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**Payment by Results and Demand  
Management: Learning from the  
South Yorkshire Laboratory**

**CHE Research Paper 14**



# **Payment by results and demand management: learning from the South Yorkshire laboratory**

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## Executive Summary

### Introduction

1. The need for effective demand management has become more transparent following the introduction of Payment by Results, Patient Choice and other reforms.
2. This report details the findings of an empirical study exploring the South Yorkshire experience of demand management. By being ahead of the game in introducing PbR for all activity in all its acute trusts in the South Yorkshire area, the experience in South Yorkshire has the potential to inform the national roll-out of Payment by Results and Choose and Book.

### Aims and objectives

3. Specific objectives included:
  - assessing local perceptions of the nature and scale of changes in demand and whether this will be affected as other reforms, specifically Patient Choice, are implemented;
  - identifying what strategies are being developed locally to manage demand effectively;
  - documenting any benefits and drawbacks of different strategies for patients, PCTs, providers and the wider health economy;
  - identifying any facilitators and barriers to developing effective approaches for managing demand;
  - eliciting opinions on how current demand management strategies could be improved or adapted.

### Methods

4. Data collection comprised two main elements:
  - *In depth semi- structured interviews with a sample of key stakeholders.* Those interviewed included: GPs and staff working in PCTs, provider organisations and the Strategic Health Authority. A total of 18 interviews were undertaken between late August 2005 and mid October 2005.
  - *A review of relevant background statistics and documentation related to PbR and demand management strategies in South Yorkshire.*
  - It should be noted that many of our findings are based on the perceptions and subjective experience of key individuals and thus open to bias and rival interpretation. In order to improve the validity of the study, where possible we cross-referenced accounts between individuals and triangulated the evidence emanating from different data sources.

### Findings

5. *Elective demand in South Yorkshire:* there has been a recent rise in acute elective activity in South Yorkshire including a marked increase in consultant to consultant referrals. We elicited a range of possible reasons for this including: pent-up latent demand because of lower waiting times; providers adjusting admission and discharge decisions in response to tariff incentives; and GPs inflating referral rates in the base year of Practice Based Commissioning. These require further research and investigation.
6. *Non-elective demand in South Yorkshire.* South Yorkshire also witnessed a growth in non elective activity in line with national trends. We gathered a range of potential explanations for this including: local demographic factors and lifestyle changes; A&E waiting time targets; the increased inaccessibility of primary care services and difficulties in accessing same-day diagnostic tests in the community. Again, these require more detailed research and investigation.
7. *Demand management in South Yorkshire:* No overall strategy has been put in place in South Yorkshire to address demand pressures. Instead a wide range of locality

specific initiatives has emerged. The majority of initiatives are recently introduced and have yet to be fully evaluated. There is evidence of ongoing monitoring of the effectiveness of these initiatives, of re-configuration of the service to improve effectiveness, and of sharing of experience across the SHA.

Demand management activity in South Yorkshire can be classified under three broad headings:

*i) Information systems proactively to monitor demand and detect variances*

- Analysis of hospital activity data.
- Analysis of GP referral patterns.
- Targeting of high risk individuals.

*ii) Actively managing demand*

- Triage referrals.
- Practice Based Commissioning.
- Pathway protocols for chronic disease management
- Appointing PCT staff to undertake assessments in A&E departments.
- Care pathway evaluation and review (eg Orthopaedics).
- Community matrons and geriatricians.
- Admission and discharge criteria (eg InterQual).

*iii) Establishing a range of alternatives to hospital*

- Use of independent sector treatment centres
- NHS walk in centres.
- A range of intermediate care provision.

8. *Provider behaviour and demand.* Commissioners and providers believed that there were joint benefits from mutual co-operation. However, the new financial system was causing tensions in commissioner – provider relations. Many of these centre around perceptions of “supplier induced demand” and information imperfections, particularly clinical coding.

## **Policy and research implications**

9. The following research and policy implications have emerged from the study:
- *The need to monitor increases in demand.* Key areas to monitor include: lower thresholds for emergency admissions; increases in consultant-to-consultant referrals; increases in the intensity of treatment; whether ‘upcoding’ is occurring; whether the short-stay tariff encourages providers to keep patients for more than 48 hours; whether patients are being discharged earlier than is appropriate; whether outlier payments influence discharge behaviour around the upper length of stay tripoint.
  - *The need to identify and control demand drivers.* To develop proportionate counter measures to unplanned increases in demand it is necessary to identify what behaviours and factors are likely to lead to demand pressures in the future.
  - *The need to strengthen the evidence base.* By synthesising and disseminating the emerging evidence on the cost-effectiveness of different demand management strategies; benchmarking and sharing good practice across PCT and SHA areas; and undertaking evaluations of existing demand management initiatives.

## 1. Introduction, aims and methods

### 1.1 Policy context

The NHS in England is in the midst of an ambitious attempt to introduce market mechanisms into a publicly funded health care system. Payment by Results (PbR) is a key driver of system reform and represents a considerable financial management and behavioural change agenda for commissioners and providers alike. Under the PbR financial regime, providers are offered high-powered incentives to improve productivity and increase their activity. These incentives, along with expanded provider *capacity* (achieved through investment in NHS and independent sector services) and reduced controls on provider activity (as NHS providers move to Foundation Trust status or more work is undertaken the independent sector), combine to increase dramatically the importance of managing patient demand.

Economic theory and experience from other countries with similar funding models suggests that under a fixed tariff system, there are at least two reasons why demand management is required:

- as a form of cost control to protect commissioner budgets;
- to ensure that levels of activity match commissioner requirements.

South Yorkshire Strategic Health Authority (SYSHA) is piloting full implementation of Payment by Results (PbR) ahead of the national timetable to all acute Trusts in the region. Notwithstanding any idiosyncrasies in the South Yorkshire health economy (see Appendix 1) and the implications this has for generalisability of findings to other regions, it is pertinent to ask - what can be learned from the South Yorkshire experiment? As demand management is a key mechanism for managing risk, this area of policy is a useful lens to examine how behaviour and financial incentives play out at the local level.

This report details the aims, methods, findings and policy implications of a Department of Health funded study which gathered evidence to assess early experience of demand management in South Yorkshire. It is organised as follows. The rest of Section One sets out the aims and objectives of the study and details the methods used. The next three sections present the empirical findings. Section Two explores the drivers of demand in South Yorkshire and discusses how these will be affected by Patient Choice. Section Three outlines key issues around the role and effectiveness of demand management strategies in South Yorkshire. Section Four explores provider behaviour and incentives to increase levels of activity. Section Five concludes with an examination of the policy implications of the study and a look forward at the emerging research agenda.

### 1.2 Aims of the study

The overall aim of the study was to explore the range of strategies in place in South Yorkshire to limit, manage and redirect patient demand for secondary care services. Specific objectives included:

- Assessing local perceptions of the nature and scale of changes in demand and whether this will be affected as other reforms, specifically Patient Choice, are implemented.
- Identifying what strategies are being developed locally to manage demand effectively.
- Documenting any benefits and drawbacks of different strategies for patients, PCTs, providers and the wider health economy.
- Identifying any facilitators and barriers to developing effective approaches for managing demand.
- Eliciting opinions on how current demand management strategies could be improved or adapted.
- To make recommendations as to what additional mechanisms might be considered.

### 1.3 Methods

Data collection comprised two main elements:

(1) *In depth semi- structured interviews with a sample of key stakeholders.* The sample was selected following discussions with SYSHA and via 'snowball' contacts once the project commenced. A total of 18 interviews were undertaken between late August 2005 and mid October 2005. The interviews were audio taped and prior to analysis were transcribed fully. Those interviewed included:

- PCT staff with an interest and experience in managing patient demand (including Chief Executives, Contracting and Service Development Managers and Finance Directors)
- Provider staff (including Finance Directors and Service Development Managers)
- SYSHA staff with an interest in performance management and demand management.
- General Practitioners.

(2) *A review of relevant background statistics and documentation related to PbR and demand management strategies in South Yorkshire.*

The evidence from both these sources was combined to build a rich picture of demand management initiatives in South Yorkshire. It should be noted that many of our findings are based on the perceptions and subjective experience of key individuals and thus open to bias and rival interpretation. In order to improve the validity of the study, where possible we cross-referenced accounts between individuals and triangulated the evidence emanating from different data sources. The various sources of data were audited in order to search for evidence that appeared to contradict the emerging analysis. A draft of the emerging themes and evidence was presented at a meeting of key stakeholders (including some of those interviewed in the study). This provided an opportunity to discuss alternative interpretations of the evidence as well as serving to highlight overlaps, gaps and areas for further investigation. Given the sensitive nature of some of the material, we have sought to protect the anonymity of individuals and their organisations. Quotes are attributed only as far as necessary for interpretation, whilst still protecting anonymity.

## 2. Demand in South Yorkshire

### 2.1 Policy context

It should be noted that increasing patient demand and provider activity is not undesirable. Indeed, many aspects of the system reform programme are designed to make NHS services more productive. For example a key objective is the need to increase elective activity to deliver the target of a 18 week maximum waiting time for a complete course of treatment by 2008-09. The key issue to examine is whether demand pressures and increased activity are efficient and affordable given budget allocations in the context of local priorities. It is therefore important to identify what behaviours and factors drive demand and to distinguish between appropriate growth in activity and excessive growth, which might be indicative of supplier-induced demand.

### 2.2 General and acute elective referrals/activity

Across South Yorkshire over the last three years there has been a year on year increase in general and acute elective activity amounting to 4.5% in 2004/05 over 2003/04 activity. The rate of growth differed by PCT area, with increases of 10% and 8.3% in two PCTs, but a reduction (-1.2%) in another, albeit following an increase (4.3%) in the previous year.

Elective referrals among the PCTs in one area to the main teaching hospital increased in four out of the last five years. The last 12 months show a particularly sharp increase in this type of referral. For example, compared with the same period in 2004, the first quarter data for 2005 show a dramatic increase in referrals for high volume/cost specialities, including ENT (13%), general surgery (6.3%) and gynaecology (24%). There was a marked increase in 'other referrals' (including "consultant-to-consultant" referrals) across the region. First quarter data for 2005 show increases of 25% in one community and 10% in another.

### 2.3 Proffered explanations for increase in elective care activity

Interviewees offered a number of explanations as to why elective care activity may have increased across certain areas and specialities:

- *Financial incentives*: hospitals and clinicians seeking ways to increase activity because of the financial incentives attached to the tariff. For example, Trusts may be keeping patients in hospital for more than 48 hours in order to gain the full tariff amount for activity that would otherwise be paid under the short-stay tariff.
- *Latent demand*: demand that had been suppressed because of long waiting lists.
- *Defensive medicine*: a more litigious culture was growing which encouraged clinicians to 'play safe' and refer patients to other clinicians for a second opinion and/or further diagnostic tests.
- *Practice Based Commissioning*: GPs may be increasing their referral rates in the mistaken belief that this will secure them larger practice based commissioning budgets.
- *Targeted health education*: may have been effective in raising health awareness issues, particularly in areas of high deprivation where groups with traditionally low presenting rates have seen the largest increase.
- *Clinical networks*: In some areas relationships between GPs and consultants are perceived to be better than those between PCTs and GPs. Therefore 'tight' clinical networks may undermine attempts by PCTs to reduce GP referrals to secondary care.
- *Inadequate controls*: primary care gatekeepers lack 'real time' information to monitor, control and query hospital activity.
- *Clinical sub-specialisation*: new regulations require some specialities to complete a minimum number of cases per year (eg Calman Hine guidelines)
- *Hospital Retention*: consultants may be reluctant to refer or 'lose' patients to the private sector.

