# Care and Resource utilisation

## Ensuring appropriateness of care

Department of Health

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This guidance has been produced following consultation with the NHS Confederation Primary Care Trust Network, the NHS Alliance and the Improvement Foundation.

Primary Care Trust Network

nhs alliance

# Contents

# Executive summary

## Health reform in England: care and resource utilisation

This document sets out for commissioners using practice-based commissioning (PBC) and primary care trusts (PCTs) some techniques to help identify areas where services can be redesigned, thereby freeing up resources to focus on clinically needy patients.

Care and resource utilisation (CRU) is all about giving the patient the right treatment in the right place at the right time. In some cases, this will mean providing more care than at present. In other cases, it will mean changing the location of care. In others, it means changing the patient pathway. The common thread is that service redesigns will be owned and agreed by clinicians, working in partnership across primary and secondary care, to deliver integrated, well-designed services. To this end, this guidance has been produced following consultation with the NHS Confederation PCT Network, the Improvement Foundation, and the NHS Alliance.

Key to ensuring the best use of resources will be the role of primary care commissioners working with their PCT to understand the needs of their local population and using this data to start redesigning care pathways for the benefit of patients. Effective practice-based commissioning (PBC) will shape CRU as a powerful way that clinicians can facilitate the right patients being treated in the right place at the right time.

The guidance sets out best practice from the NHS on several key techniques commissioners can use, to make sure services are utilised appropriately, in particular Utilisation Management (UM) and prior approval (PA). The NHS in the North West has used UM to examine the reasons for ‘over-utilisation’ of healthcare resources and as a service development tool to guide the redesign of services. The technique has helped identify those patients admitted to hospital who could have been treated effectively within a less acute setting and thereby has highlighted gaps in primary care provision. Programmes to tackle these issues have resulted in a reduction in inappropriate admissions and reduced lengths of stay in some areas.

PA would usually be applied to groups of patients (medium to high volumes) where commissioners and providers agree in advance how to manage patients according to clinically owned protocols. In exceptional cases PA could be applied at the individual level, although this is likely to be appropriate only to patients subject for a few high-cost, complex pathways.

Both techniques aim to provide patients with the most appropriate care, in the most appropriate setting, freeing up clinicians' time.

The guidance also offers some further pointers for commissioners to help in determining the most appropriate models for clinical assessment services (CASs) and referral management centres (RMCs). The principle again is that such services should be clinically led and deliver added value to the patient journey.

This guidance is by no means a definitive guide. As the evidence base and good practice develops, further information, useful tools and help for commissioners will be published on the Department of Health (DH) website. It is planned to publish further help and advice for commissioners on appropriate practice for RMCs and CASs, in the New Year.

# 1. Introduction and context

Summary

The guidance sets out for PBC Commissioners and PCTs what techniques are available to maximise the resources available to them and facilitate appropriateness of care, including information available to support the techniques (such as identification of population needs and mapping the patient journey).

1.1 This good practice guidance sets out for PCTs and PBC Commissioners:

- the aims of CRU and advice for commissioners;
- examples of techniques to help primary care commissioners facilitate appropriateness of care;
- good practice on UM
- good practice on PA
- other techniques such as practice benchmarking
- appropriate practice for RMCs and CASs;
- offers further help for commissioners around the requirement in *Health Reform in England: Update and Commissioning Framework* for commissioners to review their RMCs and CASs to make sure they uphold the framework principle and appropriate practice.

## The context – care and resource utilisation

1.2 The aims of care & resource utilisation are to:

- use resources more effectively and fairly – freeing up clinical time to focus on clinically needy patients;

- improve patient outcomes;
- improve service quality;
- improve overall value for money;
- reduce long-standing variations in treatment and pathways;
- address under-referral and under-treatment where necessary,
- improve appropriateness of care – to make sure that patients get the right treatment, from the right professional, in the right place, at the right time.

1.3 In some cases, this will mean providing more care than at present. In other cases, it will mean changing the location of care. In others, it means changing the patient pathway. But, common to all will be a grounding in providing high-quality, safe, clinical care. Clinical ownership and agreement is critical to delivering the potential benefits of CRU.

1.4 This guidance aims to help commissioners in primary care to understand what techniques are available to maximise the resources available to them, within the context of PBC. Good practice indicates that the approach is most effective when commissioners work in partnership with providers to agree integrated, well-designed services.

1.5 As CRU develops, updates to this document will be produced, with more examples of good practice and useful tools and resources for commissioners.

# 2. Identifying the needs of the local population

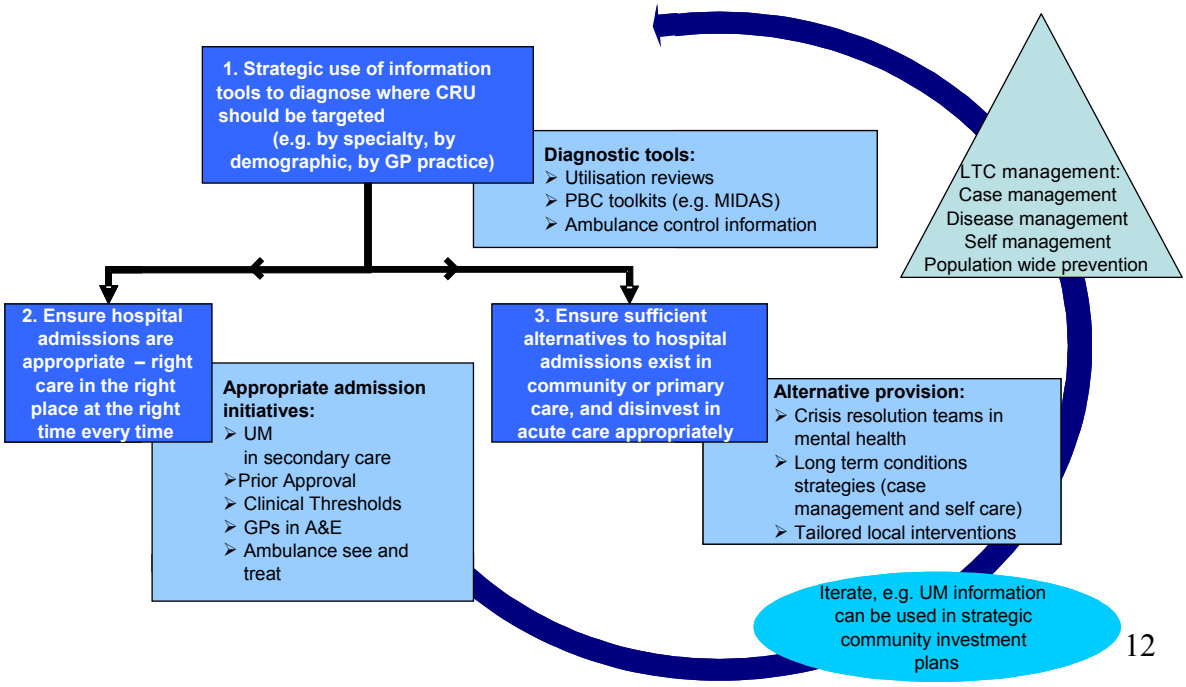
**Summary**

As a first step, commissioners in primary care should be working with their PCT to understand the needs of their local population, using readily available data.

2.1 As a first step, commissioners in primary care should be working with their PCT to understand the needs of their local population, using information from PCTs, Quality and Outcomes Framework (QoF) data for disease areas and other relevant information to begin understanding patients' service needs. In order to maximise scarce resources, the approach below can help.

## CRU Strategy

### A successful CRU strategy should consist of three elements



## Identifying Potential Target Areas - Priorities for Action

2.2 DH will shortly be publishing *Priorities for Action* on the DH website, which commissioners will find useful to inform local CRU strategies. The document will highlight readily available data and best practice (such as National Institute for Health and Clinical Excellence (NICE) guidelines), to help commissioners identify potential target areas for CRU.

## Practice-based commissioning

2.3 Effective PBC will be key in shaping CRU to help clinicians ensure patients are treated appropriately. For example:

> Westcliffe Medical Centre in Shipley peer reviews referral practice weekly, when the GPs meet and discuss referrals. This means that the patients get the right treatment, in the right place, at the right time, every time.

# 3. Pathways and protocols

**Summary**

CRU can help PCTs and practices identify areas where they can make efficiency improvements, to release funding to spend on patient care elsewhere. This process should be clinically driven and agreed so clinical time can be freed up to focus on clinically needy patients

3.1 CRU can help PCTs and practices identify areas where they can make efficiency improvements, to release funding to spend on patient care elsewhere. This should be clinically driven and provide clinical benefits to patients, as well as maximising opportunities for utilising service improvements, to improve efficiency and productivity along the patient pathway. Best practice pathways in the 13 highest volume specialties will be published by DH in January 2007.

## National e-care pathways

3.2 National e-care pathways are being designed to support multidisciplinary working, improve the use of clinical resources and underpin professional development. The first 10 pathways, which will be delivered by March 2007, will use best practice evidence and follow the patient from initial presentation (whether in a GP surgery or in an A&E unit) to discharge or to continuing care settings. The pathways have the potential to help with delivery of 18-week referral to treatment, and with CRU by using an evidence based approach to a current illness or disease and mapping best practice for the delivery of care. Local health communities could use the pathways to map current patient journeys and identify where there are potential bottlenecks within the system, thereby improving quality and dealing with patient safety issues.

3.3 Further information is available by e-mailing cathygritzner@nhs.net

# 4. Understanding the patient journey

**Summary**

Mapping the patient journey with patients and professionals together will help identify what adds value to patients, and how to manage patient pathways differently with less delay.

4.1 Mapping the patient journey with patients and professionals together will help identify what adds value to patients, and how to manage patient pathways differently, and with less delay. Other approaches, such as surveys and accessing patients' forums, will also provide understanding of the patient perspective. Further information is available from the Improvement Foundation http://www.improvementfoundation.org.uk Examples include:

- Professionals and patients from Enfield PCT and their two local hospitals mapped the patient journey for all urgent care (both in-hours and out-of-hours). This has highlighted ways to change the urgent care system to focus more on the needs of patients. The suggested ways forward can now be tested.

- Barking and Dagenham PCT ensure that the views of patients are integral to their service development work through a whole range of patient involvement activities, such as making use of their patient and public involvement forum to identify new patient pathways, 'choose and book' patient focus groups, and inter-practice patient groups.

4.2 It should not be necessary to reinvent pathways and protocols. There already exists a wide range of expertise that commissioners may wish to use, for example:

- the Improvement Foundation http://www.improvementfoundation.org.uk

- the NHS Institute for Innovation & Improvement http://www.institute.nhs.uk/ and http://www.productivity.nhs.uk/
- 
- the Royal College of Physicians http://www.rcplondon.ac.uk/standards.asp and www.rcplondon.ac.uk/pubs/brochure.aspx?e=17
- the British Medical Association www.bma.org.uk
- NICE www.nice.nhs.uk

## Model contract:

4.3 The model contract will enable commissioners to agree with providers a forecast of activity for the year, as well as other information, which can be used to determine whether patients are being treated appropriately and to waiting-time targets (e.g. waiting list levels and conversation rates). At monthly review meetings, commissioners and providers will review the agreed activity plan, and, where agreed limits are exceeded, the commissioner and provider can investigate and agree to revise the limits. Where over-activity is above the agreed revised limits, the commissioner will be able to apply a financial adjustment to payment. This will free up resources to be used elsewhere. It is not expected that financial adjustments will be applied often, or for sustained periods of time. The model contract includes further details http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4141197&chk=FcbsGi.

# 5. Information needs for practices and providers

**Summary**

PCTs are expected to provide effective, timely information to practices on the use of hospital services by their patients. CRU techniques can also provide commissioners with useful information to improve efficiency and the patient experience.

