

APPLICATION FOR PROJECT APPROVAL FOR INTEGRATED CARE ORGANISATION

Section I

1. DURHAM DALES CLUSTER INTEGRATED CARE ORGANISATION

We will deliver a Primary Care-led Integrated Care Organisation.

The Durham Dales PBC Cluster exists to determine the health needs of the local population and commission those services that best address those needs. Part of the development of our commissioning intentions and the service delivery will be via this ICO. There is a need for all commissioning processes to be transparent and services will be assessed against agreed specifications and procured in an open and contestable framework.

We will operate a managed network of care and our partners are listed below:

Providers/Partners

1. Durham Dales Practice Based Commissioning Cluster
2. Durham County Council (Social Services Provider)
3. County Durham & Darlington Foundation Trust (Secondary Care Provider)
4. Tees, Esk & Wear Valley (Mental Health Trust Provider)
5. County Durham and Darlington Community Health Services hosted by NHS Darlington
6. North East Ambulance Services

Commissioning Organisation

This Integrated Care Organisation is supported by NHS County Durham PCT.

The Outcomes we expect to deliver through this pilot will be as follows:

1. PREVENTION OF DISEASE

- Through vascular screening, obesity management and early detection of diabetes
- Through our fuel poverty initiative

2. REDUCED EMERGENCY ADMISSIONS AND A&E ATTENDANCES

- GP front-ended Acute Hospital
- An Integrated Emergency Care Directorate
- Development of a GP-run ward at our local hospital

3. IMPROVED ACCESS FOR PATIENTS

- Increasing the number of services in GP surgeries
- Increasing the number of services in our Community Hospitals
- Improved rural transport

4. REDUCTION IN HEALTH INEQUALITIES

- We will be involved in the Regional Rural Health Strategy and apply it to Teesdale and Weardale
- We will focus on our areas of high deprivation in Wear Valley

- We will reduce health inequalities through the areas listed above, but, in particular, our focus on vascular screening
- We will reduce the winter deaths index through our fuel poverty scheme
- We will improve transport in our rural areas through the development of Community Hospital and GP surgeries
- Through better management of long term conditions in our general practices

5. **GREATER PATIENT INVOLVEMENT**

- Patient participation group in each of our general practices
- We will improve consultation with patients on service development and in the quality assessment of our services locally

6. **MORE COST-EFFECTIVE SERVICES**

- Reducing A&E attendances
- Reducing emergency admissions
- Development of Community Hospital tariff
- Reduced costs associated with services delivered in our general practices

2. **Signed statement of endorsement by the Commissioning PCT Chief Executive and Local Authority Chief Executive if applicable**

NHS County Durham is a large geographical area covering 500,000 population and has high levels of deprivation, poor health and a large rural area. This proposal allows for local developments in the highly rural area of the County to consider how health improvements could be accelerated. NHS County Durham has a joint initiative with Durham University to research the effectiveness of commissioning. In addition to any Department of Health audits this scheme will be subject to an audit via our local arrangements.

NHS North east has established a rural health commission to consider health and related determinants as there are many rural areas. The work of the ICO will feed into the SHA's Rural Health Commission.

NHS County Durham is very keen to pilot new innovations and sees this scheme as an ideal way for the local providers to

The ICO will continue to sit within the commissioning governance arrangements of NHS County Durham so all new services will need to be considered through the agreed contestability framework to ensure fair and open competition.

Please see attached Statements of Commitment from Yasmin Chaudhry and George Garlick.

3. **The names, titles and organisations of the clinical/social professional leaders sponsoring the demonstrator system and a statement of commitment by them**

Please see attached the list of Clinical Leaders and Statements of Commitment from their Chief Executives. Please also see attached email from our local Acute Care Consultants expressing their desire to work with Primary Care.

- Stewart Findlay, PBC Chair Durham Dales PCT
- Robert Aitken, Medical Director, County Durham & Darlington Foundation Trust

- Chris Fisher, Medical Director, Mental Health Trust
- Will Richardson, Medical Director of the Community Trust
- Hilton Dixon, Medical Director, NHS County Durham

4. The size and location of the total target population including names, addresses and list sizes of each of the component Medical Service Providers with whom they are registered

The target population is that registered with the 12 Practices of the Durham Dales PBC Cluster in County Durham and is currently approximately 90,000 which is identified as the ideal size for an ICO. The area includes the urban population around the town of Bishop Auckland, several smaller towns in the Wear Valley, Weardale and Teesdale and the area extends from an eastern boundary of Willington in the north to Gainford in the south, and westwards through Barnard Castle to Middleton-in-Teesdale (southern boundary) and Wearhead (northern boundary).

Practice	Approximate List Size
Bishopgate Medical Centre	13,500
Station View Medical Centre	10,000
Auckland Medical Group	12,791
Willington Medical Group	9,100
The Weardale Practice	7,400
North House Surgery	13,582
Gainford Surgery	3,274
Barnard Castle Surgery	10,432
Cockfield Surgery	2,500
Pinfold Medical Practice	3,000
Evenwood Surgery	2,000
Middleton-In-Teesdale Surgery	2,859

5. The proposed start date if successful

1st April 2009.

6. Description of pilot governance and project management arrangements.

Governance arrangements are already well established in all of the contributing organisations however a joint approach will be required in order to specify and test the information governance issues resulting from sharing patient / client based records in the partner organisations. The Project Board will operate within an agreed governance framework. This will specify role and responsibilities of each individual organisation.

Mechanisms will be established in accordance with Caldicott Guardian requirements and each organisations Data Protection registration will be reviewed to ensure that all processes are fully compliant with each of the Principles of Data Protection.

We will undertake an integrated risk assessment of all dimensions of the project and will adopt the PCTs risk management policies. Risk mitigation and contingency planning will be carried out.

Any new information systems will be compliant with National requirements and their use will be based on identified best practice. Advice will be assured by involvement of senior staff from the Information Departments of all organisations with a specific Information panel being part of the Project structure.

Project management will use the PRINCE methodology requiring a Project Board and Technical, User and Business teams. Detailed Scope and Terms of Reference will be established by the Board and the project will be managed against a milestone based plan with full project review at each agreed major milestone stage.

7. Outline of costs sought through the support grant to fund pilot support. NB Full award of costs sought cannot be guaranteed

Annual Funding required is:

Project Lead (Band 8A)	53,878 (incl on costs)
Project Support Officer (Band 7)	46,406 (incl on costs)
Clinical Backfill	59,520
Admin Backfill	8,660

(Clinical backfill estimated as two GP sessions per month for each of eight key areas of project)

(Admin backfill estimated as one Practice Manager (or equivalent) session per month for each of eight key areas of project)

Annual requirement	168,464
Project Cost (three years)	505,392

Section II

The applicants should set out statements of no more than 250 words in respect of each of the following essential selection criteria (further evidence may be appended if thought necessary):

2. Senior relationships in the system

Each of the involved parties will specify a lead manager who will be the organisation's representative on the Project Board. The Project Board member will Report to the Project Manager within the project, and to the professional lead specified above (Section I/3) within his/her organisation.

3. Statement on clinical leadership arrangements and protected time

The project will be led by Dr Stewart Findlay who is currently the Chair of the Durham Dales Practice Based Commissioning Cluster. The Integrated Care Organisation is the highest priority project for the Cluster over the next three years. The PCT currently fund the PBC Chair for four clinical sessions per week. One clinical session per week will be devoted to working on the ICO. There will be a monthly meeting of the Board. Each partner organisation will provide a manager and a clinician to those meetings and we intend to fund clinical expertise on an ad hoc basis, or to look at specific aspects of our project. The Clinical Leads would be the Medical Directors of each of our partner organisations. The Clinical leads for the PBC Cluster will be the PBC Chair and we already have identified lead GPs from each of our general practices, and they already meet on a monthly basis. Again, a standing item on our Board meetings would be the progress of the ICO.