- *Coding changes*: some smaller specialities with an apparent sharp increase in activity (dental specialities and gynaecology) may be due to hospitals changing how they record referrals and activity.
- *GP contract*: there is a requirement that new angina patients are referred to a cardiologist. Previously some of these patients would have been treated with medication in the community.

## 2.4 Non elective referrals /activity

Non-elective year-on-year activity comparisons for August 2004/05 against August 2005/06 show an increase of over 3% across South Yorkshire. Again, there was variation across the areas with a 7% increase in annual activity in one part of South Yorkshire and a marginal decline (-0.6%) in another.

One health community has undertaken detailed analyses of non-elective spells at its main local provider. The analyses reveal that non elective admissions were reasonably steady during 2003/04 and through to November 2004, but then surged between December 2004 and January 2005 and have generally remained at a high level since then. Non-elective spells per month increased steadily (3.5%) from 4619 at November 2004 to 4783 at June 2005.

From a peak of 29,000 in quarter 1 of 2004/05, total attendances at the main A&E Department and the Minor Injuries Unit fell in the remaining quarters of 2004/05 – but have risen to 29,260 in Quarter 1 of 2005/06 (an increase of 0.5% against the same period in 2004/05) (Table 2.1). Overall there is not a clear rising trend in A&E attendances.

**Table 2.1: Attendances at A&E Department and Minor Injuries Unit**

	Q1 04/05	Q2 04/05	Q3 04/05	Q4 04/05	Q1 05/06
MIU	5,885	5,599	5,183	5,056	5,797
A&E	23,213	22,895	22,444	22,241	23,463
Total	29,098	28,494	27,627	27,297	29,260

Analyses of A&E attendance by day and time reveal that:

- A&E attendances are most numerous on Mondays and Tuesdays.
- A much higher proportion of patients arriving in A&E outside normal hours (defined as 7am to 5 pm, any day of the week) are admitted (32%) than patients arriving during normal hours (21%).
- Patients admitted outside normal hours make up a large proportion of total admissions via A&E (58%).

These data suggest that focusing on out-of-hours behaviour both in terms of provision and alternatives to hospital admission and of admission thresholds within A&E may be useful. In a recent working paper prepared by the health community's information services it was concluded that overall there does not seem strong support for the case that changes in A&E behaviour at the provider are the prime cause of the rise in non-elective admissions.

## 2.5 Proffered explanations for the growth in non elective activity

The interviews elicited a range of reasons to explain growth in non elective activity in South Yorkshire.

- *Rise of consumer culture*: Increasing patient information (via the internet), declining stoicism and raised expectations about the ability of NHS services to meet their health needs.
- *Access to GP services*: There are particular problems associated with accessing GP services out-of-hours (nights and weekends). For many patients A&E is seen as the 'first port of call' as NHS Direct was not perceived to offer an equivalent service (see below).
- *Problems with NHS Direct*: at peak periods NHS Direct has been known to 'silt up' creating long delays and waits for call back.

- *Waiting times*: Patients are seen more quickly in A&E due to the 4 hour wait target. For many patients this is a quicker route to diagnosis and treatment, especially given difficulties booking an appointment with a GP because of perverse behaviours encouraged by the 48 hour wait target.
- *Demographic changes*: especially increases in very elderly patients and people living alone without carer support.
- *Access to same day tests*: the only way to get some tests performed is to have patients admitted to hospital.
- *Lifestyle and poverty*: non-elective demand is largely a public health issue and changes in contemporary lifestyles (obesity, drugs etc) are impacting on the demand for NHS services.

## **2.6 Impact of patient choice**

We elicited a range of responses from interviewees when we asked them what impact they thought Patient Choice would have on demand in their area:

- *Little change*: most thought that Patient Choice would have little impact because patients were reluctant to travel to other areas for treatment even when local providers had longer waiting times. However, this may vary among demographic groups as it was thought that younger and more affluent people would be more willing to travel for treatment.
- *Uncertainty*: some people thought that the impact of Patient Choice was very hard to predict and would create a period of instability across the system.
- *Service closure*: some services and, perhaps, organisations would be required to close on economic grounds.
- *Pressures on primary care*: the advent of Patient Choice may increase GP workload as patients seek out their advice about the quality of alternative providers.

### 3. Demand management in South Yorkshire

#### 3.1 Policy context

The introduction of Payment by Results has provided high powered incentives for Trusts to increase activity in areas where the tariff is greater than marginal cost. This may be desirable in the case of outpatient appointments or for elective surgery (to reduce waiting lists) but it may be less appropriate for non-elective inpatient care where the national policy aim is to provide care for patients outside hospital settings. The Public Service Agreement target to reduce emergency bed days by 5 percent has focused the attention of PCTs on limiting, managing and redirecting demand for secondary care services.

No overall strategy has been put in place in South Yorkshire to deal with demand. Instead a locality specific “patchwork” of initiatives has developed which may be more of a reflection of each locality’s situation, than a strategic response to an emerging problem. Most initiatives are relatively new in origin and although there have been recent attempts to assess the effectiveness of some schemes, none have been subject to a full economic evaluation. Nevertheless most of these initiatives have been through a business planning process prior to implementation, and are subject to ongoing monitoring and evaluation, with initiatives being withdrawn or re-configured if they fail to achieve expected reductions in hospital activity. There is sharing of experience across the SHA. Details of demand management initiatives in place in Barnsley, Doncaster, Rotherham and Sheffield are contained in Appendix 2.

The rest of this section draws on information derived from the interviews and documentary review.

#### 3.2 The role and development of demand management initiatives

##### i) *Information and data monitoring systems*

Information systems have the potential to support demand management in a variety of ways:

- By providing information for general practitioners to monitor how their referral patterns have changed over time and to detect variances from other practices.
- By providing information for PCTs (and referral information centres) to assess whether individual practices are outliers in terms of referral patterns.
- To target those sections of the population at a high risk of being admitted to hospital in the future.
- To act as a check on hospital behaviour by making hospital doctors accountable for their clinical behaviour and referral decisions.

Sheffield has arguably the most advanced information service in South Yorkshire. A central organisation - the Sheffield Health Informatics Service (SHIS) - provides a data collection and analysis support function for all four Sheffield PCTs. It has the capability to provide practices with individual patient level data and has developed an almost ‘real time’ data analysis tool allowing monthly activity and trend data to be accessed and displayed using graphs and tables. SHIS also performs a central analysis function and produces occasional statistical summaries and short reports on specific topics for GPs, PCTs and the Strategic Health Authority.

Although the SHIS provides a potentially valuable demand management service, the view among many of those interviewed was that it was not yet fulfilling its potential. A number of reasons were cited for this.

- Practices do not routinely use the data supplied by SHIS to monitor their activity.
- PCTs do not use the activity and referral information to support their performance management function. However we heard that many PCTs were planning to do this and the introduction of Practice Based Commissioning was focusing attention on developing stronger lines of accountability between GPs and PCTs.

- Lack of technical and computer skills at the practice level prevents many GPs and practice managers from accessing and analysing these data for their own purposes. Some believed that GPs would prefer to receive 'hard copies' rather than electronic data.
- There was some sensitivity around whether practice level information should be anonymised or made available to the public.
- No 'real time' information is available on the activity of hospital consultants. This was thought necessary so that PCTs and practices could monitor referral, admission, treatment and discharge practices.
- Data on the cost-effectiveness of different care pathways is not available.
- Some GPs may act defensively and deny that they are referring inappropriately.

We heard reports that some PCTs are using information systems as a management tool for leveraging change in GP behaviour. For example, one PCT is using a data system developed to validate Quality and Outcomes Framework points as the basis of an annual review in which practices are held accountable for their clinical performance and referral decisions.

"If you are sitting in a PCT there's an analysis tool you could call up that allows you to look at a speciality activity for adults or children, and it gives you a range of graphs and tables that pick out the monthly activity over the last 2 years ... You can see what has happened to the patient queue, long waits, total queue etc. it's pretty real time. It's available for PCTs to look at and in theory there could be some proactive monitoring of demand going on at that level - I am pretty sure it isn't."

"We've tried publicising it [the information system] and making [PCT] people aware of it ... people in PCT commissioning roles aren't numbers-and-analysis friendly souls, so there is a technical skill issue."

"I think we have a lot of information, but think we are rubbish at using it."

"As soon as you challenge GPs locally eg by saying they have high referral rates they immediately get defensive and say we never send anyone inappropriate."

"We do a lot of comparison of data on an inter-practice basis. We share that with practices and we are getting better at it. Very little use of levers and incentives attached to data at the moment. Probably the only information we use is if we perceive it to be poor medical practice, we will then visit individual GPs."

"There are some practices that object to the idea of referral data and information being made available to other practices, although that's been largely overcome now."

"I think it's about the competitiveness of GPs. If the information that I had about my practice suggested I was referring far more patients I would want to try and look why."

"We don't like to lose control when a patient is referred from one consultant to another; we're totally out of the loop there. Some people suggest that you should refer them straight back to the GP but you're delaying the patient treatment then."

## *ii) Practice based commissioning (PBC)*

Since 1 April 2005, general practices in England have had the right to hold an indicative commissioning budget from their Primary Care Trust to manage the delivery of services for their patients. By promoting a policy of Practice Based Commissioning (PBC) the Department of Health envisages a range of beneficial outcomes for the delivery of health care services:

- a greater variety of services, from a greater number of providers in settings that are closer to home and more convenient to patients;
- increased support of clinician-to-clinician dialogue about improving and developing care processes;

- early and continuing involvement of practitioners in service development;
- an additional set of levers to aid demand management (Department of Health 2004).

The Department of Health's latest guidance states that given the strategic importance of commissioning to the system reform agenda. The DoH expects to see PCTs make arrangements for 100% coverage of PBC by no later than the end of 2006. However, individual practices will retain the option to take on commissioning to a greater or lesser extent depending on their wishes and capabilities.

PBC is currently not well established across South Yorkshire and the interviews elicited mixed responses regarding the potential for PBC to serve as an instrument for managing demand. There was a belief by some that PBC will be a useful vehicle for performance managing practices and give them incentives to be more "demand management aware" as any savings accrued can be spent on the development of patient services. It was also thought that PBC would allow PCTs to manage GP behaviour and referrals through agreed targets as part of the budget setting process.

