VERSION 7 – JUNE 2010

Clinical Commissioning Executive: 6 priorities - Implementation Plan

1 Introduction

1.1 "The budget delegated to Practice-Based Commissioners (PBC) was overspent at year end by £14.9 million (2.9%) in 2009-10 (as at 31/03/10 and once the risk pool has been added back in).

This mainly relates to a significant over-performance in non-elective in-patient activity, elective in-patients and out-patient first attendances, chiefly at STHFT. "

1.2

The Clinical Commissioning Executive (CCE) has the strategic capacity to set and review cross-consortia priorities for what commissioners will do to help manage demand for health care within allocated budgets. The following priorities have been agreed:

1 Improve care for the over 75s focusing on reducing unscheduled care activity
2 Better management of COPD (lead commissioners = Central)
3 Better management of Diabetes (lead commissioners = West)
4 Improve care by reducing unscheduled care activity (A&E attendances and non elective admissions) for children and adults under 75, reducing the length of stay for short stay (<2days) admissions and improving the interface between A&E and other unscheduled care services (lead commissioners = North with Central)

In addition the Confederation will work on the following two priorities:

5 Continued management of referrals including optimising the utilisation of alternative services to secondary care and a reduction in clinically inappropriate referrals
6 Engage with local Enhanced Public Health programmes where they exist

1.3 This plan provides the context for each of these priorities, clear steps for implementing the strategy and measures to enable progress to be evaluated.

1.4 Where a PBC-led business case is agreed this plan is prescriptive: while pace may vary locally, the timescales here are those by which all consortia have agreed to deliver, (enabling savings in approved business cases to projected). Where appropriate PBC-led Task Groups will be set up and implementation decided in partnership with NHS colleagues, the local authority and other key stakeholders.

1.5 It is proposed to set up a consortia-led Managers Group to oversee implementation.

2. Importance of PBC

2.1 Consortia are encouraged to continue with the implementation of local reforms already begun and this plan is not intended to preclude consortia initiating new reforms in 2010-11. However PBC leadership has been and will continue to be critical in helping NHS Sheffield manage demand within fixed budgets. PBC has enabled us to identify opportunities to put in place better quality and more cost-effective patient care and to date 47 PBC-led business cases have been approved. The establishment of the CCE in

20091-10 and the setting of cross-consortia priorities for 2010-11, all aimed at the systematic transformation of health services, are an important stage in the local development of PBC.

3. Patient and public involvement

3.1 Consultation around successive updates of *Achieving Balanced Health* has confirmed the public's willingness to use alternatives to hospital where services are available.

3.2 Where PBC-led business cases have already been approved, these have been informed by more specific patient feedback. Ongoing patient feedback on redesigned services is included as a standard in annual evaluation reports.

3.3 Where Task Groups are to be set up, proposals will be developed in consultation with patients/carers.

	Implementation Plan
1	**Improve care for the over 75s, focusing on reducing avoidable emergency admissions** In 2008-9, compared to what would have been expected for Sheffield's population, our unscheduled care activity was 12.5% higher and our costs 27% (£23 million) higher, suggesting there is considerable scope for improvement in this area (NHS Comparators). 7.4% of Sheffield's population is currently aged 75 years or more and this age group is set to grow by 20% over the next 10 years. However in 2008-9 this cohort accounted for 26% of Sheffield's emergency admissions and 43% (£46 million) of total emergency admission costs of £106 million. If we do not redesign services to better meet the needs of the frail elderly we will therefore not reduce emergency admission activity and costs which are already significantly higher than the national average. Three PBC-led projects will focus on reducing avoidable admissions of the over 75s: • A Local Incentive Scheme for Unscheduled Care, which supports practices to develop and manage registers of 75+ at risk of hospital admission in the next 12 months. Citywide, admissions of older people from the community accounted for just under £36 million of the total 75+ spend above. • A Local Enhanced Service for Care Homes. Citywide, care homes admissions (including falls) accounted for c. £4.5 million of the above total. • A Falls Prevention Service which will enable GPs to refer 75+ at risk of falling for a multi-factorial risk assessment and management plan. Citywide, falls (excluding care homes) accounted for the remaining £6 million of the above total. A 'Care of Older People at Home' specification is also being developed to enable a contract variation to be discussed with Sheffield PCT Provider Services. **This objective is covered by QIPP lines:** 13.2 Development/roll out of model identifying at risk patients PARR (ABH) – expected to deliver savings of £270k in years 1, £364k in year 2 13.9 LES CARE Homes (priority1) – expected to deliver savings of £708k in year 13.9 Falls (priority3) – expected to make savings of £26k in year 1, £222k in year 2, £9k in year 3 **Key benefits for Sheffield's population:** • 75+ patients at-risk systematically identified and managed • Reduction in 75+ emergency admissions against 2009-10 baseline (2008-9 baseline for HASC).

