



# briefing

JUNE 2008

# Investing for Health

## Step 2: Delivering our clinical vision for a world-class health service

### Our vision – from reaction to prediction

Our vision for health services in the West Midlands over the next five to ten years is that we will:

- work with patients, staff, carers, partner organisations and the public to provide a service that ‘adds years to life and life to years’
- aim to achieve levels of care comparable to the best in the world by transforming services from reacting to patients to being driven by them
- deliver patient-centred care of the highest quality and also a step-change towards great management of population health and support for people to manage their own health.

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In November 2007, NHS West Midlands published *Investing for Health – a Strategic Framework for the West Midlands*. This set out how health services in the West Midlands could build on the improvements already made during the previous ten years.

While we were developing this plan, the Government announced *Our NHS, our future*, a review that is intended to ensure that the NHS as a whole is capable of meeting the challenges it faces in the next ten years. This review is being led by Lord Ara Darzi.

Lord Darzi’s views on the case for change mirror our findings in *Investing for Health* and his review process fits perfectly with the plans for the next steps of our work into the development of meaningful clinical pathways for patients and staff.

This document is a summary of a report that is both the West Midlands’ *Our NHS, our future* vision and step two of *Investing for Health*. The report is the next stage in what Lord Darzi calls a ‘ten-year journey of change’. This is not the end of the process, however; local solutions need to be found to deliver the changes and these will involve dialogue and consultation with patients, carers, the public and NHS staff across the region.

You can see a copy of the full report and the reports from the nine clinical pathway groups at [www.westmidlands.nhs.uk](http://www.westmidlands.nhs.uk)

## Investing for Health in the West Midlands

*Investing for Health* identified seven big challenges that we need to address if we are to create a health service that meets the needs and rising expectations of local people and moves our services from good to great.

### **Challenge 1: Despite improvements in overall health status, inequalities in health have increased**

People in better-off areas live longer than people in more deprived areas – and the gap is getting wider.

### **Challenge 2: There remains an unjustifiable variability in the quality and safety of services and individual care, and a significant number of complaints are received about standards of fundamental care**

For example, we know that things go wrong too often in hospitals in the West Midlands. There are approximately 134,000 errors each year, 40,000 of which are preventable. In addition to the effect on the people concerned, such errors cost the health service in our area around £315m through the extra time people have to spend in hospital. The quality of primary care is also highly variable.

### **Challenge 3: Patients expect services to be joined up and to have co-ordination across teams caring for them, yet at present, patients and the public often struggle to understand how health services work**

The NHS aims to provide services in the right place at the right time, but often the public is not clear

what we mean by ‘the right place’. Sometimes, even NHS staff are not clear what we mean. Changes in the NHS will also lead to more organisations providing services in the future in a wider range of settings, so the potential for confusion is even greater.

### **Challenge 4: The public – our ‘customers’ – have little confidence that their local NHS will get better**

In a survey in 2006 of what West Midlands residents thought about healthcare in the region, just 26 per cent of the respondents thought that local NHS services would get better or much better over the next year or so.

### **Challenge 5: We are not investing enough in prevention**

We know that investing in preventing ill health will produce enormous benefits. However, many people continue to ignore the advice that helps to keep them healthy, while the services commissioned by the NHS to support them in improving their own health are highly variable. The way the health service is set up does not provide the right incentives to encourage those delivering services to invest more in prevention.

### **Challenge 6: We continue to spend substantial resources on clinical activities that, the evidence suggests, bring little or no return on the investment in terms of improved health, or where the evidence shows that there are other, better and more cost-effective alternatives**

The NHS estimates that £9.5m could have been saved in the West

Midlands in the first half of 2006/07 by better control over five procedures that are often overused and from which patients derive little or no benefit.

### **Challenge 7: Cost pressures arising from doing ‘more of the same’. An ageing population, a rising tide of long-term conditions and an accelerating pace of technological development combine to outstrip any conceivable rate of increased funding**

In recent years, the Government has increased the amount of money going into health, but this increase is likely to slow down. The NHS, therefore, will have to get better value for money from existing resources.

## Strategic priorities

*Investing for Health* also identified five themes – our strategic priorities – that must guide health services now and in the years to come if we are to be successful in responding to the big challenges. The five strategic priorities are listed below.

### **Full engagement**

This is about getting people more involved in their own healthcare – for example, adopting lifestyles that promote good health, avoiding things that are a risk to health and doing more to look after themselves, with guidance from health professionals. It is also about ensuring a rich supply of information for patients on health and health services, and about extending the availability of services that can support people in managing their own health.

**Improving quality and safety**

This is a priority, not because the quality and safety of care in the West Midlands is worse than elsewhere in the NHS, but because our ambitions are higher than achieving the average – we want to be the best. We are sure the quality of our services can be improved.

**Care closer to home**

The focus here is particularly on patients with long-term conditions. By developing a skilled and flexible workforce, we will be able to provide high-quality, integrated care in the community. Informed patients will be true partners in their own care, while care closer to home should

also mean earlier interventions for those with long-term conditions.

We also need to do more to ensure greater ease of access to a wider range of primary care services – including dentistry – alongside informed choice for patients.

