HSJ LOCAL briefing

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BIRMINGHAM AND SOLIHULL QIPP

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

david.williams@emap.com
@dwilliamsHSJ

In brief

Issue At the start of 2012-13, the Birmingham and Solihull primary care trust cluster identified a £16m hole in its quality, innovation, productivity and prevention savings plans. Now, the three clinical commissioning groups that provide most of the work for University Hospitals Birmingham and Heart of England foundation trusts are all predicting a year-end surplus and that they will meet their efficiency targets.

Context This has happened at a time of rising demand for acute services. Although UHB and HEFT are both forecasting year-end surpluses, both are reporting higher than planned levels of demand for services, particularly over the winter. Both are struggling to keep up with accident and emergency targets.

Outcome The health economy plugged the QIPP gap by saving lots of money this year unexpectedly on drugs and complex care. Next year, expect redoubled efforts to implement integrated care, in the form of virtual wards and the development of a "year of care" tariff. Also, UHB's admission-avoiding acute medical centre will be replicated at HEFT, while attempts will be made to involve consultants more in the referrals process, to cut unnecessary outpatient attendances.

Last time HSJ Local Briefing visited Birmingham and Solihull, at the beginning of 2012-13, the health economy faced a £16m shortfall in its efficiency programme, while clinical commissioning groups were settling down into a new configuration after 12 merged into five.

At the end of the financial year, it seems like an appropriate moment to revisit the patch and ask: how well have commissioners done on quality, innovation, productivity and prevention this year, and what does 2013-14 have in store?

On the face of it, it looks like the local system has managed to plug the £16m gap, keep its CCGs in the black and avoid bankrupting its two major hospital provider trusts.

If that's right, it's all the more remarkable given the area's well-documented rise in demand for acute services, and reported overspends on provider contracts.

The main players

The Birmingham and Solihull health economy is dominated by two large acute foundation trusts: University Hospital Birmingham and Heart of England.

As one of the main teaching hospital trusts in the country, University Hospital Birmingham has an annual turnover of around £500m and takes patients from all over England. It also serves a local population in the southern and central parts of Birmingham.

Heart of England has a £560m turnover, but does less specialist work than UHB. Instead, its scale comes from operating three main acute hospitals: Solihull Hospital in the south; Heartlands Hospital in the middle; and Good Hope Hospital to the north in Sutton Coldfield. In addition, there is the Birmingham Chest Clinic in the city centre.

These two trusts serve three principal clinical commissioning groups: Solihull; Birmingham South Central; and Birmingham Cross City. The latter merged with Northeast Birmingham CCG last autumn.

A fourth CCG, Sandwell and West Birmingham, is more closely matched to the footprint of Sandwell and West Birmingham Hospitals Trust.

This briefing focuses on the south and east of the city.

Current position

Solihull CCG's most recent board report describes its financial position as "stable", with a year-end forecast surplus of £682,000, better than originally planned.

Birmingham Cross City CCG likewise was ahead of its financial plan at month nine, and was forecasting achievement of its £2m surplus target by the year end.

In common with Solihull, the Cross City CCG's most recent report states that there was over performance on all its acute contracts, but prescribing, complex care and reserves gave enough flexibility to manage the situation.

Birmingham South and Central had a forecast surplus outturn of £700,000, also on target.

This confidence extended to QIPP, too. Birmingham Cross City reported its £29.8m target was on track. Solihull was also doing better than expected, notching up QIPP savings worth £5.5m, £100,000 better than plan.

UHB is expecting a £3m surplus for 2012-13, £2.4m better than plan.

Rising activity

Yet despite this apparently strong position, all indicators across the Birmingham and Solihull patch suggest a demand for hospital services far outstripping what was planned.

The most recent publicly available figures for the cluster relate to month seven of 2012-13 – before winter pressures fully took effect. Even then, non-elective activity was 12.4 per cent over plan, while GP referrals were 9.2 per cent over plan.

Recent data from the acute providers tells a similar story. Heart of England reported that non elective activity was 5 per cent higher than in 2011-12. Elective and daycase activity was 2.2 per cent up. Outpatient activity was 1.8 per cent above plan year to date.

UHB's data is broken down differently, but its most recent data suggests that overall, activity from West Midlands PCTs was about 6 per cent higher than planned.

