

NPfIT local clinical ownership – links to a local health system's clinical management of care pathways

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Issues

- What are care and e-care pathways?
- How are they managed in a local health system?
- How can NPfIT support the LHS and care pathways?
- What are the implications for IM&T modernisation and NPfIT?
- What are the benefits?
- Why should we use e-care pathways and clinical support?

Definition - EPA

- Care pathways are a methodology for the mutual decision making and organisation of predictable care for a well defined group of patients during a well defined period.
- Defining characteristics of pathways include:
 - An explicit statement of the goals and key elements of care based on evidence, best practice and patient expectations.
 - The facilitation of the communication, coordination of roles, and sequencing the activities of the multi-disciplinary team, patients and their relatives.
 - The documentation, monitoring, and evaluation of variances and outcomes; and
 - The identification of the appropriate resources.
- The aim of a care pathway is to enhance the quality of care by improving patient outcomes, promoting patient safety, increasing patient satisfaction, and optimizing the use of resources.

NHS National e-Carepathways service

- Established in the last year and is about best results for patients and the system, by incorporating pathways in to NCRS.
- Contractual requirement for providers and has high level support

EPA, E-care pathway is a machine based product used in an e record to derive and complete a situational specific plan for a given pt.

- Informed by pt preferences
- Clinician experiences and preferences
- Additional information from the care record

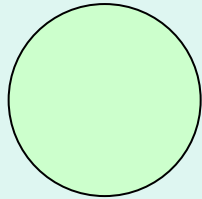
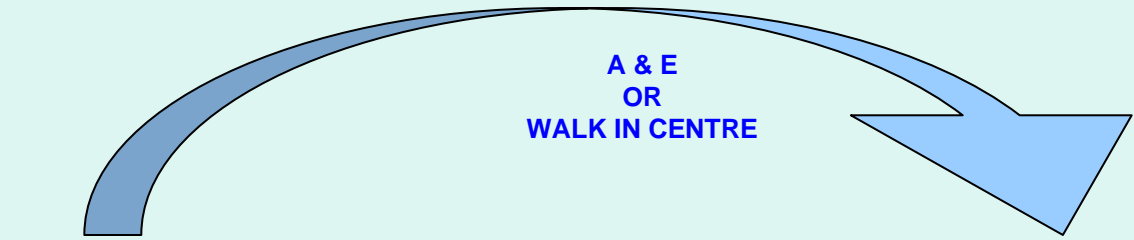
ECPS says they will...

- Give patients choice of care process
- Support implementation of best practice
- Provide better evidence and clinical support
- Better access to knowledge and tools