**Sustainable services**

Health services need to change to respond to the changing needs of patients, staff and the public. This means making sure that services are based on clear and efficient pathways and meet the highest standards of best practice, as defined by clinical evidence. The changes made must be sustainable; they

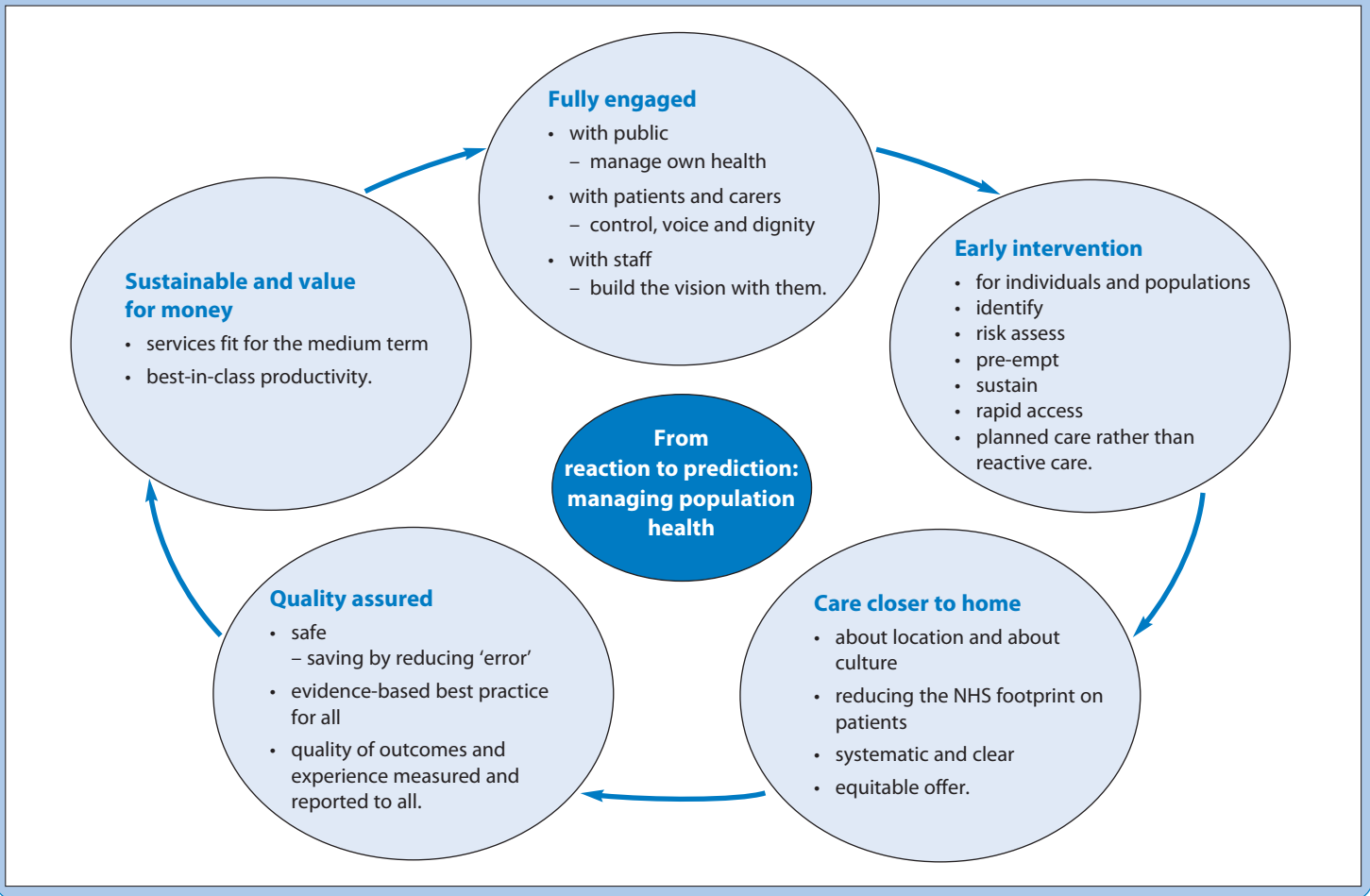
*'Improving quality is a priority because our ambitions are higher than achieving the average. We want to be the best'*

must be the right services, be affordable and make good use of resources.

**Organisations fit for purpose**

This priority is about ensuring that health organisations in the West Midlands – those who commission health services and those who provide them – have the capability to deliver a high-quality, accountable and safe health service.

**Delivering our clinical vision – from reaction to prediction, managing population health**



*'More than 1,000 frontline staff took part in the ten regional summits sponsored by NHS West Midlands'*

## What patients, carers and the public told us

Surveys of patient and public opinion played a big part in our Vision report and we built significantly on these foundations for the national review. Events that helped inform the reports of the clinical pathway groups included:

- two national consultative events in each region with public and staff
- a national survey of adults
- a national online survey open to all
- a West Midlands patient, carer and public summit with all clinical pathway groups
- a West Midlands Ipsos MORI poll of 1000 adults on clinical pathway group questions
- Ipsos MORI research on specific clinical pathway group areas of interest, with targeted patient groups<sup>1</sup>.

At the West Midlands patient, carer and public summit, participants were asked:

- if they thought that the clinical pathway groups had addressed the right issues
- if they had any concerns about what the groups had told them
- what they thought of the proposals

- how did they think obstacles to improvement could be overcome.

Some general themes emerged from these local and national conversations with patients, carers and the public. These can be grouped under seven headings (see box below).

### What people told us

- 1 We want services centred on patients and carers, with real choices.
- 2 We want care closer to home.
- 3 Give us more and better information. Information is power, so share it among yourselves too, and make your services easier to navigate for patients and staff.
- 4 It makes sense to prioritise prevention and early intervention.
- 5 We expect consistently high-quality and safe services and fairness in provision. We simply cannot understand or accept the extent of variability in quality and outcomes, nor the 'postcode lottery' of treatment/availability.
- 6 We want dignity in care and a new NHS culture of genuine engagement.
- 7 Actions speak louder than words.

More specifically, the consultative event we held in January 2008, where participants heard a summary of the clinical pathway group proposals, allowed us to identify participants' top priorities for each pathway.

## What staff have told us

In addition to the direct involvement of clinical staff in the clinical pathway groups, NHS West Midlands sponsored ten staff summits, one in each area of the region. These were mainly intended for frontline staff from hospital, community, primary care and social services. More than 1000 staff took part.

