

Turning our recommendations into reality – Enablers

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The agenda for change set out in this report is wide-ranging and complex to implement. This chapter sets out six cross-cutting areas of work which will help implementation, together with the initial first steps the NHS in Y&H plan to take.

Leadership

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Above all, effective leadership will be critical to delivery of our ambition. This will need to be at many different levels.

- One, we need to strengthen support for clinical leaders across the system, in every profession. Whilst it is for individual NHS organisations to ensure that they have systems in place to engage with the range of professions, we will appoint a Medical Director to work with the Director of Patient Care and Partnerships to lead clinical involvement across Y&H. This will be supported by a number of summits throughout the year to bring clinicians together on specific clinical issues where there is a strong evidence base for improving or developing services such as childhood asthma and diabetes.
- We have a comprehensive leadership strategy in Yorkshire and the Humber. This will be refreshed to ensure it reflects the aspirations set out in this report. All programmes and approaches will be aligned with our clinical vision. Realisation of the ambitions set out in this document will only be achieved through strong leadership which should support best practice and challenge poor practice.

- Three, in several recommendations clinicians have called for greater emphasis on well developed clinical networks to support the delivery of improved and integrated care. Leadership by clinical networks needs to align appropriately with organisational governance arrangements to ensure effectiveness and manage risk appropriately.
- Four, this is not just about leadership of a system or organisation, but also about leadership of 'place'. Delivery of this report will only be achieved through effective partnerships, particularly with local authorities.

Workforce

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Over 70% of NHS spend goes on the 140,000 staff who deliver care in Y&H. Few, if any, of the improvements outlined in this report can be delivered without our staff. We will look to draw up a specific workforce programme to support the implementation of the report.

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This will need to cover:

- Education and training – several sets of recommendations will require either national consideration by the Royal Colleges, or changes at a regional level to the curriculum content of current training programmes. We also need to ensure that clinicians and managers alike are skilled in the tools and techniques of service improvement so that changes are implemented effectively and sensitively. The improvement of health and health care services envisaged in this report can only be delivered by major investments in education and training and continuous workforce development and learning. Further work is required to build upon our “Education for Health” strategy, learning and development agreements, and NHS Education Y&H as vehicles for delivering this.
- Involving staff and trade unions in realising the vision in this report is crucial. Individual organisations will need to ensure their partnership arrangements and staff involvement strategies are robust enough to support reform, and at a regional level we will further develop our Social Partnership Forum as a vehicle to support workforce change.

- Staff commitment will need to be matched by effective workforce planning at organisational, health community and regional level, and our strategy “Working for Health” and our Regional Workforce Stakeholder Board will have a key role to play in strengthening this. In particular the need to extend hours, develop new/different patterns of work and align skills to deliver pathways across organisational boundaries will require increasing flexibility. Our ageing and more demanding population is matched by a similar ageing workforce with higher expectations from their employers. It is therefore crucial that work continues to ensure that the NHS in Y&H is seen as an employer of choice.
- To enable the implementation of change, focus needs to be placed on building organisational and system development capacity and capability.

Information

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Clinicians have focussed throughout this work on how we can improve the quality of care. But without having information it is impossible to know about the quality of care – whether it be “hard” information about outcomes and numbers of patients treated or seen, or whether it is “soft” information about the experience of care as described by individuals. High quality and timely information for commissioners and providers will support service development, and help track population health. It will deliver effective benchmarks against which the public can see whether progress is being made.

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We need to start using real time patient data to ensure management decisions informed by what patients today really think about aspects of care that matter most.

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Information is essential if individuals are to have more control over their own health and their own care. This includes not just information about conditions and how to take care of yourself, but also information about the pathway so that individuals know what to expect and what to ask for – and crucially will know when a good experience is by design not by chance.

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Good information about local populations’ needs and preferences will enhance partnerships working between the NHS and local government.

Technology

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To deliver good information, good technology is critical. Clinicians in virtually every clinical pathway group identified the need to improve information systems between different parts of the NHS and other agencies if we want to reduce the segmented experience for individuals. The inability to readily access data across organisations, or even sometimes within organisations, was perhaps one of the most common frustrations expressed by NHS staff during this process and is clearly holding back service developments.