Contract overperformance

In terms more directly relevant to QIPP, of the impact of rising demand for acute services translates into contract overperformance, meaning unforeseen costs in the health economy.

HEFT's report for the first two quarters of 2012-13 – the most recent data published – showed that year to date income was £11m more than planned.

UHB meanwhile reported an overspend of £6.2m in its divisional budgets for the first three quarters of 2012-13 – this was despite receiving £3m more in income from commissioners than originally expected. The overspend is forecasted to rise to £9.8m by the end of 2012-13.

Both trusts reported slippage on their cost improvement plans. For UHB, the shortfall was modest – £739,000, representing just 5 per cent of the total for the first three quarters of 2012-13.

However the problem was more severe for HEFT, which only registered half of its planned CIP savings for November. Year to date delivery, at £9.7m, only covered two thirds of the planned savings.

Another indicator that the Birmingham and Solihull health economy is "running hot" is accident and emergency performance. Both HEFT and UHB struggle to hit the target of admitting or discharging 95 per cent of patients within four hours.

SHA cluster data shows that through December, HEFT's

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performance against the four-hour A&E indicator never rose above 90 per cent. UHB was also consistently below the 95 per cent standard, and dipped below 90 per cent at its worst point in December.

The disappearing £16m QIPP gap

The £16m QIPP gap, identified at the beginning of 2012-13, accounted for 28 per cent of the Birmingham and Solihull target for 2012-13.

As recently as November the cluster was reporting that in the first seven months of the year, it had fallen £14.3m short against a year to date plan of £31.4m.

That month's report also predicted that end of year savings were expected to reach £35m by year end – just 60 per cent of the target figure.

So what happened changed between November and now? There was no massive turnaround in QIPP performance, but the way savings were accounted for locally changed.

Put simply, the cluster has done much better than expected on prescribing costs and "complex care", and brought these savings under the QIPP banner for the first time in early 2013.

The change more accurately reflects the "full level of savings being realised", the cluster says.

Much of the £16m gap is still there – instead of being accounted for as "unidentified savings", it is now categorised as part of the cluster's shortfall in "business efficiencies". All the major acute-based QIPP categories registered small shortfalls, but the cluster generated a positive figure overall, thanks to huge gains in medicines management and continuing healthcare.

Analysis of the West Midlands QIPP tracker for January 2013 reveals that three of seven Birmingham and Solihull workstreams were dependent on managing down demand for various types of acute activity. The cluster's QIPP plan had a red rating overall.

The SHA did acknowledge that the cluster was on course for "financial delivery" of QIPP in 2012-13 – consistent with the confident CCG reports described above.

However, in keeping with original goal of QIPP – to save money through improving services – the SHA distinguishes between financial delivery and true service transformation.

As emergency demand was "the main driver for indications of service transformational change, the overall status for the cluster will remain as red," was the SHA's verdict.

What next?

It is acknowledged locally that a sustainable health economy must be built on reversing the year-on-year rise in demand for acute services.

Dr Gavin Ralston, chair of Birmingham Cross City CCG, says that in the future, commissioners probably cannot rely on medicines management and complex care savings to bail out QIPP shortfalls in future.

In the past, he says there have been too many small efficiency schemes. "We think that's probably not the best way to approach things", he told HSJ. Future QIPP programmes will be based on several "much larger schemes" that stretch across the city.

Elective pathway redesign

In planned care, there are high hopes pinned on improvements to the elective referral procedure.

GPs are already able to call on specialist consultant knowledge via a feature supported by the Choose and Book referral service.

However, Dr Ralston is planning to bring in a more sophisticated Clinical Assessment Service in 2013-14. The system aims to redesign the patient referral pathway by making it a collaborative process between GPs and consultants. "Often [as a GP] you refer because you need information, because you've gone beyond the limit of your confidence," Dr Ralston said.

Under the new system, a GP can contact a consultant to double-check whether a particular course of drugs is suitable, whether to send the patient for diagnostic tests ahead of referral, or whether to refer straight away. It is hoped this will cut referrals by ensuring only those who need to be sent to see a consultant do so.

Fewer referrals means less money spent by the commissioner, and more efficient use of consultant time as they will no longer be seeing patients who could have been safely sent home.

The system will start on 1 April for referrals to HEFT in five specialisms: dermatology; cardiology; diabetes; endocrine and haematology.

