

# Y&HNHS Next Steps Review

## Report of the Planned Care Clinical Pathway Group

Chairs: Mark Baker and Ian Jackson

1<sup>st</sup> May 2008

## **Executive Summary and key recommendations**

It is essential that planned care pathways are commissioned to secure more integration from the first consultation, through specialist treatment, and on to the patient's return to self-care/management. The following recommendations are presented to give the clinician perspective to the development of NHS funded service in NHSYH through the commissioning cycle.

### **Recommendations for improving Clinical integration**

1. Independent contractor services should be contracted to provide access and services that reflects the needs of their populations. It is very likely that this will need greater integration between the relatively small separate services as currently constituted. This should provide the building block for integration with community nursing services and social care.
2. Increasingly primary care contractor and other community based services should be commissioned using appropriate clinical and consumer outcomes as key elements. Together with the commissioning of social care, this should help reduce the significant variation in patient and carer outcomes and experience.
3. 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 entail the transfer of specialist sessions out of the hospital setting. The aim being to provide a "virtual polyclinic" service.
4. Clinical care pathways should be designed to achieve the quickest way to get a diagnosis and to commence treatment. Central to this will be generalist and specialist clinicians having significantly greater access to diagnostic services. This should be underpinned by robust referral mechanisms that ensure the clinical skills of the diagnosticians are fully utilised; it will also demand adequate opportunity good clinical discussions between referrers and diagnosticians.
5. The team approach to clinical care should be enhanced in the community to free up GP time to enable full use of their unique skills and enable appropriate accredited sub-specialisation. This will entail more skill mixing to manage much of the first contact and long term conditions work.
6. Communication through the critical points of the care pathway should be timely and robust; this means communication in both directions of the pathway.

7. Generalist referrals to specialist services should be standardised to ensure that all essential information is provided with each referral. Similarly there should be standardisation of referrals from specialists to generalist services.
8. The above recommendations have significant implications for workforce development. Relevant training and educational organisations should be informed and involved as soon as possible.

#### **Recommendation on the management of the Estate**

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

#### **Recommendations on improving Local access to services**

10. Many more specialist consultations as well as diagnostic and treatment services should be provided closer to people's homes. These should be provided in dedicated settings that meet all appropriate building and other standards. In addition to patient convenience this supports closer generalist and specialist clinician integration..
11. Many people would like more care to be provided at home. Technological developments in treatments and health monitoring means that the current range of home treatments and "Telecare" should be expanded and be more widely available. Implementation of such technology needs to be regulated robustly.

#### **Recommendation on the delivery of high volume procedures**

12. People requiring a "high volume" procedure (medical, surgical or diagnostic) should be offered day case services as routine when it is clinically appropriate. These should be provided in dedicated settings that meet all appropriate building and other standards. Bearing in mind the geography and variable sparsity of communities in the SHA area, there should reasonable access to these services. This should not interfere with the individual's opportunity to choose where they are.
13. Day case rates for health economies should match the international best performer and that all health economies should have plans to achieve the day and short stay surgery targets contained in the British Association of Day Surgery Directory of Procedures.

### **Recommendations for the provision of low volume or more complex surgical care**

14. The provision of complex treatments or “high volume” procedures on people with high operative or anaesthetic risk factors must be provided in clinically appropriate settings. It is likely that this means patients in with this level of clinical risk will not be treated in every hospital in NHSYH.
  
15. The provision of High Dependency and Intensive Care Services requires organisation across geographical areas and hospital networks in the SHA. Intensive Care Facilities should be organised so that the national guidelines for facilities and staffing are met.

### **Recommendation**

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

### **Recommendation on improving Information systems**

17. Integration of safe clinical services will not happen without robust IT systems. Clinical IT systems must be integrated, and fully utilised by clinicians. This integration should:
  - a. include community dentist, community pharmacist, community optometric services, as well as those of Independent Sector Treatment Centres;
  - b. be explicit in commissioning contracts for NHS procured services, as well as those for social care.
  - c. be based on System One within Primary Care subject to the system delivering the required functions across health economies. Health economies that can deliver the same function and integration with other systems should be supported

### **Recommendations for the Commissioning of integrated Planned Care**

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

19. As new models of care are designed there is a real possibility that national tariff (PbR) will be a significant barrier to change. Therefore PbR must change to reflect new ways of working. 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 specialist services).
20. Commissioner and provider organisation staff should be incentivised to work differently. This will entail whole system redesign into new clinically safe ways of working and service delivery including
- individual clinicians to work as a member of a wider team.
  - maximising NHS funded service facilities by providing planned care over a greater number of hours during the week and at weekends (ie not just nine to five, Monday to Friday).
  - better use of new technology to provide mobile services such as, MRI and lower GI endoscopy.
  - increased flexibility of working through for example:
    - i. Clinical nurse specialists as a “point of contact” constant along the whole care pathway.
    - ii. Ensuring appropriateness of clinician roles. For example surgeons focus on the patient’s operation; postoperative complications are the responsibility of physicians or anaesthetists; follow up appointments are the responsibility of GPs, specialist nurses, or other clinical specialists.

### **Other issues**

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## **Introduction**

This report has been produced by the Planned Care Clinical Pathway Group (PCCPG) which was established by NHS Yorkshire and Humber as part of the “Next Steps Review”. The PCCG has membership from the fourteen Primary Care Trusts, NHS Hospital trusts, and the Yorkshire Ambulance Service. The Group also included representation from social services and the Yorkshire and Humber Public Health Observatory. The PCCG met four times and established a common understanding of the planned care issues and documented examples of good practice in Yorkshire and Humber. In addition some members attended the national “Next Steps” Conferences held in October and November where they heard of how planned care was being modernised in other Regions and abroad.

Public consultation was done as part of two national deliberative events held in York as well as through two focus group sessions for planned care; key themes identified at these events were identified and presented to the PCCG. The Chairs met with Medical Directors, Nursing Directors, senior pharmacists, and dentists from NHS Trusts and the independent contractor services across Yorkshire and the Humber. The PCCG findings and draft recommendations were presented at an NHS Yorkshire and the Humber “Big Tent” event in March. The views expressed at these meetings have all been taken into account by the PCCG.

This draft report is an outline of planned care provision in the Region and highlights where there is room for improvement. This provides the basis of the PCCG’s recommendations on how planned care services should evolve and develop in Yorkshire and the Humber.

## **The Group’s remit:**

To review the current provision of NHS funded Planned Care services for adults in Yorkshire and Humber in the following settings:

- Community service planned visit e.g. by a district nurse
- GP practice planned visit e.g. by a practice nurse
- Specialist consultation in hospital outpatient department
- Diagnostic tests in hospital or other setting
- Planned procedures, mostly in hospital
- Tertiary care in specialist hospitals

## **The aim:**

The Group’s aim is to advise how Planned Care in the Region could contribute further to improving health equitably in individuals and populations. This would be achieved through appropriate access to services that secure early diagnosis of a condition(s) followed by appropriate evidenced-based treatment that minimises any disability and handicap.

## **Background:**

**Geography:** NHS Yorkshire and Humber covers one of the largest areas of the Strategic Health Authorities in England. It has an ethnically diverse population of 5.1 million and has some of the biggest health inequalities in the country. The population is relatively sparsely distributed with an average of 323 people/sq km; this ranged from 30 people/sq km in Ryedale to 3,200 people/sq km in Hull (England 380 people/sq km, London 4,679 people/sq km).

