

FINAL DRAFT

Birmingham East and North PCT

**A Strategy for the Commissioning of Planned
Care Services for Birmingham East and North
PCT**

2009 – 2014

Version control

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Executive summary

This paper sets out a 5-year commissioning strategy for planned care with a vision to provide patients with a choice of services that improve their experience of assessment, diagnosis and treatment based on personal, seamless, convenient, safe and reliable clinical services. Patients will no longer wait to be seen but will be able to choose when and where they receive their care at a time that is convenient to them.

From a national policy perspective, reducing waiting times is a priority with a target to ensure that 90% of admitted and 95% of non-admitted patients wait no longer than 18 weeks from their referral to treatment by December 2008. Delivering this goal will require a redesign of planned care services with more assessment, diagnosis and treatment occurring in community settings. Clinical leadership and involvement in the development of new services will be key to the successful delivery of new models of care.

Locally, there have been a number of improvements in planned care services with a significant reduction in patient waiting times and good progress towards delivery of 18 week referral to treatment times. There have also been developments in the way services are delivered with new services being established in community settings.

There are major challenges to the development of effective services which include ensuring that services are accessible to the diverse population the PCT serves recognising the significant health inequalities that are present within the community. Projected increases in diseases will raise demand for planned care services and there are issues with securing the capacity needed especially in terms of workforce and facilities in the community to deliver services that will sustain the reductions in waiting times.

This strategy sets out a number of objectives and a framework which will drive and facilitate the development of planned care services that will provide sustainable and effective models of care tailored to patient need. Five key delivery areas are identified:

- Developing supportive self-care and enabling choice
- Developing clinically integrated care models based on defined patient pathways
- Promoting and supporting clinical leadership and partnership working between primary and secondary care
- Managing demand
- Developing capacity to deliver new models of care

The delivery areas form a framework for the commissioning of services through the development of integrated patient care pathways. Benefits and outcomes will include no waiting for patients, more accessible services and improved choice and sustainable planned care services that deliver quality care with optimal outcomes for patients. These reflect the PCT goals in particular that patients should experience no waiting or delays in receiving their treatment.

1. Introduction and scope

The purpose of this paper is to set out a 5 year commissioning strategy for planned care services for Birmingham East and North PCT. Planned care for the purpose of this strategy is defined as:

Any health care event that has been planned in advance involving the patient and/or their family or carers in organising their care. It includes the assessment and diagnosis of patients as well as any subsequent treatment that is identified. Patients can access planned care through a range of routes including from emergency services eg NHS Direct, out of hours services and accident and emergency departments. Planned care can take place in a range of settings, including hospital, community settings and health centres.

It is important to note that this strategy does not cover the following areas:

- Long-term conditions
- Cancer services
- Mental health services
- Children's services
- Urgent and emergency care services

Although planned care is provided, for example, for children and people with mental health issues, these areas are addressed through separate respective commissioning strategies although there are links and interdependencies with this strategy. The development of any condition specific pathway in the delivery and management of patient choice should be informed by the planned care strategy.

There are two important interlinking issues that are embedded and woven within this strategy which are equality, diversity and sustainability. The PCT is committed and as a public body required by the various equality legislations, to ensure the services commissioned and provided by the PCT do not discriminate against people on the grounds of race, religion and belief, age, sexuality, disability and gender.

Acknowledging different people will have different needs, the PCT will take into account, for example, that translation services may be required for some patients to enable them to access services. A full equality impact assessment is enclosed in appendix 1.

Sustainable development is: "development which meets the needs of the present without compromising the ability of future generations to meet their own needs" (Brundtland Commission definition in *Our common future* report to UN, 1987). This is essentially that any service redesign is robust and lasting and that developments take account of the environmental impact, making effective use of finite resources. Appendix 2 sets out the principles for sustainable development.

2. Vision and strategic aims

The vision for planned care is to provide patients with a choice of services that improve their experience of assessment, diagnosis and treatment based on personal, seamless, convenient, safe and reliable clinical services. Patients will no longer wait to be seen but will be able to choose when and where they receive their care at a time that is convenient to them.

The overarching aims of the planned care strategy are to:

- Base planned care services on agreed patient pathways that are informed by best practice
- Improve access to services, closer to where patients live if possible and make services easy for patients to navigate
- Provide services that respect the diversity of our patients
- Deliver and sustain an 18 week or less patient journey, aiming for the shortest possible times with no delays
- Ensure that as much care as possible is planned reducing patient need for emergency and urgent services

3. Strategic context and national drivers

There are a number of key national policies that inform and influence the strategic direction for planned care:

The NHS Next Stage Review

The NHS Next Stage Review (Department of Health 2008a) sets out a vision for improving the quality of care with a commitment to making services more personalised and accessible to all including people who traditionally are less able to seek help or find themselves discriminated against. A key objective is for the right for patients to choose their treatment and provider set out within an NHS constitution. Patients will have ready access to information on the quality of services so that they are able to make an informed choice.

18 weeks

The reduction of waiting times remains a priority for the NHS with a target of delivering an 18-week patient journey to include assessment, diagnosis and definitive treatment by December 2008. This is one of 5 key priorities in the Operating Framework for 2009/10 (Department of Health 2008b) and it is expected that:

90% of admitted patient pathways and 95% of non-admitted patient pathways are delivered in 18 weeks by December 2008.

The milestones for stages of treatment are shown in table 1

Table1-Stages of treatment milestones		
	March 08	December 08
Outpatients	5 weeks	5 weeks
Diagnostics	6 weeks	2 weeks
Inpatient treatment	11 weeks	11 weeks
Total	22 weeks	18 weeks

Delivering 18 week referral to treatment pathways has been acknowledged by the Department of Health (2006a) as a challenging target with orthopaedics, echocardiography, endoscopy and audiology in particular as areas that need focused work to achieve 18 week treatment times. Achieving and sustaining 18 weeks will require changes to traditional patient pathways with redesign of a range of services to enable improved access and elimination of delays for assessment, diagnosis and treatment.

Present performance suggests that 18 weeks will be achieved by December 2008 – the issue of ensuring a sustainable system with 18 weeks as the minimum standard will be critical.

Delivering care closer to home

The case for shifting care closer to where patients live was set out in the White Paper *Our health, our care, our say* (January 2006b). This remains a central theme within the report *High quality care for all: NHS Next Stage Review final report* (Department of Health 2008a) which recommends that planned care should be provided closer to people's homes, with greater use of technology, and outpatient care not always meaning a trip to hospital. Clinicians should be empowered to provide more integrated services for patients and integrated care organisations (ICOs) that bring together health and social care professionals, hospitals, local authorities and others will be piloted. The aim of ICOs will be to achieve more personal, responsive care and better health outcomes for patients.

In *Delivering Care Closer to Home* (Department of Health 2008c) two principles are identified as being fundamental to shifting care effectively and substantially:

- Working across the whole health and care economy
- Recognising that the local context is critical in defining priorities and maximising the strategic benefits and effectively managing costs

Locally, there is an opportunity to minimise carbon footprints and ensure sustainability for new services through robust planning and partnership working.

Choose and Book

Choose and Book is identified by the Department of Health (2004) as an important tool in the delivery of accessible and convenient services. This national electronic referral service gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic. Benefits include improved conveniency for patients and improved efficiency through, for example, reductions in non-attendance for appointments. The national target was for 90% of bookings to be through the Choose and Book system by March 2008 although locally and nationally this has not yet been achieved. Key to this locally will be the introduction of directly bookable services at Heart of England FT from April 2009.

Demand management

An important aspect in the delivery of effective planned care services is in ensuring that demand is managed so that patients only receive interventions

that are deemed effective in delivering the desired outcomes. The Department of Health (2006c) recommends that PCTs use care and resource utilisation techniques to identify areas where efficiency improvements can be made. Understanding the patient journey will help identify what adds value for patients and how patient pathways can be managed differently and with less delays. Locally the use of the Insight referral management tool is an example of enabling GPs to manage and review individual patient referrals thereby making more efficient use of secondary care resources.

World Class Commissioning

The Department of Health (2007b) sets out a vision for world class commissioning which will require commissioners to demonstrate better outcomes for patients; adding life to years and years to life. Investment decisions should be made in an informed and considered way, ensuring that improvements are delivered within available resources.

Clinical leadership and involvement is a critical and integral part of the commissioning process. By encouraging clinical involvement in strategic planning and service design, world class commissioners will ensure that the services commissioned reflect the needs of the population and are delivered in the most personalised, practical and effective way possible.

Practice based commissioners are identified as key, working in partnership with PCTs to drive improvements across the highest priority services and meet the most challenging needs identified by their strategic plans. There is potential for GPs to greatly increase the range of planned care services they provide, making services more local and accessible.

In summary, the development and improvement of planned care services is a priority for commissioners and is needed to ensure not only that patients receive their care and treatment within 18 week pathways but also that services are efficient and effective. The aim is to provide the right care at the right time and in the right place to meet the changing needs of the local population with services that represent value for money.

4. Local strategic context and drivers

4.1 NHS West Midlands strategic direction

Investing for Health (NHS West Midlands 2007) sets out the future direction for the NHS in the West Midlands region and the challenges in creating a service that meets the needs and rising expectations of people. As part of this strategy and the national review led by Lord Darzi, clinical pathways groups were established including a planned care group comprising clinicians, patients and the public.

The group produced a vision for planned care (NHS West Midlands 2008) which states that in future as much care as possible will be planned care which will:

- follow pathways that patients understand and that are based on clinical best practice
- be easy for patients to navigate
- respect the diversity of patients and seek to respond appropriately to the full range of their needs
- be organised so as not to waste time or resources
- involve the use of minimally invasive surgery, meaning less pain management, quicker recovery times and shorter stays in hospital
- be provided as locally as possible, depending on clinical need.

4.2 PCT strategic direction

The PCT's vision and core purpose as set out in the Strategic Plan (BEN PCT 2008a) is to improve the health and well being of local people whilst working in partnership to tackle health inequalities.

This vision is articulated through 4 audacious goals:

- To be responsive to the population we serve so that no one waits for the health care they need
- That the health and well being of our population will have improved so much that people will enjoy ten more years of quality life, wherever they live
- Our communities will be the most involved, informed and empowered in the country
- That people regard BEN PCT as the first choice organisation to work with and for.

These goals are underpinned by a set of key strategies which drive delivery of the PCT objectives:

- BRISK processes – bold, redesign, investment, sustainability and knowledge
- Quality patient services
- Promoting health and empowering staff
- Extending Working Together for Health
- Consistently fit for purpose – buildings, IT, people

The PCT Commissioning Strategy (BEN PCT 2008b) provides a framework for commissioning focused on improving health and wellbeing, securing access to a comprehensive range of services, increasing choice for patients

and achieving best value within the resources provided with the best possible outcomes for patients. Commissioning takes place at different levels depending on the services being commissioned and local need. This includes: practice based commissioning, PCT commissioning, specialised commissioning and joint commissioning with local authorities.