The key messages to emerge from these summits are listed below.

**The importance of care pathways** – staff wanted to see pathways and standards of care developed and implemented rigorously. They wanted pathways to be properly communicated to staff and patients, and adherence to them measured.

**Access** – staff recognised the need for services to be much more accessible in order to raise standards and to tackle inequalities. Although many staff did not relish working outside conventional hours, there was a view that this is now necessary, particularly for primary care, diagnostics, social care, critical care and mental health care.

**Service information and communication** – staff commented on the noticeable difference between informed and uninformed patients and how that affects ease of access to services. They acknowledged that they too did not always have a full understanding of how the health system worked in their area. Staff also said they wanted more information that allowed them to compare their services and to see where inequalities were occurring.

**Inter-agency working** – staff felt that organisational boundaries were

<sup>1</sup> Ipsos MORI Social Research Institute, 2008

inhibiting best care for patients and wanted a system that promoted inter-agency working.

**Empowering patients** – staff thought more should be done to empower patients and support them in managing their own health, and that they should be better equipped to do this.

**Commissioning for quality** – staff thought that quality should be driven by commissioning based on outcomes and on pathways, and carried out jointly with partners where appropriate.

**The ‘NHS footprint’ on patients (the impact on their time and resources when the NHS does not deliver one-stop services)** – staff accepted that current care models and organisational arrangements did not serve patients well and that this had not been given enough attention.

**Prevention needs to be prioritised and incentivised** – staff believed that prevention needed to be embedded within the culture of all services and within all pathways.

**There should be a more intelligent approach to managing the need to get best value for money** – this included: investing in the right areas to deliver the right outcomes; investing in new services where needed and ceasing to invest in those that are no longer needed; investing in training; empowering citizens to take more responsibility for their own health; and better partnership working.

**Capital investment versus care closer to home** – staff felt that there was an over-reliance on

investment in buildings, which was constraining the movement of care closer to home and investment in primary care, resulting in an emphasis on treatment rather than prevention.

**Effective information technology** – staff felt that IT was developed in isolation from frontline services and needed to be driven by staff and patients' needs to maximise its benefits in their everyday work.

**Give change time to work and invest in it properly** – while staff were often positive about change, there was also frustration that it was sometimes not allowed to settle in before more changes were required. Change was seen to be often politically motivated rather than patient focused.

## West Midlands Framework for Excellence

Having identified the seven main challenges for health services in the West Midlands, pinpointed the priorities for improvement and heard the views of patients, staff and the public, we have developed a framework against which we can test whether or not our plans meet the needs of our stakeholders.

We call this the West Midlands Framework for Excellence. It sets out the challenges alongside our aims for different groups, showing what we want for patients, for the NHS workforce, for the public, and for other organisations that work with NHS patients (see page 7).

*‘The Framework for Excellence allows us to test whether or not our plans meet the needs of our stakeholders’*

## Clinical pathway reports

The nine West Midlands clinical pathway groups were asked to consider for their services:

- what would a great service look like?
- how different is that from what we have now?
- why the difference?
- what would be the most important steps to take to bridge that gap?
- what are the obstacles that need to be tackled to make that easier?

While each group made recommendations specific to their service area/population group, eight key themes emerged across all the clinical pathway groups:

- the need for services to be centred on the needs of patients, carers and families
- the importance of pathways to deliver clinical excellence
- the opportunity to achieve much more care closer to home
- the power and importance of information and help to navigate the system – for patients and staff
- a balance of prevention and cure
- the need to target services at those with greater need for equality and impact
- the need for more and different skills, and new types of worker

## Top priorities for clinical pathways

<b>Staying healthy</b>	<ul style="list-style-type: none"> <li>• Ensure GPs are more proactive in general evaluation of health.</li> <li>• Promote self-care and help people to feel more in control of their own health.</li> <li>• Make it easier to identify lifestyle risks and assess the impact they might have; help people to access services with choice.</li> <li>• Introduce motivational services tailored to the individual, with attainable goals that are followed up.</li> </ul>
<b>Maternity and newborn</b>	<ul style="list-style-type: none"> <li>• Adopt an holistic approach, involving social, emotional, mental health and educational factors.</li> <li>• Introduce real choices, with services closer to home.</li> <li>• While pregnancy should be seen as a normal event, there should be rapid and equitable access to obstetric-led and specialist neonatal care when needed.</li> </ul>
<b>Children's services</b>	<ul style="list-style-type: none"> <li>• Put the emphasis on early detection and prevention, for example in obesity.</li> <li>• Involve families and schools in care plans.</li> <li>• Create key worker roles and promote intelligent use of communication with children.</li> </ul>
<b>Mental health</b>	<ul style="list-style-type: none"> <li>• Introduce a short referral-to-treatment time, and early diagnosis and intervention.</li> <li>• Clarify pathways for people who have depression.</li> <li>• Get rid of age discrimination.</li> <li>• Give more choice of treatment options.</li> <li>• Value groups and patient networking support.</li> <li>• Address physical health needs.</li> </ul>
<b>Planned care</b>	<ul style="list-style-type: none"> <li>• Offer diagnostics and pre-surgery checks in community settings.</li> <li>• Give GPs direct access to information so they can discuss issues with patients.</li> <li>• Provide opportunities for feedback on quality of care.</li> </ul>
<b>Acute care</b>	<ul style="list-style-type: none"> <li>• Offer the best possible treatment for life-threatening conditions.</li> <li>• Introduce consistent pathways for all patients.</li> </ul>
<b>Long-term conditions</b>	<ul style="list-style-type: none"> <li>• Empower people to care for themselves, with personalised care plans, supported as necessary by community workers.</li> <li>• Give better support and advice for carers.</li> </ul>
<b>Dementia</b>	<ul style="list-style-type: none"> <li>• Offer swift access to a memory-assessment service and appropriate diagnostic tests.</li> <li>• Enhance the quality of services in primary care, acute hospitals and within the care sector.</li> <li>• Introduce shared protocols for anti-dementia drugs.</li> </ul>
<b>End-of-life care</b>	<ul style="list-style-type: none"> <li>• Dignity is critical – end-of-life care should be top of the agenda.</li> <li>• Involve patients, carers and families in decisions.</li> <li>• Offer round-the-clock access to generalist and specialist services.</li> <li>• Always keep options under review.</li> </ul>