**What the public said:** The public were consulted at the outset of the Review. The views below were distilled from a National Deliberative event held in York (as in each of the other English SHA areas) and the subsequent NHSY&H Focus Group meetings last September for Planned Care. At these the public said that:

- They were very supportive of doctors, nurses and other clinicians working in the NHS.
- Most of them did not have difficulty in getting an appointment with a GP. However there was support for the ability to book appointments in advance rather than just the day before.
- They were interested in having GP services available outside of traditional “office hours” and at weekends.
- They would like a wider range of services to be available in the GP surgery, though most said that they would not move practices specifically for this.
- Services should be centralised when it was necessary to do it.
- They were supportive of having a choice of which service to go to but needed to have more information to inform their decision.
- There should be no variation in standards of treatment given by different services.
- Waiting times need to be improved further.
- They wanted easy access to effective treatments that were locally provided when clinically appropriate, and they should be prompt.
- Clinicians and services should communicate well and there should be continuity of care.
- There were particular problems communicating relevant clinical information about patients between different NHS services, and knowing who was going to do what. Post surgical management was used as an example.
- They felt that the NHS could more to support people to prevent illness.

## **The NHS in Yorkshire and the Humber:**

This section describes in broad terms the provision of NHS funded services in the NHSY&H area.

**General Medical Practice:** The PCCG noted that the pattern in location of GP surgeries reflects the varying sparsity of the population (Figure 1). There are 813 GP practices in Yorkshire and the Humber; this means the average practice list size is around 6,400 people. On average 33% (272) of practices had one or two partners, ranging from 15% in Wakefield to over 60% in Hull and NE Lincolnshire. Conversely 40% (329) of practices had five or more partners ranging from 16% in Barnsley to 73% in Wakefield (Figure 2). In addition GPs were unequally distributed across the Region ranging from less than 50 GPs/100,000 weighted population in Barnsley to over 70 GPs/100,000 weighted population in North Yorkshire and York (Figure 3). The average distance of a person from their GP practice ranged from under 1.5 miles in Bradford to over 2.5 miles in East Riding of Yorkshire, North Lincolnshire, and North Yorkshire and York PCTs. In rural areas significant numbers of people live several miles from their practice with poor access to public transport.

Increasing numbers of General Practitioners are developing clinical areas of special interest; these include sexual health, dermatology, musculo-skeletal problems, and urology. There are variable definitions of what a GP with a special interest is; there are no formal national accreditation processes. Individual PCTs and interested GPs have developed these roles usually with the engagement of consultants in the relevant speciality.

**Access to diagnostics:** Currently GPs have access to a wide range of haematological, biochemical, microbiological, histological, endoscopic and imaging tests. However the rapid expansion in diagnostics available in terms of the types of the investigation, “near patient” sampling and analysis, endoscopy, and imaging have not permeated through to much of general medical practice. There are examples in the Region where new approaches have been developed for general practitioners to use and in some cases provide these diagnostics. These include for example lower GI endoscopy, echocardiography, ultrasonography, BNP analysis, and chest x-ray services for early diagnosis of cancer.

**Pharmacists:** The PCCG recognised the important role that pharmacists have and are developing in NHS care. They have major roles in clinical care, medicines management, patient safety, enhancing compliance, self-care and “Expert Patient” programmes, and general health promotion. Increasingly appropriately trained pharmacists are expanding their clinical roles including the prescribing of drugs and medicines reviews.

Of particular note to the PCCG was the accessibility of community pharmacies. These are one of the most frequently accessed (if not the most) NHS funded

services with the large majority of the public going into one every year. Many people use the pharmacist as the primary source of advice for their symptoms. This may reflect the easy access, the hours of availability of the pharmacist, and in many cases the seven day opening. Increasingly community pharmacies are providing near patient diagnostics.

**Dental services:** Dental services are highly valued by the public but many find difficulty in accessing them. Dentists provide a comprehensive range of dental checks and treatments, as well as health promotion services. General dental practitioners refer significant numbers of people for orthodontic and maxillo-facial surgery. They are in the front line for early diagnosis of oral cancers. They experience the same type of skill mix issues that general medical practitioners do, for example scale and polishing teeth would be cost-effectively done through dental hygienists. Senior dental practitioners felt that it is important that their services and skills should be part of the integrated generalist/specialist local approach to service delivery advocated by other clinicians. They would like to part of the virtual poly-clinic approach to integrated health care.

**Community nursing services:** The PCCG recognised that community nursing services are the NHS bedrock of direct patient care. They look after people in all age groups by visiting them in their homes or seeing them in clinics. Community nursing teams provide increasingly important rapid response teams as well as supporting early discharge and day procedure initiatives.

By broadening and developing their skill base through initiatives like community matrons these services are expanding into proactive, planned management and support to people with long term conditions. There are excellent examples of these in Yorkshire and the Humber that are managing conditions such as chronic heart failure and lung disease. There is increasing evidence of the health benefits that these services are delivering.

**Specialist services:** The PCCG agreed that advances in specialist clinical practice and treatments over the last twenty or more years have been considerable. These developments have been associated with an increasing tendency to sub specialisation in almost all areas of accredited specialist medical practice. This trend is continuing and is reflected in changes to training in medical and surgical specialities. Thus the true hospital general physician, general surgeon, and orthopaedic surgeon are increasingly rare. As the current generation of “traditionally” trained consultants retire they will be replaced by consultants in sub-specialities. This coupled with the European Working Time directive and changes to medical training are and will continue to have significant impacts on the provision of planned care services. There are similar changes happening in nursing and other non-medical clinical staff training.

Members agreed that these advances in clinical care have also witnessed the development of a much more multi-disciplinary approach to treatment; these

involve a wide range of non-medical and non-nursing clinical specialists. Increasingly planned care treatments are being provided through formal and informal clinical networks. Again the best example of this is cancer treatment. Importantly these developments are linked to better outcomes and cost effectiveness.

**Outpatient services:** All Hospital NHS Trusts provide a broad range of outpatient services. These cover many specialist services with a good number supporting people with conditions usually managed in primary care.

Some provide initial assessment prior to referral for diagnostic procedures, with a need for a second attendance to establish the diagnosis and appropriate treatment for the person. Others are for establishing the need for a surgical procedure; this may or may not include a preoperative anaesthetic risk assessment. Subsequently there are many post operative follow up appointments.

In the first three quarters of 2007/2008 there were over a million new referrals to specialist services, 38% of which were non-GP in origin (largely consultant to consultant and general dental services) and there was a "Did Not Attend" rate of over 10%, see Table 1. In the same period there were over 2.3m follow up appointments given with a DNA rate of over 12%. DNA rates for first outpatient appointments 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 2004/5 there was an average of 2.6 follow up appointments to each new referral (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 4). Such variations do not appear to be justified on clinical grounds. There is much evidence that the current outpatient approach in the care pathway could be significantly reduced or provided closer to people's homes.

There are many examples in Yorkshire and the Humber where the numbers of outpatient attendances can be radically reduced, particularly in medical and surgical follow up appointments. This includes the long term management of glaucoma being provided by community based ophthalmology or through appropriately trained and equipped community optometrists.

**Surgery:** Modern surgical and anaesthetic techniques mean that many surgical procedures can be undertaken as a day case. Nevertheless many operations are undertaken on an inpatient basis and there is considerable room for improvement in day surgery rates across NHSYH. 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 Health Care Commission basket of 25 procedures. This variation is brought in focus if we look at 3 high volume procedures in particular (Figure 5) Complex low volume procedures require consideration particularly in high risk patients. A good example of this group is vascular patients undergoing aortic

aneurysm surgery. There is large variation in the number of patients managed by various units in NHSYH, see Table 2. These data five show that Trusts are undertaking some units performing less than one operation a week for this procedure, with five having twice as many emergency procedures than elective ones. Two Trusts undertake four or more procedures per week, the majority of which are elective operations.

