System QIPP
Plan for Suffolk:
A summary
The NHS is about to enter a new era, in which GPs – and you – are at the heart of all decision making.

Coupled with this organisational change is the huge financial challenge facing the NHS. To meet this head on, the NHS has worked with GPs, nurses, hospital clinicians, mental health trusts, community services and Suffolk County Council to come up with a plan to make the financial savings whilst not compromising on quality of the services you receive. The NHS is calling this QIPP: Quality, Innovation, Productivity and Prevention.

Our plans will make a difference to people’s lives - by improving care, preventing debilitating illnesses and making the best use of public resources. However it must be realised the NHS cannot go on as it is with rising demands on healthcare services and hospitals, an ageing population and the increasing cost of technologies. To continue improving the health and wellbeing of people living in the county (excluding Waveney, where NHS Great Yarmouth and Waveney provide healthcare services) we need to work together, to make smarter use of NHS resources.

By working more efficiently we can use the money saved to re-invest in new technologies, services and patient care.

This document is a summary of the system-wide plan, which is published today, telling you about what we are doing now and for the next four years to identify savings of up to £153m. The system – hospital clinicians, GPs, community services and the county council - will work even more closely and creatively. That will mean having to redesign some services, develop new ones and stop investing in others that are not clinically effective and do not provide quality or value for money.

If the change does not maintain or improve patient care and experience then it goes back to the drawing board. Quality remains the watchword in all the NHS organisations and social care.

That also means making sure the right people are in the right place to deliver the services to you where appropriate. More emphasis will be placed on providing services in the community. In turn this should reduce demand on overburdened hospitals.

In Suffolk expected employment changes over the years covered in this plan amount to a 2.4% increase in our paybill (wages bill).

This booklet shows there is re-investment in quality and innovation; that productivity brings sustainability, and that prevention ensures that problems never arise.
The main aim of this programme is to achieve and promote high quality, safe and sustainable local services for children, young people and their families.

In 2011/12 programmes include:

- development of a Suffolk-wide paediatric asthma pathway based on Asthma UK and NHS Institute for Innovation and Improvement best practice.
- reduction of specialist out-of-county mental health placements for young people and improving liaison with local services.
- ensuring all out of county children’s Continuing Care placements receive an up to date health assessment.

Aims:
- in 2011/12 increase the number of normal deliveries and reduce Caesarean sections by 1%, against observed 2010/11 levels.

It is thought up to 75% of asthma-related hospital attendances and admissions could be avoided, so NHS Suffolk is working with Asthma UK, the NHS Institute of Innovation and Improvement, as well as doctors, nurses and schools to prevent this continuing by encouraging effective management of the condition by a GP practice. A new system is due to go live this financial year, which will, it is planned, prevent up to 40 hospital admissions for children under 17 with asthma.

Melanie Clements, consultant paediatrician at West Suffolk Hospital, said: “This initiative has provided us with an opportunity to work together across the whole of the urgent care pathway to improve care of children with asthma. Hopefully building these relationships will also help future work.”

Carol Carruthers Assistant Director Commissioning and Partnership at Suffolk County Council, said: “NHS Suffolk’s 2011/12 schemes were developed following multi-agency discussions, including Suffolk County Council commissioners. They are managed and overseen by both NHS Suffolk and the county council. Both organisations are committed to working together to ensure their plans for the future support one another in achieving the objective of delivering efficient and effective services for Suffolk people.”
The aim of this programme is to improve clinical outcomes and experience for patients who have one or more long-term conditions such as Diabetes, Heart Failure and Chronic Obstructive Pulmonary Disorder (COPD) in Suffolk. The focus will be on supporting patients outside of hospital by improving the quality and productivity of services in the community and supporting patients to manage their condition. This will in turn, slow disease progression and reduce the need for unscheduled hospital admissions.

Aims:
- reduce unplanned hospital admissions for COPD by 10% by 2014/15
- reduce unplanned hospital admissions for Heart Failure by 120 by 2014/15
- improve access to cardiac rehabilitation programmes for patients who have had heart attacks or surgery on their heart.
- increase the use of Personal Health Planning year on year and promote the idea of “no decision about me, without me”.