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The eight reports highlighted some key areas where we could make more rapid progress. These are:

- The integration of IT systems between service providers, and in particular to enable the rapid transfer of patient information in the urgent care system.
- The potential for more up-to-date IT use by patients including:
 - ability for patients to book generalist care appointments on line.
 - ability for patients to see test results on line.
 - ability for patients to track their progress along their care pathway on line.
 - ability for patients to hold their own health record (for example in mental health services).
- The acceleration of the implementation of the new maternity system (currently scheduled in Y&H by the national Connecting for Health programme for possibly the fifth wave).
- The adoption by GPs of a common system such as SystemOne, supported by secure electronic methods of communication between consultants and GPs.

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We will work with Connecting for Health to align their current programme of work to the recommendations in this report. Already ten key system changes have been identified to be made in Y&H. These are set out below.

- Electronic administrative systems (Advanced PAS).
- Electronic ordering and receipt of pathology and radiology tests (Order Communication).
- Electronic prescribing, dispensing and stock control linked to medical records (ePrescribing).
- Electronic production and transmission of clinical letters.
- Systematic use of clinical codes in every NHS IM&T application.
- Shared electronic patients records (the Detailed Care Records Service).
- Diagnostic images available electronically (PACS).
- Secure electronic communication between GPs and consultants.
- Secure remote access to clinical systems.
- Accelerate implementation of National Summary Care Record, Electronic Prescriptions Service and GP to GP transfer.

Figure 41. Supporting people at home. 74 year old lady, diagnosed with advanced COPD having a history of frequent hospital admissions resulting in X-ray and arterial blood sampling. Provided with doc@HOME home monitor from November 2007 / Source: Report by Hull PCT

	Jan - Oct 2006	Nov - Mar 2007
Emergency Ambulances	23	2
A&E attendance	12	0
Hospital admissions	16	2
Out of Hours calls	55	3

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But technology is much wider than the systems that staff and patients use to keep track of what is going on. Technology offers real opportunities for individuals to take control of their own health or condition. Already in many places around Y&H people are beginning to use home monitoring systems with a significant impact on their own health.

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We want to see a significant transformation in the uptake of this kind of technology across Y&H to support people taking back control of their health. Figure 41 opposite from Hull PCT illustrates the kind of difference this technology can make to an individual.

Incentives

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A recurrent theme of the report is the need to align the incentives in the system to accelerate improvement and not hinder it. This is a shared objective between clinicians and policy-makers.

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Most of the clinical pathway groups have made reference in particular to the need to ensure that the "tariff" is structured appropriately to support changes in care. Clinicians have made recommendations that local organisations should look at "unbundling" the tariff – to address the need to provide care out of hospital and potentially "enhancement" – to recognise concentration of specialist services. Because the tariff is based on an average price, it may also be necessary at times for local commissioners to look at how they support more isolated services which may prove harder to deliver where the ratio of fixed to marginal cost may be greater than elsewhere. The previous chapter also highlighted similar issues.

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As a principle, services should be designed around the needs of the patients and the population and then financial systems should be designed to support that – rather than historical patterns of finance dictating the pattern of care. At the same time, there should be no drawing back from looking at how care can be delivered more efficiently to give best value for the taxpayer. Every pound spent must have the maximum impact on health and the quality of health care.

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The SHA has already begun work with a number of primary care trusts to look at how we can embed quality measures better into contracts between PCTs and providers so that high quality is recognised and rewarded. Commissioners should understand how they can incentivise better quality, and penalise poor quality through the development of mature relationships with providers and the use of contract structures.

Culture

“Culture eats strategy for breakfast”

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Our clinicians have repeatedly told us that, to make the kind of changes envisaged here, we need a cultural transformation. One where all decisions – whether it be individual practice, or pathway design – is based on the very latest evidence available not on historical patterns of care. This has already been happening in many fields, such as the treatment of cancer where over the past ten years practice has been increasingly standardised in order to deliver fairer and better outcomes for patients. The production of timely information, appropriately benchmarked, as set out above is critical to enabling this to happen. In addition, we want to bring clinicians together on a more regular and wide-reaching basis to look at specific issues – starting with two clinical summits on childhood asthma and diabetes.

