SCRUTINY COMMISSION FOR HEALTH ISSUES	Agenda Item No. 5
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Report of the Executive Director of Corporate Support, Cambridgeshire and Peterborough Clinical Commissioning Group

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CAMBRIDGESHIRE AND PETERBOROUGH CLINICAL COMMISSIONING GROUP - PRIORITIES

1. PURPOSE

1.1 To update Peterborough Scrutiny Commission for Health Issues on the work on the three priority areas for Cambridgeshire and Peterborough Clinical Commissioning Group.

2. RECOMMENDATIONS

2.1 For information

3. BACKGROUND

3.1 In July 2012, members of the Shadow Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) Governing Body selected three strategic priorities for the organisation to focus on:

- Improving out of hospital care for frail older people
- Improving End of Life Care (EoLC)
- Tackling health inequalities in coronary heart disease (CHD)

This report is an update on the work of these three priority areas since Cambridgeshire and Peterborough Clinical Commissioning Group became a statutory organisation in April 2013.

4. UPDATES

4.1 Older People's Programme

4.1.1 **Background**

The rationale for change in how care for older people is commissioned and provided has been discussed many times over recent months, but it is always important to keep the reasons in mind when going through major change processes.

Significant transformation is needed to deliver the vision of 'joined up care focused around the patient' described above in the context of forecast demographic change (see figures below for 2010 – 2016)

Peterborough	Cambridgeshire
23% growth in 65+ population	25% growth in 65+ population
23% growth in 80+ population	18% growth in 80+ population
32% growth in 85+ population	22% growth in 85+ population

- Minimal, if any, financial growth in the health sector, alongside likely reductions in funding for Local Authorities.

- Shortcomings in current service provision. There is evidence of a lack of 'joined up working' between acute, community, primary care and social care organisations. The way in which services are organised is reactive to illness rather than proactive to prevent crises and maintain independence. This results in known current service issues – pressure on Emergency Departments, high occupancy in hospital beds, delayed transfers of care, extended lengths of stay in hospital, and pressure on limited resources in community and primary care services. In addition, there are issues with information sharing, financial incentives not being aligned to support effective care, and short term contracts.

- Cambridgeshire Community Services transition. In 2012 the CCG advised the Strategic Health Authority that it was not able to support progress to Foundation trust status for Cambridgeshire Community Services. The main rationale was that this would provide flexibility over future service configuration to improve outcomes in the context of significant demographic and financial pressures. This has led to the CCS Transition Programme, and whilst the main driver is our strategic focus on older people's services, we are also currently coordinating the process for determining future arrangements for other CCS functions with partner organisations (note that the Trust Development Authority may take on some aspects of this coordination role in future).

All these factors lead to the conclusion that we need to engage with providers and stakeholders to re-design how services are commissioned and provided - no change would be a very high risk option.

4.1.2 **The Programme Overview**

The first part of the programme has focused on work to specify local aims and outcomes for the future of services for older people. This work has involved many stakeholders, and the specifications reflect local issues, but some common themes have emerged such as:

- providing better care in a consistent way for patients who are at higher risk of serious illness, anticipating and preventing crises. For example, GPs being able to get rapid access to a consultant geriatrician to ask for advice over the phone about a patient who they may be concerned about which can prevent an unnecessary admission into hospital. Another example would be a responsive and robust community support service involving GPs, nurses, therapists and carers working together to offer safe care in the community for older people if a crisis occurs.

- improving care for older people when they are admitted to hospital and enabling them to return home safely when they are well enough with the right support. For example, better discharge planning by having community matrons working more closely with hospital nurses.

These are not necessarily new, but what is different is the clinical drive to **organise care around the patient by commissioning a joined up hospital and community service specifically for older people, and using NHS funds in ways which support staff to work better together.**

Focus on Outcomes

A key aspect of the Programme is its focus on outcomes: preparatory work has been carried out on the CCG's main headline outcome measures: patient reported outcomes, patient satisfaction and emergency bed days. Emergency bed days give an indication of how well health services are working to avoid unnecessary hospital admissions, reduce delayed transfers of care and emergency readmissions to hospital. Work to analyse current spend on services for older people has also been taken forward.

The next phases cover refinement of these workstreams, further engagement with stakeholders, and dialogue with providers. The programme plan is to deliver new services from July 2014.

4.1.3 Stakeholder Engagement

There has been substantial engagement to date on local visions, outcome specifications, the case for change and the overall programme. We are now entering into the next phase of dialogue on options for service delivery and funding.

Wider stakeholder engagement will be needed to set out the case for change and the overall approach, currently programmed for June – August. The Department of Health 'Gateway Review' team has reviewed the overall programme and this has helped to determine the extent of further engagement needed.

