HEALTHY PEOPLE
living healthy lives
in healthy communities

NHS
Northern, Eastern and Western Devon
Clinical Commissioning Group

CF04 – The Top 6 Commissioner Priorities 2014 - 2016



NEW Devon CCG Commissioning Framework 2014 - 2016

CF04 : The Top 6 Commissioner Priorities

Background

Introduction

Background and context

Our combination of intentions seeks to balance equity of outcome, timely and reasonable access and value for money in the provision of services for our entire population. Reduction of health inequalities will focus on outcomes and on access. Investment may be made on a differential basis in order to achieve this.

The necessary transformation of the system will focus on the provider landscape and we can anticipate consolidation of expertise and provider development in line with the location of needs, consistent with the recommendations of the Keogh Review. A key next step with Local Authorities, specialist and primary care commissioners and health providers is to embark on the design which delivers and sustains explicit health and social care outcomes and begins from an ambitious scope for the Better Care Fund (previously the Integration Transformation Fund).

Explicitly, this will require reinvestment of current resources. An ethical framework will guide the inevitably difficult investment and disinvestment decisions across competing priorities. Such decisions must be taken. We would look for and expect provider support in reaching and implementing such decisions.

We intend to establish with providers a mutual responsibility for:

- managing the demand for services and;
- lowering the commissioned costs and provider unit costs of provision.

This to be supported through contracting mechanisms, strategic relationships and creative use of local flexibilities in tariff arrangements. Our emphasis is sustainability and quality. Lowering of unit costs and of demand in planned care in particular, to support shifts of resource to meet unplanned and emergency demand in the most appropriate settings of care, will be inevitable.

Patients and carers will experience seamless, coherent pathways for chronic and acute conditions with an emphasis on keeping well, early diagnosis, shared decision-making, supported self-management and independence.

The local commissioning landscape itself will undergo closer alignment to ensure coherent approaches across primary care, specialist commissioning, public health and social care leading to a single, straight-forward strategy.

Introduction

Finance, contracting and commissioning plans:

- On 4 December 2013, we launched CF01, our Commissioning Intentions document. This set out our high level intentions for 2014-2016
- Since then we have also issued, our Quality Schedule covering the same time frame
- CF04, our detailed plan, is released today, 20 December 2013 and is accompanied by CF05, our contracting principles and CF06 the second, more detailed version of our medium term financial plan. It is recommended that these three documents are read together

Next steps and actions:

- A further suite of detailed commissioning intentions will be published on 10 January 2014
- We will publish an ethical framework to underpin prioritisation decisions
- We will continue to develop a mutual understanding of benchmarked opportunities
- We will further develop and publish detailed cost, quality, rationale and implementation descriptions of our commissioning intentions

Our intentions focus on the top 6 issues

This plan sets out, in detail, our initial 6 priority areas for commissioning change during 2014/15. These are:

1. **Right care** – targeting resources to best effect
2. **Targeted follow-up care** – targeting resources to best effect
3. **Elective orthopaedic care** – focussing on conservative management and evidence based practice
4. **Non-elective care** – transforming our urgent care system with a real emphasis on services for frail older people
5. **Individual patient placements** – ensuring that individuals are cared for in the best setting to improve their outcomes and longer term goals
6. **Diagnostics** – standardising our approach to diagnosis and management planning

The Next Suite Of Plans

The next suite of detailed plans will be published on 10 January 2014 and will include the following commissioning/contracting intentions:

- Ambulance conveyances
- Children and young peoples' services
- Consultant to consultant referrals
- Continuing healthcare
- Dermatology
- Diabetes
- Elective care definition of admission
- End of life care
- Enhanced recovery (medicine)
- Enhanced recovery (surgery)
- Learning disabilities
- Mental health
- Non-elective care definition of admission
- Ophthalmology
- Paediatric definition of admission
- Pass through drugs
- Person care market development
- Personal health budgets
- Rapid access
- Respiratory
- Use of technology

Health and Well-Being Boards

Our Chair and a number of our Executive Directors are members of the Health and Well-Being Boards in Devon and Plymouth. We will continue to work alongside our partners to deliver the strategies of these Boards alongside the strategies of our own organisation.

Plymouth's Health and Well-Being Priorities

Five key priorities for action to explicitly address **health and well-being related** areas:

- **Inequalities** in all plans through target setting, re-focusing investment and rigorous use of equality impact assessment
- To shift the focus of investment to address **prevention and health promotion,** particularly in specified areas
- **Mental health promotion**
- To directly address identified issues of **access and take-up** of specified services
- To further develop services to **promote independence**

Devon's Health and Well-being Priorities

The priorities are based around four strategic themes:

- **Early family intervention and support** - encompassing issues such as the prevention of sexual and domestic violence, employment and the family as a safe environment
- **Lifestyle interventions and the prevention of ill health** - incorporating healthy, eating and exercise - and increased personal responsibility for health and wellbeing
- **Older people** - including promoting independence
- **Social capital** and the building of communities

Ensuring Strategic Alignment

Commissioning Intentions (Top 6 issues)	NEW Devon CCG strategic ambitions				
	Preventing people from dying prematurely	Enhancing quality of life for people with long-term conditions	Helping people to recover from episodes of ill health or following injury	Ensuring people have a positive experience of care	Treating and caring for people in a safe environment and protect them from avoidable harm
Right care		X		X	X
Targeted follow-up care		X		X	X
Elective orthopaedic care		X	X	X	X
Non-elective care	X	X	X	X	X
Individual patient placements		X	X	X	X
Diagnostics		X	X	X	

How Each Intention Impacts On Our Health And Well-Being Priorities

Northern, Eastern and Western Devon Clinical Commissioning Group

Commissioning Intentions (Top 6 issues)	Plymouth Health and Well-Being Priorities					Devon Health and Well-Being Priorities			
	To explicitly address health and well-being related inequalities	To shift the focus of investment to address prevention and health promotion	Mental health promotion	To directly address identified issues of access and take-up of specified services	To further develop services to promote independence	Early family intervention and support	Lifestyle intervention and the prevention of ill health	Older people	Social capital and the building of communities
Right care		X		X			X		
Targeted follow-up care		X		X	X		X	X	
Elective orthopaedic care		X		X	X		X	X	
Non-elective care	X	X		X	X		X	X	
Individual patient placements	X	X	X	X	X	X	X	X	X
Diagnostics		X		X					

Commissioning Intentions
Our Top 6 Issues

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Commissioning Intentions
Our Top 6 Issues

1. Right Care

1. Right Care

Our intentions

- To maximise the value that a patient derives from their own care and treatment
- To maximise the value the whole population derives from the investments in their healthcare

There are three work-streams to achieve these intentions:

- Reinforcing Commissioning Policy with regard to procedures of Limited Clinical Effectiveness. Implemented via contract
- Support to shared decision making. Implemented as a system change via CQUIN and/or headroom
- Targeted investment and disinvestments, implemented via contract

Potential system levers

Commissioning general practice or other providers (as appropriate)to support any (unlikely) return of work to primary care

Engagement and involvement

We will reinforce current LVP and LPP policies and their application and seek a confirmation of distribution to clinical and management leads. With regard to binding commissioner decisions which extend those commissioning policies, we will agree with providers, their responsibilities for implementing updates in clinical practice and in contracts.

