Oxfordshire's Transformation Programme

Service Redesign Workstreams

Progress in Further Developing 5 Clinical Pathways

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Clinical Pathways Service Redesign

- Identified 5 pathways where service redesign will demonstrate system wide collaboration at scale
  I. Maternity & Children *('Children')*
  II. Mental Health *('Adults')*
  III. Learning Disability & Autism *('Adults')*
  IV. Acute & Integrated Care : including Urgent & Emergency Care, Frail Older People, Long Term Conditions and Sustainable Primary Care *(typically older people ie 65-85 years)*
  V. Planned & Specialist Care (and Diagnostics); *('All ages')*

- The SRO for Clinical Pathways Service Redesign is Bruno Holthof, supported by a Chief Operating Officers Group and system enablers e.g. Finance, Estates, Workforce and IM&T

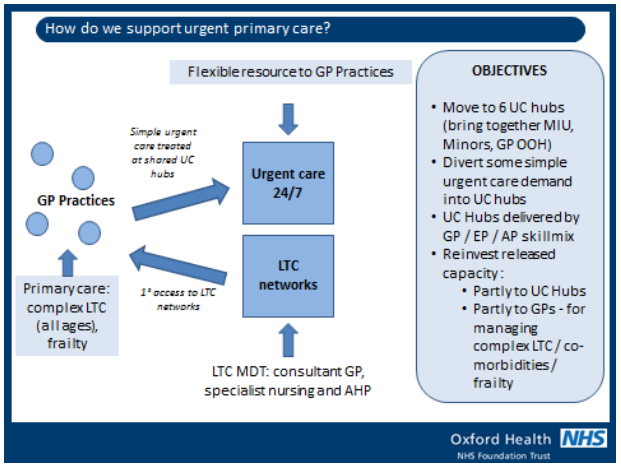
- Pathway redesign was initiated 1st April '16 and meets monthly aligned to the STP process

- The pathway service redesign will contribute to:
  - Reduced variation and improved access, outcomes, experiences and higher quality services
  - Delivery of a clinically and financially sustainability health care system by 2020/21
  - Deliver on our ambitions for *Care Closer to Home*

Pathway Redesign work to date

Each Pathway has presented on their:

- ❑ Vision & Emerging Case for Change
- ❑ 3 Gaps as per 5 Year Forward View
  - I. Health & Wellbeing Gap
  - II. Care & Quality Gap
  - III. Finance & Efficiency Gap
- ❑ National & International Trends and Challenges
- ❑ Best Practice
- ❑ Emerging ideas/options/proposals & implications



The 5 Clinical Pathways

1. **Acute and Integrated Care (including Urgent/Emergency Care, Frail Older People, LTCs and Sustainable Primary Care)**

- **Pathway leads** – Diane Hedges, Dominic Hardisty and Paul Brennan
- **Clinical leads** – Andrew Burnett, Barbara Batty, Pete McGrane, James Price, Louise Bradbury, Rachel Hardwick

2. **Planned and Specialist Care and Diagnostics**

- **Pathway lead** – Sharon Barrington
- **Clinical leads** – John Westbrook, Chandi Ratnatunga, Stephen Attwood, Shelley Hayles

The 5 Clinical Pathways (cont)

3. Maternity and Children

- **Pathway lead** – Sarah Breton
- **Clinical leads** – Wendy Woodhouse, Veronica Miller, Nettie Dearmun, Kiren Collison, Miles Carter, Andy Valentine

4. Mental Health

- **Pathway lead** – Ian Bottomley
- **Clinical leads** –Rob Bale, Bart Sheehan, David Chapman

5. Learning Disability and Autism

- **Pathway lead** – Ian Bottomley
- **Clinical leads** – Rob Bale, David Chapman

Pathway and Patient Groups

NHS
Oxfordshire
Clinical Commissioning Group

- The starting point in developing the future models of care is to identify current challenges and discuss what good looks like for the pathways:

Maternity & paediatrics	▪ Care provision for **women planning to have children and expecting mothers** from pre-conception, antenatal, birth and post-natal. Expected level of risks associated with pregnancy and child birth is critical when considering care settings (including provision of neonatal) and staffing model ▪ Care provision for **children (below age 18)** from universal prevention, primary and urgent care, more targeted community care and protection for vulnerable children to specialist acute and tertiary care
Urgent & emergency care	▪ **Mostly healthy**: people under 75 who are mainly healthy, but may require urgent care from time to time. Convenience may be an important factor when selecting the care setting ▪ **People with long term conditions**: people who either have a known, pre-existing condition or who are quickly and easily identifiable as having one so that they can be directed – or will direct themselves – to the service they need, thus avoiding overburdening the acute emergency pathway, including A&E. Within this segment, there could be differentiated physical health conditions (heart, respiratory, diabetes, cancer) and / or mental health conditions ▪ **Frail, mostly elderly**: people with 'undifferentiated', complex needs requiring rapid assessment and for whom A&E may not be the ideal way to access the care they need. They may also be best cared for outside the acute setting, at least after the first few days. Majority of the segment will be elderly (but not all) and we should include elderly beyond a certain age (+75) automatically reflecting their enhanced risk of health complications The integrated provision of prevention, self-care, community, primary and ambulatory care are important for people with long term conditions and frail patients to avoid emergency admissions.
Elective, diagnostics & specialist care	▪ Care provision for **people who require planned, routine or specialist medical or surgical services** from self-care, self-assessment, diagnostics, consultation, treatments to rehab and follow up. A combination of acuity level and scale of volume are important when considering care settings

\+ **Mental health** | **Learning disabilities**

Developing Best Practice Pathways and Models of Care

NHS Oxfordshire Clinical Commissioning Group

When outlining what good looks like, discussions will be focused on the quality standards required and different delivery and staffing models

