DRAFT – POLICY IN DEVELOPMENT

NORTH EAST LONDON
SUSTAINABILITY & TRANSFORMATION PLAN

Transformation underpinned by system thinking
and local action

Delivery Plan 6 of 8:

Specialised Commissioning

Contents

Initiative map

There are a wide range of programmes that support the aim of slowing demand growth, reducing variation and improving efficiency and quality in specialised services. These are outlined in our narrative plan for north east London and in the NHS England London (NEL) storyboard. Some of these initiatives will be managed centrally by NHS England London (London-wide capacity and access, variation, commissioning efficiencies). A selection of services provided locally are mostly used by NEL patients (>60% of the total cohort in 2015) and therefore pathway improvements can be developed at an STP level and implemented locally.

While initiatives may benefit from system-level development, implementation may occur at local level (for example rolling out the East London Kidney Services).

NEL STP Level

- Development of single care models for specialist pathways (renal and cardiology)
- Review community Neuro Rehab provision
- Earlier diagnosis and more efficient pathways in specialist cancer
- Specialist mental health planning

Local Area Level

- Delivery of renal dialysis virtual Chronic Kidney Disease (CKD) clinics and community case finding
- Delivery of AF and HF – closer working between 1° and 2° care; case finding
- Forensic and Tier4 CAMHS pathway improvements

CCG / Borough Level

- Preventative initiatives in CKD, Atrial Fibrillation and Heart Failure

London-wide

- Drugs and devices – centralised, electronic procurement
- CAMHS Tier 4 bed review
- Improving value through reducing fragmentation, variation and efficiency

Governance, design and management of pathways at STP level
Delivery may be at more local levels

Delivery plan on a page

Vision

A healthcare system working together to deliver evidence-based, high-quality and affordable specialised services to improve the health of the population.

Background and Case for Change

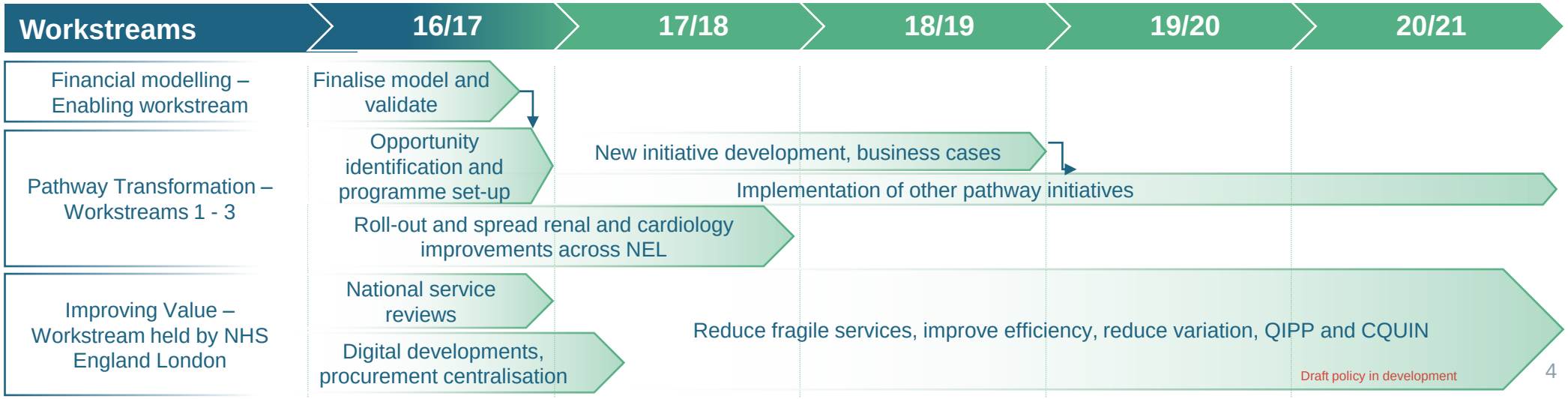
- Demand for and cost of specialist care are rising due to an ageing and increasing population, and new technologies and treatments
- With contracts for NEL providers of >£500m for specialist care in 2016/17, specialist services are an important part of the NEL health economy
- An annual predicted deficit will present a cumulative overspend of £134m by 2020/21
- A number of quality issues exist, including the meeting of some national mandatory standards.
- There is pathway fragmentation, duplication of services and gaps in provision between specialised, non-specialised and local services