In addition to local stakeholder engagement work, a CCG wide event was held on 5th March, facilitated by Chris Ham, CEO from the King's Fund. Over 100 delegates attended from Local health care providers, health and social care commissioners, voluntary organisations and patient representative organisations.

4.1.4 Provider Engagement

As part of the process, the CCG wished to assess the level of provider interest in the opportunities to deliver older peoples services. A Provider Engagement Event was held on 16th April which was attended by approximately 100 people representing 50or more organisations, which demonstrates a strong level of potential engagement from local, national and out of area providers. The Older People Programme was presented followed by a questions and answers session, and time for providers to discuss possible collaborations. Local providers all recognised the need for major change in the context of current service issues and forecast demographic and financial scenarios.

One recurrent theme was that the provisional programme did not allow sufficient time for dialogue with local commissioners or collaboration discussions between providers, and it was recommended this phase of the programme was extended through to the end of May. The 'May roadshow' covering all LCGs and various other stakeholder groups has now been completed. The follow up Provider Engagement event was held on 21st May facilitated discussions between LCG / CCG teams and 27 individual providers, as well as providing an opportunity for continuing provider – provider conversations. One further event was held on 3rd June to accommodate discussions with more potential providers.

4.1.5 Critical Success Factors

It is very important that there is clarity regarding how success of the Programme will be measured, as this drives the assessment of options for service delivery and funding, the assessment of bids which may be received as part of a procurement process, and also informs the longer term evaluation of the programme.

Draft Success Criteria

The following success criteria were discussed at a CCG Options Workshop involving LCG clinical leads and social care commissioners, and then developed by the Programme Board for recommendation to the CCG Governing Body.

The extent to which any option or proposal will deliver the vision and specifically:

a. *Improve patient experience and service quality for older people and their carers through care organised around the patient.*

b. *Deliver services which are sensitive to local health and service need, as defined in local outcome specifications.*

c. *Move beyond traditional organisational and professional boundaries, so front-line staff can work effectively and flexibly together to deliver seamless care.*

d. *Supporting older people to maintain their independence, and reducing avoidable emergency admissions, re-admissions and extended stays in acute hospitals (including delayed transfers of care)*

e. *Deliver an organisational solution for the older people's care which can demonstrate strong leadership, sound governance, resilience, and the confidence of commissioners and provider partners*

f. *Demonstrate credible approach to engaging patients and representative groups in design and delivery of services*

g. *Provide a sustainable financial model (see financial principles below)*

4.1.6 **Creating Conditions for Investment: Length of Contract**

A key consideration in this new approach will be how to create the right conditions for investment by providers. The current 3 year standard NHS contract with annual re-negotiation does not provide an environment in which providers will feel confident to invest in (for example) improving community services with a view to deriving health outcome and financial benefits later down the line.

It is therefore proposed that a longer term contract (5 years with an option to extend by a further 2) would be offered which would provide more confidence and the conditions for providers to manage significant service improvement programmes which may take 18 – 24 months to implement.

4.1.7 **Funding Options**

The purpose of dialogue with providers is to explore and develop options which could meet the financial principles, including how financial risk is shared.

One alternative to Payment By Result and block contracts which arguably fits with the financial principles is a 'year of care' budget for older people or 'capitation budget'. There are several possible approaches, such as defining a group of patients who are at highest risk of serious illness and/or admission to hospital, assessing the annual cost and using this as the basis for funding. A simpler alternative would be a 'population approach' which takes the total annual cost for a defined range of older people's services and divides by a weighted population such as over 65's to produce an average cost per year per patient. This is based on two principles:

1. If the fundamental aim is to ensure care is organised around the patient in the most cost effective and efficient way possible, and a single organisation or provider alliance is responsible for providing that care, then they should receive funds to pay for all elements of it.

2. If the provider can use the funding as it sees fit across the whole pathway, it will have the incentive to use it effectively to achieve LCG specified outcomes and cost efficiency. This could include investment in community services and services to help patients manage chronic conditions for example.

Work is in progress to cost and model various 'year of care' funding approaches.

Feedback from engagement indicates that there is recognition that current funding arrangements need to change, and that capitation approaches have potential but also risks which need to be worked through with providers.

4.1.8 **Lead Provider**

The CCG's preferred approach is that there should be a clear 'Lead Provider' which is accountable

for delivery of the defined service scope for older people in each local system. This may be a single organisation or alliance as described previously, but our preferred approach is for Lead Providers to directly provide some patient services for older people, and that they must be capable of coordinating care both at individual patient level and through contracts with 'supplier organisations'.

4.1.9 Scope of Services

Acute hospital unplanned care and community services

The underlying principle for the programme is to join up the whole pathway. Within this the major components are **acute hospital unplanned care for over 65's and community services**. The initial scoping exercise has focused on unplanned acute hospital care for older people as the area which presents the greatest challenges locally and which we want to include in scope.

