

Health

National report

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commission

# Quicker treatment closer to home

Primary care trusts' success in redesigning care pathways

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## Summary

This study reviews how primary care trusts (PCTs) are supporting redesign of care pathways from primary care into consultant outpatient services<sup>1</sup>. Its aim is to help PCT managers understand:

- which organisational and contextual factors have particular impact on a PCT's ability to progress successful redesign programmes; and
- how some PCTs have overcome local barriers to implement new care pathways.

Redesign helps to ensure that patients are treated by the most appropriate healthcare professional in the most appropriate location. This improves patients' experiences (for example, by reducing waiting times), helps to manage demand for acute care and introduces a greater range of providers, thus supporting 'patient choice'.

## Our findings

Service redesign benefits patients, but, in many PCTs, it is not a mainstream activity with sustainable outcomes.

- Redesigned services have shorter waiting times and could reduce costs. A good proportion (46 per cent to 97 per cent) of referred patients is treated in the community without the need for a hospital outpatient appointment.
- Eighty-two per cent of PCTs have already redesigned one or more care pathways at the primary/secondary care boundary (**Ref. 1**), but only 17 per cent of PCTs have developed practitioners with a special interest (PwSIs) in five or more specialties. Services are vulnerable to personnel leaving post: 36 per cent are provided by just one PwSI.
- Some services take 10 per cent or less of GP referrals in their specialty, resulting in limited impact on demand management and patient experience in the PCT.
- Those PCTs that are making the most progress on redesign (planning and funding a greater number of new care pathways) are those that have a commissioning strategy to ensure that secondary care is used appropriately across all specialties, and that investment goes into community alternatives to meet patient needs.
- PCTs whose health economies are in greater deficit find it harder to invest in new alternative services. However, commissioning strategies coupled with stringent savings regimes allowed some to fund redesigned care pathways in spite of deficits.

<sup>1</sup> Such redesign has largely involved introduction of new services provided by practitioners with a special interest as an alternative to consultant referral.

### Management information used to decide priorities and monitor redesigned services needs strengthening.

- Services are often introduced without thorough analysis of the level and types of activity needed to improve access, the human resources needed to deliver it, or the costs this should entail.
- As commissioners, PCTs need to be sure that the new pathways are meeting their objectives. Monitoring in most PCTs is weak. Cost-effectiveness was only measured in two of the ten PCTs studied in detail.

### Pathway development needs greater support, and service models may need to be more diverse.

- Only 7 per cent of PCTs feel that they have sufficient staff available to drive redesign projects. Middle-managers often absorb project management on top of other work, constraining progress.
- Nationally, only 25 per cent of PCTs think there are sufficient clinicians to meet their PwSI needs. New pathways involve nearly twice as many GPs as nurses or allied health professionals (AHPs)<sup>1</sup>. To meet future demand for PwSIs, PCTs will need to involve a greater range of healthcare professions.
- Leadership from senior managers is essential to the sustainability of redesigned care pathways and their spread to the whole PCT population, but strategic health authorities (SHAs) can also be a catalyst for broad programmes of redesign.

### Engagement with patients, clinicians and health economy partners is important to the spread and impact of new care pathways.

- Clinical ownership of redesign is strong where the Professional Executive Committee (PEC) drives redesign programmes. PEC members are key to frontline ownership of the PCT strategy, where they are supported to feedback to colleagues.
- In some PCTs, perception of the influence of national priorities has a negative impact on clinician engagement. Only 27 per cent of GPs feel that they have influence over hospital commissioning. However, change programmes are well supported where clinicians across the PCT have the opportunity to engage with the PCT and influence them.
- PCTs have successfully encouraged GPs to use new care pathways in a number of ways, for example, promoting the service to them, feeding back comparative referral rates or incentivising use of the new pathway.
- PCTs increase their influence by working with other PCTs who commission from the same acute trusts. They can identify common redesign priorities and develop a shared model for the care pathway. The concerted effort neutralises opposition, and acute trusts prefer the single co-ordinated approach.
- Patient involvement is limited. Patients are not involved in selecting specialties for redesign, but in some PCTs patients attend care pathway modelling meetings.

<sup>1</sup> GPwSIs per project = 1.12; nurses/AHPs per project = 0.62. (Ref. 1. (n= 189)).

## Recommendations to PCTs

Make redesign a mainstream strategic activity that helps achieve corporate goals.

- Integrate redesign with a commissioning strategy that prioritises community development and links to demand management initiatives.
- Ensure that service level agreements (SLAs) can reflect accurately changes in activity provided.
- Set clear objectives for new pathways in terms of activity levels, reduction in outpatient demand (if this is an aim) and improvement in patients' experiences.
- Recognise that service redesign is not an optional add-on task, but something that requires leadership, staff time and rigorous project management.

Improve the information base on which to make sound clinical and managerial decisions.

- Improve the information resource on demand, to include diagnosis at outpatients that helps to prioritise and target redesign on sub-specialties.
- Collect appropriate activity and cost data to decide on, resource and monitor new pathways.

Ensure that developments are sustainable and that service models make use of available staff.

- Develop a number of PwSIs for each care pathway, to increase sustainability.
- Expand the use of non-medical professions in PwSI roles.

Engage with local stakeholders to prioritise and deliver redesign.

- Ensure that the PEC has a leading role in setting redesign priorities.
- Encourage PEC clinicians to communicate with peers about the PCT strategy.
- Set up additional mechanisms to broaden clinician involvement in redesign.
- Promote appropriate referrals to new pathways by feeding back referral information to GPs, or by introducing incentives or a referral centre.
- In complex health economies, consider developing and implementing redesign priorities with other PCTs who refer to the same trusts.
- Incorporate patient views into decisions about redesign priorities and seek their views on potential improvements to care pathways.

# Introduction

- 1 This report looks at how primary care trusts (PCTs) can support redesign of care pathways at the primary/secondary care boundary. It draws on learning from organisations that have already established new care pathways. Its aim is to help PCT managers to understand the organisational factors that support redesign, and learn from practical examples how to overcome local barriers to create sustainable new services.

## Why did we study redesign?

- 2 Redesign is a process that reviews current care pathways and specifies improved new ones. It requires clinical and managerial input and should involve patients to decide the new care pathway's shape.
- 3 Our work has focused on redesign of care pathways from primary care into consultant outpatient services. Such redesign has largely involved introduction of new services provided by practitioners with a special interest (PwSIs), who for some conditions can provide an alternative to a consultant referral.
- 4 This type of redesign is of great strategic importance: it helps to ensure that patients are treated by the most appropriate healthcare professional in the most appropriate location. This improves patients' experiences (for example, by reducing waiting times) and also helps organisations to manage demand for acute healthcare, make appropriate shifts in activity provided by hospital and community sectors and introduce a greater range of providers. Redesign can therefore help to create more patient-focused and sustainable healthcare systems and introduce choice for patients.

## Our research focus

- 5 We have researched redesign of pathways from primary care into outpatients, but not redesign that has taken place solely within primary or secondary care, involved hospital discharge processes or intermediate care services. Many of our findings can, however, be generalised to all types of redesign, because we have focused on how PCTs drive and support redesign within their local health economies.

- 6 We have focused on the connection between the redesign of care pathways at the primary/secondary care boundary, and on the capacity and systems required within PCTs to underpin this approach. In particular we have looked at:
- which organisational and contextual factors (for example, management capacity, commissioning approach and clinician engagement) have particular impact on a PCT's ability to progress successful redesign; and
  - how some PCTs have overcome adverse factors to implement successful redesign.
- 7 We formed a broad view of the success of each new care pathway based on the PCTs' own monitoring data. However, it was **not** our objective to independently evaluate redesign processes or the outcomes of new care pathways that PCTs had put in place. Our views on the success of projects are discussed briefly in chapter 1 and a summary of each project's outcomes can be seen in appendix 1.

## Why did we focus on PCTs?

- 8 PCTs have responsibility for commissioning primary, community and secondary care for their populations. They were created closer to the 'front line' with the expectation that they will engage staff and the public to deliver more appropriate and convenient care for patients (**Ref. 2**). This combination of factors means that they should be the driving organisations behind redesign of care pathways at the primary/secondary boundary, ensuring that patients are treated in the most appropriate location and that acute resources are focused appropriately.
- 9 The Government has placed redesign high on its modernisation agenda for the NHS, developing policies to increase patient choice by extending the range of services delivered in primary care settings (**Ref. 3**). The Modernisation Agency through, for example, the Action On programmes, and the National Primary Care Development Team provide considerable support to organisations to help them redesign (**Refs. 4 and 5**). When we surveyed PCTs in December 2002, PCT chief executives rated service redesign as the most important current and future issue for their organisations (**Ref. 6**). As so much importance is placed on it, progress on redesign can be considered a test of how well PCTs are addressing the modernisation agenda in general.

- 10 A considerable amount of redesign has been carried out within the secondary care sector. PCTs, as developing organisations, need to spread the approach to primary care and the primary/secondary boundary. Eighty per cent of PCTs (or their predecessor primary care groups (PCGs)) have already redesigned one or more care pathway at the primary/secondary care boundary (**Ref. 1**). However, this is not yet a mainstream activity and many services are vulnerable, for example, to personnel leaving post. PCTs need to turn redesign from a marginal activity into a mainstream one that is corporately led and helps them to achieve their goals.

## What did we do at participating PCTs?

- 11 We carried out in-depth research at ten PCTs where new care pathways at the primary/secondary care boundary were already in operation. The ten PCTs were selected to be representative with a spread of characteristics, such as number of GPs and practices, local financial balance and PCT size and age. A full list of selection criteria, along with each participating PCT's profile, can be seen in appendix 2.
- 12 At each PCT we collected qualitative and quantitative evidence so that we could form a judgement of the PCT's position on a range of organisational and contextual factors. A description of our research methods is included in appendix 3. We interviewed key personnel to find out how those factors impacted on redesign. We also reviewed how they affected future redesign plans.
- 13 Furthermore, in October 2003 we carried out a national survey of PCTs to assess the extent and sustainability of redesign at the primary/secondary care boundary and to find out PCTs' views on their capacity to deliver redesign.
- 14 This report covers (**Exhibit 1, overleaf**):
- in brief, our views on the success of the care pathways we reviewed (chapter 1);
  - how PCTs are establishing programmes of redesign across all specialties and how systems can support this (chapter 2);
  - how they can better support delivery and evaluation of particular new care pathways (chapter 3); and
  - how PCTs are engaging clinicians, acute trusts, other PCTs and patients, both in setting the programme and in delivering new care pathways (chapter 4).

**Exhibit 1**

**The report's focus**

The report covers the support that PCTs can give to redesign: in planning redesign programmes; in developing and evaluating new care pathways and in engaging with local stakeholders.



# 1

## Redesign at the primary/secondary care interface

**15** This chapter briefly reviews the success of the new care pathways we researched and discusses the potential benefits of redesign at the primary/secondary care boundary. Our research focused on the organisational factors that impact on a PCT's ability to progress successful redesign (chapters 2, 3 and 4).

## New care pathways provide an alternative to outpatient care

- 16** The 14 new care pathways we reviewed (**Exhibit 2, overleaf**) mostly involved:
- provision of alternative diagnosis and treatment services by PWSIs<sup>I</sup> within the community sector;
  - guidelines for GPs so that appropriate patients are referred to the PwSI; and
  - further specialist triage<sup>II</sup> by the PwSI (managed by the PCT).
- 17** In many health communities, and for many specialties, a GP requiring further guidance on how to manage a patient has no alternative to consultant referral. PWSIs have an intermediate level of expertise that can substitute for consultant opinion and treatment in some cases. However, a system must be in place to determine the right care pathway for each patient. Without this, a patient could be passed from one service to another, which is distressing and risks clogging up the waiting lists for both new and traditional outpatient services.
- 18** Most PCTs we visited had provided GPs with guidelines for when they should refer a patient for PwSI opinion and treatment (**Exhibit 3, overleaf**). Urgent cases could, in most cases, be referred directly to outpatients. In some PCTs, all patients were referred to PWSIs, with no differentiation between patients by the GP. PWSIs then 'triaged' the patient to find out whether the patient was suitable for the service<sup>III</sup>. Some patients then received advice and/or treatment from PWSIs, however, some followed the outpatient care pathway because the PwSI judged a consultant opinion necessary<sup>IV</sup>.

<sup>I</sup> By PwSI we mean a healthcare professional of any profession (including, for example, therapists, GPs or nurses) who has extended their normal role to offer a specialist service.

<sup>II</sup> By triage, we mean a more specialist assessment of whether the patient was suitable for the service.

<sup>III</sup> This may be a face-to-face or paper assessment.

<sup>IV</sup> Where there are GP referral guidelines, this group should be a minority of patients so a patient should see a specialist (consultant or PwSI) only once.

### Exhibit 2

#### Different alternative pathway models

Most of the projects we researched constituted an alternative treatment service with a PCT-managed specialist triage system and guidelines for GPs to access it.

PCT		PwSIs provide alternative treatment in community	Specialist triage managed by the PCT	Guidelines for GPs
M	Orth	✓	✓	✓
M	Derm	✓	sc	
N	Derm	✓	sc	
P	Derm	✓	✓	✓
R	Orth	✓	✓	✓
R	Derm	✓	✓	✓
S	Derm	✓	✓	✓
T	Orth	✓	sc	
T	Derm	✓	✓	✓
U	Derm	✓	✓	✓
V	Orth	*	✓	
W	Orth	✓	✓	✓
W	Derm	✓	✓	✓
Z	Orth	✓	✓	✓
Z	Derm	✓	✓	✓

Key:

sc triage carried out by consultant in secondary care

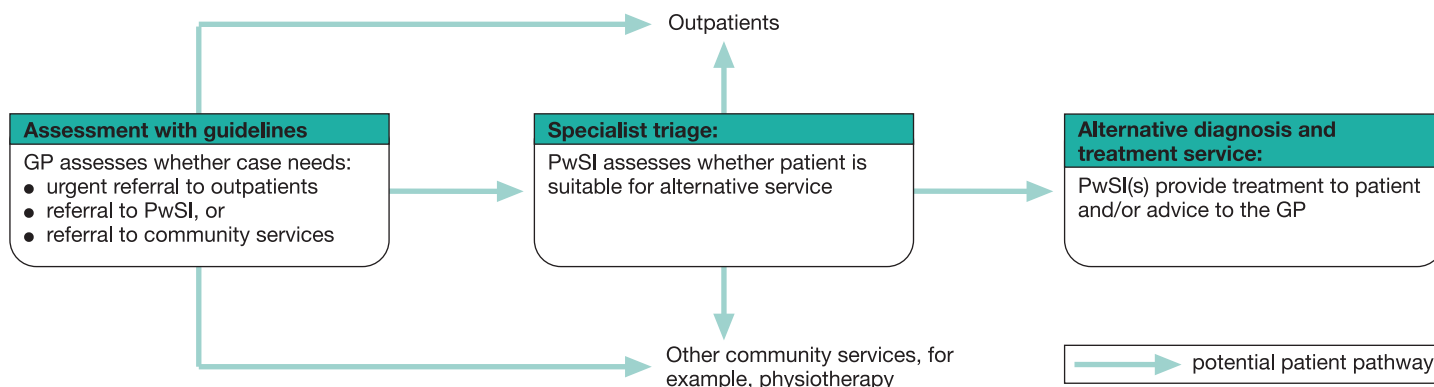
\* a new service was not provided – patients were diverted to normal community services if possible

Source: Audit Commission

### Exhibit 3

#### Model of an alternative assessment and treatment service

The most common model is guidelines for GPs followed by specialist triage and treatment.



Source: Audit Commission

## Benefits of the new alternative care pathways

19 There are a number of potential benefits to redesigning care pathways at the primary/secondary care boundary. These include:

- improving the patient experience;
- managing demand for outpatients; and
- helping to meet access targets.

### Improving patients' experiences

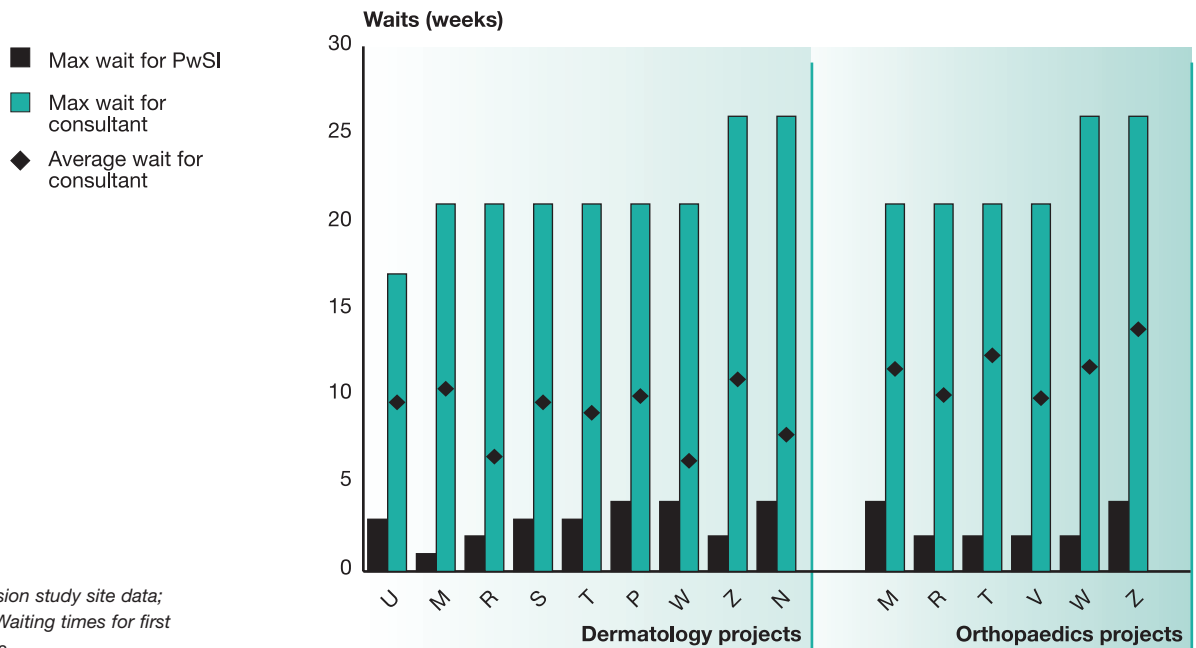
20 The Government, with strong support from clinicians and managers, wishes to create NHS services that are more patient-centred. For a proportion of patients, an alternative care pathway can, among other things, shorten waiting times for specialist assessment and treatment, provide care nearer to patients' homes and offer a more appropriate type of previously unavailable care.

