



Salford's Health Investment For Tomorrow (SHIFT) Programme

Vision and Blueprint

January 2007



Salford City Council



University Teaching Hospital

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Executive Summary

Welcome to the Salford's Health Investment For Tomorrow (SHIFT) Programme Vision and Blueprint document. SHIFT is an innovative and co-ordinated programme of improvement and investment in health and social care services in Salford, which we are keen to share with you.

We are proud of the strong SHIFT partnership which manages the programme and the objectives it has created. The outcomes of the programme are expected to make a huge difference to the people who live in Salford. This should be evident, not only in how people experience their contacts with health and social care services, but also in the health and well-being of some of our more vulnerable residents.

Anyone who lives in or visits Salford know it to be an improving and increasingly thriving city, but we also recognise that our services must develop to meet the needs and preferences of the people we serve. We hope you will work with us to bring about our vision.

We understand that people want better, more immediate access to advice and care, which is responsive to individual needs. Facilities need to be modernised to meet contemporary standards. People want to live more independently, knowing that care and support is available to them, when they need it.

We know that the health status of Salford residents is improving, but we also know that the improvement lags behind the rate of change across the rest of the country. This is why we have chosen to work in partnership across health and social care agencies – to make sure that the future will be different and better organised to bring about greater health gains.

Within this SHIFT Vision and Blueprint document, we have explained what the SHIFT aspirations are and how the five constituent projects have been established to deliver the vision. These projects are now making excellent progress, with new services and new buildings being evident across the city. We hope that this publication will help you to understand what the individual developments contribute to a whole new system of care.

Throughout the document we have included 'patient scenarios', which are there to describe the practical differences which SHIFT is either already realising or planning to deliver. These scenarios have been provided by some of our clinical staff to illustrate how they already do or plan to provide services and improve the experience of their patients. We hope you find the patient scenarios useful.

Salford's Health Investment For Tomorrow Programme

We are always keen to share our plans and receive feedback. For anyone who wants to learn more about current progress with the SHIFT Programme, further detail can be found at the following web-site:
www.shiftprogramme.co.uk



Roy Gilbert
Non-executive Director of Salford Primary Care
Trust and Chair of the SHIFT Programme Board



Mike Burrows
Chief Executive of Salford Primary Care Trust

1. Salford's Health Investment For Tomorrow (SHIFT) Programme

1.1 Establishing the SHIFT Programme

1.1.1 The Salford's Health Investment For Tomorrow (SHIFT) Programme is a longer-term service improvement initiative which is expected to transform healthcare provision in Salford. It will fundamentally change the experience of Salford residents as they access healthcare and linked social care services.

1.1.2 The SHIFT Programme was established in 2001, following approval by the Secretary of State for Health to the Strategic Outline Case (SOC). The SOC made the case for:

- ✓ the creation of contemporary healthcare buildings on the Salford Royal Hospital site and in primary care;
- ✓ an improved and comprehensive use of computer technology, to enable more effective management of patients in a range of settings;
- ✓ the development of new care models, which would result in improved accessibility and benefit to Salford's population;
- ✓ the development of new roles for healthcare staff, which would support the delivery of improved care.

1.1.3 In the intervening period since approval of the SOC, the SHIFT partnership has been established and developed its structure and governance arrangements. The SHIFT partnership is comprised of:

- Salford Primary Care Trust
- Salford Royal NHS Foundation Trust (formerly Salford Royal Hospitals Trust)
- Salford City Council
- University of Salford
- University of Manchester.

1.1.4 The SHIFT Programme consists of five distinct, but related projects. They are:

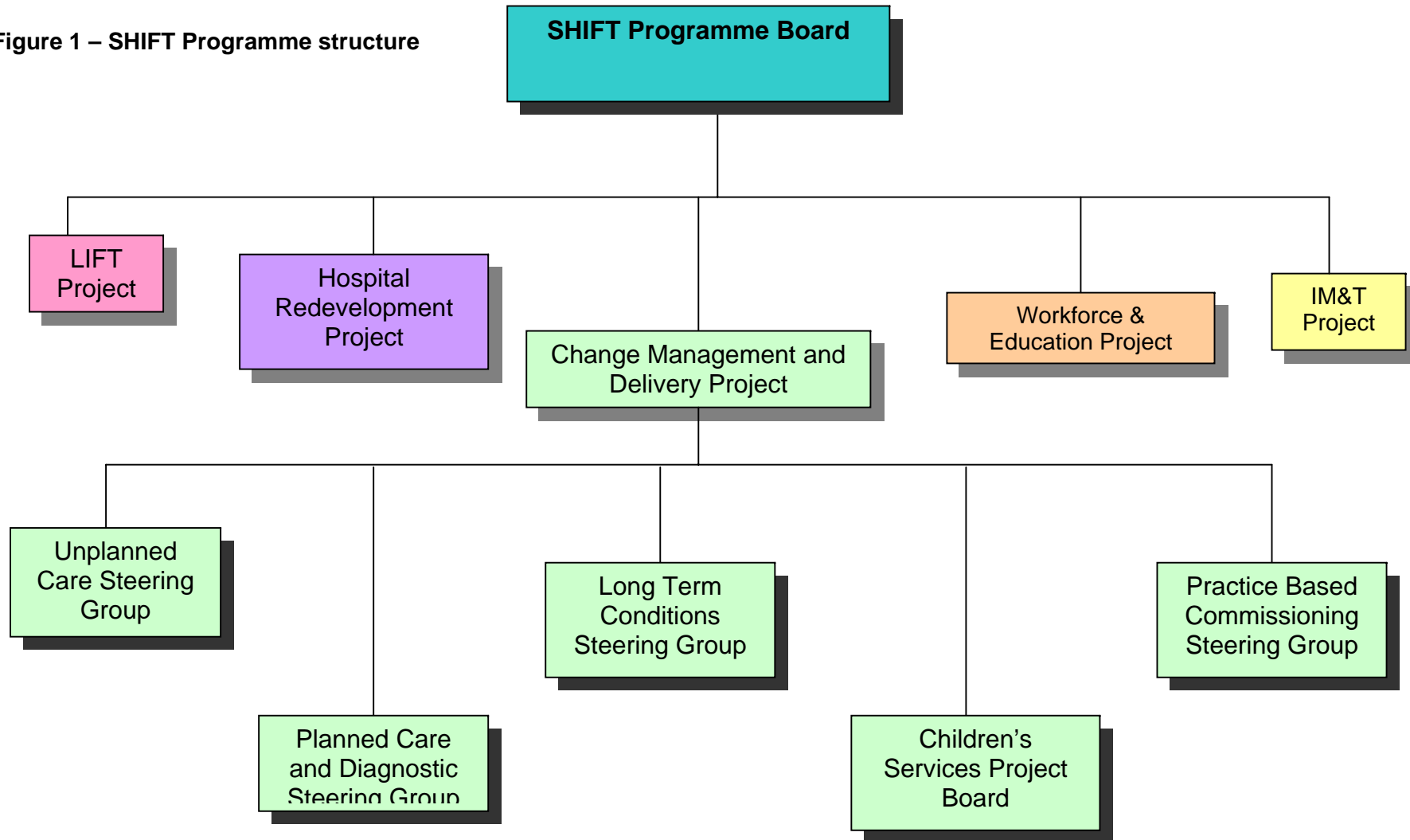
- Service Change Management and Delivery
- Salford Royal Foundation Trust Hospital Redevelopment
- LIFT (Local Improvement Finance Trust) Health and Social Care Centre developments
- Workforce and Education
- Information Management and Technology (IM&T).

1.1.5 Despite being established in 2001, the SHIFT vision has remained contemporary to present day policy for healthcare in England. This demonstrates that the strategy adopted

was genuinely forward looking and has enabled effective planning of healthcare facilities.

- 1.1.6 The following diagram provides an overview of the SHIFT Programme, identifying the constituent projects. Also shown is the structure of the Service Change Management and Delivery Project. This project has a particular prominence in the programme, as the vehicle through which services will be transformed.

Figure 1 – SHIFT Programme structure



1.2 The SHIFT Vision

1.2.1 The SHIFT Programme has defined a strategy for Salford which improves access to services and locates services "closer to home". This philosophy is being played out nationally by a centrally driven initiative to improve access to diagnostics to enable primary care management of less complex cases and reduce hospital referrals.

1.2.2 The SHIFT Vision is to:

- improve the health status of the Salford population through the availability and effectiveness of our health services
- services will be provided in the most convenient and accessible location possible, with a focus on moving services out of hospital into primary care settings
- wherever possible health and social care support will be co-ordinated to maximise the benefit to the service user
- replace a number of buildings which are no longer suitable for modern healthcare provision, extending the scope of some of the planned LIFT Centres to integrate health and social care services
- extend the use of technology to facilitate new ways of working and to empower healthcare workers in a range of settings to effectively support patients.

1.2.3 The SHIFT Vision will be delivered over the duration of the Programme, expected to continue until 2012. Regular re-assessment of the Programme to ensure its consistency

with the needs of the population and national policy will take place.

1.2.4 On the journey to 2012 there are some key landmarks which will see the delivery of key elements of the programme. These are shown on the following table:

Landmark event	Date of delivery
First LIFT building opened	October 2005
Hospital Redevelopment commences	June 2007
New service models fully implemented	2008
Final LIFT development (First phase) opened	2009
Hospital Redevelopment completed	2012 / 13
IM&T developments	Throughout
Workforce and Education developments	Throughout

More detail on these dates can be found in the respective sections of the document.

1.2.5 External scrutiny will take place through various bodies, including:

- ✓ Salford City Council Overview and Scrutiny Committee;
- ✓ Office of Government Commerce (OGC) through Gateway Reviews of the procurement projects;
- ✓ Northwest Strategic Health Authority.

1.3 The Blueprint

- 1.3.1 This Blueprint publication is provided to inform the public, patients and staff of the partner organisations of the changes envisaged by the delivery of the SHIFT Programme. The SHIFT partners believe that by managing and integrating the individual projects of the programme, the resulting changes will be more efficient, effective and will generally add value to the public's experiences of healthcare within Salford.
- 1.3.2 The Blueprint provides a model of how the health and relevant social care organisations and systems will work in the future: what it will look like and how it will work, to realise the benefits expected and desirable outcomes.
- 1.3.3 The format of this document will be to describe the future through a range of scenarios concentrating on the experiences of a number of residents of Salford, who access different levels of care and support by virtue of their health needs and circumstances.
- 1.3.4 Other parts of the Blueprint will describe the deliverables of the five constituent projects within the SHIFT Programme.
- 1.3.5 In the development of this Blueprint, a range of supporting material has been used and is referenced throughout.

