are removed. Performing an accurate and holistic assessment of needs is much more difficult when a patient is not in their usual living environment.

Home will not be the right place to care for everyone who is ill. Some of course require high levels of care in an acute hospital bed, but other alternatives must be provided that offer a 'medium' level of care.

Community capacity must be built to accommodate this shift. The required shift in resources to achieve this poses a challenge. It is not necessarily cheaper to provide care at home when intensive input is required.

### 6.1.4 Move from reactive to proactive care, including risk stratification, care planning, early detection and intervention and 'planned' urgent care

The evidence base supports the provision of proactive care for a number of specific conditions but does not yet show improved outcomes for people with multiple co-morbidities and frailty. Nevertheless, the new GP contract and local clinician consensus both support a move to providing more proactive care. Clinical experience strongly suggests that it reduces the number and severity of crises and gives reassurance to patients, families and carers that they know what to do and who to contact in the early stages of exacerbation.

There is uncertainty about what percentage of the 'at risk' population would benefit from active case management. It is important not to shift resources into ineffective interventions and targeted proactive care will remain preferable until the evidence base is clearer.

### 6.1.5 Provide timely response to exacerbation and ensure enhanced recovery and rapid reablement with a minimum time spent in acute care settings

Integrated multi-disciplinary teams are needed to address all the issues, both in community and acute settings and care must remain joined up at all times.

An exacerbation related to an existing LTC should not require admission, but may require diagnostics.

Once in hospital, the LTC tends to be ignored in preference to the exacerbation and the patient has an 'asymmetric' experience of their assessment and care because of this. Holistic assessment as a default will address this.

Discharge planning must start at the time of admission, and patients think this should be done by the ward staff caring for them, not a separate team. Provide Estimated Dates of Discharge for all patients soon after admission.

Standardise simple discharge processes and provide bespoke planning for complex discharges.

Employ strategic operational planning to maximise 0 day length of stay (ambulatory care and <3 day length of stay (frailty teams) in acute settings.

'Discharge to assess' as default once medical condition stabilised. Reablement at home where possible and in community setting if not. Aim to return patient to original level of care.

Resolve governance issues around free NHS and assessed social care which currently inhibit integrated care.

#### 6.1.6 Diagnose and plan the last year of life and stop sending people to hospital to die.

Once fully embedded, End of Life (EOL) care will become part of 'the day job' but this will require care co-ordination and equity of care for all terminal conditions. EOL care is currently unstructured and patchily commissioned. To improve this, a consolidated EOL package will provide better care and reduce costs. A roving palliative care team would be effective and cost efficient.

### 6.2 Model of Care for LTC

#### 6.2.1 Prevention

An economy wide prevention strategy driven by a commitment to wellbeing as a primary health, social, economic, political and cultural aim.

Targeted primary prevention across all health and social care settings employing 'make very contact count' and upskilling the workforce in behavioural and motivational change techniques.

Systematic secondary prevention.

#### 6.2.2 Partnership Care

Primary care generalists (mainly GPs) retain continuing responsibility for care and co-ordination with rapid access to specialist support as required.

A menu of options to facilitate timely and personal communication between generalist and specialist to share decisions and improve care planning for patients at all levels of acuity: routine, urgent, emergency and end of life.

Clinical conversations, mutual learning and honest feedback will improve working relationships and the quality of care.

Direct access for generalists to pathway driven diagnostics to reduce unnecessary secondary care referrals.

Specialists will continue to manage and be responsible for the continuing care of a smaller number of the most complex patients, but with a greater responsibility for education and upskilling the generalist workforce.

#### 6.2.3 Self Management and Care Planning

Upscale self management programmes and combine with care planning as a routine for anyone with an LTC.

Active case management for those at high risk, targeted initially to those conditions where benefit is evidenced.

Upscale peer and community support programmes

### 6.2.4 Integrated teams

Integrated multi-disciplinary teams providing case management, timely response to exacerbation and facilitating discharge.

Strong links with primary care, 'teams around the practice' aligned with 'teams around the patient'.

Specialist skills linked to and augmented by integration with acute care specialists.

