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LONG TERM CONDITIONS

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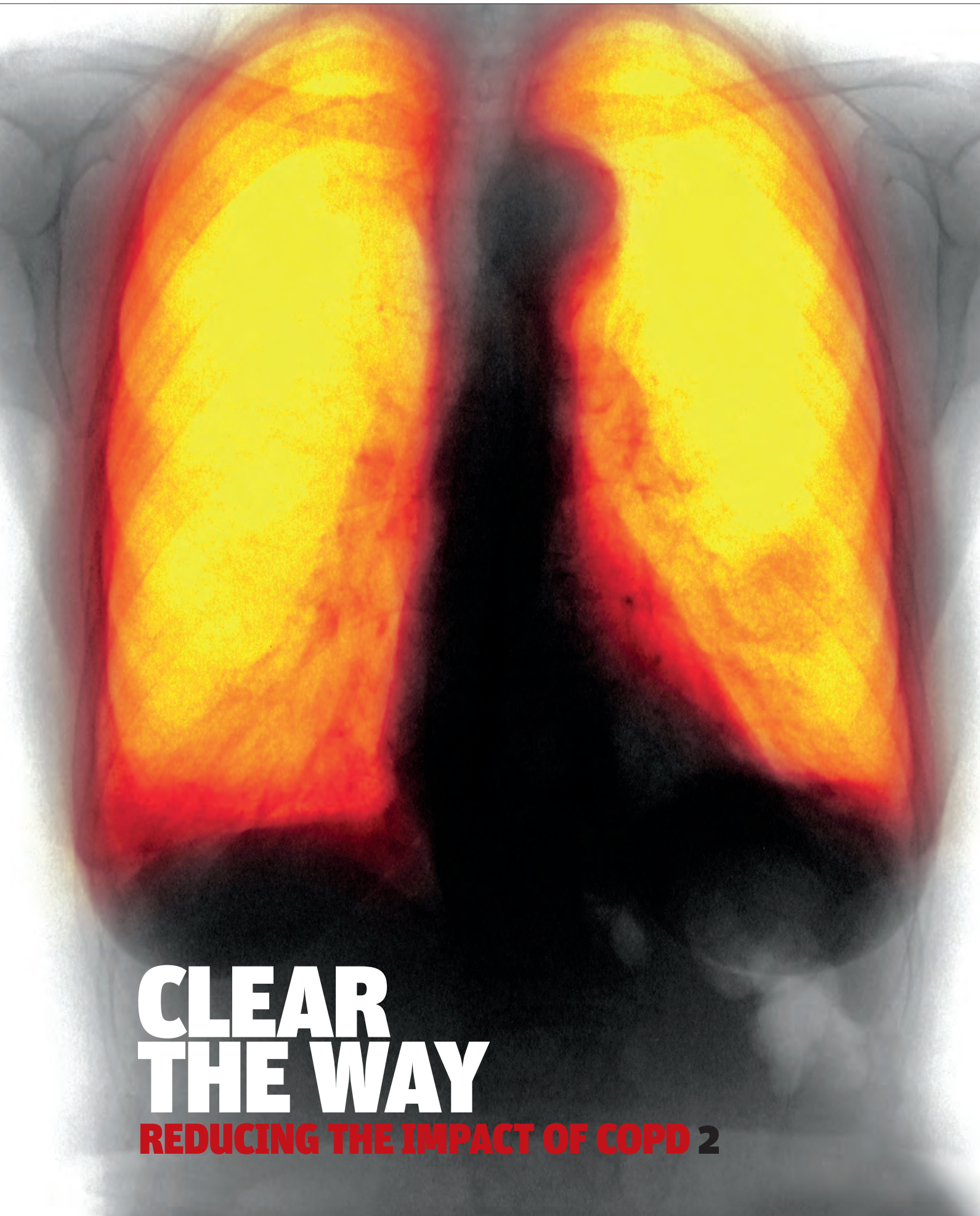

CLEAR THE WAY

REDUCING THE IMPACT OF COPD 2

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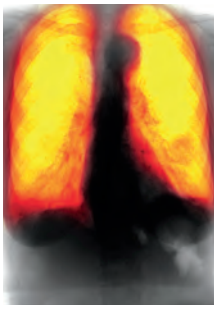

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SELF-CARE

THE LONG ANSWER

Self-care is cited as a solution to the long-term conditions problem. Helen Mooney finds out how commissioners can get the most out of it

When it comes to the future of providing for a population with increasingly complex long term conditions, there is now a consensus that current service provision is not sustainable – at least not in its current form.

Self-care is being championed as one of the ways forward, but what can commissioners be doing to shape it and commission for it?

"Commissioning for self-care is not something that has been thought about enough," says Don Redding, director of policy at patients' charity National Voices. "The Health Act places a duty on commissioners to promote the involvement of each patient in their own care, but it is not a duty that has so far been pushed very hard."

He believes that in order for patients to become proactive in managing their health and their long term conditions there needs to be much more involvement with the patient and continuity between primary and secondary care.

