

Implications for Delivery Models



Key Recommendations

1 Each clinical pathway group looked at how pathways of care for particular conditions or groups could be improved. In this chapter, we draw these recommendations together to consider how we can strengthen the organisation and delivery of care in the round to make those improvements.

Key Recommendations for the next 10 years

2 There should be systematic implementation of measures to prevent physical and mental ill health, and to make it easy for individuals and their families to make healthy choices.

3 We put forward a vision for primary care in Y&H and the way in which this should be taken forward. In particular, we highlight the potential to exploit the role of pharmacists to support improved health and better access.

4 A greater range of health services should be provided as locally as possible and we outline the range of care that could be provided in patients' homes.

5 Specialist care should be concentrated only where and when this is necessary for optimal patient safety and improved outcomes (e.g. out of hours, when the full range of specialist expertise may not be available in every single district general hospital).

6 The impact of these twin trends of increasing localisation and greater specialisation on district general services should be assessed by PCTs and the SHA in the light of individual local circumstances. It is vital that models of care are implemented with regard to the wider impact on other services, the local community and other parts of the system. The ambition and energy generated through this process should not be squandered by implementing proposals oblivious to unintended consequences.

7 In our view, given the geography and varied population density of Y&H, there is not a single blueprint for the organisational models to deliver the improved outcomes outlined in the report. These need to be developed in light of local circumstances.

8 Integrated models of care spanning specialist centres and district general hospitals (supporting the sustainability of services at both types of hospital) should be considered wherever they support optimal patient pathways – such as the model for acute stroke recommended in the acute episode chapter of this report.

9 Highly specialist care (e.g. critical care) should be supported by effective clinical networks. To be effective, the CPGs proposed that these networks should be managed by one organisation.



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Care should be integrated to make it convenient for patients and carers and to promote seamless care pathways.

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Where there are new models of care (e.g. urgent care centres) they should be developed in light of local circumstances with a focus on improving outcomes and access.

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Elective and acute care pathways should be separate so that planned work is not disrupted by emergency work and vice versa.

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PCTs should review the modelling work we have done into the impact of the proposals put forward in this report to make their own assessments of changes in demand and activity and local service provision as they take this forward.

The importance of primary care

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Every clinical pathway group highlighted the importance of good primary care in providing good outcomes for the population of Y&H. In particular, where general practice is at its best, it is clear that this makes a real difference. There were several specific recommendations which affected primary care and general practice.

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In addition to the work on the specific pathways we therefore convened a primary care "think tank" as part of the Next Stage Review in Y&H. Their report is available at www.yorksandhumber.nhs.uk. At its best the UK model of general practice with a registered population is the envy of the world. However as with the analysis of secondary care activity and outcomes, the "think tank" found unjustifiable variations in the quality and accessibility of primary care in the region. This has a knock-on impact on patient care right through the healthcare system and must be addressed.

Primary Care is the cornerstone of the NHS in Y&H. It ensures that the NHS provides appropriate care and helps people improve their health and well being. Primary care is the first port of call and main healthcare provider for the vast majority of people in Y&H. Our aim is to see universally high quality primary care that is flexible to respond to patients' needs, regardless of where, when, or to whom they are delivered.

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It is vital that we do not lose sight of the strengths of general practice in addressing the variations. In light of this, the "think tank" began with setting out a vision for primary care in Y&H. This is shown below. Given that contracts for general practice are negotiated nationally, the "think tank" was asked to work within current parameters, and see what we could improve locally, rather than look for national changes.

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General practices have a critical role as part of primary care. The practice will act as the navigator and co-ordinator of the care patients receive; it will focus on health and healthcare; and it will work in partnership with patients to ensure they are involved in determining how care is delivered for themselves and their communities.

17

The "think tank" recommended that list-based practice should remain a fundamental part of primary care. It is a model which has proven to be capable of delivering quality and measurable care in a pro-active, patient focussed and responsive manner. Practice-led primary care services will allow clinical leadership to remain central for influencing:

- Individual patient care.
- Population health.
- Commissioning of secondary care.
- Service and care pathway redesign.
- Education, training, and workforce requirements.

18

GPs will be at the centre of a primary care service that will be increasingly delivered by a range of trained professionals in a variety of settings working to deliver seamless and consistent care through a multidisciplinary team.

