NHS Dudley

heart of local health

Planned Care Strategy

November 2010

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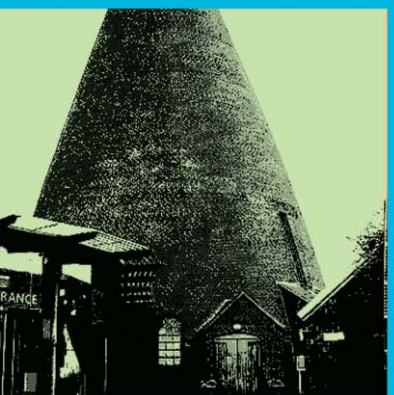

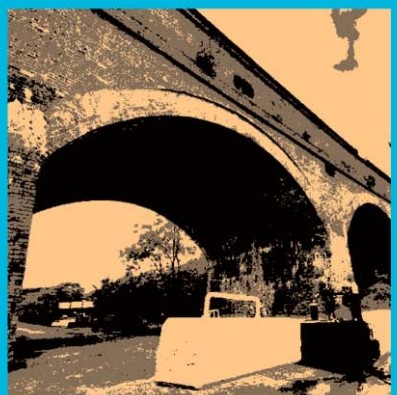

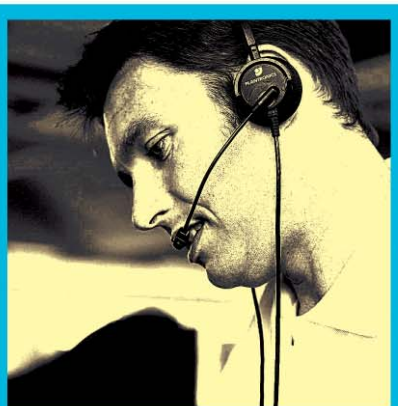

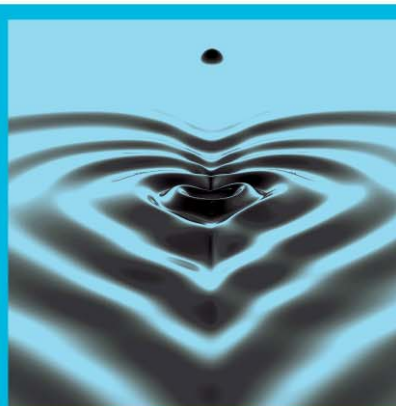

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1. FOREWORD

Planned Care is a term I feel should be applied across Healthcare, and in all arenas. Within NHS Dudley we have a developed a different role to that suggested by our title. Planned care has grown to encompass three distinct but interlinked areas which are vital to the development of sustainable healthcare in Dudley which is both deliverable both now and in the future. We work in a large area which is largely coterminous both with our monopoly local provider and the Local Authority; this presents both strengths and weaknesses.

The three areas of work are as summarised below;

1. The long term relationship with Dudley Group of Hospitals. This has long been an adversarial relationship, but over the past year everyone has worked hard to establish a position of trust which will allow effective planning and funding of Healthcare across the economy. We have no doubt that massive strides have been made in this area leading to an atmosphere of trust both managerially and clinically. We have many areas of work in progress all of which are starting to bear fruit in different ways;

    i) Redesign of Orthopaedic pathways across both Primary and Secondary Care from patient referral, through triage, decommissioning of services, GP education events, and most importantly delivery of patient care in the most appropriate setting at the right time.
    ii) Agreement with Dudley Group of Hospitals that all outpatient letters will be triaged prior to outpatients in the near future.
    iii) Triage within Gastroenterology in lieu of open access endoscopy as National Guidelines were not being observed, to improve clinical effectiveness of the service.
    iv) Agreement of a list of Procedures of Limited Clinical Value to ensure consistency of service across Dudley.
    v) Agreed policy regarding Aesthetic surgery guidelines, with prior approval core to the process.
    vi) A forum of Consultants and GPs that meets regularly, to agree clinical views together.

2. We are committed to Primary Care helping to deliver the goals we have set. I have no doubt that a connected, excited and motivated Primary Care Team is the goal we should aim for in Dudley to ensure our patients receive the care that they deserve. We have several areas we are working on to deliver this;

    i) We have well advanced plans to develop a bespoke Primary care focussed GP Intranet, to help us bring many resources together in one place to ensure easy access to high quality clinical information across Dudley. This has been discussed in many forums, and is well received; it will also dovetail well with the Directory of Services that is being planned for

Dudley, although I believe that the Primary Care/GP focus is essential for this project to succeed. The success of this project is key to GP engagement in PBC for the future. It is vital that our GP's trust and believe in us and we will deliver that trust I am sure.

ii) We soon will have a Minor Surgery Locally Enhanced Service which will encourage and incentivise Primary Care to offer minor procedures that were previously in the domain of secondary care, to provide patients with both choice, and treatment in their own or other local GP surgeries.

iii) We have an exciting and effective Paediatric Triage service which when used has reduced outpatient attendances, by 40%, and if rumours are to be believed will soon be developed internationally, and I do not mean Wales.

iv) We plan to integrate with the GP Education sessions being held in Dudley to ensure that our projects are communicated effectively.

3. Technical or contracting issues often arise, and clinical input helps resolve these issues most effectively, so we have been involved in many of these with varying degrees of success. It is key that the technical side of contracting is fair and logical or services which should be funded cannot be afforded and some areas may become cinderella specialities, areas we have been involved include;

   i) Audit of Maternity admissions, which I feel will yield huge efficiencies.
   ii) Audit of Rapid Access Breast Clinics which revealed a third of ladies were being asked to re attend without good clinical reason.
   iii) Audit of Emergency A&E attendees, to help improve patient flows.
   iv) Review of Rheumatology Research Clinics to clarify funding for this activity, work is still ongoing.
   v) Clinical support during contract discussions.
   vi) Review of Cardiology Research/Pacemaker clinics.