"Self-care is about an overall cultural change in the NHS, about seeing patients as partners in their own care which includes supporting them, dealing with health literacy, making sure shared decisions are made about their treatment, and that personalised care planning is a process that becomes integral to their care," he adds.

Some have begun to consider the need to commission for self-care in the round and ways that incentivise providers or groups of providers to provide different types of services to patients as partners in their care.

King's Fund senior fellow Nick Goodwin thinks that this is where clinical commissioning groups could be at their most powerful.

"Commissioners and providers need to think carefully about what the problems are in their populations and their client groups and what they are seeking to manage if they put in an integrated care package," he says.

"This is about taking people through a process to be able to self-care and recognising what is required to support them to do that. The payback is reduced admissions to secondary care, the question is how you do that?

"Given that there are already so many different units of care, is this added as an additional unit or is there a different way commissioners can get providers to work together to do this?"

Mr Goodwin says commissioners need to think about how they can generate different types of contracts with primary care providers with a package of funding to create new capability in terms of supporting people to care for themselves at home.

Clinical commissioning groups could be at their most powerful in commissioning for self-care

He says that commissioners will be able to measure the success of such packages of care by the improvement in patients' conditions and in reductions in unscheduled secondary care.

"The key to this is that commissioners don't prescribe the actual end point. The best examples exist where the commissioner acts as the broker with providers, and with patients, to come up with solutions," he says.

For self-care to really work well, commissioners across health, social care and housing will need to work together to commission – something that to date has not taken off in any meaningful way.

To forge ahead with the idea that patients are partners in their own health and care will also in many cases mean a mindset change in the way the NHS and the professionals within it see their role.

According to National Association of Primary Care chair Charles Alessi, the NHS is at the "start of journey" in how it develops self-care and integrated care packages.

"The new roles and responsibilities of health and wellbeing boards will be really important as they will have the responsibility of identifying areas of need for local populations and they will need to be assisted in their role by GPs," he says.

Alex Fox, chief executive of Shared Lives Plus, a network of family based and small scale ways of supporting adults in need of help to live independently, thinks the challenge is to take care out of buildings and institutions.

"There is often a Berlin Wall between formal and informal caring environments both in the NHS and in social care," he says. He argues that patient care needs to be de-institutionalised.

"If we are going to get anything from all the effort and heartache that has gone in to the NHS reforms, CCGs need to take a holistic view of a person, like good GPs do, and understand that a range of factors go in to someone's health and wellbeing and it is about finding models that fit personalised and self-care." ●

ALAMY

SUE HILL AND ROBERT WINTER ON BEATING COPD

IN ASSOCIATION WITH THE DEPARTMENT OF HEALTH

DH Department of Health

Improving outcomes for patients with chronic obstructive pulmonary disease has many challenges, especially if it is to be diagnosed earlier, progression slowed and survival improved. That is why we have asked the NHS in England to react to unwarranted variation in outcomes and patient experience and adopt a personalised approach to care.

Fundamental questions about how care is provided need to be asked. For example:

- **Why are so many patients diagnosed late, often with severe disease and sometimes only when admitted to hospital as an emergency?**
- **Why do we see such wide differences in recorded prevalence, hospital bed usage, mortality rates and prescribing?**
- **Why do patients admitted with COPD, only have a 50/50 chance of receiving specialist respiratory care – and why is this so much lower than for heart problems, cancer and stroke?**
- **Why is inhaler technique rarely taught and checked when the NHS spends nearly £1bn a year on inhalers and why does treatment often not follow evidence based guidance?**
- **Why is a third of the home oxygen prescribed to people who don't benefit or don't use it, when it costs the NHS £120m each year?**

Improving respiratory outcomes is a priority in the *NHS Outcomes Framework 2012-13*, underpinned by the publication of *An Outcomes Strategy for COPD and Asthma: NHS Companion Document* and NICE quality standards. The strategy, published in May, offers clear guidance on doing this through 18 high level actions.

'Meeting the challenge will require the NHS to be innovative'

We have cluster respiratory leads building multidisciplinary networks across England; NHS Improvement has published examples of good practice and case studies to show how services can be improved from prevention to treatment to end of life care; partnerships have been established with specialist professional societies, patient organisations and industry; and INHALE (Interactive Health Atlas for Lung Conditions in England) has been launched as a national respiratory information service enabling comparison between peers.

Meeting the challenge will require the NHS to innovate, break down barriers and introduce new models of integrated care, supported by actionable information about service quality and outcomes. Above all, this will require joint planning and successful local partnerships built around local needs and priorities.

The challenge is clear, the support and tools are in place and we have an excellent chance to deliver improved care for people with respiratory disease nationwide.

