

Report of the Planned Care Clinical Working Group

Introduction

This report is the output from the Planned Care Clinical Working Group (a list of members can be found at Appendix A), established to feed into the Healthcare for London Review. It has been informed by two meetings of the group on 30 January and 21 March, the Healthcare for London clinical conference on 19 February and the sharing of evidence and best practice examples within the group. It sets out what needs to change to improve the provision of planned care in London and recommendations for how to make that change occur.

This report endorses the principle that health services should be localised where possible and centralised where necessary. Therefore it supports the objective of the *Our health, our care, our say* White Paper to provide more services in community settings.¹

1. PROBLEMS WITH CURRENT SERVICE PROVISION

The group analysed the problems with existing planned care by dividing it into four groups:

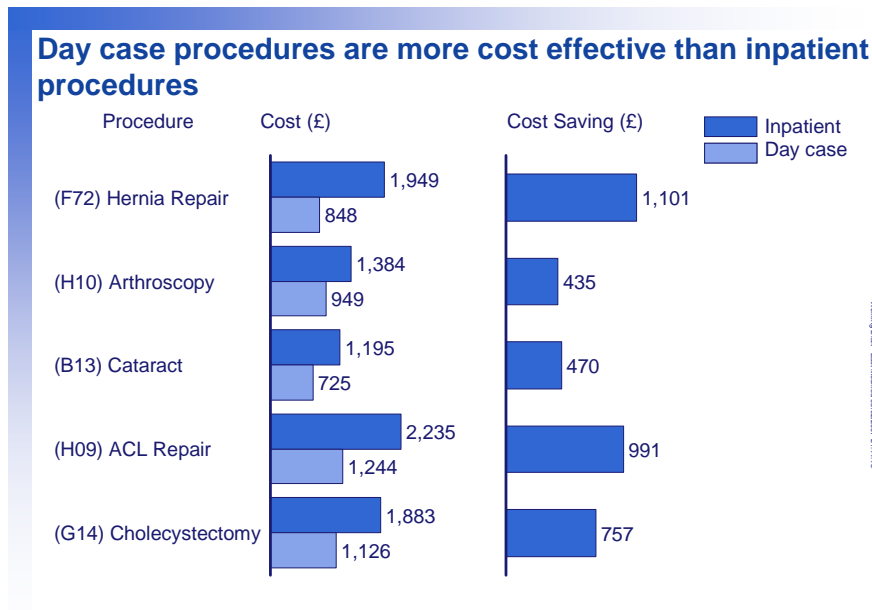
- **High-throughput procedures.** This includes high-volume procedures such as cataracts, hernia repair and gastro-intestinal endoscopies as well as traditional minor surgery. It reflects the kind of work Independent Sector Treatment Centres (ISTCs) undertake.
- **Outpatients and diagnostic services.** This includes all outpatient care and the full range of diagnostic services from simple phlebotomy through to Positron Emission Tomography Scanners. It also includes treatments such as radiotherapy.
- **Community-based supportive care.** This includes both planned services in the community such as podiatry and physiotherapy and the community-based nursing, therapy services and rehabilitation that are essential to recovery after a planned episode of hospital treatment.

¹ *Our health, our care, our say*, Department of Health, January 2006

- **Complex care.** This includes both tertiary care and the carrying out of more straightforward secondary care procedures on patients with co-morbidities. Examples of these two types would be complex cancer surgery and vascular surgery for patients who have significant long-term conditions such as heart disease and diabetes complicating their care.

High-throughput procedures

Increasing day surgery rates was identified by the NHS Modernisation Agency as one of its *10 High Impact Changes*.² Having more day cases brings increased efficiency and cost savings:



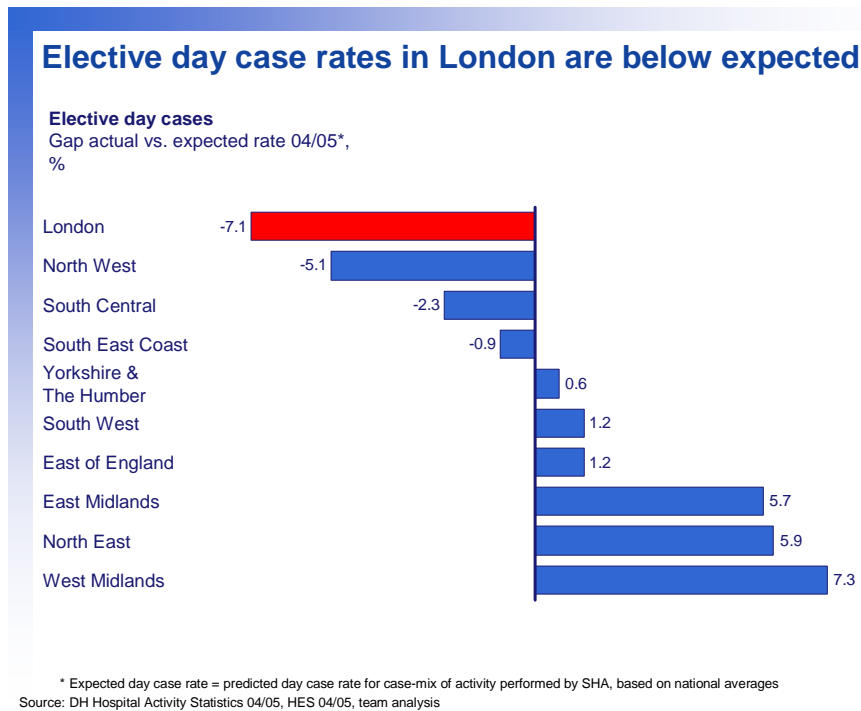
More and more procedures can be done as day cases due to technical innovations. There is also evidence that patients prefer being treated as a day case. For instance as long ago as 1991 an audit commission report found that patients were positive about receiving day surgery.³ However, despite being cheaper, applicable to more cases, and popular with patients, the percentage of total procedures done nationally as day cases has fallen from 25 per cent in 2000/01 to 23 per cent in 2004/05.⁴