Summary of Clinical Leaders:

- Stewart Findlay, PBC Chair Durham Dales PCT
- Robert Aitken, Medical Director, County Durham & Darlington Foundation Trust
- Christ Fisher, Medical Director, Mental Health Trust
- Will Richardson, Medical Director, Community Trust

4. Statement on financial viability of the organisations making up the demonstrator system

All participating organisations are publicly funded and viable financially. The project does not propose any changes to funding streams or establishment of new funding pools so there is minimal financial risk associated with this proposal.

5. Statement on financial viability of the commissioning PCT(s) and Local Authority if appropriate

All participating organisations are publicly funded and viable financially. The project does not propose any changes to funding streams or establishment of new funding pools so there is minimal financial risk associated with this proposal

6. The PCT's commissioning of Medical Services: self assessment of progress against the world class commissioning competencies

The PCT commissions medical services via GMS and PMS contracts across County Durham. It also commissions medical services on behalf of Darlington PCT. This totals 86 practices.

The following is a self-assessment undertaken by the boards of NHS County Durham and Darlington PCT and is subject to verification by the world class commissioning assurance process:

1	locally leading the NHS	2
2	engaging with partners	2
3	engaging with the public	2
4	engaging with clinicians	1
5	assessing needs	3
6	prioritisation	1
7	stimulating the market	1
8	innovation	2
9	procurement skills	1
10	managing the local system	2

7. Local track record of innovation.

The 12 practices in the Durham Dales have worked closely together initially as a locality then as a Primary Care group and finally as a stand-alone Primary Care Trust and we continue to exist as a Practice Based Commissioning Cluster. Our innovations include the development of a standard IT system across the locality and we were one of the first areas

in the country to do so. For many years now, all of our general practices have been paperless in the GP consultation, we have allowed our community nurses access to our IT systems and we have made full use of electronic path lab results and requesting of laboratory tests.

In conjunction with a neighbouring locality we set up one of the early Out Of Hours GP cooperatives and we were one of the first cooperatives in the country to introduce patient transport to bring patients into our Urgent Care Centre. We were one of the first localities in the country to bring Specialist Nurses in to every general practice to run secondary prevention clinics for cardiovascular disease and to look after patients with heart failure. Our service was described by Roger Boyle as the Gold Standard to which all other areas should aspire.

More recently, we actually involved all of our practices in beginning to look at the Primary Prevention of cardiovascular disease and this predated the Department of Health launch of their "Putting Prevention First" initiative.

We also developed, in the Durham Dales Cluster, the concept of a Quality Contract with our Acute Provider, our Community Provider and with our Mental Health Trust. This has allowed closer working between us and our provider colleagues and, again, this idea predated the Foundation Trust Standard Contract from the Department of Health. In the early days of Choose & Book, we were the only PCT that managed to hit the initial Choose & Book target.

Thus we can demonstrate a commitment to innovation in service development.

8. Section 242 of Health Act 2006: current position on consultation about the pilot services and plans

All consultative processes will be based on the guidance contained in "Real Involvement" in fulfilling Statutory requirements and ensuring good practice.

The project will endeavour to gather and act on the views of users, including those who are 'easy to overlook'. We will seek to develop innovative methods for user engagement, working closely with both local councils and community representatives to ensure an open and collaborative approach.

This will be applied throughout the period of the Project and will be fully integrated into the PCT's broader programme of consultation across the County. The findings of existing consultative processes e.g., those informing the "Seizing the Future" plans of the acute hospital trust will be taken into consideration, and the projects aims will be included in any consultations carried out by any of the partner organisations.

National and local policy drivers to be considered within the proposal include:

LOCAL:

- NHS County Durham Integrated Involvement and Communications Strategy (soon to be signed off by the NHS County Durham Board)

NATIONAL:

- Local Government and Public Involvement in Health Act 2007
- 'Real People, Real Power'
- NICE 'Community Engagement to Improve Health' guidance
- World Class Commissioning Competencies

9. Statement of commitment and goals for the reduction of inequalities

We aim to improve the informal collaborative links between Health and Social services by developing a structured framework of joint working between the Local Authority and the Healthcare providers. This will include the development of shared information and intelligence which will enable patient / client centred care planning to provide seamless delivery. Shared information will assist in identifying at risk and vulnerable groups and improve intelligence databases of all organisations.

We will explore and pilot single point of access to combinations of services eg District Nursing / Social Worker / Therapy staff in order to simplify access to, and promote faster delivery of services to the population.

The aim of the project is to ensure that all patients within the area covered by the Durham Dales Cluster are able to access all Primary and Secondary healthcare services and Local Authority Social Services without undue difficulties. Our aim is to make sure that patients are offered choice of locally-based services, as well as a choice to go elsewhere for specialist care. We would like to make sure that our local services are as good as those provided anywhere else in our region and that they will be offered to our patients regardless of their age, culture, location or social economic status. The model proposed will be used to see how services can be improved and if successful they will be extended elsewhere across County Durham.

In the Durham Dales, we have areas of significant deprivation and we also have the problem of being one of the most rural areas in England. Understanding and challenging our local health inequalities is central to our application to be a pilot ICO

There is likelihood of a hospital reorganisation with possible major changes in the way Secondary Care is provided. The proposals being considered are in line with NHS County Durham's direction of travel to move care closer to the patient and will be sufficiently flexible to take into account any future changes in how health care is delivered. We are very keen to work proactively with our Foundation Trust and with other organisations to move patient care closer to the patient's home, in line with existing national, regional and local strategies, where appropriate, and are looking for ways to make sure that there is a seamless delivery of services across Community, Primary and Secondary Care. Our aim is to put patients at the centre of their care. We intend to make sure that they have access to high quality services as near to their homes as possible, but we also intend to see a market developed to allow them more local choice.

10. Statement of commitment and explanation of how to uphold the national patient choice offer and to exceed it with choice of treatment options within a provider

We will adhere to DH guidance regarding vertical integration and ensure patients are offered free choice of provider for all services.

The proposed integrated organisation will require all providers to operate within the National guidelines and be available via the Choose and Book system. This will be a mandatory requirement in all service specifications developed by the PCT and will be included in the Any Willing Provider option for commissioning. Cluster commissioning intentions will include sections on patient choice and patient surveys for any aspect of service quality assessment will include standard questions to ensure that patients are aware that choice should be available to them and that it has been explained and offered to them at the time of referral.

We intend to work with our Provider Organisations to make sure that patients have a choice of services within a Secondary Care facility but also Secondary Care services provided by the partner Trust in, either our Community Hospitals, our GP surgeries or, potentially, other locations close to our patients. This will be audited through patient surveys to ensure that the choice offer is both made and considered by patients.

11. Evidence of improved patient outcomes and experiences

The priorities for the ICO have been informed by triangulation of the following forms of patient experience intelligence:

- Feedback from quarterly Big Conversation (a NHS County Durham initiative to improve public engagement) involvement events
- Results from the PCT Patient Survey
- Issues raised by dedicated mental health and carers' involvement groups
- Themes from involvement activity around rural ambulance service changes
- Emerging themes from consultation on 'Seizing the Future' proposed and hospital service changes.

Patient experience measures will broadly focus on the satisfaction of timely and seamless care, personalised and patient-focused services and service accessibility and choice. Particular patient experience metrics will be developed for each ICO element in *partnership* with service users. This will be done through one of the following engagement mechanisms. Those marked with a P are planned mechanisms.

- GP practice patient forums
- Young people's participation groups
- Service user groups
- Citizens panels
- Local Involvement Network (LINK)
- Community partnerships
- Virtual rural health form (P)
- Online involvement forum (P)

Minority groups including travellers, carers, mental health service users and patients with physical and/or learning disabilities will be active partners in the development of performance measures.

