

Change for the Better

Report from the

Stakeholder Event

11th December 2006

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1. Introduction

1.1 The need for change

National policies and initiatives are driving changes to how health care is provided, with an increasing emphasis on providing care closer to people's homes. At the same time, new techniques in medicine and surgery are making it possible to provide more care at home or in local health centres. There are also pressures on health services, as there is a national shortage of some health professionals. In addition, how health services are funded is changing, and there are also local financial pressures.

1.2 Change for the Better

In November 2006, North West London Hospitals NHS Trust and Brent and Harrow Primary Care Trusts launched a discussion programme called ***Change for the Better***, to seek the views of local people about how local health services should be delivered in the future.

1.3 Stakeholder event

As part of the discussion programme, on 11th December the three organisations hosted a Stakeholder Event, to bring together a wide range of stakeholders from the health service, its public sector partners and the voluntary and community sector to:

- Develop a shared understanding of how services are currently provided and the need for change
- Provide feedback on the key messages that have been emerging from discussions with local people
- Discuss the principles that should underpin any service developments
- Start to develop a shared view of how services might change as a result

Participants were invited to identify any particular areas they were interested in talking about in advance of the day. As a result, the four most commonly identified areas, on which the day focused were:

- Urgent care
- Long term conditions
- Planned treatments and operations
- Rehabilitation and intermediate care

The event was attended by over 90 stakeholders.

1.4 This report

This report summarises discussions held on the day. It covers the 'temperature check' (see below) and for each of the service areas there is a summary of the current arrangements for services and some of the challenges associated with this, proposals for how these services might be developed in the future, and some of the issues associated with implementing these proposals.

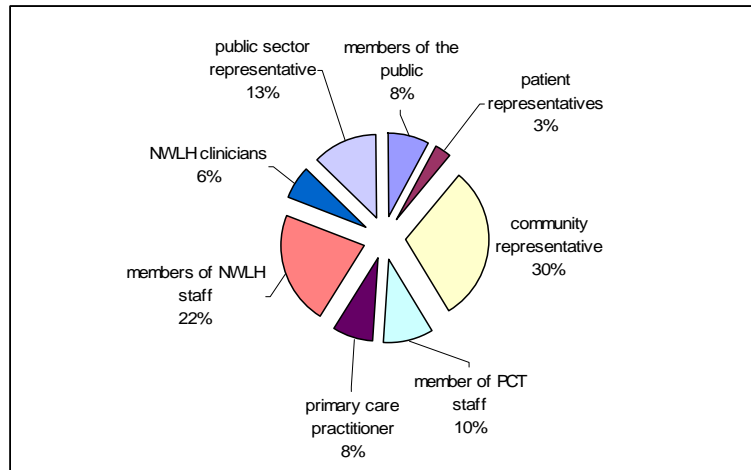
Each section also includes a brief analysis by the external observer (Julie Fenner). The analysis by the external observer is not an agreed action or approach. It is designed to stimulate discussion about the future shape of services.

2. The 'temperature check'

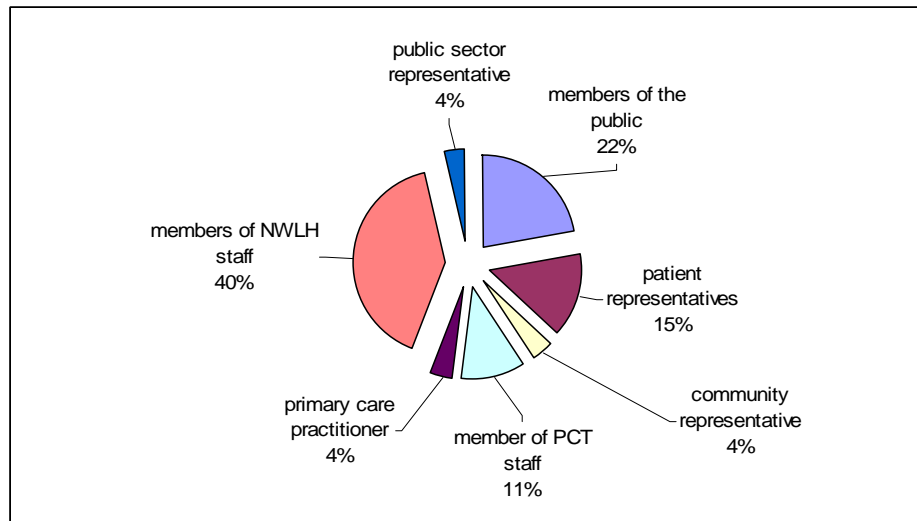
In making decisions about how health services are provided in the future, different ways of providing one element of health care will have implications for other aspects of care. For example, if we are to provide rapid access to a GP, it may not always be possible for the person to be seen by their own GP. We wanted to understand from the perspective of participants at the event what they felt was most important about how we provide health services in the future.