² Modernisation Agency, “Change 1 – Treating Day Surgery as the norm,” *10 High Impact Changes*, 2004

³ Audit Commission (1991), *Measuring Quality: The Patient's View of Day Surgery*

⁴ Analysis of Hospital Episode Statistics

The problem is particularly severe in London, where there are low elective day case rates for routine surgery. This graph shows that London compares poorly on day case rates with other strategic health authority (SHA) regions:



Looking at individual specialties, the British Association of Day Surgeons recommends that 76 per cent of gynaecological surgery and 63 per cent of breast surgery can be done as day cases. However, in London the day surgery rates in these two areas are 38 and 37 per cent respectively.

Why are day case rates low? Despite the introduction of new providers such as ISTCs, there are not enough units specifically designed for short-stay and day case procedures, resulting in lower productivity and high costs. Even more significantly, where new units have been developed, such as at Greenwich and at University College London Hospital NHS Foundation Trust, they have not been fully utilised.

Therefore, the majority of planned care still takes place in district general hospitals, which are trying to provide all services. This is bad for productivity and quality. For instance it can lead to higher infection rates. Separating elective and non-elective services, as happens at the Royal National Orthopaedic Hospital, has reduced perioperative infection rates.

The status quo continues partly because commissioners lack good quality data on outcomes (for instance many cancer services are not completing national audits)

in order to make decisions about which providers to use. Commissioners have had little control over the use of types of planned care that are not supported by clinical evidence. Monitoring of outcomes needs to improve and will require the development and use of appropriate measures such as improved function, infection and mortality rates as well as an assessment of the amounts of multidisciplinary care occurring. Good commissioning must also consider its impact on other services eg commissioning of inpatient hospital care with reduced length of stay needs to consider the required community services to support early discharge.

Outpatient care and diagnostics

The majority of outpatient care (approximately 97 per cent) is delivered in the hospital setting, which has an expensive cost structure and is not easy to access for many patients. Not all of this outpatient care is necessary - there is good evidence that primary care professionals could replace a lot of the outpatient follow-up appointments currently happening in hospital.⁵ For instance, a study comparing the outcomes of patients post-operatively demonstrated that frequency of follow-up had no effect on outcome of care.⁶ Similarly, for cancer care there is an assumption that outpatient work has to be done by specialists but evidence for this is limited. In Croydon, for example, GPs are now taking on the follow-up of patients with prostate cancer where the disease is stable.

National data show that London has long waiting times for some diagnostics compared with other SHA areas. This table⁷ compares the number of Londoners and people from the West Midlands waiting over 13 weeks for different diagnostics:

Type of diagnostic	London 13+ weeks waiters	W. Midlands 13+ weeks waiters
MRI	2,354	203
Non-obstetric ultrasound	4,226	78
Computer Tomography	523	7

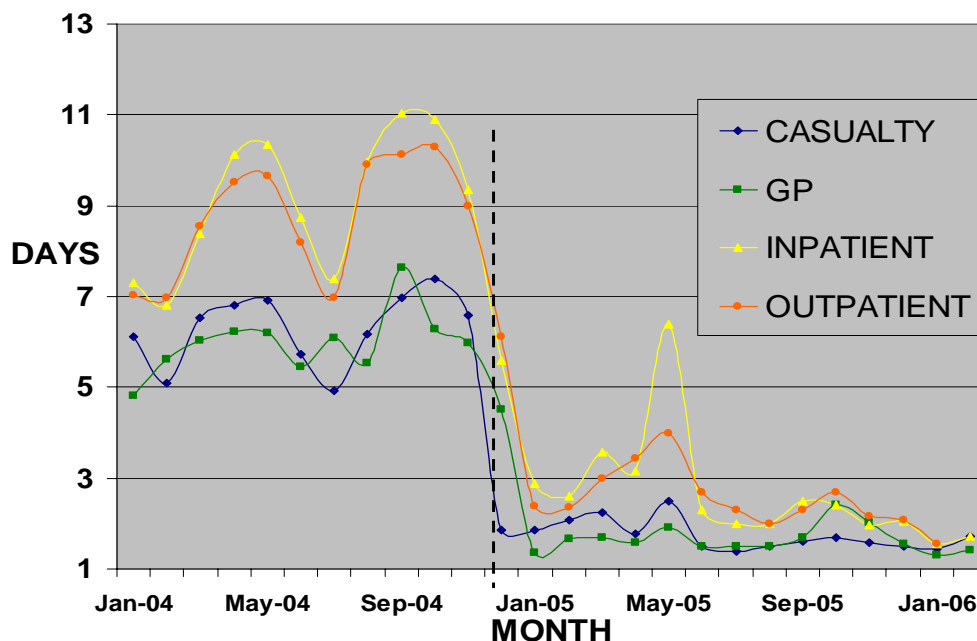
London does of course have a larger population than the West Midlands (7.4 million and 5.3 million respectively), but clearly this alone is not the reason for such large differences in the speed of access to diagnostics.