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We recognise that many of the mechanisms for delivery exist. The key tools for commissioning and delivering improved services identified by the “think tank” are:

- Information.
- A focus on quality.
- Clinical governance.
- Best practice and support.
- The quality and outcomes framework (QOF.)
- Contracts and financial incentives.
- Increasing capacity.
- Practice Based Commissioning.

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The World Class Commissioning approach should be applied to primary care services with the same rigour as to other services, recognising the centrality of primary care to patient care and the positive knock-on impact that high quality care has on the rest of the system. New contracts, investment in primary care and the health reform programme have created a range of opportunities to improve primary care services.

21

Information will be a key driver of improvement. There is a lot of high quality primary care information available and good analysis being carried out in localities across Y&H. However there is a need to standardise, co-ordinate and quality assure this data and analysis if it is to be useful to commissioners, providers and (possibly) the public. We recommend that a single dataset is created for Y&H, providing timely and quality assured practice level information.

22

We hope that this information will aid clinicians, to understand their practices’ relative position and how they compare, and help PCTs to understand and benchmark the performance of their organisations. The dataset will also be a key input for the information that is offered to patients, although PCTs will need to consider the best way for this to be presented to maximise impact with patients.



23

Although the exact details will need to be worked through, the ‘think tank’ have identified an initial dataset to include information around:

- Population and public health: including QOF analysis of disease prevalence; patient mortality by cause; demographic and socio-economic information; clustering of practice type by characteristics.
- Access to services: including patient satisfaction with various aspects of access to services (i.e. opening hours, advanced booking speed of access); performance against 24/48 hour access targets; closed lists; and information on extended opening hours.
- Quality of services: including QOF performance; analysis of exception reporting information; patient satisfaction surveys.
- Approach to care and disease management: including prescribing information, for example statins, aspirin; referral rates for procedures that could be carried out in primary care; variations in emergency attendances; triangulation of underlying deprivation, primary care interventions and secondary care interventions.

Pharmacy

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A key theme running through several of the clinical pathway groups was that we could do much more to exploit the expertise and skills of pharmacists in Y&H. Pharmacists and the services they offer have an important role to play in community and primary care based services. Pharmacists are ideally placed in the communities they serve to provide support and information on self-care and maintaining health and wellbeing. The recent White Paper for Pharmacy – Building on Strengths, Delivering the Future, details the wide role that pharmacists can have in primary and community care as well as highlighting their clinical skills and expertise in medicines.

Pharmacy – how it can help improve health in Yorkshire and the Humber

Promoting better access to pharmacists' expertise on medicines.
Wider access to pharmacy based minor ailments schemes.
Pharmacists recommending the use of NHS LifeCheck service and providing help and support to enable behavioural change.
Providing timely and opportunistic advice on healthy eating, increasing physical activity, weight management and reducing alcohol intake.
Taking on a much more visible and active role in improving the public's health through the provision of stop smoking services.
Provision of sexual health services such as chlamydia screening and access to contraception including emergency hormonal contraception.
Involvement in immunization services, including administration of vaccines and playing a crucial role in influenza pandemic preparation and crisis.

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Pharmacists now have widened prescribing rights, and there are also a number of pharmacists with special interests. These sorts of developments mean that better utilisation of pharmacists in the community - as listed opposite - could help reduce admissions to hospital, reduce the number of adverse drugs reactions and improve preventative health and the management of long term conditions.

26
These factors together with better use of IT, more robust commissioning and performance management of current services and wider involvement of pharmacists in initiatives such as practice based commissioning could have an important role in delivering healthcare and maintaining the health of the population.

¹The terms used to describe the various types of hospitals throughout his chapter accord with the definitions put forward by the Academy of Medical Royal Colleges in its September Working Party report "Acute Health Services"

Figure 40. Services to be available at home

Activities	Infrastructure	Patients and Staff
Rehabilitation	Equipment to support home care will need to be provided	Community nurses including district nurses, health visitors, specialist nurses from hospitals
Ongoing care for long-term conditions and support for self care	Community staff are based in local facilities	Community therapists
Specialist care e.g. chemotherapy	Links to major acute hospital for specialist care.	Midwives for home births
Step-up care to prevent admissions		Social care services
Step-down care to support discharge from hospital		Emergency care practitioners
Support for home birth		
End-of-life-care		

What should be provided at home?

27
A theme of every report has been the emphasis on how we can make it easier for people to access services and look after themselves. This needs to begin with better provision of care and support for people in their own homes. The following services could be routinely provided in patients' homes (figure 40).

