HEALTHY PEOPLE
living healthy lives in healthy communities
Northern Devon

NHS
Northern, Eastern and Western Devon Clinical Commissioning Group

Northern Devon

Locality Plan

2013 – 2014

Contents

Executive Summary

The Northern Devon Locality Plan for 2013/14 has been created at a time of unprecedented change in the NHS. The cornerstone for successful commissioning will be involving local communities in local decisions that are needed now and in the future to improve the health and wellbeing of North Devon residents.

This document sets the scene and proposes a health strategy to deal with this challenge effectively in the 2013/14 financial year.

Foreword:

I feel privileged to be writing this on behalf of my fellow GPs working in the Northern Locality who are committed to making a real difference to people's lives in North Devon.

In order to do this I recognise that we will need to work with our partners and local communities to improve the health and wellbeing of individuals and their families. In particular it is about taking serious action to reduce the inequalities in health that exist. We have adopted a simple vision: Healthy People, Living Healthy Lives, In Healthy Communities.

We have been given responsibility for the significant resources that are spent on the provision of healthcare in North Devon and believe that with clinicians leading the planning and delivery of healthcare we are more likely to make a real difference to people's lives.

We will strive to commission services that are safe and are based on the best research evidence available. We will be transparent in our actions and will not allow any conflicts of interest to influence our decisions. Trust is important and has to be earned; as clinicians we believe our patients trust and support us in our role as providers and we want people to feel the same way about us as commissioners.

I know that when we need urgent help it is vital that we can access it quickly and that any initial treatment should be safe and of a high quality. At other times we may have to travel to see the right specialist. We want services to be as close to patients' homes as possible, but there is a balance needed between localness, quality and cost, and this is a particular challenge in rural areas like North Devon.

Part of our Board responsibility is to be responsible for the financial resources entrusted to us on behalf of the local population. This will require us, at times, to take difficult decisions. We will engage our local population in discussions concerning those decisions and we will be honest and open about the difficult choices that have to be made.

I look forward to serving the North Devon community in the years ahead and welcome feedback on this locality plan.

Dr John Womersley
Chair, Northern Locality Board
NHS NEW Devon CCG

Chapter 1: Context

1.1 Population demographics and health needs:

Northern Devon is a rural area with significant pockets of deprivation. It has a population of 163,900 which is estimated to increase by 20,000 by 2020 with significant inward migration of people in the 40+ age group. There are a number of key health inequality issues across North Devon:

- There is both rural and urban deprivation with high rates above Devon averages. The urban deprivation rate in North Devon, although lower than the England average, is the highest in Devon. The rural deprivation rate exceeds both the Devon and England average rates. Deprivation is focused around the areas of Ilfracombe, Barnstaple and Bideford;
- There are higher birth rates in each of these deprived areas;
- Life expectancy is below the Devon average with pockets of poorer life expectancy in specific wards in Ilfracombe;
- Alcohol related admissions are high - not only from the three key deprived areas but also from rural areas. Overall standardised admission rates indicate over 400 admissions above the expected Devon average are admitted;
- Ilfracombe has a significantly higher rate for teen conceptions than the average;
- Death rates for all causes are higher or significantly higher in the North locality than the rest of Devon – linking to the lower life expectancy. The main causes of death contributing to the gap in life expectancy are CHD, suicide, chronic cirrhosis of the liver, respiratory conditions and lung and other cancers;
- Smoking prevalence is more than 1:5 of the population;
- More than 1:5 adults are obese.

1.2 Financial challenge:

The NHS needs to achieve £20bn of savings by 2015 in order to be able to meet the growing demands arising from our aging population. The Quality, Innovation, Productivity and Prevention (QIPP) programme is the means to ensuring that this happens and savings are re-invested in patient services, procedures, drugs and technologies that bring maximum benefit and quality of care.

2013/14 is the third year of the quality and productivity challenge for the NHS and the first year of the new commissioning system. Strong financial management and delivery of efficiency savings will support the locality plans and provide the basis for a sustainable future for the wider Clinical Commissioning Group (CCG)..

Working closely with other localities within the CCG, local authorities, providers and other key partners we aim to use this for maximum benefit of our population, ensuring planned efficiencies release resources for further service improvement.

1.3 Health and Wellbeing Strategy:

The Health and Social Care Act 2012 requires local authorities to form Health and Wellbeing Boards to deliver improvements to the health and wellbeing of the local population.

