NUTRICIA
Metabolics
Inspiring Futures

METABOLICS COMMISSIONING TOOLKIT

A support guide for clinicians and managers working in NHS metabolic services

NUTRICIA
Advanced Medical Nutrition

Nutricia Metabolics Commissioning Toolkit

This toolkit has been designed to support clinicians and managers working in NHS specialist metabolic services:

- To understand the wider NHS policy agenda
- To confidently engage with and successfully influence the various decision-makers that will have an impact on your service.

The toolkit is focused on the NHS in England but this may be extended to cover the Scotland, Wales and Northern Ireland in a subsequent update.

The resources in the toolkit will enable you to:

- Understand the national policy drivers that are affecting your service
- Understand the current environment, and changes occurring in it
- Work productively with your trust management team and their commissioners to protect and develop your service
- Effectively influence the decision-makers within your trust
- Help your organisation meet the current and future needs of your commissioners
- Maximise income for your service
- Provide stability for your workforce.

Contents

Chapter 1
Introduction, background and purpose 4

Background 5
NHS decision makers 6
NHS England 7
Clinical commissioning groups (CCGs) 8
Hospital Trusts 9
Decision making in nutritional metabolics 11
Influencing the decision makers 13
A detailed look at NHS England 14
Metabolic services clinical reference group (E06) 15
A detailed look at clinical commissioning groups 17
Prescribing responsibilities for metabolic treatments 18
Summary 19

Chapter 2
Environmental overview 20

The NHS environment 21
Why do you need to understand your environment? 22
The big picture – challenges 23
The big picture – money 24
The big picture – service transformation 25
Your service challenges in detail 26
Impact of current policy objectives 27
Impact of potential centralisation of services 28
Summary 29

Chapter 3
Inherited metabolic diseases (IMDs) 30

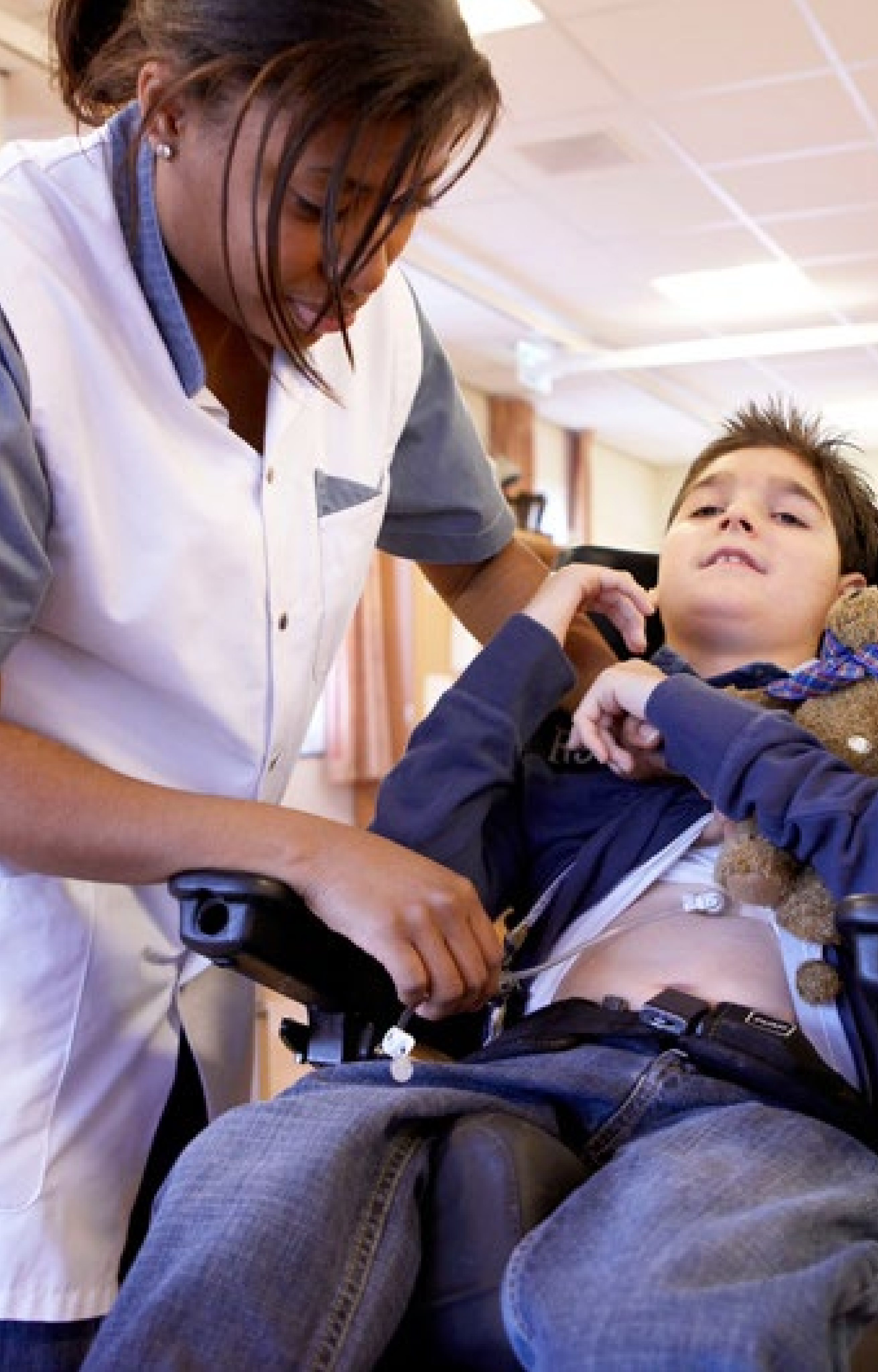
Metabolism 31
Fat, energy, protein 32
What are IMDs? 33
Dietary treated IMDs 34
Treatment: general principles 35
Treatment: why is it so important? 36
Specialised multidisciplinary team 37
Example: Phenylketonuria 38
Summary 40

Chapter 4
What and how can you influence? 41

Outline and purpose 42
Provider-led commissioning 43
New ways of working 44
Influence and change 45
What providers can influence 46
Creating the vision 47
First steps – build a funding proposal 48
Data capture 49
What does success look like? 50
Prescribing 51

Chapter 5
Appendices 52

1
INTRODUCTION,
BRAND AND
PURPOSE



Background

- Between 2000 and 2010 the NHS hospital service (inc. specialist metabolic services) has seen a period of significant growth
- Since 2010 the outlook for NHS finances has become less favourable with all sectors facing unprecedented challenges
- From 2010 to 2016 the NHS had been fully engaged with implementing large scale commissioning reforms
- Outlook for the next few years is very different with the main focus of NHS reforms now being directly aimed at service providers

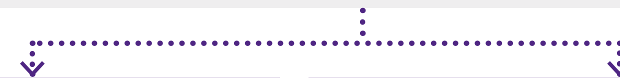
NHS decision makers

Metabolic services are influenced by decision makers operating at several levels.

In December 2015 the Government announced 44 'footprint' areas in England that would work together, across all health and social care commissioners and providers in that geography to deliver the Five Year Forward View. Each footprint would produce a Sustainability and Transformation Plan (STP) to show how local services would become sustainable over the next five years and evolve to improve health, care and efficiency.

Government (Secretary of State for Health):

- Responsible for setting NHS strategy and policy in England
- Stategy and policy in England implemented by Clinical Commissioning Groups (CCGs) and NHS England



CCGs (209 in England):

- Commission general hospital services

NHS England

- Commissions are more specialist services, including the majority of metabolic services
- Clinical reference groups:
    - Provide professional advice to commissioners
    - Specify the detail of what must be provided by specialist services such as metabolics

Role of both:

- To specify what services can be provided using NHS resources
- Ensure service providers deliver the necessary quality of service in return for the contacted payments.

NHS England

The NHS has a dual role:

National leadership body for the NHS in England	Commissioner of services, including the majority of the specialist services in hospitals

One if its key functions is to balance the needs of the wider population with the needs of patients. Particularly difficult in specialist services.

Relatively small populations of patients being treated	Require intensive and potentially costly treatment

Publishes (usually annually) its commissioning intentions.

Outlines priorities for all specialised services	Used by services to guide their discussions with commissioners

Manages specialist services in six Programmes of Care. Each contain a number of Clinical Reference Groups, responsible for a number of specialist services:

1. Internal medicine
2. Cancer
3. Mental health
4. Trauma
5. Women and children → metabolic disorders clinical reference group → metabolic services
6. Blood and infection

Clinical Commissioning Groups (CCGs)

- Commissioning organisations led by local GPs
- Responsible for commissioning most NHS services not commissioned by NHS England (inc. the majority of hospital services and all community and GP prescribing)
- Main focus: managing long term conditions and reducing the demand for hospital services
- Most CCGs have little or any involvement in the commissioning of specialised services, including metabolic services

However:

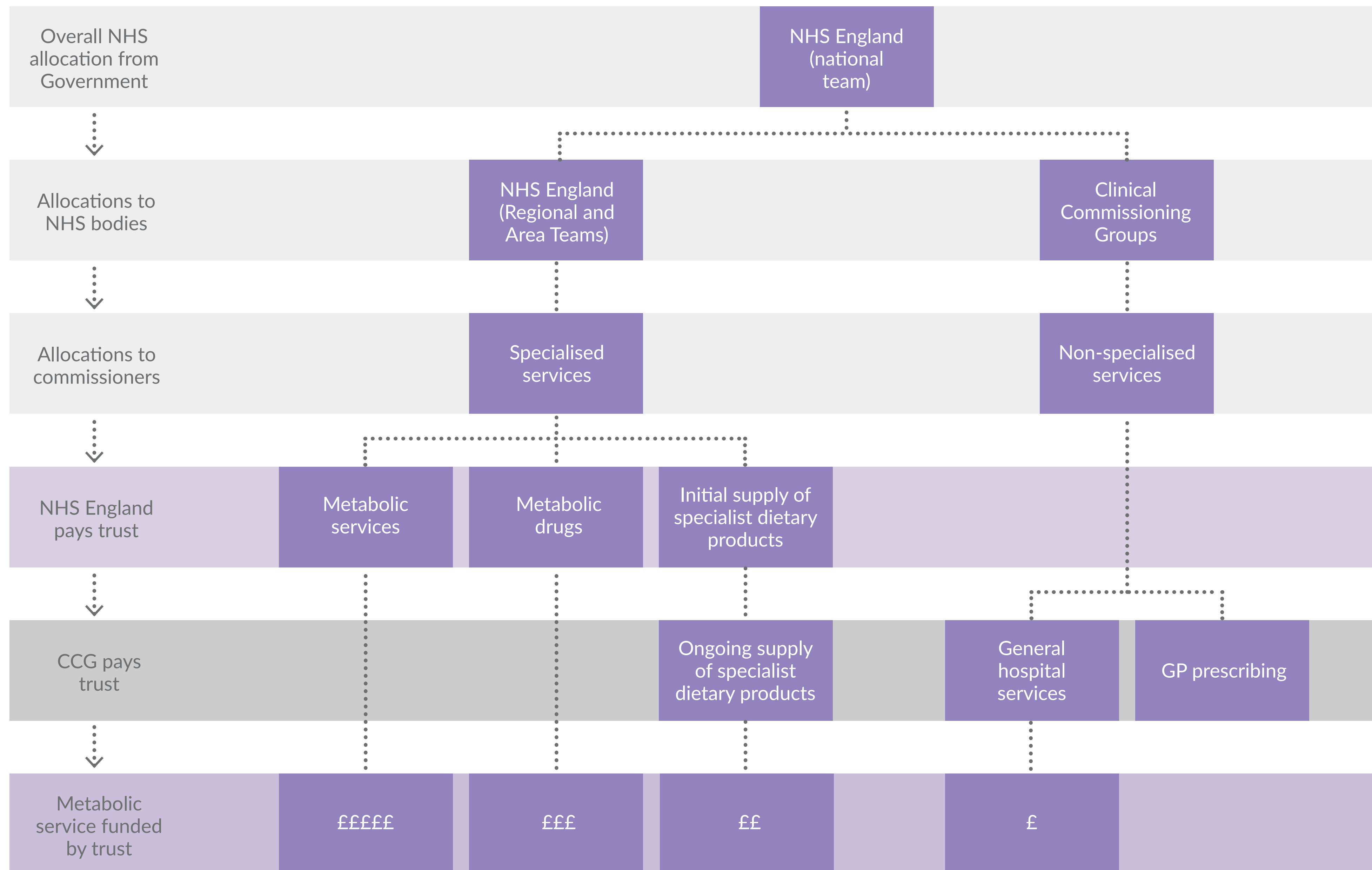
- NHS England increasingly involving CCGs in commissioning and performance management of services that fall under responsibility of NHS England
- In time may result in CCGs becoming commissioner of some metabolic services
- For now: main impact is in funding of prescriptions where the specialist service wishes to transfer prescribing to GPs

