Agenda Item 8

West Leicestershire Clinical Commissioning Group
East Leicestershire and Rutland Clinical Commissioning Group
Leicester City Clinical Commissioning Group

LEICESTERSHIRE, LEICESTER AND RUTLAND HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 10 SEPTEMBER 2019

REPORT OF LEICESTER, LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONNG GROUPS

PLANNED CARE UPDATE

Purpose of report

1. A patient's planned (elective) care journey usually starts in primary care and can begin with a diagnostic procedure, before entering secondary care for either an opinion, diagnosis, treatment or procedure.

2. The purpose of this report is to provide an update on the projects within the 2019/20 Planned Care programme, specifically progress made on Referral Support Services and to outline the emerging direction of travel for the transformation of outpatient services across Leicester, Leicestershire and Rutland (LLR).

Policy Framework and Previous Decisions

3. In November 2018, the Royal College of Physicians report: Outpatients: *The Future Adding value through sustainability* was published (RCP report). This report argues that a new approach to outpatient care is needed if it is to meet growing demand and reduce disruption to patients' lives. It describes the current 'one-size-fits-all' model as no longer fit for purpose and recommends replacing it with a person-centred approach that recognises that people have varying health needs, personal pressures and abilities to self-care or manage.

4. For LLR and its main acute provider, University Hospitals of Leicester NHS Trust (UHL), it has confirmed that what we have been doing to date has been focussed on doing the right things: to shift the emphasis on patients to manage their own care, to tackle the demand that we do not have the acute capacity to deal with and to review whether all outpatient appointments are necessary. The report has also helped us to take stock of what we are currently doing and to refresh our thinking on the national outpatient productivity challenge.

5. In January 2019, the *NHS Long Term Plan* was published setting out key ambitions for the service over the next 10 years. The plan builds on the policy platform laid out in the *NHS Five Year Forward View* which articulated the need to integrate care to meet the needs of a changing population. The *NHS Long Term Plan* includes an ambitious pledge to use technology to fundamentally redesign outpatient services over five years. The aim is to avert up to a third of face-to-face consultations in order to provide a more convenient service for patients, free up staff time and save £1.1 billion a year nationally, if appointments were to continue growing at the current rate.

6. Within LLR, over 70% of all UHL activity takes place within an outpatient setting (c900k appointments per year), and c600k of that activity occurs as a follow-up appointment.

Background

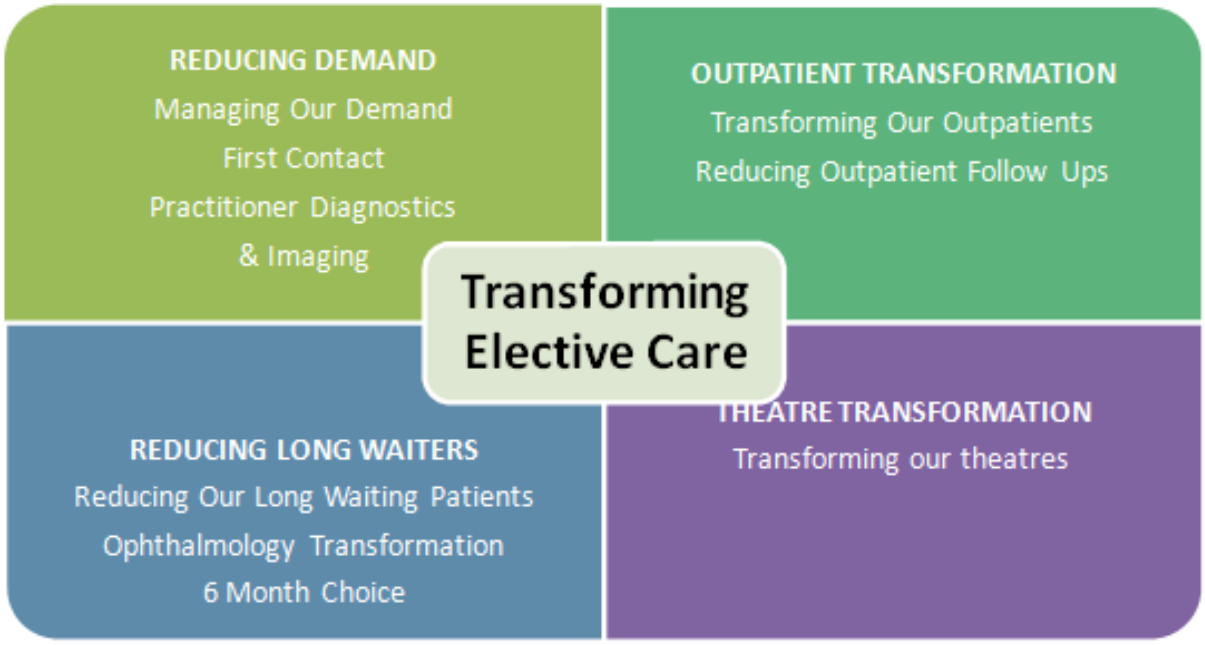
7. The NHS nationally faces unprecedented demands for health and care services, which we are also experiencing locally. Demand for outpatient services continues to grow in an over pressurised system in which the acute sector is struggling to meet demand in terms of capacity and staffing. It is acknowledged that we need to significantly change what we currently do as patient's needs and expectations are changing, technological solutions are available to support patients in their care and hospital centric outpatient care is no longer the most appropriate model of care.

