

Planned Care

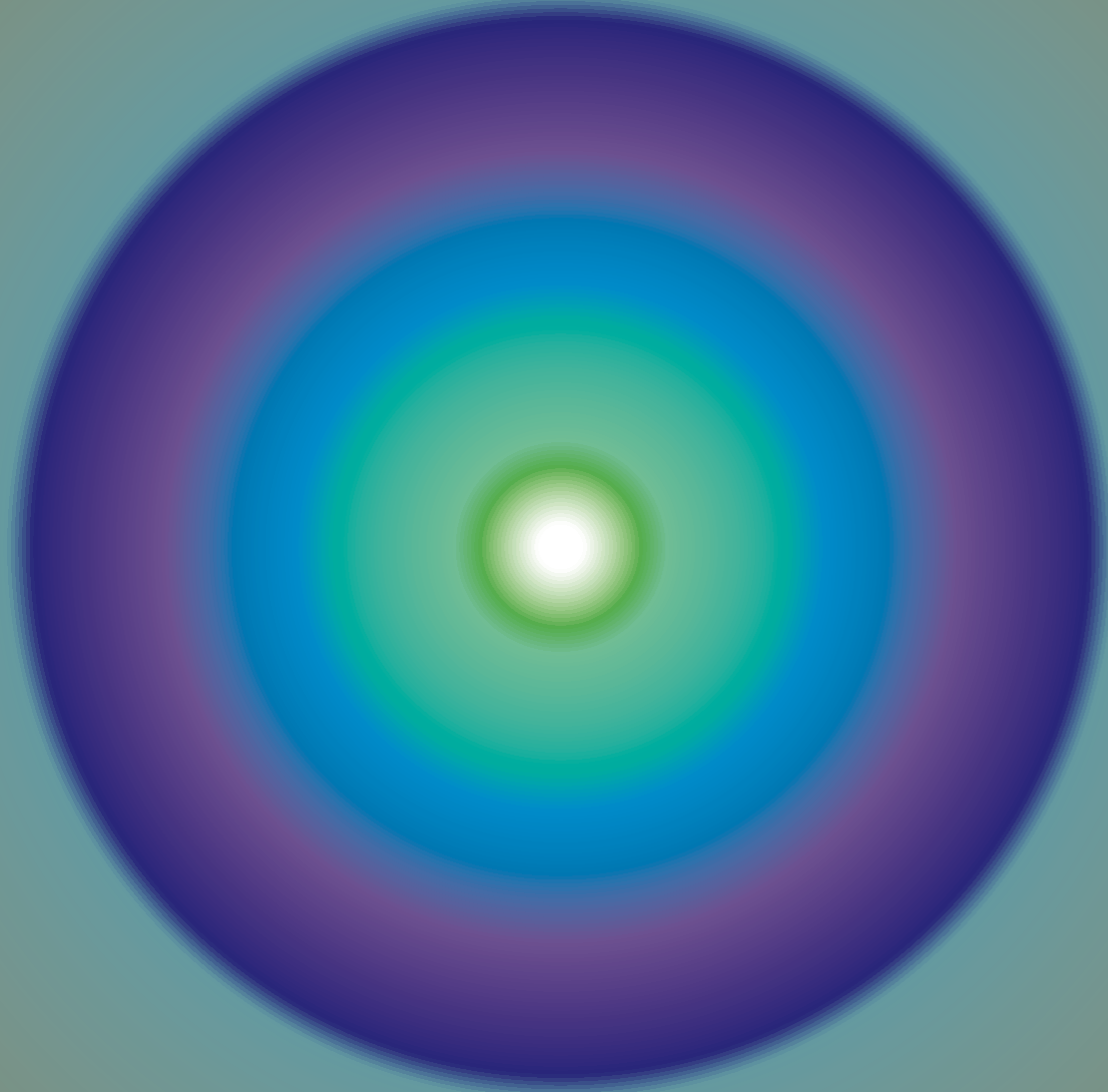
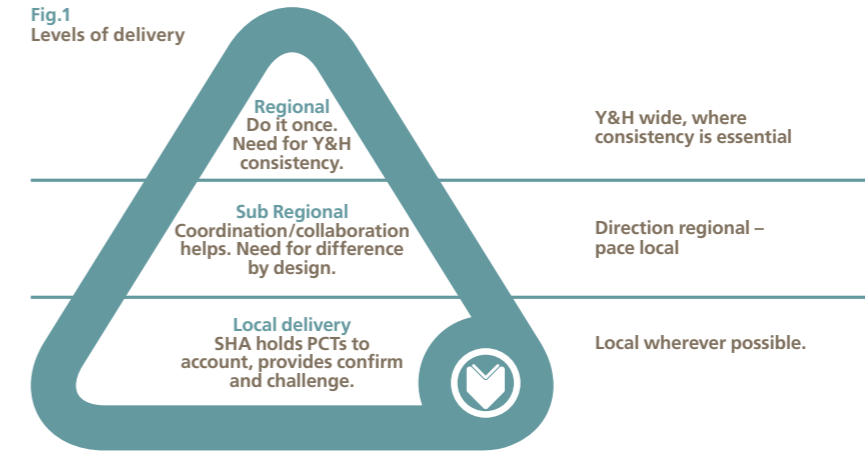


