

Bristol Health Services Plan Service Design Programme End of Phase One Report



*Bristol
North Somerset
South Gloucestershire*

1. Introduction

The Bristol Health Services Plan (BHSP) was set up in 2004 to make decisions about how NHS services should be provided for the population of 886,000 people within Bristol, North Somerset and South Gloucestershire. Individual primary care trusts, acute hospital trusts, the ambulance trust and the mental health trust¹ all acknowledged that they needed to work together to think about how best to provide services across the area. Their vision was:

“to transform health services and facilities for the population... between 2005 and 2013².”

For the first few years of its existence BHSP concentrated primarily on the buildings and made some big decisions, such as having one large acute hospital at Southmead and changing Frenchay Hospital to a community hospital. Other changes include the development of community hospitals and community health centres.

However, managers and clinicians also recognised that just changing NHS buildings was not going to be enough. To transform NHS services we also needed to think about

how services were going to be provided in and around the new facilities. As a result, in the summer of 2007, Bristol Health Services Plan set up Phase One of a ‘Service Design Programme’. Its vision was:

“to deliver high quality, safe and effective health services based on the agreed clinical strategy...which will provide a far more systematic approach to care as well as securing value for money³”

In order to deliver this vision, the Service Design Programme was set 14 objectives, which are:

- Centralisation of appropriate specialist services
- Fewer hospital based outpatient appointments
- To develop integrated pathways and support self management as an important component of these where appropriate
- Reducing hospital admissions
- Reduce overall system costs
- Design effective and efficient systems
- Shorten hospital lengths of stay
- Improved patient safety and service

quality

- Improved patient satisfaction
- Higher staff satisfaction and morale
- Improved integration between primary and secondary care
- To provide services that meet the health needs of the local population and reduce health inequalities
- To plan services jointly with service users
- To meet national recommendations and quality standards.

As Phase One comes to an end, this report looks back on our progress to celebrate what has been learnt and achieved.

¹ Bristol Primary Care Trust; North Somerset Primary Care Trust; South Gloucestershire Primary Care Trust; University Hospitals Bristol NHS Foundation Trust; North Bristol NHS Trust, Avon and Wiltshire Mental Health Partnership Trust; Great Western Ambulance Service NHS Trust

² Bristol Health Services Plan Service Design Programme Programme Vision

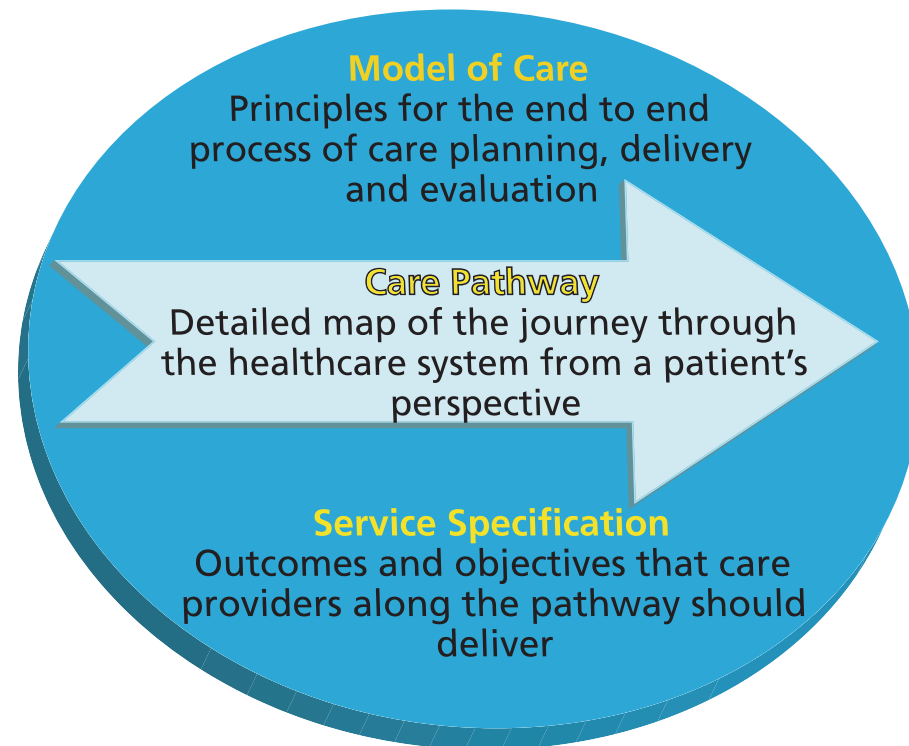
³ See 2

2. Guide to service development groups

Phase one of the Service Design Programme was made up of 12 service development groups (SDGs):

- cardiac
- end of life care
- cancer
- children
- sexual health
- rehabilitation
- elective care
- urgent care
- respiratory medicine
- diabetes
- mental health
- maternity and newborn services.

Each service development group is run by a clinical lead in partnership with a managerial lead. The groups are 'mandated' by a BHSP Service Design Programme board to identify and deliver outputs that comply with the visions set out above. The products of a service development group are summarised in the diagram opposite:



3. Celebrating our success

It is impossible to cover all of the aspects of the work in Phase One of the programme, so we have focussed on some of the key achievements using a selection of case studies from different view points. These are presented below under the headings of the fourteen outcomes.

3.1 Centralisation of Appropriate Specialist Services

As part of the Service Design Programme, new service improvements are being made for the care of people suffering acute strokes and mini-strokes. In Bristol, North Somerset and South Gloucestershire approximately 1600 people suffer a stroke every year. Stroke is the third largest cause of death and the single largest cause of adult disability in England.