Sustainability achieved through generic upskilling across professional boundaries, using individual specialist skills as the teaching resource.

Embed continuous learning and review within the teams to ensure maximum effect from integration

### 6.2.5 Increased Levels of Care

Timely and appropriate response to exacerbation through a 'tiered' increase in level of care:

- Low medical input provided by a 'hospital at home service' for minor exacerbations where short term additional care and rehabilitation at home allows the patient to continue living independently. With effective case management and early detection of exacerbation, this level of care will be appropriate for an increasing proportion of people with LTC exacerbations.

- Medium medical input provided in a community setting, but not in the patient's home. 'Step up' higher intensity care and rehabilitation can be combined with more frequent and expert medical input to hasten recovery with the aim of returning to the original level of care. Integration of care in these settings with care provided in acute settings will improve quality and flow.

- High medical input provided in a single high acuity unit with a consolidated and integrated workforce as described in the key principles.

### 6.2.6 Reablement and rehabilitation

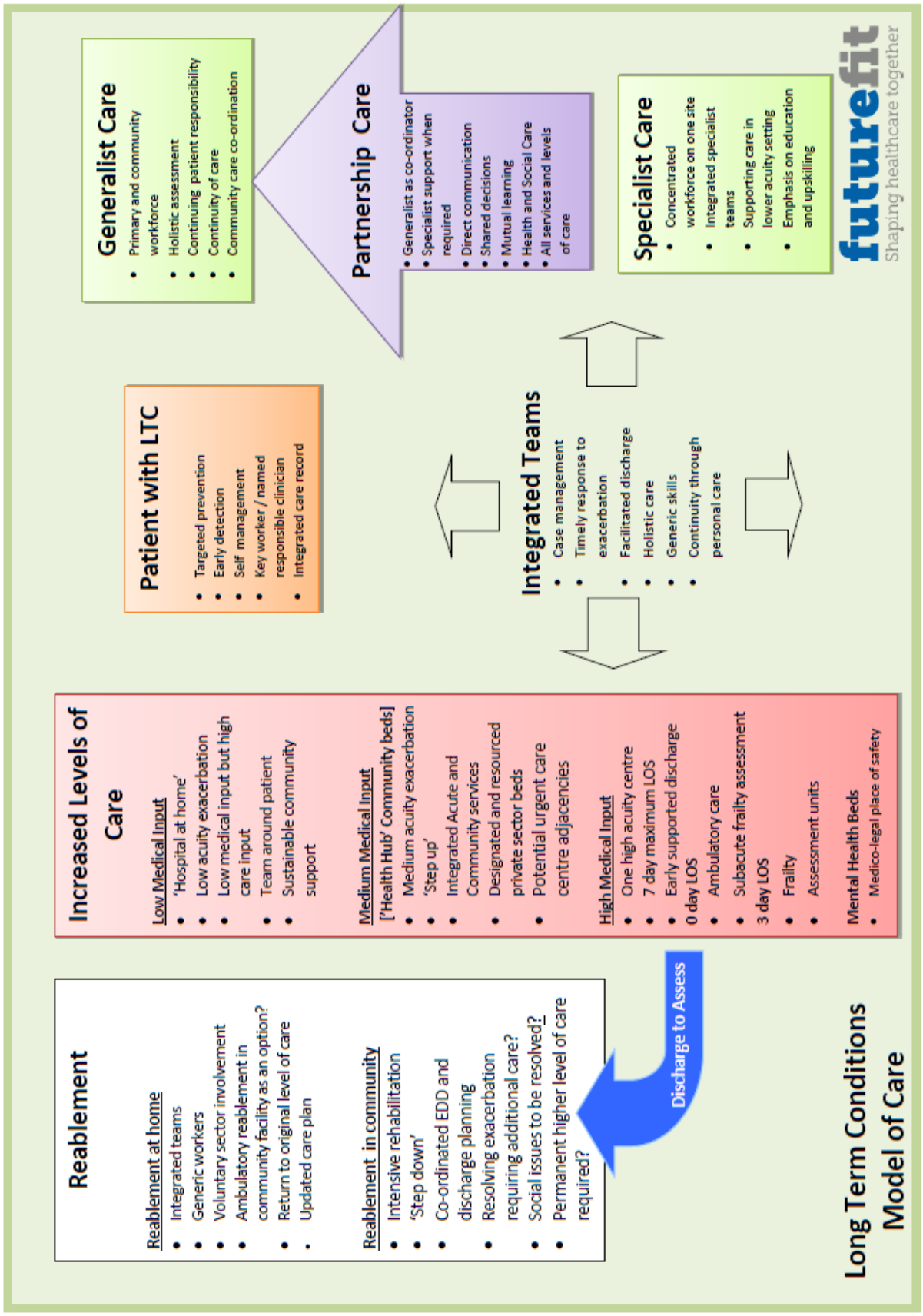
Discharge to assess as the default from acute care settings.