## The PCCG's analysis

### The Planned Care Clinical Pathway

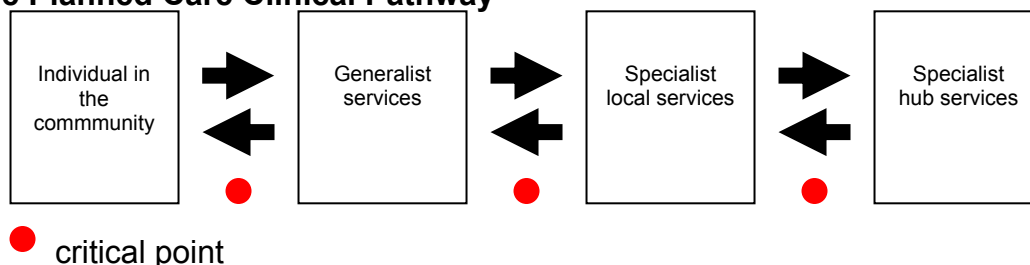
The PCCG considered that the current pattern of NHS funded care with its distinct separation into primary, secondary, and tertiary care was out of kilter with modern practice. This disconnection is reinforced by the separate location of services by, but not exclusively, the rural nature of some parts of Yorkshire and the Humber. This coupled with the very different ways of commissioning and procuring these services, acted as a significant barrier to the availability of integrated health care services along planned care pathways.

The PCCG found strong evidence that a more integrated approach provides better health outcomes and improves cost effectiveness. Members also considered that it will be a key factor in sustaining and building on the major improvements in NHS performance over the last decade. This evidenced is best exemplified in the Yorkshire and Humber by the changes that have happened in cancer care, though there is much still to do to secure earlier diagnosis. There are other examples such as significantly higher rates of day case surgery, and reduced rates outpatient consultations. The PCCG noted the patchiness of the provision of these types of services. Evidence elsewhere in England and abroad indicates that many health care systems are much better integrated and are commissioned as such.

The PCCG agreed at the first meeting that that the terms primary, secondary and tertiary care should not be used as they can create conceptual barriers to service provision. The Group's the preferred terminology being generalist and specialist care. Generalist care is that which can be safely delivered outside a hospital setting; Specialist care requires the infrastructure of a hospital for its safe and effective delivery. Noting this variation the PCCG's view was that general medical practice continues to be central to the provision of local NHS services. The registered list of patients to each practice needs to continue as the fundamental basis for NHS funded care.

The PCCG considered that the diagram below illustrates the current pattern of care pathways with individual providers working in relative isolation of each other. Members recognised that in some areas of specialist practice in hospitals very significant advances in integration have been made, this being best illustrated for cancer treatment.

### The Planned Care Clinical Pathway



The interface between communities and generalist services, and those between generalist and specialist services were considered to be key “critical points” in the care pathway. As such these deserve particular attention. However it was recognised that there were other key “critical points” in the care pathway within individual provider organisations.

The PCCG recognised that services funded by the NHS had improved significantly in recent years, in particular they highlighted:

- Many more specialist clinicians had been employed in the NHS
- An increasing proportion of hospital-based care was delivered by specially trained sub-specialists
- Services were being provided from an increased range of providers to improve access
- Waiting lists had shrunk and waiting times had fallen sharply
- Specialist care one stop shops had improved the efficiency of clinical pathways and benefited the patient experience
- The use of day surgery had safely improved efficiency and access
- Some sub-specialisation in general practice had assisted the development of shared care arrangements for a range of conditions
- Increasing evening and weekend elective clinics had improved the utilisation of facilities and reduced waiting times and bottlenecks

However the PCCG recognised that some of these improvements were not equitably available to local communities either individually or collectively. The evidence for this was:

**Generalist services:**

The Group noted the public’s loyalty to their GP surgery but also recognised the expressed desire for a wider range of services and longer surgery opening hours, including weekends.

The Group discussed the nature of the independent contractor provision and its tendency to be somewhat insular and conservative in nature. During its day-to-day business there can be insufficient integration between independent contractor services. 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 in the 1990s to provide out-of-hours services.

The PCCG considered that the variation in distribution of GPs across the Region illustrated in Figure 3 was difficult to justify as it perpetuates the “Inverse Care Law” with the highest practice lists were found in more deprived areas. Members recognised that the small GP practices can provide a very personal service. However they considered that it is more difficult for small practices to provide (or host) the broader range of local services and the extended opening hours and

weekend availability; these being important service developments that public want. The PCCG noted that 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 – again they considered that this perpetuates the “Inverse Care Law”. In this regard it was noted that Wakefield PCT had the lowest rate of small practices (15%) and the highest proportion of large practices (73%) in the Region. Looking over the next ten years the PCCG thought it unlikely that the Region would still only have 40% of GP practices that had five or more partners.

The PCCG recognised the limited range of professional expertise available at GP surgeries – mostly 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. Examples include specialist nurses (eg for diabetes, heart failure, respiratory conditions), dieticians, psychological therapists, and physiotherapy.

Many of the PCCG considered 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 the management of long term conditions. These clinicians include community matrons, specialist nurses, pharmacists, and physiotherapists. There are examples across Yorkshire and the Humber where this is already happening. In addition Members thought that the opportunities for greater integration with social care at practice level should be explored as well as other agencies such as the voluntary sector.

The PCCG recognised public transport problems of rural areas and the inequalities of access to personal transport in some of the wards. In part this is consequent on “living in the country” but the population is ageing faster in these areas which, with the limited access to transport, could impact on health and social care services. Members recognised the high mileage often covered by these services and the opportunity and financial costs these incur.

**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. The PCCG considered that ready access to a wide range of diagnostics was essential to practice modern clinical care in the community. They recognised the progress was being made in access to diagnostics but thought a great deal more should be done to improve generalist access to a wider range of diagnostics and their timeliness.

The PCCG 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; however currently these are restricted by the limited availability of colonoscopy and flexible sigmoidoscopy.

Members considered that the clinical skills of diagnosticians were being under utilised as many request for tests had insufficient clinical information such as symptoms and differential diagnosis. This can limit the efficiency of the service as the diagnostician are often much better placed to determine the type of investigation which is most appropriate for an individual patient; this could delay diagnosis and treatment.

The PCCG recognised the 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. Therefore a much expanded range of diagnostics could and should be provided more locally and be an integral part of generalist care. This would drive earlier diagnosis and better management of long term conditions.

**Specialist services:**

The PCCG noted the variation in specialist clinical practice evidenced in data covering outpatient services and day case procedures, much of which they felt could not be justified on clinical grounds. Their view was that where necessary there was a need to adapt and change current practice to be in line with best evidence and professional guidelines – this would be the best for the patient as well as making best use of NHS resources.

The PCCG recognised that increasingly services are provided through formal and informal clinical networks that often cross NHS Trust boundaries. Members fully supported this trend and consider that it is set to continue and the pace of change in planned care will escalate. Again this will impact on the provision of services with individual Trusts finding that they will not be providing the complete specialist planned care clinical pathway. Potentially this introduces real opportunities for much better care and enhanced career satisfaction for clinicians and managers. However there are possibilities to introduce clinical risks and concerns for patient safety if there are not robust governance arrangements in place.

**Ambulance Services:**

Changes to healthcare services will impact on transport requirements in terms of both patient and non-patient activity. Patient transport needs must be considered in terms of access by private, public and ambulance transport. Any changes to provision of healthcare services should consider the local public transport services in terms of the hours of their availability and how this may impact on a patient's ability to travel to a treatment centre.