The PCT Operating Plan (BEN PCT 2008c) states that practice based commissioners will be involved in implementing community based services that will increase access for patients and move services closer to where patients live. Involvement of patients and the public in the design, development and evaluation of services will be a core component of the commissioning process.

The PCT will work with a range of providers – public, private and voluntary sectors – encouraging partnerships and proposals from confederations of providers. This will include social enterprises involving patients and staff in designing and delivering services, tailoring services to patients' needs and helping put people in control of their health care. Plurality of provision will be supported in appropriate circumstances.

This approach to commissioning offers patients and users a greater choice from a wider selection of convenient, innovative and responsive services. It will also ensure that planned care is delivered with no waiting or delays. The PCT will play a central role in the procurement and performance management of commissioned services

4.3 Strategic initiatives

The PCT has been working on its core purpose and ambitious goals since 2002 and is actively engaged in the SHA's Investing for Health programme which reinforces the focus and legitimacy of our approach to meeting the health needs of the population we serve. The Investing for Health programme has 5 strategic themes:

- Full engagement in self care and health improvement
- Improving quality and safety of health services
- Care closer to home
- Sustainable services which ensure access to safe services
- Organisations which are fit for purpose and resilient

The following principles describe the elements required in redesigning current patterns of service provision to deliver both improved health outcomes and best value.

- An integrated approach to education of patients and public, maximising self care
- Best practice in Long-Term Conditions management
- Range of community 'at home' and flexible support
- Access to diagnostics
- Maximum efficiency and appropriateness in use of hospital beds
- Integrated workforce planning and development

The Working Together for Health programme brings together BENPCT,

Solihull Care Trust together with our two main NHS providers (Heart of England FT and Birmingham and Solihull Mental Health FT) and two social care departments. The programme provides a formal framework for clinical participation in a whole system approach to redesign and improvement, increasingly using formal “lean” processes.

A range of initiatives have been prioritised which reflect our local priorities and strategic focus. The following highlights key areas of commissioning activity related to planned care over the next 24 months. Plans for investment over the next five years reflect significant service redesign, which in turn will drive significant shifts in activity from secondary care to primary care and community services.

The following describes in brief the work plans relating to specific areas of planned care activity:

Musculoskeletal services

The development of an integrated musculoskeletal service delivered by a multi-disciplinary team (including consultants, extended scope practitioners, physiotherapists, pain service and other allied health professionals) in a variety of settings (primary and secondary) and in a range of locations. The service will deliver assessment, diagnosis, conservative treatment and review for all non-admitted patients, (excluding trauma patients) at an 80% conversion rate for surgery with improved clinical and satisfaction metrics.

This will lead to de-commissioning of first and follow up outpatients at Heart of England FT, which will be delivered as part of the integrated service, with reduced consultant sessions, as a substantial number of referrals can be managed by extended scope practitioners or the community physiotherapy service.

Urology service

A community based multi-disciplinary (consultant, specialist nurses and health care assistant) office urologist service which includes the continence service. Both new and follow up patients will be seen for a range of conditions including: prostate disease management, cancer follow-up, continence management and erectile dysfunction. Approximately 70% of new and follow-up patients can be seen through the more local and responsive community urology service, resulting in de-commissioning of outpatients to that level.

Dermatology

A community based multi-disciplinary (consultant, specialist nurses and GP with special interest) dermatology service, delivered in the north by Sandwell and West Birmingham Hospital and in the east by Heart of England FT. Both new and follow up patients will be seen for a range of conditions including: eczema, psoriasis, acne, warts, with rapid access for suspected cancer patients. New and follow-up patients will equate to around 80% of all current dermatology OPD activity. The current pilots suggest 20% would continue to need to see specialist dermatologists in secondary care.

Diagnostics

The PCT is developing a business case for provision of a range of diagnostic modalities based mainly in two centres: Saltley and Castle Vale/Kingstanding providing local direct access diagnostic services for a range of tests including audiology, CT scans, echocardiograms, MRI, x-rays, ultrasound. This will enable GPs rapid access to local diagnostics and will be co-located with other acute services (e.g.urgent care centre) and community outpatient services (e.g. musculo-skeletal) thus enabling one stop services and increasing capacity for safe transfer of outpatient services from secondary care.

Anticoagulation services for three localities (Kingstanding, Sutton and Sheldon, Shard End, Stetchford and Yardley North Green)

Provision of a local anticoagulation service in a range of community settings provided through alternative models utilising extended skills of pharmacists and practice staff for both stable and unstable patients covering some 14,000 tests by 2012 /13.

Gynaecology

Provision of up to 10,500 new and follow up outpatient attendances in primary care by GPs and nurses in the community reducing the need for hospital attendance. This reflects our strategy of integrating family planning and sexual health services with core primary care to maximise prevention and access, and recognise the co-existence of ‘sperms and germs’. Table 2 shows the anticipated reduction in hospital outpatient attendances/tests over the next 5 years.

Table 2- Activity shifts through redesign of services

Working Together for Health							
Service	08/09	09/10	10/11	11/12	12/13	Comments	Cross reference
Muscular-Skeletal Services (single point of access) Incl Pain Mgt	3488	23253	37204	37204	37204	Outpatient attendances prevented	Darzi Planned Care Pathway
Urology (includes continence)	0	4799	8398	8398	8398	Outpatient attendances prevented	Darzi Planned Care Pathway
Dermatology	5868	14277	14277	14277	14277	Outpatient attendances prevented	Darzi Planned Care Pathway
Anti-coagulation services	7325	11544	13970	13970	13970	Tests provided	Darzi Long term conditions pathway
Gynaecology	507	6103	8137	10575	10575	Outpatient attendances prevented	Darzi Planned Care Pathway

Map of Medicine

Building on a strong history of clinical collaboration across a range of specialties, the PCT is now working with Heart of England FT on the introduction of the Map of Medicine as a consistent basis for the introduction of new pathways as recommended by the NHS Next Stage Review. This tool supports effective clinical decision making by providing best practice information through a single website.

5. Public health profile for BEN PCT residents

The diseases which are responsible for morbidity and mortality in the majority of residents within the PCT are circulatory disease (38%), cancer (26%) and respiratory disease (14%). There are high rates of infant mortality, teenage pregnancy and low male life expectancy when compared with the national average.

Significant health inequalities exist with morbidity and mortality rates higher in certain wards of the PCT (eg Washwood Heath, Stockland Green, Kingstanding, Shard End). The greatest number of potential years of life lost is as a result of heart disease, lung cancer, strokes and liver disease. These illnesses all have an impact on the use of planned care services.

There are a range of common conditions that result in elective treatment in the largest volume specialities in secondary care. Prevalence estimates for these conditions for the PCT population are set out in Table 3. Appendix 3 provides further detail.

Condition	Specialty	Estimated numbers
Eczema	Dermatology	39,639
Back pain	Musculoskeletal	77,047
Hip osteoarthritis	Musculoskeletal	31,426
Knee osteoarthritis	Musculoskeletal	41,560
Glaucoma	Ophthalmology	2,278
Cataracts	Ophthalmology	13,272
Hearing loss	Audiology	39,498
Benign prostatic hyperplasia	Urology	33,375
Menorrhagia	Gynaecology	27,557
Fibroids	Gynaecology	75,321

*Based on national and international estimates

The prevalence of many of these conditions is increasing which has implications for elective care services. Table 4 shows the top 10 most common procedures carried out for BEN PCT patients in 2007/08 some of which are related to the respective conditions listed in table 3.

Total knee replacement
Cholecystectomy
Intravenous chemotherapy
Total hip replacement
Total abdominal hysterectomy
Bilateral excision of tonsils
Primary repair inguinal hernia
Wide excision of breast
Endoscopic resection of lesion of bladder
Total mastectomy

There continues to be evidence that some procedures and outpatient attendances are no longer required owing to changes in treatment and technological advances or could be provided in community settings closer to where patients live, thereby improving access. A reduction in the level of secondary care interventions would release resources for developing more community based services and for tackling the causes of health inequalities within the PCT.

The PCT has agreed with clinicians in primary and secondary care a list of procedures that should only be undertaken if certain criteria are met in accordance with its Prior Approval policy. This list includes tonsillectomy, grommets, hysterectomy for menorrhagia, D & Cs, diagnostic knee arthroscopy and plastic operation to breast and abdomen as well as follow up outpatient appointment for certain procedures.

6. Patient/public views and experiences

Views of the patients and the public about the planned care services provided and/or received have been elicited through a recent focus group exercise “The Big Conversation” and stakeholder events that were held in each PCT locality.

The Big Conversation – findings from the focus groups

Findings from recent focus group exercise conducted for the PCT found that the public had a number of issues around planned care services. These included:

- The need for more GP appointments to be available and more extended hours
Discharge from hospital – insufficient backup provided for patients
- Favoured joined up services rather than a proliferation of different initiatives.
- Widespread recognition of the problem of back pain. Felt that there were gaps in provision for non-surgical treatment of back and other chronic problems. Felt physiotherapy provision was inadequate
- Orthopaedic triage service – found it difficult to understand, felt it was complicating the process, standing in the way.
- Welcomed a broader range of services via their local health centre
- Introduction of new services – PCT needs to demonstrate that it is doing this in a coordinated way
- Need to ensure that those who need a service are made aware of how to access it in a timely manner

Stakeholder events

These locality events attended by providers and the public facilitated discussion around the key health priorities that have been identified for the localities. The main comments/views in relation to planned care related to the need for :

- More local services
- More partnership working required
- A wide range of providers
- Information about services readily available
- Building on best practice and engagement with patients to build services that work for all
- Simple language and description of what services do

PRIME (programme for relationships, intelligence, metrics and equality), a programme recently commissioned by the PCT, aims to improve the quality of information to inform service developments and interventions. Baseline work is underway to profile the local population and establish more effective means of communication and engagement. This will assist with ensuring meaningful patient and public input to future models of planned care services.