Hospital trusts

- Annual contracts
    - Agreed between commissioner and trust
- Funded from CCGs or NHS England
- Various payment mechanisms
- 'True' service costs can vary

Hospital trusts

How money flows to metabolic services

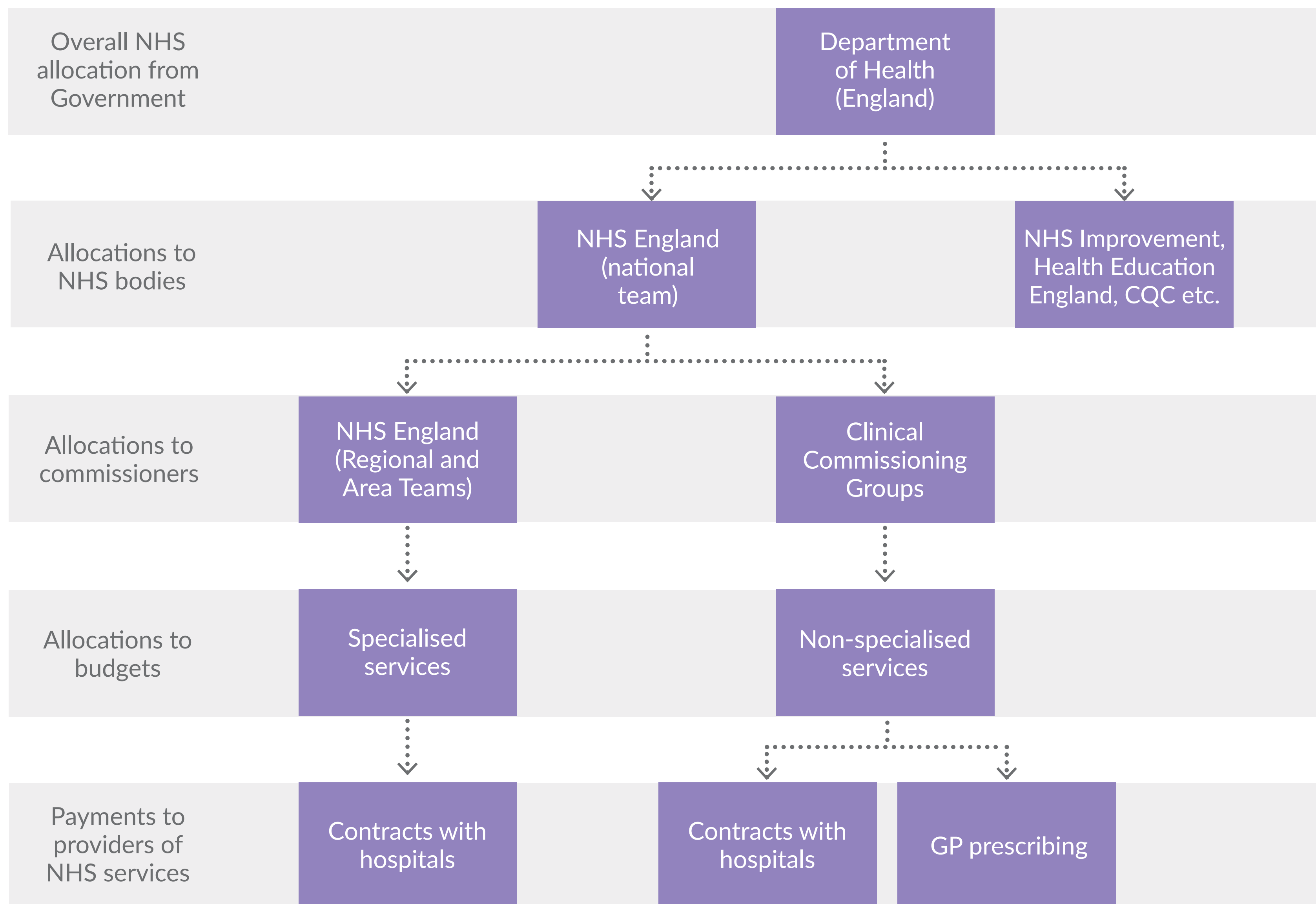


Decision making in nutritional metabolics

- NHS Commissioning organisations are NHS England and CCGs
- Specialised services are commissioned by NHS England to a national specification
- National service specifications and policies
- Prescribing: NHS England but CCGs may influence

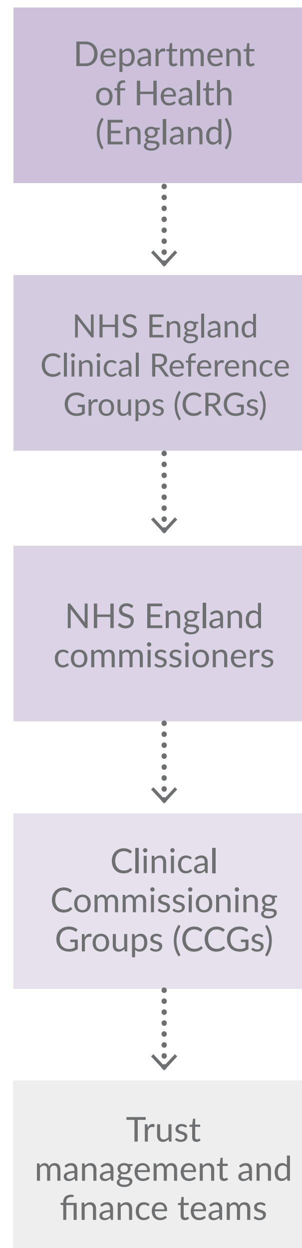
Decision making in nutritional metabolics

Money and decision hierarchy for metabolic services

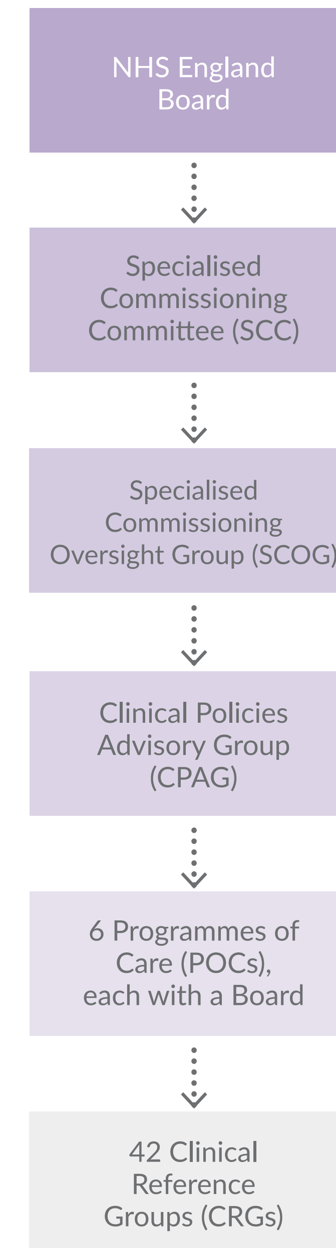


- Secretary of State for Health (SoS) has overall accountability for NHS
- Five Year Forward View: overall direction for NHS
- NHS Mandate: sets the strategy; updated annually; issued to NHS England
- NHS England: national body responsible for delivering the NHS Mandate through its own regional and area teams and the 209 Clinical Commissioning Groups (CCGs) across the country