At the start and at the end of the day we therefore asked participants to complete a 'temperature check', that presented seven pairs of statements, and for each pair of statements asked participants to select the statement that reflected what is most important to them about how health services are provided in the future.

63 participants completed the temperature sheet in the morning, of which



27 participants completed the temperature sheet at the end of the event, of which:



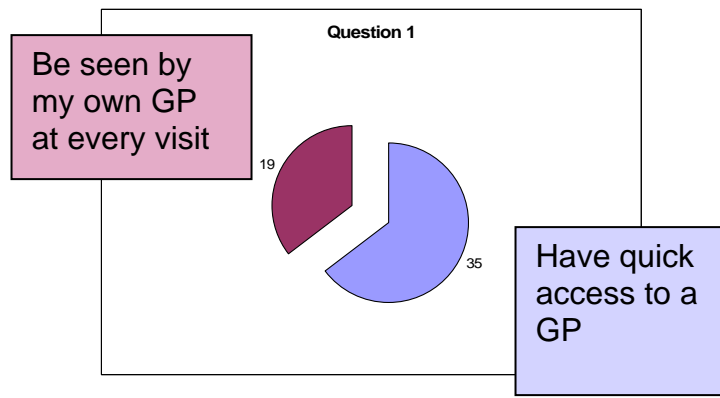
It is worth noting that:

- Approximately double the number of people filled out the temperature checks in the morning compared to the afternoon.
- In the morning, approximately 40% of those completing the temperature check identified themselves as either a member of the public, patient representative or community representative. In the afternoon, those identifying themselves within these categories was approximately 44%.

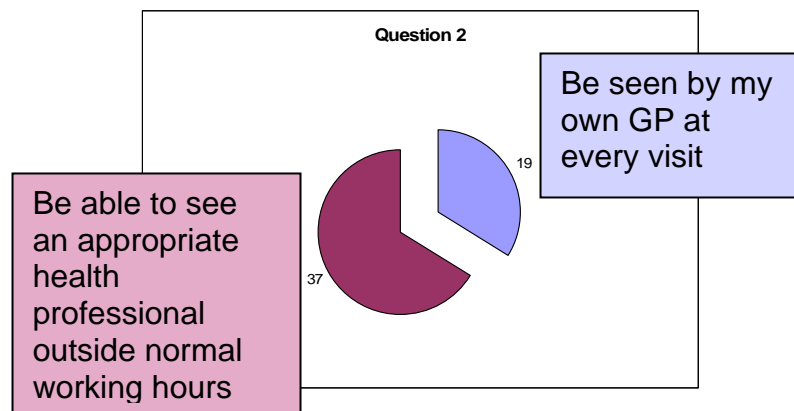
- Many of those who identified themselves either as a clinician or a member of NHS staff, also identified themselves as patients of local health services.

A brief analysis of the findings is outlined overleaf. The pie charts reflect the completed temperature checks in the morning, and are followed by a brief commentary / explanation.

When I have a health concern that is not urgent, I would prefer to...

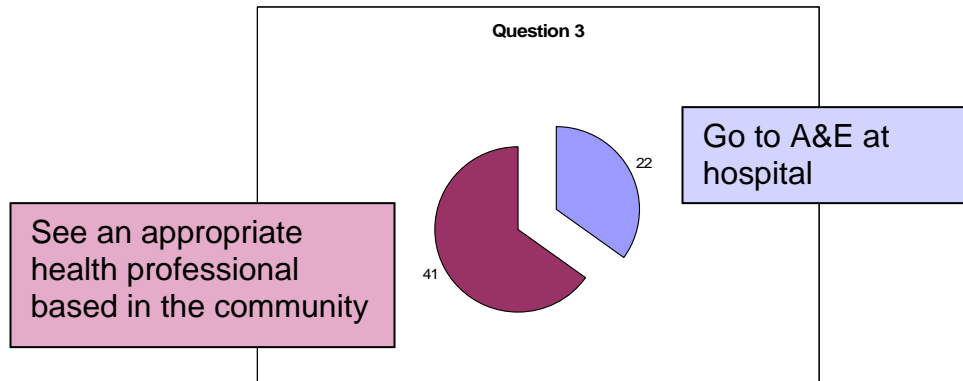


In the morning, approximately 65% of people preferred quick access to a GP to being seen by their own GP at every visit. In the afternoon this percentage had risen slightly to 68%.

