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Future of Primary Care: Clinical Health Commissioning example to reduce inequity, improve outcomes and support patient centered palliative care in East London

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Abstract

New approaches to deliver primary health care in Europe faces several future confrontations, including an elderly and palliative care population, increasing numbers of patients with various chronic conditions and a restricted workforce for people because of digitalization.

The term future transitions of health care refer to the movement of patients—between health care locations, providers, or levels of care as their conditions and care needs change—and the set of actions designed to ensure coordination and continuity. The aim of this article is to think of how palliative and geriatric care might demonstrate in the next future.

Successful transitional health care management via digitalization and health commissioning groups can prevent medical errors, identify issues for early involvement prevent unnecessary hospital care readmissions and unnecessary health expenses. We can maintain consumers' options and selection and avoid unneeded expensive health care services, by improving the quality of care via commissioning.

Key Words: Primary Care, Commissioning, Inequity, Outcomes, East London, Palliative care

"Our vision is to work

And learn from each other

With our communities

To achieve person centered care.

We will have shared outcomes

And priorities and aim

To do things differently."

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Introduction

Primary care health care provides, secure water and sanitation, immunization, universal health coverage/ access, health policy based on careful, evidence research, public assistance and participation are all essential post in keeping safe a nation's health. To rely on high priced, hospital/expert-oriented care ruin both the health care system and the public finance of any country.

Finance and performance based managerialism could harm primary and palliative health care service due to due to its public design. Health care professionals led by money matters have a habit of eating finance source in the end. The solution for the finance management is to lead and not to be led. The money which funds primary health and palliative care especially comes predominantly from general taxation, with a much lesser contribution from health obligatory insurance premium and out of pocket. Some minor amounts from prescription is not adequate.

Future digitized members of primary and palliative care will be members of a multidisciplinary dialogue team, as individual practitioners in fixing on symptom management as case director. Telehealth by that medical information is transferred via telephone, the Internet, video, or other networks for monitoring health status, offering education, consulting, and providing remote medical procedures or examinations (Schroeder, K., & Lorenz, K. 2018). It can take place between providers and patients located in clinical settings (clinical video telemedicine) as well as directly with patients in their homes (home telemedicine).

Nevertheless, as far as better focus on primary/outpatient, continuous/coordinated/patient centered, palliative and dimensional health care occurs, necessary objectives will not be achieved (Mordoch E. et all., 2013). Continuing hospital/ specialist/over-prescribed care as the predominant mode of care will damage the health system and make the option of losing what has been done. There is an urgent need to promote primary care by training of family practitioners and by educating the public to the advantages of having a "family specialist center" rather than trafficking from one specialist to another (Birks, M., et all. 2016).

Ideally, health care transition activities are based on a wide care plan and the attendance of well-trained family physician who have present day information about the patient's palliative, chronic, geriatric care treatment, possible course of action and health or clinical status. Important milestones are to define the progress of clinical commissioning groups (CCGs) along the following few years as shown in Figure 1.

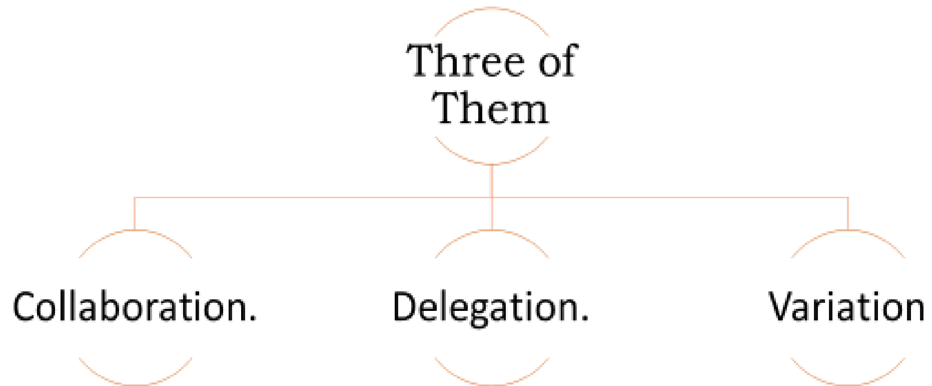

Figure 1. Three important Milestone of CCG's

I. **Collaboration**. CCGs are operating more firmly with their near general practice centers – some times by sharing and joining staff, arrangement joint committees'/governance structures or combining. This movement will continue as CCGs put in order more closely with their sustainability. It is clear that skills in developing and managing relationships and leading change across systems will be more important than ever over the next few years.