Influencing the decision makers



A detailed look at NHS England

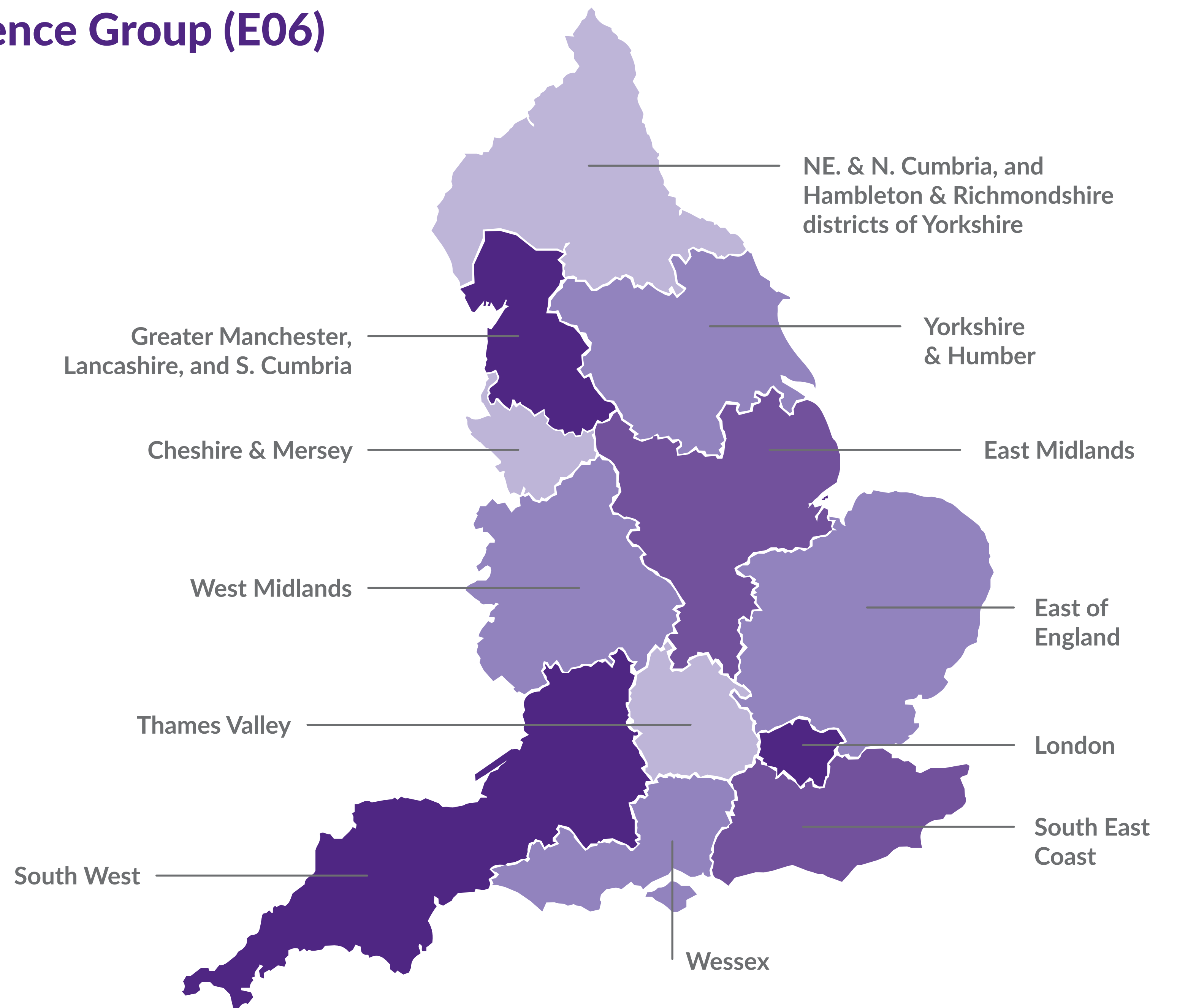


Metabolic Services Clinical Reference Group (E06)

- Constituted to provide specialist clinical advice to the Women and Children Programme of Care Board
- Mainly by developing services specifications and policy statements covering metabolic services
- Tasked with examining the evidence for the treatments available for the conditions in its' area of responsibility and then give consideration to the clinical and cost effectiveness of each treatment with a recommendation of where all interventions sit within the treatment pathway
- Has its own web page on the NHS England site
    - Details the membership of the group
    - Accountability and reporting structure of the CRGs
    - Services specifications and commissioning policies are published
- The service specifications that have been published by the E06 CRG (as at Dec 2016):
    - Alkaptonuria service (Children)
    - Barth syndrome service (Children)
    - Lysosomal storage disorders service (Children)
    - McArdle's disease service (Children)
    - Severe acute porphyria service (All Ages)
    - Metabolic Disorders (Adult)
    - Metabolic Disorders (Children)
    - Metabolic Disorders (Laboratory Services)
    - Rare mitochondrial disorders service (All ages)
- The policies published by E06 CRG (as at Dec 2016):
    - The use of Sapropterin in children with Phenylketonuria

Metabolic Services Clinical Reference Group (E06)

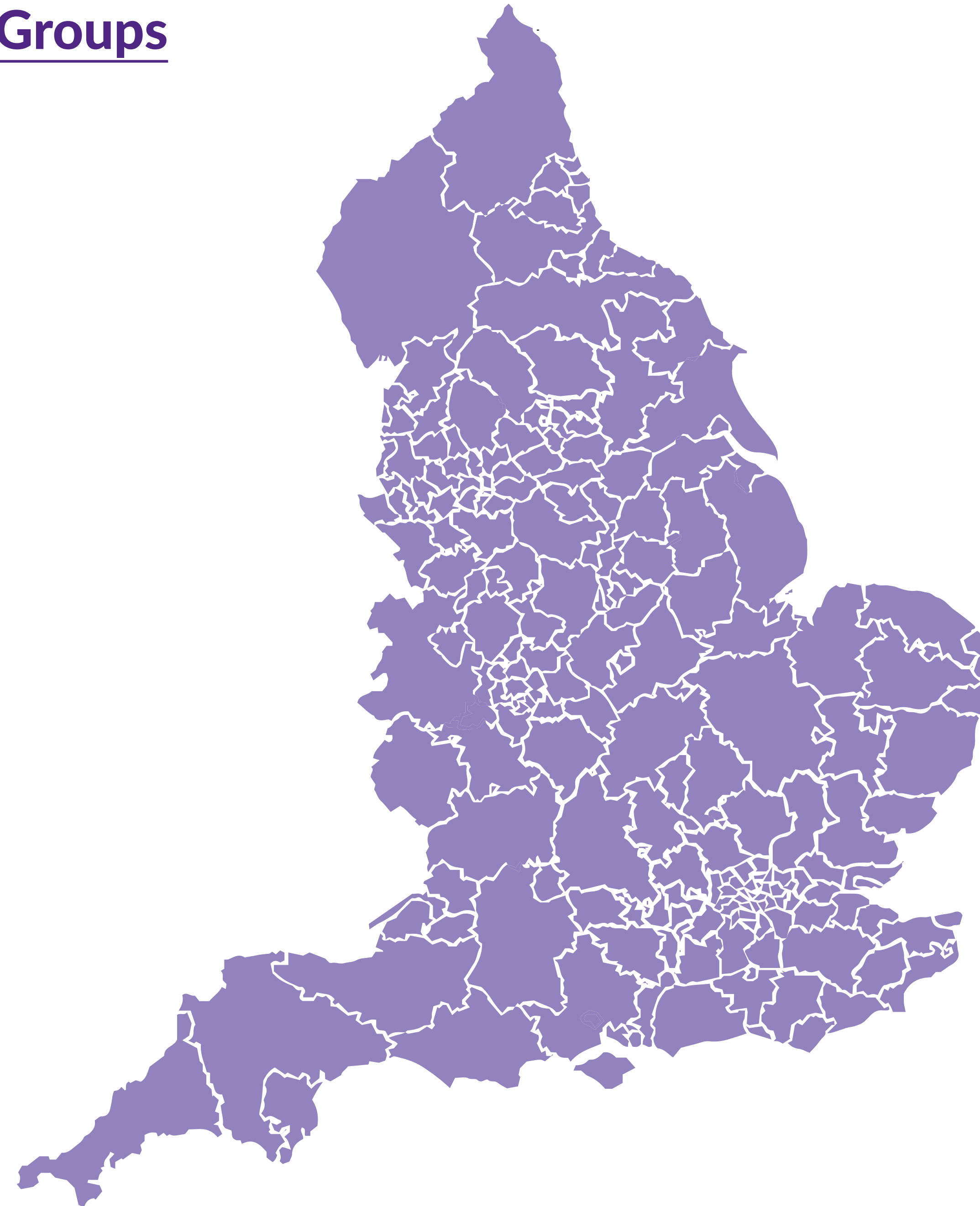
CRG membership includes representatives from each of the 12 clinical senate areas.



The 12 Clinical State Senate Areas in England

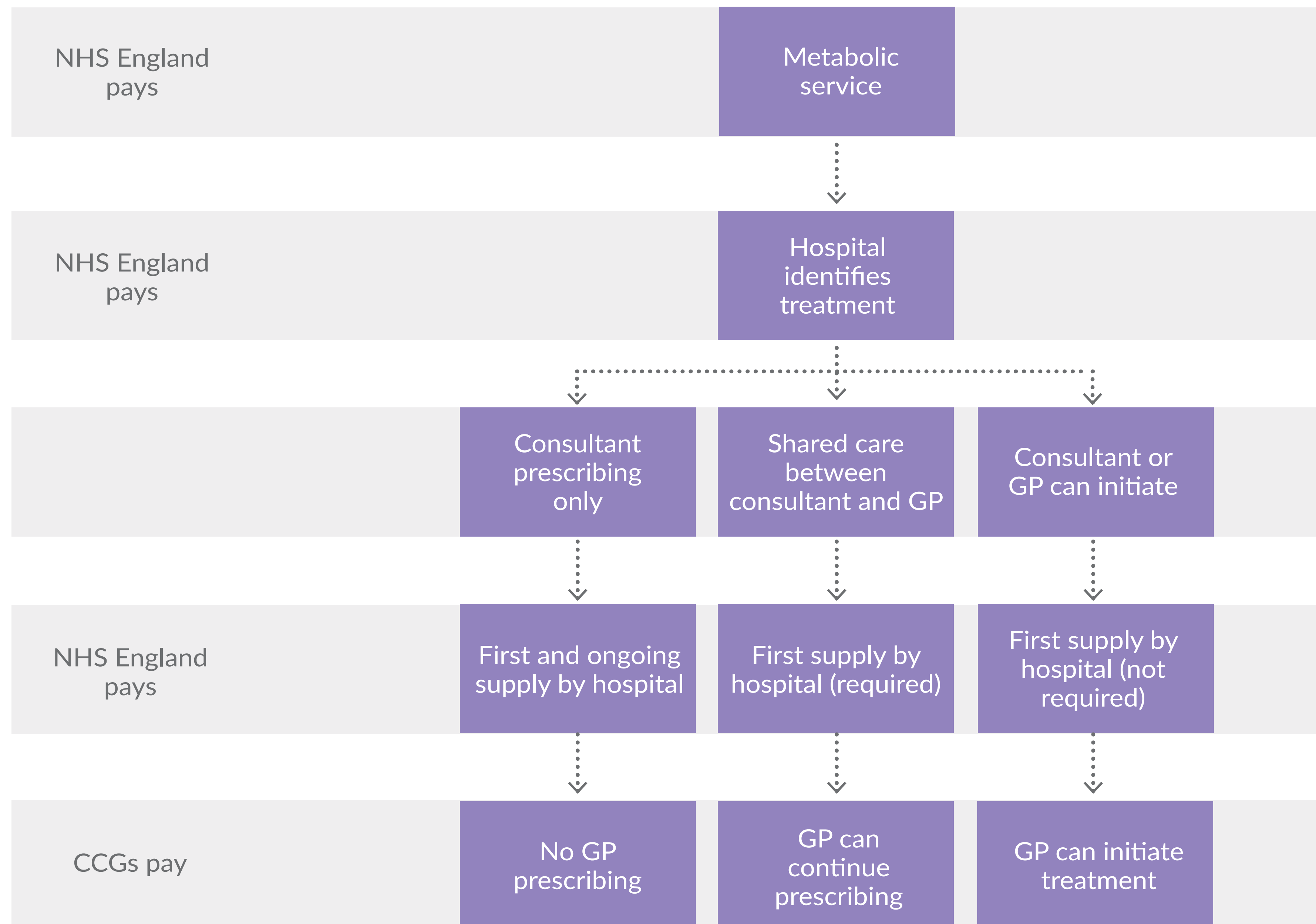
A detailed look at Clinical Commissioning Groups

- 209 Clinical Commissioning Groups in England
- Primary Care Co-Commissioning: the transfer of some of NHS England's responsibilities to CCGs
- CCGs may impact on metabolic services



The 209 CCGs in England

Prescribing responsibilities for metabolic treatments



Summary

- NHS England and Clinical Commissioning Groups (CCGs) are the main decision makers in the NHS in England
    - CCGs: general hospital services
    - NHS England: more specialist services including Inherited Metabolic Disorders (IMD)
- Metabolic Services Clinical Reference Group (CRG) provides clinical advice to NHS England, mainly through the production of services specifications and policy statements
- CCGs may become (or are currently becoming) increasingly interested in commissioning specialised services
- The Five Year Forward View describes the direction of travel for the NHS in England

2

ENVIRONMENTAL OVERVIEW

The NHS environment

This chapters describes:

- The overall NHS environment that metabolic services and your hospital trusts are currently operating within
- The implications of NHS national policy for the immediate future
- The wider local and national issues that are likely to impact on your metabolic services

This understanding will also greatly improve the chances of influencing how your services develop, perhaps by successfully attracting additional investment into your department by providing the services and outcomes that are of greatest value to decision makers.