Professor Sue Hill and Dr Robert Winter are joint national clinical directors for respiratory medicine

RESPIRATORY CARE

CLEARING OBSTRUCTIONS

There are some simple steps that can help to reduce the impact of COPD, as Daloni Carlisle discovers

Chronic obstructive pulmonary disease is common, frequently misdiagnosed and often poorly treated and managed. However, a range of relatively simple actions could change this, saving lives and money. That's why, in July last year, the Department of Health made COPD and asthma the topic of its third outcomes strategy after cancer and mental health. Now the DH has published a range of supporting material to help NHS providers and commissioners put this strategy into practice.

Dr Matt Kearney, clinical and public health adviser to the DH respiratory team and a GP in Runcorn, is one of the team behind the new companion and action plan for respiratory disease treatment, published in May 2012. A commissioning guide is expected shortly.

"The case for action is very strong," says Dr Kearney. "COPD is the fifth biggest killer in the UK, the second most common reason for admission to hospital and it is really expensive in terms of its impact, costing almost £1bn a year in NHS costs alone."

There is also a great deal of unwarranted variation that will be detailed in an atlas of variation in respiratory healthcare from NHS Right Care, which is due to be published this month.

"We see a fourfold variation in admission rates, similar variation in readmission rates and a twofold variation in inpatient expenditure," says Dr Kearney. "Admission and readmission are major adverse events for patients."

There is good evidence regarding the most effective treatments for patients as they progress through COPD from the early stages with few symptoms, through disabling illness and finally to end of life. "We know what works and have guidelines," says Dr Kearney. Yet that good practice has not reached the frontline in too many places, which may, in part be down to the fact that stigma surrounds the disease," says Karen Ashton, associate director of long term conditions at NHS South of England. "COPD is perceived as something that people brought on themselves through their own lifestyles. It mainly affects older people so it does not have a high profile."

But it also reflects the difficulty managers have with redesigning services for people with long term conditions. This is a disease for which people need treatment right along the spectrum of care, requiring both integration and proactive management.

"Everyone needs to get involved in this," says Ms Ashton. "That includes building a groundswell of interest among the public, early and accurate diagnosis and assessment, and implementing best practice across the NHS. But it is difficult. It feels like we are trying to build a new runway and refuel the plane at the same time."

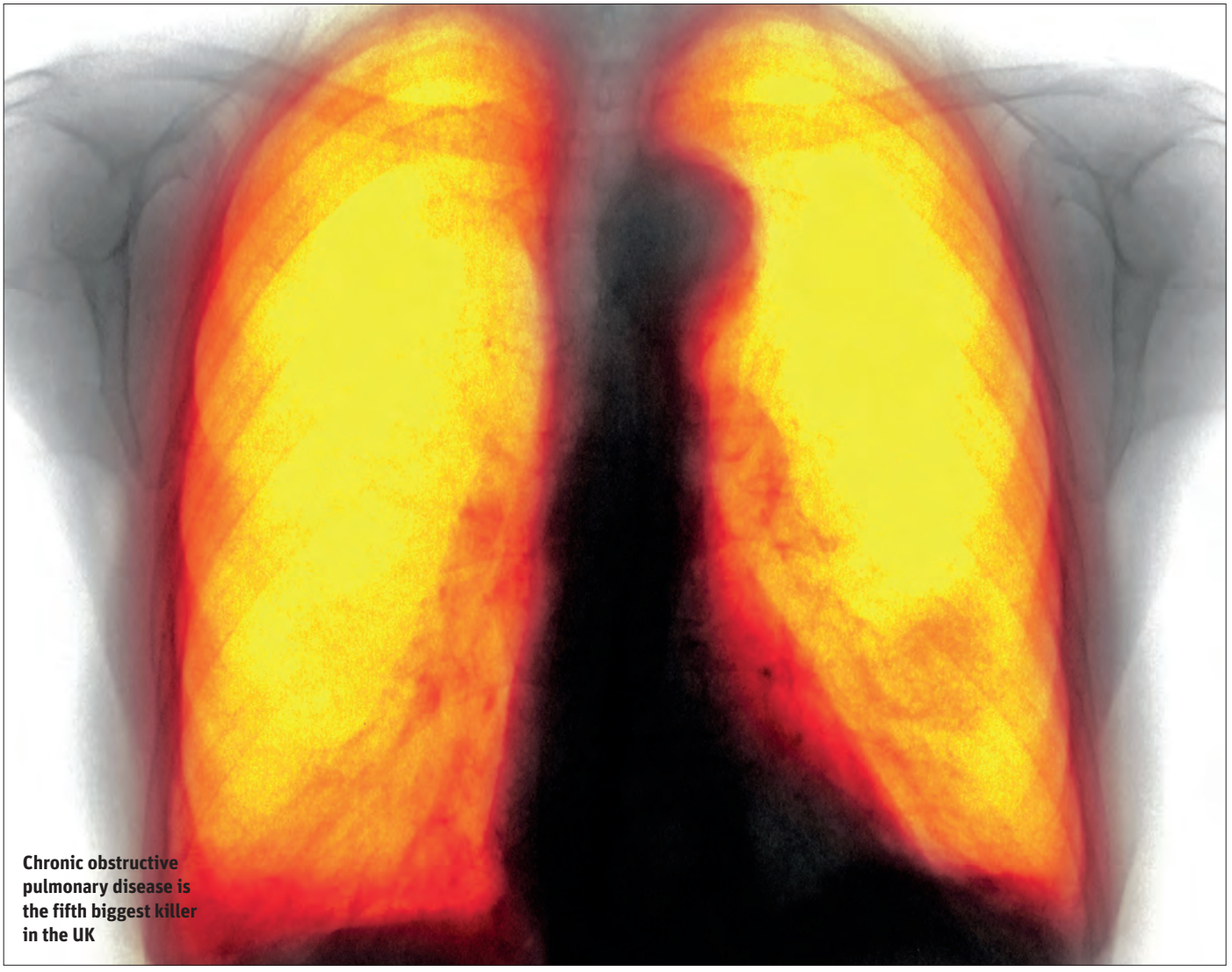
The newly published NHS companion document lists 18 actions that could make a significant difference to the cost and quality of care for people with COPD. "It is essential that you get the basics right," says Dr Kearney. "If these are in place – and they are in many places – you can have a very big impact on outcomes and productivity."