21 The alternative services we reviewed had shorter waiting times compared with outpatients (**Exhibit 4**). Patients waited a maximum of one to four weeks to access them. By contrast, maximum waiting time for an outpatient appointment varied between 17 and 26 weeks, with average wait being between 6 and 13 weeks.

### Exhibit 4

#### Patient waiting times for specialist opinion

Patients have to wait for a much shorter time to access alternative services compared with outpatients.



Source: Audit Commission study site data; Department of Health, Waiting times for first outpatient appointments

- 22 Seven (of fourteen) care pathways were provided in more than one location within the PCT, which increased accessibility to patients. Bristol South & West PCT particularly wanted to improve access in deprived wards in the area, and sited the PwSI service accordingly. Availability of suitable premises is, however, a barrier (see chapter 3) and in three PCTs, services were being delivered in locations that were less accessible than the local hospital.
- 23 Alternative services can provide an effective and potentially more appropriate response. For example, development of a hip and knee community pathway in Nottingham enabled PCTs not only to prioritise the patients most in need of surgery, but to improve the quality of life of patients waiting to access outpatients by offering a new specialist physiotherapy service (**Case study 1**).
- 24 As improving patient experience is key to redesign, we anticipated finding patients fully involved in the process at PCTs we visited. However, patient involvement in setting priorities for redesign and deciding on new care pathways, and monitoring of patients' views, was not widespread. This issue is covered further in chapter 4.

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## Case study 1

### Providing a new response to patients' needs

In Nottingham, before the development of the community hip and knee pathway, a patient with arthritis in the hip or knee would have to wait for an outpatients appointment, while their pain was managed with medication. There were no explicit criteria for when patients should be referred to a specialist and, consequently, in the absence of an alternative, many patients were referred, resulting in a long waiting time. Some patients were referred too early for treatment (an operation), using outpatient slots and potentially delaying access for patients in greater need (with more advanced arthritis).

Now, patients with these conditions are referred to an advanced physiotherapy service. Physiotherapists assess patients within two–three weeks of referral, referring on the most advanced cases to a consultant according to an agreed protocol. Those who are in less need are offered alternatives that they could not access before: exercise and lifestyle classes that help them to manage their condition until they need to be referred to a consultant. The current impact of patients' conditions was limited by improving their mobility and helping them to manage pain.

*Source: Audit Commission*

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### Managing demand for outpatients

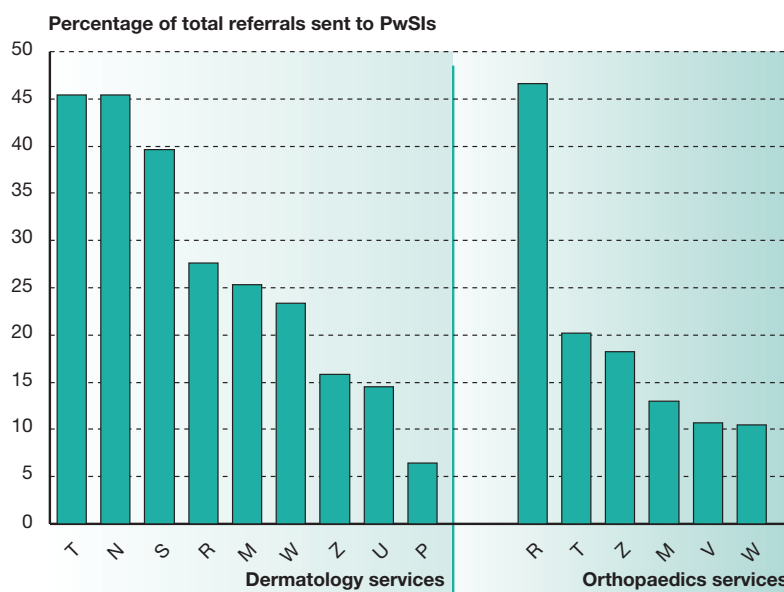
- 25 Redesign can help to manage demand for outpatients by segmenting demand for outpatient care, ensuring that demand is appropriate and rebalancing activity provided by secondary and community sectors. This can help PCTs to improve their financial control by establishing a plurality of providers and, potentially, providing alternatives at a reduced cost.

- 26 The Government has committed to increasing investment in the NHS in England by 7.5 per cent above inflation per annum until 2007-08 (**Ref. 7**). This investment has been coupled with a drive to modernise the NHS and ensure that care is delivered in the most appropriate setting. Early work by the Modernisation Agency has shown that up to 40 per cent of orthopedic referrals to outpatients can be treated appropriately in the community (**Ref. 8**).
- 27 Alternative services have successfully allowed PCTs to segment demand for outpatients and ensure that use of outpatients is appropriate. However, the impact of the work could be increased.
- 28 PwSIs working in the dermatology services that we reviewed were receiving between 880 and 3,800 referrals per year; in orthopaedic services they were receiving between 1,090 and 6,680 referrals. This accounted for between 6.5 per cent and 45.5 per cent of all GP dermatology referrals, and between 10.5 per cent and 46.5 per cent of GPs' trauma and orthopaedic referrals for the PCTs (**Exhibit 5, overleaf**).
- 29 This variation is partly due to the scope of the PwSI services. Some were intended to triage all non-urgent referrals, and so would be expected to receive a large number of referrals. Some were intended to take referrals within sub-specialties only (for example, chronic skin conditions), so would naturally account for a lower proportion of overall referrals. However, low figures could be due to the fact that some GPs are bypassing PwSI services inappropriately (chapter 4). In any case, those services taking only 10-15 per cent of referrals in a specialty may have limited impact on demand management and patient experience.
- 30 *After* being referred to a PwSI, between 57 per cent and 70 per cent of orthopaedic patients and between 46 per cent and 97 per cent of dermatology patients were treated on the new care pathway and in the community (**Exhibit 6, overleaf**). For patients accessing the PwSI, this represents a successful segmentation of demand for outpatients. Comparatively, however, some PCTs could increase the proportion of patients treated in the community by broadening the PwSI role and/or tightening the guidelines for referral to the service. This would help limit the number of patients that are assessed twice: by a PwSI and by a consultant.

### Exhibit 5

## The proportion of PCTs' dermatology and orthopaedic referrals sent to PwSIs

The level of referrals being diverted to PwSIs by GPs varied considerably across PCTs.



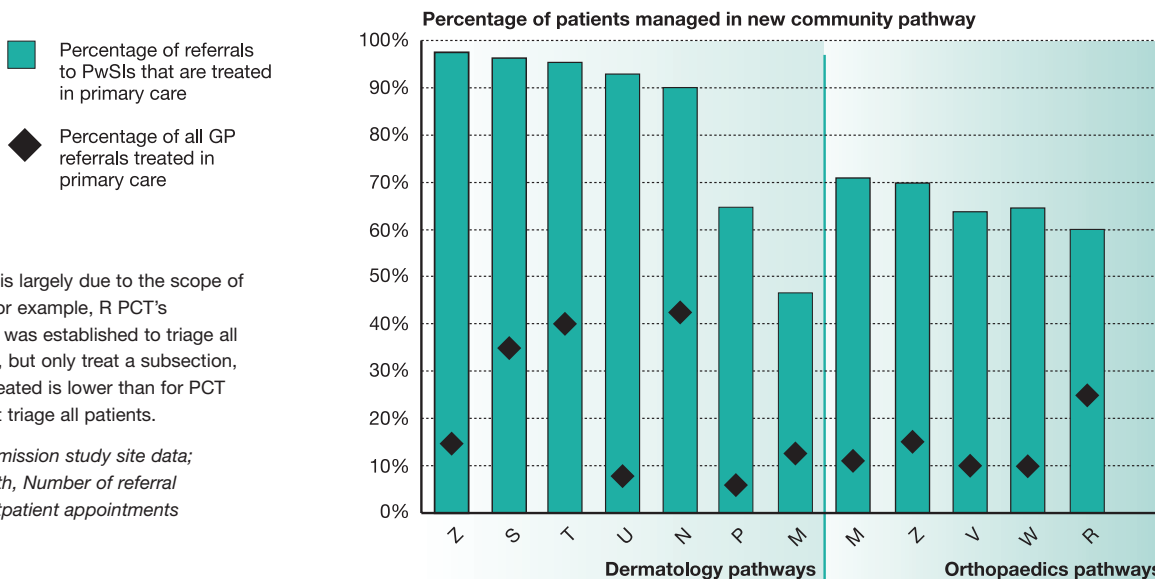
**Note:** The particularly low value for P PCT's dermatology service is because the service only covers 13 per cent of the PCT's population. If this is allowed for, the PwSI actually receives around 49 per cent of PCT referrals for its area.

**Source:** Audit Commission study site data; Department of Health, Number of referral requests for first outpatient appointments

### Exhibit 6

## Proportion of PwSI referrals managed in the community

Of patients referred for specialist triage, a good proportion of patients were subsequently treated within the community.



**Note:** The variation is largely due to the scope of the PwSI service. For example, R PCT's orthopaedic service was established to triage all non-urgent patients, but only treat a subsection, so its percentage treated is lower than for PCT M's, which does not triage all patients.

**Source:** Audit Commission study site data; Department of Health, Number of referral requests for first outpatient appointments

- 31 When taking into account overall referrals to each new care pathway (para 28), between 7 per cent and 27 per cent of all GP trauma and orthopaedic referrals, and between 15 per cent and 43 per cent of all GP dermatology referrals, were being successfully treated in primary care as a result of the introduction of the new services (**Exhibit 6**).
- 32 These figures do not mean however, that this level of demand has been diverted from outpatients. Creating a service could have encouraged an increase in overall demand, because GPs may refer patients who they would not have referred to outpatients. Research has suggested that guidelines for GPs improve the quality of referrals, but may not reduce the number of patients referred (**Ref. 9**). PCTs need to be aware of this possibility and decide whether this is an outcome they could support. They need to monitor the impact of new pathways to find out whether the new service is meeting previously unmet demand. This area is covered further in chapter 3. However, PCTs reported that 11 of the new pathways we reviewed had resulted in reduced numbers of referrals to the acute trust.
- 33 By lowering demand for hospital care, PCTs can reduce costs if the community pathway is cheaper than the traditional service. However, while PwSI time may be cheaper than consultant time, provision in a number of health centres may create more overheads than providing a central service. Furthermore, as stated above a new alternative service could generate more demand in the system, increasing overall costs.
- 34 Few of the PCTs we visited had formally evaluated cost-effectiveness. Others had only conducted a limited analysis, which is a matter of concern. In PCTs that have conducted some evaluation, however, segmenting demand appears to be more cost-effective. In the orthopaedic service operated between three PCTs in the Southampton area, including New Forest PCT, the average cost for a patient needing an upper limb, lower limb or spine appointment compared with the alternative service was £55.20, whereas an outpatients appointment costs £155.53. If all patients referred to the new service would previously have accessed the orthopaedic outpatient list, savings will be £920,000 per annum. North Bradford PCT analysed spend on healthcare for each of its practices, finding that those who were spending most per head on alternative services tended to have lower overall spend (for alternative and hospital care combined).
- 35 The Government is introducing a new financial system: 'Payment by results' (**Ref. 10**). PCTs will purchase activity from a range of providers and pay for activity according to a nationally set tariff. If a provider delivers above its contracted level of activity for a PCT (in agreement with the PCT), the PCT will have to pay for the additional procedures at full average cost, so providers will have a considerable incentive to increase activity levels. This could be achieved, for example, by lower intervention thresholds<sup>1</sup>. Failure to plan and commission appropriately, or to set criteria for access to services, therefore leaves the PCT open to considerable financial risk.

<sup>1</sup> Currently, payment by results only applies to a range of inpatient specialties and surgical procedures, but by 2005/06 it will be expanded.

- 36 By specifying care pathways for particular segments of demand for outpatient services, agreed by primary and secondary care clinicians, PCTs can ensure that use of secondary care is appropriate to patient need. Consistently applied, criteria allow PCTs to plan and review demand for outpatient specialist care. By setting up alternative pathways, PCTs are diversifying the range of services on offer locally. If commissioning these services from a range of providers – PCT community services, primary care, NHS acute and private providers – PCTs can spread financial risk: overall activity or cost increases cannot be driven by one provider alone. Furthermore, by establishing a range of care pathways PCTs can carry out value-for-money comparisons<sup>1</sup>.

### Helping to meet access targets

- 37 The NHS Plan requires significant improvement in access to specialist opinion and treatment. Health communities are expected to reduce the maximum wait for a consultant opinion to three months by December 2005 (**Ref. 3**). By the end of 2008, the maximum wait at any stage in the care pathway should be three months (with an average wait of half this time). Over the same period, demand for specialist care is predicted to increase. The NHS would need a considerable increase in consultant numbers to meet both increases in demand and access targets, but the consultant resource is scarce and takes a number of years to develop. Because PwSIs can be developed comparatively quickly, total local capacity can be expanded to segment demand and help to meet targets.
- 38 Redesign programmes were driven exclusively by the national waiting times agenda in seven of the ten PCTs we visited. Of the completed redesign projects we studied 13/14 were established to reduce waits for specialist opinion. However, only two PCTs could demonstrate a reduction in outpatient waiting times. There could be a number of reasons for this. Firstly, the impact on waiting times will take some time to observe. Secondly, only three PCTs had spread the service to other PCTs referring to the same acute trust, so benefits would have less impact at the trust. Thirdly, services were addressing growth in demand – if they had not been put in place, waiting times could have increased. However, PCTs were not effectively monitoring whether services were meeting their objectives (chapter 3).
- 39 This chapter has briefly reviewed the outcomes of redesign at the primary/secondary care interface. The report now turns to the focus of our research: the organisational factors that have particular impact on a PCT's ability to progress successful redesign and how some PCTs have overcome adverse factors to implement it. Chapter 2 covers how PCTs set strategies to support and promote redesign; chapter 3 covers how they support delivery and evaluation of particular new care pathways; and chapter 4 covers how they are engaging stakeholders, both in setting priorities and delivering them.

<sup>1</sup> Note, under 'payment by results' it is not yet clear whether work that is done in primary care should attract a different payment from that in secondary care, or whether it should be outside the tariff.

# 2

## Planning and supporting a redesign programme

- 40 Most PCTs are redesigning care pathways at the primary/secondary care boundary. The breadth of redesign work and its success in terms of sustainability and spread does, however, depend on whether a PCT has:
- a broad strategic approach to change the model of care and manage demand;
  - developed a targeted plan for redesign;
  - managed any financial deficit to ringfence funding for redesign;
  - a management team that is committed to redesign; and
  - support from the SHA.

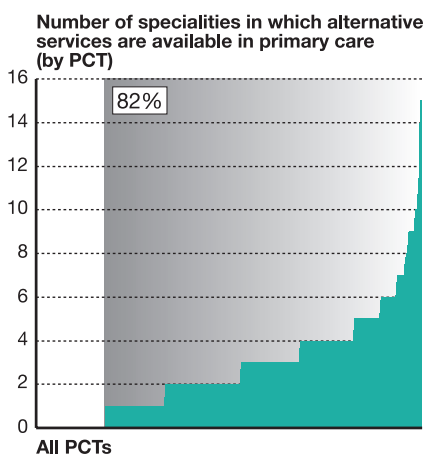
PCTs are making the most progress on redesign where it is part of a broader commissioning strategy to change the model of care and manage demand across specialities.

- 41 Redesign at the primary/secondary care boundary is taking place in 82 per cent of PCTs (**Exhibit 7**). Progress is, however, still in its early stages: only 17 per cent of PCTs have developed PwSIs in five or more specialties (**Ref. 1**). As mentioned in chapter 1, some services take only 10 to 15 per cent of referrals in their specialty, and so have limited impact.
- 42 Redesign work is most advanced in those PCTs with a comprehensive commissioning strategy that ensures more appropriate patient care, manages demand and is supported by a financial plan. Three PCTs we visited had such strategies. They aimed to change the model of care *across* the health economy in the long term. They were limiting growth in activity in traditional providers: ensuring that secondary care was used appropriately and that investment was not automatically made in the acute sector, but instead into community alternatives. They were also working to manage demand and improve GP referral consistency. In these PCTs, the commissioning strategy was always to consider redesign as a potential solution to meet patient needs more appropriately (**Exhibit 8**). They were planning and funding a greater number of new alternative pathways for 2003/04 (**Exhibit 9**).
- 43 Most of the PCTs we visited were, by contrast, using redesign as a solution to help meet access targets in a few long-wait specialties. They did not have a broader ambition to shift activity into the community sector and deliver more appropriate care across all specialties. Redesign remained a marginal activity in these PCTs and was not being mainstreamed. Commitment to the approach was lower. Furthermore, learning was lost, as it was not transferred to new redesign projects.

