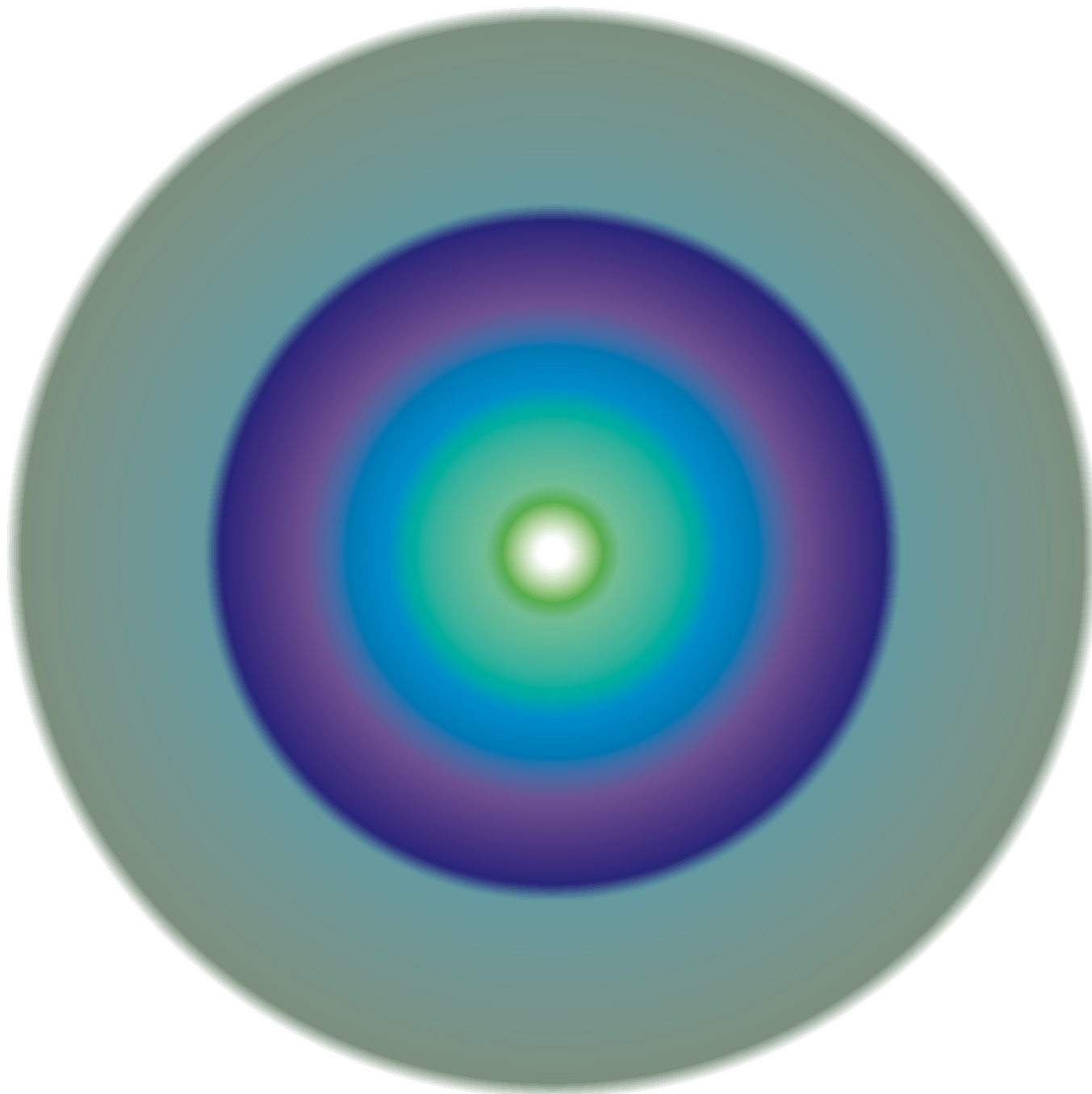




# The Planned Care Pathway



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## Right place, right time, right care

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Whilst there have been dramatic improvements in recent years – for example in waiting times which will be no more than 18 weeks from referral to treatment by the end of 2008 – we know that there are still several ways in which we can make planned care more efficient and effective. Most of us are likely to undergo planned treatment of some kind or a planned diagnostic procedure at some time in our lives. This chapter (based on the work of the Planned Care CPG – full report available at [www.yorksandhumber.nhs.uk](http://www.yorksandhumber.nhs.uk)) sets out the ways in which we can improve this type of care.