He highlights three areas where he thinks a focus from commissioners could make a rapid and significant difference. The first is inhaler use. "Inhalers are an important treatment for patients and they are among the most expensive treatments routinely prescribed in general practice," he says. Three of the top five items of expenditure in primary care prescribing are inhalers.

"When they are used well, they are fine. But the problem is that patients and healthcare professionals often do not know how to use them," says Dr Kearney. Regular updating of GPs and nurses on inhaler technique, education and training for patients, regular review of patient technique by healthcare professionals are all components of a good service, he adds.

Improving access to pulmonary rehabilitation is another priority for Dr Kearney. This is an evidence based programme designed to help people with COPD stay active. "There is good evidence

CASE STUDIES OVERLEAF ▶



Chronic obstructive pulmonary disease is the fifth biggest killer in the UK

‘Inhalers are among the most expensive treatments routinely prescribed in general practice, but patients and health professionals often do not know how to use them’

that it improves outcomes and reduces admissions as well as improving people’s quality of life,” he says. “But its availability is very variable, partly because clinicians do not understand how effective it is.”

The third is smoking cessation services for people with COPD. Too often smoking cessation is viewed purely as prevention. “But it is an important treatment for COPD,” says Dr Kearney. Commissioners and providers need to look at how to integrate smoking cessation into every part of the COPD pathway. Beyond these highlights are managing acute exacerbations, both to prevent admission and to ensure good outcomes for patients who are admitted, and improving end of life care.

Dr Kearney hopes the new guidance for the NHS will hit the mark with the emerging clinical commissioning groups. “I think this is something that will really gel with GP commissioners,” he says. “They understand the impact of this disease, they see it every day, and they understand the impact on their budgets. Now they can see how they can have a big impact on both.” ●

THE FACTS ABOUT COPD

- One person dies from COPD every 20 minutes in England – totalling some 23,000 deaths a year. If the whole NHS were to deliver services in line with the best, roughly 7,800 lives could be saved
- Death rates from COPD are almost double the average for the European Union
- COPD is the second most common cause of emergency admissions to hospital and one of the most costly inpatient conditions to be treated by the NHS. There is a fourfold variation between primary care trusts in non-elective admissions across England
- 80% of those with COPD have at least one other long term condition. COPD is linked to a higher risk of mortality from cardiovascular disease and having depression and/or an anxiety disorder
- Over 50% of people currently diagnosed with COPD are under 65 years of age
- Each year 24 million working days and £3.8bn are lost through COPD and reduced productivity

Source: *An Outcomes Strategy for COPD and Asthma: NHS Companion Document* http://tinyurl.com/COPDOutcomes

ALAMY

RESPIRATORY CARE: CASE STUDIES

HOW TO GET BETTER

With variations in COPD care and outcomes being far from uncommon, Daloni Carlisle finds out what actions some trusts are taking to best tackle the problem

NHS SOUTH OF ENGLAND

The big question with any service improvement is this: how do you know you are making things better? It is one that Rachel Collins, respiratory programme manager for NHS South of England, set out to answer in 2010 when she and colleagues developed a chronic obstructive pulmonary disease dashboard. The result has been much more than expected – rather than just being a tool for measuring a service, it has become one for leveraging improvement.

The dashboard was developed by data analyst Nikki Tizzard, who works in the South East Coast Quality Observatory, Ms Collins and Dr Jo Congleton, a consultant physician at Western Sussex Hospitals Trust and one of three regional clinical leads. It was funded by the Department of Health.

"It took a long time," says Ms Collins. "We had lots of conversations about what data we wanted, what we could get, and what story it would tell."

That "story" needed to be clinically meaningful. Length of stay or numbers of admissions alone do not tell a clinical story; the proportion of inpatients receiving a given service in conjunction with readmission rates, for example, does. The number of patients on a COPD register in general practice is fairly meaningless; the number of patients excluded from Quality and Outcomes Framework data is much more telling.

