Document Control
Document Location
This document is only valid on the day it was printed.
This document is saved in Q:\HCCG\1.Planning\2.Clincal Strategy
Revision History
Date of this revision: 31/08/2012
Date of Next revision:

Version	Date	Author/Editor	Change Description
V0.1	24/08/2012	CG	Initial early draft
V0.2	25/08/2012	ME	Governance piece added
VO.3	29/08/2012	CG	Clinical strategy additions following contract meeting
VO.4	30/08/2012	LH	Re-formatting
V0.5	31/08/12	NB	Final first draft to Board

1st Draft

DRAFT Clinical Commissioning Strategy

for

Herefordshire CCG

1st DRAFT

Contents:

1st DRAFT

1. Introduction

Herefordshire Clinical Commissioning Group aims to achieve a high quality, sustainable and pathway driven health economy with the patient and public at the heart of everything we do. However, Herefordshire CCG faces a number of specific health challenges related to a largely rural, sparsely populated geography with an underdeveloped provider market. Transforming the health economy to put the patient and public at the centre will therefore depend on realising efficiencies and demonstrating effectiveness of clinical care by using integrated pathways. Partnership working, with the Council and all our other partner organisations will also be key to the transformation as we will want to ensure that our providers work within sustainable clinical networks so that the people of Herefordshire are receiving the highest quality and safety of care.

2. Financial Context

The CCG faces a challenging financial position and the projections going forward to 2015 show that the money available to the health economy is:

Recurrent Budget Allocations 2012/13 to 2017/18 :

	£	
2012 / 13 Budget	2,10,111,593	Recurrent Budget as at Month 04
1% Insurance Risk Reserve	2,101,116	
Uplift at 2.51%	5,326,539	
	217,539,248	**2013 / 14 Recurrent Budget**
Uplift at 2.40%	**222,760,190**	**2014 / 15 Recurrent Budget**
Uplift at 2.40%	**228,106,434**	**2015 / 16 Recurrent Budget**
Uplift at 2.40%	**233,580,989**	**2016 / 17 Recurrent Budget**
Uplift at 2.40%	**239,186,933**	**2017 / 18 Recurrent Budget**

Note : Annual uplifts are estimated as detailed in the main text and will be subject to change as allocation details are confirmed and clarified.

In addition, previous estimates of the Herefordshire health economy QIPP target was estimated at £68m until 2015 see table below:

1st DRAFT

	Cash Releasing Savings				
Years	Efficiency built into provider contracts £000's	PCT action to reduce existing spend £000's	Planned disinvestment in services £000's	Other Savings £000's	Annual Totals £000's
2011/12	9,865	5,465	5,033	375	20,738
2012/13	8,893	5,231	2,611	80	16,815
2013/14	8,944	2,976	2,945	70	14,935
2014/15	8,995	4,168	2,076	70	15,309
Totals	**36,698**	**17,840**	**12,665**	**595**	**67,798**

The scale of the financial challenge we face in the future is great. Every year the CCG will face additional pressure on the funding we receive due to inflation, demographic changes of an ageing and growing population and the cost of innovative new technologies and drug advancements.

The CCG is working on and modelled through a 2.8% increase for 2012/13, for 2013/14 a 2.5% (guidance from NCB), and 2014/15 2.4% (advice from Nuffield Institute of Health Care). As a result of this work one of the objectives for the CCG Board to come into recurring balance the health economy will need to drive high levels of efficiency in the current system, look at new and innovative ways of commissioning providers to provide services and engage all clinicians in the debate about Herefordshire health system.

The CCG is also cognizant that if it is to continue to invest in additional services or new services, these will need to be aligned to the clinically driven priority areas and address the health inequalities prevalent in the population. This will have to be funded through decommissioning services that are not evidenced based or performing at a less than optimum way.

As part of the Clinical Commissioning Strategy the financial strategy has been underpinned by financial models which are being further developed with scenario modelling and risk assessment. The most important issues that have been factored in are set out below:

- **Government Spending Review**

Despite the UK economic downturn, the outcome of the 12/13 Spending Review represents a relatively favourable financial settlement for the NHS. The CCG is planning on a small element of real terms growth from 2012/13 of circa 2% year on year until 2015. . This supports all the information available at the current time and is in line with the PCT Cluster allocations already confirmed for 2012/13.