Older People's Mental Health Services

Our preferred approach is to also include **Older People's Mental Health Services** in scope on the grounds that integrating physical and mental health is one of the key themes of our OPMH joint commissioning strategy and a key OPMH priority.

Voluntary Sector Grants / Contracts

The CCG commissions a number of services from the voluntary sector which are relevant to older people's services and believes that the voluntary sector has a vital role to play in improving out of hospital care for older people in the future. Our preferred approach is the Lead Provider(s) should be responsible for commissioning services from the main voluntary sector organisations delivering services to older people, as well as being able to invest in voluntary sector provision to strengthen services. Lead Providers would need to work with other commissioning organisations to manage / develop joint funding arrangements where appropriate.

End of Life Care

End of life care is an important element of the care pathway for many older people, and is included in the CCG's preferred funding approach.

Specified primary medical services

At this point, the Care Home enhanced service is included in scope. An option to include primary care prescribing for older people will be developed as part of dialogue.

Older People – Adult Services

Estimates have been made regarding the percentage of older patients served by each CCS community service, based on samples or querying patient records. Even where this is high – such as district nursing – some patients are younger and still need the service. The CCG's preferred approach is to commission one service from the same provider, but with different funding approaches. For example, a relatively simple solution would be to apply the capitated year of care approach for the older population (over 65), with an 'adult community services premium' or 'top up' to cover the costs of providing services to the minority adult care group.

Social Care

Both Cambridgeshire County Council and Peterborough City Council have stressed that they see close alignment between health and social care leadership and frontline staff as essential for older people' services , but neither currently wish to include social care funds in any new pooling arrangement, or integrate social care staff with health provision (with some specific exceptions in Cambridgeshire). This does not preclude the possibility that social care may be negotiated in at a later stage in the contract subject to agreement by all parties.

4.1.10 Next Steps

The next steps are taking forward the procurement process (commenced 1st July), developing the next iteration of the outcome specification including outcome measures, further engagement with stakeholders and development of the contract and funding workstreams.

4.2 End of Life Programme Board

4.2.1 Background

The rationale for selecting End of Life Care acknowledged that enabling patients to die in their preferred place of death is an area in which the CCG already does relatively well, but there is significant variation across the CCG geographically and in terms of disease. In Cambridge City 38% of deaths are in hospital, whereas in Peterborough/ Fenland the figure is 48%. Whilst 40% of people with cancer die in hospital, for respiratory disease it is around 60%.

4.2.2 The Programme Board

A clinically-led programme has been established to take forward EoLC. The Programme Board met for the first time in December 2012 and subsequent meetings have been scheduled to take place every two months. The Board is chaired by a clinical lead and its voting members include patient representatives, clinicians from across the CCG, and managers. Non-voting members include representatives from provider, charitable and voluntary sector organisations.

Terms of Reference were signed off by the Programme Board in December and Board members have agreed a vision for the programme and a broad approach to the work. The role of the Board is to oversee delivery of the CCG strategy to improve EoLC whilst enabling and supporting LCGs to deliver the programme locally, and to provide an overview across the CCG. As delivery of the programme objectives will be locally driven, approach is likely to differ from LCG to LCG.

The Programme is supported by a management team which includes expertise in key business areas (clinical EoLC, public health, finance, informatics, communications, IM&T and project management). A programme plan setting out the various workstreams and timescales has been developed and a risk register has been developed and is being regularly reviewed by the Programme Management Team.

4.2.3 The Vision

At its inaugural meeting in December the Board agreed on the following vision for the programme:

> *'To optimise the experience of care for patients approaching the end of their lives (and their carers) in all settings and at all times of the day and night'*

The Programme is basing its approach on the *End of Life Care Strategy: Promoting High Quality Care for all Adults at the End of Life* and *NICE Quality standards for End of Life Care for Adults*.

4.2.4 The Programme so far

Phase 1 of the programme has recently been completed. This phase involved undertaking scoping work to inform the design and finalise the programme objectives. There were three main elements to the scoping work:

(i) GP survey

In January and February a survey was circulated to all GP practices in the CATCH, Cam Health, Hunts Care Partners, Hunts Health, Isle of Ely, Wisbech and Borderline LCGs. Practices were asked to comment on various aspects of EoLC service provision.

(ii) LCG workshops

To help facilitate local review and development of EoLC services, the Programme Management Team ran workshops, externally facilitated by Marie Curie Cancer Care, for each LCG between March and May.

Provider organisations were invited to attend the workshops and the broad remit was to identify what was working well in terms of EoLC services, what was not working well and what the LCG's ideal vision/ pathway for EoLC services was. Detailed reports were produced following each workshop giving the EoLC Board a comprehensive picture of provision and need across the CCG.

