

Visions for care in strategic health authorities

Introduction

As part of Lord Darzi's review of the NHS, each strategic health authority (SHA) outside London was commissioned to produce a report outlining their 'vision' for care in their region over the coming decade.*

To inform these reports, the nine SHAs were each instructed to establish eight 'clinical pathway groups' made up of clinicians and stakeholders. These groups were asked to develop plans for 'world quality care' in their respective clinical areas. Consultation events for patients and members of the public were also held in each region to feed into each report. The final 'vision' documents were published by the SHAs in May and June 2008 and are available from the NHS Next Stage Review website (www.ournhs.nhs.uk). Lord Darzi's final national report, published at the end of June, has been presented as an 'enabling' document which will make the policy changes necessary to allow the regional plans to be implemented.

The SHA documents could mark a significant shift for the NHS in England, which for the past eight years has been governed by strong national targets and a plethora of guidance and regulation intended to standardise care. This is not to say that the service provided by the NHS is uniform across England, but the emphasis of national policy has been on securing common standards and addressing public concerns about geographical variations in care. The SHA vision documents set out the priorities and targets for each region and are intended to be informed by and sensitive to the particular needs of each region's population and existing service structure. As a result they each focus on different issues and have produced different recommendations.

This briefing provides a thematic summary of some of the key features of the nine SHA plans, for the North West, North East, Yorkshire and the Humber, West Midlands, East Midlands, East of England, South East Coast, South Central and South West.

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* For a background briefing on the NHS Next Stage Review and analysis of the final national report, please see www.kingsfund.org.uk/publications/briefings/background_to_the.html

Themes

WAITING TIMES

A number of areas report that waiting times remain a priority for patients and the public. Some SHAs have pledged to extend existing waiting time targets, in relation to either the amount of time patients have to wait for treatments already subject to targets, or the types of care to which targets apply. For example, going beyond the 18-week target, the South West has pledged a maximum 8-week wait from referral to treatment for planned care by 2011 and the South East Coast has set a target for waits for planned care to fall to an average of nine weeks by 2009.

In terms of extending targets to new types of care, seven regions have pledged to reduce waits for mental health services. The 18-week waiting time target applies to mental health only when a patient is referred by their GP to an individual consultant. As most patients are referred to multidisciplinary teams such as a community mental health team, most mental health provision falls outside this target. Commitments in this area range in how specific they are, from a high-level pledge to introduce shorter referral-to-treatment times (West Midlands), to extending the existing 18-week targets to psychological therapies and other community-based services (East Midlands, East of England), to a commitment to have all mental health assessments completed within 4 weeks by 2011 (South West). East of England adds that it will recruit 'hundreds' of new mental health specialists to facilitate the achievement of their target.

Other targets and aspirations include: extending the maximum 18-week wait to podiatry, speech therapy, orthotics and wheelchair services (East of England); reducing waits for audiology and endoscopy (North West) and cancer diagnostics (South West); guaranteeing that patients admitted to hospital in an emergency will be seen by a consultant within 12 hours (Yorkshire and the Humber) and that pregnant women presenting at 12 weeks' gestation will be guaranteed an assessment within 2 weeks (East of England).

PATIENT CHOICE

Commitments to enhance or extend the national patient choice policy include extending the choice of location and appointment time to diagnostics and other non-consultant led services (South West, East of England); and giving greater choice of treatment options to patients with long-term conditions (West Midlands, North West) and those receiving end-of-life care (North West). The South West also committed to practice-based commissioners offering patients a greater choice in the services commissioned for them. Four areas also committed to improving the availability of performance information on local providers (West Midlands, East Midlands, North East, South Central).

All areas cite patient choice as having a role in future policy, with most confirming their commitment to delivering on the national policy for choice of place of childbirth for pregnant women. One region states that in areas where choice is not practical – such as emergency care – the NHS needs to develop markets through competitive tendering for contracts to provide services (South East Coast).

COMMISSIONING

A number of SHA regions propose to introduce different financial arrangements to those used nationally in order to incentivise quality. This includes plans in the North West for a quality, outcomes-based reimbursement system for hospital care due to be finalised this autumn,

with the possibility of an extension to primary care in the future; and introducing local changes to the quality and outcomes framework (West Midlands, South West).

In four regions integrating the commissioning of health and social care services is seen as key to delivering a more integrated service for patients (South West, South East Coast, West Midlands, South East Coast), though it is thought that this will require changes to legal restrictions on sharing budgets as well as national changes to the NHS tariff.

Yorkshire and the Humber proposes that ‘commissioners should consider the merits of commissioning services from single providers, who in turn assume responsibility for sub-contracting or delivering the required service to each locality in line with local arrangements’. It is not clear whether this plan is referring to practice-based commissioning clusters or new, unspecified forms of integrated provider-commissioners.

