ITEM: 9

MEETING:
Trust Board – 19 July 2006

TITLE: **Demand Management of Whittington Hospital Activity by Local PCTs**

SUMMARY:
The purpose of this paper is to inform the Trust Board of the work currently underway in primary care around demand management, and to give some consideration to the in year impact this is likely to have on the Trust's activity and core business.

ACTION: **For Information**

REPORT FROM: **Kate Slemeck – Director of Operations**

SPONSORED BY: **David Sloman – Chief Executive**

Financial details supplied/checked by: N/A
(Name of finance officer)

Recommendations contained within this paper have been checked for compliance with relevant statute and regulations/directions/policy as follows:

(Relevant law/direction etc.)
(Name)

None applicable

Demand Management of Whittington Hospital Activity by Local Primary Care Trusts

1. Introduction

Demand (or referral) management, is a National Policy initiative that is intended to both drive the desired shift of activity away from secondary into primary care, and reduce levels of unnecessary secondary care activity. Integral to the service redesign that will be required to deliver this change in activity flows is the expectation that patients will receive the most appropriate care in a suitable clinical setting, in a manner that utilises resources effectively.

Primary Care Trusts are tasked with developing and leading demand management programmes, however the success of their delivery is seen as the responsibility of the whole health community, including acute service providers.

The demand management process in London is being driven at Strategic Health Authority (SHA) level, and plans are being peer reviewed to ensure that they are robust, and have the support of GP Commissioners and Hospital Clinicians. Demand management plans developed by PCTs for implementation in 2006/7 have now been submitted in final draft form to the SHA. These plans are currently being assessed against key criteria and will be the subject of robust performance management against locally agreed targets.

The purpose of this paper is to provide information on the demand management schemes currently being developed locally and to give some initial consideration the impact these will have on the Whittington's activity levels, flows, and core business. Consideration will be given in this paper to the likely short-term (in year) impact of these schemes, and how this will be monitored and assessed during the year.

2. Local Plans and their Impact on Activity at the Whittington

Islington PCT and Haringey PCT have developed separate demand management plans for their organisations, which are at differing stages of development. Within each overall plan some schemes are more developed then others. Each PCT has also taken a different stance on the likely 2006/7 impact of their demand management schemes. Whilst Islington PCT have taken a more conservative approach, predicting that the demand management impact will be to contain growth within 2005/6 activity outturn, Haringey have made a more bold assumption that their schemes will not only contain any expected in year growth in activity but also reduce 2006/7 activity to below the 2005/6 activity outturn.

Both PCTs intend to reduce secondary care activity during the year in the following areas:

- Outpatients (New and Follow up)
- GP to hospital referrals
- Consultant to Consultant Referrals
- Emergency Department attendances
- Non elective (emergency) admissions

They plan to achieve this by either putting a stop to certain elements of current activity or by shifting activity from secondary into primary care.

3. A Brief Summary of Local Demand Management Schemes and their Projected Impact on Trust Activity

This section of the report is intended to provide an initial overview of the schemes being developed and implemented locally by Islington and Haringey PCTs who are the two significant Commissioners of activity from the Whittington.

There is a table of information for each activity currency, namely Outpatients, Admissions (emergency and elective), and Emergency Department Attendances. Each scheme is listed showing the activity and financial reduction that has been projected by the PCTs, and where it is possible to do so, the planned activity reduction has been compared against the full year activity undertaken for that service area in 2005/6, and expressed as a percentage reduction.

Whilst Islington PCTs activity and financial projections are profiled to reflect the likely impact during 2006/7, Haringey PCTs assumptions represent the full year effect of all schemes being in place from 1st April (which is not the case for a number listed) and therefore the likely impact in 2006/7 is overstated.

3.1 Demand Management Schemes that will Impact Upon Outpatient Activity

GP practices are being offered incentive payments to reduce referrals to outpatient services. At the same time GP practice referral trends are being reviewed at GP commissioning group level. GPs will seek to reduce outpatient referrals by creating new services in primary care settings, and by following up their own patients in their practice. The range of schemes and services being considered by Islington and Haringey PCTs are outlined in table 3.1.1 and 3.1.2.

