Virtual Ward / Enhanced Case Management (Central)

Primary Care Commissioning Committee meeting

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24 May 2017

Author(s)	Samantha Merridale, Programme Manager, Active Support and Recovery
Sponsor Director	Nicki Doherty, Interim Director of Delivery – Care Outside of Hospital

Purpose of Paper

To propose the commencement of the agreed pilot in Central Locality of rolling out of the Virtual Ward scheme to all 21 practices within Central. MOAs have been prepared to support the project for all key stakeholders; namely STH (community nursing element), Age UK, SHSC (Clover Group practice) and the GP/admin additional support for practices.

Key Issues

KPIs to support this project are being developed and it will be closely monitored against KPIs over the summer months to support rollout City wide in autumn 2017.

Is your report for Approval / Consideration / Noting

Approval

Recommendations / Action Required by the Primary Care Commissioning Committee

The Primary Care Commissioning Committee is asked to approve the commencement of the Pilot which was agreed by the Clinical Commissioning Committee (CCC) on 2 May 2017.

Governing Body Assurance Framework

To improve patient experience and access to care
To improve the quality and equality of healthcare in Sheffield
To ensure there is a sustainable, affordable healthcare system in Sheffield

Are there any Resource Implications (including Financial, Staffing etc)?

As per agreed business case (attached for information).

Have you carried out an Equality Impact Assessment and is it attached?

Attached.

Have you involved patients, carers and the public in the preparation of the report?
No. However we will be involving patients, carers and the public in the evaluation of the virtual ward / case management model in Central – report to be shared at October CCC / PCCC as part of case for citywide roll out

Business Case

Project Name	Virtual Wards – Central Locality
Date	26th April 2017
Project Manager	Neighbourhood Leads
Project Lead	Paul Wike
Director Lead	Nicki Doherty
Clinical Lead	Anthony Gore
CCG Governing Body Lead	Nicki Doherty
Provider Consultant Lead	Iolanthe Fowler

Executive Summary

Aim and Objectives

The following business case aims to articulate a range of options for the deployment of an enhanced case management model aimed at improved, more coordinated patient centred care closer to home for those most vulnerable to non – elective admissions (NEL).

Option 1	Do nothing
Option 2	Continue pilot in nine Central locality practices
Option 3	Extend pilot to all practices in Central locality
Option 4	City wide deployment (phased approach over 18 months)

The purpose of this business case is to describe the savings which can be achieved by establishing an enhanced case management model in the community, currently being tested in nine practices in Central locality. The current test has been conducted with a frail elderly population identified as being at highest risk of NEL through risk stratification, however 'at risk populations' may differ by neighbourhood e.g. substance / alcohol abuse.

It should be noted that the enhanced case management model is part of the wider range of services which are currently described within the Active Support and Recovery programme, designed to reduce NEL and increase efficiency through a more integrated, multi-disciplinary approach for those most at risk of crisis / admission.

This business case will also test the practical application of the MOU which currently underpins the AS&R programme, and how we might flex resources across the system to improve patient care and ensure we achieve greater efficiencies across the health and care system. The MOU is attached as **Appendix 1**.

The range of work-streams / projects described in the AS&R delivery plan for 2017 / 18 are all interdependent and together describe the ability to shift appropriate activity from a hospital or community bed based setting back into the patient's own home. All describe active case management / effective person-centred care planning as being pivotal in being able to achieve this, through early identification of those patients most at risk of deterioration of their health and subsequent NEL. The overall QIPP saving described in the 17/18 delivery plan is therefore based upon all these projects coalescing around the development of care out of hospital; and projects / work-streams are progressing to enable this. There will be other business cases presented over the coming months which describe other changes required to achieve high quality out of hospital care.

Detailed profiling work has identified the cohorts of patients who have the biggest health challenges and needs, and represent the largest opportunity in terms of avoidable NEL within each neighbourhood. It is proposed that using that information, in combination with risk profiling data, we can effectively identify the cohort of patients most at risk, and establish a case management approach to prevent the admission.

Options
Following initiation in some Central practices, we now believe there are a number of options open to the CCG that should be considered:

Option 1: Do nothing
Without resource, the current work within Central locality which is piloting an enhanced case management approach for the frail elderly population would cease with immediate effect as the current model is unsustainable without additional support.

Option 2: Continue pilot in nine Central locality practices
To provide resource to continue the current pilot that began in October 2016 for the Dovercourt surgery population(and was then rolled out gradually to eight other Central locality practices) to enable further data collection on the outcomes of the scheme to help build the case for further roll-out across the locality and/or city wide.

Option 3: Extend pilot to all practices in Central locality
As option 2, but to provide resource to roll-out the scheme across all 21 Central locality practices.

Option 4: Extend pilot to all practices city wide
As option 2, but to roll-out the scheme city wide to all practices.