Priorities and Objectives

- The solutions to increasing demand in specialised services lie in whole-pathway solutions.
- Pathway Transformation **– described within this delivery plan and developed locally**
  - Whole system, pathway led transformation to improve prevention, active demand management, improve quality of care and patient flows, whilst reducing variation.
  - Understand reasons for variation and barriers to improvement.
  - Priorities include renal dialysis, cardiac, paediatrics, cancer, mental health and neuro rehab.
- Improving Value **– managed by NHS England London**
  - Drugs and Devices – reduce variation, implement digital prescribing and centralise procurement
  - Improve productivity and efficiency of specialised services through reducing fragmentation and implementing national service reviews
- Initiatives identified only partially address the financial gap; further opportunities still to be developed

Expected Impact

- Slowed growth in demand for specialised services through maximised primary and secondary prevention
- Eliminated unwarranted variation
- Equity of access, outcomes and experience
- Improved quality, safety and cost effectiveness
- Reduced outpatient appointments; other activity shifts to be determined in Q3 2016/17



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Detailed plan – Work stream 1: *Pathway transformation - Renal Dialysis*

Vision

Reduce the impact of kidney-related illness in North East London.

SRO:	*Paul Haigh, CO, C&H CCG*
Delivery lead:	*Russ Platt, Head of Delivery, NHS E London*

Case for change

- Increasing numbers of people with Chronic Kidney Disease (CKD) and Acute Kidney Injury (AKI) due to population growth, demographic diversity, and lifestyle, resulting in high dialysis use. Often people present late, reducing opportunities for early intervention.
- An estimated 45% of NEL patients with CKD are undiagnosed; increasing numbers of people presenting in end stage renal failure (ESRF) previously unknown to the system.
- Renal dialysis spend for 2016/17 is predicted to be c.£35.5m in NEL.
- Earlier identification, diagnosis and treatment, through integrated working between 1° and 2° care can reduce progression of the disease and its impacts.

Objectives

- Slow the growth in demand for renal replacement therapy
- Reduce number of patients presenting with end-stage renal failure that were previously unknown to the system to <10%
- Increase uptake of home-dialysis, particularly peritoneal
- Further optimise renal transplant rate
- Improve spread of learning through the London Acute Kidney Injury Network and good practice in primary care management

	Initiatives	Enablers	Benefits and Metrics	Deliverables
1	MDT working between primary and specialist care	• Primary care – capacity, capability, new roles. • Shared care records	• Increase numbers of patients with CKD on QOF registers. • Improve access to specialist advice. • Reduce face-to-face outpatient appointments by up to 30%, replaced with c.3,000 virtual appointments. • Reduce presentations for ESRF with previously undiagnosed CKD to under 10% (c.250) of all cases • Slow the c.4-6% growth (c.100 extra NEL patients p.a.) in ESRF, and demand for renal replacement therapy (RRT) • Slow the growth in specialised service spend on renal care	• Virtual CKD clinics extended to whole STP area
2	Community surveillance and case finding	• System analytics; shared care records; GP trigger tools		• Community surveillance / case finding programme spread to all boroughs in NEL • GP trigger tools
3	Education programmes – Primary care, patients with CKD, patients with risk factors, general public	• Primary care workforce - capability • Prevention – healthy living campaigns (smoking, obesity, hypertension, cholesterol)	• Increase the number of patients identified as having CKD and receiving appropriate treatment • Reducing the deterioration of CKD to ESRF • Slow the growth in incidence of CKD	• GP and patient education programmes in all boroughs in NEL • Hypertension management and dashboards.
4	Access to treatments – out-of-hospital dialysis, transplant, patient decision aids)	• Housing – appropriate housing stock. • Appropriate primary care / community facilities	• Intervention rates (including transplant rates). • Increase out-of-hospital dialysis (satellite clinic, “place in the middle”, at-home). • Slow the growth in RRT	• Patient decision aids for renal replacement therapies.
5	Benchmarking and best practice	• System analytics and business intelligence	• Improved performance against various KPIs – spend, referral and intervention rates, waiting times, RRT rates	• CEG primary and secondary care dashboard

Detailed plan – Work stream 2: *Pathway Transformation - Cardiology (AF and HF)*

Vision

Reduce the impact of Atrial Fibrillation and Heart Failure, and associated conditions in North East London.