The Suffolk COPD service is a county-wide service, provided by West Suffolk Hospital. It is designed to provide care closer to home for more than 8,000 people who have conditions such as emphysema or chronic bronchitis, generally termed COPD, thereby greatly reducing the need for them to be admitted into hospital.

It is run by a team of specialist nurses, who work with GPs, practice nurses and community matrons to provide care in the most appropriate setting for each individual, either in the home, the community or hospital if necessary.

Nurses can visit patients at home to assess their clinical condition and for instance can arrange delivery of oxygen as and when needed. They have fully equipped cars, apart from a chest x-ray which, if required, would normally need to be carried out at hospital. In addition, the service holds “pulmonary rehabilitation” courses in community settings, such as leisure facilities, gyms and village halls to aid patient self management.

“The service is bringing benefits to patients across the county,” said nurse consultant Linda Pearce, clinical lead for Suffolk COPD Services. “We encourage our patients to become more independent, while also offering them expert, tailored care in the most appropriate setting for their needs. For most, this will be in their own homes – which evidence shows can significantly help a patient’s recovery whilst also reducing hospital admissions.”
Healthy Ambitions

This programme aims to help people to change their lifestyles so they become healthier. It will help reduce the number of people developing cancers, heart disease, and long-term conditions such as diabetes and respiratory disease. We will target those communities with high levels of illness and deaths to reduce health inequalities in Suffolk.

Aims:
• help 4,157 people to stop smoking in 2011/12 with at least 25% of those coming from the most deprived areas (which have higher prevalence of smoking and poorer health)

• decrease childhood obesity in Year 6 children to 14.5% by 2014 (measured through the National Child Measurement Programme)

• reduce the increasing trend of alcohol attributable admissions by 2% by 2014

• by 2014 we will increase the number of people who receive an NHS Health Check so that those aged 40-74 will be offered a check once every 5 years.

Case study

Many people start smoking and become addicted to nicotine when they are still children. Those who start smoking at the youngest ages are more likely to smoke heavily and find it harder to give up. These smokers are at the greatest risk of developing smoking related diseases. The Suffolk Oscars have been developed by NHS Suffolk with local partners within the Suffolk Tobacco Control Alliance as one way to prevent young people starting to smoke and encourage those that do to quit. Schools across Suffolk are asked to create a short film on the subject of smoking and to give young people the opportunity to develop creatively a message of what smoking means to them. Short listed films are showcased at a local cinema and those involved are treated to a red carpet “Oscars” type evening with typical film awards for the best actor/actress, director etc as well as the best film for demonstrating the health effects of tobacco and the peer pressure to start smoking.

‘I think the whole smoking message is really important to get across to young people because smoking is still popular amongst that age group. It was a brilliant idea to get us to highlight the dangers of smoking. I hadn’t actually talked to some of the girls in my group before but when I worked with them I knew it was going to be a really good project’. Pupil at Thurston College and winner of Best Actress Award.
Integrated healthcare

Integrated healthcare is the right care, at the right time, in the right place. Massive cultural and behavioural changes are needed if the NHS is to enhance the quality of life for people – and their families - who need care and support.

The pledges below are aimed at preventing deterioration, delaying dependency and supporting people to recover from ill health and injury as well as ensuring patients have a positive experience of the care and support they receive.

Aims:
- 5,000 people cared for in the community and not admitted to hospital by 2014/15
- 25% reduction in re-admission rates for emergency discharges by 2014/15
- 80% of stroke patients will be cared for 90% of the time on a specialist stroke unit by 2011
- 30% of over 75s will be screened for risk of falls and fragility by 2013/14
- all patients who receive community services will be offered a joint care plan by 2014/15.

Case study

Patients in east Suffolk are able to avoid unnecessary outpatient appointments at Ipswich Hospital and instead receive community management plans, enabling treatment beyond a hospital environment.