3.1.1 Like for Like Schemes

PCT	Scheme	Activity	£	2005/6 Outturn	% Reduction	Note
HTPCT	Dermatology	2,000	160,000	2,767	138%	1
IPCT	Dermatology	568	20,580	4,000	14%	2
HTPCT	Diabetes	533	79,950	1,749	30%	3
IPCT	Diabetes	60	6,560	2,658	2%	4
HTPCT	Musculo-skeletal Triage	830	140,000	10,006	8%	5
IPCT	Musculo-skeletal Triage	1,053	123,000	14,215	7%	6
HTPCT	Inter trust referrals	400	40,000	N/A	N/A	7
IPCT	Inter trust referrals	52	7,413	N/A	N/A	8
HTPCT	Anticoagulation	2,960	233,840	N/A	N/A	9
IPCT	Anticoagulation	234	63,000	N/A	N/A	10
Total		**8,690**	**874,343**			

Notes:
Dermatology

1. HTPCT have four GPs with a Special Interest in dermatology and are planning to appoint a specialist nurse. Plan to reduce activity by triaging all referrals and providing education to GPs. Haringey's activity assumptions are flawed as they are planning to remove 138% of activity undertaken on 2005/6.
2. IPCT have invited 'expression of interest' from local NHS and private sector providers to deliver community based dermatology triage and service provision. The Whittington has submitted an expression of interest to the PCT. It is anticipated that there will be a 20% reduction in secondary care dermatology activity.

Diabetes

3. HTPCT expectation that uncomplicated Type 2 patient will be repatriated back into primary care to be managed by their GPs. Practices expected to write to identified patients to advise them of the change.
4. IPCT anticipating a similar shift in activity, but still to discuss and agree 'process' for reducing uncomplicated Type 2 follow up.

Musculo-skeletal Triage

5&6 PCT triage of all primary care Musculo-skeletal referrals – which will impact upon orthopaedic and Rheumatology activity. Community based extended scope practitioners will see patients – it is anticipated that this could reduce secondary care referrals by 20 - 50%.

Inter- Trust Referrals

7. HTPCT following Strategic Health Authority guidance on this issue being followed. All Consultant to Consultant or ED to consultant referrals must be approved by the Consultant. If the condition can be managed in primary care then it should be referred back to the GP.
8. IPCT plans to reduce the numbers of Consultant to consultant referrals in specialities where referrals are high through the SLA monitoring process.

Anticoagulation**

9. HTPCT planning to set up eight outreach clinics to reduce the demand on hospital from patients on anti-coagulation who require blood test control. Secondary Care expertise and support to be funded.
10. IPCT developing a similar scheme but are at a less advanced stage.
    *** At present the service at the Whittington is not funded as activity is not recorded on PAS and therefore is not charged under PbR.*

3.1.2 PCT Specific Schemes

PCT	Scheme	Activity	£	2005/6 Outturn	% Reduction	Note
HTPCT	Gynaecology	296	39,960	6,390	5%	11
HTPCT	Post Surgical FUps	513	40,014	N/A	N/A	12
HTPCT	Regular OPD Attenders	385	40,040	N/A	N/A	13
IPCT	PBC Incentive Scheme	2,898	558,900	N/A	N/A	14
IPCT	Paeds Asthma & Excema	125	13,860	5,673	2%	15
IPCT	COPD	25	3,360	N/A	N/A	16
Total		**4,242**	**696,134**			

Notes:
Gynaecology

11. HTPCT is designing a Gynae triage service, which will involve referral protocols being developed and agreed.

Post Surgical Follow Ups

12. HTPCT intends to reduce surgical follow up appointments in secondary care in discussion with secondary care clinicians.

Regular OPD Attenders

13. Each practice in HTPCT being asked to identify between 10 and 20 regular outpatient appointments suitable for repatriation back to practices. Examples include longstanding patients at hypertension or lipid clinics.

Practice Based Commissioning Incentive scheme

14. IPCT GPs are being 'incentivised' to reduce follow up rates below an adjusted annual rate. Practices with a rate below the national average are expected to reduce their baseline by 5%.

Paediatric Asthma and Eczema

15. Primary care based nurse led eczema service being set up with the capacity to see 160 new and 80 follow up patients a year. Community nurse led management of children and young people with Asthma targeting frequent users of acute care.

Chronic Obstructive Pulmonary Disease

16. Primary care case management of COPD patients by Community Matron, COPD Nurse Specialist and Physiotherapy specialist.

3.2 Demand Management Schemes that will Impact Upon Inpatient (Non Elective and Elective) Activity

Both Islington and Haringey PCTs have invested in a range of schemes, which focus upon specific conditions such as COPD, diabetes, heart failure care of the elderly and stroke as areas where there are high numbers of hospital attendances and admissions, but considered to be 'ambulatory care sensitive', meaning the admissions may be preventable through improved and targeted primary care provision.

PCT	Scheme	Activity	£	2005/6 Outturn	% Reduction	Note
HTPCT	Various	257	380,000	N/A	N/A	17
IPCT	Various	505	789,244	N/A	N/A	18
Total		**762**	**1,169,244**			

Notes:

17. A summary of HTPCT schemes that will impact upon admissions is as follows:

COPD

Community based respiratory team providing intensive home support services for patients with moderate to severe COPD. Aim to reduce exacerbations of the condition that would lead to hospital admission.
Impact at the Whittington may be limited by the fact that a community support service is provided by the Trust.

