NHS
Dudley
Clinical Commissioning Group

Healthcare Forum at DY1

14th December 2017

Dr Steve Mann welcomed those who attended.

It was noted that as of 2018, beverages will be provided only at future forums.

Update on MCP
It is proposed that a new organisational Trust may be established for the MCP.

Work continues with the development of the integration agreement between GP's and the MCP.

Significant decisions are expected to be made over the coming months and it is hoped to conclude the dialogue phase beginning March 2018.

Presentation delivered by Neill Bucktin, Director of Commissioning (attached)

Slide 1 – Service Area Total Spend by Year:

- £400million budget with the areas covering Mental Health, Acute, Continuing Healthcare (CHC) and the smallest spend is in Primary Care compared to the Acute service area.
- Year on year spend increases for Acute and Secondary Care (Primary Care has significantly less funds available compared to the Acute setting).
- Running Costs includes the admin budget and was noted to be decreasing year on year.

Slide 2 – Service Area Spend Increase Comparison by Year:

Relative funding increases are predominantly reported in the Acute setting.

Slide 3 – Question on Future Plans:

The Dudley Clinical Commissioning Group recognises the challenges and wishes to bring services under one umbrella in order to improve performances and reduce variations in performances and referrals.

Slide 4 – Outpatient 1st Appointments for GP Referrals:

- 12 Dudley Practices are significantly above the expected referral rates.
- The amalgamated data for these 12 practices shows that referral rates in 12 specialties are significantly above the expected rate.
- There is a need to look at the variations between the GP referrals and establish clear guidelines and practices.

Slide 5 – Outlier Practice impact across Points of Delivery (Dudley):

- 8 Dudley practices are significantly above the expected A&E attendance rate.
- The amalgamated data for these practices shows that attendances are 15% above the expected rate.
- 2,045 more attendances than expected per annum from these practices have been reported.

- 7 Dudley practices are significantly above the expected emergency admissions rate.
- The amalgamated data for these practices shows that emergency admissions are 22% above the expected rate.
- 1,851 more emergency admissions than expected per annum from these practices have been reported.

- 11 Dudley practices are significantly above the expected elective admissions rates.
- The amalgamated data for these practices shows that elective admissions are 13% above the expected rate.
- 1,622 more elective admissions than expected per annum from these practices have been reported.

- 12 Dudley practices are significantly above the expected Outpatient referrals rate.
- The amalgamated data for these practices shows that Outpatient referrals are 14% above the expected rate.
- 5,100 more Outpatient appointments than expected per annum from these practices have been reported.

The key question across all these areas is 'Why?' Dudley CCG has 46 practice members and they all have system variations; there is a need to look at resources.

Slide 6 – Planning for 2018/19:

- Before the CCG can decided how to allocate budgets and agree contracts, the CCG must ensure that the National Requirements and Standards are met ie. A&E targets etc.

- Implement Better Care Fund by transferring resources to spend on social care. The CCG must transfer £7.5million to the local authority.

- Parity of Esteem for Mental Health – the CCG expenditure must increase to ensure the National Requirements and Standards are met.

- Child & Adolescent Mental Health Services including Eating Disorder/Tier 3 service requires an increase in budget of £365,000 which occurs over a three year period.

- GP Services – GP Five Year Forward View – this was published four years ago and requires additional funding.

- Quality, Innovation, productivity and Prevention "QIPP" – the CCG must make a saving of £17million in 2018/2019.

Slide 7 – QIPP – Potential Areas:

Discussions are ongoing with other CCG's, clinicians in both the secondary and primary care areas on where savings can be made, but to ensure a consistently high level of service to remain:

- Reducing variation
- Clinical Effectiveness and Activities of Limited Value (new prescribing policy implemented)
- MSK – Relative Expenditure and Pathway Changes (look at how we spend more money than other CCGs in the UK; there is a need to change pathways into services)
- Community Based Rehabilitation (there is a need to reduce spending in the acute setting and look at the services in the community; this would allow more vulnerable patients to remain in their own homes)
- Non Obstetric Ultrasound Referrals (look at referrals and feedback from social care)
- Paediatric Triage – Extension (this has been very successful and there is a wish to extend this service. Look at how the GP practices can obtain advice)
- Reducing Unnecessary Out-Patient Follow-Up Attendances (majority are unnecessary, how can this be reduced)
- Review Emergency Admissions (many admissions come from care homes and are predominantly falls. How can this be reduced? This is a key issue for the MCP.)
- Chemotherapy at End of Life (this adds to the trauma of the patient, there is a need to invest further in this area)
- Bariatric Surgery – Access Criteria (there is a need to review and address the access criterion)
- Reviewing Referrals (a peer review is required. GPs can obtain from clinical colleagues. A Referral Management Services may be required)