Addressing the needs of dementia patients admitted to STHFT for medical reasons

Sheffield has 3,318 on practice dementia registers, a higher prevalence (0.6%) than nationally (0.4%). The total budget devolved to PBC includes c. £670k for memory clinics within the Sheffield Health and Social Care Trust (SHSCT) contract. According to the national Dementia Strategy, only one third of people with dementia receive a formal diagnosis or have contact with specialist services at any time in their illness. We can expect numbers to double and costs to treble in the next 30 years

The PBC 75+ Task Group has already identified the need to develop a pathway for chronic mental health and dementia care, including care homes. The Memory Clinic already has an 18-week wait problem and we need to free up capacity by creating access to follow up care and structured peer support in the community. Spend and activity on chronic mental health/dementia services across SHSCT and Sheffield PCT Provider Services delegated to PBC will be reviewed and specified developed to support the proposed pathway.

This objective is covered by QIPP line:

11.5 dementia improve services – no savings attached as yet

Key benefits for Sheffield's population:

- Improvement in number of dementia patients receiving care against estimated prevalence
- Reduced waiting times for specialist assessment
- Easier access to care, support and advice post-diagnosis for patients and their families
- Approach developed to improve dementia care in residential settings

2	**Better management of COPD** In 2008-9 15% of patients with COPD had an emergency admission. Our local rate is little above the national average (14%) but there is considerable scope to improve the quality of care by reducing variation between practices in register management. For example, QOF requires patients receive a lung function test every 15 months but across the city the numbers receiving a timely test ranges from 34% to 100% (YHPO). Best practice in the management of COPD is well described by NICE and we will supplement this by making available to practices protocols from the General Practice Airways Group, COPD Navigator software and training. We will then agree with consortia clinical leads which patients on the database we are interested in looking at to sort and prioritise interventions for the sub-optimally treated. This objective is covered by QIPP lines: 3.1 Active programmes deliver KPIs (priority 1) – expected to deliver net savings of £159k in year 1, £397k in year 2, £109k in year 3 3.2 Develop community COPD model – city wide (priority 1) – expected to deliver net savings of £112k in year 2 **Key benefits for Sheffield's population:** • Reduction in variation of care against 2008-9 QOF baseline • Reduction in avoidable emergency admissions against 2009-10 baseline.
3	**Better management of Diabetes** Nationally we are experiencing exponential growth in diabetes prevalence and in Sheffield we can expect an increase in the number of diabetes patients of up to 40,000 in the next 15 years – a doubling of the current diabetes population. A new approach to commissioning will be implemented which will focus on commissioning diabetes care at 4 different levels (routine, enhanced, specialist and complex) ensuring patients are cared for at the most appropriate level and reduce the burden on specialist providers. **This objective is covered by QIPP lines:** **2.1a Enhanced diabetes care in the community – Tier 1 citywide (priority1) – expected to deliver net savings of £95k in year 1, £111k in year 2 and £113k in year 3.** **2.1b Enhanced diabetes care in the community – Tier 2 - CENTRAL (priority 1) – expected to deliver net savings of £17k in year 1, £78k in year 2 and £93k in year 3.** **2.2 Expand patient education programme (priority 1) – no savings attached as yet** **2.4 manage pre-diabetes/identify high risk patients (priority 1) – no savings attached as yet** **Key benefits for Sheffield's population:** • Reduction in variation of care against 2008-9 QOF baseline • Increase in patients transferred out of specialist care (level 3) into routine(level 1) or enhanced (level 2) care

4 Unscheduled care adults <75 and children

There is strong benchmarking evidence to support the view that levels of non-elective acute hospital activity in Sheffield are significantly higher than national norms. Our projections assume that very significant progress will be made, through initiatives to improve efficiency over the next four years, to bring Sheffield's activity into line with, or lower than, national averages.

By 2013/2014, allowing for the net effect both of underlying growth in demand and of efficiency initiatives, we plan to achieve a net reduction in non-elective spells of 3.2%.

Admissions avoidance/reducing short length of stay

A number of initiatives are being scoped or implemented for adults under 75 and children with the aim of:

- reducing inappropriate or avoidable admissions and A&E attendances
- improving systems so that patient pathways are streamlined and more efficient
- reducing short lengths of stay.

These objectives are covered by QIPP lines:

13.4 Admissions avoidance adults (Priority 2) – expected to deliver net savings of £300k in year 3 and £300k in year 4

13.4 Redefine pathways for short stay admissions adults - focus on nil LOS – expected to deliver savings of £250k net in year 1 and £250k net in year 2 (Also in section 1)

13.5 Admissions avoidance children (Priority 1) – expected to deliver net savings of £372k in year 1 and £544k in year 3

13.5 Admissions avoidance children – expected to deliver savings of £372k net in year 1, £544k net in year 2

Roving GP - Central consortium is currently piloting a service where a 'roving GP' visits patients that need an urgent home visit that are at risk of an unplanned admission. This service is currently being evaluated with the intention of extending it to the rest of the city.

