Healthcare for London

Involving Clinicians in Health Service Change

Responsibility

Authority

Accountability

Resource Management - Guy's Hospital 1985-1988

- Budget reduction (15%)
- Beds lost since 1983 - 340 (28%)
- Staff reductions - 576 (17%)
- Total cases 1983 - 40,736: 1988 - 41,000

The outsider can judge care but only the insider can improve it

Only those who deliver care can in the end change care

D. Berwick, 1994

Clinical Advisory Group

- **Multidisciplinary**
- **Members establish networks with specialist colleagues, within PCT's or clusters of PCT's or across London**
- **Provide clinical leadership for commissioners**
- **Assist in development of care plans and pathways**
- **Facilitate and oversee changes**

Work in Progress(1)

- Consultation on Framework for London concluded
- Each project lead by a PCT chief executive
- Polyclinics
- Trauma
- Stroke
- Long term conditions (diabetes)
- Unscheduled care (access)
- Local Hospitals

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Priority for action and incentives

- **Quality of care**
- **Productivity**
- **Integrated services**
- **Improving health and staying healthy**
- **Reducing inequalities**

'Localise where possible, centralise where necessary'
The impact on the District General Hospital

Centralise
Improve Outcomes

Highly specialist services move to centres that build the capacity and capability to improve outcomes, e.g. trauma, angioplasties, acute Stroke care, the less common Cancer treatments, some children's care

The Traditional District General Hospital

Full range of specialties, including:
- Medicine/Care of the Elderly
- Surgery
- Obstetrics and Gynaecology
- Paediatrics
- Diagnostic services
- Outpatients
- A&E

Localise
Improve Access

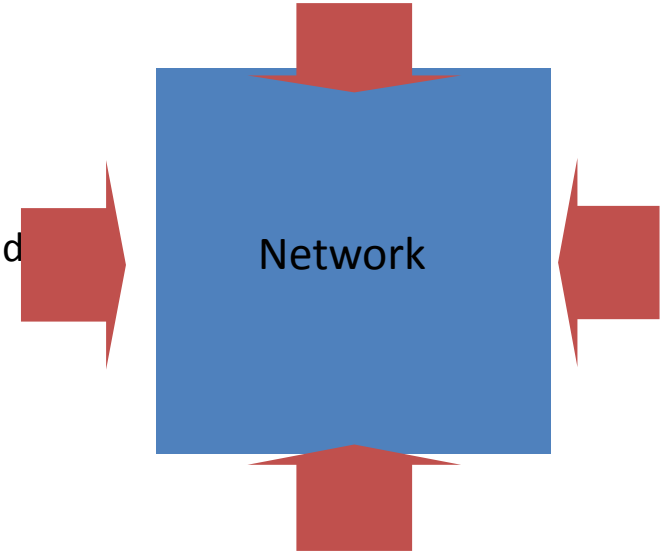
Provide high volume, low complexity treatments closer to where people live or at home e.g the management of long term conditions, outpatients and diagnostics, minor illnesses and injuries

Figure 1 – The Impact of Changes on the District General Hospital

Requirements for a successful network

Successful routing of patients across and within sites
- Clearly defined, effective triage at A&E
- Clear criteria for ambulance service
- Senior decision making needed upfront

Ability to accept patients
- Commissioning is critical
- Patients of lower acuity should be moved to accommodate more urgent cases if required
- This must be reflected in commissioning contracts



Cover across sites
- Must provide on-call cover across sites
- Contracts tied to network (not single site)
- Rotas for exposure to Major Acute to attract staff
- Reasonable travelling distance for safe transfers

Transfer protocols
- Clearly defined protocols
- Accepted by ambulance service and enforced
- Commissioning must ensure patients in hospital are not de-prioritised

Quality metrics

- Should apply to all health care organisations offering the same service in London; we must not accept a lower standard of care in local hospitals if we are to reduce health inequalities

- Need to include not only internal hospital processes but increasingly focus on networks of care so every patient reaches the correct point of care promptly and reliably - “no hand-offs”

What is performance?

$$\text{VALUE} = \frac{\text{CLINICAL QUALITY} + \text{FUNCTIONAL OUTCOME} + \text{PATIENT EXPERIENCE}}{\text{COST}}$$

