Dear Colleague,

Welcome to the second edition of the Urgent Care newsletter. This publication is designed to keep you updated with progress around some of the key projects that are improving our Urgent Care system here in Dudley.

Notable achievements within this edition include the success to date of the Intermediate Care project, with 51 patients being supported by the community intermediate care team in their own homes. I’m sure you will agree that, with Christmas approaching, services such as these really do have a big impact on peoples lives, as no one wants to spend Christmas in hospital.

The Virtual Ward project roll out is continuing to be a success and is, in some cases, ahead of schedule. This has only been possible through joint working between the team from DCS and local GPs.

We received some excellent feedback on the last edition of this publication and, as always, we are keen to hear your views and what you think we could include in future editions to make this as beneficial as possible.

I look forward to the continued success of the projects detailed in this edition throughout the coming year and wish you all a Merry Christmas.

Best Wishes,

Sue Roberts, Director Lead for Urgent Care

The Virtual Ward

Thanks to a great deal of effort put into the project by our colleagues in Dudley Community Services, the GP practices that have engaged in the programme and the work going on at NHS Dudley, Dudley’s Virtual Ward programme is proceeding on, and in some cases ahead of, schedule.

As ever, we in the project team want to hear your feedback about the roll out of the Virtual Ward and the aim of this communication is to let you know about some of the things you have brought to our attention and what has been done to address those issues for you.
Psychiatric Liaison Team

The Project is now starting to gather pace and additional funding has been made available to ensure an established service is available for all. The Psychiatric Liaison Team (PLT) will be based in the Emergency Department of Russells Hall Hospital. The PLT will work with service users who present at the Emergency Department with a mental health crisis. The service will be based at DGoH but will also be available to any patients accessing the Walk-in Centre.

The secured funding will provide staff who will have specialist expertise in general adult mental health including self harm and will:

- Provide improved access to skilled mental health assessment and treatment, including early intervention, promoting recovery and well-being for patients with mental health issues who often present in crisis to an acute medical hospital and the Walk-in Centre.

The Team will provide a focal point of contact and access for all the acute general hospital referrals for specialist assessment of mental health, substance misuse and self harm needs. They will carry out a comprehensive assessment incorporating established risk assessment screening tools with every referral from ED. Outline targets have been agreed and all assessments within DGoH will be carried out within 30 minutes, the target for the Walk-in Centre is being evaluated and is likely to be 60 minutes to allow for travelling. Other measures are being evaluated and the operating time for the service is being reviewed to ensure the most appropriate and efficient service can be provided for those in need of assistance.

Negotiations are currently underway with Dudley and Walsall Mental Health Partnership Trust in respect of a start date for this new service.

Further information is available from Elaine Woodward, Strategic Commissioning Lead - Mental Health, email elaine.woodward@dudley.nhs.uk.

Whole Systems Analysis

As part of the work done within the urgent care environment, there is recognition that a partnering agreement needs to be put in place to share data across the health economy. The Discharge Database is seen as the fore-runner for a wider sharing agreement.

Discharge Database

The element of this project looking at the Discharge Database is moving forward, with staff and IT Departments in various agencies developing this work. This project is looking at how we can have one database rather than three, to have a common understanding of who is fit for discharge that can be agreed by all agencies. This will save staff time and help speed up the discharge process for the patient. It is intended that we will have a defined proposal for consideration by the Urgent Care Programme Board in February 2011.

Whole System Analysis

As the Discharge Database has shown, the preferred method is to address the IT infrastructure and data in a modular approach rather than a Whole Systems Approach. By using this method a tight rein is kept on finance and the modules can be broken down in to achievable outcomes.