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The risk of moving towards a more standardised system is that it stifles innovation. We therefore propose to establish an Innovation and Change Board for Y&H to signal our commitment to champion new ideas, new systems, new innovations, and to provide a vehicle to support the rapid uptake and spread of proven innovation. We want to support research and development in Y&H to benefit our population. We will work with universities, Yorkshire Forward, local NHS organisations and other partners to create this momentum.

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In addition, clinicians have told us about the need to change the wider culture in society – whether it be about discussing attitudes towards death and dying, or changing the acceptability of alcohol misuse. Conversely, patients and the public repeatedly tell us of their wish to see changes in the way the NHS corporately engages with the public – to work more in partnership and less hierarchically.

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To accelerate this type of cultural change, we plan to establish a social marketing delivery unit – “Well”. Changing behaviour is the toughest of tasks, but if we are to concentrate on a healthy future we must recognise the need to lead attempts to persuade people to change both inside and outside the NHS. “Well” will create a regional plan to assist local NHS organisations to implement the range of social marketing activities identified in this report. It will build on the examples of excellent practice already underway in Y&H, such as nationally recognised “Safe Hands” campaign at

Leeds Teaching Hospitals NHS Trust and the work on lung cancer in Doncaster.

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This report sets out ambitions for change and delivery over the next ten years. The NHS cannot do it alone. We now want to work with partners across the region to develop an implementation programme – some of this will be regional, most will be for local organisations to take forward. We will publish this programme in the autumn, but we have already taken some first steps as set out below.

Mainstream

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We need to make implementation part of the everyday business of the NHS. So firstly the 14 PCTs in Y&H have already included some of the recommendations in their Annual Operating Plans for 2008/09, where these recommendations clearly help to implement nationally set targets.

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Secondly, every PCT is required to produce a strategic plan for the next 3-5 years which will be assessed, as part of a national assurance process, in the winter of 2008/09, by the SHA. This is part of the drive to develop world-class commissioning across the country. We will look in particular to see how they plan locally to take forward with their partners such as local government the recommendations outlined here, and how that is supported by financial investment.

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We will establish a Clinical Reference Panel – made up of clinicians from our current Clinical Pathway Groups – to review each strategic plan and advise the SHA on whether it is sufficiently ambitious. Where PCTs do not propose to adopt recommendations wholesale, we will want to be clear that their local populations are not disadvantaged but are securing the same or better health outcomes and experiences as elsewhere in the region.

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Thirdly, PCTs should ensure that there is early dialogue with PBC consortia so that the aspirations in this report are embedded in their plans and that these clinical leaders strongly influence commissioning strategies.

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Finally, we are clear that whilst this will be predominantly about local organisations and clinicians leading change, there will need to be a number of region-wide programmes. These will be worked up in more detail – in consultation with partners – but we would expect them to cover:

- Education and training.
- Clinical leadership.
- Information and technology.
- Innovation and change.
- Social marketing.

Conclusion

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The next ten years hold a big challenge for physical health, mental wellbeing and the quality, safety and accessibility of health services in Y&H. What difference does this report make? If we implement the recommendations from our clinicians outlined, then the kind of difference it could make would be illustrated by:

- A halt in the rise in obesity.
- Breastfeeding widespread across the region.
- Half the number of hospital admissions for children with asthma.
- No waits for mental health services, whether specialist or talking therapies
- Half the number of complications and preventable admissions caused by diabetes.
- Senior clinical decision-makers at the front door and beyond for acute care.
- 600 fewer premature deaths from stroke.
- Twice as many people dying at home, rather than in hospital.
- Fewer journeys for patients and their families.
- Better value for money/greater efficiency.
- NHS working with local government and local communities to improve health and wellbeing.

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These are just examples. We need to hold the prospect of these improvements in our mind as we work through the detail of these recommendations with partners and with patients and the public.

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Healthy ambitions. Our purpose is to make this happen.