	Pros	Cons
Option 1	* No expenditure	* No savings * NEL will increase by 9 avoidable admissions per week at a cost of £419,175 over 27 weeks

Option 2	*Extends length of current pilot to increase data to inform fuller business case *Continues to reduce NEL within a high risk population with associated savings	*Does not maximise opportunity available to reduce NEL based upon data so far from pilot as only deployed in one locality
Option 3	*Extends population able to benefit from an enhanced case management model, therefore increasing the opportunity to further reduce NEL *Locality manager / practice support to scale-up across Central locality *opportunity to test the practical application of the MOU through redeployment of current resource elsewhere in the system (finance requested reflects anticipated efficiency / economies of scale across locality based model) * embeds model in more practices to ensure greater winter effect	*Potential for inequality of access to care closer to home for those most at risk of admission
Option 4	*Potential to maximise benefits to patients and health and care system * embedded in more practices before winter 17-18	*Maximum risk as full deployment of resource prior to full year testing on a smaller scale

For option 2 to remain cost neutral, a total of 57 unplanned admissions would need to be avoided across the nine practices in Central locality throughout pilot; however it is assumed that this can easily be achieved and exceeded based on the evidence of the pilot to date and therefore, we would expect significant savings to be generated. For options 3 & 4, assuming a similar approach to the pilot so far, saved unplanned admissions required to remain cost neutral would be 124 and 391 respectively. For detailed finance table, see page 6.

The attached paper (**Appendix 2**) describes the aims, objectives and functions of an enhanced case management model (referred to as a virtual ward), which outlines a series of principles as to how this might be rolled out across a wider geography. The paper also gives clear benefits in terms of both improved quality of care for patients along with metrics demonstrating potential savings in emergency admissions and costs.

There is also local evidence of reduced length of stay facilitated by the 'virtual ward' in Dovercourt. However, it is difficult to attribute savings at this stage as it not known to what extent these are excess bed days. This will be the subject of further work during the extended pilot to ensure we are able to capture all benefits. Primarily, we expect this service to 'wrap around' a person in the community with escalating care needs who is vulnerable to admission in order to reduce the risk of an attendance / admission.

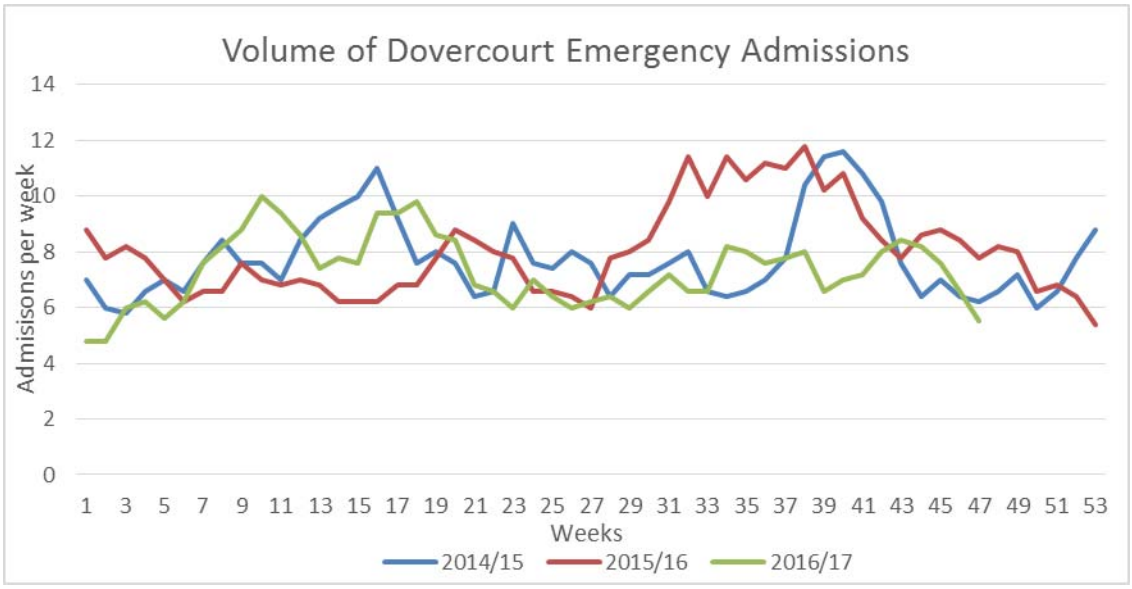
In addition, we expect the deployment of the enhanced case management model to help to further mature inter-disciplinary working, and person centred approach in the practice and neighbourhood context.