SRO:	*Paul Haigh, CO, C&H CCG*
Delivery lead:	*Russ Platt, Head of Delivery, NHS E London*

Case for change

- Specialist cardiology interventions will account for over £42m of expenditure in north east London in 2016.
- Atrial Fibrillation (AF) is a risk factor for stroke;
- Earlier identification, diagnosis and treatment, through integrated working between 1° and 2° care can reduce progression heart failure and the associated heath burden.

Objectives

- Improve the detection and management of heart conditions, in particular AF and Heart Failure (HF)
- Reduce the need for costly specialist interventions; improve the care pathways for those with AF and HF
- Optimise evidence based treatment and delay deterioration of heart conditions and associated co-morbidities, including by making every contact count
- Slow growth in demand for specialist cardiology interventions

	Initiatives	Enablers	Benefits and Metrics	Deliverables
1	Multi-disciplinary team (MDT) Interventions, incl. virtual clinics	• Primary care – capacity, capability, new roles. • Shared care records	• Increase numbers of patients with AF and HF on QOF registers and receiving appropriate treatment (e.g. stroke prevention) • Improve access to specialist advice. • Reduce face-to-face outpatient appointments by up to 50% • Reduce presentations for stroke with undiagnosed AF • Reduce length of stay for cardioversions (up to 100% day case) • Slow the growth in specialised service spend on cardiology • Deliver KPIs for specialist cardiac services at Barts	**Agreement as to deliverables to be achieved in Q3 2016/17, following further clinical engagement; to include:** • Degree of MDT working with 1° care • Case finding methodology • Strategic governance structures to manage planning, performance and sharing of knowledge • Pathway improvements such as access to diagnostics and results. • Patient and clinician education programmes. • Secondary care dashboard • **Metrics to be specified in Q3/Q4 2016/17**
2	Pathway improvements (e.g. stratified follow-up) to reduce waste and duplication			
3	Screening and Case Finding	• System analytics; shared care records	• Increase the number of patients identified as having AF and HF and receiving appropriate treatment • Reduce the incidence of in-hospital AKI.	
4	Education, prevention and wellbeing	• Primary care workforce - capability • Public Health – healthy living campaigns (smoking, obesity, hypertension)	• Slow the growth in incidence of coronary heart disease.	
5	Benchmarking and best practice	• System analytics and business intelligence	• Improved performance against various KPIs – spend, referral and intervention rates, waiting times, RRT rates	

Detailed plan – Work stream 3: *Pathway Transformation – Other opportunities*

Vision

Delivery of optimal care in specialised services.

SRO:	*Paul Haigh, CO, C&H CCG*
Delivery lead:	*Russ Platt, Head of Delivery, NHS E London*

Case for change

- The interventions described in previous slides (renal and cardiac) will not address the full £134m cumulative gap
- A number of other specialised service lines in NEL have:
  - Performance and quality issues (e.g. DToCs, waiting time targets, outcomes)
  - Variations in pathways across NEL and London
  - Increasing demand and relatively large spends
  - >60% of cases seen by the services being NEL residents
- These include cancer, neonatal and paediatrics, mental health and neuro rehab

