

Appendix T – Primary care demand management initiatives

Some examples of the sort of interventions that are being introduced to manage demand are described in the tables below.

1. Demand Management for 20% reduction in new referrals

Strand: Demand Management	
<p>What are we going to do</p> <p>Reducing the demand in new outpatient and referral activity by 20%. Managing the growth over the 5 year plan. The planned care work stream will support the CCG's with their elective demand management plans at both LLR and individual CCG level. This is based on the NHS Demand Management Good Practice Guide August 2016. Specifically supporting through the following:-</p> <ul style="list-style-type: none"> • Focus on driving down secondary care demand and referrals by 20% utilising referral management tools such as:- <ol style="list-style-type: none"> 1. PRISM 2. Advice & Guidance (roll out across all specialties) 3. Referral Triage Management <p>Whilst ensuring patients receive access to treatment in line with their constitutional right.</p> • Support and facilitate the development of speciality PRISM referral pathways and pathway redesign with an aim to have 200 pathways on PRISM by the end of September 2018. • Support the development of Referral Advisory Service in the community with an initial focus on MSK, ENT, Cardiology, Ophthalmology and Dermatology in the 'first wave' • Support CCG's with Practice Peer Review of referrals • Develop alternative to secondary care referral by having services available in primary care such as:- <ol style="list-style-type: none"> 1. GPwSI 2. Use of other health care professionals eg high street optoms / physio / ESP and specialist nurses 3. Community based clinics in the Alliance • Planned Care Implementation lead part of Clinical Priorities 	<p>Outcomes</p> <ul style="list-style-type: none"> • This will lead to a natural reduction in follow ups that are associated with the new appointment reduction therefore resulting in a reduction in follow up appointments as a direct link to the reduction in new appointments • Improved GP referral process with improved guidance and supporting guidelines to reduce the number of referrals into hospitals through the use of PRISM and Advice and Guidance. • Reviewing the evidence base, current LLR activity and existing clinical pathways and engaging directly with clinicians to agree a new pathway to redesign and/or reduce activity where identified. • Redesigned pathways to improve patient outcome and experience eliminate waste by taking out unnecessary steps. With clinical approval these will be available on PRISM. • Reduce unnecessary appointments that currently offer little benefit to patients, freeing up clinical time and space for more specialised requirement. Reducing space requirements and saving money • Better use of technology to help support the above • Ensure patients do not have treatment where the clinical value has no or little evidence to support this • Providing value for money and reducing spend • Support UHL moving from 3 to 2 sites • Provide GP's with Advice & Guidance in a range of Specialties reducing referrals. • Support the delivery of community clinics reducing the need for secondary care referrals

Strand: Demand Management

Implementation Group (CPIG) comprising clinicians and managers from CCGs and UHL plus Public Health Consultants. CPIG designing and implementing clinical thresholds and low value treatments policy.

- Support CCG's with Practice Peer Review of referrals
- Each CCG is undertaking its own Clinical Peer Review programme associated with their GP incentive schemes

2. MSK / Dermatology / ENT and Prior Approvals Referral Management Service

Strand: MSK Triage

What are we going to do

- Introduce a new Integrated MSK Triage model – this will incorporate Orthopaedics, Sports Medicine, Spinal, Pain Management and Rheumatology
- All referrals will be managed within the virtual Hub (as a single point of access) by an appropriate practitioner following a clinically approved referral process.
- The Triage has been rolled out across the above Specialities with the last one, Rheumatology, going live early 18/19
- The Triage is undertaken virtually by GPwSI who have an agreed level of MSK Triage. They are 'buddied' up with Orthopaedic / Rheumatology Consultants when needed
- The admin support is provided by the Alliance and is centralised so that it supports patients choice and captures relevant data to support the Service and ensure that outcomes are captured

To achieve this new Hub model we will be undertaking the following:

