REPORT TO:	Health Policy and Performance Board
DATE:	9 September 2014
REPORTING OFFICER:	Chief Officer, NHS Halton Clinical Commissioning Group
PORTFOLIO:	Health & Wellbeing
SUBJECT:	End to End Assessment
WARDS:	Borough Wide

1.0 PURPOSE OF THE REPORT

To inform the Health Policy and Performance Board of the outcomes of the End to End Assessment Project, commissioned by NHS Halton CCG with NHS Knowsley, St Helens and Warrington CCGs and NHS England.

2.0 RECOMMENDATION: That the Health Policy and Performance Board note the report.

3.0 SUPPORTING INFORMATION

NHS Halton, Knowsley, St Helens and Warrington CCGs and NHS England commissioned work to deliver:

- A high level retrospective review of health care activity, spend and patient flows by commissioner and by location per quarter in the past three years.
- A review of all current health care activity, spend and patient flows by commissioner and by location.
- Projected activity, spend and patient flows by commissioner and by setting for the next 3, 5 and 10 years assuming current cost and payment arrangements.

The Chief Officer of NHS Halton CCG acted as co-sponsor of this project with David Cooper, Acting Chief Finance Officer - NHS Warrington CCG. They co-chaired a steering group working with Capita, who were selected following a procurement process to deliver this project.

4.0 POLICY IMPLICATIONS

The outcomes of the End to End Assessment work have been factored into the 5 Year Strategy for NHS Halton CCG.

5.0 OTHER IMPLICATIONS

There will be an impact on the provider landscape for Halton as the 5 Year Strategy is progressed. The End to End Assessment work highlights some of the areas in which this will happen.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children and Young People in Halton

NHS Halton CCG's 5 Year Strategy will have areas that will impact on children and young people. The End to End Assessment explored paediatric activity but the outcomes focus mainly on frail and older people.

6.2 Employment, Learning and Skills in Halton

None identified.

6.3 A Healthy Halton

The End to End Assessment work will help shape the future direction of health and social care commissioning in the borough.

6.4 A Safer Halton

None identified.

6.5 Halton's Urban Renewal

None identified.

7.0 RISK ANALYSIS

The End to End Assessment work influences the risk assessment that has been undertaken as part of the development of the 5 Year Strategy by NHS Halton CCG.

8.0 EQUALITY AND DIVERSITY ISSUES

There are no equality and diversity issues arising as a direct result of this work.

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

None.

END TO END ASSESSMENT

Background

NHS Halton, Knowsley, St Helens and Warrington CCGs and NHS England commissioned work to deliver:

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The Chief Officer acted as co-sponsor of this project with David Cooper, Acting Chief Finance Officer - NHS Warrington CCG, and co-chaired a steering group working with Capita, who were selected following a procurement process to deliver this project.

Summary

This project has provided a retrospective, current, and future view of health and social care activity, spend and patient flows across the Mid Mersey area. Looking back over the past three years the four CCGs have been relatively consistent in their activity trends. Activity has generally grown in line with underlying population growth, with recent signs of this being offset by schemes put in place to manage demand. The spend over time illustrates a disproportionate increase in spend compared to activity, which may be explained by increasingly more complex case mix or coding changes. Overall the largest growth has been seen in the 65+ age group, which is also the highest spend area, suggesting that continued focus on the frail / elderly will be of particular benefit to the health and social care economy moving forwards.

At present there is a large degree of variation between practices in terms of admission rates, attendance rates and outpatient performance, even after adjusting for population characteristics and weighting for healthcare need. The degree of variation increases the smaller the practice is, which suggests that federated general practice at scale is a factor in reducing variation and spend, which may also result in improved outcomes. Working up analysis alongside local knowledge suggests that practices that have a focus on health and wellbeing and integrated care benefit from a reduced demand for acute services. Lower admission rates were highlighted for particular practices where there has been a recognised long term focus on health improvement and prevention.

Looking forward, a large proportion of commissioning intentions are interventions for the elderly and those with long term conditions – this is consistent with the areas seen to be growing in the retrospective analysis and provides confidence that the right areas are in focus. There appears to be an opportunity to reduce variation by standardising referral thresholds, admission criteria, and pathways for high volume conditions – this would improve the quality of care while managing demand and reducing spend. There is also significant opportunity to reduce variation in length of stay and deal with this demand once in hospital.