- **Implications of the QIPP Initiative on the Local Health Economy**

The 2012/13, 14, 15 QIPP initiatives have been modelled into the financial strategy and the clinicians in Herefordshire are aware of the need to deliver the savings. The overall QIPP target from 2011/12 to 2014/15 has previously been communicated as £68m.

- **Current Year Activity Pressures**

In year information on material activity pressures have been reflected in the revised plan, particularly in respect of the acute secondary care, special placements and continuing healthcare pressures.

Taken together these changes will substantially reduce the scope for new investment during the current financial planning period and emphasis is placed on the need to invest only in schemes or activities that will the greatest benefit to the population of Herefordshire using a clinically driven, evidenced based approach. The CCG will look for innovation, local tariffs, changes in national tariffs and service redesign to pump prime service configurations in line with the patients views and expectations of service delivery in Herefordshire. The strategy, therefore, will lead to a reduction in the relative expenditure on hospital based activity, allowing the acute sector services to network with other providers to provide sustainable levels of safe, high quality clinical care and to increase the services of community and primary care based services focusing on the neighbourhood team concept and wrapping services around the patient.

Regular review of investments against criteria used in the investment planning process will be undertaken and will help to inform the disinvestment process.

Scenario planning

Herefordshire CCG has identified through this draft clinical strategy a range of financial scenarios. The three main scenarios can be described as follows:

Base Case (Likely) Scenario

In this scenario the CCG will contract for a realistic level of activity over the life of the three year plan based on past activity performance and forecast future demand. Unallocated resource would be invested in a series of prioritised initiatives, aligned with the Local Authority strategies where appropriate, leading to initiatives focused on improving health outcomes, reducing health inequalities identified through the integrated needs assessment and helping the people of Herefordshire to remain independent in their localities for as long as possible. The CCG would look to invest in primary and community care. Service reconfiguration, to enable this to happen, will need to come from within existing resources of the health economy with little pump priming available.

Best case Scenario

In this scenario the CCG will again contract for a realistic level of activity over the life of the plan but the additional unallocated funding will be used to go further and faster on the transformation agenda of care closer to home and independent living for the population aligned to their localities. It is envisaged that pump priming will be provided by the CCG in order to deliver the strategic priorities and to incentivise providers to further improve quality, innovate and experience for our patients who use their services.

Worst case Scenario

In this scenario the CCG would shift the focus of activities to the management of demand and mitigation of cost increases. The CCG would contract for lower than expected levels of

DRAFT

activity and use all the available levers to manage demand, especially via the contract, on all providers. There would be no ability to fund new ways of working and the CCG would be looking to decommission activity.

The need for change and a clinical commissioning strategy that drives the change to becoming a health economy in balance is now paramount. The current Strategic health authority has also made it clear that they cannot support any non-recurrent funding of the provider going forwards from 2013.

3. Context for change

In 2008 Herefordshire embarked on a major change programme bringing together the health and social care community to look at the organisation and delivery of health and social care. The strategic 'Provider Services Review' was undertaken by Health Services Management Centre in Birmingham University. As part of this review clinical teams came together and there was consensus on the need to develop integrated care pathways delivered by an integrated hospital, community and adult social care organisation. However, the final report did not make this explicit recommendation! It should be noted that the Primary care services provided by GPs choose to stay outside of this proposal.

In 2009 KPMG were commissioned to;

'Assess the viability of Herefordshire Hospital Trust and the PCT Provider arm as standalone organisations; and determine the potential clinical and financial viability of a single integrated healthcare provider '.

As part of the work KPMG flagged to the different organisations that by 2014 the health economy would be in a cumulative deficit of £23 million if no action was taken. The result of the work was that Wye Valley NHS Trust was created in April 2011 providing acute, community and adult social care. This was the first integrated trust in England. However, this trust was predicated on a continued financial investment by PCT/commissioners and it was noted that £2.3m was required for the neighbourhood team development, which was to deliver avoidance of a need for hospital admission, quicker discharge from hospital and reductions in delayed transfers of care. Further resources were predicted to be released by the integration and this projected to be a benefit of £6m per annum. Pathways of care were also identified and it was agreed by the PCT that locally developed tariffs would be developed. Alongside this the Wye Valley NHS Trust were pursuing an application for F/T status.