   All the above I hope give a flavour of the work that goes on under the banner of Planned Care. The aim of all of these is to ensure that Healthcare is delivered equitably, efficiently, and the Health Pound is well spent, and in order to achieve that we aim to facilitate trust, high quality practice and team work across Dudley so that clinicians and their management support wherever they sit, will see Dudley as an exciting, innovative, positive and fun place to work. If we achieve this we will be successful.

Steve Mann
Planned Care Clinical Lead

Planned Care Executive Summary

Vision	Values	Strategic Critical Success	2010/2011	Prioritised	Performance	
To commission the provision of high quality, clinically relevant care, delivered efficiently and cost effectively. Ensuring that care is provided by the most appropriate professional in the correct setting in a timely manner.	We will strive to improve the quality of our services We will embrace partner-ship working We will aim to improve the value and cost-effectiveness of our services	To improve the clinical networks to support a viable clinical	To improve the Clinical Networks and Education forums and communication to support a viable clinical community	Clinical Fora – regular for a for clinicians across Dudley sharing and developing a clinically led vision	Shared Service Redesign	Ownership by clinicians across primary, community and secondary care to the programmes and issues described in this strategy The integration of Planned, Urgent and Long term condition programmes, in terms of their scope, implementation and delivery. Effective and mutually support relationships between clinicians and managers within and outside of the PCT to secure effective design and delivery of coordinated commissioning strategy The ability and flexibility of providers to adapt to the changing environment both clinical and under harsher economic conditions Effective communication with organization and at the interface Clinical leadership of pathway redesign programmes A robust performance management framework with measures of success and KPIs The right information and other forms of intelligence, both quantitative and
				Directory of services – to implement an electronic resource for everyone involved in providing healthcare in Dudley	Staff feedback on efficiency of access to services	
				GP Intranet – a unique usable resource for Primary Care	GP User Satisfaction measures	
		To make sure health services meet the needs of the local patients and are value for money and efficient	To develop a programme of Service Improvement and Pathway Redesign that ensures that patients are seen at the right time and place and appropriate clinical professional	Enhanced Recovery (ER) - enabling early recovery and discharge from hospital and improve bed utilisation by reducing hospital lengths of stay.	ER – Agreed project	
				Community based minor surgery – Ensure clinically appropriate minor surgery is carried out in the community reducing unnecessary reliance on secondary care services.	Reduced spend on acute activity – neutral impact	
				Orthopaedics Triage – Using triage as a enabling process to ensure that patients are seen by the right professional at the right time reducing the reliance on secondary care	Orthopaedic Triage – Reduce Orthopaedic outpatient activity by 25%	
				Dermatology – Review of Referral pathways and available clinical expertise to establish the optimum service model for the future.	Dermatology and Ophthalmology – Scope service redesign models and implement recommended pathways/services	
				Ophthalmology - Review of Referral pathways and available clinical expertise to establish the optimum service model for the future.		
				Glaucoma referral refinement – establish a glaucoma referral refinement pathways to reduce false positive referral to secondary care	Glaucoma Referral Refinement – Reduce Ophthalmology outpatient	
			Reducing unnecessary demand for health services	Managing demand in primary care – benchmark referral patterns and link in with the clinical forums to support increase in primary care expertise and knowledge base	Decrease in variation in referral pattern within primary care to national and local benchmarks where	
				Outpatient triage – Ensure all referral letters to an outpatient service are triaged and only accepted for both community and secondary care services		
				Consultant to consultant referrals – to ensure processes are in place to reduce internal	Introduction of referral triage leading to a 20% reduction in outpatient activity in 1st discharged appointments	
				New: Follow-up ratios – ensure that all follow-up activity is carried out if it adds value to the patient clinical pathway		
				Aesthetic Surgery and Procedures of Limited Clinical Value – implement a robust aesthetic policy, improving both equity and cost-effectiveness	Reduction of consultant to consultant referrals	
		To make a better use of information	Commissioning for quality and cost effectiveness – enabling programmes	Demand and capacity modelling - Matching capacity to projected demand in light of planned models of care for the future (and in light of known changes as a result of	Capacity matches demands	
				Information Technology and Information Provision • scrutinise clinically and financially high volume and high cost areas to ensure we are securing best value for money i.e N12 audit • identify and respond to areas of emerging pressure i.e orthopaedics and ophthalmology • benchmark outlying practice and use information to challenge provider and referrer practice- i.e New: follow-up ratios	Savings influenced by analysis	
					Actual versus benchmark standards	

3. VISION

This planned care strategy outlines a programme of service redesign and delivery that aims to deliver a greater variety of services, at higher quality and lower cost, in settings that are as local to patients as possible, outside of a hospital whenever clinically appropriate and safe to be so. This strategy sets out to achieve services that are delivered as part of integrated pathways across primary, community and hospital services where the evidence proves that this is the right thing to do. We recognise that in many circumstances care delivered in hospital is the optimum model. Commissioners will continue to work with acute providers to ensure that planned care delivered in the acute setting is delivered effectively and safely.

Patients tell us they want access to local services because it is easier for them. Inequity of access for vulnerable and poorer patients is reduced when services are delivered locally. The PCT faces higher demand for healthcare than ever before with high levels of activity being seen particularly in secondary care. We believe that providing alternatives to secondary care will be critical if it is to deliver an affordable local health service in the future. Care in hospital should be limited to specialist services and those it is not possible or practicable to provide outside a hospital setting. Those services will often be for people that require acute care specialist knowledge and expertise. Where this is not required, this strategy will promote joint working and the achievement of consensus across the clinical community on how best to put in place alternative models of care.

Services will be delivered in a community setting if they:

- are of equal or improved quality compared to existing hospital provision
- are cost effective and provide value for money
- are acceptable to patients
- promote choice and improve access
- do not present risks that undermine the sustainability of the whole health economy once all risk mitigation strategies have been employed

People also tell us they want 'seamless' service provision, especially where their treatment pathways involve joint work between professionals and agencies essential to the achievement of improved health outcomes. We believe we must do more to improve outcomes for patients whose recovery following acute illness, for example, stroke and other major trauma, relies on effective and speedily delivered post-acute rehabilitation. We will step up our work with partners to do this.