Future Potential Modules Discussed

- Bed availability in the Community – Bed Care Status
- Bed/Ward Management
- Hospital Bed State – ED through to Discharge (Developing the patient journey)
- Live Bed Status from DGoH
- Management Dashboard – (live status reports on key business drivers)
- DGoH, Community Nursing Homes, Walk-in Centre
- Threshold Bid Targets
- Minimum 96% 4 hour wait in A&E
- Achieving a maximum 4% delayed transfers of care as per national definition
- A reduction in ambulance turnaround times based on 3 national performance bands

“The way forward - A Modular approach” is to be presented at the February Board.
Redeployment of Community Health Nurse Support

Some GP colleagues have seen the redeployment of Community Health Nurses (CHNs) as a withdrawal of this service, in favour of operating the Virtual Ward. There is certainly a redeployment of CHNs and in some cases a physical relocation of the staff involved, but no contracted CHN services have been withdrawn. What we have done is identified that there was an inequality in the way that CHNs were deployed and that some were being asked to do things outside of their specification. We have looked at where these nurses’ services are most needed and moved them accordingly. We have identified a number of areas where CHNs were being used instead of another service already in place and have addressed those issues. Dudley Community Services have also developed a team of CHNs lead by a senior community nurse to look at the case loads of all the redeployed staff and ensure that all patients are supported appropriately. This team has been called the Transition Team and details of how to contact this team are at the end of this communication. Any patients not on the Virtual Ward that would usually be cared for by the CHN service can be referred to this team, but it is anticipated that use of the risk stratification tool will identify those appropriate patients felt to be most at risk - the elderly, vulnerable, chronically ill and housebound.

Community Phlebotomy Services

This has been a significant concern for our GPs as there was the perception that due to the Virtual Ward, domiciliary phlebotomy services were being withdrawn or scaled back.

What has been identified is that the current arrangement for community phlebotomy, which is contracted to Dudley Group of Hospitals to provide, has been ‘propped up’ for quite a long time by Community Health Nurses and the District Nursing Service. When the Virtual Ward redeployed staff back into the roles that they have been employed to do, it exposed the shortfall in domiciliary phlebotomy services.

We can’t leave the patients of Dudley without a domiciliary phlebotomy service, but neither can we provide a service that is contracted to DGoH to provide, so separate and in addition to the Virtual Ward and existing domiciliary phlebotomy we are providing interim support whilst commissioning at NHS Dudley can negotiate appropriate services for next year.

This service will provide domiciliary phlebotomy for housebound patients that require urgent and fasting blood tests – routine tests must still go to the phlebotomy service. This additional support can be accessed via the Transition Team.

Over 70’s Discharged from Hospital Checks

Something that has been ongoing for a number of years is the blanket referral of all patients over the age of 70 who have been discharged from hospital. They have been referred to Community Nursing Services whether there is a clinical need for the referral or not. This has been identified as significant misuse of clinical resources, and consequently the blanket referral of patients over the age of 70 being discharged from DGoH will cease. The hospital has already been informed of this change, but we do expect a small amount of referrals whilst this change passes through the system.

It will be up to the teams receiving the referral to decide, in liaison with DGoH if necessary, whether there is a clinical need for a Community Nurse visit and, whilst it is appreciated that the paperwork is time consuming, our aim is to have the message throughout DGoH by the spring to only refer people with a recognised clinical need for a specialist Community Nurse to visit and reduce this workload accordingly.

Virtual Ward - Single Point of Contact

We are now able to provide a single point of contact for the Virtual Ward. This is to ensure that we collate all attendances at DGoH and that if it is possible, a member of the Virtual Ward Team attends to assess the patient and possibly intervene to stop inappropriate admittance.

Virtual Ward Central Administrator (all patient related enquiries): 01384 365227

Transition Team (patient related enquiries and referrals): 01384 361371

Many thanks to all of you who have been working so hard on this programme - throughout the region, NHS Dudley has been highlighted as a beacon of good and innovative practice in Virtual Wards and it is thanks to your continued dedication.

Warm regards,

Brian Bostock, Clinical Lead for Clinical Knowledge Management; Project Lead - Virtual Ward
Single Point of Access

NHS Pathways

Within the Urgent and Emergency Care envelope, a variety of systems are used by a variety of service providers. This can lead to inconsistent responses to patients, great difficulty sharing pertinent information with other providers and limited ability to cross refer to the multitude of primary care services available to deliver urgent care. The proposed NHS Pathways is a comprehensive suite of clinical content, specifically designed by NHS clinicians for use in 999 control, GP Out of Hours and NHS Direct. Extensive pilots and academic evaluation led to a ministerial license of NHS Pathways for use in the NHS. NHS Pathways provides a single point of access for patients by using consistent evidence based assessment to identify the patient’s specific clinical needs. With this information, NHS pathways is able to cross-match these needs through an integrated directory to a local service provider as close to the patients home as possible. This Single Point of Access is now possible.