8. The Planned Care Programme is a workstream within the Sustainability and Transformation Partnership (STP) and the Better Care Together (BCT) Partnership linked to the NHS Long term Plan.

9. The Planned Care Programme supports patients to have access to safe, high quality and effective care, delivered locally. We want our planned care services to deliver high quality, personalised care, which enables patients to see the right person, in the right place, at the right time; working with local services to make sure that patients only go to hospital if they need to be there and that we have safe, high quality care available in primary and community settings to improve patient outcomes.

Proposals/Options

10. As a system partnership, we will transform planned care services via specific schemes for LLR citizens based on listening to what patients have told us matters to them. Our aim is to improve patient care and health outcomes. By changing the way we use community and GP facilities we can bring more care closer to home. This will free-up space at UHL for patients needing emergency and specialist services including treatment for cancer, neurology and complex maternity services. As well as bringing more services into the community, we are improving the way different parts of the local NHS work together. The diagram below highlights the strategic aims of our programme.



Managing Our Demand

11. Within our health economy, we have a number of primary and community providers of outpatient clinics that can deliver care closer to the patient's home. We are working as a system to ensure patients are offered the most clinically appropriate and local options, therefore reducing the pressure and waiting times at UHL.

12. To deliver elective care closer to home and reduce demand at UHL, we will:

    a. increase the usage of advice and guidance across all elective specialties;
    b. design a joint Musculoskeletal physiotherapy service;
    c. embed and monitor compliance for 102 procedures of limited clinical value (approved referral policies);
    d. implement Referral Support Services within specialties experiencing high demand.

13. The Referral Support Service (RSS) is our largest in-year elective transformation project and supports the process of directing referrals to the most appropriate location. The RSS is an eighteen month pilot with the LLR Alliance and is being delivered by our clinicians and nurses.

14. The objectives of this programme aim to:

    a. reduce the number of patients discharged at first appointment with no further treatment;
    b. reduce the number of referrals that could be avoided through reassurance, advice or action by the patient's GP, i.e. managed within primary care;
    c. divert clinically appropriate referrals from secondary care into lower cost primary and/or community services and in so doing reduce demand on hospital services;
    d. improve long term GP referral patterns through identifying areas of educational need and facilitating a feedback loop from the RSS clinical triage function;
    e. improve data retrieval to inform reconciliation with activity data and development of patient care pathways in primary and community based settings;
    f. provide an educational work stream that supports GPs in decision making;

g. improve levels of patient confidence and satisfaction with the referral process.

15. The pilot is focussed on six specialties (below) with each service starting in a phased method from January 2018. These specialties were selected following engagement with patients and UHL:

    a. Musculoskeletal services
    b. Dermatology
    c. Orthopaedics
    d. Ear Nose and Throat (ENT)
    e. General Surgery
    f. Ophthalmology

RSS progress to date and next steps

16. The LLR system has been closely monitoring the impact of this pilot on patient care. The table below highlights the impact of the pilot on the initial six specialties and in particular how this is reducing demand into acute hospitals.