Shared decision-making requires a particular focus via targeted specialty Clinical Pathway Groups/Clinician to Clinician groups.

Targeted investment/disinvestment will be under-pinned by an Ethical Framework

Volumes and values

Re-embedding the existing 7 limited value procedures: £861,000 (Plymouth Hospitals NHS Trust)
£354,000 (Northern Devon Healthcare NHS Trust)
£594,000 (Royal Devon and Exeter NHS Foundation Trust)

Expanding the existing 7 to 13 (slide 20) as outlined by public health: above (recurrent impact)

1. Right Care

Background and context

The challenge for the NHS is to get more for less in an era of "no more money". To do this, the NHS needs to shift its focus from lower value interventions to higher value interventions.

Figure 1. Evolution of emphasis in healthcare investments

Value being defined as patient health outcomes relative to total costs:

"Value must be measured by outputs, not inputs. Hence it is patient health results that matter, not the volume of services delivered. But results are achieved at some cost. Therefore, the proper objective is…patient health outcomes relative to the total cost. Efficiency, then, is subsumed in the concept of value." Source: Porter ME, (2008). What is Value in Health Care? Harvard Business School.

1. Right Care

A summary of our right care intentions is simply to target investment and disinvestment. The rationale for the focused work-streams is as follows:

Procedures of Limited Clinical Effectiveness:

In common with all Clinical Commissioning Groups, NEW Devon CCG has long-standing policies which identify procedures of Limited Clinical Effectiveness. That is not to say that these procedures are of no benefit to anyone but that on balance their benefit is insufficient to be commissioned by default. Funding arrangements for exceptionality exist.

These policies received some renewed emphasis with providers in 2011/12 but they have not been strictly enforced. Save for isolated instances regarding particular procedures, the step change in volumes of procedures undertaken has not taken place to date.

	Volumes				Values			
	2010/11	2011/12	2012/13	2013/14 YTD	2010/11	2011/12	2012/13	2013/14 YTD
Limited Value Procedures	9510	9857	9510	4996	£ 9,895,888	£ 8,442,028	£ 8,337,774	£ 4,304,752
Low Priority Procedures	52669	50737	50919	25916	£ 26,806,942	£ 23,220,428	£ 22,905,761	£ 11,714,658
Totals	62179	60594	60429	30912	£ 36,702,830	£ 31,662,456	£ 31,243,534	£ 16,019,410

Table 1. Volumes and values of LVPs and LPPs. 2010/11 - Year To Date

These figures are illustrated at a provider and procedure level at Annex 1.

We will commission with greater emphasis on the Prior Approvals process and decision-making with regard to exceptional funding.

1. Right Care

Support to Shared Decision Making:

International research suggests a 20% reduction in 'discretionary surgery' when Patient Decision Aids are used (Cochrane Collaborative Review).

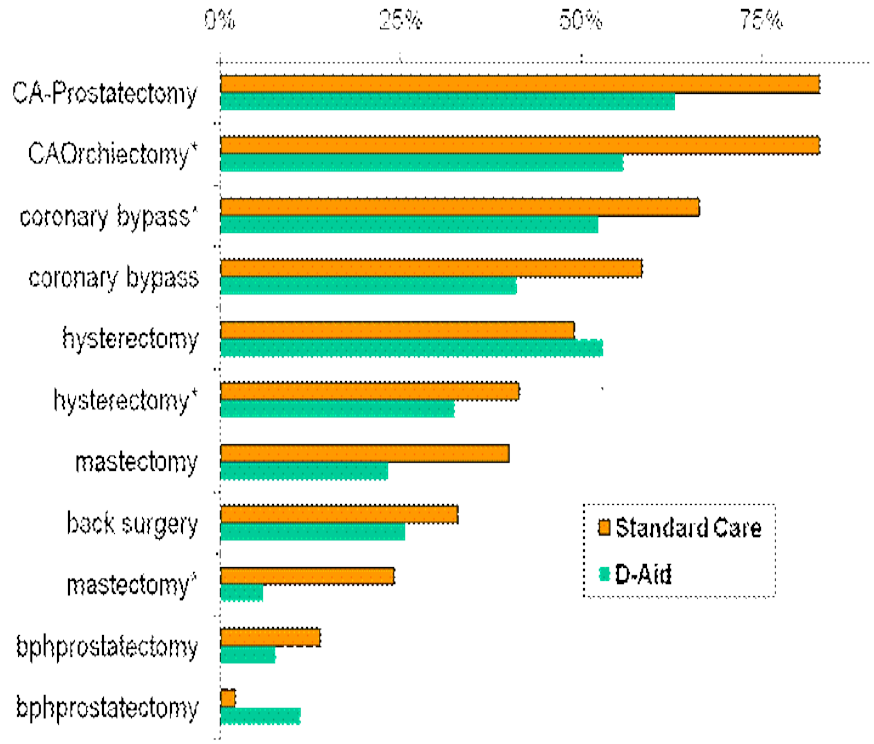

Figure 2. Decision aids reduce rates of discretionary surgery. (COCHRANE Database Syst Rev, 2011; (10): CD001431).

1. Right Care

The COCHRANE Systematic review supporting this work was completed in 2003 and has been refreshed in 2009 and 2011 as the body of knowledge regarding the effects of decision aids has grown and continues to conclude that such tools "reduce the choice of discretionary surgery and have no apparent adverse effects on health outcomes or satisfaction. The latest evidence suggests that not just tools but coaching in the process of deliberation has the greatest impact.

We will commission the use and promotion of evidence based tools and approaches to shared decision making.

