Keeping the NHS Local –
A New Direction of Travel
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Executive Summary

Introduction

The NHS Plan\(^1\) set out a vision of a service designed around the patient. To achieve that vision, the NHS is undergoing radical change, supported by a major programme of investment and reform. It is a change that will improve the quality of care and affect how and where services are delivered across the NHS.

The route for planning those changes will also be new. The NHS is now working within a new legislative framework, which will bring the voices of patients and the public into the heart of the debate. There are new duties on the NHS to consult the public and a drive to improve patient choice. Local authority overview and scrutiny powers have been extended to include local health services.\(^2\) The Independent Reconfiguration Panel is being established to advise on contested proposals for major service change, and will explicitly take account of this guidance in discharging its new responsibilities.

Key Messages

This document sets a clear direction of travel for the NHS, especially when considering service expansion and redesign. It will help the local NHS to work in a new stronger partnership with the public and staff to find high quality, sustainable solutions for local services, and deliver the agenda for reform.

The recent capacity planning exercise has shown that the NHS is developing a whole system approach to modernisation as a means of improving services and reducing waiting times. It is recognised by the service that doing more of the same is not an option.

This document demonstrates the potential that services and workforce redesign have to offer new solutions. In particular, it will help local communities broaden their options when faced with the challenges posed by the working time directive.

The mindset that “biggest is best” that has underpinned many of the changes in the NHS in the last few decades, needs to change. The continued concentration of acute hospital services without sustaining local access to acute care runs the danger of making services increasingly remote from many local communities. With new resources now available, new evidence emerging that “small can work” and new models of care being developed, it is time to challenge the biggest is best philosophy.

We outline an approach to local service design and consultation that reflects both the new requirements for partnership, the “closer to home” model of care supported by the National Beds Inquiry and the new opportunities generated by service and workforce modernisation.

The guidance proposes sustainable solutions for smaller hospitals to secure their valued role at the heart of local communities. Service and workforce redesign offer the potential for a wider range of safe,

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\(^1\) “The NHS Plan”, Department of Health, \textbf{July 2000}

effective, high-quality care to be offered in smaller hospitals than has previously been thought possible. Modernisation and improving the quality of care should not be seen as synonymous with or inevitably involve a move to centralise services into fewer, larger ‘super hospitals’. It is instead about working with local communities and staff to rebuild local services around local needs.

Patients want more, not fewer, local services. Technological developments – new equipment, information technology and communications – have opened up a whole range of possibilities for more localised services, including increasingly sophisticated day surgery and clinical networks supported by telemedicine links.

It is an exciting time for smaller hospitals in particular, as their traditional roles are developing and changing as they can provide a more integrated range of modern services at the heart of the local community. This document shows how modernisation and improving the quality of care are about working with local communities and staff to rebuild services around patient needs.

These are the three core patient principles to be followed.

- developing options for change with people, not for them, starting from the patient experience and our commitment to improve choice, and working with staff to develop new ways of delivering services;
- focus on redesign not relocate. Redesign can offer a high quality alternative to relocating services, extending the range of options for developing new configurations that meet local needs and expectations;
- taking a whole systems view: the NHS needs to exploit the contributions of different hospitals, primary, intermediate and social care providers within a whole systems centralising pressures by working in partnership, with genuine integration and joint planning of services.

A new approach

A route map shows how creative solutions that meet local people’s needs can be developed. It works by combining the new arrangements for patient and public involvement with the opportunities available through service modernisation.

Service modernisation

The framework outlines some of the modernisation strategies available to help provide high quality patient-focused care while ensuring that all staff, including doctors, are supported to work safely without excessive workloads.

These include:
- New and extended roles for doctors, nurses and other clinical staff
- Shifting from traditional medical firm based to team based working
- Exploring new ways of managing the hospital at night
- Achieving the right balance of care from generalists and specialists
- Exploring the opportunities offered by networking between hospitals, including the potential of telemedicine.
These options are applicable to acute services throughout the country, but we have been particularly interested in the issues facing smaller hospitals.

Models for smaller hospitals

We believe that the greatest challenges for sustainability will come in communities with smaller hospitals. We have drawn together some imaginative approaches to future models for the smaller hospital. These include:

Emergency medical and surgical care – using new approaches to staffing

The proposed service model enables 24 hour emergency access to medical and surgical care, by using the available trainee and career grade doctors and consultant medical staff more effectively.

The approach demonstrates the power of combined workforce and service redesign.

Emergency medical care and elective surgical care

In this model, there is 24 hour A&E access and emergency medical care, in the absence of 24 hour resident surgical cover, but with critical care. The model relies upon effective protocols and joint working across the whole local health system.

Local emergency unit

In this model unselected patients receive rapid assessment in a local hospital, with doctors from the nearest larger acute hospital site advising remotely via a telemedicine link. Based on this assessment, patients requiring more intensive acute care would be transferred to the larger hospital for direct admission to wards, avoiding the need for a further wait in A&E.

Local ambulatory care

Models of care that build on existing primary and community services (‘ambulatory care’), offer real potential to provide services for local people that integrate primary care with, for example, a minor injuries unit, outpatient clinics and diagnostics, as well as social care and other community services.

Some of these approaches are already established or being planned elsewhere. Kaiser Permanente in California shows the benefits of integrated care, with far fewer acute bed days per 1000 population than the NHS. The Scottish Telemedicine Action Forum has funded the provision of telemedicine links between Aberdeen Royal Infirmary and a number of community hospital A&E facilities to help treat patients in remote locations. In Northern Ireland, proposals have been put forward to develop Downe Hospital as an ‘enhanced local hospital’, working in partnership with hospitals in Belfast and providing emergency medical services with elective surgical care. We are now piloting the hospital models in NHS sites in England.

Consultation and evaluation – learning the lessons

These new service models are at an early stage of development and need to be tested and evaluated, though many of the component parts are already working on other hospital sites in England and elsewhere. The National Co-ordinating Centre for Service Delivery and Organisation Research and
Development is commissioning an independent evaluation of the Central Middlesex, Bishop Auckland and West Cornwall pilots.

We will also be working with the Royal Colleges and other NHS professional bodies in this evaluation process and in continuing to look nationally and internationally for models of services that can support local access delivering high-quality medical training.

How to use this document

The principles and the approach to services change described are presented as guidance. The principles in this document derived from the modernisation strategy laid out in the NHS Plan. These are principles which all health communities are expected to apply when developing services models from now on. The Independent Reconfiguration Panel will be using this guidance whenever they form a judgement, which will then inform Ministers in the decisions on whether or not to approve proposals for change. The framework does not invite change where sustainable solutions are in place or in the process of implementation.

The service models for smaller hospitals are presented for consultation, to stimulate further discussion and debate. They provide examples of how core modernisation principles might be applied in practice, but are not exhaustive or prescriptive and will be subject to further evaluation.

Next steps

Publication of this document is the first milestone for this project. There is more to come. Over the next few months we will:

• welcome feedback on the service models
• continue to refine and test these models
• strengthen the evidence base and gather further service examples
• develop the evaluation programme and initiate further pilots
• look in more detail at other specialties
• incorporate the emerging implications of developments in primary care
• develop additional resources, such as information on relevant tools and techniques.

Consultation

The service models presented in this document are intended to stimulate discussion and debate, so we have set a three month consultation period, to 14 May 2003. We welcome your views on the ideas, in particular:

• Comments on the service models described, and information about further examples.
• What further information and support would be useful to you, at national or local level?
• We have given a range of options for the smaller hospital – are we missing other imaginative solutions?
• We have identified a number of modernisation strategies. Which do you feel will be of the greatest benefit?

• Do you have experience of developing new ways of delivering services that you would like to share with us?

• Some supporting information is available on the website, in particular more detailed descriptions of the pilots, and we will be using the website to provide regular progress reports from the pilot sites. What further information would be useful to you?

• What other sorts of information or tools would help you address your local configuration issues?

• We are planning to look in more detail at specialties such as maternity and paediatrics and older people’s services. Are there others of interest?

Feedback and further information

Copies of this document can be downloaded from the Configuring Hospitals website at www.doh.gov.uk/configuringhospitals.

The website contains a range of other resources, including further detail about the examples at Central Middlesex, Bishop Auckland and West Cornwall.

Comments and consultation responses can be emailed to the Configuring Hospitals team at configuring-hospitals@doh.gsi.gov.uk, by 14 May 2003. The website will be updated regularly with summaries of the responses received to date.
1.1 This guidance was developed to improve the way in which changes to local hospital services are planned and developed. However, the future role of hospitals cannot be considered in isolation from the wider health and social care system. The direction of travel is away from thinking individually about different professions, care providers or settings, and towards a whole systems approach to planning and delivering care. This is the context in which this framework has been developed.

1.2 This work has taken account of the many areas of policy which have a bearing on the configuration of health services. These include, in particular, work on:

• developing new structures and arrangements for patient and public involvement;
• meeting the requirements of the European Working Time Directive;
• building capacity in the NHS (including implementation of the National Beds Inquiry);
• the future shape and long term strategy for the NHS workforce;
• changes in organisational structures such as the development of NHS Foundation Trusts and the role of strategic health authorities;
• the shift to primary care led commissioning and provision of services;
• the Modernisation Agency’s work on service improvement; and
• developments in information and communications technology.

1.3 The Configuring Hospitals Project has benefited from the input of many NHS and partner organisations, senior members of some of the professional bodies and the NHS Confederation Future Healthcare Network. Their contributions have helped to shape the framework and enriched its content.
An expanding knowledge base – new ways of working

1.2 The knowledge base underpinning medicine and the processing power of computers are expanding exponentially. This more sophisticated, technical and information-rich world has major implications for the way in which health care professionals will work. Clinical decision support systems are likely to become an everyday part of clinicians’ lives, and will enable all clinical staff and patients to take on enhanced roles in health care.

1.3 The increasing reliance upon others’ technical expertise will mean that people will work not as individual professionals but as a member of a multi-disciplinary team. The traditional divisions between primary and secondary care and specialty based practice are being challenged – the future may see professionals delivering care to specific patient groups rather than in specific health care settings.

New relationships with the public and patients

1.4 The public are taking an increasing interest in health as a consumer issue, and with increasing access to information via the world wide web and rights to choice, the traditional disparity of information and power between professional and patient is changing. There is an increasing recognition of the positive role that people can take in managing their own health and wellbeing.

More sophisticated diagnostic and treatment technologies

1.5 There are significant changes in medical technology. The precision and sophistication of surgery is being transformed by 3-D and miniaturised imaging capacity. All health care settings in the future could have basic imaging and pathology diagnostic capacity – and we can expect this technology to reach the public with home monitoring and diagnostics. Medicine is able to call upon more specific and effective pharmaceuticals. In the future, pharmaco-genetics will be able to match a drug to patient’s gene type and help avoid many of the adverse drug reactions experienced today. Artificial and lab grown organs, and genetic therapies offer hope of cures for the “incurable”. Medical devices will have increasing sophistication, for example, automated analysis tools and monitoring devices that can call on professional help automatically.
New Health Care Challenges

1.6 The population is ageing and this will create challenges for the NHS both in terms of the health care needs it will have to meet and the workforce it will be able to call upon. The number of people with chronic disease who have long term health care needs is growing and unless trends are reversed there are likely to be particular pressures from the growth in the levels of obesity and the consequent risks of diabetes, heart disease and renal failure.