SPECIALITY	**REFERRAL BACK TO GP WITH PATIENT SUPPORT** (April 2019-July 2019)	**PATIENT REFERRED TO MORE APPROPRIATE COMMUNITY/PRIMARY CARE OPTIONS** (April 2019-July 2019)	**PATIENTS OFFERED CHOICE OF SECONDARY CARE OPTIONS** (April 2019-July 2019)
Musculoskeletal services (incl Orthopaedics)	1014 **10%**	941 **10%**	7762 **80%**
Dermatology	368 **13%**	595 **21%**	1879 **66%**
ENT	293 **12%**	354 **15%**	1747 **73%**
General Surgery (go live Sep 2019)			
Ophthalmology (go live Oct/Nov 2019)			

17. Throughout the first three months of 2019 we explored which additional specialties could be included within the RSS. The specialties below have been provisionally identified to be included in the second half of 2019/20.

    a. Urology;
    b. Gynaecology;
    c. Cardiology;
    d. Respiratory;

e. Gastroenterology.

18. As a system, LLR will continue to monitor the success of the programme and ensure patients continue to receive the option of care closer to home.

19. The Planned Care programme focuses on further methods to reduce demand where possible and look for more opportunities to move elective activity to the most appropriate setting. These include:

    a. Working with system partners we will ensure that patients are referred more appropriately for treatment in the community closer to home, improving their experience. This would include GPs with special interests/extended roles (GPwERS), Physiotherapists and Optometrists;
    b. Rolling process of updating the specialty Directory of Service to reduce inappropriate referrals into UHL;
    c. Support the development and use of PRISM (a support tool to improve the quality of the referral and referral information) to reduce inappropriate referrals into any provider;
    d. Increase uptake in GP advice and guidance, leading to increased learning and reduced need for referral;
    e. Reductions in outpatient follow-up rates, moving to alternatives such as non-face to face appointments which allow patients to have a conversation about their care without inconveniencing them through additional waiting, travel, parking etc. whilst freeing capacity to treat patients on existing waiting lists;
    f. Implementation of two way text reminders to improve both clinic utilisation and theatre utilisation, treating patients in a slot that may otherwise have been wasted;
    g. Continued care efficiencies for admitted patients, increasing the elective surgery rate. This includes improvements in scheduling, and reduced cancellations (by both the hospital and patients) for clinical reasons by improved pre-operative assessment;
    h. Support training and development of GPs and primary care teams to prevent referrals;
    i. Use diagnostics in primary care to reduce the number of referrals into secondary care.

Delivering First Contact Practitioner

20. The *NHS Long Term Plan* has identified that the placement of physiotherapists (First Contact Practitioner) within general practices to act as a first point of contact for patients with musculoskeletal concerns greatly improves experience, reduces pressure on primary care and often removes the need for ongoing treatment.

21. By 2023/2024 all members of the public are required to have access to a First Contact Practitioner within general practice, with 15% of STP populations required to have access to a First Contact Practitioner by 2019/20 (for LLR this is 136,532 people). General Practice and the new Primary Care Networks are being supported to develop First Contact Practitioner services. This support will ensure that from the 1st October 2019 150,603 LLR patients will have access to a First Contact Practitioner (which is above the 2019 required 15%). During 2019/20 we will work with all partners and patient groups to develop a full system plan to ensure 100% coverage by 2023/24.

22. In advance of the First Contact Practitioner Transformation programme from NHSE, LLR had developed a 'Self-Referral Physio Pathway' and ran two FCP pilots from 2018/19. This resulted in a reduction in the number of referrals made to orthopaedics and 96% of patients would recommend the service.