Patients requiring transport should be assessed against the service commissioner's eligibility criteria for patient transport. Those who meet the criteria may be conveyed by a patient transport service, which may be either ambulance based or provided by a private provider.

There are commissioning considerations to be taken into account to support extended hours of service provision and diversity of sites providing the care. Currently, the Patient Transport Service (PTS) is commissioned mainly by the Acute/Foundation Trusts and operates on an advanced booking basis. The hours of operation are 08.00-18.00 for mainstream PTS, although there are some dedicated services which are commissioned separately, some by the PCT's, to provide a service for unscheduled patient transport journeys. The number and capacity of these PCT commissioned services is low and will not meet the increased demand in the community. Therefore if healthcare provision diversifies significantly in terms of location and times of day commissioning of PTS will need a commissioning scoping exercise to determine the service specification.

Ambulance services should also be considered in terms of its role in transport in a wider sense.

- Ambulance services can assist in other aspects of transport such as transporting notes, tests, equipment and staff.
- Diagnostics may involve the need for transport of equipment or even taking the test to the patient. Ambulance services could play a role in for example doing blood tests in a patient's home.
- YAS has the infrastructure to provide a 'hub' for the booking of non-emergency transport. If the patient does not travel via YAS PTS, it is possible for YAS to coordinate transport bookings for patients travelling via taxis or other providers.

## **Conclusions and recommendations**

### **Integration:**

The PCCG considered that there was 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. This situation mirrors the public perception of poor integration/communication between clinicians.

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. The Group feels strongly that 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.

### **Recommendations for improving Clinical integration**

- **Independent contractor services should be contracted to provide access and services that reflects the needs of their populations. It is very likely that this will need greater integration between the relatively small separate services as currently constituted. This should provide the building block for integration with community nursing services and social care.**
- **Increasingly primary care contractor and other community based services should be commissioned using appropriate clinical and consumer outcomes as key elements. Together with the commissioning of social care, this should help reduce the significant variation in patient and carer outcomes and experience.**
- **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 entail the transfer of specialist sessions out of the hospital setting. The aim being to provide a “virtual polyclinic” service.**
- **Clinical care pathways should be designed to achieve the quickest way to get a diagnosis and to commence treatment. Central to this will be generalist and specialist clinicians having significantly greater access to diagnostic services. This should be underpinned by robust referral mechanisms that ensure the clinical skills of the diagnosticians are fully utilised; it will also demand adequate opportunity good clinical discussions between referrers and diagnosticians.**

- **The team approach to clinical care should be enhanced in the community to free up GP time to enable full use of their unique skills and enable appropriate accredited sub-specialisation. This will entail more skill mixing to manage much of the first contact and long term conditions work.**
- **Communication through the critical points of the care pathway should be timely and robust; this means communication in both directions of the pathway.**
- **Generalist referrals to specialist services should be standardised to ensure that all essential information is provided with each referral. Similarly there should be standardisation of referrals from specialists to generalist services.**
- **The above recommendations have significant implications for workforce development. Relevant training and educational organisations should be informed and involved as soon as possible.**

#### **Outpatients:**

The PCCG agreed that a considerable number of current outpatient referrals from generalists could be avoided if they had better direct access to a wider range of diagnostics and therapy services. Similarly the Group's view is that there are far too many clinic follow up appointments by specialist services. The numbers across NHSY&H shown in Table 1 illustrate the enormous scale of outpatient activity underway. Evidence and practice indicates that new referrals to hospital outpatient services could be reduced by at least 25%; this could rise to 50% or more with locally based integrated clinical services. Further support of the potential to reduce significantly the use of hospital based out-patient services is evidenced by the three-fold variation in the ratio of follow up to new appointments between Trusts, see Figure 4. The Group considered that in part this reflects custom and practice as well as a lack of confidence in generalist skills. The Group felt that this was not helped by the poor communication described above. However it recognised that there were many successful examples of follow up undertaken by generalists in cancer care, anti-coagulation treatment, DMARDs (Drugs Modifying Anti-rheumatic Drugs), etc. It should be possible to reduce hospital based follow-up outpatient activity by around 70%.

#### **Polyclinics:**

The PCCG agreed that there was 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. Members did not support 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. Therefore the PCCG advocated the development of “virtual” polyclinics with generalists and specialist working common sessions alongside in a number of existing local facilities covering a defined population.

#### **Recommendation on the management of the Estate**

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

#### **Opportunity cost:**

The PCCG recognised 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 the Members believed that if this was managed appropriately by minimising the number of locations involved then 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. The PCCG viewed these as an excellent basis to build on and expand in scope and location, but they should be further enhanced with consultant sessions. The benefits of such a switch of planned care service delivery include a much wider range of services being locally available to patients, as well as providing a focus for governance of local health care.

#### **Recommendations on improving Local access to services**

- **Many more specialist consultations as well as diagnostic and treatment services should be provided closer to people’s homes. These should be provided in dedicated settings that meet all appropriate building and other standards. In addition to patient convenience this supports closer generalist and specialist clinician integration..**
- **Many people would like more care to be provided at home. Technological developments in treatments and health monitoring means that the current range of home treatments and “Telecare” should be expanded and be more widely available. Implementation of such technology needs to be regulated robustly.**

### **Day case and short stay surgery:**

The PCCG noted the national variation in day case rates as demonstrated by the Better Care Better Value Indicators and the reports produced by the SHA data collection for performance across Trusts taking part in the local day surgery development programme. This programme has used the regular reporting of performance for the Audit Commission basket of procedures and a support function to improve day surgery performance across several Trusts (Figure 6). The combination of publishing benchmarking material and support through local Clinical Champions has improved day surgery rates across the Trusts involved. This work could be expanded across NHSYH to involve all health economies to improve day surgery rates. This combination of reporting and publication of performance along with a support programme could be used to support improvement in other areas.

The group also considered the large variation in lengths of stay for procedures shown in publications by CHKS and Dr Foster. Many procedures may well now be performed in various settings from hospital Trusts, Independent Sector Treatment Centres and in community settings. The use of these various providers can influence a local Trusts ability to achieve high day surgery rates and so health economies should report on their day surgery rates across all these facilities.

People requiring a “high volume” procedure should be offered day case or outpatient care as routine when it is clinically appropriate. These services should ideally be provided in dedicated elective centres with reasonable access to local communities. Decisions about provision of these services will need to consider the distribution of the population, especially in rural areas. This should not interfere with the individual’s opportunity to choose where they are treated. All facilities used should meet the required standards for the safe provision of the services planned.

The view of the PCCG was that the day case rate for each health economy should match the international best performer and all health economies should have plans to achieve the day and short stay surgery- targets contained in the British Association of Day Surgery Directory of Procedures over the next 5–10 years.

This discussion has concentrated on day case surgery and surgical lengths of stay. However the same principles apply to diagnostics and elective medical care, hence the use of the word procedure rather than surgery in the recommendations.