II. **Delegation**. This include delegation within the commissioning system – since 2013 NHS England. This has delegated new responsibilities for general practice and some specialized services to CCGs, with more planned – and delegation out of the commissioning system. As new models of care develop, some CCGs are likely to take on a strategic commissioning role, delegating some of their functions to groups of providers or Accountable Care Organizations (ACOs). These are population-based models of care evolving for Five Year Forward View plans.

III. **Variation**. As regional areas stimulate their own way, commissioning is likely to look progressively. CCGs will need to play various roles depending on which organization they are commissioning. They may be a 'prudent commissioner' when interacting with a large local ACO and an 'operational commissioner' when commissioning other services.

Gap Analysis of CCG's for Palliative Care

The need to increase the identification of patients who are at the end of life, particularly non-cancer or elderly frail in primary and secondary care. The need for more hospital input into care planning and sharing the care plan across primary, community and social care. The need for an agreed care plan across the three CCGs. Patient involvement and ownership of the care plan "what matters to you". Information and self-management resources are not easily accessible /available. The need for more training of staff (generalists) in end of life care - patients, careers, health, social care and voluntary sector staff. Inadequate social care support over 24/7 in all three Boroughs. Gaps in access to community specialist palliative care and district nursing services across the CCGs. Limited access to end of life care medication out of hours as seen in Figure 2.

Reducing the inequity in service provision and outcomes for end of life patients across Newham, Tower Hamlets and Waltham Forest and between WEL and the rest of England. Enhancing the existing health and social care capacity to be able to respond rapidly across 24 hours, 7 days per week. Building expertise in End of Life Care for all health and social care professionals including the users, careers and voluntary sector to work in a more integrated way. There is growing "mobile health" market for palliative health care. It creates big data technique. With set of algorithms to expect and potential medical problems. The goals for the future of digitalized palliative care could be seen in Figure 2.

Figure 2. Future goals for palliative care

Need to understand what is already being delivered have crucial importance -The patient pathway-understanding contracts, the gaps are important. Resources Self-assessment tools /

ambitions for palliative / end of life care / NHSE commissioning toolkit are vitals. Self-assessment tool- North West Coast and end of life charter, gap analysis helps to present this visually. Social care, voluntary sector, resource in the community are fundamental. Meaningful data to help focus where the problems and incentives need to be as seen in figure 3.

Health and social care are identical partners in this effort. Cross-organizational alliance is vital to design new ways of working that will facilitate each community to achieve these terminal points. These systems must reach out over the usual networks of organizations and society to call above contributions, ideas and actions from a wider phantom of people (http://www.euro.who.int). We need integrated health and social care systems for people in need of palliative care.