In April 2008, following work by the Cardiovascular Service Development Group, a new service specification was introduced setting out the standards for high quality care and improved access to advanced treatment. As part of this work it was agreed that North Bristol NHS Trust would be designated as the Comprehensive Stroke Centre, that University Hospitals Bristol NHS

Foundation Trust would be the primary stroke centre and that Weston Area Health NHS Trust would be a district stroke centre. The benefits of a comprehensive stroke centre are that it allows for greater access to the most advanced treatments around the clock and provides a focus for the future developments of leading edge care in the fields of neuro-radiology and neuro-surgery.

One of the major developments this new service specification will provide for acute stroke patients is access to 24 hours a day, seven days a week stroke thrombolysis. The majority of strokes are due to blockage of an artery in the brain by a blood clot. Prompt treatment with clot dissolving (thrombolytic) drugs can restore blood flow before major brain damage has occurred.

Stroke thrombolysis supported by early brain imaging can significantly reduce the effects of stroke for patients who meet the treatment criteria. Before the Service Design Programme started, the treatment was only available as an in-hours weekday service but with the training of additional clinicians and a new consultant rota the service hours have been gradually extended

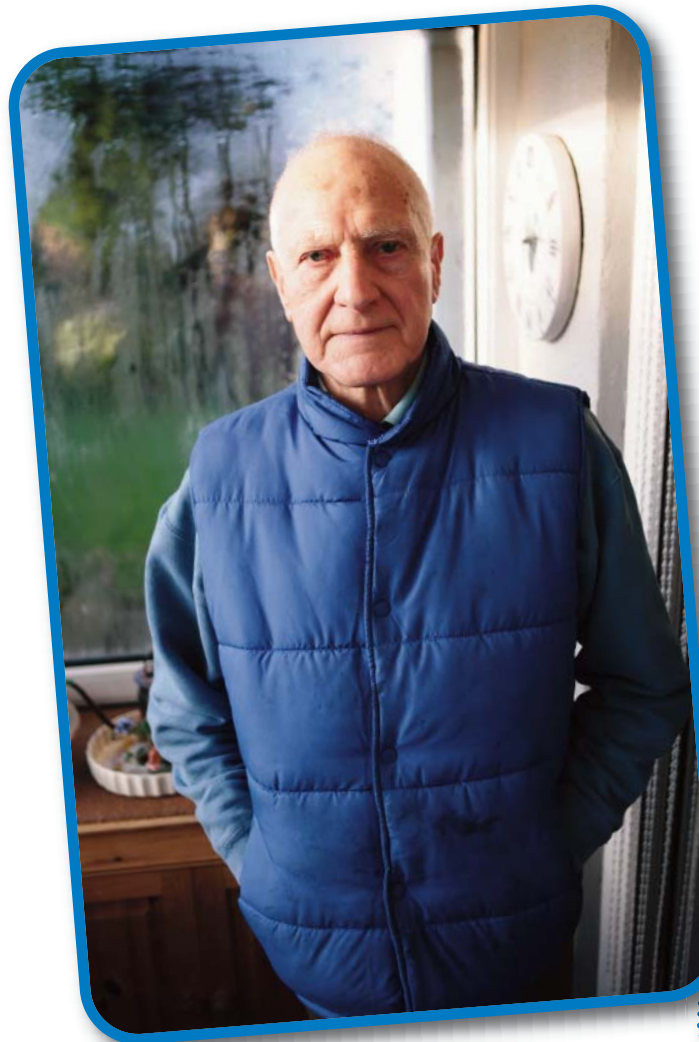
during 2009. From January 2010 stroke thrombolysis was available between 8am and 11pm seven days a week at both North Bristol NHS Trust and University Hospitals Bristol NHS Foundation Trust. A 24 hours a day, seven days a week service is scheduled to commence at North Bristol NHS Trust during 2010.

Patients suffering a mini-stroke experience similar symptoms to a stroke for a short period. Prompt assessment and treatment is important as patients can be at increased risk of suffering a full stroke. The service design project has clinics each week day at all the local hospitals. However, patients assessed as being at high risk should be seen in a mini-stroke clinic within 24 hours of their attack.

Therefore a new seven day a week clinic had been started at North Bristol NHS Trust as part of the Service Design Programme. The new service was trialled in January and will be launched on 10 April 2010.

Other improvements brought about by the Service Design Programme have included:

- the introduction of a universal referral form for GPs to improve the referral process into transient ischaemic attack (TIA) clinics
- new TIA follow-up guidelines will ensure consistent on-going care of patients in primary care following their appointment at a mini-stroke clinic
- a new online training package developed by the University of the West of England to help staff refresh their knowledge of the key tools used in the pathway to assess risk and severity of stroke/mini-stroke
- a communications campaign, using Bristol residents, to raise the public's awareness of mini-strokes and the importance of seeking help quickly.



Dennis Escott, 81, Portishead

"It was November last year. I'd just got back from a Turkey and Tinsel Weekend in Bude and went to my neighbours' house to take them some biscuits.

When I got up from the chair to come home I felt dizzy and sick but dismissed it.

Later, back home, I sat down to address an envelope. I could hold the pen but couldn't write with it. When I tried, the pen went the other way. Oh dear. I know what this is, this is a stroke.'

It was all over in about half an hour. I talked to my GP and said I think I've had a mini-stroke. She sent me for a scan at the clinic. I'm on warfarin and statins now and have been given advice on looking after myself".

3.2. Fewer Hospital-Based Outpatient Appointments

Cancer patients in Bristol are among the first in the country to have their chemotherapy in their own homes on the NHS. A pilot is being carried out in the city to compare the option of nurses administering chemotherapy drugs at home rather than patients having to travel to hospital for treatment. If the trial is a success, it could be extended across the Bristol, North Somerset and South Gloucestershire community.

