“There is always a better way...”
“There is always a better way... find it”

Thomas A Edison
When Thomas Edison created the first long-lasting, commercially practical, incandescent light bulb in 1879 no-one could predict the impact it would have on society. Today we barely give them a second thought – until we need to replace one – but the small glass orb with its glowing filament has changed the way we all live our lives.

Contrary to popular belief, Edison did not invent the first light bulb; it had already been around for a number of years. But what he did do was to make it practical and economical. It was undoubtedly one of the most successful innovations of all time.

Perhaps not surprisingly, no-one in the independent healthcare sector has improved the light bulb. It isn’t their area of expertise and there isn’t a particular need – new, commercially viable designs are readily available on every high street. But the sector is renowned for its innovation. Many independent sector providers of NHS care have found effective ways of doing things differently – they have looked at a problem and assumed “there is always a better way” and the results have helped improve what they do.

The NHS is going through tough times and the need for innovation has never been greater. Increasing demand on services coupled with downward pressure on budgets makes developing new, cost-effective ways to meet the challenge of delivering high-quality care a priority. Not an easy ask. However, with greater flexibility and the ability to attract investment, the independent sector is often the source of outstanding innovation.

Earlier this year the NHS Partners Network ran a competition to find the best examples of innovation from the independent sector. We received entries spanning the breadth of healthcare and from a diverse range of providers. This briefing highlights the top five entries as selected by our judges and demonstrates the benefit of believing there is a better way – and having both the freedom and the support to explore ways of finding it.

NHS Partners Network competition: Innovation is the name of the game…

To enter, NHS Partners Network members were asked to describe an example of innovation in not more than 1,500 words and include details of the organisation(s) involved, the costs (including set up and running costs), the overall savings and the benefits to the organisation, patients and the NHS.

The prize

The organisation judged to have the best innovation won the chance to highlight their innovation in an Exhibitor Showcase at the 2014 NHS Confederation Annual Conference and Exhibition. These are usually only available to paid exhibitors and provide a unique opportunity for the winner to promote their innovation to the widest health and social care audience.

The judges

The entries were independently judged by Alastair Henderson, Chief Executive of the Academy of Medical Royal Colleges; Ruth Holt, Director of Nursing and Quality Assurance at South Tees Hospitals NHS Foundation Trust; and Matt Tee, Chief Operating Officer of the NHS Confederation.

Further details of the competition and the terms and conditions are available on the NHSPN website: www.nhsconfed.org/nhspn.

The NHS Partners Network (NHSPN) is the trade association representing the broadest range of independent sector providers of NHS clinical services, including acute, primary, community, homecare, diagnostics, dental and medical products. Our members are drawn from both the ‘for profit’ and ‘not for profit’ sectors and include large international hospital groups and small specialist providers. All are committed to working in partnership with the NHS and to the values set out in the NHS Constitution. The NHSPN was established in 2005 and incorporated into the wider NHS Confederation in June 2007.

For further details about the NHSPN, visit www.nhsconfed.org/nhspn or email NHSPartnersNetwork@nhsconfed.org
Recovery at Home service in the West Midlands

Healthcare at Home

About Healthcare at Home
Healthcare at Home is the UK’s largest home healthcare provider, caring for more than 150,000 NHS and private patients each year throughout the UK. Our vision is to enhance the way in which clinical and pharmaceutical services are provided for patients, their families and carers. Healthcare at Home strives to improve clinical outcomes for patients by allowing them to receive treatment in the comfort of their own home.

Healthcare at Home has a team of highly skilled clinicians on board to provide a number of treatments and services to patients, including end-of-life care, chemotherapy at home, recovery at home, as well as medication management and optimisation for a range of conditions.

Background
To make the local health economy more sustainable, the cost footprint of GHH had to be reduced. To determine areas where the hospital could reduce expenditure, the Oak Group, a medical intelligence company, carried out an audit at GHH. They found that 42 per cent of admissions to the hospital were non-qualified and 78 per cent of patients admitted could have been treated at home with the provision of appropriate clinical and social services.

There was a high volume of patients occupying hospital beds who were not receiving direct medical care but were waiting for processes (such as assessments or referral decisions) to be completed. This waiting time meant patients were at greater risk of deterioration or contracting hospital acquired infections, ultimately increasing the time they spent in hospital.

These capacity problems and longer than expected lengths of stays held serious connotations for the trust’s ability to meet its performance targets around A&E and manage its elective programmes. The trust decided to seek a solution that would provide an alternative means of managing this cohort of patients and reduce its reliance on acute care in hospital.