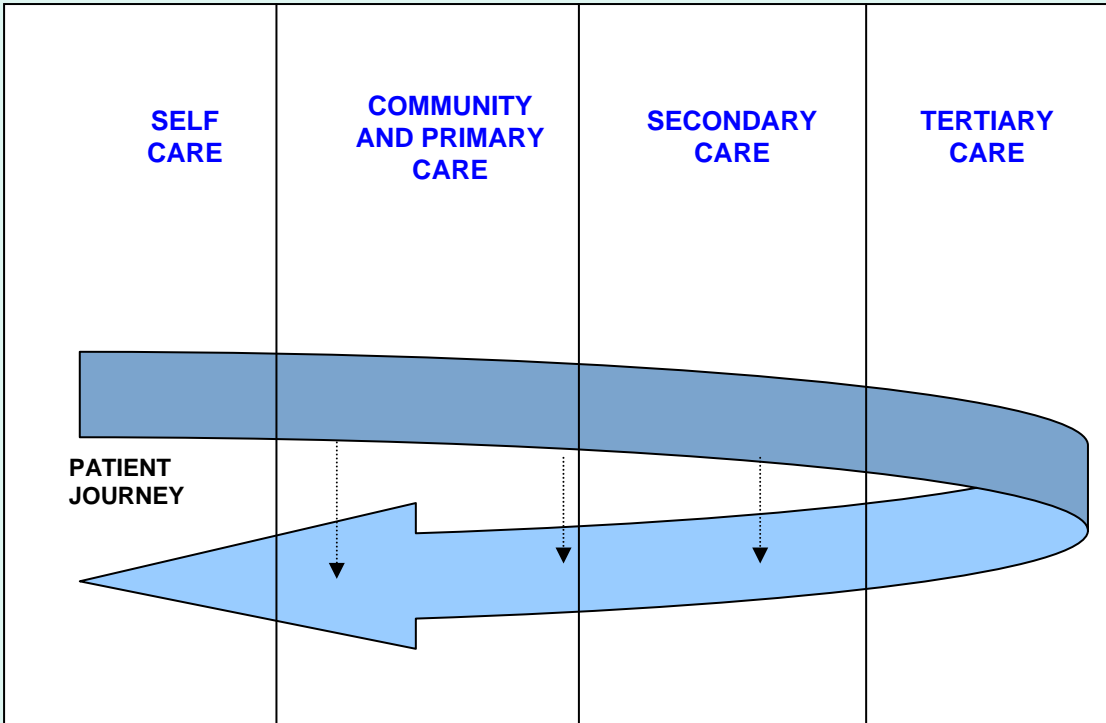
E-care pathways should be

- Available, valid, with quick access to all who need
- Record variance, be linked to the erecord
- Be able to adapt to local delivery services and to patient needs
- Able to deliver standardised care by being evidenced and national best practice
- Supportive of standardised care initiated from primary care linking information across all settings
- A way to access and input information, be locally responsive
- Able to support the analysis of patient care
- Helpful to providers to discuss process of care and ensure a faster local implementation of new knowledge

THE PATIENT JOURNEY



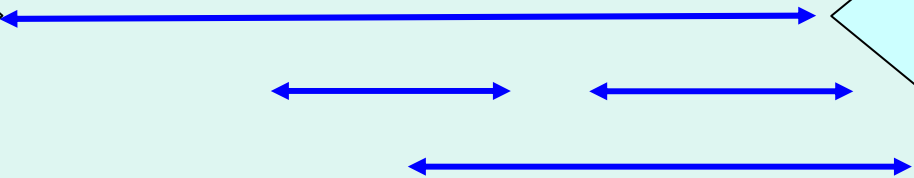
PATIENT



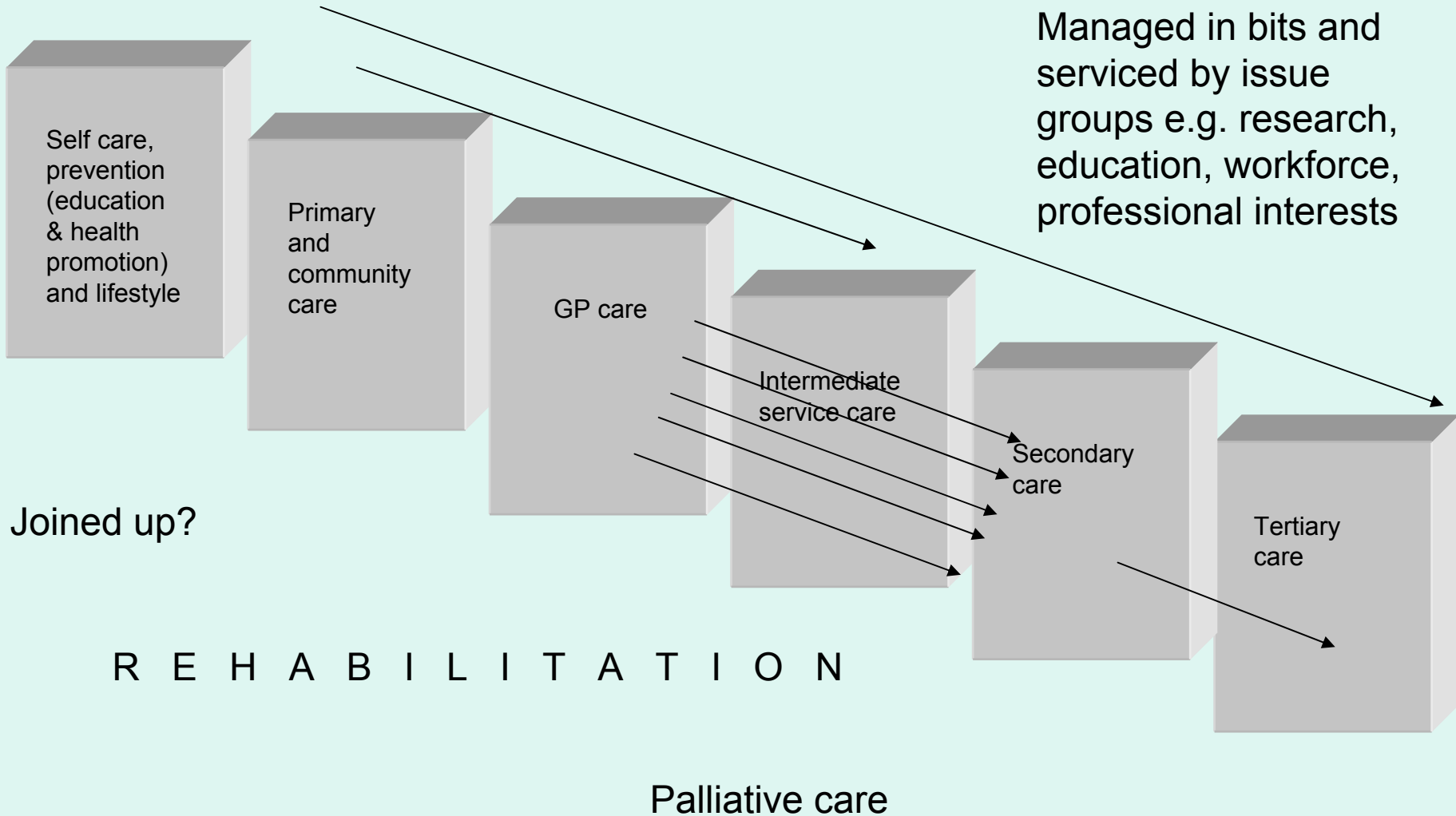
Public health and economics – lifestyle, employment, environment, genetics.