The scheme is sponsored by NHS Bristol and is being carried out in a partnership between Bristol Haematology and Oncology Centre (part of University Hospitals Bristol NHS Foundation Trust) and a private healthcare company called Healthcare at Home.

After discussing the option of chemotherapy with their doctor at the Bristol Haematology and Oncology Centre, patients are offered the choice of having their chemotherapy in the hospital's clinics or at home. A patient advisor is on hand to help answer any questions. Patients choosing to be treated at home are visited by a Healthcare at Home nurse on the day

of their treatment. They are given their chemotherapy drugs in the same way as they would be in hospital, but can be treated in the comfort of their own home. The pilot is part of a drive to give people more care closer to home as part of the Cancer Reform Strategy.

The scheme has been running in Bristol since March 2009 and so far over 140 patients have had their chemotherapy at home.



June Drayton, 73, used to run a motorcycle shop with Mike, her husband of 50 years. She, noticed a lump in her breast while in the shower on holiday and within two weeks of being referred by her GP she had her breast removed. She is now having chemotherapy at her Shirehampton home.

She said, "At first I said 'pardon?', because I couldn't believe it, but my answer was 'yes, of course'. It is an absolutely fantastic idea.

To get to the oncology centre it would involve public transport, the drag up the hill and if you go to the hospital by car, and then where on earth do you park? It is a nightmare.

With chemo at home I am all relaxed. The girls from Healthcare at Home are absolutely brilliant, they are like friends. I can do anything and usually just chat. They are great up at the hospital, but being in your own home is a big bonus."

3.3. Develop integrated pathways and support self-management as an important component of these where appropriate

The 12 Service Development Groups that make up Phase One of the Service Design Programme have been actively developing integrated care pathways, which describe the preferred patient journey from diagnosis to treatment and beyond. The following table shows details of the completed integrated pathways and the self management programmes within care pathways.

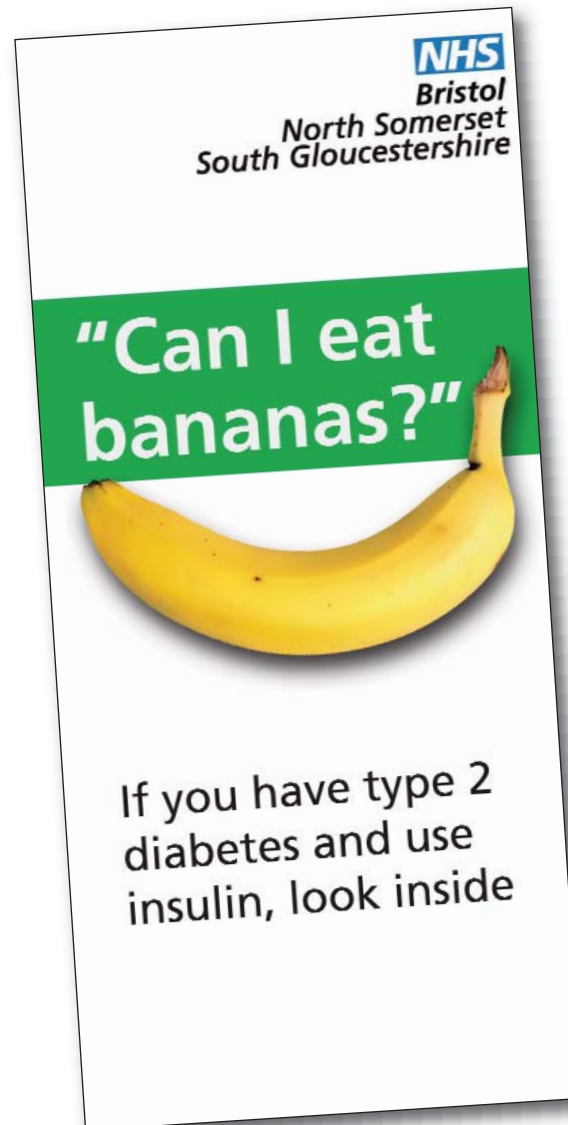
Service Design Group	Number of integrated pathways designed as part of the BHSP service design programme	Number of established self management programmes or components within care pathways
Cancer	Choose and Book two week referrals	Not appropriate
Cardiac	Acute myocardial infarction (heart attack), (Bristol, North Somerset and South Gloucestershire, BNSSG) Cardiac rehabilitation, (Bristol only) Community pathway for heart failure	Cardiac rehabilitation programme There are individual plans for heart failure patients
Maternity and Newborn Services	The home birth pathway (BNSSG)	Ante-natal education classes are offered BNSSG wide
Diabetes	There are two pathways: one for adults and one for children. Both deal with the key decision points in a person's life e.g. routine care; urgent care; diagnosis. See: www.avondiabetes.nhs.uk/professional/pathway/default.asp	

Service Design Group	Number of integrated pathways designed as part of the BHSP service design programme	Number of established self management programmes or components within care pathways
Rehabilitation	Stroke rehabilitation pathway	
Urgent care	Acute stroke Transient Ischaemic Attack pathway Urgent Care Delivery Model	
Eyes	Cataract referral refinement and follow up Community based management of suspected glaucoma and ocular hypertension	
Orthopaedics	Model of care for hands Osteoarthritis knee model of care	Not appropriate This model includes elements of self-management
Ear, nose and throat	Model of care for adult hearing loss (age 16-60) includes balance pathway and tinnitus pathway	This is a feature of the pathways
End of life care	Working to the national pathway model in the End of Life strategy	Individuals are encouraged to complete the Advanced Care Planning documentation
Respiratory	Model of care for community based chronic obstructive pulmonary disease management, which includes Pulmonary rehabilitation pathway Home oxygen assessment pathway	The proposed community based chronic obstructive pulmonary disease (COPD) service will emphasise the need for better self management; there is a significant need to educate patients and their carers on the causes and progress of COPD and promote the use of self-management plans
Sexual health	Termination of pregnancy pathway	Access to contraception is a key component of this pathway
Total	19 completed	12 self management programmes either in groups or for individuals