In the last newsletter, we reported that it was anticipated that this project would potentially evolve into a joint project with the Pathway work currently being developed by the West Midlands Ambulance Service. To this end, we can now report that an initial presentation has been made to the Directory of Service Project Team which has highlighted the following potential additional benefits to our Local Health Economy:

Additional Benefit if using both NHS Pathways/Directory of Service

Clinical Tool that allows:

- Effective identification emergencies and rapidly dispatch ambulance support without delay.
- Effective identification the level of urgent care needed and refer, at first contact, to the most appropriate local provider.
- Seamless mapping of an individual patient’s specific clinical requirements to the clinical capabilities of all local service providers that are open, have capacity and are close to the patient.
- Commissioners to be provided with detailed data showing actual clinical skills needed in their area by time of day and postcode.
- NHS Pathways to offer the NHS the means to achieve fast, effective referrals to appropriate urgent care, resulting in delivery of a viable Single Point of Access for all urgent and emergency care calls on first contact.

Next Stage

Further work is taking place to evaluate the practicalities of realising these new benefits for our Local Health Economy. This will start with a detailed demonstration of the practical use of the tool. This will ensure we understand how our clinical users will interact with the tool and the time/skills required to create the Service on the Directory.

We will also evaluate the advantages and disadvantages of producing an independent local Directory of Service versus the joint NHS Pathways/Directory of Service.

The proposed Pathway solution that is being investigated:
Front End of ED (FE’ED) and Emergency Admissions Unit

Avoidable attendance to the Emergency Department and Emergency Assessment Unit impedes patient flow through the hospital and impacts on the ability of front end emergency services to progress patients through the system. Karen Hanson (General Manager) has been appointed as the project lead based in Russells Hall, Dudley Group of Hospitals.

The Front End enhancement was for the establishment of senior specific roles to work across the Emergency Department and Emergency Assessment Unit to provide early assessment at the right time to contribute to the multidisciplinary discharge planning. As part of this initiative there is now a seventh consultant within the ED environment providing cover until 10:00pm, so ensuring all peak hours of activity are covered. Karen has further appointed a Social Worker and Therapist to ensure a complete service is provided.

The work to date has gone a long way in preventing unnecessary hospital admission and to facilitate care closer to home. Other avenues and work-streams are being evaluated including the role of Thunderburds within the ED environment. Karen will update the progress at the next Board meeting in January and further updates will appear in the next newsletter in early 2011.

Intermediate Care

The Intermediate care project is moving at pace and the recognised gap in local intermediate care provision is being closed. The funding previously secured through the threshold bids to the Strategic Health Authority is being put to good use and results are already showing through. We have developed a local service that can support people in their own home and, by the end of November 2010, 51 patients were being supported by the community intermediate care team. The work is continuing and the identification and increase of team caseload is anticipated to be 75 patients by early January 2011. This number was the initial proposal for supporting people in the community, due to the success that has been achieved this number is being reviewed with the intent of raising the bar. Without this service many of these individuals may have been in an acute setting over the Christmas period.

The multi-disciplinary team consists of:

- Community Nurse support
- Re-ablement (provided by Start team)
- Community Occupational therapy
- Dedicated physiotherapy and nursing support now working within the team
- Social Work
- Specialist Nurse Practitioner support (as and when required)

As part of the previous work carried out and distributed at least in part by this newsletter the Access criteria and referral routes had been distributed to all community, intermediate care and acute care colleagues.

Over the next few weeks:

- Local Authority transition team will be linking to the community team to ensure patients needing ongoing long term care are supported following discharge from the intermediate care service
- We are looking at commissioning extra bed based services potentially being developed at Tiled House to ensure sufficient capacity is available for intermediate care over the winter period. This will help with capacity issues at the acute setting and hopefully relieve some of the pressure over this busy period.
Referral Pathway

For further information, please contact the following:

**Jenny Cale**, Dudley PCT, Intermediate Care
Jenny.cale@dudley.nhs.uk
01384 321943

**Sue Beach**, Home Care Management Team
Sue.Beach@dudley.gov.uk
0300 555 0055

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*right care, right time, right place*