Timeframe for Implementation	The service is already operational in GPA1 Neighbourhood. If option 3 is approved as recommended, implementation across Central locality is anticipated by end of October 2017. If option 4 is approved, 50% of city practices would be covered by end of November 2017 (to maximise winter effect) and 100% of practices by September 2018. Opportunities to reduce the timeframe for implementation will be explored further with providers once approval has been achieved.
Assumptions to Quantify Benefits	• The number/proportion of patients who have been risk stratified are those in the "red and amber" tier who are most at risk of hospital admission. • Avoided admissions and unscheduled care, including patients who are rapidly approaching EOL. This can be resource intensive but prevents admission and allows patient to end life at home, according to wishes. • Six patients to date at EOL were nursed and cared for at home who were likely to have had admissions if they did not have the virtual ward service in place • Appropriate input from the right professional • Undiagnosed conditions picked up by intensive proactive review allowing for timely intervention. This could have led to a crisis if continued to be undiagnosed and untreated. • Holistic review of patient and family have led to social interventions, practical help and addressed health and social needs of carers as well as patients • The Okay2Stay plan has been found to be more fit for purpose and has helped avoid admission, and working together with the VS has shown benefits for patients • Use of Age UK and Advocacy workers has been extremely useful in identifying unmet need that impact on ability to self-care. • In depth Medication reviews by Community Optimisation Team following discharge have allowed for optimisation of medication changes following discharge, including cost saving and removal of unwanted items to prevent confusion. • PMCF and Clinical Pharmacist have been doing housebound reviews as well to prevent medication problems leading to possible admission. • Referral to AR has speeded up interventions from therapy services such as chest physio for example
Gross savings £'000	Data has been analysed from the pilot in Dovercourt practice which commenced on 1 October 2016 to assess whether a reduction in non-elective admissions could be seen. There are encouraging signs of a greater reduction in non-elective admissions when compared to previous years at Dovercourt and when compared to the average position of other practices in Central that are not within the pilot. It is difficult to draw a firm conclusion given natural variation that can occur and the relatively short time period of the pilot. The non-elective activity (age 65+ only) volume for Dovercourt practice was compared to the 2015/16 activity. The data showed a saving profile of around 3 admissions per week (14%

reduction) during the running of the pilot (primarily winter months). Any savings for summer months have had to be estimated and are assumed at a significantly lower level (assumed 1 per week, though this needs to be tested).

In order to assess confidence in the reduction in admissions seen at Dovercourt this has been compared to the level of admissions in other practices within Central locality (minus Dovercourt). It was found that in 2016/17 there was a reduction of around 5% in non-elective admissions when compared to 2015/16. An adjustment of 5% will be made to the calculation of savings based on this finding which would take 3 admissions per week per practice down to about 2.5 admissions saved per week. To account for the lower activity in summer months it would seem prudent to reduce the avoided admissions down to 1 admission per week per practice. Overall for the City emergency admissions in 2016/17 were 1.8% lower than 2015/16 (all ages exc, maternity).

The graph below shows Dovercourt Practice level of non-elective admissions for 65+ age group from 2014/15 to 2016/17. The pilot commenced in week 27 of 2016/17, the green line is fairly consistently below previous years' activity levels.



The table in the next section 'Costs' calculates the likely cost of the saved admissions under each Option based on the assumptions/evidence stated above.

This assumes that all practices embrace the programme, does not take account of local factors such as list size, differing patient cohorts etc. and the data has only been run for a short period of time. Therefore, this level of savings needs to be caveated until the effect of the pilot can be assessed.

Costs £'000

The investment required under each option and the associated savings are set out in the Table below.

INVESTMENT			Option 1 - 9 Practices	Option 2 - 9 Practices	Option 3 - 21 Practices	Option 4 - 82 Practices
Service	Volume required	Cost Per practice per week	Total cost for pilot period	Total cost for pilot period	Total cost for pilot period	Total cost for pilot period
		£	£	£	£	£
Practice based Costs						
GP time	1.5 hours per week per practice	130	0	31,558	73,636	287,532
Admin	2.5 hours per week per practice (mid band 5 £16.10 per hour)	40	0	9,781	22,822	89,114
Community Nursing	1.5 hours per week per practice (top Band 7 £26.82 per hour)	40	0	9,776	22,810	89,069
Subtotal			**0**	**51,115**	**119,268**	**465,715**
		Cost for the Pilot Period				
Locality/City Wide Costs		£				
Voluntary Sector - Age UK	For each locality	40,000	0	20,000	40,000	160,000
Primary Care Development Nurse	1 wte	27,230	0	27,230	54,460	217,840
Potential economies of scale	Likely at citywide level - 20%					(168,711)
TOTAL			**0**	**98,345**	**213,728**	**674,844**
GROSS SAVINGS ON AVOIDED ADMISSIONS						
Non elective admissions - based on 1 admission saved per week per practice	Average price per admission adjusted for readmission rebate	1,725	0	(388,206)	(905,814)	(3,536,988)
Net savings	**To contribute to Qipp AS&R savings**		**0**	**(289,861)**	**(692,086)**	**(2,862,144)**

For (the preferred) option – 3

- The required investment is **£214k** based on a 27 week period starting 1 May.
- The gross savings are **£906k** calculated on a 25 week period, thus allowing for a 2 week mobilisation.
- The net savings are **£692k.**

This will support delivery of the AS&R QIPP programme savings target, which for 17/18 are £3.9m.

There is no investment currently identified in the financial plan for new business cases. If agreed the investment would need to be prioritised against the Development Reserve leaving very little available for any other investment proposals.