Self management course commissioned by the Diabetes Service Development Group

In 2008/2009, 679 adults with newly diagnosed type 2 diabetes attended the first day of a one and a half day course, Living with Diabetes. This course is designed to help empower patients with the knowledge to look after their condition, in partnership with their healthcare professionals, to lead a healthier life, and to help prevent complications associated with diabetes. The second course (Can I Eat Bananas?) is a one and a half day course aimed at adults with type 2 diabetes who have been using insulin for at least three months. Two of these courses were run in 2008/2009. The third course (Skills for Life) is an 8x three-hour course aimed at those adults with type 1 diabetes – two were run in 2008/2009.

Living with Diabetes and Can I Eat Bananas? are commissioned to run across Bristol, North Somerset and South Gloucestershire, and Skills for Life across Bristol and South Gloucestershire.



"I found the day course very informative and lots of things I did not know were explained. I definitely think I can cope with being diabetic from the information given and lead a normal life and enjoy it. Thank you".

A quote from the evaluation form of a participant on the Living with Diabetes course.

3.4. Reducing Hospital Admissions

Based on the care pathway map in the national End of Life Strategy, the End of Life Service Development Group identified a need for advance care planning training. This was commissioned from St Peter's Hospice through the University of the West of England, using the health community's Strategic Service Improvement Fund for workforce development. Three hundred places were made available across Bristol, North Somerset, and South Gloucestershire in 2008/09, with a further 480 places during 2009/10.

The course is designed for all health and social care professionals in the area and helps them to support patients during their last six to 12 months of life to think about how they would like their end of life to be, and to record these choices. The course uses various documents which have been designed to help patients think through their end of life care options.

Participants are also helped with the practicalities of having a conversation with a patient, their carer and family members (where appropriate) about the end of their life.

Case study

Julie Davidson, a community matron working in the Fishponds area, recently attended the advance care planning training and found it gave her the skills she needed to help one of her patients who was approaching the end of their life.

The real advantage of having been on the training for Julie was that it helped her to recognise that the patient was in the last few months of life, and it helped her to start the conversation.

"I was able to say to her: 'Have you thought about where you would like to die?'" . Julie was then able to use the advance care planning guides and documents to help the patient think through and write down what she wanted. Throughout the process Julie was careful to use the patient's own words and phrases, so as not to dilute her wishes.

The patient was clear that they wanted to die at home and the process raised some simple, but very important issues that may have prevented this. The biggest

concern for them was that they would be a burden on their family by staying at home. Julie was able to talk through some of these issues with the family and helped them to talk about what everyone wanted.

Julie then made sure that she communicated the patient's wishes to everyone who may be involved in their care, so that the wishes of the patient and their family were known. Julie also presented the patient's wishes at the local GP Practice gold standard framework meeting, and updated everyone on any changes. She also put the information on the GP out-of-hours system (ADASTRA).

The patient was supported by her family and Julie to stay at home according to her wishes.

Not everyone wants to die at home like Julie's patient, but the Service Design Programme has been working to make sure that everyone who's death is anticipated has the chance to talk about their preferences.

3.5. Reduce Overall System Costs

The Sexual Health Service Development Group has developed a new pathway for women accessing termination of pregnancy services. This pathway, which was implemented during 2008, has had a significant impact on improving access to local services and delivering a more cost effective service for the local NHS.

Improvements to the old pathway included the introduction of a 24 hour a day, seven day a week central telephone booking service for Pregnancy Advisory Services and access to terminations.

As a result all women are now offered an assessment appointment within five days of contacting the service. Reducing the time women wait for an initial appointment has increased the number of women able to access an early termination within nine weeks of their pregnancy. Patients benefit from quick access to advice and earlier access to termination services which can avoid the need for surgical termination.

This in turn saves the NHS the cost of expensive anaesthesia and surgery in place of more cost-effective medical termination options.

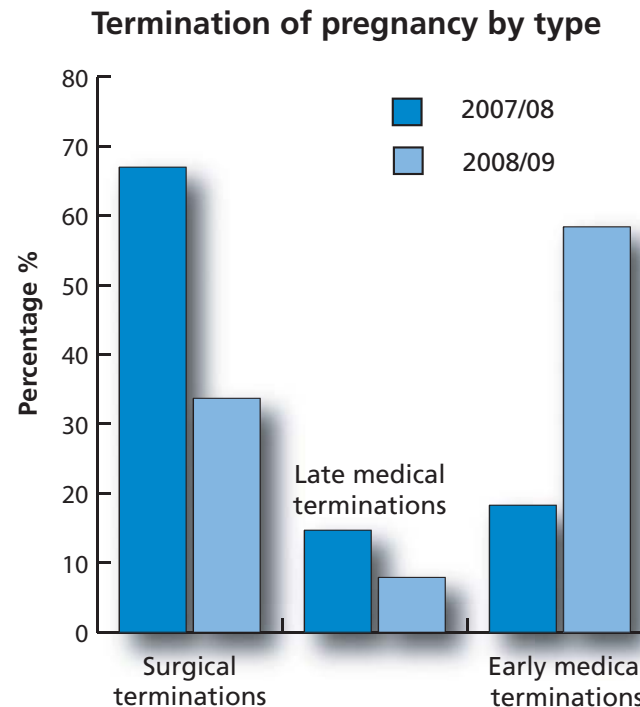
The chart opposite shows the number of patients having more invasive and costly surgical terminations compared with the medical alternative, which is only available earlier in the pregnancy.

