



Department
of Health



Department for
Communities and
Local Government



Better Care Fund Task Force

'How to' Guide: The BCF Technical Toolkit

*Section 2:
Evidence-Based Planning*

August 2014

The Better Care Fund



Contents

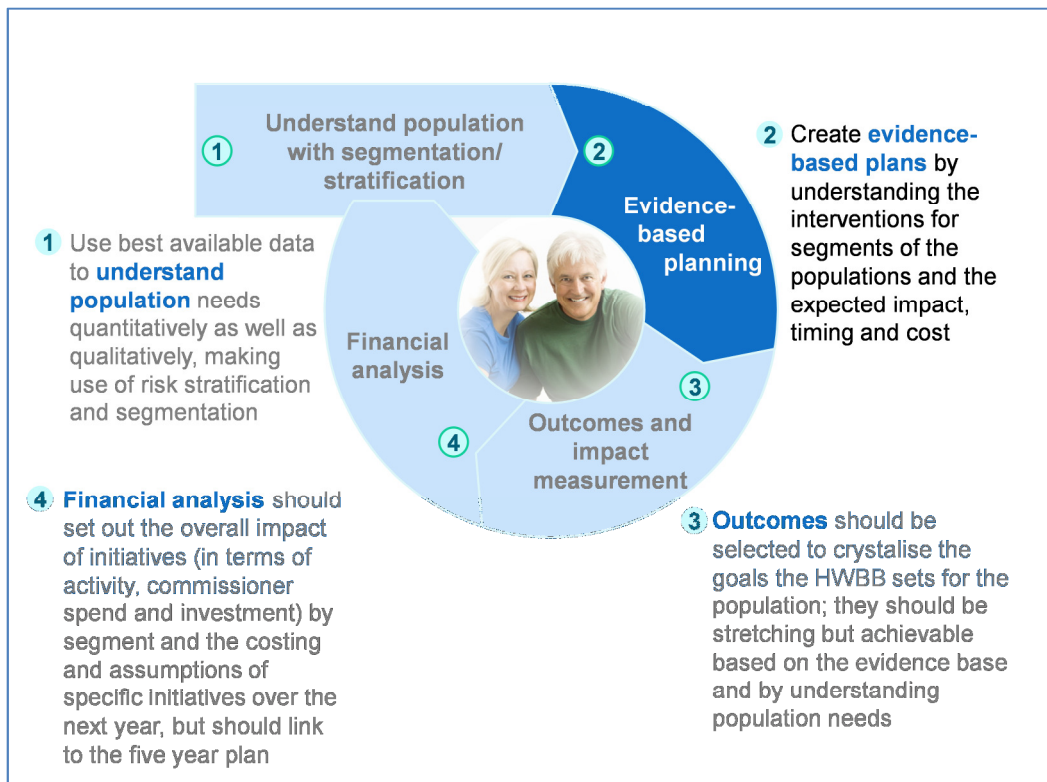
Background	1
Evidence based planning	2
<i>What is it?</i>	2
<i>Why is it important?</i>	3
<i>What is essential for your plan?</i>	3
<i>What is recommended for your plan?</i>	4
<i>How to use this information in the planning templates?</i>	7
Appendix 2: Synthesis of Integrated Care evidence base	10
Appendix 2a: Self-care	11
Appendix 2b: Falls prevention	12
Appendix 2c: Individualised care plans	13
Appendix 2d: Care co-ordination	14
Appendix 2e: Case management	15
Appendix 2f: Intermediate care, reablement and rehabilitation	16
Appendix 2g: Multidisciplinary teams	18

BACKGROUND

This document provides advice on ways to evaluate the evidence base and create an evidence-based plan. Also included in the following sections are hints and tips that will support the preparation of BCF plans as they pertain to the evaluation and use of evidence to support chosen schemes and impact targets. This document is meant to be used in conjunction with the other documents that make-up the “how to guide.” Please refer to the document entitled “Introduction to the How To Guide” to understand how to best use this document.

It is worth highlighting that an approach to evaluating the evidence is a vital component in robust, well-developed BCF planning. The other sections of this toolkit – such as outcome and impact measurement and financial analysis - build on the evidence base theory explained in this section.

Figure 1. Four steps for robust planning



EVIDENCE BASED PLANNING

What is it?