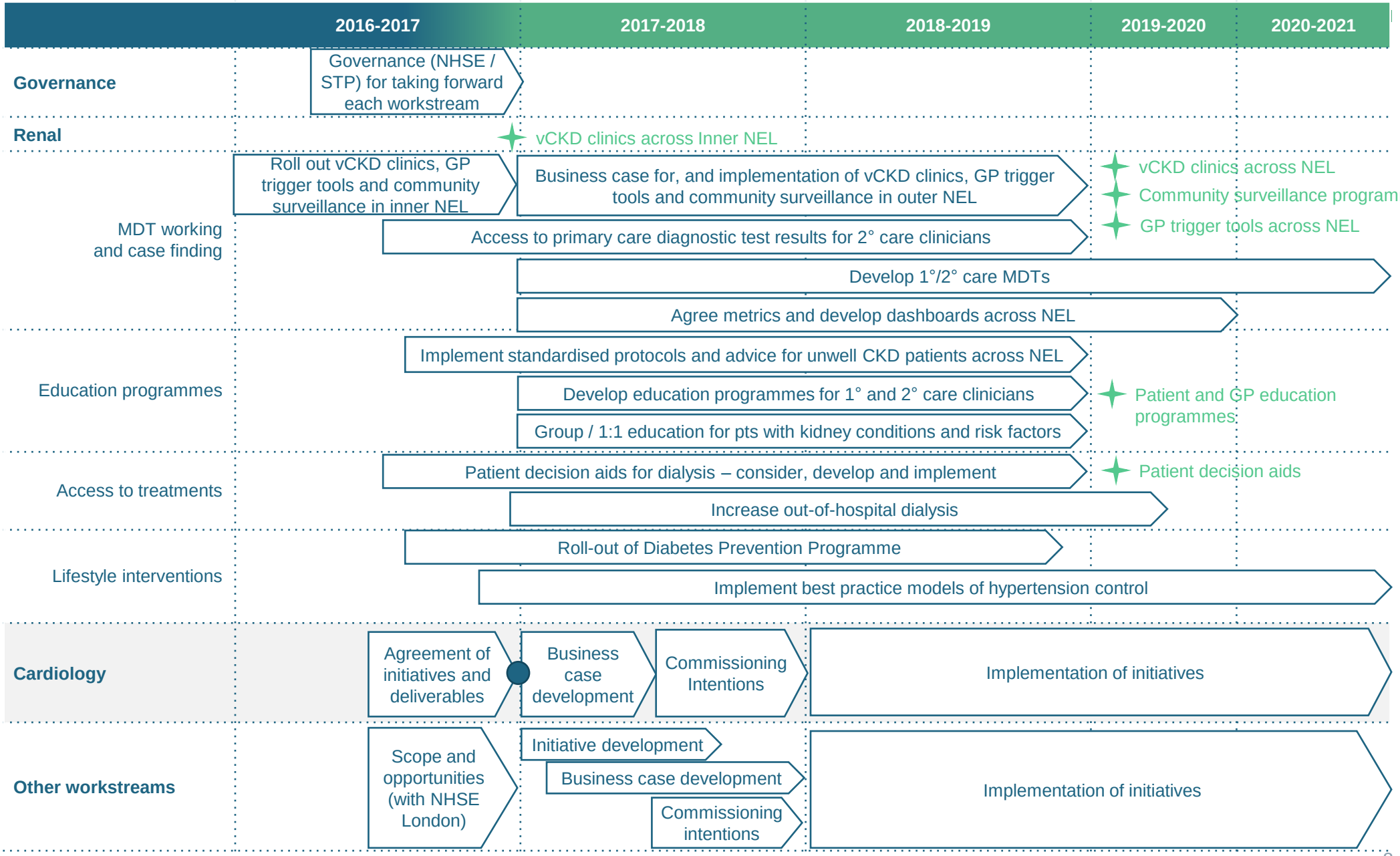
Objectives

- Understand the financial and activity case (NHSE London workstream – output expected October / November 2016), in order to:
  - Identify opportunities and initiatives to address the cumulative financial gap
  - Determine scope and Identify appropriate governance arrangements for workstreams

Area		Possible initiatives	Enablers	Benefits and Metrics	Deliverables
1	Specialised Cancer	• Stratified follow-up and move towards of self-care • Reduce risk factors (smoking, etc) • Standardise recovery packages & mental health support • Shared access to test results • Diagnostic pathways (stratification, one-stop, direct access, molecular testing)	• Shared care records • Prevention – population health and wellbeing • Primary care and community workforce – capability and capacity	• Efficient use of specialist resource. • Slow the growth in and deterioration of cancers • Reduce duplication in diagnostics	Scope, project governance, initiatives and metrics to be determined in Q3/Q4 2016/17
2	Neonatal and Specialised Paediatrics	• Stratification of support based on risk • Standardised pathways; capacity and demand review • Community support – MDT, virtual wards, networks, shared records • Transitional care pathways		• Improve care for transitional care patients, reducing length of stay (LOS) and delayed transfers of care (DToCs) • Reduce Out of Area transfers	
3	Mental Health	• Build on success of children and young people home-treatment pilot by NELFT. • Potential co-commissioning for forensic pathways • Pan-London capacity	• Co-design and co-commissioning arrangements with NHS England	• Slow the growth in demand for inpatient beds	
4	Neuro Rehab	• Pathway improvements & appropriate community support		• Reduce LOS and DToCs for neuro rehab patients in specialist beds	