However, many had reservations about the expansion of PBC for a variety of reasons:

- the incentives are not thought to be as powerful as those under GP fundholding and therefore may not lever the desired behaviour.
- currently GPs may be artificially inflating their referrals because 2005 was the base year for setting budgets, in the mistaken belief that budgets would be influenced by historical referral patterns.
- the burden of day to day referral scrutiny and demand management will fall on practice managers rather than GPs. There was also a perception that practice managers would require a lot of training in the use and analysis of computerised data systems to do this. However, it was felt that the latest reorganisation of primary care commissioning would allow staff to move from PCTs to localities or GP practices to support implementation of PBC.
- practices are only just adjusting to the new GP contract and the Quality and Outcomes Framework and so are not presently motivated to embrace another major organisational change.
- additional resources are required at the practice and locality level to fund the administrative burden of PBC.
- cost-effectiveness data would need to be supplied if GPs are to make informed decisions about where best to treat or refer patients.

"At the moment we [the PCT] have no formal performance management relationship with general practice regarding referrals ...but the PBC arrangements that have been introduced should allow us to do that because it will allow us to agree a budget with the general practice and we would agree targets in relation to that budget. It would allow us to have a more performance management relationship."

"Therefore some practices who live through the fund holding years will remember baseline's based on what you did in a reference year so they're probably all cranking the demand now to get it to the baselines. There's a lot of strange looking referral with no apparent explanation for it".

"I think it [PBC] will have a limited effect in this area ... because practices just aren't motivated at the moment...They've seen a huge change with the GMS contract and the qualities and outcomes framework and they have received big increases in income from it. They now want to bed all that down and interest in PBC is quite limited."

"Without this sort of information [cost-effectiveness and comparative referral data] PBC will not get off the ground. As a GP I need to know what I am spending, what my referral patterns are, whether they are inside or outside the average. I'd just like to know that in order to concentrate my views on how I would commission services differently."

“I think unless it [PBC] has incentives, then it won't work. GPs view it with some scepticism and unless there are resources put upfront to allow it to happen then GPs will not have enough time to make it work effectively.”

“Most of the additional work will go to practice managers. They've got to understand how the money flows ... a massive training need there. You'd expect some of the PCT expertise to move down with the reorganisation.”

“GPs are known to respond positively to incentive schemes and the quality and outcomes framework is an excellent example.”

### iii) General Practitioners with Special Interests (GPwSIs)

The NHS Plan set out proposals for the introduction of 1000 'specialist general practitioners' (GPwSIs) to establish clinics in community settings for carefully selected patients (Secretary of State for Health, 2000). The aim is to improve access in specialities that have particularly long waiting times, such as dermatology and ophthalmology, the rationale being that less complex cases are diverted to clinics staffed by general practitioners, enabling hospital consultants to have faster access to patients with more complex needs.

GPwSIs are in operation across all areas of South Yorkshire and there are plans to increase the number in the near future. While many people interviewed supported the training and funding of GPwSIs they also voiced concerns about their use as an alternative to traditional hospital based services.

- in at least one hospital the number of referrals in a specific area had increased following the recruitment of GPwSIs specialising in that area. This was thought to be due to increased referrals from other GPs, coupled with the GPwSIs' relative lack of experience and risk-averse nature.
- they may not provide as good a clinical service as hospital consultants. There are concerns about the quality of service delivered to patients as well as clinical governance arrangements.
- they may be less cost-effective than hospital consultants.
- the introduction of Patient Choice may require GPwSIs to cut their close links with local consultants, who traditionally have helped to support the system.
- PCTs have little control over the areas in which GPs specialise as areas of specialisation are voluntary. There are several specialities they would like to see being developed locally but no GP had come forward.
- There were concerns about the length of time required to train a GPwSI.
- Providers are willing to co-operate and use their consultants to train GPwSIs as they see a range of benefits. However providers would also like more influence in determining the areas they specialise in and clinical governance.

“It's a mixed bag with GPwSIs. In dermatology there are something like 3 or 4 GPwSIs established locally, but we've actually seen a massive increase in dermatology referrals over the last year. What seems to be happening is that, because there is a GPwSI, GPs are sending more patients to them, but they have limited experience and if they have anything they are not sure of they are sending them to hospital.”

[different hospital to one above] “There's a GPwSI working in dermatology who does minor surgery and essentially we still receive the referrals but the consultants hive off the referrals that can go to that service. So that's expanding our capacity in effect”.

“We want some (GPwSIs) like tomorrow. I think the training is quite rigorous and we are looking about 6-9 months training for someone in dermatology which we need.”

“I don't think the PCTs have exploited our [provider speaking] ability to influence the development of GPwSIs and I think there is a major way forward if we work collaboratively to find areas where they

are suitable and there is interest and then use our consultant body to help these people develop the skills they need. As long as we get the service impact of that – because we don't get remunerated for training a GP - we'd be happy to do that as it's a way of expanding capacity."

"With Patient Choice and Choose & Book they have to remain slightly independent from the local secondary care provider. So they can't just refer patients to the local department. So this cuts the umbilical between the specialist and the semi-specialist."

"I think it's incumbent upon us in the future if we do have a number of GPwSIs in existence. They do need to be trained on an ongoing basis, they do need to be accredited, they need to be kept up to date, and if we are the organisation that provides that kind of coaching and support, we [a provider] need to be selling that to them formally."

"Continuous professional development [of GPwSIs] is not assured and they are not tied into an audit and effectiveness system. There is not an appraisal system to ensure that their extra requirements of a specialist role are taken into account"

"Are they [GPwSIs] effective? Yes. Are they cost-effective? I don't think so. They cost as much as consultants. But the goodwill I get because I am investing the money in them compared with investing it in a hospital consultant is huge."

"What is the real purpose of a GPwSI? If it's simply a way to keep patients out of hospital it is a poor motivator, because the chances are they are going to be more expensive and the consultation's not as good."

#### *iv) The Orthopaedic project*

In July 2003, of the 25,000 patients on the elective wait list for surgical procedures in the South Yorkshire, almost 30 per cent were waiting for orthopaedic surgery. Despite attempts to improve efficiencies, the orthopaedic waiting list volume has increased by almost 4 per cent since 1998 compared to an eleven per cent decrease in waiting list volume in all other surgical services. South Yorkshire Strategic Health Authority, in an attempt to reverse the growth in orthopaedic surgery, commissioned Model Advice Consultancy Limited (MACL) to undertake a comprehensive review of orthopaedic services in South Yorkshire. The brief was to:

- Develop efficient procedures for the delivery of acute services, focused initially on orthopaedic services. This included analysing the current activities of each trust in South Yorkshire, and identifying gaps and bottle necks in service delivery.
- Advise on re-engineering care pathways for orthopaedic services.
- Develop expertise in the design and application of the orthopaedics care pathways and referral mechanisms.
- Review the orthopaedic referral management methods and tools in all Trusts.
- Review alternative approaches to commissioning cost-effective health care services to support the efficient delivery of care to orthopaedic elective and A&E patients.

The review found evidence of best practice in nearly every acute and primary care Trust. Examples include:

- *A&E "Fast Track" Programmes* (eg at Barnsley District General Hospital, Bassetlaw District General Hospital, Doncaster Royal Infirmary). This involved approaches to rapid diagnosis, intervention and treatment and discharge or transfer to the best selected environment.
- *Community or Crisis Intervention Teams* (eg at Northern General Hospital and Rotherham District General Hospital). These are multidisciplinary teams who are on call and can establish resources required for care that, once engaged, will prevent an unnecessary hospital admission.

- *Pre-assessment processes* for elective surgery patients (eg Barnsley District General Hospital). This is a comprehensive physical assessment patient education and pre-surgical preparation programme that includes screening for after-hospital support needs.
- One Acute Trust (Rotherham District General Hospital) *routinely admits patients the morning of surgery*, eliminating the need to provide hotel-style accommodation to a patient who is not acutely ill.

A number of systemic gaps and bottlenecks were also identified as part of the review:

- *Referral Management*: there was fragmented GP to Physiotherapist or Orthopaedic consultant referral management processes.
- *Pre-admission Processes*: gaps in discharge planning processes were found in pre-surgical preparation programmes.
- *Discharge Planning*: bottlenecks were identified in establishing required resources once patients were hospitalised.
- *Theatre Productivity*: throughput inefficiencies were identified throughout the processes beginning at admission through to delivery of the patient to the Recovery Room.
- *Case Management*: No 'assertive' case management was found to coordinate the patient's journey through the hospital experience.
- *Clinical Pathways*: although clinical pathways were in existence in many Trusts, the average length of stay was much higher than for similar operations in the US. For example the average length of stay for hip-knee patients was 2-8 days longer than the US.

A series of new initiatives were implemented on the back of the review:

- *Best Practice sharing with leading US health care providers*: a series of video conferences were held with Duke University and Durham NC USA to discuss issues such as pre-assessment programmes, clinical pathways, case management processes, trauma care co-ordination and theatre productivity management.
- *Re-design teams* were tasked with developing discharge planning processes and to strengthen clinical pathways. Three design teams were formed as a result of the review.
- *Triage to existing teams*: For PCTs this involves GP referral processes (eg GP referral to Physiotherapist Specialist rather than to Orthopaedic consultant, if appropriate), waiting list management, and development of case manager roles in hospitals.

A number of enablers and barriers to improving orthopaedic services in South Yorkshire were identified as part of the review:

- The Project used clinician 'champions' to gain support among the clinical community and help drive through the desired changes in clinical practice. These clinicians were thought to be more effective at leveraging change than managers.
- In one hospital there was very slow take-up of redesigning services. This was thought to be due to the culture of the organisation being driven by clinical rather than corporate interests.
- The provision of fine grained information on clinical activity and performance served to nurture a competitive spirit among clinicians who then became eager to seek ways to develop better services and procedures than their peers.
- Patients going to the independent treatment centre (ITC) served to focus managerial and clinical attention on improving care pathways, service redesign and reducing length of stay. This was mainly due to the perception that the less complex cases tended to go to the ITC, leaving hospital consultants with very complex cases that were not fully funded under the tariff.
- Best practice and lesson drawing was facilitated by networking (using teleconferences) with experts from the US. This was at very little cost to the orthopaedics team.

At the time of preparing this report analysis of the data on the impact and outcomes – 2001 as compared to 2005 - for the Orthopaedic Project showed:

- Significant reductions in average lengths of stay.
- Significant improvements in the percentage of patients admitted the day of surgery for elective hip or knee surgery beginning in 2003.
- Readmission rates declined for all hospitals from 2003.

“There were several orthopaedic consultants and GPs who were keen to change and they became what we call the ‘champions’ and we could send them into other PCT or trust environments where there was not much willing participation and, clinician-to-clinician, they would win them over.”

“The trust where we have not seen a significant drop in patient stay has been the most reluctant to change. They are very big - it’s like trying to turn direction on an oil tanker in the middle of the sea. They’re just now piloting the clinical pathways we developed last year with reduced length of stay – just over a year later. In this place the clinicians run the place, not managers.”