Patient experience measures will be built into service specifications for the ICO. Monitoring against these will utilise a range of mechanisms, each pertinent to the ICO element. Mechanisms include:

- Ulysses integrated knowledge management system (P)
- Traditional patient surveys
- Viewpoint electronic feedback system
- Patient interviews
- Patient diaries
- Service user focus groups

Feedback will be reported to the service providers and PBC Board on a quarterly basis to facilitate ongoing improvements in service delivery.

12. Summary of Equalities Impact Assessment of proposal

A brief impact assessment has been undertaken on the initial programme proposal. It is expected that as the programme is implemented, detailed impact assessments will be undertaken on each element during the planning stage by a named public health professional who will work with the project team.

Initial scoping recognises that the proposal has taken account of:

- The known health inequalities in the Durham Dales area
- The challenges presented by a rural population in relation to transport and access issues
- The health impact of fuel poverty and the importance of addressing this
- The importance of early intervention and primary prevention
- The importance of improving methods for involving and contacting “hard to reach” sections of the population
- Opportunities to develop more local services e.g., GP ward in Bishop Auckland General Hospital, Integrated Emergency Care Directorate as a result of proposed changes by the Foundation Trust and also to improve services at the two community hospitals
- Increased opportunities to develop self care
- Developing robust patient and carer involvement methods
- The need to develop more local mental health services, both increased access to psychological therapies and services for diagnosing and treating dementia.

This initial scoping suggests that the proposal if implemented will seek to reduce health inequalities in the Durham Dales area. Further impact assessments using a recognised toolkit will be required as the programme develops.

A simple snapshot of our progress and challenges to date can be seen via our community health profiles for Wear Valley and Teesdale (attached)

Section III

1. The proposed model of integration including the specific interventions planned; the target population; any specific care pathway or condition focus (as applicable) ; and any specific population health and wellbeing outcomes (as applicable) that are the focus for the demonstrator system.

The proposal focuses on improvements to processes and pathways relating to patient care rather than a structural reorganisation of the partner bodies. The aim is to develop a coordinated network of multi-disciplinary teams of health care providers supported by a system of contractual relationships between purchasers and providers using a centrally coordinated managed network of chains of care.

We will evaluate current provision of health and social care and use risk stratification tools (eg MSD, Healthdialogue UK). Using the data provided by the selected tools we will prioritise developments to best meet the needs of the most vulnerable population.

The areas to be incorporated include:

1.1 Fuel Poverty

As a direct result of local clinical concern, a County Durham wide fuel poverty partnership has already been established. The "County Durham Rights to Warmth Partnership" is led by the Dales PBC Public Health lead, and associates key stakeholders from all local authorities and relevant voluntary sector organisations.

To date, baseline assessments have been undertaken (attached) and this informs our future action plans, which include, resource led:

- Baseline data collection
- Social Marketing
- Joint Referral Pathways
- The development of a joint workforce training programme
- The development of an Emergency Response Fund

This partnership based work addresses health inequalities at a local level and has impact. It also supports the Regional Public Health Strategy, Better Health, Fairer Health (attached). Beyond this, we are also looking to make a joint appointment between Dales PBC and the Energy Saving Trust, to further develop this important workstream

In the Durham Dales, we have residents that are elderly, that are in remote locations and we also have groups of patients that are workless and live in deprived areas. We intend to work through our Local Authority and Social Services Departments, through our general practices and through our Community staff and voluntary organisations to make sure that patients are identified and appropriate help offered to those individuals. At present, tackling excess winter deaths in Teesdale represents a key challenge to the County Durham Rights to Warmth Partnership, as well as our ICO/PBC

1.2 Transport Services

As our hospitals and their services are reviewed, we will undertake a review of transport services across the Durham Dales area. We need to make sure that patients accessing more distant Acute hospitals and our Community Hospitals are not disadvantaged and have adequate transport. This may be provided by our Ambulance Trust, by a private provider or by Local Authority transport. NHS County Durham has a pilot scheme underway in another

part of the county which has an integrated transport service which is operationally led by Durham County Council. It is proposed that this is extended into the rest of County Durham with the Dales area being the first phase of the roll out.

As Secondary Care services are moved out into our Community Hospitals and GP surgeries, we need to tackle the problem of ambulance transport to those locations and this will also form part of our project.

We also need to explore the possibility of ambulance crews dealing with some minor ailments within the patient's home without onward referral. As part of the Urgent Care Strategy and the implementation of improved ambulance provision into the rural Dales, the NEAS paramedics will be trained in extended skills including clinical and prescribing, which will allow them the competencies to assess patients and encourage better treatment, reduction of admission to A&E, decreased transportation for patients and direct admission protocols into community beds with support from local GPs and Urgent Care services.

1.3 Transfer of Services to Primary Care

We intend to work with our Foundation community and Mental Health Trust to move as many services out of hospital as possible. Those services may still be run by the Provider Organisations, but in some cases the work may be taken on by practitioners with special interest in the community.

In particular, we will be looking at the possibility of setting up outpatient clinics for new, and follow-up, patients in a Primary Care setting. We will be looking at closer cooperation between Primary and Secondary Care clinicians so that patient care is passed on to Primary Care as soon as feasible.

We will look to develop more expertise in Primary Care around the provision of Mental Health services with an increase in the number of nursing personnel and Link Workers, to provide more services in general practices.

We aim to commission some specialist clinics run in Primary Care and have already started work on a One Stop Diabetes Service in one part of our locality, looking at patients with high HbA1c levels.

We also intend to increase the number of minor procedures that can be done in general practice, either within GP surgeries or in community units. An area of priority will be the removal of lesions. We also intend to work through our Quality Contract arrangements with each of the hospital specialties to develop a number of clinical pathways in orthopaedics, urology, ophthalmology, radiology and cardiology so that patients can move seamlessly from Primary to Secondary Care. We aim to do more in the way of procedures and clinics in our Community Hospitals and would like to see procedures, such as endoscopies, done in our Community Hospitals, and we also wish to see the development of greater access to echocardiography and diabetic retinal screening in our GP surgeries and Community Hospitals.

Performance will develop a framework which will report on activity, usage, delivery timescales. The Urgent Care Framework will provide suitable targets.

1.4 Use of Community Hospitals

In the most rural parts of our area, we have Community Hospitals, one sited in Weardale and the other in Teesdale. As stated above, we intend to increase the range of services available in those hospitals, covering an increased number of outpatient services,

endoscopic procedures, access to ultrasound, access to retinal screening and a wider range of surgical procedures.

We also intend to work with our Mental Health Trust to see if more services can be provided from those Community Hospitals.

At the start of the project we will work to develop a community tariff so that our Community Hospitals can be adequately funded through the Payment By Result process. This will be in line with unbundling tariffs with the Foundation Trust and working with Darlington Provider Services as they are developing community tariffs in discussion with the Department of Health.

1.5 Provision of GP Beds at Bishop Auckland General Hospital

As Acute care is likely to be concentrated on the two hospitals most distant from Bishop Auckland in the future, we see a need for a GP unit in our local hospital so that as many patients as possible can be cared for close to their relatives. Again, there will be a need for some patients with complex palliative care needs to be looked after in this facility. Palliative Care protocols will be developed as part of this process. We would also envisage that some patients may need to be observed on this ward whilst we consider whether or not they require an Acute admission. This may allow some patients to be kept under observation on the GP ward for a few hours and we feel that we will be able to avoid some Acute admissions by assessing them, performing appropriate investigations and if possible sending them home with adequate support, rather than admitting them to one of the Acute sites. The development of a GP ward has the full support of our Foundation Trust.

1.6 Integrated Emergency Care Directorate

We have been in discussion with our Foundation Trust for a number of years about the establishment of an Emergency Care Directorate. This is now an essential component of the reorganisation of acute services across the county.