Settings for Care

1.7 Technological and medical advance enable more options for care to be provided in more places. We have often heard futuristic stories of “super-hospitals”, where acute care is provided for whole regions. These visions have taken no account of the human dimension, and the need for people to see health care as part of their normal lives, in local settings. Indeed, the home is likely to be an increasing focus for consultation and care delivery, either face to face or remotely, for people who have difficulty in travelling.

1.8 We are likely to see larger, multi-disciplinary primary care teams. Some will work out of traditional health centres, but others may move to more community-based facilities as part of an integrated health, social and education community resource. We are already seeing some services, such as blood cholesterol testing, being offered through high-street chemists, and this trend is likely to continue.

1.9 The distinction between primary and secondary care is becoming blurred and this may be particularly marked in more rural areas where primary care doctors can be keen to play an active part in local hospital care. There is growing evidence that a proactive integrated approach to care can deliver substantial reductions in the need for hospital admissions, particularly for patients with chronic conditions such as chronic obstructive airway disease, diabetes and congestive heart failure.

1.10 Specialist hospital care is likely to become more differentiated and diverse. The traditional divisions in the UK between private and public healthcare are being broken down. The hospital will increasingly become part of a wider web of care.
Part Two: A new approach to configuration change

2.1 Introducing the Route Map

2.1.1 In the Executive Summary and in Part One we set out why services need to change, and the direction of travel for health services in the future. To get there, we need a new approach to change which sees configurations as part of an overall service improvement strategy, in balance with other elements of the healthcare agenda:

2.1.2 Change is inevitable in order to deliver investment in new services. But that does not mean more of what has happened in the past: an often confrontational process in which local communities have been given little real alternative to the solution preferred by the NHS, and with little real engagement. Change in future must be patient-focused and in tune with community needs.

2.1.3 This new approach to configuration change has three core principles, which health communities considering change need to apply with immediate effect:

- developing options for change with people, not for them, starting from the patient experience and our commitment to improve choice, and working with staff to develop new ways of delivering services;

- focus on redesign not relocate. Redesign can offer a high quality alternative to relocating services, extending the range of options for developing new configurations that meet local needs and expectations;

- taking a whole systems view: the NHS needs to exploit the contributions of different hospitals, primary, intermediate and social care providers within a whole systems approach. These providers can expand the range of options available to meet centralising pressures by working in partnership, with genuine integration and joint planning of services.
Putting the new approach into practice: a route map

2.1.4 The next sections of the document describe how this new approach to configuration change can be put into practice. It is based on a 'route map', illustrated overleaf, which shows how the elements of the new approach to configuration come together.

2.1.5 The starting point is the new legal framework for patient and public involvement and consultation, which has two elements. These are summarised as:

2.1.6 Firstly, Section 11 of the Health and Social Care Act 2001 places a duty on the NHS to involve and consult patients and the public:
- in the ongoing planning of services;
- in developing and considering proposals for service change;
- in decisions that may affect the operation of services.

2.1.7 Secondly, the Overview and Scrutiny Committee Regulations under section 7 of the Health and Social Care Act 2001 now require NHS organisations to consult the overview and scrutiny committee or committees of the relevant local authorities on any proposal for a substantial development or variation to health services.

2.1.8 The key message from the new duties is that open discussion with patients and the public, and with staff, needs to begin right at the outset – before minds have been made up about how services could or should change. And this discussion needs to continue right through the process – all stakeholders need to feel that they have had the opportunity to influence the debate at key stages, and have been kept properly informed throughout.

2.1.9 Stage one is about all the stakeholders understanding each other’s positions and priorities, and setting a joint agenda for discussion. In stage two all stakeholders will need to work together to develop a vision for the whole local health system, which will help to open up alternative solutions to what may initially appear to be an issue in one local hospital.

2.1.10 In stages three and four service and workforce redesign approaches can be used to expand beyond traditional thinking to offer new options that will help to secure sustainable, locally accessible services in line with the jointly agreed vision. Continuing two-way discussion and debate with patients, the public and staff will enable everyone’s thinking to evolve and develop as the practicalities and necessary trade-offs become clear.

2.1.11 Where it is agreed that the proposal constitutes a substantial variation or development of existing services the NHS has a duty to consult including the relevant overview and scrutiny committee (OSC). Following the consultation period, the NHS organisation leading the process will have to make a decision on the best way forward (stage five). Even with the best possible consultation process, this will not always be an easy decision. The OSC has a statutory right to refer the decision to the Secretary of State if they are not content. The Secretary of State may call on the Independent Reconfiguration Panel to investigate the case and offer him advice.

2.1.12 Once the preferred option has been agreed, the process moves through to implementation (stages 6 and 7). Although this document does not cover these stages in any detail, significant challenges here include the training and workforce development implications of operating services differently; keeping patients and the public informed and up to date with progress; and the need to manage the transition to the new pattern of service.

3 Separate guidance on both section 11 and section 7 duties will be published shortly. See www.doh.gov.uk/involvingpatients for details.
2.1.13 The process the route map describes and the principles that underpin it can be applied equally to any normal planning process, including the three-year plans that primary care trusts are developing now.

2.1.14 At each stage we have set out the issues and described the new approaches that have emerged during the course of our work to date. A comprehensive list of sources of guidance and further information is given in annex 1.

A New Approach

1. Health systems with different starting points & drivers

2. Developing the whole system vision
   Hospital-Community/Primary-Social

3. Defining the limits of the possible
   Pathway redesign

4. Options for change
   Consultation incl. OSC if “substantial variation”

5. Best option for whole system
   Agreed

6. Strategies for individual organisations
   and for components of the whole project
   Organisational development
   Finance
   Communications
   Building changes
   Workforce Change

7. Outline business case and/or implementation plan

Involvement of all staff throughout the process, including healthcare professionals and support staff and their representative groups, Liaison with other professional bodies including Royal Colleges

Patient and public involvement throughout the process, including Local Strategic Partnership, Overview and Scrutiny Committee, Patients' Forum, Patient Advice and Liaison Service, and wider community

Keeping the NHS Local – A New Direction of Travel
Stage One: Health systems with different starting points and pressures

2.2 Beginning the process: listening and empowering

2.2.1 Stage One of the route map is about recognising that change may be needed. Whatever the original trigger, any change needs to be seen as an opportunity to improve services for patients, moving towards the NHS Plan vision of a health service designed around the patient. This demands a fundamental shift in how services are planned and developed.

2.2.2 At the outset, information about services and the changes they face needs to be made available so local people and other stakeholders are empowered to take part in the debate. Equally, the NHS needs to understand the concerns of patients and the public, which may be very different. NHS organisations will be concerned about modernising services to meet patients’ clinical needs. But uppermost in patients’ minds may be how difficult it is to get to the hospital with either traffic congestion and an overcrowded car park, or poor bus services to contend with. Until the importance of those concerns is acknowledged, progress on other issues is unlikely. The agenda for discussion needs to be set jointly – to address both the patients’ concerns, and those of the NHS.

2.2.3 On 1 January 2003 this new approach was underpinned by a legal duty on the NHS to involve and consult patients and the public in decisions about planning and developing the health services they use.

2.2.4 The new patient and public involvement arrangements are just one element of a far-reaching programme of investment and reform in the NHS. It has been set in train with the clear goal of improving the quality of care for patients with faster, more responsive services. NHS organisations have been set challenging delivery targets for access to services and for meeting national standards for quality of care, with National Service Frameworks shaping services in key priority areas.

2.2.5 Changes in the NHS and local councils underpin the new legal duties. Overview and scrutiny committees (OSCs) have been given new powers to scrutinise local health services, and the NHS has a duty to consult them on substantial service changes. Local strategic partnerships (LSPs) are being established across England as the basis of partnership working in each local council area, bringing together the public sector, including health, with the voluntary, community and private sectors. There will be changes in the NHS locally, with the establishment of Patients’ Forums and Patient Advice and Liaison Services (PALS); and nationally, with the establishment of the Commission for Patient and Public Involvement in Health.

2.2.6 Primary care trusts, strategic health authorities and many hospital trusts are new organisations and as such have the chance to demonstrate their commitment to building new and effective relationships with local communities. NHS Foundation Trusts will also have an explicit aim of engaging with local communities. Local residents and patients will be able to become members of an NHS Foundation Trust – its owners – electing representatives to the Board of Governors which will oversee the running of the organisation.

2.2.7 This approach, of building relationships and working in partnership, needs to extend to staff as well. They need to be at the heart of the debate about how to change services to best meet patients’ needs and provide a high quality, locally accessible service. Where staff carry conviction that a new shape of service is the best way to ensure high quality clinical care, there can be no more powerful advocates in the local community.

4 Arrangements for Foundation Trusts, which are slightly different from those for other NHS bodies, are described in “A Guide to NHS Foundation Trusts” (Department of Health, 2002)
2.2.8 These arrangements together provide a framework – but the real challenge will be harnessing these opportunities for the NHS and its partners to move forward together.

Why services may need to change – Meeting patient needs

2.2.9 Significant new resources are available to the NHS – but to be effective these need to be used to offer improved choice for patients, higher quality care, more readily accessible care and better clinical outcomes. Many existing services were developed when patient needs were very different. Reconfiguration also presents an opportunity to shape services around the needs of today’s patients.

2.2.10 The needs of older people deserve particular attention. People over 65 account for two-thirds of hospital bed-days and 40% of emergency admissions. Most will receive care throughout the hospital and not just on wards for older people. Many will need the full services of an acute hospital initially, but could then be best cared for in an intermediate setting – rehabilitation, a community hospital, or supported at home. With demographic changes, the proportion and number of older people and very old, frail people being cared for in hospitals will increase. New configurations must be designed to meet the needs of this very large group of patients, both inside and outside hospital.

2.2.11 The Royal College of Paediatrics and Child Health recently described how the needs of children are changing. Serious infections and illnesses are much less common than they used to be, but have been replaced by more complex and long-term disorders that in the past would have been fatal. The number of children attending for an emergency assessment, usually at A&E, is much higher than it used to be, while the length of stay for those who are admitted has fallen dramatically. Thirty years ago the average stay was nine days. Now most stay less than two days, with many staying just a few hours for observation. This demands changes in the way services are provided, with increasingly integrated care across hospital, community and social care services.5

Why services may need to change – Safety, Quality and Practicality

2.2.12 Patient choice and patient needs are powerful reasons to build configurations around patients, and not only for convenience and courtesy. Patients need, above all, high quality care and the best possible outcomes. For highly specialised services, this may lead to a tension between the convenience of care close to home and the need to access very specialised care in a distant centre of excellence.

2.2.13 Improving quality of care will always be an important factor in developing new configurations, with patient safety coming first, underpinned by research evidence and professional opinion. The link between volume and outcome is one aspect of quality that has been hotly debated. There are a few instances where clear links have been made, for example in upper gastro-intestinal tract surgery6 but generally the links are less frequent than is often assumed. Outcomes may equally be linked to the organisation and approach of the service – for example, outcomes for stroke patients are greatly improved if they are admitted promptly to a hospital based stroke unit and receive care from a specialist multi-disciplinary stroke team.7

7 Department of Health, National Service Framework for Older People, March 2001
2.2.14 Other practical issues will also have a significant impact. These may include the availability of sophisticated equipment, which has in the past been expensive and immobile; effective organisation of services; and especially the ability to resource services (in human and financial terms) in a way which is consistent with patient safety, quality of life for staff and legal requirements.