1.4 The challenges of developing the vision

- 1.4.1 The development of such a forward looking vision remains a huge challenge within healthcare. These challenges emanate from a range of areas:
- Anticipating and shaping patient and public preferences;
 - Policy changes within the NHS;
 - The need to improve public health to manage future healthcare demands;
 - Financial constraints and the need to address the economics of healthcare provision against benefits arising from treatments;
 - Evolution of performance standards;
 - Difficulty in anticipating clinical changes;
 - Difficulty in anticipating healthcare technology developments.
- 1.4.2 The rate of change in relation to the development of new clinical techniques and supportive technologies is particularly difficult to plan for. The Healthcare Industries Task Force publication¹ in 2004 states that:
- 'As we understand more of the origins of disease, both genetic and environmental, we realise that we are on the*

¹ Better healthcare through partnership: a programme for action. Healthcare Industries Task Force Final Report – November 2004

verge of a new model. This will be based upon helping individuals understand and maintain their health throughout their lives, rather than simply treating disease after it has taken hold. The emphasis will shift from 'late' to 'early' and will expand from treating disease to maintaining health'.

- 1.4.3 This concurs with recommendations contained in the report of Derek Wanless published in 2002, which encouraged greater investment in Public Health generally and the Information Technology infrastructure.
- 1.4.4 This view is also consistent with SHIFT Programme plans and with the Government's January 2006 White Paper 'Our health, our care, our say', promoting improved public knowledge about healthy living and self care.
- 1.4.5 The SHIFT partners believe that despite the difficulties inherent in predicting future service models, the projects contained within the programme remain contemporary and will meet the needs of the population on delivery through to 2012. The culture and philosophy captured by the SHIFT Programme will also establish an approach to managing change, which will benefit future local developments.
- 1.4.6 The following sections will elaborate on the individual project plans.

Patient Scenario 1: Osteoporosis -outlining how a whole service approach to the prevention and management of osteoporosis and related fragility fractures has been adopted in Salford.

Prior to the recent introduction of the new care model described below, patients with osteoporosis were seen mainly in the hospital and those patients who presented with 'fragility' fractures were not assessed regarding their potential risk of osteoporosis.

Evidence has shown that following a fracture a patient may have as many as 13 extra GP visits and if the fracture is related to osteoporosis they will have an increased risk of further fracture. Patients of this type therefore require assessment and intervention to prevent secondary fragility fractures, lifestyle advice and self-management strategies through education and rehabilitation.

Case Study

Mrs D is a 66-year-old lady who presented to the service following a low trauma wrist fracture. She had multiple risk factors for osteoporosis, including significant co-morbidities, very early menopause, low dietary calcium, and loss of height. She also had a history of episodes of long-term oral corticosteroids.

Following identification in fracture clinic, she was assessed by the nurse specialist and referred for a bone mineral density scan. Whilst at clinic lifestyle was discussed and one area of concern for this lady was her inability to eat dairy products, advice on healthy eating was given, which was also supplemented with patient

information leaflets. The GP was also asked to prescribe a Calcium and Vitamin D supplement. Due to the level of risks this lady presented with to the GP was also asked to commence anti-osteoporotic therapy for this lady, which could be stopped if the scan results excluded osteoporosis. Drug treatment was also discussed, which included the correct method of administration and potential side effects. The nurse specialist undertakes this with all patients as compliance is a problem with long-term conditions, and in osteoporosis approximately 50% of patients stop taking therapy within the first 12 months. Unfortunately, whilst waiting for her scan this lady experienced a further fracture of her other wrist, therefore in her case it had been appropriate to start her on therapy.

The scan results revealed significant osteoporosis with an 18-fold increased hip fracture risk. Therefore the development of the primary care osteoporosis team has impacted on the care of this lady, and hopefully their intervention has prevented a future hip fracture.

To underpin this further, patients who are prescribed oral bisphosphonates (medication to help maintain bone density) are contacted to assess their compliance and establish if they are experiencing any side effects. This enables timely intervention to change therapy if required, and it further enables patients to feel confident about their treatment and ensure medication is being taken in the correct way.

To assist Mrs D to understand her condition and how she could maintain her independence, she was offered referral to the 'Bone Boosters' osteoporosis rehabilitation programme, which outlines exercise and education in a supportive setting. She found this to be very beneficial, as it was undertaken in a community clinic, in a supportive environment.

Mrs D has been discharged back to the care of her GP, but has access to the osteoporosis advice line, where all calls are answered within one working day.

2. Service Change Management and Delivery Project

2.1 Service Change Management and Delivery Project Summary

- 2.1.1 The Service Change Management and Delivery Project is established to create a new culture within Salford healthcare systems, to work in an integrated way, utilising new technologies and facilities to change and improve the experience of those who access services.
- 2.1.2 The project is led by David Dalton, Chief Executive of Salford Royal Foundation Trust, on behalf of the Salford health economy.
- 2.1.3 This is the principal project in the SHIFT Programme, as the needs of the Salford population and the services which need to develop in response to those needs drives the SHIFT strategy. The Service Change Management and Delivery Project links and overlaps with all other projects in the programme.
- 2.1.4 Wherever possible the project will influence the health and well-being of the Salford population by enabling a new approach to health and lifestyle.
- 2.1.5 Specific objectives include to:
- progress the service redesign and implementation of new care models

- develop services which are consistent with national and local strategy
- ensure services reflect best practice and effective clinical governance standards
- prepare the partner organisations and their staff for the new working processes
- inform the SRFT Hospital Redevelopment Project, Salford LIFT Project, SHIFT Workforce Project and Salford IM&T Project.

2.1.6 The diagram on page 6 shows the structure of the project.

2.2 Developing the workstreams and sub-projects

- 2.2.1 The service redesign work which took place in the first year of SHIFT provided a useful model for considering services across the whole health system. This phase was important to ensure that a range of staff could come together and develop a new model of services for Salford, without being concerned about the different organisational boundaries.
- 2.2.2 The service philosophy in SHIFT is taken from the SHIFT Vision described in 1.2.2 and can be summarised as:

- improve the health status of the Salford population through the availability and effectiveness of our health services
- services will be provided in the most convenient and accessible location possible, with a focus on moving services out of hospital into primary care settings
- wherever possible health and social care support will be co-ordinated to maximise the benefit to the service user.

2.2.3 The focus has been to consider services in the context of a patient's experience, reviewing 'patient pathways' or 'journeys'. Three key 'workstreams' were identified, within which all patients can be accommodated. These are:

- Unscheduled, or Urgent Care;
- Planned Care; and
- Long Term Conditions.

2.2.4 Other clinical areas which required a particular focus were Diagnostics and Children's Services.

2.2.5 Diagnostics services were selected as the availability of diagnostics is considered to be a key factor to facilitating primary care management and reducing 'patient pathways/journeys'. Diagnostics are considered within the Planned Care workstream.

2.2.6 The inclusion of Children's Services reflects the need to accommodate and develop provision for local children after the transfer of Pendlebury Hospital to the Central Manchester Trust site. The scope of this workstream

includes community-based care, hospital emergency care and day case surgery.

2.2.7 A final non-clinical workstream has been Practice Based Commissioning, which has enabled an alignment between the emerging commissioning model and service change. This workstream has now delivered the project outcome of establishing a Practice Based Commissioning model for Salford.

2.2.8 In this model the Salford area has been divided into eight 'clusters' (geographical areas which each contain a number of GP practices). These clusters have each identified a clinical lead (GP) and the combined group of clinical leads make commissioning decisions on the provision of clinical services from within the cluster and from other service providers, such as the hospital and primary care services.

2.2.9 Each of the workstreams are progressed by 5 Steering Groups and each is led by an Executive officer of one of the two healthcare organisations:

Steering Group	Chair
Unscheduled Care	Alison Dalley, Director of Modernisation, Salford PCT
Planned Care and Diagnostics	Raj Jain, Director of Workforce and Service Improvement, Salford Royal Foundation Trust
Long Term Conditions	Elaine Inglesby, Director of Nursing, Salford Royal Foundation Trust
Children's Services	Alan Campbell, Director of

	Strategic Commissioning, Salford Primary Care Trust
Practice Based Commissioning	Alan Campbell, Director of Strategic Commissioning, Salford Primary Care Trust

- 2.2.10 Each workstream has been established with a different remit and together they encompass the whole healthcare system. The workstreams are focused as follows:

Unscheduled Care

- 2.2.11 The Unscheduled Care Steering Group deal with the whole range of unscheduled or urgent care services, which are provided across Salford 24 hours a day, 7 days a week. These include Walk-In Centres, Accident and Emergency (A&E), General Practitioner Out-of-Hours services, Care at Home services, Pharmacists advisory services, and so on.
- 2.2.12 The development of unscheduled care services is to ensure that the needs of patients are safely addressed in a timely way. There is a significant focus on directing patients to the most appropriate part of the service and healthcare professional.
- 2.2.13 It is also important that such services are consistent with services provided in normal working hours and are linked with social care support. Intermediate care services which provide community based bedded accommodation or care at home are also a vital part of this group's remit.

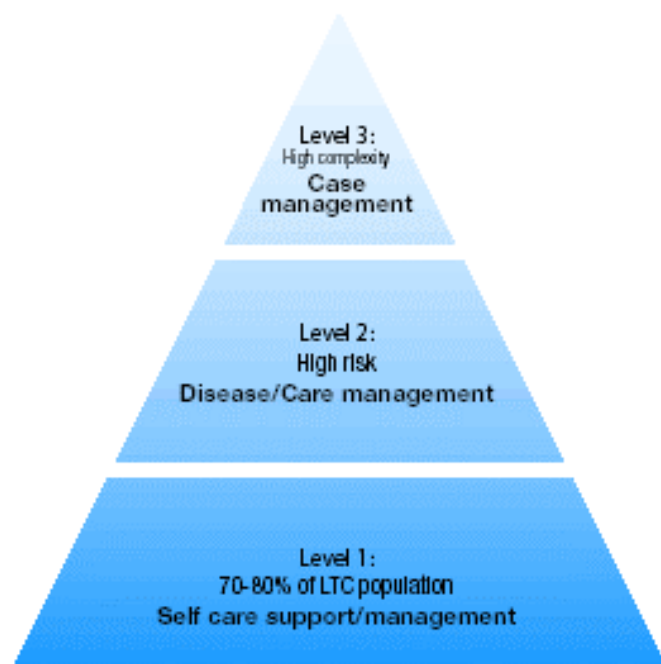
Planned Care and Diagnostics

- 2.2.14 The Planned Care and Diagnostics Group is focused on streamlining planned care services, particularly towards meeting the target, which is implemented from December 2008. The target requires that from the GP referral to the start of treatment should take no longer than 18 weeks.
- 2.2.15 This has created a substantial focus on improved access to diagnostics and ensuring administrative processes are streamlined and supported wherever possible by information technology.