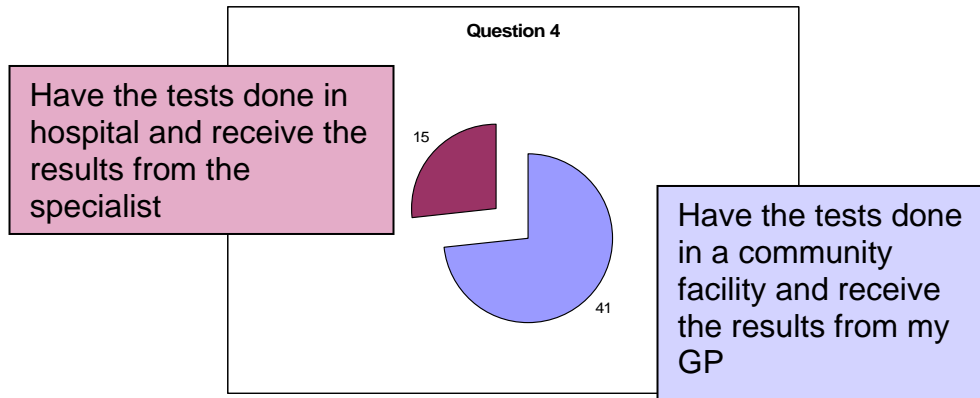


In the morning, approximately 66% of people preferred to be able to see an appropriate health professional outside normal working hours. In the afternoon this percentage had risen to 80%.

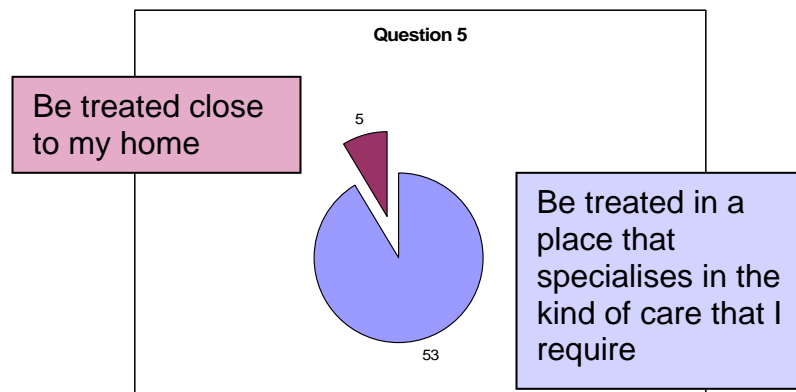
When I have a health concern and feel it is urgent for me to be seen, I would prefer to...

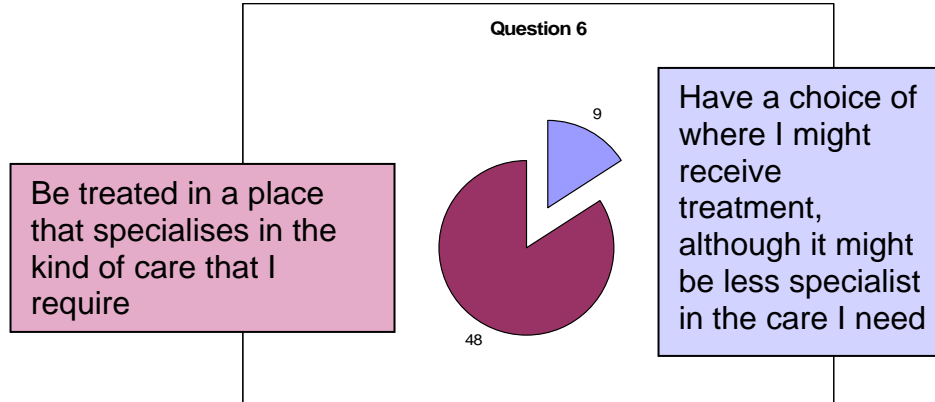


When I need to have diagnostic tests done, I would prefer to...

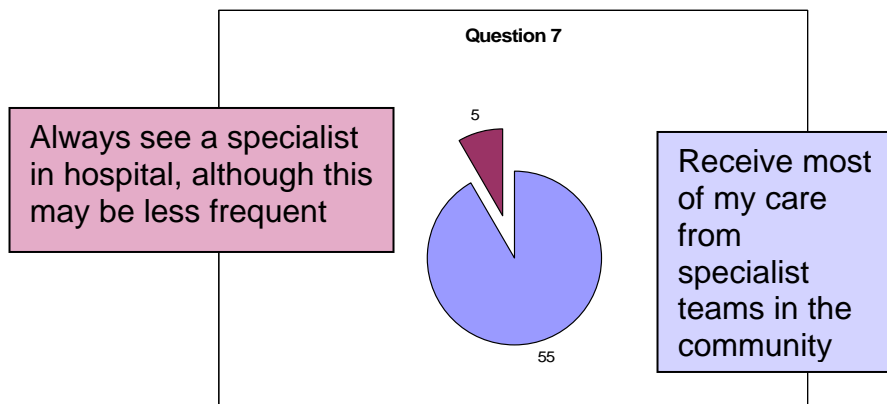


When I need specialist treatment (e.g. for a head injury) I would prefer to...