What should be provided at different types of hospitals? ¹

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Clinicians advise us that levels of service provision at hospitals and the networks between them should observe the following principles.

Local hospitals and medical admissions

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Local hospitals accepting unselected medical patients should have: 24hour on site consultant surgical and medical opinion, 24 hour emergency department with trained resident medical staff. Access to 24 hour radiology – to include x-ray and CT scanning, operating theatre services, skills to stabilise and transfer patients needing specialised services. They also need anaesthetics and high dependency care, access to ITU and explicit ambulance bypass protocols.

²Trauma can be defined as physical injury caused by events such as road traffic accidents, falls, explosions, shootings and stabbings. The term major trauma is therefore used to describe multiple injuries involving different tissues and organ systems that are, or have the potential to be, life threatening.

Trauma patients require specialist care from a multi disciplinary group of professionals. Injury is a major cause of death across all age groups with over 16,000 deaths in England and Wales each year.

Larger (district) hospitals

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Larger (district) hospitals – which will also be regarded as local hospitals described above - dealing with all but the most severe trauma should have in addition: 24 hour A&E led by A&E consultants, sufficient skills for resuscitation, ICU beds, 24hr x-ray and CT scanning with immediate reporting, dedicated emergency operating theatre(s) and daily emergency lists and a helicopter landing pad nearby. Major services on the same hospital site would be: acute general medicine, coronary care, major operating theatres with access to 24/7 CEPOD emergency theatres, acute general surgery, orthopaedic trauma, anaesthetics, intensive care, radiology, laboratory services, paediatrics – if children are treated at A&E.

Specialised Acute and Elective Care

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Some patients require even more highly specialised services (e.g. major trauma, specialist paediatrics). District hospitals with highly specialised services or tertiary hospitals should receive patients from any part of the hospital system, bypassing other hospitals where appropriate. As well as the services listed above particular specialities will need to be available e.g. neuro surgery or specialist burns units.

Major Trauma Facilities²

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There is a need to concentrate specialist major trauma facilities in Trusts which as a minimum admit more than 250 critically injured patients per year. The number of patients requiring this type of care across Y&H in any one year is likely to be very small as a proportion of overall activity. This is likely to be between 500 and 800 people out of the 300,000 patients admitted to hospitals each year from A&E.

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There should be a Y&H trauma system with a network model between hospitals – ideally as part of a national network. Each network should integrate pre-hospital care, initial transfer, inter-hospital transfer, definitive hospital care and rehabilitation.

34

Consideration should be given to the application of the new service models in the pathway chapters – for example the advantages and disadvantages of co-locating hyper specialist centres for stroke, heart attack, major trauma and specialist paediatrics. Factors to consider would be the advantages of clinical interrelationships between specialities against the potential disadvantages of size, capacity and access.

Critical Care Facilities

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The provision of complex treatments or even “high volume” procedures on people with significant co-morbidities needs special consideration. Again the rural nature of much of the Y&H is an important factor but these patients (who will be small in number how small need number) will need careful assessment and then directing.

Future of small DGHs

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We believe there is a vital future for smaller district general hospitals in implementing this report. We must work together across the NHS with local partners, find innovative solutions to support the implementation of better outcomes and better access for our local communities. Some thought has been given to this by a small group of our acute trust chief executives. (report available at www.yorksandhumber.nhs.uk)

37

It is clear that there are likely to be entirely different approaches to the ways in which services are provided in very rural areas to that which can be delivered in major conurbations. The majority of DGHs fit neither description, often located close to town centres, operating as an integral part of the community and generally being one of the largest employers in the locality.

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In this context, commissioners should consider the pros and cons for driving alternative models of specialist care aimed at ensuring the ongoing viability of local facilities. Whilst we do not prescribe any of the models suggested, we have included them as possibilities for consideration locally as these are some of the ideas that have been raised with us during this process. As set out at the start of this chapter, any changes should be considered against the wider backdrop of the impact on services for the population as a whole.

Ideas put forward about different future models for district general hospitals

'Vertical integration' of local hospital, community and potentially elements of primary care services (e.g. urgent care out of hours), particularly in more sparsely populated areas and towns, possibly through the development of Integrated Provider NHS Foundation Trust models.