Fig.1
Levels of delivery



What did we say in Healthy Ambitions?*

1
The Planned Care pathway group identified ways in which planned care could be more efficient and effective, reducing variation and improving quality across the region.

They therefore recommended:

- A re-thinking about how general medical practice is supported to further develop clinical services and reduce the variation in outcome evidenced by Quality and Outcomes Framework indicators. This would entail developing strategies to deliver more specialised services for local populations that are covered by more than one practice; these would work more closely together in a federated way to improve local access.
- Further development of the GP with a special interest role by freeing up GP time through enhanced first contact capability by skill mixing. Much more could be done to broaden and enhance the services by dentists, community pharmacists, and optometrists with particular emphasis on health promotion and the management of long term conditions.

- Improved access to an increased range of local quality assured diagnostic/tests services for primary and community care clinicians by taking advantage of new technologies. This includes the use of appropriate mobile services.
- Enabling much better integration between clinicians and diagnosticians through much fuller completion of test request forms to include symptoms and differential diagnoses. This will enable diagnosticians to advise on and undertake appropriate tests.
- Significant increase in self care, telecare and home monitoring by people with long term conditions.
- Over time there should be large reductions in the numbers of people seen in hospital based outpatient departments with 50% or more of new referrals being seen in local clinical settings. The numbers of follow up hospital based outpatient appointments should also fall dramatically as more locally based clinics come on stream.
- The role of constant “point of contact” along the whole planned care pathway through professionals such as clinical nurse specialists should be developed and evaluated.

*Full details can be found at:
www.healthyambitions.co.uk/planned_care.html



- Better communications between primary and community clinicians and hospital based clinicians with much better local access to a wide range of specialists in conditions such as diabetes and respiratory problems.
- The possibility of broadening the non acute services provided by ambulance services should be explored. This includes responsive patient transport services, transportation of notes, equipment and staff; examples of this are diagnostics and phlebotomy.
- The closer integration of primary and community clinicians with specialists should be supported by taking full advantage of capabilities of modern telecommunication and IT systems. This includes the ability to send standardised referrals to specialists. Such systems would contribute to mitigating at least in part the specialist opportunity costs incurred in community working.
- Fully integrated IT systems that link relevant clinicians caring for a patient are a fundamental to many of the Planned Care pathway recommendations.
- A wider range of and increased numbers of procedures will be done as day cases as locally as clinical facilities and safety will allow.
- There is no need to embark on a large building programme in advance of utilising current facilities to best effect. This includes extending weekday working beyond 9am-5pm as well as weekend working for planned care services.
- A regional review of the provision of intensive care with particular attention to Level 3 critical care provision; this includes Level 3 care proximity to and relationship with Level 2 care.
- A regional review of the provision of vascular services that covers the balance undertaken by vascular surgery and interventional radiology; this should take into account the latter speciality role in emergency medicine.
- As a result of the centralisations of upper gastro-intestinal (Upper GI) cancer surgery there should be a Regional review of the provision of non cancer Upper GI surgery.

Who is taking this work forward?

2

PCTs across Y&H have worked with the SHA to agree which of the recommendations of the planned care pathway should be taken forward locally and which might need action at regional level. This is summarised in fig.2 on the next page.



Recommendations & levels of delivery.