At a specialty level, per capita costs have significant potential for reduction

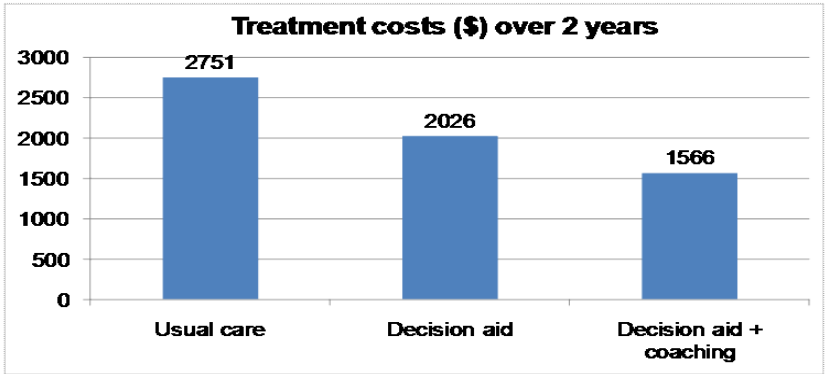

Figure 3. Decision aids and coaching in gynaecology

1. Right Care

Although decision support of this kind is advocated in the Enhanced Recovery approach to surgery which has gained ground in recent years, decision aids are under-exploited. Additionally, some research describes a mismatch between clinician and patient expectations in this regard which would not naturally lead to the consistent implementation of decision support. Barriers and facilitators for shared decision-making are well described in the literature

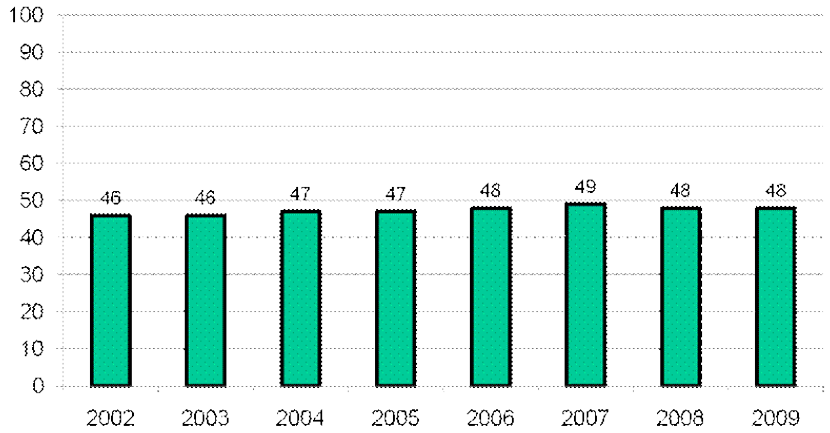

Figure 4. Wanted more involvement in treatment decisions. (NHS Inpatient surveys)

1. Right Care

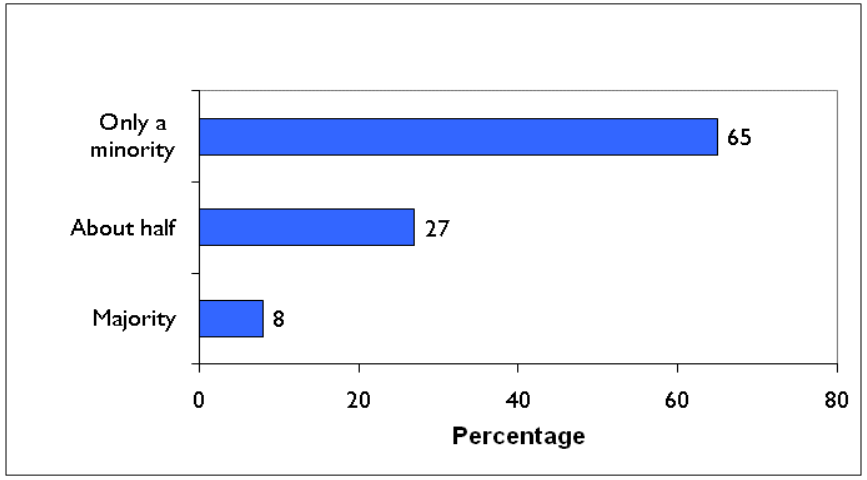

Figure 5. What proportion of your patients do you believe actually want more information than they currently receive on their treatment and its management? (SOURCE: Doctors.net.uk)

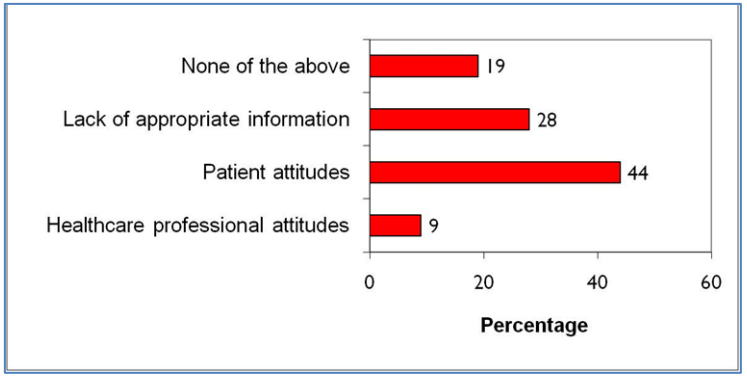

Figure 6. Which of the following do you think is the biggest barrier to increased patient engagement? (SOURCE: Doctors.net.uk)

1. Right Care

Additionally, compared with patients who have decision support, patients who do not are:

- 59 times more likely to change their mind
- 23 times more likely to delay their decision
- 5 times more likely to regret their decision
- 19% more likely to blame their practitioner for bad outcomes

(*Ottawa Hospital Research Institute*)

It is now possible to significantly implement the intention for more shared and informed decision making. Thirty-Six decision aids now exist as part of the NHS Right Care Programme with a publication timetable of further decision support in 2014.

Targeted investment

Through our emphasis on the value our investments, for patients and for our population, we will focus on the evidence and rationale for current treatments. The outcome of this work will be an incrementally extended list of Procedures of Limited Clinical Effectiveness.

The work-stream spans particular interventions themselves, the specific indications for interventions and waits and access times for interventions. There will also be a focus on variation as a key line of enquiry to where thresholds or criteria may need to be established. For example, the South West has amongst the highest rates of knee replacement surgery (see Figure 7, which might be ameliorated by clearer emphasis on and support for weight loss (as is the case for some other procedures and treatments).

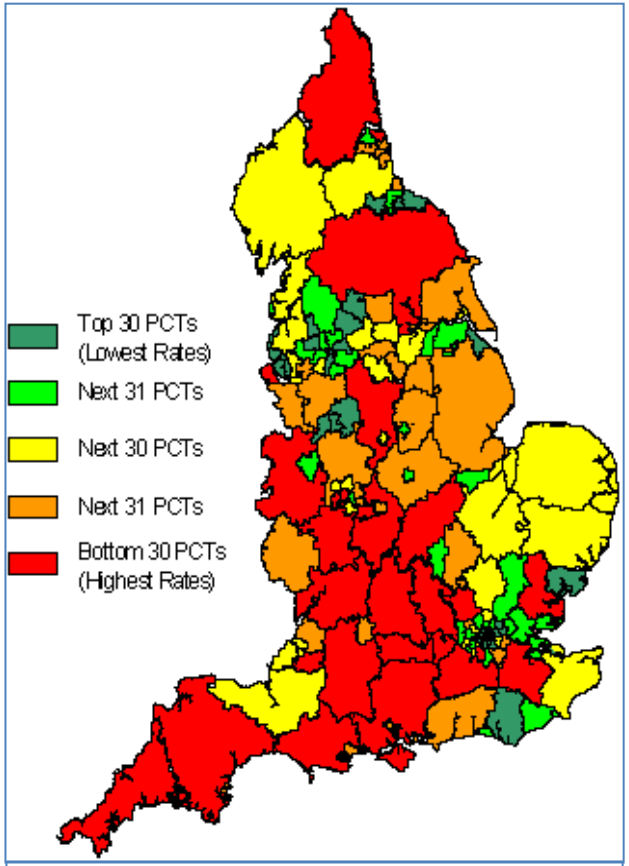

Figure 7. Rates of knee replacement surgery. (SOURCE: DH and NHS England).