It is clear from the responses in both the morning and the afternoon that the significant majority of respondents would prefer to be treated in a place that specialises in the kind of care that they require, rather than have a choice of where they receive treatment.



It is clear from the responses in both the morning and the afternoon that the significant majority of respondents would prefer to receive most of their care from specialist teams in the community to prevent them going in to hospital, rather than always see a specialist in hospital.

3. Urgent care

3.1 The current arrangements

NHS Direct, NHS On-line and the London Ambulance Service were all felt to be providing a good service for people needing urgent care. Although it was noted that people value face-to-face contact, that NHS Direct and NHS On-line cannot provide.

Current challenges for urgent care services are:

- Difficulty in accessing primary care (GP services) in a timely fashion means that people often treat A&E as the default alternative.
- Many people locally are not registered with a GP meaning that they use A&E as their gateway into health care.
- There are no arrangements or unclear arrangements for how to access primary care or other services out-of-hours, again leading people to treating A&E as the default alternative.
- There is a lack of information and people are unaware of which service they can or should most appropriately access for minor ailments or injuries, and therefore use A&E.
- People are not aware of the competences of community based health professionals, such as GPs and nurses, and are therefore not confident that they can see these health professionals for appropriate treatment. In particular, people are not confident in the competence of non-medics to deal with their health issue.
- Lack of information and awareness about which services to most appropriately access is particularly significant amongst people who do not speak English as a first language.
- Insufficient community-based health care support to maintain their health for people with long term conditions, means that people sometimes experience acute exacerbations and call an ambulance and visit A&E, when this could have been prevented.

Due to these challenges, people needing unplanned care commonly use urgent care (A&E) services.

3.2 Developing urgent care services for the future

It was felt that the following principles should underpin the development of urgent / unplanned care services in the future:

- People with long term conditions and their carers should be supported to maintain their own health, so that they need to access urgent care less.
- Services for people needing urgent care should be available on a 24 hour a day, seven day a week basis. (This may mean that people with the same health issue might access a different service according to when their health need arises).
- Unplanned care should consist of a network of services, including an urgent treatment centre (UTC), and community pharmacies.
- It should be clear to people where and how to access the service that they need.
- Information about when and how to access the appropriate care should give people confidence that services provided outside hospital have the necessary skills and expertise to provide them with the care that they need.
- Access to the appropriate service should be straightforward and rapid.
- Whatever access route is used, the service that is accessed should act as a one-stop-shop and people should be triaged on to the service most appropriate for them.
- Whatever access route is used, people should have access to the appropriate expertise and an appropriate specialist as needed.
- Services should be developed for the long-term, not in such a way that they will need to change again in the near future.

A further question that was raised during the discussions was whether and how choice should be provided for people needing urgent care, as it is currently available for those needing planned care.

3.3 Implications of implementing this model of care

The following implications of implementing this model of care were identified:

Making changes to existing services

- If more unplanned care is to be provided through community-based services, community-based health professionals will need the appropriate training and development to support this.
- The NHS needs to ensure that junior members of staff have the opportunity to receive the appropriate training.
- The NHS needs to understand when and where the peaks of activity will be under the new model, and then match the workforce appropriately.
- The capacity needs to be in place before the public is re-directed to access unplanned care differently.

Communicating with the community

- The NHS needs to communicate effectively with the community about how and where to access the most appropriate care to meet their needs.

3.4 External observer's comments

As noted above, due to the problems in accessing appropriate community-based health services, people needing unplanned care commonly use urgent care (A&E) services. This represents neither the best care for the patient, as there is often some distance to travel, nor the most cost-effective way for health services to meet unplanned care needs, as A&E is an expensive way to provide care for people who do not need the specialist expertise associated with A&E.

Because usage of A&E is often associated with poor access to appropriate community-based health services, reducing the use of A&E for unplanned care that might more appropriately be treated in a community setting can only be achieved if community-based services are able and have the capacity to provide effective, appropriate unplanned care.