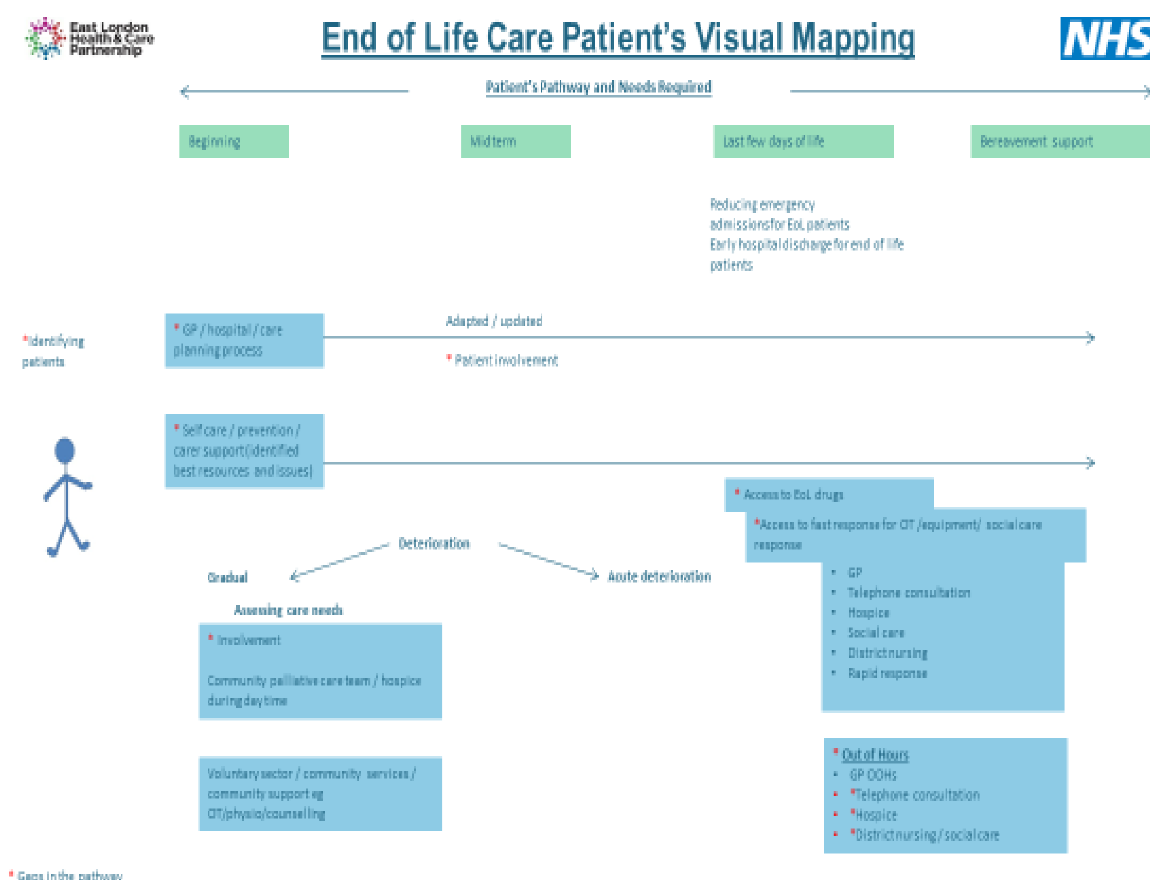

Figure 3: Patient's Pathway and Needs Required

Lessons and Challenges from Business Case Objectives of CCG's

A. Hospital beds occupied by end of life patients
B. Costs of admissions in last few weeks of life
C. Referral rates / caseload / staffing
D. Length of stay, readmission rates, rates of hospital death if known to specialist palliative care services

E. Understanding the various contracts

Planning / implementing change across CCG boundaries are needed. Staff turnover and organizational memory actions plan must be taken (https://www2.deloitte.com). Resources, Self-assessment tool / ambitions for palliative / end of life / National Health Service Executive (National Health Service; UK) NHSE commissioning toolkit must make investment in Organizational development and training (https://www.hee.nhs.uk). Current ways of working- need to change to provide patient centered care- New roles –generalist. Continuous learning. Use available levers to incentivize behavior change- Commissioning for Quality and Innovation (CQUIN) by implementing dashboard to learn from digitalization and monitor system improvement (Topol E. 2013). The main challenges of palliative care are shown in figure 4.

Figure 4. What matters most to patients?

Over the past two decades, digital technology has revolutionized. Healthcare management business will have done for elderly care management via increasing quality and lowering cost by using digitized medical records. Physicians, palliative care centers, home care agencies, hospitals, patients and their relatives will work collaboratively share and analyses information in every conditions.

CCGs, Kaiser Permanente, the Cleveland Clinic, Nordic health care system are already get on board the system. Unfortunately, these new technologies come with a heavy dose of government regulation. As authorities for policymaking and regulatory challenges are posed by digital technologies, four main questions are critical to address (see figure 5):

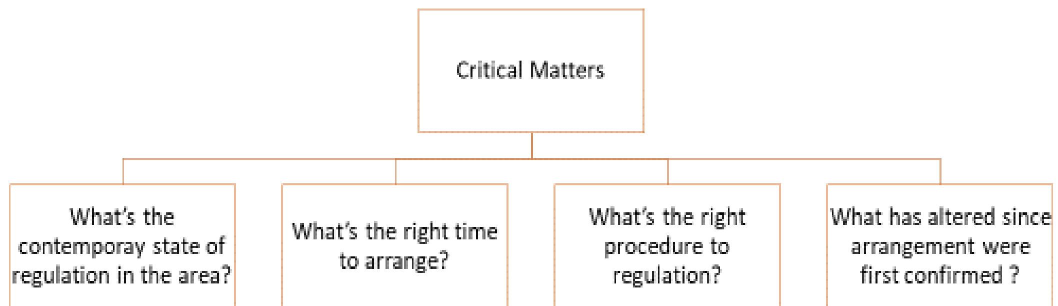

Figure 5. Critical Matters for technologies.

