

## Appendix 4:

### Reference Group Meeting: What are the answers?

	What services should no longer be provided or provided at less volume than they are now?	What services should be provided at less cost and more efficiently?	If we had the money . . . what service should be re-invested in to maintain quality?
<b>Out of Hours</b>	<ul style="list-style-type: none"> <li>• Use other health professionals e.g. nurse practitioners / first responders not GPs</li> <li>• Abolish NHS Direct</li> <li>• Stop being the middle man (referring) and provide more actual care</li> <li>• Total integration of OOH / emergency care</li> <li>• Cut GP OOH pay</li> <li>• Room for change, better streamlining</li> </ul>	<ul style="list-style-type: none"> <li>• More efficient application of OOH service</li> <li>• Improved triage directing patients to self-care / minor ailments</li> </ul>	<ul style="list-style-type: none"> <li>• Better health education – realistic expectations from OOH care</li> </ul>
<b>Community Care</b>	<ul style="list-style-type: none"> <li>• Stop unsafe procedures in community hospitals</li> <li>• Greater emphasis preventative</li> <li>• Spend less on current models of secondary care provision but invest in that provision at a community level</li> <li>• Monitoring targets and arbitrary measures of good service</li> </ul>	<ul style="list-style-type: none"> <li>• Use of trainers and supported volunteers</li> <li>• More integrated teams, more partnership approaches, more VCS involvement in pathway design</li> <li>• Clear definition of skilled volunteer roles</li> <li>• Greater use of volunteers to free up medical staff using some funds for training and supporting volunteers properly</li> <li>• Generic care worker to prevent</li> </ul>	<ul style="list-style-type: none"> <li>• Community solutions – voluntary sector, engagement with local community</li> <li>• EOLC</li> <li>• Dementia (out of hospitals)</li> <li>• Keeping patients safe and cared for at home (or redistribute)</li> <li>• Community care services</li> <li>• Relapse prevention</li> <li>• Community transport – to enable centralisations specialist services</li> <li>• Prevention &amp; health education</li> </ul>

Independent Review of Health Services in North Yorkshire and York  
August 2011

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		<ul style="list-style-type: none"> <li>escalation of problems</li> <li>• Can we really afford to support home births</li> <li>• Re-invest in district nurses and community care</li> <li>• Specialist services in the community</li> </ul>	<ul style="list-style-type: none"> <li>• Community care to maintain independence for aging population</li> <li>• Community model which increases community based services virtual not physical teams</li> <li>• Investing in lower level health needs benefit realisation of appropriate workforce level</li> </ul>
<b>Mental Health</b>	<ul style="list-style-type: none"> <li>• Out of area treatments</li> <li>• Increase community care with greater integration between health and social care organisations</li> <li>• Acute mental health beds reduced</li> <li>• Invest in community care to reduced need / demand for beds</li> <li>• Preventative counselling</li> </ul>	<ul style="list-style-type: none"> <li>• Out of area treatments</li> <li>• Improve the integrated approach to delivery of health and social care between constituent bodies responsible for mental as well as physical conditions</li> <li>• Integration with adult and community services</li> <li>• Better use of cognitive behaviour therapy – time limited</li> </ul>	<ul style="list-style-type: none"> <li>• Psychological therapies</li> <li>• Community care</li> <li>• Autism</li> <li>• Dementia care</li> </ul>
<b>Estates</b>	<ul style="list-style-type: none"> <li>• Staff based estates</li> <li>• Align with local authority</li> <li>• Reduce estate foot print</li> <li>• Suspect large amount ?? ?? up in ?? used premises – rationalise</li> <li>• Co-locate services so they provide a range of services e.g. drop in clinic at hospital, GP triage clinics</li> <li>• Reduced beds = reduced estate</li> <li>• Estates and admin to be reduced – some will be natural wastage</li> </ul>	<ul style="list-style-type: none"> <li>• Efficiency gain – fewer larger visits – rationalise back offs</li> <li>• Sharing estate and more efficient use to reduce total cost</li> <li>• Improved planning of estate in conjunction with social care</li> <li>• Ban capital investments unless including existing estate</li> </ul>	<ul style="list-style-type: none"> <li>• Consider use of freed up space to bring in services that complements existing use (could provide as in – kind contribution to VCS to reduce grant expenditure too)</li> </ul>
<b>Community Hospitals</b>	<ul style="list-style-type: none"> <li>• Decrease volume, increase ?? cost procedures at community hospitals</li> </ul>	<ul style="list-style-type: none"> <li>• Step down from acute care</li> </ul>	