This implies that:

- Urgent care needs to be considered in the context of 'unplanned care' as a whole.
- 'Unplanned care' should cover medical, social and nursing care that patients feel cannot wait for an appointment.
- Services probably need to move away from the notion of 'out of hours' and 'in hours' towards an integrated 24/7 service which meets the needs of the local population.
- The framework should also consider services in terms of what care is available when – i.e. during the daytime; out-of-hours; in hospital; and, out of hospital.
- All of this implies a need for greater integration and collaborative working between health and social care agencies.

It is likely that such changes would need to be supported by:

- Increased capacity within community services;
- Increased joint working between organisations;
- Education and promotion campaign to the public;
- Training and development for a range of healthcare staff.

The changes would also need to link closely to any changes to services provided to people with long term conditions.

Representatives from the London Ambulance Service attended the day and were keen to explore how the service might work more effectively with local health services. Examples from other parts of the country include enabling ambulance technicians to provide more treatment on-site rather than having a default service in which patients are transported to hospital for treatment, and having a system whereby some patients (for example, previously identified patients with long term conditions) are triaged into services other than A&E.

4. Long term conditions

Long term conditions include conditions such as diabetes, coronary heart disease (CHD), chronic obstructive pulmonary disease (COPD), arthritis, dementia / neurological conditions, and clinical obesity. It should be noted that a separate stream of work is currently in progress to review mental health services.

There is an increasing population with long-term conditions, both due to an aging population and an increasing incidence of long term conditions in younger people.

4.1 Current arrangements

There was a recognition that the existing model for how services are provided for people with long term conditions needs to evolve. Some of the current challenges are:

- The healthcare system is currently focused on dealing with crises as they arise, rather than prevention, early detection and on-going management of long-term conditions.
- Appointments that could be carried out in primary care or by an existing specialist based in the community are generally held in acute settings, and many patients see a consultant for appointments when they could see another health professional.
- Patients are often not aware of what services are available, and therefore use acute services more frequently than necessary.
- The competence of community-based practitioners has not been well communicated to patients, who therefore perceive that only hospital-based practitioners have the necessary expertise, and therefore prefer to receive their care through acute services.

- Arrangements for co-ordinating a patient's care are patchy and vary between different localities in Brent and Harrow, and there is a perception that people receive care based on a 'post code lottery'.
- Information flows within and between organisations are poor.
- Paediatric services for children with long term conditions are good, but the transition between children's and adult services is difficult.

4.2 Developing services for people with long term conditions in the future

The future model of care should be based on the following principles:

- There should be a strong focus on prevention and the broader determinants of health (for example, through public health initiatives).
- Services should be designed to provide early diagnosis of long-term conditions.
- People with long term conditions should be supported to manage their own health, for example through an expanded expert patient programme. This should include a dedicated strategy and structure to train and support carers.
- Recognising issues of health inequality, and that some populations experience a higher incidence of certain conditions, services should be targeted where there are the greatest needs.
- Patients should be provided with information about services available that gives them confidence in the service they are receiving – particularly for services provided in community settings.
- Written and face-to-face communications should avoid the use of jargon and terminology that patients and carers are not familiar with.

- Care should focus on maintaining people's health and avoiding hospital admissions.
- People with long term conditions should be able to self-refer to appropriate care on a 24 hour a day 7 day a week basis. (This implies that not all care will be in an acute setting).
- GP practices should have specialist professionals / teams attached to work with people with long term conditions. This could include holding specialist / disease specific clinics in community settings.
- All services need to be provided in a way that is patient-centred and able to respond to gender-specific and cultural needs.
- Services for people with long term conditions that are provided in the community need to be underpinned by robust clinical governance arrangements and care protocols, and should include evaluation and monitoring.
- Care should be seamless, with community and secondary care services working in a more integrated way. This is particularly important when patients are discharged from hospital following an acute episode.
- Services should be designed in a way that is able to respond to future changes in demographics – e.g. increasing older population with greater incidence of long term conditions.

4.3 Implications of implementing this model of care

Resourcing

- If more people are to be supported by services in the community, these need to be properly resourced before people are moved from acute-based care.
- A network of individuals, teams and services working with an individual will need robust administrative as well as financial resources.

- The NHS needs to review what the cost of re-designing the model of care to provide more services in the community will be.
- Resources should follow the patient.

Ways of working

- This model implies greater integration between primary, secondary and social care.
- If more practitioners from different agencies are to be involved in the identification and management of people with long term conditions, then there need to be clear patient pathways for these people to be referred in to.
- Multi-agency and increased multi-disciplinary working will require the systems to support information and record sharing, including IT, protocols and staff training.
- Health professionals based in the community will need training and development to support the new ways of working.
- Patients can be enabled to better manage their own conditions with support from the voluntary and community sector, expert patient programme and peer support.