⁵ National Primary Care Research and Development Centre, *Can Primary care reform reduce demand on hospital outpatient departments?*, March 2007

⁶ A randomised control trial of immediate discharge of surgical patients to general practice, Florey Cdu V et al *J Pub Health Med* 1995; (16) 455-64

⁷ *January commissioner-based diagnostic return*, Department of Health, 14 March 2007

When diagnostic tests do occur, some London providers can deliver results very quickly. For instance, the introduction of the Patient Archiving and Communications System (PACs) coupled with voice recognition software has dramatically increased the speed with which x-ray reports are available at the Hammersmith Hospital NHS Trust. This graph shows how the wait for results from radiology at Charing Cross has decreased:

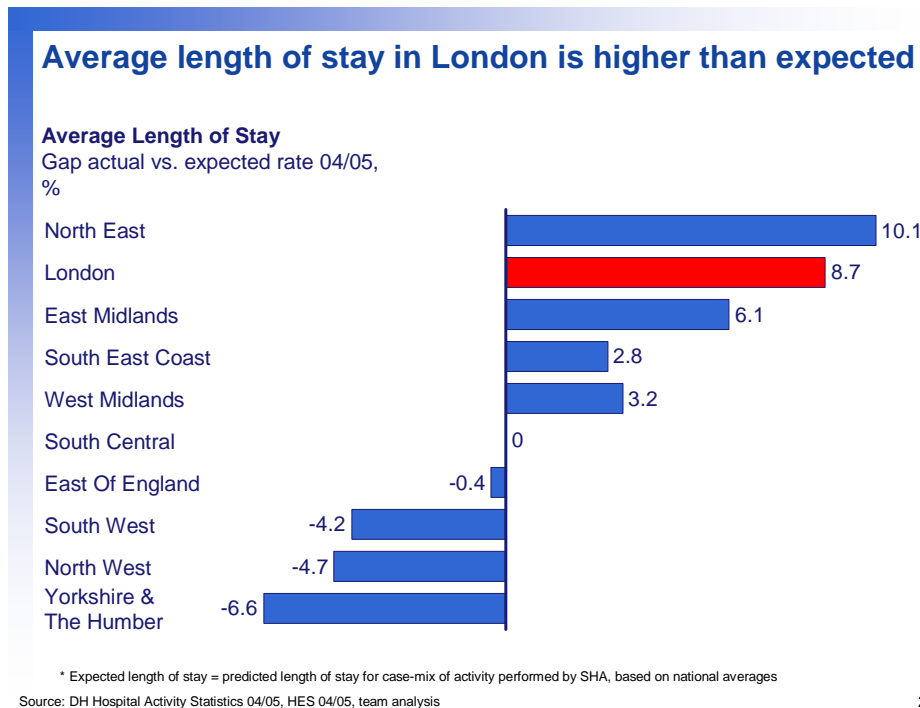


Productivity has also increased as radiologists no longer have to spend time answering calls chasing test results. However, we know that this performance is not happening everywhere in London. London also suffers from a lack of availability of diagnostic services in primary care. Ultrasounds for instance could be done more locally, but local sites would need to have the necessary IT infrastructure and workforce.

A final issue is that patients are often referred to specialists without a complete range of test results available. This results in unnecessary follow-ups and repeated tests. Simple referral protocols can be agreed which mean that a patient may only need to be seen once by a consultant, resulting in fewer outpatient attendances.

Community-based supportive care

Length of stay in hospital in London is too long:



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Studies suggest that high-quality community services, particularly rehabilitation, can substantially lower hospital lengths of stay.⁸ Yet despite this evidence, a paucity of investment has led to a lack of capacity in London to support people outside hospital.

Provision of step-down beds across London is patchy – NW London for instance has very little. Of equal importance is the lack of services to support discharge into people's own homes. Co-ordinated working with social care is needed to ensure support is available for people to return home after an operation. Surrey primary care trust commissions the services of an integrated rehabilitation team comprising district nurses, social care staff, occupational therapists and others, who both facilitate home-based rehabilitation and prevent non-elective admissions.

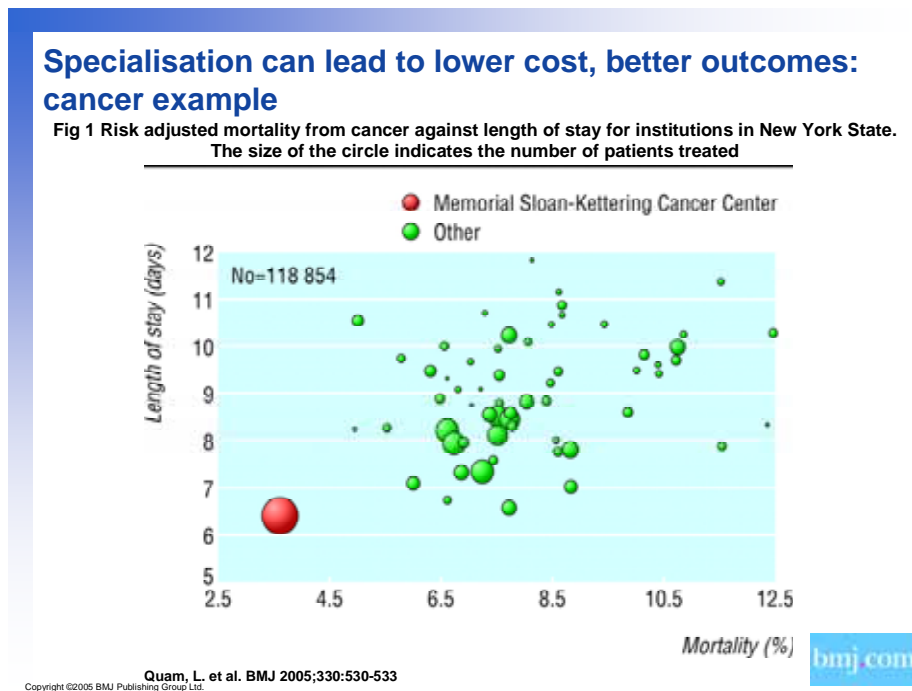
However, elsewhere, commissioning of these services has been hampered by a lack of available information on what services exist and their quality. It is not always clear how they are integrated into the care pathway. Contracting for these

⁸ University of Birmingham Health Science Management Centre, *Making the Shift: Key Success Factors*, July 2006

services is often poor, with a lack of multidisciplinary input to the commissioning process.