## The Case for Change

2  
The case for change in planned care is clear:

- We could be much more efficient – our day case rates vary from 29% to 67% for hernia repair (adults) by hospital.
- There are too many follow-up outpatient appointments (with a threefold variation). This can waste people's time, result in unnecessary journeys to hospital and is an inefficient use of resources.
- We don't make best use of latest technology e.g. by having telephone follow-ups or e-mailing the results of diagnostic tests.
- Specialist care in some places is not always staffed with the same level of expertise, and this is likely to have an impact on outcomes.

“A convenient and attractive idea wherever appropriate” but nobody should be discharged without appropriate support at home.”

3 To look at these issues in more detail:

- Outpatient services: DNA rates for first outpatient appointments have ranged from 5.3% in North Yorkshire and York PCT to 12.7% in Kirklees PCT. This questions the appropriateness of the referral and/or the quality and timeliness of communications regarding the attendance.
- In 2005 / 2006 there was an average of 2.6 follow up appointments to each outpatient appointment (England average 2.3); this ranged from a ratio of 1.9 in Doncaster and Bassetlaw Hospital NHS Trust to a ratio 3.4 in Airedale NHS Trust (figure 28). Such variations do not appear to be justified on clinical grounds.
- Day case surgery: There is considerable room for improvement in day surgery rates across Y&H. In units that have been taking part in regular data collection with the SHA we have seen large variation in day surgery activity for the Healthcare Commission basket of 25 procedures. This variation is brought into focus if we look at 3 high volume procedures in particular (figure 31). The average day case rates in Y&H for hernia repair (adults) in 2005/2006 was 49%, ranging from 29% in Rotherham NHS Foundation Trust 67% in Airedale NHS Trust. Patients told us that they were very much in favour of day case operations.

Figure 28. Number of follow up appointments per initial outpatient appointment for providers within the Yorkshire & Humber SHA 2005 / 06, excluding mental health data and providers with less than 1,000 first attendances / Source: Hospital Episode Statistics (HES), the NHS information centre for health and social care, 2005 / 06 Outpatient Att All OP (excl MH)

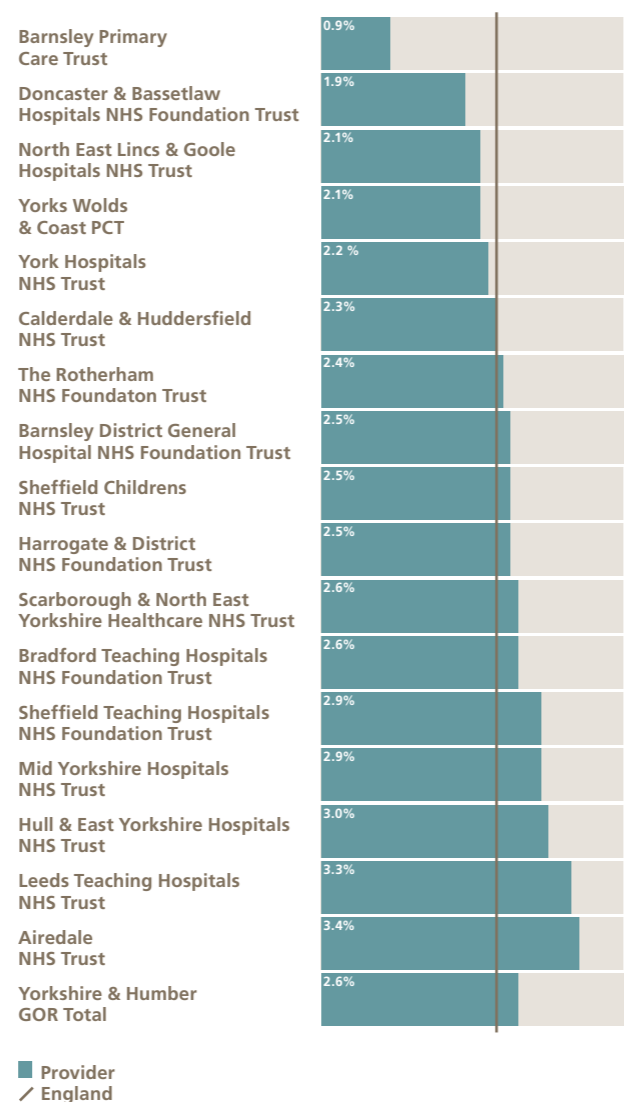
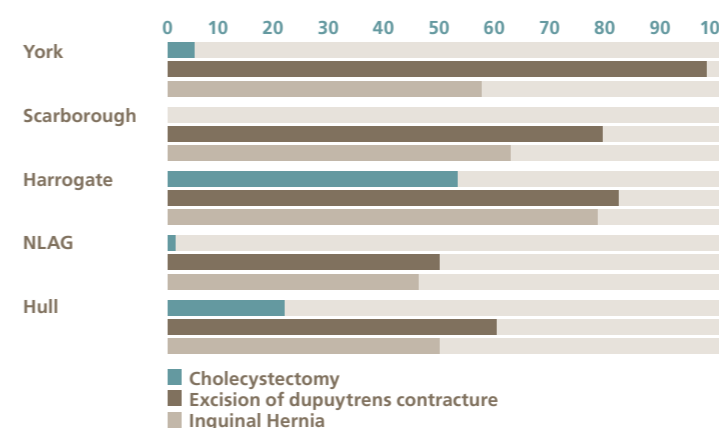