Elsewhere, practice-based commissioning is seen as a means of ensuring clinical engagement in commissioning decisions (West Midlands); for developing a stronger focus on promoting health, focusing on outcomes and delivering an integrated service (South West); and for developing primary care services to include diagnostics and services for people with long-term conditions (North East).

SHIFTING CARE FROM HOSPITALS TO COMMUNITY SETTINGS

Providing more specialist services in community settings features in all of the vision documents. Two areas specify targets to shift outpatient appointments to primary care of 50 per cent and 40 per cent respectively (South West, East of England) and a third pledges to deliver more outpatient follow-up appointments in the community (Yorkshire and the Humber). Most areas also proposed that a wider range of diagnostic tests should be made available in primary care settings, with some adding that GPs should be able to have direct access to these services, rather than the patient first requiring referral to an outpatient appointment.

Reducing accident and emergency (A&E) attendance through provision of alternative facilities or improved triage features in plans for more than half of the SHAs. Four areas are proposing to establish Urgent Care Centres and two areas specify target reductions of A&E attendance (South West – 10 per cent per annum for five years; East of England – 50 per cent provided elsewhere in ‘the long run’). All but one of the SHAs advocate establishing a new national health phone number (‘888’ is often suggested), which should act as a first point of contact and triage for health issues. One region recommends that staffing should be arranged locally to ensure that staff have local service knowledge and that there ought to be direct clinical input to decisions to avoid the risk-averse decisions which the SHA says result from the current software protocols used by NHS Direct and ambulance services (West Midlands).

More than half of the areas commit to making home births a real choice for women and some to increasing the proportion of births that take place in midwife-led units. A commitment to providing more community support to those living with mental health problems in order to reduce hospital admissions and A&E attendance is made by four SHAs. Providing children’s care in non-hospital settings wherever possible is mentioned by three SHAs, and two areas also pledge to facilitate the choice of those patients who would prefer to die at home rather than in hospital.

PRIMARY CARE AND COMMUNITY SERVICES

Polyclinic-like models, in which GP practices are co-located with a range of community and sometimes diagnostic and specialist services are mentioned in five of the reports (South West, West Midlands, North West and East Midlands, Yorkshire and the Humber). These range from proposals to use the new GP-led health centres announced in the interim Darzi report to house specialist and diagnostic services in addition to GPs (North West, East Midlands), to a broader commitment to developing an estates policy that encourages the integration of primary, community and social care services (South West). The West Midlands proposes maintaining existing GP practices; creating ‘spoke’ facilities comprising GPs, pharmacies, therapies and other community services to serve populations of 8,000–15,000; and developing ‘hubs,’ which may be based in community hospitals whose services would include some combination of diagnostic services, outpatient services, minor surgery and community beds serving populations of 50,000–100,000.

In relation to community services, the South West confirms that PCTs can continue their provider function and that acute trusts could also be commissioned to provide these services. An increased role for pharmacists along the lines set out in the recent White Paper on pharmacy is advocated by NHS Yorkshire and the Humber.

LONG-TERM CONDITIONS, CARE CO-ORDINATORS AND DIRECT PAYMENTS

In addition to some areas confirming their commitment to introduce personal care plans for people with long-term conditions as required by *Our Health, Our Care, Our Say*, proposed changes to services in this area include identifying costed pathways for common conditions to encourage care to be provided in community rather than hospital settings (North East); introducing a comprehensive training programme on managing long-term conditions for all frontline health staff (West Midlands); commissioning self-care programmes (East Midlands); joint planning and commissioning of health and social care services (South East Coast); and encouraging the use of risk stratification tools by PCTs (East Midlands).

The introduction of ‘care co-ordinators’ to act as a single point of contact for a patient throughout a treatment or series of treatments features in a number of the documents, most commonly to support patients with long-term conditions or mental health problems (South West, North West, South East Coast, South Central). Yorkshire and the Humber plan to introduce care co-ordinators within hospitals to oversee the care of admitted patients during their stay and South Central suggest that care co-ordinators (who may be a GP) will be available for all patients.

Proposals to introduce personal budgets and direct payments for people with long-term conditions feature in five of the reports. These range from plans to ‘explore’ the possibility (Yorkshire and the Humber); to plans to pilot the policy (East of England, North East); to commitments to implement these arrangements (West Midlands, North West).

CENTRALISING CARE

Almost all areas propose the concentration of stroke services and/or the development of specialist centres providing stroke care 24/7. These proposals range from a broad commitment to concentrating services, to a pledge to undertake further work at the SHA level to explore the most appropriate service model, to a specification of the number of new centres to be developed.