1. Right Care

Targeted investments and particularly disinvestments will require a very robust and transparent process for decision-making and assessment of risk. An Ethical Framework will underpin this work and the work will be undertaken as a rolling programme of evaluation and decision making.

To be clear, the emphasis is not purely about the efficacy of any given investment; it is about the choice to invest in any given area limiting the ability to invest in another area of higher clinical priority.

The key lines of enquiry within this work-stream are as follows:

- Interventions and services suggested by clinicians
- Interventions and services suggested by audit and patient feedback
- Previous recommendations from effective practice and clinical policy committee
- Review of recommendations and decisions from other CCGs and NHS commissioning bodies
- Guidance from NICE
- Systematic reviews and meta-analyses – Cochrane and other

As an illustration, the following have been raised as potential candidates for additional criteria being used to target access:

- Carpal tunnel
- Ultrasound guided (vs. Landmark guided) injections.
- Knee arthroscopy in undifferentiated osteoarthritis in people aged over 65 years
- Shockwave therapy for tendonopathies
- Knee replacement (requiring a greater emphasis on weight loss)
- Hip replacement (requiring a greater emphasis on weight loss

1. Right Care

Next steps and actions

- Reinforcing Commissioning Policy regarding Procedures of Limited Clinical Effectiveness:
  - Prior approval scheme
  - Process by which new commissioner decisions become binding on a provider

- Shared Decision Making:
  - More detailed review of opportunities. Application of evidence base to local variation and to high cost and volume
  - Implementation plan

- Targeted investment:
  - Publication of Ethical Framework
  - Publication of candidates for disinvestment
  - Publication of NICE Guidance implementation rules relevant to the CCG's processes
  - Ratification of decision making process by CCG Governing Body

Commissioning Intentions
Our Top 6 Issues

2. Targeted Follow-up Care

2. Targeted Follow-up Care

Our intentions

- To support providers in the development and implementation of innovative, co-ordinated and technology-driven approaches to the management of patients who need a clinical follow-up or continued management of long-term conditions.
- To reduce and remove unnecessary follow-up appointments for patients and their carers; improving patient experience and reducing demand on resources.
- To ensure patients receive the best possible co-ordinated approach to follow-up care, in the right setting, by the right person, in the right timescale and without duplication.

Volumes and values

Planned savings over the next 3 years (2014/15 onwards) are £7.8m based on the upper quartile opportunity and a limited range of specialties.

We are working on the assumption that we will save (full year effect):

- £3.0m in 2014/15
- £3.0m in 2015/16
- £1.8m in 2016/17

Potential system levers

Local tariffs – to enable headroom for re-investment towards innovative approaches to follow-up care as an alternative to traditional face-to-face outpatient appointments.

CQUIN – to enable clinical teams to invest time in the redesign of specific local care pathways and shared best practice.

Headroom - an example of which could be investment in the establishment of nurse specialists, as described in the example set out in “background and context”.

2. Targeted Follow-up Care

Background and context

Each year in the NHS in Devon and Plymouth, there are over 860,000 (acute provider) follow-up appointments to check progress on a patient's condition, to undergo tests or receive results of tests. Whereas many of these appointments are entirely appropriate, a significant proportion of these visits are clinically unnecessary, create inconvenience and anxiety for the patient and waste valuable resources.

In the NHS, 70% of all outpatient appointments where the patient failed to attend (DNAs) are for follow-up appointments. For the three main acute providers in the NEW Devon CCG catchment, this represents 70,000 DNAs per year for follow-up appointments. This is a huge waste of NHS resource and a reflection for many patients that they do not feel their follow-up appointment is necessary. We will use our Devon Referral Support Service to enable the necessary transformation in this area.

There are significant benefits that can be obtained by avoiding unnecessary follow-up visits and providing necessary follow-up care in the right setting. Key outcomes include:

- reduced number of follow-ups in the patient journey
- reduced DNA rates
- increased level of nurse-led follow-ups where appropriate
- redirection of consultants' time to more appropriate clinical priorities
- reduced follow-up appointments creating capacity to see new patients sooner
- follow-up in the community near to home
- choice for the patient
- patient is seen by the right person, with the right skills, in the right place and at the right time – specified by protocol
- enhanced continuity of care in nurse-led clinics for frequent visitors (particularly important for people with cancer)
- enhanced nurses/therapists role (in outpatient setting and primary care)
- reduced duplication and non-value added time
- enhances timely decision making (single visit results available)

2. Targeted Follow-up Care

Background and context

There are well established infrastructures for reduced patient follow-up and better patient experience which are under-exploited in Devon. For example - follow-up of patients with diagnosed prostate cancer, whereby men's PSA levels are monitored by a clinical nurse specialist 'remotely' via a blood test undertaken in the patient's GP practice. Patients are only called in for a follow-up appointment if the results of the blood test suggest change in their management plan or a more detailed consultation. If the PSA remains within an expected range, the patient receives a letter of confirmation, and is saved a visit to hospital. We will commission more of this innovative approach to follow-up care.

The scope of targeted follow-up care will extend beyond acute secondary care, to areas of mental health and children's services. The use of outpatient care models in mental health services should be considered as an outdated approach to mental health treatment and care giving. There is a particular problem about high DNA rates across the country in mental health outpatient clinics with a range of initiatives to address this not really delivering sustained improvement.

There is a priority to ensure that the functions of Community Mental Health Teams are delivered close to, or within, primary care settings, with an emphasis on close working between psychiatrists and GPs. Patients with a mental health condition should be seen by mental health specialist services for the minimum period time so that capacity is maintained, institutionalisation and dependence is reduced and links to community, home and employment are maintained. We will support the redirection of resources from outpatient work in mental health and replace with incentivised and contracted (in both primary and secondary care) activity for mental health in primary care and/or community settings. Our aim is to commission "primary care psychiatric liaison" as a model of care.

For children's services there are not many services where follow-ups are monitored specifically, such as speech and language and occupational therapies. Our focus in this area will not be to reduce the number of follow-ups per se but a focus on a course of treatment or intervention, working with others providers to deliver programmes of planned intervention.