In November 2012, Good Hope Hospital (GHH) in the West Midlands sought an innovative solution to both improve clinical outcomes and increase the cost-effectiveness of care. The hospital decided that finding alternative capacity to replace expensive acute care would help meet these goals and partnered with Healthcare at Home in 2012 to launch a Recovery at Home service.

The benefits
The Recovery at Home service provides an alternative for patients who do not wish to be treated in hospital by providing the option to receive clinical care at home. Since its launch, almost 1,000 patients have benefited from the service which has delivered excellent outcomes for both the hospital and patients, including:

• 10,988 bed nights have been saved
• cancelled elective operations have been reduced by 43 per cent
• the length of stay for medical patients has dropped from 10.8 to 8.6 days
• patient satisfaction with the care they received is over 97 per cent
• GHH has been able to close a 34-bed inpatient elderly care ward. This released savings of £1.2 million to reinvest in Recovery at Home.
How the service works

Recovery at Home enables selected inpatients and those presenting themselves at A&E to continue their care at home as soon as they are clinically stable. Patients are selected for the service by specialists and ward staff and are assessed against a set of inclusion and exclusion criteria, such as the patient’s home environment and their acuity.

The Healthcare at Home and GHH team then proactively work with referring clinicians and local providers to agree a comprehensive care plan for every patient, designed around the individual’s clinical and personal needs.

Healthcare at Home provides the clinical staff needed to care for the patient in the home. Each patient that uses this service remains under the care of the hospital consultant while treatment continues to be administered by a team of physiotherapists, occupational therapists and healthcare support workers.

Once at the end of their acute care pathway, the patient will be discharged from the service into the care of their GP and ongoing care by community services if required. The Recovery at Home service has not replaced any existing service providers, including health, social care and other community services, but provides a complementary service supporting and building on the professional care already provided.

“The primary objective of the service is to deliver improved patient care.”

The solution

The solution to these issues was an innovative public-private partnership with Healthcare at Home. GHH decided to establish a service where patients who met specific criteria could continue their treatment in their home, rather than in hospital.

Healthcare at Home worked with GHH to develop and deliver a Recovery at Home service suitable for the hospital’s patients. GHH re-invested the £1.2 million from the ward closure to deliver a more flexible and sustainable model of healthcare that would focus on the specific needs of the patients using Healthcare at Home’s virtual ward.

The primary objective of the service was to deliver improved patient care by enabling safe, early discharge from hospital while delivering cost savings through the reduction of inappropriate readmissions and length of stay.

The Recovery at Home model started as a 26-bed virtual ward but has now expanded to 36 beds and covers most pathways.
Outcomes

Outcomes of the Recovery at Home service have been extremely positive. It has proved to be a highly effective alternative to in-hospital care for patients and a more appropriate use of public resources and acute hospital facilities.

Conclusion

The Recovery at Home service has transformed the provision of care for hundreds of patients by allowing them to benefit from a safe, early hospital discharge. Even at an early stage of implementation it is representing a better use of public resources, resulting in an increase in the appropriate use of acute hospital facilities, a reduction in unnecessary hospitalisations and shortening the time people stay in hospital. Furthermore, it is hugely popular with patients and is leading the way in designing innovative out-of-hospital models of care, co-designed and tailored to the needs of the specific patient cohorts.

The service has led to the development of the Collaborating Care Programme, a partnership between GHH, Healthcare at Home, St. Giles Care Agency and Midland Heart, which aims to identify further patient cohorts that can receive their care out of the hospital setting, including patients directly from A&E.

For more information on the Healthcare at Home Recovery at Home service, contact Andrew Burton, andrew.burton@hah.co.uk

Key outcomes

Released capacity

- A reduction in unnecessary hospitalisations and an increase in the number of patients discharged early has saved the hospital 10,988 bed nights over the life of the service.
- Almost 1,000 patients have been referred to the Recovery at Home service, allowing one 34-bed elderly care ward to be closed. This ensures acute hospital capacity is reassigned to deliver other services and meet other demands.
- The Recovery at Home service has assisted in shortening the time people stay in hospital when it is not clinically necessary, reducing length of stay in hospital from 10.8 days to 8.6 days on average.
- Cancelled elective operations have reduced by 43 per cent.

