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West Kent Clinicians via Medical & Nursing Directors and PBC Leads

cc: All West Kent NHS Chief Executives
Acute Trust Operations Directors
PBC Managers

10 January 2011

Dear Colleague

Prioritising Treatments in West Kent

Firstly, thank you to all those who actively engaged with the PCT in discussing the potential options for prioritisation, which I shared in my previous letter. We had a great response with more than 90 replies in total and over 70 clinicians getting involved in the debate.

It was clear from the dialogue that there are many practical and clinical difficulties to adopting a number of the options we laid out. Of course this is no surprise, prioritising treatments is always going to be a difficult thing to do, but I was gratified by the pragmatic nature of the discussion, with clinicians and others accepting that in the current financial climate we will have to find ways to contain burgeoning costs and demand in the NHS. We are very keen to continue this level of open and engaging dialogue with you all in an ongoing manner as we go forward.

In the course of the debate there emerged four categories of idea:

- Those that will have a short-term effect but which we would not wish to continue in the medium term – these focused on capping activity
- Those that were unlikely to create a short term effect but would add benefit in the medium term – these focused on improving quality and prevention initiatives
- Those that we shouldn't do, either because they would have no benefit or created inequity in the system – any kind of blanket ban, for example, fell in this category
- A range of new ideas that clinicians believe will improve efficiency across the system – these focused on changing/improving clinical pathways and in some cases treatment thresholds

The proposals in this letter will be the subject of further contact between NHS West Kent and our partners in the local health economy with regard to implementation. The Chief Executive will be writing shortly to take this forward.

Actions
I have attached a report summarising the feedback we received from stakeholders for your information, and as a result of your feedback and our reflection we propose moving forward in the following way:

1. Stop non-GP primary care referrals with immediate effect. This means that nurses and allied health professionals must get a GP to refer on their behalf and secondary care colleagues will return any other referrals. The only exclusion to this policy is for the Community Ophthalmology Team, which will continue to have direct referral rights.

2. We will work together with all providers to agree reduction in all elective activity for a period to be determined. We are committed to find a way of implementing this that will take real costs out of the system rather than simply shifting costs to the acute sector, which does not deliver what we collectively require. Feedback from clinicians was consistent in suggesting that a small slowdown in all non-urgent elective activity was to be preferred to a more arbitrary approach restricting access to individual conditions.

3. Emerging GP commissioning consortia will continue and re-double focus on reducing variation in referrals from primary care. There will be more emphasis upon reducing the overall average of referrals across primary care and shifting the mean down, by identifying common areas of imperfection within clinical practice, as well as working with outlying individual practices.

4. Clinical colleagues in the acute sector acknowledged that significant variation continues to exist in secondary care practice as well as primary care referral. We will redouble our efforts to work across pathways of care to reduce variation wherever it is seen in the system.

5. We will start work now to agree with clinicians how we can insert smoking and weight advice into treatment pathways with smoking ready for implementation by April 2011 at the latest.

On the other hand, it is important to note that we have decided not to take forward several initiatives in their current form. There will be no further restrictions upon consultant-to-consultant referrals, though the process did map out areas in which GP commissioners might wish to exert a greater influence in future, and these will be dealt with individually.

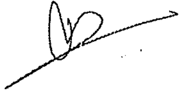
To remind you, these are in addition to the initiatives that have already been implemented and which were laid out in my previous letter. **They will still not be sufficient to close the potential financial gap;** I would appeal to every clinician to consider carefully their activity in the context of the economic position nationally and locally.

Finally, in terms of actions, I am very keen to ensure that we continue the clinical dialogue we have started in adversity. I firmly believe that it is only we as clinicians who can properly solve the economic crisis that faces the NHS, and the brief dialogue we have had has once again highlighted the fundamental willingness and enthusiasm of clinicians to embrace improvement and change, as well to acknowledge austerity. Completing this exercise has proven again that there are no magic solutions; in the end it will be down to the behaviour of clinicians to ensure that the NHS runs as efficiently and effectively as possible, balancing the legitimate healthcare needs of the population within the financial envelope available, and offering a high quality health service alongside value to the tax payer.

In the first instance I attach a detailed collation of and response to the concerns and suggestions provided to me. I will be making arrangements to meet with the wider clinical community in a further series of drop (back) in sessions during January to take this forward. In the meantime we will be setting up a number of topic related discussion forums on the Clinical Network, accessible through the PCT's website. Registration is straightforward - your contributions are both read and valued.