The Health and Wellbeing Board (the Board) includes county and district councils, GPs from CCGs, HealthWatch, the National Commissioning Board and representation from service users, carers and old people. This Board has now produced the Joint Health and Wellbeing Strategy for Devon 2013 – 2016. This Strategy has four priorities:

- Priority one - A focus on families
- Priority two - Lifestyle choices
- Priority three - Independence in older age
- Priority four - Social capital and building communities

The priorities outlined in this commissioning plan support these priorities, in particular the focus on lifestyle choices and independence in older age. We will work in partnership with HealthWatch, local authorities and voluntary and community organisations to ensure that the views of local people help shape the future health and social care arrangements in North Devon.

1.4 Care Closer to Home plan

The North Devon locality is also developing a Care Closer to Home plan. This plan will build on the projects outlined in this plan to show how the North Devon locality will work over the coming years to develop a health care system that delivers high quality care closer to patient's homes. We will be publicly consulting on a draft of this plan in May 2013.

Chapter 2: Health Strategy

2.1 Vision and strategic objectives:

The vision for the Northern Locality and for NEW Devon CCG as a whole is:

Healthy People, Living Healthy Lives, In Healthy Communities

This vision is underpinned by three core strategies:

- Ensure clinical community and the public take joint ownership of the sustainability agenda
- Ensure systems and processes are developed that make the best use of limited resources every time
- Move the focus of commissioning away from treatment and towards a prevention and maintenance approach

The Northern Locality Plan sets out the commissioning priorities for 2013/14 and outlines the main areas of service change which will deliver high quality, efficient services. This will be achieved by commissioning:

- To improve the health and well-being of the population;
- To reduce health inequalities;
- Comprehensive services for our aging population;
- Strong partnerships focussed on the individual;
- The highest quality care in the right settings;
- A clinically and financially sustainable healthcare system.

2.2 2013/14 QIPP Plan and emerging strategic commissioning intentions:

The 2013/14 QIPP plan, which takes a short one year view, has been developed through the locality team with clinical commissioning colleagues. This plan documents the projects the Northern locality will focus on in the first year of the NEW Devon CCG. At the same time as working on these projects we will be working with the rest of NEW Devon CCG and the broader health community on our strategic commissioning intentions for the longer term.

The 2013/14 plan is presented across the standard service portfolio configuration i.e.:

- Urgent care
- Long term conditions including mental health
- Planned care
- Diagnostic care

2.3 Our Health Strategy: An overview:

A key part of our Health Strategy focuses on the optimisation of urgent care provided in the primary, community and secondary care sectors. We want to focus on better prevention and improved flow through the health and social care system, with better discharge, better

rehabilitation & re-ablement and fewer admissions/ re-admissions to acute care, in order to deliver the best health outcomes for the people of North Devon.

During the coming year and over the next 3 to 5 years, we will work towards transforming care for people with long term conditions in the Northern Locality through a strategic approach focussed on the following areas:

- Increased prevention and early intervention in primary care
- Supporting self-care
- Risk profiling
- Care planning and shared decision making
- Case management
- Reducing variation in primary care

This approach will be underpinned by:

- The commissioning of integrated care pathways across primary, community and secondary care and mental and physical health
- Shared IT records
- Accessible services
- Community partnership
- Technology

In addition, we will implement quality disease specific pathways for people with long term conditions such as coronary heart disease, respiratory disease and diabetes. We want cardiology services that support people to lower their risk of heart disease or stroke, and in which clinical outcomes, access to diagnostics, timely acute care and rehabilitation services are amongst the best. For people with diabetes or respiratory conditions we want to commission the delivery of care in the appropriate setting through a partnership between primary, community and acute care, promoting good health and delivering earlier intervention services in community settings. There will be a focus on maximising independence for patients with COPD and other chronic conditions such as persistent pain.

Alcohol misuse is a particular issue in North Devon and our urgent care strategy also focuses on prevention and reduction of hazardous drinking behaviour and ongoing support and relapse prevention for more chronic patients.

And for those patients at the end of their life we want to ensure choice and dignity through convenient access to robust and appropriate services on best practice care pathways.

Our strategy for planned care focuses on the delivery of efficient and effective care pathways that emphasise localism, prevention, speed and convenience of access to diagnosis and treatment, including alternatives to surgery, in accordance with NICE and other best practice guidance. This will reduce the number of unnecessary trips to hospital for appointments and the number of stays in a hospital bed.