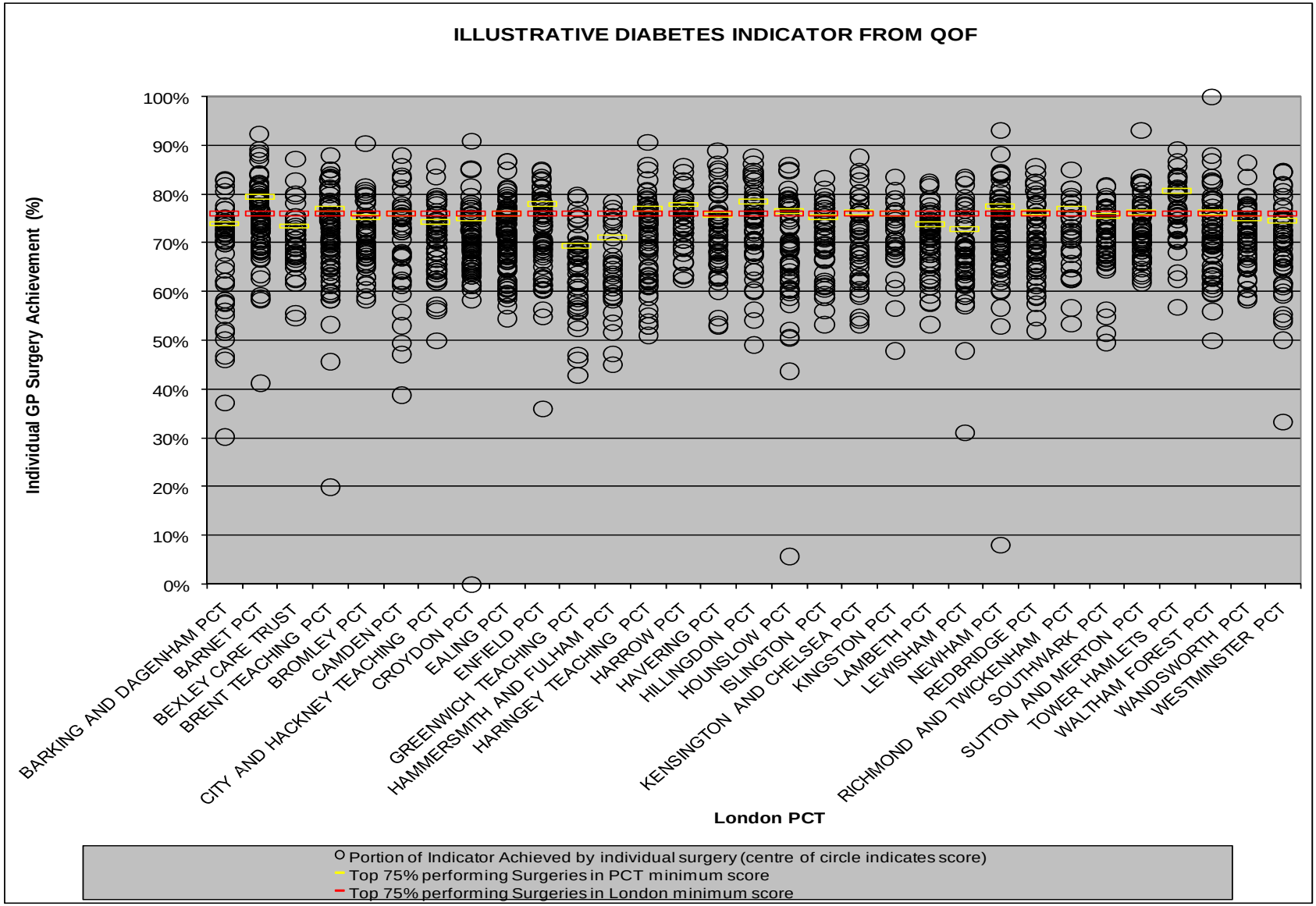
- Level of the individual condition
- Clinical quality includes outcomes and safety
- Functional outcome as measured by PROMs
- Patient experience includes access and satisfaction measures

Source: VHA; Michael Porter

Quality: chronic diseases

Outcomes and costs of a year in the life of ?

Diabetic Care: Performance of Individual Practices



Leadership is of the spirit, compounded of personality and vision; its practice is an art.

Management is of the mind, a matter of calculation, of statistics, timetables and routine; its practice is a science.

Managers are necessary, Leaders are essential

Field Marshal Viscount Slim

Team work between professionals based on mutual respect