Fig.2 Levels of delivery

KEY
● Primary Implementation



Recommendation 1

Independent contractor services should be contracted to provide access and services that reflect the needs of their populations. It is very likely that this will need greater integration between practices and should provide the building block for integration with community nursing services and social care.

YH wide implementation

-

YH wide coordination and collaboration

-

Local implementation

Yes



Recommendation 2

Increasingly primary care contractor and other community based services should be commissioned using appropriate clinical and consumer outcomes as key elements. Together with the commissioning of social care, this should help reduce the significant variation in patient and carer outcomes and experience.

YH wide implementation

-

YH wide coordination and collaboration

-

Local implementation

Yes



Recommendation 3

Clinical care pathways should be designed to achieve the quickest way to get a diagnosis and to commence treatment. Central to this will be generalist and specialist clinicians having significantly greater access to diagnostic services. This should be underpinned by robust referral mechanisms that ensure the clinical skills of the diagnosticians are fully utilised; it will also demand adequate opportunity for good clinical discussions between referrers and diagnosticians.

YH wide implementation

-

YH wide coordination and collaboration

Networks

Local implementation

Yes



Recommendation 4

The team approach to clinical care should be enhanced to free up GP time to enable full use of their unique skills and enable sub-specialisation. This will entail much more skill mixing to manage much of the first contact and long-term conditions work.

YH wide implementation

-

YH wide coordination and collaboration

-

Local implementation

Yes



Recommendation 5

Communication at critical points of the care pathway should be timely and robust; this means improved communication in both directions of the pathway.

YH wide implementation

-

YH wide coordination and collaboration

Networks

Local implementation

Yes



Recommendation 6

Generalist referrals to specialist services should be standardised to ensure that all essential information is provided with each referral. Similarly there should be standardisation of referrals from specialists to generalist services.

YH wide implementation

-

YH wide coordination and collaboration

-

Local implementation

Yes



Recommendation 7

The above recommendations have significant implications for workforce development. Relevant training and educational organisations should be informed and involved as soon as possible.

YH wide implementation

SHA

YH wide coordination and collaboration

Deanery

Local implementation

Yes



Recommendation 8

Information Systems
 Integration of safe clinical services will not happen without robust IT systems. Clinical IT systems must be integrated, and fully utilised by clinicians. This integration should:

- Include community dentist, community pharmacist, community optometric services, as well as those of Independent Sector Treatment Centres;
- Be explicit in commissioning contracts for NHS procured services, as well as those for social care.
- Be based on System One within Primary Care subject to the system delivering the required functions across health economies. Health economies that can deliver the same function and integration with other systems should be supported

YH wide implementation

NPFIT

YH wide coordination and collaboration

-

Local implementation

Local IMFT Board



Recommendation 9

Local Access to Services
 Many more specialist consultations as well as diagnostic and treatment services should be provided closer to people's homes. These should be provided in dedicated settings that meet all appropriate building and other standards. In addition to patient convenience this supports closer generalist and specialist clinician integration.

YH wide implementation

-

YH wide coordination and collaboration

Networks

Local implementation

Yes



Recommendation 10

Many people would like more care to be provided at home. Technological developments in treatments and health monitoring means that the current range of home treatments should be expanded and be more widely available. Implementation of such technology needs to be regulated robustly.

YH wide implementation

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YH wide coordination and collaboration

NPFIT

Local implementation

Yes



Recommendations & levels of delivery.



Recommendation 11

Planned Care – High Volume Procedures

People requiring a “high volume” procedure (medical, surgical or diagnostic) should be offered day case services as routine when it is clinically appropriate. These should be provided in dedicated settings that meet all appropriate building and other standards. Bearing in mind the geography and location of communities in the SHA area, there should be reasonable access to these services. This should not interfere with the individual’s opportunity to choose where they are treated.

YH wide implementation

-

YH wide coordination and collaboration

Networks

Local implementation

Yes



Recommendation 12

Day case rates for health economies should match the international best performer and that all health economies should have plans to achieve the day and short stay surgery targets contained in the British Association of Day Surgery Directory of Procedures.

YH wide implementation

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YH wide coordination and collaboration

Networks

Local implementation

Yes



Recommendation 13

Planned Care – Low Volume or more complex surgical care

The provision of complex treatments or “high volume” procedures on people with high operative or anaesthetic risk factors must be provided in clinically appropriate settings. It is likely that this means patients in with this level of clinical risk will not be treated in every hospital in Y&H.