Our vision is that we should establish a GP-fronted unit providing immediate triage and onward referral, as appropriate. The GPs in this unit would be trained to provide a level of emergency care over and above that expected by community GPs and they would work closely with the on-call physicians to assess, investigate and manage patients that either present directly to this unit or are referred in by local GPs for an assessment prior to admission. They will not deal with the obvious 999.

Bishop Auckland will be monitored carefully alongside Shotley Bridge where integration within an Acute Trust premises will occur, the service will be accountable as other provider functions to the PCT performance. The main aim of the integrated Emergency Care Directorate will be to achieve the following:

- Reduce inappropriate A&E attendances and therefore achieve a 20% reduction in overall A&E attendances, as well as an associated 2% reduction in 999 ambulance calls
- Reduce inappropriate acute admissions to hospital and thereby achieve a 20% reduction in unplanned admissions with a length of stay of one day or less, as well as a 20% reduction in admissions from nursing and care homes
- Provide care as conveniently as possible – eg closer to home and thereby achieve a 10% increase in self care
- Identifying high numbers of A/E attenders and how they may be addressed through revised service specifications.

- Providing appropriate information only once
- Seeing the right person to provide advice, consistent assessment and treatment as quickly as possible
- Align changes to GP opening hours with urgent care development.

These targets are in line with NHS County Durham's urgent care strategy.

1.7 Rural Mental Health

We intend to work closely with our Mental Health Trust (Tees, Esk and Wear Valley Foundation Trust) to provide an enhanced level of services in the community. This will require the deployment of mental health workers within GP surgeries and there has long been a need for more expertise in general practices to allow them to manage more patients in the community.

The initial project that we will take on as part of this bid will be to look at dementia as this is an area where the Mental Health Trust, Primary Care, the Community Trust and Social Services should work closely together to improve services for patients.

The suggested outcome measures for improving services to people with dementia are:

- 5% reduction in the rate of placement in nursing homes;
- 5% reduction in the rate of hospitalisation for people with dementia;
- Reduction in carer reported burden (name of the measurement tool to follow);
- Reduction in time for diagnosing dementia;
- Reduction in incidence of depression or early detection through differential diagnosis from dementia.

The outcome measures for general mental health services are:

- an increase in the rate of psychological treatment for people with a mental illness;
- a reduction in the amount of travelling patients undertake to access treatment to improve take up of services.

NHS Durham Public Health is also leading and developing new forms of community based partnerships that explore and promote positive mental health and emotional wellbeing. This builds upon exciting developments that include workplace based mental health promotion. NHS Durham Public Health have developed a web based e-learning tool (see www.mentalhealthatwork.cdd.nhs.uk/), that helps our local employers understand and develop key skills in identifying and supporting emotional and mental health related conditions across our local economy. This dynamic project was discussed and celebrated at the UK Public Health Association Annual Conference 2008. This project aims to engage 20 new workplace agencies per year

1.8 Vascular Screening

The Durham Dales Cluster began to look at vascular screening over a year ago and we are already geared up to take forward the County-wide initiative.

We already use computer software to "risk stratify" patients and have begun formal risk assessments on patients who would appear to be at high risk, based on data already within the GP IT system.

All of the practices in the Dales have signed up to take part in this Primary Prevention of cardiovascular disease initiative and our success will be measured on the following parameters:

- a. Over the three years of the ICO project, we would commit to screening three fifths of the population between the ages of 40 and 74.
- b. We will measure the increasing number of people who have an actual risk score within their electronic medical record.
- c. We will measure the number of people referred through those clinics to a lifestyle intervention. This will include services for smoking cessation, weight management, exercise on referral and alcohol reduction.
- d. We will measure the number of people started on statin therapy.
- e. We will measure the number of people who have been discovered to be hypertensive or diabetic, or who have suffered from chronic renal disease or are new diabetics.
- f. We will undergo a patient satisfaction survey assess our patients response to this initiative.
- g. We will do an annual check on those patients to see how many have continued to comply with their lifestyle interventions or medication.

The above is line with an agreed strategy across NHS County Durham and Darlington PCT led by the Director of Public Health, Tricia Cresswell.

Although we intend to base Primary Prevention around our general practices, we intend to involve our pharmacies and our Public Health Department to help us to reach hard-to-reach patients to risk assess them and to refer them into their general practitioner, should they require more intensive risk assessment or treatment.

2. Statement of key risks – corporate including financial, and clinical/professional and the proposed risk management and risk sharing arrangements.

Corporate risk is viewed as being minimal as all proposed changes are centred on pathway and process re-engineering rather than organisational restructure. The financial implications will be outlined in the project planning stages of “Seizing the Future” and will be associated with commissioning intentions from PCT and Cluster with the aim of either moving to a lower tariff service (shift from secondary to primary Care delivery) or the development of a tariff base for Community services or those to be delivered in a different environment which will also be lower tariff than existing provision and will provide better analysis of costs against case-mix.

No significant changes in staffing structure are envisaged which mitigates against any HR difficulties or unexpected staffing costs. Any impact assessments will be considered by the host organisation to assess any likely changes. This will need to be overseen by the ICO Board as it may interfere with the success of the pilot.

Corporate risk is viewed as being minimal as all proposed changes are centred on pathway and process re-engineering rather than organisational restructure. The financial implications will be outlined in the project planning stages of “Seizing the Future” and will be associated with commissioning intentions from PCT and Cluster with the aim of either moving to a lower tariff service (shift from 2ary to 1ary Care delivery) or the development of a tariff base for

Community services or those to be delivered in a different environment which will also be lower tariff than existing provision and will provide better analysis of costs against case-mix.

No significant changes in staffing structure are envisaged which mitigates against any HR difficulties or unexpected staffing costs.

3. The specific **improvement objectives** and for each, **the clinical or professional process or outcome measures** and the **patient reported outcome, satisfaction, quality of life or wellbeing measures**, intended to be used (please submit suggested measures or scales not input descriptions. For example for improvement in outcomes in diabetic patients, a commitment to measurement of HbA1Cs in a specific target population, not a description of a one stop clinic)

FUEL POVERTY					
Outcome	Measure	How will we do it	Expected improvement	Financial consequence	Risk
Increased use of service		Referral rates, collaborative working with Local Authority	Increased number of patients using service	Reduced tariff-based attendances at hospital	Climatic conditions affecting numbers using and hospital outcomes
Decreased preventable admissions due to hypothermia	Hospital admission data with hypothermia as primary or associated HRG	Monitor MIDAS information	Reduction of 10% in hypothermia admissions	Reduced expenditure against PBR services	Climatic conditions affecting numbers using and hospital outcomes
Decreased Early Winter Death Index	Public Health data of EWDI	Regular monitoring of Public Health data	Reduction of 10% in death index	To be agreed	Severe winter causing increase in EWDI

TRANSPORT SERVICES

Outcome	Measure	How will we do it	Expected improvement	Financial consequence	Risk
Review and report of available transport services to identify future development needs		Link with rural health strategy and PCT	As outcomes from review		
Establishment of alternative or enhanced rural transport services	Number of new services introduced	In conjunction with Durham County Council's Transport Unit and in liaison with North East Ambulance Service and RSVP drivers within practice systems	Better access for rural patients to centralised health services	To be agreed based on service development	
Improved service performance	<ul style="list-style-type: none"> - Time taken to travel to hospital appointments - Number of patients on time for appointments - Waiting time to be returned home after patient care 	<ul style="list-style-type: none"> - Results from Ambulance Service monitoring statistics - Patient survey 	Improved times against baseline measurements	To be agreed	