“For patients with chronic disease in the hospital environment, the case manager is the ‘air controller’ of the patient’s care and makes sure the patient needs to be here, and applies admission and discharge criteria from Interqual. They make certain that the patient’s on a pathway, that the care elements are being followed and, if not, find out why and push the patient towards a discharge date.”

“The cultural competitive issue arises. When I first shared information it showed the differences in length of stay, readmission rates etc. It created quite a stir among the trusts as they had never seen that sort of information before at that level of detail and it became an incentive trying to out do each other.”

“We not only had cross sharing of information and cross-fertilisation of ideas processes during our redesign team meetings but every 2 months we hosted a video-tele conference with the best performers in America - best performers in clinical pathways, theatre productivity, referral processes. The US people are thrilled to be asked and don’t charge an honorarium.”

#### v) *Chronic disease management and intermediate care*

South Yorkshire is developing a model of chronic disease management for people with long term conditions. This is in part based on Wagner’s ‘Chronic Disease Management Model’ which is augmented to reflect the needs of those whose clinical symptoms may be deteriorating but for whom short term intensive input and a focus on self management may be enough to reduce their risk to a more sustainable level. The overall management of chronic disease comprises five levels with cross cutting themes at all levels ranging from data modelling, project management, commissioning arrangements, education and workforce developments and IT strategy:

- 1) Public Health programmes: prevention, health promotion, health protection
- 2) Case Finding and diagnosis, action plan and active case review.
- 3) Level 1 Care is for chronic disease management of low/medium risk patients (about 70-80% of a chronic care management population). This covers a range of services and intervention ranging from encouraging patients to be active in their own self care, supporting patients and carers to develop skills for self management and proactive arrangements for early intervention in crisis.
- 4) Level 2 Care is dynamic/intensive case management for higher risk patients. This covers case finding systems to identify the subgroup of patients with risk reduction potential, a range of intensive interventions co-ordinated by case managers, agreed protocols and pathways to access services and planned discharge from the caseload.
- 5) Level 3 Care involves proactive care management of complex conditions and community matrons. A case finding system is in place to identify a small target group of potentially high users of secondary care. Case managers (Advanced Practitioners/Community Matrons) manage patients and practice management plans are used for emergency crisis or acute exacerbation of chronic disease.

Intermediate care services comprise a range of services at the interface between secondary care and primary care that are intended to facilitate patients' transitions from illness to recovery, or to prevent their transition from home-managed chronic impairment to institution-based dependence, or to help terminally ill people be as comfortable as possible at the end of their lives. The services do not require the resources of a general hospital, but are beyond the scope of the traditional primary care team. In South Yorkshire there are many examples of intermediate care services targeted at reducing avoidable hospital stays and to improve the transition from hospital to home by supporting timely, appropriate discharge. Some of these are outlined below.

In Sheffield the Community Assessment and Integrated Care scheme involves using 4 multidisciplinary teams attached to each of the PCTs to assess and meet the care needs of older people in their own homes. GPs refer the patient to the scheme if they believe the patient would otherwise be admitted to hospital as an emergency, but could remain at home, were suitable support available.

In Sheffield there is a Rehabilitation and Resource centre in each PCT area. These centres are local authority run residential homes that have earmarked beds for short term care. Some have been earmarked for patients who have been discharged from hospital but who are not ready to return home.

A Community Intervention Team in Doncaster provides 24 hour nursing interventions for acute and chronic illnesses. The service is hospital-at-home, dealing with a range of care packages.

A team from Sheffield Teaching Hospital has been working with Sheffield's PCTs and Social Services to develop a more co-ordinated approach to the care of older people and provide them with greater stability and comfort at the end stages of life. The discharge liaison team employed by STH tries to ensure that inappropriate admissions to hospital are prevented and where possible the care of these patients is managed in their residential or nursing home by GPs, community nurses and the Intensive Case Management Teams (ICMTs).

The ICMTs track patients from residential and nursing homes when admitted to hospital. They determine reason for admission and facilitate the patient's return home by working closely with care home staff and PCT colleagues. It is reported that the length of stay of those patients who are able to return home has more than halved under this system.

Information on the admissions is collated and shared with PCT nurses to inform the Intensive Case Managers of any common themes or issues that can be identified. This means that further training needs or support can be provided to the care home managers and staff. As part of the scheme, nursing and residential homes are encouraged to utilise the expertise of the nursing staff and call on them, particularly when an out-of-hours GP is unable to attend, to ensure proper assessment is carried out and that appropriate care is provided in the right setting, the aim being to prevent hospital admission wherever possible. A recent pilot study by North Sheffield PCT involving ten of their highest admitting residential and nursing homes led to a noticeable reduction in admissions to hospital after care and residential staff received extra training and support from community nurses and GPs.

"There is an issue about the expertise of GPs to provide intermediate care. Quite often the theme that emerges is that someone requires intravenous antibiotics and most GPs have not used them since they were in hospital and that can be twenty or thirty years ago."

"So the big lever for demand management in [our area] is our intermediate care where we have some intermediate care beds. The discussion is around step-up or step-down, early discharge or avoiding admissions. I think that's the core of our future demand management work."

"We are looking at PCTs trying to establish a database of their thousand top risk patients and try and pick up the high users or 'frequent flyers'. For each of these people you develop a contingency plan so you say, 'Look, we're expecting you to go into crisis at some point, how are we going to handle that?' "

"Ninety per cent of the costs are wrapped up with 10 per cent of patients. If you can find out who those 10 per cent are likely to be, you can then put plans in place to stop them getting into hospital

and treat them in their own home. So we want to identify the top 1000 patients to target for the remainder of the year.”

“So the whole thing in terms of cost-effectiveness is to keep the number needed to treat as low as possible and if you can't keep your numbers needed to treat low, which is probably the case with the second level, what you need to be doing is batch processing them so you can get as many of them through as you can ... So that is where we are bringing in the idea of dynamic case management where the dynamic bit is that you don't keep people on caseloads indefinitely ... and then you let them fly solo and try and get away from the dependency culture which is cost-ineffective.”

#### *vi) NHS Walk- in centres*

NHS Walk in Centres are a nurse-led local facility providing fast access to health advice and treatment. They are open from early morning to late evening, 365 days a year. A key demand management function is to offer a more appropriate source of care for patients who might otherwise attend a busy A&E department. The services offered generally include:

- treatment for minor illnesses and injuries.
- assessments by an experienced NHS nurse.
- information on out of hours GP and dental services.
- information on local pharmacy services.

Sheffield has a well established Walk in Centre and Rotherham has plans to introduce walk in facility following a short term pilot which appeared to reduce avoidable admissions to A&E departments.

“We ran a Walk-in Centre over the Easter period. Over the Easter period we had 700 people walk in, of which 20 per cent said they would have gone to A&E because they couldn't have got access to out of hours service etc.... So Walk-in Centres are something we are actively considering as an alternative, not just to hospital but as an alternative to inaccessible primary care as well. So there are big plans on the horizon with the Department of Health to build a walk in Centre in the centre of [the city].”

#### *vii) GPs in A&E*

“GPs in A&E” is a pilot scheme which started in May 2005 under which GPs who currently work for the out-of-hours service provide a primary care medical assessment of patients who present in A&E and who do not require secondary care intervention. The rationale for the pilot was that it was felt that there were a number of patients who presented at A&E who could be classed as having primary health care needs. These patients could have a negative impact on the four hour wait for A&E and potentially cause unnecessary hospital admissions.

In the pilot most of the patients selected by GPs were patients with minor complaints (patients walking into A&E). A number of problems arose in the pilot:

- GPs felt at times that there were insufficient consulting rooms and a lack of privacy for patients within the unit.
- Individual GPs work differently, depending on experience and training. This has resulted in some inconsistencies in the patient pathway service.
- A decision to admit some of the more complex patients had been made before the GP opinion had been sought.
- The shifts selected for a GP presence have not been checked to ensure they are the most relevant to manage capacity and demand.

As part of the evaluation of the service, patients being seen by a GP were asked to give a reason for their choice of accessing health care via the A&E department. The most cited reasons between May and June 2005 were:

- Thought they would be seen quicker
- Did not know where else to go
- Brought in by Police or Ambulance

Analysis of data gathered between May and June 2005 and compared to the same period the previous year does not give a clear indication as to whether or not admissions have been avoided. The figures for paediatrics may indicate that GPs are having an impact on admissions although the sample is too small for a clear judgement to be made.

#### *viii) Targeted Long Stay Patients (and reductions in excess bed day costs)*

Some PCTs are developing policies to identify long term patients who are incurring, or likely to incur, excess bed day charges under the national tariff. This is difficult because the HRG is not determined until after the patient has been discharged.

Analysis by SHIS reveals that in 2003/04 for non-electives, only 35% of patients who stay longer than 14 days incur excess charges. However after 34 days the position is reversed, with 65% of patients going on to incur charges. This increases to 85% after 56 days and 94% after 90 days.

Similar analysis for elective admissions reveals that 30% of patients who stay in hospital longer than a week incur excess bed day charges, but 70% of those who stay more than 3 weeks do so. After a stay of four weeks this rises to 80%.

A two stage programme (using the above cut offs as benchmarks) to reduce length of stay is currently being implemented in Sheffield:

- At Stage 1, a standard maximum length of stay of 28 days for elective admissions and 90 days for non elective admissions.
- At Stage 2, a standard maximum length of stay of 21 days for elective admissions and 56 days for non elective admissions.

Sheffield PCTs now identify patients who are approaching the maximum length of stay and undertake intensive interventions, including home support and intermediate care if appropriate.

### **3.3 Conclusion**

This section has provided a brief summary of key issues and concerns over different demand management initiatives in South Yorkshire. In the following section we broaden the discussion to explore the secondary care provider perspective on demand management.

## 4. Provider behaviour and demand

### 4.1 Incentive context

The structure of tariffs under Payment by Results provides high powered incentives for providers to:

- increase activity in areas where the tariff is greater than marginal cost;
- reduce costs per case, for example through reducing lengths of stay;
- reduce activity where their costs are much higher than the tariff;
- identify areas where it is possible to increase financial return, for example by more accurate coding of existing activity or by coding previously unrecorded activities.

Risk is an inevitable consequence of such an incentive based system. Providers face greater financial exposure from changes in activity levels and those that are relatively high cost (compared to the average) must bear down on costs to remain viable. Whether the new financial arrangements will spur the necessary financial discipline and drive improvement in productivity and service redesign will in part depend on how providers respond to these new opportunities and challenges. A knowledge of provider behaviour, not least their relationships with PCTs, is therefore key to understanding the dynamics of the new system.

### 4.2 Relations between commissioners and providers

To deliver the desired changes in outcomes and behaviour, Payment by Results requires a healthy tension between commissioners and providers, while retaining a collaborative spirit and trust (Audit Commission, 2005). In an era of expanded patient choice, it may be difficult to tread the fine line between co-operation and competition.