- Introduce a virtual triage
- We have also reviewed the provision of alternatives to secondary care to support patients, these include the triage providing advice & guidance to GP's, links to the MSK Physiotherapy model and the provision of community based clinics with appropriate trained GPwSI's. Access to podiatry and podiatric surgery, where appropriate

Outcomes

- A reduction in referral growth supporting demand management
- By introducing an integrated triage service, the pathway redesign will improve patient outcome and experience by eliminating waste and taking out unnecessary steps.
- Standardised service and a streamlined pathway will ensure consistency in care..
- Improved referral forms on PRISM
- Promote lower wait times, ensuring patients are seen and treated in a timely manner to prevent patients with acute conditions from becoming chronic.
- An improved MSK Physiotherapy service with close links to MSK Triage will prevent patients from being inappropriately referred into UHL Orthopaedics. This will also lead to a reduction in inappropriate diagnostics (scans).
- Evidenced to date has shown that 30% of the referrals triaged, that would of historically gone to UHL, have been triaged to other services or discharged at source with advice & guidance
- We have brought together the MSK Physio (First Contact Practitioner model) and put it at the front of the patient pathway so that the triage is used for the right patients and patients have direct access to MSK Physio which is being rolled out over 18/19 as a first port of call
- MSK Physios can refer directly to MSK Triage without going

Strand: MSK Triage	
<ul style="list-style-type: none"> • Our MSK Physiotherapy Service can directly refer to MSK Triage without sending the patient back to the GP • An integrated IT system that can accept and support the triage of referrals, and offer advice and guidance through PRISM, ERS and self-referrals. Additionally, there should be integration with diagnostic results and access between primary and secondary care for continuity of patient care. • Develop referral forms with clinicians that can be used on PRISM, ERS • Promote awareness of new service and information available to GPs • Following the implementation of MSK Referral Management we plan to roll it out to the following Specialities:- <ul style="list-style-type: none"> ○ Dermatology ○ ENT ○ Gastroenterology <p>As the next 3 services. The goal is to provide signposting via a referral management process that understands the alternatives to that Specialty and can provide effective advice & guidance to GPs</p> • To review the LLR process for IFR for Low Value Treatments across the CCG's ensuring rigour and compliance with our low value treatment criteria 	<p>back to the GP</p> <ul style="list-style-type: none"> • Improved management and access in primary care for patients where services are available in the specialties identified that are outside secondary care • Improved access to secondary care for those patients who require it • Reduction in cost <ul style="list-style-type: none"> • Ensuring that patients do not have procedures where there is evidence of no or little clinical benefit therefore reducing the risks of complications or negative outcome for patients in these categories • Reduce spend within secondary care

Strand: MSK Physiotherapy (linked to First Contact Practitioner)	
<p>What are we going to do</p> <ul style="list-style-type: none"> • Introduce a new MSK Physio model across UHL and LPT Provider that links to the First Contact Practitioner providing direct access for patients, telephone triage within 2 days of referral, advice, patient information, exercise, direction to websites, only seeing patients face to face who need it within 5 days for urgents and 4-6 weeks for routine. This also includes Physio's being able to refer to MSK Triage and discharge patients • All referrals will be managed within the virtual Hub (as a single point of access) by an appropriate practitioner following a clinically approved 	<p>Outcomes</p> <ul style="list-style-type: none"> • By introducing an integrated triage service, the pathway redesign will improve patient outcome and experience by eliminating waste and taking out unnecessary steps. • Standardised service and a streamlined pathway will ensure consistency in care. • Provide better access to MSK Physiotherapy; in addition to GP referrals there will be the introduction of self-referrals and open access to the service for three months for the same condition following treatment. • Improved referral forms on PRISM and for self-referral will support

Strand: MSK Physiotherapy (linked to First Contact Practitioner)

referral process.