Diagnostics & Imaging

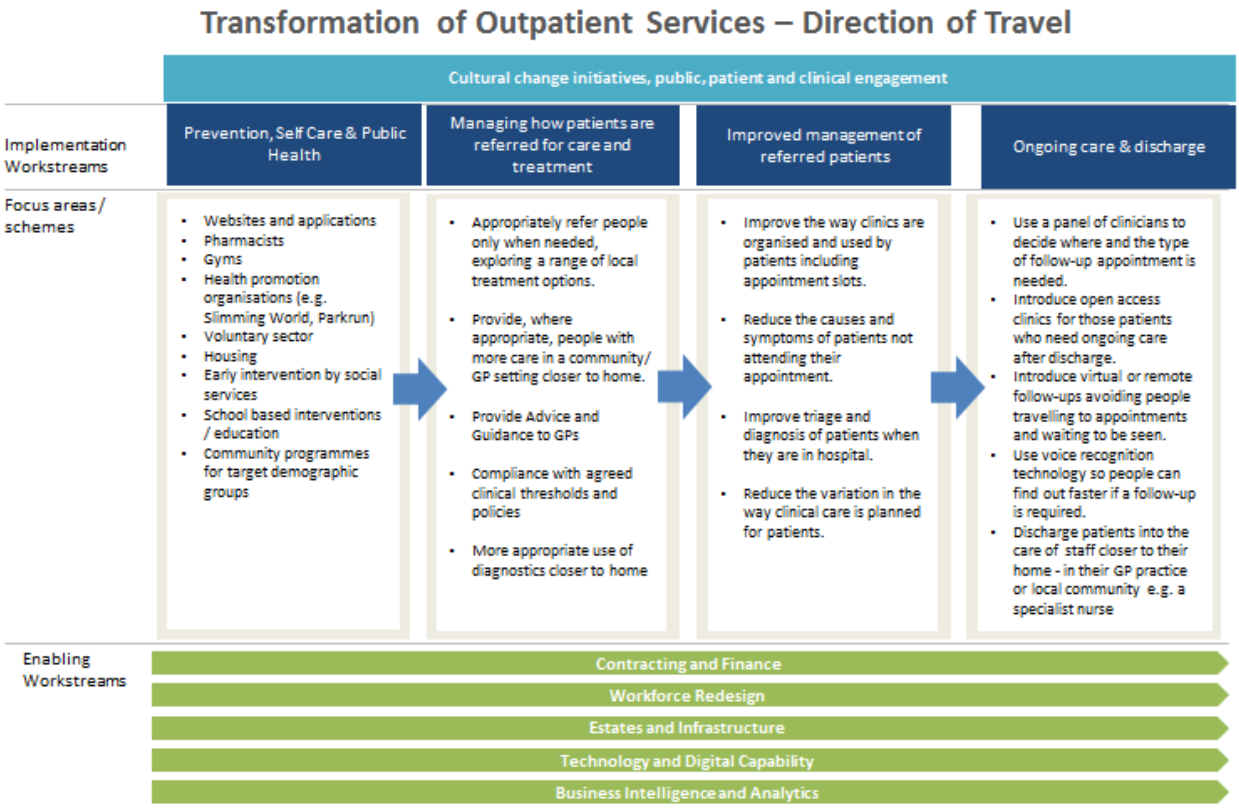
23. There is notable variation in the requests for diagnostic/imaging investigations amongst our GPs and secondary care doctors and this variation can result in unnecessary patient investigations. During 2019/20 we are working collaboratively across the system to ensure that every test/investigation is clinically appropriate (for the patient's needs), not duplicating previous tests and in line with recommended guidelines.

24. To deliver this programme we will undertake a series of system-wide clinical pathway reviews as well as service transformation. We will also share benchmarking data with practices via the primary care teams to provide GPs with the visibility on how they benchmark with peer practices, and what the drivers of their relevant diagnostics/imaging benchmarks are. We will also develop a system-wide training programme to support these discussions.

Transforming our outpatients and reducing follow ups

25. As a system, we are committed to transforming how we deliver outpatient services for the population of LLR. We aim to deliver "best in class" outpatient services, designed around the needs of our patients.

26. We are developing an emerging direction of travel with key stakeholders, and initial thinking at this formative stage covers four main areas:



a. Prevention, self-care and public health

i. Everyone knows that prevention is better than cure. Similarly, the long-term sustainability of the NHS depends on doing all we can to keep people healthy and away from dependency on NHS services. We will do this by close working with public health for the STP area, Leicester City Council, Leicestershire County Council and Rutland County Council, the voluntary sector and, by making sure the NHS takes appropriate action.

ii. We aim to work with local gyms and other organisations such as WeightWatchers, Slimming World, schools and workplaces to develop appropriate dietary and exercise programmes which aim to reduce the incidence of a range of long term conditions.

iii. Use digital technology to support patients in their own home, such as the use of websites and apps will help patients with their self-management to improve care and support independence.

iv. This approach is aligned with the *RCP Report* and *NHS Long Term Plan* which suggest services should be designed to minimise disruption to patients, valuing patient and carers time and beginning to shape patient behaviour in terms of supporting them to manage their own health through healthier lifestyles.

b. Managing how patients are referred for care and treatment

i. Expand the range of elective specialties using RSS and where appropriate, maximise the range of treatment options in primary and community care. For example, we are already providing hand surgery and Dermatology from six GP practices across the city and county and plans are in place for a hernia hub and glaucoma follow-ups to primary care later in the year.