7. Review of the evidence

Some of the findings from the literature relevant to planned care are summarised as follows:

Day surgery

Day surgery is promoted and supported by all the Royal Colleges in that it provides the best outcomes for patients in terms of recovery and makes better use of hospital resources, freeing up hospital beds. The Department of Health's *NHS Plan* (2000) set a target that 75% of elective admissions should be day cases. The Healthcare Commission (2005) however, found that take-up of day surgery in the UK is disappointing with levels of day surgery far lower than the expected target

Diagnostics

Right Test, Right Time, Right Place: a Framework for Primary Care Access (RCR and RCGP 2006) identifies that a lack of access to diagnostic tests has created a bottleneck for patients and frustrations for GPs. Patients expect prompt and timely diagnoses and to do this requires the appropriate use of modern imaging techniques. It also needs close partnership between GPs and radiologists, both in determining the correct test and in ensuring that the results are correctly interpreted in the context of the individual patient

Providing services closer to home

The Audit Commission (2004) found that redesigned services in the community had shorter waiting times and could reduce costs as many patients would not need a hospital outpatient appointment. Redesign helps to ensure that patients are treated by the most appropriate healthcare professional in the most appropriate setting. PCTs should have commissioning strategies that ensure secondary care is used appropriately and that investment goes into community alternatives to meet patient needs.

In *Shifting Care Closer to Home* (Department of Health 2007c) examples are provided of services that have been successfully established in community settings provided by a multi-disciplinary team for orthopaedics, urology, general surgery, ENT, gynaecology and dermatology. Common themes and issues are identified as key to the successful delivery of new models of care delivery in the community. These are:

- Developments based on local need
- Collaboration and partnership working between primary and secondary care and between clinicians and managers
- The identification of local clinical champions
- The role of hospital consultants encouraged
- Fully integrated, patient centred services
- Services not delivered in isolation
- Rapid access to diagnostics
- Training and sustainability key to long-term service survival
- Comprehensive patient information systems
- Clear outcome measures

Evidence from work undertaken by the Department of Health identified seven key challenges to the shifting of care into community settings. These are summarised in table 5

Table 5 – Key challenges to shifting services into the community from <i>Delivering Care Closer to Home</i> (Department of Health 2008b)
Challenge 1 – Involving people as partners in designing and delivering their care and addressing health inequalities
Challenge 2 – Ensuring that services closer to home are part of integrated care pathways for users
Challenge 3 – Building commissioning capacity and capability working with communities to establish the outcomes that matter to them and most appropriate ways of meeting them
Challenge 4 – Developing clinical and managerial leadership to grasp strategic opportunities, working with local communities to co design change
Challenge 5 - Developing community premises and estates fit for the future
Challenge 6 – Developing the workforce with roles and skills needed to deliver community services
Challenge 7 – Making greater use of technology

The integration of services is supported by Lord Darzi in his review (Department of Health 2008a) and the need to bring family doctors together with other community clinicians and with specialists working in hospitals to develop more integrated care for patients.

Commissioning pathways

The Department of Health (see DH 18 weeks website) has published thirty-five commissioning pathways with symptom-based models of care for each of the highest volume 18 week specialties with more being developed, to assist commissioners with the redesign of services to ensure delivery of 18 week referral to treatment times.

In summary, PCTs need to commission planned care services that are focused on the needs of patients and are organised around agreed care pathways. Services should be provided in community settings where possible, ensuring that secondary care services are used appropriately. New models of care should be evidence based, lean and responsive and represent value for money. Successful redesigned services are likely to be ones that are clinician led, are developed through partnership working and are based on integrated primary and secondary care multi-disciplinary teams. Rapid access to diagnostics will be essential and inpatient procedures, where possible, should be performed as day cases.

8. Profile of planned care services

8.1 Primary care and community services

The vast majority of care that is provided to patients who might present with conditions that require planned care is undertaken in primary care often with support from community services. There are currently 82 GP practices within the PCT serving a population of 440,000.

Primary care plays a key role in the management and support of patients with a range of conditions, identifying patients who need referral to other providers for more specialist assessment, diagnosis and treatment. This role has been further developed with the introduction of enhanced services and GPs with specialist interests which means that far more assessment, diagnosis and treatment now occurs in primary care.

Table 5 lists the enhanced services and GPs/practitioners with specialist interests providing planned care in the community in BEN PCT

Table 6 – Enhanced services and GPs/practitioners with specialist interests BEN PCT	
Enhanced services	GPs with specialist interest
Wound care	ENT
Near patient testing	Dermatology
Anticoagulation	COPD
Diabetes	Pain management
Minor surgery	Sexual health
Sexual health	Palliative care
Drugs misuse	
Intrauterine contraceptive devices	Practitioners with specialist interests
Advanced sexual health	Anticoagulation
Contract value circa £725,000	Contract value circa £171,000

Community services provide a range of support, therapy and treatment for a wide variety of conditions through the nursing and therapy services. This includes the Orthopaedic Triage Service for patients presenting with musculoskeletal problems and the pain service for patients with back pain.

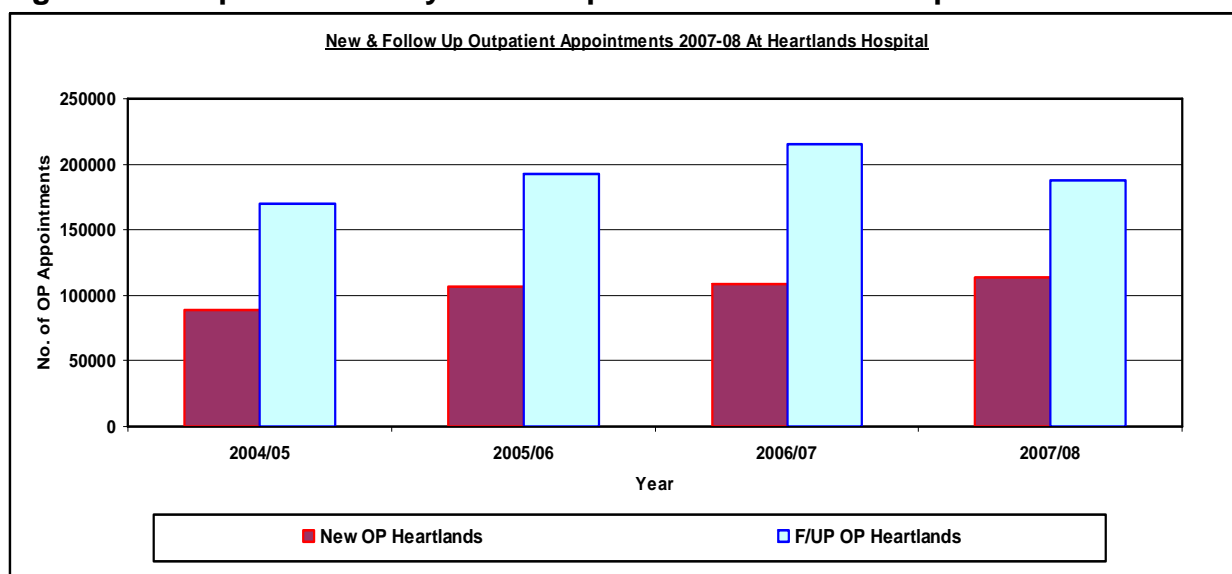
Community services may provide therapeutic input for part or all of the patient pathway eg pre operative assessment and support and post operative rehabilitation.

8.2 Secondary care

For most patients, the start of their planned care pathway begins with a GP referral to a consultant in secondary care. The vast majority of BEN PCT residents receive their planned care from Heart of England FT (HoEFT) for most conditions.

Figure 1 shows outpatient activity for HoEFT 2004/05 to 2007/08 which reveals a steady increase in new outpatient appointments over the last 3 years. Appendix 4 provides detail of outpatient activity by all providers with a similar trend with increases of 25% for new and 9% for follow-up outpatients over the last 3 years. This is a particular issue in orthopaedics where outpatient referrals to HoEFT have increased by over 17% last year yet the conversion rate to surgery is only 22%.

Figure 1 – Outpatient activity Good Hope and Heartlands Hospital



Both outpatient and inpatient activity and cost by provider is shown in appendix 5

Day case activity as a proportion of overall inpatient activity is shown in table 7 and figure 2. This reveals that 77% of all inpatient activity is performed on a day case basis which exceeds the Audit Commission's target of 75%. Day case activity includes procedures such as renal dialysis and chemotherapy as well as surgical interventions.

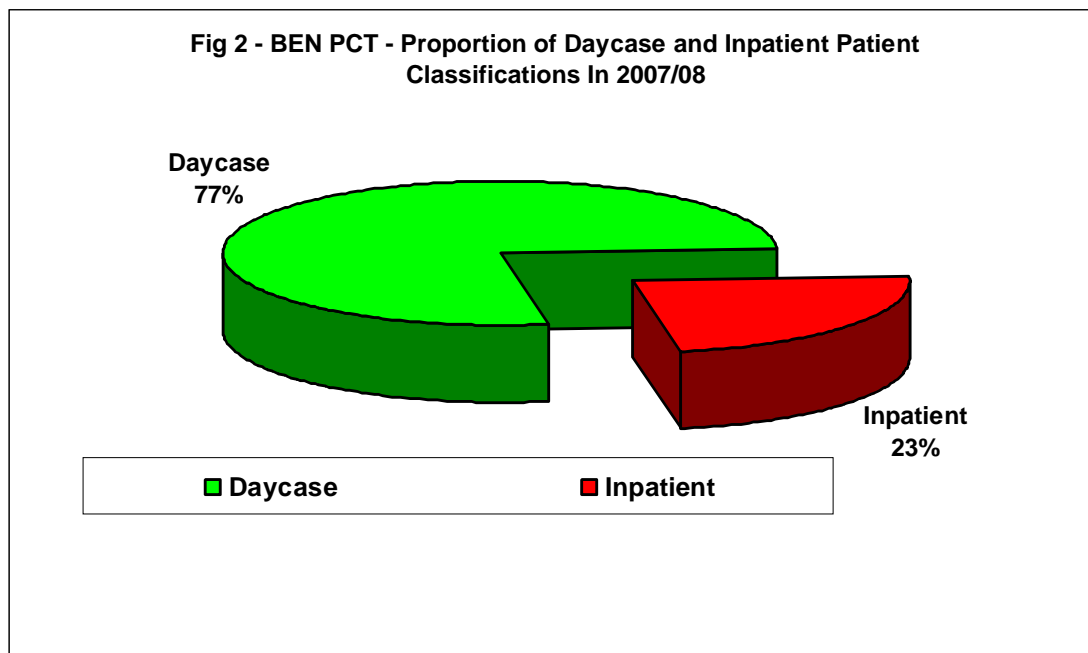
HoEFT provides a comprehensive range of elective outpatient, diagnostic and day case/inpatient treatments from Good Hope Hospital, Heart of England Hospital and Solihull Hospital sites.

Diagnostic tests such as MRI, CT and ultrasound are provided as direct access, enabling GPs to determine if referral to secondary care is needed. However, the majority of diagnostic tests are performed in conjunction with referral to secondary care. There is an issue with OPD tariff which includes diagnostic tests so if patients should need onward referral to secondary care, the PCT is in effect paying twice for the diagnostic test.