Reablement at home as the preferred option with the aim of a rapid return to the original level of care and the withdrawal of additional care and support.

Reablement in a community setting but not at home for those patients with slow to resolve exacerbations, people who will not return to their original level of care, including those awaiting care home placements. Aligned with 'step up' processes, an EDD and discharge planning will be standard for 'step down', using the same or similar criteria to those employed in acute care settings.

Identify and fill gaps e.g. neuro rehabilitation.

## 6.3 Diagram of the Long Term Conditions model of care



## 7. Planned Care

For the purposes of this report, planned care is defined as care that is non urgent and accessed either directly by the patient or through referral from a generalist to a specialist. LTC management includes much planned care and some urgent care is 'planned' if it is referred to a next day clinic.

### 7.1 Key Principles

#### 7.1.1 Patient empowerment and navigation

The current planned care system is complex, fragmented and difficult to navigate. It disempowers and frustrates patients who then seek professional help to signpost and navigate when this should not be necessary. The initial referral has benefitted from the Referral Assessment Service (RAS) and the Telford Referral and Quality Service (TRAQS) but their roles do not extend beyond making the first appointment.

Patients want easy access to understandable and trustworthy information about self care options and local services to which they can gain direct access, as well as to information that guides them to seek professional help when necessary.

Patients find it understandably hard to distinguish 'want' from 'need' and, although clear information will resolve some of this, they often require professional expertise to distinguish between the two.

Once referred, patients want clear information about what is going to happen next and the timescale they should expect.

Navigation through the planned care system should be patient focused and facilitate self navigation wherever possible

Professional or peer advocacy to assist in navigation should be the exception rather than the rule.

Some patient groups (e.g. people with learning disabilities) should be offered pro-active advocacy.

#### 7.1.2 Pathways

Planned care should be largely pathway driven, with as few stages as possible to minimise error and delay.

Pathways will vary in type and complexity depending on the degree of diagnostic uncertainty and treatment options. Patients should be able to gain access to the simplest 'out of hospital' and diagnostic pathways without the need for a professional referral, whilst the most complex will require expert specialist decision making at an early stage because of diagnostic uncertainty.

### 7.1.3 Partnership care

Aligned with the principles described in acute and LTC care, a richer and more dynamic conversation between referring generalist and specialist will result in higher quality referrals, better outcomes and mutual learning.

### 7.1.4 Levels of care

In planned care, this is about 'who does what where?' There is a compelling evidence base for a tiered arrangement of treatment centres, with the most complex and risky surgery being performed in a site co-located with a critical care unit, but the majority not requiring this. Separate treatment centres for routine surgery can also benefit from being designed and delivered through a different business model.

There is a 'critical mass' issue to consider when planning the number of treatment centres. For minor surgery, this is less of an issue, although the skill of the operator still influences the outcome, whereas for intermediate treatment centres outcomes are influenced by volumes – the larger the number, generally the better the result.

## 7.2 Model of care

### 7.2.1 Patient portal

Facilitated self management through a web based patient portal which provides trustworthy localised information about common conditions, when to seek professional help, options for self management and direct access to simple therapies and diagnostics

### 7.2.2 Pathways

Systematic design, approval and implementation of whole system pathways driving the majority of planned care. A tiered model:

- patient self referral and self management
- diagnosis or symptom complex known with direct GP / generalist access to the pathway
- diagnosis or symptom complex unknown requiring expert specialist decision making early in the pathway.