A review in August 2012 of the Integrated Care Model by Wye Valley NHS Trust Programme Management office has identified that the investment was not made due to the financial pressures across the health economy and the resources being required to fund the over performance of the trust in 2011/12; the model of care did not deliver enough savings to bridge the gap between income and expenditure resulting in increasing cost improvement plans; the proposed locally developed tariffs were not developed or implemented; that organisational integration took precedent over the clinical integration which was integral to the whole change programme. The review also found that commissioning intentions have

1st DRAFT

been made piecemeal rather than as an overarching strategy to support the transformation of care.

4. Current issues

In May 2012 Wye Valley NHS Trust produced a document 'Case for Change: Financial viability and the Way Forward' to the Midlands and East, West Midlands SHA asking for £9.5m non-recurrent support in 2012/13. Following that meeting the Trust were asked to fully identify the £5.5m of CIPs and the SHA made it conditional on the £9.5m being offered that the CIPs were delivered. In addition, the PCT/CCG was asked to agree and present a narrative identifying 'the future clinical strategy and governance structure to oversee securing a clinically and financially viable sustainable organisational form for the Trust by the start of September.'

This work has now begun.

5. Integrated Needs Assessment

In order to work through a high level clinical strategy it is important to understand the health context of Herefordshire in 2012 and further information can be found in 'Key Findings about Herefordshire Localities' at www.herefordshire.gov.uk/aboutlocalities. Key issues that come from the integrated needs assessment are:

- Herefordshire has a population of 182,800, representing growth of 4% (7,900 people) since 2001; it is predicted to grow by 205,700 by 2013;
- The population already has a relatively old age structure but older people are expected to increase disproportionately to the total population. 6,500 households consist of elderly, socially isolated persons.
- By 2031 the number of people aged 85+ will more than double to 12,700.
- Amongst the Minority Ethnic population the largest single group is 'White: other than British or Irish' (at least 4,300 people) and it is likely that many are Polish;
- Life expectancy at birth is significantly higher than nationally and regionally for males and females. Male life expectancy is 79.3 years compared to 78.6 years nationally, for females life expectancy is 83.6 years compared to 82.6 years.
- There are 1,900 deaths a year and 80% of all mortality in the county can be accounted for in three groups: circulatory diseases; cancer and respiratory diseases;
- There are 31,200 adult smokers in Herefordshire. However, 61% of current smokers (19,000 people) would like to stop; Smoking related admissions to Wye Valley Hospital account for £3.15m per year.
- Two in five adults report drinking alcohol above recommended guidelines at least once a week and the highest prevalence is found in residents in Hereford City. Alcohol related hospital admissions have increased to 3,500 in 2010-11 a 30% increase since 2007-8 and is second highest rate for West Midlands. The majority are emergency admissions at a cost of £4.6m for 2011-12.
- Hospital admissions are significantly lower than PCT comparator sites but elective admissions have risen by 12.4% from 2006-7 to 24,700 in 2010-11. Cataracts are

DRAFT

the commonest cause of elective admission, along with breast cancer and colo-rectal cancer; emergency admissions have risen by 11.6% since 2006-7 with approximately 14,850 admissions in 2010-11, a further 4,400 admissions relating to maternity services. The commonest causes of emergency admissions are complications in pregnancy, bronchitis/COPD and pneumonia.

- Dementia is a significant challenge to Herefordshire. It is suggested that two-thirds of people living with dementia are undiagnosed but currently there are 3,000 residents with the diagnosis.
- Immunisation rates have not improved for Herefordshire have slipped from 'above average' to 'poor'
- Herefordshire's economic output is low at £15,296 per head of population compared with £16,602 in West Midlands and £20,498 across England. Unemployment is low (2.8%) compared with England (4.0%). Female, young people and long term claimants are higher than previous years and there are more people claiming out of work benefit for health reasons than are unemployed. The working age population is less well qualified (14% have no qualifications in 2010) than across England (11%).
- There are a rising number of homeless applications from teenagers as a result of parents no longer able or willing to accommodate them. However there is also a need to build more accommodation suitable for older people within the local area they know.
- There are low levels of multiple deprivation. However, in several areas of South Hereford and Leominster there are some of the most deprived households in England for over 10 years, with Leominster Ridgemoor still the area with the highest percentage of children in poverty.
- Herefordshire still remains one of the least densely populated areas of the country with residents scattered across its 842 miles. 54% of the population lives in rural areas and 43% lives in the most rural locations. Recent surveys of Herefordshire residents have shown that some health services, GPs, Dentist and hospital visits, were felt to be difficult to access due to public transport links.