Figure 29. Variation in day surgery performance for 3 procedures Source: SHA analysis based on trust data.



4 Our Planned Care CPG discussed the nature of GP service provision and advised us that there can be insufficient integration between services. GPs have unique skills as generalists. This is a valued model internationally and should be acknowledged. This can impact on other service providers such as community nursing and on the quality of care provided. Precedents have been set for much greater integration of GP services, the best example being the establishment of GP Cooperatives to provide out-of-hours services.

5 The CPG considered that the variation in distribution of GPs across the region was difficult to justify as the highest practice lists were found in more deprived areas.

6 The CPG recognised the limited range of professional expertise available at GP surgeries – which can be restricted to GPs and practice nurses. Members considered that a much wider range of NHS funded skills should be available locally to practice modern health care. This will be easier to support if GPs work together.



7

At present, the two PCTs that were outliers in the region for small practices were NE Lincolnshire (63%) and Hull (61%), which have high levels of socio-economic deprivation. This appears to perpetuate the “Inverse Care Law”. Looking over the next ten years the CPG thought it unlikely that the region would still only have 40% of GP practices that had five or more partners if practices are to provide the wider range of services that patients want.

8

Diagnostic services: Generalist clinicians are often limited in the range of tests they have access to and, in addition, may have to wait for days or weeks to get the results.

9

The CPG thought it highly probable that the demand for diagnostics currently expressed by generalist clinicians significantly under represents the potential need. An example of this is people with alarm symptoms for bowel cancer as defined in DH guidance; estimates suggest if all potential referrals were made the demand for lower GI endoscopy would rise significantly and is currently restricted by the limited availability of colonoscopy and flexible sigmoidoscopy.

10

The CPG considered that the clinical skills of diagnosticians were being under utilised as many requests for tests had insufficient clinical information such as symptoms and differential diagnosis.

### Key Recommendations

#### Clinical integration

11

To exploit the potential of new technologies, and reduce journeys to hospitals, GP services could be contracted to provide a wider range of access and services to 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.

12

Independent contractor services should be “levelled up” to reduce the significant variation in services provided. (This issue is covered in more detail in the chapter on delivery models).

13

Community based generalist clinicians (Independent contractor services and community nursing teams) should be integrated locally with specialist clinicians reflecting the health needs of local people. This will support the transfer of specialist sessions out of the hospital setting – the aim being to provide a “virtual polyclinic” service.

14

Generalist and specialist clinicians must have significantly greater access to diagnostic services with robust referral mechanisms to ensure clinical skills of diagnosticians are fully utilised.

15

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.

16

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

17

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

#### Information systems

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Clinical IT systems must be integrated, and fully utilised by clinicians. Integration of safe clinical services will not happen without robust IT systems.