Thank you once again for your contribution to the debate; I do hope you will choose to be actively involved in the future, either through the face-to-face opportunities I've described or via the Clinical Network. I trust that we can rely on your co-operation to implement those things we've agreed and look forward to continuing to work together on solving the economic conundrum that faces us all.

Yours sincerely,



Dr James Thallon
Medical Director

Prioritising Treatments in West Kent – Summary Feedback
December 2010

Proposed Initiative	Feedback	Response	Action
Consultant-to-Consultant Referrals	Most clinicians conditionally supported this initiative but with multiple and various exclusions proposed There was a lack of consensus amongst clinicians about the threshold at which a GP would wish to have control over C2C referrals Lay respondents expressed concern about the potential to extend waiting times and thereby negatively impact outcomes	The multiplicity of exclusions makes this initiative both extremely challenging and potentially costly to implement. The imposition of a blanket ban was felt likely to cause delay, error and thus clinical harm	No direct PCT action but consultants asked to take personal action wherever possible A large number of opportunities for an improved dialogue between primary and secondary care were identified. These will be taken forward individually. Most will have benefits in both clinical quality and operational efficiency
Routine Elective Surgery	There was a preference to extend average waiting times for non-urgent treatment for all rather than penalise individual specialities. The perceived excess of activity in the independent sector was singled out for criticism	The need to spread the inconvenience of increased waiting times equitably within the system is acknowledged.	PCT to work with acute trusts to agree suspension of all elective activity for a period to be determined
Routine elective surgery and patients who smoke	Difficult to enforce. Concerns over equity and ethics. Acknowledgement of the clinical benefits and a wish to do more to deliver these.	Difficulty in implementation of blanket imposition acknowledged.	Public Health to work up plan with clinicians for implementation by April 2011 latest
Selected elective surgery and patients with a BMI >30	The evidence base behind this intervention was felt to be relatively weak compared to smoking and the means to deliver a pre surgical intervention to such a large potential population were felt to be sparse.	The PCT acknowledges this, and will progress the smoking initiative first.	Public Health to work up plan with clinicians for implementation during 2011
Short Stay Admissions	No specific comments received		PCT will work with acute trusts to agree a common tariff for short stay admissions wherever they are in the hospital

Proposed Initiative	Feedback	Response	Action
A&E	A&E was identified as 'the crucible' in terms of the impact of service restriction upon acute trust and health economy functioning. A wider variety of ideas were identified which might seek to improve demand management both in the short and medium terms.	A number of promising ideas and potential interventions were suggested that will feature in the feedback document.	The Urgent Care Boards are seeking to implement a number of immediate operational improvements.
Primary care non-GP referrals	A number of secondary care clinicians provided verbal feedback that this category of referral was generally more variable in quality than GP referrals. There is little empirical evidence to support this, but the assertion received support from more than one source in secondary care.	The scope of this referral source is not well understood in primary care. Action to increase knowledge and control in this field may assist GP commissioners in the long run. A number of exceptions may present themselves as reasonable once exposed.	Implement with immediate effect
Prescribing	There were some reservations expressed over 28 day prescribing, both in terms of possible savings as well as widespread concern over the inconvenience that would be caused to patients.	The potential for a one-off saving in this field will be the subject of a proposal by the Medicines Management department of the PCT.	The PCT will generate a proposal which will be subject to further consultation before implementation.
Low Priority Procedures (LPP)	There were a couple of specific queries about this policy, but there was widespread acceptance of the need for such guidance for clinicians.	The LPP document is always open to reasoned amendment, and we welcome comments upon individual pathways. We plan to develop this further as a Kent & Medway wide policy statement.	The LPP policy and its development will continue as already agreed.
Bariatric Surgery, IVF and Gender Reassignment	There was concern as to the equity of singling out these groups for individual attention	Treatment is to be delayed and not stopped, and the potential for this relatively brief delay to cause clinical harm is felt to be minimal. Urgent cases will be treated without delay at the clinician's discretion.	Implement with immediate effect

Reducing Variation	Obvious in everyday clinical practice in both primary and secondary care. There was recognition that outlying clinical behaviour must be firmly tackled.	There is substantial activity in primary care in this respect, with evident effect at the level of the individual or practice. The principle is well-established in secondary care, for example in MDT or Clinical Governance work, but needs further extension into other fields, for example non-elective care.	Clinical variation will be challenged in both primary and secondary care whenever it occurs. In addition, particular areas will be specified to target primary and secondary care improvement in practice.