5.1 PCTs are expected to provide effective, timely information to practices on the use of hospital services by their patients by individual, specialty, day case, etc. Good practice indicates that this should include key performance indicators. This data is also included as a requirement for monitoring as part of the model contract. PA, UM, and appropriate RMC (RMCs) and CASs can facilitate PBC by producing information and data that will be useful to GPs – for example on the NHS Modernisation Agency's 10 High Impact Changes and the NHS Institute's & the Improvement Foundation's set of High Impact Changes for Practice Teams.

5.2 Commissioners may wish to make arrangements for 2007/08, with providers, to facilitate a timely monthly data set to support CRU.

5.3 Further information for commissioners, including actions, is set out below.

The NHS Modernisation Agency, through its work with thousands of NHS clinical teams, has identified ten high impact changes that organisations in health and social care can adopt to make significant, measurable improvements in the way they deliver care:

• Avoid unnecessary follow-ups for patients and provide necessary follow-ups in the right care setting
•Treat day surgery (rather than inpatient surgery) as the norm for elective surgery
•Improve patient flow across the whole NHS system by improving access to key diagnostic tests
•Manage variation in patient discharge thereby reducing length of stay
•Manage variation in the patient admission process
•Increase the reliability of performing therapeutic interventions through a Care Bundle approach - a systematic way of encouraging clinical teams to examine their processes of clinical care by giving rapid feedback on the way therapeutic interventions are delivered.
•Apply a systematic approach to care for people with long-term conditions
•Improve patient access by reducing the number of queues
•Optimise patient flow through service bottlenecks using process templates
•Redesign and extend roles in line with efficient patient pathways to attract and retain an effective workforce

The Improvement Foundation and the NHS Institute worked with people at the front line of primary care to develop the changes. They are:

•Promote patient self care and self management
•Improve the management of patients with long term conditions
•Improve patient access
•Improve care for patients by redesigning roles in general practice
•Use data and information to drive improvement
•Improve care through systematic review of patient feedback
•Avoid unnecessary follow-ups in primary and secondary care
•Provide services closer to patients
•Maximise the use of Practice Based Commissioning

# 6. Other techniques – Utilisation Management

**Summary**

Schemes such as PA and UM can help commissioners improve the clinical process and add value to the patient experience. Techniques should be clinically owned and agreed.

## Approach to UM

6.1 Achieving appropriate UM means ensuring that the right patients are treated in the right place, in the right setting, at the right time, every time. UM can help commissioners understand whether this is currently the case or not.

6.2 UM has several purposes:

- to help local health communities strategically plan the correct mix of patient settings, both in and out of hospital;
- to facilitate a shift of patients out of hospital, reducing follow-ups, etc – and to facilitate the availability of alternatives to hospital;
- to help commissioners and providers save patients from unnecessary interventions and make sure that care is appropriate;
- to target reductions in admissions down to a threshold margin of tolerance.

## The North West Approach

6.3 There are a variety of techniques primary care commissioners can use to make sure there is correct utilisation of services – the key aim being to free up wasted clinical time to focus it on clinically needy patients. The

technique detailed below has been developed by the NHS in the North West to assess the appropriateness of hospital admission and length of stay according to a clear protocol - a two-part process that assesses the severity of illness and the appropriateness of the procedures undertaken. However, UM can be much broader and further information will be included in updates to this guidance.

6.4 The North West UM approach involves a trained review team (nurses in this instance, but commissioners could use equivalent clinicians or, in the future, appropriately trained members) looking at all admissions over a given period. 'Inappropriateness' can take two forms:

- **inappropriate admissions**, **but only from a local health economy perspective**. This group includes patients who could have been treated in the community in principle, but were admitted because there were no primary/community services to manage them in other settings. This is an issue for commissioners, who need to make sure the right services are in place;

- **inappropriate admissions because the patient did not require hospitalisation**, either because sufficient services were available elsewhere or because they did not need such intensive healthcare support.

6.5 UM has shown a range of outputs in the North West:

- a reduction of 9 per cent in inappropriate admissions and a consequential reduction in bed days, total beds and length of hospital stay.
- new initiatives to develop primary care based clinical decision units.
- diagnostic capacity planning data that now contributes to national thinking on the role of diagnostics within 18-week referral to treatment.

## What can UM do for patients?

6.6 Overall, patients benefit from service redesign as funding is targeted more appropriately, and patients are treated in the right place at the right time.

## What can UM do for commissioners?

6.7 As a service development tool, UM enables commissioners to look at the reasons why there is 'over-utilisation' of healthcare resources, and thereby helps them to:

- redesign services (e.g. where the patient care package received could have been effectively provided within a less acute setting);
- highlight gaps in primary care resources;
- target and reduce delays that add no value to the patient – so that wasted clinical time is freed up to focus on clinically needy patients;
- release beds.

6.8 UM also highlights those patients who would benefit from management away from secondary care, including people with long-term conditions. It can also provide intelligence that aids commissioning e.g. diagnostics.

## What can UM do for providers?

6.9 The data provided by UM highlights opportunities for increased efficiencies, including improved inpatient flows and reduced lengths of stay. This in turn has the potential to improve bed occupancy levels, which can help providers achieve the four-hour A&E target.

## Targeting UM

6.10 UM is more complex and resource intensive than some other CRU techniques - each cycle usually takes 10 weeks from start to finish and the cycle is repeated two or three times per year within each health economy. To facilitate optimum benefits, commissioners may wish to commit to a UM process for a minimum of one year, to give the benefits time to manifest, and to give providers the opportunity to implement actions. UM can, however, provide valuable insights for commissioners (e.g. to help plan demand over the year, taking account of seasonal variations), in particular when it forms part of a contractual CRU package.

## Model Contract

6.11 The model contract will require providers and commissioners to co-operate and participate with UM, and implement any recommendations from utilisation reviews, within reasonable timescales. This will include:

- sharing appropriate, timely data with commissioners, including access to patients' notes;
- allowing access to review teams, and allowing data to be shared within the health economy.

6.12 The contract will enable commissioners or providers to use UM where a problem becomes apparent, provided each party gives the other a month's notice before conducting a UM scheme. This may be waived by mutual agreement.

6.13 UM is primarily a service development tool, and so commissioners may want to specify a range of outcomes from utilisation reviews for their locality, to improve the patient journey. For example, if an issue with diagnostic delays was evident from a review, a commissioner could stipulate that all non-elective admissions should have access to relevant diagnostics within a timeframe that allows for discharge.

6.14 As part of their local UM scheme, commissioners may wish to consider setting **local** standards for inappropriateness of admissions. Acceptable levels of inappropriateness will vary from provider to provider however, the aim should be to manage levels down. Updates on CRU will include emerging evidence on inappropriateness levels. Levels will also vary seasonally, and commissioners and providers may wish to review (and amend) these thresholds in light of utilisation reviews and, as the UM process develops, when they have built up a clear picture of seasonal variations.

6.15 Further details are in the model contract http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4141197&chk=FcbsGi.

## Implementing UM

6.16 NHS North West has established and developed an embedded UM programme – further details are included at Annex A which provides commissioners with an overview of the UM process and with the information they need to begin to develop a UM process or commission appropriately.

## The Northumberland Approach

6.17 Commissioners may wish to explore other tools for ensuring appropriate utilisation. For example some commissioners (such as the three Primary Care Organisations in Northumberland) are using a software package to provide user-friendly access to information relating to clinical outcomes of patients' and the progress of their services against targets.

# 7. Prior approval

**Summary**

PA should involve a targeted approach, focusing on where it can have the most impact. Protocols for PA should be agreed by and with clinicians. PA should **never** delay clinically necessary treatment.

## Approach

7.1 PA requires clinicians in secondary care to confirm the appropriateness of a proposed intervention or course of treatment with the referring GP. This can be done through the PCT or another mechanism, such as protocols agreed and led by clinicians. The process should be non-bureaucratic to avoid unintended consequences, such as delaying urgent or necessary treatment or undermining efforts to deliver the 18 weeks referral to treatment target. Therefore, it is expected that commissioners will adopt a targeted approach to PA, focusing on the areas where they can have the most impact. Before applying PA, commissioners must have evidence that there is an issue that needs to be resolved, and it must be agreed that PA is the most appropriate intervention.

7.2 PA can apply at two levels: firstly on groups of patients, where commissioners and providers agree in advance how to manage patients or pathways. It is expected that this method of PA will mainly apply to medium to high volumes of patients. Under such arrangements, providers do not need to get PA on each individual patient; instead, they agree to treat all patients to the agreed protocol, so, in effect, patients are automatically approved.

7.3 Secondly PA can work at an individual level, where providers must get agreement before initiating treatment on a specific patient. Clear agreement is needed on where such PA is required and how clinicians should communicate with the patients affected. This form of PA needs sensitive handling, as it requires real-time interventions in patient treatment pathways. It is likely to be appropriate only in decision-making where there is a low volume of requests for PA, for example patients who are subject to very high-cost, complex pathways. Many PCTs will already have in place complex case panels, to which GPs have access, and therefore extending the responsibilities of these panels to consider PA requests maybe the simplest and most appropriate way of delivering individual PA.

7.4 PCTs and GPs may also wish to use these panels to extend the PA process to cover pre-referral. This would involve commissioners using the panels to confirm certain sets of patients as appropriate for referral (for example where the clinical effectiveness of a procedure is in doubt, e.g. varicose veins or breast augmentation).

7.5 PA should never delay clinically necessary treatments – the model contract allows providers to retrospectively ask for approval in clinically urgent or necessary circumstances

7.6 Key to PA will be good communication with patients about its purpose and benefits. This should be led by clinicians.

7.7 Birmingham East and North PCT (BEN PCT) has been trialling a number of PA techniques, so that the learning can be shared with, and help, other commissioners. The process set out at Annex B represents early learning from work under way. However, this is only one way of approaching PA - commissioners should adapt the approaches for their local area.

## Sharing good practice

7.8 As PA develops in BEN PCT, a series of bulletin updates will be published on the DH website, including updates on outcomes and key learning. Updates could also cover PA in relation to urgent rather than routine patients in the future.

## Focus of prior approval

7.9 The key principle of PA is that it should be pathway driven and include a failsafe system that allows for swift action if PA does not work as intended. Key to effective PA is focus on areas where:

- clinical effectiveness is questionable (e.g. tonsillectomies);
- potentially unnecessary work is undertaken in specialities where there seems little benefit or reason for that work (e.g. certain outpatients following elective surgery);

- hospital trust data suggests (when benchmarked) that the trust is undertaking work that is outside expected norms (e.g. consultant-to-consultant referrals);
- the costs of intervention seem to be disproportionate to the work carried out (e.g. code N12 maternity attendances charged as an admission when a ward attendance is the most appropriate charge).

7.10 To implement a PA scheme successfully, the following are critical:

- clinical leadership – in particular to develop protocols for PA;
- clarity on the role of PA in particular circumstance i.e. PA should be used as a targeted approach, be clinically led, and be used in a transparent manner;
- good relationships;
- good communication systems in place with all interested parties including patients. There will be a perception that PA is being used to save money, and therefore PCTs must be able to demonstrate a range of outcomes and benefits from implementing PA schemes.

## Protocols and guidelines

7.11 It is recommended that the protocols and guidelines are developed clinician to clinician. BEN PCT agreed with clinicians that PA will be undertaken at PCT and/or local level to avoid individual PA requests to GPs, which could create delays in the system.

7.12 Clinicians in the PCT and trust will have agreed, for each speciality, the changes to the pathway – e.g. PA for tonsillectomies. The PA directive will specify the graduation process for patients. If the patient has received treatment in line with the pathway, the intervention has not worked and the patient continues to have significant health problems, then the consultant will be able to undertake the procedure in line with the PA directive without recourse to the PCT. The trust must be able to demonstrate through appropriate detailed clinical information back to the GPs, that the procedure was necessary and in line with the agreed PA.

7.13 This has been the most appropriate approach within the health economy of BEN PCT. Commissioners may wish to undertake PA at an individual level and via GPs – this will be for local decision. Commissioners may also wish to consider using PBC localities to lead PA in the future where these are developed.