Milestone
Deliverable

Route map



See Appendix for more detail (NHS England London Storyboard)

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Expected benefits & metrics

Note: Integrated outcomes and measures will be established in line with NHS E national metrics and current best practice guidance

This section provides a summary of the key benefits that we expect to achieve through the implementation of this Delivery Plan.

Benefit description (Health & wellbeing, care & quality or financial)	Measurement (metric)	Current performance	Target performance	Target date (default 2020)	Linked workstreams
Slow the growth in prevalence of CKD	QOF prevalence registers	2.4% (1.9-3.4%)	Growth to be projected	2020/21	Renal dialysis
Increase numbers of patients diagnosed with CKD	Derived from Quality Outcomes Framework (QOF) registers	c.55% (expected prevalence: 2.9-6.7%)	Increase	2017/18	Renal dialysis
Reduce presentations for ESRF with previously undiagnosed CKD to under 10% of all ESRF cases.	A&E presentations in ESRF with previously undiagnosed CKD	>10% (specific value to be derived from UK Renal Registry)	<10%	2020/21	Renal dialysis
Reduce A&E attendances for stroke in patients with undiagnosed AF	A&E presentations for stroke with undiagnosed AF	To be derived from provider data	Reduce	2020/21	Cardiology
Increase number of HF cases identified and proactively managed;	QOF prevalence registers	Prevalence 0.5%	Increase known prevalence	2020/21	Cardiology
Maintain specialist commissioning spend at or below allocation	Specialised commissioning budget	£534m in 2016/17	Maintain balance	2016/17 and beyond	All workstreams
Additional metrics to be developed as work progresses, and product of finance and activity projections workstream is realised – see appendix (NHS England London storyboard) for more information					