Working with patients and carers

- The NHS needs to explain what services are being provided in the community and how these replace hospital-based services.
- The NHS needs to work with patients and carers to increase understanding of the skills and competencies of community-based health professionals, in order to give people confidence in these services.
- Patients and carers will need support and information to enable them to access the different services appropriately.
- The voluntary sector can provide an enormous role in supporting patient education and self management. This needs to be harnessed and underpinned by appropriate clinical governance / quality assurance.

4.4 External observer's comments

Discussions identified that some populations have a higher incidence of certain long term conditions than others. Public health data on long-term conditions will therefore be key to understanding local needs and planning services accordingly. It will be important to know where the 'clusters' are for long term conditions in order to target services / awareness raising effectively.

It was felt that services should enable early detection of long-term conditions. Some examples of how this might be achieved are:

- Extending the role of some groups already working with high risk groups, for example Meals on Wheels, lunch clubs and other voluntary agencies. At the event, representatives from the voluntary and community sector were keen to understand how they might work with NHS locally. However, it is likely that this would need to be resourced.
- Providing more widespread community based screening, targeted at high-risk groups (e.g. pharmacy based diabetes screening – 'high-street' setting in places such as supermarket pharmacies, that provide a suitable environment for protocols to be developed).
- Extending the role of specialist nurses and health visitors to diagnose, as they are able to although this role is currently primarily undertaken by GPs.

The emphasis on maintaining people's health within the community and avoiding acute exacerbations and hospital admissions implies that there should be a network of providers delivering quality, flexible, patient focused care. As with the early detection of long-term conditions, it is likely that other agencies could provide a useful role in supporting people to maintain their own health (e.g. social services). This implies more inter-agency working, where the patient is considered as a whole person and is offered a package of health and social care. However, this will have resource implications for those agencies.

There is a perception currently that only hospital-based clinicians have the necessary skills and expertise, and many people therefore prefer to receive their care in an acute setting. However, the proposals outlined imply that people should be treated at the lowest appropriate level of clinical intervention. This needs to be well explained and properly understood by patients to give them confidence in alternative services.

More community-based care will mean that more care is delivered close to people's homes. It may be helpful to think in terms of routine and non-

routine care, where the aim is that routine care is provided as close to home as possible, whilst non-routine care may be further away.

During discussions the potential conflict of interest between some national policies e.g. practice-based commissioning, payment by results and patient choice was identified. These need to be addressed through discussions between the different commissioning and providing groups and organisations.

Discussions also identified that patients with long terms conditions should have choice in their treatment. This might include choice in terms of how they access services (variety of locations / route ways / professionals involved) and implies that more vulnerable groups might need advocacy support to enable them to make informed choices.

5. Planned treatments and operations

Nationally there is a new target that all patients are treated within 18 weeks. In order to achieve this, health services across the country will need to look at how they provide planned treatments and operations. Likely approaches to achieving this target include

- Carrying out more preparation for treatment in community health services;
- Carrying out more surgical care on a day-case basis;
- Providing more support and follow-up for hospital-based treatments in the community.

5.1 Current arrangements

Challenges identified in the current arrangements are:

- Information and communications with patients prior to their out-patient's appointment or admission to hospital is often poor, and people do not know where their appointment is in the system. Clerical staff are often unhelpful and lack customer care training.

- There is insufficient separation between planned treatments and operations and emergency care, meaning that the need to respond to emergencies can lead to delays and cancellations in planned treatments and operations.
- Food provided in hospital does not always reflect the dietary requirements associated with a patient's condition.
- Communications between different parts of the health system (e.g. between the hospital and GP) and other agencies is often poor. The discharge process from acute to community health and social care services is not always smooth with, for example, social services not ready and equipment not in place.
- There are insufficient skills and capacity within community health services to provide the necessary level of support and care to people discharged.
- Different agencies appear not to always know what the other provides or is available to support patients in the community.
- Patients value receiving support to manage their own conditions when they are discharged from hospital – e.g. the expert patient programme.
- People living on the boundaries of Brent, Harrow and other local Boroughs may find it difficult to understand how to access specific services.

It was also noted that the national policy of payment by results – where the acute Trust is paid by the relevant PCT for each patient it treats – potentially creates tension between the Trust and PCTs.