Reduce stages in all pathways to improve quality and safety and reduce errors. 'Optimise' patients prior to referral as a routine. Referral made by most appropriate professional (e.g. could be physio for arthroplasty). Patient choice expressed at time of referral assisted by navigator and / or Patient Recorded Outcome Measures (PROMS) data. Eliminate duplicated diagnostics. Provide expert opinion at first out patient appointment, preferably from the surgeon who will be performing the procedure. Date of surgery agreed immediately after first out patient appointment. Single multi-disciplinary pre-op assessment to include anaesthetist, physio and social worker. Admit on day of surgery. Enhanced recovery with the shortest possible LOS. Out patient follow up in the community as appropriate.

### 7.2.3 Navigation

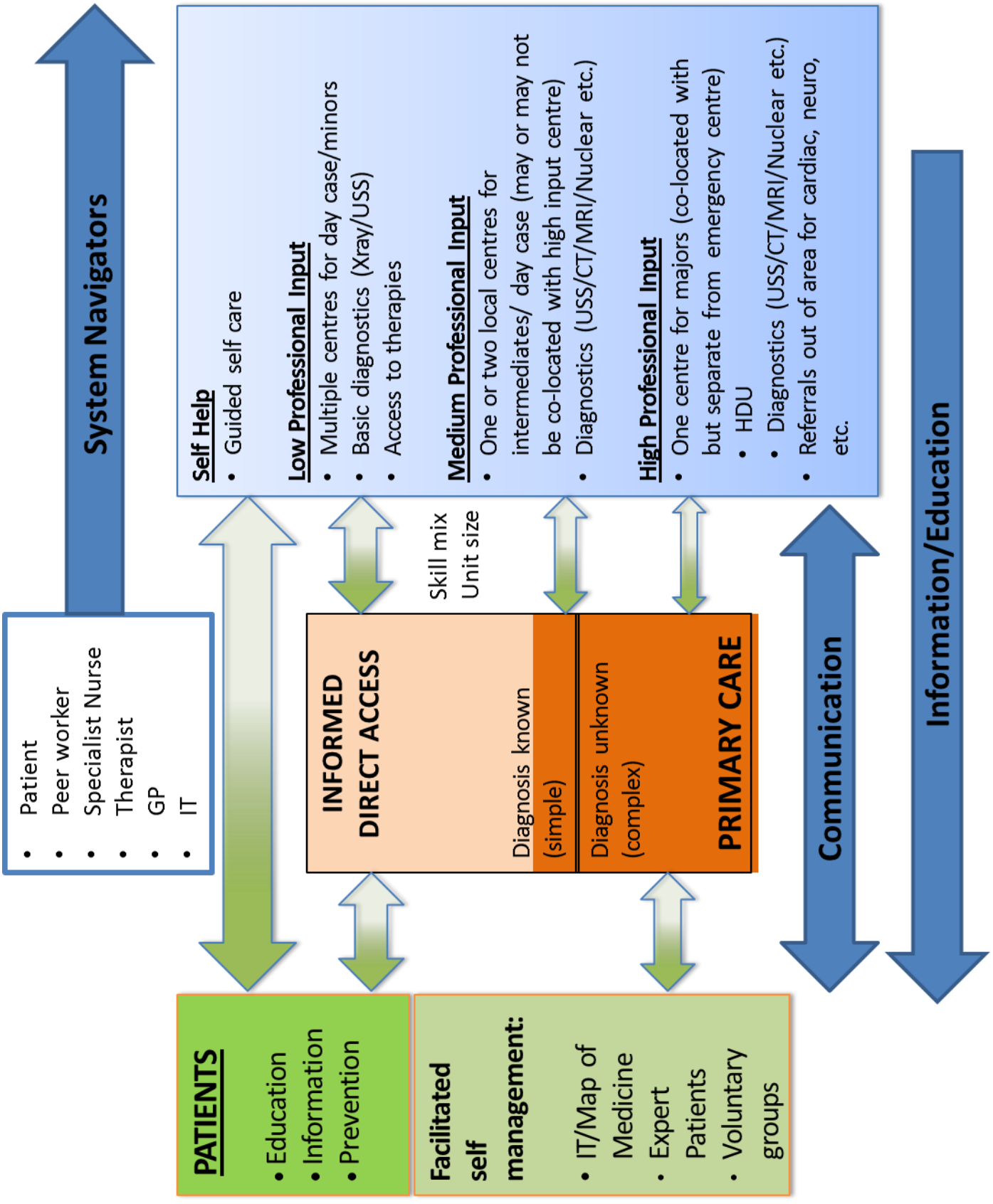
A simpler planned care system requires less navigation. Patients should have access to updated information about their stage of the planned care journey and be able to self navigate as a default. Some advocacy will be required which the RAS and TRACS teams may be able to provide. In more complex and serious situations, or when a patient has special needs, then a navigator / advocate will be required. This could be a peer group volunteer, specialist nurse, therapist, GP or other professional.