Some specialist services, for example, neurosurgery and cardiac surgery are not provided by HoEFT and patients are referred to other specialist providers within the city either directly by the patient's GP or via HoEFT. This means

that patient pathways may travel across a number of providers which has implications for ensuring care is co-ordinated to prevent delays so that definitive treatment is delivered within 18 weeks.

Patient Class	Activity Total	Tariff Total
Day case	31,715	£21,675,675
Inpatient	9,644	£22,131,373
Grand Total	41,359	£43,807,048



8.3 Waiting times

Waiting times for outpatient appointments, diagnostic tests and inpatient treatment have significantly reduced over the past year as shown in figure 3.

Overall, referral to treatment times in terms of 18 weeks for both admitted and non-admitted patients have also reduced with 90.26% of admitted patients (December 08 target 90%) and 94.60% of non-admitted patients (December 08 target 95%) receiving treatment within 18 weeks (September 08 data). See figure 4

Figure 3 – Waiting time trends

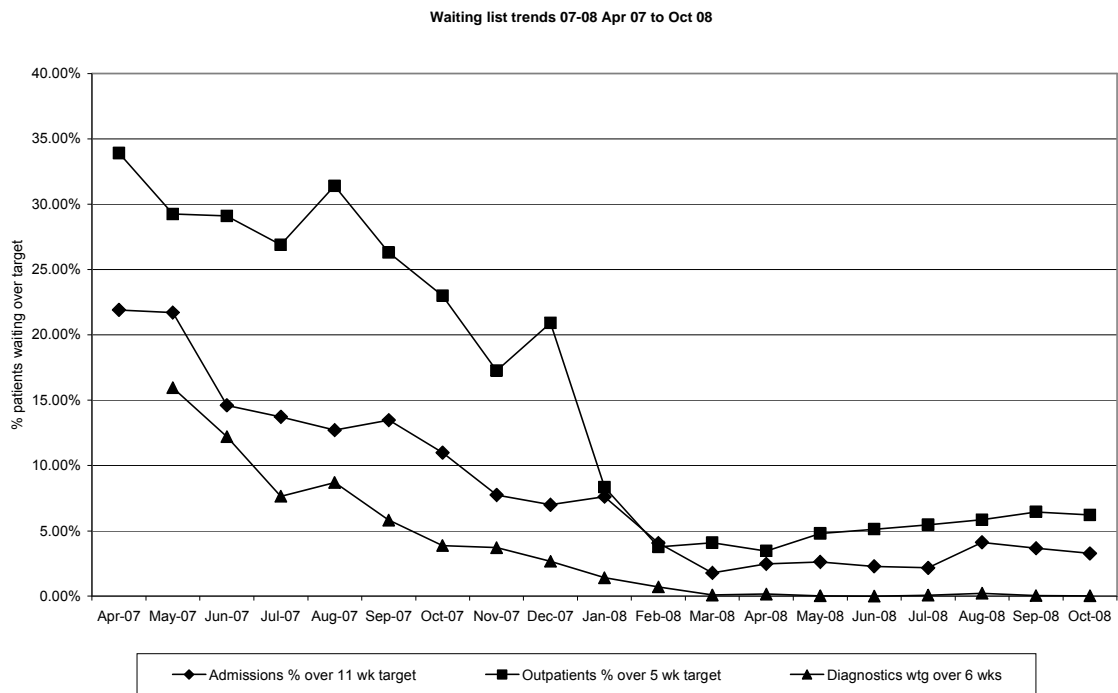
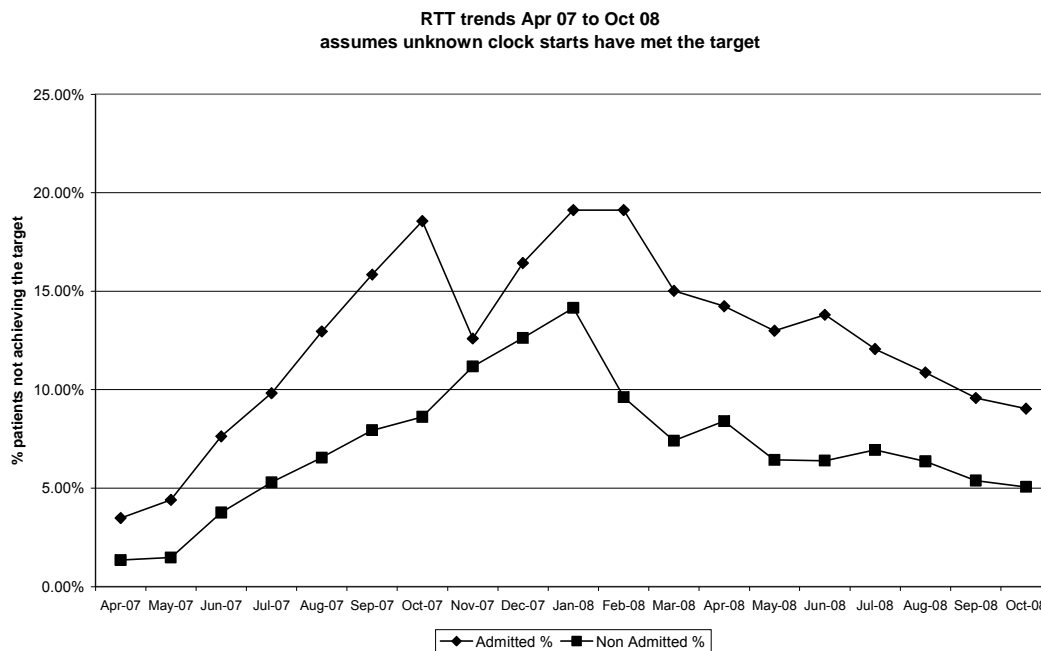


Figure 4 -BEN PCT referral to treatment times*

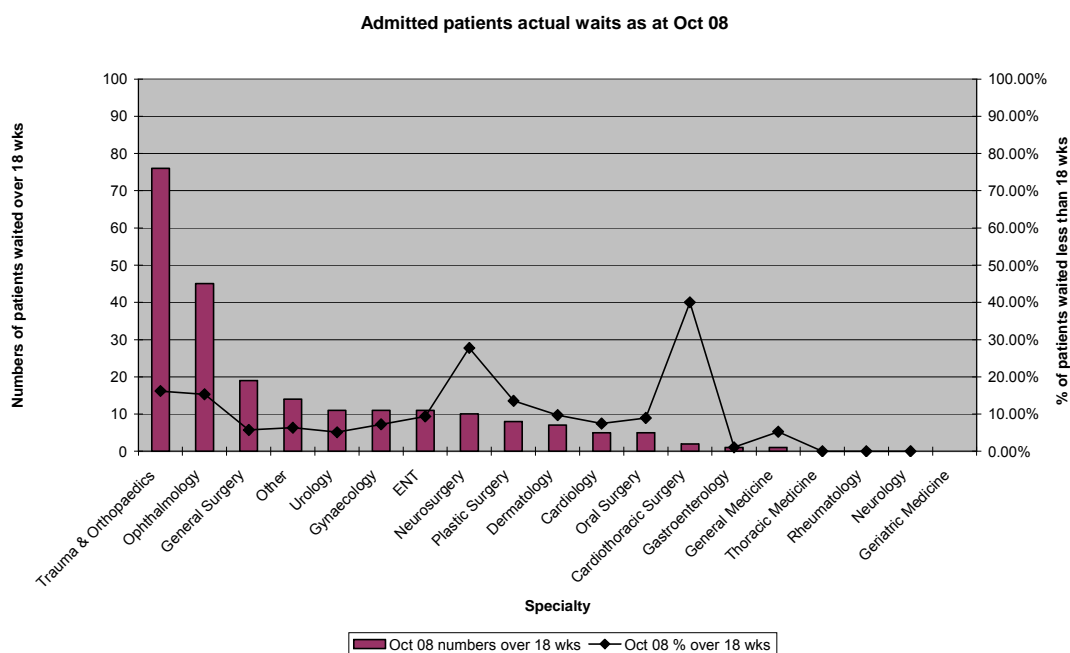


* Initially in 07 the performance appeared better owing to the large number of unknown clock starts which were assumed to be achieving 18 weeks. There are now very few unknown clock starts.

However, analysis of referral to treatment time by speciality (see figure 5) shows waiting times are variable with trauma and orthopaedics having

significant challenges in meeting 18 week referral to treatment times largely owing to the volume of activity.

Figure 5 – Referral to treatment times by specialty



8.4 Independent sector

The PCT has agreements with and/or uses a small number of services provided by the independent sector: These include:

- Alliance Medical providing MRI scans in collaboration with Heart of England FT (this is a Department of Health contract and is free for BEN PCT patients). A mobile unit is to be established on the Castle Vale site.
- MUST providing ultrasound tests based in two GP practices
- Aston Academy of Life Sciences and Midland Eye Institute providing cataract operations
- Spire Hospitals providing a range of procedures under the extended choice scheme

See appendix 6 for expenditure against some of the larger contracts

8.5 Service developments

The PCT has pioneered collaborative working with Heart of England FT and Solihull Care Trust based on an integrated approach to care adopted from a collaboration with Kaiser Permanente in the United States. This has led to nationally recognised work in commissioning services formerly provided in secondary care being shifted into primary care. This has included the development of the orthopaedic triage service in primary care and the new community based pain service for patients with back pain. Work is currently underway to further redesign the orthopaedic service to integrate and streamline patient pathways.

New initiatives are being taken forward through practice based commissioning including the development of anticoagulation services in primary care and

telemedicine for leg ulcer management in the community. Other developments include the commissioning of a dermatology outreach service in the north of the PCT. New areas that are being developed include urology services, audiology services, a community dermatology service for east of the PCT and provision of diagnostic services in community settings.

8.6 Demand management

The PCT has successfully implemented a number of demand management initiatives around elective care including:

Insight referral management tool – this is a web based tool that GPs use to manage, record and review their referrals. This resulted in estimated efficiencies of £2.5 million in 2006/07 owing to avoidance of referrals to secondary care.

Prior approval and utilisation review – work was undertaken in 2006/07 involving pairings by specialty of clinical leads in primary and secondary to review and agree pathways and protocols for procedures and follow up outpatients with limited clinical benefit. This was published and circulated to GPs and clinicians in primary care (see appendix 7 for list of procedures and outpatient follow up that were agreed as prior approval).

An audit of activity for the first two quarters of 2007/08 has shown a reduction in outpatient follow up for agreed procedures and in inpatient activity for procedures with Prior Approval protocols.

Resource utilisation - approaches have been applied to other areas including an agreed policy for consultant to consultant referrals so that patients with a separate condition are not automatically referred on to another specialist but are referred back to their GP for consideration. This also has benefits to the patient in terms of exercising choice.