ii. UHL Consultants in a range of specialties have sessions dedicated to provide advice and support to GPs to manage and treat patients in a timely fashion instead of a traditional referral being used as the only form of receiving specialist advice and opinion.

c. Improved management of referred patients

i. Throughout 2018/19 UHL have implemented technology across 98% of outpatient clinics and have seen reductions in the number of missed appointments. In 2019/20 and 2020/21 we will implement this technology across community and primary care outpatient clinics. Ensuring every outpatient clinic is fully utilised is a central priority and through a weekly review process, new scheduling tools and standardising clinic templates, UHL will maximise the number of appointments delivered.

d. Ongoing care and discharge

i. A large scale transformation in follow-up care is required in order to achieve the *NHS Long Term Plan* commitments. We want to approach decisions by asking first what is best for patients and the system:

1. Is a further follow up appointment required?
2. Can the patient self-manage?
3. Is virtual management possible?
4. If a face to face follow up appointment is required, does the patient need consultant review and can it be undertaken by other clinical

staff in primary and community care (GPs, specialist nurses, optometrists etc)?

ii. We already have successful examples at UHL, such as the Leicester Arthroplasty Remote Clinic (LARC), where hip and knee replacement patients receive a virtual clinic assessment following completion of a co-designed patient questionnaire at one year as opposed to a follow up appointment post-surgery at 6-12 months. This has led to improved clinical outcomes, higher patient satisfaction scores and very low rates of patients requiring actual physical attendance in clinic (eg 1% of hip replacement patients).

iii. We will use lessons learnt from Vanguard sites such as Morecambe Bay where they have implemented patient initiated follow up (PIFU), which put the patient in control of any further outpatient appointments with consultants or nurses for their existing condition. Instead of being offered regular clinic visits and routine check-ups with their consultant, patients can make their own appointment only when they need it e.g. when a patient experiences a flare-up of their condition.

Reducing the number of patients with long waits

27. The number of patients waiting over 18 weeks (long waiters) has been steadily increasing as treatment capacity has not grown fast enough to keep up with patient need. Within UHL, each clinical specialty (such as Dermatology, Urology, Gynaecology) holds a weekly meeting where 'long waiting' patients are reviewed. Patients are booked according to clinical priority and then in date order.

28. Patients who are approaching a 40-week waiting position are reviewed via a Weekly Access Meeting (WAM) chaired by the UHL Head of Performance. Specific actions are noted against individual patients in order to ensure treatment prior to 52 weeks. These actions are reviewed at each meeting to ensure agreed steps are taken. If at the weekly meeting the service highlights a patient cannot be seen within 52 weeks, this is escalated and a proactive plan to treat patient is developed.

29. UHL has not had any patients waiting over 52 weeks since June 2018 and plans to have no patients waiting 52 weeks in 2019/20. Effective implementation of the transformation of outpatient services will be critical to the continued delivery and improvement of this standard.

Ophthalmology Transformation

30. In 2018/19 NHS England launched a series of high impact interventions within Ophthalmology to minimise the risk of harm to patients both now and in the future. Within LLR we have responded to this and developed a system wide plan to improve Ophthalmology service provision.

31. During 2018/19, we undertook a system-wide assessment of our Ophthalmology service provision. The findings identify that the demand for our ophthalmology services outweighs the current capacity. To address the high impact intervention challenge we will re-design our Ophthalmology services by the first quarter of 2020/21. This will include:

    a. Increased provision of safe, appropriate ophthalmology services away from acute Hospital Eye Services (within primary and community settings);

b. Increased care delivered closer to our patients home;
c. Continued service redesign in acute Hospital Eye Services;
d. Improved management of waiting lists and the associated risk of delays to follow up appointments;
e. A single ophthalmic Electronic Patient Record (MediSOFT) for Hospital Eye Services in UHL and UHL pillar of the Alliance will be introduced.

26 Week Choice

32. The 26 weeks choice commitment was set out in the *NHS Long Term Plan* to enable those patients waiting longer than 26 weeks to be offered a choice of alternative faster treatment.

33. As a system we are considering options on how this will be achieved given the capacity constraints across many of the local providers used by our patients. There is work in progress to review the processes in place to manage our longer waiting patients (40 weeks) and identify how these individuals' wait can be reduced to 35 weeks or less and this is work in progress.

