PACESETTER SCHEMES 2018-19

Health Board	**Abertawe Bro Morgannwg University Health Board**
Pacesetter Title	**Community Treatment Centre** *(12 months pacesetter funding)*
Context: what is the current evidence and how does this project add value?	Current evidence shows that a significant amount of low healthcare value work is undertaken in general practice. In particular, care for people with complex wounds, people who require regular injectable therapy such as hormone therapy for cancer treatment, depot contraceptive treatments, sexual health services etc is dispersed throughout general practice and is not systematically provided to a common standard of quality across our 11 cluster networks leading to inequity of access and variation in patient experience and outcomes. It is more cost effective to aggregate the needs of patients and deliver such services through specialised centres within community venues in each aggregated cluster network area (based on Local Authority boundary). In addition, there is a wealth of clinical activity being delivered in outpatient departments on hospital sites that could be transferred into a community setting, closer to patients homes, for example, vascular led and complex TVN wound services, MSK injecting services, therapy services, diabetes services, etc and there is a need to extend provision within some of our services to have a more preventative approach, for example, the establishment of an early identification, fast track diagnosis and intervention podiatry led service for peripheral arterial disease. The value is added from the workload transfer away from hard pressed general practice teams and away from secondary care outpatient departments into community based treatment centres staffed by specialised practitioners (eg vascular and TVN nurses, / injectable teams, podiatrist technicians). This releases capacity in general practice, as well as potentially providing better clinical outcomes for patients from a more specialist consistent service. It supports general practice at a time of significant workload pressure, and has the potential to see further significant shifts of work out of practice and into shared teams within the cluster to compliment the “hub and spoke” approach to new models of care delivery.

Aims of project	• To reduce workload in general practice and consequently address ongoing practice sustainability • To provide equity of provision and access to services across a cluster area mitigating from the patchwork provision generated through Enhanced Service take up across primary care • To provide a specialist vascular led TVN wound care service that helps improve patient care, reduces complications from inadequate wound care treatment (eg amputations) and is responsive to patient needs • To provide access to a range of specialist skills in a community setting eg tissue viability nurses, vascular surgeons, podiatry services etc • That has the ability to take on additional specialised tasks such as injectable of a range of therapy, including but not limited to depot contraceptive implants, hormone therapy, occupational vaccinations • To pilot a Podiatry led, technician operated, community, Peripheral Arterial Assessment & Diagnostic Service (PADs) for early identification, diagnosis and intervention of peripheral arterial disease and cardiovascular crisis service to facilitate improved outcomes • To support the transfer of appropriate services and associated staffing from secondary care hospital sites into community venues closer to peoples homes • To increase the opportunity for cluster based working and working at scale
Allocation	£232,000, initially for period of one year to prove concept with ongoing funding build into the Health Board IMTP process and through service / funding realignment
Start date of project	1 April 2018
Alignment with Emerging Model	Through removing a significant volume of work from general practice, it will help with GP sustainability. By using the skills of specialist teams in a community setting, patients will have easier access than if such skills are constrained to an acute hospital site model. To support skill mix and workforce diversification within the cluster networks, to extend the range of community podiatry teams to pilot a new way of working to reduce of inappropriate need to attend secondary care, and reduce the need for ED and emergency vascular surgery with resultant increased LOS through earlier identification and community management.

Potential to demonstrate financial redesign / resource shift	Earlier access to specialist advice and skills is highly likely to reduce complications from wounds, and lower limb vascular disease in turn reducing the need for expensive and distressing procedures such as amputation. Each amputation avoided is the equivalent of £12,300 of direct healthcare costs, as well as the societal impact of disability benefits, ongoing social care, patient distress and burden of health. Standardised treatment will also lead to efficiency and savings to wound care dressings through the provision of a centralised store and formulary. Retravision of other low healthcare value work from general practice and transfer of work and staff off a secondary care site to rebalance the financial and workforce systems towards cluster based working.
Dates for submission of Business Plan and Delivery agreements	Delivery Agreement for the Community Treatment centre will be submitted with the other funded delivery agreements at the end of February. A business case to inform IMTP service commissioning and service / budget realignment across the healthcare system will be worked up over the next six months to inform the 2019/20 service planning cycle.
Status within: **HB strategy** **IMTP process** **Cluster Action Plans**	Health Board strategy – GMS Sustainability, MDT working, workforce diversification and moving the provision of high quality high value services closer to peoples homes is placed at the core of the Health Board 5-year Primary and Community strategy and specifically complies with the workforce development model to create a more sustainable and agile future General Practice. Included in draft submission to Welsh Government for 2018/19 – one of the key service drivers for the PCS Unit and HB in 2018/19 to support GMS and core community services sustainability and supporting the shift of services away from secondary care Cluster action plans – Sustainability and alternative workforce development and implementation is forefront in all Cluster action plans.
Timescales for each stage of project, with rationale	Introduction of complex wound care incremental from 1 April