## West Midlands Framework for Excellence

### What we want for patients

- You are treated with dignity.
- You receive the safest, highest-quality care as close to your home as possible – but where specialisation and centralisation is essential to ensure highest clinical outcomes, we will deliver it for you.
- You and your carers are involved in decision making about your care and are able to make informed choices about the care you receive – your preferences are sought, respected and documented in a personalised care plan. You are supported to manage your own health if that is what you want.
- You are able to access and receive care in a timely manner, including out of hours.
- You are assisted to be aware of the effect that lifestyle choices such as exercise, fruit and vegetable consumption, alcohol and smoking have on your health and can access and choose between a range of services you need to help you to make healthier choices. The NHS will support you in seeing these changes through.
- You receive care that is joined up in a way that makes sense to you and your family/carers, and that makes the minimum possible demands on your time and resources.
- You have clear information about what excellent services look like and about how the choices available to you compare with that.
- You can access regular health check-ups and that, at every contact you have with the NHS, your health professional will be working with you to spot health issues early and to offer preventive options.

### What we want for the NHS workforce

- You feel proud to work for your local NHS and not just for your own organisation.
- You work in an environment that champions good and safe practice and you receive excellent training, development and personal support.
- You are trusted and empowered to do what is right for patients, including working across organisational boundaries.
- Clinical pathways will be identified and respected.
- You will be given skills and support so that you can make every patient contact an opportunity for improving health.
- That you are treated with respect and dignity in healthy and safe work environments where there is zero tolerance of violence and aggression.
- You are given meaningful information to show you how services and health compare across areas.
- You are fully involved in designing the NHS of the future.

### What we want for the public

- All parts of the population can be confident that you, your families and loved ones have equitable access to high-quality care because the NHS is identifying and sharing best practice so that real improvements are quickly made available to all.
- The NHS makes available excellent information in a wide range of formats so that everyone has sufficient information about the services we offer and about their own health to make best use of those services.
- The NHS is offering taxpayers value for money, spending every pound to maximally improve health and reduce disabilities and so that fewer people are denied work through ill health and fewer children have disrupted schooling through ill health.
- The NHS is deciding how to develop its services and is in a full and serious dialogue with the public about that.
  - You can be confident that the NHS is making its full contribution to the wider economic and social good through its role as employer and trainer, buyer of goods and services, developer of major infrastructure and in its demands for energy, transport and waste management.
  - You can be confident that the NHS is fully prepared and able to respond to major **crises**.

## Investing for Health

### The seven challenges

**Widening inequalities** > *narrow the gap*

**Variability in quality and safety** > *reduce variability and raise the bar*

**Too little prevention** > *right the balance, effectively*

**Low return on investment** > *buy what works, consistently and robustly*

**Cost pressures and opportunity costs** > *the bold investment strategy in Investing for Health must be pursued*

**Low public confidence** > *build confidence through demonstrating progress in what matters to people, sharing information and joining up services, reducing the NHS footprint on patients*

**Services difficult to navigate** > *tackle that explicitly*

### What we want for other organisations that work with the NHS

- Your contribution is respected and valued by the NHS.
- You are given clarity on which contributions are NHS priorities, so as to enable you to focus your energies in developing plans and proposals, and so that you can be clear about where to take those plans for consideration.
- You are part of co-ordination systems supporting the care of patients.
- You are given the opportunity to get involved as a partner in designing the NHS of the future.
- You can make a contribution to how the NHS utilises its resources in pursuit of education, training and workforce development.

*The change will help people enjoy healthy lives, live longer and maximise independence'*

- Vision into action – the importance of getting the basics right, with rigorous and consistent local planning within a regional framework of continuing clinical leadership.

Each group has produced a full report on its findings along with recommendations for action. Here, we present a brief outline of the vision set out in each report. For further details of specific pathways and the associated actions, however, it is essential to view the full report, which is published at [www.westmidlands.nhs.uk](http://www.westmidlands.nhs.uk)

### Staying healthy

Our overall vision is that the NHS as a whole should do more to support people in staying healthy. This means commissioning evidence-based and high-quality services that promote good health, targeting work on known health risks, encouraging healthy lifestyles and underlining people's need to take responsibility for their own health.

For individuals, the changes we envisage will help them enjoy healthier lives and live longer. Investing in the prevention of ill health can produce enormous benefits – it has been estimated that at least 80 per cent of all premature heart disease and over 40 per cent of all cancers could be prevented through healthy diet, regular exercise and by not smoking.

Patients in general will benefit from the changes in a number of ways. Communities will become actively engaged in improving their own health and everyone, throughout their life, will have better opportunities to take greater control of their health. This is what we call full engagement.

The changes will make it easier to get hold of information about specific services, as well as tailored information to help people improve their lifestyles. This will help people to stay as healthy as they can be, and maximise independence for as long as possible. The opportunity to tackle preventative health improvement will be incorporated in the clinical pathways for all other services, so that every clinical contact can be a health-improving contact. This will require extensive staff training and support to ensure the workforce can support people in managing their own health.

People with mental health problems will benefit from a wide range of services to promote mental health, for example schemes to improve their physical fitness. Mental health services will include schemes to help people back into the workplace and support them once they are there.

Differences in needs and expectations between ethnic minority groups, between age groups and between social groups will be reflected in our services.