6. Clinical case for change

It is against this background, and the deteriorating position of Wye Valley Trust financially that the Herefordshire Clinical Commissioning Group with Wye Valley Trust clinicians and Herefordshire Council have been rethinking the clinical strategies that need to be employed over the next five years to ensure that the challenges identified within the Integrated needs assessment are being systematically dealt with.

A series of working groups have already been established and all groups are clinically led.

A) A **Steering Group –** will lead the process it will be responsible for ensuring that
- The project methodology and timelines are adhered to
- Clinically/ financially robust proposals are developed with costs and milestones
- Sponsoring organisations and a critical mass of stakeholders support the agreed solution
- The updated service model is implemented

1ST DRAFT

The Steering Group will be accountable to the Boards of HCCG and WVT and will report to the Herefordshire Health & Wellbeing Board.

B) Clinical/**Professional Strategy Group** will be responsible for the production of the updated health and social care model and plans**.** Specific tasks will include:

- Developing a Clinical Strategy for Herefordshire by February 2013 with a high level overview of priorities by the end of August 2012
- Auditing progress to date in delivery of the current model of integrated health and social care
- Identifying gaps in that model
- Developing an updated model which delivers the required cost improvements and maintains/ improves quality.
- Ensuring that any proposals are assessed for their impact on quality

The Professional/Clinical Strategy Group will quarterly and will be co-chaired by the Chair of HCCG and the Medical Director of WVT.

C) **A Pathfinder team** (Quick wins group) will support the CSG and will be chaired by the HCCG secondary care advisor. The Pathfinder Team (membership to be agreed) will be tasked with developing at high speed:

- an alternative model for care for an agreed service
- a non PBR funding solution providing an appropriate incentive to support this alternative model

Providing a template for use between meetings of the Clinical and Service Strategy Groups will be the implementation group which will track the progress and ensure new ideas are aligned into workstreams.

D) The **Implementation Group** will

- assist the Clinical/Professional Strategy Groups in auditing progress to date in delivery of the integrated model of health and social care and gaps in that model
- plan implementation of the updated model
- implement the updated model.

The Group will employ a Programme Management Office approach to support implementation of the agreed model.

Principles for clinical change

Out of the first deliberations of these groups have already come some high level principles that all organisations have agreed will start to address the issues:

- All phases of the strategy must be clinically led;
- Resources need to shift from treatment and hospital admission to health promotion, education and preventative strategies;

1st DRAFT

- Herefordshire residents should have services 'wrapped around them' so that they are enabled to stay in their own homes and localities for as long as possible;
- Care will be given closer to home and as a result of this the function and purpose of community hospitals needs to be reviewed;
- Patients, carers and the public should expect to be cared for on an integrated care pathway and not be concerned about organisational boundaries;
- In order to provide a safe and high quality service Hereford hospital services should be networked with other providers;
- The PbR funding mechanism needs to be re-examined for our health community and all other traditional funding streams in order to allow the shift to occur from hospital to community provision.

7. Pathway development

In order to work on each service and be innovative a recognised methodology will be used on pathway development. Both the HCCG and Wye Valley Trust have agreed that the Map of Medicine will be the clinical decision tool to be used in redesigning pathways, clearly designating which parts of the pathway are carried out in primary and secondary care. Support and guidance has been sought from Map of medicine and this system will be deployed following training for both clinicians, social services and partners. Both Secondary care Consultants and GPs will develop the pathways and will ensure that they are agreed with social service colleagues. The CCG has identified a programme manager post to be the map of medicine support manager and secured the services of Sir Muir Gray to facilitate the introduction and on-going clinical strategy work.

The first pathways to be tackled will be those relating to care of the elderly services, frail elderly and dementia services. This is to align with the integrated needs assessment but, in addition, will also start to address some of the long term condition pathways that will need to be implemented so that patients and carers can have services wrapped around them rather than admission to hospitals.

However, there is recognition that Wye Valley Trust must play its part in the wider health community of West Midlands health services and as such development of networks will be positively encouraged as part of the organisational development of the Trust. Already the CCG and Trust have participated in a review of Stroke services and are working with colleagues across Worcestershire/Herefordshire/Powys footprint to ensure a new way of delivering stroke care can be delivered for the population. The strategy will continue to build on this way of working, using Map of Medicine agreed pathways.