With a clear understanding of the needs of the population, the evidence base around what works can be used to identify the schemes likely to have the most significant impact for particular segments of the population. The evidence base will also help quantify the impact and timing of expected benefits, as well as indicating essential requirements for success.

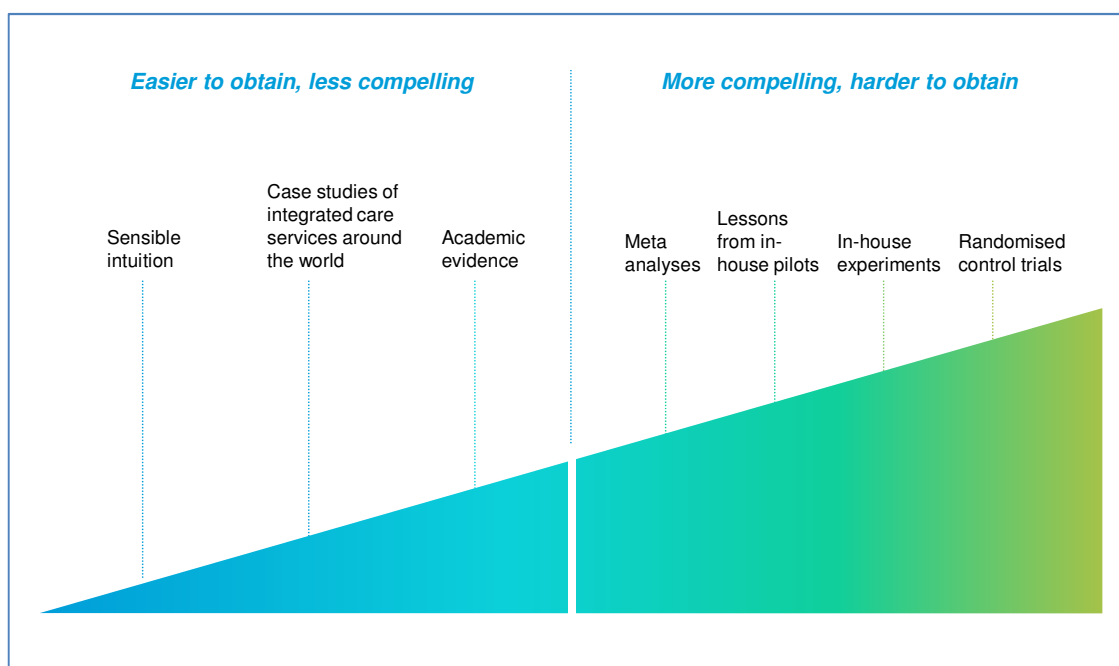
Evidence-based planning is about applying the available research (evidence) to planning decisions. There are three core types of evidence relevant to planning integrated care:

1. *Academic evidence*: there are numerous academic papers on integrated care and individual schemes. The most robust academic evidence comes in peer-reviewed journals, or from reputable specialist think tanks and consultancies.
2. *Meta-analysis*: is a statistical technique for combining the findings from academic studies. Meta-analysis is most often used to assess the clinical effectiveness of healthcare interventions. Meta-analysis of trials provides a precise estimate of treatment effect, giving due weight to the size of the different studies included.¹
3. *Case studies*: examples of successful schemes from the UK or elsewhere around the world. Good case studies explain the context or problem the scheme has sought to solve, how the solution has worked, its impact or track record in action, and what the key enablers of impact were. It is unlikely that one case study could be directly reproduced in a different environment, but case studies can provide an indication of the level of impact that is possible and the enablers required to achieve that impact.

¹ Oxford Medical School, What is meta-analysis, <http://www.medicine.ox.ac.uk/bandolier/painres/download/whatis/meta-an.pdf>

Figure 2. The spectrum of evidence

A best practice evidence-based plan will include a thorough review of the most relevant and compelling evidence (those on the right side of the spectrum below). The best plans will be supported by a broad range of evidence, including comprehensive reviews or in-house studies. It is recognised that localities are likely to be at different points in developing an evidence base, and for those without an existing localised base can rely on evidence that is easier to obtain (those on the left side of the spectrum) in evidencing their planning choices in the BCF plan.



Why is it important?