Current Pathway Management Structures (Networks, Boards, Steering Groups, LITs, operational groups etc) may cover patient journey through whole LHS or just bits.

CLINICAL 'NETWORKS or 'INTEGRATED CARE PATHWAYS' cover the whole patient journey.e.g Cancer, CHD, Diabetes, Older People, Mental Health.



The 'integrated' care pathway

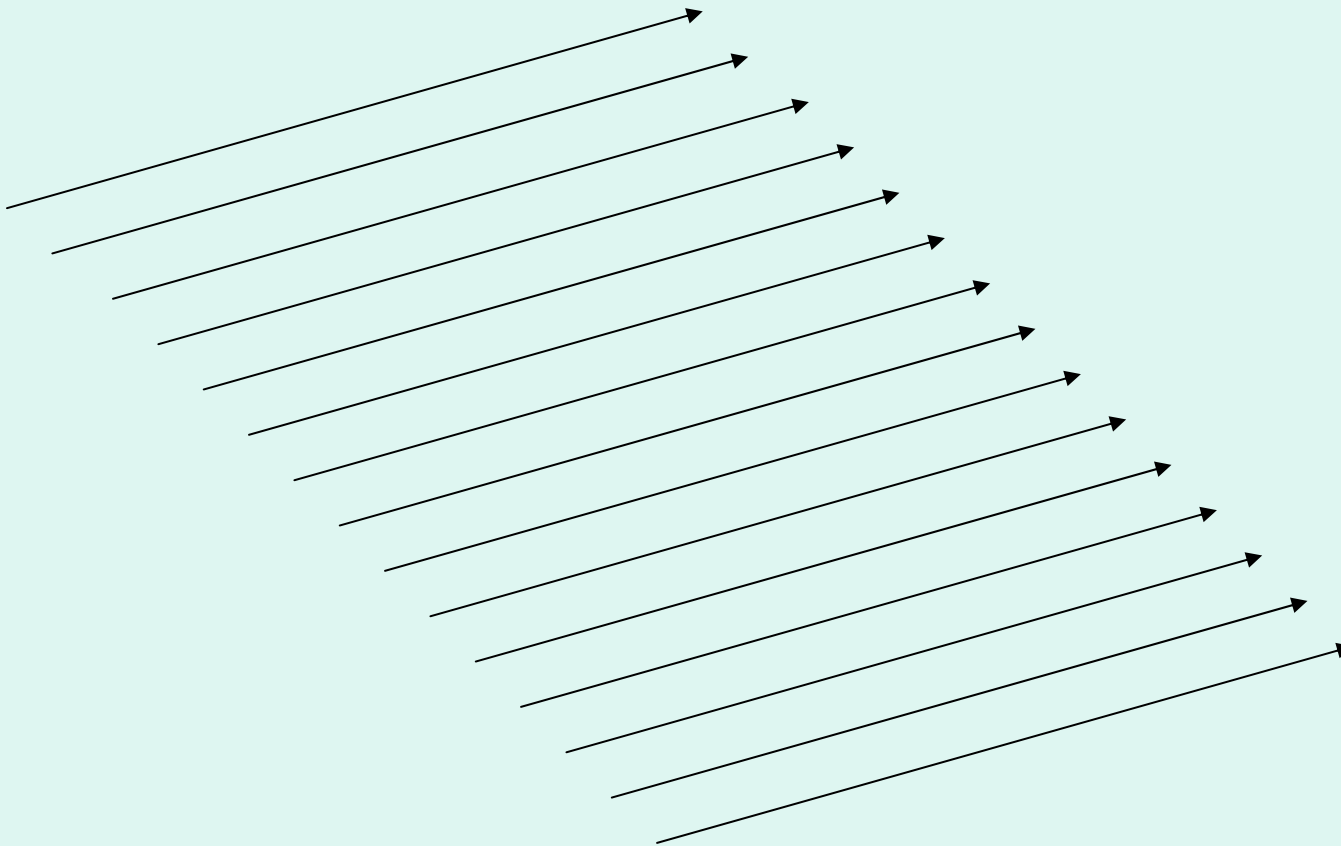


The care pathway management issues

IM&T impact?