Heart Failure

Heart failure nurse led team working across the borough and identifying potential heart failure patients, facilitating early diagnosis and treatment and preventing exacerbations, and avoiding admissions through case management.

Care of the Elderly

Creation of four community matrons for older people to work with 'at risk' caseload who have a history of frequent admissions to hospital.

18. A summary of IPCT schemes that will impact upon admissions is as follows:

Care of the Elderly

- Appointment of a Community Geriatrician to work alongside the community rehabilitation team, with capacity to see 18 patients per week. Plan to focus on 'at risk' older people who have a history of frequent admissions to hospital.
- 'Twilight' nursing services will also strengthen out of hours support to vulnerable people.
- The number of 'intermediate care' beds will also be reviewed – with plans to ring fence 2 beds and resource those to be able to admit patients directly from the community at the GP or District nurses request.
- Plan to identify 30-40 people at risk of falling and link into falls prevention services and programmes.

COPD

Expand specialist community team and extend pulmonary rehabilitation.

Heart Failure

Expand heart failure nurse led team. Case-find patients at risk of admission and support them in managing their condition more effectively.

3.3 Demand Management Schemes that will Impact Upon Emergency Department Attendances

During 2005/6 ED attendances increased by 8% over and above 2004/5 attendance levels. ED activity is commissioned and funded by IPCT in their role of host Commissioner. Islington PCT has established a planning group for demand managing ED activity, and as part of this plan wish to discuss the

future configuration of phase 2 of the Walk in centre, as there is concern that provision of a WIC will drive ED activity up further.

PCT	Scheme	Activity	£	2005/6 Outturn	% Reduction	Note
IPCT	Walk in Alternative	3,722	213,000	N/A	N/A	19
IPCT	Out of Hours	52	3,692	N/A	N/A	20
IPCT	Alcohol Support	285	20,200	N/A	N/A	21
IPCT	Sickle Cell	366	26,000	N/A	N/A	22
IPCT	Various	57	2,413	N/A	N/A	23
Total		**4,482**	**265,305**	**85,000**	**5%**	

Notes:
Walk in Alternative

19. IPCT is currently reviewing the options for delivering care to the proportion of ED activity (approx 53%) that is considered to be ‘minor injuries’ and suitable for management by a WIC facility. 26% of this group could be managed in primary care and IPCT are proposing a service model that would involve triaging all patients on arrival at ED and re-directing those suitable for primary care management.

Out of Hours

20. IPCT is reviewing out of hour provision to reduce attendance upon ED/WIC. To include offering GPs financial incentives to extend surgery hours.

Alcohol Support

21. Recognising that a high proportion of ED service users attend with alcohol related problems, IPCT plan to recruit an alcohol worker to work with the ED department and to provide follow up in the community. It is assumed that for every 2 patients see by the Alcohol worker there will be one less subsequent ED attendance.

Sickle Cell

22. IPCT reviewing current service provision to reduce unplanned ED attendances and admissions. Planning to develop a community based case management approach. IPCT are working with secondary care clinicians to develop options.

Various

23. IPCT anticipates that the work of the community matrons with older people, heart failure, COPD and Children will reduce ED Attendances.

4. Other Issues for Consideration

1.1 Secondary Care Support for Proposed schemes

Many of the schemes listed and described above are at an early stage of development, and will require support and leadership from secondary care clinicians to assure their success. Active involvement of some of our clinicians is already being requested and negotiated to both support and deliver the muscular-skeletal triage service, dermatology, anticoagulation, and sickle cell

schemes. The Trust needs to give careful consideration to how this 'expert' time is re-charged, particularly as there will be a requisite loss of income aligned to the successful delivery of each scheme.

1.2 Measuring and Reporting Activity Changes

It is important both to the Trust and the PCTs that the impact of the demand management schemes on Trust activity is closely monitored. The PCTs require success to deliver financial balance, whereas the financial position of the Trust will be adversely affected if activity and the associated income that comes with that activity reduces significantly in year.

Activity levels in the key areas to be affected are being measured and benchmarked in order that changes in GP referrals and activity flows can be highlighted at an early stage. Monthly reports will be provided to the Hospital Management Board on the impact of demand management in order to support decisions about capacity management.
The PCTs will also be developing reports to demonstrate the impact of the schemes on activity and finance and these will be shared with the Trust.

2. In Summary

The main purpose of this paper is to highlight the work currently underway in primary care around demand management, and to give some consideration to the in year impact this is likely to have on the Trust.

It is recognised that the schemes being proposed are at an early stage of development, and many are reliant upon the availability of secondary care expertise and engagement, which needs to be costed. It is anticipated that these schemes will have an impact upon Trust activity during 2006/7, and whilst the Trust needs to work closely with the PCTs and remain engaged in the delivery of these programmes, serious consideration will need to be given to how Trust available capacity might be re-aligned to minimise potential activity and income loss.