### Exhibit 7

#### The number of care pathways into outpatients that have been redesigned

82 per cent of PCTs have already redesigned one or more pathways into outpatients (n=235) (Ref. 1)


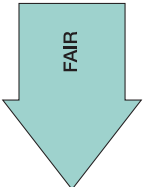
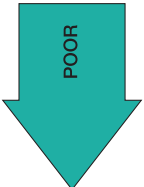


Source: Audit Commission

### Exhibit 8

#### The breadth of PCTs' commissioning strategies

Three PCTs had a comprehensive commissioning strategy to change the model of care across the health economy, controlling growth in, and demand for, secondary care.

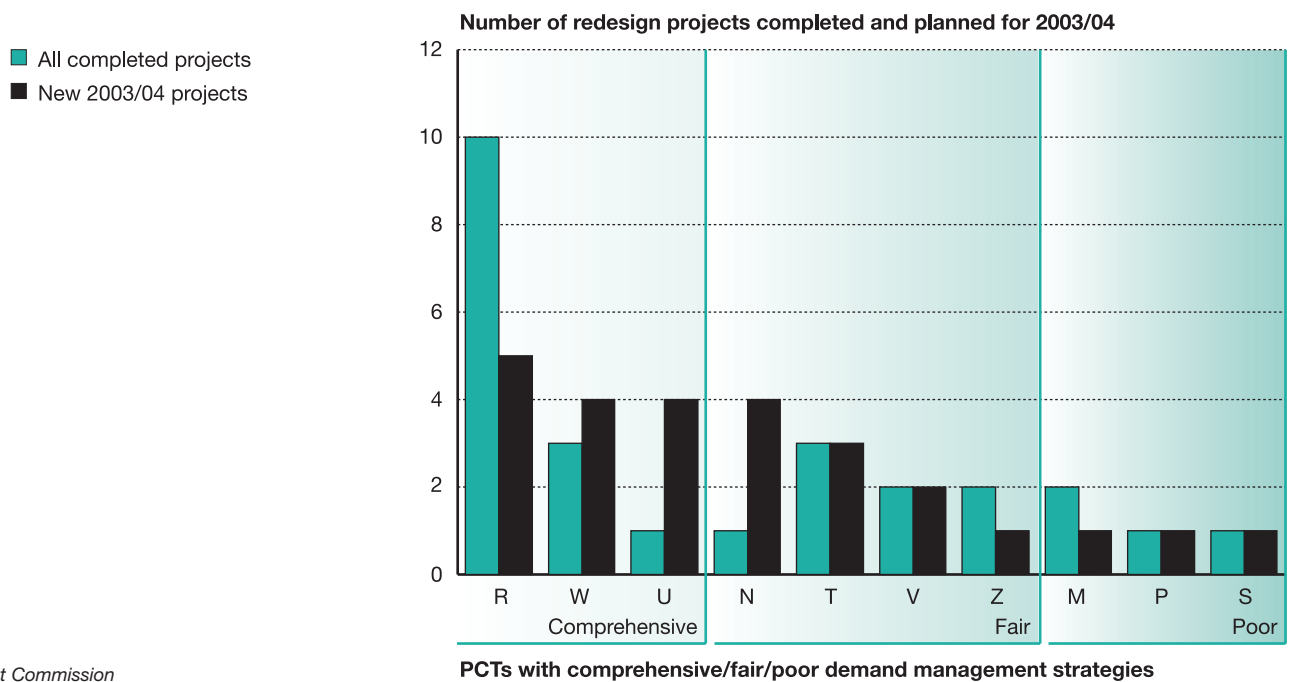
PCT	W	N	R	U	V	Z	T	M	P	S	
<b>Limiting growth in traditional providers</b>											
Cap acute growth in activity	✓	✓	✓	✓	✓						
Limit development funding to secondary care	✓	✓	✓	✓	✓	✓					
Contract ensures delivery	✓	✓	✓	✓	✓		✓				
Detailed work on acute efficiency	✓	✓	✓			✓	✓				
<b>Improving GP referral consistency and managing demand</b>											
Ongoing review of GP referral rates	✓	✓	✓	✓		✓	✓	✓			
Mechanisms to reinforce appropriate referrals	✓	✓	✓	✓	✓						
											

Source: Audit Commission

### Exhibit 9

#### The impact of commissioning strategies on redesign

Those that had comprehensive commissioning strategies were making greater progress in redesigning care pathways.



Source: Audit Commission

44 Two complementary approaches combined to form comprehensive commissioning strategies (Exhibit 8):

- limiting growth in activity within traditional providers; and
- monitoring demand and improving GP referral consistency.

#### Limiting growth in activity within traditional providers

45 To limit traditional acute sector growth, some PCTs had:

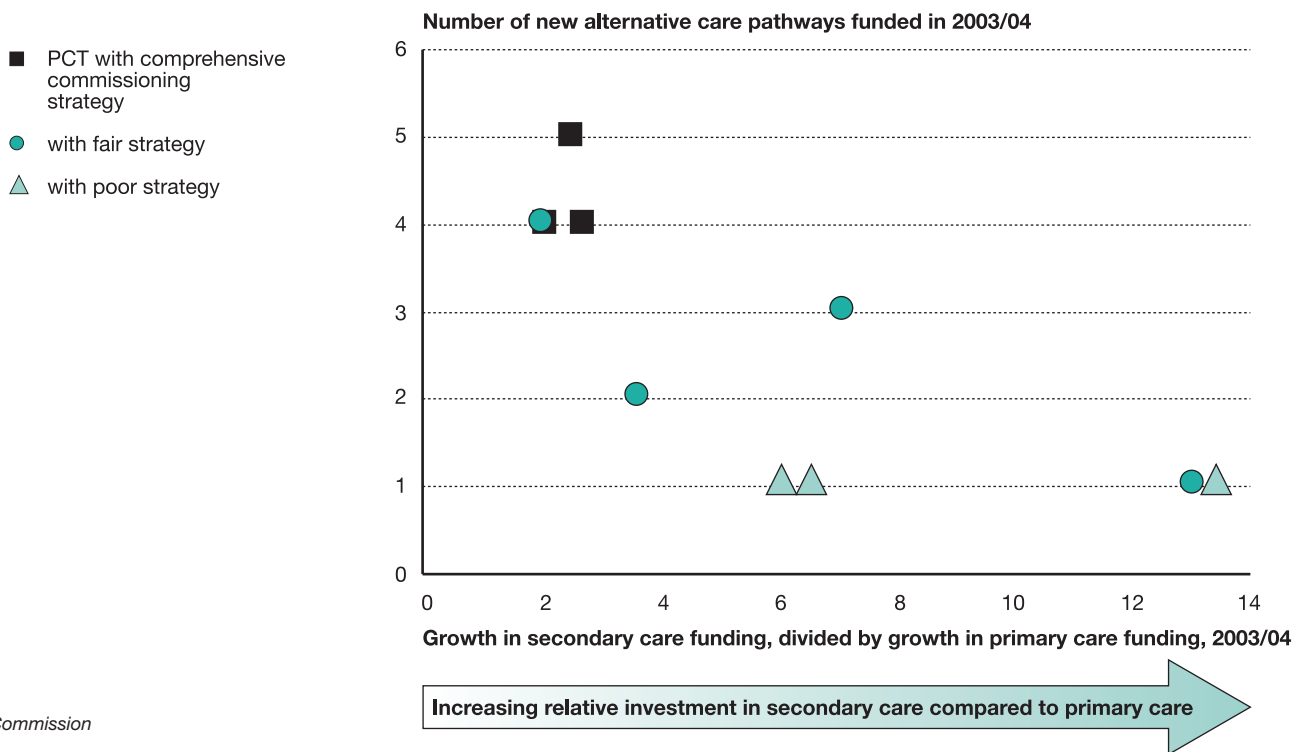
- explicitly limited growth in activity to be provided within the traditional acute sector in capacity plans, financial plans and cost and volume contracts;
- set up SLAs that promoted delivery and redesign; and
- required specific improvements in outpatients efficiency (Exhibit 8).

- 46 A number of the PCTs we visited were limiting growth in acute activity within capacity plans, financial plans, and SLAs for inpatient and outpatient care. This sent a strong message to the acute trust that models of care across the health economy were changing. It also limited development funding passed to the acute sector, so these PCTs were able to invest in a greater number of alternative community pathways. Some PCTs were, however, investing heavily in the acute sector, spending over 13 times as much development funding in secondary care as primary and community care (**Exhibit 10**), which limited funding for community development and redesign.
- 47 The type of SLA a PCT operates has considerable impact on its ability to redesign. Some contracts make it hard to reclaim funds in cases of under-performance – funds that could be used for redesign projects. Some contracts do not enable PCTs to reduce funding to traditional pathways even if they have redesigned and are sending reduced numbers of referrals to traditional pathways. Having a cost/volume contract with up-to-date activity levels is critical so that redesign can be taken into account in the SLA.
- 48 Four of the ten PCTs we visited were still operating block contracts, finding it hard to extract payment when trusts had not met activity targets. Three of these PCTs were investing significantly in the acute sector (which limited their funds for redesign) and yet were not getting appropriate activity in return. They also found it difficult to have transparent debate about activity or cost growth. PCTs need to ensure that their contracts clearly specify the activity a trust is expected to deliver and the level of payment. One PCT had already implemented a ‘payment by results’ style contract, where full costs were refunded to the PCT in cases of under-performance.
- 49 PCTs that commission with others using out-of-date block or cost and volume contracts have a considerable disincentive to redesign because they cannot withdraw funding in line with reduced activity in particular care pathways. A PCT with alternative care pathways would be sending reduced (or reduced growth in) numbers of patients to the acute sector, so they should expect to bear a smaller proportion of acute cost increases. This could free up further funds for its population. However, seven PCTs we visited were paying for activity on a population basis or according to historical activity levels. Any acute cost growth was shared accordingly between commissioning PCTs irrespective of whether an individual PCT had redesigned care pathways, that is, as if their referral patterns were unchanged. Current contracting arrangements in some PCTs do not, therefore, promote good financial management or give good value-for-money for their populations.
- 50 Full implementation of ‘payment by results’ should eliminate these problems. However, if PCTs do not put in place systems to manage demand, the new contracting system could put them at considerable financial risk.

### Exhibit 10

#### The impact of development priorities on redesign

As PCTs spend proportionally more development funding within the acute sector, this limits the scope of their redesign developments (Ref. 11).



Source: Audit Commission

51 As well as monitoring performance to ensure that refunds are actioned for under-performance, PCTs need to ensure that they are getting value for money from acute trusts by assessing potential for efficiency gains. Efficiency improvements can deliver capacity increases without extra funding; they can potentially release funds for investment in new priorities.

52 All PCTs were expecting their local trusts to deliver the minimum 1 per cent cash releasing efficiency savings and 1 per cent productivity improvements. However, some had studied efficiency in the local acute trust, analysing, for example, day case rates, lengths of stay, or outpatient follow-up rates. By setting improvement targets for the trust, they were able to specify how much increased activity they expected the trust to deliver in different specialties, at no extra cost. In some cases this contributed significantly to capacity plans and released investment for community alternatives (Case study 2).

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## Case study 2

### Setting detailed efficiency targets

Eastern and Western Wakefield PCTs, working with Mid-Yorkshire NHS Trust, identified the potential to achieve efficiency gains. They carried out a detailed analysis of 2002/03 baseline data for outpatient 'did not attends' (DNAs) and follow-up rates across specialties. By setting targets for improvement for each specialty, they anticipated the release of 2,196 outpatient sessions over the period 2003/04 – 2005/06. This released resources to help reduce waiting times. Efficiency targets were written up in PCT Local Delivery Plans. Savings allowed the PCTs to invest growth monies in redesign.

*Source: Audit Commission*

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### Monitoring demand and improving GP referral consistency

53 PCT work in this area included:

- collecting information on GP referrals to all specialties and providing GPs with comparative referral data; and
- setting up mechanisms to reinforce appropriate use of traditional pathways (**Exhibit 8**).

54 Reviewing and influencing the referral behaviour of GPs is critical to demand management and adherence to the commissioning strategy, as it is their referral decisions that drive activity across all care pathways. By feeding back information, PCTs can encourage GPs to compare their referrals with other GPs. This approach helps to ensure that patients are treated in the best and most consistent way and that activity provided by all providers is appropriate and keeps within anticipated levels (as expressed within SLAs). Referral review is also critical to the sustainability of new alternative care pathways, as it can ensure that they are used appropriately.

55 Six of the PCTs we visited were reviewing referral patterns across all specialties, however, only two were feeding this back to GPs to encourage comparison and change (**Case study 3**). Stockport and Salford PCTs are each establishing a referral centre for all referrals. This will, among other things, enable them to get good-quality information on referral behaviour and demand across specialties to feedback to GPs.

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## Case study 3

### Analysing GP referrals

Wakefield PCTs have analysed GP referrals data across specialties. Eastern Wakefield has an open approach with local GPs and access to GP-held primary care data. It has worked with the local trust to analyse 18 months' worth of referrals to:

- identify the top five specialties by referral volume and by referral growth;
- review practice referrals for these specialties, comparing to the PCT average;
- work with the top five practices, who refer (on a population basis) the greatest number of referrals, to understand referral rates and set targets for reduction if possible; and

- likewise work with the top five practices who have the greatest growth in referrals.

The PCT is also reviewing the referral rates of single-hander GPs and data on prescribing and emergency admissions.

*Source: Audit Commission*

- 56 Some PCTs have set up mechanisms to support demand management and reinforce appropriate use of new care pathways, for example, referral guidelines, incentives in personal medical services contracts and referral centres. Salford's referral centre, as well as booking patients for treatment, will enable the PCT to triage patients suitable for PwSIs or outpatient care. Nationally, 5 per cent of PCTs require GPs to refer patients via a central referral point in the PCT for all specialties and 29 per cent of PCTs operate a central referral point for some specialties. This benefits PCT demand management, however, GPs may feel disempowered and clinical engagement may be put at risk. North Bradford's incentive scheme (see Case study 15, page 46) promotes consistent referral practice, but does not reduce GP autonomy when making referrals.

### PCTs need to develop a targeted plan for redesign work

- 57 Nationally, 26 per cent of PCTs have not planned how they want to use PwSIs to deliver services (**Ref. 1**). The extent to which PCTs we visited had developed priorities for redesign varied (**Exhibit 11**). The most developed strategies analysed demand, including waits and anticipated growth, building on the capacity plan. The PCTs used this analysis to target particular specialties for redesign, set targets for the level of activity the new pathways should deliver and limit growth in activity in traditional pathways.
- 58 Of the ten PCTs we visited, five had developed clear priorities and set objectives for redesigned services in terms of activity and reduction in outpatient demand, which were described in the capacity plan and local development plan (LDP). These objectives set targets to drive the range of redesign projects within the PCT and also helped to convince health economy partners of the merits of redesign. The Southampton health economy modelled capacity, assessing the improvement that different solutions would produce (**Case study 4, overleaf**).
- 59 Other PCTs' plans remained unclear and aspirational. Three PCTs were facing considerable outpatient access problems, yet their LDPs had little analysis of which specialties needed redesign and no estimates of redesigned service activity and potential impact on outpatient waits or demand. Few redesign projects were planned in these PCTs. Furthermore, their LDPs set aside no, or very little, money to develop redesigned services between 2003-06, which will limit the scope of any work.
- 60 Redesign was often driven by clinicians' individual interests, rather than by a PCT redesign strategy. While harnessing, for example, GPs' desire to offer enhanced services, PCTs must ensure that developments fit their strategic aims or new services may not be sustainable (page 28).

## Exhibit 11

### Targeting redesign programmes

Some PCTs had analysed demand to produce well-developed strategies (Ref. 11).

	PCT P	PCT M	PCT Z	PCT S	PCT T	PCT W	PCT R	PCT U	PCT V	PCT N
Local outpatient capacity problems	!!	!!	!!	!	!	!	!	!	!	!
Redesign seen as a response to capacity problems		✓	✓	✓	✓	✓	✓	✓	✓	✓
Analysis of demand, so that one or more specialties are targeted			✓	✓	✓	✓	✓	✓	✓	✓
Targets set for number of contacts to be provided						✓	✓	✓	✓	✓

**Key:**

! problems meeting future targets    !! problems meeting current and future targets

Source: Audit Commission

- 61 Redesign was often introduced without thorough analysis of the level and types of activity needed to relieve an access problem, or of the human resources needed to deliver that activity. Furthermore, contracting for redesigned pathways was underdeveloped. Clinicians charged sessional rates for their work, rather than delivering activity within a SLA. Contracting needs to be improved so that new pathways deliver the activity and quality the PCT intends.
- 62 After deciding specialties in which redesign would be beneficial, a PCT needs to work with clinicians to model the new care pathway. This requires detailed analysis of demand at a sub-specialty or even condition/symptom level. Within a specialty, some conditions may be more suitable for community treatment, or some conditions may give rise to a greater level of inappropriate referrals. A few of these conditions may account for the majority of the outpatient workload. To do this, PCTs need finer-grain information including outpatient diagnoses and conversion rates to decide which conditions the new care pathway should be established for.
- 63 Beyond waiting times and the number of outpatient contacts by specialty, the information available to PCTs was limited (**Exhibit 12**). Most PCTs relied on information from acute trusts and this did not include diagnosis at outpatients. Some PCTs had been able to get information on suspected diagnosis at referral from GPs. This was dependent on information systems and resources available to GPs to collate the information. North Bradford PCT requires and pays its GPs to provide such information (**Case study 5, overleaf**). This approach has benefits for service redesign and financial management, as it enables PCTs to understand how demand for outpatients could be segmented.

- 64 In the absence of good information for planning, PCTs brought clinicians together to make judgements about demand and propose new pathways. Under this less - planned approach, PCTs must keep new care pathways under review to check that they are achieving their aims and that staffing levels and criteria for access are appropriate (chapter 3).

### Exhibit 12 Information available to PCTs.

The information available to PCTs to target redesign was limited.