- The new streamlined MSK Physiotherapy model will provide a consistent and standardised service, continuity of care, and better access to Physiotherapy through self-referral and open access.
- An improved service will see shorter wait times- patients who are seen quicker are more likely to need less appointments.
- Introduce a payment model per patient pathway rather than cost per appointment so as to incentive provider efficiencies.
- This is being piloted across 40 practices across the 3 CCG's with the plan to roll out to rest of the Practices by December 18. The Physio will be locality based for face to face appointments.

To achieve this new Hub model we will be undertaking the following:

- Introduce a virtual triage and treat hub model that will be lead by Extended Scope Practitioners and Senior Physiotherapists with access to GPwSI in MSK if required.
- Administration staff from across LLR to manage appointment bookings.
- Access to telephone system for telephone triage where applicable.
- Promote awareness of new service and information available to both GPs and patients via GP practices.
- Allow open access for three months following treatment for the same condition.
- Development/use of website and applications that will promote self-management and prevent unnecessary referrals.

a streamlined process and patient pathway.

- Access to a new website/ online resources and applications will promote self-management of conditions; this information will also be available to GPs on PRISM.
- Greater emphasis placed on self-management that will be enabled through online resources/tutorials and leaflets.
- Promote lower wait times, ensuring patients are seen and treated in a timely manner to prevent patients with acute conditions from becoming chronic.
- An improved MSK Physiotherapy service with close links to MSK will prevent patients from being inappropriately referred into UHL Orthopaedics. This will also lead to a reduction in inappropriate diagnostics (scans).

3. Service transformation



Strand: Service Transformation

What are we going to do

- We are reviewing the top 10 Specialities based on volume, capacity constraints, demand, waiting list issues and areas where we know we have staffing constraints. We have split them into 2 phases:-

Phase 1:-

- Gastroenterology
- Dermatology
- Cardiology
- Orthopaedics
- Ophthalmology

From March 2018 to the end of July 2018 each of these specialties has or are undertaking 2 Listening Into Action Events per specialty. The events will consist of Clinicians and managers from primary and secondary care, patients, Public Health, nurses, physio's, optometrists and any other staff group in secondary, community and primary care. The aim of these events are to:

- Describe what good would look like
- Taking away organisational barriers and boundaries.
- Putting aside historical processes
- How are we going to get there working together
- Quick wins (September start) medium wins (December start) and long term wins (April 2019 start)
- To identify approximately 5 pathways that we could use a different contract model that is pathway based to agree across LLR for 19/20 contract based on Dermatology and Gastro
- This is an end to end pathway starting with patient self management all the way through to discharge or primary care

Phase 2:-

- Respiratory medicine
- Urology
- General surgery
- ENT
- Haematology

The scoping workshops are taking place across July and August 18 for work up by the end of Q3

Outcomes

- Reduction in secondary care attendance for outpatients
- Reduction in number of patients with Long Term Conditions needing to be seen in secondary care on a regular basis as maintenance in primary care will provide support in a timely fashion
- Reduction in ED attendances by the provision of alternatives to ED via ambulatory care models. We are working with Urgent Care on this
- Reduction in duplication of attendances and diagnostics through improved communication and IT connections
- Reduction in follow up as this redesign is linked to the follow up reduction programme
- Patients are seen right place, right person, first time
- Improved communication between healthcare professionals
- Improved communication between healthcare professionals and patients
- Reduction in unnecessary visits to hospital – freeing up outpatient capacity or reducing the need for as many clinics as we already have
- Improved patient experience ensuring that a patient is fully informed and part of their care.
- Care is provided closer to home where appropriate
- Reduction in cost to the health system by reducing unnecessary visits and intervention
- Patients only access secondary care when they need secondary care

Strand: Service Transformation

This programme links with the follow up reduction programme as they both together provide the transformational requirements for the future.