Why do you need to understand your environment?

- Increasing financial and organisational pressures in the NHS
- Growing demand, falling funding
- Five Year Forward View is the strategy for change
- Service Transformation to the new environment required for long-term sustainability
- Sustainability and Transformation Plans (STPs) are the vehicle to implement the Five Year Forward View and change
- Carter Report
    - Hospital Pharmacy Transformation Programme (HPTP)
    - Better buying, lower stockholding, better data
    - Procurement Transformation Programme (PTP)
    - Avoiding delayed discharges
    - Model Hospital and Associated metrics

NHS England Five Year Forward View

The big picture
Challenges

Challenging five years ahead for the NHS:	Challenges to metabolic services:
Falling funds	Rising numbers of patients
Rising demand	More costly treatments
Need for financial balance	Need for Trusts to remain in financial balance
More complex healthcare	NHS England drive to decrease the number of specialist centres?
Drive for transformation	Carter Report drive for hospitals to work collaboratively
Expectation of collaboration	Access to treatments restricted?
Transformation of providers and decision-makers	Reducing staffing costs

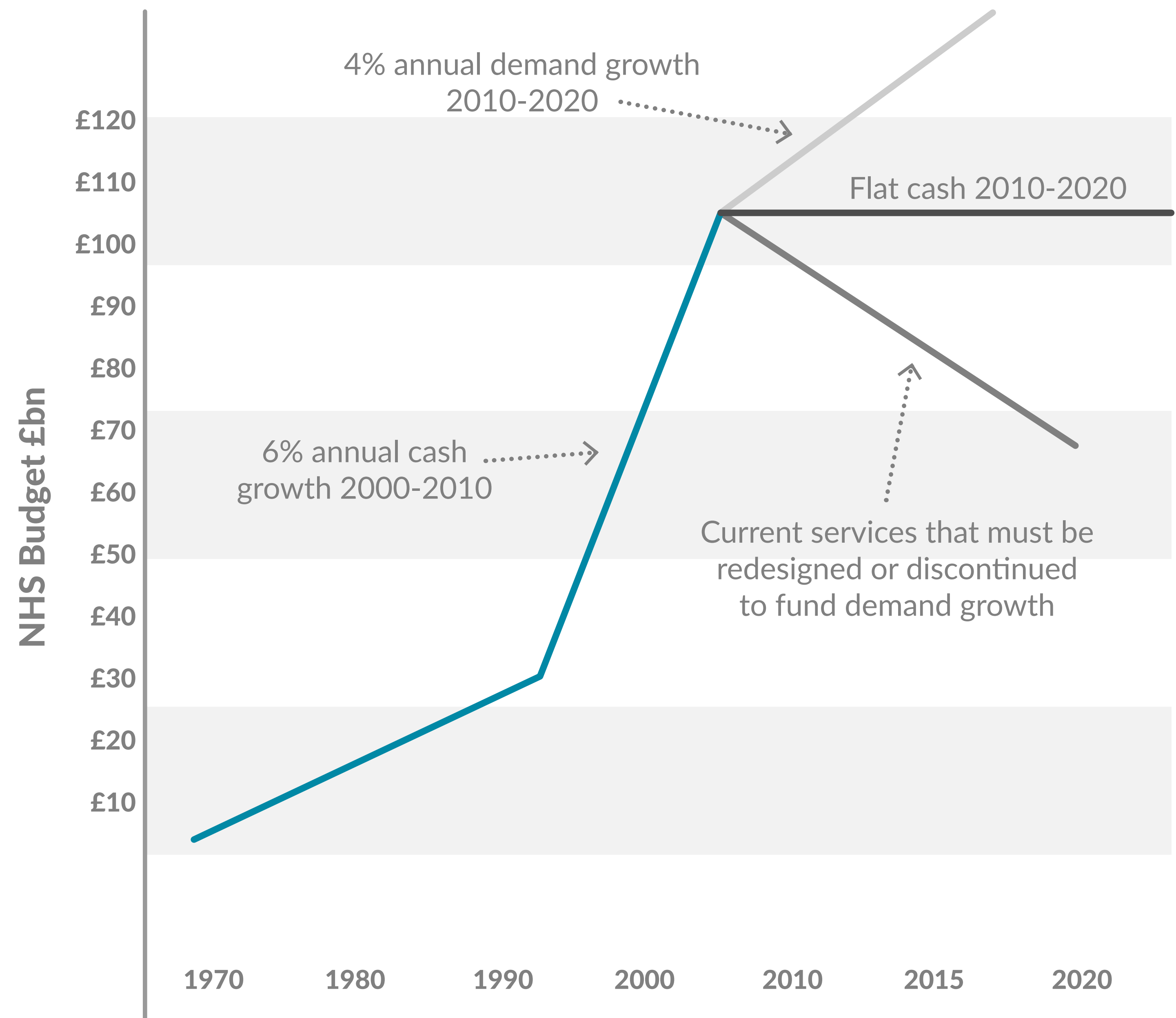
The big picture
Money

The QIPP Gap

The size of the QIPP (quality, innovation, productivity and prevention) challenge for the NHS can be understood from the graphic below.

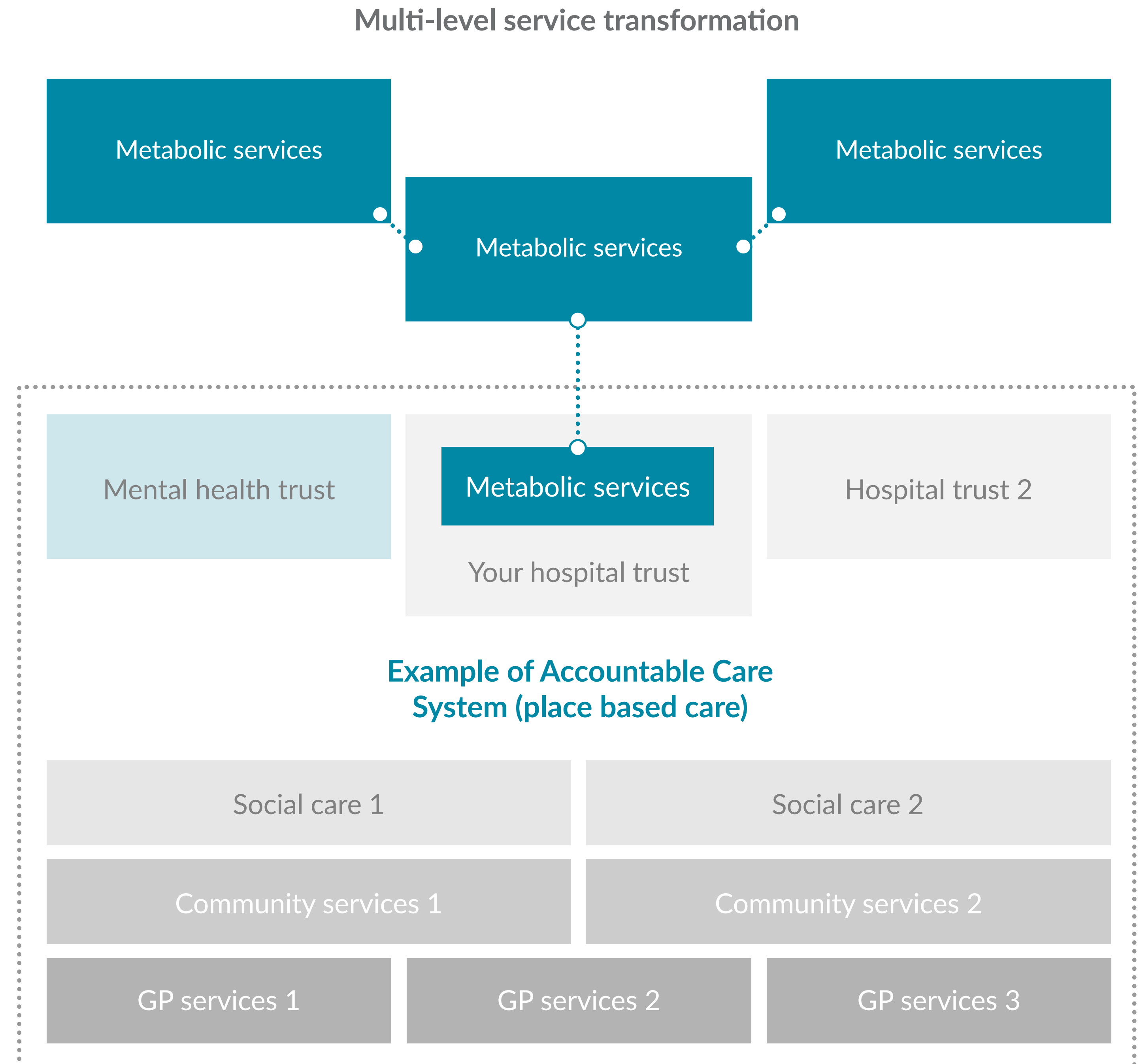
In the 10 years up to 2010 the NHS received significant additional funding each year which kept pace with the increasing demands from rising numbers of more complex patients and more costly treatments.

Since 2010 NHS funding has remained largely the same but the demands are still rising. The only way to meet the gap in funding is to do more with the existing resources.