Besides some technical digital aspects of health care, it will likely sustain in the hands of health care professionals for a while. Clinical data group, overall both medical questions and physical examination, is on top of the inventory still now. Providing work force and capacity building Figure 6 mainly in oncoming world is of extreme importance to break this booming shortage of technology(Zhou, J., et all. 2012)..

The main palliative care decision is being stronger

"Making stronger of palliative care as a component of connected treatment within the process of holistic medical maintenance," emphasize upon the significance of completion of palliative care into country's healthcare system, training labor, ensuring availability of drugs, and formulation of legal procedures in different countries with different socioeconomic background.

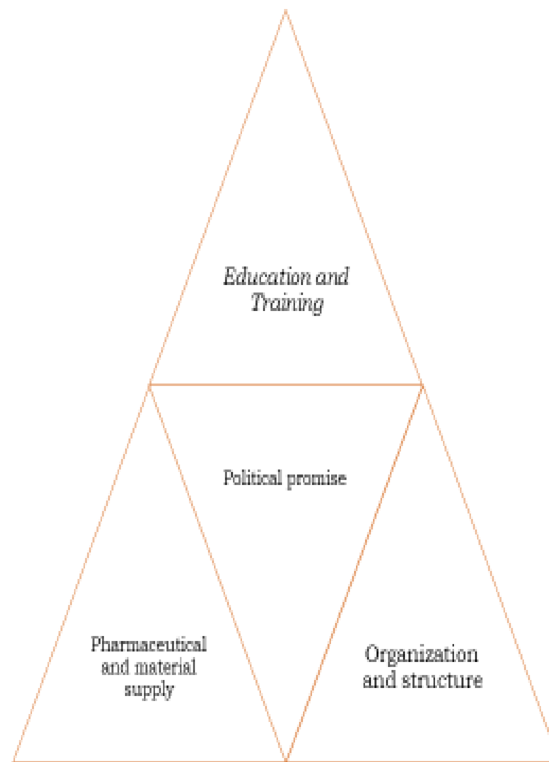

Figure 6. Supplying human labor force and talent making

Furthermore, by developing and building on data-driven medical applications a medical doctor's expertise in surgery technics, physiology, and health-care systems, is going to be pivotal in the development of this new generation of tools (http://www.altfutures.org). Health insurance firms will have leading role in involving hospitals, family practitioners and palliative care centers in accurate digitalization of medical records for everyone (Meskó, B., Drobni, Z., Bényei, ., Gergely, B., Győrffy, Z.2017).

Palliative care is accepted to be a part of all national health programs of all countries destination at decreasing the overall burden of cancer and managing bad prognosis chronic disease with collaborating as shown in figure 7.

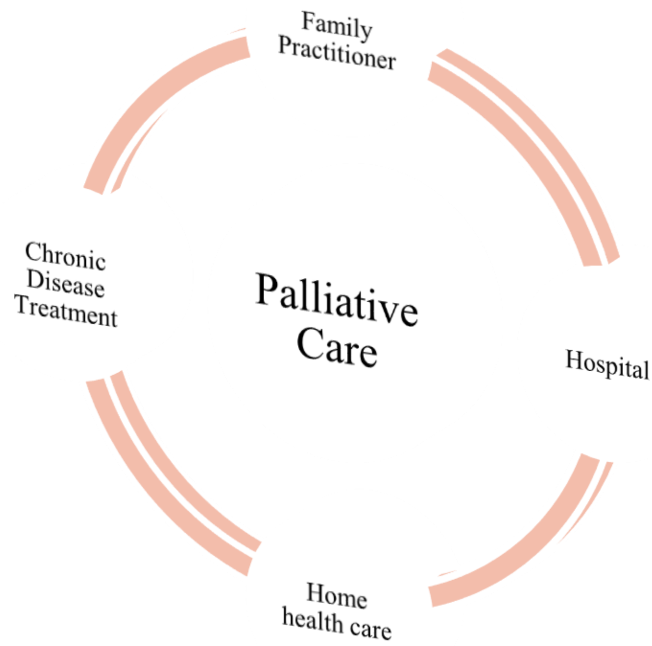

Figure 7. Combining and connection needed for either for worldwide and country based accessibility

Juridical model of palliative care: public hospitals delivers healthcare services to majority of population these geographical areas. It is this healthcare sector, which is most unwilling in including palliative care in its services nearby. The vital importance to palliative care model is the finance-centered health system is shown in figure 8.