8.7 Choose and Book

Choose and Book is being implemented across practices in the PCT with facilitation and support provided by the Choose and Book team. A new local enhanced service is being offered until March 2009 to provide an additional incentive to practices to achieve 90% of all bookings being made through the Choose and Book system. Currently, around 52% of bookings are being made and with the introduction of a direct booking system at Heart of England FT later this year, this figure should rise significantly.

9. Challenges and issues

The current system of planned care in the context of the requirements of national policy, the evidence base and local issues has many positive features with the delivery of good quality patient care and treatment and significant reductions made in waiting times. However, there are significant challenges and issues including:

- Health inequalities with evidence nationally that people living in more affluent areas better able to access planned care services
- A lack of primary care alternatives to secondary care referral
- Lack of diagnostic facilities in the community
- Too many patients being referred to secondary care causing capacity issues in some specialties eg orthopaedics
- Sustainability of waiting times an issue as secondary care will not be able to maintain 18 week referral to treatment times if referrals continue to increase
- Inadequate IT systems that do not support patient pathways and facilitate communication between primary and secondary care
- Many patients currently treated in secondary care settings could be assessed, diagnosed and treated in the community
- Workforce limitations and lack of staff with the required skills
- Current financial structure does not provide the right incentives
- Resistance to change and lack of ownership

10. Objectives of the planned care strategy

The principle objective of the strategy is to create a system for commissioning that is designed around patient pathways and the needs of the wider population. The strategic aims and objectives for planned care reflect the PCT aims which are:

- Tackling health inequalities
- Improving health
- Supporting self-care and wise choices
- No waiting for the care patients need
- Personalising care

The specific objectives towards delivering these aims are:

- 1) To develop community based, clinically integrated planned care services, delivered by multi-disciplinary teams with a single point of access in primary care
- 2) To move outpatient services into community settings where appropriate and feasible so that patients only attend hospital where this is necessary
- 3) To increase the use of Clinical Assessment Centres (Triage) driven by appropriate clinical pathway development
- 4) To expand the provision of diagnostic services in the community
- 5) To provide patients with personal, individual, high quality services that are locally available (where possible and appropriate), timely and meet the requirements of our diverse communities

- 6) To provide patients with full and consistent, peri-operative assessments in primary care
- 7) For patients to receive inpatient treatment as a day case or minimum stay where possible
- 8) For patients to have an informed choice of how and when they receive their treatment in the context of Choose and Book from a range of providers across primary and secondary care settings
- 9) To review all community based services and enhanced services to ensure they offer best value and performance identifying alternatives as necessary.
- 10) To increase the use of the Prior Approval and Utilisation Management techniques, reducing the use of interventions with limited clinical value

Further market testing will be undertaken to secure pathways that are more appropriate for patients providing quicker access and treatment in a Primary Care setting. This will include commissioning a range of high quality services having reviewed both the care given and the resources utilised. There will be a continued commissioning focus on reducing unnecessary Consultant to Consultant referrals, follow up outpatient attendances and reducing short stay unplanned admissions for ambulatory sensitive care conditions where services are or will be available in Primary Care.

The PCT is currently reviewing the arrangements for practice based commissioning with a view to reinvigorating the current system. GPs as clinical leaders are recognised as playing a pivotal role in commissioning planned care for their local populations and their involvement in the development and redesign of services will be strengthened.

11. Strategic plan for commissioning planned care services

11.1 Delivery areas

The planned care strategy comprises 5 key delivery areas. These are:

- Developing supportive self-care and promoting choice
- Developing clinically integrated care models based on defined patient pathways
- Promoting and supporting clinical leadership and multi-partnership working between primary and secondary care
- Managing demand
- Developing capacity to deliver new models of care

The delivery areas form a framework for the commissioning of planned care services through the development of integrated patient care pathways.

i) Developing supportive self care and promoting choice

A key principle of this strategy is that patients will no longer experience waiting and that the time spent before appointments and treatments will be in preparation through, for example, finding out more about their condition and/or treatment or improving health, for example, reducing weight, exercising and giving up smoking.

The introduction of free choice enhances the rights of patients. Choose and Book facilitates choice for patients and GPs have an important role in enabling patients to make an informed choice about where they go for their treatment.

The PCT will publicise and provide appropriate information to primary care staff, patients and the public about choice and the providers it commissions. Information will be provided in a wide variety of formats including information leaflets and a local website. There will be a targeted approach to certain groups in the community eg those with specific language or cultural needs or with disabilities to ensure that they have equitable access to information about choice of providers. This will include working with local community groups and voluntary organisations.

Choice also requires the PCT to make sure that there is sufficient capacity available from a range of different providers for local people to have a meaningful choice. The development of alternative and/or additional capacity and provision will be an important aspect of the commissioning strategy for planned care.

The continued implementation of the Choose and Book programme across the PCT and the improvement in booking rates along with the introduction of a direct booking system at Heart of England FT will be important in facilitating choice for patients and ensuring patients have appointments for to see specialists at times that are convenient for them. This will improve the patient experience and give greater confidence in health services

We will build on successful local initiatives that have been implemented to provide supportive self care, such as the Expert Patient Programme and Birmingham Own Health working with patients and the public to develop integrated, self-care programmes for condition specific pathways. We will use the methods and approaches developed through PRIME (programme for relationships, intelligence, metrics and equality), to apply innovative and effective approaches to patient and public engagement and involvement in the development and implementation of new services. This will include providing support and information tailored to the need of different community groups and people with specific requirements such as those with disabilities.

A key objective will be the introduction of a patient held record or “patient passport” which will enable patients to have information and assist with navigating their planned care pathway.

ii) Developing clinically integrated models based on defined patient pathways

The development of new, clinically integrated models of care delivered around defined patient pathways will be at the heart of this strategy. The key characteristics of the clinically integrated service model are outlined as follows:

- Developed through clinical partnerships and collaboration
- Have clearly defined pathways that are easily understandable to both patients and clinicians
- Evidence based with clear, measurable outcomes.
- Provided in the community in a range of settings where possible
- Easily accessible diagnostic tests provided in the community where feasible with quick access to results
- Provided as one-stop services where possible
- Underpinned by clinical governance and quality requirements so that patients receive safe and effective care and treatment.
- Entail discharge planning which will be an implicit part of all patient pathways

Current and planned service redesign programmes include:

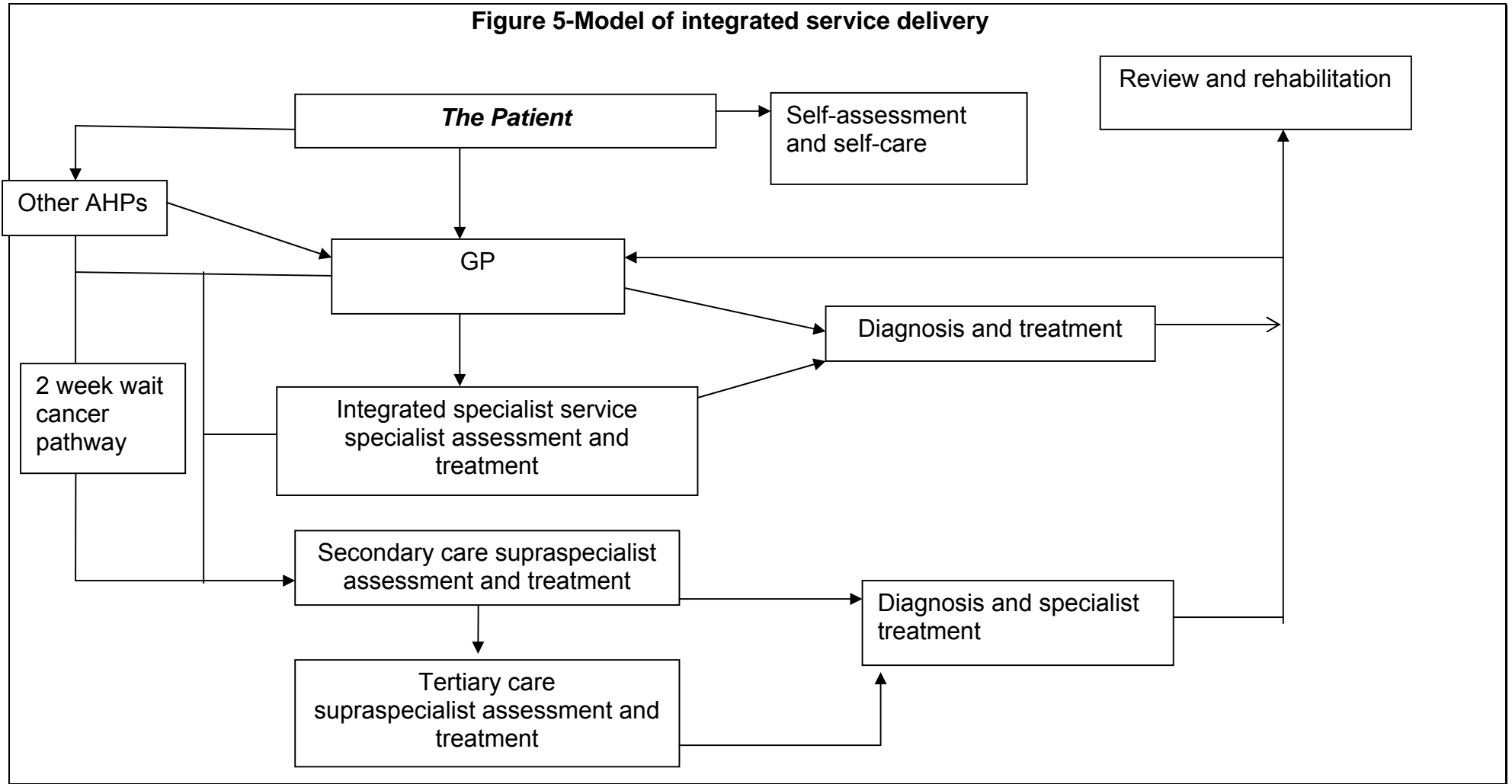
- Integrated musculoskeletal service primarily community based
- Community urology office
- Community dermatology services
- Audiology follow up service
- Anticoagulation services