Modelled interventions are projected to keep pace with underlying growth over the next 3 years, after which this underlying demand is projected to overtake the reductions in activity that these initiatives are expected to make. This suggests that a more radical approach to meeting the challenge will be needed – current plans could be strengthened by exploring opportunities for more upstream intervention in health and wellbeing, shifting the emphasis from diversion to prevention of demand. In addition, the CCGs could explore more radical approaches to delivery of integrated, proactive care, involving redefining the role and shape of primary, community and social care for the longer term, with the current plans being used to generate headroom to put the necessary investment into non-acute services to enable long-term change.

Retrospective Analysis

The key purpose of the initial high-level analysis was to differentiate between underlying growth and acuity, shifts between providers, re-provision of activity in alternative settings, changes to tariffs, local prices, payment mechanisms, technical coding and counting, contract penalties and incentives, recurrent and non-recurrent changes. Data was assembled and validated for financial years 2010/11, 2011/12, 2012/13 and 2013/14 to January 2014. Capita created a 'standardised' view of the historic data to allow a like-for-like comparison over the three-year period. This work found that:

- The four CCGs have been relatively consistent in their activity trends seen over the past three years.
- With exception of a peak in winter 2012/13, non-elective activity has grown in line with underlying population growth, and has been relatively flat or decelerating in recent months, it appears that population pressure has been offset by schemes put in place to manage demand.
- Elective demand is growing overall but more of this is being carried out in the day case setting.
- The majority outpatient growth over the last year has been in non-GP referred activity
- All CCGs have seen a reduction or slowing of the upward trend in A&E attendances over the past year.
- The largest overall non-elective cost increases in individual specialties has been seen in Respiratory Medicine and General Medicine.
- The spend over time illustrates a disproportionate increase in spend compared to activity, which may be explained by increasingly more

complex case mix, coding changes over time may have impacted on this.
- Overall the largest growth has been seen in the 65+ age group, which is also the highest spend area, suggesting that this is a particular area of opportunity, and that continued focus on frail/elderly patients will be of particular benefit to the health economy.

Current baseline

Capita applied similar principles as to the historic analysis to 2013/14 activity to date to profile current activity, spend and patient flows in order to present a picture of current activity using 2013/14 organisational structure and coding. They provided a statement of the baseline position as well as comparisons of current activity levels between practices and between CCGs to understand variation in the baseline. The main findings were that:

- There is a large scale of variation between practices in terms of admission rates, attendance rates and outpatient performance, even after adjusting for populations an weighting for healthcare need.
- The degree of variation increases the smaller the practice is, which suggests that federated general practice at scale is a factor in reducing variation and spend, which may also result in improved outcomes.
- There is a similar level of overall acute spend per head between the CCGs, combined with larger variation in non-acute spend per head, this may indicate that the level of acute activity is either true patient demand (i.e. there is a level of acute activity that goes into hospital regardless of what is commissioned elsewhere) or that this is led by the providers capacity to accommodate demand (supply led demand).
- With some exceptions the patient flow from practice to provider follows a natural pattern, with limited opportunity for repatriation from Liverpool or Manchester.
- Working up analysis alongside local knowledge suggests that practices that have a focus on health and wellbeing and integrated care benefit from a reduced demand for acute services. Lower admission rates were highlighted for particular practices where there has been a recognised long term focus on health improvement and prevention.

Forecasting the future

Capita worked up a projection of future activity, spend and patient flows. It is made up of the following elements:

• The collation and understanding of commissioning intentions and strategic plans.
• The mapping of intentions to specific patient cohorts impacted by the change.
• The modelling of the impacts on future activity, spend and patient flows.

The main findings are:

- Grouping of commissioning intentions has shown that by far the biggest area of focus for interventions is for the elderly and those with long term conditions – this is consistent with the areas seen to be growing in the retrospective analysis and provides confidence that the right areas are in focus.
- There appears to be an opportunity to reduce variation by standardising referral thresholds, admission criteria, and pathways for high volume conditions – this would improve the quality of care while managing demand and reducing spend. There is also significant opportunity to reduce variation in length of stay and deal with this demand once in hospital.
- Modelled interventions are projected to keep pace with underlying growth over the next 3 years, after which this underlying demand is projected to overtake the reductions in activity that these initiatives are expected to make.
- Working up analysis alongside local knowledge suggests that practices that have a focus on health and wellbeing and integrated care benefit from a reduced demand for acute services. Public health initiatives and preventative schemes may have an impact over the longer term but would need investment now for longer term benefits to be realised.