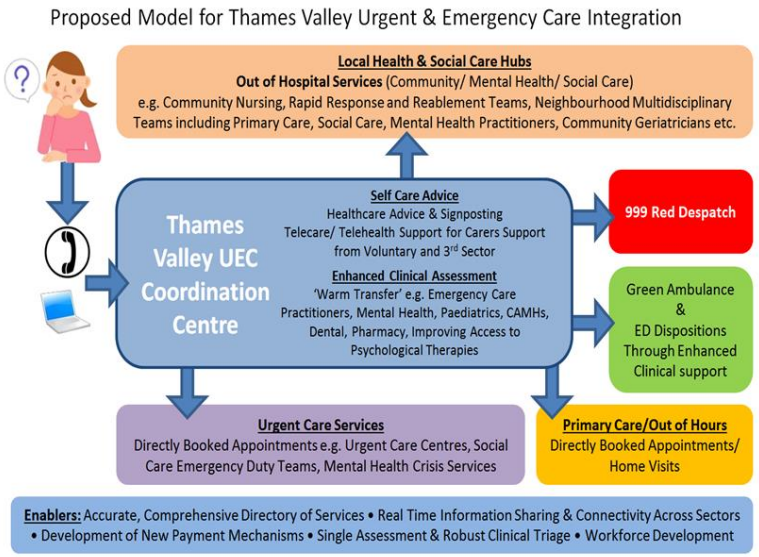
Proposed discussion questions for developing best practice pathways and models of care

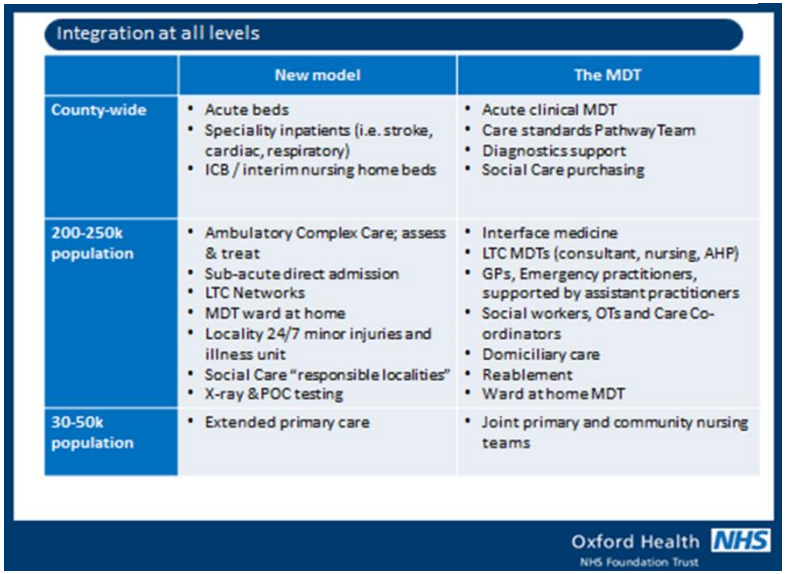
Maternity	▪ What are the quality standards for the delivery of services? ▪ What delivery models would best support this? High risk units? Medium risk? Low risk? Home birth? ▪ What could / should staffing models look like? Do these support self-care? Are these as efficient as they could be?
Paediatrics	▪ What are the quality standards required for urgent and acute paediatrics care? ▪ What are the options for meeting these standards? ▪ Are there likely to be changes in community provision that will materially alter acute demand?
Urgent & emergency care	▪ What does good practice look like for frail and chronic? ▪ What are the most effective ways of providing high quality urgent care in the community? What roles do phone services play, who else can play a key role? How can 24/7 day a week urgent care be provided in the community? How can this be made affordable? What other services are required, e.g., diagnostic support? ▪ What models of hospital based care can best support high quality, cost effective urgent and emergency care? What key interdependencies need to be considered?
Elective, diagnostics & specialist care	▪ What do high quality and efficient elective services look like? ▪ What are key interdependencies and requirements for different services? ▪ Should there be dedicated elective centres? How should specialist services be organised, what is the minimum scale?

Next Steps -

For the next meeting on the 29th April, each pathway will set out further detail on:

- The pathway(s) and flows (including current flow and redesigned flow based on learning from best practice)
- How it needs to be redesigned to achieve better flow, outcomes & VFM to 20/21
- An outline of options including implications for Workforce, Estates and IM&T etc
- Detail of what options might need to be consulted on (if at all) and mapping
- Criteria for evaluating the options that have presented by workstream leads.
- Implications for locality plans





STP Clinical Pathway Timeline

NHS
Oxfordshire
Clinical Commissioning Group

15 April 11:30 - 14:30 Jubilee House	29 April 12:00 - 15:00 Jubilee House	20 May 12:00 - 15:00 Jubilee House	17 June 12:00 - 15:00 Jubilee House
1 Emerging case for change	**2 Emerging clinical models**	**3 Refined clinical models**	**4 Enablers**
▪ Presentation of the emerging case for change, focusing on trends and challenges in current health care provision along the pathways ▪ Include best practices and case examples of models of care and discuss potential implications for Oxfordshire	▪ Presentation to include current pathway/flow and options for redesigned pathway and flow ▪ Detail of the supporting infrastructure needed to deliver the new pathway e.g. workforce, technological solutions and estate ▪ Identification of what parts of the new pathway will require consultation ▪ Review and input into emerging models of care	▪ Presentation of the refined pathways/models of care ▪ Identify what is needed in different care settings, including out of hospital care, to make the models of care sustainable in the long term	▪ Discuss key enablers for the new models of care: – Settings for care provision – Workforce – Ways of working – Technology