### 7.2.4 Levels of Care

Three tiers of treatment:

- Low professional input. Multiple centres for day case / minors, basic diagnostics and access to therapies
- Medium professional input. One or two centres for intermediates / day case. Beds available for low / medium risk orthopaedics. May or may not be co-located with high input centre. Advanced diagnostics (USS/CT/MRI/Nuclear etc)
- High professional input. One centre for majors, co-located but operating separately from single emergency centre. Co-located HDU. Advanced diagnostics. Potential for repatriation of elements, at least, of out of area specialist surgery (e.g. cardiac, neuro). Whilst it is appropriate that some work goes to specialist tertiary centres, there is opportunity to develop shared care models in which a concentrated local centre might provide pre- and post-operative care.

**7.3 Diagram of Planned Care model of care.**



## 8. Cross Cutting Themes

A number of important cross cutting themes have emerged in all the clinical meetings thus far. The following is a summary of discussion from different clinical meetings.

### 8.1 Embedding compassion and healthy relationships

Although compassionate care requires the right attitude, this must be translated into action and supported in system design and team working practices. Every member of a team must have clearly understood roles and responsibilities, especially when working within complex systems and environments. However, over-definition of roles, especially when restricted to one care setting, can prevent professionals 'going the extra mile' to ensure compassionate care and seamless patient journeys.

Named key workers or responsible clinicians will improve co-ordination of care for vulnerable people.

Values based recruitment will become the norm and compassionate attitudes, behaviours and relationships will be more visible throughout the whole organisation.

### 8.2 Rural and Urban solutions

The problems of providing equality of access and quality of care to rural populations will be partially mitigated by achieving greater care in the community. Care provided by teams around the patient with home as the default can be provided equitably in both urban and rural settings. Access to services that require travel clearly require better transport solutions, but there is also a balance to be achieved between the advantages of providing truly local services for all levels of care and the better outcomes and reduced cost of providing care at larger scale in fewer units.

### 8.3 Workforce issues

Many parts of the health and social care workforce are in crisis. A full workforce review and plan is required as part of, or alongside the FutureFit programme in order to resolve this. 7 day working is a requirement across the whole system and brings additional workforce challenges.

Local clinicians expressed some strong views about potential components of the solution:

- Consolidate services to make posts more attractive by improving the quality of work, gaining more experience working in larger units, offering better rotations through fully staffed co-located departments and services, all in an improved working environment.

- Fill medical rotas to fit the available workforce and fill the gaps with new roles (Advanced practitioner, Emergency Nurse Practitioner, Physicians assistant etc.).

- Prototype and implement rotating (and split) posts through different care settings to improve mutual learning, understanding and trust, provide better risk management, encourage better use of shared protocols, pathways, training opportunities and shared documentation and improve consistency and quality of care through generic upskilling.

- Improve recruitment and retention of staff through more effective succession planning and better role development and CPD

- Gain academic status by establishing an economy wide link to university and other education and training programmes to attract people to come to Shropshire to train and work.