Long Term Conditions

- 2.2.16 The Long Term Conditions Steering Group is focused on improving the experience of patients with one or more long term conditions and that their risk of deterioration is reduced. Self-care is crucial to reducing this risk and this project area retains the focus of 'self-care', which equally applies to unscheduled care.
- 2.2.17 A further aspiration of the Long Term Conditions Steering Group is to ensure care is provided in the most appropriate setting by the most appropriate clinician. This will result in the de-hospitalisation of Long Term Conditions and result in a system which is more empowering and responsive to the needs of the patients and carers. Only those patients with complex needs will require care by hospital-based clinicians.
- 2.2.18 The Long Term Conditions service model can be illustrated on the diagram which follows. This is taken from the

American model which was originated by the healthcare provider 'Kaiser Permanente'. It shows that for the entire population of people of who have a Long Term Condition, the greater numbers are those shown in the bottom of the triangle and who will be able to self-manage. The next level up, within which there are fewer people, are at a higher risk of complications and warrant a more managed level of care. The tip of the triangle, which represents a very small proportion of Long Term Condition sufferers, are high risk and need to be actively managed to prevent or reduce the impact of deterioration.



Children's Services

- 2.2.19 As described above, the inclusion of the Children's project ensures local services are established and developed in Salford, which address the needs of the population. This is relevant because of planned changes in existing services, which will include the closure of Pendlebury Hospital and the transfer of those services to the Central Manchester Trust site.
- 2.2.20 The Steering Groups report to the Service Change Management Project Board, chaired by David Dalton.

2.3 Current projects

- 2.3.1 The Service Change Management and Delivery Project have agreed a range of projects, some of which have been awarded 'pump-priming' monies in 2006/7 to be progressed, with a view to being self-funding by the end of a fixed period, generally of 2 years.
- 2.3.2 The following table provides an overview of the projects and what they seek to achieve:

Steering Group	Project	Project aims and objectives
Long Term Conditions	Clinical Decision Support (PCII)	An integrated patient record system that permits patients to view and understand their own diabetes health record and care plan at any time; health care professionals to share and view all relevant patient documentation; audit, reporting and research across the whole care community.
Long Term Conditions	Active Case Management	A proactive approach to optimise the primary and secondary care of patients with complex health needs by identifying those with complex health needs and using a predictive risk system. The model anticipates predictable risk, advocates self/carer management and promotes independence. It also aims to reduce hospitalisation and early discharge from hospital. Central to the concept is the role of the Case manager/Community matrons in whom accountability and responsibility is vested.
Long Term Conditions	Chronic Obstructive Pulmonary Disease (COPD) and Asthma	Establishment of a consultant physician (60:40 Acute : Primary Care) and a Nurse Consultant (60:40 Primary Care : Acute) to improve the management of COPD and Asthma. The focus to be placed on primary care management and supporting primary care practitioners to manage cases to prevent exacerbation. A range of supporting enablers includes: supported self management; register, recall, review; Clinical Decision Support; case and care management; guidelines, protocols and pathways.
Long Term Conditions	Diabetes Supported Self Care	Development of patient educational materials and training for both patients and staff in self management of Diabetes.
Long Term Conditions	Inflammatory Bowel Disease Supported Self Care	Development of patient educational materials and training for both patients and staff in self management of Inflammatory Bowel Disease.

Steering Group	Project	Project aims and objectives
Long Term Conditions	Alcohol abuse	A project aimed at supporting patients with alcohol related problems admitted to Secondary Care. To include those attending the A/E Dept, those with alcohol liver disease and those who have an underlying condition identified whilst in hospital. Extended nurse provision linked to the Salford Drug and Alcohol Team will support and direct patients to specialist support.
Planned Care	Weight Management	Development of a three tier model to support a reduction in obesity rates in Salford. Based mainly in primary care and leisure services, this project will provide a new care regime for healthcare professionals to offer to patients.
Planned Care	Anticoagulation	Develop a primary care based element to the Salford Anticoagulation service. Transfer has already commenced for 50-60% of appointments and 60-70% of patients from the Hope Anticoagulation clinic to primary care settings.
Planned Care	Case Tracking	Case Tracking - review processes through the hospital to reduce delays in both the emergency and elective processes. The outputs of this project will interlink with Diagnostic access reviews and the 18 week project.
Planned Care	18 week project	Reviewing processes and implementing initiatives towards meeting the 18 week target, which requires no patient to wait more than 18 weeks from GP referral to the commencement of treatment by 2008.
Planned Care	Tier 2	This is an on-going project to establish primary care based management of patients who would previously have been directed into hospital care. Established services include musculo-skeletal triage; minor surgery, including vasectomy; dermatology; headache, etc.
Planned Care	Day Case	This project is reviewing and increasing the proportion of day case procedures carried out within Salford, to ensure national averages are met or exceeded, within safe practice parameters. This benefits patients by reducing the requirement for overnight stays and minimising the risk of contracting hospital acquired infections.
Unscheduled Care	Pathways into and out of the Integrated Assessment Centre	This project seeks to implement new and develop existing pathways into and out of the Integrated Assessment Centre as part of the Salford Royal Foundation Trust Emergency Village. These pathways will contribute to the Planned Care 18 week project and case tracking. Of great relevance will be improved access to diagnostic services.

Steering Group	Project	Project aims and objectives
Unscheduled Care	Admission Avoidance Assessment Team	This project will develop a new team in the Emergency Village, which comprises of an Acute Physician and Intermediate Care GP, who will interface with the community based Rapid Response Assessment team.
Unscheduled Care	Transfer of Care Process	The main focus of this project is to review and streamline the Transfer of Care process, extending cover to 7 days per week. This will ensure the safe and timely transfer of patients, many of whom are elderly, through the primary / secondary / intermediate care system. It supports the efficient use of hospital resources and enables safe transfer home for patients.
Unscheduled Care	Intermediate Care Bed and Bed Equivalents	The development of Intermediate Care beds and bed equivalents to support the care of patients in the community, who otherwise would require hospital admission. The focus of this initiative is to provide patients with the opportunity to regain or retain independence, with the necessary level of healthcare and social support.
Unscheduled Care	Walk-in Centre development	To develop a hub and spoke Walk-in Centre model, with the hub in the Salford Royal Foundation Trust Emergency Village and community spoke in Little Hulton.
Unscheduled Care	Integrated Unscheduled Care Services in A&E footprint	To integrate the unscheduled care services based in the A&E footprint, including minors, majors, Walk-In Centre, GP Out-of-Hours service, Rapid Response Team, Mental Health Crisis Team and Over-night District Nurses.
Children's Services	Development of Pendleton Health and Social Care Centre (HSCC)	To develop and commission a model of service in Salford which effectively integrates the Pendleton HSCC with other parts of the children's care system. The HSCC will be delivered as part of the LIFT Project and will provide a focus for community level services and local clinics for secondary and tertiary based services.
Children's Services	Observation and Assessment Facility in A&E	Development of an integrated team for the management of acutely ill children and young people at Salford Royal Foundation Trust, which will link across the new system of services in Salford and the tertiary centre.
Children's Services	Paediatric Day Surgery	Establish the provision of paediatric day surgery at Salford Royal Foundation Trust, along with arrangements for overnight facilities. An objective is to ensure that 75% of elective procedures on Salford children will be on a day case basis.
Children's Services	Workforce development	Establish and develop a skilled and effective workforce to deliver redesigned integrated services for children and young people in Salford.

Steering Group	Project	Project aims and objectives
Diagnostics	Improved access to EEG/Neurophysiology	Reduce patient waiting times through capacity and demand studies.
Diagnostics	Prevent unnecessary admissions	Overlaps with unscheduled care and case tracking projects. Focus is to improve access to appropriate diagnostics.
Diagnostics	Improved access to Gamma Camera / Myoview	Reduce patient waiting times and extend access through capacity and demand studies.
Diagnostics	Improved access to Fluoroscopy	Reduce patient waiting times and extend access through capacity and demand studies.
Diagnostics	Improved access to Intra Venous Urograms	Reduce patient waiting times and extend access through capacity and demand studies.
Diagnostics	Improved access to breast imaging	Reduce patient waiting times and extend access through capacity and demand studies.
Diagnostics	Improved access to Radioisotopes	Reduce patient waiting times and extend access through capacity and demand studies.
Diagnostics	Improved access to Endoscopy	Reduce patient waiting times and extend access through capacity and demand studies.
Diagnostics	Improved access to Audiology	Reduce patient waiting times and extend access through capacity and demand studies.
Diagnostics	Improved access to ECG	Reduce patient waiting times and extend access through capacity and demand studies.
Diagnostics	Improved access to Ultrasound	Reduce patient waiting times and extend access through capacity and demand studies.
Diagnostics	Improved access to Cellular Pathology for cancers	Reduce reporting times capacity and demand studies.
Diagnostics	Establish diagnostics in designated Health and Social Care Centres	Development of effective and responsive care models, in a community based setting.

2.3.3 The projects will deliver at different points over a two year timeframe, concluding in 2008. Over the coming period,

further service improvements will be initiated, each contributing to the SHIFT service philosophy.

Patient Scenario 2: A respiratory patient²

This case scenario briefly depicts a typical picture of the patient pathway for a Salford resident with Chronic Obstructive Pulmonary Disease (COPD). By comparing the experience of the patient 5 years ago to the present day, the scenario is illustrating the type of change which the SHIFT Programme is delivering.

5 years ago

Sixty six year old Edward Turner had smoked tobacco since he was 12 years of age. He worked on the docks and in dusty warehouses all his life. He recently retired and lives with his wife, who is in relatively good health, in a period property in a deprived area of Salford. They had five children that all live with their families locally.

Over the past eight years he had gradually reduced his activity levels as a result of mild breathlessness that he attributed to the aging process. His appetite remained healthy, nonetheless he steadily lost weight and his BMI was 19. For the past fifteen years he had been coughing and expectorating a small amount of phlegm each morning and seems to have more cold viruses in the winter months than he did as a younger man. He had not mentioned any of these changes to his General Practitioner as he was not unduly concerned.

² Provided by Helen Pyne, Lead Respiratory Nurse/Advanced Practitioner

Mr Turner developed a chest infection and his condition deteriorated to a level where he was struggling to breathe when walking 10 meters on level ground. He had a persistent cough and was expectorating larger volumes of thick green sputum every day. His wife was concerned and booked an appointment at the GP surgery for the following day. Overnight his conditions significantly deteriorated and his wife arranged an ambulance to take him into the hospital for assessment.

At this point he was treated for an exacerbation of COPD. The exacerbation was so severe that he did not meet the criteria for the early support discharge team (CAST) and was managed in a hospital bed for the following nine days. Once his condition was stable he was referred to the Respiratory Nurse Specialist (RNS) who initiated an educational programme of self-management and identified the most appropriate therapies and delivery devices. His GP was informed of the diagnosis by immediate discharge letter and advised that follow-up would be with the RNS in out patient clinic.

Mr Turner would then be followed-up by the RNS in out patient clinic periodically and provided with a comprehensive programme of education for self-management of his condition. The severity of disease would be identified at least six weeks post exacerbation by spirometric lung function test. Treatments would be titrated until optimal therapy identified. Social circumstances and oxygen levels would be assessed when recuperation completed. At this point he would be invited onto the hospital-based pulmonary rehabilitation programme and dietary support advised. His ongoing management would then be handed back to his GP and practice nurse.