The pilot will also test whether any existing roles within the current health and care system are able to fulfil the ward manager post e.g. whether this could be carried out using existing community matron resource.

Net savings £'000

Option 3 net savings are expected to be in the region of £692k based on the assumptions within the business case.
Following short pilot to date, assume £692 for length of extended pilot for option 3

Completion/ Savings delivered date

End of pilot – end October 2017

<table>
<tr><th colspan="2">Project Description</th></tr>
<tr><td>What is the proposal intended to achieve?</td><td>Evidence to date suggests a potential reduction in excess bed days but for the purposes of this business case, we are focussing on demonstrable reduced admissions.

Proposed options 3 & 4 will ensure continuity and expansion of the enhanced case management model piloted in Central locality.</td></tr>
<tr><td>How will this be achieved?</td><td>By testing our ability to flex resources across the system to provide more effective pathways of care for our patients, in line with the MOU currently supporting the Active Support and Recovery programme.

We will agree a set of KPIs that clearly identify both the cohort of patients to be monitored for admissions avoidance and measure progress.

<table>
<tr><th>Risks</th><th>Mitigation</th></tr>
<tr><td>Practices do not engage</td><td>Central roll-out has support of Central locality and ASR Board. There is great motivation in the health and care system to make this scheme work for the benefit people and their families</td></tr>
<tr><td>Practices engage but do not replicate the results seen in the Dovercourt pilot.</td><td>See above</td></tr>
<tr><td>Additional investment duplicates some elements of current baseline funding</td><td>This will be explored within the proposed continued / extended pilot and any efficiencies which can be made will be identified in October business case.</td></tr>
<tr><td>Projected savings are not realised</td><td>Break even position is deemed to be easily achievable and therefore there is high confidence in savings being generated. It is also possible that we have under estimated the potential to reduce admissions over the summer months (to be tested over the requested pilot period)</td></tr>
<tr><td>Recruitment to additional posts is delayed</td><td>We have a short term contingency plan to mitigate this risk to ensure that the model can be deployed on time if extended model agreed</td></tr>
</table>
</td></tr>
<tr><td>Clinical, patient, public, stakeholder views</td><td>Informal feedback from service users and professionals involved has been extremely positive</td></tr>
</table>

What is the evidence base for this proposal?	*Lewis G, Vaithinathan R, Wright L, Brice MR, Lovell P, Rankin S et al. Integrating care for high risk patients in England using the virtual ward model: lessons in the process of care integration from three case sites. Int J Integr Care. 2013. November 5;13 **The King's Fund 2013 "Coordinated Care for People with Chronic Complex Conditions Key Lessons and markers for Success" London
Is this proposal dependent on any other?	Yes – as part of the wider AS&R programme we are currently redesigning the intermediate care service with a shift in the use of bed based care to other more efficient pathways.
Are any other projects dependent on this proposal?	Yes – as above
Does this proposal overlap with any agreed contract efficiencies?	As part of agreed QIPP savings for 2017/18. This proposal demonstrates opportunities for reducing emergency admissions by the more proactive management and treatment of patients in their own home environment.

Financial Summary	
Implementation date	1/5/2017 – 31/10/2017 (already in place in nine central locality practices)
Cost of the proposal – year 1	See Page 6 for investment options
Cost of the proposal – year 2 onwards	Not applicable as pilot period ends Oct 2017
Gross savings – year 1	See Page 6 for gross savings
Gross savings – year 2 onwards	Not applicable as pilot period ends Oct 2017
Which QIPP line does this relate to?	AS&R
Which contract(s) does it release money from?	STH
How?	Reduction in NEL, savings from excess bed days

How do we know this gives the best possible value for money?	Evidence base Existing pilot project

Outcome Summary	
How do we know if the proposal has succeeded?	A reduction in non-elective admissions for the practices within the pilot at a higher level than the rest of the City. Evaluation to be carried in early September to meet the proposed deadline for the development of the next business case.
Outline how the proposal will be implemented	The pilot is already implemented across nine practices in Central locality. This business case presents options to roll-out the service either across the whole of Central locality or city wide.

Impact assessments	
Equality Impact Assessment	No negative impacts have been identified from the introduction of the proposed service. The service will move appropriate activity away from hospital to the patient's home, thereby preventing admission with a 'wrap-around' of care provided with a multi-disciplinary team approach.
Quality Impact Assessment	The virtual ward will use risk stratification to identify patients with highest chance of admission as well as being able to react to crises as they occur, all intended to keep patients at home and avoid admissions.

CCG Priority Aims	
To improve patient experience and access to care	The pilot in Central locality has enabled responsive care closer to home. It has promoted continuity of care through the coordination of an integrated approach at practice and neighbourhood level
To improve the quality and equality of healthcare	This approach will work with patient groups most at risk of admission within each neighbourhood
To reduce healthcare inequalities	See above
To ensure there is a sustainable, affordable healthcare system	The pilot has demonstrated that this approach can reduce NEL admissions that should be scalable by neighbourhood and locality.