2.2.15 Buildings are often a major source of discussion and debate. Local people may feel strongly about existing hospital buildings, which are often of great historical significance to the local community. But they may also be very old, expensive and difficult to maintain, and their architecture may place significant constraints on how services within them can be designed. That is not to say that a new building will solve these problems. The way healthcare is delivered is continually evolving. The only thing that can be known for certain is that any hospital designed for today's cutting edge will be out of date in ten or twenty years' time, although the building itself will still be relatively young. Designs need to be as flexible as possible to allow services to develop over time. And, difficult though it may be to move the focus away from the buildings, the most important debate is not about the bricks and mortar, but about what will go on inside it.

Why services may need to change – European Working Time Directive

2.2.16 While the European Working Time Directive (EWTD) already applies to the majority of NHS staff it will soon apply to doctors in training as well. Implementation will be on a phased basis starting in 2004, with a maximum 48-hour week applying to this group of staff by 2009 or 2012 at the latest. It is important that future service models allow working patterns that are compliant with the EWTD, and achieving this has been taken as a given in developing the framework.

2.2.17 The requirements of the EWTD for continuous rest periods, and the ruling of the European Court of Justice that time spent resident on call counts as working time, (the SiMAP judgement), mean that it will impact most strongly on services which require 24 hour cover. Currently much of this cover is provided by doctors in training. If working patterns stay the same, compliance with EWTD would imply a sharp rise in the number of doctors needed to run a 24 hour service. This would present real problems for many smaller hospitals with limited staff in individual specialties.

2.2.18 This makes the EWTD a powerful force driving the NHS to look at how services are provided. At the same time, implementing the EWTD has provided valuable pointers to solutions for smaller hospitals, focusing attention on how services are provided. As part of the process for implementing the EWTD for doctors in training, the Department of Health is funding a programme of pilot projects to test a range of solutions covering new working patterns, new non-medical healthcare practitioner roles, and new service models. These include examples referred to in this document such as the BeCAD model at the Central Middlesex Hospital. Full details are provided to support the guidance on EWTD implementation (see Annex 1 for more details).

2.2.19 Solutions initially proposed for achieving compliance with the EWTD – relying on massive increases in the medical workforce, or major reductions in the locations where 24 hour services are provided – were unrealistic. A more varied implementation strategy has now emerged, focusing on changing working patterns and redesigning services round patient needs. Measures as diverse as changes to medical training, the development of extended roles for nurses and other non-medical practitioners and greater use of information and communications technology (ICT) form part of the strategy. Reorganisation of working patterns and team working are prominent features.

2.2.20 These measures will all make a major contribution, but at the same time, the nature of 24 hour services in a number of locations may need to change. Making greater use of networking between community
minor injuries units and acute centres and other redesign approaches will be needed to ensure that people have locally accessible emergency care.

A focus on smaller hospitals

2.2.21 Over time we have become more sophisticated in our understanding of the needs of different patients. A patient suffering major trauma may need access to a full range of specialist opinion and diagnostic equipment. A pre-assessed patient undergoing planned minor surgery does not. Local access to services is more important for an older person with congestive heart failure than for a once-in-a-lifetime operation. Similarly, understanding of how to achieve the best outcomes for patients changes over time. The evidence emerging from clinical governance reviews is suggesting that the critical factor in high quality clinical practice is a culture of learning and evaluation, with a pro-active approach and implementation of organisation-wide policies and strategies on clinical governance. The size of the clinical health, often suggested as the main factor in high quality clinical practice, does not appear among the most common barriers to effective clinical governance.

2.2.22 In today's NHS it is clear that there continues to be an important role for acute hospitals in providing highly specialised care, and services catering for emergencies on a 24-hour basis and major planned procedures which could require intensive care. These services are increasingly concentrated in larger hospitals.

2.2.23 But not all services need to centralise and there are very powerful reasons for keeping services local. The influence of the patient choice agenda in particular has highlighted the need to improve access to services locally, while being balanced by other considerations. Community hospitals can provide a rich variety of local health and other community services. The mix of services can be tailored to local priorities, and they are often particular well-suited to ensuring access for older people and the more disadvantaged. One common theme for this type of hospital is a key role in the provision of intermediate care, but developments now mean that there is considerable potential to grow beyond this, as day case and ambulatory care services develop.

2.2.24 The growth in services provided on a daytime basis or involving only an overnight stay offers new opportunities for providing care away from the main acute hospital. These 'ambulatory care' facilities might include consultation, investigation and diagnostics, some planned surgical procedures and low-dependency inpatient care. This is further supported by the development of integrated health and social care models such as intermediate care, and redesign of the primary/secondary care interface to improve the management of chronic disease. The development of the role of General Practitioners with special interests will accentuate that trend. Seen alongside the local implementation of the recommendations of the National Beds Inquiry, these trends will enable an overall increase in capacity across the whole system.

2.2.25 But these forces – centralising of highly specialised care and the growth of ambulatory care – act in opposite directions, and can leave the smaller general hospital feeling the pinch. We have therefore taken as our first task the need to find new ways of developing services to support the maintenance of effective acute and emergency care in smaller general hospitals.

2.2.26 The recent Royal College of Physicians report ‘Isolated Acute Services’* highlighted the tensions that these services face. It found that, if hospitals are to maintain acute medical emergency services safely, critical care and anaesthetic facilities should be available. But it was also clear that acute medicine could be

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* Royal College of Physicians, “Isolated Acute Services”, July 2002
provided in the absence of acute surgery, providing that patients likely to require urgent surgery are not admitted to such units, and that a surgical opinion is available promptly when needed.

2.2.27 In future these small hospitals will also have a continuing vital part to play in bridging the gap between specialist, tertiary centres and ‘ambulatory care plus’ or community hospitals. In this framework we describe how service redesign can help to remodel services to meet this new challenge. Models are already emerging around the NHS showing how this can work in practice. We describe some of them later in this document, and they are further supported by experience in Scotland and Northern Ireland.

2.2.28 The NHS operates in a highly complex environment. Everyone – staff, patients and the wider public – needs to understand that patient safety must come first, and this may limit the range of possible options for change. For example, some specialised services are only viable across a particular population size. Equally, even with the current expansion in staffing and resources, some possible models may not be viable.

2.2.29 There then needs to be understanding about the place of hospitals within the whole system. Hospitals, with their large buildings, are the most visible parts of the health and social care system, and take pride in being part of the local community. But how do they fit into the whole? The next section describes the vision across the whole system.
Stage Two: Developing a whole system vision

2.3 Where do we want to be?

2.3.1 Hospitals are no longer seen as free-standing units able to work in isolation from neighbouring health and social care providers. The growth of intermediate care, managed clinical networks (where teams across several hospitals co-operate), and the emerging vision for integrated care recognise the need to work in concert. This gives a far wider range of strategic options than when trying to sustain local services, deploying not only the resources of a single hospital, but those from across the whole system.

A whole systems approach

2.3.2 A whole systems and integrated approach also offers the opportunity to maintain access to services while enhancing quality. Patients benefit at an individual level from a seamless journey through a smoother system without rigid boundaries being imposed between primary to secondary, general and specialist care.

2.3.3 Kaiser Permanente in California is one model of integrated care that has been in place since 19459. The system is based on the premise that the most expensive component of the health system – hospital beds – should be used as efficiently as possible. This is achieved by monitoring admissions, reducing the length of stay, creating disease management programmes for acute conditions, and opening doctors’ offices out of hours to reduce use of A&E for non-emergencies. The system is underpinned by good information technology – particularly electronic patient records, comprehensive and convenient primary care facilities, ambulatory surgery centres and better use of scarce clinicians, nurses, and other staff.

2.3.4 There are also examples of whole systems and integrated care in England. In Poole, for example, a whole system approach is being taken to improve services for older people. Older people may be cared for on either geriatric wards or specialist wards, but a geriatrician is assigned to every ward to ensure the patient has the right specialist care, and work is being done to develop skills for caring for older people across the hospital. When patients no longer need to be cared for in the acute hospital, most beds in community hospitals are consultant led, facilitating rapid transfer. A rehabilitation and community team has been found to be successful in getting older people home more quickly than would otherwise be the case.

2.3.5 Good relationships and communication between all parts of the system – general practitioners, the full range of primary and community services, social care and the acute hospital – are essential to the smooth running of the system. Not only does this mean a better service for older people, geared to meeting their individual needs, but tackling the bottlenecks in care for this group, who make up the majority of patients, is key to increasing capacity across the whole hospital.

Starting from the patient journey

2.3.6 Patient journeys or pathways can be a powerful tool, which can be readily understood by both lay people and health professionals. They can be used to develop a whole system vision through discussion and debate with all the stakeholders. Considering how the same patient would be taken through the existing healthcare system identifies the bottlenecks and pinch points that need to be addressed from the perspective of both patients and staff.

2.3.7 We have developed some patient journeys to illustrate how the ideas and proposals set out throughout this framework could come together to deliver a better patient experience. The story of Mohammed – a 13 year-old boy who has broken his leg – is set out on the next few pages. Journeys for James – a 55-year old man who has a heart attack, and Joan – a 71-year old woman who develops a diabetic leg ulcer, are set out in Annex 2.

2.3.8 Some parts of the patient journeys may seem futuristic, but the world they reflect is not very far removed from the world of today. Many of the individual elements described are already being piloted and used in hospitals in England today.
Mohammed breaks his leg

- Mohammed, a 13yr old, falls from his skateboard in the park.
- He goes home in acute pain. His mother doesn't have a car so a neighbour drives them to an accident treatment centre (ATC), in the town centre.
- The emergency nurse practitioner in charge calls up Mohammed's full health record. She sees he has no serious medical problems. She x-rays Mohammed's leg and concludes that surgery may be required.
- Using a digital-imaging link, the nurse sends the x-ray over to the acute Trust in the local network where the orthopaedic registrar looks at the image and confirms the nurse's diagnosis of a fracture requiring surgery. She asks the nurse to refer Mohammed to the acute Trust and an electronic emergency admission request is sent by the Nurse.
- Mohammed and his mother use hospital transport to get from the ATC to the Trust.
- When Mohammed arrives, he is sent to the adolescent ward with children his own age, and his mother is offered a bed for the night. Ward staff call up the full electronic health record and start the Trust admission log for his stay.
- The ward is managed and run by non medical staff at night who can call upon doctors when needed.
- The out of hours Registrar looks at Mohammed. His hand held computer shows him that an orthopaedic opinion based on the x-ray sent from the ATC confirms that surgery is needed. Ward staff to book a theatre slot for the next morning.
- While waiting for surgery the ward staff prescribe Mohammed pain relief using the Trust’s electronic prescribing system, which ensures the right dosage for the boy.
- Consultants review the pre-op work-up and go through the consent procedure with Mohammed and his mother, offering a translation using the Trust’s remote system.
- The surgical trainee undertakes the procedure, while the consultant observes and advises. A non-medical assistant, with special training, helps with the work.
- The post-op plan is drawn up by the surgeon, with an analgesic prescription and advice about physio.
- His post-op care, including medication, will be managed by the ward nursing team and physiotherapist who agree that Mohammed is ready to go home, with appropriate medication.
- The ward administrator puts together an electronic discharge summary with advice for follow up care, using the information that has been stored on the EHR system during Mohammed’s stay. It is e-mailed to Mohammed’s GP. Mohammed and his mother are given a paper record along with advice about his care including for his school. Before Mohammed leaves, an outpatient appointment is booked for the following Monday and transport home arranged.
Moving clinical information

2.3.9 Mohammed’s journey (and the others we describe in the annex) show how the whole systems approach also relies on the clinical history and the results of procedures carried out in hospital A being available to and used by hospital B, so that batteries of tests and questioning are not repeated unnecessarily. This saves patients’ time, worry and discomfort.