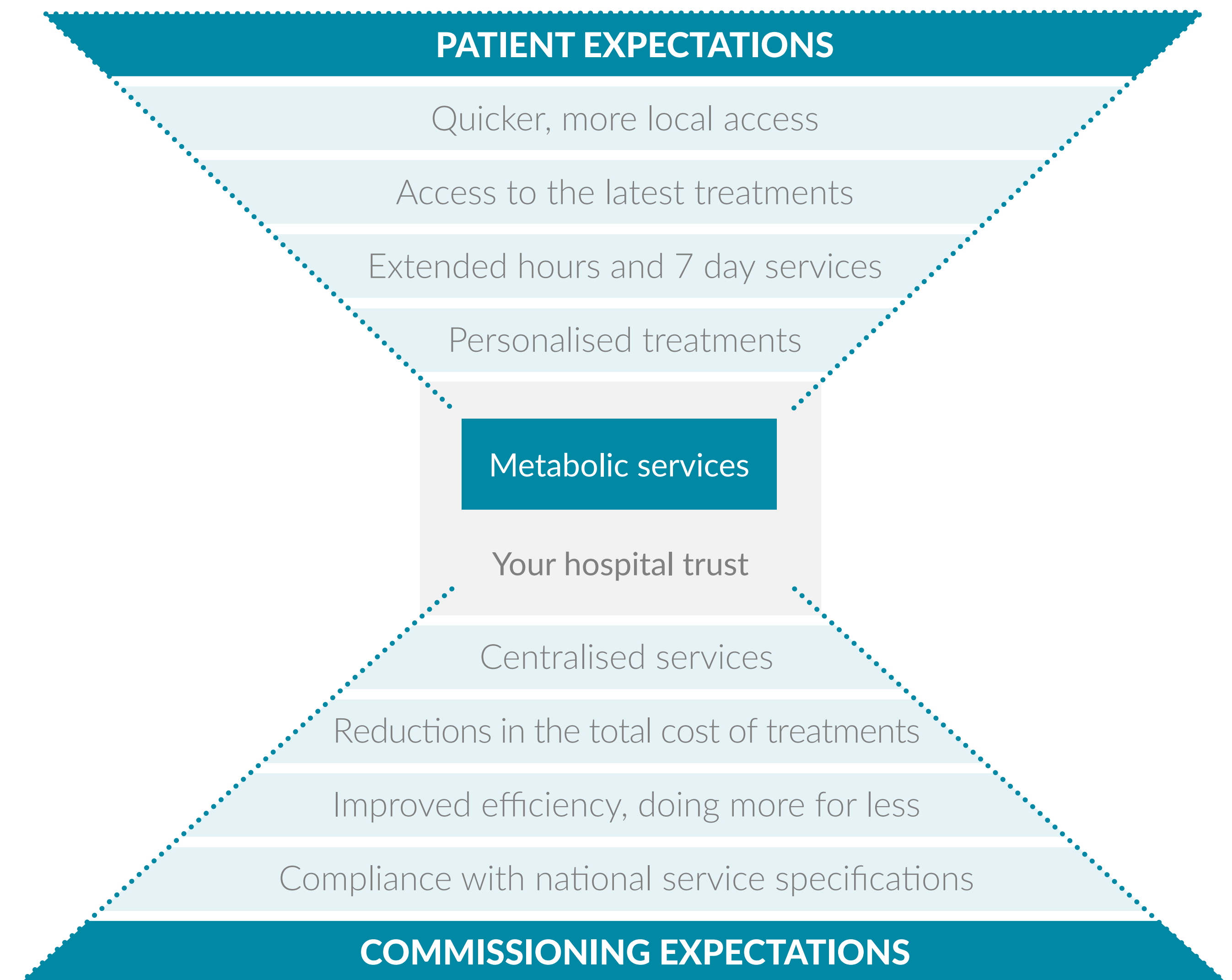
The big picture
Service transformation

- 'Placed based care' being introduced into the NHS
    - All NHS organisations and local authorities in natural geographies work together
- New Models of Care emerging, giving rise to 'Accountable Care Organisations'.
- All parts of the NHS to have plans on how they will become an Accountable Care Organisation
- Plans known as Strategic and Transformational Plans: aimed to be vehicles to deliver the Five Year Forward View



Your service challenges in detail

- Increasing patients' expectations
- Demand for services continues to rise
- Cost of individual treatments rising
- Introduction of seven-day services
- Centralisation of specialist services
- Restricting access to some treatments



Impact of current policy objectives

- Requirement of financial balance for trusts
    - Metabolic services:
      low volume / high cost = financial risk
- National service standards and performance measures
- Drug costs and specialist treatments increasing
    - Other costs need to reduce to afford them
- Blueteq prior approval system
- National tariff revision in 2016
- Move towards co-commissioning

Impact of potential centralisation of services

- National policy objectives
- Move towards Accountable Care Organisations
- NHS England Vanguard Programme and Sustainability and Transformational Plans

Summary

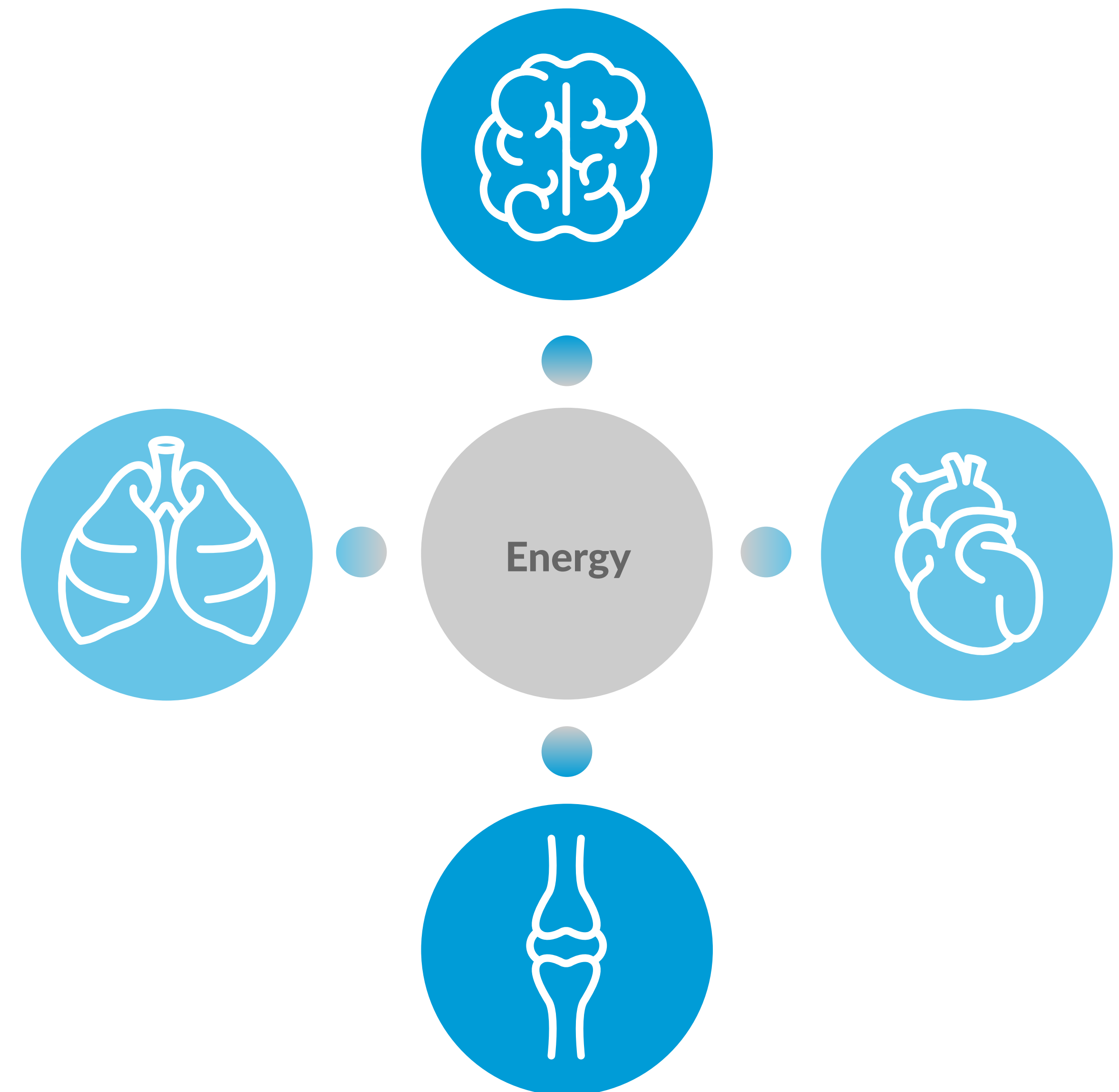
- Demand for services is growing, funding is falling, increasingly restricted access to treatments
- NHS Organisations required to achieve financial balance by end of 2016/17
- The Five Year Forward View is the direction of travel for the NHS in England: Sustainability and Transformation Plans to drive its implementation
- Expectation of transformation and collaboration within the NHS
    - Place based care: NHS and local authorities working together
    - Accountable Care Organisations
    - Move towards co-commissioning: CCGs 'taking on' specialised commissioning responsibilities
    - Low volume/high cost service centres (such as IMD?) at risk of being reduced

3

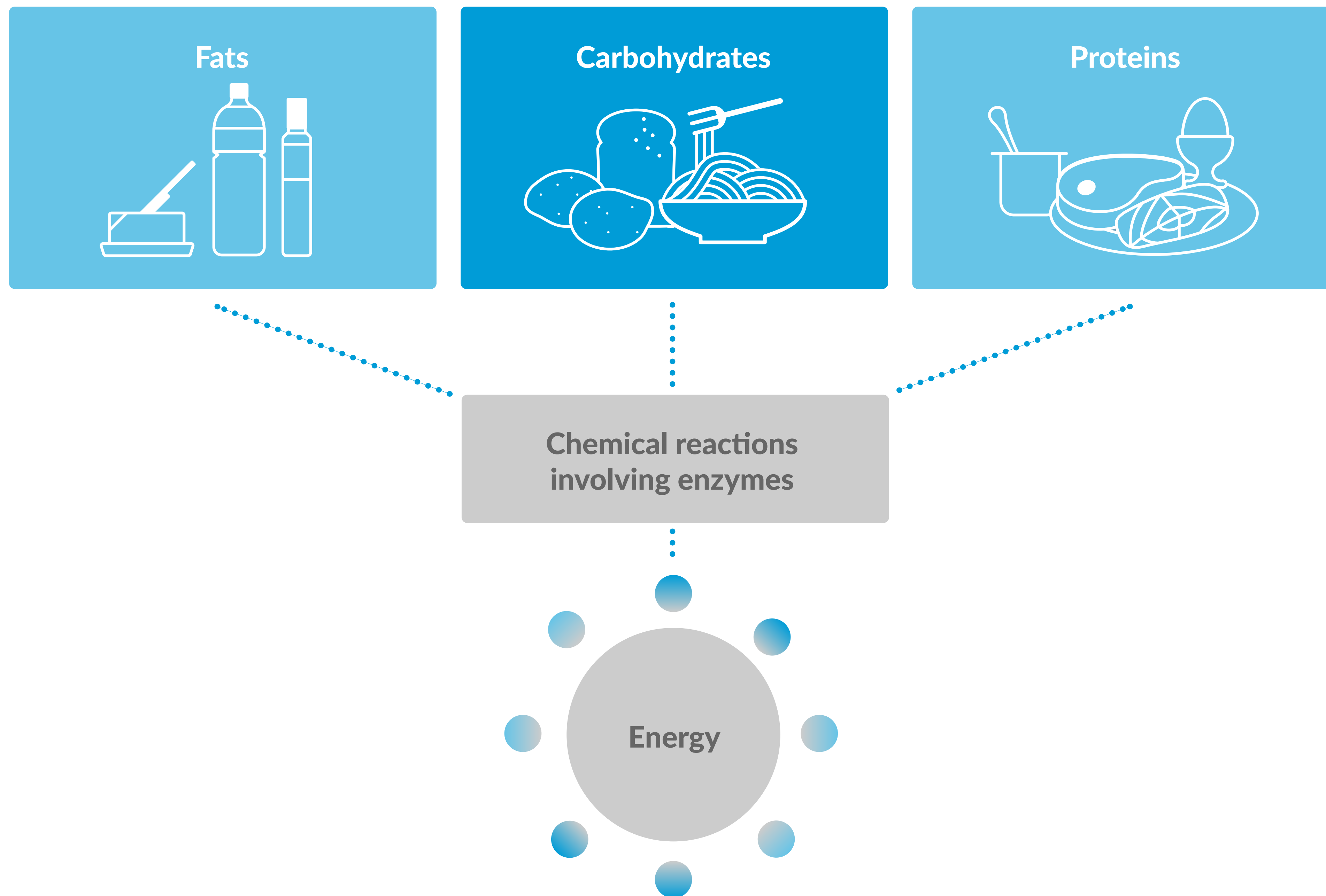
INHERITED METABOLIC DISEASES (IMD'S): An introduction

Metabolism

The chemical processes occurring within the body needed to produce the energy and substances required for normal body functioning.