Strategic vision	Choice	Process of care – complex range of sub-pathway processes
Service specification	Targets	
Capacity	Partner providers	Standards for better health
Price		
Budget management	Trouble shooting	Clinical audit & effectiveness
Efficiency	Skill mix	Research and innovation
Patient perspective	Patient categorisation and allocation	Hazard awareness

Local health system – how many pathways need managing?21



- Emergency care
- Cancer
- Cardiovascular disease
- Diabetes
- Endocrine
- Mental health
- Learning disability
- Substance misuse
- Older people
- Children's health
- Renal
- Sexual & Reproductive health
- Respiratory disease
- Orthopaedics, rheumatology, spinal and trauma, MSK
- Long term neuro conditions & stroke
- Digestive system conditions
- Urology
- ENT, eyes and dermatology
- Infectious disease
- Specialist commissioning
- Health and social care in criminal justice

Are they all there, fit for purpose, and managed effectively?

Local Health System cross cutting issues

- Standards for better health – LHS joint approaches
- Choice
- Workforce planning
- Performance monitoring
- Public involvement
- Clinical pathway integration e.g. rehab., diagnostics
- Public health
- Infrastructure, IT, buildings and kit
- LHC LDP & financial balance
- Accountabilities and reporting
- Academia, research
- Strategic direction and innovation
- Organisational relationships
- Ethics
- Prescribing



Is this comprehensive?

Cross cutting issues

A whole system clinical leadership group – PEC

- Standards for better health – mostly at organisational level, but should ideally deliver whole LHS working
- Public involvement new structures, same agenda
- Public health – Prevention, screening and early diagnosis, lifestyle factors main focus. Involving LA, community and industry.
- Academic issues – by individuals, research governance
- Ethics – LREC and PEC group
- Prescribing

Cross cutting issues

ISIP, LDP, LHS commissioning (structure?)

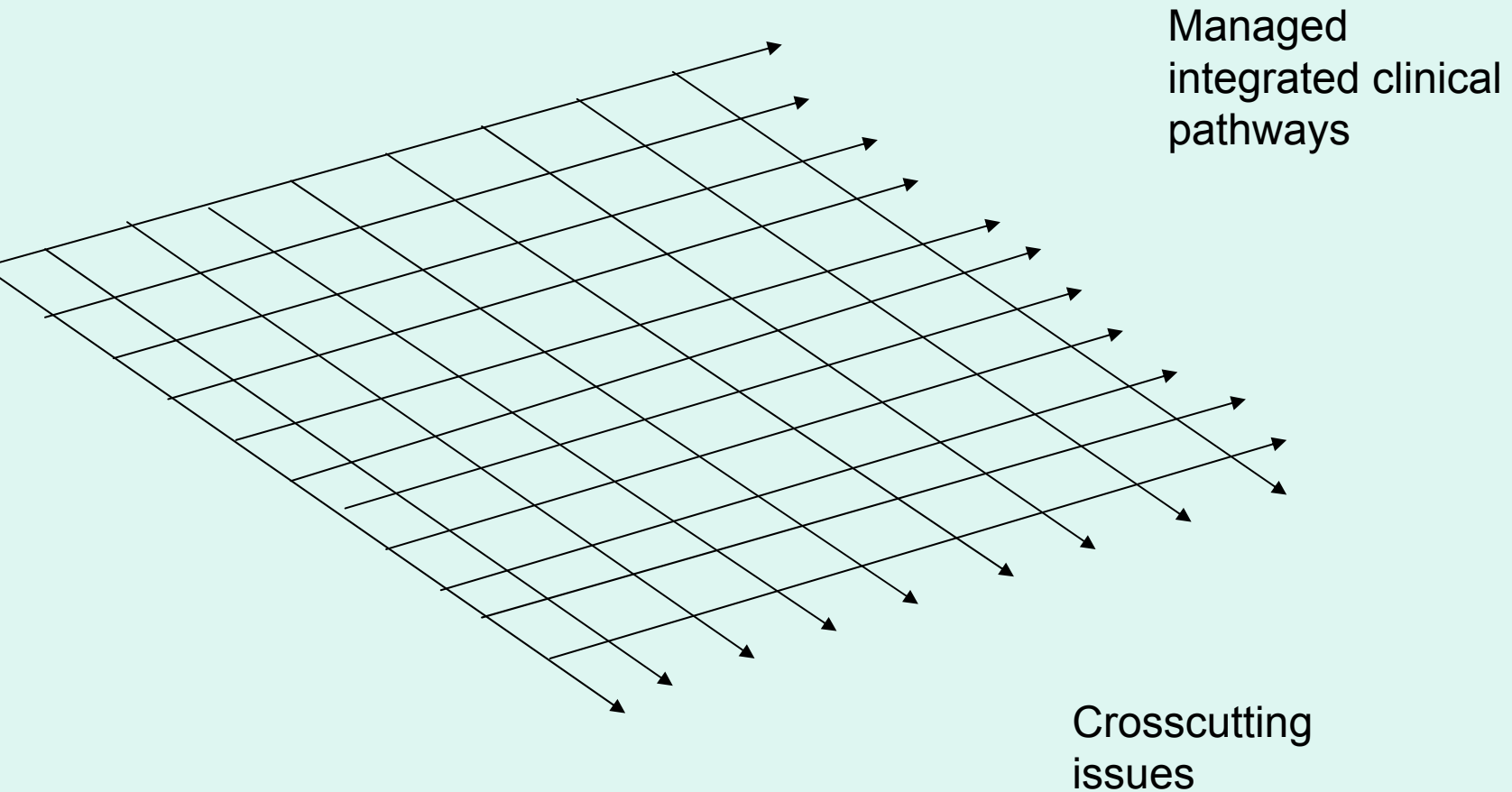
- System oversight
- Choice
- Workforce development and planning
- Infrastructure, buildings and IT
- LHS financial balance