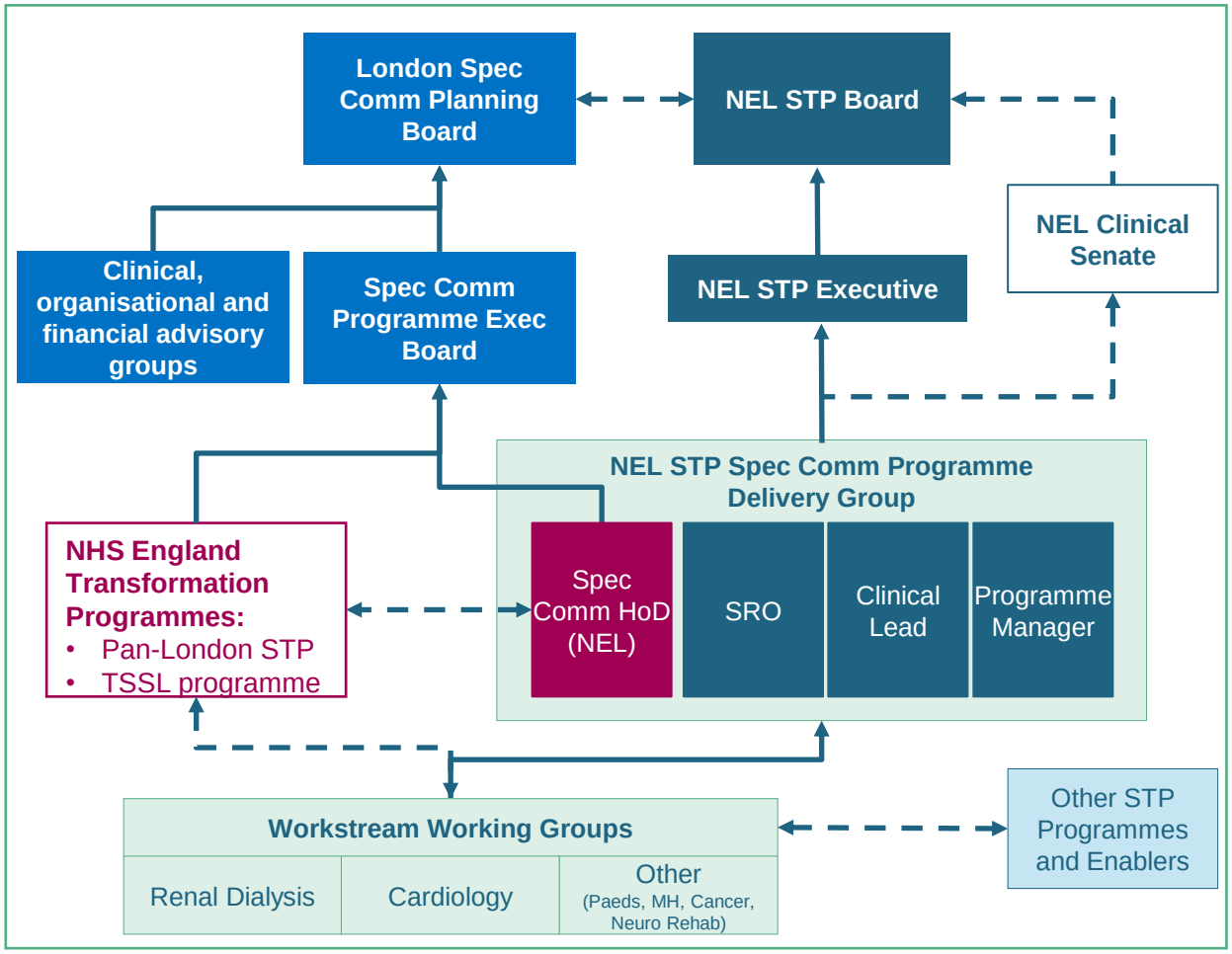
Resources & delivery structure

6.1 Resources

	SRO	Delivery Lead
Delivery plan	Paul Haigh, CO, City & Hackney CCG	Russ Platt, Head of Delivery, NHS England London
Renal dialysis	Paul Haigh, CO, City & Hackney CCG	Russ Platt, Head of Delivery, NHS England London
Cardiology	Paul Haigh, CO, City & Hackney CCG	Russ Platt, Head of Delivery, NHS England London
Other pathway transformations	Paul Haigh, CO, City & Hackney CCG	Russ Platt, Head of Delivery, NHS England London

- NHS England London Head of Delivery for NEL is the delivery lead for the NEL STP specialised commissioning delivery plan.
- NHS England London has Planning and Executive Boards for oversight of specialised commissioning programmes, including pan-London STP initiatives; collaboration between NEL STP and this structure is necessary to plan changes as a whole system across London.

6.2 Delivery structure



- Some pan-London workstreams have yet to be scoped by NHS England London, and thus governance arrangements for delivering these workstreams have yet to be determined. This is planned for Q3 2016/17, based on NHS England London opportunity analysis and scoping, and following the output of the NHS England finance and activity projections workstream (see appendix NHS England London Storyboard).

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Risks

Risks			
Workstream	**Description: impact**	**Mitigating action**	**RAG**
Renal and Cardiology	Risk that defined workstreams do not result in large savings for CCGs and providers, reducing financial incentive to change. Insufficient risk/gain-shares to manage patients outside of specialised services	Define projected demand and financial increase in a “do nothing” scenario. Identify spend-to-save initiatives Engage primary care and CCGs in design.	R
Pathway workstreams	Insufficient funding available for invest-to-save initiatives.	Develop robust business cases for investments. Decisions to invest will be taken at programme level against relative benefit	R
Pathway workstreams	Risk that demand management initiatives are insufficient or too long-term to slow growth in demand sufficiently by 2020/21	Opportunity analysis to identify quick wins, and longer-term demand mitigation.	R
All workstreams	Co-commissioning arrangements and NHS England improving value initiatives could shift risks and/or costs to local CCGs and providers. Changes to the commissioning responsibility for certain conditions may present additional pressures to CCGs and providers.	Determine appropriate governance and collaborative planning arrangements to ensure engagement, buy-in and agreement to initiatives.	A
Pathway workstreams	Long-term demand management requires behaviour change from patients and members of the public in terms of lifestyle (smoking, obesity). Demographic changes (ageing population) may present higher growth than can be mitigated	Develop preventative initiatives with public health and the Prevention workstream.	A
Pathway workstreams	New demand management initiatives are not embedded at primary care (for reasons including behaviours reverting to the norm, lack of buy-in, lack of capacity and capability)	Engagement with primary care representatives in developing initiatives. Implement appropriate technology and protocols	A