Patient outcomes and satisfaction

- 97 per cent of patients said they were satisfied with the service. This can be attributed to the empowerment and support patients receive which facilitates more independent living. Recovery at Home provides a service tailored to the individual needs of the patient, while they are able to experience the familiarities of home with friends and family in the local community.
- Clinically, risk is dramatically reduced as patients recovering at home are less likely to deteriorate through infection, falls or medical errors.

Culture change

- The Recovery at Home service has helped improve working relationships with community providers as they are forced to think about the same patient outcome.
- Staff have become more open to ‘disruptive innovation’ as GHH and Healthcare at Home have shown that things can be done differently and that it is something that yields positive results for patients.
- It has laid a foundation upon which future service developments can be implemented with the aim of delivering care to patients in the most appropriate setting and generating greater economies of scale.
Delivering innovation in musculoskeletal services
Connect Physical Health

About Connect Physical Health
Connect Physical Health is the leading independent community NHS provider of musculoskeletal physiotherapy services in the UK. Our organisation is led by clinicians and physiotherapists by background, meaning that clinical excellence and patient outcomes are at the heart of what we do. We pride ourselves on our exceptional standards of patient care, the variety of treatments on offer and short waiting times we achieve for our NHS partners. With over 20 years of experience partnering with the NHS, we have developed numerous models of delivery which optimise patient outcomes while also providing value for money.

Connect Physical Health, partnering with Newcastle West Clinical Commissioning Group (NWCCG) and Newcastle upon Tyne Hospitals NHS Foundation Trust, undertook an innovative pilot to reform musculoskeletal (MSK) services locally and delivered exceptional results.

The positive outcomes of the pilot demonstrate the benefits to patients and commissioners of collaboration and integration across the health community.

As MSK conditions are becoming increasingly prevalent, currently taking up to one in every four GP consultations, it is crucial to consider how the NHS alongside its partners can respond to these challenges. The Newcastle West Pilot not only shortened the pathway of care for patients but enabled us to support more patients at less cost through streamlining the process.

“The service was a doorway to joined-up treatment for a wide range of muscular and bone problems. I enjoyed being kept well informed of my patient’s progress.”
Dr Mike Scott

The need for change
• In 2008, Connect Physical Health operated a community MSK Clinical Assessment and Treatment Service (CATs) provider, Connect Physical Health, to operate the whole community pathway for the pilot.

• The service was utilised effectively by some GPs, but not consistently across the board, and many patients were still referred unnecessarily to secondary care.

• Undifferentiated patients at secondary care led to low conversion rates for surgery and inefficient use of consultant time which resulted in poor outcomes for patients and a strain on NHS budgets.

• The success of reforms relied upon gaining the confidence of GPs by markedly reducing physiotherapy waits.

Figure 1. Newcastle West MSK pilot pathway 2011
The CCG commissioned the existing Clinical Assessment and Treatment Service (CATS) provider, Connect Physical Health, to operate the whole community pathway for the pilot.
Reforming the pathway

• NWCCG commissioned Connect Physical Health to undertake a MSK pilot study for two years in 2011/12, working with nine local GP surgeries (total patient lists exceeding 77,000).
• GPs referred all patients (other than defined exclusions) to the community service.
• The decision to access secondary care would be taken by the MSK CATs service itself.
• New physiotherapy services were sited in numerous GP practices to improve access and reduce waiting times.
• All referrals were coordinated via a specialised ‘call referral management’ centre to ensure patients were dealt with promptly and efficiently.
• Telephone triage was introduced to enable patients to access immediate guidance from the comfort of their own home.
• Sports, exercise and orthopaedic specialists were included as part of the clinical team to enable patients to access specialist care in the community.
• The pilot was ‘pump-primed’ to put in place a new and efficient physiotherapy service, allowing the existing physiotherapy service to concentrate on a smaller number of practices with the same level of funding.

“Both professionally and on behalf of the overwhelming majority of our patients, we have found this community based service to deliver in accessibility, responsiveness and quality.”
Dr David Black

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Outcomes

A corresponding increase in community consultations occurred, including a large increase in physiotherapy consultations, of which 15 per cent were telephone only. Overall, there were 62 per cent more patient episodes in 2012, demonstrating that a large number of extra patients received care ranging from telephone advice early in their care through to traditional secondary care attendance.

Waiting times were also significantly reduced, including less than 48 hours for physiotherapy telephone triage, and an average wait of six days for face to face physiotherapy – important both in tackling problems early and reducing chronicity.