QIPP outcome	
Quality	• Enabling patients to feel better supported in the management of their own health in their own home environment; • By taking a more proactive approach to identifying patients at risk of deteriorating health by means of risk stratification; • By offering all patients who fall within the scope of the programme an individualised approach to case management ensuring that their condition is better managed; • By offering a fully integrated suite of services to reduce duplication and improve outcomes by means of multiple providers offering a single point of access and pathways of care
Innovation	• Through the use of new pathways developed through the "Test Beds" project; • Through the introduction of new technology such as telehealth / telemedicine to support self-management and more proactive intervention when required; • Through the use of risk stratification, Frailty Index, predictive analytics to help identify those most at risk of admission; • Through new means of integrated/joint commissioning and contracting to put in place pathways or packages of care which are more streamlined and reduce duplication and improve access; • By offering additional methods of access to a primary care clinician by means of telephone consultation, or the 111 advice line.
Prevention	• Improvements in clinical outcomes for patients identified at most risk of admission by better case management of their condition; • Reduction in the number of "fallers" with better outcomes through improved dispositions following a fall; • Reduction in the number of readmissions through more effective discharge planning, improved access to rehabilitation and other support services
Productivity	• Reduction in A&E attendances of those patients; • Reduction in unplanned emergency admissions / readmissions of those patients; • Reduction in the number of delayed discharges and excess bed days in secondary care of those patients; • Reduction in the number of subsequent cancelled operations; • Reduction in the number of fallers with consequent admission to an emergency surgical bed; • Improvements in primary care productivity by means of additional points of access (e.g. telephone consultations, 111 advice line)

Recommendation
Recommendation 1 That CCC recommends the approval of **Option 3** to enable the model to be introduced at a scale that allows sufficient data collection to support a decision on citywide roll-out before winter 17-18 *Recommendation 2* That CCC endorses the monitoring of delivery including delivery of realisable financial savings through existing AS&R Board mechanisms and QIPP sub-group *Recommendation 3* That CCC agrees to receive a further business case at October 3rd meeting which describes the case for a city-wide deployment *Recommendation 4* That CCC considers the options presented and agrees to continue the current Dovercourt pilot in Central as a minimum. Without this, NEL will increase by 9 avoidable admissions per week at a cost of £419,175 over 27 weeks

Memorandum of Agreement with XX Practice and NHS Sheffield CCG

Transfer of Funding to support pilot of Virtual Ward / Enhanced Case Management Model in Central Locality

Reference Number:	
Title of Scheme:	Virtual Ward – Central Locality

1. How will the transfer secure more health gain than an equivalent expenditure of money in the NHS?

This is an integrated programme, delivered in primary / community care with multiple stakeholders, which is better provided through a partnership arrangement because of the creation of economies of scale. Health staff have been able to benefit from training and practice development which enhances their joint working capacity with key partners.

This funding to be transferred to Central practices, STH community nursing and Age UK for the period of the pilot (27 weeks) assuming that the scheme will start no later than 1st June 2017.

2. Description of scheme (in the case of revenue transfers, please specify the services for which money is being transferred).

This scheme aims to deploy an enhanced case management model aimed at improved, more coordinated patient centred care closer to home for those most vulnerable to non – elective admissions (NEL) across all 21 practices in Central Locality in Sheffield.

The original business case described the potential savings which can be achieved by establishing an enhanced case management model in the community, currently being tested in nine practices in Central locality. The current test has been conducted with a frail elderly population identified as being at highest risk of NEL through risk stratification, however 'at risk populations' may differ by neighbourhood.

It should be noted that the enhanced case management model is part of the wider range of services which are currently described within the Active Support and Recovery programme, designed to reduce NEL and increase efficiency through a more integrated, multi-disciplinary approach for those most at risk of crisis / admission.

The scheme will provide resource to continue the current pilot that began in October 2016 for the Dovercourt surgery population (and was then rolled out gradually to eight other Central locality practices) and will now be established in all 21 practices in Central Locality to enable further data collection on the outcomes of the scheme to help build the case for further roll-out city wide.

There are three main funding streams for the work, as follows:

- Practices - GP (1.5 hours per week per practice) and admin support (2.5 hours per week per practice)
- Age UK
- Community Nursing

The CCG will pay the amounts indicated below up front, but reserve the right to take back funding if the agreed outcomes/KPIs are not met.

The suggested KPIs are as follows:

- Total number of patients through the scheme *(as a minimum the top 100 patients per practice as identified as being most at risk of emergency adm*ission, *using frailty index scores / risk stratification).*
- Reduction in unnecessary/non elective admissions particularly in the most vulnerable.
- Onward referrals to other services e.g. Active Recovery, Falls, Social Prescribing/Voluntary Sector etc.
- Number of Ok2Stay plans completed (due to be on a template shortly so can read code/audit).
- Satisfaction surveys - feedback from patients and staff

Funding allocations:

Year	Organisation	Amount
2017/18	**GP practices x 21**	**£4594**
2017/18	**STH Community nursing**	**£22,810**
2017/18	**Age UK**	**£40,000**

4. Please state the evidence you will use to indicate that the purposes described at questions 1 and 2 have been secured.