Mr Turner was invited into the surgery for annual review of his condition by his practice nurse. Generally he was coping very well with self-management. Nonetheless over time he found that his medication was not providing sustained relief of his symptoms. He was referred back to the RNS at the hospital for a nebuliser assessment. During the consultation it was identified that his blood oxygen levels were low. He underwent an overnight assessment at the hospital for long term oxygen therapy (LTOT). The combination of nebuliser and supplementary oxygen therapy return his symptoms to optimal control. He was very depressed and the community psychologist was requested to assess him at home with his wife.

In the future it is proposed that Mr Turner's journey will be very different. Awareness of COPD and its symptoms will be raised within the community. This provides the opportunity for individuals to recognise early signs and symptoms of disease and seek advice. A programme of education for GP's and practice nurses in the diagnosis and management of COPD in practices has been undertaken that supports the identification of need. This facilitates early diagnosis and dedicated COPD clinics in all practices. The COPD treatment pathway and COPD self-management plans support this development.

RNS will link with individual clusters of GP practices, lead by the respiratory nurse consultant and medical consultant, with many of the hospital based services relocated into the community. The RNS manage the complex and severe COPD patients in clinics similar to the hospital based ones. In addition they actively case manage in a more formal manner the patients that have home visits as they require specialist respiratory support. Community matrons and active case managers manage the complex patients with significant

co-morbidity or anxiety driven recurrent admissions. Community based pulmonary rehabilitation provides rotational services around the clusters. Links with the hospice and community nurses provide improved palliation of symptoms for patients with end stage respiratory disease. There are close links between primary, secondary and intermediate care, social services and support services.

In the future

Mr Turner should be identified much sooner. Smoking cessation will have been initiated earlier to prevent the severe level of disease that he experienced or indeed prevent it developing. Almost all services should be provided at his local surgery or within the locality.

3. Workforce and Education Project

3.1 The Workforce and Education Project Summary

3.1.1 The Workforce and Education Project is established to help identify the key workforce requirements resulting from the creation of a new culture within Salford healthcare systems. This new culture will enable and encourage staff to work in an integrated way, utilising new technologies and facilities to change and improve the experience of those who access services.

3.1.2 Wherever possible the Project will influence the ability of the health workforce to assist in the health and well being of the Salford population by enabling a new approach to health and lifestyle.

3.1.3 Specific project objectives include to:

- Identify and progress workforce requirements resulting from the service redesign and implementation of new care models;
- Develop workforce strategies which are consistent with national and local strategy;
- Ensure workforce strategies are consistent, reflect best practice and effective clinical governance, and are evidence based;
- Identify and work with the partner organisations and their staff to implement the new working processes

minimising duplication of effort, which results in seamless working directly benefiting patient care;

- Inform the SRFT Hospital Redevelopment Project, Salford LIFT Project, Service Change Management and Delivery Project and Salford IM&T Project of any critical issues identified in workforce requirements that may affect delivery of projects;
- Liaise with external education providers to ensure future capacity matches the new roles and skills required.

3.1.4 Ultimately the key measure of success is:

The improvement in the health and well-being of the population of Salford through a well managed motivated workforce that possess all the relevant skills and competencies to meet the needs of the job roles identified and performed.

3.1.5 The benefits of the Workforce Project are drawn from the benefits identified in the SHIFT Project Outline Business Case (OBC) and are:

- The effectiveness of the workforce to delivery improved health care in the community
- Improved Access of patients to health care professionals

- Improved environment
- Efficiency and productivity gains from implementing new ways of working
- Flexibility of approach of workforce to patient health care.

3.2 Achievements to date

3.2.1 The project workstreams are derived mainly from the initiatives within the Service Change Management and Delivery Project, but with some specific elements which have been identified locally. These include:

- Workforce planning in the Salford Children's Project – focusing on the establishment of new services for the area, replacing and enhancing those less complex services currently provided by the tertiary Children's Hospital, as part of the Central Manchester and Manchester Children's Hospital Trust.
- Workforce planning for the various change management projects within the Service Change Management and Delivery Project. Some of these projects require the development of new types of roles and any training implications of such developments requires effective collaboration and planning with local academic institutions.
- Introducing new inter-organisational employment policies to support and enable staff to work effectively across organisations. The principle benefit of this will be to ensure that patients, who access a range of health

and social care services, will have delays and misunderstandings minimised.

- Ensuring the scope of change being experienced by staff in the NHS, and particularly within Salford, is recognised and planned for within the partner organisations. Whilst the SHIFT partner organisations continue to develop their local organisational development initiatives, the Workforce and Education Project Board maintain an overview and seek to develop an integrated approach to leadership skills for the change agenda.
- Acknowledgement that as Teaching Trusts, both Salford PCT and SRFT have responsibilities to maintain their respective academic and research agendas. Formal integration of the Teaching and Research Directorates has taken place, providing opportunities for developing new approaches in a more integrated health and social care system.

3.2.2 The scope of work within the Workforce and Education Project will continue to develop in line with the wider SHIFT Programme.

Patient Scenario 3: Tier 2 Musculoskeletal Service

These two patient scenarios illustrate the benefits to patients of the introduction of 'Tier 2' services. Tier 2 is a level of service which bridges the gap between the care generally provided in a GP practice to that provided by specialist consultants in hospitals. The service is provided by health care professionals who have developed specialist skills in the field and from a convenient location in a community setting. Monitoring patient experience has shown that patients feel more relaxed outside of a hospital setting and enjoy the convenience Tier 2 offers.

Example 1 – Mr W.

Mr W presents to his GP in September with a history of a few months of pain and locking in his right thumb. Mr W is right-handed and the symptoms are sufficiently severe as to interfere with his every day activities e.g. brushing his teeth. The GP refers him to the PCT Tier 2 Nurse Assessment service using the new electronic Choose and Book system so that Mr W leaves the surgery with an appointment to telephone the Referral Centre in five days time. The GP explains that all musculoskeletal referrals are triaged by a clinician specialist who decides what the most appropriate service is to treat the condition.

Mr W rings up the Referral Centre and is told that he is going to see the GP with special interest in musculoskeletal problems. The GPSI will assess his thumb and decide if a steroid injection is an appropriate treatment. He books an appointment for four weeks time at the Health Centre.

Mr W arrives at Health Centre and is pleasantly surprised to see that it is easy to park and not far from the car park to the front door. He is 30 minutes early for his appointment but he takes the opportunity to have a cup of tea at the café. Ten minutes before his appointment is due, Mr W goes to sit in the clinic waiting area. There are a couple of other patients waiting to see the physiotherapist.

Dr F comes out and calls for Mr W. He introduces himself and examines the thumb. Dr F explains how the symptoms are caused and that a joint injection is the first line of treatment. The injection is administered and Mr W is advised to go back to his GP if the symptoms persist to be referred for a further injection.

Example 2 – Mr M.

Mr M presents to his GP with left leg pain after he reached and twisted funny at work. This caused immediate back pain that disappeared but left the residual leg pain. There are no aggravating or easing factors and there were no previous episodes similar to this. The GP refers him to the PCT Tier 2 Nurse Assessment service using the new electronic Choose and Book system so that Mr M leaves the surgery with an appointment to telephone the Referral Centre in five days time. The GP explains that all musculoskeletal referrals are triaged by a clinician specialist who decides what is the most appropriate service to treat the condition.

Mr M rings up the Referral Centre and is told that he is going to see an ESP (extended scope physiotherapist) for a full assessment. He chooses to be seen at a Health Centre offering this service close to his home. The assessment is in three weeks time.

At the Health Centre Mr M is seen by a physiotherapist with extended skills, experience and training in assessing musculoskeletal conditions. The examination is very thorough and includes taking a full history of all Mr M's medical conditions past and present, his medications and activities. The ESP explains to Mr M that he may have suffered from a disc prolapse with sciatic root nerve compromise.

The ESP explains that she is referring him for an MR scan in preparation for being seen by a consultant spinal surgeon. At the same time she refers him for physiotherapy to work on his movements in the hope of reducing some of the symptoms.

Mr M is pleased to have been assessed so quickly. He feels that he now understands what might be causing his symptoms and is pleased that investigations are already requested and an initial treatment plan actioned, while he waits to see the consultant.

4. Hospital Re-development Project

4.1 Salford Royal Foundation Trust Hospital Re-development Project Summary

- 4.1.1 The Salford Royal Foundation Trust Hospital Re-development Project is established to:
- replace functionally unsuitable hospital accommodation;
 - improve the co-location of services to improve patient experiences;
 - enable the modification of the estate to provide for:
 - ✓ new care models, focusing on patient 'pathways' through the hospital system, ensuring systems are streamlined
 - ✓ local children's services
 - ✓ the target capacity required for Renal Services to the western half of the Greater Manchester conurbation
 - ✓ transferring appropriate activity into primary care
- 4.1.2 This project is an important feature of the SHIFT Programme as although the remit is in part to move services out of the hospital into community settings, the need for hospital based care will continue and become more complex as medicine and technology develop. The poor state of parts of the hospital site are not conducive to modern healthcare and do not meet the needs of the patients served by the Trust.
- 4.1.3 The scope and scale of the scheme have changed over the

duration of the SHIFT Programme, but the overall intention has remained to demolish and replace the Victorian ward-blocks in the centre of the hospital site. The design solution achieves that objective, whilst also providing for the future establishment of the 'Christie at Hope' Cancer Centre.

- 4.1.3 The design principle adopted is to establish a public access route, running on the North – South axis, and linking into the East-West route around which clusters of service areas have their adjacency. It is anticipated that this will benefit patients and visitors to the site to more easily orientate themselves.
- 4.1.4 The value of the entire scheme is £190m, made up through a combination of PFI and Public Capital. The PFI scheme is valued at £134m and the Public Capital is £56m. The elements of the public capital work are closely linked with the major PFI buildings, and as a result the Public Capital Works span the whole of the PFI time frame. The entire scheme will start with minor enabling works in autumn 2006 and will be fully delivered in 2012.