This objective is covered by QIPP line:

13.7 Roving GP service – roll pilot out (priority 2) – expected to deliver net savings of £250k in year 2, £500k in year 3 , £200k in year 4

Follow up after discharge

There is potential to reduce re-admission rates through quick intervention post discharge. An idea to introduce post discharge 'follow ups' in primary care is currently being scoped.

This objective is covered by QIPP line:

13.9 GP follow up after discharge (priority 2) – expected to deliver net savings of £400k in t=year 2, £400k in year 3

Key benefits for Sheffield's population:

- Improved patient experience gained through the development and implementation of improved management guidelines for common conditions with both health professionals and carers
- Reduction in non-elective against 2009-10 baseline
- Reduction in non-elective admissions spend against 2009/10 baseline
- Reduction in A&E attendances against 2009/10 baseline
- Reduction in A&E attendances spend against 2009/10 baseline
- Reduction in number of non-elective admissions with short length of stay against 2009/10 baseline
- Reduction in spend of non-elective admissions with short length of stay against 2009/10 baseline
- Reduction in non-elective re-admissions
- Reduction in spend on non-elective re-admissions

5	**Continued management of referrals including optimising the utilisation of alternative services to secondary care and a reduction in clinically inappropriate referrals** *(description of where we are going with RIS etc)* **This objective is covered by QIPP line:** 1.8 Reduction in referrals (priority 1) – expected to make net savings of £520k in year 1, £700k in year 2, £600k in year 3 **Key benefits for Sheffield's population:** • Sustained reduction in GP referrals to secondary care (*define*) • Increase in activity at services provided as alternatives to secondary care (*set baseline*)
6	**Engage with Public Health Programmes where they exist** • Engage with local Enhanced Public Health programmes where they exist by promoting with appropriate member practices

	Milestones	By when	Who
1 Improve care for the over 75s	• Get practices signed up to LIS. Unscheduled Care • All 75+ patients scored • Audit practice-level progress • 6/12 evaluation • 12/12 evaluation • HASC to implement Phase 2 audit and pilot enhanced care planning approach	April 2010 August 2010 Quarterly from June 2010 November 2010 March 2011 Sept 2010 (audit) Pilot complete December 2010 roll out thereafter	Eithne, Agnes, others identified as required
	• LES Care Homes service commencement • Plug gaps in consortia • 6/12 evaluation • Audit information sharing across agencies and quality of care plans, EOL planning and DRARs • Survey residents/carers as part of 12/12 evaluation	April 2010 Ongoing November 2010 March 2011 March 2011	Practices Consortia leads Agnes, Eithne Agnes, Eithne
	• Feedback on 'Care Of Older People at Home' spec • Final draft to all stakeholders	June 2010 Aug 2010	All consortia
	• Get Falls Prevention Team case approved • Service commencement, practices to refer • 6/12 evaluation • 12/12 monitoring report, including patient feedback	April 2010 September 2010 November 2010 March 2011	Agnes All practices Agnes, others as required Agnes, others as required
Dementia care	• Understand SHA baseline review • Identify Task Group to review Memory Clinic/pathway • Devise/share work plan with CCE for info	April 2010 May 2010 June 2010	Eithne, Agnes, Sarah, others TBC
2. COPD	• Identify COPD GP/clinical leads in each consortium • Circulate practice information packs re performance • Organise COPD Navigator demo • Install COPD Navigator • Run software across city to identify nos. on COPD register: - With severity recorded - With management plan • Consortium-level plan to tackle sub-optimal on register – plan to be produced in July with cross city PH nurse input • Run software to identify nos. at-risk not on registers: - No confirmed diagnosis (smokers v non-smokers) - Current and ex-smokers (35+) - Ex-smokers with chest infection in last 12 months	June 2010 July 2010 July 2010 August 2010 Aug/Sept 2010 July 2010 August 2010	Consortia Sue Thackray/public Health Sue Thackray/public Health Sue Thackray/public Health All practices Maria Read/ PH nurses All practices

	• Update consortium plan to include at-risk not on register • 6/12 evaluation – criteria to be set • 12/12 evaluation, including patient feedback	September 2010 October 2010 March 2011	
3. Better management of Diabetes	• Agree how Practice Based Commissioners, the Diabetes Planning and Commissioning group and NHS Sheffield representatives will work together • Lead the development of a specification(s) for Level 2, to include the boundaries with level 1 and 3 and quantification of demand at each level of care, and to be accompanied by a business case. • Quantify the demand at each of the four levels and model potential commissioning solutions • Analyse the market to identify and stimulate providers in order to meet growth in demand • Progress the commissioning of a level 2 service for Sheffield, ensuring that it is steered by clinicians (PBC &DPCG advisors) and effectively commissioned, through robust and clear processes, including decommissioning where necessary and appropriate procurement.	June 2010 September 2010 September 2010 September 2010 October 2010 onwards	Jenny Stephenson/PCT Strategy & Public Health Marianna Hargreaves to support development of spec; Lis Reid to lead development of business case and quantification of demand. Marianna / Caroline Mabbott Marianna / Lis / others as appropriate