In 2007/08 before the new pathway started only 18.3% of terminations in Bristol, North Somerset and South Gloucestershire were early medical

terminations. Of these 14.7% of women had late medical terminations and 67% of accessed surgical terminations (including local and conscious sedation).

When the telephone service was introduced during 2008/09 all women were offered an appointment for assessment within five days and the percentage of women accessing an early medical termination increased to 58.4%, with 7.9% of women accessing a late medical termination and only 33.7% accessing surgical terminations.

This shift from surgical to medical terminations was not only far better for the women as it was less invasive, it also saved the local NHS £85,000 in just one year.



"I just want to say how kind and reassuring everyone was. From the first phone call I made through to the treatment everyone made this potentially difficult situation bearable because of their kindness and attitude towards me."

Quote from someone who has used the central telephone booking service

3.6. Design Effective and Efficient Systems

Before the Service Design Programme began work on the heart attack pathway, someone suffering a heart attack would be taken by ambulance to the nearest emergency department there they would receive different treatment depending on the hospital, time of day and day of week.

Today if you have a heart attack⁴ in Bristol, North Somerset or South Gloucestershire, no matter what time of day, or day of the week, Great Western Ambulance Service NHS Trust staff will take you straight to the Bristol Heart Institute (part of University Hospitals Bristol NHS Foundation Trust) for a “primary angioplasty”⁵. This involves a small balloon at the tip of a tube being inserted into the body and guided to the blocked artery in the heart. The balloon is then inflated and removed, leaving behind a 'stent', a rigid support which creates a new wall in the artery to allow blood to flow more easily.

A patient's chances of survival and a speedy recovery are greater the quicker they can be conveyed to the Bristol Heart Institute for this treatment. As part of the



Opposite: a coronary angiography revealed an occluded left anterior descending artery (arrow). This was treated with primary percutaneous coronary intervention (PPCI) a stent to this vessel restored flow.

work done within the Service Design Programme on heart attacks, Great Western Ambulance Service NHS Trust has implemented a care pathway that promotes early recognition of patients having a heart attack by ambulance clinicians, reducing 'on scene' time and conveying them as quickly and safely as possible to the Bristol Heart Institute. Ambulance crews provide the hospital with a pre-alert so that the facility and team can be ready as soon as the patient arrives.

⁴. Of the type known as a “STEMI” or ST-elevation Myocardial Infarction

⁵. Known as a Primary Percutaneous Coronary Intervention, or PPCI.

Case study

The ambulance service received a call from a GP practice at 12:23pm on Thursday afternoon. A male patient had walked into the surgery complaining of chest pain and the surgery immediately called 999.

The nearest ambulance was staffed by an emergency care practitioner (ECP), who arrived at the GP surgery at 12:27pm. The ECP identified that the 48 year old male patient had the signs and symptoms of a typical heart attack. The patient stated that he had central chest pain radiating down both arms and he was pale and sweaty. The ECP obtained a brief history from the patient and a set of clinical observations (e.g. blood pressure, oxygen saturation).

An ambulance arrived at 12:31pm and

the ECP asked the crew to obtain a tracing of the patient's heart beat (an electrocardiogram or ECG).

The ECG confirmed that the patient was suffering a type of heart attack called an "ST elevation myocardial infarction".

The patient was put into the ambulance and the Bristol Heart Institute was alerted that the ambulance would be arriving in approximately 10-15 mins.

The ambulance left the scene at 12:43pm and arrived at the Bristol Heart Institute at 12:57pm.

The patient was taken straight to the Cardiac Catheter Laboratory (theatre) for a primary angioplasty to open up the blocked artery, just 34 minutes after he had first walked in to his GP practice having a heart attack.



The Bristol Heart Institute

3.7. Shorten Hospital Lengths of Stay

People with diabetes occupy a significant proportion of hospital beds – about 10% in the UK. Although it is possible that their diabetes is the main reason for their admission to hospital, it is more likely to be something else. Evidence shows that it is not uncommon for people with diabetes who use insulin to lose control of their diabetes while in hospital – for example because of the timing and quality of their meals. This can lead to the patient having to stay in hospital for longer.

The Diabetes Service Development Group recognise that many people with diabetes probably know more about managing their own diabetes than the hospital staff who are looking after them. Some hospital staff may have had little training about diabetes management and only a minority of inpatients with diabetes are seen by the hospital specialist diabetes team.

In an effort to help patients and staff alike, the local acute hospitals are implementing the *Think Glucose* toolkit, which aims to support staff to help patients manage their own diabetes while in hospital.

Sian Erasmus, the diabetes specialist nurse at Weston General Hospital explains how they are implementing the tool kit in Weston.



“Before Christmas, the ‘Think Glucose’ staff from Coventry came to Weston to meet with a group of key staff here and then we all travelled to Coventry for module 1 of the training course. Since then we have chosen two wards to implement our pilot, they are coronary care and cardiology.

We have run training with staff on these wards to raise their awareness of diabetes and how best to manage people who come onto their ward and need to use insulin.

We are also introducing a number of tools from the Think Glucose toolkit. For example, staff are now using a patient assessment tool which has a traffic light system to help them decide when it is

appropriate to refer a patient to the specialist diabetes team.