Independent Review of Health Services in North Yorkshire and York  
August 2011

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	<ul style="list-style-type: none"> <li>• Levels of care work – no longer do social care in community hospitals or let social care do it!</li> <li>• Less beds as a product of investment in preventative and community care</li> <li>• Transfer sub-acute care to community and home care</li> <li>• Less active bed requiring more community preventative</li> <li>• Community hospitals admissions criteria to be changed to reduce volume</li> <li>• Community hospitals become a local resource for diagnostics and rehabilitation</li> <li>• There needs to be consolidation of acute and community hospitals – what is the purpose?</li> </ul>		
<b>General Practice</b>	<ul style="list-style-type: none"> <li>• Lower numbers of GPs</li> <li>• More health promotion services through community pharmacy</li> <li>• De-commission re-commission models of primary care</li> <li>• Need to reduce service e.g. medicine reviews, blood taking etc in GP surgeries and move this into community such as pharmacies</li> <li>• Lower PMIG and QOFF</li> <li>• Re-distribute GPs – allocate to areas of greater need</li> <li>• Minor ailments referred to</li> </ul>	<ul style="list-style-type: none"> <li>• ?? out of hours provision</li> <li>• Target GP provision at deprived areas – reduce GP provision from well provided areas</li> <li>• NHS employed GPs – put different contractual / clinical levels into terms and conditions</li> <li>• Re-design QOF</li> <li>• Medicines management – provide from pharmacies</li> <li>• A more critical approach to prescribing e.g antibiotics for colds / coughs</li> </ul>	<ul style="list-style-type: none"> <li>• Preventative health promotion</li> <li>• Public &amp; patient engagement (especially under new GP consortia arrangements)</li> </ul>

Independent Review of Health Services in North Yorkshire and York  
August 2011

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	<p>pharmacy</p>	<ul style="list-style-type: none"> <li>• QOF payments is a disincentive to efficiency – needs revision</li> <li>• GP should accept national average – NO MPIG</li> <li>• The whole concept of primary care need to be changed – whilst they are businesses they will always want to protect income</li> <li>• Better sharing and with multiagency approach use of dentists, opticians, pharmacists, community support, voluntary services</li> <li>• Community hospitals stop what they currently do e.g. level 2</li> </ul>	
<p><b>Planned Care</b></p>	<ul style="list-style-type: none"> <li>• Hospitals become more specialist centres</li> <li>• Hips, knees &amp; cataracts raise clinical thresholds for elective care</li> <li>• Elective care no longer provided - decrease number of hip, knee &amp; cataracts</li> <li>• Ensure procedures of ?? clinical value reduce in areas where about average (reduce variation)</li> <li>• ?? public cost of procedures ? impact</li> </ul>	<ul style="list-style-type: none"> <li>• ?? decision making re commissioning</li> <li>• Evidence based care – so stop NHS vasectomy &amp; limit range of contraception (for example)</li> <li>• Less reliance on secondary care services including mental health</li> <li>• Improved partnership working between healthcare and social care</li> <li>• Interventions or reduce obesity eg: cognitive behaviour therapy, dietetic support, group therapy, counselling before we get to gastric banding, hip / knee replacements &amp; diabetes etc</li> <li>• Patients should either be ?? or</li> </ul>	<ul style="list-style-type: none"> <li>• If planned care waiting timescales increased in Q2 then reinvestment in planned care would be appropriate given a better resource situation</li> </ul>

Independent Review of Health Services in North Yorkshire and York  
August 2011

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		<p>enhanced recovery</p> <ul style="list-style-type: none"> <li>• Good pathway management from primary to secondary care</li> </ul>	
<b>Emergency Care</b>	<ul style="list-style-type: none"> <li>• Nursing home must be able to lift patients</li> <li>• Nursing home protocols re emergency admissions</li> <li>• Keeping the patient when the emergency care is no longer relevant</li> <li>• Reduce emergency care needs as a result of investment in community care</li> </ul>	<ul style="list-style-type: none"> <li>• Improve emergency care to taking a holistic instead of a specific view of patient recovery</li> <li>• Better management of long term conditions in community setting – education; medicines management support</li> <li>• Top up insurance for sport injury</li> <li>• GP surgeries as centres for community health – open longer; integrated services; joint estates</li> <li>• Acute emergency care – take beds out</li> <li>• Criteria should be tightened for some cosmetic / lifestyle surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Increase health promotion services</li> <li>• Easily accessible in the community – Pharmacies; drop in centres; outreach centres</li> </ul>

**Other Thoughts:**

- Technology – telehealth; health informatics; brokering access for patients
- Keep communicating with social care and voluntary sector – open & transparent
- Invest in older people – dementia; slow-stream rehabilitation to prevent emergency care
- Patient empowering to make choices; provision of information, on costs and services available
- Workforce demand?
- The geographical and logistical review of current services needs addressing – physical presence of services more equitable & efficient
- Charge for DNAs
- Community pharmacists and GP pharmacists

Independent Review of Health Services in North Yorkshire and York  
August 2011

- Pharmacy services, medicines management and control – pharmacists working as part of a GP team
- Workforce model – 24 x 7, weekend working
- Medical leadership in the region / community per speciality
- Establish a body responsible in its own right for deliverance health and social care in the community
- All services have the potential to provided more efficiently