8. Next developments for community services

During the first phase a significant amount of development will need to be undertaken in primary care to ensure that the activity and capacity are aligned across the health system. To date the GPs and primary care have not been aligned with the integrated care system

1st DRAFT

and this has caused tension in the system. The CCG is talking to a range of providers about how services could be developed and how they could be geographically located. As part of this agenda the HCCG/Local Authority have worked on a specification for neighbourhood teams. This is the first specification produced by the commissioners and it is intended the next specification will be for 'virtual wards' so that patients can be discharged back to their homes rather than to community hospital beds. Following on from this will need to be a reconfiguration of the services for the community hospitals which the CCG wishes to see become Community Resource Centres with the remit of ensuring patients have services provided to them in their localities i.e. Outpatient services and has a more positive message of health improvement and prevention rather than a sickness service. All of these potential developments will need to be further worked up but the underlying premise is that they will release money from the acute services to be redistributed into community based services. This work will be subject to a S242 order under the consolidated NHS Act 2006.

9. Next developments for acute services

The acute services will need to change in line with the development of community services but in order to have effective community services there needs to be clinically safe and patient centred acute services. Clinical discussions have lead to the need to ensure that there will always be an Accident and Emergency/Trauma unit available as well as a Maternity service in Herefordshire. This is because of the geographical and social reasons and the fact that Wye Valley Trust serves 8,400 people from Wales for Powys Local Health board. In order to have a fully functioning unit there needs to be consideration of a number of important co-dependencies:

Services relating to acute medicine; acute surgery; trauma in relation to trauma and orthopaedics; anaesthetics; paediatrics and obstetrics. There will also need to be access to Pathology and Radiology as well as provision of a Cardiac Care Unit and an Intensive Care Unit.

This needs to feature heavily in the on-going development of the clinical strategy but there must be focus on a) which services can be shared/networked; b) does elective surgery need to be so closely aligned to the current service configuration and c) what tertiary services can be repatriated/provided from other Hospitals to Herefordshire so patients can have care 'closer to home' but help to sustain the hospital as the CCG and Local Council commissioners realign services into community and primary care provision.

As part of this shift of services the CCG and Local Council will want to look at innovative ways of working with the Wye Valley Trust and the clinical strategy group are looking at ideas generated from other groups and CCGs such as getting consultants to triage referrals to ensure patients are seen in the correct clinics, to creating a community management plan that GPs can implement, to asking Secondary Care Consultants to manage the programme budget spend on a pathway approach to release savings that can be released to invest in innovation and other development needs.

1st DRAFT

10. Information

The clinical strategy and revised model will need good, clear sources of information to aid the clinical decisions making process. As discussions have gone on the need for an information management and technology strategy has become clear. To date there has not been a whole system approach to information management or data collection or a financial strategy to fund the hard and software requirements and this will need to be addressed as part of the Herefordshire clinical strategy going forward, so that there is a clinically useful flow of patient centred information.

11. Market Management

The CCG and Local Authority commissioners wish to see innovation in provision and to develop other providers by bringing them into the providers market. Work will need to be undertaken to develop the market and provide choice for the people of Herefordshire to ensure that they remain active and part of their communities for as long as possible. Herefordshire CCG and the Council will undertake modelling of demand and supply for a five year cycle as part of the financial strategy as well as applying scenario planning to the models. As part of this work we will adopt a proactive approach to market development by working with existing NHS, independent and voluntary sector providers to ensure continued provision of quality services. We want to see all current providers develop high quality but cost effective and appropriate services. Where existing providers cannot meet the needs of Herefordshire residents in terms of cost or quality we will explore the potential to introduce alternative providers from NHS, independent and voluntary sectors as a means to seeking innovative solutions to our commissioning intentions. Herefordshire CCG will also use the route of any qualified provider to develop the market as well as tendering of services where appropriate. By developing the market management strategy with the clinical strategy there will be an opportunity for providers to innovate services but it will mean for certain conditions a reduction in secondary care activity and an increase in community and primary care based activity.

Cathy Gritzner – Chief Officer (Designate)
Jill Sinclair – Chief Financial Officer
31st August 2012

1ST DRAFT