7.14 Commissioners may want to consider including prescribing in PA. Secondary care clinicians could recommend the class of drug for a patient, and the actual drug would be determined by the patient's GP – for example recommending statins rather than a specific statin. Commissioners may also wish to consider agreeing a drug formulary across health economies.

7.15 To reduce bureaucracy, where providers are taking patients from a number of PCTs and there is a lead commissioner arrangement in place, the provider would be expected to follow the co-ordinating PCT's PA scheme. It will be the responsibility of that PCT to seek agreement on this PA scheme from its neighbouring PCTs.

## Model contract

7.16 The model contract enables commissioners to specify the circumstances in which PA to treat would be required. This includes ensuring new and/or amended care pathways are agreed with the provider.

7.17 As part of the monthly review meetings, commissioners will be required to identify where providers have not complied with PA schemes. If PA is required, either for a group of patients or for individuals, and the evidence to support that PA has taken place is not produced by providers, commissioners will be able to withhold payment. Alternatively commissioners may wish to withhold part payment, for example where non-compliance is considered to be a mistake on the part of provider staff. Commissioners will be expected to implement a trial period of PA for one month before financial deductions can apply, allowing providers time to adjust to the process.

7.18 Commissioners can also ask providers to manage down activity levels to a locally agreed level, for example where capacity in primary care is being built up to provide an alternative pathway, or activity at Healthcare Resource Group level is higher than national benchmarks. The effects of this approach on activity levels would need to be taken into account in

the activity plan. Commissioners may also wish to specify that a new pathway for high-cost treatments is not initiated without PA.

7.19 If commissioners wish to introduce a new PA scheme, or amend an existing one, they will be expected to give providers reasonable notice (one month is considered a reasonable notice period). Commissioners will also be required to respond to a provider's request for PA in relation to an individual patient in no more than three working days – a failure to respond will be considered an approval. This is conditional on the provider giving all the necessary information in the form that the commissioner has specified. More information is in the model contract http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4141197&chk=FcbsGi.

# 8. Clinical assessment services and referral management centres

**Summary**

RMCs and CASs should be clinically led, deliver tangible benefits for patients, and should not lengthen the patient journey.

## Principles

8.1 *Health Reform in England: Update and Commissioning Framework* (July 2006) set out principles for appropriate CRU which RMCs and CASs should abide by. PCTs are required to review existing RMCs and CASs to make sure they create tangible benefits for patients. These services:

- must not lengthen the patient journey or create 'hidden' waiting times;
- must carry clinical support and abide by clear protocols that provide clinical benefits to patients – including allowing clinicians to 'opt out' and bypass the service in certain instances (e.g. urgent cases or second cataracts);
- should provide feedback to practices on referrals, thus enabling GPs to review the appropriateness of their referrals, and support PBC. This will include ensuring that referral letters contain sufficient information to enable consultants to understand the reason for referral;
- should not preclude practices from the effective redesign of services under PBC where this might necessitate changes to the pathways used by the RMC (in certain circumstances, service redesign may necessitate the use of new pathways outside those normally used by the RMC);

- should not be imposed on practices without their agreement or used as a device to avoid constructive challenges to poor or inappropriate referral behaviour.

## Clinical assessment services

8.2 CASs are developed by primary care commissioners and are a mechanism in the patient journey to improve patient mapping. They can also make efficiency gains, while adding real value to the patient journey (e.g. access to other professional opinion). They often involve GPs with a special interest, nurses, and allied health professionals with additional skills. The team have access to appropriate diagnostic services, to which patients are referred for initial diagnosis, further investigation, and advice on management of their condition. Following assessment or diagnosis, some patients may be referred to a secondary care consultant, for which they would be offered a choice of provider.

8.3 ***This CAS model is appropriate as it is not just a simple mechanism to manage demand.***

## Referral management centres

8.4 Acceptable RMCs are clinically led, set up by PBC commissioners with the backing of local GPs and practices, and provide feedback to GPs on their referral practice. This also includes what happens to patients, so that this can be used to demonstrate measurable improvements by commissioners. Again, where these RMCs have been established properly, they have added real value to the patient journey.

8.5 ***This clinically led model is appropriate, provided that RMCs are established with good prior engagement of hospital clinicians and GPs, so that the service is not simply a mechanism for managing demand.***

8.6 ***Where RMCs are not clinically led, and this model does not add any value to the patient journey, they become purely a mechanism for managing demand. Such RMCs will not be acceptable.***

## Actions

8.7 It will be good practice that PCTs (with their partners) review, and where necessary develop, existing RMCs and CASs by April 2007 to make sure they create tangible benefits for patients, uphold the principles in the Commissioning Framework and meet the acceptable practice requirements set out above.

## Good practice

8.8 We will be publishing further information on best practice from the NHS around developing RMCs and CASs at the beginning of the year, illustrating where primary care commissioners have developed innovative services.

# 9. Other techniques to facilitate correct utilisation of services

**Summary**

This section sets out a variety of approaches that primary care commissioners can use to ensure that clinical time is focused on clinically needy patients, e.g. risk profiling and practice benchmarking

9.1 There a variety of other techniques primary care commissioners can use to make sure services are utilised correctly.

## Risk profiling

9.2 Risk profiling of vulnerable adults can contribute to identifying patients who would benefit from co-ordination of care and case management. Practices can use locally agreed criteria, including the number of chronic diseases, previous admissions, social circumstances, and the number of medications. For example:

- In the Selby and York area of North Yorkshire and York PCT, community matrons and district nurses are able to access the hospital system both to flag up to hospital colleagues that a particular patient is case managed, and also to access performance data about their hospital admissions, test results, A&E attendances etc.

- A practice-based integrated health and social care team in East Devon, including district nurses, practice nurses, a social worker and a pharmacist, has developed a method of risk classification and management for vulnerable patients, based on available practice-based and social care information.

> A GP at Castlefields Practice in Halton and St Helen's PCT has developed a simple six question risk calculator to identify which patients need case managing as part of the Unique Care approach. The validated tool (Emergency Admission Risk Likelihood Index – EARLI) is in use across the PCT and in many Unique Care sites.

> Further information available on the Improvement Foundation website at www.improvementfoundation.org.uk

9.3 Practices can use QOF data for disease area to begin understanding patients' service needs in their own practice. Practice data can be compared with the results at PCT, Strategic Health Authority and national levels. Data can be accessed through the QOF pages provided by the NHS Information Centre for health and social care at: www.ic.nhs.uk/servicesnew/qof06/spreadsheets/ICfolder_view

9.4 Identification of patients with chronic diseases through a practice disease register is the foundation for case management and preventative work with those patient groups.

9.5 Practices can also link with third sector organisations to make use of community intelligence about service needs. For example, Barking and Dagenham PCT have implemented a shared database with the charity Age Concern and with partners in social care.

9.6 Practices can use public health inputs to access morbidity and mortality data. Some PCTs provide public health data directly to practices at practice level. For example, Somerset PCT provides practices with a practice profile that includes practice population by age and /sex, the Index of Multiple Deprivation, disease prevalence, standardised mortality rates, screening coverage, smoking prevalence, emergency admission rates and outpatient attendances. Figures for the PCT are provided as a comparison. PCTs can also provide this information to practices within clusters, allowing them to compare themselves to the cluster average and to the county or national position.

9.7 Census data is available at ward and neighbourhood level from the office for national statistics website at

http://neighbourhood.statistics.gov.uk/dissemination/LeadHome.do;jsessionid=ac1f930dce500b18a5370d943aa8d25eb5ff8c79266.e38OaNuRbNuSbi0Lah0PaNyQbxaQe6fznA5Pp7ftolbGmkTy?bhcp=1

## Other Examples

9.8 Annex B contains examples of where commissioners have used other CRU techniques to facilitate effective utilisation of care and resources, including:

- **practice benchmarking**- BEN PCT used practice benchmarking to identify ambulatory care sensitive conditions and to develop alternative pathways for patients to facilitate clinical and cost effectiveness – potential savings, with up to £14 million per year;

- **benchmarking and review of outpatient referrals** – BEN PCT has a programme of reviewing and benchmarking outpatient referrals that has produced an average 21 per cent reduction in outpatient referrals (31 per cent in some localities) since April 2006– saving an estimated £2 million by the end of the financial year.

# Annex A

# Utilisation Management

## The NHS North West approach – scale and scope

A.1 As demand for non-elective services increases. the development of intelligent tools for the interpretation of trends, increases and seasonal factors is key to matching demand with appropriate service provision. Interpretation of these issues is considered complex and difficult. An NHS North West UM programme has illustrated that it is possible to understand, and at least partially resolve, issues underpinning admission trends.

A.2 NHS North West, which incorporates 24 PCTs, has developed and embedded a UM programme which aims to support commissioners, over time, to shift care safely and efficiently closer to patients. This aim is supported by the provision of patient level information on admission trends, service availability and trends in appropriateness and inappropriateness of admission to hospital. The latter output, inappropriate admission trends, directly supports either service change or the provision of alternatives. UM can be applied to both elective and non-elective cases, although NHS North West has found the biggest impact when applying UM to non-elective admissions, as greater cost investment can be achieved by targeting non-elective cases, which form the majority of inpatient activity.

## When is UM the best technique to use - Evidence Base?

A.3 Failure by many providers to meet current targets consistently suggests that there are inefficiencies within systems that need to be addressed, e.g. to achieve a reduction in non-elective admissions, or in length of stay (LoS). Other techniques could be employed, but providers would need to scope, cost and compare potential benefits with the UM approach.

## Principle:

> Commissioners must have evidence that there is an issue that needs to be resolved

A.4 UM identifies 'appropriate' hospital admissions by the application of a modified Appropriateness Evaluation Protocol. This enables the determination of trends in admission activity and analysis of factors contributing towards 'inappropriate' admission. The value of each occupied bed day is considered when determining trends in efficiency of provision, effectiveness of services and appropriateness of location. There are several protocols available including the Appropriateness Evaluation Protocol, modified Appropriateness Evaluation Protocol, Oxford Bed Study Tool, Milliman USA, and InterQual Severity Discharge Criteria. The protocol used by NHS North West is included at Appendix 1.

A.5 Between 16 per cent and 52 per cent of non-elective admissions to hospital are not considered to be appropriately placed (Manchester Bed Study, 1988; GMSHA UM programme, 2002-06, North West UM programme, 2006). This does not mean that the admissions were not appropriate, but that they could have been provided in other settings, e.g. in primary care.

A.6 In some studies 16 per cent of elective admission days (day zero) show no clinical value and there are clear correlations between early pre-operative admissions and high percentage medical outliers GMSHA UM programme, 2002-2006)

A.7 To ensure optimum benefits, a commitment to UM can potentially be a lengthy process, so commissioners may want to undertake it only when and where they are clear the return and benefits will be greatest.

A.8 As noted above, the majority of inpatient activity is non-elective, so it is anticipated that the higher gains would be made in that area. It is recommended that review actions are prioritised in areas where the greatest gains/benefits can be achieved.

## Engaging with providers and clinicians

Principle:

- Commissioners should discuss the issue with providers and relevant clinicians;
- the most appropriate intervention must and the need to escalate the issue;
- the information requirements to ensure that adherence can be identified will need to be clear and agreed.

A.9 To ensure clinical engagement, it is recommended that providers invite clinical representation early in the UM process, describe the process to key provider stakeholders, and outline potential benefits for patients, clinicians and organisations (quality, standards and strategic planning). Providers should also agree 'clinically indicated interventions' for specific conditions/pathways.

## Protocols/guidelines

Principle:

- The protocol or guidelines must represent good clinical practice.

