HSJ LOCAL briefing

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July 2012

SOUTHAMPTON AND PORTSMOUTH ACUTE SERVICES

HSJ Local Briefing is our new in-depth analysis of the key issues facing the NHS's major health economies

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In brief

Issue Demand for acute services, particularly on the non-elective side, is rapidly rising in Southampton and Portsmouth. It is causing trusts to slip behind on their targets for both emergency waiting times and referral to treatment.

Context Across England, non-elective admissions fell in each of the first three quarters of 2011-12, compared with the same quarter the year before. However in quarter four emergency admissions hit their highest ever levels for February and March. GP referrals fell year on year in the first half of 2011-12, before rising in the second half. Data for April 2012 shows that both emergency admission and GP referral rates are continuing to rise.

Outcome Few expect emergency admissions to come down to target levels this year – not least because this would require a behavioural change among local people who currently tend to go to hospital first. Some hope that better clinical engagement brought by clinical commissioning groups, some contracting innovations, and renewed efforts between community and acute trusts to work together, will lead to more successful activity management than before. But early indications show that growth in demand for acute services is continuing to rise, and trusts are still planning to deal with ever-higher levels of activity during 2012-13.

National context

After year upon year of steadily rising demand for acute services, the national picture became more interesting in 2011-12. In September 2011, NHS chief executive Sir David Nicholson was able to tentatively welcome a drop in hospital admission rates as possible evidence that clinical commissioning groups had begun to turn the tide.

Across England, non-elective admissions fell in each of the first three quarters of 2011-12, compared with the same quarter the year before. As Sir David said, "that has never really happened before".

However the good news ended in quarter four, as emergency admissions hit their highest ever levels for February and March. Meanwhile GP referrals fell year on year in the first half of 2011-12, before rising in the second half. Data for April 2012 shows that both emergency admission and GP referral rates are continuing to rise.

SHIP cluster

At the end of 2011-12 commissioners in the Southampton, Hampshire, Isle of Wight and Portsmouth primary care trust cluster were able to trumpet the fact that they had beaten their target quality, innovation, productivity and prevention savings target (£103.3m saved against a plan of £99.8m) while at the same time referring far more patients to hospital than they meant to.

Board reports reveal that "managing levels of non-elective demand in particular has proved extremely difficult". Southampton and Portsmouth had to release extra cash through "slippage on investments or other contingencies".

Across the cluster as a whole, elective work exceeded plan in every category. GP outpatient referrals were 1.5 per cent higher than planned, accounting for an extra 5,000 patients, while other outpatient appointments were 2.8 per cent – or 6,000 patients – more than expected. Although the figures may be skewed by changes in counting at University Hospital Southampton Foundation Trust, Hampshire, Southampton and Portsmouth all reported day case admissions and total elective admissions several per cent ahead of plan.

Emergency care

The story around emergency activity reveals a split between town and country - perhaps unsurprisingly given that both Southampton and Portsmouth have some of the most deprived wards in England. In Hampshire, non-elective admission rates were mitigated by data from Hampshire Hospitals Foundation Trust, starting 8 per cent more than planned and falling to just over 4 per cent over target.

But in Southampton, emergency attendances had leapt up to 10 per cent over plan by August and stayed there for the rest of the year.

Southampton PCT overspent by £8m – or 3.2 per cent – on NHS commissioned services in 2011-12. This was partially mitigated by some savings in primary care and internal running costs, but the gap ultimately had to be plugged by £5.5m from unallocated investments, contingency and general reserve cash.

In Portsmouth, 2011-12 started with emergency activity 8 per cent higher than planned. Activity levels stayed more than 10 per cent above plan from August to the end of the year, peaking at 12 per cent over plan in November.

Portsmouth Hospitals Trust finished the year with a modest surplus, but only after the PCT cluster re-calculated its activity baseline upwards, resulting in additional payments to the trust of £13.6m. At the beginning of the year it had been hoped these could be capped at £2.8m.

Although the trust reported that its £25m cost improvement programme had been delivered in 2011-12, £6m of that was non-recurrent, increasing the size of the financial challenge for this year.

Impact on performance

High rates of admissions are affecting trusts' performance as well as their balance sheets. In Portsmouth the 95th percentile emergency wait was six hours and five minutes in April, while referral to treatment times also underperformed throughout the year. The trust cited "the profile of emergency activity across all sections of the health sector".