YH wide implementation

Regional reviews of upper GI, radiology, vascular, etc.

YH wide coordination and collaboration

Networks

Local implementation

Yes



Recommendation 14

The provision of High Dependency and Intensive Care Services requires organisation across geographical areas and hospital networks in the SHA. Intensive Care Facilities should be organised so that the national guidelines for facilities and staffing are met.

YH wide implementation

Regional reviews of upper GI, radiology, vascular, etc.

YH wide coordination and collaboration

Networks

Local implementation

Yes



Recommendation 15

Emulating the organisation of modern cancer services, the role of “clinical network” hubs should be developed across a range of planned care specialities. It is particularly important to review the organisation and delivery of vascular surgery and urological surgery. Consideration should also be given to the future organisation and delivery of upper gastrointestinal surgery and interventional radiology. Services such as these should be delivered by specialist teams working across a number of organisations but with clear governance arrangements residing with a single host.

YH wide implementation

SCG

YH wide coordination and collaboration

Networks + SCG as appropriate

Local implementation

Yes



Recommendation 16

It will be important that commissioning strategies, service specifications, and contract monitoring enable the Planned Care Groups recommendations to be implemented over time. This includes ensuring robust governance is in place with every provider of care for NHS funded patients.

YH wide implementation

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YH wide coordination and collaboration

-

Local implementation

Yes



Recommendation 17

Commissioner and provider organisation staff should be incentivised to work differently. This will entail whole system redesign into new clinically safe ways of working and service delivery including:

- individual clinicians to work as a member of a wider team.
- maximising NHS funded service facilities by providing planned care over a greater number of hours during the week and at weekends (ie not just nine to five, Monday to Friday).
- better use of new technology to provide mobile services such as MRI and lower GI endoscopy.
- Increased flexibility of working through for example:
 - Clinical nurse specialists as a “point of contact” constant along the whole care pathway.
 - Ensuring appropriateness of clinician roles. For example surgeons focus on the patient’s operation; postoperative complications are the responsibility of physicians or anaesthetists; follow up appointments are the responsibility of GP’s, specialist nurses, or other clinical specialists.

YH wide implementation

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YH wide coordination and collaboration

-

Local implementation

Yes



Recommendation 18

Estate

The Region has a large number of public service care facilities in and from which staff work. In addition many independent contractors own their own premises and there are a variety of private health care facilities from which NHS services are provided. As changes to locally based care are implemented some of the estate will become redundant for their current use, for example out-patient clinics. Much of this will need to be redesigned to provide other services. This approach may well significantly reduce the need for new build.

YH wide implementation

-

YH wide coordination and collaboration

-

Local implementation

Yes

NB: These recommendations reflect the detail from the planned care CPG report rather than the summary in Healthy Ambitions.





When is it happening?

3
The actions to be taken forward in the first year of implementation for the Planned Care pathway are shown in fig.3.

Local delivery

4
PCTs have prioritised the recommendations in Healthy Ambitions in light of the needs of their local community and the current position of their services.

Working with their local partners and providers they have all set out the action that they will take to start to turn the recommendations in Healthy Ambitions into reality in their five year strategic plans.

An example of the action being taken by Hull PCT is shown in fig.4.

Fig.3 Timetable

1. Clinical Integration	
Primary and Community Care	Strategies to deliver primary and community care services possibly as federated services reflecting the need of local communities Skill mixing primary care including GPSWI development and enhanced role for pharmacists, dentists and optometrists Significantly enhanced access to locally accessible diagnostics Better use made of diagnostician skills through better referrals requests Standardised electronic referral and discharge communication systems Potential enhanced role for ambulance services Specialist clinical services in community settings Telecommunication and video conferencing systems to support integration
a. Networks	Each Network should have a strategy and clear work programme to meet national and local timescales. This will be agreed by June 2009.
b. Local	Each PCT will need to develop its priorities in line with its strategy and operation plan
2. Information Systems	
a. Networks	Timescales governed by NPFIT Contract and Y&H Rollout programme
b. Local	PCT IM&T Board work programme
3. Local Access to Services	
	Local agreement required on shift of appropriate activity from hospital to community in each LHC
4. Planned Care Procedures	
	Reviews required:- • High volume procedures eg. Day cases, joint replacement • High volume procedures on high surgical and/or anaesthetic risk patients • Complex treatments – including Upper GI non cancer surgery, interventional radiology and vascular surgery • High dependency and intensive care • Other planned care specialities outpatients and surgical treatments
5. Commissioning of integrated planned care	
	Services changes will be brought about through World Class Commissioning that reflects the differing needs between local communities. Commissioner assurance and monitoring systems needed to demonstrate safe and effective services
6. Estate	
	Local agreement required on impact of service changes and the shift in activity on existing estate

