Response to NHS Chief Executive’s Open Call for Evidence and Ideas

Respondent ID: 4

Organisation name: Warrington PCT

Type of response: Multiple documents
My background:

NHS Turnaround Director – track record, using business innovation, of successfully delivering turnaround/ transformation in health economies;

Emeritus Professor (Business Innovation Knowledge Transfer), Manchester Metropolitan University Business School;

Author of six books focussed on optimising NHS delivery of government reform, including on Transformation, Reform and Efficiency, Prioritisation and the adoption of commercial approaches.

My response:

I use business process engineering to change the approach of NHS organisations in delivering reform, QIPP and turnaround. Recent successes include £15m QIPP in Western Cheshire (2010/11) with a further £15m in delivery this year and £25m turnaround in delivery in Warrington. The approach is so effective that it is being adopted by other health economies and by AquA. That is, I have a track record in getting NHS organisations to adopt and spread innovation.

I have also been in discussion with the DH, predominantly with the Right Care team, but also with John Oldham and with Barbara Hakin’s team, on how to share this innovative approach. To date, this has included case studies and is due to include press coverage and webex seminars. However, these approaches do not deliver en masse – they all rely on others wanting to innovate and seeking out how to do so. It does not, therefore, ensure wider adoption in itself.

If approaches such as mine were more widely adopted, turnaround would rarely occur in the first place and NHS reform policy would be more effectively implemented across the system.

There are two key workstreams that do not exist in a formalised and systematic way in the DH/ NCB that would facilitate wider and faster adoption of innovation:

1. The identification of transferable innovations from the private sector – for example, Manchester Airport and Salford University have agreed in principle with me to conduct a three-way knowledge transfer project with the NHS in which we share techniques and effective practice on pathway specification and change implementation. The similarities in principle and operation of pathway management in airports and hospitals are extensive. The NHS could learn a huge amount from this project. However, despite agreement in the project’s potential value from all NHS/ DH parties I have discussed this with (e.g. DH Long-term conditions team, AquA, NWSHA), there is no relevant work- or funding stream to support it.
2. The DH has focussed the NHS in recent years on ‘what to deliver’ (via targets and the cascading of national benchmarks). Whilst this is a useful part of the system and inevitably has to be part of the remit of the NCB, it should increase the level of focus given to ‘how to deliver’. All parts of the NHS know what they ought to be doing, what changes need to be made, etc. Where individual organisations fall down is on how to actually do it. If the NCB produced ‘how to’ guides to known success methods, techniques and processes (such as the business processing approach I use), promoted their use and supported their adoption (via, for instance, regional workshops, the consortium development workstream, etc), they could then build this into the accountability system. That is, not necessarily oblige the use of these innovations, but be clear that, if economies/ organisations do not deliver the required value and outcomes, they will need to explain why they didn’t use the known success techniques and then be expected to adopt them to improve performance. That is, a support/ oversight system that says “we know these approaches deliver and we can help you to adopt them – you don’t have to adopt them but you had better deliver the same or better outcomes using other means or you will have to.”

The systematic business process approach I embed in organisations that is succeeding in delivering QIPP and turnaround in Western Cheshire and Warrington and has previously succeeded in delivering world class commissioning, transformational change and the adoption of commercial approaches, is generic, transferable and delivers the objectives of the NHS, whatever these are at the time. It works for commissioners and providers alike and is how many of the most successful organisations in industry function. I would be more than happy to discuss this and how to spread it across the system. Please feel free to contact me on matthew.cripps@wcheshirepct.nhs.uk or matthew.cripps@warrington-pct.nhs.uk
Business Process Engineering

Business process engineering is a term used to describe the systems, techniques and tools employed to coordinate and direct the corporate management structure of an organisation to deliver its core purpose. When designed and operated effectively, it ensures:

- A focus of management and supporting resources on the objectives and purpose of the organisation, for instance, to improve the healthcare system and deliver financial sustainability;
- Delivery of prioritised outcomes, such as patient safety in an environment of expenditure reductions;
- Development of proposals in a way that ensures appropriate decision-making;
- Decisions at optimal points in the process to drive delivery;
- Actual and timely implementation of decisions made, and;
- Minimal use of resource on inappropriate/unnecessary activity, such as on the development of reform proposals that are not viable or capable of implementation.