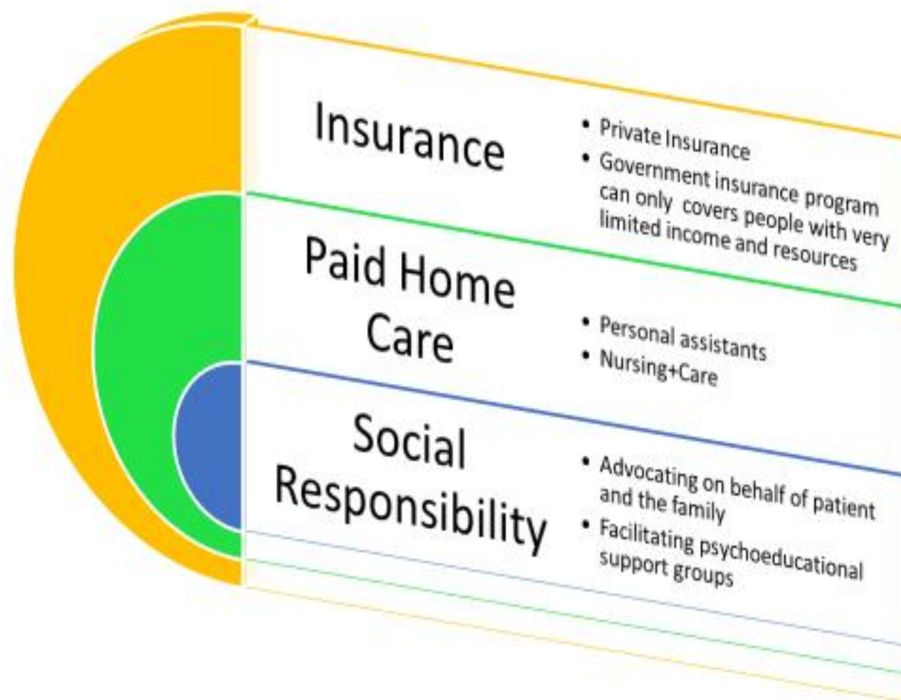

Figure 8. Uni disciplinary to a multidisciplinary level of palliative health care

Leading from uni disciplinary to a multidisciplinary and interdisciplinary level of palliative health care: Modern palliative care definitions from various organizations tension. People are also getting more informed of the healthcare services provided to them. It happens of vital importance to provide specialized and multidisciplinary services to meticulously meet palliative care needs (Davenport R.D., 2005).

Cancer, diabetes, dementia constitute 70 % of health care spending. With the arrival of internet, patient now have approach to much more health care information. Platform like NHS Choices and WebMD network maintain guidance on symptoms and treatment like GP intelligence monitoring. Computerized diagnosis, treatment and follow-up systems have started to provide unrivalled service in palliative care. There is proof that these healthcare digital technologies can have a positive impact that further research (Nomura T., Tejima N. 2002).

Robot nurses are operating in worldwide therefore it will be in next future and it is hoped to be effective. In the future of nursing robotics, questions of empathic protocols should be explored upwards. Challenges and advantages of robotic nursing care is shown in figure 9.

Figure 9. Challenges and advantages of robotic nursing care

Having well-coordinated and well-integrated care, with continuity of provision (not fragmentation of care e.g. avoiding not knowing professionals, having to repeat to different professionals, etc). Getting more health professional of palliative care interested in the development of technology would ensure that the human caring point of view is simplifying. Digital machine technologies will be able to replace health care practice in case if we are willing to grow more professionally and become even better versions of the remarkable palliative healthcare providers in the future (Safran, D.G. 2003).

Results

As a result of past success people in health care, which means that people are leaving longer with expensive with the arrival of internet, patient themselves now have approach to much more health care information long term care conditions like palliative health care management.

Nowadays, innovative new ways of managing palliative health care situations for this people are needed. Social befriend robots may provide important and possible alternatives to some of the care request. These alternatives must be balanced with warning to provide quality human communication in this care and to not gratis thin down the important aspect of human affection in the care of people. Health care has always related self-care.

In the future, however, the lines between self-care and primary and palliative home based care will surprise further as their primary health care providers give self-care tools to patients. Many of self-care knowledge is and has been independent of patients' doctors and tools such as digital coaches or health robot will be important.

The person's doctor may provide such tools or health care system, be get, or acquire free. While, these devices become more powerful, they can be arranged with patient-directed health plan instruments to make possible individuals to not only use self-care but to largely self-operate their own care.

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