2.3.10 Successful working across the NHS requires the rapid and efficient flow of information around the system. Clinical staff need to treat patients based on the best and most complete information available. This means that clinical information needs to travel with or precede the patient.

2.3.11 Patient-held records have been used for some time in maternity, resulting in lower rates of missing records. Where it is not appropriate for information to travel physically with the patient it needs to accompany them virtually, and for this implementation of the Electronic Health Record, due in spring 2005, will be vital.

Technological advance

2.3.12 The possibilities of technological advance also offer a broader strategy for developing configurations. Centralisation has traditionally moved patients to where the staff are, allowing more efficient use of staff but patients have to travel. Localisation can move staff to where the patients are, but travelling is a heavy commitment of staff time, especially for doctors who may need to work in several centres. Information and communications technology (ICT) developments now raise the possibility of moving neither patients nor staff, but information.

2.3.13 Future applications may involve patients in their own homes communicating directly with clinicians in remote centres. But in the short- to medium-term, the relevance for configurations is that doctors based in a large unit could assess patients remotely in a smaller local hospital, using the Electronic Health Record and assisted by nurses or other non-medical staff based in the local hospital. This would be of particular relevance to rural areas, with the hospitals and health centres involved working together in a network.

2.3.14 Experience abroad demonstrates the clinical value and cost-effectiveness of telemedical systems. In a recent major study in Finland, for example, patients in a remote rural area were able to avoid a long trip to hospital through a teleconsultation system in which GPs transmitted data to specialists via a secure web-based system. Remote case conferences were shown to be as effective as face-to-face sessions. High levels of patient satisfaction and significant cost savings were also demonstrated.10

2.3.15 In Japan, significant success was achieved in detecting early lung cancers in residents in rural areas using telemedicine. Patients in small villages were screened by CT scanners in a ‘Mobile Hospital’, consisting of a satellite communication system linked to a large van in which patients were scanned. Again, major cost savings were achieved, as well as reductions in length of hospital stays.11

2.3.16 An evaluation of video diagnosis and management of patients with skin disease in Northern Ireland further demonstrates that such systems are a safe and reliable alternative to in-person consultations at acute hospitals.12

2.3.17 In England telemedicine, digital transmission of x-rays, scanned images of biopsies and other material is well established in some parts of the country, allowing remote diagnosis and specialist support to on-site clinicians. Videoconferencing is also being successfully used to permit multidisciplinary team meetings to take place across sites.

2.3.18 The Scottish Telemedicine Action Forum has established a number of pilots in Scotland which have particularly focused on how remote locations can access specialist support and advice. In England, a notable example is the electronic patient record pilot in Cornwall, which has implemented the use of telemedicine to support minor injuries units. The recent NHS Digital TV pilots explored the potential for tele-health through a range of services including:

- “NHS Direct in Vision” (talking to and seeing an NHS Direct nurse)
- booking an appointment with a GP through the television
- a text message reminder service for children’s vaccination dates; and
- a call-back service to get further information about local services.

2.3.19 All these developments in ICT are pushing towards closer working between primary and secondary care, and much better support for self-care. They are powerful tools to ease the workload on key staff, and to support care in a wider range of locations.

2.3.20 We have shown here how ICT and the potential of a network approach to healthcare within the local area can support a whole system view of healthcare provision. The next step is to consider the detail within each element of the system.

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Stage Three: Defining the limits of the possible

2.4 How do we change?

2.4.1 A whole system vision, as set out in Stage 2, needs to be tested against reality. What is the vision for each part of the whole system? How can existing services change to realise that vision?

2.4.2 Service and workforce redesign coupled with new information and medical technologies provide the NHS with the tools to maximise the effectiveness and efficiency of scarce resources – in particular, hospitals and their highly skilled workforce. This then provides the foundation for any strategy to improve the patient experience and provide local access to services.

Service redesign

2.4.3 A basic principle of service improvement is to build services around the patient journey. Bottlenecks in the journey need to be eliminated. Matching staffing levels to the peaks and troughs in demand will cut out delays and ensure that valuable staff time is being used efficiently. Redesign can also deliver an increase in capacity.

2.4.4 Diagnostic and staffing resources work much more efficiently if patients are grouped and managed according to the sequence of procedures they need, rather than by diagnosis. These ideas are being applied in the Modernisation Agency Emergency Services Collaborative programme to provide more streamlined emergency care.

2.4.5 Within primary care, immediate access primary care services, be they NHS Direct, walk-in services advanced access GP surgeries are providing a much more responsive service. Linking GP out of hours co-operatives with 24 hour minor injuries units can then streamline emergency care for the 30-40% of people who currently attend A&E with minor ailments.
2.4.6 The Access, Booking & Choice programme is building the infrastructure through new technology and service redesign to allow patients to choose not only when they will access planned care, but where. Experience shows that patients want local choice.

Workforce redesign

2.4.7 The centralising pressures experienced in smaller hospitals are felt most acutely within their medical workforce. The NHS is currently developing a range of innovative strategies to address these pressures through

- New and extended roles for doctors, nurses, and other clinical staff
- Shifting from traditional medical firm based to team based working
- Exploring new ways of managing the hospital at night
- Achieving the right balance of care from generalists and specialists.

Extended roles

2.4.8 The EWTD implementation pilots, the Changing Workforce Programme Pilots (see Annex 1) and many other hospital sites are exploring the opportunities for

- Nurse practitioners to provide a first on call tier cover in medicine, surgery, A&E and intensive care – especially at night.
- Senior House Officers providing cover across related clinical specialties eg surgery, trauma and orthopaedics and ear, nose and throat.
- Pharmacy technicians to manage patient medicines
- Medical assistants to reduce the workload on doctors in training through administrative support
- Surgical discharge led by nurses or other non-medical practitioners.

2.4.9 When developing these new roles, the chances of success are greatly enhanced if they are coherent and supported by protocol-based care with clear clinical governance procedures.

2.4.10 The Wanless Review explored the potential contribution of skill mix changes on the requirement for an increased number of doctors. It concluded that 20% of the work of doctors could be safely undertaken by nurse practitioners. Based on this assumption a further 10% of nurses would be required, with a commensurate increase in health care assistants (HCA). Incorporating extended roles as part of new service configurations will be an integral part of a wider strategy of skill-mix redesign.

New roles

2.4.11 In addition to extending the roles of current staff there are also opportunities for new roles – particularly in the provision of rehabilitation, general medicine and chronic care. These new roles can bridge old divides within and between health and social care and enable more comprehensive assessment and continuity in the management of care, particularly for the elderly.

2.4.12 The evidence shows that physician (or medical) assistants have made an invaluable contribution to the US health service where there are now 45,000 of these practitioners.\textsuperscript{14} After a two-year course, physician assistants are able to perform many tasks performed by junior doctors or senior nurses including performing physical examinations, taking diagnoses, ordering and interpreting lab tests and assisting at surgery.

2.4.13 The American experience is now being followed in the UK, with an increasing number of acute trusts (including William Harvey, Kingston and Southend NHS Trusts) introducing similar or related roles. It has also been found to be indispensable in the British armed forces. In the Royal Navy, there are now 618 ‘medical assistants’ compared to 280 doctors. This role is one that is still developing, and the approach taken may vary in different places. In some cases the role is primarily a support worker, while in others a wider range of tasks may be undertaken, when the post may be termed ‘health care practitioner’.

2.4.14 Developing this kind of role could also prove very valuable in the provision of emergency care for patients with general medical needs, and play a significant part in the night team discussed below. In addition, the more junior roles of clinician’s assistant or medical technician are growing in popularity as ways of reducing the working hours of doctors in training and improving patient care.

Team working to deliver EWTD compliant rotas

2.4.15 Changing working patterns is not just about who does the work, but how they do it. Traditional arrangements whereby doctors work in consultant ‘firms’ can significantly reduce flexibility in using the medical workforce.

2.4.16 In a small hospital there may be only five consultant-led surgical firms with a few trainee and career grade doctors in each. Each firm will have a mix of outpatient, booked theatre and emergency work. Emergency rotas for the hospital frequently rely on staff within these firms to provide emergency “cover” while undertaking a range of other duties. This increases the probability of delays for patients and generates a need for high numbers of staff to be on during the day.

2.4.17 A surgical team approach allows a junior staff member to be aligned with a stream of work rather than the firm, for example one for booked work, one for emergency and one for outpatients. This can significantly reduce the core cover requirements during the day. Our modelling suggests that it allows a working time directive compliant rota to be constructed with six Specialist Registrars (if there is nurse practitioner support) or seven without.

2.4.18 A team based approach has also been argued for on the basis of improved patient care.\textsuperscript{15} In some areas merged teams can increase the pool of all staff (consultants, trainees and career grade doctors), available for 24 hour cover, for example by combining general medicine with A&E.


\textsuperscript{15} The Senate of Surgery of Great Britain and Ireland “Consultant Surgeons – Team working in surgical practice”, May 2001
‘The hospital at night’

2.4.19 Current working practices with long anti-social shifts worked by comparatively inexperienced doctors, are not ideal, and consume a significant proportion of scarce medical resource at a time when patients are sleeping and clinical activity (obstetrics and ITU excluded) should be low.

2.4.20 The ‘hospital at night’ concept helps to address these underlying problems. The concept puts a multi-disciplinary team of appropriately skilled, alert and motivated staff to cover the whole hospital at night 11pm – 7am (ITU and obstetrics excepted). The team works to agreed protocols and has the competencies to cover a wide range of interventions but also the capacity to call in specialist expertise when necessary.

2.4.21 The team could have both medical and nursing staff, the numbers and specialty mix would depend on the hospital. This concept is more theoretical than practical at present, though many hospitals have variants in place – for example nurse-led first tier cover after 11pm. This is a concept which several of the EWTD pilots and other hospitals are currently exploring and seems to offer a powerful means to support 24 hour services in hospitals with very constrained levels of medical staffing.

New balance between generalists and specialists

2.4.22 The trend for all hospital doctors to become more and more specialised has begun to be questioned. Now, new roles for hospital clinicians are placing a premium on generalist skills in assessment and diagnosis. These are particularly important in ensuring that patients receive the best overall package of care straight away, rather than waiting for a succession of partial judgements. The emerging roles have a place in both small and larger hospitals working as part of networks, with specialist opinion available when it is needed, either from clinicians based in the hospital or through networking arrangements.

2.4.23 Meanwhile, General Practitioners with specialist interests (GPSIs) can offer local access to specialist opinion, in collaboration with hospital-based colleagues, and in some cases work on an ‘inreach’ basis in acute hospitals where they can access the full range of back-up facilities.

