

The 10 High Impact Changes

<p>Change No 1: Treat day surgery (rather than inpatient surgery) as the norm for elective surgery</p>	<p>The Gloucestershire Health Community has performed well in increasing the numbers of day surgery cases against the Audit Commission 'basket' of procedures. In 03/04 Gloucestershire were above the 75% target for the total day case for the basket of 25 procedures. We are confident that further progress will be made given the increased focus on BADS (British Association of Day Surgery) list of 10 procedures that can readily be undertaken as day cases and the impact of Practice Based Commissioning. There is also a concerted move towards undertaking an increasing number and range of day case procedures within primary care/community hospitals, however financial 'disincentives' can militate against this demand management activity, for example, daycase procedures coming under the same tariff as their inpatient equivalent.</p>
<p>Change No 2: Improve patient flow across the whole NHS system by improving access to key diagnostic tests</p>	<p>It is accepted that people are waiting too long for their diagnostic tests and as part of our move towards the 2008 18-week target, our current planning assumption will be to migrate towards a 2-week target wait for diagnostic tests. The PCT has already invested in primary care in order to improve local access to diagnostic tests i.e. the provision of Spirometers for the diagnosis of COPD. The roll-out of the primary care-led Heart Failure service has also led to direct referral and access to Echocardiography procedures for diagnosis within a primary care setting. It is anticipated that a number of initiatives will positively impact on the improved access to diagnostic tests such as the opportunities of Independent Sector procurement, the implementation of the Community Hospital Strategy (improved access to more localised diagnostic tests), the introduction of Practice Based Commissioning and the development of access to some diagnostic tests e.g. ultrasound, in primary care. In addition, as part of the Department of Health's commitment to reduce waiting lists for diagnostic tests, West Gloucestershire PCT will receive its share of 1,000 nationally procured MRI scans.</p>

<p>Change No 3: Manage variation in patient discharge thereby reducing length of stay</p>	<p>The management of delayed transfers of care remains a key priority for the PCT and Social Services. The PCT is currently implementing its Community Hospital Strategy which will further expand intermediate care services, resulting in more flexibility around the discharge process. PCT-supported design work in one of our registered residential homes has resulted in greater flexibility around beds and more appropriate use of this facility for delivery of true intermediate care. The PCT is also fully engaged with the secondary care-led Assisted Discharge Scheme which establishes a discharge process at the point of admission for patients with a primary diagnosis of COPD or an exacerbation of the same. Continued PCT monitoring of delayed transfers of care, analysis of elective admissions, times and pattern of discharge, cancelled operations and focus on short stay patients will help to inform developments in this area. The Chronic Disease Management work currently being undertaken by the PCT will also positively impact on the patterns of discharge.</p>
<p>Change No 4: Manage variation in the patient admission process</p>	<p>An e-referral system has been introduced into GP practices across the county over the last 18-months enabling GPs to refer patients directly to GHT. This has recently been expanded to expand to enable GPs to refer directly into primary care services e.g. vasectomy procedures. Development of the Referral Management Centre has ensured that all 'urgent, soon, 2-week wait and rapid access chest pain' e-referrals go straight through to GHT. All routine e-referrals within West Glos. PCT go via the Referral Management Centre within the PCT which reviews the referrals within appropriate referral criteria developed jointly by the PCT, PEC and GP representatives. The referrals can be re-routed through a different pathway with a shorter waiting time and have 'quality' checks applied against INNF guidelines. We are currently undertaking a review of the level to which these benefits might be maintained within the 'choose and book' programme. Peer review of referral practice has also been included within GP Protected Learning Events.</p>

<p>Change No 5: Avoid unnecessary follow-ups for patients and provide necessary follow-ups in the right care setting</p>	<p>The PCT has begun to address the issue of reducing (unnecessary) follow-up appointments in secondary care. One example of this can be seen in the management of diabetes care. The PCT has identified a significant number of patients whose condition is stable but continue to receive routine follow-up appointments in specialist clinics in secondary care. By identifying these patients, follow-up appointments (if required) can be undertaken by the most appropriate person (often in nurse-led clinics) in the right place (primary care) and at the right time; it is anticipated that this will result in reduced waiting times, and greater choice and control for the patient and hence greater patient satisfaction. Roll-out of Phase II of the Heart Failure Service will see the identification of those people admitted to secondary care with a diagnosis of heart failure. These patients, typically with more complex and palliative care needs will be case-managed within the community.</p> <p>The appointment of a Consultant post for Mental Health in Older People will support service re-design and help sustain older people in the community together with providing increased choice.</p>
<p>Change No 6: Increase the reliability of performing therapeutic interventions through a Care Bundle approach</p>	<p>There is a requirement for the PCT to engage with specialist care providers to ensure that evidenced-based practice is included in local protocols and implemented across all therapeutic interventions. This process can be augmented by the implementation of the standards set out in the relevant National Standards Framework documentation and NICE technology appraisals and clinical guidelines and will provide an objective assessment of the quality of care. The PCT via its role on countywide, multidisciplinary service groups will be able to fulfil a monitoring and governance role by measuring reduced morbidity, and reporting on complication rates and adverse events. Outcome-based monitoring has also been introduced within the GHT Foundation Trust contract. Best practice and clinical efficacy also forms an integral part of the remit of a number of groups within the PCT including the Gloucestershire Medicines</p>