Evidence-based planning involves learning from the best available evidence from around the world on what works and what could be different. BCF plans which are underpinned by robust evidence are more likely to achieve their intended objectives as well as increase confidence across stakeholders and the wider local system. The evidence is helpful in assessing the potential impact of schemes and understanding what makes schemes more or less likely to be successfully implemented.

What is essential for your plan?

It is likely that schemes in the BCF submissions have been identified based on available evidence relevant to local target population segments. Ideally this will be evidence drawn from a combination of different sources and parts of the

evidence spectrum shown in figure 2. However, if synthesising the evidence has been challenging, the appendix to this section provides a summary of evidence for seven specific interventions which are thought to account for a large majority of the impact of widely studied integrated care programmes. This can be used to supplement the existing evidence base and strengthen submissions.



Appendix 2 synthesises the evidence base for 7 specific integrated care interventions which account for a large majority of impact in integrated care programmes, including:

- Self-care
- Falls prevention
- Individualised care plans
- Care co-ordination
- Case management
- Intermediate care, reablement and rehabilitation
- Multi-disciplinary teams

Plans may also contain schemes that are unsupported by an evidence base. They may be based on local area knowledge or on input from key stakeholders (patient groups, clinicians) but have not yet been robustly studied. In these cases, BCF encourages the inclusion of the schemes, but requires a summary of the rationale for their inclusion, a list of the key outcome and impact indicators of relevance and a plan for monitoring impact.

What is recommended for your plan?

Best practice evidence based plans will be widely understood and supported by local stakeholders and will identify:

- The specific changes in care to be made for the population segments identified in section 1
- The changes in behaviour and skills of the workforce required
- The supporting enablers (including information and payment mechanisms) to be put in place to allow the changes in care to happen
- The level and timing of expected benefits.

Developing these plans requires the use of existing evidence and a high level of engagement from local clinicians and other professionals, users, commissioners, providers and other key stakeholders. A prioritisation needs to be undertaken with key stakeholders to agree which schemes should be prioritised considering factors such as:

- Segment(s) reached


- Expected level and timing of impact
- Robustness of evidence
- Ability of local system to implement
- Level of implementation risk

Consideration also needs to be given to the key enablers that are required for successful implementation of the chosen schemes. This includes payment systems aligned with outcomes, informatics, governance requirements and clinical leadership. Consideration of the local provider market and the development of this market to deliver the required schemes is also important.

BetterCareTown HWBB case study exhibit 1: Reviewing the evidence
In section 1, BetterCareTown HWBB chose to target the 75+ aged group with one or more LTCs. They started their research by looking at care models for this segment around the world. On a web search, they identified ChenMed, an innovative scheme for the elderly. The HWBB quickly gathered the most relevant evidence: what is the context?; what are the interventions?; what has been the impact?

Elderly people with LTCs example

- ChenMed is a primary-care led physician group providing a one-stop shop for elderly patients with multiple chronic conditions







Key elements of model of care

- Focus on relationship with patients, e.g., **>85% GP continuity** for patients
- Offer **longer appointments**
- **Multidisciplinary teams** based at centre

- Provide non-emergency **transport** for patients for scheduled appointments or last-minute walk-ins

- Digital robotic prescription centre means **patients leave with their medication**

- Achieve **35% reduction in hospital admissions**
- Ensure near real-time information flows (especially A&E visits and admissions) and review admissions

Similarly, walk-in centres in the UK are very popular with “mostly healthy patients” as they eliminate the hassle of visiting the GP and meet this group’s need for fast, convenient care

Source: Tanio et al. – Innovations At Miami Practice Show Promise For Treating High-Risk Medicare Patients Health Aff June 2013 vol. 32 no. 6 1078-1082, Interviews

BetterCareTown HWBB case study exhibits 2 and 3: Compiling the evidence

After reviewing several examples like ChenMed, BetterCareTown HWBB was left with a list of interventions that would be relevant to their target segment. They prioritised the four interventions that they believed would be most beneficial to their target segment based on: amount and diversity of evidence available, input from clinical partners, the similarity of the populations in the evidence base to their own population, expected impact levels and time scale to achieve impact