PCT	Information from Primary Care						Information from Secondary care	
	Referral by specialty	Referral by condition	GP consultations by condition	Information on suspected diagnoses at point of referral	Inpatient actual diagnoses by GP	Outpatient actual diagnoses by GP	Outpatient first cases by speciality	Conversion rates by speciality
M	✓			✓			✓	
N	✓						✓	
R	✓	✓	✓	✓	✓	✓	✓	
S	✓	✓					✓	
T	✓						✓	✓
U	✓				✓		✓	
V	✓			✓	✓	✓	✓	✓
W	✓				✓		✓	✓
Z	✓				✓		✓	

Source: Audit Commission

### Case study 4 Modelling capacity information to test redesign solutions

At Southampton University Hospital Trust, a data model was developed to understand orthopaedics capacity issues across the health economy. It maps all stages of the patient journey and describes visually what impact capacity increases and changes in referral levels will have on waiting lists and patient length of stay.

The tool was used by the Orthopaedics Whole System Group (primary and secondary care clinicians and managers) to identify capacity constraints. As a result the multi-professional triage team was established to deliver orthopaedic assessment clinics in primary care across the health economy.

The excel spreadsheet used information already available to the health economy and contained a 'snap-shot' of data from typical patient lists.

Modelling was not 100 per cent accurate, but sufficient to support decision making. The analysis was refreshed every three-six months and it became apparent that the predictions were more accurate than was originally envisaged. The model has been developed as answers to new questions are required.

Source: Audit Commission

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## Case study 5

### Access to information from primary care

As hospital referral data available to North Bradford PCT was poor, the PCT funded general practices to collect referral data. Practices received £2 per head of population for administration and were reimbursed 100 per cent of information systems spend to service clinical governance audits, as well as data collection.

Patient details, date of referral, symptoms and suspected diagnosis are collected for all potential outpatient referrals in an Access database. They are then forwarded to the PCT. This system operates in parallel with the clinical record systems in use within each practice as the use of different clinical record systems did not allow data to be merged between practices. The referrals database and the clinical systems are updated by each practice. As data collection is labour intensive, the PCT is setting up a central server so that data can be extracted centrally rather than being entered individually by each GP practice.

Funding for administration is now part of the PCT's practice incentive scheme, which is worth up to £5-6 per head of population. The incentive scheme covers provision of referral data to the PCT; attendance at the GP advisory group and practice manager's group; production of a business plan; attainment of Investors in People and implementation of remote booking and booked admissions.

*Source: Audit Commission*

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### In health economies that have financial difficulties, PCTs need to manage deficits and ringfence funding for redesign

- 65 Having specified redesign priorities, PCTs need to earmark funding for developments. When this research was undertaken, some health economies were having financial difficulties. PCTs as commissioners are managing different degrees of financial deficit with their provider partners and this impacts on the extent of redesign work taking place. However, some PCTs in poor financial positions were still managing to invest in redesign.
  
- 66 None of the PCTs we researched anticipated reducing the activity provided by the acute sector as a result of redesign: they were using redesign to reduce growth in demand for secondary care and reduce waits. Therefore, no PCT envisaged recouping funding from the acute trust. Redesigned pathways needed ongoing, as well as pump-priming, funding.
  
- 67 Consequently, local financial position has an impact on the scope of redesign work in PCTs: PCTs whose health economies were in greater deficit found it harder to invest in new alternative services in 2003/04 (**Exhibit 13**). These PCTs were investing some money in other developments, but the need to meet financial balance and cost pressures limited funds for innovation. Furthermore, established pathways we reviewed had reported annual revenue costs of £18,000 to £152,000. Services varied in terms of activity levels and type (from assessment only to a range of treatments), and the type of staff employed to deliver them. However, part of this variation in costs

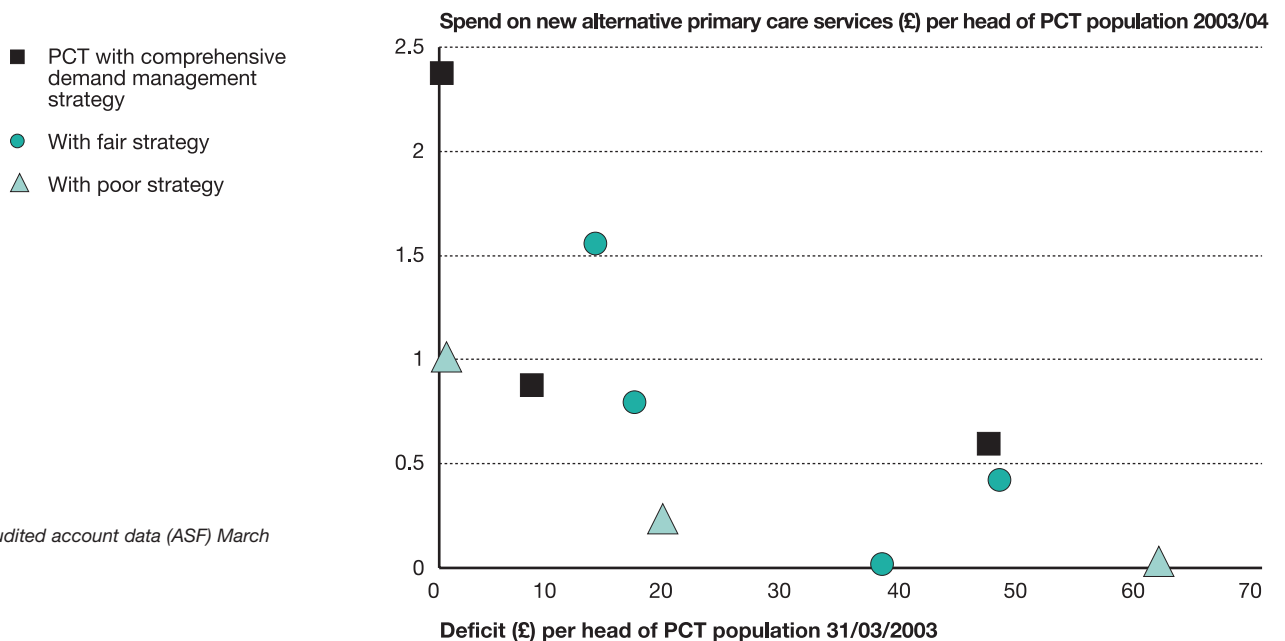
is due to the fact that financial planning for new services was often driven by the funding that was available, rather than by a specification of what the service should deliver.

- 68 Local financial position is not, however, an insurmountable barrier to investment in alternative care pathways. Eight out of ten of our health economies were managing some degree of financial risk, but six of these had allocated some funds to redesign. Significantly, PCTs with a comprehensive strategy to change the model of care allocated greater funding to redesign than other PCTs in similar positions of deficit (**Exhibit 13**). Their commissioning approach enabled them to reserve funding for developments.
- 69 Two PCTs in high-risk health economies, and two in moderate risk, had set stringent savings regimes for local providers and some central PCT functions. Cost pressures (for example, prescribing and consultant’s contract) and some NHS Plan developments within the primary and acute sectors were funded from these savings. This allowed the PCTs a greater degree of flexibility with growth monies, some of which they committed to redesign at the primary/secondary care boundary. However, gaining acute sector backing for LDP savings and investment proposals involved considerable negotiation in some health economies. Support from SHAs can be particularly helpful in this circumstance (see page 31).

### Exhibit 13

#### The impact of financial position on investment in alternative services

Financial position affects investment in alternatives, but PCTs with a comprehensive strategy are able to invest more than those in a similar position.



Source: PCT audited account data (ASF) March 2003

## Support from PCT senior managers<sup>I</sup> is essential to the success of the commissioning strategy and of redesign

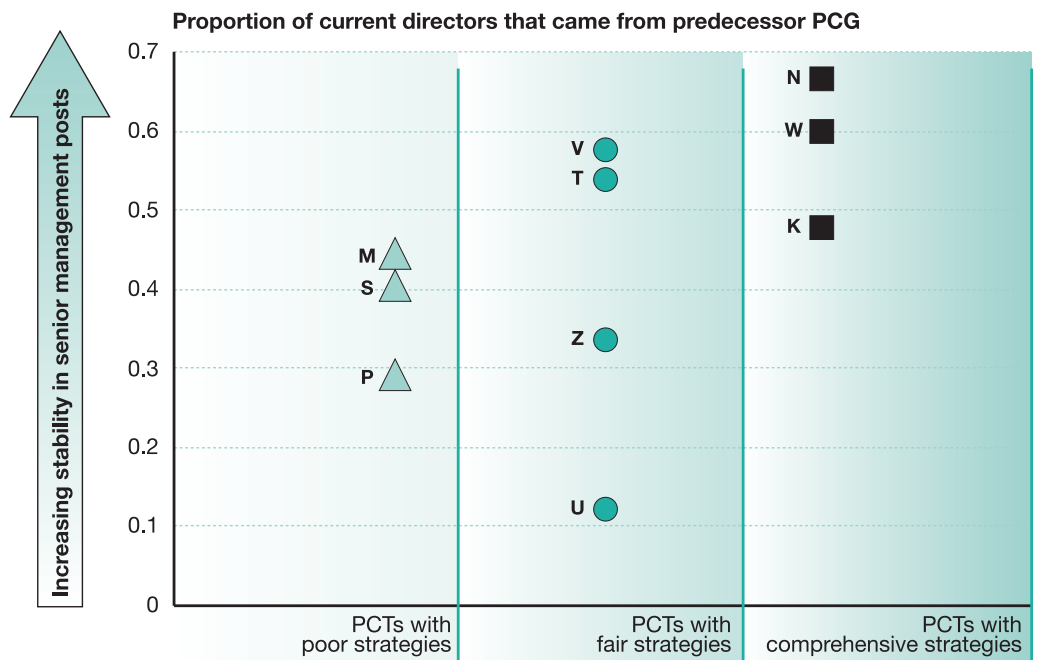
- 70** Responsibility for redesign varies between PCTs. In some it falls to a single director, in others, it is shared. However, the model in use does not seem to impact on success. Leadership of redesign was weak in five PCTs. In the three PCTs with a comprehensive strategy to change the model of care, redesign was a major part of the PCT's vision and leadership was strong. In these PCTs, lead directors were closely involved in projects, helped to make the link between strategies and project work and offered practical help to project managers.
- 71** During development stages, lead directors ensured that staff understood the importance of redesign to the success of the PCT. They regularly reported on progress to the management team and board, linking with other directors to ensure that financial, estate and human resources strategies supported redesign of care pathways. Open access to a director enabled valuable hands-on support for project managers and helped them to develop solutions when projects reached barriers. For example, in one PCT the director became involved in negotiations with the acute trust when the project manager met opposition to proposals.
- 72** After the development stage, ongoing support from PCT leaders is essential to ensure that mainstream funding continues and spreads to the entire PCT population. Ten of the fifteen redesign projects we reviewed had started under a PCG. Most of these had been driven by clinicians in response to local waiting time problems. As such, these early PCG projects were usually supported by PCTs, as they fitted with their NHS plan-driven strategies. However, two projects were not supported, which has had consequences for their spread and sustainability. One had not been spread to serve the whole PCT population and the other was at risk of withdrawal of funding, despite long outpatient waiting times locally. Neither service had been expanded and both were maintained by a single dedicated clinician and so were vulnerable to the person leaving the service. Nationally, 13 per cent of redesigned services have not been spread to all practices within a PCT and 36 per cent of services are provided by a single PwSI (**Ref. 1**).
- 73** Those PCTs with a more comprehensive commissioning strategy had particularly strong leadership. These PCTs also tended to have had a greater level of stability in senior management positions. The presence of forward-thinking leaders, driving the approach consistently from predecessor PCG days (**Exhibit 12**), has enabled such strategies to develop. This stability seemed to be a more important factor than size or age of the PCT, which were controlled for in our sample of research sites. (For example, the three PCTs with a comprehensive strategy served populations of between 92,000 and 170,000.)

<sup>I</sup> Clinical leadership is covered in chapter 4.

**Exhibit 14**

**Importance of stability in senior management positions**

Those PCTs that had co-ordinated strategies to manage demand and support new care pathways tended to be those with a greater level of stability in senior management positions.



Note: U PCT's strategy was fair due to considerable support from the SHA.

Source: Audit Commission

**SHAs can have an effective role in promoting redesign**

- 74 PCT corporate support for redesign is critical, but SHAs can also be leaders, promoting redesign. However, the extent to which SHAs supported redesign varied.
- 75 Four of eight SHAs associated with the PCTs we visited provided strategic support for redesign. They supported PCTs by highlighting area-wide specialty priorities, collecting and sharing information on local redesign projects, setting up networks to share expertise and promoting redesign as a suitable strategic approach to achieving targets. Support was particularly important in those health economies in financial deficit, encouraging PCTs to invest in redesign in spite of strong calls on funding from providers. Greater Manchester SHA's approach co-ordinated redesign across the whole area and provided commissioning support to PCTs, increasing their leverage with acute trusts (Case study 6).

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## Case study 6

### SHA support for redesign

Greater Manchester SHA provided strong direction to local health economies. It specified specialties in which PCTs should carry out redesign (based on analysis of waits) and stated that growth capacity monies should be used for investment in alternative services and alternative acute providers. It also required local acute providers to deliver productivity improvements that were larger than required nationally (thus encouraging local work between PCTs and acute trusts to identify where savings could be made).

This SHA related to two of our PCTs and its approach had a number of benefits:

- Redesign was co-ordinated across the area so that all PCTs worked openly on a particular specialty. (This could be expected to deliver more appreciable change in outpatient waiting times and would reduce 'poaching' of practitioners between PCTs within the SHA area.)
- The strength of the message from the SHA made it clear to acute trusts that models of care had to change.
- It backed PCTs to reserve funding for redesign, this had particular impact in economies in financial deficit where it supported savings regimes across providers.

The approach did, however, have some disadvantages: in particular there was an impact on local ownership of change. Overall, however, the SHA's leadership was enabling a broad range of redesign work across Greater Manchester PCTs.

*Source: Audit Commission*

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- 76** SHAs are now the focus of Modernisation Agency support for PCTs and trusts. The agency has passed significant resources to each SHA over the past year to be used for local modernisation initiatives. SHAs should be sure that they understand the range of redesign taking place locally, thus aiding local learning and spread and ensuring that Modernisation Agency support is targeted appropriately.
- 77** Integration of redesign within a commissioning strategy to change the model of care, targeting it appropriately, allocating funding and providing corporate support are important to the establishment of a significant and sustainable redesign programme. However, the capacity to deliver individual new care pathways also depends on the approaches the PCT takes to overcome shortages in personnel and premises. These issues are discussed in the next chapter.

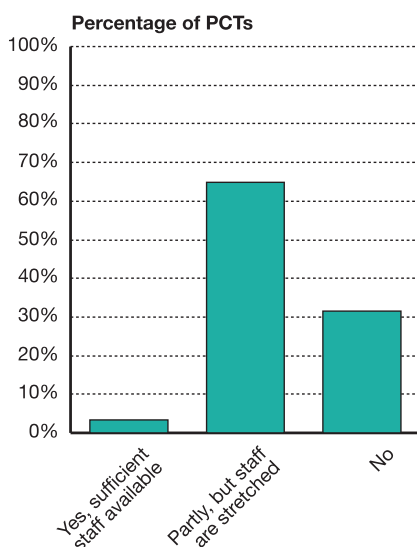
# 3

## Delivering and evaluating a redesigned care pathway

### Exhibit 15

#### The management resource supporting redesign projects

Only 3 per cent of PCTs feel they have sufficient management resource to drive redesign projects (n=234) (Ref. 1)



Source: Audit Commission

78 Having established and funded priorities for redesign, PCTs need to set up projects to deliver each new care pathway. Clinicians and managers need to work with patients to decide what the new pathway should look like (clinician and patient engagement are covered in chapter 4). This process needs to be managed and its possible outcomes will depend on human and estate resources available in the PCT. Having set up a pathway, PCTs should monitor outcomes to assess if it is delivering its objectives.

79 Successful redesign is associated with:

- a management resource that is structured to prioritise project management;
- spreading extended skills and using a range of staff groups;
- appropriate training and support for PwSIs;
- availability of premises or participation in Local Improvement Finance Trust (LIFT) or Public Private Partnership (PPP); and
- reviewing the success of the new care pathway.

PCTs make the best progress where they structure the management resource to free up time for development work

80 A designated project manager was critical to the success of projects in the set-up and implementation stages, co-ordinating progress across organisations, organising training and premises and generally acting as a 'catalyst' to drive the work forward. One PCT developed parallel projects in orthopaedics and dermatology: the dermatology project, with a designated project manager, has achieved what was intended; the orthopaedics project, led by a practising clinician (without a project manager), has struggled to keep going. Progress in two other projects we reviewed suffered when project managers left their posts.

81 Management capacity is a problem in many PCTs, which can limit availability of project management staff. Nationally, only 7 per cent of PCTs feel that they have sufficient staff available to drive redesign projects (**Exhibit 15**). Three of the ten PCTs we visited reported middle management shortages due to inadequate management resources or recruitment and retention problems. This impacted on their ability to bring about change. An Audit Commission study of PCTs' ability to shape general practice also found considerable variation in capacity to manage new relationships with practices (**Ref. 12**).

82 PCTs had nonetheless allocated redesign project management responsibility: ten of the fifteen projects had part-time project managers. Because of resourcing constraints, however, the project work was usually carried out on top of the manager's day job. Consequently, project managers felt overstretched.