With data in place for both the acute and primary care trust (now the clincial commissioning group) side, the team took the dashboard to "communities of practice" – groups that included GPs, consultant physicians, commissioners and members of the community respiratory teams.

"We shared the data, and asked them to take joint responsibility for the outcomes for patients that the data reflected," says Ms Collins. "It was amazing how much conversation it provoked. Because we had taken it to the teams, there was nowhere to pass the buck. The acute team could not blame the community and vice versa."

Initially teams criticised the data, but slowly Ms Collins won them round to accepting the trends shown. "The dashboard does not look at a snapshot but at how things are changing over time," she says.

And slowly but surely, peer pressure has come into play. "It really does promote healthy competition," says Ms Collins. For example, one trust compared the proportion of patients receiving non-invasive ventilation across its two sites – prompting improvements where the numbers were low.

GPs in clinical commissioning groups have also put pressure on peers who were excluding higher than normal numbers of patients from their QOF data. "What that means is that a higher proportion of patients in those practices are now receiving their annual review," says Ms Collins.

The data is updated quarterly and shared via an NHS Networks website and regular meetings with clinical teams. The complaints about data quality are starting to fall away as the trends become more and more apparent – and as service improvements start to affect them. The next step is to roll out the tool across the whole of NHS South of England.

Ms Collins says: "This has really focused people's minds. It is interesting how the data is now being owned by the clinicians – not just doctors, but also the community nurses and physiotherapists who are beginning to realise the impact that they have."

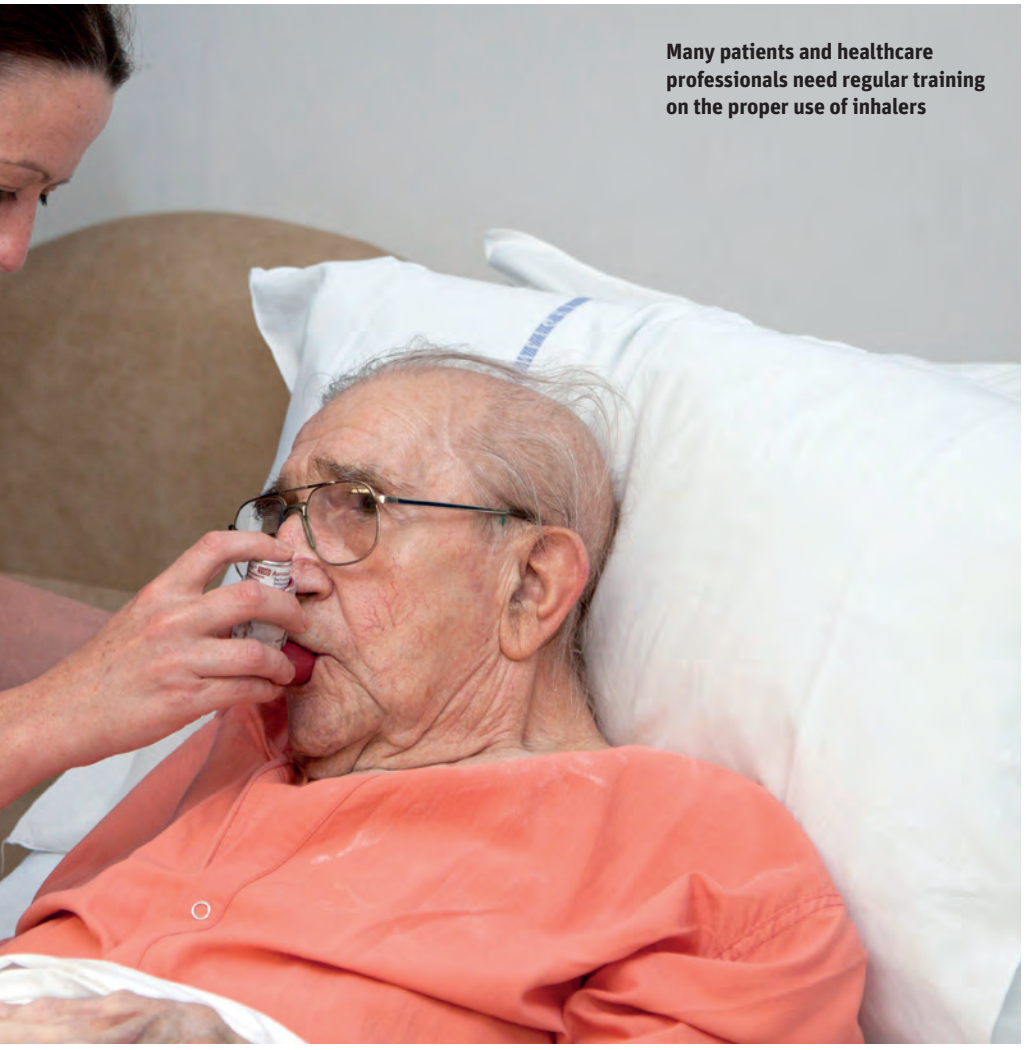
SHERWOOD FOREST FOUNDATION TRUST AND NHS NOTTINGHAMSHIRE COUNTY COMMUNITY COPD TEAM

The archetypal media image of the COPD patient must be an older person in an armchair, with a tube in their nose and an oxygen cylinder by their side. But any clinician who has looked into this more closely will see, behind that image, a great deal of waste and missed opportunity.