The interviews revealed that across some areas of activity commissioners and providers believed that there were joint benefits from mutual co-operation and were therefore keen to invest time to develop and nurture close working relationships. From the commissioner perspective there was a view that providers currently held the balance of power in the local health economy as they had access to and controlled activity data. This information was deemed essential to containing commissioners' exposure to financial risk. Commissioners reported they were establishing channels for sharing and monitoring this information. Meanwhile, the view among providers was that close involvement with PCTs, particularly around service redesign and planning, was key to limit their financial risk. All the commissioners and providers participating in the study were working towards the use of common data sets on provider activity and financial flows. We also heard reports that in some areas commissioners and providers were working together to ensure that their local health economies gained under the new financial system.

“[PCT] we ask questions and get full information. So I suppose as an example, when we were doing our contracting and the Trust believed it was going to get a certain amount of transitional monies, I got the full breakdown of everything they were going to use that on, knowing that if we were a different type of commissioner we would have used that against them to say: ‘why are you bailing out this non-clinical area? We think you ought to be doing that’. I think our view from commissioners is that the power lies with the information and with the Trust. At the moment we get an advantage by having this relationship where we can share information. So it’s very much based on trust rather than checking.”

“It isn’t in our [provider] interests to bankrupt our major customer. So on that basis we’re not looking to massively increase the level of services we offer. What we are looking to do is work with the PCT to develop new services where they can afford them. Equally, if the PCT working with us isn’t able to manage demand appropriately and we continue to get sent an increasing amount of work in non-elective areas, then we’ll have to deal with that level of demand.”

“It’s very difficult for us to plan. So, for example, we agreed with the PCT that, you know, we’d work with them, there’d be a reduction in non-elective demand this year of one percent. We’ve in fact seen an increase of five percent. In terms of us planning our capacity, making sure we’ve got the right workforce, the right level of theatres, the right number of beds, that’s extremely difficult. What we can’t afford to do is actually have excess capacity because the tariff only gives us the average cost.”

“There were specialities where they were below tariff and we agreed activity and other aspects and we worked with them on that.”

The interviews also elicited many examples of where the new financial system was causing tensions and ‘flashpoints’ in commissioner – provider relations. Many of these tensions were ignited by issues around perceptions of ‘supplier induced demand’ and information imperfections, particularly clinical coding and the associated cost implications. These are discussed in more detail below.

### 4.3 Are providers inducing demand?

International evidence from countries with similar funding mechanisms suggests that, in addition to driving the desired changes in reducing costs and increasing activity, the new incentives may also inadvertently induce providers to use the system to their advantage in a variety of ways. The Audit Commission has recently developed a classification of potential gaming activity under Payment by Results:

- i) recording of additional (unnecessary) diagnoses and procedures, or selecting the most expensive diagnosis for a patient (up-coding).
- ii) discharge and readmission of patients to attract additional payments for each single spell.
- iii) inappropriate admissions (for example, from A&E).
- iv) keeping patients in hospital for more than 48 hours so that they attract the full (rather than short stay) tariff; transferring patients out of hospital as soon as possible after 48 hours; or manipulating patient stays so that they attract outlier payments.
- v) re-classifying patients into specialist HRGs, which are funded through separate arrangements.
- vi) cost-shifting between activities covered under payment by results and excluded services that are funded at cost. (Audit Commission, 2005).

Providers participating in the study were adamant that they were not seeking to ‘game’ the system to their financial advantage by inappropriately inducing demand.

Analysis has been undertaken in one health community to examine whether there is any evidence that the main local provider could be altering length of stay for particular patient groups in order to attract higher PbR tariffs. The study identified, for 2004/05 in full and for 2005/06 so far, patients with HRGs for which there is now a lower tariff for stays under two nights. After excluding patients who died in hospital, the study looked at the proportion of those patients, in each year, whose stay in hospital was either one night or two nights. In theory, had any manipulation taken place, the proportion of two-night stays would have increased in 2005/06. In practice, they found that this has not been the case (Table 4.1)

**Table 4.1: Proportion of patients by number of nights**

	2004/05 % of all spells	2005/06 so far % of all spells
1 night	11.57%	11.57%
2 nights	9.34%	9.45%

The study also looked at the overall change in the proportion of patients who are admitted but have a very short length of stay (Table 4.2). The analysis confirmed that there had indeed been an increase over time in the proportion of such patients.

**Table 4.2: Proportion of patients with length of stay 0 or 1 nights**

	Proportion of patients with length of stay of 0 or 1 night 2003/04	Proportion of patients with length of stay of 0 or 1 night 2004/05	Proportion of patients with length of stay of 0 or 1 night 2005/06
All spells	67.9	68.7	69.6
Non-elective spells excluding obstetrics and oncology	36.8	37.6	38.8

The study states that interpreting these data is problematic. This is because the findings could be the result of improved patient pathways and appropriate treatment being offered more quickly. Or it could be consistent with patients being admitted 'unnecessarily', perhaps partly because of the pressure of the A&E four hour wait target. Nevertheless, there is an increasing and significant proportion of patients who are admitted non-electively for very short stays in hospital. This suggests that PCTs should be addressing these increases through demand management strategies.

In the interviews we heard that providers had faced allegations that they had sought to increase their non-elective activity to benefit financially. However, providers were keen to point out that unplanned increases in activity worked against their interests, for a range of reasons:

- to meet the challenges of expanded patient choice providers would need to lower their non-elective waiting lists to be competitive and to meet waiting list targets. Therefore any increases in non-elective activity would divert attention and resources from this;
- if beds are filled with non-elective patients then there may be insufficient elective activity to cover other costs (eg of theatre);
- the majority of non-electives are paid only at short term tariff;
- any excess capacity means that elective patients are sent to the independent sector which managers and clinicians do not want to encourage.

Providers also explained that they were motivated by a strong public service ethos which guarded against them seeking to exploit the system to their advantage and that, at the present time, their clinicians had little knowledge of the new financial system and how it might potentially be manipulated for their own gain.

"I'm not suggesting at all that the hospitals are gaming on non-elective or elective work, other than they're doing, they're maximising as much as they can get away with because everything gets a tariff. But I wouldn't suggest that they're actually going out there and creating a new demand. There's a limited amount of hips that need to be operated on and they're operating on as many of them as possible."

"The Foundation Trusts are attracting in new business as an important part of their strategy and therefore, you know, while on the one hand the commissioners are saying 'We can't afford this, more of this or this or this' the providers are saying, you know 'Isn't it great, we've seen a rise in referrals', and so they're encouraging work."

"The Trust is obviously maximising its income. It is also maximising its income primarily in coding, it's maximising its income through consultant-to-consultant referrals and they have gone up twenty-five percent in the last year"

"No, I don't think they are doing loads of gaming but what they are doing is they're maximising their income. So some things which could have been done as day cases are being done as an inpatient admission."

"The major factor that's driving choice at the moment is less around the clinical quality of care and more around waiting times and, if we induce demand, all we do is put up our waiting times, which actually is counter-productive in many ways. What that means is that the independent sector or any other provider, whether it's another NHS organisation or a Foundation Trust, can get a toe-hold in our

market. If their waiting times are lower, people will be attracted to go there rather than here. So at the moment we're putting all our emphasis into getting our waiting times as low as we possibly can."

"When they [non elective patients] were occupying beds that we'd planned to use for major elective work, it wasn't good news and in terms of hitting ninety-eight percent A&E target it certainly wasn't good news."

"Also to the extent that our beds are filled with non-elective medical patients, then we're obviously then not recovering our theatre costs properly through tariff. So I think there are real financial disincentives to increasing non-electives from our point of view."

"Most of our clinicians are battling away doing their clinical work with actually a worryingly poor understanding of PbR and how it affects the environment in which they work ... My overwhelming sense with the clinicians is that they can barely understand the financial system."

"That's where I get frustrated by this [reference to] 'supplier induced demand'. It's a really an important debate in terms of turning off clinicians and the business managers who are working incredibly hard to make things better if this debate's allowed to continue to grow and become almost the dominant assumption."

"There is a view, rightly or wrongly, that we admit far too readily. That's disputed but it's very clear that at a point in time the patients in hospital don't really need to be there, and that's been validated numerous times now, which creates the view that we bring patients in inappropriately. I think the agreed position is that we admit people appropriately but we keep them inappropriately."

#### 4.4 Clinical coding and assurance

Coding clinical data involves allocating a code to diagnostic and procedural information contained in the clinical notes. Under Payment by Results the quality and depth of clinical coding of diagnoses and procedures is a fundamental concern as these codes determine which HRG the patient is assigned to, which in turn determines the magnitude of financial flows and income. Therefore, under the new system, incomplete and inaccurate coding leads to inaccurate payments, which can have a negative impact on the finances of providers and commissioners. The Audit Commission reported that the average number of diagnoses coded per case has increased by over 3% for all Trusts and especially for Foundation Trusts (5%) between 2004/05 and 2005/06 (Audit Commission, 2005).

Given the importance of coding within the new financial system, South Yorkshire Strategic Health Authority has commissioned Woodward Associates UK Ltd to conduct work in the South Yorkshire to explore the relationship between Acute Patient Coding (Episode Data) and PbR tariffs. At the time of writing data from one Trust relating to 2002-2004 has been analysed. Preliminary analyses of these data indicate that the average complexity of episodes coded has increased over the period and so has the depth of coding.

Recent work by another health community suggests that the depth of coding at their main provider is subject to annual variation. There are a maximum of 26 data fields for diagnostic and procedure codes which can be completed for any one inpatient episode. By looking at the average number of clinical codes used per completed episode, taking Q1 data for each of the last four years, the study demonstrated that:

- There has been very little change in the depth of coding of elective cases (probably because coding here relies primarily on getting the main procedure code right).
- There is no clear trend in the depth of coding for non-elective cases (Table 4.3).

**Table 4.3 Changes in codes per episode for non-elective and elective care 2002/03-2005/06**

	Codes per episode Non-elective	Codes per episode Elective
2002/03	3.21	2.96
2003/04	3.43	3.03
2004/05	3.32	3.02
2005/06	3.45	3.02

Even if coding depth had improved, it is not straightforward to demonstrate that it leads to an increase in income to the Trust under PBR. For activity in general, the overall correlation between code frequency and HRG cost is low. But the relationship may be clearer in some specialities. There has been an increase in coding depth from 3.72 codes per episode (2004/05) to 4.18 (2005/06) for non-elective admissions in general medicine in one area. This may have led to increased income compared to what would have been realised with less completely recorded activity.

In the interviews it was reported by providers that they were investing significantly more in training and supporting clinical coding functions and improving clinical data quality assurance processes. And there was a general view among commissioners that, although hospital Trusts had inaccurate and incomplete clinical data, they were not 'upcoding' to any great extent, merely recording activity more accurately. However, there was a view that this situation may change in the future if providers and clinical staff learn to "work the system" better.

PCTs and providers also highlighted the problem that as coding improved, PCTs would have to pay more for the same amount of activity. However this would be a short term issue as the new depth of coding would eventually be incorporated within the new tariff rate. Providers believed that new investment in coding functions would deliver benefits for patients as it could be used to improve quality and clinical governance within the organisation.