TRANSFER OF SERVICES TO PRIMARY CARE					
Outcome	Measure	How will we do it	Expected improvement	Financial consequence	Risk
Increase in patient numbers seen in Primary Care setting compared to baseline year	MIDAS data or equivalent monitoring	Setting up new services within Primary Care or modifying patient pathways	Increase of 10%, actual value to be agreed	Movement of services to lower tariff	Non-achievement of % target due to lack of services or inappropriate referrals
Reduction in follow-up to new appointment ratio	MIDAS data or equivalent monitoring	Increased numbers of follow-up appointments within Primary Care setting after first appointment in Secondary Care	Aim for 10% reduction in follow-up/new ratio	Movement to lower tariff	Non-achievement of % target
New services developed for delivery within the community	Number of new business cases approved	Regular review and proposed business cases for identified areas			
New services implemented in community settings each year	Number of new services from business case development	- Multidisciplinary approach and agreement between Primary and Secondary Care - Targeting one new pathway every two months throughout the three years of the project	Better access for patients to Primary Care setting services	Movement from PBR tariff to lower community tariff	Non-establishment of new services
Improved quality of care to patients in Primary Care setting	Patient satisfactory survey	Six monthly survey of random selection of patients	Increase patient satisfaction throughout lifetime of project		
Reduction in HbA1c in patients with levels >10	HbA1c value	Improved monitoring and regular access to community-based diabetic services	Reducing stratification target from 10% at yearly intervals during the project		

USE OF COMMUNITY HOSPITALS

Outcome	Measure	How will we do it	Expected improvement	Financial consequence	Risk
<p>Increased number of services available within a Community Hospital setting</p>	<ul style="list-style-type: none"> - Number of new services - Number of outpatients seen - Number of transfers from Acute Hospitals linked with reduction of average length of stay in Secondary Care - Patient satisfaction surveys and measures of Health Care Associated Infections 	<p>Business case development based on risk stratification and movement of services within Acute Trust</p>	<p>Range of new services available in Primary Care setting, previously only available in Secondary Care</p>	<p>Improved cost-effectiveness by movement from Primary Care PBR tariff to lower Community tariff</p>	<p>Lack of service development and lack of referrals into service from Primary Care</p>

PROVISION OF GP BEDS AT BAGH

Outcome	Measure	How will we do it	Expected improvement	Financial consequence	Risk
Establishment of GP Ward	Establishment by December 2009, specific resources developed thereafter	Discussion and agreement with Secondary Care on range of patients suitable and facilities to be made available	Service available to patients locally	Dependent on tariff development	Low uptake of use of beds Attracting GPs with appropriate expertise to look after those patients
Development of palliative care protocols	Target 6/year minimum	Working within palliative care strategy with provider PCT	More patients provided with palliative care closer to home, associated convenience for relatives and Primary Care carers	Tariff changes	Lower uptake
Future development of GP Ward	- Increase in number of beds available - Increase in bed occupancy	Throughout life of project look to increase range of services available and increase number of patients using service	Increased range of services to suitable patients, increased patient use	Movement from Primary Care PBR tariff to Secondary Care community tariff	

INTEGRATED EMERGENCY CARE DIRECTORATE

Outcome	Measure	How will we do it	Expected improvement	Financial consequence	Risk
Establishment of unit	Target date April 2009	Development within Urgent Care strategy	Improved access to locally-based 24/7 Urgent Care Centre	Movement from higher to lower tariff as less patients require traditional A&E services	Inappropriate use of unit
Reduction in inappropriate A&E attendances	Activity and attendance data via MIDAS or equivalent	Use of triage and range of professionals available within the unit	- In line with Urgent Care Strategy targets - 30% reduction in overall attendances - 2% reduction in 999 calls		
Reduction in inappropriate acute admissions to hospital	MIDAS activity data	In line with Urgent Care Strategy	- 50% reduction in pre-planned admissions with length of stay one day or less - 50% reduction in admissions from nursing and care homes		
Identify high attenders at A&E	Frequent Flyer records	- Patient re-education and signposting to alternative or appropriate services - Changes in service specifications	- Reduction in average number of attendances within time period - Reduced numbers of patients with 10 or more attendances per year		
Improved information systems in order to provide information only once and share with all system users	- Development of multidisciplinary information systems - Transfer of information using NHS spine - Shared access to patient records	Providing information from single record	Reduced duplication and errors	To be evaluated based on existing costs	Information governance associated and cost of systems

RURAL MENTAL HEALTH

Outcome	Measure	How will we do it	Expected improvement	Financial consequence	Risk
Improved access to mental health services for patients in rural areas	Contact rates for all mental health professionals stratified by practice and/or postcode	Improved information systems, increased numbers of mental health professionals, better information exchange	Improved patient satisfaction, wider range of services available and reduced times for access to services	HR dependent, recruitment of new staff, retention of staff	
Specific outcome measures for dementia	<ul style="list-style-type: none"> - Reduction in rate of placement in nursing homes - Reduction in rate of hospitalisation for patients with dementia - Reduction in carer reported burden - Reduction in time to diagnosis of dementia - Reduction in incidence of depression - early detection of depression through differential diagnosis 	<ul style="list-style-type: none"> - Deployment of mental health workers in GP surgeries - Increased joint working between Mental Health Trust, Community Trust and Social Services - Improved information systems and use of electronic data interchange 	<ul style="list-style-type: none"> - 5% reduction in nursing home placements - 5% reduction in hospitalisation for patients with dementia 		
Specific outcome measures for general mental health services	<ul style="list-style-type: none"> - Increase in the rate of psychological treatment for patients with mental health illnesses - Reduction in the amount of travelling those patients undertake to access treatment to improve take-up of services 	<ul style="list-style-type: none"> - Deployment of mental health workers in GP surgeries - Increased joint working between Mental Health Trust, Community Trust and Social Services - Improved information systems and use of electronic data interchange 			

VASCULAR SCREENING

Outcome	Measure	How will we do it	Expected improvement	Financial consequence	Risk
60% of the total population between the ages of 40 and 74 will be screened in the first three years of the project	<ul style="list-style-type: none"> - Increase in CVD risk score recorded in GP records - Number of patients started on statin therapy - Number of patients referred for: <ul style="list-style-type: none"> - Smoking cessation - Weight management - Exercise on referral - Alcohol reduction 	<ul style="list-style-type: none"> - Identification of patients based on risk stratification - Prioritise those likely to have highest risk 	Increased number of patients screened and long term decreased presentation of CVD-related conditions in Secondary Care	Initial increase in cost due to screening - Long-term reduction in cost against PBR tariff as we delay the onset of cardiovascular disease	
Measurement of newly diagnosed hypertensives, diabetics, chronic renal disease	Patient satisfaction survey and measurement of number of patients accepting annual checks to monitor take-up of lifestyle interventions / medications				

COPD

Outcome	Measure	How will we do it	Expected improvement	Financial consequence	Risk
Decreased hospital admissions	Hospital admission data from MIDAS	Promote self-care and home self-treatment packs	Reduced admissions	<ul style="list-style-type: none"> - Reduction in cost against PBR - Initial increase in cost due to screening - Long-term reduction in cost against PBR tariff as we delay the onset of cardiovascular disease 	Severe winter leading to increase in appropriate admissions
Screening of smokers >35 years of age and offer of spirometry service	Practice searches to produce register and measure uptake of screening	<ul style="list-style-type: none"> - Training of specialist spirometry skills within practice team and possible provision of cluster-wide service - Targeted lifestyle advice 	Early detection of COPD	<ul style="list-style-type: none"> - Reduction in cost against PBR - Initial increase in cost due to screening - Long-term reduction in cost against PBR tariff as we delay the onset of cardiovascular disease 	<ul style="list-style-type: none"> - Shortfall in recruitment/training of practice staff - Low uptake of screening offered