	Milestones	Who	By when
4.1	**Adult admissions avoidance/reducing short length of stay**		
4.1.1 Extension of Rule out services in A&E (chest pain and DVT)	• Scope potential for expansion of rule out services in A&E (chest pain and DVT) and make decision to pursue or not • If idea is to be pursued produce first draft business case **Further quarterly milestones to be agreed in year as appropriate**	Mid July 2010 End August 2010	A Heaton/ I Tabani A Heaton/ I Tabani
4.1.2 Expansion of OPHAT	• Promote existing community OPHAT services to referrers • Scope potential for expansion of community based infusions to other conditions/treatments and produce action plan • Specify services/changes to existing pathways and develop business cases as appropriate **Further quarterly milestones to be agreed in year as appropriate**	End June 2010 Mid July 2010 End August 2010	R Oliver/ A Heaton
4.1.3 Consultant advice pre admission	• North and Central to continue to participate in STH pilot scheme (system for obtaining advice from Alan Fletcher (acute cons) when GP requests non-elective admission – resulting in reduction in admissions - Pilot commenced October 2009) • Evaluate pilot (STH) • Support development /roll – out of pilot as appropriate	TBA	R Oliver STH colleagues
4.1.4	• North GP leaders to meet with Central GP leaders and others as appropriate to suggest a number of potential initiatives (to reduce admissions or short length of stay) that can be scoped. **Further quarterly milestones to be agreed in year as appropriate**	Mid July 2010	North steering group GPs
4.2	**Children's admissions avoidance/reducing short length of stay**		

4.2.1	• Establish working group
	• Commission Audit of AAU activity with SCT
	• Analyse audit results
	• Confirm areas for focus (e.g. a) for service improvement/systems change, b) promotion of revised management guidelines for common conditions, c) development of community services
	  • Confirm whether audit supports proposal to shift GP admissions from AAU to A&E
	  • Develop action plan for above service change if pursued
		1 April 2010
		End May 2010
		End June 2010
		Mid July
		
		Mid July
			R Oliver/
			K O Connor/
			S Haigh/
			A Heaton/
			M Ferris
			SCH colleagues

	Further quarterly milestones to be agreed in year as appropriate	End July	
4.2.2	Common conditions project (see (b) above) • Agree final list of conditions/symptoms where greater clarity around treatment protocols would be helpful for both primary and secondary care clinicians and parents • Agree shared protocols/management guidelines • Share protocols as appropriate with clinicians and public (e.g. leaflets) • Agree how to maintain the use of protocols with clinicians	Mid July 2010 End Sept 2010 November 2010 End Sept 2010	R Oliver/ K O Connor/ SCH colleagues A Heaton
4.3 **Roving GP**	• Evaluate Pilot service and take decision to roll out or not If yes: • Review specification for service • Write business case for roll out and gain approval • Secure engagement and support • Procure service • Mobilisation – preparation for new service • New service starts	Mid June 2010 End June 2010 Mid July 2010 End October 2010 End Nov 2010 1 December 2010	J Skinner/S Heaton/S Haigh/clinical leaders in North and Central
4.4 Follow up after discharge	• Scope potential for service aimed at and make decision to pursue or not **Further quarterly milestones to be agreed in year as appropriate**	Mid June 2010	T Turner/A Heaton/R Barnes

References to related projects:
Work to redefine SPA
Work with PCT colleagues to explore the potential to procure new minor injuries service for adults/ children (co-locate minor injuries STH/SCH and walk in centre with GP centre)
Negotiation with SCH to agree reduced local tariff for AAU admissions
Work with Alan Fletcher STH re: consultant advice pre admission
North A&E audit and actions to target A&E frequent flyers/social marketing Choose Well campaign

5. Referrals	**Continued management of referrals including optimising the utilisation of alternative services to secondary care and a reduction in clinically inappropriate referrals** • All practices making all hospital and 'alternative provider' referrals via RIS or Choose and Book	October 2010	Consortium leaders/Robert Carter
6. Public Health - Engage with Enhanced Public Health Programmes where they exist	• Ensure consortium leaders are aware of local EPH programmes • Work with Public Health colleagues to ensure current local EPH programmes are promoted with member practices	End June 2010 End September 2010	Consortium leaders/Public Health colleagues