Slide 8 – Questions To Consider:

1. Is the balance of spending right?
2. Where should we spend more?
3. Where should we spend less?
4. Is it appropriate to restrict access to services such as bariatric surgery?
5. What other restrictions might apply?
6. What is your view of the QIPP plans?

Each table was tasked with answering a question and providing feedback later in the meeting.

Feedback from discussion and flipcharts

Is the balance of spending right?

- Outcome based
- Balance is clearly not right – have to have an MCP
- Investment in community and primary services
- Inappropriate referrals to secondary care
- Must be done – Planning requirements
- Differing tends of skills in primary care – CPD to develop skills
- Savings can be found both in primary/secondary care
- Follow up appointments

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Where should we spend more?

- Prevention
- Triage at GP surgery before seeing GP
- Promotion of other services 3rd party
- Education
- Promote wellness & services and provision
- Domestic abuse, more services, mental health
- More targeted services for cancer alternative medicines

Where should we spend less?

- Reduce acute spending but needs extra money up front to do
- Work with hospices to learn how to do end of life care better (best practice)
- Identify services provided by clinicians that could be provided in partnership with voluntary organisations in the community – de' professionalise some preventative services if a clinician not needed
- Move services into the community settings like out-patients clinics/physio
- Hold consultants more accountable for variations in approach – more consistency/protocols for out-patients follow ups
- Re: withdrawing chemotherapy at end of life – might be a good idea but who decides in individual cases – don't keep people alive against their will
- Buy generic medicines rather than expensive ones
- Inappropriate referrals
- Primary care- Dr's seeing patients who need the skills of a DR

Is it appropriate to restrict access to services such as bariatric surgery?

- Get away from the idea that everything is free
  - Self discipline
  - Educate the young
- Combined services??
- Vanity services??? Depends on reasons
- Restrict access to services – yes subject to triage
- Restrict to cosmetic uses?
- CRITERIA
  - Physical issues
  - How do you measure pain?
  - Need?
  - Playing the system?? : Rely on GP's own experience
- Mental health issues
- Risk versus cost?
  - Cut access to ambulance services
  - 111 service fit for purpose

What other restrictions might apply?

- Blanket restriction should not be introduced. Each situation needs to be considered based on…
  - Impact to person
  - Quality of life
  - Cost to other services such as mental health

- Communication/Reducing Variation
- How GP's communicate with patients is key – the level and detail of information given has a massive impact on choices that effect recovery

What is your view of the QIPP plans?

- Q: Are these good or bad GP practices, as the patients registered with them are clogging up the A&E? Could it be the area from which the patients come from?

- A: Mr Bucktin advised that social deprivation can affect this and the CCG are to look into all factors. There is a need to understand why this is happening.

- Q: The CCG should understand the issues of the practices. Should the practices justify themselves to the CCG?

- A: Dr Gee confirmed that he visits all the practices and in one month alone 161 DNA's (Did Not Attend) were reported in November 2017. This equates to 1.5 day closure of a GP practice. This problem is created by the patients, regardless of asking for appointments to be cancelled if no longer required.

- Mr Bucktin advised that there is a variation between secondary care as well as in primary care ie two consultants may see one patient in different ways – there is a need to look at the services.

- Dr Mann stressed that the key is to help change patient expectations and behaviours. Patients must understand the impact of their behaviour on the services. This is a national problem it is not isolated to the Dudley area. The loss of funding from failed attendance at appointments could be used for other services ie hip replacements, ITU beds or nurses etc.

- Q: Some patients are unable to get a doctor's appointment for two weeks – so patients attend A&E. What should they do?
- A: Dr Mann advised that patients do not always know how to use the services available ie. Self-refer to physiotherapy – this saves GP time and money.

Dr Mann thanked everyone for their honest feedback.

Date/Time/Venue of next Healthcare Forum

Date: 22 March 2018
Time: 4.30pm
Venue: Brierley Hill Civic Hall