The group identified seven essential elements of effective staying healthy pathways (see box, right).

### Seven elements of staying healthy pathways

#### Everyone's business

Everyone – individuals, communities, organisations and society as a whole – needs to take more responsibility for good health.

#### Mainstream, not marginalised

All commissioning specifications should require providers to promote healthy lifestyles, and all clinical pathways should take account of 'staying healthy'.

#### The highest priority

All NHS organisations should expect to demonstrate a year-on-year shift of resources towards prevention.

#### Systematic and evidence based

Right across the NHS, we need to be better at implementing interventions that we know work well.

#### Led from the top

Promoting good health and disease-preventing services should be a priority for the most senior managers as well as for health promotion workers.

#### Effectively commissioned

Commissioners must ensure that the services they commission follow the good health pathway right through from primary prevention.

#### All inclusive

People and patients will be fully involved in their own health and healthcare, adopting healthier lifestyles on the basis of an assessment of their risks, with the option of support and guidance from a range of professionals.

## Maternity and newborn

Maternity and newborn services represent the care provided to women and their babies before, during and after childbirth.

Our vision is for maternity services that are planned and delivered as a community-based service, integrated with primary care and embedded in the wider community provision, with a focus on health and well-being. While it is essential that pregnant women have rapid and equitable access to high-quality, obstetric-led and specialist neonatal care if needed, our vision is of a service that starts from the belief that pregnancy is a normal physiological event.

Care should be based on assessment of social as well as clinical risk, with targeted outreach support for the most vulnerable women. Midwives should be the named professionals for normal pregnancy, able to provide women with a network of social and clinical support. This should result in improved satisfaction, better detection and early treatment of high-risk mothers and babies, leading to long-term health gains.

Consideration should be given to meeting some of the current growth in the birth rate with community-based birthing units. Women should have much greater choice over where they receive their care.

### The model of care

The model of care recognises the importance of a balance between the emotional, social and educational needs of all and the need for medical intervention for the few. It is based on:

- a mother- and baby-centred approach that treats pregnancy and maternity in general as a normal event
- an emphasis on the recognition and assessment of social and medical risk
- the available infrastructure and resources to provide 'high-risk' care where required.

The model involves actively assessing and managing personal and family factors that are recognised to cause problems – such as smoking, obesity, mental health and substance misuse. Women who have experienced domestic abuse or whose first language is not English will also need additional support.

Other important aspects of the model of care include:

- equity of access to pre-conception advice, antenatal screening and assessment, normal birthing centres, home visiting, mental health services, health improvement, social support, education and the obstetric service
- access for women and their babies to obstetric and neonatal services as clinically necessary, supported by a dedicated transfer service from the community base to the obstetric service
- a professional-development programme to extend the skills and competencies of maternity and neonatal staff to meet the wider needs of women, not just their immediate obstetric need
- pregnancy-support workers to provide additional support to meet women's more specific needs

*'Midwives should be the named professionals for normal pregnancy, able to provide women with a network of social and clinical support'*

- support from integrated maternity and neonatal networks across the region – it is essential that neonatal and maternity services are not planned in isolation from each other
- an emphasis on competencies, not professions. All professionals dealing with children should have appropriate training and experience. Skills and competencies of staff are more important than their professional alignment.

## Children's services

The clinical pathway group covered all aspects of services for children from birth to 18 years of age, as well as services for the unborn child. Children's services interface with all of the other clinical pathways, and it is critical that there is a smooth transition between child and adult services. It should be recognised, however, that the needs of all children and young people differ from those of adults. Children's health, education and social care are all linked.

The clinical pathway group's vision is 'to provide high-quality children's healthcare that focuses on the needs of the child and is delivered at home, or as close to home as possible'.

The needs of children and their families will drive the organisation and provision of high-quality, family-centred health services, based at home or in the community wherever possible. All organisations, including local authorities and the

*'Children will benefit from better health promotion and earlier detection and intervention'*

education, health and voluntary sectors will integrate services. Organisational boundaries and contractual agreements will not stand in the way of providing the best possible care.

There will be a clear pathway for children between the universal and specialist services they require, so as to avoid unnecessary steps and duplication of effort. The pathway also helps the NHS to ensure staff have the appropriate skills and competencies.

The clinical pathway group put forward seven key messages (see box, below).

From the patient's point of view, this approach should mean fewer admissions to hospital, fewer inappropriate referrals, and less duplication and variation within the system. Children will benefit from better health promotion and early

detection and intervention and there will be a smoother transition from child to adult services.

Family-centred services will allow children more chance of maintaining 'normality' in home and school life, especially those with long-term or complex conditions.

Eight care pathways have been expanded upon in the report: the sick newborn; the vulnerable child/safeguarding; the child with trauma or head injury; the child with a long-term condition such as Duchenne muscular dystrophy; obesity; emotional health and well-being; palliative care; and paediatric surgery.

### **Mental health**

Mental illness is common. It affects about one in six people in Britain. People with a mental illness can experience problems in the way they think, feel or behave. This can significantly affect their relationships, their work and their quality of life.

The clinical pathway group adopted the overarching message: 'There is no health without mental health'.

Our vision is for a pathway that aims to:

- promote and sustain good mental health
- provide easy access to services and prompt diagnosis
- offer a choice of effective interventions and swift treatment
- promote recovery and long-term health and well-being.

The pathway will result in coherent, consistent services for people with mental health problems, equity of access by age or additional disability and the delivery of services based on evidence.

It should lead to fewer premature deaths, a better quality of life for people with mental illness and a reduction in unnecessary treatments, especially for those who also have physical health problems.

Mental health cannot be just an NHS responsibility, since many mental health problems do not respond to clinical intervention alone. A range of other support is needed, for example, social support and help with housing or employment. Comprehensive care, structured through a care pathway, requires strategic commissioning and better partnership working across the health, social care, voluntary and community sectors.