"[PCT] We're starting to see that the Trust is coding for greatest income at the same time as well. So whilst the primary procedure might be one procedure, the secondary coding might actually make it more worthwhile, so there's something about the PbR process."

"You could be kind and say they've just realised the importance of coding so they're now doing it properly. Or you could be unkind and say they're making sure they maximise their income. I think it's a mixture of both to be honest."

"We're trying very hard to cut down on coding errors because our position in the reference cost world isn't good and there is an awful lot of indicative evidence that our coding is not good compared to our comparative Trusts."

"I think it'll have a two year impact, because of the way the tariff's calculated. The tariff's calculated on the basis of average cost. Now in the first couple of years of the tariff people are going to start either counting more stuff or they'll get more accurate with the coding. Therefore there'll be more things with complications. Now there will be a gain for those first couple of years. After those first couple of years that additional work that's being counted will form part of the tariff calculation for year three."

"One of the things that we're currently investing in is the Dr Foster real-time management system, which is the system that allows you to identify clinical outliers. One of the major benefits for me in PbR is in those discussions. I have much more confidence now that our coding is good and that's really powerful."

## 5. Summary, policy and research implications

The need for effective demand management has become more transparent following the introduction of Payment by Results. This report details the findings of an empirical study exploring the South Yorkshire experience of demand management. By being ahead of the game in introducing PbR for all activity in all acute trusts in the South Yorkshire area, the experience in South Yorkshire has the potential to inform the national development and roll out of Payment by Results and Patient Choice.

Specifically our research aimed to provide information on the following:

- Local perceptions of changes in demand and whether this will be affected by Patient Choice and related reforms.
- The range and scope of strategies being developed locally to limit, manage and redirect demand.
- The relative benefits and drawbacks of different strategies.
- The facilitators and barriers to developing effective approaches for managing demand.
- Opinions on how current demand management strategies could be improved or adapted.

In addressing these issues we have sought the views and experiences of key NHS stakeholders in South Yorkshire. Interviews were conducted with GPs and staff working in PCTs, provider organisations and the Strategic Health Authority. We also reviewed relevant documentation and statistics on local demand and demand management activity.

In the rest of this section we start by summarising the main empirical findings of the research and identifying the most important issues arising. Following this we discuss the policy options and distil a possible research agenda that the Department of Health might consider.

### 5.1 Summary of key findings

#### *i) Demand pressures*

In Section Two we document the recent rise in acute elective activity in South Yorkshire and the marked increase in 'other referrals' (such as consultant-to-consultant referrals). This rise in activity in South Yorkshire is not reflected across the country where there has been a slight fall in elective care admissions in both Foundation and non Foundation Trusts (Audit Commission, 2005).

The interviews elicited a range of possible explanations for why elective activity in South Yorkshire may have risen. These include: the release of pent up latent demand because of lower waiting times; providers adjusting admission and discharge decisions in response to tariff incentives; and GPs inflating demand in the base year of Practice Based Commissioning in the mistaken belief that this would feed through into more generous PBC budget allocations.

South Yorkshire also witnessed a growth in non-elective activity, although the rate and range of growth differed markedly between PCT areas. This is broadly in line with national trends (Audit Commission, 2005). As with elective activity the interviews elicited a range of potential explanations for the growth in activity, including: local demographic factors and lifestyle changes; A&E waiting time targets; the increased inaccessibility of primary care services and difficulties in getting access to same day diagnostic tests in the community.

There was a commonly held view that Patient Choice would have little impact on demand for local services because patients were perceived to be reluctant to travel far for treatment. However many also thought that Patient Choice would usher in a period of instability and financial pressure in the local health economy with the prospect that some local services and organisations would be forced to close. Providers are investing heavily in marketing functions to retain and attract new patients and this may expand the market in South Yorkshire. Experience in the US shows that intensively advertising surgical procedures has generated new demand.

## ***ii) Demand management strategies***

No overall strategy has been put in place in South Yorkshire to address demand pressures. Instead a locality specific “patchwork” of piecemeal initiatives has emerged organically. Most initiatives are relatively new in origin and although there have been recent attempts to assess the effectiveness of some schemes, none have been subject to a full economic evaluation. Nevertheless most of these initiatives have been through a business planning process prior to implementation, and are subject to ongoing monitoring and evaluation.

Demand management activity in South Yorkshire can be classified under three broad headings:

### *1) Use of information systems proactively to monitor demand and detect variances*

- Analysis of hospital activity data.
- Analysis of GP referral patterns.
- Targeting of high risk individuals.

A sophisticated information and data analysis function was available in some PCT areas. However, the full potential of this service for demand management was not being realised. Practices do not routinely use centrally compiled data to monitor their activity and manage variance, and PCTs do not use this information to performance manage GPs. However, there was a belief that the introduction of Practice Based Commissioning would spur improvement in this area. The lack of computer skills and analytical capability at practice level appeared to be a key reason for why these data sets were currently under-exploited. PCTs would like ‘real time’ information on the activities of hospital consultants so that these could be challenged when necessary. They would also like to develop new data systems for monitoring the length of hospital patient stays. Those patients approaching the HRG trimpoint could then be targeted and offered intensive intervention, enabling them to leave hospital and thereby reducing excess bed day outlier payments.

### *2) Actively managing demand*

We found a wide variety of demand management initiatives in operation, including:

- Triage referrals.
- Practice Based Commissioning.
- Pathway protocols for chronic disease management.
- Appointing PCT staff to undertake assessments in A&E departments.
- Care pathway evaluation and review (eg Orthopaedics).
- Community matrons and geriatricians.
- Admission and discharge criteria (eg InterQual).
- Targeted reductions in excess bed days (long stay patients).

Although none had been subject to a full systematic evaluation, data were becoming available on effectiveness in terms of hospital admissions avoided. Other issues of concern include:

- There is scope of more learning about and sharing of best practice. A good example of how to do this is the Orthopaedic project which had drawn on the expertise and experience of leading US health care organisations in the development of the service in South Yorkshire.
- Some initiatives (eg GPwSIs) may have actually increased rather than decreased demand for secondary care in some instances.
- There were concerns that existing incentives within the system were not strong enough to encourage demand management in primary care (eg Practice Based Commissioning).
- Service development did not always take into account providers’ views and expectations (eg GPwSIs in some areas).
- Problems associated with changing the culture of hospital clinicians to make them more aware of demand management.

### 3) *Establishing a range of alternatives to hospitals*

- Use of independent sector treatment centres
- NHS walk in centres.
- A range of intermediate care services

Assessments of the cost-effectiveness of alternative care pathways and services had not been undertaken and in some areas there was a fear that competition from intermediate treatment centres and private facilities may force the local hospital to close.

#### ***iii) Provider behaviour and demand***

We found that across some functions, commissioners and providers were working well together. From the commissioner perspective there was a view that Trusts held the balance of power in terms of being able to access key activity data deemed essential to containing commissioners' exposure to financial risk. Commissioners reported they were establishing channels for sharing and monitoring this information. Meanwhile, the prevailing view among providers was that close involvement with PCTs was essential to reduce uncertainties around future capacity growth, particularly around service redesign.

The interviews also elicited examples of where the new financial system was causing tensions in commissioner-provider relations. Many of these tensions were around perceived 'supplier induced demand' and clinical coding. Hospital Trusts were investing significantly more in coding functions. There was a general view among commissioners that although hospital Trusts had inaccurate and incomplete clinical data, they were not 'upcoding' to any great extent. Data analysed in some communities do not provide strong evidence of changes in coding behaviour as yet. Nevertheless, there remains concern among PCTs that future improvements in coding completeness would imply having to pay more for the same level of activity. Providers believed that new investment in coding functions would deliver benefits for patients as it would be used to strengthen accountability for quality and support clinical governance.

## **5.2 Implications for policy and research**

### *i) Demand containment*

System reform is designed to make the NHS more responsive and productive and therefore increased demand may be a marker of success. However to develop proportionate counter measures to unplanned increases in demand it is necessary to identify what behaviours and factors are likely to lead to demand pressures in the future. The South Yorkshire study highlights that increased activity may be due to a wide range of factors, some but not all of which are within the span of NHS control. Research is urgently required to assess on a national scale:

- the behaviours or factors most likely to drive demand in an era of Patient Choice;
- quantify the risks (measure the scale, extent and likelihood);
- distinguish between legitimate growth in demand and 'supplier induced demand';
- identify those factors that are within the span of NHS control;
- separate out the highest risk (costs) and develop counter measures that address these risks.

### *ii) Supply side measures*

The structure of tariffs under Payment by Results provides high powered incentives for providers to increase activity because:

- they are rewarded for hospital activity, not for co-operating in service re-configuration.
- payments for increases in activity are made at full average cost.

A simple, but crude, supply side mechanism to manage demand would be to cash limit provider budgets irrespective of activity. However such a 'cap' may reduce incentives for efficient behaviour and may be at odds with Patient Choice.

An alternative approach would be to introduce a system of "full average and split average (aka tapered) pricing". This involves paying an average price (ie the national tariff) up to some threshold level of activity, and paying a proportion of average price for activity above this threshold. This requires determining where the threshold should be set, which may not be straightforward, particularly in the context of Patient Choice.

### *iii) Developing an evidence base*

The South Yorkshire study reveals that commissioners have little hard evidence to inform the development of demand management strategies. Yet such information is essential if health care resources are to be deployed efficiently and equitably. Many countries have developed policies for containing demand and have developed new techniques and tools. Similarly within the UK, private medical insurance providers have put in place a variety of initiatives to contain demand. Primary research and review work is required to:

- synthesise and disseminate the available international evidence on the cost-effectiveness of different demand management strategies.
- benchmark and share good practice across PCT and SHA areas.
- undertake economic evaluations of existing demand management initiatives.

### *iv) Practice Based Commissioning (PBC)*

The government is committed to PBC as a way of devolving power to local doctors and nurses to improve patient care. It is also a way of aligning clinical and financial responsibilities and serves as a tool to encourage GPs to manage demand effectively. The effectiveness of PBC as an aid to demand management depends on:

- How budgets are determined;
- The incentives GPs have to live within their budget;
- The incentives GPs have to work together to manage care effectively.

Evidence from early implementers of PBC highlights a number of key success factors contributing to effective demand management:

- The provision of financial incentives for GPs to manage demand with no conditions on how the savings are used.
- Provision of monthly information on performance and referrals to practices.
- The use of objective data on avoidable referrals to gain hospital consultant support.
- Identification of "consultant champions" and the need for buy-in from other consultants.
- Investment in a dedicated PCT team to validate and analyse the data from all providers and GPs.
- Use of PMS contract to gain agreement from GPs to provide data.
- Use of activity data to reinforce the commissioning process-eg to identify 'spikes' in provider performance, to benchmark GPs and reward high performance.