Application of appropriateness protocols

A.10 In market-driven health economies, the application of appropriateness protocols leads directly to the payment or non-payment of fees for care. In the UK setting; the determination of inappropriateness trends correlated with actual or derived Key Performance Indicator (KPIs) or Key Quality Indicators (KQIs) provides insight into efficiency improvement opportunities within the patient journey. This approach provides the ability to plan capacity accurately against demonstrated need in respect of:

- pathway reform;

- diagnostic provision;
- assessment services & alternatives to admission;
- bed management application;
- discharge support;
- out-of-hours service provision;
- primary care based nursing support;
- walk-in-centre provision;
- social care provision;
- workforce planning ;

UK application of appropriateness protocols

A.11 In the UK setting, appropriateness protocols have previously been applied mainly for academic purposes, but more recently they have been used to provide the 'intelligence' necessary for appropriate capacity planning both within and outside the acute hospital setting. NHS North West has implemented a full recurrent programme entitled 'UM'.

## Service model

A.12 The UM process as implemented in NHS North West consists of four distinct phases.

- Phase 1: - A detailed site by site and health economy comparative analysis of attendance at A&E data, admission to hospital data, admitted patient care data sets, use of alternatives to admission data and of submitted situation report (SitRep) and other obligatory returns. Data illuminates relationships between admission flows such as the impact of bank holidays on increases in medical outliers and any consequent impact on cancellations of elective surgery. Data is 'pushed' to NHS organisations through the North West intranet and each onsite review is preceded by a face-to-face agreement of priorities for action.

– A&E dataset from the trust

Providers supply the previous five quarters (one year and one quarter) of complete A&E data. The following fields are required:

Patient ID
Date of Birth
Sex
GP Practice
Source of Referral
Triage Category
Major/Minor
Attendance Date
Arrival Time
Triage
Seen By AE Clinician
Referral
Seen By Specialty
Decided To Admit
Ward Arrival
Left Department
Attendance Disposal
Outcome – ie > or < 4 hours

Attendance patterns by day of week, arrival hour, 'In hours', 'out of hours' in relation to 4-hour outcome and time in department.

Data quality issues are highlighted - i.e. extreme values, rounding time issues – Scatterplots – locate extreme values in data and possible data errors

Admitted patient flow via A&E - the patient journey times will be profiled and plotted.

Box Plot

Admitted patient journey times table.

Data quality issues highlighted - i.e. extreme values, rounding time issues

- SitRep analysis

  The provider supplies the UM team with access to SitRep data via Strategic Executive Information System (STEIS) website. Using existing and derived measures, statistical process control (SPC) charts are constructed and analysed to ascertain the current system or working and demand. This allows remote understanding of site activity, e.g. A&E attendances and percentage of attendees admitted, and indications of 'pressure' such as, levels of medical outliers and cancelled electives.

- Phase 2 - A UM review- an intensive review over a minimum two-week period of all admitted patients to establish hourly, daily and presentational trends in inappropriateness using the modified Appropriateness Evaluation Protocol (mAEP). A team of trained reviewers audit the care package (i.e. patient record) of every admitted patient during the 14 day review period to determine 'appropriateness' to illuminate non value delays in the pathway and to aggregate information to allow trends to be illustrated. Providers are expected to supply the team with the details of each new non-elective admission every day for the duration of the review. Details of every intervention per patient, and a judgement of appropriateness, are entered onto a database. At the end of the review period, anonymised data is sent to a Strategic Health Authority (SHA) data processing centre. The data submitted is far more extensive than the initial data from the trust, including grade of doctor admitting, whether there is another responsible adult at home, means of arrival at hospital etc.

- Phase 3: A feedback and priority-setting event. Commissioners and providers come together to agree which indicated actions they will pursue and to agree the measures that will indicate success.

- Phase 4 - A rapid improvement cycle event takes place as soon as is practicable after the review and feedback event. Action is targeted on areas that deliver high wins, such as reducing LoS for large groups of admitted patients.

## Timescales

A.13 Each cycle usually takes 10 weeks from start to finish, and the cycle is repeated two or three times a year within each health economy. To ensure optimum benefits, commissioners may wish to commit to a year of UM because the benefits take time to manifest. This period also gives providers time to implement improvements and reveals the pattern of seasonal variations. Commissioners and providers can then use this to plan demand over the year, taking account of seasonal variations.

## Review analysis

A.14 UM data analysis is carried out on the specific review data, and a comparative standard output is produced.

A.15 The dataset is interrogated for locality-specific outcomes, and typical findings include quantified information on delays in patient pathways, bottlenecks affecting diagnostics, potential for alternative pathways and 'levels of quality' inputs.

A.16 Commissioners may wish to focus on the following areas:

- diagnosis and prevalence of patient admissions with potential for management in primary care – to consider assessment and care delivery in the most appropriate setting, avoidance of admissions and improved management of people with long-term conditions;
- prevalence of queuing inpatients in order to expedite diagnostic testing – this can help commissioners focus on ways to avoid using acute beds for expedition of diagnostic interventions when the patient derives no other benefit from an inpatient stay;
- clinical adverse incidents or near misses, and the relationships with effective bed management;

- GP referral patterns and quality of referral (referral letters) – this can be used to focus on variation in GP referral patterns. Data demonstrates types of referral made by GPs, which may highlight lack of primary care-based services available to GPs at certain times. The quality of referral is also affected by the presence or absence of supporting information. The lack of a referral letter, for example, can delay a patient's journey time and lead to unnecessary interventions, especially 'out-of-hours'

- overall and disaggregated patient 'process' times and impact of targets on flow, and therefore differential propensity to admit – this data can be used for reducing process times and removing bottlenecks and delays from systems, especially as UM data outputs are reported in context to all other inpatient activity at the site,

- impact of elective throughput on non-elective performance – this information can be used for understanding the inter-relationship between the two admission streams i.e. that variation in elective throughput, when not managed effectively can impact significantly on non-elective flow and associated targets.

A.17 It is usual to agree a follow-up review after a four-month interval, to monitor impact and progress.

A.18 NHS North West have used an IT system to support this process – there are many options available to commissioners who want to go down this route.

Data collection/analysis for GPs

A.19 All standard outputs are available for participating commissioners and associated provider organisations. Interpretation of the data is available with the outputs.

Appropriateness categories

A.20 The UM process establishes four types of admission status, as outlined in the table below. Criteria that validate subsequent days of care can also be applied.

A.21 The process scores the value of the bed day and is not a 'gate keeping' exercise. Application of criteria to deny access to care is inappropriate in that some care packages become appropriately located over time. Criteria scores are aggregated to illustrate **trends** and therefore comparative efficiency and potential for change.

| | **Appropriate** | **Inappropriate** |
|---|---|---|
| **Inevitable** | An **appropriate** admission to an acute hospital bed | An **inappropriate but inevitable** acute hospital admission |
| **Not Inevitable** | An **appropriate but NOT inevitable** admission | An **inappropriate and NOT inevitable** acute hospital admission |

A.22 **Appropriate (and inevitable)** hospital admissions are those patient admissions that demonstrate a need for services (and have those services delivered) that are generally only available within an acute setting e.g. surgical intervention under general anaesthetic on the first full day of care. Some patients inadvertently receive services that they do not require and, although an appropriate score is recorded, a reviewer override is appended to identify that the care package was 'over utilised'.

A.23 **Appropriate but NOT inevitable** hospital admissions are those admissions that fulfil the intensity of service criterion which for that individual could safely be delivered in a primary care environment e.g. some intravenous antibiotic therapy.

A.24 **Inappropriate but inevitable** hospital admissions are those admissions where the admission could not be avoided because services to support discharge were not available on that day or at that time. This patient group provides the capacity planning data to deliver accurate provision of alternatives to hospital admissions e.g. enhanced diagnostics, enhanced community care, appropriate overnight support. This category of patients has the potential for a relatively short LoS and/or assessment in a primary care environment.

A.25 **Inappropriate and NOT inevitable** admissions are those 'avoidable' admissions whereby the patient does not require a hospital admission but is admitted. Typically, these admissions occur at times of peak hospital attendance (high numbers of presentations) and out-of-hours when adequately trained or appropriately delegated staff members are not available to make a discharge decision. This category of patient has the potential for a relatively short LoS.

A.26 Since the introduction of the A&E 4-hour target the proportion of inappropriate admissions falling within this group has shown the greatest growth.

## Funding base

A.27 The UM process in NHS North West employs a central team hosted by one PCT on behalf of others, with locality-based teams delivering phase 2 of the review cycle through trained and accredited UM reviewers. The cost of each review cycle is between £14,000 and £22,000, depending on site geography and site. The cost per PCT is approximately £35,000 pa.

## Review team

A.28 The North West approach involves using a team of nurses, who bring clinical skills to the 'judgement' of whether or not a patient is appropriate. The key aspect is that the review team should have the appropriate skills to interpret the UM data. A generic job description is at Appendix 2 which contains some core skills commissioners may want their teams to achieve.

## Exceptions

Principle:

> Commissioners should expect a proportion of patients to follow some pathways (for example consultant-to-consultant referral) and should monitor and intervene only if the proportion changes significantly.

A.29 UM would be the method by which a determination could be made of how many patients who should be on pathways actually are. The

development and implementation of clinical pathways should be based on 'gold standards' for clinical inputs for individual presentation types such 'chest pain', stroke, hip fractures.

## Outcome measures

A.30 Commissioners may wish to consider specifying certain outcome measures appropriate to their locality in order to measure success. Such measures may depend on the initial findings of a review. For example, if an issue with diagnostic delays were evident from a review, the commissioner could stipulate that all non-elective admissions should have access to relevant diagnostics within a timeframe that allows for discharge (if applicable) e.g. within one day, if this impacts on tariff (under Payment by Results).

## Outputs/benefits

A.31 Outputs achieved in the North West include:

- a reduction of 9 per cent in inappropriate admissions and a consequential reduction in bed days, total beds and length of hospital stay;
- eradication of the need, in some areas, for winter pressure beds and a change in understanding of system and winter pressure,
- new initiatives to develop primary care-based clinical decision units,
- diagnostic capacity planning data which now contributes to national thinking on the role of diagnostics within 18-week referral to treatment,
- cost reinvestment opportunities in excess of £1 million pa at large acute hospital sites.

A.32 Several health economies outside the North West have adopted all or part of the UM programme with demonstrable benefit. Examples include:

- a reduction in inappropriate admissions at a London hospital from 28 per cent to 16 per cent (sustained for 36 months).

- the full-scale renegotiation of a local delivery plan
- the redesign of services within a Yorkshire health economy.

A.33 Scrutiny of admission information with senior clinicians suggests that up to 10 per cent of patients do not need acute assessment. Further analysis of UM data from all participating sites suggests that up to 10 per cent of total bed days in some hospitals are utilised by patients awaiting diagnostic assessment in the acute phase, whilst care packages received in the interim are deliverable at a lower level of care. Specific data shows that in many smaller hospitals approximately 10 per cent of bed days are needlessly occupied by inpatients queued in hospital for off site diagnostics where the diagnostic provider specifies that access is predicated on inpatient status.

## Top tips for success

A.34 NHS commissioners are empowered and expected to employ a variety of care and resource utilisation approaches. Commissioners should ensure that, whichever approach is employed, they have:

- engaged with, and gained ownership of, clinicians;
- determined and acted upon the drivers and scale of inappropriate 'over utilisation' of hospital services;
- established a locally agreed target reduction in inappropriate admissions;
- used the intelligence to plan the correct and dynamic mix of care settings both in and out of hospital;
- established a dispute mechanism for providers and commissioners to ensure that UM and PA implementations do not result in system paralysis;
- ensured that care and resource utilisation strategies are aligned with other initiatives such as 'real capacity planning', development of 'Capture, Assess and Treat' (CATs) in primary care, and referral management initiatives;

- developed strategic measurement tools to agree and measure success.

## Prior approval

A.35 Target areas for PA implementation can be established through the application of UM tools. UM can tell commissioners the sample of patients that they might want to invoke PA on. Utilisation reviews can help support this process by allowing closer examination of inpatient throughput.

## Implementation and support

A.36 NHS North West has established an embedded UM programme, and can help commissioners with implementation on the basis that the implementing organisation funds local initiatives. This help includes:

- outline implementation plans;
- job specifications, person specifications and adverts;
- analysis tools;
- training and accreditation packages;
- support and guidance in implementing UM.