- 83 We compared PCTs' management resources (cost per head of population) with our assessment of their resources for project management. Among those we visited, there was no relationship between these variables. Some of the smallest PCTs with the least management resource had allocated significant management resources to oversee redesign projects. They had explicitly prioritised redesign and commissioning to ensure that there were sufficient middle managers to take on redesign and development work, irrespective of the overall management resource.
- 84 PCTs adopted further strategies to overcome project management shortages. North Bradford PCT cascaded redesign skills within the clinical workforce to support central project managers and spread understanding of redesign (**Case study 7**), while Broxtowe and Hucknall PCT employed a project manager jointly with other PCTs. Three PCTs took part in Action On programmes and viewed the funding available for full-time project posts as the main benefit.
- 85 PCTs need to plan for management time to develop projects as the volume of redesign work they deliver increases. Current arrangements in some PCTs, where middle managers are absorbing the project management workload, will constrain progress.

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### Case study 7

#### Cascading redesign skills and supporting project management

North Bradford had comparatively low overall management spend, but had prioritised commissioning and made redesign a major component of commissioning managers' jobs. They had also devolved redesign skills. Key members of PCT staff received training on redesign methodologies, for example, Plan-Do-Study-Act (PDSA) cycles, via Modernisation Agency collaborative schemes. This knowledge is, in turn, cascaded to others in the PCT, such as service heads. Staff organise sessions in the PCT and district-wide to explain methods and run workshops for managers and clinicians.

*Source: Audit Commission*

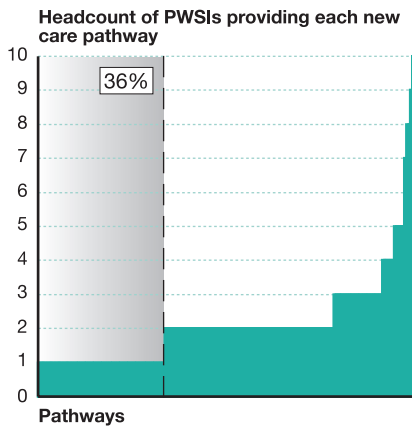
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#### PCTs need to increase the number of practitioners with extended skills, and make better use of a range of health professionals

- 85 It is widely recognised that many community health professionals and GPs are able, and want, to extend their roles to provide specialist services. The NHS Plan anticipated that 'up to 1,000 GPs with a special interest will be taking referrals from fellow GPs for conditions in specialties such as ophthalmology, orthopaedics, dermatology and ear nose and throat surgery' (**Ref. 3**). This target has been met early, and the ongoing Government strategy is supported further in the new General Medical Services (GMS) contract agreement, which provides PCTs with an opportunity to increase use of PwSIs through enhanced services.

### Exhibit 16 PwSIs working in new alternative services

Nationally, 36 per cent of new alternative pathways are vulnerable as they are provided by only one clinician (n=155) (Ref.1).



Source: Audit Commission

87 In the PCTs we visited, development of alternative services was often driven by practitioner interest and availability rather than by an assessment of the type and number of clinicians needed to provide a particular level of activity. As a result, services have tended to employ a limited number of clinicians. Nationally, 36 per cent of new care pathways are provided by only one practitioner (GP or other professional) (Exhibit 16). This is of concern, as services are small and sustainability of the service is at risk if the clinician decides to stop providing it. The level of activity delivered is also limited. PCTs need to consider increasing the number of clinicians with specialist skills and working with PwSIs to ensure good succession planning. Broxtowe and Hucknall PCT and Bristol South and West PCT have adopted different approaches to increasing the number of frontline clinicians with more specialist skills (Case study 8).

88 Having clinicians who are interested and willing to extend their roles is obviously critical. Nationally, only 26 per cent of PCTs thought that there were sufficient available clinicians to meet the PCT’s PwSI needs (Ref. 1). Of the PCTs we visited, five felt that there was a good level of interest among their nurses in becoming PwSIs, but only three felt that there was a good level of interest among GPs. Lack of information in this area may have led PCTs to be overly pessimistic, as between 21 per cent and 47 per cent of GPs responding to our survey expressed an interest in becoming GPwSIs<sup>1</sup> (Ref. 13). PCTs should ensure that their information on clinicians’ interests is up-to-date: only four of the PCTs we visited had formally asked primary and community staff if they would be interested in becoming a PwSI. Eastern Wakefield PCT keeps an up-to-date record of interests by asking practices to record and forward the information to the PCT. This information is used by the PCT when planning redesign.

### Case study 8 Spreading skills across clinicians to increase sustainability of new services

Broxtowe and Hucknall, with other Nottingham PCTs, introduced specialist physiotherapists to assess and treat patients with hip and knee problems. Quick implementation of the scheme across the city limited the number of staff the service would be able to recruit.

The PCTs divided the role in two: specialist assessment (triage) and treatment (exercise classes and advice). The PCTs recruited a limited number of physiotherapists to the exercise class/advice posts. All other existing community physiotherapists were trained to carry out the assessment process so that it became part of their everyday job. They were trained by local consultants and received ongoing support in their new role. This led to a reduction in the need to recruit new staff and, since assessments could be carried out by a large number of staff, the service was not as vulnerable to staffing changes.

Dermatology GPwSIs in Bristol South and West PCT are paid to deliver two sessions in the community per week. The sessional rate covers both clinical and teaching work. One aspect of the GPwSI role is to provide a channel for communication, education and support in primary care, to improve dermatology knowledge among other

<sup>1</sup> However, our survey had a 29 per cent response rate. It is possible that those who were more interested in becoming PwSIs responded.

*Impact on the rest of the practice is a problem. We have just two full-time GPs. Getting one session off from practice is disruptive as time still has to be managed for extra things that I am not able to do (paperwork, telephone calls etc) while away working as GPwSI.*

*It's difficult for GPs already working in practice to develop a special interest, because they can't take the time out from the practice.*

*It is all in all time-wise not very sensible to work as a GPwSI as I need the time in my practice more than the money.*

#### **(Interviews with GPwSIs)**

- I GPs often cover sessions for each other within group practices. This may have an impact on the ability of GPs from small practices to become GPwSIs. To cover for GPwSI sessions, single-handed GPs would need to employ another doctor or locum.
- II 55 per cent of PCTs nationally employ salaried GPs (n=189).
- III The 2003/04 figures expect that services currently funded under the following arrangements, continue: GPwSI services, Local Devt Schemes [S36 1997 Act], Improving Primary Care Incentive Scheme, HSG (96) services [secondary to primary care transfer], Access to primary care including Advanced Access and PMS+.

professionals in the community. The GPwSI team have developed a community dermatology service, running lunchtime workshops for GPs, health visitors and podiatrists. The workshops are promoted by the PCT and have focused on the most common skin care conditions and how they can be treated in primary care. The dermatology service has a website and the GPwSIs have published guidelines for the service. GPs who send inappropriate referrals are sent the relevant guidelines. The workshops and guidelines increase both the sustainability and effectiveness of the service across the PCT.

*Source: Audit Commission*

- 89 Arranging cover affects whether GPs feel able to come forward to become PwSIs. GPs at four PCTs described particular problems arranging cover for the practice workload and said this deterred them from becoming GPwSIs. They felt unable to attend training sessions (during surgery time) and had concerns about 'letting down' practice colleagues. In one PCT, the GPwSI said he was unlikely to continue with the post in the long term because of problems with covering the practice workload. GP vacancy rates, availability of locums and practice size affected the ease with which cover could be arranged: nine of the ten PCTs had problems finding locums and PCTs with a large number of single-handed practices tended to have fewer GPwSIs, potentially because there were fewer opportunities for internal cover<sup>I</sup>.
- 90 PCTs need to consider ways to support arrangement of cover so that a GP is able to develop interests that match PCT priorities. PCTs we visited were overcoming local barriers to participation in a range of ways: four employed salaried GPs to provide both cover for other practitioners and new services<sup>II</sup>; four employed part-time GPs for GPwSI sessions, which meant there was no need for locum cover; and five had formally reviewed primary care skill mix in the last two years. They had implemented changes such as introducing health care assistants and nurse practitioners and consequently found it easier to accommodate change and organise backfill. Salford PCT found that creating specialist roles made it easier to recruit GPs in the area as GPs were attracted to the opportunity of developing portfolio careers.
- 91 The Personal Medical Services (PMS) and GMS contracts enable funding of GPwSI services in PCTs we visited, and the new GMS contract agreement will be an important tool for the further development of services. It identifies a significant investment in 'enhanced services<sup>III</sup>' between 2003/04 and 2005/06. National guidelines on GPwSI remuneration state that settlements should be agreed locally, but generally should be sufficient to fully replace that doctor's time in practice (**Ref. 14**). Remuneration was an issue of contention in three PCTs, with two of these consequently losing GPwSIs during the implementation phase.

- 92 PCTs need to look increasingly across the community workforce for staff with the potential to provide alternative services. Alternative care pathways in PCTs across England have been nearly twice as likely to make use of GPwSIs than nurses or allied health professionals (AHPs)<sup>I</sup>. As redesign becomes more widespread, PCTs will need to recruit and develop individuals from a range of healthcare professions in order to meet demand. The GPwSI model should not always be the model of choice – AHPs and nurses are interested in, and able to provide, a range of enhanced services. Furthermore, a PCT may simply not have access to sufficient numbers of GPwSIs. Southampton PCTs' orthopaedic service employed a range of professionals to assess and treat patients (**Case study 9**).
- 93 PCTs we visited had developed a range of service models using different staff groups, depending on local availability (**Exhibit 17**). Three PCTs originally intended to include GPwSIs in their service model, but failed to recruit GPs so, instead, increased their use of therapists and nurses. They found that they did not have to make great changes to their proposed care pathways, and the only constraint they reported was inability to prescribe. Furthermore, some PCTs found it easier to employ AHPs or nurses in redesigned services. Agreement over terms and conditions for these professions was usually less problematic than for GPs, as they were employed directly by the PCT, receiving salary enhancements to reflect their extended roles. 'Agenda for change' gives PCTs a modernised pay structure with which to reward staff with extended roles.
- 94 To ensure widespread and sustainable modernisation, PCTs must link redesign needs with long-term workforce development strategies so that an increasing number of sustainable services can be established.

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## Case study 9

### Developing a service model using a range of professions

The Southampton health economy<sup>II</sup> has developed a multi-professional triage team (MPTT) to deliver orthopaedic assessment clinics in primary care across the health economy. The model was developed to fully utilise skills of different healthcare professionals and to provide the most appropriate care for patients. The team comprises GPs, physiotherapists, occupational therapists, nurses, podiatrists and a radiographer who, by working together, provide a holistic patient-centred service.

*Source: Audit Commission*

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I GPwSIs per project = 1.12; nurses/AHPs per project = 0.62. Source: Audit Commission survey of PCTs (n= 189).

II New Forest, Southampton City, New Forest and Eastleigh and Test Valley PCTs and Southampton University Health Trust were involved in establishing the service.

### Exhibit 17 Use of different staff groups

PCTs had developed a range of service models using different staff groups.

Dermatology redesign		
PCT	GPwSI	Nurse
M	✓	✓
W		✓
N	✓	
P	✓	
R	✓	
Z		✓
U	✓	
T	✓	
S	✓	

Orthopaedics redesign		
PCT	GPwSI	AHP
M		✓
W		✓
R	✓	✓
Z	✓	✓
T	✓	
V		✓

Source: Audit Commission

#### Training and ongoing support for PwSIs

- 95 Training and ongoing support affect PwSIs’ confidence and job satisfaction, and therefore the sustainability of alternative services. They are also key to patient safety and PCTs need to be sure that new services do not involve unacceptable levels of clinical risk. In three of the PCTs we visited, PwSIs perceived their training and ongoing supervision to be insufficient.
- 96 Agreeing the level of training and expertise needed by PwSIs was often problematic. For these early projects, the Cardiff dermatology GPwSI diploma was one widely recognised standard, but for other professions and in other specialties, the level of training and accreditation provided depended on the views of the PCT and local consultants. One GPwSI left a service because he lacked confidence. In another PCT, there was no consultant input for the first 18 months and PwSIs felt isolated as well as lacking in confidence. The Department of Health (with the Royal College of General Practitioners) and the Modernisation Agency have published guidance on the development of GPwSIs in 16 specialties, which is welcomed (Refs.14 and 15).
- 97 Nine PCTs had arranged on-the-job training in outpatient departments, which allowed trust to be built up between PwSIs and consultants. At the start of one project all the GPwSIs worked part-time in secondary care for three months. Consultants reported that they consequently felt confident in supporting the GPwSIs in primary care.

98 PCTs need to ensure that PwSIs receive good, ongoing support from other specialists. Ongoing support for PwSIs was insufficient in three PCTs (**Exhibit 18**). Successful ongoing links included attendance at specialty teaching meetings or tutorial meetings with consultants, use of telemedicine (in dermatology) to seek advice from consultants, regular consultant audit of PwSI decisions and joint clinics. PwSIs and consultants particularly valued joint clinics and telemedicine, as they helped PwSIs to make decisions about individual patients.

99 New services were often developed or staffed by those local clinicians with pre-existing *specialist skills*. Of the projects we reviewed, all ten involving GPwSIs, and two of the three involving nurses, used staff with previous experience or training in the speciality<sup>1</sup>. This has allowed new care pathways to be developed relatively quickly. In future, staff may have limited or no specialist skills and more extended training periods will be required.

I Instead of creating more capacity among the workforce, some redesign projects ‘poached’ experienced nurses or clinical assistants from hospital departments. This allegedly affected outpatient waiting times.

### Exhibit 18 Support for PwSIs

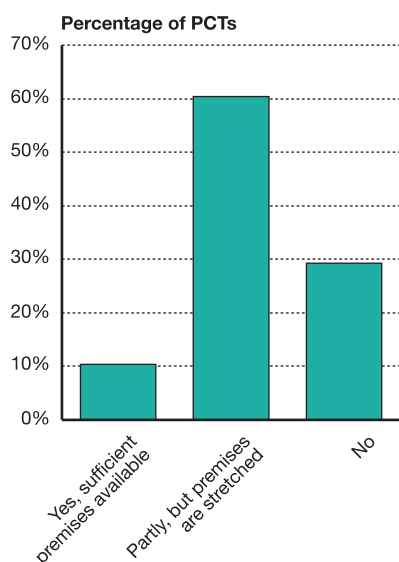
A range of ongoing PwSI support mechanisms were being used.

PCT	Speciality	Ongoing support	Telemedicine	Tutorials/specialty teaching meetings	Consultant ‘audit’ of PwSI decisions	Clinics with consultant in primary care	Clinics with consultant in secondary care
M	Derm	✓ for GPwSIs (insufficient support for nurses)	✓			✓	✓
N	Derm	✓		✓		✓	✓
P	Derm	✓	✓				✓
R	Derm	✓		✓			
S	Derm	✓	✓	✓			
T	Derm	Insufficient		✓			
U	Derm	Insufficient			✓		
W	Derm	✓	✓		✓		✓
Z	Derm	✓	✓				
M	Orth	✓				✓	
R	Orth	✓		✓			
V	Orth	✓		✓			
W	Orth	✓			✓		
Z	Orth	✓				✓	

Source: Audit Commission

## Exhibit 19 Premises capacity for new services

Only 10 per cent of PCTs felt they have sufficient physical capacity to house new redesigned services (n= 232.) (Ref. 1).



Source: Audit Commission

PCTs need to look across the local community for suitable premises and integrate redesign plans with any LIFT or PPP proposals

- 100 Nationally, only 10 per cent of PCTs felt that they have sufficient physical capacity to house new services (**Exhibit 19**). Availability of suitable premises was a considerable barrier to change in four of the PCTs we visited; only one PCT had good availability of space to locate new services. Services were provided in health centres, GP surgeries and, in one case, an outpatients department.
- 101 Although PCTs with a lack of premises found space by working closely with estate and health centre managers, progress was often delayed. Three PCTs services were provided in premises that were unsuitable, for example:
- one orthopaedic service was housed in an unsuitably small room;
  - one service had its assessment and treatment provided in different locations in the PCT; and
  - one service used a clinic in a neighbouring PCT and GPs were reluctant to refer to location out of town.
- 102 PCTs should consider the potential for delivering new services in all suitable premises, including those owned by the local authority or the acute trust. Seven PCTs were involved in or bidding for LIFT or other PPP investment. This will help to solve problems in the medium term. However, PCTs need to ensure that their strategy to move services into the community is costed and feeds into LIFT/PPP schemes.

## Reviewing the new care pathway

- 103 As commissioners, PCTs need to be sure that the new pathways are delivering the activity and outcomes envisaged during the planning stage. They must monitor the effectiveness of new care pathways, assess how they are being used, and be sure that change is sustained.
- 104 All PCTs collected a range of activity and outcome data, for example, waits for the new service, the number of patients seen, type of interventions carried out and numbers of patients referred on to outpatients. A number of important elements were not, however, monitored in most PCTs:
- the (audited) number of referrals direct to traditional pathways and the new pathway (see chapter 4) – needed to improve GP referral consistency;
  - whether overall referral rates in the system had increased once new capacity was provided;
  - whether outpatient waiting times had reduced;
  - cost-effectiveness and affordability of the new service; and
  - patient views of the baseline (traditional) and new pathways (see chapter 4).

- 105 Without monitoring these factors, it is hard for PCTs to demonstrate that redesigned services have led to improvement. For example, a PCT may wish to reduce demand for outpatients. Without knowing whether overall referrals in the system have gone up, PCTs cannot tell whether patients treated by the new community service are genuinely diverted from outpatients, or whether they are patients who would previously not have been referred (**Case study 10**).

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## Case study 10

### Monitoring referrals in the system

North Bradford monitors GP referrals to outpatients, alternative services and private services on a monthly basis. It also monitors the overall level of referrals, to check that referrals into the system do not go up when it introduces a new service. Its PMS 'Quality Marker' system helps to ensure that referrals do not go up by more than 2 per cent if a service is introduced (see Case study 15, page 46). Comparative referral data is fed back to GPs.