### *v) Management of commissioner-provider relations*

Payment by Results will inevitably give rise to tensions between commissioners and providers and may impact negatively on attempts to develop shared approaches to managing demand across the local health economy. As the effective implementation of Payment by Results will depend on constructive relationships between all parties working in the system it is essential that activity planning is shared and financial issues resolved efficiently, thereby enabling all parties to focus on patient care.

The Code of Conduct for Payment by Results currently being developed by the Department of Health will support this aim by providing 'ground rules of engagement' and clarifying the roles and responsibilities of the different organisations operating within the new financial regime. As Payment by Results is rolled out nationally commissioner-provider relations will need to be monitored and best practice shared to ensure:

- Providers make available to commissioners information about capacity and quality in accordance with their legally binding contracts.
- Commissioners and providers share and agree changes in coding practices, particularly where these could result in cost increases unrelated to activity growth.
- Commissioners and providers collaborate in service redesign and development of new care pathways.
- Agree who carries financial risk if planned changes are not delivered.
- All parties work together to reduce the potential unplanned and unaffordable increases in activity.

vi) *Strategies to manage increases in activity*

Secondary care providers have high powered incentives to increase activity knowing that they will receive the full tariff amount for every patient treated. While the traditional public service ethic may help guard against increasing demand inappropriately, this needs to be monitored as Payment by Results develops over time and reshapes managerial and professional cultures. Key areas to monitor include:

- whether thresholds decline for emergency admissions;
- if and why consultant-to-consultant referrals increase;
- whether intensity (eg by ordering more extensive diagnostic tests) of treatment increases;
- greater coding accuracy and the possibility of deliberate 'upcoding' specifically to benefiting from higher tariff payments;
- whether the short-stay tariff encourages providers to keep patients in hospital for more than 48 hours, in order to secure the full tariff amount;
- whether patients are being discharged earlier than is appropriate;
- whether outlier payments influence discharge behaviour around the upper length of stay tripoint.

### **5.3 Concluding remarks**

The lack of prescriptive central guidance may result in a wide diversity of models being piloted by PCTs at the local level. While this may be difficult to capture within an overarching national evaluation, it is important that the different approaches to demand management are subject to economic evaluation and the accumulated evidence base shared across the NHS.

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## **Appendix 1**

### ***Description of South Yorkshire Strategic Health Authority area***

#### **South Yorkshire Strategic Health Authority**

The Authority serves 1.3 million people across Barnsley, Doncaster, Rotherham and Sheffield. The area as a whole is one of the most deprived parts of the country, but also has a small percentage within its boundaries of the most affluent in the country. The inequalities in health resulting from deprivation serve to clearly emphasise the gap between rich and poor and offer a major challenge for planning and delivering health services for South Yorkshire people.

Life expectancy for many people across South Yorkshire is poor compared to the average for England. The PCTs in Barnsley & Doncaster are in the lowest quintile for life expectancy while Rotherham PCT is in the lowest quintile for female life expectancy and the bottom 30 percent for males. Sheffield city is also in the bottom 30% for male expectancy.

## **Appendix 2**

### **Demand Management Strategies in South Yorkshire**

#### **Sheffield – City Wide**

##### **Consultant to consultant referrals**

- The Sheffield PCTs have agreed with Sheffield Teaching Hospitals Foundation Trust that consultants will refer patients back to their GPs for non-urgent problems they identify that are unrelated to the condition they are treating. This was prompted by considerable evidence that consultant-to-consultant referrals are often for problems that are appropriate to be managed in primary care. Practices will, of course, refer to hospital those patients needing specialist care.

#### **South East Sheffield PCT**

##### **GPwSI in care of older people & Evercare pilot**

- Frail older people with complex health needs (mental and physical)PMS consortium
- Team of GPwSI in care of older people plus 3 specialist community nurses providing holistic care to frail older people with complex health needs or at high risk of admission. Focus on meeting the needs of the individual to preserve independence, comfort & function. (Assertive outreach)

##### **Intensive Case Management**

- Frail older people 75+ at risk of emergency hospital admission

##### **Support to Nursing and Residential Homes**

- Nursing and residential home patients with chronic disease
- 3 specialist G grade chronic disease management DNs working within Older Peoples Care Network. Achieved through Specialist PMS contract, with all patients registered with the DCM team

##### **Improve intermediate care bed usage**

- Patients requiring residential intermediate or interim care
- Management of intermediate care beds by Intermediate Care Manager. Review criteria for use of beds to enable more flexibility including use as step up beds. (plus plan to increase in numbers of IC beds – LIFT projects)

##### **Primary care interventions**

- Increase uptake of flu vaccs, introduce pneumococcal vaccs, fall prevention

##### **Assertive outreach**

- 3 practices with high rates of emergency admissions
- Reduce admissions by 25% in target practices

##### **Rapid response nursing service**

- Older people whose condition has deteriorated including: Terminal care; Mobility problems; UTI or respiratory infection
- Assessment of patients and intensive nursing support for time-limited period. Inclusion of elements of Hospital at Home (eg IV antibiotics, blood and platelet transfusions)(Reactive intervention)

##### **A&E protocol**

- Older people admitted to A&E with cardiac, respiratory, neurological, gastro-intestinal and mobility problems or minor injuries
- Assessment of older people in A&E - screen, assess, diagnose and treat. Use of admission criteria & rapid diagnostic procedures to prevent avoidable admissions. InterQual.

**Specialty specific initiatives**

- **Orthopaedics.** The PCT has completed a tendering process and is negotiating with the preferred bidder to implement a Musculoskeletal Interface Service which will triage all non-urgent orthopaedic referrals. The service will also aim to manage 40% of patients without onward referral to a hospital provider. This will be done through physiotherapy, orthotics and medical management.
- **Gastroenterology.** There is good evidence that a “test and treat” approach to Dyspepsia is very effective and can substantially reduce outpatient attendances. This should also lead to earlier diagnosis of diseases such as Irritable Bowel Syndrome, stomach ulcers and inflammatory bowel disease. South East Sheffield also has higher than average admissions for endoscopy and there is scope to explore alternative methods and delivery modes for diagnosis.
- **ENT.** The PCT has employed a GP with Special Interest (GPwSI) to work up proposals for managing ENT conditions in primary care. It is expected that this could reduce outpatient referrals by up to 30%. Benchmarking has also shown that Sheffield Teaching Hospitals has a high outpatient follow-up rate and proposals to reduce this have been developed. Scope to reduce inpatient admissions may be more limited, although it is noted that adenoidectomies and septoplastys represent a high proportion of the inpatient casemix.
- **Oral Surgery.** It is suggested that increasing numbers of referrals to secondary care oral surgery departments, are in part due to the shortage of dental practitioners in primary care and increasing workload issues. It is anticipated that the new dental contract will incentivise dentists and create new opportunities for PCTs to commission traditional secondary care procedures and services from GDPwSI. SE PCT intends to undertake a scoping exercise in 2006 to identify potential GDPwSI, and assess the potential for secondary care to primary care service shift. A moderate reduction in both inpatients and outpatients has been assumed for the first year.
- **Anticoagulation.** A number of practices have already signed up to provide a level 4 enhanced service and two practices are engaged in a community pharmacy pilot scheme which will potentially enable the PCT to provide further community based anticoagulation.
- **Gynaecology.** A high number of secondary care referrals are for menorrhagia. These could be managed more cost effectively by Central Health Clinic and work on developing a service specification has been completed. We are also looking at options for the provision of termination services to improve access and waiting times.

**North Sheffield PCT****Intermediate Care**

- Individuals requiring assessment and care in any intermediate care setting.  
Those with COPD and lower respiratory disease who would traditionally be cared for in hospital.
- To support more people at home by providing nursing assessment into the Intermediate Care Team and additional therapy support.  
To provide a multi-disciplinary rapid response following an un-scheduled care episode to support individuals to remain at home.

**Intensive Case Management**

- Patients with two or more admissions to in the previous 12 months
- District Nurses and Social Workers actively seek out those patients with multiple admissions and intensively case manage them for a maximum of 90 days to prevent further avoidable admissions

**Older Peoples Specialist Support Team**

- Residents of nursing and residential homes
- Multi-disciplinary team that works with nursing and residential homes to prevent avoidable admissions by falls management; medical support; identification of social needs and exercise; the provision of training and education; intensive Case Management

### **Unscheduled Care (in hours)**

- Those individuals requiring immediate attention that can be dealt with without an A&E attendance
- Emergency Care Practitioners (ECP) to respond to calls from the public, GPs or other professionals.  
ECPs will be based with the Intermediate Care Team who can support by rapidly responding to on-going care needs

### **Chronic Disease Management**

- People with CVD (inc CHD, Heart Failure, Stroke, PVD), diabetes  
People with COPD or people with symptoms of COPD not yet diagnosed
- Development of registers (in particular diabetes) - national target  
Support for systemic care - in particular optimising treatments for HT, blood glucose levels and cholesterol (national target)  
Pre-admission specialist heart failure intervention - optimise medication etc.  
Identification and diagnosis of COPD - supporting practice teams and/or undertaking spirometry  
Smoking cessation advice and optimise treatments - in particular patients on nebulisers and oxygen therapy  
Assessment of people with severe COPD for nebulisers and/or oxygen therapy

### **Specialty specific initiatives**

- Anti-coagulation. Rollout redesign of anti-coagulation primary care management of patients (currently 10/21 practices) across all practices
- Near patient testing. Implement near patient testing for the monitoring of patients on three specific drugs primarily used for rheumatology conditions, (with the caveat that monitoring systems robust enough to ensure clinically safe to do so).
- Insulin initiation Deliver insulin initiation programme in primary care, training primary care staff in diabetes management and reducing referrals and OPFU to secondary care.
- Type 2 diabetes management On-going management of patients with controlled type 2 diabetes
- H-pylori testing Implement helicobacter pylori testing for patients with dyspepsia
- Orthopaedic screening service & management of podiatry Implement a primary care based orthopaedic service and transfer some podiatric surgery currently done at STH into a community based service.