Financial benefits

• When national secondary care and locally negotiated community tariffs were applied to the modernised pathway the total cost in a six month period in 2012 was £42,000 less than the same period in 2010. This covered a population of 77,000. In a typical CCG population of 200,000, savings are likely to be around £220,000 a year.
• The pilot also saw a saving of 41 per cent per average episode of care, with costs reducing from £281 in 2010 to £167 in 2012.
Benefits for Connect Physical Health

• Connect benefited from the relationships that developed with the local hospital foundation trust and local GPs who commissioned the pilot service. The strong level of trust that now exists bodes well for the future. Each organisation has been able to dispel some myths about adverse philosophy and intentions regarding NHS provision and work together for the benefit of patients and the NHS.

• Through being able to apply a supremely efficient service and pathway for a whole community service, we have gained the confidence to innovate and influence others. We have since entered into three formal partnerships with other hospital foundation trusts who have been impressed by our partnership knowledge.

Broader lessons from the Newcastle West pilot

• The principles of this pilot can be applied across the country.

• The Newcastle West pathway is one of many innovative approaches which can improve MSK delivery.

• It is crucial in undertaking MSK pathway reform to communicate and build confidence with primary care, secondary care clinicians and providers.

• There are significant potential financial benefits to reforming MSK. This should be a priority for any CCG.

• Improved capacity can be delivered without the need for significant investment.

Going forward

Newcastle West CCG applied the guidance from the MSK Framework during a two year pilot and demonstrated that more patients could be treated at a reduced overall cost using this model. Data revealed that quality of care had not suffered and GPs were so positive that the pilot was extended into 2013 with plans to utilise the model more permanently.

Key outcomes

• Improved patient satisfaction – an academic study of the pilot revealed that 96 per cent of patients rated their care as ‘excellent’ or ‘very good’ and there were no significant complaints or incidents throughout the two years of the pilot.

• Widespread GP support – 97 per cent of GPs interviewed said the reformed MSK service was ‘better’ or ‘much better’ than the service in 2010.

• Reducing waiting times and improving delivery – the partnership increased patient care by 62 per cent in 2012, compared to 2010, while still reducing overall expenditure and waiting times.

• Reducing NHS costs – the pilot saved the NHS £42,000 in six months.

• Direct access to surgery – appropriate referrals and direct access to surgical consultants meant that patients were fast tracked through the pathway and received speedier treatment, while making best use of consultants’ time.

• Reduction in outpatient activity – as a result of a 174 per cent increase in community physio referrals.

• Effective partnership working – partnership working between a clinical commissioning group, NHS foundation trust and an independent NHS provider can produce excellent results for the NHS.

1. Dr Graeme Wilkes (2 May 2013), The Newcastle West Community MSK Pilot

For more information on the Newcastle West Pilot, see: www.connectphysiotherapy.co.uk/connect-the-nhs/newcastle-west-pilot/

To see a video case study with more information on the Newcastle West Pilot, see: www.youtube.com/watch?v=mMJpCe-R32g

For more information, contact Katharine McHugh, Development Manager, on 0191 250 4974 or email katharinemchugh@connectphysiotherapy.co.uk
Innovation is crucial to the ongoing success of any organisation. An important feature of the Horder Healthcare business model is that we continually identify ways in which we can improve our systems and processes in order to enhance patient experience. As part of this, we hold regular patient forums where we invite patients who have experienced our unique brand of care to come back and share their experiences with us, telling their stories to our staff. This enables the forum members to work out new ways of doing things together and in a way that our patients value.

During these forums it was identified that some patients, particularly those undergoing joint replacement surgery, needed extra support at home following their discharge from hospital. To help them, patients are given an exercise sheet to follow at home after having been shown the exercises by our specialist physiotherapy team. Patients can also attend one of the outpatient group therapy sessions frequently held at our outreach facility in their local community.

Through these forums some patients mentioned that once they had got home they did not particularly want to travel in order to access physiotherapy and would prefer to stay in the comfort of their own homes. Other patients said that with all the information they are given on discharge it is all too easy to forget exactly how to do the exercises that they are given to help their recovery.

Developing an approach to achieve innovation

As a result, the forum proposed that a simple video showing step-by-step actions and giving advice would be extremely helpful and of additional benefit to patients.

Once this idea was identified, a multi-disciplinary project team was pulled together from across the organisation to identify how we could develop this innovation and identify the likely costs and impact. The team highlighted a number of exercise programmes that would definitely have a positive effect on patients and then prioritised those that would have the greatest impact.