Complex care

There is evidence that providers carrying out high volumes of more complex procedures have better outcomes:



There is also evidence that individual surgeons carrying out higher numbers of procedures achieve better results, as practice and team working improve their skills.⁹ In addition, changes to working practices including the European Working Time Directive (EWTB), the increase of sub-specialisation and the impact of guidelines such as the NICE improving outcomes guidance, will create an even greater need for complex care to be centralised.

However, in London, complex planned care is not particularly centralised. As a result, a lack of critical mass in many centres leads to dilution of expertise, worse clinical outcomes and higher costs.

⁹ M. Chowdhury et al., "A systematic review of the impact of volume of surgery and specialization on patient outcome," *British Journal of Surgery*, 2007; 94; 145-161

As well as services being provided on too many sites, a lack of shared ownership of patients between secondary/tertiary care consultants and primary care practitioners leads to disjointed planning of care and discontinuity.

2. BEST PRACTICE

Best practice can be simplified into two main principles:

Localise where possible. The focus should be on convenience for the patient receiving care rather than for the organisation providing it. Patients should only travel to a large acute hospital when they need to. This means more outpatient appointments, diagnostics and treatment being provided locally. It means more local day case surgery in elective centres where surgeons are free from the pressures and disruptions of emergencies.

There is evidence that Londoners want this. The MORI survey of 7,000 Londoners found that closeness to home was the top factor (mentioned by 52 per cent of respondents) when people were asked what would influence their choice of provider when referred on by their GP.¹⁰

There are many examples of this happening both nationally (see box) and in the London area, such as the day case surgery, diagnostics and clinics being offered at the Old Cottage Hospital in Epsom by the GP-owned Epsom Day Surgery Ltd.¹¹

More local planned care – Buckinghamshire ophthalmology case study¹²

Practice Networks is a company running a primary care ophthalmology service in Buckinghamshire. The service currently has 60 referrals a month, but the target is to treat 60 per cent of patients who are currently being referred to hospital.

The quality of care has been audited and found to be as good as the hospital based-service. However, the primary care service is significantly cheaper as a first appointment costs £65 in primary care, compared with over £100 under the tariff.

It is also better for patients as they are seen within two weeks and can choose from six clinics across Buckinghamshire (and the number of sites is set to increase). Not surprisingly, patient satisfaction scores are high.

¹⁰ Ipsos Mori, *London Residents' Attitudes to Local Health Services and Patient Choice*, January 2007

¹¹ David Colin-Thomé, *Keeping it Personal: The Clinical Case for Change in Primary Care*, Department of Health, February 2007

¹² *HSJ*, 12 March 2007

One final example is the Sutton and Merton musculoskeletal centre, which is a collaboration between the PCT and Epsom and St Helier NHS Trust. Staffed by a team of GPs with special interests, a specialist physiotherapist, a consultant orthopaedic surgeon and a consultant rheumatologist it both triages referrals by GPs and provides treatment. It has significantly reduced the number of outpatient attendances and referrals for surgery.

The other side of this equation is that people should be discharged from their planned care as soon as possible. This means more day cases, so patients are never admitted. It also means more community support is required for people to be discharged home after a procedure or more inpatient intermediate care in step-down beds or their equivalent is available. Although the evidence for the efficacy of intermediate care is mixed, the reductions in length of stay in the US achieved by organisations such as Kaiser have been built in part on the greater use of intermediate care.¹³

There is more scope for close working with social care to discharge people promptly. There is also scope for geriatricians to work in community settings to provide rehabilitation both for planned care such as joint replacement and after emergency admissions for conditions such as fractured neck of femur and stroke.

Productivity also needs to improve. Best practice would mean extending the working day to provide more capacity as well as convenience for patients. It also means examining working processes to ensure efficiency, including the implementation of lean working techniques.

Centralise where necessary. Complex care should be provided in a smaller number of specialist centres with world class outcomes. This concentration of cases should achieve a critical mass of talent and financial sustainability. Such an approach will improve patient safety and the quality of care, which should be the primary goal of any service reorganisation.¹⁴

