Clinically Effective Commissioning (CEC)

CEC Programme Team
August 2017

How do we address waste and achieve best value?

CEC focussed on planned care (rather than urgent care)

In order to help the whole system balance resources and demand there is a need to:

1. Decide what the system will and won't do (e.g. medicines, procedures or other treatments) based on a defensible and clinically led decision making process
2. Enact those choices in formal policies, embed them in systems and communicate our decisions widely
3. Keep those policies up to date and under continuous review to ensure they reflect clinical evidence as it emerges and the needs of our local populations
4. None of these discussions undermine the hard work of clinical redesign which is also required, but these hard decisions will create the space in which redesign can occur

Releasing resources

Key assumptions:

- As a system we have identified all areas of waste and have addressed them via savings schemes – if examples of pure waste are located these are being addressed as an absolute priority
- We recognise that there is no more money likely to be forthcoming – we need to manage within the resources we have been allocated
- Managers can do a lot to implement change and identify the issues and challenges, but ultimately as a clinically led organisations, it is the membership of the CCG which need to decide the priorities for the local population – led by our clinical leaders

Why this is good practice, even if there weren't financial challenges

Resources required for the innovation

Implementation of high value innovation e.g. troponin in heart disease funded by reduced spending on lower value intervention in the cardiovascular programme budget and control of innovation of uncertain value.

Innovation adopted

Resources freed by reducing lower value activity

Programme Governance

CCG commissioned, STP oversight

There are 8 CCGs in the STP – they commissioned the work as it is core business for CCGs, but ultimately as the implementation needs the whole system to play a role, so CEC is a key work programme for the STP

CEC Programme is governed as follows:

•Decisions to change must be made by the CCGs – clinical policies are 'owned' by each CCG – so each must come to their own decision, but work in common to arrive at the same result by:

•Overseeing the work via the CEC Programme Board (all 8 CCGs are represented)

•Reporting weekly and monthly progress and issues

STP oversees and reviews

•STP executive monthly – highlight report

•STP clinical board – advises on clinical issues which may have wider system impacts

Three CEC Objectives

1. Common Policies - Objective

There are 8 CCGs in the STP – and there are at least 5 main versions of each clinical policy (this means that Patients referred to the same hospital for the same treatment are subject to different threshold policies).

The different policies mean that patients get different access and outcomes. If a common, revised policy can be established there will be:

- **Greater equality of access to treatments across the whole STP footprint**
- **It will be cheaper for CCGs to maintain currency of common policies**

All policies are being reviewed and detailed assessment of evidence supporting the policy and the degree of difference between each policy is being assessed.

Latest information on what the 8 CCGs spend with local acute hospitals indicates that there is substantial variation in numbers of treatments per 100k population – which indicates that there is non-clinical variation which could be addressed to release resources.

In other locations, improved policies and increased effort on end-to-end processes and compliance has stopped 5 - 15% of the activity, which could release £3-6m in a full year after implementation of the total programme

Three CEC Objectives

1. Common Policies – Progress

A first group of policies are being finalised – these are policies where most CCGs already had an existing policy and there is strong evidence body of clinical evidence exists to support a common policy which will set a threshold for treatment.

- **STP clinical board has agreed that most of the policies are uncontroversial**
- **all CCGs have had multiple rounds of drafts to review.**
- **Final drafts to be provided to CCGs in August for decision making within CCG processes**

A second group of policies is being reviewed and developed. These are more complex, as CCGs have different existing policies, or there is more clinical debate required to find the appropriate standard.