The approach encourages the generation of proposals to improve the health system and deliver a financially sustainable health economy. It drives the use of the optimal lever to implement individual changes, for example contract management, clinical leadership, policy development or procurement. It assures the governance process throughout and aids decision-makers to make clear and concise decisions that drive the next step towards delivery.
The Healthcare Reform Process

The Healthcare Reform Process takes reform, innovation and efficiency proposals from initiation, through case for change development to delivery. The process plays a key role in generating the ideas for reform and identifying the opportunities for innovation and efficiency, both via the market and via pathway and service redesign and consolidation.

The key components of the system are: A Service Review; A clinically-led policy development process to ensure the continuing sustainability of the health economy; A programme approach to delivery, and; The business delivery process itself.

The Service Review Programme reviews all service areas currently provided within the economy to determine their worth and the opportunities for efficiencies and improvements.

The clinically-led policy development process ensures the appropriate level of appropriate treatments are provided within the economy, accounting for the benefit to patients and the wider population and for the level of available resource.

The business delivery process takes the findings from both of the above, plus innovative proposals for reform from other sources, adds detailed option appraisals, service specifications, costing models and impact assessments as appropriate, and processes them through clinical and corporate decision filters (such as a Board committee). Implementation of approved proposals is then delivered by the contracts, procurement and primary care development functions, working closely with other directorates and stakeholders.

The business delivery process is underpinned by a programme approach.
NHS Western Cheshire

Business Processing and QIPP Service Reviews
Headline Summary

• NHS Western Cheshire deliver £7m savings from 1st Wave of Service Reviews

• Contracts team then increase this to £11m by spreading principles across secondary care contracts

• More savings to come from repeating process – Waves 2, 3, 4…etc
How?

• Designed and implemented a new systemised approach to reform, decisions and implementation

• Focus on:
  • driving down spend

• Used Investment Pack data, evidence and tools

• Created lean PCT – management time focussed on viable reform projects and cutting costs
How long?

- Months 1 and 2 – Wave 1 Service Review diagnostics and cases for change

- By end of Month 3 – immediate impact savings delivered

- By end of Month 6 – 80% of savings delivered (rest are longer term – delivered via procurement)

- Month 7 – start Wave 2 Service Reviews
Who?

- Every commissioner involved – Chief Executive to Band 5 Project Support
- GP commissioners/clinical champions
- Provider clinicians, executives, general and business managers
Overcoming Barriers

• Culture – “what about the day job?” became “reform is the day job”

• Evidence and relevant information – used Health Investment Pack data and tools for
  • 1) Identifying where to look
  • 2) Diagnostics
  • 3) Case for change

• Clinical buy-in – GP clinical champions and Acute clinicians held key project AND delivery roles
Lean PCT

• Use decision trees to guide managers through policy and operational decision process
• Only spend time on viable, deliverable, net-saving projects
• Re-align corporate processes to support reform proposals and delivery
• Focus executive and committee decision-making time on reform
• How? Provide tools:
  • Systemised Corporate Process
  • Templates that collate evidence and give decision-makers the detail they need (and no more!)
  • Decision trees that guide when to take which decision
  • Decisions lead to delivery (not requests for more information)
  • Unavoidable implementation processes
Moving PCT, GPs and Health Economy (QIPP level 2) from Red to Green end to facilitate continuing delivery

Ability to change

Focus on targets
Multi-layered decision-making
Unclear accountability
Bureaucratic

Relevant metrics
Efficient business processes
People aligned and engaged
Streamlined organisation

CHANGE SPECTRUM
Some of the outcomes…
New trend in Western Cheshire – Demand Management is working
2010/11 ACUTE SPEND