4.2 The scheme design

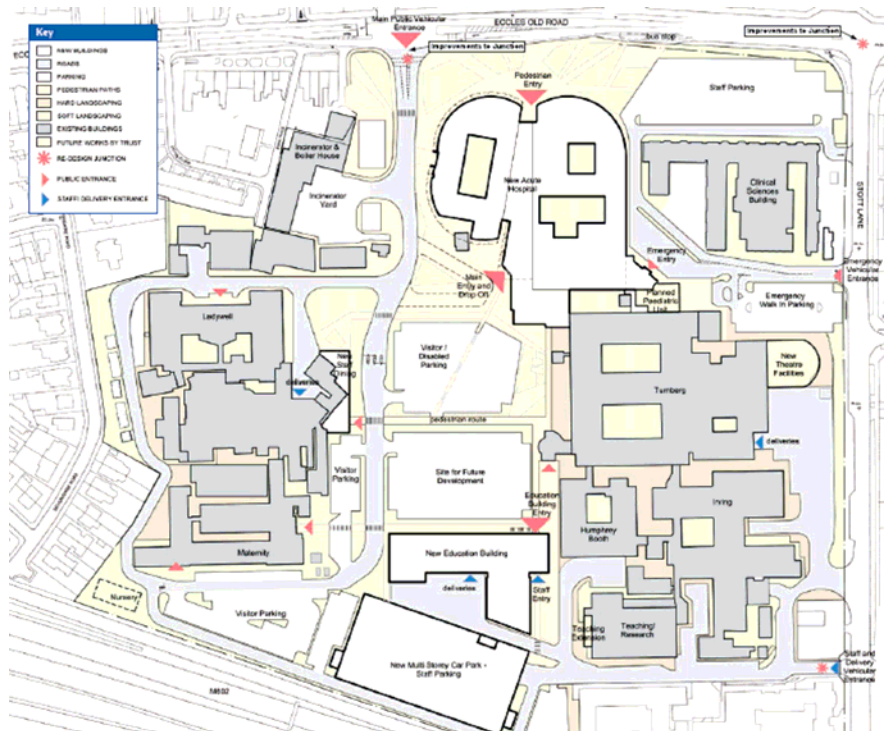
- 4.2.1 The scheme improves the standard of patient accommodation, beyond that which it replaces. General ward accommodation provides for approximately half of in-patient beds being in single bedded rooms with *en suite*

bathroom facilities. As well as being more acceptable to patients, this feature will support the reduction of Hospital Acquired Infection rates.

- 4.2.2 Public areas and corridors are more spacious, with increased levels of natural light and good quality, contemporary finishes. Greater design detail has been focused on maintaining each patient's privacy and dignity.
- 4.2.3 Staff will also benefit from the opportunity to work in a more pleasant environment. The SHIFT partners anticipate that a range of stakeholders will benefit from this initiative.
- 4.2.4 The two tower blocks adjacent to Eccles Old Road will have been demolished in readiness for the creation of the main clinical block in the scheme.
- 4.2.5 A focus of the new facility will be the new main entrance, accessed from the visitors' car-park in the centre of the site, or via a pedestrian entrance off Eccles Old Road. This light and spacious atrium will provide a new focus to the hospital as well as acting as a central information / reception point from where all wards and departments can be accessed. The following image shows the Eccles Old Road aspect of the new ward building.



- 4.2.6 To the western side of the new clinical development are specialist in and out-patient facilities. To the east of the development the Emergency Village concept will be established by creating a new Emergency Department and adjacent integrated Emergency Admission Unit focused on early diagnosis, stabilisation and intervention. Two new Radiology rooms will support this area in addition to existing facilities on site. The existing Emergency Department will be extended to create a Paediatric Observation and Assessment Unit.
- 4.2.7 On the floors above the Emergency Village will be more in-patient accommodation, linking up with existing theatres and Critical Care.
- 4.2.8 An illustration of the site development is shown below, with Eccles Old Road at the top of the image:



establishment of a multi-storey car park adjacent to the site-boundary facing onto the M602.

4.2.11 A new education and research block will support the integration of education, teaching and lecture facilities.

4.2.12 A range of smaller schemes and service modifications will be associated with these more significant developments.

4.3 Delivering the redeveloped hospital scheme

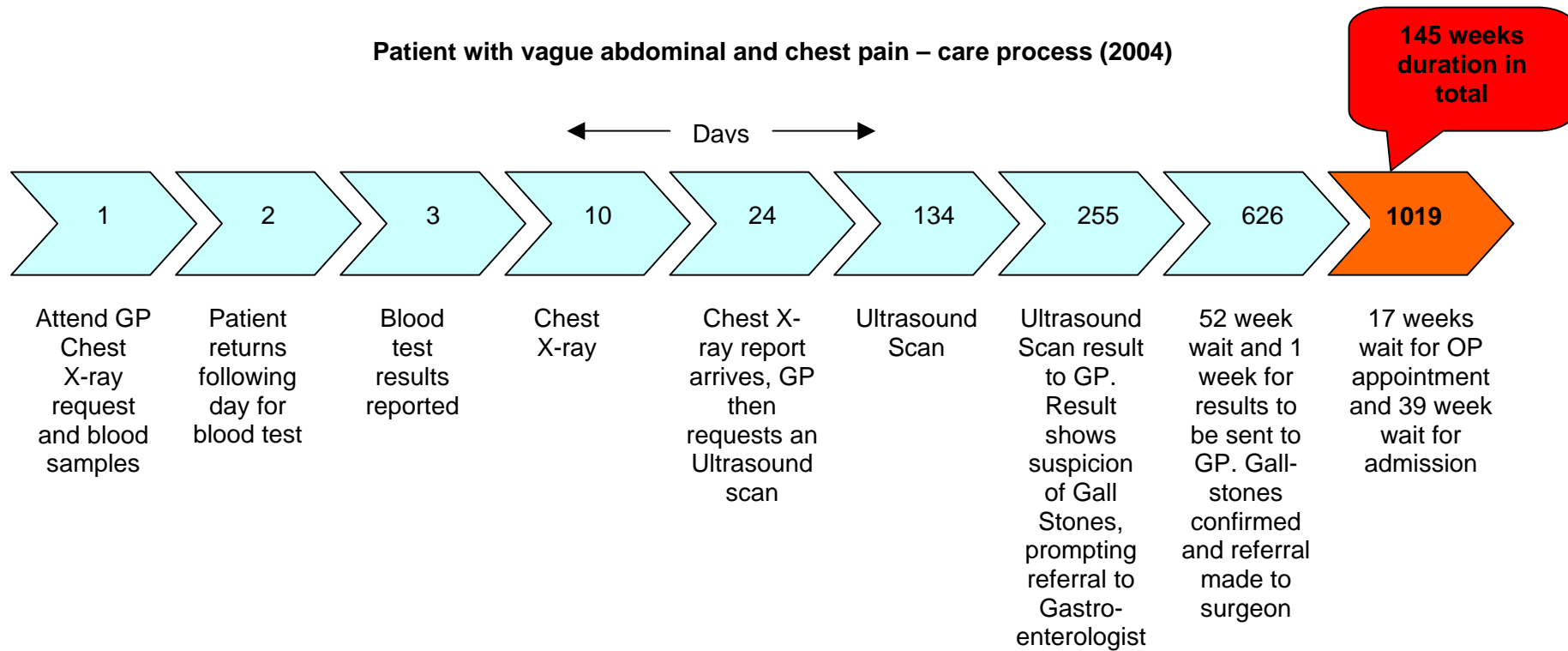
4.3.1 The financial close for the hospital redevelopment is expected in April / May 2007. This will initiate the main demolition and construction programme, which is expected to complete in 2012.

4.2.9 The Ladywell Building and Women's and Neonates Building retain their current purpose, although the expansion of intermediate care and care at home services will modify the use of Ladywell to include specialist medicine, along with the Heart Care Unit and a new Cardiac Catheterisation Laboratory.

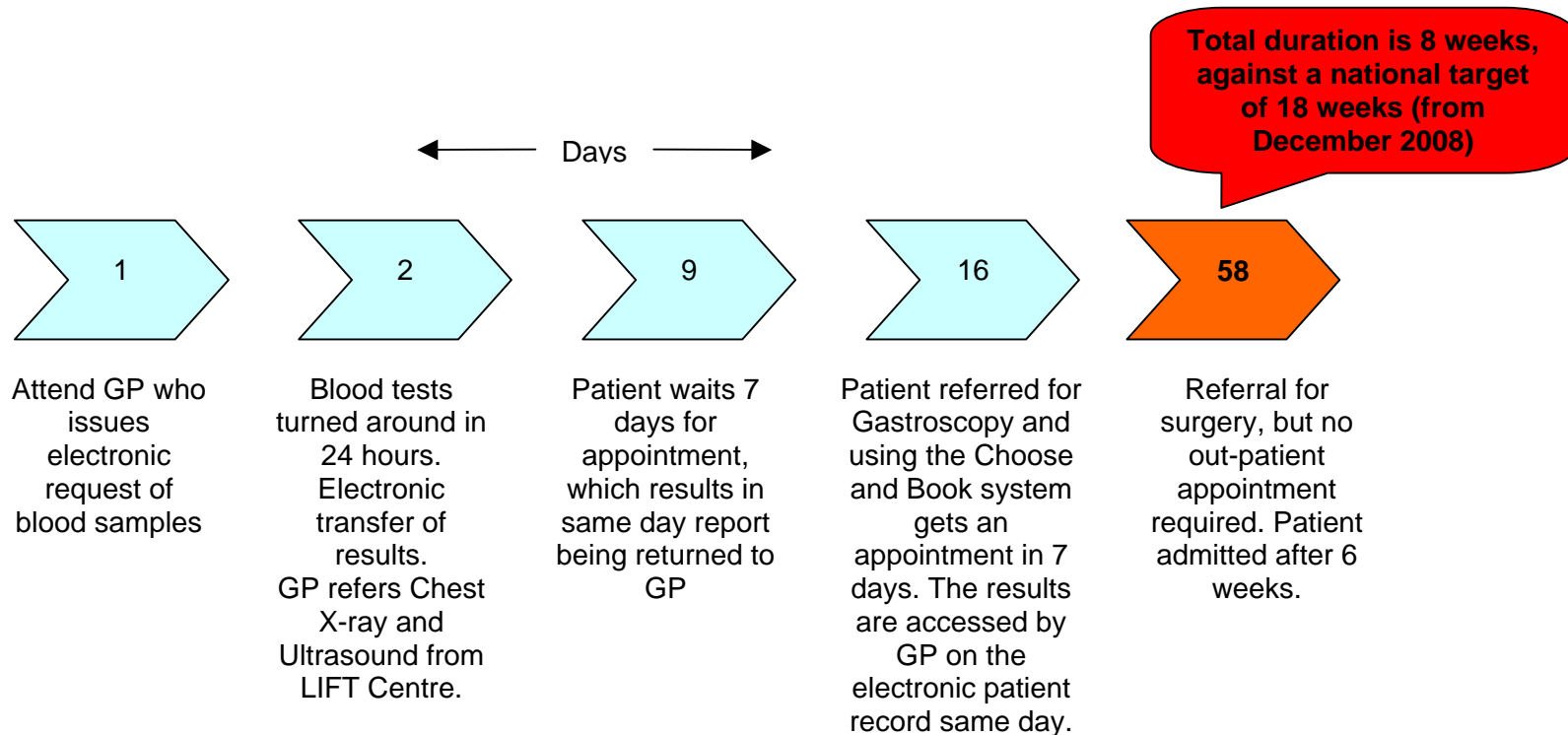
4.2.10 Car parking pressures on the hospital site will be managed through adoption of a Green Transport Policy and

Patient Scenario 4: The changing role of diagnostics in a surgical patient's healthcare experience / pathway

In this scenario, improving the responsive of diagnostic services, through both process design and the use of technology, will reduce the time taken from first seeing the GP to admission for surgery from 145 weeks (1019 days) to a little over 8 week (58 days).