*Source: Audit Commission*

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- 106 It is a matter of concern that cost-effectiveness was only measured in two PCTs. Most PCTs assumed that alternative care pathways were cheaper, as consultant staffing costs are high and payment has to cover acute trust overheads. Without proper costing information, PCTs do not have evidence that the new pathways are affordable in the long term and any strategy to improve sustainability of the local healthcare system may fail.
- 107 An Audit Commission study of financial management reports auditors' recent concerns that over one-third of PCTs have inadequate finance staff and management capacity (**Ref. 16**). Auditors question PCTs' capacity to carry out financial planning to support primary care development, including understanding what money is being spent, whether value for money is being achieved and how additional investment can be used to improve services.
- 108 For the reliability of future investments and service planning, PCTs must comprehensively monitor the output and cost of their new care pathways and their impact on the local system. Furthermore, using evidence of the effectiveness of early redesign work will support the spread of the redesign approach more broadly.

# 4

## Engaging local stakeholders to establish the redesign programme and deliver new care pathways

- 109 PCTs need to engage a range of local stakeholders, both in setting the agenda for redesign and delivering redesigned care pathways. The participation of local clinicians, acute trusts and patients is critical. There can also be considerable benefits to working in partnership with other PCTs, particularly in areas of geographical complexity.
- 110 Successful redesign is associated with:
- PEC leadership of the PCT redesign strategy;
  - effective engagement of frontline clinicians;
  - engaging acute trusts on a common agenda;
  - partnership working with other PCTs; and
  - ongoing patient engagement.

### PEC leadership of redesign

- 111 The NHS Plan commits to clinician involvement, stating that local doctors and nurses 'would be in the driving seat in shaping services', contributing to planning and commissioning in a primary care led NHS (**Ref. 3**). At the same time it lays down a comprehensive agenda for change. A key challenge for PCTs is to engage local clinicians to bring about changes required by the NHS Plan and develop local priorities.
- 112 Primary-, and community-, based clinicians are essential to the success of redesign programmes and new care pathways. Firstly, a core group of clinicians needs to work with managers and decide the steps of the new pathway. Secondly, a small number will form the workforce that provides it. Thirdly, broad GP support for the pathway is essential so that they can discuss the new care pathways with patients and refer appropriate patients to the new service. Because the GP is a major referrer of patients to secondary care we have focused on the engagement and perspectives of GPs in our research<sup>1</sup>. Involvement of clinicians in secondary care is covered later in this chapter.
- 113 The PEC is the bridge between PCT managers and frontline clinicians. Clinician members of the PEC should bring their clinical experience to drive priorities for redesign and contribute to key decisions regarding PCT strategy. PEC clinicians can also promote ownership among frontline clinicians, communicating back to them, explaining the environment in which the PCT operates and why particular priorities have been invested in. Direct communication between PEC and other clinicians can build ownership of the PCT strategy; 'Ideas travel through conversation and

<sup>1</sup> This is by no means to imply that GPs are the only profession with whom PCTs have to engage.

interaction among trusted peers' (**Ref. 17**). The Department of Health has indicated that the PEC should provide operational leadership, as well as support and direction to the Board (**Ref. 18**).

**114** The role of the PEC was, however, still unclear in the majority of PCTs that we visited, which had impact on clinical ownership of change. PEC members often felt that their clinical backgrounds were not being made good use of and that their PEC was just 'rubber-stamping' decisions made by the executive and board. They felt that they had insufficiently focused agendas, which limited debate on the important issues. They also felt unsure of the extent to which they should be directing PCT priorities and the board. Furthermore, some PEC members we spoke to were unsure to what extent they should be communicating PEC discussions and decisions back to frontline colleagues. The opportunity for leadership was, therefore, lost. Reflecting this, 46 per cent of GPs we surveyed said that they do not get enough information on PCT priorities and strategies for investment (**Ref. 13**).

**115** The PEC worked well to support redesign and PCT strategies where:

- PEC meeting agendas were slimmed down to allow sufficient debate on key issues;
- items were brought to the PEC early in the decision-making process;
- clinicians could make a distinct clinical contribution to key decisions, and
- members were supported to feedback to the front line.

**116** Eastern Wakefield (**Case study 11**), Sheffield West and Stockport PECs have a remit to make decisions on which services could benefit from redesign and to decide on investment priorities. Bristol South & West PEC is supported to communicate with GPs and community staff via quarterly meetings in three localities. One PEC, however, worked very well to select redesign priorities, but had not communicated this back to the frontline and so involvement and perceptions of frontline GPs remained poor. North Bradford PCT benefits from being small, (with only group practices) but it has co-opted extra members (clinical professionals and practice managers) onto its PEC so every practice is represented. This effectively promotes informal communication and leadership across all practices within the PCT.

### Engaging frontline clinicians

**117** To maintain GP ownership of PCT strategy and redesign, PCTs need to:

- communicate investment in local priorities;
- broaden engagement to allow more clinicians influence; and
- inform GPs about redesigned services and incentivise their use.

## Case study 11 Role of the PEC

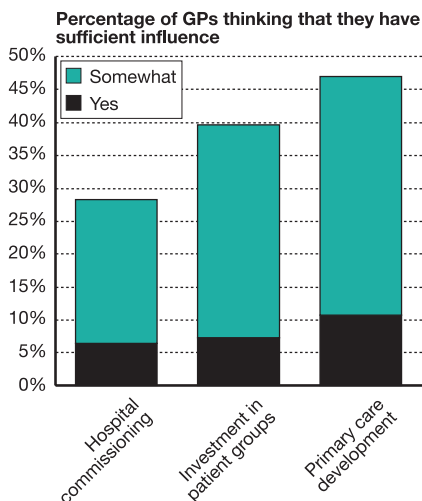
Eastern Wakefield PEC has a strong role in thinking through strategy and recommending ideas to the Board. It also hears from local GPs about their ideas and priorities. There are quarterly clinical group meetings, which feed into a steering group and then into the PEC. The PEC meets weekly and schedules alternate formal and informal sessions enabling open discussion on a wide range of topics. Attendance, especially by GPs, is very high. Having heard from frontline clinicians, the PEC makes decisions on what and how services are developed. The Chief Executive feels that, 'the PEC are critical to the redesign of services'.

Source: Audit Commission

## Exhibit 20

### GPs' influence over PCT commissioning

Influence over acute commissioning is perceived to be not as good as for primary care development or for investment in patient groups (Ref. 13).



Source: Audit Commission

National targets have a negative impact on clinician ownership of change.

Most in primary care would say targets are secondary-care based.

Clinicians do not like the emphasis on targets but would not argue against most of them – patients should not have to wait months. The issue is targets altering priorities.

Interviews with PEC chairs or other PEC members

## Communicating investment in local priorities

118 A national focus has the potential to disengage clinicians if local concerns are perceived to be different. Most of the GPs we met agreed with the priority placed on improving waiting times for specialist care, which was the driver behind current redesign work in all but two of the PCTs we visited. However, in some PCTs the extent to which national priorities were seen to drive work had a negative impact on GP engagement and participation in redesign, with dissatisfaction that so much money and effort was going to meet ‘secondary care problems’. GPs feel that their influence over commissioning of acute services is weak (Exhibit 20) and (as managers do) want to have a stronger focus on the health improvement agenda and community services.

119 Many GP priorities do, however, overlap with national priority areas. Across the PCTs we visited, GPs highlighted the need to invest in a number of clinical areas (Exhibit 21). Of the top 21 GP priorities, 13 are national, and the outstanding GP priority of mental health has a National Service Framework (NSF). Areas in which PCTs had carried out redesign were all GPs priorities. PCTs, and particularly clinician PEC members, need to communicate the fact that the national agenda is allowing local priorities and patient needs to be taken forward. Some PCTs had communicated such overlaps, and also highlighted the benefits of redesign to patient care, successfully encouraging support for PCT work.

120 Four out of ten PCTs had canvassed frontline views of investment needs and managed to keep funding a limited number of local priorities, or had aligned their local investment needs with NHS Plan areas (using new monies to address locally identified problems). They reported that working with targets in this way had been important for keeping clinicians on board, Sheffield West PCT, and linked local priorities with the NSF in mental health to invest in developments (Case study 12). PCTs need to find out clinicians’ views of local priorities. Where these fit with local needs assessment and are backed by PCT strategies they should, if possible, make some provision in these areas.

## Case study 12

### Investing in local priorities

Sheffield West PCT and the predecessor health authority have carried out two surveys of GP opinion on priorities for primary care development. Mental health is a key local priority in Sheffield and GP views have resulted in a large financial allocation to mental health services. This is being used to develop a range of community services and to help build up capacity to assess and treat mental health problems in primary care. The availability of funding was influenced by NSF work, as well as by local views. The PCT is keen to take opportunities to fund local work, through, for example, HAZ funding or by linking to access targets in the LDP.

Source: Audit Commission

GPs are feeling disenfranchised, they would like more money to develop new services for patients and more referral options.

Because there is no money, proposals are still on the table but not progressing. GPs are demoralised and see no point in developing further ideas.

The PCT is only spending money on access.

National targets have definitely had impact at the PEC. We are tired about money needed in secondary care, and tired about reporting being all about hitting targets.

Grassroots GP feel betrayed when their initiatives cannot be taken forward, so LMC meetings can be difficult when GPs feel that the PCT is not working on their behalf.

There is some evidence that lack of support for GPs' priorities constrains their support for PCT priorities.

The PCT is only spending money on access.

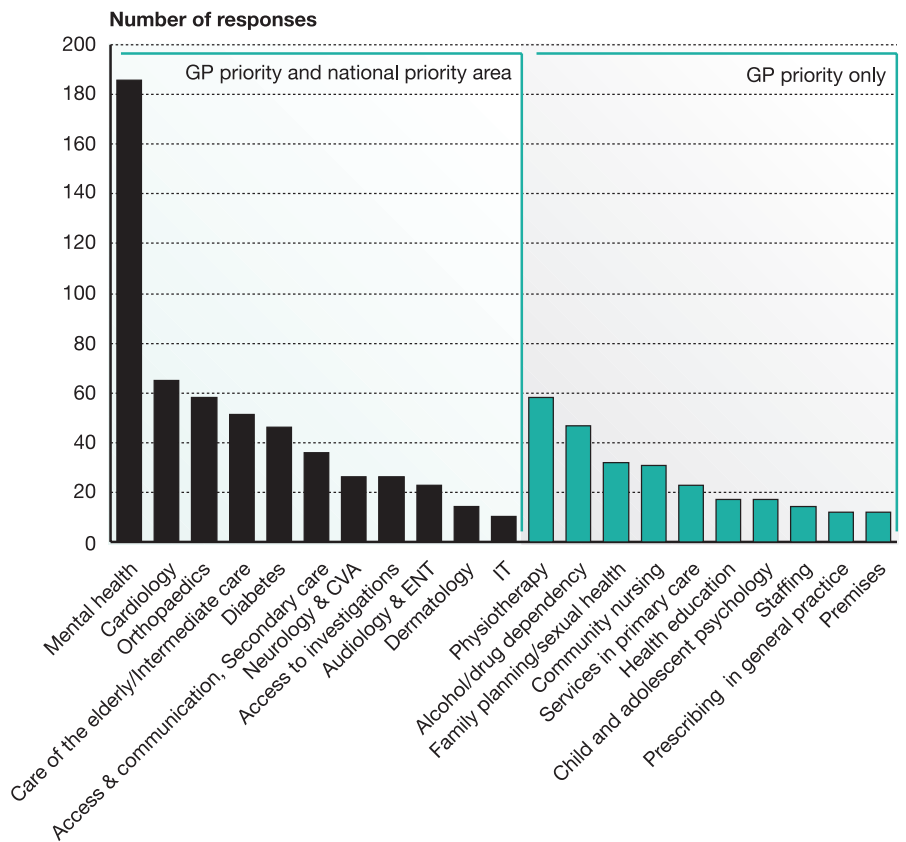
The preventative focus could be stronger.

[targets] aren't related to the PCT's core mission to improve health and well-being.

**Interviews with PEC chairs or other PEC members**

**Exhibit 21  
GPs' priorities**

Many of GPs' priorities overlap with national priority areas (Ref. 13).



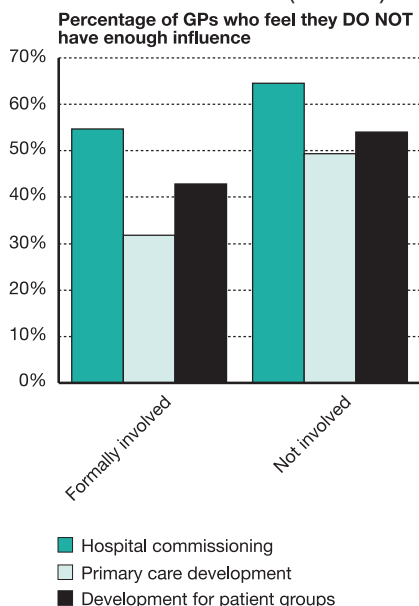
Source: Audit Commission

**Broadening engagement**

- 121 Investment decisions and redesign were well supported in PCTs where clinicians across the PCT had the opportunity to influence them. However, of the ten PCTs we visited, only 27 per cent of GPs felt that they had influence over hospital commissioning, primary care development and investment in particular care groups (Exhibit 20, Ref. 13). Earlier research found that GPs feel they have 'little or no involvement in PCG/T decision-making processes' (Ref. 19), and CHI's recent reviews of clinical governance found limited clinical engagement in commissioning (Ref. 20).

### Exhibit 22 GP involvement and influence in PCTs

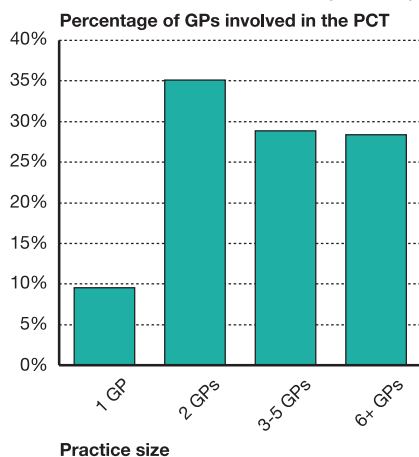
GPs that are involved with the PCT feel they have more influence than those who do not (Ref. 13).



Source: Audit Commission

### Exhibit 23 Involvement of single-handed GPs

Single-handed GPs are less likely to be involved with a PCT (Ref.13).



Source: Audit Commission

122 GPs’ perceptions of their influence is affected by their involvement. Of the GPs responding to our survey, 28 per cent were involved with the PCT: either as a member of a committee/working group or the PEC, or as a GP lead. Those involved in this way felt that they had more influence (Exhibit 22). Earlier research has shown that those clinicians who are not involved with the PCT are disillusioned by Government policy (Ref. 21). To overcome this position, PCTs we visited increased the breadth of GP involvement by setting up a range of mechanisms (Case study 13):

- professional groups (in addition to the PEC) to work on more operational/contractual issues;
- ‘lead clinician’ roles in each NSF priority and other areas, using professionals other than PEC members;
- quarterly meetings for all clinicians focusing on different care groups or clinical areas;
- standing sessions to discuss the PCT’s work at monthly education days for all GPs;
- ‘workshop’ days for all clinicians to discuss particular issues;
- regular practice visits;
- a monthly newsletter for practices;
- website;
- communication about the PCT and collection of feedback during individual practice clinical governance visits; and
- devolving budgets and incentivising referral behaviour and participation at a practice level (Case studies 13 and 14).

123 Involving clinicians is particularly difficult for large PCTs. PCTs we visited with a larger number of GPs involved a lower proportion of clinicians (Ref. 13) as the PEC accounts for a lower proportion of them. However, some large PCTs are managing better than others by dividing the PCT into smaller administrative areas and involving GPs at those levels. For example, one PCT operated two health economies that have devolved responsibility for commissioning and primary care development and lead GPs attended regular health economy meetings. Two PCTs were re-introducing localities in part to communicate better with clinicians.

124 Single-handed GPs are less likely to get involved with a PCT (Exhibit 23), potentially because of difficulties arranging cover. This is a particular problem for those PCTs with high proportions of single-handers. Again, good involvement mechanisms can overcome some barriers. For example, Salford PCT set up a monthly education and communication meeting for all GPs, with protected time. Some PCTs co-opt extra members into their PEC to increase involvement: one PCT has set up six-month ‘placements’ on the PEC, specifically for single-handed GPs. This allows them to participate in the PCT but does not require a long-term commitment.

125 All participation should be funded so that clinicians are able to cover their normal workload. This will be costly, so PCTs should have clear objectives for clinician involvement in ongoing PCT business and redesign and understand the cost that this entails.

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## Case study 13

### Broadening clinical engagement

North Bradford PCT has very broad clinical engagement, and GPs in the PCT feel that they have good influence compared to other PCTs we visited. This is helped by the fact that the PCT has a low number of practices (13) and that are all group practices. However, the PCT has established a range of involvement mechanisms and incentives that promote good involvement.

The PEC has a member from each GP practice, having co-opted extra (non-voting) clinical professional and practice manager members. This improves communication and ownership at a practice level. AHPs are not employed by the PCT, but they are also represented at the PEC.

There is an Advisory Group for each of the professions working under the PCT: nurses, practice managers, GPs, optometrists, dentists and pharmacists. All advisory groups have a member from each practice, usually a different person to the practice's PEC member. The Advisory Groups have a more practical focus, and are used for consultation, raising problems and finding solutions. Attendance at practice manager and GP advisory groups is encouraged with incentives and attendance is good. Complex and important issues discussed at advisory groups may go to the PEC for endorsement. Attendees at PEC and Advisory Groups are paid for protected learning time.

The PCT has clinical leads working on NSF areas, who are funded one session per week, or month, to develop PCT work, in conjunction with the lead manager for that clinical area.