PRE-DIABETIC SCREENING

Outcome	Measure	How will we do it	Expected improvement	Financial consequence	Risk
Earlier identification of at-risk groups and undiagnosed diabetics	<ul style="list-style-type: none"> - Number of newly discovered diabetics - Number of pre-diabetics referred for lifestyle advice - Number of pre-diabetics that accept an annual follow-up 	Screening programme on BMI >30	<ul style="list-style-type: none"> - Earlier detection of undiagnosed diabetes - Prevention of the development of diabetes by early intervention in pre-diabetics 	<ul style="list-style-type: none"> - Reduced costs associated with reduction in incidence of diabetes - Initial increase in cost due to screening - Long-term reduction in cost against PBR tariff as we delay the onset of diabetes and cardiovascular disease 	Lifestyle interventions may be unsuccessful

OBESITY MANAGEMENT

Outcome	Measure	How will we do it	Expected improvement	Financial consequence	Risk
Identification of population with a BMI >30	<ul style="list-style-type: none"> - Increased numbers from baseline - Numbers referred for lifestyle intervention - Numbers treated with drug therapy - Numbers referred for surgery 	<ul style="list-style-type: none"> - Screening programme through GP surgeries, pharmacies and the workplace - Referral for lifestyle interventions / drug therapy / surgery 	<ul style="list-style-type: none"> - Earlier lifestyle intervention - Reduced incidence of diabetes - Reduced incidence of CVD 	<ul style="list-style-type: none"> - Reduced costs associated with reduction in incidence of diabetes - Initial increase in cost due to screening - Long-term reduction in cost against PBR tariff as we delay the onset of diabetes and cardiovascular disease 	Lifestyle interventions may be unsuccessful

PROPOSED PATIENT INVOLVEMENT IN ICO

ICO element	P/E outcomes	Method(s)
Fuel poverty	Timely intervention, services working together around the patient, improved quality of life through having heated home and less worry about paying bills	Patient satisfaction survey Patient interviews
Transport services	Access to transport – from a location and physical access perspective Comfort of journey Affordability of transport Timeliness of transport in relation to health service appointment times etc	Patient satisfaction surveys Citizen's panel polls Service user groups
Transfer of services to primary care	Improved access to care closer to home Experience of high quality care Seamless patient experience throughout journey Informed patients through good service-to-patient communication	Practice patient forums, patient diaries and service user focus groups, including mental health and carers' forums
Use of community hospitals	Improved access and choice of care Care closer to home	Patient surveys, feedback cards, service user groups
Provision of GP beds at Bishop Auckland Hospital	Improved access High quality care Informed and empowered patients Speedier recovery times through more time spent in home/visitors close to home	Patient surveys, patient feedback cards, patient interviews
Integrated emergency care directorate		Rural ambulance services monitoring group
Rural Mental Health	Patient-focused services with respect and dignity exercised at all times Patients active partners in their own care Clear and understandable communication High quality care Accessibility and choice Families' perception of improved quality of life	Mental Health Service Users' and Carers' Groups in Wear Valley and Teesdale
Chronic disease management (vascular screening, pre-diabetic screening, obesity management, COPD)	Patient-focused services with respect and dignity exercised at all times Patients active partners in their own care Clear and understandable communication High quality care Accessibility and choice	Patient surveys

STATEMENT OF INTENT FROM SECONDARY CARE CLINICIANS WISHING TO WORK WITH PRIMARY CARE CLINICIANS

Following the last Alliance Meeting I enclose the response to an email to express an interest in developing clinical links and services with GPs including exploring email / telephone advice.

I have lifted the comments with minor edits to give a flavour of the enthusiasm and ongoing work in some departments. Most specialties are represented.

I am also copying this to the Divisional Leads and Bob Aitken, Director of Medical Services.

The email links are in blue, if underlined they can be clicked directly; if not underlined, then "CTRL + Click" to open the link. Sorry for the inconsistency (David Laird, Consultant)

We in Dermatology have been developing primary care links with Co. Durham PCT for well over 2 years. I do one session per fortnight in the PCT in Darlington, and my Associate Specialist one per fortnight in Derwentside.

We have been working on a specification for an integrated Dermatology service across the Primary/Secondary Care interface with the PCT for over a year – and a soul-destroying business it has proved! We were 'put on hold' for 9 months while the PCT reorganised itself (yet again!) and we have finally reached the point of signing-off the spec next week. I am telling you this, not to discourage you, but to warn you that you should encourage the GPs to be heavily involved as negotiation with non GPs can be challenging. I don't think we are well enough staffed to contemplate telephone services at this stage.

Best wishes,

Mary.Carr@cddft.nhs.uk Consultant Dermatologist

As Bob (Aitken) knows, I have been involved with a GP group in Darlington for more than 2yrs now & in 2006 this was turned into a formal group called DART (Darlington Respiratory Team) which is chaired by a GPwSI (Dr Basil Penney) trained between us at DMH & Bradford Univ. It now consist of Dr Basil Penney, two Community Resp nurses, Sue Alcock (my senior Resp nurse), myself, a secretary & a PCT manager (Joanne Johnston). At one stage Dr Hilton Dixon (PCT Med Director) & Liz Graham (PCT Clin Governance lead) were also members but had to leave as DART doesn't represent the greater PCT. Through DART we have been able to see that each GP practice in Darlington has a Resp lead & also both an asthma nurse & a COPD nurse.

These nurses all have received (& continue to be refreshed) training in spirometry etc.

We have also been instrumental in drawing up specs for an home O2 service & also an early discharge service for COPD. The Community Resp nurses are also starting to have a positive effect on frequent admissions of our chronic resp patients.

I assume the Gp chairs of the cluster groups are aware that I am already involved but perhaps I could be of some use in helping others to set up similar groups & forge productive links. Regards

alwyn.foden@cddft.nhs.uk Consultant Physician
Respiratory Unit, DMH Darlington DL3 6HX Tel: 01325 743425

I am interested in clinical links and am at present in discussion with the PCT re integrateion of respiraotry care. I am leading on this on behalf of my directorate.

Sarah.Pearce@cddft.nhs.uk

Consultant physician & Hon. senior lecturer

University Hospital of North Durham,
Durham, DH1 5TW
tel. 0191 333 2246/2285

Yes, I am interested. I'm based at UHND and CLS but as the Clinical Lead for Stroke for the trust I would like to be put in touch with GP leads with an interest in stroke across the patch, not just in the north.

I'm also interested in exploring section email / telephone links.

Thanks,

Cath.Church@cddft.nhs.uk

Consultant Elderly Care

I'm more than happy to develop further links with GPs. Acute medicine has already made several advances in this respect but would be better if incorporated into these formal processes as it will have an even bigger impact.

Regarding telephone/email advice, I have already given my thoughts about this to Ian Bain as I thought he said he would take this forward. Again, happy to be involved from both an acute medicine and immunology point of view.

Lucy.Hansen@cddft.nhs.uk

Consultant Acute medicine

I am interested in exploring advice services by telephone / email: Yes

I would be keen to develop such services for Inflammatory Bowel diseases and Nutrition related problems.

Deepak.Kejariwal@cddft.nhs.uk

Consultant Gastroenterologist

Yes, I would be very interested in joining up with a local GP with an interest in Inflammatory Bowel Disease to develop a shared care pathway and telephonic helpline (we already have that at Bishop Auckland, run through my IBD Specialist Nurse,

anjan.dhar@cddft.nhs.uk Consultant Gastroenterologist

Bishop Auckland Hospital, Cockton Hill Road, Co. Durham DL14 6AD

Tel: (Secretaries: Helen / Susan) 01388 455170 Fax: 01388 455057

I am interested

Bernard.Esisi@cddft.nhs.uk

Consultant Physician

Please include me for forging partnerships in the Clinical Area of Liver Disease

thanks

Sushma.Saksena@cddft.nhs.uk

Consultant Physician

Happy to contribute (Gastroenterology / medicine)

Stephen.Mitchell@cddft.nhs.uk

Consultant Physician

I am very much interested in being part of this endeavour to get primary and secondary care working together. All for it. Regards

Paul.Peter@cddft.nhs.uk Consultant Physician
Diabetes and Endocrinology

I am sure we can do something in Diabetes

Alan.Mcculloch@cddft.nhs.uk Consultant Physician

I would be very keen to forge greater links with the GPs so count me in. I have actively sought out the GP who organises the GP evening meetings at BAGH and will be talking to them in November. Thanks.