Patient with vague abdominal and chest pain – care process (2010)



5. Health and Social Care Centre developments in the Local Improvement Finance Trust (LIFT) Project

5.1 LIFT Project Summary

5.1.1 The Salford LIFT (Local Improvement Finance Trust) Project focus is to:

- establish a range of services and facilities which enable the provision of more locally based care, avoiding the need, where safe to do so, of accessing hospital-based services;
- create facilities which can provide integrated services across health and the Local Authority;
- improve the primary care estate in Salford;
- create a range of facilities which respond to the needs of the local population.

5.1.2 These objectives remain innovative and have been developed over the period of the SHIFT Programme, drawing on the views of local people and in consideration of the desire to provide safe and convenient services.

5.1.3 The Local Improvement Finance Trust is a method of procuring the facilities introduced by the Government in 2001. It secures and maintains good quality, purpose built accommodation from which to provide a range of services which are planned to improve the health profile of Salford

and bring a new image to a selection of town centre locations.

5.1.4 There are 6 developments in the first phase of LIFT. These include 2 health facilities in Charlestown and Lower Kersal, developed using New Deal for Communities funding, and 4 Health and Social Care Centres (HSCCs). These 4 HSCCs are the main focus within the SHIFT Programme, creating facilities for transferring services from Salford Royal Foundation Trust and providing the necessary infrastructure for extended primary care management.

5.1.5 The standard of the facilities will complement new care models being developed in Salford, which require access to more complex diagnostics and interventions than have previously been available. Salford PCT intends to continue a programme of improving primary care accommodation, to ensure that the health status of Salford continues to improve.

5.1.6 The combined capital value of the 4 HSCC schemes is in approximately £47.5m

5.1.7 The following section provides more information about the content and design of the HSCCs.

5.2 The Health and Social Care Centres

- 5.2.1 The 4 HSCCs are in town centre locations in Eccles, Pendleton, Swinton and Walkden. The main objective in identifying such locations is to make them accessible to Salford's population, via a network of public transport as well as by car.
- 5.2.2 The location of the LIFT Centres will also strengthen the sustainability agenda of the four town locations, through the additional economic activity that they will generate and reinforce the need to retain or extend public transport systems. The four sites have been selected after considerable health and economic impact analysis, taking maximum 'footfall' into account. Jointly the Council and the PCT have determined that they are the best locations to meet both health and socio-economic regeneration objectives.
- 5.2.3 These four town centres will provide a solid foundation for the Council and the PCT to make new linkages for promoting public health, increased uptake of library and other services, thereby promoting an increase in overall well being.
- 5.2.4 The Centres will also provide the physical infrastructure for a significantly increased range of primary health services under one roof such as podiatry, speech and language, physiotherapy and other therapies through to clinical services / interventions which have traditionally been delivered from a hospital setting.
- 5.2.5 Accessibility to services will be further facilitated through the co-location of Council services. The result will be that the majority of Salford citizens will be able to benefit and particularly those with long term conditions or whose ability to travel distances in order to access services is, for whatever reason, limited.
- 5.2.6 This type of seamless service is very different to that currently delivered in most towns and cities, but we expect that it will significantly change for the better the experiences of local residents.
- 5.2.7 Each of the four centres has, in addition to generic clinical accommodation, a particular clinical focus. This has enabled the cost effective provision of more specialist hubs to be created in a community setting. In broad terms, the focus of each centre is:
 - Pendleton – Children and young people
 - Swinton – diagnostics and treatment
 - Walkden - therapies
 - Eccles – Teaching, learning and research
- 5.2.8 Each HSCC has provided a unique opportunity for Salford PCT to provide services in a different type of setting than has previously been available: the Swinton Centre is crucial to the transfer of diagnostic and interventional services from the hospital, whilst the Pendleton Centre will enable the establishment of enhanced community-based services for children and young people.

5.2.9 The following illustration show exterior aspects of the Eccles Health and Social Care Centres.



5.2.10 The next two images are of the Pendleton Health and Social Care Centre. The Pendleton Centre, as the Centre for children and young people, will replace a selection of service previously provided at Pendlebury Hospital, due to transfer to Central Manchester in 2009 (see Section 2).



5.2.11 The Walkden Health and Social Care Centre will provide a range of services and specialise in rehabilitation therapies, such as physiotherapy, orthotics, etc. The external appearance of the building will be as shown below (view from south-west: Bolton Road):



The service model

5.2.12 The service philosophy for the LIFT Centres builds on the principles of the SHIFT vision and contemporary Department of Health Guidance. Applying these principles in an integrated health and social care setting has resulted in a service model which assumes:

- People will attend the centre to access either health-related services or Local Authority support;
- Through the convenience of town-centre location, there is a greater likelihood of 'drop-in' attendance;
- Through careful design, the buildings will feel neither overtly clinical nor intimidating. The overall impact of the environment is intended to create a sense of confidence, efficiency and high quality standards.

5.2.13 Members of the public attending any of the centres on either a drop-in basis or for an appointment will be greeted at a central reception area by staff trained to deal with enquiries and to make appointments for health or Local Authority services either contained within the building or a selection provided elsewhere. Anyone wishing to make a confidential enquiry will be offered the opportunity to be dealt with in a discrete area.

5.2.14 Access around the buildings are designed to enable young, old, disabled and those with young children or dependents to move easily and freely around public areas. The privacy and dignity of those attending for any reason is protected by the design and the skills of attending staff.

5.2.15 GP practices have been incorporated into three of the four Health and Social Care Centres (Eccles, Pendleton and Walkden). The presence of these GP practices is considered to be vital in these centres to encourage a high footfall into the facilities. In the Swinton centre the strong emphasis on diagnostics, interventional and intermediate tier services, along with a substantial Local Authority presence, will ensure a high footfall and consequently contact with health-related services.

5.2.16 Services offered from the centres will be provided over extended days and beyond the traditional General Practice surgery times. It is anticipated that this will encourage the attendance of people who traditionally avoid seeking help and advice, such as young men and shift workers. Also through these extended hours and improved access, the

centres should be seen as an asset within the community and foster a sense of pride and ownership.

5.3 Delivery of the Centres and proposed designs

5.3.1 The timescales for delivery of the first wave of LIFT facilities in Salford is as follows:

LIFT Centre	Financial Close date	Operational date
Charlestown	July 2004	October 2005
Lower Kersal	May 2005	December 2006
Eccles	December 2006	September 2008
Pendleton	November 2006	November 2008
Swinton	2007	2009
Walkden	November 2006	July 2008

Patient Scenario 5: Primary Care-based (Tier 2) vasectomy service

Like scenario 4, this scenario describes the patient experience of another Tier 2 service – vasectomy.

Mr A goes to see his GP requesting male sterilisation as he and his partner have agreed that their family of three sons and one daughter is complete. He is quite positive that he needs to be completely unconscious during the whole procedure because he feels that being awake would be too embarrassing. The GP refers him to the PCT Tier 2 Vasectomy Nurse Assessment service using the new electronic Choose and Book system so that Mr A leaves the surgery knowing the **date and time of his appointment, in 3 weeks time**¹. The nurse assessment clinics are on **Monday and Wednesday evenings from 5-7pm**² which is great because Mr A does not need to take time off work – his mum can look after the children so that he and his partner can go together.

At the Assessment Clinic they both see the specialist nurse for a very in-depth counselling session about why they have chosen the procedure, how it is carried out and the possible complications. This discussion helps them to talk through issues that they had not thought of before, such as “what if something happens to your partner, your relationship or your children”. It also reassures them about how the procedure is carried out and as there are no anatomical or co-morbidity issues Mr A is offered the choice of a procedure under Local Anaesthetic, to be carried out by staff at the Health Centre. Mr A is not sure about being awake so he asks if he can have time to think about it. A few days later he rings the Health Centre to say that he has decided to **have the procedure under LA**³ and he is offered a choice of appointment times for the Thursday **Vasectomy clinic in three weeks time**⁴.

Mr A arrives at the Centre feeling very nervous. He is called by the specialist nurse, who takes him through to the consultation and preparation area. This is the same nurse that Mr A met at assessment so he feels reassured and able to ask any questions that are still worrying him. After getting ready for the procedure, he meets the GP with Special Interest in Vasectomy who talks through what is going to happen, what to expect afterwards and answers all his questions. Feeling very nervous, Mr A goes into theatre and meets the operating staff. The atmosphere is surprisingly relaxed with some background music. The staff nurse watching Mr A keeps his mind occupied with discussing the promotion prospects of the local football teams. In no time at all, the procedure is over and Mr A is sitting up with a cup of tea. He leaves knowing he can ring back if he has any concerns.

Mr A is followed up by telephone 10 days later by the assessment nurse. He has no complications but takes the opportunity to remind himself about a few things he could not remember. Some weeks later, he gets a letter reminding him to provide a sperm sample. Within a few days, the Centre telephone him to say that the procedure was successful.

*“I was then operated on and felt completely at peace; the experience was exactly as described.
I was treated with the utmost care and everyone involved was completely professional.”* Mr A 27/9/2005

¹ In May 2004 waiting time to see Urology consultant for male sterilisation was approximately 18 weeks

² No evening clinics in secondary care

³ In May 2004 60% of male sterilisation procedures were under GA and 40% under LA in secondary care. This is now <10% GA in secondary care and >90% LA in primary care.

⁴ In May 2004 waiting time for procedure was up to 26 weeks

6. Information Management and Technology (IM&T) Project

6.1 The IM&T Project

- 6.1.1 The Salford IM&T Programme will oversee the implementation of Information and Technology (IT) systems to support delivery of service change. This will include systems provided by CfH (Connecting for Health) as part of the National Programme for IT. Current local systems will also be upgraded to be compliant with CfH where appropriate including, for example, integration with the national spine (the national service that will hold the NHS Care Records at a national level), which will be accessible across England.
- 6.1.2 The Department of Health have centrally contracted with organisations to deliver applications to health communities and their patients. These organisations are called Local Service Providers (LSPs) and are appointed to geographical areas or clusters.
- 6.1.3 Salford is part of the North West and West Midlands cluster and the LSP is Computer Sciences Corporation (CSC) Alliance. As the LSP, the CSC Alliance is responsible for delivery of a range of IT services incorporated into the contract in a specified locality. Some systems which either do not meet local standards of functionality or fall outside of the National Programme will be procured separately.
- 6.1.4 Moving to CfH systems will eventually allow multi-disciplinary teams to have access to a single record 'the Spine' which, over the next 5 years will become increasingly rich in clinical data. The national systems will be much more resilient, secure and accessible to NHS staff. The benefit to patients is that a summary of their care record will be available wherever it is needed across the country. These centralised summary records will also provide a rich data source for reporting health status locally and on a wider scale.
- 6.1.5 Within Greater Manchester, the area has been divided into sectors to manage the programme of investment in IT. Salford is part of the North West sector and the IT Programme Board oversees IT developments in Wigan and Bolton, as well as Salford. Working alongside neighbouring health economies brings the operational benefit of shared knowledge and experience.
- 6.1.6 The parameters of Connecting for Health have some limitations in the context of the SHIFT Programme, by overlooking the need for integration across agencies, notably with Local Authorities. This has been identified as a priority within SHIFT and is a feature of local IT developments.