Exercises to strengthen the knee after surgery was identified as the first video to produce. This decision was based on a number of factors, including:

- patient feedback – through the forum
- data analysis – through both ranking and rating and following analysis of our PROMs (Patient Reported Outcome Measures) data
- potential for improvement – while our PROMs data for patients having undergone knee replacement surgery compared well to other organisations, there was felt to be more room for improvement with regards to this procedure than others.

The specialist clinical team used their experience, current best practice and research methodology to develop the video.

“We continually identify ways in which we can improve our systems and processes in order to enhance patient experience.”
Cost
The cost of making the video, including staff preparation time, filming, production and editing, was estimated to be only £1,200 in total. This was felt to be very reasonable when considering the potential benefits.

Results
The video has achieved its aim of giving support and encouragement to patients once they are back home and helping them through their early post-operative recovery following knee replacement surgery. The video is available to view on our website and can also be downloaded free of charge onto smart devices.

“Since its launch the video has already been viewed over 500 times and is now being embedded into practice.”

The video reminds patients of the importance of specific daily exercises. It discusses the pain and discomfort they are likely to experience and what can be done to alleviate this.

Since its launch in January, the video has already been viewed over 500 times and is now being embedded into practice to help the clinical teams support their patients preparing for their discharge from hospital. Clinicians and patients are also starting to realise the benefits of using the video pre-operatively.

However, the long-term benefits of this innovation will have to be evaluated qualitatively through future forums, patient experience questionnaires and via the PROMs data. Other benefits may include cost savings derived from a reduction in the number of patients needing additional physiotherapy. We also hope to see a reduction in the number of paper copies of discharge exercises being produced.

Continuing to innovate and measure impact
One of Horder Healthcare’s strategic aims is to provide benefit to ever increasing numbers of patients and this project was felt to provide a real opportunity to achieve this. The project group therefore looked at extending the project. It identified other videos which could provide help and support, not only to our patients but to a wider audience.

A budget was set for the project of £25,000, which was funded from Horder’s innovation fund. Further videos have now been developed, including:

• preparing for surgery
• patient journey
• exercises to strengthen your knee after surgery
• exercises to strengthen your hip after surgery
• exercises to help lower back pain
• modified Pilates principles and exercise series.
This project is still in an embryonic stage and now more diverse in terms of the benefits which will be gained. While potential key benefits have been identified, we will now need to measure impact.

We are hoping that the result of this innovation will demonstrate an impact on a personal level by ensuring people are better informed, aiding them to recognise the importance of specific daily exercises in helping them with their musculoskeletal problems and supporting them to improve their general health and wellbeing. We hope it will also demonstrate the societal impact of this change.

It will be an extensive piece of work and we have already developed the framework for achieving this. From a business and marketing perspective we have seen a positive impact on the number of hits to our website which has helped raise awareness of our brand in the communities we serve and beyond.

**Stakeholder engagement**

Another of Horder Healthcare’s strategic aims is to lead continuous and meaningful engagement with our key stakeholders in order to develop services that work best for our communities. We hold regular educational sessions with our local GP and allied health professional communities who have welcomed this innovation. Feedback from them so far is that they find the videos a very functional and valuable resource to refer patients to during consultations.

We believe that through this innovation we will continue to enhance the lives of people with musculoskeletal disorders as well as improve outcomes and experience for our patients. Looking forward, we will be able to demonstrate to key stakeholders the positive impact of our work and therefore enhance Horder Healthcare’s reputation for excellence.

The Horder Healthcare video demonstrates post-operative exercises for patients recuperating in their own home. It is available at: www.horderhealthcare.co.uk/healthy-living/topic/video

For more information on Horder Healthcare and their musculoskeletal videos, contact Karen East, Business Development Manager, at Karen.East@horder.co.uk or on 01892 601455.
Locally designed referral service reaps rewards
Optum and NHS Hounslow

From November 2010, Optum, in partnership with Hounslow CCG and NHS Hounslow, developed a locally designed Request for Services (RFS) model aimed at facilitating the whole patient pathway from the GP to the healthcare provider and making use of the care that is available for the population. Patient engagement and involvement throughout the whole process has been key to ensuring a timely and responsive service is delivered to meet patients’ needs.

“I have always found the referral service staff to be polite and helpful, whether for myself or my children’s bookings. This service is very good to have, thank you.”