For further information, contact:

seamus.mcgirr@northwest.nhs.uk or gill.cooper@northwest.nhs.uk

**APPENDIX 1**

## THE APPROPRIATENESS EVALUATION PROTOCOL CRITERIA

**Adapted for European use from the original criteria as set out in the 1991 MANUAL by *J Restuccia*, *Boston University.***
Professor Maggie Pearson, May 1996,

Adapted by the BIOMED Project Group
***Further adapted for the Manchester Utilisation Review Project (2002-3) by S McGirr, Greater Manchester Strategic Health Authority under the guidance of the original author.***

# I ADMISSION CRITERIA

The adult admission criteria are divided into two subsets: Intensity of Service and Severity of Illness. In applying these items, be careful to distinguish between acute onset of signs or symptoms and the presence of chronic conditions which are a common outcome of a chronic disease.
The Severity of Illness section contains a list of major physiological conditions and signs of acute illness that are sufficiently severe to justify the patient being admitted to an acute hospital. The Intensity of Service criteria represent treatments that are generally available only in an acute hospital setting. Remember, the screening criteria are generic rather than diagnosis specific.

## I A INTENSITY OF SERVICE

***IA1 Surgery or other procedure in 24 hours, requiring:***

(a) general/regional anaesthesia; and/or
(b) equipment or other facilities available only for in-patients.

***Manual note:*** Same day surgery is now the norm, so a pre-op day is no longeraccepted in the absence of some special clinical consideration (see Surgical AEP).

***IA2 Vital signs monitoring at least every two hours***

***Manual note:*** In the absence of telemetry or bedside cardiac monitor, minimal vital sign recordings are blood pressure, pulse and respiration.

If the medical record does not chart this information (nursing notes, vital sign sheet or ICU record) and only the physician's order is found, consider a negative answer.

***IA3 Intravenous medications and/or fluid replacement (does not include tube feedings)***

***Manual note:*** This criterion includes any substance given continuously or intermittently during the admission day but does ***not*** apply to "keep-open IV." Substances given via a heparin lock are also included. However, if you feel these fluids and/or medications could have been given in a less intense setting (e.g. outpatient or nursing home) and no other criteria are satisfied, then use the override option to indicate that the day is medically unnecessary.

***IA4 Observation for toxic reaction to medication***

***Manual note:*** This criterion is met only if the medical record documents the potential for a life threatening reaction and the need for continuous observation. If in doubt, consider criterion unmet, list the agents on your data collection form and refer to physician advisor.

***IA5 Continuous or intermittent (at least every eight hours) respiratory Assistance***

***Manual note:*** This criterion includes any continuous respirator use during the first calendar day. Intermittent use of an IPPB, Puritan Mist, nasal 02 or spirocare would meet this criterion, with or without chest physical therapy, provided that the documented use of such services is at least three times daily. Chronic intermittent use of a positive pressure machine is not sufficient, nor is the use of 02 p.r.n. Special respiratory toilet by floor nurses at least three times per day would also fulfill this criterion.

**IB SEVERITY OF ILLNESS**

***IB1 Severe electrolyte/acid-base abnormality -- any one of the four following sets:***

***(i) Na < 123mEq/L or > 156mEq/L***
***(ii) K < 2.5 mEq/L or > 6.0 mEq/L***

***(iii) $Co_2$ combining power < 20 mEq/L or > 36 mEq/L***

***(iv) arterial pH < 7.3 or > 7.45***

***Manual note:*** Be sure to rule out a "chronically" abnormal $CO_2$ value if this
value is the only item under this "set" meeting the screen (e.g. a patient with
chronic obstructive lung disease).

***IB2*** ***Acute loss of sight or hearing (within 48 hours of admission***)
***Manual note:*** The suddenness of the loss should be applicable to, and part of the reason for, admission. For example: most diabetes mellitus patients lose their eyesight or visual acuity in the course of the disease, but the loss is gradual and not acute. In the absence of trauma, this item would most often apply when the cause of the loss was unknown. See discussion following criterion IB13.

***IB3*** ***Acute loss of ability to move any body part (within 48 hours of admission)***

***Manual note:*** In the absence of trauma, this item would most often apply when the cause of the loss was unknown. For both IB12 and IB13, if the loss
occurred earlier than forty-eight hours prior to admission or the time of onset is unknown, to admission or the time of onset is unknown, then criterion is not met. In order to override that decision, the medical record should be a patient living alone found with one of those conditions by a relative or visiting nurse on the day of admission. If you feel other information justifies an override, be sure to document this information on your data collection form.

***IB4*** ***Persistent fever >= 38,0 $_0$ C, for more than five days***
**(> = 100 (PO) or 101 (R) )**

***Manual note:*** As an admission screen, this item is most applicable to patients transferred to the hospital from another facility (e.g. nursing home) or followed regularly by a visiting nurse. If in doubt concerning the length of time the patient has had a fever, then consider this criterion unmet. If you feel other information justifies this admission for

"persistent" fever and no other criteria are met, use the override option and indicate why on your data collection form.

***IB5 Active bleeding***

***Manual note:*** This item is most applicable when the cause of the bleeding is unknown and/or the attempt to control the bleeding has failed (e.g. patient was first treated in the emergency room and subsequently admitted). If in doubt, consider this criterion unmet. The override option can be utilised if this is the only item appearing to justify the admission. An example of meeting this criterion would be a patient with active, bleeding oesophageal varices.

***IB6 Wound dehiscence or evisceration***

***Manual note:*** This criterion applies only to surgically repaired wounds and not to other surgical wound complications such as incisional hernia (see the Clinical Services item IB1). It does not apply to non-healing of surgical wounds or conditions such as "non-union" of fractures.

***IB7 Pulse rate: < 50 per minute or > 140 per minute***

***Manual note:*** This criterion is met when abnormal pulse rate is recorded at least twice with readings a minimum of five minutes apart.

***IB8 Blood pressure:***

***systolic < 90 or > 200 mm HG; and/or***
***diastolic < 60 or > 120 mm Hg***

***Manual note:*** As under IB17, the pressures should be noted at least twice with readings minimally five minutes apart. If, in your judgment, the pressure represents a "normal" reading for this patient (by history and/or physical examination report) consider using the override option. For example: a sixtyfive year old, known hypertensive, with a history of blood pressure 195/125 and a current reading of similar value, is admitted. This patient would "technically" meet this item and you would code this item as criterion having been met. If this is the only criterion met to justify the admission, the medical record should document some other problem (not covered by the items provided) or the override option should be utilised.

***IB9 Sudden onset of unconsciousness (coma or unresponsiveness)***

***Manual note:*** This criterion includes a patient found in a comatose state, the time of onset being unknown. For example: the patient was found at home. It does ***not*** include alcohol intoxication or simple "dizziness".

***IB10 ECG evidence of acute ischaemia, must be suspicion of new MI***

***Manual note:*** Although myocardial ischaemia may be mimicked electrocardiographically, this criterion is met only if a myocardial infarction is being actively considered on clinical grounds. A "yes" here would be highly suspect in the absence of a "yes" for criterion IB2 under the Clinical Services listing.

***1B11 Suspicion of MI, admitted for Troponin T (I) analysis 12 hours post pain onset.***

***Manual note:*** this criteria is only met if an ECG has been performed, the patient is undergoing continuous cardiac monitoring and explicit confirmation of suspicion of acute MI is documented. It would normally be expected that the blood sample will be taken within 1 hour of the 12 hour wait, post pain onset. The criteria is not met if Troponin analysis is negative or less than 0.05 µgm AND the patient remains in hospital for more than 4 hours following laboratory confirmation of results.

# II ADULT DAY OF CARE CRITERIA

## IIA MEDICAL SERVICES

This section contains a list of major services that justify the patient being in an acute care hospital. These procedures justify appropriateness whether related to the primary diagnoses or not. If you feel that a particular procedure could have been done on an outpatient basis, use the override option and explain why.

***IIA1 Procedure in operating room (theatre) that day (i.e. the day reviewed)***

***Manual note:*** Any procedure actually performed in the operating room qualifies for this criterion. If one of the procedures IIA3-6 (below) is done in the operating room then this criterion is met.

***IIA2 Scheduled for procedure in operating room the next day requiring extraordinary pre-operative consultation or evaluation***

***Manual note:*** Patients already in the hospital are ideally located to have routine preoperative evaluation by anaesthesiology without the addition of days to their hospital stay. It is only in the case of a very complex medical problem that it should take an extra day for special testing or for examinations by consultants to ensure that it is safe to proceed with the planned procedure.

***IIA3 Cardiac catheterisation that day***

***Manual note:*** This criterion includes both the visualisation of heart chambers via the injection of contrast material and the sampling of blood from and measuring of pressures in the heart chambers and/or pulmonary artery. Also included under this criterion would be any indwelling cardiovascular diagnostic monitoring catheter.

***IIA4 Angiography that day***

***Manual note:*** This criterion includes various types of angiography, most arteriography (especially coronary arteriography), as well as major venography and lymphangiography.

***IIA5 Biopsy of internal organ that day***

***Manual note:*** Biopsies of kidneys, liver, lungs and brain are the most common, but this criterion also includes biopsies of gastrointestinal, bronchial, and bladder mucosa and needle biopsy of the prostate.

***IIA6 Invasive CNS diagnostic procedure that day***

***Manual note:*** This criterion includes procedures such as lumbar puncture, sternal tap, ventricular tap, myelogram, etc. (Please remember these are examples, not exhaustive categories of procedures).

### *IIA7 Any test requiring strict dietary control*

***Manual note:*** These are usually prolonged tests of metabolic function often involving timed blood and urine collections, such as those done to establish the diagnosis of aldosteronism.

### *IIA8 Treatment requiring frequent dose adjustments under direct medical supervision*

***Manual note:*** This criterion includes any situation in which frequent (i.e. virtually daily) observation and dose adjustment is required. It does not have to be a truly experimental drug or treatment, but rather it is a new or experimental situation for the individual patient. Unusual doses or routes of administration or well-known agents, new uses of old medications, and truly experimental therapeutics are included.

### *IIA9 Close medical monitoring by a doctor at least three times per day*

***Manual note:*** This criterion must be documented by doctors' notes that such monitoring has been performed. At a teaching hospital, notes by medical students count as "doctor's" notes. However, the patient must be monitored by a doctor three different times. Thus, three different notes (one from a student, intern, and attending) discussing the same observation.

### *IIA10 Post operative day (after operating room procedure or 3-6 above)*

***Manual note:*** If any operating room procedure or any of the procedures under Medical Services criteria 1, and 3-6 have been performed within the preceding twenty-four hours, then this day is appropriate. The procedures named usually require a period of post-facto bed rest and observation, although the observation and recording of vital signs may not be of sufficient magnitude to satisfy Nursing/Life Support Services criteria.

## IIB NURSING/LIFE SUPPORT SERVICES

***Manual note:*** This section contains a list of nursing and life support services the provision of which would justify the patient being in hospital. In this section, it is particularly important to require documentation for all criteria. If a service must be provided at least

three times daily for the criterion to be met, then it must be documented at least three times during the day of review.

***IIB1 Continuous or intermittent ( at least three times daily ) respiratory Assistance***

***Manual note:*** This criterion includes any continuous respirator use for any portion of the day of review. If, for example, a patient was weaned from an MA1 on the day of review, the patient would meet this criterion. Intermittent use of an IPPB, Puritan mist, nasal 02 or spirocare would meet the criterion, with or without chest physical therapy, provided that the documented use of such services is at leas three times daily. Chronic intermittent use of a positive pressure machine is not sufficient, nor is the use of 02 p.r.n. Special respiratory toilet by floor nurses, at least three times per day, would also fulfill this criterion.

***IIB2 Parenteral therapy: intermittent or continuous IV fluid with any Supplementation***

***Manual note:*** This criterion includes any intravenous substance given continuously or intermittently during any portion of the review date. Intravenous medications given via heparin lock and daily infusions of cancer chemotherapy are also included, while a "keep-open IV" is not. Special care should be taken to carefully examine days that appear to be solely related to maintenance cancer chemotherapy, since this can frequently be provided on an outpatient basis.