It is difficult to find cover for clinicians while they are working for the PCT. However, all practices have nurse practitioners and salaried GPs, and all are group practices, which helps to cover the practice workload. Some practices have employed another partner purely on the money raised by a GPwSI colleague.

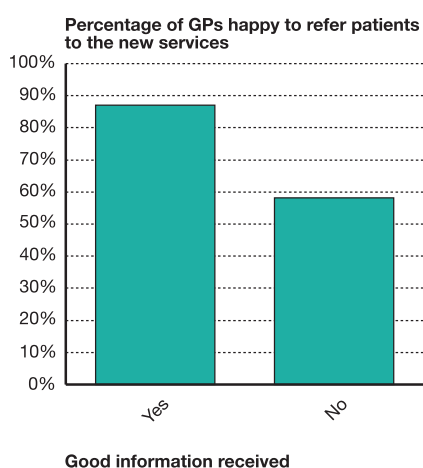
*Source: Audit Commission*

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## Exhibit 24

### Advertising a new service

Providing information to GPs increases their willingness to refer to new care pathways (Ref. 13).



Source: Audit Commission

### Informing GPs about the new service and incentivising its use

126 Promoting a new care pathway to GPs through launch events, postal information and practice visits can increase their willingness to refer patients to it (**Exhibit 24**). Across PCTs, however, a number of GPs (15 per cent) are still unhappy about complying with new care pathways (**Ref. 13**). PCTs have encouraged GPs to use new care pathways in a number of ways, for example, by promoting the service and its referral guidelines (**Case study 14**) or feeding back comparative referral rates to GPs. North Bradford PCT used incentives to encourage GPs to refer to its community alternatives. It used its PMS 'quality marker' system, which encouraged appropriate use of community alternatives without taking away either GPs' autonomy or the potential for patients to choose the outpatient pathway (**Case study 15**).

### Case study 14

#### Promoting a new service to GPs and the PCT

Eastern Wakefield PCT wrote to all GP practices when the dermatology service was launched and staff visited practices, if requested, to explain the service further. The PCT sent regular reminder letters to GPs advertising the short wait for the service and were happy to receive calls from GPs who were unsure about the types of patients that could be referred.

The Southampton Orthopaedics MPTT was launched through open days, lunches and visits to GP practices. When roll-out of the service generated high levels of interest from primary care, courses were held at the PCTs to promote MPTT to board members, senior managers, clinicians and therapists. The courses included perspectives from both primary and secondary care and outlined the referral process, clinical governance issues and costs per patient for the new service and traditional outpatients services.

Source: Audit Commission

### Case study 15

#### Incentivising use of alternative pathways

The PMS scheme at North Bradford PCT includes 36 quality markers. All practices collect data on their own performance. The quality markers are updated yearly, are drafted by lead GPs and nurses (if clinical) and consulted on with practices. It takes one year to develop a measure and collect baseline data. Improvement is measured against the baseline in year two.

A hospital services incentive scheme will become part of the PMS marker scheme. There are a number of quality markers within the hospital scheme. If a practice achieves the required number of markers, they get an incentive payment. Furthermore, if the practice does not spend its allocated budget (for prescribing, hospital and community health services) it can keep some of the balance for practice investment, if it has met the quality markers.

The quality marker for dermatology is that at least 60 per cent of all GP referrals should go to the GPwSI service (GPs can refer urgent cases directly to consultants). This encourages use of the specialist triage service (but does not enforce it). There is a further marker that has helped to control overall referral growth: a practice's overall dermatology referrals should not go up by more than 2 per cent per annum. When the quality marker was introduced, there was an observable increase in referrals to the GPwSI service.

*Source: Audit Commission*

## Engaging acute trusts on the redesign agenda

- 127** PCTs need to have support from the acute sector to develop alternative pathways. In particular, they need input from consultants to help to determine the pathway and to train, accredit and supervise PwSIs.
- 128** PCTs need to persuade hospital managers of the potential impact of redesign on demand for outpatient care, to explain why they are not investing in acute capacity to meet access targets. The capacity planning process helped the PCTs we visited to persuade health economy partners that a new solution to waiting problems was needed. As a result, there was generally good support for these initiatives from acute trust managers, as they recognised that the projects could help them to meet NHS Plan targets. Four of fifteen new services were developed by acute trusts.
- 129** As NHS Plan targets are achieved, the redesign agenda may become increasingly motivated by the need to create a plurality of providers to manage demand and offer patient choice. In this circumstance, acute trusts may be less supportive of redesign because the incentive to reduce outpatient waiting times will be reduced. Furthermore, as discussed earlier, PCTs are currently not withdrawing funding from the acute sector when redesigning: in future they may. Acute trusts may view alternative care pathways as competitors that will limit growth in funding for their organisation.
- 130** The projects we reviewed, although supported by acute trusts, did meet opposition from local consultants in a number of cases. Engaging local consultants was a barrier commonly cited by project managers, PCTs anticipated that this would continue to be the case.
- 131** Consultants expressed concerns that included:
- 'loss of control' over which patients attend outpatients;
  - lack of confidence in the abilities of community-based staff to assess and treat patients; and
  - clinical risks associated with supervising practitioners that are not working in close proximity to the consultant, and the time needed to do this.

*It took a lot of hard work and perseverance to get the consultants on board in the early stages.*

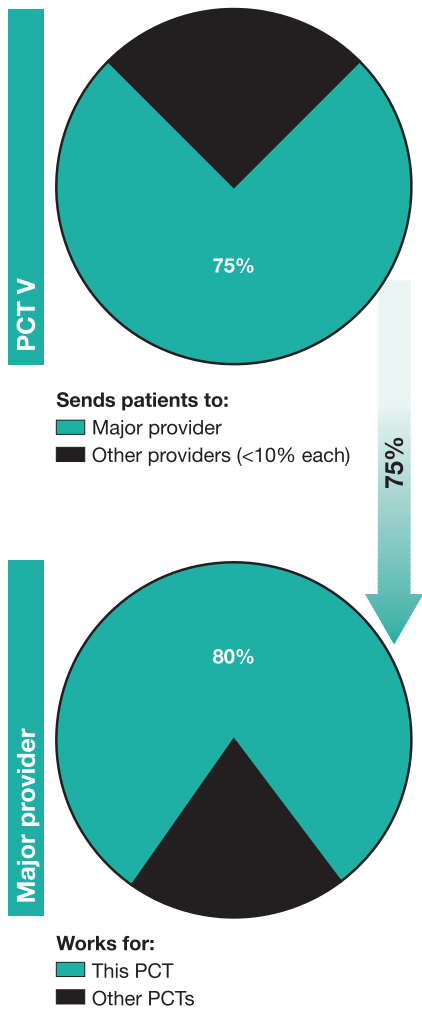
*After one project, we have to start again from scratch with a new consultant team.*

**Quotes from interviews with redesign project managers**

- 132 PCTs (and predecessor PCGs) had responded to these concerns in a number of ways, including:
- Presenting consultants with nationally available evidence on inappropriate referrals to outpatients, and asking them to reflect on, or audit, the number of referrals to their directorate that they would consider inappropriate. (PCTs successfully proposed redesign as a way to allow the consultants to focus on more complex or specialist cases.)
  - Facilitating primary secondary clinician links, via the PEC and medical director and also via particular working groups and clinical networks for example, focusing on NSFs.
  - Involving the consultant fully to develop criteria for referral to the new care pathway.
  - Asking the consultant to develop a training and accreditation programme for the practitioners. (One particularly successful model involved PwSIs training alongside consultants in outpatients for a period of time, then operating the triage or treatment pathway in outpatients before moving out into community premises. This built up trust between the clinicians, and increased consultant confidence in the PwSIs).
  - Establishing ongoing links between PwSIs and consultants, to facilitate supervision and trust. This included access to email and telemedicine so that PwSIs could get opinion on unclear cases, regular meetings and occasional joint consultant PwSI sessions, either in outpatients or the community.
  - Negotiating changes to consultant job descriptions, so that they could support PwSIs effectively.
- 133 PCTs had to work hard to find local consultant champions. In one case, the PCT had to work with a consultant from an alternative acute trust, because consultants at their local major provider would not support the new care pathway.
- 134 In many cases of redesign there is common interest between the trust and PCT to reduce waiting times and, consequently, acute trust leaders should become more involved in promoting redesign to, and challenging, consultants. Medical directors in particular could have a greater role in this area. In Stockport PCT, the medical director and PCT PEC chair worked together to engage all directorates in the redesign agenda (**Case study 16**). A persistent approach can persuade consultants of the importance and success of redesign: in North Bradford, redesign has been taking place for many years and the acute trust had 'come to expect it'.

### Exhibit 25 PCT V is in a relatively helpful situation

There is one local provider to which the majority of PCT patients are sent, and whose activity is commissioned mostly by PCT V.



Source: Audit Commission

### Case study 16 Engaging acute trust managers and clinicians

At Salford PCT, the dermatology project manager enlisted the help of the acute trust’s Director of Operations to promote the change management perspective in the hospital. He was enlisted to change the acute managers’ perspective of modernisation and to increase their assertiveness when responding to staff concerns.

The PCT and the acute trust also developed a modernisation forum to promote communication and joint planning. The directors and managers of both organisations meet monthly. The meeting is chaired by, and held in, the PCT or the acute trust alternately. Although joint work has been difficult, the shared and open approach allows managers from both sides to communicate effectively and discuss concerns constructively.

The PEC chair at Stockport PCT worked closely with the acute trust medical director to involve acute directorates in modernisation. They visited each directorate in turn, asking them to visualise the service in 15-20 years, with care delivered in the community where possible. Directorates generated a number of ideas for redesign, which they presented to the PEC. The PEC assessed the ideas for feasibility and mapped them against PCT priorities, finally making recommendations for a redesign programme to the PCT.

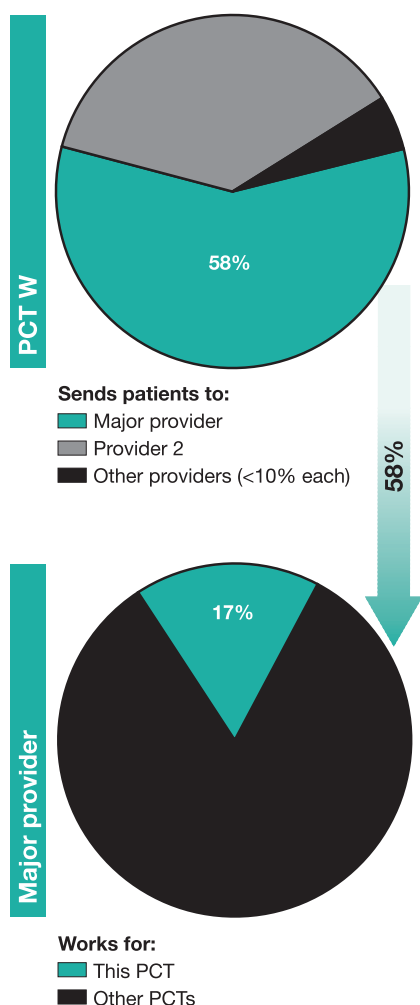
Source: Audit Commission

### Partnership working with other PCTs in complex health economies

- 135 Working with the acute sector is more complex for some PCTs, due to their geographical position. This can affect the spread and speed of progress of redesign. Where there are a number of acute providers, a PCT may have to link with each one separately to develop a care pathway, which can limit spread. Of alternative care pathways across England, 13 per cent are not accessible to all practices within their PCT (Ref. 1). Also, if it is a minor commissioner from the local trust, a PCT’s influence may be small and so it may find it hard to engage the trust in implementing change.
- 136 Three of the PCTs we visited had one main acute provider, with the PCT commissioning the majority of the trust’s workload (Exhibit 25). These PCTs were at an advantage: they had only one set of hospital clinicians and managers to influence and work with to develop pathways. Additionally, the hospital covered the majority of their population, so it was easier to spread the implementation of the care pathway across the whole PCT. Four PCTs were, however, in a more complicated position (Exhibit 26, overleaf). In these cases, the PCT population was either covered by a number of local providers (and the PCT felt it needed to work separately with each); or the PCT was a minor commissioner from a large trust (and as a minor partner among a group of PCTs, found it hard to engage the trust on its redesign agenda). As a result, redesign progressed more slowly or did not spread across the whole of the PCT, resulting in inequity for patients.

### Exhibit 26 PCT W is in a less helpful situation

It purchases from two major providers, and only accounts for 17 per cent of the activity of its major local trust.



Source: Audit Commission

Following an even more integrated approach, two health economies had developed a shared service to which all local PCTs could refer. Although this did not necessarily benefit patient travel times, these larger services had more PwSIs who could support and cover for each other.

- 137 PCTs can overcome local geographical complexity and increase their influence, when they share priorities, by working with other PCTs who commission from the same acute trusts. Three PCTs we visited had worked with other local PCTs to form a ‘commissioning group’ to redesign care pathways (Case study 17). At one of these, joint redesign work arose from lead commissioning arrangements. At the other two, the joint working came from a shared need to address whole-systems issues in orthopaedics. These PCTs identified common redesign priorities and set up a single steering group to communicate with local acute trusts and oversee development of the care pathways. They developed a common model for the care pathway and spread it to all PCTs involved.
- 138 There are further benefits to working with other PCTs. PCTs who refer to the same outpatients clinics, if redesigning together, are likely to have a greater impact on outpatient waits. Developing a common model avoids duplication and PCTs can employ a joint project manager. Acute trusts prefer the single co-ordinated approach.<sup>1</sup>
- 139 Nationally, however, a maximum of only 10 per cent of redesign has been duplicated across neighbouring PCTs who refer to the same trust. This means that there is considerable potential for increasing the impact of redesign. Across the country there are access problems in the same specialties, so agreeing common priorities should not be difficult for PCTs. In particular, if a number of local PCTs send patients to the same provider, their long-wait specialties and priorities for redesign are likely to be the same.
- 140 This approach naturally still permits PCTs to adopt individual priorities according to local need. If PCTs cannot agree any priorities with their neighbours they need to become more assertive commissioners and redesign on their own. There may be less impact, however, on outpatient waits. There may also be difficulty agreeing how much the PCT should contribute to development funds for the acute sector. If the acute trust is expanding its capacity, the PCT may feel that it should not contribute, as it is developing alternatives itself. Payment by results will, however, help to ensure that the PCT pays only for the care that its patients receive from the acute sector, irrespective of activity carried out for neighbouring PCTs.

### Case study 17 Working with other PCTs on redesign

The history of lead commissioning in Nottingham has helped PCTs to work together. Different PCTs have lead responsibility for commissioning types of care (for example, elective and emergency) across the health economy, and there is a joint commissioning forum ‘NottComm’, where planning decisions are made.

The hip and knee pathway was initially developed at the health authority (with consultant and public health input) to improve services for patients with hip and knee pain. It was approved by one PCG and was piloted for a year. A musculoskeletal (MSK) steering group co-ordinated roll-out of the project across the six Nottingham PCGs (which became four PCTs in 2003). The MSK steering group reports to the

NottComm forum and is attended by commissioning managers from each of the PCTs and a representative from the acute trust. The PCT with responsibility for commissioning elective care had lead responsibility for the scheme, which was rolled out across all PCTs between June and November 2003.

Each PCT allocated funding to a communal pot at the beginning of 2003/04. The lead commissioning director had authority to spend this money, reporting back to NottComm. A project manager on the steering group was jointly appointed to manage roll-out across the PCTs and the steering group sought approval for the pathway from each of the four PECs, who then communicated with local clinicians. The steering group is now working on future priorities, such as rheumatology. Broxtowe and Hucknall PCT is also working independently on piloting GPwSIs in other specialties, for example, ophthalmology, with a view to spreading the approach to the other PCTs if appropriate.

*Source: Audit Commission*

## Patient engagement in redesign

- 141 The major drive behind redesign, even if the immediate aim is to meet access targets, is to improve patient care. It was, therefore, a matter of concern that patient and public involvement in redesign at the PCTs we visited was limited.
- 142 Patients and the public were not involved in discussing priorities for redesign; neither had patient liaison officers been asked to contribute information on patient experiences to the process. In some PCTs, a small number of patients attended care pathway modelling meetings to give their views on proposed new pathways once priorities had been decided.
- 143 The majority of PCTs we visited looked at patient satisfaction once the new care pathway was established. This was not always systematic, for example, in one PCT the project manager telephoned a few patients to get their views to contribute to a press article. No PCT recorded patient views of the old care pathway, so even if they could demonstrate that patients were happy with the new care pathway, they could not demonstrate subjective improvement in patients' experience.
- 144 Patient and public consultation is time consuming, but PCTs have a range of existing networks and user groups with which they should link to discuss redesign proposals. Trust boards bring a lay perspective and should be involved in agreeing redesign strategies and investment decisions; however, wider communication with patients and the public is critical to ensure that investment in the NHS genuinely improves patients' experiences.

# 5

## Conclusions

- 145 In this report we have reviewed redesign of care pathways at the primary/secondary care boundary, the capacity and systems required within PCTs to underpin this approach, and how PCTs can improve their position in order to better support successful redesign programmes.
- 146 Redesign has helped PCTs to improve provision for patients: offering more appropriate care, shorter waiting times and a range of treatment options. By helping PCTs to manage demand for outpatient's services, it has helped to create more sustainable local healthcare systems.
- 147 Redesign at the primary/secondary boundary will quickly develop as PCTs become more experienced. There is a risk, however, that the potential of redesign work will not be realised if it is not part of a comprehensive commissioning strategy to change the model of care and manage demand locally. PCTs now need to move from developing isolated, small projects to an approach where the new model of care, with diverse care pathway options and a new balance in favour of community alternatives, is set across specialties. Such an approach will be essential for the successful implementation of patient choice.
- 148 There is a particular need for PCTs to plan services more carefully, setting objectives for what they expect them to achieve (for example, in terms of activity or reduction in referrals to outpatients), calculating the staffing numbers and types that will be needed to deliver them and how much this will cost. As redesign becomes more widespread, PwSIs will need to be drawn from a greater diversity of professions in order to deliver these objectives.
- 149 It is of concern that new services are not being monitored comprehensively. Redesign should be part of a continuous cycle of service planning, development and review and new care pathways will need to evolve to respond to changing demands and priorities. Without comprehensive information on the impact and cost of new pathways, services may not achieve PCT objectives and PCTs are at risk of investing inappropriately.