Cross cutting issues

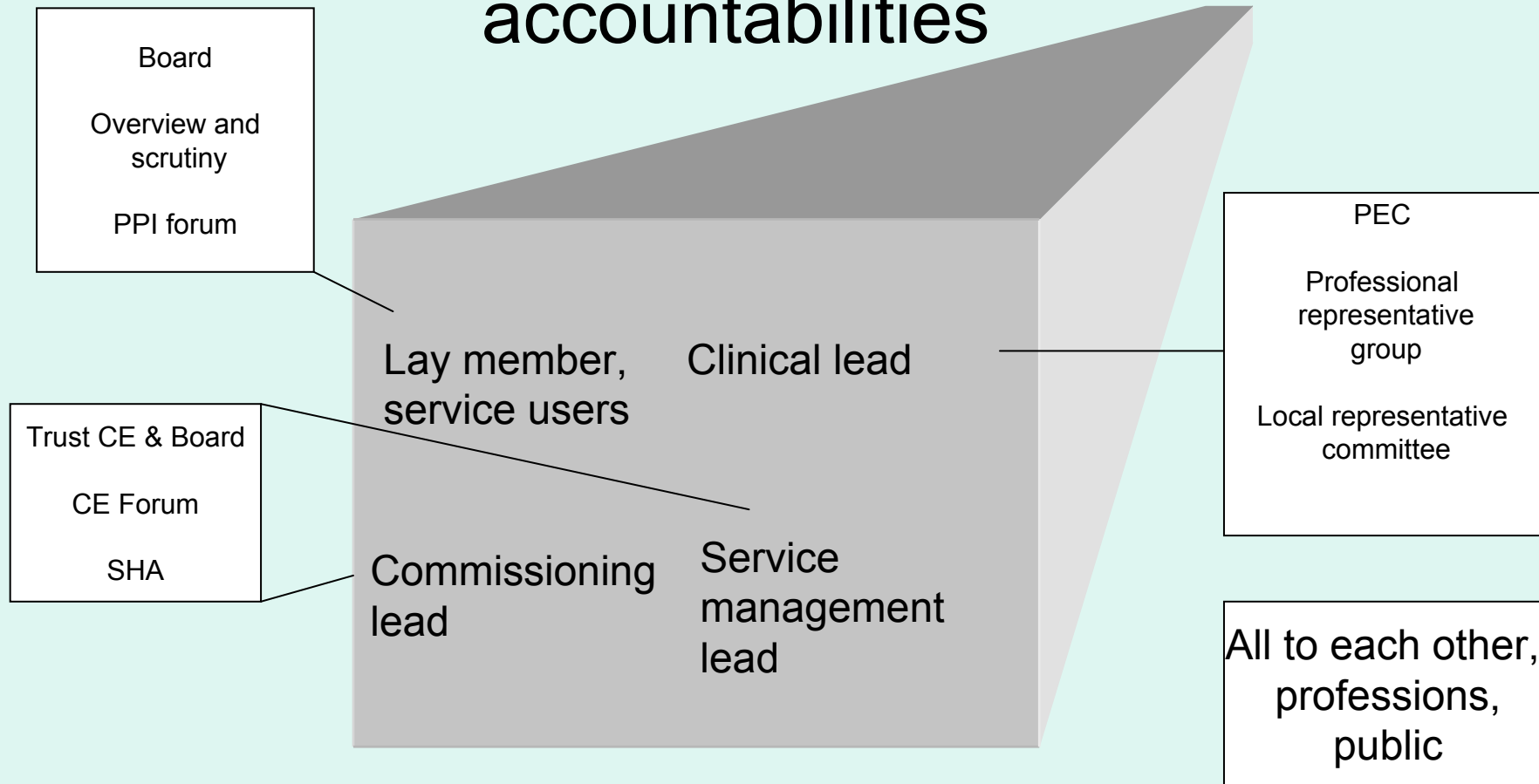
Strategic health and social care CE group

- Performance monitoring – largely organisational and collaborative, but increasingly accountable to clinical leaders.
- Integration across sectors and agencies
- Accountabilities and reporting – delegating the authority of organisations and the need to develop the management structures to support delivery.
- Strategic direction and innovation – matrix approach will support and enable, collaborative issues to be effectively incorporated, develop vision.
- Organisational relationships – delegated authority required to deliver a pathway approach and enable a culture of modernisation, patient focus, and mutual support.