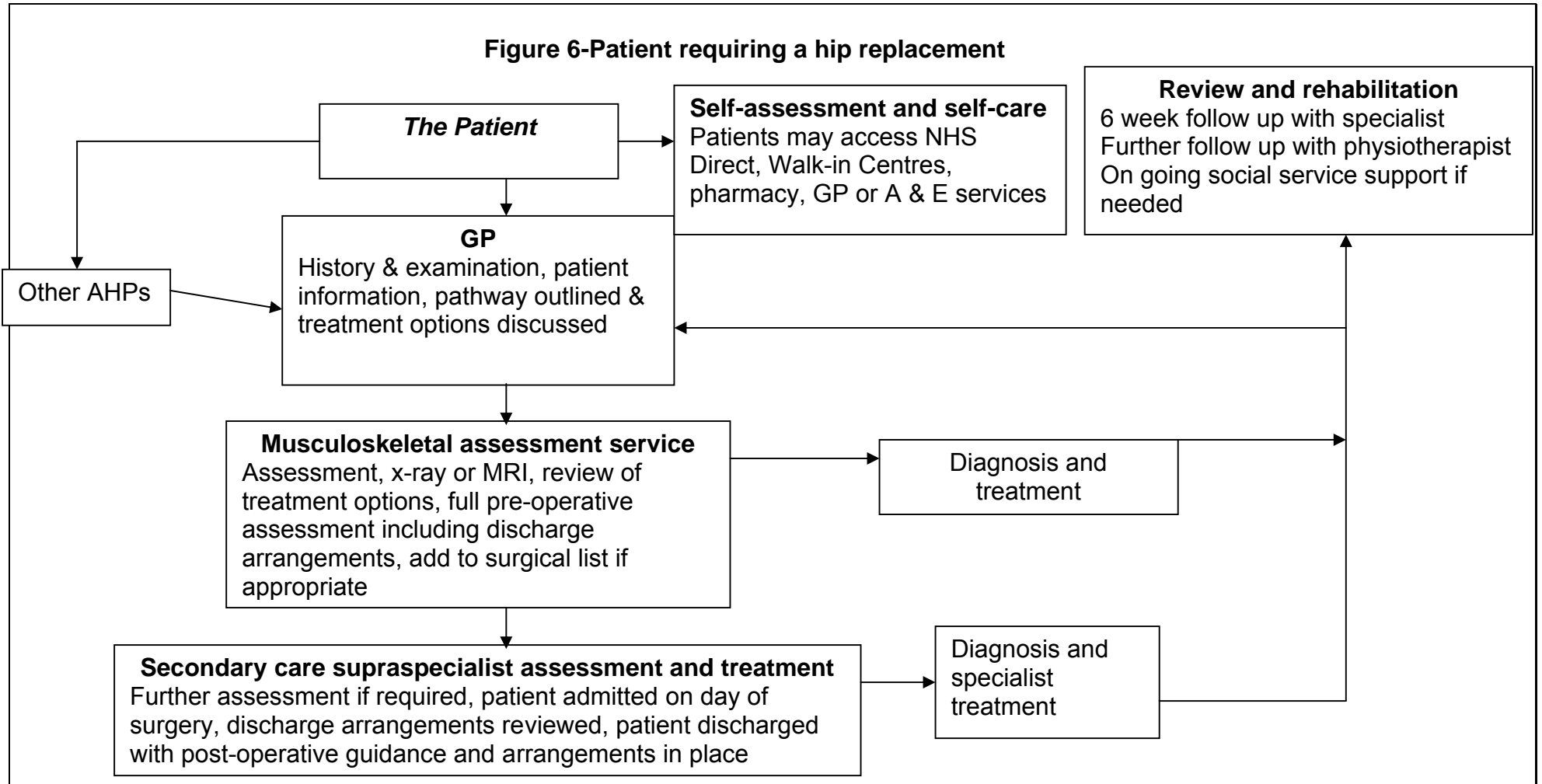
The proposed six major stages of the patient pathway underpinned by a set of principles are:

- Self-assessment and self-care – patients supported in their decision regarding their care with advice on symptoms and condition management
- Primary assessment and treatment – access to primary care supported by diagnostics and electronic referrals (Choose and Book)
- Specialist assessment and treatment – range of options for first stage of specialist assessment, preferably provided as one stop and delivered locally by a multi-disciplinary team
- Supraspecialist assessment and treatment – concentration of specialist treatment where there is clear evidence of benefits
- Review and rehabilitation – preparation of patients for discharge with a range of community services to provide ongoing therapeutic interventions and support

These stages of the patient pathway are not necessarily sequential. They will be underpinned by clear condition-specific pathways, high quality information for patients and effective systems of communication including integrated IT systems.

Figure 5 illustrates a model of integrated service delivery and figure 6 shows the model applied to a patient requiring a hip replacement.





iii) Promoting and supporting clinical leadership and multi-partnership working

Clinical leadership and multi-partnership working between, for example, primary and secondary care will be essential to ensure that new models of service delivery are based on evidence and working knowledge of patient pathways.

The PCT will promote and support clinicians in the development of patient pathways and will facilitate collaboration with partner organisations in the development of redesigned services. This will build on the positive and constructive relationships that have evolved through, for example, the Working Together for Health programme and will enable the development of robust commissioning pathways and service models.

Map of Medicine will be introduced to facilitate the introduction of new pathways of care and support effective clinical decision making by providing best practice information through a single website.

GPs as practice based commissioners will play a pivotal role in the commissioning of new services for planned care. PBC clinical leads will be involved in the development of new models of care delivery working closely with other clinicians and partners in provider services. This could be at PCT or locality level depending on the care pathways and new models being developed.

iv) Enabling choice and managing demand

• Demand management

The PCT will continue in developing and reviewing approaches to the management of demand for planned care services. This includes:

Insight referral management tool – continued use and development of this tool to ensure appropriate and systematic management and review of referrals in general practice

Advice and guidance – the Choose and Book system has an advice and guidance facility that enables GPs and other health care professionals to obtain specialist advice from consultants in secondary care prior to the referral of patients. This will help to increase the amount of primary care management and improve the appropriateness of referrals that are made to secondary care for a specialist opinion. The PCT will develop this function in collaboration with Heart of England FT.

Prior approval – continued audit of prior approval procedures and the development of new protocols. The PCT will work with clinical leads in primary and secondary care in taking this work forward.

Patient pathways – publicity and education and training for GPs and other health care professionals to ensure patients receive diagnostic tests and treatment at the right time and in the right place.

Successful demand management initiatives will require the involvement and ownership by clinicians in both primary and secondary care

v) Developing capacity to deliver new models of care

New models of care will require sustainable capacity to deliver effective services that are high quality, timely and produce the desired outcomes for patients. Capacity requirements for new models of care include:

- Sufficient workforce with the right skills to deliver the care and treatment required which will include the development of new roles where desirable
- Diagnostic capacity to deliver the required tests at the right time and in the right place. Where possible and cost-effective to do so diagnostic tests will be colocated with services in primary care
- Facilities to provide new services in primary care. This will include utilisation of current primary care facilities and ensuring plans for new buildings reflect the requirements for new models of care

The PCT takes an active approach to understanding the local market and developing plurality of provision. Additional capacity may be commissioned through current NHS providers or through the independent sector through PCT tendering processes. Where appropriate any willing provider will be encouraged to deliver services that will enable patient choice as well as the capacity needed to meet waiting times. The aim will be for commissioned services to deliver the quality of service required, represent value for money and be sustainable.

The significant changes planned over the next 5 years in the local profile of health services, for example, the decrease in outpatient activity will require a disinvestment strategy with affected providers to reflect the impact and success of proposed transitions of care.

12. Infrastructure requirements

There are three key work streams that are essential to building the infrastructure needed to enable the successful implementation of the planned care strategy. These are:

- **Workforce, education and training**

The strategy for planned care will have a significant impact on the local health community workforce. An integrated workforce strategy will be required to ensure that consideration is given to all the implications of service model changes across the health economy. The workforce strategy will be developed to ensure account is taken of the need for:

- increases in staff numbers and changes in skill mix
- redesigned roles
- appropriate education and training
- programmes of organisational development to support workforce changes

Account also needs to be taken of developments in the wider health system across the strategic health authority area and the implications of other commissioning strategies which may present opportunities for co-ordinated action on workforce issues.

- **Estates strategy**

The strategy for planned care will inform the PCT estates strategy and the plans for the development of new health centres and facilities and their functional requirements. It is important that this strategy is co-ordinated with the requirements of other commissioning strategies so that service requirements are clear.

- **IT**

The development of new models of care will require supportive IT systems that enable communication and the transfer of information between providers in a timely fashion. This strategy will interface with the Connecting for Health programme to develop the appropriate IT platforms needed to support patient pathways.

13. Financial profile

The PCT invests some £630m of taxpayers' money annually and investment is made with a range of providers with a significant amount being spent on planned care services. In 2008/09, the PCT is experiencing some pressure in its acute contracts particularly in elective care as we move closer to delivering 18 weeks.

The development of integrated, planned care services will result in a shift of secondary care outpatient, diagnostics and day case activity into community settings. Investment will be needed to expand the workforce and infrastructure in the community but it is anticipated that this will be funded through a reduction in outpatients with savings made that can be reinvested in other services. Some modelling has been undertaken showing the anticipated costs and savings from moving activity for urology, musculoskeletal and dermatology outpatient services into the community. See appendix 8

14. Outcomes

The expected outcomes from the implementation of the planned care strategy are set out in table 8 using the OSCAR framework.

Table 8 – Planned care strategy outcomes using the OSCAR framework
<p>Organisational</p> <ul style="list-style-type: none"> • Multidisciplinary working • Development of skills around assessment, diagnosis and treatment • Significant increase in capacity of community service • Integrated, seamless service – community and secondary care services • Promotion and enhancement of partnership working between primary and secondary care and the NHS, independent sector and voluntary sector
<p>Satisfaction</p> <ul style="list-style-type: none"> • Improved staff satisfaction – no delays for patients, partnership working, improved systems • Improved patient satisfaction – no waits, improved outcomes, more accessible services, better informed, more choice of services
<p>Clinical</p> <ul style="list-style-type: none"> • Improved clinical and health outcomes with patients receiving prompt assessment and diagnosis • Improved quality of life – condition treated earlier
<p>Activity</p> <ul style="list-style-type: none"> • Shift of activity from secondary to primary care - more outpatient, diagnostic and day case activity provided in community settings
<p>Resources – Financial or Economic</p> <ul style="list-style-type: none"> • Workforce – consultant sessions, GPs with specialist interests, nurse practitioners, allied health professionals and health care assistants • Education and training to develop skills • Organisational development and learning • Working in partnership with other organisations • Facilities – eg buildings, equipment, diagnostic facilities

14. Implementation

14.1 Structure for delivery

The PCT will have clear managerial and clinical leadership to implement the planned care strategy as well as robust project planning. A Planned Care Executive Group, chaired by the Darzi clinical lead, is being established to oversee and co-ordinate the implementation of the strategy. The group will develop an overall implementation plan with priorities for service development identified. This will inform the Local Delivery Plan for 2009/10.

The strategy group will have links with the practice based commissioning Locality groups and with other commissioning groups ensuring that service proposals are communicated and consulted on.