2.4.24 In Bradford, for example, consultants and GPSIs work together in purpose-built locality centres to provide a broad range of outpatient sessions and diagnostic and surgical procedures. Other PCTs are seeking to emulate this model and it is likely that a new breed of such locality units, integrating working across primary and secondary care, will be created – breathing new life into existing NHS stock which may otherwise be under-used. The GPSIs also perform procedures in the acute hospital where backup is needed.

2.4.25 The development of these new roles around the NHS is taking place alongside growing recognition among professional bodies that the balance between generalists and specialists needs to be adjusted. A number of medical Royal Colleges have begun developing proposals for shortening the training period leading to award of the Certificate of Completion of Specialist Training (CCST), coupled with competency-based assessment. This would make the CCST more focused on generalist skills with the option of further specialist training at a later stage. Unfinished Business – proposals for reform of the SHO grade, published for consultation in August 2002, puts these ideas on the agenda for national debate, alongside restructuring of the earlier years of postgraduate medical training.16

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Much is happening already

2.4.26 Many of the approaches outlined in this section are being tested within the EWTD implementation pilot schemes and Modernisation Agency programmes. Annex 1 gives details of sources of further information.

2.4.27 These approaches can all point to individual solutions for individual elements of the system, tailored to meet the needs of the local situation. But how can these be brought together to develop whole systems?
Stage Four: Options for change

2.5 Alternative ways of changing

2.5.1 In this guidance we have set out how service improvement strategies, coupled with a better and more detailed understanding of patient needs, can open up possibilities for service development. Options need to be developed openly in discussion with all stakeholders – local people, staff, the local council and others, starting from a clear understanding of the opportunities and constraints.

2.5.2 Priorities will not always coincide – local people’s views about the relative importance of risks, costs and benefits may differ to those of the local NHS organisations. Nor will local people, staff and patients all share the same view.

2.5.3 Local councils will also look at the wider implications of configuration changes for local economies and the potential for regeneration. Transport is often a major issue. The NHS needs to engage fully with local councils and work both with the executive, (which is the decision-making body and responsible for provision of services), and with the overview and scrutiny committee, (who scrutinise both local councils and local health organisations, and make recommendations).

2.5.4 Many of the most problematic reconfigurations of recent years have related to the closure or loss of core services from smaller general hospitals. These have felt the effect of competing pressures acutely, as centralising and localising pressures have pulled in opposite directions. And these hospitals are particularly hard hit by practical constraints on providing services. Faced with these pressures, merging the services of two smaller hospitals into one larger one has been the common response. But there is evidence that centralising services into larger hospitals does not necessarily deliver the expected benefits. The link between volume and outcome for surgical procedures is often overestimated; the financial benefits often expected from such mergers do not always materialise; and access to services may be reduced, particularly for older and poorer people.\(^{17}\)

2.5.5 Services requiring cover 24 hours a day have traditionally depended on nursing staff and doctors in training to provide out of hours cover. The New Deal, in improving the quality of life for doctors in training, has also resulted in higher numbers of doctors needed to staff on call rotas. Implementation of the European Working Time Directive will reinforce this effect if working patterns remain unchanged.

2.5.6 These themes recur in innovative thinking around the NHS which shows how the gap between large acute hospitals and ambulatory services can be bridged. The starting point is maintaining local access to quality services, with the emphasis on core services and joint working between organisations.

2.5.7 But where distances between population centres are large – and sometimes where they are not – this pattern of services can leave a large gap between acute hospitals and ambulatory care services, with long travelling times for emergency services. And if there is a history of a local hospital providing a broad range of services, the prospect of losing core services such as emergency medicine, A&E, maternity and general paediatrics is often strongly resisted, although the need to travel for highly specialised care may be readily accepted.

\(^{17}\) CRD Report 8: “Concentration and choice in the provision of hospital services”, University of York, April 1997. See www1.york.ac.uk/inst/crd/crdrep
A new role for smaller hospitals – bridging the gap

2.5.8 An important focus of the Configuring Hospitals Project has been on finding ways of bridging this gap. The aim is to find sustainable solutions for smaller hospitals which meet the needs and expectations of local communities and are consistent with the broader modernisation and localisation agenda.

2.5.9 The models emerging, outlined below – are of smaller general hospitals focusing on common conditions, routine procedures and immediate access. These would vary considerably in different locations, so it is impossible to describe a typical hospital. In general, the objective is to provide at a minimum a “first port of call” (a service able to receive and provide assessment, initial treatment and transfer where necessary), and wherever possible a complete service, for:

- patients referred by primary care practitioners for diagnostic or routine surgical procedures
- patients referred by primary care practitioners for assessment
- patients arriving under their own steam
- some or all (depending on location) patients arriving at A&E by ambulance.

2.5.10 Although some of these hospitals would be geographically remote, none would be isolated, as they would operate in partnership with surrounding primary care teams and with neighbouring hospitals. This is key to changing the configurations landscape, and will build on the growing success of specialist networks around the NHS.

2.5.11 These hospitals would form part of a family of care meeting the needs of their populations. There is reason to believe that they could contribute to reducing avoidable hospital admissions and shortening episodes of care, as well as providing ready access to services.

Emerging models

2.5.12 The whole hospital models offer the prospect of viable long term options for local services which have often been subject to strong centralising pressures. They offer the potential to provide a significantly larger range of services in smaller hospitals than is currently considered sustainable, including local assessment and admission as well as planned procedures.

2.5.13 They are at an early stage of development and need to be tested and evaluated, though many of the component parts are already working well in other hospital sites. More detailed case studies will be made available as implementation progresses, through the national evaluation programme described at the end of this section.

2.5.14 The models are presented here to prompt further discussion and debate. Further details of the consultation are set out in section 3.2.

Emergency medical and surgical care using new approaches to staffing

2.5.15 The proposed service model for the centre enables 24 hour emergency access to medical and surgical care, with relatively small numbers of trainee and career grade doctors and consultant medical staff. The approach demonstrates the power of combined workforce and service redesign. The hospital model depends heavily on integration of primary, secondary and intermediate care services to support quality patient care. This is being developed at the Central Middlesex Hospital in North London.
Emergency medical care and elective surgical care

2.5.16 A model of A&E access and emergency medical care being offered in the absence of 24 hour resident surgical cover, but with critical care. The model relies on effective joint working across a number of acute hospital sites. Deploying resources from all sites supports the viability of services on each site. This approach is being implemented at Bishop Auckland Hospital in County Durham, working in partnership with University Hospital of North Durham and Darlington Memorial Hospital.

Key Model Elements

Offers:

A&E with unselected admission

New ways of working

- unified general medicine and A&E
- senior front end/rapid diagnostics
- surgeons operating as unified team
- extended day and strong day/night differentiation
- nursing practitioners providing first-line cover for acute patients

Supported by whole system

- well-developed transfer arrangements
- elective and emergency surgery as part of a network

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Emergency medical care and elective surgical care

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Key Model Elements

Offers:

A&E with unselected admission

- acute medicine – locally defined criteria for medical patients
- no emergency – only elective surgical patients

New ways of working

- nursing provides first line cover to post operative patients

Supported by whole system

- on site critical care as part of network with well developed transfer arrangements
- surgery working as a network enabling access to a surgical opinion on call
2.5.17 A model similar to this has been proposed for Downe Hospital in Northern Ireland\textsuperscript{18}. The model has been developed as a response to the particular challenges faced in delivering emergency services to a dispersed rural population, with journey times to Belfast taking up to an hour. The hospital will be linked to the acute hospital network, and supported to maintain a 24 hour A&E unit, capable of providing resuscitation and emergency coronary care, a consultant-led in-patient medical service, and out-patient, diagnostic and day surgery procedures. Patients requiring emergency surgery will be transferred to Belfast.

**Local emergency unit**

2.5.18 In this model unselected patients receive rapid assessment in a local unit, with doctors from the nearest acute hospital site advising remotely via a telemedicine link. Based on this assessment, patients requiring more intensive acute care would be transferred to the acute hospital site for direct admission to wards, avoiding the need for a further wait in A&E. Local stakeholders in Penzance are developing this model for implementation in West Cornwall Hospital.

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**Key Model Elements**

*Offers:*

**Local acute assessment**

- Fast track step up/step down
- Potential for wide range of ambulatory care elements

**New ways of working**

- Joint assessment by local clinical staff and remote specialists
- Nursing and other non medical practitioners providing first line cover
- Software driven escalation protocols

**Supported by whole system**

- Linked to larger centre, primary care and ambulance services
- Fast digital links to remote centre

2.5.19 This model builds on the experience of the telemedicine pilots established by the Scottish Telemedicine Action Forum. In one of the pilots, all fourteen community A&E departments in Grampian region are using videoconferencing facilities to enable the general practitioners and highly trained nurses based in the community hospitals to seek specialist advice from the main hospital in Aberdeen. Additional posts were put in place in the A&E department in Aberdeen Royal Infirmary to enable the additional work to be managed effectively. When patients are discussed using the telemedicine link the referral rate has been reduced by between 70 and 80 per cent. Studies show that patient satisfaction with the service is extremely high.

‘Ambulatory care plus’

2.5.20 We have stated that the small hospital models outlined above can bridge the gap between large acute hospitals and ambulatory care. But ambulatory care itself is an area which is already proving to have real potential as a setting for delivery of a wide variety of services, with the advent of ‘ambulatory care plus’.

2.5.21 ‘Ambulatory care plus’ is a general term used to describe models of care that build on existing primary and community services, such as Walk-in Centres, advanced access surgeries and community hospitals. These services already exist in a number of areas, and such services may include facilities for

- consultation, investigation and diagnosis
- most outpatient services
- many planned surgical procedures
- urgent treatment for patients other than the most seriously ill (ie for all non-999 cases, but could include category C ambulance patients)
- low-dependency inpatient care
- chronic disease management
- intermediate care.

2.5.22 Variations on the ‘ambulatory care plus’ model have emerged from a number of different starting points. The model builds on the commonalities between specialties to maximise the range of services which can be provided with minimum resident medical cover. In some areas, community hospitals are developing on these lines by adding to an existing range of services. Some of the pioneering community-based Diagnosis and Treatment Centres share common features. Elsewhere, service provision of this kind has been proposed to replace existing services that have proved difficult to sustain.

2.5.23 ‘Ambulatory care plus’ is an exciting concept with great potential for development to meet local needs. It has much in common with the Kaiser Permanente (California) approach to primary care. In Kaiser, primary care physicians include doctors accredited in family medicine, internal medicine, paediatrics, obstetrics and gynaecology. As a result physicians in the primary care setting are able to perform more complicated procedures, freeing up referral specialists to focus on more complex cases. The primary care doctors work in multi-specialty centres that employ between 5 and 40 doctors and are supported by physician assistants and nurse practitioners, who have their own lists of patients and are able to conduct clinical examinations, make diagnoses and prescribe some medicines. These “physician extenders” increase the number of medical staff available by almost two thirds. Laboratory, radiology and pharmacy services are usually available on site. Some centres also have physiotherapy and mental health services, while others include various specialist services in the same building. In addition, these facilities are open in the evenings and weekends for urgent visits.

2.5.24 Queen Mary’s Hospital, Roehampton is one of the locations in England where the concept is being put into practice. A local minor injuries unit provides services from 8 am to 8 pm seven days a week. It provides general outpatient and rapid diagnostic services for the local population, along with local and supra-district rehabilitation services for older people and people with physical disabilities. Local outpatient services include general medicine and surgery, orthopaedics, audiology, cardiology, dermatology, diabetes, ear, nose and throat, gastroenterology, gynaecology, neurology, rheumatology and sexual health.