In Southampton there were similar strains in the emergency department. PCT board papers said that the high levels of demand were having knock-on effects on the quality of care - and the cluster's clinical governance committee had met the trust to discuss the impact of a Norovirus outbreak.

"There have been further discussions with the trust about their continuing difficulty in managing planned and emergency activity and this potential adverse impact on quality." Further work is planned to ensure all patients, either in hospital or the wider community, "can be cared for safely at times of increased activity."

What is the cause?

The ability to find a local solution to the issue depends on providers and commissioners first being able to agree on what the cause is.

GPs, commissioners, community providers, acute trusts and the public are all responsible, depending on who you speak to. That alone is a sign of a health economy where not all the parts are as sympathetic to one as you might hope. An example of how difficult it is to get different organisations to work together in the interests of patients emerged early

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this year when a plan to establish a network for vascular services was scrapped after trusts failed to agree how the services should be spread.

One local commissioning source described the system as "dysfunctional", with a culture among organisations to "think of themselves first and the system second". This, some commissioners argue, is exacerbated by the tariff system, which encourages trusts to admit a patient rather than transfer them to primary care or community treatment. Although there are punitive marginal rates for excess activity, and the structure is flexible where both sides agree to an alternative, the strain in the system has not yet prompted major innovation so far. One commissioner observed that payment by results "doesn't incentivise providers to actively go out and prevent admissions".

Acute sector sources see the issue differently. They say vast majority of patients who arrive at hospital need to be there – the problem is that patients with long term conditions can go into a "spiral of decline" without non-acute services intervening until they're so ill they have to go to hospital.

The Southampton trust sees little financial incentive in admitting more and more patients. A well-placed figure said: "The volumes of emergency activity coming into an organisation like ours is almost strangling us financially."

The ever-growing activity uses up the trust's spare capacity, and so holds them back from reconfiguring services on site or investing in new innovations.

New ideas for 2012-13

There is some guarded optimism that commissioners can bring in new incentives for trusts to work more closely together. Under the commissioning for quality and innovation scheme, this year acute and community providers across the SHIP area will receive extra payments if they work together to cut emergency demand.

A well placed local source said this should directly incentivise Solent Trust, and Southern Health Trust, the local community providers, to work to cut accident and emergency admissions for the first time, rather than "work in splendid isolation".

This is the main commissioning innovation in 2012-13. Although the amounts of money at stake are relatively small, at 1.5 per cent of the contract value, commissioners observe that such a margin could make the difference between a trust recording a surplus or a deficit at the end of the year.

HSJ has also learned that the Southampton and Solent trusts are also currently exploring ways that surplus capacity in the community sector can be used to relieve pressure in the general hospital. It is hoped that the acute provider will be able to move a ward providing services for elderly patients into community facilities.

The trusts are understood to be working out the commercial and staff implications of such a move. In the acute sector, managers are enthusiastic about the proposals because they would enable care to be delivered closer to patients' homes. Having hospital and community staff working side by side could also help bring new skills to community teams, enabling them to care for patients outside of hospital for longer.

A similar arrangement was introduced in November last year in Portsmouth, involving Portsmouth Hospitals, Southern Health and Solent. Commissioners believe it is currently preventing one hospital admission a day.

Community providers in Portsmouth are also introducing rapid response teams and putting "step up beds" in nursing homes, to deal with long term patients whose conditions escalate.

Meanwhile a community team has also been established in Portsmouth's emergency department, to attend to patients who need treatment but not necessarily a hospital admission.

Further efforts in Southampton

At Southampton General Hospital, managers are keen to increase the working hours of senior clinical "decision takers", to enable the diversion of patients who attend accident and emergency but do not need to be admitted. In the emergency department, consultants are now on the "shop floor" until midnight, every day. With the hospital now designated a major trauma centre, that coverage will be lengthened again to 2am. Similar measures brought in at the hospital's acute medical unit mean that 40 per cent of GP referrals can be treated without being admitted to hospital.

The trust has also increased the number of nurse practitioners in the emergency department, to treat less severe cases and avoid admitting them by default.