In some areas we want to re-organise the delivery of services. For example, for ophthalmology patients we want to commission new models of provision delivered through joint working arrangements between providers to ensure a transfer of clinical skills and supervision in support of patients being seen in the right clinical setting, by the right clinician, first time.

Our strategy for women and children focuses on the provision of high quality safe services. For obstetric and midwifery patients we want to focus on the development and enhancement of care

provision in line with the principles outlined in the Department of Health's *Maternity Matters* guidance. This will deliver improved choice, access and continuity care.

For children we want to focus on the provision of high quality safe local services based on an integrated model of care with an emphasis on more support and caring for the child out of hospital in primary care and community settings.

Delivery of the Health Strategy will deliver a number of key benefits. These include:

- A reduction in acute hospital emergency admissions
- A reduction in acute hospital emergency admissions in the last days and hours of life
- A significant shift to home based care
- A reduction in the number of face to face secondary care out-patient contacts and unnecessary trips to hospital
- Improved access to assessment and therapy
- An improvement in long term conditions morbidity and mortality in North Devon
- Increased numbers of patients successfully self-managing their disease
- Increased integration and co-ordination of services with significant system efficiencies

Overall the delivery of this Health Strategy will lead to an improved experience, and better clinical outcomes, for patients and carers.

2.4 Local priorities for NEW Devon Clinical Commissioning Group

The NHS Commissioning Board has provided data to all CCGs so each CCG can benchmark itself against other CCGs across the country. The NEW Devon CCG performed better than the national position for 17 out of 20 indicators. However, there are areas where we need to do better.

To build on this data the CCG is identifying three priority areas of care to focus on to improve the outcomes for patients in the 2013/14 financial year. Areas that are currently being considered include:

- Children (Under 19's emergency admissions for lower respiratory tract infections, asthma, epilepsy and diabetes)
- Dementia Diagnosis
- Mental Health
- Long Term Conditions
- Self-Care & End of Life

Chapter 3: Operational Plan 2013/14

3.1 Introduction:

The 2013/14 commissioning (QIPP) plan for the North Devon locality is structured around the 5 key areas of care that straddle a number of service specialties, which are broken down as follows:

- Urgent care
- Long term conditions
- Planned care
- Diagnostic care
- Maternity and paediatric care

The following sections briefly describe the projects within each of these care areas.

3.2 Urgent Care:

Virtual ward

Virtual wards were introduced during 2011/12 across 21/22 practices in North Devon and have become gradually embedded into the daily Complex Care Team routine. We know that this model is already demonstrating reductions in admissions of those patients most at risk. Project work is focussed on working with practices to maximise the effectiveness of the virtual ward.

Anticipated benefits: It is expected that this up-stream case management approach will avoid a number of acute hospital admissions in 2013/14.

COPD Whole System Approach:

This project involves taking a whole system approach to looking at how to improve the outcomes of patients with COPD. This includes a range of initiatives including:

- prevention
- predictive modelling
- telehealth
- self-management
- integrated O2 system
- integrating IT systems.

Anticipated benefits: We expect to see a reduction in the number of acute hospital admissions in 2013/14 from this work.

Cardiology Pathway:

Analysis of the current flow of patients between NDHT, RD&E and Plymouth Hospitals indicates an area for qualitative and financial improvement. This project is about improving the delays in these pathways, specifically in the first instance focussing on diagnostic angiography and pacing. These patients can experience a long waiting time, either waiting at home or in hospital beds in North Devon, and, following treatment, patients are transferred back to NDDH rather than directly home.

Anticipated benefits: With new streamlined pathways, initially focussing on these areas, it is expected that this would significantly reduce delay and the numbers of unnecessary acute transfers/ admissions.

Alcohol:

We will continue to work with NDHT to provide a hospital based and assertive community outreach service to support a reduction in alcohol dependency and abuse rates amongst identified hazardous drinkers. This will include screening, delivering brief interventions and advice or referral to specialist services.

Anticipated benefits: It is expected that a significant number of hospital presentations will be avoided in 2013/14, the majority of which will be A&E and general medical admissions.

End of Life:

This project focuses on helping patients who are approaching the end of their life, to die in their chosen place with dignity.

Anticipated benefits: It is expected that a number of hospital emergency admissions will be avoided and more people will have an active choice about where they end their life.