**8.4 Co-ordination, integrated and consistency across the whole system**

There is universal agreement that improving the co-ordination, integration and consistency of care delivered across the whole economy is a necessary precondition for achieving sustainable improvements in quality and safety. The will to do this is evident; it is the barriers to it that require systematic identification and removal. These include a fragmented organisational structure, multiple incompatible IT systems, 'old fashioned' commissioning mechanisms and an overwhelming administrative burden. Where any pathway components are supplied under the 'Any Qualified Provider' system or through private sector tendering, these will need to be commissioned in a way which supports improved integration.

'Siloed' care does not incentivise clinicians to 'go the extra mile', and professionals are increasingly reluctant to fill gaps in care if it is not within their defined role. Clinicians should have more control over appointment systems.

**8.5 Delivering effective high quality care with no extra money**

Financial austerity is one of the key drivers for radical change. There is a need to move beyond organisational interests so that funding follows the patient. Pragmatism is required to find the 'key enablers' of change to concentrate our limited resources.

Currently, the status quo is incentivised with the need for organisations to show a surplus contributing to this.

'Disruptive' change is required to overcome the NIMBY (not in my backyard) problem.

From the clinical perspective, there was a clear case for unifying health and social care funding and to integrate acute and community care.

### 8.6 Social Care

Health and social care are clearly interdependent and should be designed to reflect this. There is currently an anomaly which makes closer integration difficult in that social care is means tested whilst health care is always free. To achieve integrated working, health and social care should run parallel and share risk, not run in series as is mostly the case at the moment. No-one enters the social care system without a health problem and currently both systems focus on those most in need and pay much less attention to prevention and self care. Although there is no statutory obligation for Local Authorities to invest in prevention, there was a clear consensus that health and social care must tackle prevention, education and patient empowerment to increase self reliance together. The Better Care Fund is a potential vehicle for this, but concern was expressed that, because its not new money, the opportunity would be missed.

The financial challenge in social care provision attracted specific comment and some suggestions to mitigate its effect were made:

- Increase community and carer input
- ensure more patients return to the same rather than a higher level of care
- manage patient and public expectations
- provide more education and information about options
- incorporate the voluntary sector as a core component of care provision
- implement the models of care described in this report which deliver timely response and intervention, enhanced recovery, early supported discharge and reablement

### 8.7 Mental Health

There was unanimous agreement that mental health should be integrated with primary, community and acute health care. The models of care described in the three main areas of Acute, LTC and Planned Care were all contributed to by mental health professionals and further detailing will demonstrate more clearly the potential for closer integration.

Partnership care in particular was felt to be a model which was equally applicable to mental health services. Psychological management of all LTCs should be ‘part of the day job’ and, within the context of partnership care, mental health specialists should have a greater role in education and upskilling of generalists. Young people have particularly stressed the need for support for problems with stress and self harm.

The RAID model of liaison in the acute sector was felt to be a good one, but it needed further development, especially in regard to education and training (the RAID effect)

### 8.8 Children

This area needs further exploration, but initial comments are: there is a lack of psychological and family support. There are big gaps, such as Autism (now 1:80) and age transitions. Obesity is not being systematically tackled. GPs and others are become more and more risk averse around children, Paediatric training for GPs should be mandatory. Partnership care is an excellent model for Paediatrics.

### 8.9 Therapeutics

Clinicians recognised that a whole system and strategic approach to therapeutics was required and that the importance of this was mostly under-estimated. Community pharmacies are not clustered with GP practices and do not have a defined working relationship with them. Community pharmacies can take a bigger role in minor urgent care and also in routine / repeat prescribing. They would need access to integrated care records to do this. Their impact in minor urgent care would be increased if some OTC medicines were free to stop unnecessary diversion to GPs. All pharmacies should have consistent and longer opening hours. In the acute sector, everyone should have a medication review <24hrs after admission. Evidence that if they are on 4 or more meds then 2 need changing due to acute presentation. These reviews should also apply to lower risk groups – often only the highest risk patients get them. More work with patients at home (e.g. the HARMS scheme) would add value (hoarding, poor compliance etc). There are too many admissions for technical therapeutics which could be done at home or in a community setting. There is little co-ordination of medication across care settings, dressings are a particular example.