2. Targeted Follow-up Care

Engagement and involvement

The issue of reducing follow-up appointments across all the key providers contracted by the CCG has been a long-standing and sometimes contentious issue throughout numerous clinical pathway meetings. So far, limited success has been achieved in this area despite widespread evidence and clinical support that alternative approaches to follow-up care can be achieved without the need for the patient to have a face-to-face appointment.

Working with our clinicians in both primary and secondary care, we will develop the most appropriate and safe mechanisms for returning patients to the care of their registered GP.

Next steps and actions

Commissioning teams will work collaboratively with both their respective local providers and colleagues across NEW Devon CCG to develop a truly integrated and innovative strategy for the sharing of good practice and innovation in follow-up care. Plans will be tailored to ensure local variations in the provision and availability of follow-up care are considered. However, NEW Devon CCG will commission and contract for follow-up care, where appropriate, without the need for a face-to-face appointment, and in alternative settings to outpatient clinics.

We will also lead on the redesign of specific and agreed high-impact care pathways of follow-up care, drawing on best practice and established models of care from across the healthcare community.

We will free providers to adopt safe but radical changes to the way follow-up care is managed, putting patients' needs first and ensuring resources are directed towards a sustainable model of provision.

Commissioning Intentions
Our Top 6 Issues

3. Elective Orthopaedic Care

3. Elective Orthopaedic Care

Our intentions

We will implement an evidence based, integrated model of elective care, intervening at the optimum point for maximum benefit. This will improve value for patients, reduce costs and ensure future sustainability in the face of increasing demand.

There will be an increasing focus on prevention and effective conservative management will be the cornerstone of care. Individuals will be empowered to make decisions and initiate care. GPs will be better informed to support patient choices.

Clinicians and patients will view surgery as the 'least preferred' option not the 'end goal' but with an efficient route for referral to surgery where it is the most appropriate solution.

We will encourage direct access to services wherever appropriate and encourage the use of alternatives to the traditional face to face contacts and commission face to face contacts with patients only where there is demonstrable clinical value to patients.

Examples of similar in other areas of the UK i.e. West Pennine Partnership : http: //www.pmskp.org and Bedford CCG: https://www.bedfordshireccg.nhs.uk/news

Volumes and values

Over the next 3 years we will make a total reduction in acute spend of £4.2m in elective orthopaedic non-trauma activity, hip and knee procedures (equivalent to an 11.5% reduction in the number of acute spells).

This is broken down as follows over the next 3 years as £1.7m (2014/15), £1.6m (2015/16) and £0.9m (2016/17) .

Currently the indicative impact in 2014/15 by provider is forecast to be:-

- Plymouth Hospitals NHS Trust - £435k
- Royal Devon & Exeter NHS F Trust - £532k
- Northern Devon Healthcare NHS Trust - £84k
- Other providers (including Nuffield and Care UK) - £678k

System levers

A range of measures including CQUIN, headroom and supporting the shift of work from secondary care to primary care are likely to be put in place

3. Elective Orthopaedic Care

Background and context

The CCG spends £2.7m above average for the Southwest CCGs on elective orthopaedic non-trauma activity and £5.4m above top quartile. The biggest productivity opportunity is in the Western and Eastern localities with a smaller productivity opportunity in the Northern locality.

Orthopaedic spend has been increasing year on year and 80% of spend is on secondary care with 50% of spend on inpatient care with evidence of lower levels of investment into conservative management or avoidance. Our peer group areas indicate better outcomes for patients by shifting investment towards prevention and maintenance.

We appear to be different from comparator group i.e. we have standardised admission rates (SAR) that are 12% higher than the national average and 8% above that of the Southwest CCGs; a local settings of care audit in Plymouth showed that 4,521 bed-days could be saved, with 1,912 of those associated with elective orthopaedics if patients were discharged when they were deemed 'non-qualified' i.e. their level of need was below the level of acuity for the bed they were staying in. Prescribing of opioid and non-opioid analgesics and NSAIDs are significantly higher than the national average with associated gastro-intestinal, cardio vascular and renal risk.

There is room for improvement in the overall health gain for individuals as a result of hip and knee replacements, e.g. in 2012/13 NEW Devon CCG had average health gains as measured by PROMs for both hip and knee replacements. However, the pre-operative health state of patients indicated that we undertook primary hip and knee replacements on patients that were significantly healthier than most CCGs nationally (putting us in the bottom quartile). This suggests we may be operating earlier in a patients journey compared to the average nationally. This could be linked to the relatively high activity levels, SARs and acute inpatient spend we report.

3. Elective Orthopaedic Care

Background and context

The current service provision in Devon suggests that there are inconsistent pathways and service offers across the community and variation between acute providers. Orthopaedic referrals have increased year on year across all sub-specialties and a significant number of patients suitable for primary care are seen in secondary care due to lack of commissioned alternative (conservative) capacity.

There has been an increase in replacement surgical activity due to an increase in activity since 2005 which appears to have coincided with the increased investment in orthopaedics in order to deliver an 18-week referral to treatment pledge. Historical increases in surgical capacity have resulted in potential overcapacity (very short waiting times can drive intervention e.g. arthroscopy).

It is reported by individuals referred for treatment that they do not feel well informed before their referral and this is supported by the fact that approximately 30% of people do not go on to surgery at out-patient review.

The national direction of travel, recognition of the growth in orthopaedic demand and the variable quality and outcomes for patients is set out, and supported by Lord Darzi, in 'Getting It Right First Time - Improving the Quality of Orthopaedic Care within the National Health Service in England' (Briggs, 2012).

"The concept of "getting it right first time" is to identify and administer the correct treatment at the appropriate time, to a high standard with minimal complications. Not only will this reduce mortality and morbidity rates, but also reduce the need for often expensive revision surgery."

3. Elective Orthopaedic Care

Engagement and involvement

Each of the Localities has some form of clinical engagement group for orthopaedic care. Whilst limited work has been undertaken in terms of engaging with people with orthopaedic conditions or disease specifically, there has been good engagement with people in Devon regarding their ambition for their future health, care and well-being through the Transforming Community Services work programme. This programme has told us that whilst some want to be completely in control of their health and well-being, others (the minority) want health staff to be completely in control and the vast majority of respondents are ambivalent. Partnering CCGs are also involved in the relevant Clinical Pathway Group and the Orthopaedic Project Group and Local Authority partners in Plymouth, including those commissioning children's services and public health, have been involved in the development of a proposed new model of care.

Patient reported outcome measures (PROMs) are used to identify improvement areas.

Data from referral management system on patient choices being made at the point of referral and reasons. There will be patient involvement in selection of provider if re-procurement is required to achieve outcomes.