## **Sheffield South West PCT**

### **Emergency Care Practitioners**

- EMA avoidance
- 1<sup>st</sup> line call out/referral to rapid response/intermediate care service

### **Diabetes monitoring/chronic disease management**

- Diabetics in local areas
- Expansion of primary care based diabetes services in 2 areas of high incidence

### **Medicines management in nursing and residential homes and training for staff**

- Older people in nursing and residential homes
- Small team to review patients medication in line with Older peoples NSF  
Links with PCOP and Free Nursing Care

### **COPD/Asthma**

- Respiratory disease  
People with severe respiratory disease
- Expansion of primary care based COPD/respiratory disease services – linked to reinvested HAZ monies

### **Expansion of intensive case management**

- People with chronic diseases in residential and nursing homes
- 1 G grade nurse and care assistant time. Practice WSPI
- Training NH/RH to manage patients in a better way including end of life plans. Also potential for practice with special interest to increasingly manage medical care in all our residential and nursing homes through the locally enhanced service provisions in the new GMS contract

### **Rapid response/hospital at home nursing service**

- EMA avoidance
- Additional qualified nurses as part of intensive home nursing service

### **Citywide scheme – intensive case management**

- High risk patients
- Part of citywide project to reduce EMAs by 1000. SW share 200

### **Expert Patient Programme**

- Patients with chronic disease
- Continuation and expansion of SW EPP scheme

### **Specialty specific initiatives**

- Gastroenterology. Patients who currently present at their GPs with dyspepsia symptoms are almost all referred onto secondary care for an outpatient's appointment to have a helicobacter pylori breath test done. Patients with ongoing dyspepsia problems who may not have been successfully treated with antibiotics may be on a long term use of the proton pump inhibitor (PPI). Current NICE guidance estimates that approximately 30% of patients currently referred into secondary care for Gastroenterology will require the h pylori breath test, which can be undertaken within primary care.
- Ophthalmology. The purpose of this project is to reduce secondary care ophthalmology outpatient activity by establishing alternative appropriate options for relevant diagnosis and management in non-acute settings. Specifically the project will (i) implement monitoring of Glaucoma by Community Optometrists (currently the Optometrist would refer to a GP and the GP would refer on to Ophthalmology for an outpatient appointment if glaucoma is suspected) and (ii) to reduce referrals via a city wide training and education event.
- Disease Modifying Anti-Rheumatic Drugs (DMARDS) Provision of near patient testing in South West GP practices for Methotrexate, Sulfasalazine and Azthioprine using a Locally Enhanced Service Specification (LES). These drugs are predominately used by patients with Rheumatology conditions although to a lesser degree, they can also be used by patients with

renal, gastro and neurology conditions. Providing this service in GP practices would save quarterly or six monthly outpatient appointments in Rheumatology plus costs of blood tests.

- Dermatology. To (i) reduce the demand for secondary care Dermatology out-patients by establishing a SSWPCT GPSI in Medical Dermatology and (ii) to reduce referrals via a PCT wide training and education event.
- Orthopaedics. A musculoskeletal service in primary care to reduce referrals into orthopaedics in secondary care.
- Urology. To establish a Nurse Led Community based Urology Assessment Service leading to a reduction in the number of patients attending outpatients in Urology.
- Podiatry. To encourage SSW referrers to send potential nail surgery patients to the Podiatry Service for assessment and treatment and to develop the Podiatric Service provided by SSW PCT to divert a proportion of people currently treated in Orthopaedics in secondary care, where clinically indicated and appropriate.
- Anti TNF. To look at ways of bringing the administration of high cost drugs closer to the patient and away from a hospital setting. In the case of ANTI TNF drugs they are currently administered at STH FT. These drugs are outside the remit of Payment by Results and are charged on a cost per case basis to the PCTs. In addition, the PCTs also pay for the hospital episode. A patient on such a course of treatment would attend several times each year. There is therefore the potential if the administering of the drugs could be done in the community, that costs associated with the drugs and the hospital episodes could be saved.

## **Sheffield West PCT**

### **Emergency Care Practitioners (ECPS)**

- Patients with Minor illness/injury age range 6 and above. Role of the ECP will be to assess and treat a variety of medical conditions, ranging in degree of seriousness, with a view to treating the patient in their own home or local geographical area, with a view to avoiding hospital admission.
- The ECP would also work closely with other unscheduled care /rapid response services, referring on to other services as and when required, whilst also accepting referrals from other agencies/depts, including Cat C referrals from SYAS

### **GP in A&E**

- To see patients presenting in A&E with complaints that could be seen and effectively dealt with by a primary care clinician.
- To use the skills and expertise of a GP to see patients presenting in A&E who could be assessed, treated & potentially discharged by a GP, thus avoiding hospital admission.

### **Intensive Case Management**

- Elderly adults:  
2 or more admissions in one year  
History of Chronic disease or falls  
Likely to be emergency admission within 3 months
- Nursing and social care over a period of up to 90 days focussing on regaining stability and self management

### **Enhanced evening nursing service**

- Short term input for adults who by receiving evening nursing support would be able to remain at home
- Evening nursing referral criteria extended to include care such as help with continence, help with ability to get into bed, support following discharge from A&E Dept, medication etc

### **Clinical skills and Falls Awareness training for Nursing Home staff**

- Nursing Home staff
- To provide continuous in house clinical skills training of staff (known to be of high turnover) in order to prevent avoidable attendance at A&E Dept or avoidable admissions for catheter care, ear syringing venepuncture and palliative and terminal care  
Falls awareness programme to reduce accidents resulting in emergency admission

### **Hospital at home and rapid response nursing teams**

- Adults who are acutely ill but medically able to remain at home with community nursing input and adults who could receive clinical treatment at home with skilled community nursing input
- Eg elderly adult with flu like symptoms requiring nursing care to remain at home, blood transfusions, chemotherapy

### **Influenza and Pneumococcal Vaccination programmes**

- Adults over 65 years and those adults identified within vaccination target groups
- Vaccination programme offered to target group September-December annually

### **Specialty specific initiatives**

- Dyspepsia – to provide a practice based “test and treat” service that will provide standardised effective & evidence based management of patients with dyspepsia and provide Helicobacter pylori testing in primary care for those patients that require it, as per NICE clinical guideline for the management of dyspepsia. This will ensure that all requests for endoscopy are appropriate and only those patients with ALARM symptoms are referred to secondary care.
- Dermatology – development of a triage and treatment service for patients in a primary care setting. The primary aim of this service will be for a specialist primary care practitioner to see dermatological patients referred by GPs, undertake appropriate investigations, make diagnosis and recommend treatment. The service would, of course, refer to consultants those patients requiring secondary care treatment.

- Orthopaedics –a musculoskeletal assessment service that will assess all orthopaedic problems requiring specialist treatment or opinion, undertaking physical examination where appropriate, providing physiotherapy or other treatments in primary care, referring to consultants for surgery or specialist opinion where required and advising referring GPs of further treatment in the practice.
- Anticoagulation – a service specification is already in place for practice management of anticoagulation therapy. The PCT is currently working with practices and hospital clinicians to identify patients whose care can be safely transferred back to their practice.
- DMARD monitoring – a specification is being consulted on to support practice based monitoring and management of patients on DMARD therapy.
- Diabetes – Insulin Initiation – a specification is being developed to enable practice based initiation of insulin therapy.

## **Rotherham PCT**

### **Orthopaedic triage**

- Extend scope physiotherapist and GPSIs review all referrals to orthopaedics. The scheme has been effective, reducing referrals by 60% plus.

### **Dermatology**

- The Dermatology GP works with hospital dermatology service. Referrals are split between non complex cases seen by GPSI and more complex cases referred to secondary care.

### **Minor Surgery**

- A scheme which allows those GPs not providing minor surgery in the practice to refer to a GPSI who will see and treat.

### **Community Nursing and Therapists – a number of initiatives:**

- Dynamic Case Managers - 3 senior nursing staff working with patients with long term conditions who experienced a number of admissions in a year. Initiative will link closely with development of community matrons.
- CARATS - Community Assessment, Treatment and Rehabilitation. A team of nurses and therapists working with clients who would otherwise be admitted to hospital or remain in hospital. They are able to implement short term packages both health and social care to enable patient to remain in their own home.
- Intermediate Care Beds - A specific contract with local nursing and residential homes to provide step up/step down and rehabilitation support to prevent inappropriate admission to nursing homes and in the longer term to nursing and residential homes.
- Senior Nurse Practitioner - Nursing Homes - This experienced nurse will support nursing homes to ensure clients are not inappropriately admitted to hospital with easily managed conditions eg. dehydration.
- Rheumatology Monitoring - This is a Locally Enhanced Service for which local GPs contract to provide testing for levels in the local surgery rather than the patient having to attend at hospital.
- Walk In Centre - A WIC was operated over the Easter weekend to give patients improved access to primary care outside normal working hours. Plans are being developed to introduce on a more permanent basis from November, 2005.

## **Barnsley PCT**

### **Intermediate care services**

- This comprises of a number of connected areas of service provision aimed at supporting older people who need care at a level between hospital and community.
- The PCT has a range of options available:
- Intermediate care beds – based in a number of resource centres across the PCT to enable care to be provided close to the patients own home,
- In reach team - to facilitate appropriate discharge,
- Rapid response team - to help prevent inappropriate admission,
- Hospital at home schemes - to support care in a persons own home.

### **Enhanced services and care pathway design in chronic disease management**

- Currently work is being advanced in three areas - Diabetes, COPD and CHD.
- Each of these areas has a managed clinical network where clinicians and providers can discuss care pathway redesign and resource utilisation across primary and secondary care.
- All three areas have developed a local enhanced service, influencing the development of service specifications and required levels of clinical expertise, to increase the range of care available within a primary care setting.

### **Demand management schemes**

- Musculo skeletal services – GPSI led primary care based service with a triage service for lower back pain incorporating allied health professionals and extended scope practitioner
- ENT – GPSI led with links to a PMS plus contracting route, utilises LIFT premises to provide services in a primary care setting
- Dermatology – GPSI led utilising LIFT premises, linking secondary care and primary care aspects of the care pathway
- Anti coagulation – local enhanced service based on national specification. Large scale provision within general practice. Seeking to expand this further.

### **Expert patient programme**

- Scheme provided to support those with chronic disease.
- Links to Barnsley's fit for the future programme.

### **Further schemes**

- It is anticipated that work currently being undertaken will all have further effects on levels of demand at secondary care and the ability to provide services in the most appropriate setting.
- Areas include Community Matrons development, The Sexual Health Modernisation Framework, Basing nurses in A&E to undertake assessment and diversion as part of intermediate care/rapid response

### **Alternative provision of secondary care in a primary care setting**

- Utilising HSG(96)31 the PCT has commissioned alternative provision in a primary care setting of two secondary care procedures - vasectomy and carpal tunnel release.

## **Doncaster PCT EAST/WEST/CENTRAL**

### **Redesign of unscheduled care**

The health community is in the process of agreeing a 3 strategy on unscheduled care. In essence this is the redesign of the whole system, which should impact on the demand for secondary care A+E services.

### **Pilot GP in A+E**

We are currently providing a GP service in A+E in the out of hours period and measuring the impact this has on admissions specifically to general medicine. Evaluation and future of the pilot will be known in March 2005.

### **Demand management of Trauma + Orthopaedics**

We are in the process of developing a service specification for an orthopaedic clinical assessment service.

This specification details a comprehensive orthopaedic clinical assessment service, which builds on the existing service provided by the orthopaedic physiotherapy practitioners and direct access physiotherapists, both practice and hospital based.

### **COPD Management in Primary Care**

14 Practices across East PCT providing management of COPD patients in primary care. Nurse led clinics undertaking review including spirometry to identify and categorise patients, development of patient care pathway and advice/guidance on self-care to prevent avoidable admissions.

### **Enhanced Winter Access Scheme**

Provision of additional support to GP practices to manage increase in demand over the winter period. Enabling practices to provide additional clinical contacts, including GP telephone appointments, provision of MI Clinics and Nurse triage. In place to reduce inappropriate demand on A&E and Out of Hours.