Mental health problems must be identified early and tackled by ensuring that there are sufficient resources and appropriate skills available. All health and social care staff should have a basic understanding of mental health issues and actively work to reduce the stigma that surrounds them.

### **Children's services: seven key messages**

- 1 More effective health and well-being promotion is needed.
- 2 Each local area must provide specialist services in the community for children with illnesses or long-term conditions.
- 3 Each local area must provide adolescent services.
- 4 The NHS should make it easier to identify and share good practice.
- 5 Providers must work together to construct integrated, seamless pathways and to improve quality and outcomes.
- 6 Children's needs are paramount.
- 7 Reconfiguration of services is vital to ensure viable and safe services, and it is essential to engage with communities and to seek public opinion where potentially controversial changes are proposed.

The group identified the key themes for developing a pathway for mental health (see box below).

### Key themes for developing a pathway for mental health

**Get the core services right** – ensure equitable, consistent, modern, comprehensive mental health services for people who need them.

**Stop premature deaths** – ensure high-quality, equitable physical health services for people with mental health problems, learning disabilities, substance-misuse problems and organic mental health problems.

**Better support for carers** – recognise the role of carers and do more work on identifying needs following assessments; provide more respite care.

#### Planned care

Planned care is care that can be scheduled in advance and involves patients and/or their family or carers in its organisation. It can take place in primary care, community settings or a hospital. The planned care pathway usually involves the scheduling of a range of interventions, including assessment, diagnostic testing, treatment and review. Common examples of planned care include hip-replacement operations, cataract removal and hernia treatment.

Our vision is that, in future, as much care as possible will be planned care – as opposed to urgent or emergency care when the problem has become critical. This will:

- follow agreed pathways that patients understand and that are based on clinical best practice
- be easy for patients to navigate – they will know where they are on the pathway and be aware of what happens next
- respect the diversity of patients and seek to respond appropriately to the full range of their needs
- be organised so it does not waste patient or clinical time or resources
- be provided as locally as possible – care closer to home.

For patients, the vision also means less time in hospital if they require surgery and faster recovery from less invasive surgery.

The proposed pathway for planned care is based on the major stages set out below and a set of principles that should apply to these stages.

#### Self-assessment and self-care

Support for patients in their decision to access planned care, with reliable, accessible advice on symptoms and condition management.

#### Primary assessment and treatment

Quick and convenient access to primary care, supported by diagnostics and electronic links for referral.

#### Specialist assessment and treatment

A range of routes for more specialist treatment. All should aim to be 'one stop' and delivered as locally as possible.

#### Supra-specialist assessment and treatment

Certain specialist treatments will be

*'A single point of access to acute care could potentially be an 888 number available around the clock'*

carried out at specialist centres – for example cancer surgery.

#### Review and rehabilitation

Patients should be well prepared for discharge. A range of community services should be in place to support care closer to home.

#### Acute care

This clinical pathway group concentrated on urgent and emergency care in an acute setting. This is care that is not planned – for example, an accident, a suspected heart attack or the worsening of an existing condition. Often patients themselves will decide where to go in such a case and at present, that is generally a hospital's A&E department, or their GP – including out-of-hours services.

Our aim is for patients to get the right treatment in the right place without unnecessary delay. At the moment, people can be unsure what to do or where to go if they think they have an urgent health need – indeed, not all NHS staff are clear about which services should be used, when and how.

The vision is for a single point of access – potentially an 888 telephone number available around the clock. People calling this number would have their needs assessed (triaged). Although this single point of access would be widely promoted, there would also be other ways for people to enter the urgent and emergency care system, for example by going to an urgent care

*'Vulnerable and hard-to-reach groups will be sought out to ensure they have equal access to high-quality care'*

centre. However, the assessment would be common to wherever patients accessed the service and the system will be responsible for ensuring that the patient is seen and treated by the most appropriate professional in the most appropriate setting.

Better provision of information to the public, combined with education programmes and alternative support services in the community, could increase the number of people who have the ability and confidence to self-care.

Overall, the quality of care will be increased, along with patient and staff satisfaction, because of the streamlined access to appropriate urgent care services.

The pathway will increase the number of patients being assessed and receiving treatment in or close to their own homes. It will also increase the numbers receiving rapid diagnostics and given care plans.

The clinical pathway group made three key additional points (see box, below).

### Long-term conditions

Long-term conditions are those that cannot, at present, be cured but can be controlled by medication and other therapies. At least 15 per cent of people in the West Midlands have a long-term condition, such as diabetes, asthma, hypertension, heart disease or chronic kidney disease.

The vision for people with long-term conditions combines much greater involvement by patients in their own care, which will be better co-ordinated and more personalised. People will be helped to take responsibility for their health, including how to prevent, detect and treat their illness. The vision demands an approach that seeks out vulnerable and hard-to-reach groups to ensure they have equal access to high-quality care.

There will be active care, finding a rapid diagnosis with early interventions, provided closer to home, with patients as lead partners in decisions. All interventions will be co-ordinated around patients, and accessible at their convenience.

Healthcare professionals will work as a single team across traditional health boundaries, using the best evidence to discuss a range of treatment options with their patients. Patients will benefit from greater involvement in their own care and from being able to better manage their conditions. Care will be personalised, tailored to individual needs and the approach will be one of treating the whole patient, not just the condition. Patients will be guided through the system by their own care co-ordinator.

The clinical pathway group identified a number of steps (see below) on the long-term conditions pathway and highlighted the actions that we need to take in the West Midlands to make our vision of an improved service a reality.

### Prevention and early detection

This is about doing more to tackle many of the underlying causes of long-term conditions, such as smoking, poor diet or lack of physical activity, and identification of at-risk patients.

### Self-care

We need to introduce more self-management programmes, which will result in increased well-being for patients.