Next steps and actions

The following next steps will be undertaken as soon as possible:

- Agreement on the generic orthopaedic care pathway
- Development of a detailed service specification
- Understanding of the current community service provision across the CCG compared to the new model of care and clarity on any additional investments that may be required to achieve the improvements in the care pathway. This may include additional investment in:-
  - Health promotion and primary prevention
  - Community services focusing on self management including physiotherapy
  - Community diagnostic service

Commissioning Intentions
Our Top 6 Issues

4. Non Elective Care

4. Non Elective Care

Our intention

We will commission optimal pathways of care for people presenting to secondary care in an unplanned way, specifically:

- We will work with providers of secondary care to establish child friendly pathways for children who, following assessment, need urgent access to specialist opinion and;
- In recognition of the increasing needs of older people with complex needs we will work with providers to commissioning pathways of care, that include both multidisciplinary and comprehensive geriatric assessment, in all acute hospitals that make rapid admit and discharge decisions and establish pathways of ambulatory care for all secondary care specialities.

We will re-commission pathways of urgent care in each locality, re-specifying our requirements for both out of hours primary care services and minor injury units, treatment centres and walk-in centres, to ensure that people across Devon can access the urgent care services when they need them.

The introduction of new “front door” services with capability to make rapid assessment/discharge decisions and access to ambulatory care across all pathways and specialities will mean that a significant proportion of this £9m activity could be provided in an ambulant setting on the same day and be more appropriately remunerated using out-patient tariffs.

We will continue to transform community services across Devon and commission differently for adults with complex needs. In response to the significant demographic challenge in Devon we plan to move from a bed based model of reactive care to a model of care that is closer to home and places prevention and well-being at its heart. We will start this journey in some localities in 2014/15 by changing the use of some our community hospitals. It is our intention to use funding released from bed based care to increase the capacity of our community teams, the total volume of care that is available for people living in Devon and ensure that all people living with a dementia and/or cognitive impairment are identified.

4. Non Elective Care

Volumes and Values

A review of contract activity information across all acute providers identifies a volume of emergency activity, at HRG level, where an 'admission' has happened without any procedure taking place. The cost of this activity at full tariff is £9m in 2014/15.

Potential system levers

It is our intention to use contracting levers and quality payments to support the remuneration of true and extensive ambulatory care and a significant reduction in unqualified admissions across all providers.

Engagement and involvement

Public health summits have been held in market towns across Devon and Plymouth to introduce the CCG's transforming community services process to allow the attending public to give their views on how they would like the services in the community to be provided in the future.

Other forms of engagement have included meetings with local healthcare professionals, stakeholders including the voluntary and community sector, councillors and members of the community. Our processes of involvement and engagement of local people and their communities are on-going in each locality.

Each locality has systems to ensure engagement for managers and clinicians from all providers. A series of pan-Devon conferences with leaders drawn from across the health and social care system have occurred in the year to develop the process and emerging consensus for unplanned care and community services.

Conversations with the public through our TCS processes have demonstrated that many people want more control over the lives and their health, want to be cared for in their own homes and to have a more preventative, holistic approach to their health, well-being and care.

4. Non Elective Care

Background and context

The population of the area served by our CCG is approximately 898,800 and expected to rise by 11.9% by 2026. The population of the CCG aged 65 or over is 22%, which is 3.54% above the national average for people aged 65 and over. Eastern Devon's population of people over 65 today won't experience the same proportion of people over 65 years currently in Eastern Devon until 2027. It is estimated that the proportion of persons 85 years and over in the sub-locality Wakley today, (5.28%) compares to England in the year 2042.

In 2012, people 65 years and over residing in the CCG area accounted for 49.2% of all emergency admissions. The highest rate is observed in those 85 years and over.

If current rates of secondary care in the CCG remain constant, the number of emergency admissions as a result of increases in the ageing population is set to increase by 9.5% in less than ten years. Elective admissions will increase by 8.6%. An annual reduction of 2.02% in age-specific emergency admission rates would be required to maintain admission levels in over 65s at the 2012 baseline.

In 2012 there were 15,393 people over the age of 65 living with dementia, predicted to rise to 7,728 by 2020 (an increase of 21%). In Devon overall, it is predicted that 221 people aged between 30 and 64 have early onset dementia, most prevalent in the 50-59 age band. Devon's average prevalence of dementia is 6.56% in the over 65 age group, but Sidmouth, Seaton, Exmouth and Exeter all have higher rates.

1 in 10 people provide unpaid care for family or friends. This means that more than 72,400 people (of all ages) in Devon are carers, which will rise proportionately as the population increases. 14,400 (20%) provide more than 50 hours of care and support per week. Of the 8,700 carers in Devon who are aged 65+, 2,884 consider themselves to be in poor health, presenting risks for both the carer and the cared for. In the CCG, the number of people aged 65 and over who had had a fall in the last 12 months was 22,940, this is predicted to increase to 27,047 in 2020 (an increase of 18%).

4. Non Elective Care

Northern Locality will:

- Work with South Western Ambulance Service (SWASFT) to further develop work-streams to reduce conveyance to hospital rates, and avoidable admissions based on the principle of 999 ambulances being "*mobile urgent treatment services*". We will reduce both attendances and emergency admissions to an acute hospital where the patient's condition can be safely and quickly managed elsewhere
- Improve the discharge process for individuals
- Continue and expand the benefits associated with Transforming Community Services (TCS) as currently trialled in Torrington. This will be based on both needs assessment and an Asset-Based Approach to develop locality based systems founded on the principles of:
    - Improved usage of community hospitals and re-targeting health investment released by re-evaluating community in-patient beds
    - Increased investment in the skills of primary care and community nurses, including clearer specification of the district nursing role
    - Locality-based trials and public consultation to ensure that each community, share in the vision for change including communities who, through historical accident, have no community hospital to ensure that quality of, and access to, care is equal for all of our residents

- Use the opportunities presented by the redesign of out-of-hours GP services to better align services across the Northern Locality with the aim to reduce Emergency department (ED) attendances and avoidable admissions
- Work with all services, to develop more robust healthcare responses for frail older people, particularly those in care homes
- Develop a clear vision for what is required for a Single Point of Access, integrating it with all of the developments above.
- We will work with partners in the Eastern Locality and the Northern Devon Healthcare Trust to develop a locality-based model of delivery for minor injury and minor illness, delivery taking into account the geographical and population-level issues in the Locality

4. Non Elective Care

Eastern Locality will:

- Continue to commission front door services for both paediatrics and adults with complex needs. The locality will work with the RD&E to extend further, to include all specialities, ambulatory pathways of care for people who do not need to be admitted to an acute hospital. This intention will seek to reduce the total number of admissions made to the RD&E and lower the total unit cost of the urgent care pathway for adults and children presenting to the RD&E in an unplanned way.