This is a list of the highest-rated risks. Additional risks identified at a lower mitigated risk rating

Dependencies, constraints and assumptions

Dependencies, constraints & assumptions (in order of impact)			
Workstream	**Type: Dependency/ constraint/ assumption**	**Description**	**Actions / next steps**
Pathway transformations	Dependency	Access to 1° care records from 2° care is possible across NEL (part of Digital Roadmaps)	Confirm timeline for interoperability with Technology programme
Pathway transformations	Constraint	Initiatives in prevention, and primary and community care aiming to reduce demand for specialist services may require management of budgets across the whole pathway – speed of development of different models of co-commissioning could limit the implementation of interventions	Confirm timeline for delegation of specialised budgets. Identify where progress can be made without co-commissioning.
Pathway transformations	Assumption	Increase in case-finding leads to earlier, more cost-effective treatment, not simply more specialist care.	Develop detailed clinical model
Improving value	Assumption	Sufficient efficiency initiatives can be identified to reduce variation and costs	Work alongside NHS England London to identify initiatives
All workstreams	Constraint	Progress of local initiatives dependent on development of pan-London initiatives by NHS England London.	NHS England London to identify opportunities, scope and programme governance for delivering pan-London initiatives (see Storyboard appendix)

Dependency map

This dependency map highlights where this delivery plan is linked to another delivery plan within our STP.

	Prevention	Access to care close to Home	Accessible quality acute services	Infra-structure	Productivity	Specialised Commissioning	Workforce	Digital
Pathway transformations: renal dialysis	Patient Activation; improving lifestyle (smoking, obesity, hypertension)	Primary care (technology and workforce); Commissioning of demand management initiatives	Diagnostics (access to diagnostics; availability of test results) Reduction of outpatient appointments Medications management – use of biosimilars; procurement	Suitable out-of-hospital premises for community dialysis		Cardiology (similar upstream interventions)	Primary care workforce and MDT working; networks	Access to care records
Pathway transformation: cardiology						Renal (similar upstream interventions)		
Pathway transformation: other conditions		Specialised elements of specific pathways, incl. mental health and cancer		TBC	Centralised procurement and efficient pathways	NHS England London pan-London STP programmes		

Summary of Financial Analysis

The basis for the financial modelling has been the five year Operating Plans prepared by individual NEL commissioners and providers, all of whom followed an agreed set of key assumptions on inflation, growth and efficiencies. The individual plans have then been fed into an integrated health economy model in order to identify potential inconsistencies and to triangulate individual plans with each other. In the June submission the starting point for this modelling was the 16/17 operating plans. This has since been refreshed to be the month 6 forecast outturn.

The NEL STP financial template summarises the:

- Latest financial gap projection
- The anticipated financial impact of the workstreams on closing the gap
- The BAU effect on closing the gap
- The capital requirements for the STP
- The investment requirements including 5 year forward view investments

While substantial progress has been made on the financial and activity modelling for the NEL STP, the finance and activity plan for the October 21st submission should not be regarded as the final position. Further detailed worked-up analysis will follow over the coming months.

Work done since 30th June

- Expanded the Transforming Services Together capacity and activity model across the whole NEL STP footprint
- Updated the new capacity and activity model to include the BHR ACO schemes
- Refined the capital investment requirements
- Incorporated the estimated costs for the delivery of the 5 Year Forward View requirements
- Refreshed the underlying financial calculations to be based on month 6 forecast outturn
- Agreed the STP resourcing requirements
- Commenced detailed analysis of the financial and activity impact of the workstream initiatives
- Applied the capacity and activity model to calculate the capacity requirements for the Whipps Cross capital business case

Planned future work

- Update the new capacity and activity model to include Hackney Devolution pilot
- Identify opportunities to obtain additional funding from national investment funding sources (e.g. the Mental Health 5 Year Forward View)
- Undertake more detailed modelling of the financial and activity implications of workstream initiatives
- Reach agreement on the STP wide system control total (taking into account organisational control totals).
- Agree the implementation of the system control total, including handling of key dependencies (e.g. the NHS E specialised commissioning)

Contribution to our framework for Better Care and Wellbeing

This delivery plan sets out how it will deliver improvements against the core areas of prevention, out-of-hospital care and in-hospital care.