***IIB3 Continuous monitoring of vital signs, at least every 30 minutes, for at least 4 hours***

***Manual note:*** This criterion includes patients who are on continuous cardiac monitoring. It does include part of the day spent in a recovery room. It does not include patients who have their vital signs checked every four hours. If the medical record does not specifically chart this information, a negative answer should be assumed. This information can be found in nurses' notes, vital sign sheets, recovery room sheets and ICU sheets.

***IIB4 Fluid balance***

***Manual note:*** Intake and output is appropriate for people whose fluid intake needs to be restricted or ensured and for those whose urinary output is suspected of being abnormally low or high. Measurements of I&O are subject to error, as are measurements of weight, and neither obviates the need for clinical examination to detect rales, ascites, oedema, or poor skin turgor.

***IIB5 Major surgical wound and drainage care***

***Manual note:*** This criterion includes those patients who require skilled wound and drainage care. Wound care must be documented as having been done in either the doctor's or nurse's progress notes. Any patient having a surgically place drainage tube that requires checking or emptying every shift will qualify. Chronic nasogastric or gastrostomy feeding tubes or indwelling foley catheters do not satisfy this criterion, but they may be included as an override at your discretion.

***IIB6 Close nurse monitoring under physicians orders at least three times per day***

***Manual note:*** This criterion must be completely documented and includes monitoring by any non-physician clinical professional, e.g. LPN, respiratory therapist, etc. There must be at least three observations during the day of view, under the orders of a physician. The results of these observations should include more than just vital signs. An example would be observing neurological signs in a patient with recent unconsciousness.

**IIC PATIENT CONDITION**

Sometimes a patient who needs to be in the hospital will not be receiving any of the services in either of the preceding two criteria sets. In such a case, it is usually the condition of the patient that justifies being in hospital. This section includes eight criteria which indicate medical instability requiring a hospital stay. Please note the different time spans considered. Criterion IIC18 must have been met within the past 24 hours, IIC19-25 consider conditions within the past fortyeight hours.

***IIC1 Inability to void or absence of intestinal movements, in last 24 hours***

***Manual note:*** This criterion is generally concerned with post-operative problems. Chronic indwelling catheters are not included.

***IIC2 Transfusion due to blood loss, in last 48 hours***

***Manual note:*** If there is a transfusion for any reason, this criterion is met, regardless of the nature of the blood loss. However, chronic, slow blood loss requiring routine, intermittent transfusion (aplastic anaemias, for example) does not normally require hospitalisation, and usually should be noted as an override. Otherwise, the ***cause*** of blood loss is not pertinent.

***IIC3 Ventricular fibrillation or ECG evidence of acute ischaemia, in last 48hours***

***Manual note:*** Any ventricular fibrillation satisfies this criterion, as does acute myocardial infarction. Although myocardial ischaemia may be mimicked electrocardiographically by such conditions as left ventricular hypertrophy and various electrolytic imbalances, this criterion will be met whenever the diagnosis of ischaemia is being actively considered on clinical grounds, even if the ECG changes were finally determined to be due to other causes.

***IIC4 Fever > 38,0 C rectally (or at least 38,0 C orally) in last 48 hours, if the patient was admitted for reason other than fever (or > 100 (R) or 101 (OR)***

***Manual note:*** This criterion is also met if the patient was admitted with a fever which abated either with or without treatment and then recurred.

***IIC5 Coma : unresponsiveness for at least one hour, in last 48 hours***

***Manual note:*** This criterion is met by any condition producing unconsciousness which was not caused by a general anaesthetic agent.

***IIC6 Acute confusional state, in last 48 hours, not due to alcohol withdrawal***

***Manual note:*** This criterion is only met by patients with transient episodes of concussion such as a cerebral concussion, but not simple syncope. Mild flare-ups of chronic dementia do not fulfill the criterion

unless the symptoms represent a new pattern for the patient (development of hallucinations, for instance).

***IIC7*** ***Signs or symptoms due to acute haematologic disorders, (significant neutropenia, anaemia, thrombocytopenia, leucocytosis, erythrocytosis, or thrombocytosis yielding signs or symptoms) in last 48 hours***

***Manual note:*** This criterion is only met if there are signs (for example, ecchymoses or bleeding) or symptoms (for example, vascular thrombi) of one of the acute haematologic disorders. High or low counts of the blood constituents do not necessarily require acute hospitalisation or treatment.

***IIC8*** ***Progressive acute neurological difficulties in last 48 hours***
***Manual note:*** This criterion includes evolving stroke from any cause, as well as the onset of conditions such as Guillam-Barre. It excludes minor intermittent flare-ups or chronic disorders such as multiple sclerosis.

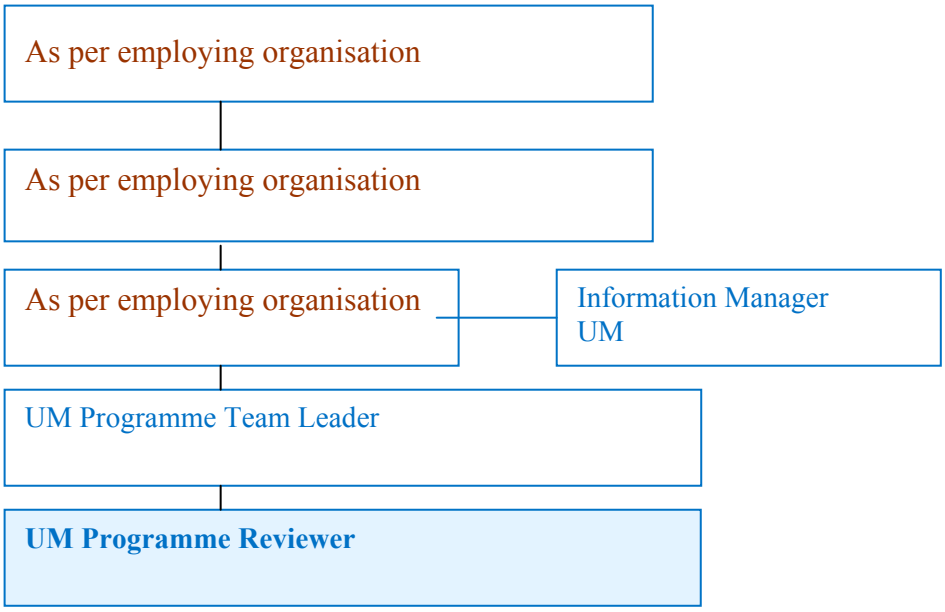
**APPENDIX 2**

## Job Specification - Example

**JOB TITLE**: **UM Programme Reviewer**

**GRADE:** Band 6 £22,328 - £30,247

**ORGANISATION CHART:**




## Job Summary:

To review admissions to hospital, using the 'modified Appropriateness Evaluation Protocol' (mAEP). To identify opportunities to drive process improvement initiatives, identify areas for improvement and provide managers with enhanced decision supporting information by the identification of practices, policies, case mix, resource deficit and patient-level clinical performances leading to inappropriate hospital admissions.

## Job Details

Job Title: UM Programme reviewer

Hours of Work: 37½ Hours

Department/Ward: UM Team

Division:

Base:

---

Reporting Arrangements

Managerially Accountable to:

---

## Duties and Responsibilities

## Communication and relationship skills

- Positively projects the UM philosophy, activity and outcomes effectively with all grades and disciplines of staff.
- Communicates project objectives, the effect of change and improvements in care, based on project findings, to managerial level at **employing organisation**, acute trusts and primary care trusts.
- Communicates empathetically and sensitively with staff when performing reviews.
- Prepares, presents and delivers highly complex information to all levels of staff, clinical and managerial, within **employing organisation**, acute trusts and PCTs.
- Requires highly developed communication skills to gain co-operation and build relationships in sometimes hostile and unpredictable environments.

- Ensures effective communication in order that patients receive best care, and takes action, where applicable, to relay findings at ward level.

## Knowledge, training and experience

- Registered Nurse.
- Health-related diploma or Level II research study desirable, with a willingness to undertake further study.
- Requires knowledge covering a broad range of clinical procedures and terminology to accurately complete reviews.
- Requires in-depth knowledge of host PCT/acute trust policies and procedures.
- Able to utilise IT to interrogate data.
- Highly developed presentation skills.

## Analytical skills

- Able to critically appraise research and analyse evidence-based practice in order to effectively utilise the Appropriateness Evaluation Protocol.
- Data analysis skills to analyse and interpret a variety of complex information.

## Planning and organisational skills

- Responsible for planning workload for self and others.
- Liaises with other professionals and agencies to organise project requirements.

- Responds flexibly to any changes in project requirements, effectively and efficiently.
- Works flexibly in order to complete reviews on the first day post-admission.
- Effective personal time management.

## Physical skills

- Able to travel between **employing organisation**, host PCT and acute trusts.
- Requires developed keyboard skills to input data accurately.
- Able to walk distances and climb stairs around large sites.
- Able to work flexibly including early starts, to fit the needs of the project in host sites.
- Able to walk and carry equipment substantial distances, outdoors, due to lack of available parking facilities at some sites.
- Uses underpinning knowledge to adhere to current policies and procedures both for health and safety and for moving and handling, with particular regard to transporting/transferring equipment to other venues.

## Responsibilities - for patient/client care

- Positively promotes the benefit of the reviews to patients/clients.
- Maintains patient/client confidentiality according to NMC guidelines.
- Continues own professional development, to ensure high standard of up-to-date, research-based information.
- Assists project development to maximise long-term patient benefit.

- Advises and reports on critical incidents and near misses as local incident reporting procedures dictates.

## Responsibilities for policy and service development Implementation

- identifies areas for service reallocation and changes, based on review findings, to relevant personnel at employing organisation, acute trusts and PCTs.
- Contributes to the development of UM policies and working practices.

## Responsibilities for financial and physical resources

- Responsibility for security of expensive equipment required to perform reviews.
- Responsibility for security of premises used for reviews at host trusts.
- Orders supplies as required.

## Responsibilities for human resources

- Assists with the recruitment and selection of new staff.
- Assists with planning preparation and allocation of daily patient reviews.
- Maintains inter reviewer reliability.
- Provides clinical expertise to ward and other staff in order to inform, teach and benefit patients.
- Collaborates with Team Leader to provide staff rotation for reviewing purposes.
- Collaborates with clinical governance to maintain continuous professional development.

- Acts in the role of the UM Team Leader in his/her absence.

## Responsibilities for research and development

- Completes ongoing audit investigations.
- Identifies and implements updates to the database.
- Accurately completes outcomes of evaluations using the database.
- Regularly updates in order to maintain evidence based practice.

## Freedom to act

- Adheres to the NMC code of professional conduct.
- Acts independently and autonomously within occupational guidelines.
- Autonomous and lone working when performing reviews.
- Collaborates with team members, and other UM teams and agencies as required, to organise and complete reviews.

## Responsibility for information resources

- Accurately records outcomes of evaluations/reviews, using the pro forma/database.
- Ensures the security of medical records and is responsible for the sharing of patient information for the benefit of reviews.
- Produces and assists in the collation of statistical data to be shared with other agencies/trusts.
- Regularly uses computer software to produce reports, documents and charts.

- Completes reviews, ensuring that information is accurate and complies with the Data Protection Act, and maintains patient confidentiality in line with NMC guidance.

## Physical effort

- Prolonged use of computer for processing data.
- Drives to host sites around the **employing organisation**.
- Regularly carries equipment to various venues.
- Able to commence work early and be flexible to the needs of the review team.
- Able to walk, stand and climb stairs, over many hours, during reviews at large teaching hospital sites.

## Mental effort

- Prepares, presents and delivers review reports at all levels within the **employing organisation,** acute trusts and Primary Care Trusts.
- Intense concentration required when completing reviews, to ensure accurate information gathering onto database/pro forma.
- Able to cope with frequent interruptions from staff/patients during the completion of the reviews.
- Ability to work to a strict schedule/timeframe.
- Patience and ability to collaborate with other medical/nursing staff when locating medical records required for review.
- Continually updating to maintain own and NMC professional standards.