Intervention	Case study												
	Torbay	Greenwich	Tower Hamlets	Dementia	Milands	Australia	Knappschaft	Valencia	ChenMed	Geisinger	CareMore	Kaiser	NYCC ¹
1 Self-empowerment and education		✓	✓	✓	✓	✓			✓	✓	✓	✓	✓
2 Multi-disciplinary teams	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
3 Care coordination	✓	✓	✓	✓			✓		✓	✓	✓	✓	✓
4 Individualised care plans	✓		✓	✓	✓	✓			✓	✓	✓	✓	✓
5 Rapid response	✓	✓		✓						✓	✓		✓
6 Training for care professionals	✓	✓	✓	✓	✓	✓			✓	✓	✓	✓	✓
7 Co-location of services	✓	✓	✓					✓	✓	✓	✓	✓	✓
8 Shared electronic care records		✓					✓	✓	✓	✓	✓	✓	✓
9 Frequent primary-care appointments		✓			✓				✓		✓		✓
10 Risk stratification	✓		✓			✓			✓	✓	✓	✓	✓
11 Case management	✓	✓	✓	✓	✓	✓			✓	✓	✓	✓	✓
12 Discharge support	✓	✓	✓	✓					✓	✓	✓	✓	✓
13 Service user registries	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
14 Scheduled service user follow-ups		✓	✓	✓	✓	✓			✓	✓	✓	✓	✓
15 Co-located pharmacies							✓	✓	✓		✓	✓	

1 New York Coordinated Care
SOURCE: Richardson, Dorling – Global Integrated Care Case Compendium (McKinsey)

Intervention	Number of reviews showing positive evidence	Additional insight from evidence base	Average impact ¹
1. Self-empowerment and education	83% (20 of 24 reviews) assessed patient support for self-care and found a positive impact	Supported self-management has the strongest effect on clinical outcomes of all IC components when estimated at component-level <i>Tsai et al, Am J Manag Care, 2005 (August), 11(8), 478-88 (Table 4)</i>	Hospitalisations reduced by 25-30% (inter-quartile range)
2. Multi-disciplinary teams	81% (13 of 16 reviews) assessed MDTs and found a positive impact	All reviews have concluded that specialised follow up of patients by a multidisciplinary team can reduce hospitalisation <i>Holland et al, Heart, 2005, 91, 899-906</i>	Hospitalisations reduced by 15-30% (inter-quartile range)
3. Care coordination	57% (8 of 13 reviews) assessed care coordination and found a positive impact	Interventions involving case management reduce HbA1c [in patients with diabetes] by 22% more than interventions without case management. <i>Shojana et al, JAMA, 2006, 296(4), 427-440</i>	Hospitalisations reduced by ~37% (pooled estimate only reported in 2 relevant reviews)
4. Individualised care plans ²	64% (7 of 11 reviews) assessed care plans and found a positive impact	Personalised approaches using tailored information influence health behaviour more than uniform approaches <i>Graffy et al, Primary Health Care Research & Development, 2009, 10(3), 210-222</i>	Hospitalisations reduced by ~23% (pooled estimate only reported in 2 relevant reviews)

Inclusion criteria

- Strong, consistent published evidence of efficacy
- Also used in the overwhelming majority of the 13 case studies looked at

1 Impact measured from systematic reviews, including relevant interventions and containing meta-analyses of hospitalisation rate
2 Cochrane review of the evidence for personalised care planning (Coulter et al.) currently in process
SOURCE: Richardson, Dorling – Global Integrated Care Case Compendium (McKinsey)

How to use this information in the planning templates?

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

b) What difference will this make to patient and service user outcomes?

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

This information will be required to complete *Part 1, Section 2* of the template, which requires a description of the changes that are planned to services over the next 5 years and how the BCF has contributed to this.

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

Part 1, Section 3 asks for an analytically driven understanding of how care can be improved by integration. This requires a description of the evidence base around integration, and how it has been applied locally.

Part 1 Section 4d asks for a listing of the planned BCF schemes, which can be agreed as part of the prioritisation process outlined in this section. *Part 1 Annex 1* asks for a description of the evidence base that has been used to select and design each scheme and to drive assumptions about impact and outcomes. *Part*

1 Annex 1 also asks for key success factors for implementation of the scheme, which can partly be drawn from the evidence about what has worked elsewhere.

ANNEX 1 – Detailed Scheme Description	
For more detail on how to complete this template, please refer to the Technical Guidance	
Scheme ref no.	
Scheme name	
What is the strategic objective of this scheme?	
Overview of the scheme	Please provide a brief description of what you are proposing to do including: <ul style="list-style-type: none">- What is the model of care and support?- Which patient cohorts are being targeted?
The delivery chain	Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
The evidence base	Please reference the evidence base which you have drawn on <ul style="list-style-type: none">- to support the selection and design of this scheme- to drive assumptions about impact and outcomes
Investment requirements	Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme	Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop	What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
What are the key success factors for implementation of this scheme?	