Patient and public involvement in the implementation of the strategy is critical to the development of services to ensure that they meet patient requirements. A patient involvement strategy will be developed setting out how patients will be engaged and their views sought in the implementation of the strategy and development of new services.

14.2 Action plan

A high level action plan for the implementation of the planned care strategy is set out in appendix 9. More detail with specific work programmes and time frames will be developed through the Planned Care Executive Group.

15. Consultation

Consultation with a range of stakeholders on this planned care strategy will take place including:

- Patient and public groups
- Localities
- Overview and scrutiny committee
- NHS providers
- Health care professionals
- Local strategic partnerships

The approaches, tools and techniques developed through PRIME will be used to obtain views and suggestions.

16. Conclusion

This strategy sets out a vision and framework for the future commissioning of planned care services that will deliver a no waiting experience for patients and sustainable models of care delivery with significantly more services provided in community settings. This will result in better choice for patients with more care delivered closer to where they live and will assist with tackling underlying health inequalities. It will also deliver services that are value for money, making better use of the resources available for healthcare.

The strategic approach of developing integrated models focussed on patient care pathways will build on and enhance existing clinical partnerships and ensure that services are deliverable and effective. Clinical leadership and practice based commissioning will be important vehicles in making the strategy a reality along with the qualities and competencies set out in World Class Commissioning particularly those of innovation and improvement, collaborating with clinicians, working with community partners and importantly engaging with the public and patients.

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Access to Imaging

Appendix 1 -Planned Care Strategy Full EIA Assessment:

1. Function assessors

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2. Function nature

Planned care refers to care provided to patients who require assessment, diagnosis & treatment on a planned as opposed to emergency basis. Patients can access planned care through a range of routes including NHS Direct, GPs, Dentists, Optometrists, out of hour's services & accident and emergency departments. Planned care can take place in a range of settings, including hospital, community settings and health centres.

The Planned Care Strategy has been developed to set out a five year commissioning strategy for planned care towards 2013. The strategy will be implemented by the Planned Care commissioning team within the Strategy & Redesign directorate of BEN PCT.

3. Function purpose

The strategy aims to provide patients with a choice of services that improve their experience of assessment, diagnosis and treatment based on personal, seamless, convenient, safe and reliable clinical services.

The principle objective of the strategy is to create a system for commissioning that is designed around patient pathways and the needs of the wider population. The strategic aims and objectives for planned care reflect the PCT aims which are:

- Tackling health inequalities
- Improving health
- Supporting self-care and wise choices
- No waiting for the care patients need
- Personalising care

The planned care strategies aims & objectives are informed and influenced by the following national & local health provisions:

- **NHS Plan 2000** – optimal outcomes for patients & more accessible services
- **18 weeks** no waiting care beyond this time frame
- **Delivering care closer to home** as set out in the White Paper *Our health, our care, our say* (January 2006b) & In *Delivering Care Closer to Home* (Department of Health 2008b)

- **Choose and Book** choice over were to receive treatment as identified by the Department of Health (2004)
- **Demand management** so that patients only receive interventions that are deemed effective in delivering the desired outcomes
- **Right Test, Right Time, Right Place: a Framework for primary care access** (RCR & RCGP 2006).
- **World Class Commissioning** where the PCT as a commissioner of planned health services ensures these demonstrate better outcomes for patients; adding life to years and years to life.
- **Standards for better health** quality care
- **NICE** evidenced based care
- **Birmingham East & North PCT Strategic Plan** (BEN PCT 2008a)
- **Birmingham East & North PCT Commissioning Strategy** (BEN PCT 2008b)
- **Birmingham East & North PCT Operating Plan** (BEN PCT 2008c)

4. Function activities

The strategy has been developed by the PCT lead commissioner for planned care services in consultation with the chief executive, chief operating officer, GP leads for planned care and other commissioners and with input from information, public health and finance leads.

The strategy will be approved through the PEC and PCT Board.

The development and improvement of planned care services is a priority for commissioners and is needed to ensure not only that patients receive their care and treatment within 18 week pathways but also that services are efficient and effective.

Planned care should be the right care at the right time and in the right place to meet the changing needs of the local population with services that represent value for money.

Planned care should fulfill five key expectations over the next five years:

- Developing supportive self-care and enabling choice
- Developing clinically integrated care models based on defined patient pathways
- Promoting and supporting clinical leadership and partnership working between primary and secondary care
- Managing demand
- Developing capacity to deliver new models of care.

The vast majority of planned care is undertaken by primary care services often beginning with a GP referral to a consultant in secondary care (e.g. hospital). Planned care may also have involvement from community services that provide a range of support, therapy and treatment for a wide variety of conditions.

5. Function beneficiaries

This strategy and its principles covers all planned care services commissioned on behalf of all adult patients resident and registered with a BEN PCT GP requiring services which fall into this strategy.

6. Function's planned impact

The PCT is committed and as a public body required by equality & human rights legislation to ensure the services it commissions and provides do not discriminate against people on the grounds of race, religion and belief, age, sexuality, disability and gender.

Equality, diversity and sustainability are embedded within this strategy. Indeed the strategy acknowledges that there are significant health inequalities across the PCT and recognises that in redirecting services to be provided in more appropriate settings, there may be the opportunity to reutilise potential savings to address health inequalities.

When commissioning services, the strategy recognises that acknowledging different people will have different needs:

- **Ethnicity** – the PCT will take into account, for example, that translation & interpretation services may be required for some patients to enable them to access services. That transient and newly arrived communities may experience difficulties accessing planned care.
- **Disability** – Accessible transport services will be provided for patients requiring transport. Sign language interpretation will be used when required.
- **Gender** – the strategy will ensure that services are commissioned and will be provided for both male and female patients. When commissioning services, for example community urological services, separate toilet facilities will be available for both male and female patients.
- **Belief** – the strategy will ensure that services will be commissioned and provided to take into account patient's beliefs and religious requirements. For example, despite commissioning care closer to home, patients will be able to choose to attend services provided in a variety of settings, including a secondary care setting if this is their preference.
- **Sexual orientation** – the strategy ensures that services will be commissioned regardless of sexual orientation.

7. Function's actual impact

7a. Engagement

Patients and public consultation through focus group exercises at “the Big Conversation” and stakeholder events held in each PCT locality revealed the following about planned care:

- The need for more GP appointments to be available and more extended hours
- Discharge from hospital – insufficient backup provided for patients
- Favoured joined up services rather than a proliferation of different initiatives.

- Widespread recognition of the problem of back pain. Felt that there were gaps in provision for non-surgical treatment of back and other chronic problems. Felt physiotherapy provision was inadequate
- Orthopaedic triage service – found it difficult to understand, felt it was complicating the process, standing in the way.
- Welcomed a broader range of services via their local health centre
- Introduction of new services – PCT needs to demonstrate that it is doing this in a coordinated way
- Need to ensure that those who need a service are made aware of how to access it in a timely manner

7b. Metrics / informatics

18 week performance (90% of admitted patient pathways and 95% of non-admitted patient pathways are delivered in 18 weeks by December 2008).

Choose & Book (90% of bookings to be through the Choose and Book system)

- An integrated approach to education of patients and public, maximising self care
- Best practice in Long-Term Conditions management
- Range of community 'at home' and flexible support
- Access to diagnostics
- Maximum efficiency and appropriateness in use of hospital beds
- Integrated workforce planning and development

7c. Research

National research on:

Day surgery: by all the Royal Colleges shows that it provides the best outcomes for patients in terms of recovery and makes better use of hospital resources, freeing up hospital beds. The Department of Health's *NHS Plan* (2000) set a target that 75% of elective admissions should be day cases. The Healthcare Commission (2005) however, found that take-up of day surgery in the UK is disappointing with levels of day surgery far lower than the expected target

Diagnostics: in the *Right Test, Right Time, Right Place: a Framework for Primary Care Access* (RCR and RCGP 2006) report identifies that a lack of access to diagnostic tests has created a bottleneck for patients and frustrations for GPs. Patients expect prompt and timely diagnoses and to do this requires the appropriate use of modern imaging techniques. It also needs close partnership between GPs and radiologists, both in determining the correct test and in ensuring that the results are correctly interpreted in the context of the individual patient

Providing services closer to home: The Audit Commission (2004) found that redesigned services in the community had shorter waiting times and could reduce costs as many patients would not need a hospital outpatient appointment. Redesign helps to ensure that patients are treated by the most appropriate healthcare professional in the most appropriate setting. PCTs should have commissioning strategies that ensure secondary care is used

appropriately and that investment goes into community alternatives to meet patient needs.

8. Function's actual impact evidence gaps

8a. Engagement gaps

A patient involvement strategy will be developed setting out how patients will be engaged & their views sought in the implementation of the strategy & development of new services.

Consultation with a range of stakeholders on this planned care strategy will take place including:

- Patient and public groups
- Localities
- Overview and scrutiny committee
- NHS providers
- Health care professionals
- Local strategic partnerships

8b. Metrics / informatic gaps

The planned care strategy will influence the need for collecting data on planned care services by diversity eg disabled or ethnic users of planned care. This will be collected by individual service and will be used when reviewing, redesigning and evaluating services.

8c. Research gaps

Throughout the life of the planned care strategy information will be continuously gathered & fed into the commissioning of future services.

9. Function's findings and recommendations

9a. Impact findings

The evidence considered in section seven (7) above suggests that the overall actual impact of the planned care strategy will be **positive** for patients from all backgrounds requiring planned care services. The strategy does not promote or breach equality, human rights or diversity requirements. The strategy explores the most appropriate settings for planned care services, and where identified, supports the transfer of care from secondary care into primary care settings. There remains however clear areas where improvements are required and these are identified in the recommendations below.

9b. Recommendations

To address findings and evidence gaps.

Rec1: Analysis of service use

Rec2: Research of effective models of care that address the diverse needs of the population served eg improve access

Rec3: Consultation with groups to identify need

Rec4: monitoring will be undertaken to explore the impact and utilisation of services more when delivered in a local, community setting.

10. Function monitoring and publication

10a. Monitoring

The senior management team of the directorate in which this function belongs will ensure that its findings and recommendations will be integrated into its programme of work.

BEN PCT through its Planned Care Executive Group (PCEG) will ensure any recommendations identified in this equality impact assessment are implemented leading to an overall improvement in planned care.

BEN PCT in its role as commissioner of local planned care provision will performance monitor all planned health care providers to ensure health care is delivered to best planned care standards including equality, diversity & human rights.