Clinical networks, possibly with clinicians in a specialty employed by one provider on behalf of the rest, with responsibility for ensuring the needs of each locality is met in line with commissioning requirements.

Specialist service dispersal across a network. Different hospitals within a sub-region could assume lead responsibility for particular services, including elective inpatient services, with the aim of securing a critical mass of work which provides a significant and long-term contribution to fixed costs and overheads of locality based providers.

The development of DGHs to elective treatment centres, operating in a similar fashion to independent sector treatment centres.

Tertiary centres focused on tertiary work, with neighbouring DGHs delivering a greater proportion of the region's elective secondary care, relieving capacity demands on the tertiary centre, and maximising use of the available estate.

Reduced access to DGH acute services out of hours for specific services such as acute stroke care.

Conversion to GP led community/intermediate care/polyclinic facility with visiting specialists, diagnostic services and outpatient clinics.

39

To deliver many of the recommendations, the SHA, PCTs and providers will need to build new service models around 'integrated care teams' working in both hospitals and the community, to share expertise and to ensure that 'shifts' in the location of care can be enabled and staff more readily redeployed to support traditional client groups in a more varied range of care settings (as has been successfully achieved in many areas of mental health services in recent years).

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This may require PCTs to commission services in a more integrated way, or to support the vertical integration of existing services. It is important for PCTs to progress the development of alternative care settings and capacity, and to incentivise the care system to use them.

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The SHA has an increasing responsibility for overall system management. As such we will need to ensure that commissioning intentions are compatible with the outcomes required across, as well as within a sub-region, to ensure equity of access and to minimise the emergence of even greater health inequalities. This responsibility will be driven by an explicitly stated set of principles regarding the design of services that not only meet local need but which are clinically and financially sustainable.

42

Commissioners could consider the merits of commissioning services from single providers, who in turn assume responsibility for sub-contracting or delivering the required service to each locality in line with local requirements. In doing so, commissioners would need to have regard to the 10 Principles for Competition and Co-operation published by the Department of Health at the end of 2007.

43

At a national level, further work is required on the intelligent unbundling of the tariff and the application of tariffs which incentivise desirable reform of the system.

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The financial system must be organised to support the delivery of service and health improvement, not the other way round. Local experience in Y&H would suggest that, for some services, there are issues about the ability to meet even the most efficiently organised service within current tariffs – either because of geography or isolation. This issue will need to be resolved sensibly to deliver care where it is needed and can be delivered to the highest standard.

45

One example raised with us was that – if our ambition is to provide care as locally as possible – consideration could be given to align incentives such that acute hospitals are supported in maintaining patients in the community rather than admitting them.





46

We want to take stock of the range of innovative ideas emerging from our local communities about the practical ways in which they can deliver better outcomes and sustainable local services. We will work closely with all partners in the system to do so.

47

It is important to stress that whilst our proposals mean that the role and scope of some DGHs will be redefined, we are committed to ensuring that they remain viable and well placed to serve the needs of their populations. The changes proposed in this report build on those which have already taken place over the last 10 years (e.g. cancer services) and are rooted in the evidence about what is needed to provide the best outcome for patients.

Modelling the Impact on Current Patterns of Activity and Investment

48

We have done modelling to assess the future demands on the health service in Y&H and the impact of the recommendations in this report. The outcome of this work is the technical appendix to this report (available at www.yorksandhumber.nhs.uk).

Our modelling does three things:

- It sets out an overview of current investment and activity across Y&H – our baseline scenario.
- It assesses the ways in which this is likely to change - as a result of the impact of demographic change on activity and changes in disease prevalence – our “do nothing” scenario. Based on current patterns of service delivery, expected growth in secondary care activity resulting purely from demographic change is between 4% and 10%, and real terms secondary care cost increases are projected to be in the region of 9%.
- It goes on to assess the high level impact of some of the key recommendations from the CPGs – our pathway scenarios.

49

This analysis is necessarily high level and illustrative. It will need to be supplemented by PCTs making their own assessments according to their local circumstances and the priorities they identify locally which may result in changes in demand and activity (e.g. reducing attendances at A&E through improved and extended primary care services, establishment of Urgent Care Centres etc) in and the pattern of local service provision.

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Any major changes to current patterns of service which emerge as a result of these recommendations would need to be the subject of local consultation in the appropriate PCT area, in line with existing legislation and best practice. The SHA would expect there to be clearly articulated benefits for local populations to any proposed service changes.