Much of this strategy will be delivered through the design and commissioning of effective care pathways. We believe that:-

Pathways
There are generic similarities between all pathways of care. Whilst the point at which care becomes planned may vary, most pathways should be designed to arrive at this point sooner rather than later.

Much planned care is delivered for people whose lives are affected by chronic long term conditions. We can plan better how to manage such patients in a crisis situation. We can plan to reduce the impact of such people's conditions by better understanding their risks of falling ill and of needing acute care if nothing is done to manage those risks. This strategy builds on the work of the urgent and long-term conditions strategies and aims to contribute significantly to programmes of work in those areas designed to support people with life-limiting long-term illness. The risk stratification tool, now being implemented across primary care in Dudley, once embedded, will help shape some of the planned care workstreams by identifying areas where additional or different planned care services are required. Together the three strategies will support the delivery of excellent patient care for the population of our local health economy.

In delivering this strategy we will:-

- ensure all service redesign is **clinically led**, strengthening links with existing clinical forums such as Local Implementation Teams (LITs) and maximising the opportunities afforded by the establishment of our Commissioning Consortium Pathfinder
- ensure all programmes of work deliver **better value for money** through closer joint scrutiny by clinical and financial leads
- put **quality and equity of access** as the central principle behind all programmes, informed by a stronger clinical view and by **patient experience outcomes**
- reduce i**nequalities and unmet need** by ensuring that access criteria are clear for all services. We will free up resources to meet unmet need by promoting collaborative agreement between clinicians about how inappropriate activity is identified and reduced, and we will
- develop pathways **that integrate care, governance and communication across and within organisational boundaries, i.e., primary, secondary, community health services and non-health organisations**. In doing this, our aim is to reduce duplication and delays in both process and care delivery.

4. CONTEXT

4.1 Population Demographics

The PCT spends 45% of its acute spend on planned care activity. Of this, 82% is spent with our main acute provider. The demand for planned care services has risen by 2% from 2008/09 and if we do nothing, it is predicted to rise by 6% by 2013/14. Factors contributing to this rise in demand include rises in life expectancy and the increase in the number of people with long term conditions:-

- Most recent projections show that the population of Dudley is expected to rise by 8,000 (2.6%) by 2020 (2006 base). The population aged 65+ and 85+ is projected to rise by 24% and 52% respectively over the same period. 8.7% of people in Dudley are from black and minority ethnic communities

- Comparison of numbers on primary care disease registers, with estimates of community prevalence, suggests there are still substantial numbers of people with undiagnosed diseases. Comparing the observed and expected registers for a population can give an indication of areas with potential under-diagnosis. For all the major diseases Dudley PCT has percentage ratios below 100 but close to those reported nationally

- Demographic pressure will lead to greater numbers of people with chronic disease unless upstream population preventive interventions are implemented on a wide scale

- Smoking remains an important health risk though the smoking prevalence rate has been falling*

- Obesity prevalence has risen over the last 2 decades; we estimate that we have 40,000 adults in Dudley who are currently obese. Application of national estimates suggests that we have 800-900 obese children in Dudley and a further 8,000 who are overweight. The annual medical spend for Dudley for treating diseases related to overweight and obesity is estimated to be £84 million in 2010

- Alcohol related mortality rates have increased rapidly in recent years, though there is now an indication that the rate may be slowing. The rate of alcohol related admissions continues to rise and at a faster rate than seen both regionally and nationally*

- Approximately 10% of Dudley PCT admissions are for ambulatory care sensitive diagnoses, comparing well with other PCTs in the region but less well nationally

*** See relevant public health strategies to understand what we are doing about these issues**

4.2 Public and Patient Engagement

This strategy is designed to deliver the aims and objectives outlined in Dudley's Strategic Plan *At the Heart of Local Health*. Consultation events with local people informed that strategy. They told us that they want:-

- an increased say in how and where they are cared for
- to be helped to make informed choices through the provision of better more easily accessible information
- more care closer to home and
- improved access to diagnostic and other services where and when they need them

Patient and public expectations of health services are at their highest. Patients are more aware of the choices available to them, more understanding of the NHS's obligation to deliver those choices, and more able to challenge when things go wrong. We welcome this increased 'patient power'.

This strategy will build on the picture drawn following consultation the priorities contained in *At the Heart of Local Health*. We will build on established mechanisms of involving patients and the public to ensure that commissioners continue to be updated about what people want and what they think about the care we commission on their behalf. General stakeholder engagement programmes will be established to capture broad themes; targeted service specific programmes will be run as a contribution to all service transformation and reconfiguration programmes.

4.3 National and Local Priorities

4.3.1 The NHS White Paper *Liberating the NHS* (2010) - sets out a number of high level strategic objectives for the NHS. We must do more to put patients and the public at the heart of decision making about their care and about how services are commissioned and delivered on their behalf. We must improve health outcomes and incentivise for better quality in favour of contracting for activity. Local healthcare professionals and providers will have more autonomy locally to shape the way health services are designed and delivered, in turn they will be held more closely to account for what they do. And all of this must be achieved whilst significantly reducing the numbers of non-clinical staff hitherto engaged in supporting delivery of the health service agenda (target reduction of 45% in management costs over the next 4 years).

4.3.2 ***High Quality Care for All*** **(2008)** - emphasised the importance of high quality care for patients and the public, quality at the heart of the NHS and working in partnership with staff. The report acknowledged that there are significant variations in the quality of care provided across the NHS and that addressing it should be the priority of local health economies and identified mechanisms to achieve this.

4.3.3 **World Class Commissioning**, whilst no longer an externally validated national 'policy', world class commissioning nevertheless, drove key improvements in the way we think about our commissioning role. This planned care strategy is mindful of the areas for improvement identified in our competency assessments and will continue to strive to address them.