#### **Recommendations on the delivery of High volume procedures**

- **People requiring a “high volume” procedure (medical, surgical or diagnostic) should be offered day case services as routine when it is clinically appropriate. These should be provided in dedicated**

**settings that meet all appropriate building and other standards. Bearing in mind the geography and 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.**

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

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 SHA 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

Importantly the PCCG's view is that it will not be possible to maintain services for the latter group in every general hospital across the SHA. The provision of Intensive Care facilities (Level 3) is a key part of this issue. There are clear guidelines about the Consultant and Nursing Staffing of Intensive Care Units. These facilities also require support from a multidisciplinary team including bacteriology, cardiology, renal medicine, surgical specialties, diagnostics and strong links with physiotherapy and pharmacy are also important. Intensive Care requires the maintenance of skills by all those involved and requires reasonable patient numbers so it will not be possible to provide a Level 3 service in every general hospital across the SHA. However it is important that services are configured with consideration to the geography of the SHA and hospitals without Level 3 care will require Level 2 facilities that are equipped for the stabilisation and management of patients who need Level 3 care prior to transfer. Agreement is required across the SHA about the future provision and configuration

#### **Recommendations for the provision of low volume or more complex surgical care**

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

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

Whilst there has been a systematic reorganising of surgical services for cancer care, many other services remain fragmented. Furthermore, changes in training models and future clinical roles necessitate a new approach to the organisation of some specialist services.

The Vascular Society report that outcomes are linked to numbers of elective patients managed within a unit. They suggest that patient numbers to support a single clinical team of at least 6 Vascular Surgeons (and the associated services e.g. radiology) is required with the single clinical team working across organisational boundaries. This requires consideration across NHSYH based on patient numbers and the geography of the region. In urology, elective work is dividing between office-based practice and major surgery and the future provision of local emergency requires consideration. Again a reasonable population base will enable all of these needs to be managed coherently within the context of a unified team with clear accountability to a single organisation but working for a wider community.

Although less urgent, changes in the roles and training of upper GI surgeons suggest that further work is required to ensure the future sustainability of this specialty. Interventional radiology is of increasing importance (RCR) in diagnosing, staging and treating a wide range of conditions. However, access to these skills is highly variable.

We believe that these services can be classified into 4 broad areas with differing needs for their future development.

1. There are some services where explicit standards exist but have not been systematically implemented and which would lead to a degree of service reconfiguration to improve the quality of care. The especially include Level III Critical Care and Vascular Surgery.
2. There are other services where the skills required are scarce and where their role is growing and that these ought to be considered for organisation and delivery on a wider basis than existing Trusts. Such services would include interventional radiology and resonate with aspects of stroke care and emergency medicine covered by the Acute Care PG.
3. There are also hospital specialties whose training programme and output have changed dramatically such that the future organisation of these services should be planned on a larger population basis of the order of 1 million or more. This includes arrangements for the delivery of urgent care.

The typical specialties in this category are urological surgery and upper GI surgery.

4. The knock-on effect of such changes is that these services should be organised on a network basis by a unified team providing a comprehensive service covering an agreed population, almost always larger than that of a single Trust. However, the governance arrangements must be all the tighter and should be invested in a single host organisation. The effect of this would be to separate clinical governance responsibility from the ownership of the estate in which the service is delivered, in line with many recent hospital development schemes.

### **Recommendation**

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

### **Information Technology:**

The Group has serious 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.

In addition to the ready availability of relevant clinical information for the treating clinician the Group 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 able to see their test results on line.
- Patients able to track 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 appoints on generalist clinics for stitch removal or other similar reasons.
- Supporting self-care.

### **Recommendation on improving Information systems**

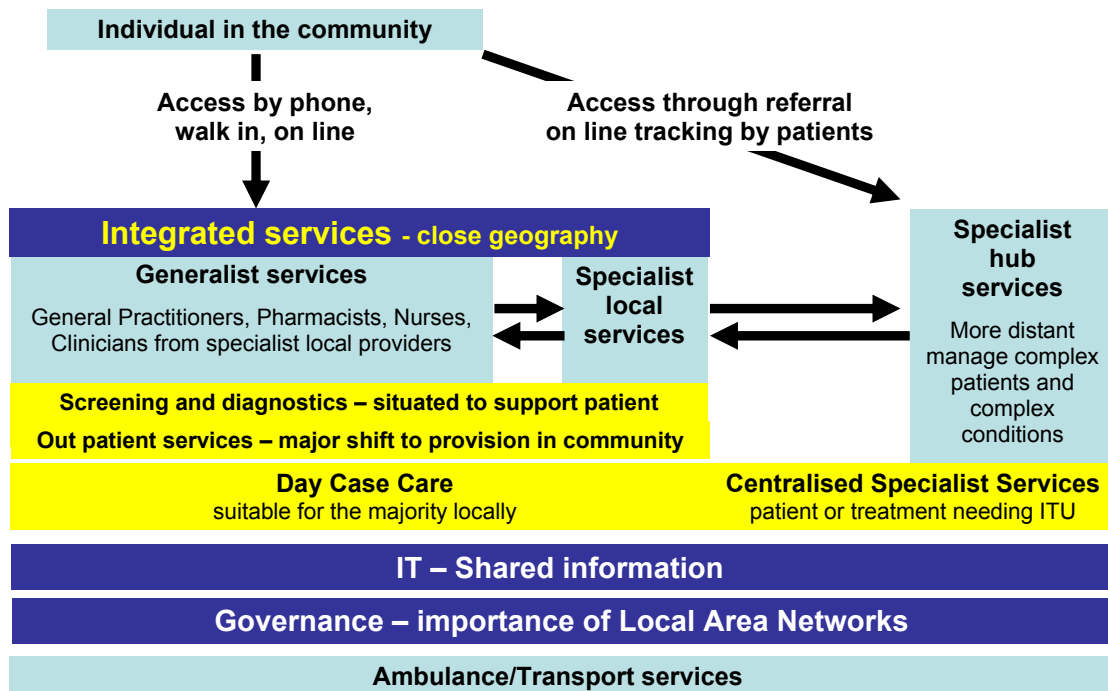
- **Integration of safe clinical services will not happen without robust IT systems. Clinical IT systems must be integrated, and fully utilised by clinicians. This integration should:**

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

## The new Planned Care Pathway

The Group developed a revised illustration of a modernised Planned Care Pathway and this is illustrated below. The diagram summarises conclusions drawn from the Group's meetings detailed above. It stresses the importance of integration across the care pathway, robust governance and the centrality of fit-for-purpose IT systems to delivery.

### Planned Care - Key Elements



## **The role of commissioning**

The Group believed that planned care should be commissioned in a way so as to enhance its acceptability, quality, integration, availability, efficiency and timeliness. Thereby it will make a significant contribution to improving health and reducing the health inequalities in the region. The Group considered that this will need a different approach by NHS commissioners. Specifically it will need to pay significant attention to each of the three critical points to the care pathway, including ways to ensure rapid discharge from hospital.

The Group's view was that the planning of planned care should be grounded in the differing needs of local communities informed through the DPH Annual Report. The advent of Practice Based Commissioning consortia (PBC) gives a significant opportunity to make this approach a reality. Therefore the Group considered that a basic unit of PCT planned care strategies should be community populations of 50,000 – 100,000. Furthermore these populations should be coterminous with local authority ward boundaries. This approach should provide a population sufficiently large enough to give meaningful numbers of people needing planned care to design an optimum range of community orientated services, but be small enough to be sensitive to local health and social care needs. Such commissioning strategies would be supportive of the formal Joint Strategic Needs Assessments that are now required.

**An example - early detection and treatment of cancer:** The Group considered that much progress had been made in the redesign of cancer services. Whilst recognising there is still more work to be done, the Group 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.

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

Of the 300 patients with a cancer diagnosis, about 200 will receive surgery aimed at cure, 120 will receive radiotherapy (of which about one third will be curative or adjuvant curative), 100 will receive chemotherapy and 25 will receive hormone therapy.