We have worked with the ward staff to help them record data on some core measures, such as patient satisfaction and length of stay. These measures will help us evaluate whether the Think Glucose initiative is improving the patient experience and reducing the amount of time people have to stay in hospital.

We plan to roll out the initiative to other wards in the hospital once we have learnt the lessons from the pilot”.

Sian Erasmus
Diabetes specialist nurse

3.8. Improved Patient Safety and Service Quality

The Strategic Framework for Improving Health in the South West⁶ set out a wide range of ambitions for patients in need of acute care. Three specific ambitions relate to patients suffering a fractured hip (neck of femur):

1. By March 2010, 95% of fractures requiring surgery are to be operated on within 24 hours of admission or being fit for surgery
2. To reduce hospital admissions following a fall by 30%
3. For 95% of patients that have been admitted to hospital with a fractured neck of femur to have length of hospital stay within the best quartile of national performance by 31 March 2010.

Ensuring that there is an effective clinical pathway for the management of fractured neck of femur would be an important component of achieving these ambitions. The Service Design Programme was tasked with setting up a group to design the clinical pathway that would achieve the South West's ambitions.

A baseline assessment was carried out in May 2009 which revealed that improvement

work on falls and the fractured neck of femur pathway was being carried out by several different organisations in the health community but there was a lack of co-ordination between these different work streams.

In addition, much of the work both nationally and locally had focused on hospital care – from the arrival of the patient at the emergency department, to the point of discharge from the acute setting. The project team recognised that the achievement of the improvement targets would depend on the efficacy of all stages within the whole patient pathway and would include work to improve services for falls and bone health for older people. Therefore it was agreed that the scope of the pathway design work would incorporate all stages of the patient journey from prevention of falls and fractures right through to return to place of residence with or without ongoing care and including prevention of any future falls and fractures.

Due to the diversity of the professionals

and organisations involved at different stages of the pathway, the task was broken down into three sections and a Rapid Improvement Event was held for each, as summarised in the diagram below:

- Fall to Hospital Door



- Primary Prevention
- From Emergency Department to Return to Place of Residence.

The "rapid improvement" event comes from "lean" methodology. "Lean" is a service improvement approach developed in the manufacturing industry⁷ and promoted by the NHS Institute of Innovation and

⁶. NHS South West (2008) The Strategic Framework for Improving Health in the South West 2008/09 to 2010/11 available from www.southwest.nhs.uk

⁷. Womack, J.P., Jones, D.T. and Roos, D. (1990) The Machine That Changed the World.

Improvement. Lean is a common sense approach which views a process from the customer/patient perspective and in so doing seeks to identify any steps that do not add value. These are classified as 'wastes' which can be stripped out to save time and money so that the resources available (e.g. staff and equipment) can be used for the improved benefit of patients.

A rapid improvement event is the process by which the wastes and therefore future 'Lean' process are agreed. It involves mapping out the "current state" (what patients are experiencing at present) from the patient's perspective. An interactive visual format is used so that areas of waste or for improvement can be clearly identified. Once the issues have been identified, the participants work together to design a future state process map which aims to ensure that each step adds value to the patient and that wasteful steps are eliminated.

Clinical staff involved in the events were asked to ensure that the future-state pathway safeguarded patient safety and had a robust clinical evidence base.

The future-state design for the Fractured Neck of Femur pathway focused on

measures to prevent falls and improve bone health to reduce the incidence of hip fractures. It also introduced steps to clinically optimise (maximum possible physical fitness) the patient for having an operation at the earliest stage in the pathway. This would ensure that they were ready for surgery and that they had the best chances of a speedy recovery post-operatively, thus reducing their length of stay in hospital. This was based on the latest national evidence and guidance.

The "rapid improvement" events involved a wide range of participants, especially patient representatives, and the draft pathway was also discussed at a focus group with other patient representatives and relevant local third sector organisations such as the Osteoporosis Society. These members added valuable insights that would later inform the development of the specification for the service.

A self assessment tool has now been developed alongside the pathway and is to be used by providers of healthcare services to measure their performance against the agreed set of standards. The tool covers all stages of the patient's journey and identifies everything that should be in place



Patient representatives get down to work to improve the pathway for broken hips.

in order for services to achieve the highest possible quality of care.

3.9. Improved Patient Satisfaction

The Urgent Care Service Development Group was interested in understanding patient and public attitudes to local urgent care services.

They produced a summary of reports and surveys which demonstrated that people needed to know how they might use the new services being developed as part of the urgent care pathway to avoid confusion.

A communications work plan was then produced which included work streams on:

- What to call services so that their function is as clear as possible
- Understanding what the term 'urgent care' means to people in order to develop better guides of how to use the services available
- Working with groups who regularly attend emergency departments for conditions better managed by general practice or other services to raise awareness of the alternatives and how to access them
- Working with primary care to make sure that they are recognised as the first point of contact for urgent care and contactable when they are needed urgently.

As part of this workplan the Urgent Care Service Development Group developed communications materials for winter 2009/10. These included a leaflet on where to go for urgent care, development of the Choose Well programme – including a local website, and a media diary to tell local people about the services available.



3.10. Higher Staff Satisfaction and Morale

As outlined in section 3.8, Rapid Improvement Events have emerged as a helpful tool for ensuring open involvement and debate whilst delivering an outcome ("future state") in the minimum amount of time – often a day. This can be as motivating for the staff involved as it is for the patients, as the Breast Care Review demonstrated.