Further reading

- https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/304139/Transforming_primary_care.pdf
- Blunt, I (2013) 'Focus on preventable admissions: trends in emergency admissions for ambulatory care sensitive conditions, 2001 to 2013' Quality Watch, The Health Foundation, Nuffield Trust
- Purdy S (2010). Avoiding hospital admissions: what does the research evidence say? London: The King's Fund. Available at: www.kingsfund.org.uk/publications/avoiding-hospital-admissions (accessed on 19 December 2013).
- Poteliakhoff E, Thompson J (2011). Emergency bed use: what the numbers tell us. London: The King's Fund.
- Shepperd S, Doll H, Angus RM, Clarke MJ, Iliffe S, Kalra L, Ricauda NA, Tibaldi V, Wilson AD (2009). 'Avoiding hospital admission through provision of hospital care at home: a systematic review and meta-analysis of individual patient data'. *Canadian Medical Association Journal*, vol 180, no 2, pp 175–82.
- Oliver D, Foot C, Humphries R (forthcoming). Making our health and care services fit for an ageing population. London: The King's Fund.

APPENDIX 2: SYNTHESIS OF INTEGRATED CARE EVIDENCE BASE

The following section is an overview of some of the available evidence which will support planning. The extent to which you use this section will depend largely on the level of evidence which you have already included in your plan. If you have a broad evidence base drawing from different sources this section can be used to supplement or triangulate that evidence at the level of individual interventions. If you are yet to develop a broad evidence base, this section may help to build a narrative around which interventions you have chosen and why.

The following section shows seven evidence-based schemes, all of which are supported by research that provides proof of impact.

They are:

- a. Self-care
- b. Falls prevention
- c. Individualised care plans
- d. Care co-ordination
- e. Case management
- f. Intermediate care, reablement and rehabilitation
- g. Multi-disciplinary teams.

The combined impact of these schemes is to reduce emergency admissions and place greater emphasis on primary and community care. However, it is important to remember that the schemes are not additive as they are overlapping in the population they target, so simply adding together the expected benefits is likely to overestimate the total benefits. A meta-analysis of published academic articles on integrated care showed that these schemes delivered an overall reduction in hospitalisation of 19%.²



For overall summaries of the evidence base please see:

- Integrated care value case toolkit (LGA)
- Making best use of the Better Care Fund (The King's Fund), http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/making-best-use-of-the-better-care-fund-kingsfund-jan14.pdf

² Richardson, Dorling – Global Integrated Care Case Compendium (McKinsey)

APPENDIX 2A: SELF-CARE

Self-care interventions can reduce hospitalisations, improve outcomes and reduce costs for the system. For example, one study found that supported self-management had the strongest effect on clinical outcomes of all integrated care interventions, and reduced hospitalisations by 25-30%.³

The evidence base highlights the following techniques:

- Involving patients in co-creating personalised self-care plans
- Telephone health coaching
- Tailoring interventions to the condition (e.g. structured education for diabetes self-care, behavioural interventions for depression)
- Programmes to encourage lifestyle and behavioural change.



Further evidence on self-care:

- Naylor et al (2013) 'Long term conditions and mental health - the cost of co-morbidities'
- Purdy S (2012) *Avoiding hospital admissions: what does the research evidence say?* London: the King's Fund
- De Silva D (2011) *Helping people help themselves: a review of the evidence considering whether it is worthwhile to support self-management.* London: The Health Foundation
- A NICE Local Practice example is available at: [Self-care support for long-term conditions](#)
- For guidance on making a local business case for self-care, please see the work done by the NESTA people powered health programme: '[The business case for people powered health](#)'

³ Ibid.