5.2 Developing planned treatments and operations in the future

Participants felt that the following should be in place for planned treatments and operations in the future:

- The model of care for people with long term conditions should be developed to provide more support to maintain their health in the community, and to provide care to them out-of-hours. This approach should include improved patient education (e.g. through the expert patient programme). This will potentially relieve some of the pressure of people requiring emergency care and distorting waiting times and access for planned treatments and operations.
- The models of care for planned treatments, operations and urgent care should be more clearly differentiated, so that the needs of urgent care patients have less of an impact on those undergoing planned treatments and operations.
- Access to planned treatment and operations should be timely.
- Patients should have access to the level of clinical expertise appropriate to their needs, recognising that this may vary over time for an individual patient. This implies a more team / network approach to care, rather than all care being provided via a hospital-based specialist.
- Where possible, care should be provided by teams based in the community rather than hospital.
- Where possible, specialist appointments and support should be provided in community rather than hospital settings.
- As far as possible, there should be consistency in the health professionals involved in an individual's care.
- Communication between health services and patients and between different parts of the health service and between the health service and other agencies – particularly social services – should be improved.
- The relationship between the patient and clinical and non-clinical staff has a big impact on patients' experience of health services. Patients should be treated as customers and with care and respect.
- All services should be designed to respond to diverse cultural needs.

5.3 Implications of this model of care

The approach described above would potentially mean moving minor acute services away from majors, and would also reduce the number of out-patient attendances.

It was noted that if more follow-up care for planned surgery is shifted into home care then this will have implications for community nursing and potentially for the social care workforce.

In turn services will need to consider how they assure the quality of the services provided, and that robust clinical governance arrangements will need to be put in place.

It was also noted that funding must be there to support change.

5.4 External observer's comments

Some people within the population served by the Trust, particularly in Brent where the population tends to be more reliant on public transport, find travel difficult. The model of increasing the amount of care provided in community settings should therefore provide more equitable access. In considering future models for how services are provided, plans need to take into account access issues relating to public transport and the distance between services.

The proposals above all imply that Trusts should identify and expand the range of medical treatments that can be undertaken as day cases rather than on an inpatient basis. This means that new care pathways will need to be developed, extending the range of pre-operative assessment, work up and aftercare undertaken by primary and community services.

The proposals also imply that there should be an expansion of the number of procedures undertaken by GPs and community nurses – these might include, for example, minor surgery. Work will need to be done to scope and define which procedures these might be.

Other care could also be shifted into the community – for example outpatient follow-up clinics could be reduced through a combination of nurse led clinics or GP shared care.

However, these changes will have a significant impact on the services that are currently and will need to be provided in the community in the future.

This means that care pathways should be co-ordinated with clear protocols (e.g. for when a patient should go where), with associated implications for how these services are managed (e.g. should this be by a single organisation?)

Also, implications for the workforce potentially include:

- Moving some staff currently based in hospital into community teams;
- Integrated multi-disciplinary teams;
- Changes in skills mix of existing community-based clinicians.

6. Rehabilitation and intermediate care

Intermediate care is provided to people who do not require all the services associated with an in-patient stay on an acute ward, but are too unwell to be cared for at home. Typically intermediate care is provided to people before and / or after they have an operation.

6.1 Current arrangements

Participants were able to identify a number of positive aspects about the way rehabilitation and intermediate care is currently provided, including:

Willesden

- Friendly, less institutional
- Multi disciplinary teams
- Timely discharge
- Proximity to community

HART/CCT

- Rapid response to prevent admissions

Early Discharge teams

- (CCS)
- Collaborative Care Team (CCT)
- BRS/ Health and Rehabilitation Team (HART)
- Facilitating discharge – being there for support

Voluntary organisations

- Working in partnership
- Brent Carers Elders voice etc. Stroke Association

It was also felt that the care provided by GPs and GPs with a Special Interest (GPSIs) is good, and that acute care is very good.

However, participants also identified a number of challenges in existing arrangements for rehabilitation and intermediate care, including:

- 1 Not enough people know about the range of services available and what those services do.
- 2 There are issues of “trust” between older people and services.
- 3 Social needs vs health needs.
 - Acute trust v. PCT resource issues – organisation boundary issues
 - Capacity in the system
- 4 No regular assessment / review system for those most at need
Access to GP → access system
- 5 Right person at right time.
- 6 There are capacity issues around the provision of support to people with mental health problems.
- 7 Very bureaucratic.
- 8 Discharge planning is poor, leading to some patients ‘slipping through the net’ when they are discharged from hospital.
- 9 Related to this, there is not enough collaborative working and communication between health and social services to support the needs of people in the community.
- 10 Constant changes.

- 11 There is the perception that people receive services on the basis of a 'postcode lottery'.