Patients are too often prescribed home oxygen therapy without an assessment, without it being linked to pulmonary rehabilitation and without an end point in the treatment. Patients don't get the value they could and the NHS wastes resources. That's why Sherwood Forest Foundation Trust and NHS Nottinghamshire County Community COPD team last year jointly enrolled with the NHS Improvement's Lung Programme to carry out a project to improve home oxygen prescribing.

Assessing patients is fundamental, says Sue Revill, clinical scientist for COPD services. "You really need to understand what patients are doing, their level of functionality and where they are in the disease process," she says. "There are evidence based guidelines but they tend not be followed and prescribing can be imprecise."

Baseline data showed that only half of patients on home oxygen in Nottinghamshire received an evidence based, gold standard service that included



Many patients and healthcare professionals need regular training on the proper use of inhalers

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an assessment. Inappropriate prescribing was costing the health economy an estimated £98,000 a year. The project team tackled this variation on multiple fronts. They set up a pathway for direct access to an assessment service for general practice supported by education and training for healthcare professionals. Another pathway supported referral of inpatients waiting for discharge to the assessment service. There has also been an education and training element for patients and carers.

The team also integrated the pulmonary rehabilitation pathway and the home oxygen therapy assessment pathway. "This was an innovative redesign of how we delivered these two key aspects of care," says Ms Revill. "It allows professionals to refer directly between the pathways and for the first time links pulmonary rehabilitation, which focuses on increasing patients functionality, with home oxygen therapy."

The project has been a great learning experience, improved services for patients and produced some concrete savings. In one PCT alone, the spend on oxygen has fallen by 20 per cent. "We have a gold standard service now," says Ms Revill.

'Inappropriate prescribing was costing the health economy an estimated £98,000 a year'

She has some key messages for others trying to tackle the same variation locally. "It is really important to understand the guidelines on prescribing oxygen, how home oxygen is supplied and to factor in time to spend with patients. Most importantly, consider the integration of pulmonary rehabilitation and home oxygen assessment."

WHITTINGTON HOSPITAL

The award winning Whittington Hospital respiratory team, led by consultant respiratory physicians Louise Restrick and Myra Stern, has been working to improve the care of people with COPD for over a decade, with a focus on integration and multidisciplinary team working.

Dr Restrick says: "COPD care is not about writing a prescription for the patient in front of you but about the services that work alongside the patient and how those services feel to patients. We have to make it easier for health professionals to do the right things in COPD care."

That means helping patients to quit smoking, making it easy to refer patients to pulmonary rehabilitation, supporting them to complete the rehabilitation programme, case finding in general practice, and having multidisciplinary teams working with patients in the hospital and at home so they are able to live better with COPD.

"We work with anyone whose expertise touches this group of patients, but most importantly with patients and carers, as only they can tell us if we really are delivering integrated care," says Dr Restrick.

The starting point was, and still is, supporting smoking cessation as part of treatment. "We know that 40 per cent of our patients admitted with COPD are still smoking," says Dr Restrick. "It has involved massive organisational change to make quit smoking part of everyone's work." Today, 90 per cent of smokers are referred for help.

NHS Islington and the Whittington jointly fund both consultants' posts and this has helped forge relationships with primary care colleagues. In 2010, they worked with GPs and public health colleagues to set up a local enhanced service, one component of which was case finding. In the first year, 37 practices between them identified 500 people with COPD who were previously undiagnosed.

The Whittington Hospital team now employs a respiratory psychologist who supports patients to complete pulmonary rehabilitation programmes, driving up the completion rate from half to 90 per cent; this in turn has reduced bed day use by these patients.

Risk stratification of the inpatient population has identified those who would benefit most from supported discharge with intensive community support to prevent readmission to hospital, saving on average 1,000 bed days a year over 10 years. This is just a flavour of the approach that includes using data, agreeing on Commissioning for Quality and Innovation, developing care bundles and much more.

Is the service patients receive better now? "I think so, but there is still lots more to do," says Dr Restrick. "The DH outcomes strategy gives us a way of framing what we need to do and as Whittington Health is now an integrated care organisation we have an exciting opportunity to transform and integrate across the services – not just what we do clinically but how we manage and deliver services too." ●

THE STEPS TOWARDS TRANSITION

Moving care away from hospital into community settings is more important than ever, but staff need the skills to ensure a successful transition, explains Alison Whyte

The idea of shifting NHS services out of hospitals and into the community has been around for about 40 years. We all know the reasons – a growing ageing population, more people with long term conditions, the patient choice agenda and the financial squeeze.