Since May 2011, GPs have been able to easily ring a senior consultant in the emergency assessment unit at Ipswich Hospital to discuss and agree a care plan for patients with an urgent health need. The consultant has a range of services available to him or her which, when appropriate, can provide care outside of hospital. They work closely with a senior community nurse who can rapidly go and treat patients at home. In the first week of this new scheme a gentleman was referred to the consultant and a decision was made for the nursing team to quickly attend to him at home. The nurse completed some further investigations and also found the patient to be very dehydrated. The nurse was able to care for him at home and arrange for him to come into hospital the next day for a diagnostic test. Without the consultant and nurse working together the patient would have had to have spent the night in hospital.

Beverly Green, team leader for Suffolk Community Healthcare, said: "We were able to provide a quick response for this patient in his own home. We helped to make him feel a lot more comfortable before he went to hospital for his test the next day by which time Ipswich Hospital had put all the necessary arrangements in place and he was seen within an hour of his arrival by the endoscopy department. This is a good example of how we can support patients and improve their overall experience."
Mental health

Fostering independence and allowing people with mental health issues to take control of their lives will see better recovery rates and quality of life. Reducing the number of people with mental health issues or learning difficulties, who have to travel out of the county to receive care, is a key part of this.

Aims:
By March 2012:

- 30 fewer people placed out of the Suffolk area bringing patient care closer to friends and families
- 60% of psychological therapy service users who have accessed the services to show significant improvement in self-reported well being.

Suffolk Mental Health Partnership Trust’s two Complex Care Teams – based at West Suffolk and Ipswich hospitals – work alongside colleagues on the hospital wards to provide an earlier diagnosis if someone is admitted for a physical health problem, who is also showing signs of dementia or delirium. Some 40% of older people in general hospital beds will have dementia, confusion or delirium. David Jarrold, a lead specialist nurse for the mental health trust, said: “Sometimes people consider becoming forgetful an inevitable consequence of aging – this need not be the case. If appropriate, an early diagnosis of dementia can make a real difference to people, enabling them to enjoy a good quality of life for as long as possible.”

NHS staff work together to improve the quality of care in three ways:

- If the hospital is aware a person has dementia – often even the patient or their family is unaware – then they can provide appropriate support to reflect the confusion that the patient may be experiencing. This can reduce a person’s length of stay so they don’t spend longer in hospital than they need to.
- Secondly, the Complex Care Team is able to support family carers at an early stage about what they could expect and what support is available to them.
- And finally, the earlier a correct diagnosis of dementia or delirium is provided, the quicker a patient can start treatment for their mental health condition, which will help keep their mind active for longer.
Planned care

Covering a broad spectrum of services in most healthcare settings, it will make changes to joint replacement, carpal tunnel syndrome, minor oral surgery and ophthalmology services.

Cancer patients will have improved care under this programme. Patients will be able to choose their preferred place to die as they reach the end of their lives.

Aims:

• enable 30% of minor oral surgery patients to have their treatment in a community setting near to their home during 2011

• screen for glaucoma in the community preventing unnecessary visits to the hospital by July 2011

• by May 2011 225 people will not need carpal tunnel surgery, following improved provision of non-surgical care

• 600 patients each year will be helped to manage their hip arthritis through physiotherapy, weight management and pain control as an alternative to immediate surgery starting January 2012

• 80% of people requiring a mastectomy for breast cancer will be admitted and managed on a 23-hour pathway by March 2012

• increase the proportion of deaths occurring in usual place of residence to 50% by March 2012.

Case study

Every year hundreds of patients in Suffolk visit their GP with a specific, painful and sometimes disabling wrist complaint – carpal tunnel syndrome. This complaint is caused by pressure on the nerve in the wrist that supplies feeling and movement to parts of the hand, and it can lead to numbness, tingling, weakness, or muscle damage in the hand and fingers. Until now, most patients have had to be referred for surgery.