Home from Hospital (currently under review for future funding):

This project provides short-term assistance to patients returning to their home following a stay in hospital. Support from volunteers' services is provided in the form of practical help that enables patients' safe transition from hospital (NDDH & Northern Community) and supports them to regain their self-confidence and independence in their own homes.

Anticipated benefits: It is expected that this project will lead to savings in bed days in both acute and community hospitals.

3.3 Long Term Conditions:

Bone Health:

This project involves the improvement of the Osteoporosis and Fragility Fracture pathway which focusses on "responding to the first fracture and preventing the second" as well as identifying people who are risk of osteoporosis and commencing early treatment in primary care.

Anticipated benefits: It is expected that the implementation of an improved pathway would lead to a reduction in the number of some fracture related admissions, a reduction in the number of care home admissions and improved assessment and treatment of patients with osteoporosis.

Chronic Pain:

This project involves further work on the service that was introduced recently where patients suffering from persistent pain are seen by a specialist community multi-disciplinary service as the first line of treatment, where appropriate.

Anticipated benefits: It is expected that the new service model will improve the quality of service and reduce secondary care costs.

Stroke/TIA:

This will involve the expansion of the Transient Ischaemic Attack (TIA) service to 5 days from 2 days as well as exploring and determining a support mechanism for thrombolysis decision making. This project will also look at other areas of the stroke pathway including psychological support and establishing a joint care plan.

Anticipated benefits: It is expected that this project will improve the outcomes for stroke/TIA patients in North Devon.

Diabetes:

This project involves a range of initiatives to improve the outcomes for patients with diabetes. It includes developing a replacement for the DESMOND patient education programme, improving access to psychological support and ongoing professional education.

Anticipated benefits: It is expected that this project will improve the outcomes for patients with diabetes in North Devon.

Improving Access to Psychological Therapies (IAPT):

This project is about supporting patients with long term conditions and medically unexplained symptoms to access support to IAPT resources and services.

Anticipated benefits: It is expected that this project will improve the outcomes for, and the quality of the service offered to, patients with long term conditions and medically unexplained symptoms.

Liaison psychiatry:

This project is about building on the liaison psychiatry service at NDHT to provide further improvements to the service.

Anticipated benefits: It is expected that this project will improve the outcomes for NDHT patients with currently unmet mental health needs.

3.4 Planned Care:

Referral Management:

This project involves working closely with NDHT, GP practices and the DART to improve the quality of referrals to NDHT. There are a range of components to this project which include:

- introducing pre-booking triage by secondary care consultants for those specialties that lend themselves to this (for example, vascular, cardiology, gastroenterology referrals)
- pathway development – working closely with secondary care clinicians to develop local pathways
- increasing the use of pre-referral advice and guidance where GPs can seek advice from secondary care clinicians before making a referral

- top tips – disseminating top tips from secondary care clinicians to GPs
- using DART to check compliance of referrals against agreed clinical pathways.

Anticipated benefits: It is expected that this project will reduce the number of inappropriate referrals to secondary care and avoid unnecessary outpatient referrals. This will improve the quality of the service offered to patients as well as freeing up capacity in secondary care.

Follow ups:

This project is about reducing the number of unnecessary follow up outpatient appointments that take place in secondary care. It will involve working closely with NDHT to identify specialties with follow-up appointments that are not clinically necessary. Pathways, processes and procedures will then need to be changed to remove these appointments while ensuring that the safety of patients and quality of care is retained.

Anticipated benefits: It is expected that this project will reduce the number of unnecessary secondary care follow up appointments. This would lead to cost savings and improved quality for patients by saving unnecessary trips to hospital.

PSA tracker:

This project will transfer routine follow up appointments for patients with prostate cancer from the hospital to GP practices. Rather than attend hospital to have their PSA levels measured by a consultant urologist, patients will instead have a PSA blood test carried out in a GP surgery with the results interpreted and acted upon by a urology nurse specialist.

Anticipated benefits: It is expected that this project will reduce the number of outpatient PSA follow-up appointments. This will provide cost savings as well as providing improved convenience for patients by replacing trips to hospital with visits to their local GP practice.

Ocular Hypertension (OHT) refinement scheme:

This project will introduce an enhanced service for community optometrists so patients with raised intraocular pressure following non-contact tonometry have their pressures rechecked using contact tonometry before they are referred to the hospital eye service.