Although commissioners are optimistic that the system should revolutionise outpatient referrals, its success depends on goodwill from local clinicians. It remains to be seen whether hospital consultants want to become more actively engaged in the referral process, and CCGs are aware they will have to win the "hearts and minds" of local GPs.

Mr Ralston notes that some GPs did not adopt the admittedly "clunky" previous system. Some have also been reluctant to bother with UnitedHealth's ScriptSwitch tool – which enables them to use the lowest cost version of a drug available. Sometimes a more effective way of working does not appeal to some clinicians.

Front-end changes

As a result, a successful scheme to manage non-elective admissions in UHB is now going to be brought in at HEFT. The "acute medical clinic" is run by a senior clinician, and exists to deal with patients who come to hospital who can be treated and discharged without admission. Patients have access to diagnostic services and the clinical specialisms based at the trust. Eighty per cent of those seen go home with a diagnosis and a treatment plan, where before they might have had to stay overnight.

The model will be brought in at two of HEFT's main hospitals. It is hoped this will save £2.54m in 2013-14, based on reduced admissions.

HEFT chief executive Mark Newbold said: "What these [schemes] represent is a ramping up of the demand management activities that have gone on in the last few years, which haven't really impacted.

"We're trying to convert some of our acute medicine into an ambulatory model, rather than an inpatient model."

The system is more "fleet of foot" than the typical outpatient way of working, Mr Newbold said. "If we've got an open access clinic with specialist teams in it, patients don't need to be admitted to get access to CT scans – they can come back in a day or two days or a week."

"So effectively you manage them as an acute outpatient. The idea is you keep them active, keep them ambulatory."

Year of care tariff

The most ambitious transformation scheme is to move away from "payment by results" and introduce a block contract based on a year's care for a population. The approach is suited to areas with high concentrations of patients with long term conditions such as respiratory disease or diabetes, where it is best to encourage providers to keep patients as well as possible at home.

UHB are said to be interested, but in 2013-14, expect the most progress

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on this to be made with HEFT, who already have a risk-sharing agreement with their local commissioners, which splits the cost if the local contract over performs.

Although rising demand is ultimately bad for all NHS providers, it is probably worse for HEFT than UHB at present. This is because HEFT's patient mix is skewed towards the frail elderly and people with long term conditions, while UHB has comparatively more income from specialised commissioning. Out of the two, HEFT is the one with the strongest incentive to change the way long term conditions are treated on its patch.

Designing such a system is a significant piece of work, as it involves identifying a cohort of patients, and then working out the total spent on them over a financial year. Although Birmingham Cross City CCG want the system to be up and running before the end of 2013-14, Mr Newbold says that would be "ambitious".

He is, however, fully signed up to the project, and has been involved in discussions led by minister Norman Lamb around setting up integrated health and care systems.

"The reason [to do this] is to try to get the trust in a place where we are a play in managing down demand... we want to be part of that and not just have it done to us," he said.

Virtual ward

HEFT has also drawn encouragement from the introduction of a "virtual ward" in Solihull. The project, which aims to identify the highest risk patients and treat them in the community to keep them out of hospital, has already been hailed as an "exemplar" nationally. By December 2012, 310 patients were being supported in that way, and admissions among the cohort were reportedly down 12 per cent.

Progress has been easier in Solihull because the health economy there is particularly neat – there is one CCG, one council providing social care, and HEFT is the sole provider of acute and community NHS services.

However, a second virtual ward has been set up in Sutton Coldfield, in partnership with private provider Healthcare At Home. Another is planned around Heartlands Hospital, which HEFT will run.

But although the model is encouraging enough to roll out more widely, Mr Newbold admits its main selling point at the moment is that it "feels like the right thing to do for patients", rather than being a source of hard QIPP savings.

"In Sutton Coldfield we've closed a ward [in hospital] to open a ward [in the community]". The main reason the virtual ward isn't saving much money yet is because it only reaches the most high risk patients. In order to capture substantial savings, the model must be extended to the "middle ground" of patients with long term conditions, who make up the bulk of avoidable admissions.

Revolutionising the care of that group is ultimately what will make the difference between whether the rise in demand for hospital services can be reversed – and whether sustainable long-term QIPP efficiencies are possible.