## 9. Whole system synergies

There are a number of key principles and components of models of care which were repeated in slightly different but synergistic forms across all three care areas:

| Reablement | Increased Levels of Care for LTC | Levels of Care Planned care | Acute and Episodic Care |
|---|---|---|---|
| **Reablement at home**<br>• Integrated teams<br>• Generic workers<br>• Voluntary sector involvement<br>• Ambulatory reablement in community facility as an option?<br>• Return to original level of care<br>• Updated care plan | **Low Medical Input**<br>• 'Hospital at home'<br>• Low acuity exacerbation<br>• Low medical input but high care input<br>• Team around patient<br>• Sustainable community support | **Low Professional Input**<br>•Multiple centres for day case/minors<br>•Basic diagnostics (Xray/USS)<br>•Access to therapies | |
| **Reablement in community**<br>• Intensive rehabilitation<br>• 'Step down'<br>• Co-ordinated EDD and discharge planning<br>• Resolving exacerbation requiring additional care?<br>• Social issues to be resolved?<br>• Permanent higher level of care required? | **Medium Medical Input**<br>**['Health Hub' Community beds]**<br>• Medium acuity exacerbation<br>• 'Step up'<br>• Integrated Acute and Community services<br>• Designated and resourced private sector beds<br>• Potential urgent care centre adjacencies | **Medium Professional Input**<br>•One or two local centres for intermediates/ day case (may or may not be co-located with high input centre)<br>•Diagnostics (USS/CT/MRI/Nuclear etc.) | 'Some' Urgent Care Centres |
| | **High Medical Input**<br>• One high acuity centre<br>• 7 day maximum LOS<br>• Early supported discharge<br>**0 day LOS**<br>• Ambulatory care<br>• Subacute frailty assessment<br>**3 day LOS**<br>• Frailty<br>• Assessment units<br>**Mental Health Beds**<br>• Medico-legal place of safety | **High Professional Input**<br>•One centre for majors (co-located with but separate from emergency centre)<br>• HDU<br>• Diagnostics (USS/CT/MRI/Nuclear etc.)<br>•Referrals out of area for cardiac, neuro, etc. | One Emergency Centre |

| | Acute Care | LTC / Frailty | Planned Care |
|---|---|---|---|
| **Prevention** | Make every contact count | Targeted prevention | Information / Self care |
| | Whole economy long term strategic prevention programme | | |
| **Patient Empowerment** | Access to reliable info about signposting and self care. | Self management. Care and EOL plans with shared decisions. | Access to reliable info re self care, local services and direct access |
| **Advocacy and Continuity** | Integrated care record | Key worker | Pathway navigation |
| **Partnership Care** | Timely specialist support to generalist in Urgent Care Centre | GP led care with specialist support and education | Tiered pathway driven care with GP and specialist at defined points. Feedback and education as the norm |
| **Levels of Care** (see diagram) | One Emergency Centre 'Some' Urgent Care Centres | Low, medium and high medical input care settings | Low, medium and high professional input care settings for procedures |
| **Integrated Teams** | SPA to access integrated community services | Integrated multi-disciplinary teams | Teams integrated around service |

## 10. Next Steps

This report details the output of the Clinical Design workstream over the first 3 months of its activity. The models of care are emerging but are still at a high level.

A process of refinement will continue through a number of cycles where they will be repeatedly tested using patient scenarios, patient characteristics and flow volumes and financial impact.

A further detailed review of the evidence base around each component of the model will be undertaken.

External clinical assurance will be sought from an expert clinical team overseen by the West Midlands Clinical Senate.

Clinical engagement will be deepened, both by continuing involvement of the clinicians in the clinical reference group and subgroups, and through events, such as

webinars and meetings, designed to reach 2/3 of the clinical workforce of Shropshire and Telford & Wrekin.

Patient representatives and patient groups will continue to be involved and co-creating at every stage of the process.