This scheme will be project managed by a multistakeholder Task and Finish Group which in turn will be monitored by the Active Support and Recovery Delivery Group. The Delivery Group itself has multistakeholder representation from commissioners and providers across Sheffield. There is also a high level board (AS&R) chaired by the lead Clinical Director and which has Exec Director membership.

5. Signed

Signed on behalf of Sheffield Clinical Commissioning Group: _____

Position: Director of Finance

Date: _____

Signed on behalf of Practice X: _____

Position: _____

Date: _____

Payment will be made by NHS Sheffield CCG once the MOA has been signed.

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5. Signed

Signed on behalf of Sheffield Clinical Commissioning Group: _____

Position: Director of Finance

Date: _____

Signed on behalf of SHSC: _____

Position: _____

Date: _____

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2017/18	**Age UK**	**£40,000**

4. Please state the evidence you will use to indicate that the purposes described at questions 1 and 2 have been secured.

This scheme will be project managed by a multistakeholder Task and Finish Group which in turn will be monitored by the Active Support and Recovery Delivery Group. The Delivery Group itself has multistakeholder representation from commissioners and providers across Sheffield. There is also a high level board (AS&R) chaired by the lead Clinical Director and which has Exec Director membership.

5. Signed

Signed on behalf of Sheffield Clinical Commissioning Group: _____

Position: Director of Finance

Date: _____

Signed on behalf of Sheffield Teaching Hospitals: _____

Position: _____

Date: _____

Please submit an invoice to Linda McDermott at NHS Sheffield CCG.

Memorandum of Agreement with Age UK and NHS Sheffield CCG

Transfer of Funding to support pilot of Virtual Ward / Enhanced Case Management Model in Central Locality

Reference Number:	
Title of Scheme:	Virtual Ward – Central Locality

1. How will the transfer secure more health gain than an equivalent expenditure of money in the NHS?

This is an integrated programme, delivered in primary / community care with multiple stakeholders, which is better provided through a partnership arrangement because of the creation of economies of scale. Health staff have been able to benefit from training and practice development which enhances their joint working capacity with key partners.

This funding to be transferred to Central practices, STH community nursing and Age UK for the period of the pilot (27 weeks) assuming that the scheme will start no later than 1st June 2017.

2. Description of scheme (in the case of revenue transfers, please specify the services for which money is being transferred).

This scheme aims to deploy an enhanced case management model aimed at improved, more coordinated patient centred care closer to home for those most vulnerable to non – elective admissions (NEL) across all 21 practices in Central Locality in Sheffield.

The original business case described the potential savings which can be achieved by establishing an enhanced case management model in the community, currently being tested in nine practices in Central locality. The current test has been conducted with a frail elderly population identified as being at highest risk of NEL through risk stratification, however 'at risk populations' may differ by neighbourhood.

It should be noted that the enhanced case management model is part of the wider range of services which are currently described within the Active Support and Recovery programme, designed to reduce NEL and increase efficiency through a more integrated, multi-disciplinary approach for those most at risk of crisis / admission.

The scheme will provide resource to continue the current pilot that began in October 2016 for the Dovercourt surgery population (and was then rolled out gradually to eight other Central locality practices) and will now be established in all 21 practices in Central Locality to enable further data collection on the outcomes of the scheme to help build the case for further roll-out city wide.

There are three main funding streams for the work, as follows:

- Practices - GP (1.5 hours per week per practice) and admin support (2.5 hours per week per practice)
- Age UK
- Community Nursing

The CCG will pay the amounts indicated below up front, but reserve the right to take back funding if the agreed outcomes/KPIs are not met.

The suggested KPIs are as follows:

- Total number of patients through the scheme *(as a minimum the top 100 patients per practice as identified as being most at risk of emergency adm*ission, *using frailty index scores / risk stratification).*
- Reduction in unnecessary/non elective admissions particularly in the most vulnerable.
- Onward referrals to other services e.g. Active Recovery, Falls, Social Prescribing/Voluntary Sector etc.
- Number of Ok2Stay plans completed (due to be on a template shortly so can read code/audit).
- Satisfaction surveys - feedback from patients and staff

Funding allocations:

Year	Organisation	Amount
2017/18	**GP practices x 21**	**£4594**
2017/18	**STH Community nursing**	**£22,810**
2017/18	**Age UK**	**£40,000**

4. Please state the evidence you will use to indicate that the purposes described at questions 1 and 2 have been secured.

This scheme will be project managed by a multistakeholder Task and Finish Group which in turn will be monitored by the Active Support and Recovery Delivery Group. The Delivery Group itself has multistakeholder representation from commissioners and providers across Sheffield. There is also a high level board (AS&R) chaired by the lead Clinical Director and which has Exec Director membership.