APPENDIX 2B: FALLS PREVENTION

Identifying people at risk of falls and developing preventative interventions reduces hospital admissions and the use of residential care homes. For example, one study in Torbay used patient-level linked datasets to explore the health and social care costs for patients in the year before and after a fall. It showed that in the 12 months after a fall, community care costs increased by 160%, social care costs by 37% and acute hospital costs by 35%.⁴

The evidence base highlights the following techniques:

- Strength and balance training
- Home hazard assessment and intervention
- Vision assessment and referral
- Medication review with modification/withdrawal



Further evidence on falls prevention:

- NICE clinical guideline NICE (2013). Falls: assessment and prevention of falls in older people. NICE clinical guideline 161. London: NICE. Available at www.nice.org.uk/nicemedia/live/14181/64088/64088.pdf (accessed on 17 December 2013).
- For the economic case for investing in falls prevention, see 'Fracture prevention services: an economic evaluation' (Department of Health, 2009).
- For a recent independent evaluation of a working falls prevention service, see Campbell et al (2013), which evaluated the impact of Northamptonshire Crisis response service
- Page 65 of the LGA Evidence Review: 'Integrated care evidence review, November 2013'
- Department of Health (2009). Fracture prevention services: An economic evaluation. London: The Stationery Office.
- Centre for disease control compendium of effective fall interventions: http://www.cdc.gov/HomeandRecreationalSafety/pdf/CDC_Falls_Compendium_lowres.pdf

⁴ Tian et al (2013), '[Exploring the system - wide costs of falls in older people in Torbay](#)'.

APPENDIX 2C: INDIVIDUALISED CARE PLANS

A care plan is a document owned by the person receiving care and their general practice. It should be co-created with them and set out their agreed year of care. For long-term conditions or for people whose conditions need regular management, having a proactive care plan is vital. The care plan should be wellness focused and should cover a comprehensive and up-to-date understanding of the persons' needs and circumstances.⁵

North West London Integrated care toolkit highlights the following key principles of an individualised care plan⁶:

- Focus on patients most at risk of hospitalisation
- Patients and carers own care plans with agreed goals
- Access to single electronic health record
- Information sharing across health and social care

7 of 11 published reviews which were analysed found a positive impact of assessing care plans.⁷ Other studies have shown a reduction in hospitalisations by ~23%.⁸



Further evidence on individualised care plans:

- Graffy et al, Primary Health Care Research & Development, 2009, 10(3), 210-222
- NHS England, Transforming participation in health and care 2013, <http://www.england.nhs.uk/wp-content/uploads/2013/09/trans-part-hc-guid1.pdf>

⁵ North West London – Whole systems integrated care toolkit, 2014

⁶ Ibid.

⁷ Richardson, Dorling – Global Integrated Care Case Compendium (McKinsey)

⁸ North West London – Whole systems integrated care toolkit, 2014, pooled estimate only reported in 2 relevant reviews

APPENDIX 2D: CARE CO-ORDINATION

Care co-ordination is the practice of having someone (not necessarily a clinician) co-ordinate the care received by an individual that has been designated as needing additional support. Typically, these are older people and those with chronic conditions who often represent 10-20% of the population and 30-70% of costs in the health and care system. There are several essential steps that are required to implement care co-ordination including the identification of individuals who would benefit from care co-ordination, the enrolment of those individuals into a programme, the development of care plans for those individuals and then on-going follow-up in line with the plan.

The evidence base highlights the following techniques:

- A holistic focus supporting self care at home
- Single entry point to provide continuity
- Shared electronic health records
- Coordinating care at the neighbourhood level with engagement of local community
- Prioritising engagement with GPs and links with secondary care

8 out of 13 reviews which were analysed assessed care co-ordination and found a positive impact. Other reviews of literature have concluded that hospitalisations may be reduced by approximately 37%.⁹ Interventions involving care co-ordination have shown to reduce HbA1c (in patients with diabetes) by 22% more than interventions without care co-ordination.¹⁰



Further evidence on care co-ordination:

- 'Case management: what it is and how it can be best implemented'
- 'South Devon & Torbay: Proactive case management using the community virtual ward and the Devon predictive model'
- Goodwin N, Sonola L, Thiel V, Kodner D (2013). Co-ordinated care for people with complex chronic conditions. London: The King's Fund.

⁹ North West London – Whole systems integrated care toolkit, 2014, pooled estimate only reported in 2 relevant reviews

¹⁰ Shojana et al, JAMA, 2006, 296(4), 427-440

APPENDIX 2E: CASE MANAGEMENT

Case management focuses on the small proportion of the population (e.g. <5%) with much more intense needs than the population addressed by care co-ordination. Given these needs, a case manager is required who can help to actively manage the condition of a person.