At least half of the surgery can safely be delivered in local general hospitals (e.g. breast excision without reconstruction, most colorectal surgery, non-radical bladder treatment and some renal surgery, early uterine cancer). The remainder will be carried out by specialist cancer teams working in designated centres. Although currently centralised, radiotherapy will increasingly be delivered in satellite units linked to a main centre. Most chemotherapy should normally be

administered in local hospitals or even closer to home. Follow up arrangements after treatment will be managed through shared care arrangements between the treating hospital, local specialists (where not the treating team) and generalist staff.

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.

### **Recommendations for the Commissioning of integrated Planned Care**

- **It will be important that commissioning strategies, service specification, and contract monitoring enable the Planned Care Groups recommendations to be implemented over time. This includes ensuring robust governance are in place with every provider of care for NHS funded patients.**
  
- **As new models of care are designed there is a real possibility that national tariff (PbR) will be a significant barrier to change. Therefore PbR must change to reflect new ways of working. 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 specialist services).**
  
- **Commissioner and provider organisation staff should be incentivised to work differently. This will entail whole system redesign into new clinically safe ways of working and service delivery including**
  - **individual clinicians to work as a member of a wider team.**
  - **maximising NHS funded service facilities by providing planned care over a greater number of hours during the week and at weekends (ie not just nine to five, Monday to Friday).**
  - **better use of new technology to provide mobile services such as, MRI and lower GI endoscopy.**
  - **increased flexibility of working through for example:**
    - iii. **Clinical nurse specialists as a “point of contact” constant along the whole care pathway.**
    - iv. **Ensuring appropriateness of clinician roles. For example surgeons focus on the patient’s operation; postoperative complications are the responsibility of physicians or anaesthetists; follow up appointments are the**

**responsibility of GPs, specialist nurses, or other clinical specialists.**

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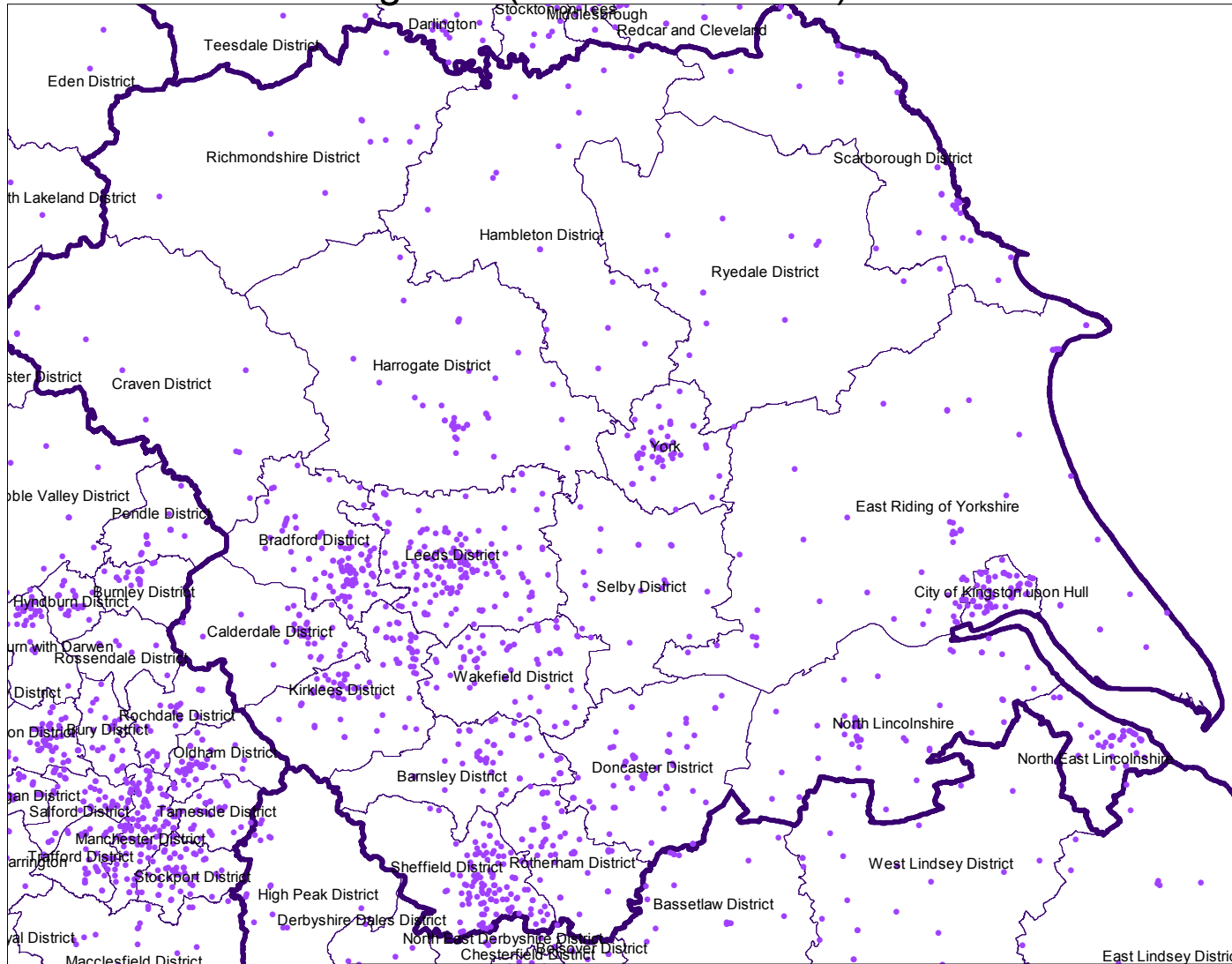
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Figure 1:

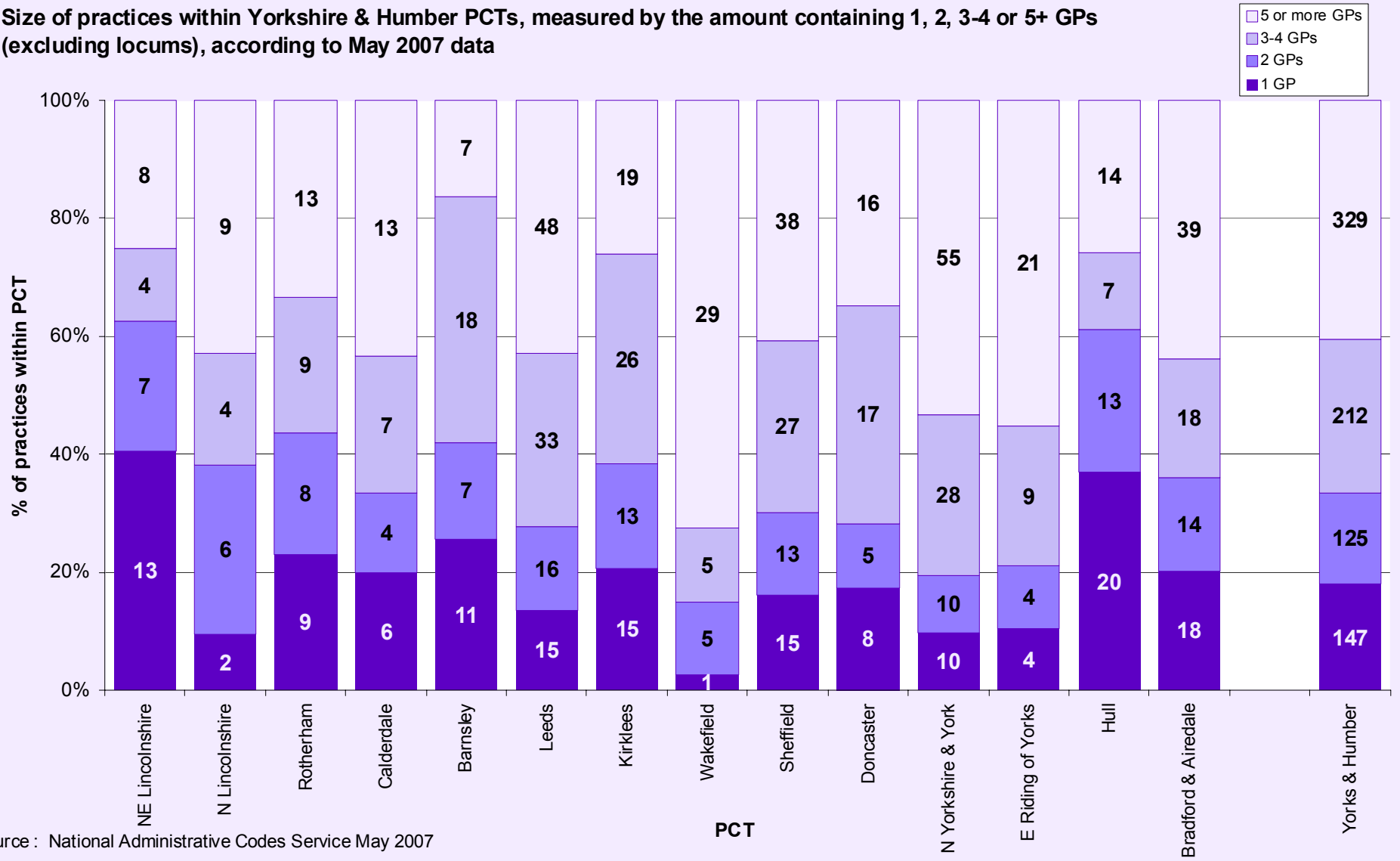
# Location of GP surgeries (main and branch) in Yorkshire and Humber