Implications for commissioners

The purpose of the assignment was to undertake modelling of historic, current and forecast activity, flows and spend. The ultimate aim of this exercise was to support commissioners in their decision making for the longer term. Capita offer a commentary on some of the key points arising from the review, which help address some of the questions CCGs are seeking to answer, and signpost the CCGs to what they might consider next to address remaining gaps in their knowledge. The key issues are summarised below.

Scope of plans	The analysis shows that the current plans will help stem the tide of demand growth from population change but that in the long term, demand will continue to grow. This suggests that a more radical approach to meeting the challenge will be needed – current plans could be strengthened by exploring opportunities for more upstream intervention in health and wellbeing, shifting the emphasis from diversion to prevention of demand. In addition, the CCGs could explore more radical approaches to delivery of integrated, proactive care, involving redefining the role and shape of primary, community and social care for the longer term, with the current plans being used to generate breathing space to put the necessary investment into non-acute services to enable long term change.
Community data	The data provided for community services is not adequate to derive reliable calculations of the impact of commissioning intentions and the information provided in this report should be seen as illustrative. We would recommend that the basis

	for our modelling should be validated in collaboration with providers and further work be undertaken locally to understand the extent to which capacity in community services could be released to support the activity shifts associated with the commissioning intentions, and then the true quantum of additional capacity that will be required to support the long term shift indicated in the first point above.
Impact of social care resource constraints	The modelling suggests that austerity across the system is having an impact on the provision of social care, with a reduction in spend on assessments and shift in provision from institutional to home based care . The impact of this on health status and demand for health services cannot be inferred from the modelling at this point, but it seems logical to assume that there will be an increase in demand, particularly for home-based health care. By investing in more integrated approaches to risk stratification, population segmentation, prevention and proactive care, and by considering further opportunities for pooling resources to achieve this, health and social care commissioners will be better able to avoid this demand emerging in acute services and to deliver the most beneficial outcomes for the population in terms of overall health status. Further work should be undertaken now to understand the nature of social care provision, the client groups impacted and the care pathways / packages needed to address their needs.
Specialised Services / impact of new technologies	Despite the direction of travel to consolidate further the provision of specialist services into larger centres, from the information available, this is unlikely to have a major impact on patient flows within the Mid Mersey geography, as neither of the two local providers delivers significant specialist services (the key exception being burns). The delegation of commissioning of some services to CCGs will impact on local commissioning intentions but is unlikely to impact on patient flows. It is likely that, with technological and pharmaceutical advances, more services and procedures become more amenable to local delivery (as in the case of renal dialysis and chemotherapy) but the need for these to be linked back to specialist expertise suggests the development of outreach from specialist centres of chains of providers, rather than involving a shift of provider.
Aligning wider system changes	The modelling has been built on commissioning intentions and it is suggested that these be compared with the impact of provider supply strategy and business plans, where known. For example, it would be helpful to understand the strategies of local trusts in respect of attracting activity from competitors. The pressure at St Helens and Knowsley Trust to optimise the use of Whiston Hospital may drive it towards a more aggressively competitive approach to practices in Halton, where flows are more varied, which would impact on the viability of the Halton Hospital site. While it is unlikely that the Greater Manchester Healthier Together strategy will impact on flows from mid Mersey, any plans for reconfiguration of services across Liverpool (and in the longer term, the re-build of the Royal Liverpool Hospital)

	may impact on flows from practices on the western edge of the patch. A more likely scenario for CCGs to consider is the impact of their plans for a sustained shift from acute to community services on provider sustainability and consequently, behaviour. To mitigate the impact on income, Trust responses may focus on developing partnerships and alliances with community services, or they may become more overtly competitive, seeking to develop vertically integrated alternatives to current provision. The latter, coupled with potential for establishment of GP Federations, provides a potential threat to Bridgewater Community Trust, which in turn may threaten the implementation of CCGs' plans in the medium term. Further work to understand community services flows would help CCGs develop a clear approach to this area of the market.