System reform achieved

Still to be delivered

Traditional performance against outturn

2009/10 outturn

2010/11 actual

2010/11 budget
Business Process Engineering

- Key principles of BPE are:

- Every activity drives and adds value to the next activity (business pathway = same principles as clinical pathway)

- All activities culminate in delivery
  - Delivery means real change in the healthcare system

- Don’t Waste Time or Effort
*As minimum, to include Clinical Sponsor, Project Manager and leads from Finance and Contracts, Public Health, Information and Communications

**As minimum, to include Business Commissioning Support Unit and Key Provider engagement (managerial and clinical as appropriate)
Service Review Pathway – Diagnostic steps

Step 1 – define:

CURRENT SERVICE

- Fit for Purpose
- Efficiency and market options
- Supply and capacity options
- No/low benefit

Step 2 – define:

FUTURE SERVICE

- Maintain
- Redesign, Contract, Procure
- Contract, Procure, Divest
- Divest

Step 3 – categorise:

- Step 3 - categorise:

- Step 4 – recommend:
Reform Ideas Pathway: Decision Tree to prioritise proposals

**Priority**

- High
- Med
- Low

**Net impact**

- > £0.25 m
- > £0.1 m
- < £0.1 m
- > £0.5 m
- > £0.25 m
- < £0.25 m
- > £0.75 m
- > £0.5 m
- < £0.5 m

RoR = Now: Fast & Easy → Y
RoR = 0-2y: Fast → Y
RoR = >2y: Easy → Y

1. If there is no clear evidence of impact and the rate of return is greater than 2 years, select Do Not Proceed. If rate of return is immediate, select Analyse (i.e. seek more evidence). If rate of return is 0 to 2 years, make selection based on strength of evidence.

2. Net impact ranges and Priority levels are based on fast and easy implementation. If proposal is fast or easy, add £0.1m to net impact ranges.

**Case for Clinical Policy**

- Y → CPD
- N → DNP

DNP = Do Not Proceed
eol = Evidence of Impact
CPD = Clinical Policy Development
RoR = Rate of Return

If “DNP” or “Low”, assess if there is any appropriate exceptional circumstance for an alternative decision.
Service Reviews
What are they?
Where are we up to?

Summary Presentation
Background

• Part of the £15million of savings for 2010/11. We will have to disinvest in some health programmes and services to invest in others.

• This programme focuses on “allocative efficiency”: using our resources to produce the right quantity of each service. The “right quantity” must take into account the views of patients and the wider public.

• The programme will help us deliver one of the core requirements of a commissioning organisation; to understand what we spend our money on and what value we get from it.
Methodology

Three stage approach:

1. Understanding our current expenditure
2. Service reviews of identified areas / health programmes
3. Implementation of agreed recommendations from service reviews
Understanding our Current Expenditure

- We have analysed, by health programme, our expenditure using the most up to date comparative information. We invested £373 million of the public’s money in 2008/09.

- Programme budgeting information gives a greater understanding of where public money is being invested in the NHS and what value is obtained for the investment.

- The information maps all expenditure to 23 programmes of care based on medical conditions such as mental health, cardiovascular disease and cancer.
Chart 1: Column Chart showing the variance of NHS Western Cheshire expenditure from cluster average for main programmes

Source: Department of Health 2008-09 Programme Budgeting PCT Benchmarking Tool
Where we spend more than we should!

- We have used this information to compare our expenditure with that of similar organisations (other prospering smaller towns). This shows that we spend more on:

- Genito urinary system (£24.3m) - £2.7m more than similar PCTs
- Musculo skeletal system (£26.5m) - £2.5m more than similar PCTs
- Circulatory problems (£39.2m) - £3m more than similar PCTs
• Our intention is to systematically review all programmes over the next two years

• Service reviews have been conducted using a four stage process:

1. Describe current services: cost, volume, efficiency and effectiveness

2. Define best practice: Rapid appraisal of what the best performing organisations are doing

3. Recommendations: Identifying proposed changes within the service to prevent illness increase quality, drive productivity or introduce innovation (QIPP!)

