Report to STP Board: 14 March 2019

Agenda item:	2.3
Title:	Selecting clinical areas for radical transformation
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Report purpose *(Please mark one in bold)*			
APPROVAL	**DECISION**	ASSURE	INFORM

Link to STP Priorities *(Please mark all applicable in bold)*			
AT HOME IS BEST	SAFE & EFFECTIVE HOSPITAL CARE, WHEN NEEDED	WE'RE ONLY SUSTAINABLE TOGETHER	**SUPPORTED DELIVERY**

Committees/groups where this has been presented to before *(including date)*

Health and Care Executive (HCE) 12 February 2019.

Purpose of the paper

To describe a prioritisation process to identify clinical areas for possible radical transformation (pathway redesign) and make recommendations

The STP Board is invited to:

The STP Board are asked to agree the following:

- The areas for an STP-wide transformation are Cardiovascular Disease, Respiratory Medicine and a radical prevention agenda around Obesity, Diabetes and health inequalities;
- To support identifying CEO/system leader sponsors for each project and adequate resources from within provider organisations, SDU and CCG; and
- To involve Health & Wellbeing Boards, Healthwatch, disease-specific groups and voluntary organisations, staff and the local community in the identification of values underlying these healthcare priorities, as well as at every stage of the transformation process.

1. INTRODUCTION / BACKGROUND

Over the last six months the STP has agreed three priorities; *A&E performance, Delayed Transfers of Care (DTOC) and addressing drivers of the financial deficit.* Over the medium term these will be achieved, in part, through *Integrated Neighbourhoods.*

Recent NHS Planning Guidance 2019/20 and the NHS 10-year Plan have also described the importance of local STPs developing a population health management approach and emphasized that "*All systems will work with **NHS RightCare programme** to implement national priority initiatives in Respiratory and Cardiovascular conditions in 2019/20. They will also be expected to address improved care in at least **one additional pathway** outside of the national priority initiatives*"

Members of the Care Advisory Group (CAG) and wider stakeholders have addressed which clinical areas would be most appropriate and ranked them against defined criteria. The HCE and STP Board will make a final judgement on which of the rank areas to address.

2. BODY OF REPORT

Purpose and potential scope of transformation

The purpose of these initiatives will be to improve population health outcomes. The STP's triple aim of improving patient experience, outcomes and value for money will apply. The scope will include prevention, non-elective and elective/planned care, in/outpatients' settings, patient activation and co-production. Integration of mental health, health, social care and voluntary organisations will be delivered where relevant through an Integrated Neighbourhood model.

Stakeholders

In order to identify which of many contending areas for transformation we should address, we have consulted widely including the Clinical Commissioning Group (CCG) (Mark Sanderson, Gary Howsam, Fiona Head), specialty STP Clinical Leads, CCG GP Clinical Leads, Clinical Directors within provider organisations, North and South Alliances and members of CAG.

A shortlist of ten potential areas were developed, including diseases e.g. Dementia, or syndromes e.g. Multimorbidity.

Assessment criteria

Criteria against which the potential areas were assessed included:

a) National priorities from Planning Guidance and 10 year Plan;
b) Current local STP priorities; A&E performance, clinical drivers of DTOC, and drivers of the deficit;
c) Local Public Health priorities; hypertension, smoking and workplace health;

d) Impact on health inequalities; local drivers for health inequalities across our STP include MSK, cardiovascular disease, respiratory diseases;
e) Evidence of poor population health outcomes including from RightCare and Getting it Right First Time (GIRFT) programmes. Within our area RightCare has identified cardiovascular, respiratory and neurological (stroke) disease as areas where we are outliers. Not all clinical areas have yet been assessed through the GIRFT process;
f) Evidence elsewhere of innovative pathways. Areas where an innovative pathway has previously been demonstrated to deliver improved care for patient have been sought;
g) Strong specialty clinical community support and readiness. It is not possible to undertake radical re-design of a clinical area without the support of the relevant clinical community. Not all clinical areas have reached the same level of maturity and are, at this stage, enthusiastic for considering re-design; and
h) Amenable to a clinical model of Integrated Neighbourhoods. Some clinical areas are more amenable to the holistic, population based approach implicit in Integrated Neighbourhood model of care.

Those that addressed the triple aims of the STP, patient experience, outcomes and value for money carried greater weight than others. Transformation is not the same as increased funding, which some area may need whilst not requiring a major transformation of clinical pathways and service delivery.

Those which require a system wide approach, working with all partners, are more relevant to an STP led transformation than those which can be addressed within a single provider.

CAG members also felt that more work needed to be completed to understand the local public's views on priorities for healthcare delivery. This could be undertaken in conjunction with Health and Wellbeing Boards, Healthwatch and local communities as part of the engagement process required for the STP 5 year Plan.