- 150 PCTs are successful in establishing a broad and sustainable range of new care pathways where:
- redesign is integrated with a strategic approach to change the model of care;
  - the PCT develops an information resource so that it can target redesign;
  - developments are prioritised for funding;
  - the management team is committed to redesign;
  - the management resource is structured to free up time for project work;
  - specialist skills are spread;
  - a range of professionals provide PwSI services;
  - the service model was developed flexibly to fit with premises availability;
  - outcomes were monitored to feedback into ongoing service review and planning;
  - local PCTs work together on redesign if necessary;
  - clinicians are involved in decision making in the PCT; and
  - patients' views are monitored to check for improvement.

## Further Audit Commission support to PCTs in this area

- 150 The Audit Commission is following up this publication with a website for PCTs. The website will include a short explanation of the key issues, expanded versions of the good practice examples contained in this report and further good practice examples. It can be found at [www.audit-commission.gov.uk/pcts](http://www.audit-commission.gov.uk/pcts), and can also be accessed via relevant sections of the NatPaCT website.

# Recommendations

## Recommendations to PCTs

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### Planning and supporting redesign

- Integrate redesign with a commissioning strategy that prioritises community developments, helping to promote a diversity of supply.
  - Limit growth in acute activity within SLAs, where appropriate.
  - Limit development funding to the acute sector, where appropriate, to maximise funding for community development and redesign.
  - Ensure that the SLA clearly specifies the level of activity to be delivered in a cost/volume contract.
  - Ensure that activity levels relating to the PCT within the SLA are up to date.
  - Work with acute providers to release funds for cost pressures, NHS Plan and other priorities, through efficiency savings.
  - Assess potential for efficiency gains in the acute sector, setting targets for improvement (for example, in outpatient DNA or follow-up rates) linked to the SLA if necessary.
  - Provide GPs with comparative data on referral rates, to encourage debate and greater consistency.
  - Provide support to practices to examine high referral rates and growth in referrals.
- Develop clear corporate priorities for specialties to be redesigned, following on from capacity planning and patient feedback.
- Set clear objectives for new pathways in terms of activity levels, for example, reduction in outpatient demand (if this is an aim) and improvement in patients' experiences.
- Improve the information resource on demand, to prioritise and target redesign on subspecialties.
  - Consider asking all GPs to forward referral data to the PCT, or set up a referral centre to get good-quality information.
  - Ask GPs to include information on sub-specialty and symptoms/suspected diagnosis.
  - Work with acute providers to improve information returned to the PCT, to include, for example, diagnosis at outpatients.

- Specify funding for redesign in the LDP and financial strategies.
- Ensure that senior managers actively support redesign and provide practical help to project managers.

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### Delivering and evaluating redesigned pathways

- Prioritise commissioning/development functions within the PCT to ensure that each project has a manager with time set aside for the work.
  - Consider cascading redesign skills (techniques) to service heads.
  - Consider employing a project manager jointly with other PCTs.
  - Apply for ‘Action On’ and other sources of project management funding.
- Develop a number of PwSIs for each care pathway, to increase sustainability.
- Expand the use of non-medical professions in PwSI roles.
  - Survey community staff and GPs on their interest in extending their roles.
  - Support GPs, particularly single-handed ones, to cover practice workload so that they can develop special interests (for example, provide salaried GP cover).
  - Link redesign with long-term workforce strategies.
  - Agree the PwSI training needed with local consultants, using national guidelines and taking into account individuals’ existing expertise.
  - Promote ongoing support for PwSIs: for example, ongoing attendance at specialty/tutorial meetings; joint outpatient clinics; ongoing consultant audit of, and feedback on, PwSI decisions.
  - Negotiate with acute trusts so that they use the opportunity of the new consultants’ contract to secure consultant support for redesign and PwSIs.
- Consider spare premises capacity in NHS (community and acute) and non-NHS buildings (for example, local authority premises).
  - Link redesign with the long-term estates strategy and PPP/LIFT.
- Collect comprehensive activity data to monitor the effectiveness of new pathways, including:
  - number of referrals to the service;
  - waits for treatment;
  - number of patients seen;
  - outcomes for those patients (including percentage referred on to outpatients);

- number of inappropriate referrals to outpatients;
- overall referral rates for the specialty;
- cost-effectiveness with respect to the outpatient model; and
- patient views.

NB it is important to collect both baseline and outcome data so that improvement can be monitored.

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### Engaging local stakeholders to establish the redesign programme and deliver new care pathways

- Ensure that the PEC can drive the redesign agenda and contribute clinical perspectives to key PCT decisions.
- Encourage the PEC to communicate with peers in the community about the PCT strategy.
  - Explain the PCT strategy and investment priorities regularly to clinicians, for example, at education events, and highlight any overlaps between PCT and clinician priorities.
  - Formally collect GPs' and other clinicians' views on development needs in primary and secondary care.
  - Incorporate local priorities in investment strategies, where possible.
- Set up additional mechanisms to broaden clinician involvement in PCT work
  - for example, establish uni-professional working groups, lead clinician roles and education days.
  - Consider co-opting extra members onto the PEC to broaden engagement (perhaps for short periods to encourage participation).
  - Set objectives for clinician engagement and allocate a budget for the work.
  - Provide sufficient funding for clinicians to arrange cover so that they can participate. Consider providing incentives to encourage participation in PMS/GMS contracts.
- Promote appropriate referrals to new pathways by feeding back referral data to GPs.
  - Consider encouraging the use of community alternatives in PMS/GMS contracts through the use of incentives.

- Engage all acute clinical directorates in developing ideas and priorities for rebalancing care into the community.
  - Analyse the projected impact of the pathway on local capacity as a means of promoting redesign to acute trusts.
  - Involve the medical director so that they can lead promotion of redesign.
  - Involve consultants fully in developing the new pathway, criteria for its use and training/accreditation programmes for PwSIs, to increase ownership.
  - If necessary, work with consultants from an alternative trust to support new services.
- In complex health economies, consider developing and implementing redesign priorities with other PCTs that refer to the same trusts.
- Use existing resources within the PCT to incorporate patient views into decisions about redesign priorities.
  - Ensure that patients contribute to the shaping of new pathways.
  - Collect patient views of old and new services.

## Recommendations to SHAs

- Support PCTs to target and spread redesign
  - Where needed, help PCTs to analyse capacity figures and develop priorities. (This analysis will also ensure that Modernisation Agency resources in the SHA are targeted appropriately).
  - Highlight common redesign priorities across PCTs to facilitate joint working.
  - Consider establishing a common programme of redesign across the area, to have maximum impact in key specialties.
  - Collect information on current and completed redesign across the SHA area, to share with PCTs and promote networking and learning, and to target Modernisation Agency support.
  - Set up problem-solving/learning networks of project managers or lead directors.
  - Where appropriate, back PCTs that wish to invest growth monies in redesign rather than traditional solutions.

## Appendix 1: success of redesign projects reviewed

We looked at a number of parameters to determine the impact and success of the redesign projects in 10 PCTs.

	Parameters	PCTs									
		M	N	P	R	S	T	U	V	W	Z
<b>Activity</b>	PwSIs triage AND treat?	Ortho: Yes Derm: No	Derm: Yes	Derm: Yes	Ortho: Yes Derm: Yes	Derm: Yes	Derm: Yes Ortho: No,treat only	Derm: Yes	Ortho: No	Ortho:Yes Derm: Yes	Ortho: Yes Derm:Yes
	Has it reduced referrals secondary care?	Yes	No, they have gone up	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Ortho: Yes Derm: Yes
<b>Access</b>	Are all GPs happy to refer to it? *	Ortho: 78% happy to refer Derm: 95% happy to refer	81% happy to refer	79% happy to refer	100% happy to refer	100% happy to refer	Ortho: 64% happy to refer Derm: 64% happy to refer	93% happy to refer	67% happy to refer	69% happy to refer	Ortho: 69% happy to refer Derm: 65% happy to refer
	Are patients from across the PCT (no matter what secondary care trust they access) referred to the service?	Yes	Yes	No	Yes	No - 1 GP practice not referring	Yes	Yes	Yes	Yes	No
	Has it succeeded in providing a more localised service? (service provided in >1 location)	Ortho: No Derm: Yes	No	Yes	Yes	Yes	Derm: Yes Ortho: No	No, 1 centre	Yes, 6 centres	No	Ortho: Yes Derm: Yes
	Has it reduced patient waits for a first specialist opinion?	no data	Yes	No data	Yes	Yes	Yes	Yes	Yes	Yes	Ortho: No Derm: Yes
<b>Impact</b>	Spread to other PCTs who refer to the same acute trust?	Yes	No	No	No	No	Derm: Yes Ortho: No	No	No	Yes	Ortho: Yes Derm: Yes
	Is the PCT, as a result of the redesign, limiting growth in the acute sector or reducing funding to it?	No	Yes	No	Yes, no increase	No	No	No	No	Yes limiting	Yes
	Is it reducing secondary care waits?	No data	Yes	No data	No data	No data	Derm: Yes Ortho: no data	No data	No data	No data	No data
<b>Sustainability</b>	Is it vulnerable to staff changes?	Derm: No Ortho: Yes	No	Yes	No	Yes	Derm: No Ortho: Yes	No	No	Docs: No Physios: No	Yes

## Appendix 2: PCT sampling framework and characteristics

Study sites visited for our in-depth research had all completed projects in orthopaedics or dermatology and were selected to include an even spread of properties across a number of characteristics. Characteristics and each PCT's profile are shown below.

PCT	PCT date operational	Population (quartile)	Deprivation (quartile)*	Health region	Rurality	SHA overall financial position**	Star rating	Number of GPs (quartile)	Number of GP practices (quartile)	% of single-handed practices (quartiles)	% of ex-GPFH practices	Number of GPSIs	Number of other PwSIs	Projects
MPCT	01/04/2002	3	2	SW	Urban	-0.74	1	4	3	2	31	2	2	D, O
WPCT	01/04/2001	2	3	T	Urban	0.51	2	2	2	2	33	2	1	D, O
PPCT	01/04/2002	3	4	SE	Mix	-0.09	2	4	4	2	50	1	0	D
NPCT	01/04/2001	2	1	NY	Urban	0.46	2	3	3	2	100	8	1	D <sup>M</sup>
ZPCT	01/04/2001	2	4	SE	Rural	-0.84	2	3	2	2	63	4	11	D <sup>M</sup> , O
RPCT	01/10/2000	1	2	NY	Urban	0.46	3	1	1	1	46	31	2	O
UPCT	01/04/2001	3	1	NW	Urban	0.90	1	4	4	4	53	3	5	D
TPCT	01/04/2001	2	2	T	Urban	0.58	3	2	2	2	30	10	2	D, O
VPCT	01/04/2001	3	3	NW	Urban	0.90	3	4	4	3	58	3	4	O <sup>M</sup>
SPCT	01/04/2002	2	3	SW	Rural	0.01	2	2	1	1	41	2	0	D

### Key:

- \* Lowest deprivation scores – quartile 1
- <sup>M</sup> Modernisation agency Action-On funding
- D Dermatology project
- O Orthopaedics project
- \*\* Purchaser plus provider balance (or break even) as % net operating costs

PCTs we visited for in-depth research were: Bristol South & West, Broxtowe & Hucknall, East Elmbridge and Mid Surrey, Eastern Wakefield, New Forest, North Bradford, Salford, Sheffield West, Stockport and Taunton Deane.

# Appendix 3: methods and data sources

## Phase I research

We carried out exploratory interviews with key staff from 16 PCTs, a SHA and an acute trust to identify barriers to change when addressing priorities in the NHS Plan.

Findings were published in a consultation document and sent to all PCT chief executives, PEC chairs and board chairs in November 2002. (PCTs and redesign: consultation paper, Audit Commission, November 2002 also at [www.audit-commission.gov.uk/primarycare](http://www.audit-commission.gov.uk/primarycare)). There was a 41 per cent response rate, covering 80 per cent of PCTs. Respondents confirmed our findings; most common difficulties were in the areas of redesign, responding to national targets and attaining financial balance. This consultation defined the next phase of our work and identified those PCTs developing services at the primary/secondary care boundary.

## Phase II – developing the research framework

We chose to work with PCTs that had developed alternative dermatology and/or orthopaedics services. We chose these specialties because they represent the largest body of redesign work in PCTs and because the Modernisation Agency has already published information on what redesign in these specialties can achieve. A representative sample of PCTs was chosen (see appendix 2 on PCT sampling framework and characteristics).

Ten PCTs that had carried out 14 projects were selected for in-depth research to identify the levers and barriers to the development of successful alternative services.

Consolidating the key areas described in our consultation paper, we structured the research around four main areas to describe PCT development in redesign:

### **Area 1: Strategy for redesign**

Analysis of information on demand to plan redesign; development of a strategic approach to redesign; planning and commissioning; leadership and management team commitment to redesign and support from the SHA.

### **Area 2: Delivering redesign within the local context**

Management of financial position; engagement of local acute trusts; partnership working with other PCTs and influencing acute trusts.

**Area 3: Engaging clinicians in redesign**

Involvement of local GPs and their influence in PCT activity.

**Area 4: Capacity to develop new care pathways**

Developing and supporting a workforce for redesign; project management and availability of premises for new services.

All interview and survey questions and analyses were structured around these areas.

## Phase II – in-depth PCT research

We visited PCTs between May and August 2003. At each we:

- interviewed key personnel in the PCT, local acute trust and SHA;
- carried out an analysis of LDPs, capacity plans, financial plans, commissioning strategies and SLAs;
- reviewed the PCT's project monitoring information;
- carried out a postal survey of all GPs;
- conducted a questionnaire on organisational and functional capacity;
- reviewed nationally available data, for example, OSCAR and audited account data; and
- analysed data available on acute hospital efficiency from the Audit Commission 'Acute Hospital Portfolio'.

## Further research

In October 2003 we sent a national survey to all PCTs, to review progress on redesign and PCTs' views on their capacity to progress redesign. Responses came from 239 PCTs (79 per cent) (**Ref 1**).

All research tools are available on our website at [www.audit-commission.gov.uk/pct](http://www.audit-commission.gov.uk/pct)

All in-depth project sites received feedback after our research phase was completed.

## Appendix 4: membership of the advisory group

The study team is grateful for the guidance provided by the Advisory Group members:

Tina Ambury, Vice Chairman of Council, The Royal College of General Practitioners

John McKenzie, Association of Medical Secretaries, Practice Managers,  
Administrators and Receptionists

Peter Berman, National Association of Lay People in Primary Care

Virginia Morley, Independent Consultant

Pamela Bishop, Non-Executive Director, Mansfield District PCT

David Moss, Audit Commissioner

Andrew Burnett, Medical Director, Barnet Primary Care Trust

John Oldham, Head of National Primary Care Development Team, NHS  
Modernisation Agency

John Chisholm, Chairman, General Practitioner Committee, British Medical  
Association

Veena Raleigh, Assistant Director, Research & Information, Commission for Health  
Improvement

David Colin-Thome, National Clinical Director for Primary Care, Department of Health

Martin Roland, Director National Primary Care Research & Development Centre,  
University of Manchester

Michael Dixon, Chairman of NHS Alliance

Yvonne Savage, Community and District Nursing Association

Sue Faulding, Senior Pharmaceutical Adviser, West Yorkshire Strategic Health  
Authority

Jo Setters, Commission for Healthcare Audit and Inspection Transition Team

Steve Gillam, Public Health Teaching Specialist, Department of Public Health &  
Primary Care, University of Cambridge

Sue Skewis, Professional Adviser, Chartered Society of Physiotherapy

Sally Gorham, Chief Executive, Waltham Forest PCT

Elizabeth Smith, Community Practitioners and Health Visitors Association

Sian Griffiths, President, Faculty of Public Health Medicine

Peter Smith, Chairman, National Association of Primary Care

Nick Hall, Director of Policy and Development, National Primary and Care Trust Development Programme, NHS Modernisation Agency

Michael Sobanja, Chief Officer, NHS Alliance

Graham Hart, Audit Commissioner

Kieran Sweeney, Commission for Health Improvement

David Haslam, Chairman of Council, The Royal College of General Practitioners

Rob Webster, Programme Director, GMS & PMS Contract, Department of Health

Tim Jones, Primary Care Commission Manager, Vale of Aylesbury PCT

Cathryn Williams, Formerly Head of Business, London Borough of Barking & Dagenham Social Services

Sylvain Laxade, Head of Service Design, Salford PCT

Ian Williamson, Chief Executive, Sefton PCT

Graham Lewis, Professional Executive Committee Chairman, Richmond and Twickenham PCT

Diana Whitworth, Chief Executive, Carers UK

Paul Lewis, Professional Executive Committee Chairman, Maidstone Weald PCT

Lynn Young, Primary Care Officer, Royal College of Nursing

Richard Lewis, Visiting Fellow, Kings Fund

## Acknowledgments

The study team comprised Maggie Kemmner, Katerina Vardulaki and Irene Vaughan under the direction of Wendy Buckley. Kim Vuong provided analytical support and Sonia McKenzie provided secretarial support. David Quinney, Diane Ridley and Alison Blight assisted PCT research visits.

The Audit Commission is grateful for help and guidance during the course of this review. Responsibility for the contents and conclusions of the report rests solely with the Audit Commission.

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