The evidence base highlights the following techniques:

- A focus on early action and prevention, targeted at particular communities to mobilise local people
- Community-based multi-professional teams based around general practices or groups of practices that promote close working and communication between staff in different organisations, for example, through co-location
- A single point of access, single assessment and shared clinical records
- Targeting individuals who are at high risk of future emergency admission to hospital, before they deteriorate, which requires access to good quality health and social care data

The evidence base for case management is “promising but mixed” (Purdy, 2010). This is in part due to difficulty in attributing any positive changes to case management when there are multiple factors at play (for example, how to disentangle the effect of case management from any specific interventions that might be planned e.g. falls prevention, reablement, self-care).

Further evidence on case management:



- Ross S, Curry N, Goodwin N (2011). Case management: what it is and how it can best be implemented. London: The King’s Fund.
- Challis D, Hughes J (2011) Intensive care/case management, PSSRU, Manchester
- Graffy J, Grande M, Campbell J (2008). ‘Case management for elderly patients at risk of hospital admission: a team approach’. Primary Health Care Research and Development, vol 9, no 1, pp 7–13

APPENDIX 2F: INTERMEDIATE CARE, REABLEMENT AND REHABILITATION

Intermediate care services, including rehabilitation and reablement, have the potential to reduce length of stay by facilitating a stepped pathway out of hospital (step down) or preventing deterioration that could lead to a hospital stay (step up).

The evidence base highlights the following techniques:

- Commissioning for outcomes instead of periods and tasks
- Workforce led by a senior clinician with specific reablement services and skills
- Adequate provision for rehabilitation and reablement outside acute hospitals, based on demographic characteristics of the local population

A Department of Health funded review showed that home care reablement is almost certainly cost-effective and improves outcomes for users. The study showed that in the first year of setting up a service, set-up costs cancel out savings.¹¹

- Social Care Institute for Excellence (2013). Maximising the potential of reablement. London: SCIE.
- NHS Benchmarking Network, British Geriatrics Society, Association of Directors of Adult Social Services, College of Occupational Therapists, Royal College of Physicians, Royal College of Nursing, Chartered Physiotherapists, The Patients Association, Royal College of Speech & Language Therapists, NHS England (2013).
- National Audit of Intermediate Care 2013 [online]. Available at: www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/delayed-transfers-of-caredata-2013-14/ (accessed on 17 December 2013).

¹¹ <http://www.york.ac.uk/inst/spru/pubs/rworks/2011-01Jan.pdf>



Further evidence on intermediate care, reablement and rehabilitation:

- <http://www.york.ac.uk/inst/spru/pubs/rworks/2011-01Jan.pdf>
- SCIE Research briefing 36: Reablement: a cost-effective route to better outcomes
- <http://www.scie.org.uk/publications/briefings/briefing36/>
- NICE Local Practice Examples:
 - Management of patients with stroke: REDS (Reach Early Discharge Scheme)
 - Rapid Response Services: intermediate tier, multi-disciplinary health and social care service
 - Enhanced home-based palliative care for adults
 - Early discharge and intensive community rehabilitation for stroke patients
- www.nhsbenchmarking.nhs.uk/projects/partnership-projects/National-Audit-of-Intermediate-Care/year-two.php

APPENDIX 2G: MULTIDISCIPLINARY TEAMS

Multidisciplinary teams (MDTs) bring together the relevant professionals needed to care for someone with complex needs. MDTs should include everyone required to look after the physical, mental and social health and care needs of the individuals they serve. The aim is to manage the complexity of individual cases and facilitate the delivery of the best possible care.

The evidence base highlights the following techniques:

- Multi-disciplinary teams
- MDT meetings about every person admitted to hospital
- Hire specialists to work in community settings rather than hospitals
- Expanded hours for GPs and coordinators
- Dedicated housing workers for SEMI/vulnerable groups
- Allow nurses or nurse practitioners to prescribe certain drugs
- Mental health liaison teams
- Direct phone/email access from GPs to MH experts



Further evidence on MDTs:

- Holland et al, Heart, 2005, 91, 899-906
- Proactive care partnership
http://www.sussexcommunity.nhs.uk/Downloads/services/proactive_care/proactivecare_coastal_leaflet.pdf
- Case study examples: NHS North West London, Torbay, Towers Hamlets