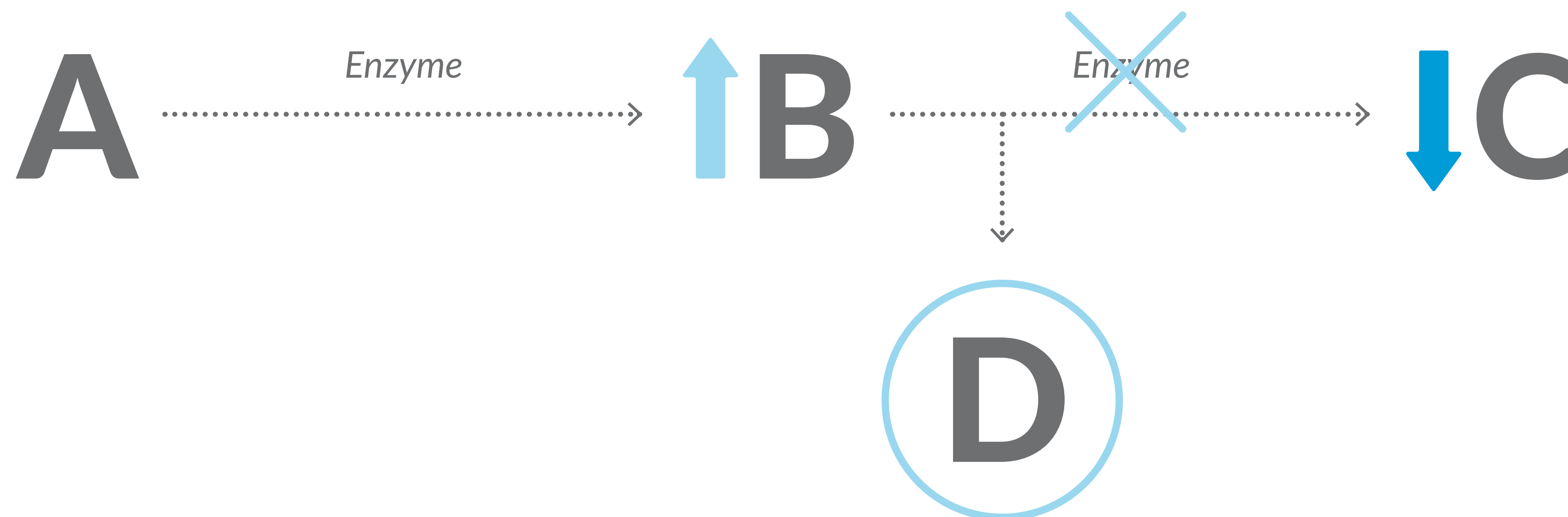


Metabolism



What are IMD's?

- Genetically inherited, rare conditions
- Defective enzyme involved in fat, carbohydrate or protein metabolism



Leads to:

- Build-up of intermediary metabolites proximal to the block (B)
- Deficiency of products after the block (C)
- Formulation of alternative products (D)

Note: Only dietary treated conditions are discussed in this presentation, alternative IMD's and pathways are not mentioned.

Dietary treated IMD's

<table>
<tr><th>Protein</th><th>Carbohydrate</th><th>Fat</th></tr>
<tr>
<td>Phenylketonuria (PKU)
Tyrosinaemia Type 1
Homocystinuria (HCU)
Maple Syrup Urine Disease (MSUD)

Urea cycle disorders:
• Ornithine Transcarbamylase (OTC)
• Citrullinaemia

Organic Acidaemias:
• Methlymalonic Acidaemia (MMA)
• Propionic Acidaemia (PA)
• Isovaleric Acidaemia (IVA)
• Glutaric Aciduria Type 1 (GA1)</td>
<td>Glycogen Storage Diseases (GSD):
• Galactosaemia
• Hereditary Fructose Intolerance (HFI)
• Fructose-1, 6-biphosphatase deficiency</td>
<td>• Medium chain acyl-CoA dehydrogenase deficiency (MCADD)
• Very long chain acyl-CoA dehydrogenase deficiency (VLCADD)
• Long chain 3-hydroxyacyl-CoA dehydrogenase deficiency (LCHADD)</td>
</tr>
</table>

Diagnosed via new born screening in the UK.

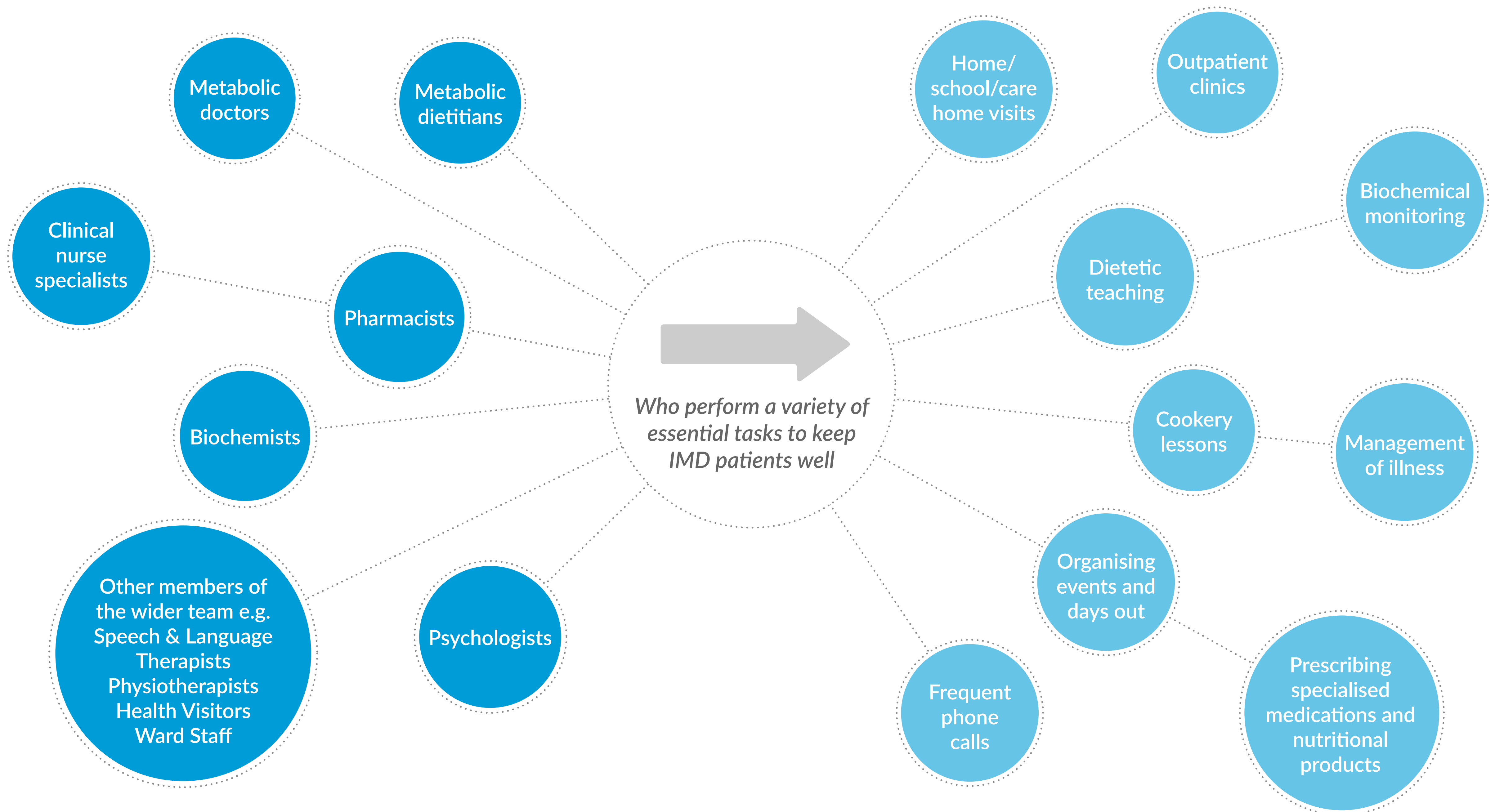
Treatment: General principles

- Reduce intake of the accumulating metabolite to a safe level using a prescriptive, medical diet (e.g. low protein, low fat)
- Prevent deficiencies and ensure the diet is nutritionally adequate using specialised metabolic products (e.g. amino acid based protein substitutes, low protein medical foods, other sources of calories, vitamins, minerals and essential fats as needed)
- Stimulate activity of residual enzyme, or reduce the load on the affected pathway where possible using medical management
- In some IMD's, catabolism leads to the build up of harmful metabolites and acute deterioration. Swift and effective management of illness is required using an Emergency Regimen.

Treatment: Why is it so important?