But with a predicted 4.5 million people aged over 85 by 2020 and those with a long term condition totalling 18 million by 2025, the need to make the shift is becoming urgent and one of the priorities must be to reskill staff to work in community settings. When it comes to community services, nurses make up the bulk of that workforce.

Head of policy at the Royal College of Nursing Howard Catton says thus far, this reskilling is not happening on anything like a large enough scale to make a difference. "We have a lot of nurses in the wrong place – around 65 per cent in the acute sector. This doesn't mean we need fewer nurses in future, but we need to support nurses to work in new and different ways. You can't simply spend two days acclimatising hospital nurses to work in the community," he says.

He calls for a fundamental rethink. "We need to look at how to develop the community nursing workforce as a whole. The terms 'acute' and 'community' may be unhelpful. Nurses need to be able to work in a whole range of settings. Some people see home care as basic, but many patients in the community have complex health needs. We need specialist nurses and advanced or expert generalist nurses to care for these patients at home."

Even highly experienced hospital nurses become novices when they move into the community where clinical decisions are made quickly, away from professional colleagues and amid multiple and often confusing systems. And in the community the patient (at least in theory) is in control of his or her own healthcare.

Rosemary Cook, director of the Queen's Nursing Institute, says the new reforms are adding to the confusion. "We have even more of a sense that we don't know what is happening. Nurse services are becoming very scattered. In the past 10 years we have lost one third of district nurses. The danger is you pass the tipping point and you don't have enough qualified people to keep it safe. In a ward, nurses keep a constant watch, but the patient alone at home may not be seen for a day or two."

Ms Cook says the fact that community nurses have upped their game will make the transition easier. There are now more services being provided in the community that once would have been possible only in an inpatient setting. She says: "This can be done, it must be done and it will be done. Nursing has been quietly revolutionising for years. There are patients on ventilators receiving chemotherapy, especially children who in the past would have been in hospital, and patients who needed big machinery in hospitals now use small machinery at home. In future, nurses will update the GP but a lot of nurses already work autonomously and patients can self refer."

Some trusts have successfully integrated their acute and community services after a merger under the Transforming Community Services agenda. Andy Irvine, chief of community services at The Rotherham Foundation Trust, formed last April, has been working on just such a merger. He says: "The fact that I worked with senior teams in the community for about a year in the run up to integration really helped us develop relationships and build trust.

"The key is to change the culture. Up to now, many of these individuals competed with each other in separate organisations. We need to get them in the same room, talking the same language. Hospital staff truly need to understand the benefits of not admitting patients into acute care, that the hospital is just another setting. They need to trust that their colleagues in the community can look after very sick people."

Likewise, Croydon Health Services Trust integrated its acute and community services in 2010. Sharon Jones, director of health and wellbeing, says you need a robust transition plan. "We were clear from the beginning – this wasn't a takeover by the hospital," she says. "You need to start with quick wins, find out local sticking points and solve them straight away. Our stroke and sexual health pathways worked well, so we focused on them initially. All of my senior managers spend time shadowing the community teams and our outreach teams are based on the ward. If a district nurse needs more experience doing IVs [intravenous therapies], we say 'Come in tomorrow, do all the IVs on the ward to build your confidence and skills'."

Pre registration training is another crucial area. Professor Fiona Ross, of the Faculty of Health and Social Care Sciences at Kingston University London and St George's, has reoriented nurse training towards the community, but fears others lag behind.

"Nurses need to be able to work in the community from day one," she says. "We need to get away from the idea that nurses are being trained to work in hospitals. We still don't encourage students to be passionate about working in the community,

Healthcare that is administered in the community is just as important as that delivered in hospital

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THEY SAY

‘Some people see home care as basic but many patients in the community have complex health needs’
Howard Catton

‘The danger is you pass the tipping point and you don’t have enough qualified people to keep nurse services safe’
Rosemary Cook

that it’s a great place to be, that it’s a great career. I think there’s still a lack of joined up thinking between universities and healthcare organisations about how to meet the needs of patients in the community.”

But she argues this is not likely to be enough – just because nurses are trained to work in both settings does not mean the settings are there to employ them. She says: “One barrier is the difficulty of transferring resources from one bit of the health service to another because the medical, acute lobby still has the power. Although GP commissioning provides an opportunity, there is a risk GPs will outsource the running of community services to private sector organisations. This will raise tricky policy issues, such as how do I train nurses to work in the private sector?”

Jenny Hargrave, head of workforce strategy at NHS Professionals, agrees. “The current funding and commissioning streams don’t make it easy to implement this transition,” she says. “We’re in a state of flux, there’s a lot of tension and uncertainty. People are waiting to see how the new landscape is going to look. At NHS Professionals we are scoping out what transferrable and additional skills are needed and we’re encouraging trusts to include a larger more flexible workforce into their plans.”