4.3.4 ***At the Heart of local health*** **(2009 NHS Dudley**) - summarises Dudley's vision for improving the health and wellbeing of the people of Dudley. This planned care strategy contributes to the delivery of the PCT's overarching aim to provide effective and efficient care closer to home, achieved by engaging people in how best to meet their needs.

4.3.5 The PCT's financial position going forward and the imperative to achieve economic recovery is a key local requirement. This is covered in the various sections below.

4.4 PCT Long-Term Conditions Strategy

The PCT's long-term conditions strategy identifies the projected growth in activity and spend on long-term conditions should services not respond to meet that demand (Table 1). This planned care strategy identifies programmes of work to support people with long-term conditions, some of which are included in the summary of planned care QIPP programmes below. Joint work programmes between planned, long-term conditions and urgent care will deliver a reduction in hospital attendances and admissions for people with a long-term condition, chiefly through new ways of identifying the risks for those people of needing acute care and of establishing new ways of addressing those risks in the community such that crisis situations and need for acute intervention is minimised.

5. FINANCE & ACTIVITY

The PCT is facing significant financial challenges and needs to make savings in order to achieve its financial targets. The savings targets up to and including 2013/14, which need to be cash releasing, are as shown in Table 1:-

Table 1 – PCT Savings Targets

	PCT Savings Targets
2010/11	5,739,000
2011/12	13,488,000
2012/13	8,787,000
2013/14	6,240,000
TOTAL	34,254,000

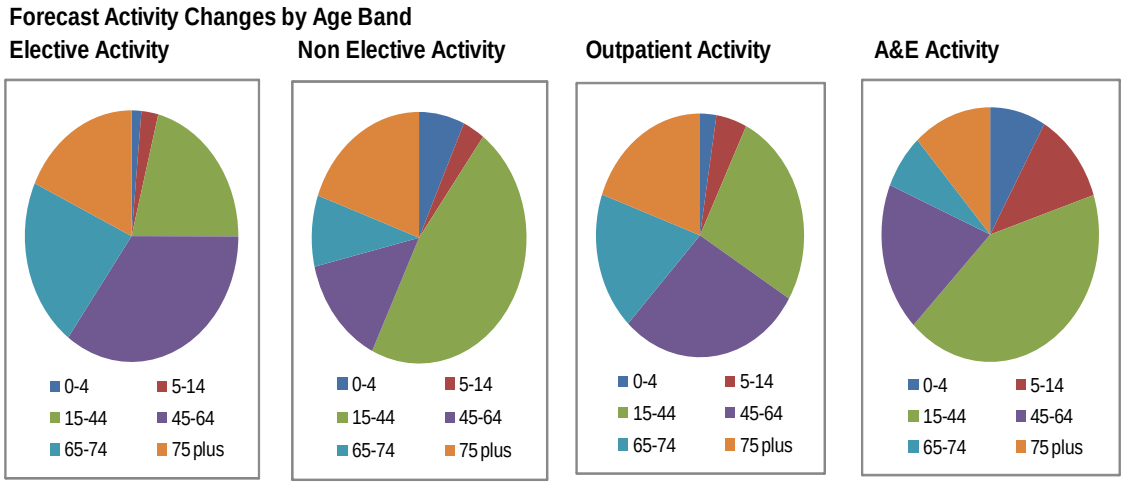
5.1 Planned Care Activity and Spend Analysis

The following table demonstrates impact of the potential increase in demand for planned care by attendance type:-

Table 2 - Activity and Spend Analysis for Planned Care

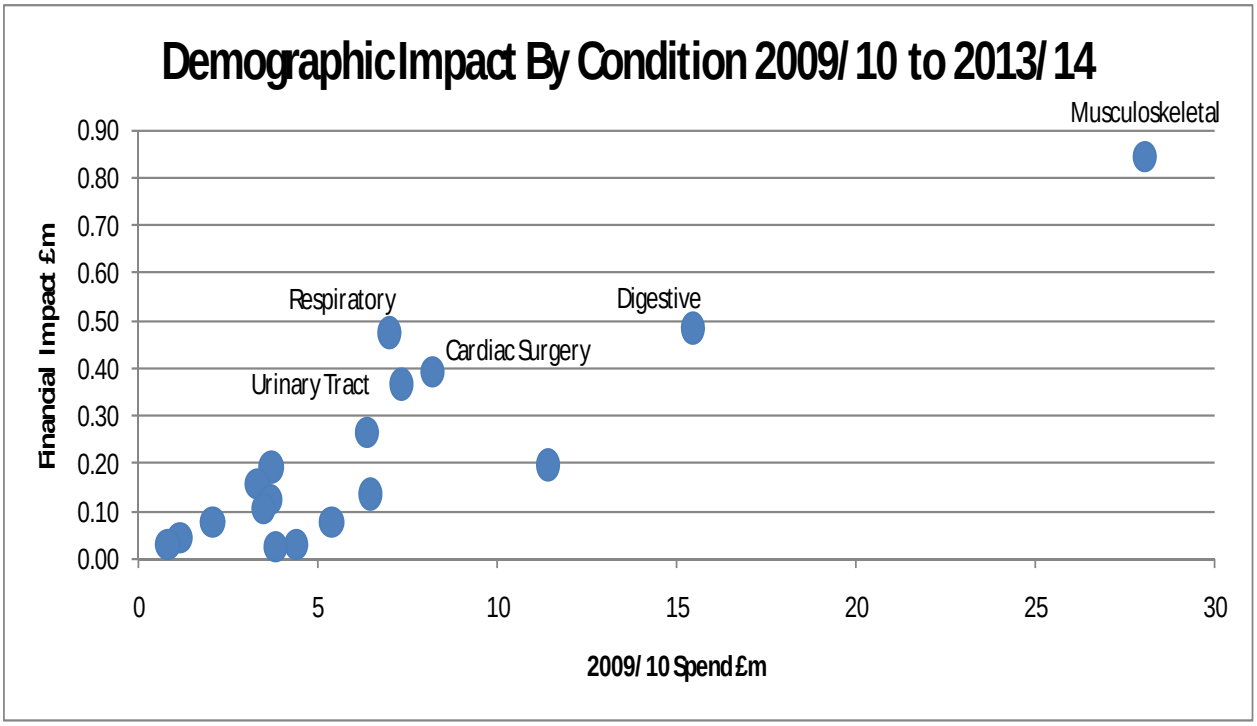
Point of Delivery	October 09 - September 10		2013/2014 (projected)		Increase	Increase
	Activity	Cost	Activity	Cost		%
Daycases	38,149	£29,435,283	40,484	£31,236,958	£1,801,675	6%
Electives	9,539	£23,291,467	10,123	£24,717,092	£1,425,624	6%
Outpatient Firsts	109,308	£15,577,693	115,999	£16,531,172	£953,479	6%
Outpatient Follow-Ups	322,601	£21,621,489	342,347	£22,944,898	£1,323,408	6%
Outpatient Procedures	24,501	£3,827,223	26,001	£4,061,480	£234,257	6%
Total	**504,098**	**£93,753,156**	**534,953**	**£99,491,599**	**£5,738,443**	6%