6.2 Developing intermediate care and rehabilitation services in the future

It was felt that the principles that should underpin the development of these services in the future are:

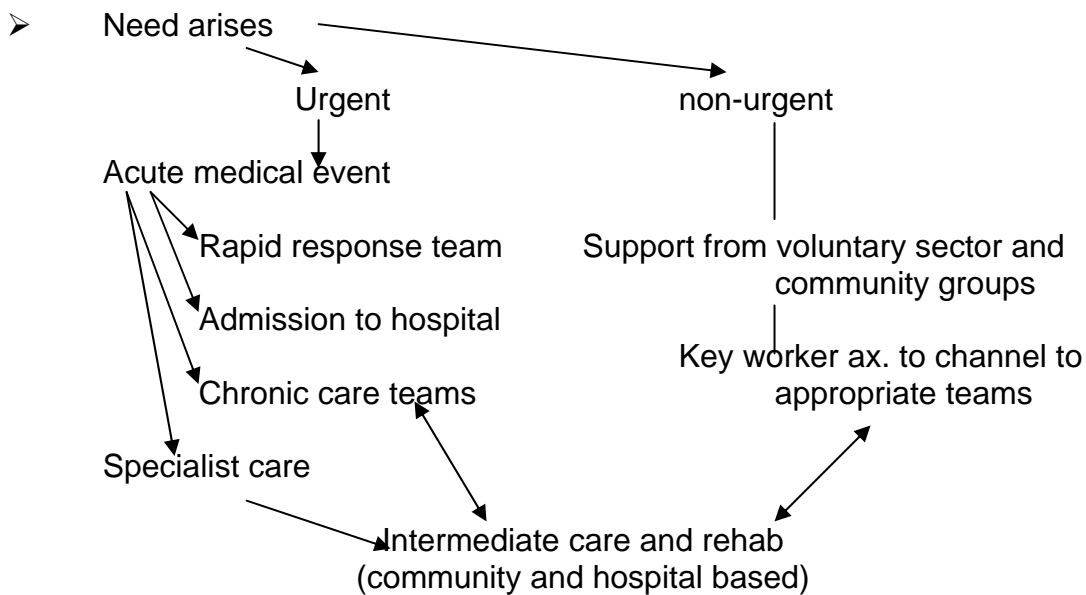
- Care should be patient-focussed and involve patients and their carers in decision making about their own care.
- People should be treated at home wherever possible
- There should be excellent communication between those providing care and those receiving it and between the various teams and organisations involved in providing care to an individual.
- Care should be 'seamless' from a patient perspective with minimal organisational barriers, good partnership working and shared goals.
- Live within your means
- There should be promotion/publicity and access

The model of care should:

- Be a preventative / proactive community based model
- Enable the health service to identify people's care needs
- Involve GP practices in identifying at risk people and monitoring them. This may require larger teams in GP practices to help identify these needs accurately and navigate intelligently.
- Provide a key worker to navigate patients
- Seek to limit the amount of time people need to spend in an acute-setting, through robust care and support in the community

- Provide a seamless pathway of care from the community into intermediate care, acute care, rehabilitation and back to the community and between agencies – including social services and the voluntary sector
- Include measures of success, such as:
 - Best practice
 - Patient satisfaction
 - Benchmarking
- Be able to respond to the needs of a diverse community
- Be fluid and able to adapt to changing needs

The diagram below provides a graphic illustration of how this model of care could be delivered:



6.3 Implications of this model of care

- Social and healthcare budgets/team integrated into one service
- Integrated health care team across health/community settings. Where and when the patient needs it.

- Multidisciplinary teams/single point of access
- Multi-skilling
- Voluntary sector inclusion and participation
- Empowering the patient
- Clear criteria/protocols
- Clear costs
- Good information
 - Directorate
 - Management systems

6.4 External observer's comments

In addition to the principles identified above, it is likely that services should be designed and seek to enable people to remain in their own homes as far as possible. This is because long-term in-patient care can lead to older people losing their mobility, community / family support structures and ultimately their independence. As well as people often preferring to be treated locally or within their home rather than go into hospital, if the model of care results in people losing their independence, this is ultimately more expensive for health and social care services.

However, it would potentially be very expensive to have specialist professionals (e.g. consultants) delivering home care and / or travelling between local areas. The economies of scale associated with centralised services will have to be balanced with patient needs and preferences to ensure financial viability is achieved.

An implication of seeking to maintain more people in the community is that carers need to be recognised as key people within this model. It should be noted that it has been demonstrated to be more cost effective to provide greater care and respite for carers than provide care for someone once the carer is unable to cope. Carers therefore need to be given sufficient support if a community based approach is to be effective.

In this model, savings could also potentially be achieved through reducing the length of stay / rehabilitation phase. Integrated community based teams would need to be in place and play a key role in ensuring support structures are in place for effective rehabilitation at home.

Discussions at the event touched on integrated health and social care teams and budgets. Efficiencies can potentially also be achieved through eliminating duplication and pooling budgets across health, social care and voluntary sector providers.