Portsmouth commissioning plans

Dealing with acute sector demand is a recurring theme in Portsmouth CCG's commissioning plan for 2012-13. The CCG plans to tackle emergency admissions among older people by introducing risk profiling of patients, and re-procure GP out-of-hours services – the disconnect between those services and the rest of the NHS is widely complained about in this health economy.

A "system approach to contracting and CQUINs" is also planned - potentially reflecting the work in Southampton - along with a "community heart failure service".

Primary and community care emergency pathways for children are to be reviewed this year, and commissioners want to set up a "single point of access" for paediatrics emergencies.

It is also hoped that the introduction of "anticipatory" care plans will lead to fewer acute admissions among older patients with long term conditions.

QIPP workstreams

More profound service redesigns are inching into view through the QIPP programme. Commissioners in Southampton have adopted the Sir John Oldham's workstream for long term conditions. Having identified the 0.5 per cent of the population most at risk, they have established integrated health and social care teams led by community matrons to manage their care at home. Those teams work with clusters of GP practices and provide care seven days a week.

QIPP leads want to extend that model to the 5 or 10 per cent of the population who use NHS services the most, with the teams led by specialist nurses - although this potentially transformational change is thought unlikely to bear fruit in terms of savings in 2012-13.

Still further away, commissioners are keen to adopt the year of care tariff, the trials of which begin in selected locations in England this year. Rather than paying trusts for each encounter with a patient, providers would be paid to care for a patient for a year, giving trusts a direct financial incentive to keep patients out of the emergency department for the first time.

The new commissioning system

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In the short term, the health economy is seeing more subtle innovations in commissioning. There is optimism across the health economy that, although this year's QIPP plans don't look much different to last year's, an increasing level of clinical engagement - both sides of the purchaser/provider split - makes it more likely that they will be successful.

Commissioners also feel that the requirement for every GP to be a member of a CCG also binds the entire local primary care sector into system improvement for the first time. Practice based commissioning groups, the forerunners to CCGs, struggled to "mobilise" their fellow GPs.

A further change is the creation of Commissioning Support South, the local commissioning support service initially covering the SHIP cluster area. Substantial change is not expected to come until CCGs have identified what contracting and analytics support they need to commission more effectively. However, even now the CSS has been asked to supply GP practice-level information to the CCG, providing more detail on local variations than previously existed. This could enable CCGs to understand where unnecessary admissions are coming from and help them work with practices to address outliers.

Can acute activity fall in 2012-13?

There are hopes that earlier activity management schemes, only beginning to take root in 2011-12, will begin to bear fruit this year. But even the most optimistic local figures acknowledge from past experience that the new NHS structure will not instantly cause all local organisations to start operating together as a coherent system.

"The moment you get to the point of saying, 'Organisation A's income drops, but Organisation B's grows', the people not growing are not happy," one said. "The commitment and engagement changes depending on whether you're a winner or a loser."

A large piece of analysis is being done during 2012-13, in time for the 2013-14 contracting round, about how patients are treated by community providers. It is currently much easier to see which patients go where and for which treatment in the acute sector and better information about the community sector will enable CCGs to assess how well the two are joining up.

Few predict that acute sector demand will come within plan in 2012-13. A local culture among patients of going to hospital first - common in less settled, urban populations - is widely cited. Changing the expectations and behaviours of large population groups will not happen fully in a single financial year.

Beyond the CQUIN innovations, radical commissioning changes remain something for the future, when CCGs have fully come into their own. "I would hope to see some stabilisation this year", is one commissioner's guarded predication. "I would hope we would control to some extent what's gone on in terms of growth, and if we're really lucky some reduction."

In Portsmouth, this year's plan is for emergency department activity to rise by two per cent on last year's levels. Although 2012-13 is still young, emergency department attendances are two per cent beyond even that rise, with non-elective activity as a whole ten per cent higher than planned. Nevertheless, a trust source told HSJ the situation would be "much more tricky" than it is had existing initiatives not been introduced.

Just how confident University Hospital Southampton Foundation Trust is of substantial progress being made on this issue this year can be seen in its financial plans. The trust is setting aside a contingency reserve, like the one it maxed out each month in 2011-12, allowing it the capacity to flex up if, as expected, demand for services exceeds contracted levels.

"Regardless of what the contract says - we've looked at the reality of the situation and organised our capacity can infrastructure around that," HSJ was told. "We've planned for underlying growth of 6 per cent."