4. Implementation. Delivering the required commissioning changes
Cardiology

- Major burden of ill health in Western Cheshire so a proportionately higher spend in this area is expected and may be appropriate
- However, benchmarking information shows efficiency opportunities
- Primary prevention will play a key role in managing demand
- Comparative information suggests reduce the overall number of outpatient attendances. Introducing clear referral pathways for cardiology and educating GP practices about cardiology management and care pathways will reduce this variation.
- There are also opportunities to explore transferring outpatient care from the acute sector to primary and community care.
- The length of stay data suggests that service redesign can release savings through reduced length of stay and excess bed days in secondary care.
- NHS Western Cheshire benchmarks poorly in national efficiency indicators (better care better value) for prescribing of drugs relating to the management of cholesterol and heart failure.
Recommendations

• Do more vascular health checks focusing on men within the most deprived areas. This would cost c. £120,000 as well as additional expenditure on prescribing but is estimated to save around £1.6m for NHS Western Cheshire.

• Continued focus on the identification of patients with hypertension (high blood pressure). This would cost c. £360k in primary care prescribing. Estimated savings of £1.37m in non-elective stroke admissions.

• Reduce outpatient attendances (estimated saving £185k):
  – Introduce referral thresholds for GPs
  – Commission a “telephone consultation clinic” for GPs to speak to consultant at agreed phone consultation tariff.
  – Establish a community-based service for cardiac patients

• Reduce outpatient attendances following an emergency admission by referring an agreed cohort back to primary care Estimated saving £65,184.

• Introduce a threshold for varicose vein treatment. Estimated saving £237,480.

• To improve Deep Vein Thrombosis (DVT) pathway (already at case outline stage). Estimated savings of £259,440

• Reduce excess bed days through contract enforcement (i.e. not paying for lengths of stay beyond peer group of hospitals) Estimated saving £205,000

• Increase the efficiency of statin prescribing Estimated savings £400,000.

• Increase the efficiency of heart failure prescribing. Estimated savings £180,000.

• Ensure benefit realisation from introduction of generic version of clopidogrel. Estimated savings £500,000
Out Patient 1st Attendance Following an Emergency Admission per 1000 Population
Orthopaedics

- Reduce outpatient attendances which increased last financial year
- Reduce follow up appointments following joint replacement.
- Determine whether the musculoskeletal assessment service adds any patient or administrative value to the pathway.
- Major inefficiency of our utilisation of the Independent Sector Treatment Centre at Halton. Although this contract is about to enter its final year it is essential that NHS Western Cheshire focuses its attention on achieving better value for money from this contract.
- Scope to reduce prescribing by about £50,000 in this programme area.
Recommendations

- Review musculo skeletal assessment service- best practice services manage 80% of referrals within a community service.
- Maximise the usage of the ISTC contract: Estimated savings of between £387k and £1.8m.
- Introduce more restrictive thresholds for carpal tunnel Syndrome surgery and other hand conditions: Estimated savings of £380,512.
- Implement the glucosamine prescribing policy. Estimated savings £50k.
ISCT - contract variance

Month | Value
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Jun-07 | £0
Jul-07 | £50,000
Aug-07 | £100,000
Sep-07 | £150,000
Oct-07 | £200,000
Nov-07 | £250,000
Dec-07 | £0
Jan-08 | £50,000
Feb-08 | £100,000
Mar-08 | £150,000
Apr-08 | £200,000
May-08 | £250,000
Jun-08 | £0
Jul-08 | £50,000
Aug-08 | £100,000
Sep-08 | £150,000
Oct-08 | £200,000
Nov-08 | £250,000
Dec-08 | £0
Jan-09 | £50,000
Feb-09 | £100,000
Mar-09 | £150,000
Apr-09 | £200,000
May-09 | £250,000
Jun-09 | £0
Jul-09 | £50,000
Aug-09 | £100,000
Sep-09 | £150,000
Oct-09 | £200,000
Nov-09 | £250,000
Dec-09 | £0
Jan-10 | £50,000
Feb-10 | £100,000

Target line at £0
Rheumatology

- Year on year increase in both first and follow up appointments

- Benchmarking information shows that there are efficiencies to be made particularly in follow up outpatient appointments through both contractual levers and in the shift of service to primary care. This has already been piloted by practice based commissioners and is now recommended for full implementation.