	<p>Management Committee, Research and Clinical Effectiveness Group and Interventions Not Normally Funded. The NICE Implementation Sub-Group also plays a role here overseeing the published guidance.</p>
<p>Change No 7: Apply a systematic approach to care for people with long-term conditions</p>	<p>The PCT is developing a strategic and systematic approach to the management of Long Term Conditions. An action planning meeting is scheduled to determine strategy and coordinate the implementation around the various strands of work currently underway across the PCT. These include the roll-out of Phase III of the Primary Care Collaborative – Chronic Disease Management, engagement in the ‘Patch Works’ project – a joint initiative with Social Services to improve the management of people with chronic diseases’ and referral of appropriate people onto the Expert Patient Programme – an Expert Carers Programme is also being piloted across the patch. The ‘Unique Care Model’ in conjunction with the NHS and Social Care Model is being promoted regionally to encourage systematic and proactive approaches to care. The Heart Failure Service is now moving into its 2nd Phase which will see the identification and management of those patients with palliative care needs. The PCT will also be rolling out the DESMOND programme – an accredited education programme for newly diagnosed type 2 diabetics. Those patients with COPD who have greater than 2 non-elective admissions into secondary care within a 12-month period are being systematically identified and followed up in primary care and appropriately managed by the PHCT.</p>
<p>Change No 8: Improve patient access by reducing the number of queues</p>	<p>The PCT has undertaken a baseline assessment of current GHT activity against Clinically Prioritise and Treat (CPaT) methodology. Further assessment is underway using the National CPaT Toolkit software. The CPaT principles are clearly incorporated into the Demand Management schedule of the FT contract and the PCT continues to work with the Hospital Trust to ensure appropriate monitoring is in place. The e-referral system also provides a default system of referral (i.e. Dear</p>

	<p>Doctor,) and the Referral Management Centre enables the PCT to monitor patient access and wait times. We envisage that the introduction of Practice Based Commissioning will provide an opportunity for greater management of waiting list issues at primary care level in response to local circumstances.</p>
<p>Change No 9: Optimise patient flow through service bottlenecks using process templates</p>	<p>The PCT undertakes regular analysis of patient flows which helps to inform our re-design activity (including through the Referral Management Centre). Examples of such include the work undertaken around the implementation of Out of Hours and co-location with Accident & Emergency in Gloucester, 'Collaborative' methodology for the management of patients with long-term conditions such as Diabetes and COPD, the SMART Care Rheumatology and GI projects and ongoing work with those patients who are identified within the system as multiple non-elective admissions. A specific countywide group has been set up to address care pathway design as part of the Choose & Book implementation programme.</p>
<p>Change No 10: Redesign and extend roles in line with efficient patient pathways to attract and retain an effective workforce</p>	<p>The PCT through a number of service-led groups will continue to monitor that patient pathways and clinical skill mix is optimised to ensure a smoother transition through the patient journey. Redesign is at the heart of developing independence for the patient and primary care services where appropriate. This will require developing the skills of the primary care workforce and increased partnership with other local organisations – both statutory and non-statutory. The PCT has already embarked on a number of initiatives such as the appointment of 2 Diabetes Specialist Nurses (to develop and re-design the management of care for people with diabetes in the community, and the re-design of access to Podiatry services including the planned development of a Podiatry Assistant role and appointment of the Podiatric Surgeon to a podiatric surgery post to divert appropriate orthopaedic activity into primary care. The 'choice' initiative will further open-up alternative primary care-led patient pathways, examples of which include the implementation of Physio Direct (direct self-referral and access), the Orthopaedic Screening Service, the development of Diabetes Specialist Nurse</p>

	<p>roles, Nurse Consultant for Carpal Tunnel Syndrome, Nurse Practitioners in Accident & Emergency and the development of Modern Matrons to underpin the chronic disease management agenda. Work has also been undertaken in Mental Health in particular to provide an enhanced GP role in the treatment of substance misuse and the employment of Graduate Mental Health workers to triage and support patients within primary care.</p>
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