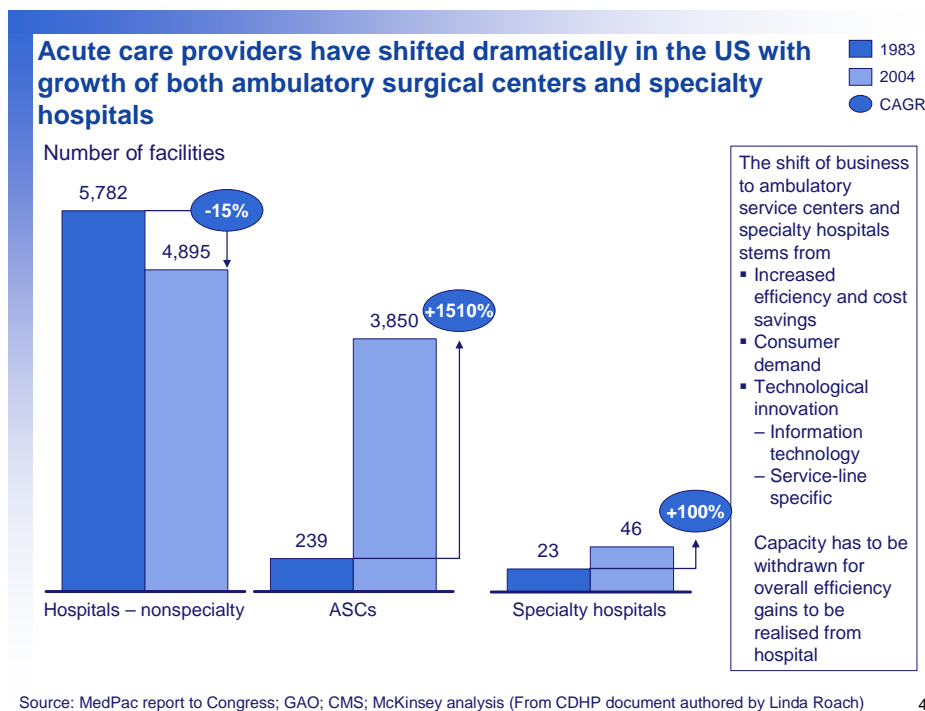
An ideal way to achieve this centralisation of complex care would be to move to a hub-and-spoke model with large well-regarded hospitals forming the centre of a hospital network. Modern technology means that patients would not always have to go to the “hub” for specialised care. For instance a diagnostic test can be undertaken locally and then reviewed by a specialist at the “hub.” They can give their opinion remotely, all without the patient actually having to journey to the specialised hospital.

¹³ C. Ham et al., “Hospital bed utilisation in the NHS, Kaiser Permanente and the US Medicare programme: analysis of routine data,” *BMJ*, Volume 327, 29 November 2003

¹⁴ J. Farrington-Douglas, *The Future Hospital: the progressive case for change*, IPPR, January 2007

When patients are admitted to the “hub” they should be cared for by teams specialising in specific diseases, rather than having individual consultant ownership of the patient. These teams should be multi-professional, so a patient admitted for vascular surgery would be under the joint care of a cardiologist, a vascular surgeon, an intensivist and specialist nurses. These teams should have a high number of patients under their care. For the most complex care, emergency and elective surgery will be the responsibility of the same team and should not be separated out eg the elective neurosurgical team will also treat the trauma victim with head injuries.

Specialisation would mean hospitals focussing on particular aspects of healthcare. So hospitals would not specialise in everything – best practice would not simply be fewer, bigger district general hospitals, but large hospitals specialising in particular aspects of health. This is something which has already happened in the US, where more specialist and elective centres have developed:¹⁵



¹⁵ We recognise this is not a planned approach to provision, but rather reflects how hospitals have responded to incentives in the market.

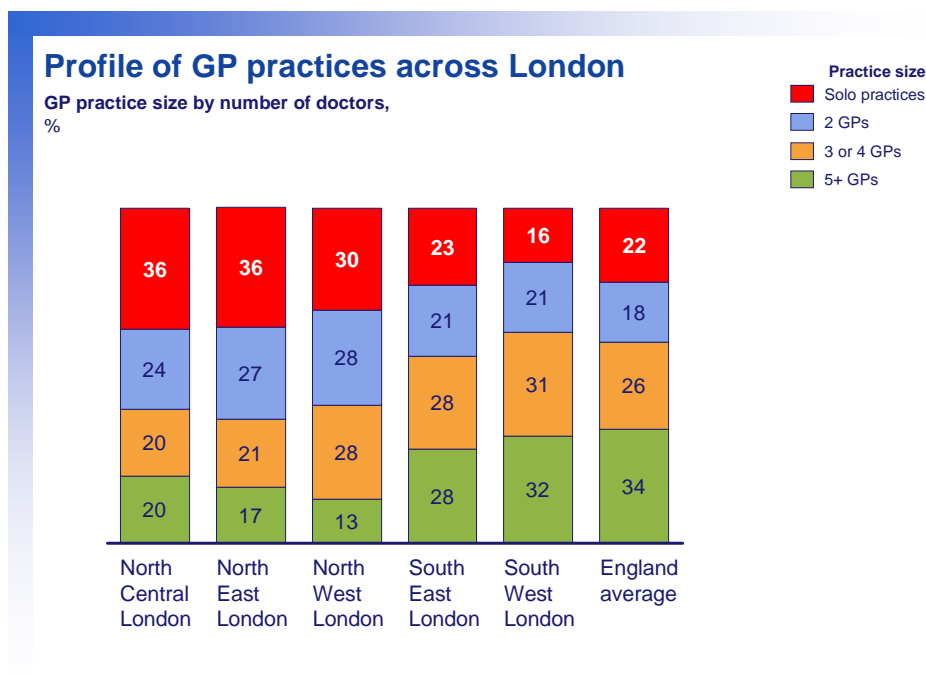
3. BARRIERS TO CHANGE

There are several sizeable barriers hampering movement to this vision of best practice.

Estates. Facilities to achieve these changes are a major barrier. On the one hand there are not enough community consultation rooms, local diagnostics or day case facilities. On the other hand it is difficult for successful providers to expand the volumes of care they provide because of the restrictions of their existing buildings.

Access to capital. The issue of estates is exacerbated by the difficulties of accessing capital to expand facilities. Tariff prices are based on operating costs in existing buildings and do not take sufficient account of the need for new buildings. Foundation Trusts have to borrow at commercial lending rates.