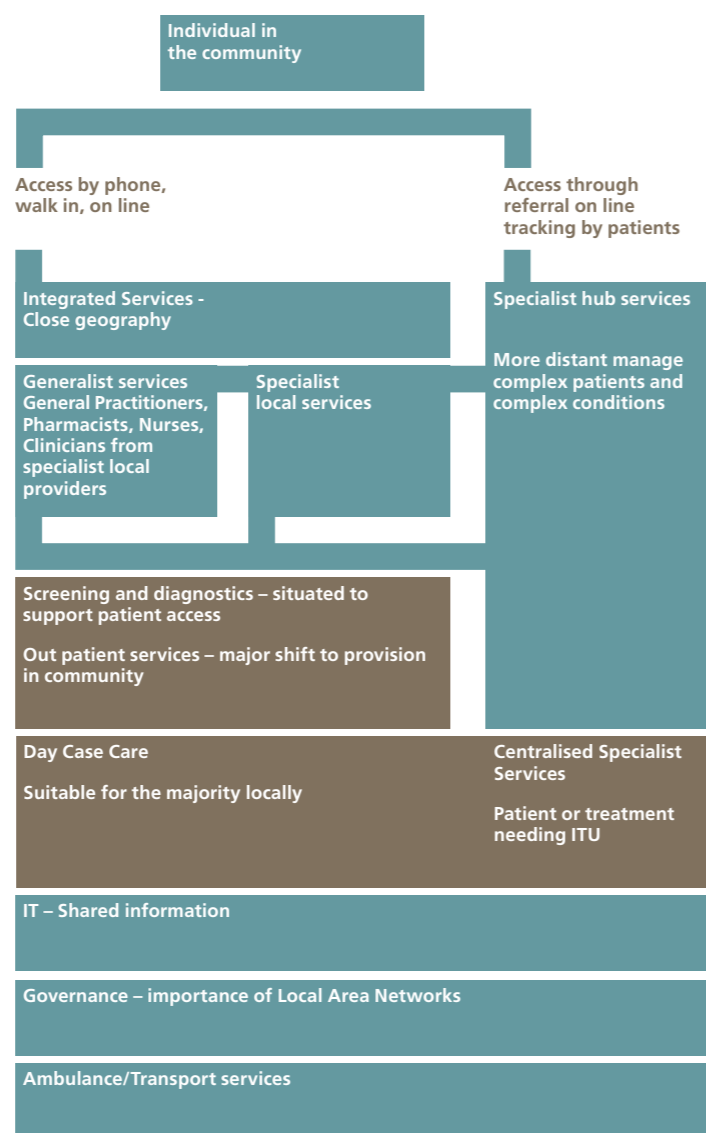
Local access to services

19 Clinical services should be localised when possible and centralised when necessary and the impact on other services properly understood.

20 Many people would like more care to be provided at home. In our focus group work, more follow up care at home attracted the most support from a range of proposals. Technological developments in treatments and health monitoring means that the current range of home treatments should be expanded and be more widely available.

Figure 30. The Planned Care Pathway / Source: Y&H Planned Care CPG.

Planned Care – Key Elements



High volume procedures

21 People requiring “high volume” procedures (e.g. hernia repair) should be offered day case services as routine when it is clinically appropriate. These should be provided in dedicated elective units and/or dedicated elective centres. Bearing in mind the geography and variable sparsity 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.

22 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 this means that, to improve outcomes, patients with this level of clinical risk would be better served being treated in appropriately staffed and resourced units. The CPG recommend that a review of critical care services should be commissioned across the region to ensure the NHS is delivering the very best care. For similar reasons the CPG also recommend a review of vascular surgery.

23 Emulating the organisation of modern cancer services, the role of “clinical network” hubs should be developed across a range of planned care specialities.

Estate

24 As changes to locally based care are implemented some of the estate may 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 buildings.

The Planned Care Pathway

25 The Planned Care CPG developed a revised illustration of a modernised Planned Care Pathway and this is illustrated in figure 30. The pathway stresses the importance of integration across the care pathway, robust governance and the centrality of fit-for-purpose IT systems to delivery.