5.1.1 Impact of Demographic Change on Activity Levels



Age Band	2009/10 Outturn	2013/14 Forecast	Percent. Change	2009/10 Outturn	2013/14 Forecast	Percent. Change	2009/10 Outturn	2013/14 Forecast	Percent. Change	2009/10 Outturn	2013/14 Forecast	Percent. Change
0-4	705	719	2.1%	2906	2980	2.6%	12339	12601	2.1%	7202	7361	2.2%
5-14	1195	1199	0.3%	1416	1414	-0.1%	23489	23285	-0.9%	10145	10048	-1.0%
15-44	9979	9555	-4.2%	20028	20058	0.2%	129382	125242	-3.2%	36939	36213	-2.0%
45-64	16627	16668	0.2%	6007	6055	0.8%	139647	140219	0.4%	16421	16683	1.6%
65-74	10389	11187	7.7%	3893	4177	7.3%	89887	96388	7.2%	6050	6493	7.3%
75 plus	8571	9279	8.3%	8326	9113	9.4%	95859	104273	8.8%	10154	11094	9.3%
Total	47465	48608	2.4%	42576	43797	2.9%	490605	502008	2.3%	86911	87892	1.1%

5.1.2 Financial Impact of Demographic Pressures by Condition



5.1.3 Financial Impact of Demographic Pressures by Condition (£m)

	2009/10	2013/14	Impact
Musculoskeletal System	£28.04	£28.88	£0.84
Digestive System	£15.44	£15.92	£0.48
Respiratory System	£6.97	£7.45	£0.47
Cardiac Surgery and Primary Cardiac Conditions	£8.18	£8.57	£0.39
Urinary Tract and Male Reproductive System	£7.31	£7.68	£0.37
Nervous System	£6.36	£6.62	£0.26
Obstetrics	£11.39	£11.59	£0.20
Eyes and Periorbita	£3.67	£3.87	£0.19
Immunology, Infectious Diseases and other contacts with Health Services	£3.29	£3.45	£0.16
Skin, Breast and Burns	£6.46	£6.60	£0.14
Vascular System	£3.67	£3.79	£0.12
Hepatobiliary and Pancreatic System	£3.48	£3.58	£0.11
Haematology, Chemotherapy, Radiotherapy and Specialist Palliative Care	£2.05	£2.13	£0.08
Mouth Head Neck and Ears	£5.37	£5.45	£0.08
Endocrine and Metabolic System	£1.13	£1.18	£0.04
Multiple Trauma, Emergency and Urgent Care and Rehabilitation	£0.79	£0.82	£0.03
Female Reproductive System and Assisted Reproduction	£4.38	£4.41	£0.03
Diseases of Childhood and Neonates	£3.81	£3.83	£0.02
Total	£121.80	£125.82	£4.02

5.2 Planned Care Savings

5.2.1 QIPP plans

NHS organisations at regional and local level have QIPP plans in place to address the quality and productivity challenge. Supporting these are national work streams designed to help NHS staff successfully deliver these changes. The planned care strategy's contribution to the PCT's savings targets is shown in Table 3 below:-