Quality Assuring the LHS Clinical management framework – the role of a PEC



Pathway management groups and accountabilities



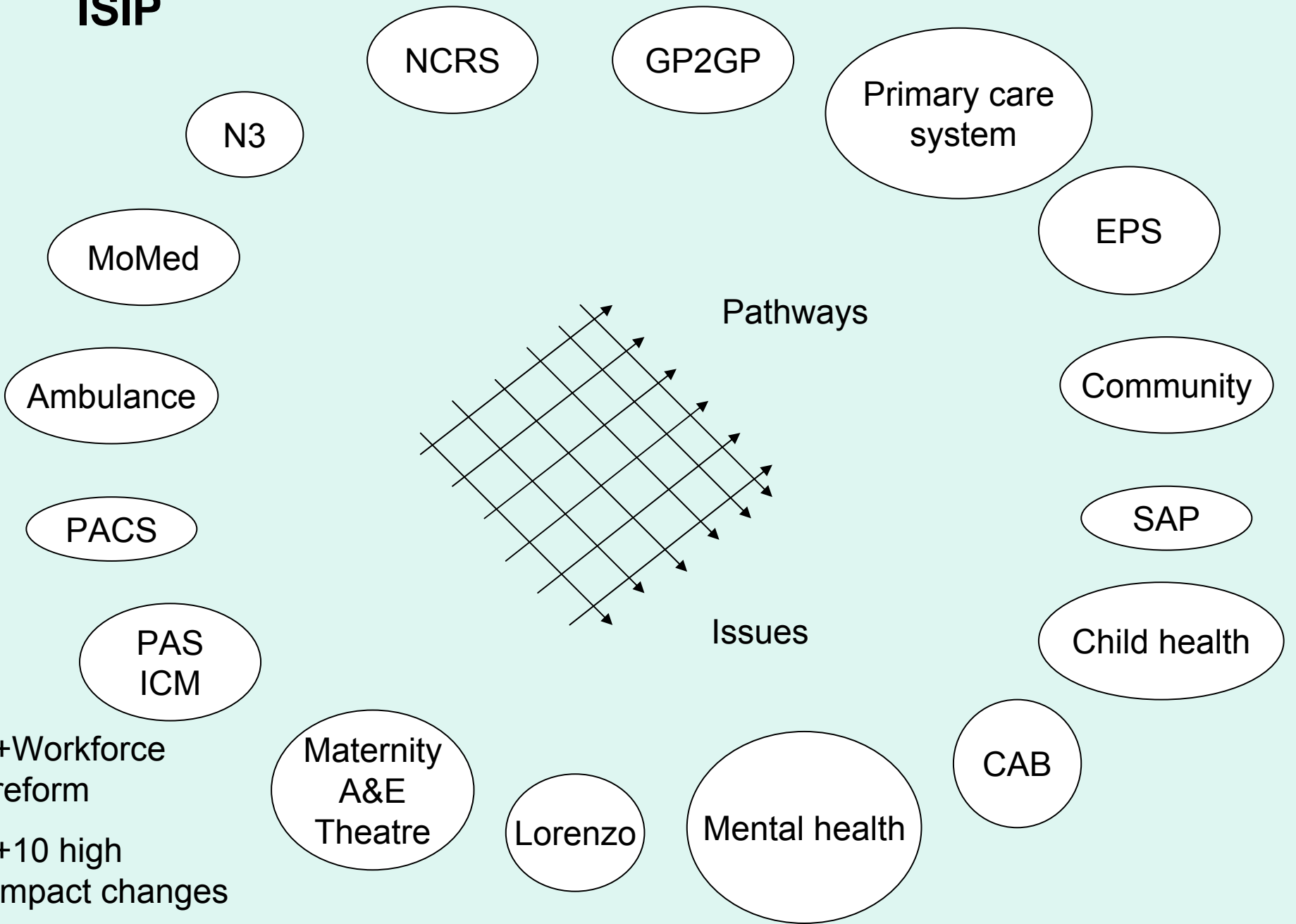
Accountable individuals resourced and incentivised from appropriate local NHS and partner organisations.