Two-thirds of SHAs propose some concentration of services for heart attacks. As with stroke care, the detail of these plans ranges from broad commitments to concentrating services, to requirements for PCTs to establish the correct pattern of services, to the SHA specifying the number of specialist centres to be developed to ensure that primary angioplasty is available within three hours for the majority of eligible patients with myocardial infarction.

Four SHAs commit to reviewing the case for centralisation of some types of complex and/or low-volume surgery in areas such as vascular surgery, paediatrics, cancer surgery, spinal surgery, neurosurgery and thoracic surgery. Each of these areas cites a different combination of specialities as likely candidates for centralisation, with paediatrics being the one area that all four say they will review.

Plans to centralise major trauma care also feature in just under half of plans.

Few areas set out fully detailed plans for what new service configurations might look like, with a number suggesting that further evidence-based modelling work ought to be undertaken at the SHA level and others that the precise organisation of services will be a matter for primary care trusts. However, some assurances are provided in relation to keeping existing services functioning: three areas state that they do not foresee any A&E closures and the East of England SHA pledges to keep open all safe small obstetric units, which could require PCTs subsidising such units up to £500,000 per year.

CARE PATHWAYS

All nine of the regions discuss the development of 'care pathways' for some conditions. 'Pathways' set out and standardise the types of care a patient will receive at each point in their contact with health services for some particular condition or combination of conditions, often including a timeframe for these contacts. The SHAs commit to developing consistent – and often 'evidence-based' – care pathways and protocols for a range of areas and conditions, including planned care, acute care, mental health care, services for long-term conditions, end-of-life care and care for heart attacks and strokes.

PUBLIC HEALTH

The South East Coast SHA pledges that by 2011 there will be no 'avoidable' cases of hospital-acquired MRSA and fewer than 2,000 cases of *Clostridium difficile* in their region.

Targets to reduce gaps in life expectancy are established in two regions: the South West pledges to reduce the gap between their worst and best areas by one-third by 2013; and the North West pledges to reduce the overall gap by 11 per cent for men and by 16 per cent for women by 2010.

The East of England pledges to reduce the number of smokers by 15 per cent by 2011 and the North West to contain obesity levels to 2000 rates by 2010 and to reduce alcohol-related hospital admissions by 1 per cent a year.

Encouraging employers to develop workplace 'staying healthy' schemes is proposed by South Central and the East of England.

The North East plans for everyone to complete 'lifestyle questionnaires' and develop a

corresponding health and well-being plan, while the East of England pledges to ‘deliver packages of integrated lifestyle support services to targeted groups’.

Using social marketing techniques to change attitudes to health-related behaviours such as alcohol misuse is advocated by Yorkshire and the Humber who plan to set up an SHA level social marketing delivery unit. This region also floats the possibility of developing an ‘NHS Club Card’ which could hold someone’s medical history and ‘lifestyle rating’ and accumulate points to be cashed in against health food purchases or car parking fees.

What happens next?

Six of the SHAs are putting their documents out for consultation, and the majority pledge that more detailed SHA and PCT plans will be published in the autumn and winter of 2008/9. PCTs are legally obliged to consult their local populations on any decisions that may affect the operation of the local health service, and must also consult local authority overview and scrutiny committees on any ‘substantial’ plans for change.

A number of areas plan to maintain the clinical pathway groups (or develop new equivalents) to oversee the implementation of their plans and the East of England has set up a special regional NHS Bank to finance implementation. The East Midlands commits itself to commissioning an annual independent review of progress and to holding annual events to reflect on progress to which patients and members of the public who contributed to the review will be invited.

Some of the proposals – such as introducing local variations to the quality and outcomes framework – will require national policy change before they can be implemented. Ara Darzi’s final national report has been presented as a document that should ‘enable’ local plans for change.

If all the proposals contained in the SHA plans are successfully implemented, it will result in significant regional variations in the standards of care provided to NHS patients. For example, in the South West, waiting times are likely to be shorter than elsewhere; in Yorkshire and the Humber, primary care trusts may play a very different role if integrated provider-commissioner organisations assume responsibility for commissioning; and in the South East Coast, patients may be better protected against hospital-acquired infections than elsewhere in the country as providers focus on meeting the local target. Although there have always been regional variations, implementation of these plans would formalise these variations. This raises questions over the legitimacy of SHAs’ agreeing differences of this kind and the extent to which they are accountable for those differences to patients and residents in their regions. While devolution of decision-making from Whitehall to local bodies may be seen as increasing the responsiveness of policy to local needs, the extent to which members of the public will tolerate formalised regional variations in the standards of NHS care is not yet clear. This will in part depend on the extent to which the plans have been informed by the public consultations.