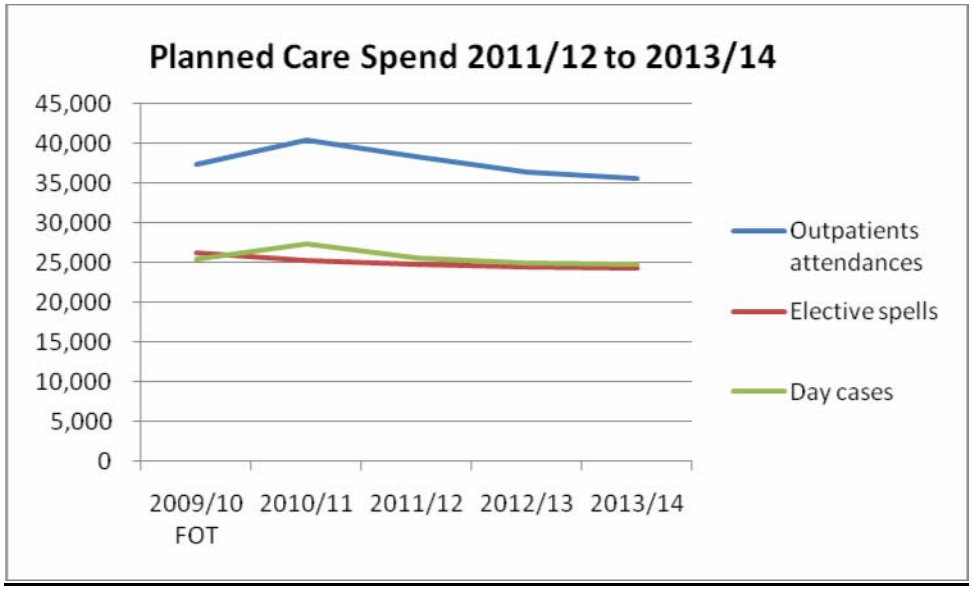
Table 3 – Planned Care QIPP Plan

Scheme	Forecast 2010/11 £	2011/12 £	2012/13 £	2013/14 £	Cumulative Total £
Procedures of Limited Clinical Value	500,000	1,107,643	0	0	1,607,643
Upper GI and Colonoscopy	88,015	176,032	0	0	264,047
Outpatient Modernisation	215,000	0	0	0	215,000
Outpatient First to Follow up	900,000	0	0	0	900,000
Minor Surgery LES	50,000	540,617	196,873	0	787,490
Dermatology SLK	14,749	0	0	0	14,749
Dermatology Worcester Street and Cluster One	38,533	0	0	0	38,533
Vasectomy Service Wordsley Green	94,892	0	0	0	94,892
Vasectomy Service Brierley Hill	23,571	0	0	0	23,571
Duplicate Orthopaedic Services	369,000	0	0	0	369,000
Hospital at Home Decommissioning	151,566	148,434	0	0	300,000
Pathways Team Decommissioning	21,667	43,333	0	0	65,000
Orthopaedic Triage	0	219,304	0	0	219,304
Paediatric Triage	10,000	90,000	0	0	100,000
Community Gynaecology	4,679	0	0	0	4,679
Glaucoma	0	102,942	0	0	102,942
Providing External Advice and Triage (to be scoped)	0	2,451,000*	0	0	2,451,000
Pathway Redesign (to be scoped)	0	2,000,000*	2,000,000	2,000,000	6,000,000
Enhanced Recovery - Joined up plans of care (to be scoped)	0	141,000	0	0	141,000
Total	**2,481,672**	**7,020,305**	**2,196,873**	**2,000,000**	**13,698,850**

* to be scoped and subject to change

5.2.2 Projected impact to 2013/2014

The following chart highlights the impact of QIPP schemes and other planned care programmes outlined in this strategy on future spend



6. GOALS

Planned care refers to a wide range of processes, treatments and procedures which, although they can be complex, follow a predictable pattern. This means that planned care can be organised and planned around a series of specified stages, steps and timescales together to create care pathways or patient journeys to meet the needs of individuals. Much of the complexity around planned care relates to the need for patients to move between different services and organisations as part of their diagnosis and treatment pathway.

If planned care is to be commissioned effectively it must aim to meet the challenges of increasing demand for diagnostics and treatment services, and to provide evidence-based, clinically effective and cost effective services. Related to this is the responsibility for delivering services on the basis of need rather than demand or historical trend alone. This philosophy underpins the planned care programmes that are outlined below:-

6.1 Goal 1 - Clinical Networks and Education Fora

6.1.1 Clinical Fora

NHS Dudley has an effective framework to ensure that clinicians are placed at the heart of decision making, promoting innovations and strengthening community engagement through the Practice Based Commissioning (PBC) framework and respective clinical leads, supporting pathway redesign that releases efficiencies and ensures high quality clinical care.

The following forums are supported by the Planned Care Programme:

- Regular clinically focused meetings around specialist areas to support the QIPP agenda for planned care
- Regular 6 weekly meetings with DGOH Clinical leads and primary care Clinical leads, led by the PCT Planned Care clinical lead, this forum has been developed to build and strengthen relationships and to focus on clinical development
- The Planned care programme will also link in with the PCT Primary care education forums when it is clinically appropriate to share service re-design pathways or raise awareness of clinical protocols to improve existing pathways

6.1.2 GP Intranet

There are many challenges that NHS Dudley faces in the near future, but the major one of these is increasing demand for medical intervention in all its forms, which is out of balance with limited resource. It is widely accepted that Primary Care, more importantly GPs are seen by the NHS and importantly by the Public as occupying a central role in access to NHS services, so called ‘Gatekeeper Role’.

The amount of information, change, protocols, and forms available to any GP continues to expand at an exponential rate, to a point where it now becomes impossible to manage all the information, especially in smaller practices, email is sometimes seen as a solution to communication, sadly being one of 200 recipients of a circular email does not feel like being a member of an effective team.

The Planned Care Clinical Leads vision for all Dudley General Practice having direct access via their computers in every surgery, with a bespoke Dudley focussed Intranet/Portal. Maintained on this facility would be all the information needed to help manage patients most appropriately. This may include clinical protocols for investigation of conditions, directories of patient services, advice sheets for all common conditions to help patients to self manage, agreed management plans for local providers, all medically related referral forms, links to medical websites i.e. DVLA, NICE, internal email, emergency and essential information, Map of Medicine, the list is endless. This will enable us to monitor Intranet traffic to assess usage, link this to referral data, clinical outcomes, and gain valuable intelligence into areas of strength and weakness within our health economy.

6.1.3 Directory of Services

The urgent care strategy is developing a directory of services to improve access to urgent care services, the planned care clinical lead is a member of the steering group facilitating this workstream. The aim is to co-develop the directory such that there is more information available including planned care and long term condition services with clear information on access and sign-posting to local services voluntary, community and secondary care and specialist services.

6.2 Goal 2 – Service Improvement and Pathway Re-design

6.2.1 Enhanced Recovery

Enhanced recovery programmes use evidence based interventions to improve pre-, intra-, and post-operative care, which enables early recovery and discharge from hospital and improves bed utilisation by reducing hospital lengths of stay. The improved planning achieved by using an enhanced recovery approach improves patient outcomes by reducing complications and enabling a more rapid return to function.

The local health economy (LHE) has a programme in place that supports the enhanced recovery regional approach ensuring that wherever clinically possible the default approach to surgery for both elective and emergency is in line with these principles.