Current service organisation. Localising services is hampered by the number of London GPs who work either single-handedly or in small practices:



Source: Information Centre for Health and Social Care, GMS/PMS statistics

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It is difficult for such small practices to provide comprehensive services. GP practices and community services are also often in unsuitable accommodation. Many community healthcare facilities do not comply with disabled access legislation.

Clinical resistance. There is potential for clinical resistance to both localisation and centralisation. Some hospital clinicians may resist attempts to allow more direct access eg to diagnostics. Centralisation and the consequent reduction in services at some sites may impact on professional pride. There is also likely to be clinical resistance to moving away from a nine to five approach to elective care.

Information technology (IT). IT could be a barrier to the greater use of community services. Although they should become integrated within the Connecting for Health programme this will take time and could act as a short-term barrier to shifting care more locally. Interim solutions will certainly need to be developed.

Tariff. A move to best practice will greatly alter casemix. More complex procedures will be done by different providers from those doing the easier cases and the tariff must be sophisticated enough to recognise this. Complex centres will need to obtain some form of premium to recognise their work, whilst tariff needs to fall for simple day case procedures. In addition, there should be further unbundling of high-throughput procedures so that PCTs and practice-based commissioners have an incentive to provide diagnostics and rehabilitation more locally.

Inadequate links to social care. Discharge is not always possible because the social issues for a patient have not been addressed. Inadequate links to social care can result in greater lengths of stay for patients. PCTs and local authorities should work collaboratively to resolve this issue.

Community equipment. A related barrier is that it is difficult in some areas to get community equipment (eg suitable beds, hoists and grab rails) in place promptly to support discharge, due to bureaucratic and funding obstacles.

Political will. In the past there has been a lack of political will to support changes that are in the best interests of patients. MPs in particular are worried that they will be “Kidderminstered.” A circular pattern can occur where the public, politicians and clinicians feed each others’ concerns about change – all have to be communicated with and convinced of the need for change.

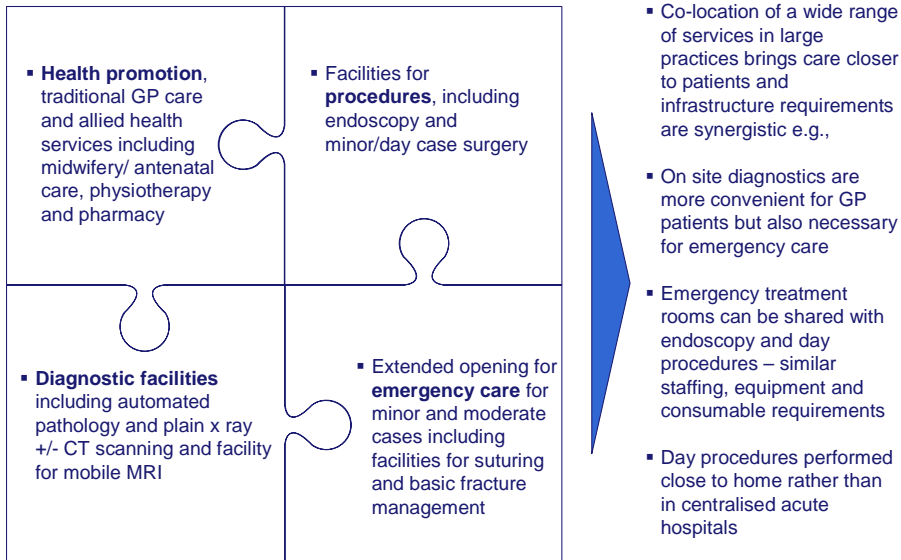
Commissioning. Commissioning of both community and hospital services has been inadequate. Commissioners are reluctant to decommission poor services. There is a lack of well-developed commissioning skills and little consideration of commissioning for quality and outcomes.

4. SOLUTIONS

Recommendation one. A general recommendation is to draw on international and London best practice to create new models of care.

- **Major acute hospitals.** Will do high volumes of more complex cases. An international example would be the Texas Heart Institute at St Luke's Episcopal Hospital which does 10,500 heart operations a year (the US average is 137 per provider) at more than 50 per cent less cost and with better survival rates.
- **Elective centres.** Will do high volumes of less complex cases. They will offer day case and inpatient surgery. A London example would be the Ambulatory Care and Diagnostic Centre at Central Middlesex Hospital which undertakes 65,000 outpatient procedures/visits and over 13,000 surgical operations per year. Another London example of an elective centre would be the South West London Elective Orthopaedic Centre. This stand-alone unit on the Epsom hospitals site carries out more major surgery, performing 3,000 joint replacements a year and serving a large catchment area of 1.5 million people. Its average length of stay is less than five days, because at its inception PCTs were involved in developing community infrastructure to facilitate discharge from the centre.
- **Polyclinic/primary care.** Will offer consultation rooms for outpatient consultant and GP appointments and some facilities for day cases eg endoscopies. An international example would be the Polikum clinic in Berlin, which has a mix of primary and secondary care physicians. It has a range of diagnostics on site as well as physiotherapy, pharmacy and dentistry. This slide shows the range of services which could be provided in large primary community clinics:

Larger GP practices can offer a wider range of services with better facilities and longer opening hours



- **Home.** Will be where people are cared for after a planned care episode and also to avoid the need for an admission. People want to be cared for at home, so the home should be seen as a location where care is given. Much planned care can be delivered at home including intravenous antibiotics and some cancer treatments. Better use should be made of specialist nurses to deliver high-quality care at home. In addition, much more can be done to support early discharge and rehabilitation. For instance Medihome and the Royal National Orthopaedic hospital have formed a partnership to allow patients to be discharged early and then cared for at home. Patients prefer it, there are cost savings and it is clinically safe.