The Pathway in Practice

26 The CPG advised us that much better use could be made of the medical skills of GPs if their time could be freed from undertaking work that other appropriately trained clinicians could do such as first contact care and management of LTCs. GPs are an invaluable part of the NHS and we need to make the very best use of their scarce skills. These clinicians include a range of specialist nurses, pharmacists, and physiotherapists. There are examples where this is already happening. The opportunities for greater integration with social care at practice level should be explored as well as other agencies such as the voluntary sector.

## Diagnostic services

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Ready access to a wide range of diagnostics is essential to practise modern clinical care in the community. Progress is being made in access to diagnostics but a great deal more should be done to improve generalist access to a wider range of diagnostics and their timeliness.

28

Clinical skills of diagnosticians may be under utilised as many requests for tests have insufficient clinical information such as symptoms and differential diagnosis. This can limit the efficiency of the service as the diagnostician is often much better placed to determine the type of investigation which is most appropriate for an individual patient; this could delay diagnosis and treatment.

29

Significant technological advances that have been made in diagnostics such as digital imaging and PACS (Picture Archiving and Communication System), mobile scanners, mobile endoscopy, near-patient testing, diagnostics by post, etc. mean that many diagnostics could and should be provided more locally and be an integral part of generalist care.

## Specialist services

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Integration: There is insufficient integration between generalist and specialist services. Whilst there are many examples of clinician-to-clinician discussion about individual cases, usually there is little direct day-to-day contact between generalist and specialists.

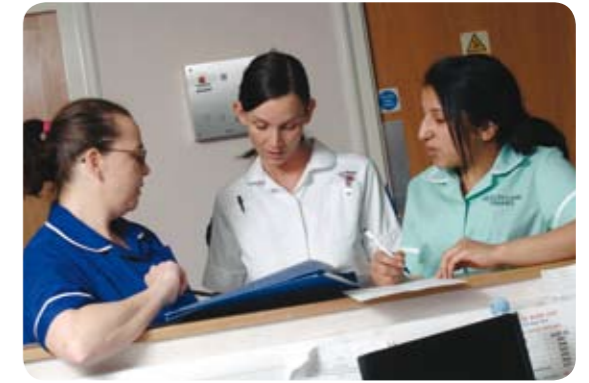
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Generalist referrals to specialists are often regarded as being of poor quality with incomplete information. The converse i.e. the poor quality of specialist service communications back to GPs is also a commonly held view of generalists, particularly when a patient is discharged from hospital. Generalist referrals should be much more standardised and include all clinical information relevant to the case. Similarly communication back to generalists should be of a high standard and timely.

## Outpatients

32

A considerable number of current outpatient referrals from generalists could be avoided with better direct access to a wider range of diagnostics and therapy services. Similarly there are far too many follow up appointments by specialist services. This is supported by the evidence of a three-fold variation in the ratio of follow up to new appointments between Trusts. However it is recognised that there are many successful examples of follow up undertaken by generalists in cancer care, anti-coagulation treatment, DMARDs (Disease Modifying Anti-rheumatic Drugs), etc.



## Integration

33

There is a great need for much closer integration between generalist and specialist clinicians. Ideally this needs to be direct face-to-face contact underpinned by common information systems to share relevant clinical information. This would be facilitated by working in the same building as envisaged in the polyclinic advocated by Lord Darzi's London NHS Review. This model is increasingly prevalent in parts of Europe and North America. The CPG do not advocate a large building programme of polyclinics in this region because there are already many suitable premises available such as LIFT schemes, large GP premises/health centres, community hospitals and local general hospitals. Clinicians advocate the development of "virtual" polyclinics with generalists and specialist working common sessions alongside in a number of existing local facilities covering a defined population.

## Opportunity cost

34

The CPG recognise that enacting this will entail a radical change in style and location of work for clinicians, especially for some specialists. Such a transfer of specialist clinical sessions out of hospital facilities may incur increased opportunity costs in travel time. It will also dramatically reduce the use of hospital outpatient facilities. However we are advised that the benefits of much closer integration would outweigh these opportunity costs. There are already examples where a degree of such developments have happened through the use of GPs with a Special Interest in dermatology, musculo-skeletal problems, gynaecology and urology.