Halton specific issues

Capita worked with NHS Halton CCG and Halton Borough Council to produce some findings specific to the borough:

- Including the Better Care Fund there is a governed pooled arrangement worth £42m between NHS Halton CCG and Halton Borough Council for adult services.
- The pooled arrangements delivered savings of £158k in complex care in 2013/14.
- Joint commissioning and funding of intermediate care ensures the reduced need for nursing placements.
- NHS Halton CCG and Halton Borough Council have integrated safeguarding teams, leading to improvements in working arrangements and responsiveness.
- The Integrated Care Home Teams are contributing to a continued reduction in A&E attendances and subsequent admissions.
- Integrated Discharge Teams working with the two main acute providers are ensuring that there are little to no delays for Halton residents. They are contributing to length of stay (LOS) maintenance and improvement.
- Pooled budgets for Continuing Health Care (CHC) result in one assessment and one package of care; this potentially explains the data in the report which shows low assessment levels for Halton.
- The pooled arrangements and Better Care Fund place Halton in a good position to meet the challenges of Social Care Act.
- The Better Care Fund and NHS Halton CCG investment to provide 2 Urgent Care Centres will further reduce A&E activity and non-elective admissions (NELs).

i5 Work

In addition to the work with Capita, NHS Halton CCG commissioned i5, who are health economists, to review the potential benefits of the Better Care

Fund, 2 Year Operational Plan and 5 Year Strategy with a specific focus on acute activity.

I5 reviewed actual patient data over a seven month period from April to October 2013 using:

- the actual numbers of patients attending A&E
- what time they attended
- how long they were admitted for (if they were admitted)
- what treatment / diagnostics they received (if any)
- the types and acuity of the conditions they presented
- the costs associated with the attendance and/or admittance

i5 also calculated the actual cost of activity which could have been treated elsewhere. In common with Capita, i5 assumed some growth in elective activity and did not factored in the cost of the schemes needed in the community or elsewhere to achieve the savings required from the acute sector.

NHS Halton CCG has compared the i5 and Capita work against our plans (Appendix One). Overall both the i5 and Capita assessments give assurance that the commissioning intentions of NHS Halton CCG with Halton Borough Council are focussed in the right areas (acute care and older people). They also provide assurance the level of savings identified in the financial and operational plan are broadly achievable, although at the top end of what is possible.

Conclusion

The Capita End to End Assessment work has shown that the 'Mid Mersey' CCGs all have similar strategic commissioning intentions. The Capita and i5 work suggest that the plans of NHS Halton CCG, in partnership with Halton Borough Council and local providers, are achievable but that there are some significant challenges ahead.

Appendix One Potential savings in acute sector

Savings Identified, (figures in £,000's)						
Financial Plan (2 year)*	Financial Plan (5 year)*	Operational plan (2 year)**	i5 Health***	BCF****	Capita likely savings (5 year)*****	Capita Max savings (5 Year)******
3,708	7,951	3,930	3,638	377	1,665	3,393

* The Financial plan figures reported here are the cumulative recurrent QIPP savings and do not include running cost, tariff and price efficiency savings)

** The Operational plan 2 year savings should match the financial plan 2 year savings, this variation will be amended in the operational plan before submission to NHS-E on the 20th June

*** The sum total of i5 Health's savings is actually £5,978,000 (adjusted for a more realistic A&E attendance cost), however this include schemes in which the savings overlap, when an adjustment is made for this the total amount of savings available in acute care is £4,522,000, This includes some schemes which have not been identified in the operational plan such as 'Roving GP support with Ambulance crews' When these schemes are excluded the total amount of savings for schemes which match in i5 and the operational plan is £3,638,000

**** The savings identified in the BCF are the top level reported in the template, this does not show the breakdown of all savings, as some schemes whilst saving money in the acute sector will cost money elsewhere.

*****The Capita likely savings are based on reductions on acute activity to the best performing 25% of Practices in regards to A&E attendance, Outpatient appointments (first and follow up), Avoidable emergency admissions and early supported discharge.

******The Capita Max savings scenario includes savings identified in the BCF and operational plan, since these plans over cover a two year period the bulk of the £3,393,000 savings identified as 5 year, will in fact be achieved in the first two years, assuming that the Urgent care centre and reduction in variations in general practice activity can be achieved.