A patient in Hounslow

The service was driven and designed by local GPs, for local GPs. The RFS supports Hounslow practices with local GP-led referral management and advice, patient assisted Choose and Book utilisation and service provider advice to general practice. Algorithms and locally designed clinical guidelines have been used to support clinical triage by local GPs and this has facilitated the sharing of best practice, peer-to-peer education and learning between referrers.

Central to the programme is regular, timely and ongoing engagement with GPs and other key stakeholders. Staff are designated to communicate and work with local practice teams, including reception staff, practice managers and GPs, to promote the value of the programme and drive best use of the service.

Centralised tracking and data management are also delivered by Optum technology. This provides detailed data and information about referral behaviour and activity levels, which provides NHS Hounslow with the information needed to manage demand in the acute trusts and evidence for conversations with providers. Optum have applied lean methodology principles to process mapping of the service and, together with regular service review activities, this has enabled efficiencies to be identified and implemented to ensure the service is continually refined, developed and monitored to assure quality.

Key principles for the service

- **Innovation drives simplicity** – all process and procedures must make the referral process simpler for the patient, referer and provider.
- **Transparency creates trust** – the service is accessible to all stakeholders and actively seeks their involvement in development and improvement of the service.
- **Outcomes need to be proven** – Key Performance Indicators (KPIs) and commissioning data prove the value of the service to all stakeholders.
Costs
Start-up costs were in the region of £50,000. Hounslow has a population of 273,000 and the number of referrals processed in the last year was 113,000. Cost is approximately £8 per referral or £2.40 per patient.

We have rigorous reporting mechanisms already in place and are compliant with the Data Protection Act and Connecting for Health Guidelines. As part of the triage process our system can be adapted to incorporate any feedback response from the triager that the commissioners may find useful to collate. For example, the question “Have you identified a potential commissioning opportunity within this referral?”, when collated could provide the commissioner with information on which to explore future commissioning opportunities.

Our reporting can also be extended to incorporate provision of information at practice level and any combination of information relating to that practice. For example, we can tell you how many referrals any GP in any practice, including locums, have made to cardiology or were returned for a clinical reason by making use of each clinician’s General Medical Council number. This has been particularly useful for tracking which practice locums are working across the CCG.

Ongoing engagement
Following on from the initial engagement activities, a strategy to deliver ongoing communication is in place. Engagement visits provide a platform for discussion between the GPs and the RFS staff and these enable feedback on performance to the individual GP and practice as well as management of any complaints. Feedback includes evidence related to usage of the service from the practice and individual GP as well as sharing of comparable data to allow the GP/practice insight as to how they compare across NHS Hounslow. As part of that engagement work, we produce a bi-monthly newsletter for GPs and practices which contains information on any new CCG-wide service developments or initiatives, important updates or reminders, along with RFS statistics and diary dates.

Benefits to organisations, patients and the NHS
The RFS delivers a high-quality, proactive service with numerous benefits. This is reflected in both the delivery of the stringent key performance indicators and the positive feedback from patients, GPs and secondary care providers in satisfaction survey results.

Future innovation
Optum, Hounslow CCG and the RFS will continue to work together to further innovate and develop the service, in order to:

• increase the number of referrals that are triaged by local GPs within the service and add additional clinical specialties
• increase the number of internally generated referrals (C2C) by working with secondary care providers and the commissioning support unit to build in the RFS process within acute contracts
Key benefits

- Open 8am–8pm, five days a week, offering a central point of contact for patients who have an enquiry about their referral. This includes the option to change hospital appointment times on Choose and Book and telephone support for vulnerable patients when making appointments.

- Provision of assistance for patients identified as having extra needs when using Choose and Book and booking hospital transport.

- Consistent achievement of four-hour turnaround for cancer referrals and two-day turnaround for all urgent and routine referrals.

- Increased quality of information and data about Hounslow patients and the usage of secondary and community care services.

- Increased quality of referral letters, standardising the referral process and adherence to local guidelines.

- Increased treatment options for patients.

- Reduced day-to-day administrative burden for referring practices as a result of the central referral point and the central point of contact for patients with referral queries.

- Feedback on referral patterns and the sharing of good practice amongst GPs results in reduced variation in referral practices.

- Implementation of a GP education plan to reduce unwarranted variation in referral practice that may lead to delays in patient care.

- Supporting local peer support networks for practices through provision of data information on practice referral patterns.