4. Decommissioning follow up attendances

Strand: Decommissioning of follow-up outpatients

What are we going to do

1. Drive down outpatient follow ups by 20% over 5 years as per the original Planned Care stretched target. The planned care work stream will focus on 31 specialties over the next 4 years focusing on 6 specialties per year. This is on top of the reduction in follow up included in demand management project.
2. This project has links to the speciality transformation project and the work contributes to the transformation savings
3. Drive down outpatient follow-ups by 55,000 in 18/19. To look at this and the following areas have been identified as areas to pursue the reduction:-
 - Gastroenterology
 - Cardiology
 - Dermatology
 - Orthopaedics
 - Ophthalmology
 - Respiratory Medicine
 - ENT
 - General Surgery
 - Haematology
 - Integrated Medicine
 - Medical Oncology
 - Gynaecology
 - Breast Care
 - Clinical Oncology

Outcomes

- Prevent patients being followed up unnecessarily effecting work and school
- Support providing value for money by reducing unnecessary visits and driving down costs
- Helping UHL reduce from 3 to 2 sites by reducing foot fall across the 3 hospitals
- Redesigned pathways to improve patient outcome and experience eliminate waste by taking out unnecessary steps
- Reconfigure services to be available in the community, closer to patients homes
- Promote lower wait times, ensuring patients are seen and treated in accordance with national standards. This will also prevent patients developing chronic problems
- Reduce unnecessary appointments that currently offer little benefit to patients, freeing up clinical time and space for more specialised requirement. Reducing space requirements and saving money
- Better use of technology to help support the above
- To deliver not only the 20% decrease in follow-ups but also the extra 55,000 reduction required in 18/19
- To support the repatriation of LLR activity back into LLR



Strand: Decommissioning of follow-up outpatients

- Diabetology
- Infectious Diseases
- Maxillary Facial Surgery
- Rheumatology
- Neurology
- Pain Management

To achieve this we will be undertaking the following:-

- For certain specialities a Doctor Opt-In approach for any follow-up as opposed to a current Opt-Out model
- Reduce clinical variation between clinicians in all specialties, where appropriate
- Increase the use of open-access follow-ups and expand to other areas other than procedure based specialties with a limited time period and a specific criteria
- Review specialties where remote access follow-up would be useful similar to the Hip and Knee work currently happening
- Introduce follow-up by other trained professionals to reduce cost, eg optometrists to glaucoma follow-up.
- Increase the percentage of virtual follow-ups in a wide range of specialties
- Introduce group follow up for a range of conditions. This is likely to be Nurse / Physio led and would be suitable in speciality areas in Orthopaedics, Rheumatology and some Long Term Condition areas.
- Revisit new to follow up ratios
- Look at specialties who undertake surveillance monitoring as a follow-up and develop a model for this to be carried out in a community setting, e.g. Haematology MGUS monitoring
- Developing Nurse / Therapy / Pharmacist follow up for appropriate areas

5. Diagnostics – imaging and non imaging

Strand: Diagnostics – imaging and non imaging

What are we going to do

This is a continuation of work commenced in 2017/18 to manage the ongoing demand for a range of imaging and non imaging investigations. This will be done by

- Further development of diagnostic referral pathways (e.g. shoulder/pelvis) on ICE
- Increase the number of PRISM referrals that support diagnostic decision making
- GP education sessions by diagnostic teams
- Advice and guidance introduced for imaging plain film and then extend to other imaging modalities
- Development of referral hubs for local diagnostics for GPs

Outcomes

- Reduce the need of patients to go to UHL for diagnostic investigations
- Reduce the number of referrals to secondary care
- Ensure patient requiring secondary care referral are appropriately worked up so reducing the number of outpatients visits
- The patient receives the appropriate investigation in a timely manner to support early diagnosis and appropriate level treatment
- Increase the number of pathways to ensure patients are receiving the most appropriate investigation at the appropriate time – imaging and non imaging. All providers will be expected to use the pathways
- Embed Advice and Guidance in to Radiology
- Provide more services closer to patient's homes, improving patient outcomes and experience and eliminate waste through redesigned pathways
- Better use of technology to help support the delivery of the programme
- Patients will not have treatment where the clinical value has no or little evidence to support it.
- All diagnostic requests will be made electronically using Sunquest ICE