These models of care are not intended to be mutually exclusive – a major acute hospital could have an elective centre on the same site but in a separate facility.

Moving to these models of care will require a number of actions.

1. **The provision of appropriate facilities.** There is scope for refurbishing and reusing the considerable number of facilities within the present NHS London estate. However, careful consideration is needed to ensure that doing this provides value for money – it may be better to start from scratch in some cases. There is a particular lack of community facilities suitable for use by GPs and others eg as polyclinics. This will require capital investment to rectify.

2. **The conglomeration of practices.** At the same time, where appropriate, primary care practices will need to be encouraged to come together and use these new facilities. Resistance to change and issues around equity in existing premises will need to be overcome. There will also need to be careful consideration to ensure that larger practices and conglomerations of practices do not de-personalise primary care nor give rise to inequity of provision.
3. **Pan-London planning.** There should be a pan-London perspective on how to organise the most complex care to ensure it is concentrated in centres of expertise and to ensure the development of high-volume elective centres serving large catchment populations.

Specific recommendations

Recommendation two. There should be joint commissioning by health and social care to ensure rapid discharge from hospital is achieved. This could be facilitated by the carrying out of joint strategic needs assessments by local authorities and PCTs advocated in the new *Commissioning Framework for Health and Wellbeing*.¹⁶ Particular focus should be given to tackling issues around the availability of community equipment.

Recommendation three. As we move to the new models of care the national tariff needs to change to reflect this. The tariff needs to be both unbundled (to address the need to provide care out of hospital) and enhanced (to recognise the increasing concentration of specialised care).

Recommendation four. Clarification is needed on what care should be localised and what should be centralised. London guidelines for which procedures can be performed in community settings could be introduced to help disseminate best practice. Such guidelines could build on the list of examples that follow:

¹⁶ *Commissioning Framework for Health and Well-being*, Department of Health, March 2007

A number of procedures could be performed in a primary care setting NOT EXHAUSTIVE

HRG code	HRG description	Elective spell tariff £
C07	Minor Medical Head, Neck or Ear Diagnoses <70 w/o cc	560
H22	Minor Procedures to the Musculoskeletal System	581
H32	Musculoskeletal Signs and Symptoms <70 w/o cc	719
J45	Minor Skin Infections	1031
L21	Bladder Minor Endoscopic Procedure w/o cc	408
L41	Vasectomy Procedures	466

Sources: Team analysis, DH

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Recommendation five. At the same time, work should be set in train to clarify which procedures should be classified as complex and only provided in specialist centres. This complex care should be provided by multidisciplinary teams wherever possible.

Recommendation six. Best practice in planned care needs to be disseminated. An effective way to do this would be the introduction of NHS London-endorsed “care bundles,” which identify all the different elements of care that are needed for tackling a particular procedure or condition. An example care bundle for dealing with a clostridium difficile infection can be found at Appendix B.

Recommendation seven. Staff should be incentivised to operate outside of the nine to five, five days a week, traditional way of working. There are several good examples in London where this has already been done (eg the radiology department at Hammersmith Hospital).

Recommendation eight. Staff in both the community and in hospital must not be tied to one service and one particular way of working. For instance the workforce could rotate through high-throughput elective centres and other service environments to ensure training is delivered successfully and that there is flexible capacity to respond to changes in need. Staff in the community should already be working in people’s homes, in primary care facilities and going into hospital to assist with discharge.

Recommendation nine. Commissioners should work with providers to reduce inappropriate use of services (eg questioning the need for less evidenced-based procedures such as tonsillectomies) and decrease the ratio of follow-up to new appointments. This could be achieved with the active involvement of practice-based commissioners in redesigning pathways of care.

The group considered that in the following three areas there was a need for in-depth recommendations: intensive care, children's services and for retrieval teams.

Recommendation ten (intensive care). The impact and cost-effectiveness of intensive care services could be considerably improved by the implementation of new ways of working. A long running study in Melbourne Australia has seen the average length of stay in ICU and the mortality rates for patients with major abdominal surgery fall dramatically. In 1985 the average length of stay was fifteen days and in 1999 it was just three, whilst mortality had fallen from nineteen per cent to 0.5 per cent over the same time period. This was achieved by improvements in pre-operative assessment, peri-operative care and post-operative support.¹⁷

When integrating the Melbourne model of treatment into a care package with other (cheap) evidence-based interventions (such as use of perioperative doppler studies and early feeding/topping up of fluids) quality of care is further improved and length of stay reduced. Thus, seven randomised trials have shown simple use of cheap Doppler technology to reduce length of stay consistently by two to three days in elective intra-abdominal surgery. It is recommended that physician and intensive care management be better integrated with surgical practice, and that appropriate evidence-based care bundles be rapidly established and implemented London-wide.

Recommendation eleven (children's services). A pragmatic approach should be taken to planned care for children, in line with the major principles of this report. This means the provision of local care where possible by nurses, GPs and paediatricians dealing with common conditions. Sometimes care can take place at home or it may be more appropriate for it to happen in a children's centre and/or a polyclinic (we would encourage the co-location of these two facilities). Local services would include adolescent services, dental services and health education.