David.Burton@cddft.nhs.uk

We have had some GPs with an interest in providing enhanced sexual health services through the dept for training and supervision but would be happy for contacts on a wider scale. We do get quite a few telephone calls for advice already which is fine – prob with email is that there may be a delay in replying which is no good if you have a pt in front of you and need an answer now

Alison.Wardropper@cddft.nhs.uk Consultant GUM

I am happy to represent O& G and feed back to consultants as to what is involved

Rob.Wood@cddft.nhs.uk Consultant O & G

Fiona.Lloyd@cddft.nhs.uk Consultant O & G

I would be interested as well (Gynaecology/Gynaecological Cancer/Colposcopy) i.e. I am interested in forging clinical links / developing partnerships.

Clinical area: (Gynaecology/Gynaecological Cancer/Colposcopy).

Regarding telephone/e-mail links I would need more information.

Best wishes

Gynaecological Cancer & Colposcopy Lead Clinician

University Hospital of North Durham

County Durham & Darlington Foundation NHS Trust
North Road, Durham , DH1 5TW

Tel: 0191 333 2258 (Gynaecology - Durham)

0120 759 4429 (Colposcopy - Shotley Bridge)

0191 333 2357 (Colposcopy - Durham)

Fax: 0191 333 2940 (Gynaecology - Durham)

Partha.Sengupta@cddft.nhs.uk

Joyce.Brown@cddft.nhs.uk (Gynaecology Secretary)

Just to express my interest in involvement with these developments. I certainly have no objections to explore advice services Tel/email.

Keep me informed

Cheers

Remko.Beukenholdt@cddft.nhs.uk

Consultant Gynaecology

I am interested in forging clinical links / developing partnerships in the Clinical area: Obstetrics and Gynaecology

I am Not interested at present in exploring advice services by telephone / email :

Philippa.Marsden@cddft.nhs.uk

Consultant O&G

this is definitely something I would like to do in paediatrics. I am interested as for the advice service - would need more info about how it is funded & works etc.

Helen.Leonard@cddft.nhs.uk

consultant pediatrician

Ewa.Posner@cddft.nhs.uk

consultant pediatrician

I am forwarding my name as one of the paediatrician interested in forging closer links with primary care – particularly in the area of asthma. I am also developing my interest in allergy and keen to start an allergy service but also need input from dietetics etc. It would be good to link in with them to know whether there is a need for such a service (with my recent number of referrals I am getting, I expect so) and what sort of service would they like to see.

Kind regards,

Claire.Ang@cddft.nhs.uk

consultant pediatrician

From Paediatrics I shall be willing to be involved

Indra.Thakur@cddft.nhs.uk

consultant pediatrician

I am interested in forging clinical links / developing partnerships. (already have some good relationships)

I am interested in exploring advice services by telephone / email : Yes (Colleagues and I already provide this by telephone. For e-mail would need an nhs e-mail account)

I am copying this to my clinical services manager because the issues about non face to face contact and payment are important.

I am copying this to Helen Duncan in line with Trust IT policy as this would need an encrypted e-mail (nhs e-mail)

John.Furness@cddft.nhs.uk

consultant pediatrician

Secretary Anne Gibson

Anne.Gibson@cddft.nhs.uk

01325 743581

We have an established link with the relevant GP “Clinical Champion”: Kat Noble and have for some time offered telephone advice/referrals to our clinics (recently republicised).

Richard.Harden@cddft.nhs.uk

Consultant A&E

I would be very happy to develop clinical links with GPs and we already do email telephone advice (although it has never been well publicised – perhaps the Trust could help with that)

I wanted to go yesterday but it clashed with an STC meeting which made it impossible.

Robert.Gregory@cddft.nhs.uk

Consultant Orthopaedic Surgeon

I'm interested

Andrew.Jennings@cddft.nhs.uk

Consultant Orthopaedic Surgeon UHND

I would also be interested, thanks

Patrick.Duffy@cddft.nhs.uk

(Orthopod DMH)

I would be interested in ophthalmology, now I do a clinic at Durham as well so the cover includes all three main hospitals.

Would be grateful if you include me

Partha.Chakraborty@cddft.nhs.uk

Consultant Ophthalmic surgeon

Interested in all aspects of developing links with GPs

Vivek.Shanker@cddft.nhs.uk

Consultant ENT surgeon

I will be interested from Plastic surgery.

Sam.Rao@cddft.nhs.uk

Consultant Plastic Surgery

Yes to all!

Jag.Varma@cddft.nhs.uk

Consultant General & Colorectal surgeon

COLORECTAL SURGERY links with GPs but not telephone advice

Keith.Gunning@cddft.nhs.uk

Consultant Colorectal surgeon

Developing clinical links

Gareth.Tervit@cddft.nhs.uk

Consultant General & Vascular

surgeon

I'd be interested to forge clinical links/develop partnerships for the vascular service.

Ian.Hawthorn@cddft.nhs.uk

Consultant General & Vascular Surgery

Very willing to be involved for lab diagnostics- you know about the Web site, and I've run an email advisory service with GPs for a number of years (actually the S Tees service was born from a meeting with John Main and myself with some GPs for the renal protocol).

A lot of work is going on nationally in pathology on knowledge services so it would be nice for the trust to get involved at a local level.

Stuart.Smellie@cddft.nhs.uk

Consultant Chemical Pathologist

Happy to get involved on the lines of effective use of microbiology tests antibiotic policy etc. Have been involved in this area and had two papers published this year on this subject. Have worked with Stuart Smellie in Biochemistry who is very interested in GP use of lab.

John.Sloss@cddft.nhs.uk

Consultant Microbiologist

I am interested in radiology aspect of this and especially musculoskeletal radiology

Nanjundiah.Vishwanath@cddft.nhs.uk Consultant Radiology

I am more than happy to be involved for Radiology in the south of the trust and have already forged some links but am keen to take this further.

Nigel.Grunshaw@cddft.nhs.uk

Lead Clinician (Radiology South)

Interested in developing clinical links with GPs as well as advice on patient queries /results from primary care

Alexis.Chuck@cddft.nhs.uk

Consultant Rheumatologist

I am interested in developing links (discussion, training, guidelines, audit, collaboration etc) with GPs and other Primary Care providers to develop Chronic Pain Management in Primary and secondary Care including the use of email and telephone advice and also their use in follow up as appropriate

david.laird@cddft.nhs.uk

Consultant in Pain Management

01913332599

Julie.Hill@cddft.nhs.uk

Secretary to Pain Management Team

Anaesthesia can be linked through myself or Stuart.Dabner@cddft.nhs.uk who is also an Associate Medical Director. Other Associate Medical Directors are

Richard.Prescott@cddft.nhs.uk

Consultant Physician / Care of Elderly /

Parkinson's Disease and Director of Medical Education

Alan.Mcculloch@cddft.nhs.uk

Consultant Physician

NOTES FROM NHS ALLIANCE MEETING
HARDWICK HALL

2nd OCTOBER 2008

DR STEWART FINDLAY

INTRODUCTION

This meeting was sponsored by the NHS Alliance and funded by AstraZeneca Pharmaceuticals.

The main aim of the event was to look at the current clinical engagement and communication between Primary and Secondary Care and to find ways of greatly expanding and develop this to, ultimately, improve delivery of quality care to patients.