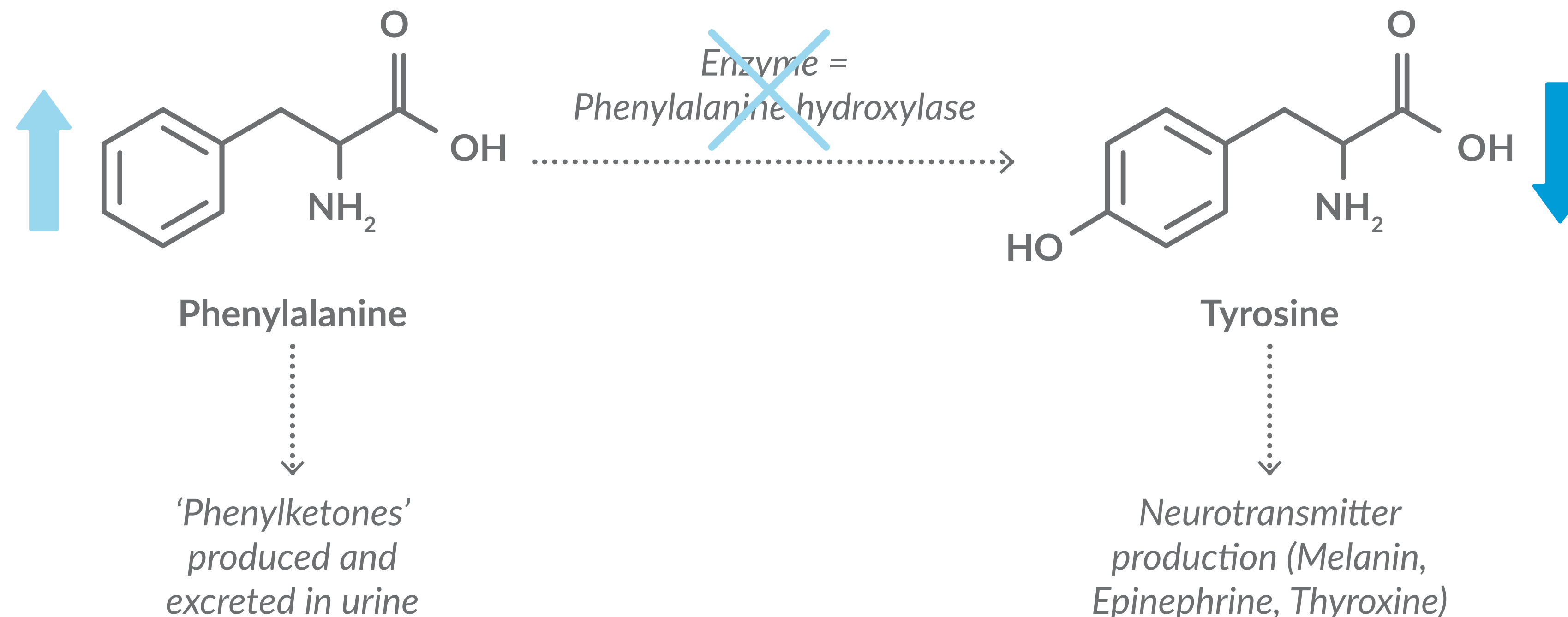
- Without treatment, intermediary metabolites accumulate in the body and have serious acute and/or chronic consequences. For example:
  - Developmental delay
  - Movement disorders
  - Cardiomyopathy
  - Liver and/or kidney involvement
  - Coma/death
- Early detection and ongoing specialist treatment improves quality of life and health outcomes for patients and families
- Effective management of illness using Emergency Regimens reduces hospital admissions and the associated costs, and can save lives

IMD patients need a specialised multidisciplinary team (MDT)



Example: Phenylketonuria (PKU)

- Disorder of protein metabolism
- Newborn screening commenced 1969 (UK)



Consequences of untreated PKU: severe, irreversible brain damage (IQ<30), seizures, severe behavioural difficulties, eczema, musty body odour, light pigmentation (eyes, hair, skin)

Example: Phenylketonuria (PKU)

But… these complications can be prevented with early initiation of treatment by a metabolic team:

- A low protein (Phe) diet
  - Measured amount of protein/Phe adjusted with frequent blood testing. Commonly as little as the equivalent of 3g protein per day!
  - Intensive dietetic teaching and ongoing support needed
- A Phe-free protein substitute taken everyday
  - Usually includes vitamins, minerals and essential fats
- Low protein medical foods needed to provide variety and energy to the diet
  - Prescribed via GP

Summary

- IMD's are a complex, heterogeneous group of conditions requiring individualised, lifelong treatment by a specialist metabolic team.
- Effective and timely treatment improves quality of life, health outcomes and reduces hospital admissions.

WHAT AND HOW CAN YOU INFLUENCE?

Outline and purpose

Options and approaches for engaging with various key stakeholders

- How to influence and motivate them
- What the initial steps might be.

Need to understand what the major drivers for change

- How to exploit them to enable influences over future structures, specifications and service delivery.

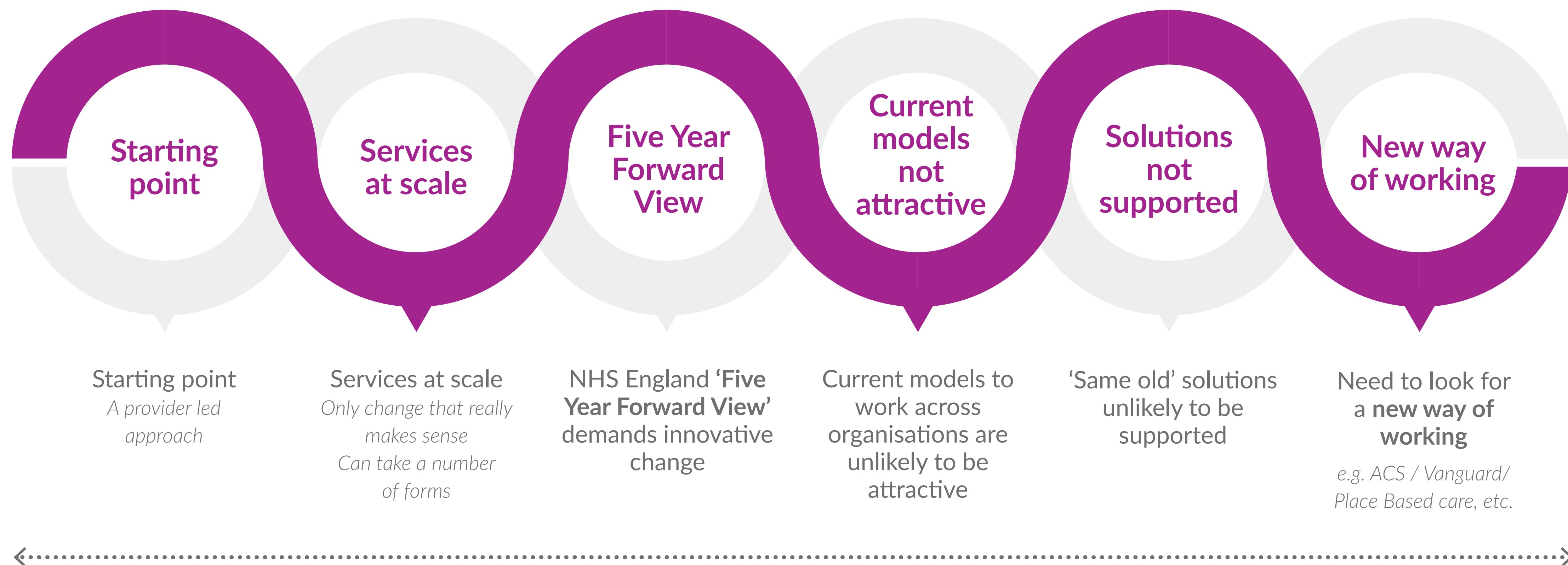
NHS England looking for provider-driven change

- New models of care are being developed e.g. Vanguards or an Accountable Care System (ACS).

Provider-led commissioning

Commissioning: 'The process of planning, agreeing and monitoring services'.	Commissioners and providers will be dominated by the need to **reduce costs** and improve service quality.
Metabolics not on CCG and NHSE radar.	Service change unlikely to be driven by traditional commissioners. Service Change will only happen if **providers** decide to do things differently. Trusts will act as pseudo-commissioners.
Trusts are commercial organisations. Need to at least be solvent, ideally make money.	Metabolic are small, invisible services.
Any **proposition** needs to **add value**: Either by improving clinical outcomes or generating income/save money for the Trust.	Usually, both.

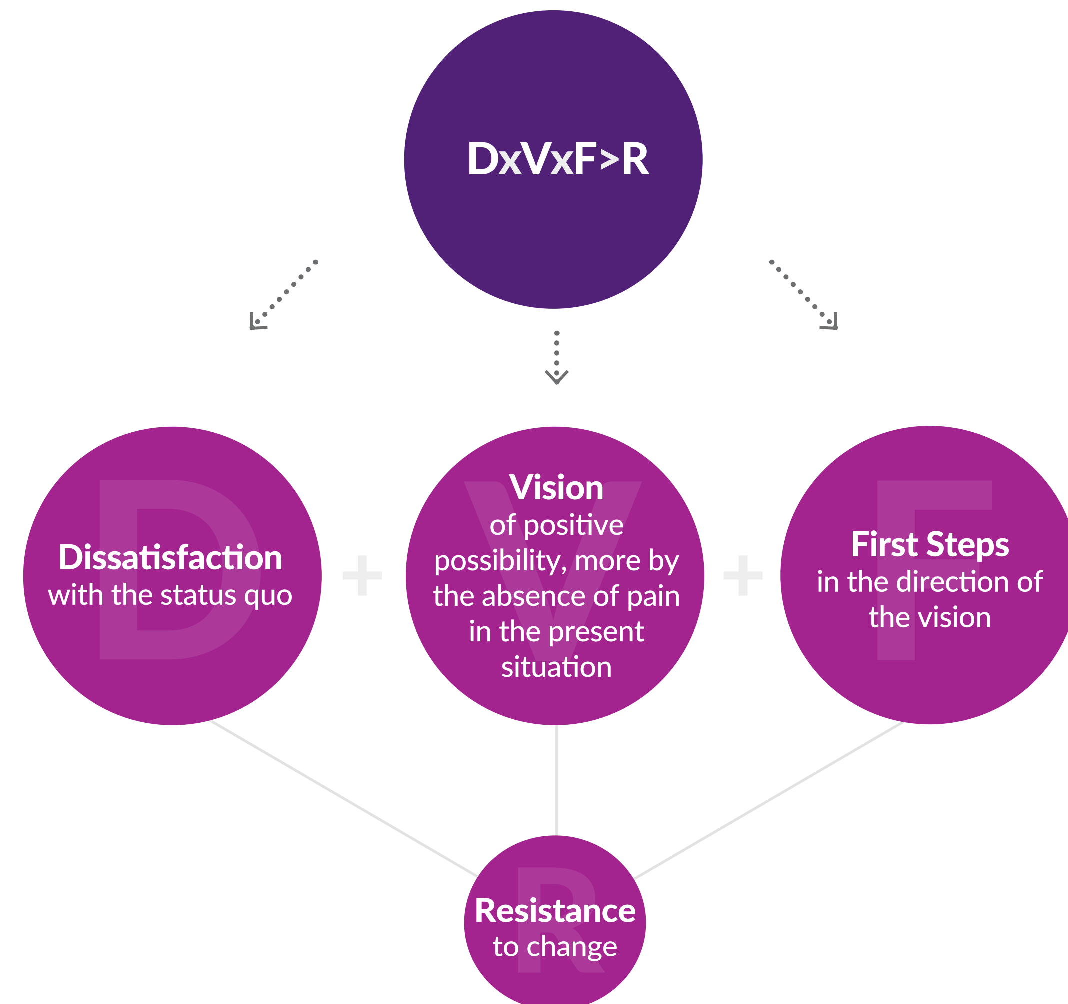
New ways of working



Influence and change

To overcome the natural resistance for change, show:

- Dissatisfaction
  Current service could be better.
  e.g. small is less efficient.
- Vision
  Set out what the better service would be.
  Money matters. New service makes a profit.
- First Steps
  Engage with key stakeholders and build a proposal.