Source : ONS Neighbourhood Statistics 2006  
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**Figure 2**

**Size of practices within Yorkshire & Humber PCTs, measured by the amount containing 1, 2, 3-4 or 5+ GPs (excluding locums), according to May 2007 data**

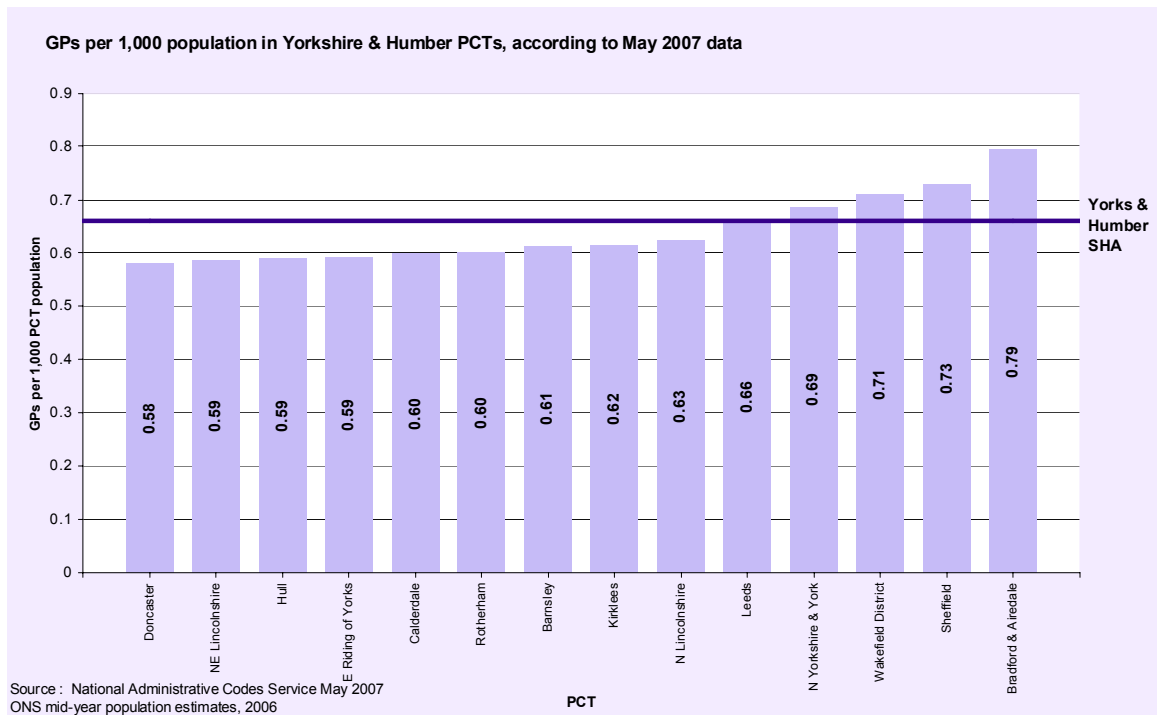


Source : National Administrative Codes Service May 2007

**Figure 3**

GP provision by PCT

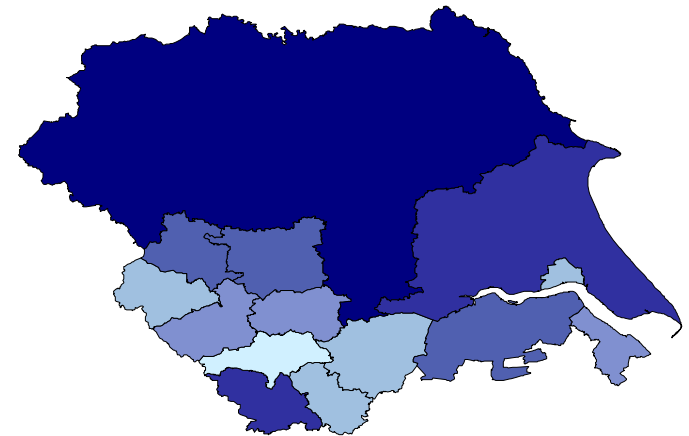
unweighted



weighted

GPs per 100,000 Weighted Population

- 70 to 75 (1)
- 65 to 70 (2)
- 60 to 65 (3)
- 55 to 60 (3)
- 50 to 55 (4)
- 45 to 50 (1)