The LHE already has some local pathways in place that adopt some aspects of the enhanced recover principles:

- Integrated Orthopaedic Surgery- Hip & Knee / Social care pathway
- Breast Surgery – Mastectomy
- Moving towards laparoscopic urology procedures

- Moving towards laparoscopic colorectal procedures
- Carbohydrate loading

This programme will continue to ensure the engagement of both primary and secondary care services in enhanced recovery programme development. The priorities speciality areas to be addressed by this program are:-

- Gynaecology
- Trauma and Orthopaedic
- Urology
- Colorectal

Within the local health economy a steering group has been set up at DGoH to ensure that we are on track to achieve the milestones set by the National QIPP programmes. It is recognised that this approach focuses heavily on acute provider setting but recognises the need to ensure that primary care are fully engaged in ensuring that the patients is fit for surgery prior to referral, this will be driven by local clinical protocols. It is also acknowledged to provide enhanced recovery it is vital that the discharge pathway must be seamless to ensure patients can be sent back to their respective community settings when it is clinically appropriate, this requires strengthening existing social care pathways. The efficiencies here will support the acute provider to improve patient flows and reduce bed numbers.

6.2.2 Community Based Minor Surgery

NHS Dudley has worked closely with lead clinicians to develop a definitive list of minor surgery procedures to be provided within a community setting in line with the Minor Surgery Directed Enhanced Service (DES). The aim of this work is to improve patient experience and equity of access, and to maximise the uptake of the DES amongst local practices. Service implementation began in 2010 and will be further strengthened in 2012/12 .The work to date has highlighted a major cross over between minor surgery rheumatology, dermatology and plastics and NHS Dudley will be seeking to maximise opportunities to develop community services for all clinically appropriate procedures currently undertaken within a hospital setting in the way that has already happened with respect to NHS Dudley's newly commissioned vasectomy service, for respective savings please see QIPP section of Strategy.

6.2.3 Orthopaedics

Musculoskeletal conditions have been recognised nationally as a major cause of ill health, pain and disability. They are the most common reason for repeat consultations with a General Practitioner (GP). This national picture is reflected locally with the number of musculoskeletal referrals in NHS Dudley being recognised as a significant pressure as our demand modelling shows.

An ongoing process of service re-design within orthopaedics to ensure patients are seen by the right professional at the right time, have led to the following service re-designs work streams, for respective savings please see QIPP table summary:

- Decommissioning of the Hospital and Home service and community pathways. The decisions to decommission was made jointly by both DGoH and Community provider as both services were set up prior to the PbR tariff and enhanced recovery programmes
- Outpatient Orthopaedic Triage –Following a joint audit of outpatient referral letters by the Planned Care Clinical lead, Orthopaedic Surgical Lead at DGOH and Orthopaedic practitioner, it was recognised that 25% of referrals to outpatient services could be better managed in the community either via their primary care clinician or community services such as Orthopaedic Assessment and community physiotherapy

6.2.4 Dermatology

Skin disorders are amongst the most common diseases encountered by health professionals. Whilst there are some four and a half thousand skin diseases, eight of them make up 80% of consultations in general practice, and between 15 and 20% of GP consultations have a dermatological element to them.

Over the last 10 years, there have been increasing deficiencies identified in existing models of dermatology provision exacerbated by too few trained dermatologists, a significant increase in demand driven, in part, by a dramatic increase in the treatments available. Waiting times for outpatients and treatment have grown and Dudley is seeing increasing pressure in many sub-specialty areas.

In spite of additional investment in community dermatology services in Dudley, secondary care services continue to be under severe pressure. Referral pathways will be reviewed by the local dermatology forum and audits undertaken to understand better demand which will support the decision process for service models for the future.

6.2.5 Ophthalmology

Ophthalmology services are under pressure in Dudley, this has partly been contributed by the glaucoma NICE guidelines April 2009. This guidance has opened up access to a wider range of patients and because of the increase in the older age population and the number of false positives being referred to secondary care due to the lower ocular pressure thresholds.

A local ophthalmology project group has been set up to identify priorities for service redesign including how and where to improve access such that patients can have their conditions better maintained to reduce the impact of their disease. Demand and flow will be analysed to inform future service configuration options, especially between primary and secondary care such that the significant service pressures on clinicians and facilities can be best overcome.

6.2.6 Glaucoma Referral Refinement

Glaucoma is a difficult disease definitively to diagnose. Is has a low prevalence and affects around 2% of the population over the age of 40. There is no one definitive test that arrives at the right diagnosis. Instead, there are a number of tests which help build up a picture for the eye care practitioner to interpret. It has been proven that repeating tests will improve the accuracy of the onward referral to secondary services for glaucoma.

A glaucoma referral refinement pathway is being fine-tuned with local optometrists and hospital consultants to repeat ocular pressures in the community. The impact of this once in place will reduce unnecessary outpatient activity by 35% realised a saving of £102, 942 by 2012/13 as shown in the QIPP programme above.

6.3 Goal 3 – Reducing Unnecessary Demand for Health Services

The initiatives described above are designed to do 'drive up quality and reduce costs', a core imperative confirmed in many of David Nicholson's communications with us. Whilst having a significant impact, these programmes will not be enough to help achieve a sustainable, affordable, health economy for the future. The following programmes of work are also being delivered through this strategy:-

6.3.1 Managing Demand in Primary Care

Referrals from GPs are driven in the main by either clinical necessity or management of uncertainty or both. If these drivers do not apply, then questions may be reasonably asked about the necessity of the referral. In addition consideration needs to be given to the destination of referrals. Is the requested destination the best one for the patient, and have all options been considered? Finally, the quality of referrals is extremely variable, and the adequacy of information contained in a referral letter can be poor. The question is how can all of these issues be address?

Primary care clinicians have a key role to play in ensuring that only high quality, clinically appropriate referrals are sent to hospital services. We can only have an effective planned care strategy if we have high quality systems of primary care services. The Primary Care Strategy for Dudley, *Reaching Excellence*, links to the PCTs over arching strategic plan but sets out how primary care services can be commissioned to deliver a step-change in service provision and performance, which will improve the health and well-being of Dudley people.