6.2 Salford's IT priorities

6.2.1 The success of Salford's clinical service re-design will depend on the availability of a range of IM&T services, including:

- **Electronic Communication:** between patients, staff and organisations
- **Electronic Booking:** of appointments
- **Electronic Medical Records:** providing electronic ordering and results, electronic prescribing, care pathways, patient access/health records, alerts and decision support, telecare, electronic image management and multimedia
- **Knowledge Access & Education:** for patients and professionals
- **Messaging Standards & Datasets**
- **Information Services:** for data analysis, reporting etc.

6.2.2 The benefits these systems will bring will be recognised by patients, service users and staff as a more streamlined and 'joined up' system of healthcare, regardless of where services are provided. It has long been recognised that delays occur when information is required to be moved from one part of the system to another, such as to initiate a test, consultation or to return a test report. Such delays will be significantly reduced by the deployment of technology and reference to Patient Scenario 4 illustrates this point.

6.2.3 The local roll-out of technology is scheduled to complement the necessary replacement of existing systems and the

development of new services. The current programme of IT developments is summarised on the following table:

System	Function	Implementation date
Lorenzo Patient Administration System (PAS) - SPCT	Will provide the foundation for future developments, ultimately leading to a National Care Record System (NCRS).	December 2005
Blithe Lillie system for Sexual Health service.	The Blithe Lillie system is a new system being rolled out in Greater Manchester to support the development of Sexual Health Services.	June 2006

System	Function	Implementation date
Picture Archive And Communication System (PACS)	PACS will electronically manage x-rays and other clinical images, which can be accessed in a range of locations and by different healthcare professionals.	November 2006
Choose and Book	Choose and Book is a national IT system which allows GPs to book patients directly into hospital appointments.	Expected to be comprehensively deployed across Salford early in 2007.
Employee Staff Record System	An integrated personnel system which brings together Human resources and payroll data.	April 2007
Patient Administration System - SRFT	Will feed into the NCRS.	Postponed until further notice, due to present level of functionality of the <i>iSoft</i> Clinical Manager (iCM) system.
Theatre system - SRFT	Will interface with PAS and record comprehensive clinical	December 2007

System	Function	Implementation date
	data on operative procedures for care record. Provides Theatre scheduling function and Activity Reporting. Sterile Services Support.	
Snowmed Clinical Coding system - SRFT	Records diagnostic coding on day-case and in-patient attendances.	March 2008
Document Management System	Electronic case note storage for existing paper-based records, for integration into the existing <i>iSoft</i> Clinical Manager (iCM) system.	To be confirmed.

Patient Scenario 6: Healthwise Case Studies

Weight management services in Salford have been limited and uncoordinated in the past, but with increasing concerns about the impact on health of increasing obesity levels, the SHIFT Programme initiated the development of a new and comprehensive care model which provides for 4 levels of care, depending on the circumstances of the person's need to lose weight. These two scenarios illustrate the potential flexibility and success of the new service.

Case Study 1: Mr L

	Week 1	Week 12
Weight (Kg)	109.6	99.2
BMI	34.5	31
Waist (Cm)	124.5	110.5
Activity Rating	1	6

This case study outlines how a locally focused and delivered service has had a substantial change on a Salford resident. Prior to the development of the Salford Healthwise service, advice on diet and exercise was available from different sources at different times. GPs would often give general advice and specific advice on how to use gym equipment would be available once enquiries were made from Salford City Council leisure staff, but it was never delivered at a single consultation.

Mr L is 38 years old, in general good health and rarely visited his GP. He held a sedentary middle management job and work and family commitments gave him very little free time to visit a gym or incorporate any formal exercise into his life. He played football once a week with work colleagues but had seen a gradual increase in weight over the last 8 years. Although he had attempted a number of diets, he found them difficult to adhere to and he usually returned to his former eating habits over time. He had recently been offered Sibutramine in an attempt to prevent any further weight increase.

With the establishment of the Healthwise Service within Salford, this 38 year old male saw a 9% reduction from his week 1 body weight. Mr L is taking Sibutramine and is a good example of how effective pharmacotherapy is when accompanied with the correct behaviour changes. Associated health improvements included increased self-esteem and mood, and decreased back pain. The Healthwise Service provides both dietary and exercise advice from trained professionals. This dual approach has encouraged Mr L to join a gym and he is now a regular,

independent exerciser. He has started to incorporate exercise into his everyday life, seeing it as an integral part of his weekly routine, rather than simply another “task” which has to be fitted in around all his other commitments. He has started taking his son swimming and teaching him new and healthier lifestyle choices. Mr L feels he has especially benefited from the advice on lifestyle, portion sizes and keeping a food diary.

Case Study 2: Mrs S

	Week 1	Week 12
Weight (Kg)	107.3	99.5
BMI	40.8	38
Waist (Cm)	104	101
Activity Rating	1	7

Mrs S is a 54 year old female. She lives with her husband in Salford. Her children have all moved out and live locally within the area. As Mrs S's children moved away and became independent, Mrs S found that she had more free time than she was used to. Her husband still works. Mrs. S is in good health although she has arthritis, but this does not restrict her independence.

Mrs S attended 11 of the possible 12 sessions. Overall the patient lost 7.8Kg. The patients BMI dropped from 40.8 to 38, and Mrs S lost 7.3% of her body weight. This is an outstanding achievement and was achieved through a significant change in lifestyle by Mrs S. Through joining the classes, Mrs. S. met new people and made new friends. She started swimming, something she had not done for much of her adult life and she was soon arranging to meet her friends from the group at the swimming pool. This exposure to Salford Leisure Services gave her more confidence to explore the other exercise options that both appealed to, and were suitable for her.

Associated Health Improvements included reduced pain in her arthritic knees and increased self-confidence and energy levels. Mrs S also took up Salsa Dancing lessons and has gained a new friendship group.

Mrs S is now attending a weight maintenance session and since leaving the class has lost a further 1.5Kg. When asked to comment on the session she wrote:

“Thank you for giving me a new lease of life and showing me exercise I can do! I have made new friends and it has been a really great experience”

7. Changing patient experiences

7.1 Salford's health status

- 7.1.1 Salford, like many inner cities, has particular health needs and social circumstances which require addressing. An overview of relevant demographic trends, socio-economic data and health statistics across Salford is shown on the following table:

Demographic trends:	<ul style="list-style-type: none"> • Estimated population of 216,000 people based on the 2001 Census • Overall population has been in decline over thirty years but projections suggest that this decline is levelling out at approximately 204,000 people by 2015³ • Age and gender profile of the local population is broadly in line with national averages although not evenly distributed across the wards in the city. • BME population in Salford is 3.9% in 2001 (Census data 2001). Broughton is the most ethnically diverse electoral ward in Salford having a percentage population from BME groups above the national average (9.3%) – (average for England is 9.0%).
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³ Salford PCT (2005) Public Health Data

Socio-economic:	<ul style="list-style-type: none"> • 12th most deprived local authority in the country. • 4th most deprived local authority in the North West. • Deprivation levels varies across the city – <ul style="list-style-type: none"> ○ Central Salford, Winton and Little Hulton are in the top most deprived ○ Walkden South and Worsley and Boothstown are some of the most affluent areas in the country.
Health statistics:	<ul style="list-style-type: none"> • Higher prevalence of coronary heart disease, chronic obstructive pulmonary disease, asthma and diabetes than national average. • Higher prevalence of mental health needs than the national average. • More people die each year from non-malignant conditions than from all cancers. • People in Salford live fewer years compared to the average for England and Wales and compared to other parts of Greater Manchester. • Health is improving in Salford, but not at the same rate as the country as a whole.

- 7.1.2 There are acknowledged links between levels of deprivation and ill-health, and people living in less affluent areas of Salford have more ill-health than the more affluent parts. There are many reasons why this should be the case and there are similar links across employment levels and housing standards.

7.2 The SHIFT Programme contribution to improving health in Salford

- 7.2.1 Nationally there are policy drivers towards improving the health status of the population, most notably in the publication of the Wanless Report⁴ in 2002. In this report Derek Wanless examined future health trends and identified the factors determining the long-term financial and resource needs for the NHS to 2022. In particular the NHS was compared to other developing countries with a view to matching best practice standards.
- 7.2.2 The report adopted three scenarios of how services could be supplied and considered the level of 'take-up' in terms of a 'slow up-take', 'solid progresses' and 'fully engaged'. The report argued the case for encouraging people to be more engaged, with the consequence that they were more inclined to use primary care and self-care, rather than hospital-level care.

⁴ *Securing Our Future Health: Taking a Long-Term View*, Derek Wanless, 2002

- 7.2.3 An associated benefit would be the lowering of key risk factors, including smoking and obesity. This illustrated the potential for effective public health measures to reduce health pressures in the longer term.
- 7.2.4 Against this backdrop the SHIFT Programme has focused on improving the health status of Salford and wherever possible promoting self-care and improved life-style. This will contribute to bringing Salford in line with the England average for life expectancy.
- 7.2.5 The SHIFT Programme is able to contribute to the wider regeneration agenda for Salford, over and above direct health service provision. It is doing this through:
- The establishment of impressive civic buildings, which have a positive impact on the local community and utilise sustainable construction methods.
 - Creating employment opportunities for the local population.
 - Working with local schools to encourage interests in healthcare related careers. These are not necessarily within clinical environments, but may be associated with accountancy, management, catering, building maintenance, etc.
 - Seeking to improve transport links across the conurbation.
- 7.2.6 The SHIFT Programme seeks to deliver a different type of healthcare in Salford – one which will have a positive impact on the people who live here.

Patient Scenario 7: A diabetes patient⁵

This final patient scenario explains how a patient (Mr AB) has experienced being a diabetic in the old-style healthcare system and then in the 'fully engaged' scenario described by Derek Wanless in Section 7.2 above.

Mr AB CURRENT SCENARIO

Mr AB is a 60-year-old male who works as a plasterer. He is divorced, lives alone and takes as much work as he can get to try to cover his large maintenance payments. He smokes 15 - 20 cigarettes per day and drinks 30 units of alcohol per week.

Type 2 diabetes was diagnosed at the age of 53. He is prescribed medication which he takes somewhat erratically. He does not attend for systematic preventative care review.