- Following the completion of current consultation and options appraisal, introduce a new model of service and configuration of minor injury/urgent care service. The consultation is expected to conclude in January and confirm the total number of minor injury units, walk-in and urgent care centres that are required across the locality. The consultation will also confirm the extent to which enhanced provision needs to be available in the community through Any Qualified Provider or from primary care. This aims to reduce the cost of providing urgent care across the locality and release funding for investment in community pathways to increase the total capacity of community nursing and therapy services and the increased provision of care at home.

- Re-specify the pathway of care for people who have suffered a stroke. The on-going consultation will conclude in March and confirm if a fully integrated pathway of care that includes the acute stroke unit, community inpatient rehabilitation beds and supported discharge service will be created across the locality. The locality will understand in early February if there is a need to re-procure this entire pathway. This intention will ensure equity of outcomes for people who have suffered stroke across the locality.

- Consult on a new model of care with the communities in Eastern Devon. The locality will evolve hubs in Budleigh Salterton and Moretonhampstead and explore further changes of use in Exeter, Crediton and Ottery St Mary. Monies released from the change in use of these hospitals will be used to increase the capacity and secure robust clinical leadership of cluster teams and services.

- Improve the discharge process for individuals.

4. Non Elective Care

Western Locality will:

- Continue to commission NHS 111
- Participate in the re-commissioning process for GP out-of-hours provision
- Review our Minor Injury Units and minor injuries provision, determining the optimal option for the future
- Review the Acute GP Service, determining the optimal service for the future
- Extend the paediatric out-reach service (PACOT)
- Work with NHS England's Area Team to develop the role of GPs and pharmacists in managing urgent care
- Commission and support the implementation of a revised frailty pathway
- Work with GPs and the Area Team to explore the concept, and impact, of having the GP at the cornerstone of all patient care with services wrapped around GP and the patient
- Re-design services to ensure that individuals receive as much care a possible in their own beds
- Commission 24/7 services where evidence supports need
- Reduce delayed transfers of care by rolling out a "pull" philosophy – community providers will pull people out of hospital at the best moment in their recovery
- Commission the development of a fully integrated workforce, staffing single points of access and egress
- Commission the development and roll out of enhanced recovery (medicine) based on national best practice
- With our Partnerships Directorate and Local Authority partners, develop pooled, personal health and care budgets for a range of preventative measures and optimise long term conditions management
- Roll out the "virtual ward" to the rest of the Western Locality (currently being piloted in a sub-locality)
- Ensure that assistive technology becomes a core part of the service offer for individuals in the Locality
- Treat service users as part of the integrated team
- Truly put the individual at the centre by rolling out personal health and care budgets during 2014/15 to a small group of individuals
- Commission integrated pathways for individuals with long term conditions, ensuring that the majority of care can be offered by primary care, in the community, with a very small proportion (maybe less than 10% of individuals) needing to access specialist, secondary care provision

Commissioning Intentions
Our Top 6 Issues

5. Individual Patient Placements

5. Individual Patient Placements Complex Care

Our intention

- Our ambition is to reduce the use of out of area placements for adults and children, and commission care for more people with complex problems closer to home. This ambition is set within a context of increasing numbers of people being placed out of area, and recognition of the system-wide commissioning arrangements which could create perverse incentives in the system. Our focus is upon the individual patient, to ensure best care arrangements which encourage and promote recovery.

- We will achieve change by commissioning services that are integrated, personalised, flexible and responsive to changes in individuals' circumstances, delivered within the least restrictive environment to meet needs, and as close to home as possible. We will challenge the current system model. For children we will commission an Assertive Outreach service with NHS England.

Volumes and values

Successful repatriation of service users from secure beds may lessen the number of secure hospital and CAMHS Tier 4 bed days required annually. However, this saving will currently be realised by NHS England rather than the local CCGs without the release of resources to the CCG. New ways of working with individuals who may previously have been cared for out of area, can also generate pressure on existing community service providers and will incur a cost to the CCG without a shift in investment. This will require further discussion with NHS England to enable us to work collaboratively to commission care provided in the most appropriate setting.

In 2014/15 we aim to reduce current spend on all IPP's by 10% and review the potential to reduce the budget by a further 10% in the subsequent 2 years. Resources will be redirected to develop local services providing appropriate care and support through a range of strategies including preventative strategies, improving system flow, more effective utilisation of locally provided services and new ways of working. This will release and redirect approximately £1.5m.

5. Individual Patient Placements Complex Care

Background and context

As part of their experience of learning disability, mental health and social care support and treatment services, considerable numbers of people, both adults and children, are placed in facilities in the public, independent and third sectors for support. In many but not all cases, services are local to families, friends and services. For some, services may be at a considerable distance from their usual support networks. All out of area service use can impact on people's contact with family and friends and limit opportunities for social inclusion, employment, education and independence. From a commissioning and financial perspective, use of out of area services also means that funding and specialist skills are being lost to the local system that could be used to improve local capacity, capability and skills.

The Winterbourne View action plan contained clear expectations regarding the reduction in out of area placement for people with a learning disability. This plan focused on overcoming the negative consequences of out of area placement and the learning from individuals' experiences of Winterbourne View can be applied to all patient groups.

Once an individual is placed out of area there are a number of challenges for both the individual, their families and service providers. It is preferable to keep people locally focused, where their needs can be met, and this is our ambition. It is considered preferable to prevent further out of area placements or to reduce them significantly and concentrate on repatriation once the primary recovery objective has been achieved. This will have the impact of limiting the expansion of IPP spend and reductions will follow once the number of placements/days are reduced.

This plan has been developed in conjunction with Southern Devon and Torbay CCG, local providers and with NHS England. Effective planning and rehabilitation can lead to many people returning to their area of origin and to lower levels of support – 63% in one study (Killaspy et al 2009). This plan will be focused on ensuring that support and treatment prevents crises and community breakdown, therefore mitigating the need for IPPs.

5. Individual Patient Placements Complex Care

Engagement and involvement

- All service users with complex needs in the community will be involved in the design of their own individualised support plans.
- All stakeholders will be involved in the development of an integrated strategic commissioning plan for Individual Patient Placements.

Next steps and action

We will work with providers to continue to improve clinically led referral and individual care review processes. We will focus on treatment outcomes, discharge planning and contingency planning, both where service users are currently out of area and within local mental health services. For example, we will continue to use the 'blue light' protocol where escalation occurs for anybody with a learning disability being considered for placement out of area. This protocol results in a multi-disciplinary discussion about alternative services and prior agreement of any short term additional service requirements to ensure a safe, local alternative.

We will focus on the prevention of out of area placements through the provision of alternatives to hospital admission and the redesign of pathways for

Next steps and action cont/d

individuals requiring step down from higher levels of secure care.

We will consider utilising a risk stratification tool to identify those individuals most at risk of repeated admissions or an out of area placement and target resources to support these individuals appropriately.

We will improve services for people with complex needs and personality disorder and improve the integration of services for people with a dual diagnosis. We will identify service gaps and develop commissioning plans where these are identified.