10b. Publication

The action plans from all completed EIA's will be compiled into one document and:

- (a) Used to annually upgrade the action plan section of the single equality scheme that is made available to the public via the PCT website & on request.
- (b) Entitled EIA outcomes and published on the PCT website & intranet.
- (c) Mentioned in PCT annual report.
- (d) The implementation of the strategy will be monitored through the Planned Care Executive Group (PCEG). Each development will be evaluated and will include the views and experience of patients, clinicians and other interested parties.

Version 3
Jenny Belza
11th Feb 09

Appendix 2 -The principles of sustainable development

Living within environmental limits.

Respecting the limits of the planet's environment, resources and biodiversity - to improve our environment and ensure that the natural resources needed for life are unimpaired and remain so for future generations; and

Ensuring a strong, healthy and just society.

Meeting the diverse needs of all people in existing and future communities, promoting personal well-being, social cohesion and inclusion, and creating equal opportunity for all.

An obvious implication of this definition is that the two goals are not - or, at least, should not be assumed to be - mutually exclusive but mutually reinforcing; that is, an environmentally sustainable community is also thought to be one that promotes personal well-being and strong social ties.

Achieving a Sustainable Economy

Strong and sustainable economic growth, providing prosperity and opportunity for all, where environmental and social costs fall on those who impose them. Therefore moving away from the traditional method of measuring economic growth through GDP, to one that includes environmental and social indicators.

Promoting Good Governance

Actively promoting effective participative systems of governance in all levels of society - engaging people's creativity, energy, and diversity: The democratic accountability and legitimacy.

Using Sound Science Responsibly

Ensuring policy is developed and implemented on the basis of strong scientific evidence, whilst taking into account scientific uncertainty (through the precautionary principle) as well as public attitudes and values.

Appendix 3- Prevalence estimates for common conditions*		
Condition	Specialty	Estimated numbers BEN PCT
Eczema -10% adults -15% school-age children	Dermatology	30,193 9,446
Back Pain - 8% age 25-44 - 33% men ≥65 - 25% women ≥65 <i>above are for <u>persistent pain</u></i> - 16% adults consult a GP	Musculoskeletal	9,226 9,422 10,090 48,309
Hips - 14% >60 yrs pain most days - 13.5/1,000 ≥55 need arthroplasty - Fracture risk 34.5% ≥70	Musculoskeletal	12,465 1,496 17,465
Knee Osteoarthritis - 25% of ≥55 – pain episode >4 weeks - 10% of ≥55 – disabling knee pain - 2.5% of ≥55 – severely disabling	Musculoskeletal	27,706 11,083 2,771
Glaucoma - 4.5% of ≥70	Ophthalmology	2,278
Cataracts - 21.6% of 65-74s - 67.3% of ≥85s	Ophthalmology	7,646 5,626
Hearing loss - 33% of >65s - 50% of >75s	Audiology	22,741 16,757
Benign prostatic hyperplasia - Diagnosed, 50% of >70s - Affects 30% 60-70s - Affects 90% >70s	Urology	9,946 5,527 17,902
Menorrhagia - 5% women 30-49 consult GP - Up to 30% women reproductive age	Gynaecology	3,055 24,502
Fibroids - 20% women reproductive age - 35% women overall	Gynaecology	16,335 58,986
*Based on national and international estimates		

Appendix 4 – Outpatient activity by provider 2004/05 – 2007/08

Trust Name	New OP 2004/05	F/UP OP 2004/05	New OP 2005/06	F/UP OP 2005/06	New OP 2006/07	F/UP OP 2006/07	New OP 2007/08	F/UP OP 2007/08
BIRMINGHAM CHILDREN'S HOSPITAL NHS TRUST	1740	5960	1276	5037	3075	7473	3375	9179
BIRMINGHAM WOMEN'S HEALTH CARE NHS TRUST	801	2656	982	3460	1608	4729	1495	2700
DUDLEY GROUP OF HOSPITALS NHS TRUST	57	631	56	612	78	492	85	441
GEORGE ELIOT HOSPITAL NHS TRUST	10	48	8	43	16	65	15	68
GOOD HOPE HOSPITAL NHS TRUST	33789	83292	46055	96376	49915	113111		
HEART OF ENGLAND NHS FOUNDATION TRUST	55490	86627	60558	96478	58536	102626	113524	188218
ROYAL ORTHOPAEDIC HOSPITAL NHS TRUST	921	3076	2133	7011	2269	7153	2164	7129
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	11614	36330	12997	39450	10240	35997	10112	31167
THE ROYAL WOLVERHAMPTON HOSPITALS NHS TRUST	61	143	73	235	74	177	79	172
UNIVERSITY HOSPITAL BIRMINGHAM NHS FOUNDATION TRUST	2520	14715	2479	14546	3142	15227	2869	14201
UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	117	117	102	178	182	210	167	335
WALSALL HOSPITALS NHS TRUST	290	1021	398	1176	468	1337	575	1334
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	18	73	53	114	82	128	53	73
Grand Total	107428	234689	127170	264716	129685	288725	134513	255017

HeFT &
GHH merged

Heart of England by hospital site

Year	New OP Good Hope	New OP Heartlands	F/UP OP Good Hope	F/UP OP Heartlands
2004/05	33789	55490	83292	86627
2005/06	46055	60558	96376	96478
2006/07	49915	58536	113111	102626
2007/08		113524		188218

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Appendix 5 – BEN PCT Secondary care activity and cost by provider

Trust Name	New OP	Follow UP OP	Total OP	IP	OP Cost	IP Cost	Total Cost
BIRMINGHAM CHILDREN'S HOSPITAL NHS TRUST	3375	9179	12554	908	£1,172,734	£1,268,983	£2,441,717
BIRMINGHAM WOMEN'S HEALTH CARE NHS TRUST	1495	2700	4195	146	£431,818	£174,618	£606,436
DUDLEY GROUP OF HOSPITALS NHS TRUST	85	441	526	54	£24,654	£47,202	£71,856
GEORGE ELIOT HOSPITAL NHS TRUST	15	68	83	11	£7,378	£11,497	£18,875
GOOD HOPE HOSPITAL NHS TRUST							£0
HEART OF ENGLAND NHS FOUNDATION TRUST	113524	188218	301742	29198	£29,509,026	£29,345,171	£58,854,197
ROYAL ORTHOPAEDIC HOSPITAL NHS TRUST	2164	7129	9293	1749	£914,171	£4,061,130	£4,975,300
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	10112	31167	41279	4203	£3,388,540	£4,301,733	£7,690,273
THE ROYAL WOLVERHAMPTON HOSPITALS NHS TRUST	79	172	251	20	£20,243	£32,701	£52,943
UNIVERSITY HOSPITAL BIRMINGHAM NHS FOUNDATION TRUST	2869	14201	17070	2054	£1,237,423	£2,755,440	£3,992,863
UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	167	335	502	60	£52,566	£92,854	£145,420
WALSALL HOSPITALS NHS TRUST	575	1334	1909	253	£189,266	£336,197	£525,463
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	53	73	126	7	£12,889	£11,780	£24,669
Grand Total	134513	255017	389530	38663	£36,960,707	£42,439,305	£79,400,011

Appendix 6 – Contracts with the independent sector of significant value for planned care services

Provider	Value of activity in 07/08
Aston Academy of Life Sciences (cataracts)	145,611
Spire (formerly BUPA) Hospitals (range of procedures)	534,014
Midland Eye Institute (cataracts)	42,757

Appendix 7– list of Prior Approval procedures
No routine procedures for the following:
Tonsillectomy
Grommets
Plastic surgery to breast (not cancer) and abdomen
Diagnostic arthroscopy
Hysterectomy for menorrhagia
Cosmetic lumps and bumps
No outpatient follow up for hernia repair, cholecystectomy, excision of lumps and bumps, haemorrhoidectomy, minor skin procedures

Appendix 8- Summarised Savings / Costs of Moving Activity from Acute setting to Community Setting

Urology	Year 1		Year 2		Year 3	
	Activity	Cost	Activity	Cost	Activity	Cost
Saving through Diversion	0	0.00	4,799	523,691.02	8,398	916,459.28
Cost of Community Provision		0.00		(276,511.73)		(348,320.98)
Total		0.00		247,179.29		568,138.30

Musculoskeletal	Year 1		Year 2		Year 3	
	Activity	Cost	Activity	Cost	Activity	Cost
Saving through Diversion	3,488	366,714.47	23,253	2,444,763.14	37,204	3,911,621.02
Cost of Community Provision		(252,925.70)		(1,011,702.79)		(1,011,702.79)
Total		113,788.77		1,433,060.34		2,899,918.22

Dermatology	Year 1		Year 2		Year 3	
	Activity	Cost	Activity	Cost	Activity	Cost
Saving through Diversion	5,868	376,928.21	14,277	917,100.27	14,277	917,100.27
Cost of Community Provision		(376,928.21)		(917,100.27)		(917,100.27)
Total		0.00		0.00		0.00

Appendix 9 – Planned care strategy action plan			
Workstream	Action	Time scale	Lead
Governance	<ul style="list-style-type: none"> Establish PCEG Agree membership Develop work programme and agree leads Develop a communication plan 	Jan 09 Jan 09 Feb 09 Feb 09	Jenny Belza (JB) Pete Thebridge (PT) Paramjit Moonga (PM)
i) Supportive self-care	<ul style="list-style-type: none"> Roll out patient passport following pilot Continue implementation of choose and book Review results of publicity campaign for choice, booking and 18 weeks Review use of new patient information website Develop a communication strategy 	Nov 08 Ongoing Jan 09 Jan 09 Jan 09	JB JB JB JB JB
ii) Integrated models	Continue development and pilots for the following integrated service models: <ul style="list-style-type: none"> Integrated musculoskeletal service Community office urology service Community dermatology service Audiology telephone follow-up service Scope other planned care areas for redesign and develop work programme	Pilot commencing from Jan 09 Full implementation from 2009 to 2011 Pilot commences Jan 09 6 month pilot commenced Oct 08 Develop model Feb 09 Pilot April 09 Jan- Mar 09	JB/PM JB/PM JB JB PT/PM/JB
iii) Clinical leadership and partnership working	Identify clinical leads for each work programme	Jan 09	PT/JB/PM

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iv) Managing demand	Promote, support and review use of Insight	Ongoing	JB/PM
	Develop education and training strategy for GPs	January 09	JB/PM/PT
	Implement Map of Medicine	Roll out from January 09	PT/PM/JB
v) Capacity	Develop a diagnostics strategy	Jan –Mar 09	JB/PT/PM
	Develop a workforce strategy	June 09	JB
	Review community facilities requirements and ensure planned new builds reflect future requirements for planned care	Dec 08 and ongoing	JB
	Set out plan for disinvestment to reflect planned shifts/changes in activity	Feb 09 and ongoing	JB
	Identify areas for market stimulation	Feb 09 and ongoing	JB