5. Signed

Signed on behalf of Sheffield Clinical Commissioning Group: _____

Position: Director of Finance

Date: _____

Signed on behalf of Age UK: _____

Position: _____

Date: _____

Please submit an invoice to Linda McDermott at NHS Sheffield CCG.

Equality Impact Assessment

Title of policy or service:	Virtual Ward Business case	
Name and role of officer/s completing the assessment:	Samantha Merridale. Interim Senior Programme Manager - ASR	
Date of assessment:	27th April 2017	
Type of EIA completed:	**Initial EIA 'Screening'** ☒ ***or*** **'Full' EIA process** ☐	*(select one option - see page 4 for guidance)*

1. Outline	
Give a brief summary of your policy or service • Aims • Objectives • Links to other policies, including partners, national or regional	To provide an enhanced case management model in the community – firstly in Central locality and ultimately citywide. There is a current pilot which exists within 9 practices including Dovercourt in Central locality, which focuses on the frail elderly population who are at high risk of emergency admission to hospital. The case is part of a wider range of services which are currently described within the AS&R programme, designed to reduce non-elective admissions and increase efficiency through a more integrated, multi-disciplinary approach for those most at risk of crisis or admission. Central locality demonstrate a high number of frail elderly patients who are at risk of emergency admission. If this scheme is ultimately rolled out beyond Central locality into other locality areas, we would intend to target those vulnerable adults who are most at risk of admission, dependent on the profile of that particular area – this might include the homeless, those suffering from mental health etc, and ultimately so it is not restricted to the frail elderly. The key performance indicator for this scheme is the reduction of non elective admissions, potentially 1 per practice per week.

Identifying impact:

- **Positive Impact:** will actively promote or improve equality of opportunity;
- **Neutral Impact:** where there are no notable consequences for any group;
- **Negative Impact:** negative or adverse impact causes disadvantage or exclusion. If such an impact is identified, the EIA should ensure, that as far as possible, it is either justified, eliminated, minimised or counter balanced by other measures. This may result in a 'full' EIA process.

2. Gathering of Information

This is the core of the analysis; what information do you have that might *impact on protected groups, with consideration of the General Equality Duty*.

(Please complete each area)	What key impact have you identified?			For impact identified (either positive and or negative) give details below:	
	Positive Impact	**Neutral impact**	**Negative impact**	**How does this impact and what action, if any, do you need to take to address these issues?**	**What difference will this make?**
Human rights	☐	☒	☐	No notable consequences for any group	
Age	☒	☐	☐	The initial business case focuses on frail elderly within Central locality	By improving the quality of care they receive in a community environment, thus preventing a hospital admission
Carers	☒	☐	☐	The target patient group are potentially those who will have long term care arrangements in place including that provided by the patient's family.	By reducing unpredicted non-elective admissions it enables greater stability in care arrangements, which will also positively impact on the patient's family.
Disability	☒	☐	☐	The target patient group may include those with a physical or mental health disability	Better care in their own home or a community based setting and continuation of their long term care arrangements will eliminate the need for specialist care within an acute environment.

Sex	☐	☒	☐	No notable consequences for any group	
Race	☐	☒	☐	No notable consequences for any group	
Religion or belief	☐	☒	☐	No notable consequences for any group	
Sexual orientation	☐	☒	☐	No notable consequences for any group	
Gender reassignment	☐	☒	☐	No notable consequences for any group	
Pregnancy and maternity	☐	☒	☐	No notable consequences for any group	
Marriage and civil partnership (only eliminating discrimination)	☐	☒	☐	No notable consequences for any group	
Other relevant groups	☐	☒	☐	No notable consequences for any group	
HR Policies only: Part or Fixed term staff	☐	☐	☐		

IMPORTANT NOTE: *If any of the above results in ' **negative'** impact, a 'full' EIA which covers a more in depth analysis on areas/groups impacted must be considered and may need to be carried out.*

Having detailed the actions you need to take please transfer them to onto the action plan below.

3. Action plan				
Issues/impact identified	**Actions required**	**How will you measure impact/progress**	**Timescale**	**Officer responsible**
By improving the quality of care they receive in a community environment, thus preventing a	The scheme will mirror the current pilot project in Dovercourt practice by using	KPIs are being set to look at both quantifiable and qualitative benefits to this	By October 2017	Nicki Doherty

hospital admission	community nurses / GPs and a ward manager to proactively identify and case manage the patient in their own home.	scheme, including PROMS/PREMS. The principle KPI is the reduction of non elective admissions by 1 patient per practice per week.		
By reducing unpredicted non-elective admissions it enables greater stability in care arrangements, which will also positively impact on the patient's family.	The scheme will mirror the current pilot project in Dovercourt practice by using community nurses / GPs and a ward manager to proactively identify and case manage the patient in their own home.	KPIs are being set to look at both quantifiable and qualitative benefits to this scheme, including PROMS/PREMS. The principle KPI is the reduction of non elective admissions by 1 patient per practice per week.	By October 2017	Nicki Doherty
Better care in their own home or a community based setting and continuation of their long term care arrangements will eliminate the need for specialist care within an acute environment.	The scheme will mirror the current pilot project in Dovercourt practice by using community nurses / GPs and a ward manager to proactively identify and case manage the patient in their own home.	KPIs are being set to look at both quantifiable and qualitative benefits to this scheme, including PROMS/PREMS. The principle KPI is the reduction of non elective admissions by 1 patient per practice per week.	By October 2017	Nicki Doherty