He is admitted to hospital at midnight as a '999' emergency his daughter having found him collapsed at home blue and breathless. His only previous admission to hospital had been 12 months ago with chest pain. His notes are not available. The Casualty Officer takes a history from the daughter who knows little about her father's medical state and nothing about his medications. Clinical examination shows respiratory and cardiac changes. Initial lab results show Type 1 respiratory failure, hyperglycaemia (raised blood sugar) and slight impairment of renal (kidney) function. He is treated for a severe onset of a heart condition is transferred at 3am

⁵ Based on a scenario provided by Dr Bob Young, Consultant Diabetologist

to the acute medical ward. There he is given further treatment. His history is re-taken and re-documented and as his condition improves.

But the pressure on beds is intense and at 11am, because his condition is improving, he is moved to one of the general medical wards. The team on the new ward does not know that his most up to date results have been sent to the acute admitting ward. At 4pm he has a cardiac arrest. He is resuscitated successfully and transferred to the Coronary Care Unit (CCU). His history and medications are re-charted by the CCU team. Serial ECGs and blood tests do not show changes of an Myocardial Infarction (or heart attack). The lab results that had been sent to the acute admitting ward showed his potassium to have fallen and is the presumed cause of the arrest. He returns to the general ward after 48hrs.

His medications are re-charted. On the general medical ward he has his medication adjusted, but is found to remain hypoglycaemic. Oral hypoglycaemic therapy recommenced. He is referred to the diabetes centre where sight-threatening retinopathy is diagnosed and he is identified to have sensory polyneuropathy requiring intensive preventive footcare. The ward is advised to refer him for urgent ophthalmic treatment and adoption into the community foot protection programme. He is also offered insulin therapy but declines this believing that if he took his medication more consistently he would manage to control his diabetes.

Two days later, feeling much better, he insists on being discharged because he feels that he must get back to work as soon as possible. His hand written discharge note indicates what medication he is taking. A note is made in the case record that

supplementary letters need to be sent to the ophthalmologist and the community podiatrist and the community heart failure rehabilitation programme. The nurse asks the ward clerk to book an appointment booked for the ward discharge follow up clinic in 6 weeks time. His discharge is delayed by the delayed preparation of his discharge script.

The general practice has difficulty reading the hand written discharge summary that arrives 6 days after discharge. His discharge medications are transcribed onto the practice system, Lisinopril dosage (Lisinopril is used to treat high blood pressure, congestive heart failure, and to improve survival after a heart attack) being recorded as 25mg, and he is asked to return for review in a month. He does so because he is not feeling very well and bloods are taken for testing. He continues to feel tired and easily breathless. He remembers that they told him something about this when he was in hospital but it all seems very vague now and he does find all these medications very confusing. He therefore goes to the ward follow up clinic desperately anxious about the time he is losing from work. The doctor he sees there cannot find the echocardiograph result from his admission, he is unsure about his current dose of medication, and does not know about his recent blood test. He therefore carries out an x-ray and ECG and a further blood test and tells Mr AB that he will write to his GP when all the results are available.

A few weeks later Mr AB is again admitted as an emergency at 10pm as he was vomiting blood, this time under the surgical specialists. His blood pressure is 136/74. He has a rapid pulse and abnormal biochemistry results. His previous records are unavailable and Mr AB is still uncertain which medications he is taking. His glucose on admission is 34. He is given supportive

therapy with intravenous fluids and insulin. Gastroscopy arranged the next day shows only limited evidence of gastritis and he quickly improves only to deteriorate 36 hours later with acute relapse of his left ventricular failure. During his subsequent admission to the CCU he develops a pressure ulcer on his left heel. His HbA1c (blood sugar test) is repeated on the CCU and with the value of 13% and feeling chastened by recent events Mr AB is persuaded to commence insulin therapy. He is discharged on a medication plan. Unfortunately he had never been sent an appointment for the Eye Hospital and has by now lost vision in his right eye. By telephone an urgent appointment is arranged. But when he gets to the clinic it is packed, they know little about him, he is told to come back for tests and eventually he starts laser treatment two months later. He is told he will need to attend at least every 3-4 months indefinitely. By this time he can read out of his remaining eye only with the aid of a magnifying glass. He has to attend diabetic foot clinics in both the community and hospital for 4 months until his foot ulcer is eventually healed. He has lost his job and his driving licence, cannot now get work and his financial problems have intensified. Six months later his daughter finds him dead in bed.

On the next page is a different scenario for Mr AB, enabled through the development of new health care IT systems and care models.

Mr AB REVISED SCENARIO
Different Experiences and Outcomes of Care

Mr AB has been very difficult to involve in preventative diabetes care. The efforts of his practice nurse have consistently been resisted. But recently his new community diabetes care manager has telephoned him in the evening. He has been allocated secure access to his own personal web based diabetes record. He logs into this through his digital TV and has explored it a few times because of feeling rather tired and breathless recently. He gets flashing alerts about missed eye, foot and blood checks each time he logs on. The care manager mentioned these as well.

On Saturday he decides to attend his optician for an eye examination, to get a blood test and blood pressure at a local health check centre in the pharmacy and to click the button requesting a personal foot testing kit. The foot testing kit arrives on Tuesday. He logs on to enter the data and sees a new alert. His digital retinal photographs have been read electronically and suggest a problem. An appointment (date, time and name of ophthalmologist shown, arrangements for re-scheduling clearly explained) has been arranged at the eye hospital, and he is led to a web site that explains all about diabetic retinopathy with wonderful, easily understandable pictures and a simple spoken and written commentary. It tells him how high blood sugar and blood pressure cause retinopathy and how progression to blindness can be prevented even now. Alarmed at first he now feels more reassured. But what's this? His Blood Pressure, blood glucose, lipid and UACR (the urinary albumin:creatinine ratio is a useful measure of renal function used in diabetic renal disease) results are all in his record as well. He has alerts everywhere. And they clearly make sense now he understands a bit about the retinopathy. When he enters his foot examination data and immediately gets another alert plus an

appointment at the community foot-care protection programme he decides he needs more than the web site can offer.

He phones the diabetes call-line at 10pm and is able to speak to a call centre operative. She ascertains that the GP diabetes specialist for his locality would best handle the problem. An appointment is arranged for Thursday evening because that will suit him. She directs him to some further web links and he spends an hour listening to the stories of people just like himself. He also reviews his medication list on his web record, compares it with the bottles on his bedside table & reflects on just how much he has been neglecting himself. He knows that in addition to the medication for his diabetes he should be taking medication for hypertension. When he picked up a prescription 3 months ago the nurse insisted on checking his BP. It was high so his own GP checked what to give him on his computer and added in an appropriate medication. But he has not been taking any of these medications regularly. His web record lists the medications he is prescribed and also exhorts him to keep to a healthy eating diet and exercise regularly. Links from each of these recommendations explain why the treatment is appropriate. For the diet and exercise recommendations there is lots of further information about how to do it including video clips some of which feature people just like him. It all begins to make more sense. When he visited clinics in the past he was always so irritated by the time off work and the patronising attitude of the staff that he didn't take much in.

Unfortunately during the Wednesday night at 3am he awakes acutely short of breath. He calls the diabetes help-line again and after a couple of questions they call an ambulance. The casualty officer asks if he has a web record. He gives him the password and all his diabetes data is immediately copied into his hospital record. The doctor can see at a glance that Mr AB has had Type 2 diabetes

for 7 years and that he should be taking a range of medication. He can see that after 3 years of missed reviews he got some tests a few days ago. His recent blood results have been satisfactory but his blood sugar levels in the past have led to the identification of early nephropathy, sight threatening retinopathy, sensory neuropathy and appointments for the eye hospital, community podiatry and his GP. The GP visit is quickly cancelled electronically. His admission has already been notified to the GP's email. Vital signs and an ECG are already appearing in the record as he looks at it. The casualty nurse has entered them. Examination and a chest x-ray quickly confirm Left Ventricular Failure (an acute heart condition). After urgent treatment with medication and oxygen he is transferred to the acute admitting ward. There the admitting doctor can immediately access the same previous information plus the casualty officer's clinical findings and test results. Mr AB has Type 1 respiratory failure, hyperglycaemia and slight impairment of renal function.

The admitting team elects to amend his prescribed medication and recommends introduction of a beta blocker (medication for the management of [cardiac arrhythmias](#) and cardio-protection after [myocardial infarction](#)). There is pressure on beds and he is improving steadily so he is transferred urgently to a general medical ward at 11 am. On opening up his electronic record at 1pm in the receiving ward the house officer is immediately alerted to the low potassium identified by a blood test taken just before he left the acute admitting ward. He discusses the situation with Mr AB illustrating his argument by charting Mr AB's results on the screen. He sees the alert about using a particular prescription in the presence of renal impairment and a graphical illustration of the progressive deterioration in glucose control over the past few years. He is persuaded that insulin would be sensible. A diabetes

specialist nurse visits and agrees an initial regimen plus a glucose monitoring schedule that her community colleague, his care manager, will follow through with him. In the Diabetes Centre as well as learning about insulin therapy he is shown how to check his blood sugar with an electronic meter and download the results to his web record.

Two days later he is fit for discharge. At the time of discharge electronic bookings are made for his practice, the cardiac rehabilitation clinic, the ward follow up clinic and the diabetes centre. He is immediately presented with written confirmation of all these appointments and told that they will already be displayed on his web record. He is also given written information generated from the electronic patient record system about cardiac rehabilitation, preventative foot care, and smoking cessation and told how to access more educational information via his web record. The house officer prepares the discharge script by checking the inpatient drugs that are to be continued. The discharge medication request was processed without delay and Mr AB left hospital just as his daughter arrived to collect him.

His immediate discharge summary was received in the practice before he actually left hospital. It created an alert on the practice email system. Copies went also to his web record, the retinal unit and the diabetes centre. The general practitioner confirms receipt of the email and authorises up-dating of the practice system with further diagnostic and treatment information. He looks at the latest blood results and electronically orders repeat urea and electrolytes to be checked immediately before Mr AB sees him in 2 weeks time. Mr AB is automatically notified about this request via his web record and voicemail. Meanwhile at home Mr AB is doing regular glucose checks as advised by the diabetes specialist nurse. He downloads

his meter every day or two and schedules video conferencing calls with his diabetes specialist nurse care manager who advises on insulin adjustment.

He gets back to work 5 months later using special protective boots organised by the podiatry service. He retires, still in reasonable health, two years later. Three monthly blood tests are done at the local pharmacy. He videoconferences with his diabetes care manager and his GP every 6 months routinely or in-between if his results slip outside the target ranges, when treatment adjustments are negotiated. Prescriptions are authorised electronically at the pharmacy. He is prompted to get 2 monthly foot checks at the local podiatry centre and 6 monthly digital eye photographs and vision checks at the optometrist. The photographs are sent electronically to the ophthalmologist who calls him up only if more treatment is needed. He has not needed to attend the eye hospital now for 18 months.

He feels well and in control of his life.