The Service Design Programme was tasked with reviewing breast care services across Bristol, North Somerset and South Gloucestershire with a view to deciding how services should be organised and delivered. In order to do this a rapid improvement event was organised on 17 July, 2009. Clinicians, managers, patient and lay representatives all came together to map out the new clinical pathway. Eleven clinicians were part of the event including breast care nurses, radiologists, GPs and breast surgeons.

"It has been very helpful having so many clinicians and patients involved in this exercise. It has also been made possible by the support of managers from the PCT's - by spending time together we resolved the anxieties and fears which are natural when facing change to a system that is working well to what we all believe will be even better! We started building new relationships, trust and agreement and by the end of the event the vision of the new clinical model was shared by all the participants and through this team event we have improved staff satisfaction with the review process".

Simon Cawthorn, breast surgeon at Frenchay Hospital

Participants at the breast care review rapid improvement event

The Maternity and Newborn Service Development Group took the same approach to deciding how home birth services should work. Fourteen clinicians, mostly midwives, came together for three days in November and December 2009 to map out what happens at the moment and then design a new pathway which reduces waste and improves the patient and staff experience of home births.



Sara Jane Sheldon, manages the community midwives at University Hospitals Bristol and she recalls:

"After the first day, we had a half day away day for all the community midwives and we talked about the pathway for home births and how they could be involved in developing a new pathway. There was lots of very good feedback. The midwives said it was really exciting and it fired up their imaginations. They were happy that home birth was back on the agenda and that their views were being included. One midwife commented that she had been considering leaving community midwifery, but being involved in the work to increase the number of home births had made her want to stay and be part of it".

3.11. Improved Integration between Primary and Secondary Care

Current systems and processes mean that, if a GP does not have personal contact with hospital-based colleagues and they want some specialist advice on managing a particular patient, they will probably end up referring the patient for a hospital outpatient appointment.

The Elective Care Service Development Group has worked with GPs and hospital consultants to design and pilot a service called "advice and guidance" to improve integration between primary and secondary care.

The trial

A GP considering referring a patient for specialist opinion could send a query (using a secure email address) about that particular patient's care to a specialist based in the hospital. They would use this route when they thought that advice from the specialist may help them continue to care for the patient without the need for them to go to hospital.

One of the service standards for the trial was that advice from the specialist had to

be received within three working days. In many cases the advice either helped the GP to care for the patient outside of hospital or confirmed that referring the patient to hospital was the right thing to do.

The next steps

The trial demonstrated that in many cases, referrals to hospital clinics could be avoided if the GP had access to specialist advice on how to manage specific elements of the patient's care. This helped the Service Development Group to write a business case for a much wider pilot of the service covering many more clinical specialties.

If the service is commissioned in 2010/11, it will see GPs and specialists working more closely together to manage patients appropriately. Other GPs will have access to specialist knowledge to add to their generalist knowledge of clinical conditions and hospital specialists will learn more about what GPs are able to manage in primary care. From the patient's perspective, they will know their care plan is based on specialist medical advice whilst avoiding the disruption and anxiety of having to wait for a clinic appointment and

making the necessary arrangements to get to the hospital.

A case study from the trial

A GP had a patient who had a longstanding skin problem and who didn't like seeing doctors and was resistant to the idea of hospitals. The GP sent a query to the skin specialists which described the patient's condition and the medicine that they were using.

The GP asked about whether they should change the medicine and if so, whether it was reasonable to do it in primary care. The specialist replied and gave the GP some ideas about what to try next, what other tests might be done and when it would be reasonable to make a referral if that did not help.

3.12. Provide services that meet the health needs of the local population and reduce health inequalities

For a programme covering nearly 890,000 people the term “local” is inevitably quite broad. There are many initiatives carried out at local level in the individual areas of Bristol, North Somerset and South Gloucestershire, and in the smaller local communities they serve. One area of inequality that could be tackled together was stroke awareness and treatment.

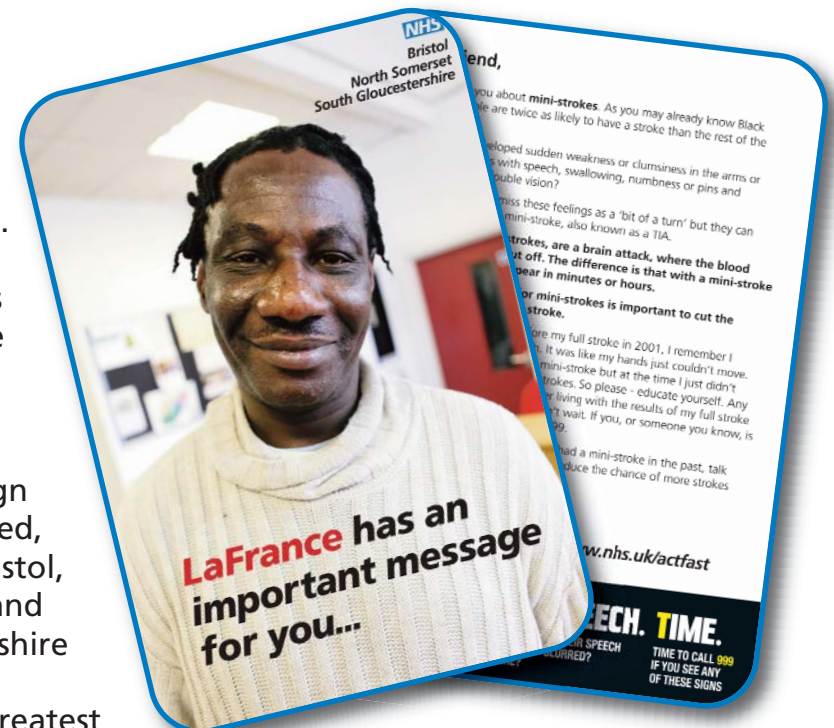
Treating stroke as an emergency has a significant impact on a person’s health outcomes reducing their risk of significant disability or death. The Department of Health has run a high

profile FAST awareness campaign (Facial weakness, Arm weakness, Speech problems, Time to call 999). This has been highly effective in

improving people’s awareness of the warning signs of stroke.