Skills for Health offers practical support for trusts making the transition. It runs a two-day transition workshop and has developed transferrable role templates. Candace Miller, director of business development and consultancy, says it’s easy to get bogged down. “HR, financial systems, moving staff from here to there – this can suck out a lot of energy. To make it work you need sign up at the highest level, and you need to build on the skills and competences you have. You don’t just parachute in new roles. And don’t feel you have to start from scratch, there’s plenty of support out there.”

Skills for Health has a list of good practice on its website and Ms Miller cites a pilot in Western Cheshire – community nurses showed the significant benefit to patients of receiving good end of life care at home.

Most commentators stress that moving services into the community shouldn’t be seen as a cost cutting exercise. Jo Webber, deputy policy director of NHS Professionals, says: “We need to dispel two myths. Number one is that community services will be cheaper. It may save money in the medium to long term, but in the short term you may need to invest. Number two, you can reconfigure health services all you like but if there is no sustained funding for social care, it simply won’t work. The health and social care system has to work together.”

She is cautiously optimistic. “My hope is that GPs and general practice will be part of the whole system, that this time it will not be a false dawn and we will get tailored services that support people to live independently in their own homes.” And that means having nurses with the right skills.

As Andy Irvine says: “We are just at the beginning, but we have a great opportunity to do what we should have been doing all along.” ●

A FUTURISTIC ENTERPRISE

Enterprise wide scheduling could revolutionise your trust by streamlining patient administration, appointment and equipment booking systems, as Daloni Carlisle discovers

Imagine an NHS in which any health professional with an interest in a patient could book appointments, visits or equipment. So, a ward sister preparing a discharge plan for an older patient could organise an appointment with the patient's GP, a visit from the district nurse, support equipment from the occupational therapist and a physiotherapy appointment. Or a GP could book in a patient for a series of linked appointments taking diagnostic tests and a review with the consultant on the same day.

This scenario is not exactly over the horizon, but a number of enthusiasts in NHS IT departments are working towards it. It is, they say, technologically entirely doable. The approach is known as enterprise wide scheduling.

At its most basic, it means making all the appointments in the hospital visible via an electronic system. Administrators booking patients into slots follow a series of rules to make sure the right patient is placed in the right type of appointment. But it can be much more sophisticated. Clinic lists can be tailor made, allowing different slots for urgent cases, new referrals or routine appointments. The system can support order sets that support a series of appointments and tests that need to happen in the right order.

Enterprise wide scheduling can link not only the appointment type but also the team of health professionals, the room and the equipment needed for the care episode.

"Enterprise wide scheduling can really start to maximise the efficiency of your planning," says Steve Parsons, director of IT at Doncaster and Bassetlaw Hospitals Foundation Trust. "You can avoid the situation where a team arrives to carry out an operation but the piece of kit they need – and of which the hospital has only one – is already in use somewhere else because the system books the team, the kit and the theatre together. People can ring up and cancel their appointment and very quickly it is on offer again through the system."

Heart of England Foundation Trust is one of a handful that has developed enterprise wide scheduling and extended it beyond the confines of outpatient appointments. It uses UltraGenda, which was acquired by iSOFT (now part of CSC) in 2010, and is used across Europe. Enterprise wide scheduling is now a core part of the trust's picture archiving and communications system replacement and has also replaced large chunks of the patient administrative system altogether.

'Without making any changes at all to the service we were able to generate an additional 50 per cent capacity'

Patients with long term conditions could get all their appointment dates at one time

"Computers often force the way you work," says Andrew Laverick, director of IT. "But we have found that the philosophy around scheduling fits in for the right reasons: the way the computer manages the work is the right way for a hospital to work."

It can also deliver real efficiencies, he adds. "We did some analysis with our respiratory department. Just by helping people to look systematically at what was available and without making any changes at all to the service we were able to generate an additional 50 per cent capacity."

The real stumbling block is not the technology but the culture change. "Uptake of enterprise wide scheduling is very, very low in the UK and that is because it is such a big cultural change," says David Hextall, head of systems development. "People think that once they expose their services through a schedule they will lose control, but that is not how it works."

Heart of England now wants to use enterprise wide scheduling to manage patient pathways for specific long term conditions.

"Suppose a patient is referred for, say, diabetes," says Mr Laverick. "The pathway is a series of appointments and contacts with clinicians. If you know what the pathway is, you can give the patient all the dates they need and they can get on with their lives."

The trust has built a pathway system that is fully operational – although not yet fully used. "We are now in a position to build pathways with key consultants," explains Mr Hextall.

So could enterprise wide scheduling extend beyond the boundaries of the hospital? Yes, say Mr Laverick, Mr Hextall and Mr Parsons. It is a matter of system integration, rigorous patient identification, and web based portals.

"It is absolutely possible," says Mr Parsons. "At the end of the day, people want to feel they have joined up care and they do not expect to see cracks in the system. The technologies that are coming to us now can help us join services, and joining booking systems is an important part of that."

The question remains, though, whether this is a cultural change too far. ●

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