2.5.25 Within this service approximately twenty clinics are managed within a ‘rapid diagnostic pathway’, including breast, rectal bleeding and stroke. The aim of this is to reduce the number of visits patients
make to the hospital by delivering all the tests, diagnosis and treatment packages on the first visit. This can potentially reduce the waiting time for some treatments from months to just a few days.

2.5.26 The local PCT has plans in place to develop these services further, leading to the development of a new community hospital opening in 2005. Services will be easier and quicker for patients to access, supported by close, effective links with local GPs and neighbouring acute hospitals such as Kingston and St Georges.

2.5.27 This example shows how investing in community-based infrastructure to support ‘ambulatory care plus’, including diagnostics and basic laboratory facilities, provides an opportunity to bring basic emergency, elective and immediate access primary care services together to provide a cost-effective resource. Currently diagnostic and treatment facilities can be scattered around practices and health centres. There is a danger that these may be under-used or placed a heavy burden on individual practices.

2.5.28 In many parts of the country, a combination of large acute hospitals and local services including 24 hour access, diagnosis and treatment provides timely and responsive patient-focused care, and services are developing in this way with strong local community support. Recent work completed by the Prime Minister’s Office of Public Service Reform (OPSR) and the Department of Health focuses service redesign around enhancing primary care and provides a complementary analysis of services models that address the interface between primary and secondary care. (Further details of ‘ambulatory care plus’ models are available online. See Part Three for details.).

Summary comparison of hospital examples

2.5.29 The key differences between the three examples described above, and with the ‘ambulatory care plus’ model can be summarised in very broad terms as

<table>
<thead>
<tr>
<th>Medicine</th>
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<tr>
<td><strong>Elective</strong></td>
<td><strong>Emergency</strong></td>
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<tr>
<td>Central Middlesex</td>
<td>Broad range</td>
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<tr>
<td>Bishop Auckland</td>
<td>Broad range</td>
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<tr>
<td>West Cornwall</td>
<td>Limited range</td>
</tr>
<tr>
<td>‘Ambulatory Care Plus’</td>
<td>Limited range</td>
</tr>
</tbody>
</table>
Examples in individual specialties

2.5.30 Our main focus in developing this document has been looking at generic redesign principles and how they may be applied in smaller hospitals as a whole. An initial survey of individual specialties (anaesthetics, paediatrics and maternity), shows that there are many examples of local initiatives that have been designed to tackle very specific local issues, especially in relation to EWTD implementation. Fewer examples exist of a more holistic approach to service design, but it is clear that solutions for different specialist services will vary according to both local circumstances (such as geography), and the nature of the specialist service.

2.5.31 Early indications of themes and local examples are described in the supplementary material available online, with key messages summarised below. We expect to consider the issues relating to key specialties in more detail in the next phase of the Configuring Hospitals Project (see Part Three).

Anaesthetics

2.5.32 Anaesthetists are involved in many different aspects of patient care, providing pain relief for women in labour and managing patients in intensive care as well as administering anaesthesia for surgical patients. This makes anaesthetics key to service design.

2.5.33 A variety of ways have been identified in which anaesthetic resources could be used more effectively to support patient care. Some can be implemented quickly, such as the substitution of anaesthetists in cardiac arrest teams by clinical staff with appropriate additional training. Others represent a more radical change which would require thorough testing and evaluation. The Department of Health and the Royal College of Anaesthetists are working closely together on these issues and have recently undertaken three study visits to the Netherlands, Sweden and the US to look at the scope for making greater use of non-medical anaesthetic staff.

Children’s services

2.5.34 We have already described how the pattern of care for children is changing, with in-patient stays now being far shorter than they used to be, and far more care provided at home. In November 2002, the Royal College of Paediatrics and Child Health published Old Problems, New Solutions: 21st Century Children’s Healthcare,\(^\text{19}\) which sets out a number of imaginative approaches to the provision of healthcare for children. These are already in place in several locations around the country, many building on the kinds of service and workforce redesign ideas outlined earlier in this document.

2.5.35 These examples include ambulatory care services aimed at minimising hospital admission (Homerton Hospital, Hackney); extended roles for nurses including advanced neonatal nurse practitioners (Ashington, Southampton) and nurse specialists (Liverpool Alder Hey – paediatric epilepsy); and consultant-led services based on integrating acute and community paediatrics (Dorchester). Some areas are developing fully integrated children’s services.

2.5.36 These examples provide real encouragement that effective solutions for paediatrics are already being found. They not only help solve the problem but, more importantly, they are in line with the underlying philosophy of hospital care for children – that it should be for the shortest possible time, and only when

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unavoidable, because children do best at home. We will consider these examples and others in more
detail alongside the emerging work of the Children’s National Service Framework in the next phase of
the project.

Maternity

2.5.37 There is scope for changing working patterns in some types of maternity services, working on a
networked basis, and there are a variety of local examples of service redesign. Pilot work in Gloucester
will test whether increasing the consultant cover in teams of two to three will achieve significant
improvements in service, EWTD compliance and supervision of trainees. The Changing Workforce
Programme and Children's Care Group Workforce Team conducted a scoping exercise earlier this year
which identified a range of new ways of working in neonatal services being put into place around the
country. A pilot is now being developed to look at the implementation of selected new or amended
roles in the immediate post-birth care of newborn infants. (More information from the scoping study
is available at www.doh.gov.uk/configuringhospitals).

2.5.38 Midwife-led units away from main hospital sites operate successfully in some parts of the country.
At present, however, only a minority of women for whom this type of care is clinically appropriate
choose to give birth in these units. We need to identify and understand the factors that enable women
to feel confident about choosing this type of care.

2.5.39 The challenge facing maternity services is the need to identify EWTD-compliant models of care in
the middle ground between large consultant obstetric units and midwife-led units. This appears to
be due to the nature of maternity care, particularly for women in labour, which means that greater
differentiation between day and night – a key feature of the smaller hospital models outlined above –
is not likely to be possible.

2.5.40 Further work is needed to consider how the service and workforce redesign possibilities we have
highlighted in this document can be brought together to address the particular circumstances of
maternity services. We will be taking this forward in the next phase of the project, drawing on the
findings of the Maternity and Neonatal Workforce Working Group, and the maternity module of
the Children’s National Service Framework.

Evaluating the service examples

2.5.41 This document presents a wide range of service examples, from ideas still in the early stages of planning
through to well established services that have been running successfully for a number of years. Success
factors need to be identified, and an assessment made of how the individual examples could be applied
more widely. A programme of evaluation is planned, which will be developed with the National
Co-ordinating Centre for the Service Delivery and Organisation Research and Development
Programme.
Stage Five: Identifying the best option

2.6 Preferred option for the whole system

2.6.1 The best option is the one that most closely meets the whole system vision signed up to by all stakeholders, within the limits of what service and workforce redesign can safely deliver, and the financial limits that will always be a factor.

2.6.2 Where it is agreed locally that the proposed changes are a substantial variation or development of existing services, the local NHS has a duty to consult on the proposals. From 1 January 2003, that consultation has had to include the local council overview and scrutiny committee. Once the consultation period is over, the NHS organisation leading the process makes a decision on the option to be implemented.

2.6.3 The aim here is to have an open and transparent process, taking everyone’s views into account and not just those who know their way round the system. If a comprehensive picture of the community’s views can be developed alongside those of the local NHS organisations, there will be a firm basis for building a consensus around the best fit option, backed up by clear reasoning. This is sometimes known as socially sustainable decision-making.

2.6.4 The process is one of developing a health service that local people can support and feel confident in. It will be achieved by

- communicating effectively with local communities to build understanding of how services work and the drivers for change
- engaging people at an early stage in the process so that input is creative rather than a reaction to proposals that are already well-defined
- learning about people’s real concerns and looking for ways of addressing them
- with staff and local communities, looking at the opportunities presented by the modernisation agenda to see what alternative strategies could be considered.

2.6.5 This will sometimes mean making difficult decisions, but what we do know is that these decisions will be all the harder without the full involvement of local people.

2.6.6 Given the complexity of some situations, there will be occasions when the OSC disagrees with the decision made by the NHS organisation. If this cannot be resolved by further negotiation and compromise between the OSC and the NHS, then the OSC has the power to refer the decision to the Secretary of State. They may do so if they consider that consultation has been inadequate, or if they consider that the proposal itself is flawed.

2.6.7 The Secretary of State may call on the Independent Reconfiguration Panel to advise him, but this will depend on the reasons for the referral. For example, a referral on the grounds that consultation was inadequate, where it is clear that proper consultation procedures were not followed, may be dealt with directly by the Secretary of State.

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20 See www.doh.gov.uk/involvingpatients for details of legislation, guidance and further information.

21 In the case of the NHS Foundation Trusts, referral will be to the Independent Regulator.
2.6.8 The IRP will be using this guidance whenever they form a judgement, which will then inform Ministers in the decisions on whether or not to approve proposals for change.

Moving on

2.6.9 Once the preferred option has been agreed, the process moves on to implementation. This is not something this guidance covers in any detail, but in the next section we highlight a few key points about how the new approach to working with people needs to be followed through.
Stages Six and Seven: Implementation strategies and outline business case

2.7 Implementation

2.7.1 This guidance does not address in detail the implementation issues associated with service change, but references to guidance on the private finance initiative (PFI) and other relevant guidance are given in Annex 1. But in addition to the specialist project management techniques needed to turn plans into reality, much of the work that has brought the whole community to this stage needs to continue:

- Ongoing communication with patients and the public. People need to know that work is going forward, that their input hasn't been forgotten, and feel reassured that the transition from the current system to the new one will be smooth.

- Working with staff. Organisational development needs may be significant as major changes in working practice are contemplated. But staff are also local people. Where they carry conviction that a new shape of service is the best way to ensure high quality clinical care, there can be no more powerful advocates in the local community.

- Working across the whole system. Solutions across organisational boundaries will only work if care is truly integrated along the patient journey. This needs real commitment from all parties and depends crucially on clinicians feeling the same responsibility for patients wherever in the network they happen to be. Building trust is essential: between clinical staff in different locations, organisations and professions, and is a process that needs to continue.

2.7.2 Successful implementation relies on good working relationships between all parts of the system. If, in the planning stages, strong links have been forged with patients and the public, with staff, and across all the organisations in the health and social care system, then this will provide a firm basis for effective implementation.

2.7.3 Implementation often means a strong focus on buildings – building new ones, demolishing old ones, moving services to temporary ones while changes take place. But as discussed earlier in this document, buildings are just bricks and mortar. It is the people within them who will make healthcare services a success.
Part Three: The way forward

3.1 Next steps

3.1.1 In this document we have shown how the new arrangements for patient and public involvement can be brought together with service and workforce redesign techniques. Together these provide powerful tool for devising innovative and tailored solutions for the provision of healthcare that local people want and need.

3.1.2 The new arrangements for patient and public involvement in the development of health services are now set out in legislation and came into force on 1 January 2003. Further information can be found at www.doh.gov.uk/involvingpatients.

3.1.3 We have also discussed at some length the potential that service and workforce redesign have to offer new solutions. New ideas need to be challenged and debated. We want to hear your views. In the next section, we set out some questions and tell you how to send us feedback.