## Emotional effort

- Demonstrates empathy and understanding when handling sensitive patient data.
- Responsibility for performing reviews in potentially hostile and unpredictable environments.
- Required to adapt to emotionally challenging situations e.g. presentations, managerial meetings.

## Working conditions

- Required to use computer frequently for part of most days when reviewing.
- Required to use computer continuously when compiling audits/reports.
- Ability to perform reviews in potentially hostile and unpredictable environments.
- Travelling by car and public transport to host sites.
- Adjusts to lack of suitable environmental facilities requiring adaptability and flexibility.
- Adjusts to different temperature settings/inclement weather.
- Required to walk and carry equipment due to lack of nearby parking facilities.
- Required to walk substantial distances over large hospital sites daily during reviews.

## Health, safety and security:

- All employees have a duty to report any accidents, complaints, defects in equipment, near misses and untoward incidents, following trust procedure.
- To ensure that Health and Safety legislation is complied with at all times, including COSHH, Workplace Risk Assessment and Control of Infection.
- Confidentiality:
- All information relating to patients and staff gained through your employment with this trust is confidential.
- To ensure safe storage of confidential patient information during on-site reviews
- To ensure the safe disposal of all paper and electronic records pertaining to patient information once the review is complete.

## Training

- To ensure completion of training and update requirements as started by the NMC to ensure continuing professional registration.
- All employees have a duty to attend all mandatory training sessions as required by the Trust.

## Person Specification

The person specification sets out the qualifications, experience, skills, knowledge, personal attributes, interests, and other requirements that the postholder requires to perform the job to a satisfactory level.

Job Title: Utilisation Management Programme Reviewer

| | **ESSENTIAL** | **DESIRABLE** | **METHOD OF ASSESSMENT** |
|---|---|---|---|
| **QUALIFICATIONS** | Registered Nurse or Pams equivalent<br>Evidence of post registration education | Specialist Practitioner<br>Health related Diploma or level 11/111<br>Research study<br>Degree/post graduate research experience | Application |
| **EXPERIENCE** | Minimum of 5 Years experience in an acute hospital/community setting | Experience at senior nurse level | Application & Interview |
| **SKILLS** | Able to accurately record information on pro forma and computer databases<br>Excellent communication skills<br>Able to utilise IT to interrogate data<br>Ability to liase with all levels and grades of staff | Developed data analysis skills<br>Formal 'research methods' training<br>ECDL<br>Developed report writing skills<br>Developed presentation skills | Application & Interview |
| **KNOWLEDGE** | Expert knowledge and understanding of clinical terminology | | Application & Interview |

# Annex B

# Prior approval – and other techniques

## What is prior approval?

B.1 Prior approval (PA) requires clinicians in secondary care to confirm the appropriateness of a proposed intervention or course of treatment with the referring GP. This can be done through the PCT or through other mechanisms, such as agreed protocols. The process should be non-bureaucratic. This will avoid unintended consequences, e.g. reducing opportunities to deliver the18-week referral to treatment target.

B.2 PA can apply at two levels – firstly; on groups of patients, where commissioners and providers agree in advance how to manage patients or pathways. Under such arrangements, providers do not need to get PA on each individual patient; instead, they agree to treat all patients to the agreed protocol. Commissioners can retrospectively audit activity to ensure adherence to the agreement (with clear statements on payment over non-adherence to PA agreements).

B.3 Secondly PA can apply at individual level, where providers must get agreement before initiating treatment on a specific patient. Clear agreement is necessary over where such PA is required and how clinicians should communicate with affected patients. This form of PA needs sensitive handling, as it requires real-time interventions in patient treatment pathways. It is likely to be appropriate only in decision-making where there is a low volume of requests for PA, for example where patients are subject to very high-cost, complex pathways. Many PCTs will already have in place complex cases panels; and therefore extending the responsibilities of these groups to consider PA requests of this nature may be the simplest and most appropriate way of delivering individual PA.

B.4 The key principles of PA are that it should:

- be clinically owned;
- never delay clinically necessary treatment;
- be pathway driven; with a fail safe system that allows for swift action to ensure that PA works as intended.

## Putting prior approval into practice

B.5 Birmingham East and North PCT (BEN PCT) has been trialling on behalf of the Department of Health a number of PA techniques, so that the learning can be shared with, and help, other commissioners. The process set out below represents early learning from the work under way. It is important to note that this is only one way of approaching PA (but one has produced early benefits), and commissioners should adapt the approaches for their local area as they see fit.

### Sharing practice

B.6 As the BEN PCT scheme develops, a series of bulletin updates will be published on the Department of Health website. This bulletin will include outcomes and key learning.

### Evidence base

Principle:

- Commissioners must have evidence that there is an issue that needs to be resolved
- The key to effective PA is to focus on areas where:
  - clinical effectiveness is questionable (e.g. tonsillectomies);
  - potentially unnecessary work is undertaken in specialties where there seems to be little benefit or reason for that work: (e.g. outpatients following elective surgery);

- hospital trust data suggests (when benchmarked) that the trust is undertaking work is outside expected norms (e.g. consultant to consultant (C2C) referrals);
- the costs of the intervention seem to be disproportionate to the work carried out (e.g. code N12 maternity attendances charged as an admission when in fact a ward attendance is the most appropriate charge).

B.7 BEN PCT used the following information to support its targeting of schemes for PA:

- NICE guidelines and NICE commissioning tool;
- public health data on prevalence (e.g. BEN PCT has identified higher than average interventions in some procedures, diagnostic and outpatient areas);
- Dr Foster high-level intelligence data;
- local data (e.g. analysis of short-stay admissions, in particular ambulatory sensitive care conditions). This data was then compared Dr Foster benchmarking data. This shows the PCT in highest category for short-stay admissions to hospital for conditions that could and should be managed in primary care e.g. COPD and cellulitis;
- best practice clinical pathways –e.g. 82 per cent of diabetic referrals were C2C referrals when patients could be referred to primary care community diabetic team;
- Department of Health/NHS Institute for Innovation data on productivity;

B.8 All these data sources were used by the PCT at no cost. BEN PCT used the high-level data to pinpoint problem areas, then identified local staffing resource to drill down as required to specialty and procedure level.

B.9 In developing and implementing the PA scheme the PCT agreed the following process:

- a paper was agreed by the Board on the care and resource utilisation approach;
- a presentation on the PA approach was signed off by the Professional Executive Committee (PEC);
- each clinician PEC member agreed to focus on one specialty area;
- each clinician, supported by a manager from the Redesign and Commissioning Directorate, was tasked with identifying the top 5 to 10 procedures, conditions, and outpatient attendances with the following factors: high volumes, limited clinical effectiveness evidence base, non-life threatening;
- the PCT sent out a press release linked to the publishing of Department of Health/NHS Institute for Innovation productivity metrics, to highlight that the PCT was actively reviewing procedures, tests, investigations and outpatient attendances where little or no evidence of clinical effectiveness or benefit to patients exists. The PCT also considered areas of high intervention rates where the evidence of effectiveness was not proven. This was undertaken by the clinical governance leads of both trusts (e.g. diagnostic arthroscopy). The principle behind this approach was to highlight how the PCT was attempting to ensure good use of taxpayers' funds;
- there must be engagement between PCT clinicians/trust clinicians to agree target areas (e.g. black list/grey list) also reducing unnecessary outpatients after elective surgery and achieve reductions in C2C in target specialities;
- PA criteria will be developed and produced for each area/speciality/procedure;
- the PCT will set up a panel for immediate decision-making under PA until pathways documentation has been fully developed and agreed;
- develop the pathways required and sign-off by all parties;

- the PCT will reflect all changes in contracts with local acute trusts from 1 April 2007. This will include updating exclusions and setting very clear tolerances in areas such as C2Cs and outpatients after elective surgery. The PCT will also signal any potential in-year changes prior to the start of the financial year within the new model contract.

B.10 To deliver the above, it is important to ensure that all clinicians have the relevant data (e.g. the range of procedures that could be on grey and black lists, the number of outpatients undertaken after elective surgery by procedure).

### Engaging with providers and clinicians

Principle:

- Commissioners should discuss the issue with providers and relevant clinicians. It must be agreed that PA is the most appropriate intervention and that there is a need to escalate the issue.

- for example, before incurring the expense of PA, commissioners should usually share with providers their cause for concern, identify the likely nature and target for PA that they are considering, and introduce a trial period of prior notification;

- and while group-level PA may appear an easier option, the information requirements to ensure that adherence can be identified will need to be clear and agreed

B.11 The PCT has held discussions with the Local Medical Committee (LMC). The LMC were keen to ensure that all GPs were aware of the process. The LMC also made the point about keeping schemes simple and transparent, to avoid GPs feeling that there would be a transfer of work to primary care, which was not funded.

B.12 As part of the process, the PCT will write to all GPs and Consultants outlining the approach and the agreements reached on where PA will apply; for example PA could apply to:

- C2C referrals;

- outpatient follow-ups no longer required after elective surgery;
- elective procedures where clinical benefit is limited;
- tests and investigations that might be undertaken in primary care;

B.13 To implement a PA scheme successfully, the following are critical:

- clinical engagement and ownership;
- clarity on the role of PA in the particular circumstance i.e. PA should be used tactically and in a transparent manner;
- good relationships;
- good communication systems with all interested parties including patients. There will be a perception that PA is being used to save money and therefore PCTs must be able to demonstrate a range of outcomes and benefits from implementing PA schemes.

### Protocols/guidelines

Principle:

- The protocol or guideline being introduced must represent good clinical practice.

B.14 The protocol and guidelines were developed clinician to clinician. This process involved six PCT clinical directors and the PEC chair, supported by a commissioning manager. This team will work jointly with clinicians from acute providers to produce pathways and PA group directives.

B.15 Having developed a list of the proposed PA schemes (both individual and group-based), BEN PCT discussed these matters with the LMC, and agreed that PA will be undertaken at PCT and/or locality level to avoid individual PA requests to GPs, which could create delays and slow down the system. Therefore the majority of BEN PCT's PA schemes will be group-based. The key to this system working will be the development of PA group directives.

B.16 Clinicians in the PCT and trust will, for each specialty, have agreed the changes to the pathway through the production of a PA directive. The directive will specify the graduation process for patients. If the patient has received treatment in line with the pathway and with the directive, the consultant will be able to undertake the procedure (this procedure will be on an agreed PCT grey list) as agreed within the PA directive without recourse to the PCT. The Trust must be able to demonstrate, through appropriate detailed clinical information, which should have been sent back to the GP, that the procedure was necessary and in line with the agreed PA directive.

B.17 On receipt of an invoice for procedures undertaken under PA, the PCT will undertake to validate a percentage of these procedures by reference to the patient's GP, to ensure that the relevant directive has been followed. If there is no clinical information and/or the PA directive has not been followed, the PCT will not make any payment for this procedure.

## Timescales - ensuring no delays to the patient pathway

Principle:

> Unnecessary delays must not be introduced into patient pathways. For PA, this clearly means that commissioners must respond to requests for approval in a timely manner.

> Required response times need to be specified in advance, and failure to provide responses within this period can be taken by providers as permission to proceed.

> Where retrospective group-level PA has been established, commissioners must complete any audits within specified time periods (likely to be within the financial year the treatment was undertaken). Patients must be informed of the process clearly.

B.18 The PCT black and grey lists will be agreed between organisations, both for elective procedures and outpatients following surgery. BEN PCT have found that this approach has worked well where the PCT PA Panel meets fortnightly. A simple form will be developed for consultants to request PA. This is purely a interim measure while:

- pathways are developed and agreed;
- PA directives are developed and agreed.

B.19 A detailed communication strategy with GPs is critical to avoid confusion about what is and what is not on each list. Direct communication with patients, this is particularly important as some patients will already be listed for a surgical procedure which it may now have been agreed to put on a black list or grey list.