Although the national campaign was well presented, we knew that Bristol, North Somerset and South Gloucestershire had some of the communities at greatest risk of stroke. Local stroke and communication leads have therefore worked together to make sure the message gets to the people who most need to hear it. This includes older people and their carers and certain black and minority ethnic groups.

In January 2010 NHS Bristol, North Somerset and South Gloucestershire



also launched a campaign to raise awareness of mini-strokes. People who suffer a mini-stroke are at a significantly higher risk of having a full stroke; however it is believed that many mini-strokes are not being reported.

The important message of the campaign is that any type of stroke is an emergency and people should call 999. Also, anyone who has had worrying symptoms that have gone away again should get themselves checked out by their GP. The campaign

message is “don’t ignore a funny turn”.

By using stories from a range of local people, representative of those communities at higher risk of mini-strokes, we hope to reach as many people as possible with the health awareness message.

The campaign involves radio adverts, in the press, on billboards and at bus stops. Posters, flyers and postcards will be delivered to 50,000 homes in deprived areas where people are known to be less likely to use health services. The campaign will also be featured on BBC’s Points West.

Our innovative approach is attracting national and regional interest in the NHS and, as a result of our work, NHS Choices have agreed to commission the first film on the subject for their website.

3.13. Plan services jointly with service users

Working with service users is central to the Service Design Programme’s approach.

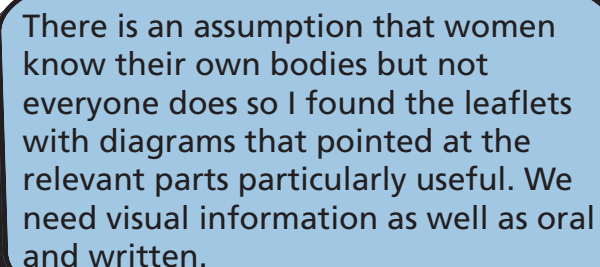
A good example is the work underway to develop a model of care for a gynaecological diagnostic and treatment service closer to patients’ homes.

A rapid improvement event was held which involved a wide range of hospital and primary care clinicians and health service commissioners. They worked together to produce a process map to describe a draft model of care and patient pathways for the new service. This model was then taken to a patient focus group whose purpose was to comment on our proposal, test the draft model of care and generate ideas for patient focused improvements for inclusion in the specification for the service.

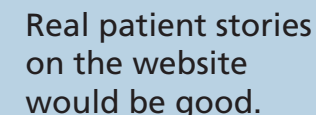
The members of the focus group were selected to reflect our diverse population and included women who were black British, white British, white Ukrainian, Somali and black Caribbean.

The participants were first encouraged to discuss their experiences of the care they

had received and issues for improvement were identified. The model of care was then presented and comments were invited. The group came up with a wide range of suggestions in relation to communication, continuity of care, dignity, diagnostic test results, location and facilities and the types of staff required for this service. Some examples of the participants’ comments are:



There is an assumption that women know their own bodies but not everyone does so I found the leaflets with diagrams that pointed at the relevant parts particularly useful. We need visual information as well as oral and written.



Real patient stories on the website would be good.

I think if you were told you're coming in at 8am but actually your surgery is at 1pm and we just need to prep you beforehand it would have been okay. It's just not knowing...

I felt my particular experience with Dr A, getting to know her and having that relationship was very, very important because every time I came into the surgery regardless of how busy she was it felt like I walked into the room and there was an instant connection. She knew about me, she knew about my case... that gave me a lot of confidence in whatever she was going to suggest as the next step.

It sounds like a very good thing if they also have the ability to then pass on people who need more than that into the next level of services fairly swiftly.

Because a lot of people who are going to gynaecological services have got kids, and they're working, you need to have the choice so that you could go after work say. If you have to come with children you have to get on buses and all of this. So there's no point in it being out of the city you need something fairly central.

I would find it very positive and helpful to have everything in one day and know what's going to happen to me.

The nurse came and she put a thermometer in my ear and I felt the buzz. She didn't explain what she was doing first so this was not good.

The focus group discussion generated a rich variety of suggestions and comments which were used to develop the specification for the service.

3.14. Meet national recommendations and quality standards

The Service Design Programme is committed to delivering services that meet national recommendations and quality standards. Whenever we design a new pathway of care we make sure that there is a clinical lead for the project and that a range of clinicians advise us to make sure that the final result is safe and evidence-based.

Our work on cancer is assured by our participation in the National Cancer Peer Review Programme, which is an integral part of the NHS Cancer Reform Strategy. It supports quality assurance of cancer services and informs quality improvement. The process engages patients and carers, who are involved in both the assessment and the Peer Review Panel visits (where applicable).

The Cancer Service Development Group monitors local Peer Review activity to ensure that any recommended improvements are acted upon. Most recently they have initiated the development of a community skin cancer service that meets the recommendations set

out in the national Improving Outcomes Guidance for Skin Cancer⁹. The work includes developing a proposal for more community-based management and treatment of skin cancer. This entails working closely with clinicians and the authors of the guidance to ensure that the suggested services are clinically appropriate as well as responsive to service user views and requirements.

⁹. NICE (2006) Guidance on Cancer services: Improving outcomes for people with skin tumours including melanoma: the manual NICE: London