Is there effective delivery of these roles in existing structures? Can they be strengthened and helped to operate more effectively?

The model applied to NPfIT

- A cross cutting issue and a pathway issue
- Illustration shows how IM&T is relevant to the LHS infrastructure and its clinical delivery
- Illustrates how the model can be used to plan the benefits realisation of the NPfIT
- The NPfIT products are mapped on to the model

ISIP



Implications for clinical pathway IM&T support – the requirement set

- Applies to all pathways therefore systems integration requirement
- The LHS needs an NPfIT delivery strategy, sector and project leadership accountability and structures, with effective clinical input
- Focus on timely product delivery, integration, cross sector communication, clinical relevance
- This is about wiring up LHSs not regional performance management - NLOP.
- Enabling the delivery of the LHS cross cutting issues.....

Implications for clinical pathway IM&T support – the requirement set

- Standards for better health, better care and patient experience
- Choice, service directories, web and direct CAB
- Workforce planning
- Performance monitoring against targets
- Public involvement, services available
- Integration by information sharing across sectors and partner agencies, clinician, admin and patient awareness
- Public health, support to health needs assessment, health promotion planning and emergency planning
- Buildings and kit, joining up
- LHS LDP & financial balance, financial planning and budget monitoring
- Accountabilities and reporting, report creation
- Academic issues, research and teaching support
- Strategic direction and innovation, planning support
- Organisational relationships, appropriate information sharing
- Prescribing

Implications for clinical pathway IM&T support – the requirement set

- Deliver early adoption of world best practice
- The support delivered depends on service specification
- Efficiency of process and improved patient experience
- Monitor capacity and service utilisation real time
- Enable financial management, tariff price, budget monitoring
- Able to monitor efficiency implications of pathway redesign, identify waste
- Support capture of patient feedback and help deliver clarity of information to patients
- Support patient choice, awareness and execution

Implications for clinical pathway IM&T support

- Monitor performance of the managed pathway against targets
- Enable design and planning assumptions testing
- Support workforce utilisation and planning
- Help clinicians and patients to ensure right patients see right clinician at right time in right place
- Enable patient tracking through pathway
- Monitoring of standards for better health
- Support use and audit of effectiveness based protocols of care, and audit of exceptions
- Support research
- Support hazard recognition, risk register and risk management

ISI Planning

ISIP five aims:

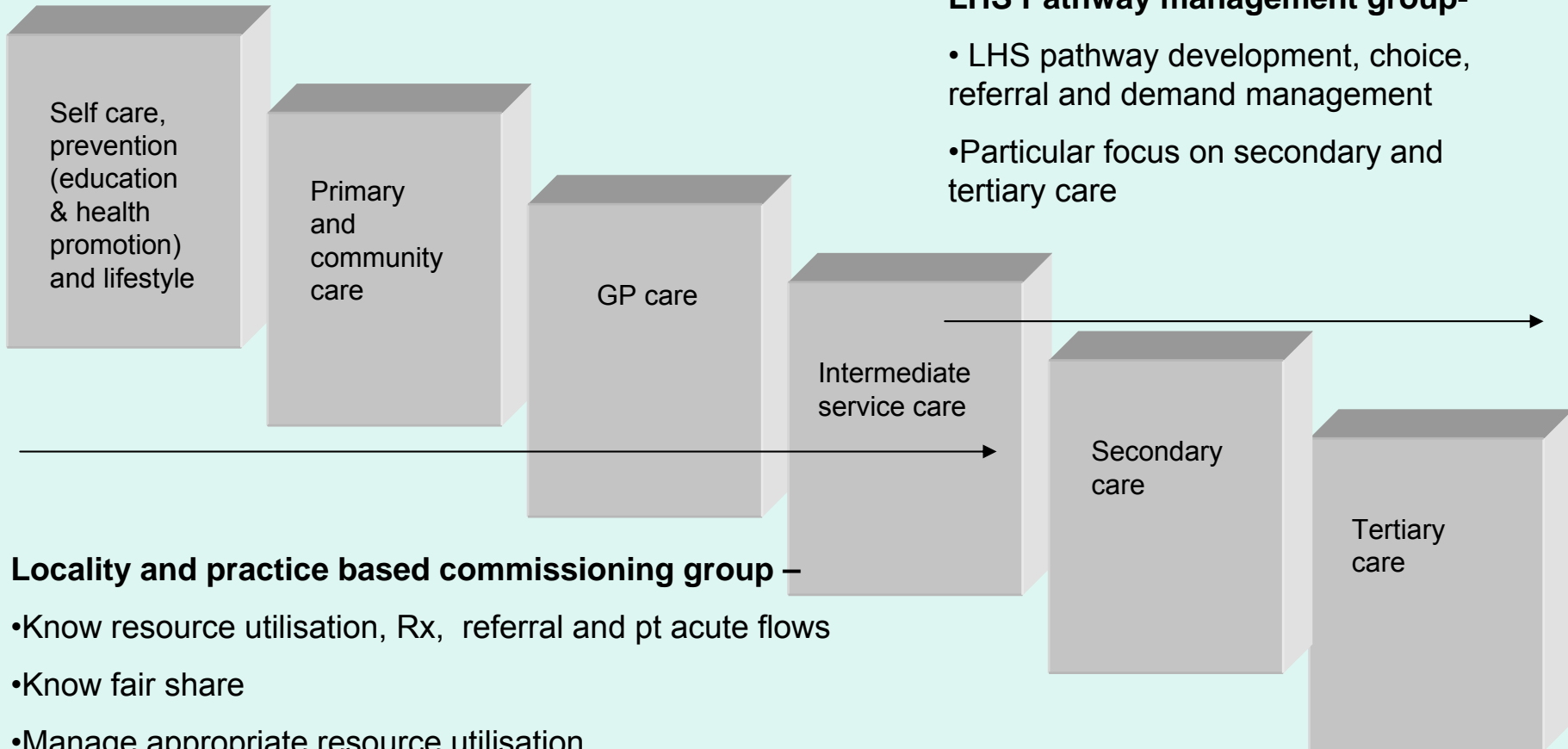
- Delivering a patient-led NHS
- Delivering quality and value
- Local action; national voice
- Spreading best practice
- Integration