(iii) Topic specific scoping groups

The final strand of scoping work consisted of groups looking at specific areas considered by members of the EoLC Board to be of particular importance:

Topic	***Lead***	***Remit***	***Ultimate aim***
Admission avoidance/ discharge planning	Dr Stuart Shields (Hunts Care Partners)	To review discharge planning, crisis avoidance and day to day community care (including district nursing, hospital at home and social care)	Increase in community support enabling avoidance of hospital admission where this is the patient's preference
Acute/ Secondary Care	Dr Richard Partidge (PSHFT/ Thorpe Hall)	To look at the quality of palliative care in acute setting	Increased quality of EoLC in acute and secondary care settings
Support for Carers	Sandy Ferrelly (Hunts Health)	To look at the role of the carer and the support required to enable carers to perform this role effectively	Improved support to carers supporting patients in their last months/ days of life
Bereavement	Dr Stephen Barclay (CATCH)	To look at support required for those who are bereaved	Improved support and care for those who are bereaved

The results of all elements of the scoping work were presented to the EOLC Board on 5th June 2013. Draft deliverables were agreed at the meeting, and follow-up meetings will be taking place with each LCG in June and July to finalise local and CCG-wide delivery plans for EOLC.

4.3 Coronary Heart Disease programme Board

4.3.1 Background

National evidence demonstrates that progress has been made over the previous decade in reducing morbidity and mortality rates for coronary heart disease both nationally and locally. However there remains a variation in mortality rates for defined geographical areas across the CCG. (See Appendix C)

As of 1 April 2013, Clinical Commissioning Groups took on a statutory duty to *"have regard to the need to reduce inequalities between patients with respect to their ability to access health services and the outcomes achieved for them".*

This programme aims to reduce premature deaths and unnecessary emergency admissions arising from coronary heart disease in people aged under 75 years, with a focus on reducing premature death rates fastest in areas of poorest outcome ('leaving no-one behind') To reduce the inequality in coronary heart disease this programme has chosen to focus on populations resident in Peterborough LCG, Borderline LCG and Wisbech LCG and other practices identified in 20% more deprived areas across the other LCGs

4.3.2 Overall programme outcome

The overall programme outcome is to reduce the premature mortality rate from coronary heart disease in the population's resident in Peterborough, Borderline and Wisbech to the same rate as that in the rest of the CCG. The baseline for this overall outcome measure is shown as Figure 1 Appendix C.

This outcome will be monitored on a three year rolling average at 6 monthly intervals by the Public Health data team. Data can be dis-aggregated by LCG area but will be difficult to interpret for smaller LCGs because of the low numbers involved.

The programme will focus on coronary heart disease (CHD) rather than the wider remit of cardiovascular disease (CVD). However, primary prevention strategies for identifying and effectively managing risk factors will have a positive impact on both the local programme and the national CVD strategy launched by the Department of Health January 2013.

4.3.3 Programme Structure

The Clinical Lead has recently been recruited. The Board has been established and has met twice since January 2013. The Board brings together all key stakeholders including CCG and LCG representatives, public health colleagues, community and secondary care clinicians, local authority and patient representatives.

In the first two meetings the Board has:

- Agreed membership and Terms of Reference.
- Drafted a Communication Strategy and developed specific communication tools to be shared across patient forum groups, public websites and internal communications to member practices and commissioning teams.
- Reviewed the Public health evidence in more detail to quantify the impact of the major risk factors in causing coronary heart disease in our local area.
- Considered the different levels of prevention that will reduce coronary heart disease and the relative impact these factors have had on the fall in coronary heart disease mortality that has been observed nationally over the last 30 years.
- On the basis of this analysis four work streams have been identified that will focus on specific interventions highlighted as critical factors in improving outcomes and reducing inequalities for coronary heart disease.

4.3.4 **Change Principles**

The programme is underpinned by 5 change principles:

- Partnership working to address environmental risk factors
- Partnership working to address the key socio-economic factors
- Monitor modifiable risk factors and offer interventions
- Secondary prevention will be systematically offered in line with national guidance
- Systematic management of people with established disease including cardiac rehabilitation programme and access to heart failure services where appropriate.
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4.3.5 **Programme Approach**

Appendix B, 'Plan on a Page' presents a high level overview of the programme priorities and key milestones for each work stream planned over the next 6 months.

10. APPENDICES

10.1 *Appendix A Older People's Programme Plan on a Page. pdf.*
10.2 *Appendix B Coronary Heart Disease Programme, Plan on a Page. pdf.*
10.3 *Appendix C Figures for Coronary Heart Disease Programme Board (Below)*
10.4 *Appendix D Older People's Programme on a page.pdf.*

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