4. Monitoring, Review and Publication				
When will the proposal be reviewed and by whom?	**Lead / Reviewing Officer:**	**Nicki Doherty**	**Date of next Review:**	**May 2017**

Once completed, this form **must** be emailed to Elaine Barnes, Equality Manager for sign off: elaine.barnes3@nhs.net.

Elaine Barnes signature:	

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Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Once form is completed please email to Project Lead	Scheme Number: **Quality Impact Assessment**		
Scheme Name	Implementation of Virtual ward – Central Locality		
Scheme Overview	To provide an enhanced case management model in the community – firstly in Central locality and ultimately citywide. There is a current pilot which exists within 9 practices including Dovercourt in Central locality, which focuses on the frail elderly population who are at high risk of emergency admission to hospital. The case is part of a wider range of services which are currently described within the AS&R programme, designed to reduce non-elective admissions and increase efficiency through a more integrated, multi-disciplinary approach for those most at risk of crisis or admission. Central locality demonstrate a high number of frail elderly patients who are at risk of emergency admission. If this scheme is ultimately rolled out beyond Central locality into other locality areas,w e would intend to target those vulnerable adults who are most at risk of admission, dependent on the profile of that particular area – this might include the homeless, those suffering from mental health etc, and ultimately so it is not restricted to the frail elderly. The key performance indicator for this scheme is the reduction of non elective admissions, potentially 1 per practice per week.		
Project Lead	Paul Wike	Portfolio	
Clinician Completing QIA	Anthony Gore		

Quality Indicator(s)				
KPI Assurance – Sources & Reporting to Monitor Quality Indicator(s)	Reduction in NEL admissions Reduction in emergency readmissions Care closer to home			
Patient Safety For example could the proposal/action impact positively or negatively on any of the following: safety, systems in place to safeguard patients to prevent harm, including infections, delivery of safe clinical standard of care?	Likely to have positive impact only – reducing emergency admissions will reduce HAI, and improve delivery of safe clinical care in a more appropriate environment to the patient's needs.	Impact 1	Likeliho 1	Score

Clinical Effectiveness For example could the proposal/action impact positively or negatively on evidence based practice, clinical leadership, clinical engagement and/or high quality standards or any other areas?	Likely to have positive impact only – treating patients in their own homes / usual place of residence will improve clinical effectiveness and quality standards by maintaining continuity of care and eliminating risks associated with hospital admission	Impact 1	Likeliho 1	Score

Patient Experience For example could the proposal/action impact positively or negatively on any of the following: positive survey results from patients, patient choice, personalised and compassionate care?	Likely to have positive impact only – patient experience will be much improved by offering proactive management / treatment in their own home / community based environment. To be measured through PROMS/PREMS.	Impact 1	Likeliho 1	Score
Prevention For example could the proposal/action impact positively or negatively on promotion of self-care and health inequality?	Likely to have positive impact only – the scheme is focussed around proactively identifying and case managing patients before their condition deteriorates to the extent that it requires hospital admission.	1	1	
Productivity and Innovation For example could the proposal/action impact positively or negatively on the best setting to deliver best clinical and cost effective care' eliminating any resource inefficiencies; improved care	Likely to have positive impact only – the scheme is aimed at reducing emergency admisisons which will positively improve productivity and deliver more cost effective care in the most appropriate environment.	1	1	

pathway?				
Vacancy Impact For example could the proposal/action impact positively or negatively as a result of staffing posts lost?	No.	1	1	
Mitigation	[ils			
	Overall Risk Score			
Signed Clinical Director			Date	
Signed Medical Director			Date	
Signed Chief Nurse			Date	
Comments Medical Director Chief Nurse				

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Appendix 1

		IMPACT				
		1	2	3	4	5
LIKELIHOOD	1	1	2	3	4	5
	2	2	4	6	8	10
	3	3	6	9	12	15
	4	4	8	12	16	20
	5	5	10	15	20	25

Risk score	Category
1 - 3	Low risk (green)
4 - 6	Moderate risk (yellow)
8 - 12	High risk (orange)
15 - 25	Extreme risk (red)

LIKELIHOOD		IMPACT	
1	RARE	1	MINOR
2	UNLIKELY	2	MODERATE / LOW
3	MODERATE / POSSIBLE	3	SERIOUS
4	LIKELY	4	MAJOR
5	ALMOST CERTAIN	5	FATAL / CATASTROPHIC