Design and delivery

These transformation initiatives will be designed within relevant Clinical Communities which will include clinicians, patients, voluntary organisations/specialty charities as well as commissioning and operational staff. Primary prevention involving social, environmental and health/mental health factors, will be considered as well as clinical pathways and mechanisms of delivery. The latter would be devolved to the appropriate level and might include a single provider for the whole STP, a single provider for an Alliance, or by Federations/GP networks.

Each selected area will require a CEO and system leader sponsor from HCE. Throughout the design process there will be close collaboration between providers and commissioners.

Prioritisation

Aggregated scores from the clinicians ranked the potential areas as follows:

Cardiovascular	25
Respiratory Medicine	24
Dementia	22
Diabetes	22
End of Life	22
Mental health	22
MSK (falls, #NOF etc)	22
Stroke	22
Multimorbidity, frailty	21
ENT	17

Healthwatch also ranked these areas on the basis of their feedback from patient/public concerns:

Mental health	3
MSK (falls, #NOF etc	3
Multimorbidity, frailty	3
Diabetes	2
End of Life	2
ENT	2
Dementia	2
Cardiovascular	1
Respiratory Medicine	1
Stroke	1

Following a further meeting of CAG on 14 February 2019, Cardiovascular disease and Respiratory Medicine were agreed as areas for transformation.

- Cardiovascular Disease to include primary prevention of vascular disease, hypertension and stroke as well as cardiology. *Leads Drs Nick West & Liz Warburton.*
- Respiratory Medicine to include smoking cessation, air quality as well as clinical pathways in respiratory disease and lung cancer. *Lead Dr Jaki Faccenda.*
- Prevention and health inequalities. A third area is proposed to be a radical move away from single disease pathway transformation to a wider prevention agenda involving social, environmental, health and mental health determinants of disease. In the first instance this will be focussed around obesity and diabetes, which are also major determinants of health inequalities.

Time frame and Sustainability

These transformation projects will need to be supported with health analytics and project management support for more than one year. These could be diverted from other areas to focus on the priority projects selected by STP Board and HCE. It is recommended that transformation staff within the CCG, SDU and provider organisations are focussed on these areas.

3. RECOMMENDATIONS

The STP Board are asked to agree the following:

- The areas for an STP-wide transformation are Cardiovascular Disease, Respiratory Medicine and a radical prevention agenda around Obesity, Diabetes and health inequalities;
- To support identifying CEO/system leader sponsors for each project and adequate resources from within provider organisations, SDU and CCG; and
- To involve Health & Wellbeing Boards, Healthwatch, disease-specific groups and voluntary organisations, staff and the local community in the identification of values underlying these healthcare priorities, as well as at every stage of the transformation process.

26 February 2019

Appendices: ***Annex 1: Points for re-design in pathways.***

Annex 1: Points for re-design in pathways.

Pathway	For	Against
Musculoskeletal (MSK)	A major driver of QALYs lost within health inequalities; very disjointed commissioning in the community; part of the Hinchingbrooke Hospital solution	Not a major driver of A&E attendance or DTOC; addresses only one of local PH priorities (workplace health).
Mental Health	Core service underfunded; section 117 costs; un-integrated H/MH community delivery. PRISM needs better integration of community /primary care. Has public support	Doing reasonably well already with good delivery model with national recognition. Large part could be addressed within CPFT alone.
Multimorbidity and frailty	Major driver of A&E attendance, DTOC and health inequalities. Has public support	INs not yet mature, and this will in any case be their core work, and so is already a priority area for the STP; no clinical community; no agreement on multi-morbidity/frailty score. Lack of RCT evidence of improved outcomes/cost effectiveness (excluding Falls).
Cardiovascular disease	Major driver of health inequalities, with local poor outcomes on RightCare; would include hypertension (PH priority) and could potentially include Stroke (cf thrombectomy). In addition, this is listed as a 2019/20 planning requirement.	Not a major driver of DTOC clinical community not yet cohesive
Respiratory Medicine	Major driver of NEL and health inequalities with local poor outcomes on RightCare; would include smoking cessation (PH priority). In addition, this is listed as a 2019/20 planning requirement.	Clinical community only just started
Diabetes/Obesity	Major co-morbidity and driver of health inequalities; poor outcomes from RightCare and NDA.	Not directly a driver of DTOC
ENT	Multiple providers, discrete service, potentially open to new single provider delivery.	Not a drive of A&E attendance or DTOC
Dementia	Strong driver of DTOC, NEL, health inequalities.	Local strategy still being formed, less evidence from RCT of improved outcomes from new delivery mechanisms.
Stroke	Not a major driver of NEL, moderate impact on DTOC, hypertension in PH priority, centralised neuro-rehabilitation. Could be included with cardiovascular disease	Results improved in recent year; some remaining issues are within single organisations (thrombectomy).
End of Life	Identified as important by HealthWatch; new processes to be introduced (ReSPECT). Important QoL indicator	High value, small volume(relatively). Could be undertaken separately