Variation in referral patterns will continue to be discussed with GP practices and a consensus sought about why the variation exists and what can be done to support a change in practice where appropriate. The Commissioning Consortia will have a key role to play in designing education programmes to support this work alongside a performance framework.

6.3.2 Outpatient Triage

Referrals between clinicians within the acute setting as well as from primary to secondary care are important routes of accessing care and treatment in an outpatient setting. As in other stages of the pathway, the desired aim is consistency of decision making and practice and adherence to a common set of principles designed to deliver care outside of hospital wherever possible and minimised visits for patients.

Triage is a key plank in any strategy to manage out unnecessary demand, to address inadequate referral practice and to highlight problems with poor referral information. Triage will be undertaken at the point of receipt at the hospital. Referrals will only be accepted where there is a clear clinical need for secondary care specialist opinion and advice. Where this is not the case, referrals will be returned to GPs for alternative action. Areas where triage has been effective in reducing unnecessary demand are in specialities such as orthopaedics, medical paediatrics and gastroenterology. It is estimated that there are efficiency gains of approximately 20-25% to be had in these areas and these have been reflected in the QIPP summary above.

6.3.3 New: Follow-Up Ratios

In 2010/11 there is a planned reduction in follow-up activity in Dudley by 7.5% on 2009/2010 outturn. Work will be done to reduce follow-up activity further to bring Dudley more in line with the best performing acute trusts as shown by national benchmarking data.

This strategy aims to achieve a reduction in follow-ups to the regional best averages which have the potential to release 33% cost savings, see QIPP summary above.

6.3.4 Consultant to Consultant Referrals

The Triage initiative described above will reduce consultant to consultant referrals, especially those between consultants in the same specialty. In addition, where consultants identify a patient need for a referral to another consultant or specialty for a condition unrelated to the original referral, the referral will be returned to the patient's GP for consideration of the most appropriate way to meet the identified additional need.

6.3.5 Procedures of Limited Clinical Value including Aesthetic Surgery

Following extensive consultation between primary and secondary care clinicians, a list of agreed procedures of limited clinical value, including aesthetic surgery procedures, has now been agreed. Clinically led policies governing what Dudley PCT will commission in these two areas have now been agreed as a result. Policies

became effective wef 1 November 2010 and the impact of those policies on savings for the PCT is shown in the QIPP summary above.

6.5 Goal Four – Commissioning for Quality and Cost-Effectiveness – Enabling Programmes

Dudley PCT recognises that there has never been a greater need to secure best value for money in health services. There is a seemingly unyielding rising demand for care year on year that it will not be possible to meet given the limited resources available.

What follows, is a summary of the enabling programmes that will be established in order to secure successful implementation of this strategy:-

6.4.1 Demand and Capacity Modelling

Raising quality whilst at the same time reducing costs are central aims of this strategy and the initiatives described above are designed to do these two things. What is also needed is a better understanding of exactly what capacity we need in the system for the longer time in light of all we know about current and projected future demand and of what we can and cannot do about that demand. Service redesign will achieve significant financial savings going forward, but not enough to achieve economic sustainability for the longer-term. Matching capacity to projected demand in light of planned models of care for the future (and indeed in light of known changes as a result of existing initiatives) is a key pre-requisite for economy wide economic recovery. Taking out costs by taking out surplus capacity in light of the impact of the PCT's commissioning intentions is also required.

This is a complex piece of work the design of which will be undertaken in support of the Black Country Cluster acute reconfiguration programme.

6.4.2 Information Technology and Information Provision

If we are to take speedy, correct, decisions about how, what and where we commission, and if we are to respond effectively when trends or patterns of referral or provision are not as expected or commissioned, then easily accessible information, available in 'real-time', will be critical to the success of this strategy. As will the way in which information is shared across organisational boundaries.

- We must be able to scrutinise clinically and financially high volume and high cost areas to ensure we are securing best value for money
- We must be able to benchmark outlying practice and use information to challenge provider and referrer practice
- We must be able to know what we are commissioning and why and the impact on the whole economy of commissioning decision taken
- We must quickly identify and respond to areas of emerging pressure
- We must use choose and book systems to their best advantage for the benefit of patients

- We must be able to transfer care from one provider to another with the right real time data to support seamless transfer and ongoing service provision

The planned care leads will work with the information and IT teams to secure the right level of information support to the planned care programme.

7. MONITORING DELIVERY

The planned care programme will be monitored via the PCT's internal planned care programme board and the QIPP performance monitoring processes both internally and via the Black Country Cluster framework. The work covered by this strategy will also be the subject of scrutiny via the newly formed health and social care CEO level strategy meetings.

Measures of success and Key Performance Indicators (KPIs) will be devised in order that success can be measured and reported upon.

Should any initiatives prove not be delivering their aims, or in need of amendment, they will be changed in real-time to ensure that only financially viable workstreams are progressed. Lessons learned will be shared widely between the three strategies and beyond via the PCT business case committee so that learning can be shared positively.

8. CRITICAL SUCCESS FACTORS

Critical to the success of this strategy are the following:-

- Ownership by clinicians across primary, community and secondary care to the programmes and issues described in this strategy

  In particular
  - Clinical leadership by cluster chairs to influence primary care practice
  - Clinical leadership by acute trust clinical leaders to influence secondary care practice
  - Combined clinical leadership, speaking with one voice, to shape health and related social care service development policy across all sectors

- The integration of Planned, Urgent and Long term condition programmes, in terms of their scope, implementation and delivery

- Effective and mutually respectful relationships between clinicians and managers within the PCT to secure effective design and delivery of a coordinated commissioning strategy

- The ability and flexibility of providers to adapt to the changing environment both clinically and under harsher economic conditions

- Effective communication within organisations and at the interface

- Clinical leadership of pathway redesign programmes

- A robust performance management framework with measures of success and KPIs.

- The right information and other forms of intelligence, both quantitative and qualitative, to support decision making both for investment and disinvestment

Work programmes will be delivered to ensure these critical success factors are put in place.

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