- More accurate referrals so that patients are sent to the most appropriate place first time, improving the patient experience and lowering acute activity costs to Hounslow CCG as patients are not inappropriately sent to secondary care providers.

- Update and develop further guidelines to support GP triage and primary care decision-making and develop and appraise GP triagers to ensure consistent and agreed protocols are followed.

- Continue to support GP practices with regular structured visits and accurate and timely reported referral data.

Innovative initiatives currently under development include:

- Implementation of processes to further support the accuracy of evidence-based clinical triage decisions. This includes a second layer of triage to ensure consistent and appropriate triage decisions are made. This will be supported by Optum’s proprietary electronic referral system with its real-time reporting capability that will ensure that triage activity will not delay the referral process.

- Working with our secondary care providers, Optum will enable consultant triage for agreed specialties. This will be undertaken remotely with the secondary care consultant accessing the electronic referral system. The system enables a simple RFS administered process to provide timely feedback to the referring GP from the consultant that will further support GP education and ultimately impact on increasing referral quality.

- Coordinate clinical advice for GPs from consultants. RFS will be the intermediary of clinical advice from secondary care consultants as jointly agreed with providers.

For more information on the Optum’s Request for Services model, contact Kate Howie, Head of Operations at Optum, on 07811 392 608 or email kate_howie@optum.com
Clinical management solution improves patient care in Surrey

Virgin Care

Virgin Care recently implemented a unique clinical management solution (CMS) as a catalyst to delivering effective change. Initially implemented across Surrey’s community nursing service, the CMS has already delivered significant benefits including improved clinical performance and operational efficiencies.

About Virgin Care

Virgin Care provides more than 230 services across England. In Surrey, Virgin Care has more than 300 community nurses delivering frontline healthcare, along with six community hospitals and a range of other community-based services ranging from health visiting to palliative care.

The background

As part of the Surrey ‘Transforming Community Services’ project that began in 2012, Virgin Care began analysing all aspects of the services provided. Surrey’s community nursing service was prioritised due to the significant administrative burden that staff encountered. The review involved examining current performance through direct observation studies, interviews with staff and patients, and workshops with clinical leads.

This identified areas where improvements to the community nursing service could be made as the analysis showed that nurses were only able to spend a third of their time face-to-face with patients. A significant amount of the rest of the time was spent on administration.

From an operational perspective, examples included:

- an inconsistent approach by other healthcare providers to referring patients into the service led to time wasted collecting relevant patient information and the potential for referrals to be missed
- ineffective scheduling of staff using a paper-based system made centrally coordinating clinical activity and efficient utilisation of resources almost impossible
- the use of paper records forced staff to make multiple trips to base to pick up records when changes in the day occurred.

From a clinical perspective, examples included:

- nurses duplicating paper records up to three times for the same appointment – in the patient’s home, the core system within the service and the GP system
- missing master clinical records which were kept in the patient’s home
- poor datasets made it difficult for the service to review and enhance clinical performance
- combination of paper and electronic records resulted in appointments not being transferred onto the electronic system.

CMS in action

Virgin Care has committed to investing £3 million over a three-year period in a CMS in order to reduce clinical risk and enhance operational management of the service, and in an experienced partner Total Mobile (TM) to develop an end-to-end solution to suit the healthcare market.

The CMS is designed to support effective management of services and enable healthcare workers and their managers to carry out their specialist roles wherever their location, from capacity planning and scheduling through to systems integration and mobile data management.

The solution works alongside, and integrates directly with, existing clinical systems, enabling the development of a comprehensive patient record from multiple systems. It includes a number of elements:

- a workflow manager enhances Virgin Care’s referral/case management processes, capturing patient referrals and other critical patient information, enabling referrals to be processed effectively and appointments made, with all stages being recorded, tracked and auditable
- once appointments are made, the nursing staff in the hub use the CMS to allocate and schedule activity to the most appropriate clinician. Clinical managers can track work in a ‘live’ environment, giving them up-to-the-minute status of progress
- data management is supported across a range of mobile devices and with an offline capability. All information is electronically transferred, enabling staff to work in a truly mobile way.
The benefits

The CMS has brought about significant improvements for staff and patients. Nurses now have tablets linked to their core clinical system, allowing them to maintain records in the community. Dependency on paper and physical offices is now reduced as information about patients is received and updated electronically and stored locally on each secure device.

Before the system was introduced, nurses were spending up to 90 minutes each morning working out their schedule and planning routes. Now this information is sent to them electronically the night before, enabling them to go straight to their first patient.