Fig.4 An example of local action being taken by NHS Hull

NHS Hull will:

- Through the implementation of the SSDP, the PCT plans to develop up to three integrated care centres (ICC) across the city.
- The integrated care centres will be big enough to have different combinations of outpatient services, diagnostic tests, day surgery and minor injuries units depending on need and proximity to other services. The range of services for planned care will be based around a 'core' of diagnostic and support services to support a range of specialty based outpatients consultations and treatments and minor surgical procedures. The model will be based, where clinically appropriate and viable, on providing pathways of care outside hospital not just single appointments.
- The design of the centres will be flexible to give a variety of options in the future, depending on how services and patients' needs change. They will also aim to provide a range of community and mental health services, public health promotion and social care needs.



Each PCT is responsible for delivering recommendations in line with local priorities and strategic plans.

Who will make sure that this work happens?

6

There are a number of key leadership roles in the delivery of this pathway:

Locally

Each PCT is responsible for working with local partners and providers to ensure the delivery of recommendations in line with their local priorities and their own strategic plans.

Collaboratively and Regionally

Delivery will be overseen by a Pathway Delivery Board – as described in the chapter on governance arrangements.

For Planned Care the chair will be Jan Sobieraj Chief Executive at NHS Sheffield, who will act as “the guardian” of the planned care recommendations in discussions amongst the CE community.

The clinical leads are Mark Baker, lead cancer clinician at Leeds Teaching Hospital Trust, and Ian Jackson, Consultant Anaesthetist at York Hospitals NHS Foundation Trust. They will oversee progress against the planned care pathway recommendations; act as champions for the recommendations; advise on delivery processes and encourage regional colleagues to continue to focus and give priority to the planned care recommendations.

The SHA’s Medical Director Chris Welsh will ensure that regional reviews of critical care, vascular surgery, urology, interventional radiology and upper GI take place with appropriate clinical involvement and governance arrangements – in discussions with the clinical networks and specialised commissioning group where appropriate.



How will we measure success?

7

We have developed a ‘Healthy Ambitions Dashboard’ based on a small number of key indicators which taken together can be used to start to measure the success of Healthy Ambitions programme as a whole. This is underpinned by trajectories which each PCT will set to reflect their local priorities and circumstances. It will show the measurable improvements they are making in each pathway area. This will supplement the ‘vital signs’ indicators and trajectories which will support delivery of the targets set out in the NHS Operating Framework and the selection of outcome measures which PCTs have included in their strategic plans. In many cases these measures are one and the same. All of these measures will feature in PCTs annual operating plans to be agreed with the SHA and be the basis for the SHA’s performance management regime.

Recognising that the pathway recommendations are many and various, we intend to start by tracking progress against the key pathway pledge, which for the planned care pathway is to reduce the number of repeat journeys for patients and carers.

We know that this doesn’t tackle all the priorities in this chapter and that many other outcomes will be tracked through existing routes. GP practices offering extended hours, breast cancer screening rates and patient experience measures are all Vital Signs, whilst implementation of hip and knee best practice is a CQUIN measure.

The key indicators we will therefore track in the “Healthy Ambitions Dashboard” will be:

- Number of outpatient appointments per spell of treatment (hip and knee)
- Admission and re-admission rates (within 3 months) for hip and for knee
- Average length of stay (for hip and for knee)
- Day surgery rates for the basket of 25 procedures

Work has been undertaken to establish baselines for the pledge and by the end of March ‘09 trajectories for improvement will have been agreed between the SHA and PCTs and will be reflected in annual operational plans.* We intend to publish progress against individual trajectories.

*More details can be found in the performance metrics chapter.



“Taking this opportunity to improve standards will help save lives.”

Dr Ian Jackson
consultant anaesthetist, York