- There is also scope to administer intramuscular injections in primary care but this requires further work before a business case can be made for this change.
Recommendations

- Implement first to follow up ratio into contract with the Countess of Chester Hospital. **Estimated net saving of £248,214**
- Reduce number of reviews for stable chronic rheumatoid arthritis patients to once a year conducted at primary care rather than secondary care through the implementation of a Rheumatology Follow up service. **Estimated net saving of £20,000**.
- Promote the administration of intramuscular injections in primary care. Financial impact to be quantified.
- Localise Map of medicine pathways
- Education of GPs and practice nursing staff
- Improved self care management
Arthritis Summary and Recommendations

- Activity and cost information largely included within rheumatology.

- Two specific recommendations are being made as a result of the review and analysis of best practice elsewhere in the country.

- Introduce more restrictive thresholds for arthroscopic procedures for osteoarthritis of the Knee. **Potential Cost Savings: £76,413**

- Introduce more restrictive thresholds for surgery for Carpal Tunnel Syndrome and other hand conditions. **Potential Cost Savings: £380,352**
Osteoporosis

- Significant emphasis on prevention, targeting bone health and exercise as these have the strongest evidence base.
- Osteoporosis often only recognised after an older person falls and sustains a fragility fracture. NHS Western Cheshire has commissioned a fracture liaison service at the Countess of Chester Foundation Trust Hospital.
- Diagnosis needs to be confirmed by a DEXA scan. There is currently no local provider and GPs have to refer out of area to a range of providers who charge from £50 to £134 a scan. Analysis shows that around 400 additional scans are required if NICE guidance was followed systematically.
- Oral medication of a group of drugs called is one of the main treatments for osteoporosis and the review has identified efficiency savings in primary care prescribing.
Recommendations

• Redesign the DEXA scanning pathway and procure a local service. Potential Cost Savings: £51,024

• Increase the clinically appropriate proportion of patients on alendronate: Potential Cost Savings: £85,000 (assumes 50% conversion rate)
Urology

- Demand for urology services is increasing especially in the over 50s who make the heaviest demand upon urology care.
- Work is shifting away from surgery towards diagnostics and medical treatments
- There are a number of contractual opportunities including a cost reduction in a high volume outpatient procedure, setting follow up appointment ratio to that of comparable organisations, setting a benchmark for outpatient “did not attends” (i.e. “missed appointments”) and reducing lengths of stay.
- Quality schedules should include the requirement to deliver enhanced recovery programmes to support the reduction in lengths of stay.
- GPs should review patients who did not attend their appointment as well as those who appear to have multiple first outpatient appointments in one year.
- Redesign of community continence service to both play a greater educational role, particularly with the care home sector and to reduce outpatient referrals from general practice.
Recommendations

• Remodel urology services to develop “one stop” community clinics for haematuria, ultrasound, urinary flow diagnostic service. The service will also be able to deliver follow ups cystoscopies for bladder cancer. This links with the business case already under development for community diagnostics services. **Projected full year savings of £347,505.**

• Reclassification of cost of Dynamic Flow Studies reducing from £425 to £185 per attendance. **Projected full year savings of £200,000**

• Reduce follow up ratio. **Projected full year savings £87,630**

• Review multiple first outpatient attendances. **Potential savings of £45,654**

• Reduce DNA Rates for outpatient clinics (2205 wasted appointments a year). Savings would not directly accrue to NHS Western Cheshire but this could suggest a level of inappropriate referrals by primary care and could also enable the provider to reduce the number of clinic sessions.

• Contract for lengths of stay to that of comparable peer group. Embed enhanced recovery into quality schedules. Potential 455 bed day savings.