Each entry clearly defines all the relevant patient details (demographic and clinical) and includes the list of clinical and non-clinical tasks for each appointment.

All tasks are supported by a series of locally generated ‘smart-forms’ which record the necessary information. With automated integration to the relevant clinical system, records no longer need to be duplicated after the visit. Nurses are now able to spend up to 40–45 per cent of their day caring for patients, rather than 26–30 per cent, enabling them to care for patients in their own home.

For the patient, the delivery of care is seamless as clinicians are fully equipped with all the information they need. The referral management element means patients are managed through the triage and referral process, with information being recorded at each stage of the patient journey. With a ‘real time’ tracker following the activity on the ground, patients are now able to have accurate appointment times and SMS message updates.

It also means staff can be re-assigned appointments through a ‘drag and drop’ facility ensuring postponing visits can be minimised. Outcomes are recorded with assigned steps to ensure all elements are completed before the clinician goes to the next patient.

From a service delivery perspective, the Red, Amber, Green (RAG) triage rating has been introduced into the system which helps the teams book appointments and schedule activity based on clinical need. This also gives greater insight into performance from both a clinical and operational perspective.

Benefits summary

Although it is early days, the initiative has already increased face-to-face patient time by 30 per cent, or almost two additional visits per day per whole time equivalent nurse. This has been delivered through large reductions on a like-for-like basis in:

- clinical records input (50 per cent)
- visit scheduling (75 per cent)
- general administration (60 per cent)
- referral handling and scheduling (33 per cent).

<table>
<thead>
<tr>
<th>Clinical risk</th>
<th>• automated clinical data record (cutting 50 per cent of time)</th>
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<tbody>
<tr>
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<td>• improved clinical record keeping through ‘mandated fields’</td>
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<td></td>
<td>• data availability</td>
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<td>Managerial control</td>
<td>• objective benchmarking now possible</td>
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<td></td>
<td>• responsive visits scheduling</td>
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<td>• effective rostering, maximising available resources and meeting appointment times</td>
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<td>Staff satisfaction</td>
<td>• patient face-to-face time increased by 30 per cent with average length of appointment remaining the same</td>
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<td>• structured teams and roles</td>
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<td>• protected time for peer support and shared learning</td>
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<td>Financial performance</td>
<td>• increased staff productivity</td>
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Figure 1. Benefits of the CMS
Figure 2. Summary of the CMS

<table>
<thead>
<tr>
<th>Issue</th>
<th>Clinical Management Solution</th>
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<tbody>
<tr>
<td>Protection of staff when patient records are lost in the home - often the only record held</td>
<td>Records held electronically and sent to relevant clinician providing ready access to information and better decision-making</td>
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<td>Clinical risk associated with the duplication of patient records into multiple systems</td>
<td>Electronic data entry enables an automated upload into all appropriate systems as per best practice</td>
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<td>Poor measures in place to support lone workers</td>
<td>Lone workers able to automatically update on progress (arrived/started/finished etc) and have a panic alarm</td>
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<td>Managers currently have no ‘real time’ centralised oversight of clinical activity undertaken by teams</td>
<td>Central oversight of all staff for managers, enabling re-tasking where, and if, appropriate</td>
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<tr>
<td>Absence of clinical information at the clinician’s disposal</td>
<td>Pre-agreed data sets including patient records available for clinicians which can be sent to staff electronically</td>
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<tr>
<td>No guarantee that all appointments are given an outcome</td>
<td>Outcomes enabled on the mobile device and restriction on proceeding without this</td>
</tr>
<tr>
<td>No assurance that all appointments planned are undertaken</td>
<td>All activity will be logged and flagged enabling managers to ensure all activity is undertaken</td>
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</table>

Sharing the benefits of the CMS

Virgin Care has worked closely with the Health and Social Care Information Centre (HSCIC) to create a solution that enables integration between the CMS and Rio, a National Spine solution supported through smart cards. This process required the support of robotic automation which had not previously been approved within the NHS. Work continues with HSCIC to further enhance the solution and integration with the wide number of clinical systems used throughout the healthcare sector.

“I am incredibly proud of what we have achieved within the first few months of this project and I have no doubt that this will change the way community services are delivered, while providing a better patient experience. I believe the opportunities are endless.”

Marie Cummings,
Virgin Care clinical lead for the project

For more information on the clinical management solution at Virgin Care, email innovation@virgincare.co.uk or see virgincare.co.uk