NHS

North West London Collaboration of Clinical Commissioning Groups

Clinical Standards included in the Strategic Outline Care part 1, published in December 2016

Clinical standards

- The following clinical standards were included in the Strategic Outline Case – part 1 (SOC1), published and submitted to NHS England in December 2016. These standards were developed from those in the Shaping a Healthier Future Decision Making Business Case published in 2013.
- These standards are divided into two sections: Out of Hospital (OoH), and primary care.
- The current programme to provide investment and support for GPs and their teams, part of the priority area 'better care for people with long-term conditions' (formerly Delivery Area 2 in the original STP) has adopted the SOC1 standards.
- These are being developed in light of the national work on Primary Care Home. Developed by the National Association of Primary Care (NAPC), this model brings together a range of health and social care professionals to work together to provide enhanced personalised and preventative care for their local community.
- These locality plans may lead to a refresh of the clinical standards - until then, hubs should work towards the SOC1 clinical standards as below.

Clinical standards

Out-of-hospital quality standards – Individual Empowerment and Self Care

	Standard
Individuals will be provided with up-to-date, evidence-based and accessible information to support them in taking personal responsibility when making decisions about their own health, care and wellbeing.	
1	Individuals will have access to relevant and comprehensive information, in the right formats to inform choice and decision making
2	Individuals will be actively involved together with the local community health and care services to support personal goals and care plans.
3	Information and services will be available for individuals who are able to self-manage their conditions or who need care plan support

Clinical Standards

Out-of-hospital quality standards – Access, Convenience and Responsiveness

	Standard
Out-of-hospital care operates as a seven day a week service. Community health and care services will be accessible, understandable, effective and tailored to meet local needs. Service access arrangements will include face-to-face, telephone, email, SMS texting and video consultation.	
1	Individuals will have access to telephone advice and triage provided 24 hours a day, seven days a week. This will be either through their General Practice or known care provider's telephone number or through the telephone single point of access for all community health and care services (111). As a result of the triage process, cases assessed as urgent will be given a timed appointment or visit with the appropriate service provider (including a doctor where required) within 4 hours of the time of calling. For cases assessed as not urgent and that cannot be resolved by phone, individuals will be offered the choice of an appointment with the appropriate service provider within 24 hours or an appointment to see a GP in their own practice within 48 hours, or at a subsequent time convenient to them.
2	An individual who is clinically assessed to be at risk of an admission to hospital which could be prevented by expert advice, services, diagnostics, or the supply of equipment, will have their needs met in less than 4 hours
3	Clinical protocols with access times to routine investigations will be made available and followed by service providers. This will include simple radiology, phlebotomy, ECG and spirometry.

Clinical Standards

Out-of-hospital quality standards – Care Planning and Multidisciplinary Care Delivery

	Standard
	Individuals using community health and care will experience coordinated, seamless and integrated services using evidence-based care pathways, case management and personalised care planning. Effective care planning and preventative care will anticipate and avoid deterioration of conditions.
1	All individuals who would benefit from a care plan will have one. Care plans will be agreed with individuals (i.e. patients, users, carers) and will: • Be co-created, kept up-to-date and monitored by the individual and appropriate professional(s) • Include a common approach to assessment covering both health and social care, with an onward package of care in place to meet the individual's needs • Include a carer's assessment where appropriate • Be available in the format suited to the individual, with the relevant sections shared amongst those involved in delivery of their care • Include sources of further information to help patient's decision-making and choice about treatment and self-care.
2	Everyone who has a care plan will have a named "care coordinator" who will work with them to coordinate care across health and social care. The role of the care coordinator will be clearly defined and understood by the individual and those involved in providing care. Clinical accountability will remain with the patient's GP.
3	GPs will work within multi-disciplinary groups to manage care delivery, incorporating input from primary, community, social care, mental health and specialists
4	Pooled funding and resources between health and social care will be included in commissioning plans to ensure that efficient, cost-effective and integrated services are provided

Clinical Standards

Out-of-hospital quality standards – Information and Communication

	Standard
	With an individual's consent, relevant parts of their health and social care record will be shared between care providers. Monitoring will identify any changing needs so that care plans can be reviewed and updated by agreement. By 2015, all patients will have online access to their health records.
1	With the individual's consent, relevant information will be visible to health and care professionals involved in providing care. This should be available electronically and in hard copy.
2	Any previous or planned contact with a healthcare professional should be visible to all relevant community health and care providers, in particular, when a patient is admitted or discharged from hospital. This should ensure that care providers are aware of any planned or outstanding activities required for the individual.
3	Following admission to hospital, the patient's GP and relevant providers will be actively involved in coordinating an individual's discharge plan (including intermediate care and reablement) as well as continuing care needs
4	Any previous or planned contact with a healthcare professional should be visible to all relevant community health and care providers, in particular, when a patient is admitted or discharged from hospital. This should ensure that care providers are aware of any planned or outstanding activities required for the individual.