## Day case and short stay surgery

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The CPG recommended that Trusts' day case rates should match international best performers and all Trusts should have plans to achieve the day and short stay surgery targets contained in the British Association of Day Surgery Directory of Procedures. This means that people requiring a "high volume" procedure should be offered day case services as routine when it is clinically appropriate. These should ideally be provided in dedicated elective centres with reasonable access to local communities.

36

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) will need careful assessment and then directing to centres with appropriate skills and support services according to planned need. Patients can be stratified into two main groups:

- Those who can be managed within local facilities through normal wards or High Dependency Care.
- Those who will require management of a multidisciplinary team and care through an Intensive Care Unit.

37

The provision of intensive care facilities is a key part of this issue. There are clear guidelines about the consultant staffing of intensive care units – however these patients also require support from a multidisciplinary team including bacteriology, cardiology, renal medicine, surgical specialties and diagnostics. Strong links with physiotherapy and pharmacy are also important.

38

Intensive care requires high level skills in all those involved and so requires reasonable patient numbers to ensure clinical skills are developed and maintained. It will not be possible to provide this service to a world-class standard in every general hospital across the region. This is why the CPG advocate a review of critical care.

### Barriers to Change

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As new models of care are designed there is a need to exploit the potential to use the national tariff (PbR) as an enabler for change. Local organisations should make full use of the tariff to promote new ways of working – for example unbundling (to address the need to provide care out of hospital) and enhancement (to recognise the increasing concentration of specialist services). Such changes may require PCTs to seek the support of the SHA.

40

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 efficiently 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 (i.e. not just nine to five, Monday to Friday).
- Better use of new technology to provide mobile services such as PET scanning, MRI, and lower GI endoscopy.

### Information Technology

41

The CPG had concerns about the current state of the NHS information systems. Their view was that there remains insufficient integration of IT systems between service providers. This is a major impediment to integrating planned care and localising services. It also presents significant risk to clinical governance as the range and complexity of treatments increases, as well as the expanding number of potential providers of health care.

42

In addition to the ready availability of relevant clinical information for the treating clinician the CPG considered there should be a much more up-to-date IT use by patients. This includes:

- Expanding patient booking of generalist care appointments on line.
- Patients seeing the test results on line.
- Patients tracking the progress along their care pathway on line.
- Making Choose and Book two way, that is enabling specialist clinicians to send discharge information and book patient appointments on generalist clinics for stitch removal or other similar reasons.
- Supporting self-care.

43

An example of good practise is the early detection and treatment of cancer: The CPG considered that much progress had been made in the redesign of cancer services. Whilst recognising there is still more work to be done the CPG felt that cancer care provides a good model of service integration and sub-specialisation. Therefore an outline of the PBC perspective on cancer commissioning is given below. Similar constructs can be developed for other common diseases.

44

In a PBC population of 70,000 there will be around 50,000 adults. Of these 3,000 each year may well experience cancer alarm symptoms (as defined by DH). These should be referred for a specialist opinion including diagnostics. Around 300 will be found to have a form of cancer and enter the 62 day pathway. The remainder will be found

1

This chapter is based on the work of the Yorkshire and the Humber Children's Clinical Pathway Group. Report available at [www.yorksandhumber.nhs.uk](http://www.yorksandhumber.nhs.uk).

2

Yorkshire and Humber Focus Group Reports – September and December 2007.

3

'Standards for Consultant Staffing of Intensive Care Units', Intercollegiate Board for Training in Intensive Care

to not have cancer but may have benign disease(s).

45

PBC consortia are well placed to work with other local specialist services to design the most appropriate care pathway for these patients. The first challenge is how to ensure that those with alarm symptoms are encouraged to seek advice. The second challenge is how to ensure the 300 new cases of cancer are diagnosed promptly and entered in the relevant cancer care pathway. The third challenge is how to manage the symptoms of the remaining 2,700 individuals. Addressing such challenges would need to involve local people, social care providers, and the voluntary sector, to secure the commissioning of an appropriate range of locally based services integrated with specialist cancer treatment teams.

### Conclusion

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The Planned Care CPG has made a clear case for change and one which was attractive to patients. The impact of the changed recommendations will need to be considered by all PCTs in detail, building on the examples we have looked at in the chapter on delivery models.

47

Our pledge in taking forward this pathway will be to reduce the number of repeat journeys for patients and carers.