We will continue to focus on re-commissioning PICU services with the primary intention of reducing the need for acute beds, followed by a greater focus on managing complex patients in local facilities.

There is a need to develop high quality multi-disciplinary CAMHS Teams as an alternative to in-patient care for children and adolescents with complex mental health needs. We will continue to work with partners to prevent complex mental health needs through early years intervention strategies for specific families.

Commissioning Intentions
Our Top 6 Issues

6. Direct Access to Diagnostics

6. Direct Access to Diagnostics

Our intentions

To reduce the variance currently observed across NEW Devon CCG. This reduction in variance will look for peer reviewed, evidence based national guidance to harmonise the requesting and use of diagnostics. These commissioning intentions will focus on the following elements of the service:

- Standardised QOF Diagnostics
- Standardised Order Sets
- Standardised Care Pathways
- Standardised Tariff
- Standardised Commissioning/Decommissioning of Diagnostic tests

The harmonisation of the use of diagnostics will reduce unnecessary costs on the assumption that:

Variance = Waste = Sub optimal care = Increased cost

Volumes and Values

Standardised Tariff and Standardised QOF/Order Sets/Care Pathways:

Savings during 2014/15 could be as much as:

£2.5m – Northern Devon Healthcare NHS Trust
£ 0m – Plymouth Hospitals NHS Trust
£1.0m – Royal Devon and Exeter NHS Foundation Trust

Further work is required to develop the assumptions behind these numbers and agree implementation plans for changes to testing protocols.

Potential system levers

Local prices will be reviewed in accordance with national guidance. Clear test protocols will be described within the contract.

6. Direct Access to Diagnostics

Engagement and involvement

There has been significant clinical engagement in commissioning of diagnostics. Those engagement processes have involved:

- Support from the relevant Diagnostic Consultant to Consultant or Clinical Pathway Groups
- Promotion of key operational and clinical change at GP education days
- Promotion of key operational and clinical change to Practice Manager and Practice Nurse meetings
- Ensuring that secondary care clinicians have fully supported those changes in primary care and have been actively involved in the delivery of guidance on the key topics

Background and context

The diagnostic commissioning team have identified that patients do not receive the same diagnostic response for the same disease diagnosis and management across the footprint of NEW Devon CCG. This results in a variance of service according to geography. Using evidence based, peer reviewed national guidance as the basis for the standardisation of the use of diagnostics across NEW Devon CCG we aim to minimise that variance and provide patients and clinicians the assurance that the diagnostic service provided in primary care meet those national standards of care.

6. Direct Access to Diagnostics

Next steps and actions

The key element of this standardisation of care is that the recommendations contained in this document are delivered as a whole CCG response to reduce variance and not as a locality by locality initiative. These recommendations are:

Standardised QOF Diagnostics

The current QOF activity accounts for approximately 25% of all primary care use of the diagnostic service. The type and number of tests requested for each QOF subset is not standardised across NEW Devon CCG and currently shows considerable variance from surgery to surgery, locality to locality. Using evidence based, peer reviewed national guidance commissioners will look for delivery of the same diagnostic response for the same QOF subset regardless of location. Work on the development of common QOF diagnostics has already been initiated.

Standardised Order Sets

The delivery of electronic requesting in primary care (Order Comms) enables the specification of the same order sets (protocol guided investigations) for any specific disease diagnosis and management regardless of location. Again, the constituents of the order sets will be determined by evidence based, peer reviewed national guidance. Commissioning intentions will use the work on the development of common order sets that has already been initiated using the expertise of GP's, secondary care consultants and specialist scientists.

Standardised Care Pathways

A major element of the diagnostic commissioning team's recent work has been in the development of standardised care pathways and the sharing of this work across the localities of NEW Devon CCG. The Clinical Cabinet, comprising of acute providers, lead GPs from each locality and the secondary care pathology leads from each provider Trust, and the future commissioning intentions will support and develop the continued delivery of the same care pathways across NEW Devon CCG which again will reduce the variance and waste currently identified across its footprint.

6. Direct Access to Diagnostics

Next steps and actions

Standardised Tariff
The considerable inequity of diagnostic tariff across NEW Devon CCG is apparent and previously identified. The involvement of commissioners in the development of new procurement models will look to reduce these inequities while maintaining the quality of the service and the engagement of clinicians from both primary and secondary care.

Local prices will be reviewed, in accordance with national guidance, with the aim of agreeing a CCG wide currency system and tariff to support the care pathways.

Standardised Commissioning/Decommissioning of the diagnostic repertoire
Diagnostics is a service based on technology and science. As advancements are made in that technology and science, new diagnostic tests become available. Currently, there is no standardised approach to the commissioning of these new diagnostic processes and conversely, little common approach to the decommissioning of redundant tests or those with limited clinical value. The delivery of some new diagnostics has, in the past, resulted in increased costs for commissioners without patients seeing any clear improvements in the service delivered. Using the Clinical Cabinet as a decision making body that can utilise the specialist knowledge of secondary care and research groups, we will continue to support this process of commissioning/decommissioning and to formalise the proposed model into the current assurance structures of NEW Devon CCG such as the Clinical Policy Committee.

Appendix I: Elective Orthopaedic Care

Extract from 'Getting It Right First Time - Improving the Quality of Orthopaedic Care within the National Health Service in England' (Briggs, 2012). *Sign-up by all key stakeholders: Royal Colleges, Patients Assoc, British Orthopaedic Assoc.*

"The concept of "getting it right first time" is to identify and administer the correct treatment at the appropriate time, to a high standard with minimal complications. Not only will this reduce mortality and morbidity rates, but also reduce the need for often expensive revision surgery.

Appropriate primary care pathways with a referral system designed to allow the right patient to be seen by the right specialist at the right place at the right time in secondary care by "getting it right first time", thereby improving patient outcomes and satisfaction and reducing complications which will deliver significant annual savings.

Appropriate patient follow-up: The introduction and use of new implants within the NHS needs further regulation with appropriate Specialist Units, with a proven track record of translational research, taking on a leading role in their evaluation.
Instead of orthopaedic departments and clinicians acting alone, they should form part of a network of hospitals and treatment centres forming specialist orthopaedic units, with ring-fenced elective beds, working to quality assurance standards. This will generate standardised protocols for prostheses and treatment pathways across the NHS benefiting patients, thereby improving outcomes and reducing complications.
Specialist services, such as revision hip arthroplasty, should only be undertaken in either a specialist unit, or as part of a specialist network following agreed quality assurance standards, all aspects of which should be subject to regular performance review including audit. This will inform the CCGs and NCB so in future years networks with the best outcomes secure funding."
Advantages of this solution

- *Patient focused*
- *Clinical solutions driven by frontline clinicians*
- *Improving quality*
- *Significant cost savings*
- *Significant reduction in risk of rationing*