• Redesign of Continence services to provide an integrated service Specify requirement to increase education on continence issues to the care home sector. Redesign in other health economies has saved outpatient appointments and emergency admissions.
Urology: Practice Do Not Attend Rates
Review focuses on the patient pathway for chronic kidney disease

Currently 7537 patients registered as having chronic kidney disease with 112 patients receiving dialysis and 7 patients having received a kidney transplant during 2009/10.

Scope to increase the proactive identification of patients with chronic kidney disease and ensure these patients are robustly monitored in primary care

Earlier proactive identification of patients would reduce the risk of expensive “crash landers” where patients hit the acute system in renal failure.

Referrals from GPs has reduced slightly since 2007.

We refer more than similar PCTs and there is significant variation between practices.

High follow up ratio. Patient cancellation rate for follow ups is 25%.

We should work with specialist commissioning to contract for home and peritoneal dialysis. Financial savings here likely to be short term as a tariff change in 2011/12 is expected to be the same for all modalities.
Recommendations

• Work with primary care to prevent inappropriate referrals and delay the deterioration of chronic kidney disease. Initiatives should include:
  – Sharing best practice and raise awareness of variation
  – Clinical education events in primary care with secondary care clinicians
  – Awareness raising of NICE guidance/Map of Medicine through clinical networks
  – Inclusion of additional local quality indicators in line with NICE guidance within local quality profile particularly around anaemia management
  – Promotion of self-care including referral to Expert Patient Programme

• Bring outpatient referrals in line with cluster average to include:
  – Localise Map of Medicine to include local notes with link to referral template to standardise referral process and prevent inappropriate referrals
  – Implementation of an electronic referral template to standardise referral into secondary care
  – Peer review of referrals across localities to share best practice with support from nephrologists to reduce first attendances to cluster average

  **Projected savings:** £9,472

• Contract for first to follow-up ratio at national average (1:8) at specialty level at Countess of Chester Foundation Trust.  **Projected savings:** £269,400

• Shift specialist nurse follow-up clinics into the community. Projected savings: Not yet identified

• Redesign of care pathway to enable more patients to have home dialysis.  **Projected savings** £48,900 (likely to be one year only although still desirable as a quality improvement)
Diabetes and CKD prevalence per 1000 patients across Western Cheshire
Gynaecology

- We perform poorly on several indicators which likely to explain excess activity including GP first outpatient attendances and the first to follow up outpatient ratio.
- There is wide variation in referral rates between GP practices. It is estimated that NHS Western Cheshire could save approximately £350K on outpatient appointments alone.
- A lot of the issues identified in this service review can be addressed by actions under the following categories:
  – Defining service provision clearly
  – Educating and supporting clinicians.
  – Improving the pathways of current services
  – Removing service duplication and waste.
Recommendations

• Produce clinical guidelines for polycystic ovary syndrome, abnormal uterine bleeding, and pelvic pain. **Estimated savings: £29,600**

• Deliver GPs education programme on management of common conditions (menopause, referral criteria for fast tracks) and increase awareness of pathways and guidelines available. **Estimated saving: £29,600**

• Improve GP direct access to diagnostics ((trans vaginal ultrasound, pipelle biopsy, hysteroscopy). **Estimated saving: £29,600**

• Ensure community services undertake as many of the complex Mirena coli fittings as possible. **Estimated savings: £8,000**

• Reduce number patients not receiving 1-stop service and being charged multiple first outpatient attendances. **Estimated savings £7,600**

• Ensure procedures of limited clinical value policies are adhered to. **Estimated savings: £348,000**

• Review termination of pregnancy pathway and offer initial consultation in community. **Estimated saving: £26,000**

• Investigate the clinical and economic feasibility of introducing a community diagnostics service or intermediate tier service. **Estimated saving: £402,000** – will be some overlap with above recommendations (These are savings suggested in recent case outline)

• Develop service specification defining pathways and activity and link to contracts. No identified savings but recommended best practice.

• Ensure Map of Medicine is used as the portal for pathways and clinical polices by primary care and address “access issues” identified by GP practices. No identified savings but recommended best practice.