34. We are currently reviewing patients on the waiting list within clinical specialties within our RSS to determine if an alternative treatment pathway could be offered.

Theatre Productivity

35. Within UHL and community hospitals, we have access to 45 inpatient or day case operating theatres. Our operating theatres are vital to the delivery of excellent cancer care, routine operations and ensuring that our patients wait no longer than necessary. Following a referral from a GP, our patients will be seen in an outpatient appointment. Within this outpatient appointment a decision will be made to list the patient for surgery that is completed in a day or an operation that will require an overnight stay. Following this listing process our patient will experience a preoperative assessment to ensure they are optimised for surgery before the operating takes place.

36. We are aware that within UHL, elective theatres have benchmarked in the lower quartile of performance on key measures such as starting and finishing on time as well as how many operations are undertaken in a four hour operating period. This lower quartile of performance has a negative impact on patient care with our patients having to wait longer for treatment and recovery. With this in mind, the UHL Theatre Improvement Programme was developed to provide safe, efficient and effective elective operating theatres that places the patient at the centre of the service.

37. Throughout 2018/19, the theatre programme has increased efficiency levels within operating theatres and allowed Orthopaedics surgery to continue through the winter (despite the pressures of additional emergency patients). This improvement has allowed outpatients to wait for a shorter period of time and reduce reliance on the private sector hospitals to treat NHS patients.

38. The approach to improving theatre productivity is a multidisciplinary programme that involves surgeons, nurses, administrators as well as patients and GPs. We believe that there are further efficiencies available above those delivered in 2018/19 (identified by NHS England Four Eyes Insight). Specifically, UHL's plan to accelerate the efficiencies

associated with combining day case activity into one site through the LLR reconfiguration programme.

Consultation

39. Over the past few years, either for specific planned care projects or wider BCT events, we have undertaken insightful engagement with patients, service users, carers and staff to understand their experiences of health and social care services and what matters most to them. The insights gathered through this engagement provide an evidence base to influence our transformational planned care programmes. We are committed to ensuring that patients and stakeholders continue to be involve including in co-designing digital services.

40. To date, the insights we have captured are that what matters most to people includes:

    a. People want care closer to home where possible, provided by experienced, caring staff;
    b. People want IT systems that talk to one another and improved professional relationships across services, so that there are no barriers;
    c. People want to see 'whole person-centred care' including a focus on mobility and on physical and mental health as equals;
    d. People want improved signposting and education on use of services to support self-care, so there is more prevention and people need to go to hospital less;
    e. Service users and carers need information that is appropriate, accurate, relevant and in an accessible format. Service users and carers feel empowered by having accessible and correct information on their diagnosis and treatments;
    f. People living with long term conditions want to be able to look after themselves when possible, but to know that support exists for them when they need it.

Conclusions

41. The historic model of outpatient care is no longer fit for purpose and continued rates of growth and use of the acute services is not sustainable, neither is it right for patients going forward. The *NHS Long Term Plan* and *RCP report* recommend optimising the benefits of alternative models and increasing the availability of non-face to face appointments going forward.

42. Work is already in progress through projects such as RSS and is having an impact in terms of reducing demand into stretched hospital services. An emerging direction of travel is being informed by stakeholders to transform how we deliver care, putting patients at the centre of their care, valuing patient carer and staff time, as well as making sure patients are managed in the most effective way by the right professional at the right time and in the right place.

43. Technology will have a significant part to play in terms of how we communicate with patients and train and begin to shape patient behaviours to better manage their own healthcare. Connectivity between systems to assist care providers in delivering value adding care and eliminating waste is a challenge but forms a vital part of delivering high quality care in the most efficient way.

44. Insight from patients, service users, carers and staff will continue to be used to develop plans for transformation and to understand the impact of the improvement we are making.

Background papers

https://www.rcplondon.ac.uk/projects/outputs/outpatients-future-adding-value-through-sustainability

https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

Officer to Contact

Ket Chudasama, Director of Performance and Corporate Affairs, WLCCG / Joint SRO LLR Planned Care
Telephone: 01509 567739
Email: Ket.chudasama@westleicestershireccg.nhs.uk

List of Appendices

N/A

Relevant Impact Assessments

Equality and Human Rights Implications

45. A full equality impact assessment (EIA) is undertaken for the planned care programme and EIAs are completed for individual planned care projects and are available upon request.

This page is intentionally left blank