Anticipated benefits: It is expected that this project will significantly reduce the number of patients referred to the hospital eye service for raised IOP only (i.e. patients with no additional eye-related issues).

Using community optometrists for follow ups for stable glaucoma:

This project is to shift follow up appointments for patients with diagnosed stable glaucoma into the community rather than the acute hospital setting. This would involve community optometrists seeing patients for routine follow-up appointments in accordance with protocols and procedures that had been agreed with secondary care.

Anticipated benefits: It is expected that this project would lead to a reduction in the number of patients with established glaucoma who need to attend regular follow ups at the acute hospital. This would ease pressure on the hospital eye service, allow patients to be seen closer to home and would produce financial savings.

Orthopaedics:

This project involves building on the improvements already made by the introduction of the New Zealand scoring system for assessing patients in a hip and knee assessment clinic to further reduce the NDHT Standardised Admission Rates for hips and knees.

This project involves further development of the pathway for referral for osteo-arthritic hip pain to include easier access to lifestyle support i.e. level 2 obesity services and other alternatives to major surgery.

Anticipated benefits: It is anticipated that this will avoid a number of hip replacement elective admissions in 2013/14.

3.5 Pathology/Diagnostics:

Pre-analytical phase:

This project will optimise the collection and testing of pathology and diagnostics including improving the placement of community diagnostics. It will involve the integration of electronic requesting (order communications) with clinical pathways and standardising the processing of primary care specimens.

Anticipated benefits: It is expected that this will lead to a reduction in the number of admissions due to abnormal blood results and repeat phlebotomy in the surgeries.

Reducing Catheter Associated Urinary Tract Infections (CAUTI):

This project will reduce the level of CAUTI in primary care, secondary care and care homes. It will include work to reduce the use of catheters in primary care and secondary care and work to target CAUTI in care homes as well as the provision of a telehealth model.

Anticipated benefits: It is expected that this project will lead to a reduction in CAUTI associated emergency admissions and CAUTI associated bed stays.

Deep Vein Thrombosis (DVT) pathway:

This project will involve using diagnostics to improve the DVT pathway. A diagnostic test will be used at an earlier stage in primary care to improve the quality of referrals to secondary care for patients with suspected DVT.

Anticipated benefits: It is expected that this project will reduce unnecessary ultrasounds as well as reducing unnecessary prescribing of LMWH drugs.

Wound pathway:

This project will build on the positive work of the Barnstaple Leg Club to optimise lower leg wound care in primary care. This will involve looking at extending the Leg Club to other areas as well as improving the wound care pathway.

Anticipated benefits: It is expected that this project will lead to a reduction in wound swabs, more appropriate vascular and podiatry referrals as well as improving the healing rate for patients with leg ulcers.

Rationalisation of pathology/diagnostics testing:

This project will reduce the use of tests which have little clinical value or which have become redundant because of changes to clinical practice over time.

Anticipated benefits: It is expected that this project will deliver cost savings and quality improvements as unnecessary tests are removed from patient pathways.

High Vaginal Swab (HVS) pathway:

This project is about ensuring that HVS testing is clinically appropriate and will involve working with secondary care to develop an agreed pathway.

Anticipated benefits: It is expected that this project will lead to a reduction of HVS swabs.

Peninsular pathology provision:

This project will involve working with other localities in the NEW Devon CCG and other peninsular CCGs to look at how pathology can be modernised.

Anticipated benefits: It is expected that this project will lead to a more transparent, modernised pathology system in the NEW Devon CCG and to consistent costs across the CCG for pathology provision for primary care.

3.6 Other projects

Rollout of 111 phone number

We will be working closely with other localities in the CCG ahead of the rollout of the new 111 phone number in June 2013 for non-emergency health advice and guidance.

Transforming Community Services (TCS)

We will be working closely with our stakeholders in the North Devon health community as well as other localities within the CCG, local authorities, community and voluntary sector groups as the Transforming Community Services project develops.

3.7 New projects to be scoped

This section lists new ideas and projects that still require further work to be fully scoped.

Joint injections

This project will look at options for increasing the number of joint operations that can be carried out in primary care with the appropriate level of clinical supervision.

Review of cancer referral pathways

This project will review the 2-week wait pathway for cancer referrals and look at improvements that can be made to the pathway.

Work with mid-Devon on pathology pathways

This project will involve working with mid-Devon to ensure pathology pathways are optimised. This will also include ensuring that radiology requesting is appropriate.