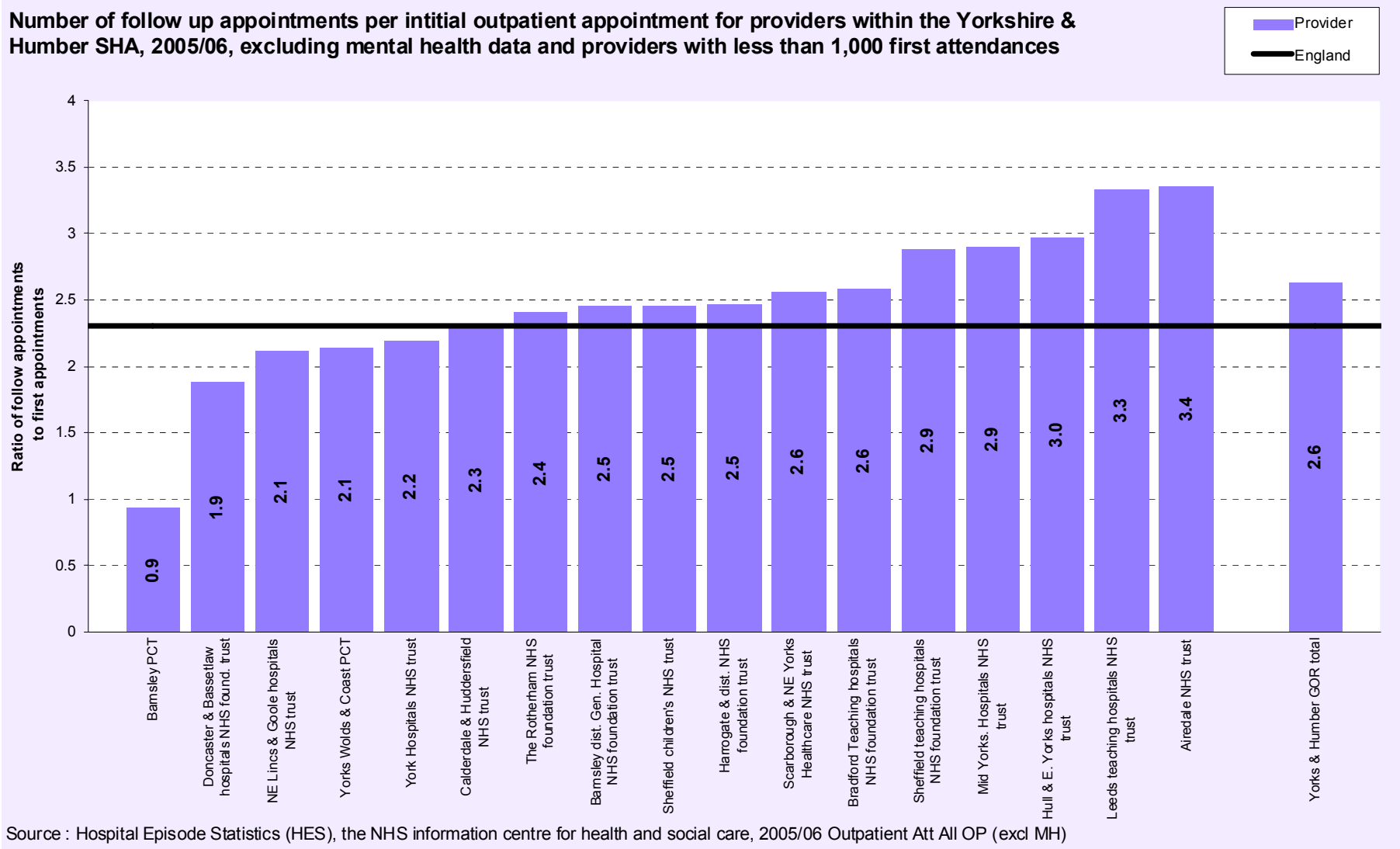


**Table 1 : Yorkshire and Humber Out-Patient Attendances and DNAs April – December 2007**

<b>GP written referrals</b>	<b>Other referrals</b>	<b>First attendances</b>	<b>DNA</b>	<b>Subsequent attendances</b>	<b>DNA</b>
689,497	423,261 (38%)	967,548	102,523 (10.6%)	2,370,642	296,852 (12.5%)

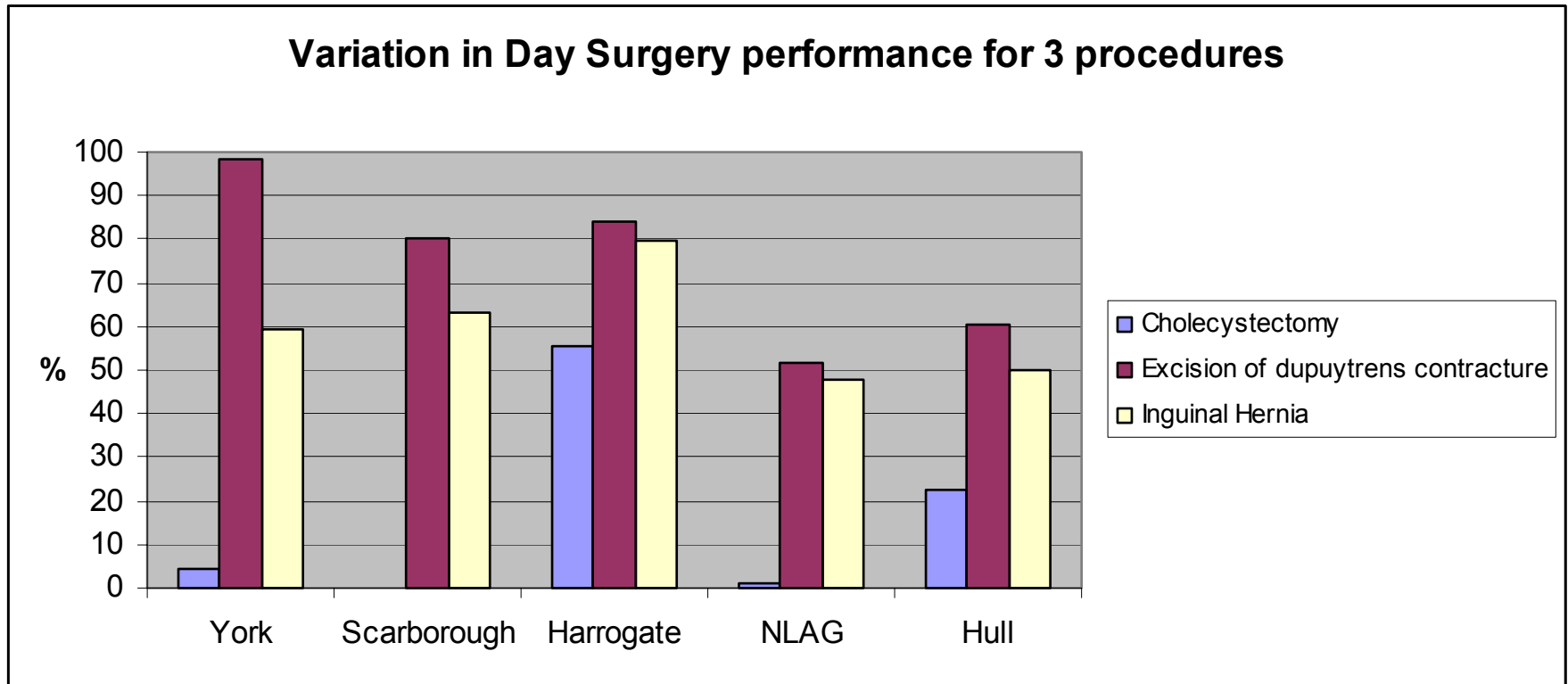
**Figure 4**

**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 5



**Table 2: Numbers of emergency and elective aortic aneurysm patient operations 2006/7**

Hospital	Admission Type			Ratio Emergency to Elective
	Elective	Emergency	Other	
Bradford Teaching Hospitals NHS FT	40	28	*	0.7
York Hospitals NHSFT	43	37	*	0.9
Scarborough and NE Yorkshire Health NHS Trust	12	23	*	1.9
Harrogate and District NHS FT	9	12	*	1.3
Airedale NHS Trust	7	20		2.9
Barnsley Hospital NHS FT		8		
The Rotherham NHS FT	*	17	*	
Sheffield Teaching Hospitals NHS FT	116	98	15	0.8
Northern Lincolnshire and Goole Hospitals NHS FT	18	46	*	2.6
Doncaster and Bassetlaw Hospitals NHS FT	40	55	9	1.4
Leeds Teaching Hospitals NHS FT	113	84	12	0.7
Hull and East Yorkshire Hospitals NHS Trust	70	41	13	0.6
Calderdale and Huddersfield NHS FT	16	49	*	3.1
Mid Yorkshire Hospitals NHS Trust	24	50	*	2.1
<b>TOTAL</b>	<b>508</b>			<b>1.1</b>

## Planned Care - Key Elements