Promote prevention, and personal and psychological wellbeing in everything we do

- People will be more aware of the impact of their lifestyles on their bodies, through prevention programmes and a move towards better self-care
- Blood pressure control, cholesterol reduction, smoking cessation and alcohol intake moderation will reduce the incidence of chronic conditions such as CKD, CHD, cancer, and deterioration of those conditions, improving the lives of NEL patients and residents.

- Patients will manage their conditions themselves with fewer outpatient appointments required.
- Out-of-hospital dialysis will become more prevalent.
- Patients' care will be managed more in primary care with access to a specialist MDT.

Promote independence and enable access to care close to home

- Patients will receive quicker specialist input and advice without the need to attend a hospital.
- Follow-ups will be stratified, reducing outpatient appointments and to enabling efficient use of resource
- This will result in more capacity to manage the increased demand for hospital services and allow waiting times to be maintained or reduced.

Ensure accessible quality acute services for those who need it

Addressing the 10 'Big Questions'

Q1. Prevent ill health and moderate demand for healthcare

- Roll out of the Diabetes Prevention programme across NEL.
- Deterioration in chronic conditions will be reduced.

Q2. Engage with patients, communities & NHS staff

- Patients will be better able to manage their conditions with support from specialist MDTs and education programmes.

Q3. Support, invest in and improve general practice

- GPs will have better access to specialist advice.
- Communication will be improved through 2° care access and input to 1° care records.

Q4. Implement new care models that address local challenges

- Introduction of virtual clinics across NEL will result in 2° care having the capacity for the projected increase in demand.

Q5. Achieve & maintain performance against core standards

- Achievement of referral to treatment (RTT) targets through managing more patients in primary care.

Q6. Achieve our 2020 ambitions on key clinical priorities

- Specialist cancer transformation will contribute to achieving the cancer waiting time target and outcomes.

Q7. Improve quality and safety

- Earlier intervention in chronic conditions will result in reduced deterioration, in turn reducing emergency admissions and premature death.

Q8. Deploy technology to accelerate change

- The use of virtual clinics across NEL will improve access to specialist advice.
- The potential of healthcare analytics and community surveillance to stratify patients will enable resources to be targeted more effectively and reduce harm.

Q9. Develop the workforce you need to deliver

- Increasing the use of specialist MDTs will improve access to specialist advice for primary care clinicians and improve care.

Q10. Achieve & maintain financial balance

- Upstream demand management and earlier intervention will reduce demand for specialist services. This will mitigate increases in demand stemming from population growth.

Draft policy in development

Addressing the 9 'Must Do's'

1. STPs

- This delivery plan outlines our agreed STP initiatives and milestones and the timeline for delivering them. We have also begun to map out the metrics against which we will measure our progress.

2. Finance

- Pathway transformations are across whole pathways, using prevention, demand management, case finding, virtual clinics and MDT working to slow growth in demand for specialised care.

3. Primary Care

- Improvements to pathways between primary and specialist care, reducing waiting times for specialist advice and improving shared care.
- Reduce variability and spread best practice management via education and dashboards.

4. Urgent & Emergency Care

- Reduction in demand for urgent and emergency care through better management and self care of chronic and complex conditions.

5. Referral to treatment times and elective care

- Reduce time to receive specialist advice, additionally reducing the number of referrals requiring face-to-face outpatient appointments and follow-ups.

6. Cancer

- Alignment with the cancer delivery plan and through the cancer board, specialist cancers will see an improvement in pathways and achieving the waiting time targets and improving survival rates.

7. Mental health

- Reducing demand for inpatient beds by improving community and step-up / -down care (for example CAMHS Tier 4 in outer NEL).

8. People with learning disabilities

- Refer to NEL STP Delivery Plan 2 of 8: Care Close to Home.

9. Improving quality in organisations

- Better use of resources, improving access to specialist advice and closer MDT working between primary and secondary care.
- Developing performance dashboards across NEL for chronic and complex conditions and specialist care.

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