John Johnson presented an example of good practice around data transfer in Liverpool, being the Gold Standard in its field in the UK.

Stuart Smellie, Consultant Pathologist and Lipidaemiologist, presented an overview of www.bettertesting.org.uk, a very useful tool, in the form of web guidance, which gives clear advice to clinicians on common subjects he is frequently consulted on.

Iain Bain, Consultant Surgeon and Clinical Director, gave a presentation on communication and improvements being made currently in Secondary Care.

Key areas being addressed were discharge letters and electronic transfer of these to practices - should be possible in 2 months time via NHS Net.

Dr Kendrick gave a presentation on COPE, a scheme set up in Durham looking at significantly reducing the numbers of avoidable admissions for elderly patients from A&E.

Bob Aitken presented Seizing The Future, which outlined the plans for the reconfiguration of the County Durham and Darlington hospitals, the consultation process and the programme of events for this,

Sushma Saksena, Consultant Gastroenterologist, brought to our attention the increasing problem of Hepatitis C in the region. She offered practices the opportunity to engage with her and her team to find new ways to combat this problem.

ACTION POINTS

Clinical engagement:

1. Identify key networks and clinicians and identify gaps.
2. Create a database of this information.
3. Circulate PBC Chair details to all clinicians as first point of contact for suggestions and ideas
4. Set up a website accessible to all which would act as a "one click" site, giving contact information, a current issues section, suggestion box and ideas forum, announcement of new services section, document find section, event calendar
5. Look at merging the annual Innovation Days for consultants with the NHSA event
6. Look at using Time In/Out sessions to get Primary and Secondary Care clinicians in the same place.
7. Remuneration for Representative Clinical Input.
8. Update information at all levels on Commissioning and Delivery.

IT

1. Outpatient scripts should be computer-generated with a bleep number for pharmacies/practices to use in case of query.
2. Discharge letters – Improve quality, possibly by increased secretarial staff on the wards.
3. Advice email – copy the JCUH Renal Physician model with the PBC purchasing advice lines in bulk.
4. C&B referral letter attachments – take up with Robert Peacock as still problems with these.

BETTER TESTING

1. Contact Clusters.
2. Link from reports to the site.
3. Contact (HPA) Ian Coates.
4. Contact/involve the Offender Health Team.
5. Contact/Involve Pauline Smith, Head of Professional Development.

FUTURE MEETINGS

It was decided that we should hold an even bigger event in February of 2009. Meeting should follow the same format but should include more managers from the Acute Trust.

It was decided to hold the next meeting between 2:00 pm and 5:00 pm (lunch at 1:00 pm) on a Thursday, at Hardwick Hall Hotel.

TOPICS FOR FUTURE DISCUSSION (Taken from this meeting and the last)

1. Electronic communication. **Done**
2. C&B problems.
3. Increased use of email advice.
4. Possibility of general practices having NHS user numbers so that consultants can contact them more easily.
5. Incentives for Directorates to use a proportion of the income they generate for education/research.
6. PCT reviews such as Pain Management, MSK.
7. Barriers between Primary and Secondary Care and the role of management in getting rid of those barriers.
8. Unblocking tariffs.
9. GPs working directly with consultants within hospital departments and in the community.
10. Reduction in Emergency Admissions.
11. Emergency Care Directorate.
12. Increased use of community hospitals and future use of BAGH.
13. Better access to direct consultant advice in order to reduce admissions.
14. We also thought that it might be useful to look at a research project looking at working relationships, now and in the future, possibly by enlisting the help of a university department. We should look at the healthcare system and how it is working.
15. Reducing anaesthetic risk of patients by using our Exercise on Prescription referrals, Smoking Cessation clinics etc.
16. Possibility of doing pre-op checks in surgeries in the future.
17. Action points from last meeting and hold Trust to account over promises made - eg Emailed letters within 2 months.

NHS ALLIANCE EVENT – 2nd October 2008, Hardwick Hall Hotel, Sedgfield

ACTION PLAN FOR: BETTERTESTING (STUART SMELLIE)

What needs to be done?	By Who?	By When?	How will you know if it is successful?
Contact cluster or PDA	Denise Elliott	4/12	Use and feedback from GPs/Nurses
Link from report to site	Stuart Smellie (Mark Walsh, Mike Brierley)	4/12	Getting links established
Contact (HPA) Ian Coates (27/10)	Stuart Smellie (Jackie Kay)	1/12	Adoption of project
Offender Health Team – Julie ?Dennie	Stuart Smellie	4/12	Use and feedback
Pauline Smith, Head of Professional Development	Stuart Smellie		Educational planning

NHS ALLIANCE EVENT – 2nd October 2008, Hardwick Hall Hotel, Sedgefield

ACTION PLAN FOR: CLINICAL ENGAGEMENT (GROUP 1)

What needs to be done?	By Who?	By When?	How will you know if it is successful?
Make easier ways to contact each other (Primary-Secondary and Secondary-Primary). Contact details should be more widely available to all, ie PBC Chair info and clinician email details. Clinicians to be given “hotphone” numbers for practices.	Deborah Perry	1/12	More information passing between the two groups of clinicians.
More joint events, ie Innovation Days possibly merged with either NHSA events, Time In/Out Sessions. Clinicians to attend PBC cluster meetings to give updates/news on services.	Deborah Perry/Stewart Findlay	4/12	More consultants attending PBC meetings and all gaining better understanding of each other’s problems. Joint events organized for 2009.
Set up a joint website with different sections for: contact details, new service announcements, event calendar, write on wall, suggestion box/bright ideas forum,		6/12	
Clinically-led groups to be set up between 2 or 3 consultants, 2 or 3 GPs and possibly 1 or 2 managers with shared interests.	Stewart Findlay	3/12	
Invite the four Clinical Directors to future NHSA events.	Deborah Perry to contact Iain Bain, Neil Munro, Ahmed Ali and Robin Mitchell	ASAP	Attendance at next event.

NHS ALLIANCE EVENT – 2nd October 2008, Hardwick Hall Hotel, Sedgfield

ACTION PLAN FOR: CLINICAL ENGAGEMENT (GROUP 2)

What needs to be done?	By Who?	By When?	How will you know if it is successful?
Identify key networks and clinicians (gaps?)	Appraisal secondary/primary interface, PBC, clinical Champions etc. Secondary division, clinical leads, tutors. Include identifying secondary Clinical Champions, NB: ALL providers.	January 2009	Database achieved + growing
Database of above info.	PCT – identify individual/group.	March 2009	Database established, growing and being used
Update / info at all levels commissioning and delivery.	Secondary care divisions identify leads (PBC). All Commissioners not branch, circular hub and spoke.	April 2009	Key clinicians/ front line involved at all points of communication process and highlighting service issues/positives to commissioner.
Remuneration for representative clinical input			Key clinicians/ front line involved at all points of communication process and highlighting service issues/positives to commissioners.

NHS ALLIANCE EVENT – 2nd October 2008, Hardwick Hall Hotel, Sedgfield

ACTION PLAN FOR: IT

What needs to be done?	By Who?	By When?	How will you know if it is successful?
Outpatient scripts – should be computer generated + bleep number attached	Outpatient computer need – urgent update	6/12	Feedback from pharmacists
Discharge letters via email with 24/24 rather than paper copy as these are inadequate, inaccurate, untimely. Improve quality of discharge letters to practices.	Address Medical Directorate. Increase secretarial staff?	4/12	Hospital should tell us when implemented
Advice email. If advice is see in OPA then double fee attracted.	PBC purchase advice lines in bulk copying Renal Physician model at JCUH.	3/12	Feedback from GPs
Referral letter attachments Hospital needs to read attachments	Robert Peacock	3/12	Feedback from hospital consultants
Develop single patient medical record.			