### Single-team approach

To provide proactive, responsive and integrated care, we need a system that will help us to know more about the population and the risks of people developing long-term conditions.

We need to identify patients who are being seen in hospital outpatient

### Acute care: key points

- In the absence of demonstrable benefit to alternative urgent care provisions, there is a need to gear up A&E services to cope with the instinctive path that patients take – this will be influenced by local geography.
- All A&E departments should incorporate urgent care centres (UCCs) but not necessarily the other way round.
- In the West Midlands, some concentration of the most specialist emergency services into major emergency departments is necessary to achieve the best quality of care for patients with, for example, stroke, heart attacks and major trauma.

departments who could be seen in the community. Good rehabilitation services need to be in place to help patients live independently.

We need a major programme of training to ensure a far greater proportion of the frontline workforce are able to support people with long-term conditions and understand key clinical alert signs. Staff also need the ability to develop individualised care plans with patients, to empower patients and to support them with behavioural change.

### End-of-life care

End-of-life care has to be considered in relation to the care pathway for people with long-term conditions.

### Dementia

Dementia is a neurological condition with symptoms of progressive decline of mental abilities, accompanied by personality and behaviour changes. There is usually a loss of memory and the ability to carry out everyday activities.

Our vision is that by 2012, all people with a suspected or confirmed diagnosis of dementia will access a locality-based service that is integrated, seamless, proactive and high quality, and that encompasses all the expertise necessary to meet their needs and those of their carers. The emphasis will be on personalisation and choice. Patients will also find that the staff they come into contact with will have much improved awareness of dementia and will be competent to address their physical and behavioural symptoms.

The group has identified the features of a good care pathway for dementia.

These include respect for patients and their carers, services that maximise personal control and empowerment, and seamless transitions between organisations.

The pathway will start by raising public awareness and making information available on prevention activities. The second step will be early intervention, including GP screening and specialist memory assessment via a single access point. Pre-assessment counselling should take place at an early stage to enable people to make an informed decision about the future. Assessments will be carried out in the patient's own home if possible.

Once a person has been given a diagnosis, they will receive support from a co-ordinator for the rest of the dementia 'journey'.

The aim will be for ongoing treatment to take place closer to home, although there will still be a need for institution-based care, and respite care will be important. Residential care services should develop high-quality, affordable, person-centred care and promote well-being, recovery and independence.

A critical message from this clinical pathway group is the importance of better support for carers and of finding new approaches to caring as the population ages.

### End-of-life care

When thinking about end-of-life care, we consider:

- living well at the end of life
- care in the last days of life
- support for carers after death.

*'With the pathway in place, dying at home should become the norm if that is what people choose'*

End-of-life care also involves taking account of the needs of the families of the dying.

When patients and those around them recognise that they are coming to the end of their lives, they want their communities and carers to talk to them about their wishes and choices. In the last year of life, most people become more dependent on others, so when help and support is needed, they want it to be provided promptly and to meet their needs. Patients also recognise that those close to them will have their own needs and want these to be met as well.

With the pathway in place, dying at home should become the norm if that is what people choose. Patients and carers will have more opportunity to be informed and involved in decisions about treatment and settings for their care.

Wherever someone chooses to die, that patient and their family will be treated with dignity by staff who are confident in their end-of-life skills. Overall, care will be co-ordinated, seamless and equitable, taking account of the needs of patients and the carers before and after death. Religious and cultural beliefs will be respected.

The report contains a proposed care pathway with a description of what 'excellent' looks like under each of the steps listed below.

*'We need local models for each of the clinical pathways and specific plans for particular specialties'*

**Being informed**

This will empower the public to make informed end-of-life choices.

**Discussing wishes**

Patients will be prepared for appropriate discussions with clinicians. Clinicians will use tools to identify when these discussions are needed and have the necessary communication skills.

**Assessment and care planning**

Active, repeated, and explicitly recorded and shared with other professionals, the patient and their carers.

**Co-ordination of care**

Health and social economies will have systems designed to deliver co-ordinated and proactive care, and also respond to crisis.

**Integrated care**

Round-the-clock care, including high-quality nursing and medical care, and also a range of supportive services, such as housekeeping and transport.

**Last days of life**

The use of established end-of-life tools will be recognised and death will occur, where possible, in the place of the patient's choice

**Care after death**

Respect for the beliefs and cultures of our communities, and care for the bereaved.

**Implications for local services**

While it is for NHS West Midlands to set the overall strategy and framework for the future of health services in the region, it is for local health service commissioners – the organisations who 'buy' services from a range of organisations, including hospitals – to develop plans to meet local needs.

All commissioners in the West Midlands are working on a vision for a local model of care that is:

- evidence based
- clinically owned
- clear about clinical and economical viability
- mapped onto local geography.

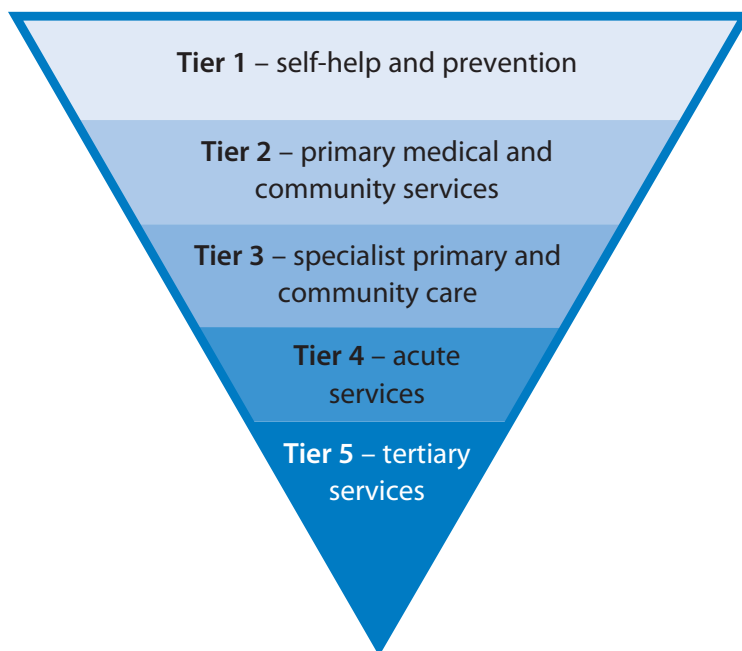
They need to set out a model of care for each of the clinical pathways, and a specific plan for particular specialties such as paediatrics, maternity and A&E.