	Increase in specialist input 1 June (eg Vascular support, podiatry led vascular service, phlebotomy) Increase in range of services 1 September eg injectables, sexual health, other treatment pathways
Evaluation methodology and measures to be used	The primary means for evaluation will be whether workload can safely and effectively be transferred from general practice and outpatient clinics to the community based new treatment centres without significant detriment to patient reported outcomes. In addition, whether the more specialist care provided earlier in the pathway reduces onward referrals, rates of lower limb / extremity amputation fall compared to the current baseline etc Each service delivered within the treatment centres will have a specific monitoring and outcomes framework attached to it
Project support available	Specialist Nurse to be appointed to support the operational introduction of the treatment centres Unit Head of Primary and Community Services Development will provide senior oversight for the development of the treatment centres Unit Primary Care Estates manager to source suitable treatment locations, links to the ARCH Strategy and development of community base health and wellbeing centres Financial and other support as required at key stages of progress
Describe anticipated impact on health inequalities	By providing specialist care earlier in the patient journey, will reduce inequalities caused by variability of practice nurse skill set. By standardising access to services within the cluster area it will mitigate the variation and inequality experienced through differential Enhanced Service delivery in practices The location of the treatment centres will, initially, be driven by the availability of community space, once proof of concept and sustainable business model has been developed the centres can be located / developed in communities of greatest need. The community treatment centres will operate over six days providing better access to patients at

	weekends when GP surgeries are closed
Potential for rollout at scale, with indication of costs and workforce implications	Could be rolled out across health board area; costs likely to be approximately 2 times initial estimate for this pacesetter of around £232k pa. Workforce implications are that there is a current deficit in qualified nurses and health care assistants. It is likely that with a permanent recruitment, training could be justified to enhance skills and the knowledge base, improve efficiency and lead to better patient outcomes Establishment of community treatment centres will provide the framework to support the shift in service and workforce off secondary care sites into community settings.

NATIONALLY AGREED CRITERIA FOR PACESETTER PROGRAMME – 2018/19

1. The schemes should be aligned to the work of the Implementing the Emerging Model Group in terms of building on:

    - Outcomes of previous Pacesetter projects
    - The whole system emerging model for primary care
    - Outcomes of the Pacesetter Critical Appraisal
    - Outcomes of the Parliamentary Review into Health and Social Care

2. Projects should actively explore the potential for whole system financial redesign and resource shift between sectors

3. Each project to be underpinned by a clear business plan and delivery agreement that has been agreed by the Health Board executive team, PC Directorate, cluster leads, the relevant cluster and the professionals responsible for delivering project outcomes.

4. A clear and realistic approach to timescales for project outcomes that takes account of bedding in, transforming care and reporting arrangements.

5. Robust measures for evaluation to be defined at the outset and using an appropriate range of methodologies to give a clear understanding of outcomes and benefits, including costing

6. The programme of work to be an integral part of the relevant cluster action plan, the health board strategy and the IMTP process

7. Evidence that the project team will be supported through appropriate backfill arrangements; dedicated project management; access to expertise in research analysis, IT systems usage and data analysis.

8. Consideration should be made of the specific challenges faced by professionals working with deprived communities in relation to innovation and redesign. Primary care teams in these areas often need more support and/or resource to initiate new ways of working and a proactive approach is required to promote innovation.