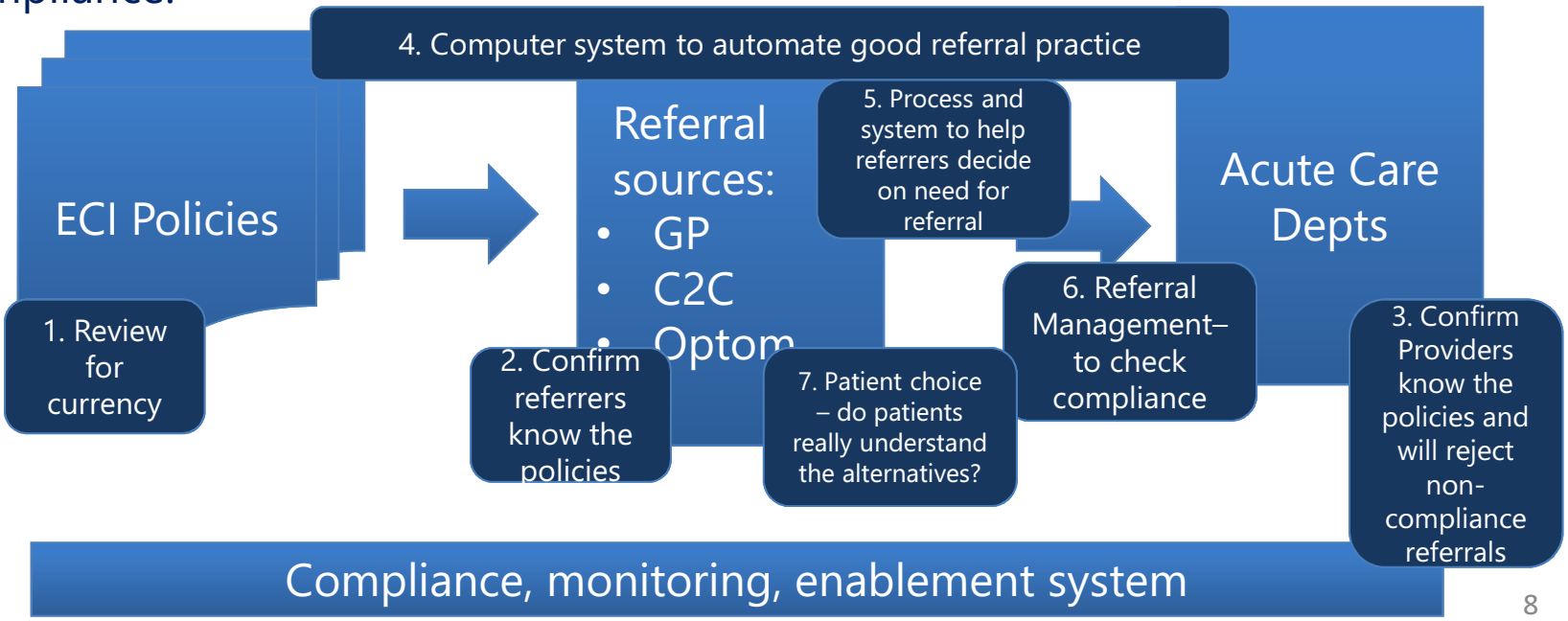
- Four clinical evidence review workshops have been booked for September – to bring acute providers, GPs, patient reps and others together to discuss the evidence base and as far as possible agree on an outline common policy
- If new policy proposals represent a significant change, then engagement and consultation processes will follow to ensure CCGs involved and engage all relevant stakeholders

CEC Objectives

2. Improved processes - Objective

There are 8 CCGs in the STP each of which have differing approaches to ensuring end to end compliance with existing policies. This leads to differing effectiveness of the thresholds – as in some cases there is evidence of significantly differing use of medicines and procedures, despite similar or identical policies.

There are significant advantages in the CCGs working together to develop best practice approaches and in some cases co-developing new processes and systems to aid compliance.



CEC Objectives

2. Improved processes - Progress

Each stage of the process has been analysed for each CCG.

The CEC programme has developed project outlines for 12 initial projects to improve each step of the process. Not yet been approved for implementation as there are key stakeholders who have yet to be involved.

- **PID 1**: Set up STP wide process to update, maintain and upload policy changes onto GP systems.
- **PID 2**: Help referrers work within the process (link to the introduction of supporting software e.g.. DXS)
- **PID 3**: Implement decision support tools to standardise GP referral
- **PID 4**: Harmonise uptake of E-referral (ERS) across Provider Trusts and support GPs to adopt
- **PID 5**: Standardise GP dashboard to review variation in GP referral patterns
- **PID 6**: Shared decision making and PDA processes to help patients make more fully informed decisions about their care
- **PID 7**: Align IFR processes to harmonise with prior approvals arrangements at Trusts
- **PID 8**: Advice & Guidance – Secondary care assistance to GP referrers – opportunity for common approach
- **PID 9**: Promote common approach to 'referral hub' function for validation of prior approvals.
- **PID 10**: Implement easy to use prior approval system in the four principal acute Trusts (BSuH, SaSH, ESHT, WSHFT). Capture C2C referrals.
- **PID 11**: Coding and costing optimisation supporting standardised reporting and compliance processes
- **PID 12**: Audits to demonstrate quality and compliance

CEC Objectives

3. Accelerating savings

There are 8 CCGs in the STP and an emerging cost pressure in 2017-18 for the Commissioners' budgets

Working across the CCGs, we aim to identify a range of opportunities which can be rapidly assessed and put in place across the system to improve the financial position.

This work takes place in the context of the Capped Expenditure Process, which required the whole system to demonstrate that all possible options has been considered then prioritised for further development based on criteria also developed in the project.

There are a small number of options which CCGs believe could be pursued in 2017-18 most of which involve the 8 CCGs working more closely together to share best practice and take advantage of the scale offered by the STP.

Further work to take place in August to gather more options, quantify the opportunities and examine the timescales for delivering sustainable change.