3.1.4 The underlying principles in this document are clear: it signals a need to think differently about reconfiguration, shifting the focus from relocation to redesign; from individual hospitals to whole systems, and from designing for local people to designing with them. It will inform the development of the criteria applied by the Independent Reconfiguration Panel in considering contested reconfigurations.

Action at local level

3.1.5 The principles and the approach to service change described are presented as guidance, which all health communities are expected to apply when developing proposals for service change and new service models from now on. The guidance does not invite change where sustainable solutions are in place or in the process of implementation.

3.1.6 The service models for smaller hospitals are presented for consultation, to simulate further discussion and debate. They provide examples of how the core modernisation principles might be applied in practice, but are not exhaustive or prescriptive and will be subject to further evaluation.

3.1.7 The recent capacity planning exercise has shown that many local health communities are using whole system working and modernisation initiatives to improve services and reduce waiting times. Many comment that “doing more of the same is not an option”. This document has discussed in more detail the potential that service and workforce redesign have to offer new solutions, built in partnership with local populations. The ideas it contains may be useful in suggesting ways of doing this – or you may wish to feed back on other local solutions which have been found and which others could learn from.

3.1.8 One of the most important aspects of developing effective solutions is that all the different organisations in the local health community need to work together effectively, helped by the strategic health authority and buttressed by the duty of partnership which applies to all, including NHS Foundation Trusts. There are a number of sources of development support on reconfiguration and related issues, particularly emphasising the need to work in partnership, including Department of Health and the Modernisation Agency.
3.1.9 The Modernisation Agency is building new thinking on reconfigurations into development programmes, and this framework and the ideas it presents have particular resonance with the implementation of clinical governance and the work of the Clinical Governance Support Team. The National Primary and Care Trust Development Team (NatPaCT) is also supporting reconfiguration at local level through its programmes on reconfiguration and community engagement. The NHS Confederation Future Healthcare Network brings together NHS organisations involved in service redesign and configuration change to facilitate learning and support.

3.1.10 At any one point in time many areas are undergoing reconfiguration in some form, and there is no intention that existing plans already agreed and well advanced should be put on hold while options for change are re-examined. But, where possible, opportunities should be taken to consider whether a service redesign approach may offer more effective solutions in any given set of local circumstances. Although some ideas set out here need further piloting and evaluation, this document has shown that redesign is already providing effective solutions in many places, and many more could benefit.

Action at national level

3.1.11 The national project is now moving into an action learning phase. This means:

• Continuing to test and refine the service models in this document with stakeholders, including patient groups and local government, in view of the new patient and public involvement arrangements which came into force in January 2003;

• Strengthening the evidence base and gathering further service examples;

• Developing further pilots to test new approaches;

• Developing the evaluation programme;

• Developing additional resources, such as information on tools and techniques, to support the concepts described.

3.1.12 Publication of this document is by no means the end of this work. New thinking and ideas are emerging all the time. The ongoing challenge is to work out how these advances can be harnessed to ensure that local people continue to have local access to the health services they want and need in the future.

3.2 Questions for consultation

3.2.1 The service models presented in this document are intended to stimulate discussion and debate, so we have set a three month consultation period to 14 May 2003. We welcome your views on the ideas, in particular:

This document

• Comments on the service models described, and information about further examples.

• We have given a range of options for the smaller hospital – are we missing other imaginative solutions?

• We have identified a number of modernisation strategies. Which do you feel will be of greatest benefit?

• Do you have experience of developing new ways of delivering services that you would like to share with us?
Some supporting information is available on the website, in particular more detailed descriptions of the pilots, and we will be using the website to provide regular progress reports from the pilot sites. What further information would be useful to you?

Further work

• What other sorts of information or tools would help you address your local configuration issues?
• What further information and support would be useful to you, at national or local level?
• We are planning to look in more detail at specialties such as maternity and paediatrics and older people's services. Are there others of interest?

3.3 Feedback and further information

3.3.1 The service models this document describes are intended in part to be a contribution to the current debate about the future organisation of care. As such, we would welcome feedback and comments, which can be sent to the Configuring Hospitals email address, by 14 May 2003.

3.3.2 To support the guidance, the Configuring Hospitals website will be developed with further information and resources (tools and techniques), as they become available. As a first step, more detailed descriptions of the service examples in this document, and additional examples, are already available at www.doh.gov.uk/configuringhospitals.

3.3.3 Regular updates will be published on the Configuring Hospitals website. To get notification of new information on the website, please get in touch with the Configuring Hospitals team at this email address:

Configuring-hospitals@doh.gsi.gov.uk
## Annex 1
Sources of Further Information and Guidance

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<thead>
<tr>
<th>Reference</th>
<th>Summary</th>
<th>Website</th>
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<tr>
<td>Policy documents</td>
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<tr>
<td>Department of Health</td>
<td>Here you will find the latest on the Department’s work, as well as health and social care guidance, publications and policy.</td>
<td><a href="http://www.doh.gov.uk/">http://www.doh.gov.uk/</a></td>
</tr>
<tr>
<td>Configuring Hospitals Project</td>
<td>This website explains the background to the project on configuring hospitals in health and social care systems. It provides access to material and work-in-progress for comment and feedback and is a route in for organisations seeking further information or support relating to reconfigurations.</td>
<td><a href="http://www.doh.gov.uk/configuringhospitals/">http://www.doh.gov.uk/configuringhospitals/</a></td>
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<tr>
<td>National Service Frameworks</td>
<td>The National Service Frameworks (NSFs) set national standards and define service models for a defined service or care group. NSFs are introduced in <em>The New NHS</em> and <em>A First Class Service</em>. The NHS Plan re-emphasised the role of NSFs as drivers in delivering the modernisation agenda. This website links to all the NSFs, but particular ones mentioned in this framework are:</td>
<td><a href="http://www.doh.gov.uk/nsf/">http://www.doh.gov.uk/nsf/</a></td>
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<td><em>The Cancer Plan:</em> drove significant reorganisation of cancer surgical workload at both an individual consultant and hospital level, to ensure cancer surgical volumes for individual clinicians met minimum threshold levels. This, alongside a number of other factors, is now delivering improved survival rates.</td>
<td><a href="http://www.doh.gov.uk/cancer">http://www.doh.gov.uk/cancer</a></td>
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<td></td>
<td><em>The National Service Framework for Older People</em> is providing the policy framework to help drive this service development and improve local access</td>
<td><a href="http://www.doh.gov.uk/nsf/olderpeople">http://www.doh.gov.uk/nsf/olderpeople</a></td>
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## Department of Health

### The National Beds Inquiry
The National Beds Inquiry provided strong evidence that significant proportion of inpatients could be looked after at home or in a residential care setting if the appropriate “intermediate care” services were available. New home monitoring technologies could revolutionise the capacity to look after people in their own home.

### Unfinished Business – Proposals for Reform of the Senior House Officer Grade
**Unfinished Business – Proposals for Reform of the Senior House Officer Grade** was published for consultation in August 2002. The report proposes that the SHO grade should be reformed so that all SHOs pass through time-limited, managed basic specialist training programmes with clearly defined end-points.

### Patient and public involvement in health
Information on the range of new patient and public involvement arrangements, including overview and scrutiny committees and the new duties to involve and consult patients and the public, is available at this website. The new arrangements came into force on 1 January 2003, and guidance will be issued shortly.

### Overview and Scrutiny Committees
*Local authority Overview and Scrutiny Committees (OSCs) now have powers to scrutinise local health services (as of 1 January 2003). The NHS will have a legal duty to consult the OSC at an early stage on any substantial change to health services. All meetings of the OSC will be open to the public.*

### Delivering 21st Century IT Support for the NHS
Delivering 21st Century IT is the implementation plan for the 1998 document ‘Information for Health’. The primary focus is the delivery of Integrated Care Record Services, which incorporates both Electronic Health Record and Electronic Patient Record concepts.

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<td><a href="http://www.doh.gov.uk/nationalbeds1.htm">http://www.doh.gov.uk/nationalbeds1.htm</a></td>
</tr>
<tr>
<td>Unfinished Business – proposals for reform of the Senior House Officer Grade</td>
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### Policy documents

**Building the Information Core: Implementing the NHS Plan**

*Building the Information Core: Implementing the NHS Plan* provides an update of Information for Health. It outlines the necessary information and IT infrastructure investment required to deliver the NHS Plan and support patient-centred care and services.

[http://www.doh.gov.uk/ipu/strategy/overview/index.htm](http://www.doh.gov.uk/ipu/strategy/overview/index.htm)

### Other Organisations

**Royal College of Paediatrics and Child Health**

The Royal College of Paediatrics and Child Health has published a number of documents that discuss the issues facing children's services in the future, and present a number of examples of innovative approaches already in place.

[http://www.rcpch.ac.uk](http://www.rcpch.ac.uk)

**Department of Health, Social Services and Public Safety of Northern Ireland**

Published ‘Developing Better Services: Modernising Hospitals and Reforming Structures’ for discussion earlier this year. Consultation document on the future shape of hospital services in Northern Ireland, including the Downe model.


### Toolkits, practical guidance and support

**Working with people**

**Involving patients and the public in health.**

Sections 7–11 of the Health and Social Care Act 2001 and associated regulations, SI 2002/3048, with new duties on the NHS to involve and consult patients, came into force on 1 January 2003. This website gives further details, including guidance.

It covers both duties to involve patients (section 11), and the new arrangements for overview and scrutiny of health (sections 7–10 and associated regulations).

[http://www.doh.gov.uk/involvingpatients](http://www.doh.gov.uk/involvingpatients)

**Guidance for Local Strategic Partnerships**

The Local Strategic Partnerships are the key element in developing integrated approaches to local service delivery, and to tackling policy priorities in a joined-up way.


**Modernisation Agency: Improvement Leaders’ Guide to Involving Patients and Carers**

The service improvement and collaborative programmes of the Modernisation Agency have gained considerable practical experience in ways of directly involving patients and carers in service redesign. The *Improvement Leaders’ Guide to Involving Patients and Carers* is one of the first three guides in this series.