They also need to show that their plans will work in practice, for example that the right facilities and services are in place to support a particular activity, and that the plans are financially sound.

The model of care that is emerging can best be visualised using a pyramid. The number of tiers and the description of them varies depending on local circumstances, but essentially the vision for future services is shown in the diagram below.

This model of care is then made specific in each local area for each

**West Midlands model of care**



of the nine clinical pathways. Primary care trusts (PCTs) are also being asked to identify 'neighbourhoods', or local areas within which services are clustered and interlinked.

Supporting these local models of care and plans are a set of health investment proposals that will lead to:

- increased investment in preventive and early-intervention services
- enhanced capacity and capability in primary care and systematic management of people with long-term conditions
- a shift from hospital to community for a great deal of care, diagnostics and assessment
- some patients who need the facilities of an acute hospital accessing more specialist sub-regional centres that are able to provide round-the-clock specialist care
- provision of the highest-quality care to patients throughout the system
- investment in specific areas of weakness.

## Investment framework

The status quo is not viable from a financial point of view. Increases in costs associated with population change, the prevalence of disease, advances in medical technology and increases in patient expectations mean that the costs of running the NHS will quickly outstrip anticipated increases in funding.

However, our strategy should enable us to bring costs back within available

resources and create a 'quality dividend', where we save money by:

- getting people more involved in improving their own health
- improving commissioning and service productivity
- avoiding preventable errors
- adopting new technologies.

We anticipate spending more on care closer to home, advances in medical technology, new IT, interventions designed to prevent illness, and increased responsiveness – such as shorter waiting times.

## Implementation

Although the scale of change is significant, it does not involve dramatically new, untested ideas. It is about doing what we already know can work and doing that comprehensively, robustly and quickly.

Achievement of the aims of *Investing for Health* and the clinical pathway group reports relies on six important characteristics:

- the foundations of our plans need to be in the local community and must fit with the aspirations of the public and our partner organisations
- we will need to use all the 'levers' we have to achieve change
- the framework must lead to immediate action on the most important issues
- the opportunities presented by national NHS reforms must be seized to help us take forward our objectives

*'It is about doing what we already know can work and doing it comprehensively, robustly and quickly'*

- the framework should prompt joint working across our patch in areas where change is needed
- we must be able to measure success and be held accountable by our publics.

*Investing for Health* also involves ten collaborative projects that are being carried out with all the PCTs in the region. In addition, West Midlands SHA is working with partners in the region to establish Academic Health Science Centres to provide greater research and development capability.

Our vision requires a cultural and skills shift and will depend greatly on the quality of leadership. Clinical leaders are vital to the process. At a local level, the key to clinical engagement in commissioning will be through strengthening practice-based commissioning.

At a strategic level, NHS West Midlands has created a new structure to support clinical leadership and local commissioning across the region. This involves appointing up to 15 new clinical leads, who will concentrate on implementing the clinical pathway group recommendations and *Investing for Health*, working with PCTs and providers.

Effective implementation will also rely on:

- patient, carer, public and staff engagement in strategic planning

*'We are getting on with the work that will turn our vision of a world-class health service into reality'*

- greater collaborative commissioning across PCTs
- specific workforce actions such as training, reviewing and enhancing the skills we have, and retraining as necessary
- securing some 'quick wins' – that is, where things can be done now, we must do them
- being held to account – for example, we intend to hold an annual event where patients, carers, public and staff representatives who have contributed to the work are invited to review progress with us. We will also have an annual independent review of our progress, which will be made public.

## Measuring success

We need to make sure that the changes are making a difference by delivering improved healthcare and improved outcomes for people in the West Midlands. We need to understand what works and what does not.

In *Investing for Health*, we published 33 core indicators that would help us see if we were meeting the seven big challenges and five strategies. To these we will add indicators that identify progress on implementing the clinical pathway group visions. We will also use national indicators and track PCTs' progress in meeting their local targets for improvement. All will be tested against the West Midlands Framework for Excellence.

## Conclusion

This is an exciting time for the NHS in West Midlands. We are already

getting on with some of the work that will turn our clinical vision for a world-class health service into reality. We are taking steps now to build the clinical leadership that will guide us through the next stages of that work.

We have a broad agreement from patients, carers, public, staff and partner organisations about the way forward for our health services. It is for NHS West Midlands to lead the work and we will report regularly and fully on what has been achieved. We will continue to work with all who have contributed so far to ensure that our plans remain fit for purpose to deliver *Investing for Health*.

## More information

If you would like more information about *Investing for Health – Step 2: Delivering our clinical vision for a world-class health service*, or have comments on the proposals please visit [www.westmidlands.nhs.uk](http://www.westmidlands.nhs.uk)



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Produced on behalf of NHS West Midlands by The NHS Confederation.  
Contact [Tom.hardcastle@nhsconfed.org](mailto:Tom.hardcastle@nhsconfed.org)



St Chad's Court  
213 Hagley Road  
Edgbaston  
Birmingham B16 9RG  
Tel 0845 155 1022 Fax 0121 695 2233  
[www.westmidlands.nhs.uk](http://www.westmidlands.nhs.uk)



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