Of course waiting times have reduced over the last few years, and surgery is very successful - however recovery and healing after surgery can take several months. NHS Suffolk has been working with GPs this year to find a quicker, less invasive and more cost-effective alternative for many of our patients. Hundreds have benefitted already. The solution is simply to make hand splints easily available to GPs, which they can immediately give to patients to help relieve their symptoms. Many patients are finding immediate relief from pain, and also that they don’t need further intervention or surgery.

Dr Jon Tuppen, a GP with the Derby Road Surgery in Ipswich, said: “Already I have saved a number of referrals to the hospital by using a splint which is a relatively cheap and effective alternative to surgery. More importantly for the patient I have the skills to inject the carpal tunnel and fit the splint, so they can have the treatment closer to their home in a speedy fashion.”
A voucher scheme has been developed which allows GPs to order special medicines, such as vitamin D for people who do not have sufficient sunlight, directly from Ipswich Hospital’s manufacturing unit. GPs are guaranteed consistency, quality and speed of these special medications, and patients receive their medication by courier. This has provided substantial savings.

“The new voucher scheme has enabled the practices to save money whilst improving patient service as their medicine is delivered straight to their home - therefore creating a win win situation,” said Lois Taylor, pharmacist.
Primary care

One of the main areas of focus is on dental and pledging to increase the number of Suffolk people who have access to an NHS dentist. People who need to see a GP or a dentist will see improved access under this programme.

Aims:
- enable 7,000 new patients to be able to see an NHS dentist through a reduction in the recall intervals between check ups by 2013.

Case study

Technology and treatments have moved on in dentistry, so it is not always necessary to be so prescriptive about subsequent check ups. Previously after a check up if all was well all patients were asked to return in six months as a matter of course. That is no longer the case.

Dentist Adam Hunter, of Parkview Dental Centre, said: “Things have changed in dentistry, and patients don’t always need to visit their dentist for a check up every six months. How often you visit your dentist for a check up will be based on individual need.”
Throughout this booklet we have given examples of how doctors, nurses and healthcare staff in the community as well as in the hospitals are helping to reduce costs while identifying innovative ways to improve services.

Ipswich and West Suffolk hospitals and Suffolk Community Healthcare also have their own programmes.

**Ipswich Hospital NHS Trust**
The hospital recognises the need to improve clinical standards and cut down on the doubling up which goes on within the hospital. The hospital continues work started more than two years ago with the PIE team (programme for innovation and excellence) working with clinical teams across the organisation to improve productivity and provide focus to the QIPP agenda within the hospital. The teams work closely with partners at NHS Suffolk and GPs where changes cross boundaries to make sure NHS savings can be achieved for all organisations.

Ongoing work on improving discharge planning and improving patient experience has improved pathways and discharge opportunities for patients currently in our care. We have seen an overall reduction in the number of patients staying in hospital when medically fit, due to improved care records for all inpatients, improved use of day care operating for minor procedures and improved discharge planning meetings lead by ward Matrons and therapy teams working in partnership with medical staff and patients. This has all resulted in patients going home sooner and a reduction in the number of beds we use on a daily basis.

**Case study**

ALL (Advice Letter Listing) project, a partnership between NHS Suffolk, the East Suffolk Federation GPs and hospital consultants, ensures that every GP referral letter is reviewed by a hospital consultant within three days and before an outpatient appointment is made. This means that the consultant has an opportunity to recommend a community management plan - where appropriate - with the patient being treated in the community rather than in hospital. ALL has been trialed by GP practices in east Suffolk and results showed the number of unnecessary gynaecology and urology outpatient appointments dropped by 23%.

Dr John Havard, GP and chairman of the GP consortia called the Commissioning Ideals Alliance, said: “Using the knowledge of hospital consultants and the skills of local GPs, patients are able to receive treatment that meets their needs, where they need it.”
West Suffolk Hospital NHS Trust
Better designed services can deliver both better quality and value for money and an improved patient experience.

Part of the hospital’s QIPP programme includes reviewing patients’ care pathways to improve the flow of patients through the hospital and reduce length of stay. Where appropriate hospital staff work closely with GPs and community colleagues to provide integrated services closer to home that help to reduce the number of hospital admissions.