Paediatricians should move outpatient consultations to polyclinics. The group did not endorse the need for *dedicated* paediatric polyclinics although areas appropriate for children within all-age polyclinics should be provided. Integration of

¹⁷ Improving Surgical Outcomes Group, *Modernising Care for Patients undergoing Major Surgery*, June 2005

children's services should be a priority ie between paediatric, social and mental health services and education, as outlined in *Every Child Matters*.¹⁸

The group also recommends the centralisation of more complex planned paediatric care into fewer centres, as already happens in many European countries. Just as with adult care this allows for the concentration of specialist staff, which should provide better care and is also necessary to comply with the European Working Time Directive. At present the Royal College of Paediatricians and Child Health estimate that only 75 per cent of current acute paediatric units will be staffed with EWTD compliant rotas in 2009.¹⁹

Recommendation twelve (retrieval teams). Transport of the critically ill by experts in this field has been shown to confer no significant risk, but also substantial benefits to outcome, especially when compared to non-expert transfer.²⁰ Experts in critical care transport are also able to offer good advice and support to all hospitals, even when transport is not deemed necessary.

The group recommends the provision of a dedicated critical care transport service across London to allow the moving of the critically ill to 'hubs of excellence' where they can receive the best care. In particular, expert safe patient transport is required for some centralized emergency procedures (such as 'hot' angioplasty). Effective retrieval teams also allow for the optimum use of ICU beds and would be particularly important at a time of major disaster, such as a pandemic disease, or a major terrorist event. In the latter situation, centripetal movement of existing ICU patients will be needed in order to free beds in centres capable of managing the multiply-injured patient (ie those requiring plastic, neurosurgical, cardiothoracic, orthopaedic and critical care services).²¹

Issues that Professor Sir Ara Darzi might like to consider further

There were also some issues the group thought had potential, but needed further consideration.

- Do we need new organisational structures which encompass primary and secondary care, such as the Health Management Organisations in the US? The provider arm of primary care could integrate with secondary care

¹⁸ *Every Child Matters: Change for Children*, HM Government, 2005

¹⁹ *Healthcare for London – RCPCH response*

²⁰ Bellingan G et al., "Comparison of a specialist retrieval team with current United Kingdom practice for the transport of critically ill patients," *Intensive Care Med.* 2000 June; 26(6):740-4

²¹ *Report of the transport subcommittee of the department of health critical care contingency planning committee*, 2006 (transport chair, Dr AR Webb; committee chair, Dr Bruce Taylor)

(either practically or formally) to facilitate delivery of more services within the community setting.

- Franchising of services, where leading centres provide care on other sites and bring in their expertise, should be explored. This is already happening in some cases in London such as the Royal Marsden providing cancer care at Kingston Hospital and St Mary's providing heart services at Queen Mary's Roehampton. Doing this will require the taking on of risk, as volumes of patients cannot be guaranteed. There will also need to be rigorous efforts to ensure quality is really of the high standard that the name implies.
- Practice-based commissioning could potentially offer the opportunity for more planning on a population basis by practice, although there is the inevitable tension between planning and a more market-based approach.

Appendix A

MEMBERSHIP OF PLANNED CARE CLINICAL WORKING GROUP

Martyn Wake (Chair)	Sutton and Merton Primary Care Trust
Charles Alessi	Kingston PCT
Dominic Blunt	Hammersmith Hospitals NHS Trust
Shona Brown	Whipps Cross University Hospital NHS Trust
Nick Cheshire	Imperial College and St Mary's NHS Trust
Justin Cobb	Imperial College
Tim Crayford	Croydon PCT
Chris Elliot	Sutton and Merton Primary Care Trust
John Foran	Epsom and St Helier University Hospitals NHS Trust
Martin Gore	The Royal Marsden Foundation NHS Trust
Celia Ingham Clark	Whittington Hospital NHS Trust
Chris Jones	Epsom and St Helier University Hospitals NHS Trust
Sheila McKenzie	Barts and the London NHS Trust
Hugh Montgomery	UCL Hospitals NHS Foundation Trust
Jo Pritchard	Central Surrey Health
Elizabeth Robb	North West London Hospitals NHS Trust
Tim Richardson	GP and Epsom Day Case Surgery Ltd.
Michael Sheaff	Barts and the London NHS Trust
Simon Williams	London Borough of Merton
Chris Llewellyn (Facilitator)	McKinsey & Co

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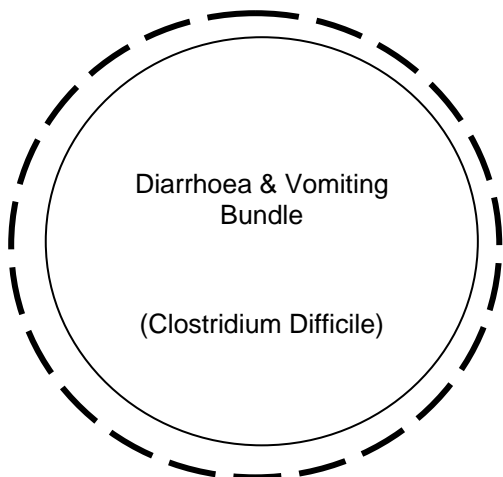
Patient label

Appendix B - Diarrhoea and Vomiting, Care Bundle (Clostridium Difficile)

Diagnostic criteria

1. Persistent diarrhoea and vomiting.
2. Laboratory confirmation of C.DIF

Clostridium Difficile Management		
Action	Time completed, or reason for variation	Signed
Isolation Care		
Review antibiotic Prescribing		
Hand hygiene		
Personal protective equipment		
Enhanced Environmental Cleaning { Three times a day }		
Notify Infection Control Team		



Instructions

1. Attach patient details and fill in box A
2. Detach square sticker, place in clinical notes, and follow
3. Detach round sticker and place on front of brown notes folder
4. File this backing sheet (with patient label) in designated audit tray