Clinical Standards

Out-of-hospital quality standards – Care Planning and Multidisciplinary Care Delivery

	Standard
	Individuals using primary care services will experience coordinated, seamless and integrated services using evidence-based care pathways, case management and personalised care planning. Effective care planning and preventative care will anticipate and avoid deterioration of conditions.
1	**Case finding and review** Practices identify patients who would benefit from co-ordinated care and continuity with a named clinician, and proactively review those that are identified on a regular basis.
2	**Named professional** Patients identified as needing co-ordinated care have a named professional who oversees their care and ensures continuity.
3	**Care planning** Each individual identified for co-ordinated care is invited to participate in a holistic care planning process in order to develop a single care plan that is: used by the patient; regularly reviewed; and shared with and trusted by teams and professionals involved in their care.
4	**Patients supported to manage their health and wellbeing** Primary care teams and wider health system create an environment in which patients have the tools, motivation, and confidence to take responsibility for their health and wellbeing, including their mental wellbeing, including through health coaching and other forms of education.
5	**Multi-disciplinary working** Patients identified for co-ordinated care will receive regular multidisciplinary reviews by a team involving health and care professionals with the necessary skills to address their needs. The frequency and range of disciplines involved will vary according to the complexity and stability of the patient and as agreed with the patient/carer.

Clinical Standards

Primary care quality standards – Pro-active care

	Standard
	Pro-active care will be initiated so that Individuals using primary care services can more effectively manage their health and wellbeing and have access to relevant sources and information to achieve their health goals. Effective care planning and preventative care will anticipate and avoid deterioration of conditions.
1	**Co-design** Primary care teams will work with communities, patients, their families, charities and voluntary sector organisations to co-design approaches to improve the health and wellbeing of the local population.
2	**Developing assets and resources for improving health and wellbeing** Primary care teams will work with others to develop and map the local social capital and resources that could empower people to remain healthy; and to feel connected to others and to support in their local community.
3	**Personal conversations focused on an individual's health goals** Where appropriate, people will be asked about their wellbeing, including their mental wellbeing, capacity for improving their own health and their health improvement goals.
4	**Health and wellbeing liaison and information** Primary care teams will enable and assist people to access information, advice and connections that will allow them to achieve better health and wellbeing, including mental wellbeing. This health and wellbeing liaison function will extend into schools, workplaces and other community settings.
5	**Patients not currently accessing primary care services** Primary care teams will design ways to reach people who do not routinely access services and who may be at higher risk of ill health.

Clinical Standards – NOT APPLICABLE TO SINGLE CONTRACT – FOR INFO

Primary care quality standards – Accessible care

	Standard
	Individuals using primary care can effectively use accessible care services. These include being understandable, effective and tailored to meet local needs. Service access arrangements will include but not limited to face-to-face, telephone, email, SMS texting and video consultation.
1	**Patient choice** Patients have a choice of access options (e.g. face-to-face, email, telephone, video) and can decide on the consultation most appropriate to their needs.
2	**Contacting the practice** Patients make one call, click, or contact in order to make an appointment, whilst primary care teams will maximise the use of technology and actively promote online services to patients (including appointment booking, prescription ordering, viewing medical records and email consultations).
3	**Routine opening hours** Patients can access pre-bookable routine appointments with a primary health care professional at all practices 8am-8pm, 7 days, via network coverage where appropriate.
4	**Extended opening hours** Patients can access a GP or other primary care health professional seven days per week, 12 hours per day (8am to 8pm or an alternative equivalent offer based on local need) in their local area, for pre-bookable and unscheduled care appointments.
5	**Same-day access** Patients who want to be managed (including virtually) the same day can have a consultation with a GP or appropriately skilled nurse on the same day, within routine surgery hours in their local network.
6	**Urgent and emergency care** Patients with urgent or emergency needs can be clinically assessed rapidly, with practices having systems in place and skilled staff to ensure these patients are effectively identified and responded to appropriately.
7	**Continuity of care** All patients are registered with a named member of the primary care team who is responsible for providing an ongoing relationship for care coordination and care continuity, with practices offering flexible appointment lengths (including virtual access) as appropriate.