More procedures are being carried out as day cases in the hospital, where patients come in, have their treatment and return home on the same day. Advances in medicine have also seen more patients being treated in an outpatient setting. The result is more time available in the main theatres and reduced waiting times. Patients want to spend as little time as possible in hospital.

An important part of the QIPP programme is the monitoring that takes place to ensure that any changes to the way services are provided maintain and where possible enhance the quality of the service.

More young patients at West Suffolk Hospital are being assessed, treated and discharged within just four hours of arriving, following the creation of a specialist unit designed to improve care for children.

The short-stay CAU Children’s Assessment Unit (CAU) opened last October to provide a 24/7 assessment, observation and treatment service for children who have acute illnesses but do not need to stay in hospital for more than 24 hours.

Since then, more than 70% of all young patients coming to the hospital have been able to access care on the unit rather than being admitted to the Rainbow Children’s Ward.

Figures also show that nearly twice as many children are being treated and discharged within just four hours compared with the same period last year.

Dr Melanie Clements, consultant paediatrician at West Suffolk Hospital, said: “The CAU is making a real difference to our young patients and their families by ensuring they receive rapid and effective care which meets their individual needs.

“It allows us to observe children so that we can distinguish serious disorders from minor illnesses and treat them appropriately. In many cases, patients are discharged within just four hours and are able to continue their recovery at home, which feedback shows us both the children and their parents appreciate.”
Suffolk Community Healthcare (SCH)
SCH has embraced the challenge of smarter working with its Cost Improvement Programme (CIP).

This is an initiative looking at every aspect of the way it works to see how improvements can be made to patient care while saving public money.

The priority is to maintain excellent care and support for patients and their families in the community, making sure this is not compromised. To achieve this, staff have been asked to identify cost savings that can be made without affecting patient care, taking big steps and little steps for the CIP. Big steps have included looking at how equipment is bought and stored, from bandages to wheelchairs. Small steps have involved individual staff thinking about car journeys, phone calls, photocopies and faxes.

An overarching goal is to use internal staff communications, such as emails, dedicated web pages and special editions of our newsletter, to keep all our colleagues informed about the programme and ask them for their suggestions and support.

Case study
The Community Equipment Service (CES) is the arm of Suffolk Community Healthcare that provides wheelchairs and other assistive technology to people in their own homes or other community settings. To support the CIP, the following improvements have been made:

• combining the Wheelchair and Equipment services under one service lead
• appointing an operations manager to support the service
• using the Central Buying Consortium to ensure that core equipment provided is the best value for money
• ensuring that specials and non-stock items returned to store are reused and can be viewed online
• reduction in the stock levels held within the stores at any one time
• sharing the budgetary information with staff and adhering to a strict monthly outlay to control expenditure.

The Strategic Health Authority’s equipment service review report said: “Suffolk (CES) provides one of the highest performing services in the region that delivers a high number of goods per head of population with a low logistic cost.”
The Suffolk System has identified a financial challenge of £109m over the next four years. This includes the impact of pay and price pressures as well as projected demand and quality pressures. We have worked as a system to identify productivity opportunities of up to £153m made up as follows:

**Productivity Opportunities**

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<tr>
<th>Category</th>
<th>Amount (£m)</th>
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<tr>
<td>Children, Young People and Maternity</td>
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<tr>
<td>Disease Management</td>
<td>3</td>
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<tr>
<td>Healthy Ambitions</td>
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<td>Mental Health</td>
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Figures have been rounded up to the nearest £million.
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Chinese [MANDARIN]
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Bengali
শপি পাঙ্কালে এই লবর্ডার্ক একটি পার্থক্য সম্পর্কে, বা সম্পূর্ণ
লবর্ডার কস্তা কর্ম প্রতিফলনটি - সমাপ্ত এর শর্তে পার্থক্য সম্পাদন করুন / প্রতিফলন করুন। অন্যতম করুন অধিকাংশ সম্পর্কে ০২৪/০২ ২০০৫ ভারতে সমাপ্ত করুন।