Local Health Systems (LHSs)

LHSs most appropriate level to champion integrated service improvement because they:

- have the perspective to identify benefits, enabled by **integrated care pathways**, across the whole health and social care community
- can prioritise between benefits and broker interests across different organisations within the health community
- can co-ordinate changes in operational processes across organisational boundaries which are essential for the optimal realisation of benefits
- can support programme delivery resources and skill-sets which are difficult for individual trusts and Primary Care Trusts (PCTs) to sustain.

Practice based commissioning



LHS Pathway management group-

- LHS pathway development, choice, referral and demand management
- Particular focus on secondary and tertiary care

Locality and practice based commissioning group –

- Know resource utilisation, Rx, referral and pt acute flows
- Know fair share
- Manage appropriate resource utilisation
- With saved resource -design, develop and deliver primary, community, intermediate services, out of hospital care
- Support LHS pathway management group

Driven by timely information linked to care pathways

NPfIT benefits realisation

- As per the last six slides applying in detail to all clinical pathways
- Only credibly done at LHC level if mainstreamed
- Principles of accountability and linkage to NHS business planning are key
- Project to framework mapping will support project benefits realisation

The role of clinical support software

- Long experience in primary care – 10% uptake
- Significant and growing international experience
- Evidence supports its use
- National resources, CfH pathways service, MoM, NeLH, bandolier, **Prodigy**, NICE etc
- Now the benefits and risks of local tailoring

Reasons not to use ICPs – the top ten excuses explaining failure of uptake

1. Pathways mean cookbook medicine
2. Pathways increase the amount of clinical documentation.
3. Pathways are merely a cost cutting tool.
4. Pathways will put the more complicated patient at risk.
5. Pathways are expensive and time consuming to design.
6. We have too many different types of patients in our department.
7. Pathways increase the risk that doctors will be sued.
8. Patients and their families will not like having 'mechanistic care'.
9. Pathways will constrain research and development.
10. We need more computer systems to support pathways

Benefits

- Benefits from care pathways themselves
- From standardisation and national availability
- From availability of NCRS

Evidence shows care pathways deliver.....

- Fewer days in hospital
- Fewer complications
- Faster access
- Reduced door to needle time
- Fewer readmissions
- Less tests,
- more success
- and satisfaction

QA

- Keep relevant - what are the clinical and technical requirements from the frontline in to SHAs?
- Ecare pathways need authoring and assurance
- National repository to ensure access and version control
- Content management services, keep up to date
- Clinical knowledge services, links to the expertise
- Flexibility demands effective local clinical governance when managing variance, need for clinical leadership
- Difficulty re collating old information in the record in to a current pathway
- People start to beat the pathways if unhelpful and clunky
- Balance of complexity v quality and standardisation

Concluding issues

- The challenge is to do e-pathways locally, across NHS, SC and independent sectors, utilising the wealth of tools available,
- How do we do this with the various constituents of the Local Health Community or System and the local population?
- Mechanisms and levels of delegated authority?
- Investment in pathway facilitation.
- Joint planning and financial risk?
- Fixing problems, monitoring and managing variance?
- Options of a pure form of LHS pathway working, a system based on organisational pre-eminence or a hybrid?
- Can highly developed clinical pathways (eg. cancer) be further improved in the LHS?
- Can well established ICPs be used as a template for other pathway development?
- Taking forward on the basis of health and social care
- Maximising the impact of the IM&T on patient care