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<tr>
<td><strong>Improveing Working Lives Standard</strong></td>
<td>The Improving Working Lives Standard sets a model of good HR practice against which NHS Employers and their staff can measure the organisation’s HR management and against which NHS employers will be kite-marked. NHS organisations will be required to achieve accreditation against the Standard by April 2003, demonstrating they are improving the working lives of staff.</td>
<td><a href="http://www.doh.gov.uk/iwl/background.htm">http://www.doh.gov.uk/iwl/background.htm</a></td>
</tr>
<tr>
<td><strong>Working Together: Staff Involvement</strong></td>
<td>This tool aims to help you assess how much progress your organisation has made in involving staff in planning as well as delivering services.</td>
<td><a href="http://www.doh.gov.uk/pdfs/staffinself.pdf">http://www.doh.gov.uk/pdfs/staffinself.pdf</a></td>
</tr>
<tr>
<td><strong>Modernisation Agency: The National Primary and Care Trust Organisational Development Programme (NatPaCT): Engaging Communities Learning Network</strong></td>
<td>NatPaCT is helping PCTs build their capacity and capability and lead change in the NHS. It creates opportunities for people working in PCTs to learn from each other. It has a number of strands of work, one of which is the Engaging Communities Learning Network.</td>
<td><a href="http://www.natpact.nhs.uk">www.natpact.nhs.uk</a></td>
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### Service and Workforce Redesign

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<tr>
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<tr>
<td><strong>European Working Time Directive implementation, including Working Time Directive pilots.</strong></td>
<td>Guidance on implementation of the EWTD. A number of pilots have been established, and further information about them is available on the working time website.</td>
<td><a href="http://www.doh.gov.uk/workingtime/">http://www.doh.gov.uk/workingtime/</a></td>
</tr>
<tr>
<td><strong>Modernisation Agency</strong></td>
<td>The Modernisation Agency has a wide range of programmes and initiatives supporting service and workforce redesign. Some of the ones most relevant to the Configuring Hospitals Project are described in more detail below, but there are many others which will be of interest, including Action On and Collaboratives, and a range of other service improvement programmes. Details are available on the Modernisation Agency web pages.</td>
<td><a href="http://www.modern.nhs.uk">http://www.modern.nhs.uk</a></td>
</tr>
<tr>
<td><strong>Modernisation Agency and the National Institute for Clinical Excellence: Protocol-Based Care: Underpinning Improvement</strong></td>
<td>This site provides an information pack giving advice on the development and use of protocol-based care in the NHS associated organisations.</td>
<td><a href="http://www.modern.nhs.uk/protocolbasedcare">http://www.modern.nhs.uk/protocolbasedcare</a></td>
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<tr>
<td><strong>Modernisation Agency: NatPaCT</strong></td>
<td>The National Primary and Care Trust Organisational Development Programme (NatPaCT) helps PCTs build their organisational capacity and capability in the NHS. Specific strands of work include programmes on reconfiguration and community engagement (see also above).</td>
<td><a href="http://www.natpact.nhs.uk">http://www.natpact.nhs.uk</a></td>
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<td>Reference</td>
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<tr>
<td><strong>Toolkits, practical guidance and support</strong></td>
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<td>Modernisation Agency: The Changing Workforce Programme</td>
<td>The Changing Workforce programme has been set up to help the NHS and associated organisations redesign their workforce. There is a great deal of good practice that can be shared, and areas where potential changes need more intensive support to achieve change.</td>
<td><a href="http://www.doh.gov.uk/hrinthenhs/changingworkforce.htm">http://www.doh.gov.uk/hrinthenhs/changingworkforce.htm</a></td>
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<tr>
<td>Modernisation Agency: The Clinical Governance Support Team</td>
<td>Clinical governance is the framework which helps NHS organisations provide safe and high quality patient care. The programme enables a wide variety of NHS organisations to involve staff and patients in improving services and continuing to do so. Clinical governance is about changing the way people work, demonstrating that effective teamwork is as important to high quality care as risk management and clinical effectiveness.</td>
<td><a href="http://www.modern.nhs.uk/cgs">http://www.modern.nhs.uk/cgs</a></td>
</tr>
<tr>
<td>Modernisation Agency: GPs with Special Interests</td>
<td>The NHS Plan sets out clear targets for improving access to and convenience of primary care services, by reducing waiting times in primary care and extending the range of services available in primary and secondary care settings. Recruiting a GPwSI is one of a range of options available to PCTs to help achieve these aims and this website has further information about this.</td>
<td><a href="http://www.doh.gov.uk/pricare/gp-specialinterests">http://www.doh.gov.uk/pricare/gp-specialinterests</a></td>
</tr>
<tr>
<td>Developing key roles for nurses and midwives – a guide for managers</td>
<td>Across the country nurses and midwives are working in different ways, developing their roles to improve the patient’s experience of care. Drawing together a range of case studies of good practice, useful contacts and resources, this guide aims to help managers by providing ideas and practical ways of meeting service objectives.</td>
<td><a href="http://www.doh.gov.uk/newrolesfornurses">www.doh.gov.uk/newrolesfornurses</a></td>
</tr>
<tr>
<td><strong>Information and communications technology, confidentiality and consent</strong></td>
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<tr>
<td>Information Guidance by the Department of Health</td>
<td>This guidance is based on patients’ expectation that information about them will be treated as confidential; and the importance of making patients fully aware that NHS staff and sometimes staff of other agencies need to have strictly controlled access to such information, anonymised.</td>
<td><a href="http://www.doh.gov.uk/ipu/confiden/protect/pguid1.htm">http://www.doh.gov.uk/ipu/confiden/protect/pguid1.htm</a></td>
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## Capital investment

**NHS Estates**

This website is aimed at all those who are involved in proposing, developing and assessing schemes in NHS Trusts, Strategic Health Authorities and Primary Care Trusts and Groups and succeeding organisations. It will be of use and interest to Chief Executives and senior managers as well as to teams involved in planning, finance, performance management, service delivery and estates and information departments.

[Website](http://www.nhsestates.gov.uk/capital_procurement/index.asp)

## General information

**NHS UK**

NHS UK gives access to information on services available. This is the official gateway to National Health Service organisations on the Internet.

It connects to local NHS services and provides national information about the NHS.

[Website](http://www.nhs.uk/)

**NHS Direct**

NHS Direct gives access to personal clinical advice. This is a confidential telephone advice line staffed by nurses. This is open 24 hours a day, 365 days of the year.

[Website](http://www.doh.gov.uk/nhsexec/direct.htm)

**NICE Guidelines**

Clinical guidelines are recommendations for the care of individuals by healthcare professionals; they are based on the best available evidence.

[Website](http://www.nice.org.uk/)

**The National Electronic Library for Health (NELH)**

NELH gives access to in-depth clinical guidelines and evidence.

[Website](http://www.nelh.nhs.uk/)

## Toolkits, practical guidance and support

**NHSIA**

In May – June 2002 the NHSIA undertook research jointly with the Consumers’ Association and its magazine Health Which? to find out how people wanted their health information to be managed in the NHS. This site brings together information about confidentiality and it will keep you up-to date with progress from the national confidentiality programme.

[Website](http://www.nhsia.nhs.uk/confidentiality/pages/)

**The Cornwall electronic patient record pilot**

The Cornwall electronic patient record pilot has implemented a successful use of telemedicine to support minor injuries units and there is a fairly widespread take-up of teledermatology services.

[Website](http://www.nhsia.nhs.uk/erdip/pages/evaluation/docs)
Annex 2
Examples of patient journeys

These patient journeys may seem futuristic but many elements of each of them are already being piloted or are established practice in many parts of the NHS. These have been put together with planned and likely developments in the near future to show how services may develop in the next few years.

James’s Heart Attack

- James is a 55yr old man. He suffers central crushing chest pain at home. His wife calls 999.

- A first responder paramedic arrives within 4 minutes and administers morphine and aspirin, and establishes there are no reasons not to give clot-busting drugs if required. The ambulance arrives within 8 minutes and ECG confirms a heart attack. The paramedic administers thrombolysis. With James’ consent, the details are phoned ahead to the hospital.

- The ambulance sets out immediately for the hospital, monitoring James’ ECG and transmitting it directly to the A&E emergency receiving team along with key details of the history and clinical signs. This allows A&E emergency team to warn the cardiologists that a heart attack patient is on the way in, contact the Coronary Care Unit for a bed and call up his previous medical record/electronic health record.

- James is fast tracked as an emergency patient and taken straight to the resuscitation room, where a receiving team including a senior A&E doctor and nurse are waiting. The doctor greets James by name – he has already been able to scan through James’ EHR and seen that he does not have a clinical history of heart problems but is a heavy smoker.

- In A&E James is reviewed by the team including the consultant, nurse and junior doctor and on the advice of the cardiologists a low molecular weight heparin is given to help continue to work of the clot busting drugs. He is transferred to the CCU.

- In the CCU, James and his wife are met by the ward sister. Nurses provide the first level of on call cover in critical care. CCU specialists are available around the clock. They are frequently, but not always, on the ward. Nurses are able to give opioid analgesia using Patient Group Directions.

- When James is well enough he is linked to wireless monitors. This allows him to move around the bed and ward, and use the toilets, without removing ECG leads etc.
When James has a relapse and experiences acute shortness of breath, the CCU specialist nursing staff recognise likely heart failure and the need for emergency assistance. An emergency team arrives within 4 minutes. The team includes: Resident consultant (Anaesthetist, A&E or general physician) SpR (Medicine or A&E), SpR (Anaesthetist), Senior Nurse.

James spends 3 more days on the CCU, and is then moved to a general acute ward. James is assessed on the ward by the outreach home care team. His wife is very anxious to have him home, so they agree a care plan in which James will have daily visits from the team after discharge from hospital and keep an eye on him using tele-monitoring facilities. His discharge plan includes medication in line with NSF recommendations to reduce the risk of a further heart attack.

When James is at home he has tele-monitoring equipment which he uses to transmit his ECG, BP and heart rate 3 times a day or if there is any concern about his condition. The results from this monitoring are reviewed by the outreach team.

James will receive community cardiac rehabilitation from a multi-disciplinary team. James principal care at home is given by his wife who had a visit from the outreach team before James’ discharge to help prepare her for this role. She is given written information and contact numbers for the team. She is told signs to watch out for and when to call for help, as well as being given practical advice about how to improve James’ diet, and managing the daily medication routine.

Managing Joan’s chronic illness and leg ulcers

Joan is 71 and has had diabetes for 5 years. Joan goes on holiday to Spain with her sister, and while she is there she develops leg ulcers. She visits the local health centre who provide some basic care but suggest she seeks further advice as soon as she returns home. With Joan’s consent they email her local primary care centre to let them know they have seen Joan and give details of the treatment they have given.

Joan’s diabetes care is managed by the specialist diabetes nurse, who runs clinics in her local primary care centre. As soon as Joan returns she arranges to see her nurse at the primary care centre.

The nurse examines her legs. Using decision support software she prescribes some first line treatment and dresses the ulcers, and recommends that she should see the specialist GP in diabetes as she will need tight control of her blood sugar if her ulcer is to heal.
• The nurse also recommends to Joan that she should have her ulcers looked at by a specialist GP in dermatology. The nurse makes both appointments using the on-the-spot booking system. In three days’ time they both have convenient slots available so Joan can see them both on the same day. Joan sees both specialist GPs at the neighbouring health centre, about a mile away.

• After receiving Joan’s consent, the specialist GP in diabetes reviews Joan’s medical history using the shared EHR, including the results from her visit to the nurse a few days earlier. He makes some changes to her diabetes medication, and also prescribes medication to control her blood pressure. He enters the details on the EHR, and sends the prescription to the local pharmacy.

• Joan moves on to the GP in dermatology, who is able to use the EHR to see the results of Joan’s consultation with the GP in diabetes. She takes some digital photographs of Joan’s legs to send up to the dermatologist at acute hospital for a second opinion on best treatment. She also takes swabs so that she can send pathology results, using near patient testing, at same time. The dermatologist responds within two days confirming best treatment.

• The dermatologist recommends that Joan does not need surgery now, but suggests some additions to the management protocol that the specialist nurse will use to treat and watch the development of the ulcers.

• Based on the dermatologist’s recommendations the specialist GP prescribes some anti-inflammatory and dressings for the ulcers, and once again uses an electronic link to send this to the local pharmacy. The pharmacy delivers both her prescriptions to her home later that day.

• Joan continues to see the specialist diabetes nurse regularly, who both supports Joan as she manages her blood glucose and blood pressure more strictly, and monitors the ulcers, arranging for further specialist advice as necessary.