B.20 It is important to develop group directives for each area. As an interim measure, it is suggested that the clinical PA panel is convened as outlined above. This panel will authorise any requests for procedures on the grey list. A policy on how these interim measures will be developed including timescales, is being drawn up by the PCT.

B.21 BEN PCT's approach to PA is to build on existing mechanisms in the organisation. The PCT already has an embedded system of GP peer review via a referral reporting and verification system (Insight). Therefore, all the referrals made are already considered appropriate from the GP perspective and in effect a PA approval is already in place in many practices through the use of Insight. This ensures that all systems and processes are set up to achieve effective care and resource utilisation.

B.22 Development of appropriate pathways underpins the PCT's approach, which ensures that there are no delays to the patient journey. The principle underpinning PA within the health economy is that, where possible, PA is built in to the decision-making process as part of clinical care.

### Exceptions

Principle:

- Commissioners should expect a proportion of patients to follow some pathways (for example consultant-to-consultant referral), and should monitor and intervene only if the proportion changes significantly.

B.23 The key to the above is a robust contracting process, which lists contract exclusions in sufficient detail to ensure that organisations are clear about the processes by which a procedure can or cannot be undertaken.

### Data Sharing

B.24 Data on the use of PA will be fed back to GPs as part of the PBC information set.

### The model contract

B.25 The model contract will enable commissioners to define where providers need to seek PA for conducting activity for individual patients or groups of patients in line with guidance on key principles for PA. It is expected that most PA will take place at group level, to protocols agreed by clinicians. Under such arrangements, providers do not need to get PA on each individual patient; instead, they agree to treat all patients to the agreed protocol, so in effect patients are automatically approved.

B.26 The model contract will require commissioners to respond to a provider's request for PA in relation to an individual patient in no more than three working days. A failure by the commissioner to respond in this time period will be considered to be an approval for the provider to proceed, as long as the provider has given all the necessary information in the form that the commissioner has specified. Retrospective approval for individual patients will be permitted where there is deemed by the provider to be urgent clinical need or risk to the patient.

B.27 The model contract also sets out that commissioners will give providers one month's notice in writing of any changes or additions to any PA scheme. It also requires commissioners to identify where providers have not complied with PA schemes at the monthly meetings to review actual activity against forecast activity. Where providers have not complied with PA schemes, the commissioners will be entitled to not pay for the activity.

B.28 The contract sets out that commissioners will be expected to pilot a trial period of PA (for one month) before financial deductions can apply, to enable the process to bed down. The commissioner will be able to pay for the activity wholly or partly where the non-compliance with the PA scheme was considered to be appropriate in the specific scenario, or

where non-compliance is considered to be a mistake on the part of provider staff.
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4141197&chk=FcbsGi.

### Implementation

B.29 BEN PCT sends the list of procedures to clinicians for review. The clinicians will have dialogue with consultants to finalise areas to be targeted. There would then be immediate implementation of agreements while the pathway work is being undertaken. Some PA schemes will be implemented over a shorter timescale than others. It is important to remember this will be an ongoing process throughout the year and that the national model contract will allow for in-year changes. Commissioners may wish to minimise bureaucracy by avoiding frequent changes.

### Funding base

B.30 PA has required no extra funding from the PCT. However, it does require clinician and manager time. PA is a priority and should be part of a PCT's core business. It will enable strengthened commissioning function by focusing tactically on areas which, both in care and cost terms, are outside expected norms.

### Outputs and benefits

B.31 Outcome metrics need to be agreed at the start of the PA scheme. BEN PCT has identified five metric 'buckets' finance, activity/productivity, clinical outcomes, satisfaction (patients and clinicians) and organisational benefits.

B.32 It is important to use the data available to identify where to focus efforts to gain the best return on time invested. BEN PCT has targeted unnecessary interventions, alongside provision of more appropriate services in primary care. The PCT identified outcome measures in each bucket (see example below).

An example of the above is the introduction of the Insight referral management system. The need to engage GPs in managing referrals at practice level was key. The system is non-judgemental as it is designed to create an environment for peer-reviewing referrals similar to the way that prescribing operates. The results to date show an average 20 per cent reduction in referrals for first outpatient consultations this year, which is estimated to save approximately £2 million. Over and above the PCT has been able to take out from the contract a large number of follow-up appointments which will not now occur because of these reductions approximately £800,000. The agreed outcome metrics were reduced costs, reduced activities in secondary care, increased patient management in primary care, retention of satisfaction levels of GPs (i.e. no demonstrable increase in workload), no reduction in patient care, and support to achieve PCT financial balance.

## Top tips for success

- gain clinical ownership;
- cultivate relationships with acute providers – have a shared strategy between the PCT and the acute providers, to build primary care capacity;
- invest time in building primary care capability/capacity;
- use all the mechanisms and data available, e.g. the PBC Directed Enhanced Scheme was a driver for assisting in changing behaviour and ultimately creating the GP PA scheme;
- work to agree joint standards of referral information and information on patient outcomes to achieve clinician engagement;
- focus on key areas using all data sources.

## Other care and resource utilisation techniques to ensure effective utilisation of services

## Case study Birmingham East and North PCT

### Evidence base

Principle:

> Commissioners must have evidence that there is an issue that needs to be resolved.

B.33 In BEN PCT short-stay admissions (one to two days) for ambulatory care sensitive conditions (ACSCs) are increasing – performance to month 4 shows an 8 per cent increase on 2005/06.

B.34 National evidence shows that a number of these admissions were preventable and in some cases could be construed as inappropriate admissions. In BEN PCT, ACSCs are at high-levels (13.76% of all emergency activity).

B.35 Clinical directors have reviewed the 19 ACSC areas. In reviewing the data the clinical directors focused on the area of cellulitis admissions. The six clinical directors reviewed 10 per cent of cases relating to ACSC over a four-month period and estimated 25 per cent of these admissions could potentially have been handled in primary care. On the issue of cellulitis, the PCT asked GPs to review all cases for a four-month period as a new pathway had been introduced for this condition, which allows for all cellulitis patients to be treated in primary care. The PCT reinforced the pathway with trusts, to ensure that patients were treated in the most appropriate place. The PCT confirmed that any admissions for cellulitis would be deemed as inappropriate, and the PCT would not expect to pay for these admissions.

### Engaging with providers and clinicians

Principle:

> commissioners should discuss the issue with providers and relevant clinicians;

- the most appropriate intervention and the need to escalate the issue must be agreed and that there is a need to escalate the issue. and

- the information requirements to ensure that adherence can be identified will need to be clear and agreed.

B.36 BEN PCT wrote to acute providers, outlining its approach and the potential benefits of this approach (reducing inappropriate admissions, commissioning increased services in primary care, managing to thresholds and tolerances in contracts). It also explained clearly what it was not setting out to achieve (i.e. delaying treatment by holding back demand for services).

B.37 As part of its approach, BEN PCT has also changed the emphasis of its primary care based assertive case management model from the present caseload arrangements to a model which actively puts assertive case management at the front end of unplanned care services.

B.38 The PCT is communicating with all key stakeholders to ensure that they understand the new model.

### Protocols/ guidelines

Principle:

- The protocol or guidelines being enforced must represent good clinical practice.

B.39 The PCT's objective is to create a model of care; which means that any patient with one of the 19 ACSCs who contacts the emergency services or attends the A&E in the PCT area will be identified and then assessed by an assertive case manager (ACM) in conjunction with either Ambulance, or A&E staff, to avoid unnecessary admission to hospital. It will link to current intermediate care arrangements, tracker nurse systems and other community services, including social care. ACMs will capture the information required to ensure that where an admission takes place and the ACM did not believe an admission was required and this will be recorded and passed to the Redesign and Commissioning Directorate for further discussion with the Trust.

Principle:

- Unnecessary delays must not be introduced into patient pathways.
- Patients must be informed of the process clearly.

B.40 The principles underpinning this new development are that the ACMs will:

- work 7 days per week up to 10pm or have an on-call system available out-of-hours;
- ensure that the model will be flexible to accommodate working with the Ambulance Service and A&E;
- ensure that the pathways are in place, and are designed to clearly aid a decision about the appropriateness of an admission;
- have responsibility for orchestrating care across health and social care.

### Implementation

B.41 The work to develop the model is underway through the provider arm.

### Outcomes and benefits

B.42 Outcomes and benefits are expected to be:

- reduction in hospital costs by approximately £2million from November 2006 to March 2007;
- reduction in contracted activity back to acceptable levels;
- increased management of patients in primary care;
- reduction in future exacerbations for patients with ACSC conditions;
- reduction in risk factors, which lead to exacerbations;
- increase in planned care;

- timely information for GPs;
- assistance in meeting financial balance;
- more appropriate treatment in the right setting;
- improved quality of life and maintenance of independence;
- development of new services with freed-up resources (e.g. commissioning of pulmonary rehabilitation for patients with COPD);
- satisfaction surveys for Patients and Clinicians, focusing on patient outcomes;
- organisational outcomes in place in relation to future commissioning of services.

### Top tips for success

B.43 All the work undertaken by BEN PCT is underpinned by:

- clinical engagement;
- health economy principles (e.g. Working Together for Health);
- constructive dialogue;
- transparency/open book approach;
- use of information in a tactical way;
- focus on clinical effectiveness and clinical governance;
- focus on coding issues.

### Other Points

B.44 BEN PCT has developed very explicit overall organisational goals, which set the commissioning vision. It is important to use all tools available to deliver change. PCTs need to ensure an environment where there is healthy challenge within a framework of good relationships. PCTs should ensure that they cover a range of issues in terms of volume, clinical effectiveness etc. as one approach will not work for everything. PCTs will need to mix and match their approaches.

## Other care & resource utilisation schemes

### Outpatients

B.45 The PCT used Insight (a bespoke data collection system) to monitor and peer review GP outpatient referrals and create a GP practice PA scheme. This was implemented from 1 April 2006 and will achieve savings of approximately £2.5million by the end of the year. Further information on Insight is available from andrew.donald@benpct.nhs.uk

### A&E

B.46 The PCT has introduced a new urgent care centre with extended opening hours that will enable 20,000 patients to be treated **more appropriately** in Primary Care. Based on present activity levels this will save £400k per annum. The PCT has also agreed that if anybody who attends A&E out-of-hours and is then asked to attend the out-of-hours centre then an unbundled tariff will be applied. This is in line with the fact that the out-of-hours provider is delivering the service. The acute trust is only therefore paid £16.00 for triage and registration.

### GP emergency referrals

B.47 BEN PCT has requested GPs to maximise the use of community services prior to considering referral to the acute sector. There is already some evidence that GP emergency referrals for short-stay admissions have reduced this year.

### Ear Nose and Throat

B.48 Referrals to this acute service have reduced by 40 per cent this year.

### Care management/intermediate care/community stroke service

B.49 These are all services, for example support managing demand in the short, medium or long term. Intermediate care has avoided admissions equating to £1.5million, the stroke service has avoided a smaller number of admissions, care management has in the first six months and seen a reduction in A&E attendances and GP visits in the cohort being managed (1,000 patients).

B.50 The PCT has also agreed with its out-of-hours provider that it will highlight on their records patients with a long term condition; to allow for more appropriate management and referral. In practice this means that patients with long term conditions will be given information about what to do if they have an exacerbation of their condition e.g. they would be asked to phone the out-of-hours provider, not 999, and depend on the assessment of the patient's condition, the case manager would be contacted.

### Market testing

B.51 PCTs should consider market testing. BEN PCT is market testing the dermatology service to introduce a clinical assessment service, which will mean a predominantly primary care-based service for a large proportion of patients.

## Conclusion

B.52 All the above approaches highlight how both PA and other techniques could be applied by PCTs with their partners. There will be many other ways of implementing PA and other techniques. PCTs should use the experience of BEN PCT as an indicator of what can be achieved.



[DN: insert document reference]

Care and resource utilisation: ensuring appropriateness of care is available to view or download from www.dh.gov.uk/publications