For any organisation to change, the Dissatisfaction with the status quo multiplied to the Vision of a possible future multiplied with the First steps in the direction of change needs to be greater than the resistance to change.

What providers can influence

Current services unlikely to succeed in new centralised commissioning environment

- Trusts are commercial
    - Need to make a profit
    - Service must be, at least, solvent.
- Clinical champions - critical to change.
    - Find them. Support them. Use them.
    - Forge relationships with or be part of
    - Clinical Reference Groups
    - Provide input into prescribing choice decisions
- People take decisions
  Organisations and systems don't...

Clinical Reference Groups will be key to setting the parameters and guidelines on metabolic services.

- Clinicians are rarely skilled in commissioning techniques
- Will need assistance and 'skilling-up' for these tasks
- Facilitate groups of metabolic services to start to work together.
- Learn from similar exercises
  e.g. reorganisation of pathology or stroke services

CRGs are comprised of a range of experts

But they may know little about commissioning or reconfiguring services

Skill up leading clinicians to become clinical champions to influence change

Creating the vision

Show the service as robust and making a positive contribution.

This is what a profitable and clinically sound service looks like.

Ensure **CCGs & GPs** value the service.

Helps deliver the **CRG Strategic Plan.**

Utilise Clinical Champions as Advocates

CRGs advocate for the service to be the specialist lead.

First steps

Build a funding proposal

	WHAT	DO	DON'T
1.	Commissioners will want a costed Outline Business Case (OBC)	• Clearly set out the value of the proposition • How, specifically, it benefits the organisation	Be seen as a simple 'empire-building' exercise or demand for more staff in an over-worked area.
2.	Demonstrate the most cost effective way of providing clinical support	• Opportunities to improve productivity • And/or reduce costs (additional staff business case)	No expensive staff resource if cheaper options are (clinically) competent
3.	Embody new ways of working	Consider alternative methods of delivery *e.g. ACS/ Vanguards*	Avoid reproducing tried and failing solutions
4.	Will new funding required?	• Show the return on investment	Benefits that take too long to manifest/ too marginal will be quickly dismissed
5.	Size & scope matter	• Make the service sustainabl *e.g. expanded population/catchment area*	Base a service around a small numbers, vulnerable to unexpected staffing shortages.
6.	Annual Commissioning Intentions set in the Autumn	• Start discussion early enough to feature in the Planning Cycle	Assume an intention is automatically granted permission to go ahead
7.	Understand your audience	• Ensure proposal 'fits' with organisational strategy and helps deliver CRG Strategy	Ignore guidelines & policy
8.	Use your Compelling Story	• Make it unreasonable not to undertake the change	Avoid the proposal being easily dismissed

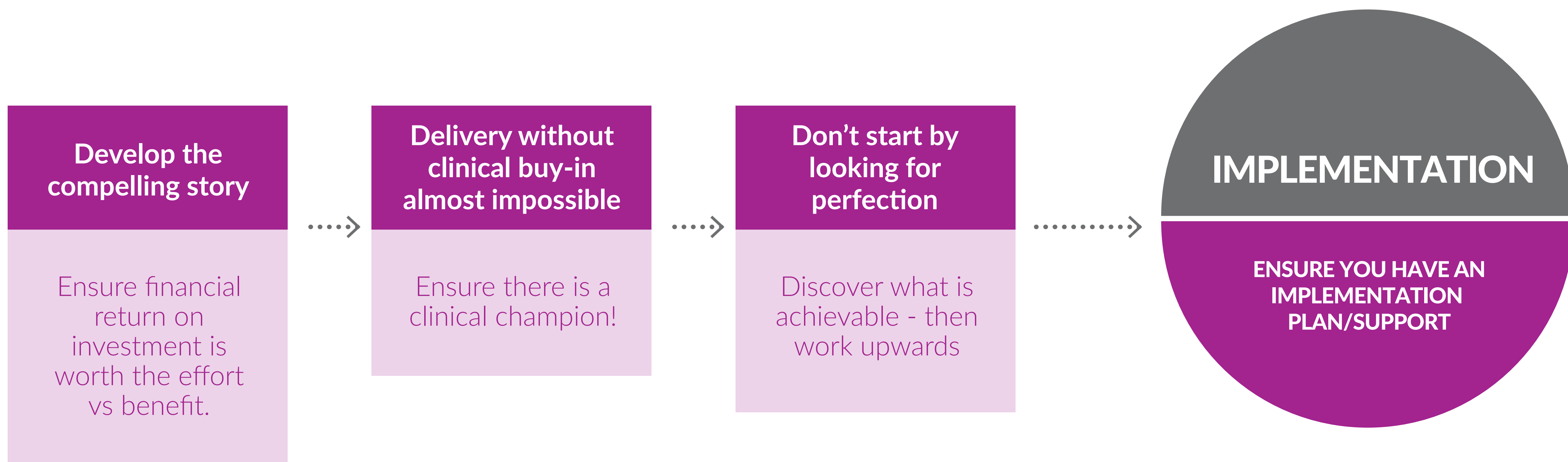
Data capture

- First identify what and why you are trying to change.
- Ensure the evidence will help build your business case?
    - May take more than one attempt to gather correct data to ideal level of detail and quality
    - Trust Finance colleagues will want an input to review the data: encourage this.
- Are all current activities known and charged for ?
    - Are all patient contacts/clinical time being charged for?
- Understand which hospital services utilise/are reliant on metabolics:
    - Capture all service requests for metabolic services
    - What specialties and HRGs each activity is associated with
    - What are the direct/attributable costs of staff time/resources and consumables
    - Can any activity be charged for separately

What will success look like?

Find the Sweet Spot- Better clinical outcomes/patient experience & reduced costs

- What is the scenario that works for everybody?



Prescribing

- NHS prescribing of medicines and devices is undertaken by prescribing clinicians in secondary and primary care.
- Most CCGs and Trusts adopt a Joint Formulary, which indicates which may be prescribed and funded by commissioners.
- Formularies are developed by local prescribing committees, and also describe what level/experience is required to prescribe certain drugs.
  - Formularies often follow a 'Traffic Light' process to indicate the level of expertise required to prescribe a drug, e.g
    Red = consultant/hospital only
    Amber = consultant/hospital initiated and prescribing continued under "shared care" arrangements in primary care general practice
    Green = prescribed in primary care general practice.

5 APPENDICES

BACK TO PRESENTATION ···>

Background

Between 2000 and 2010 NHS hospital service (inc. specialist metabolic services) have seen a period of significant growth

- Unprecedented levels of investment
- Expansion of services
- Provision of new and more expensive treatments to patients
- Introduction of shorter waiting time targets
- New payment models

- Incentivised hospitals to invest in larger specialist services and treat more patients
- Growth of NHS budgets allowed most trusts to be fully reimbursed for the supply of drugs and other treatments, meaning that the service itself decided which treatments to use

Since 2010 the outlook for NHS finances has become less favourable with all sectors facing unprecedented challenges:

- Increasing numbers of patients
- More expensive technologies available
- Constrained resources

The changes facing in the hospital sector are perhaps the most challenging across the NHS, as trusts are under significant pressure to deliver higher quality services and cut internal costs at the same time.

From 2010 to 2016 the NHS had been fully engaged with implementing large scale commissioning reforms:

- Replaced Strategic Health Authorities and Primary Care Trusts with NHS England and Clinical Commissioning Groups (CCGs)
- No great impact on the day to day running of most hospital services and the treatment of patients
- Changes have been managed by trust executives and finance teams - specialist services such as metabolics may not have been involved in negotiations with commissioners about the configuration and specification of services and the funding of treatments.

Outlook for the next few years is very different:

- Main focus of NHS reforms now being directly aimed at service providers and integration with social care
- Hospital sector in particular being asked to transform services on a scale that has not been seen since the inception of the NHS
- All hospital trust staff, particularly clinical leaders and senior managers: will need to understand how to best navigate these changes in order to continue to develop their services in-line with national and local priorities.

A detailed look at NHS England

Specialised Services Single Operating Model

- Reports to the Board of NHS England through a series of commissioning committees
- Seek to balance: health needs of population versus available resources
- Ensures a consistency of approach across all the specialist clinical areas
- 143 specialised services placed in six Programmes of Care (PoC):
    - Internal medicine, Cancer, Mental health, Trauma, Women and Children (including congenital and inherited diseases) and Blood and Infection
- Each PoC has a number of Clinical Reference Groups, bringing together groups of clinicians, commissioners, public health experts, patients and carers with a focus on a specific clinical therapy areas within the PoC. Following a review in 2016, several CRGs closed or merged. There are now 42 CRGs within the six Programmes of Care (POC)
- The 6 POC clinical strategies receive further alignment through the work of the Clinical Priorities Advisory Group (CPAG) and the Specialised Commissioning Oversight Group (SCOG)
- The resulting overall commissioning strategy then receives approval from the Specialised Commissioning Committee (SCC) which is a subgroup of the NHS England Board.

Metabolic Disorders CRG

- Sits within the Women and Children PoC along with 8 other CRGs
- The 9 CRGs are responsible for developing a single clinical strategy for the Women's and Children POC.

Commissioning intentions

- Normally published annually in the autumn by NHS England for the following year
- Gives providers a broad view of the strategic priorities that will for the basis of the contract discussions with each individual trust that provides any of the specialised services
- Updated service specifications and policies published at any time during the year.
- Most recent publication made a 2-year announcement (17/18 and 18/19) of changes and priorities- none which directly affect Metabolic Disorders

Standard national contract

- Secures provision of services for NHS England with providers
- Normally revised annually, but latest announcement for 2 years (2017/18-2018/19)
- Hospital trusts required to provide services that meet the requirements of the national services specifications and any commissioning policies
- Intention is NHS England will only pay for activity that meets national service specifications - less scope for local variation in services provided
- National generic policies that describe how commissioners will work with providers to fund in year developments in services and meet the requirements of NICE guidance and technology appraisals.

BACK TO PRESENTATION

A detailed look at Clinical Commissioning Groups

Clinical Commissioning Groups

- Independent of, but authorised and regulated by NHS England.
- Each CCG is constituted by the GPs from the constituent general practices and is led by a Governing Body which is sometimes referred to as a Board.
- 209 CCGs in England, ranging in size from just over 60,000 registered patients to almost 900,000 registered patients.
- NHS England provides up to date information on all CCGs on its website - (list of CCGs), (detailed map of CCGs).
- Responsible for commissioning all NHS services that are not commissioned by NHS England, with the exception of a small number of services that are commissioned by public health teams in local authorities.
- Legally responsible for commissioning approximately 66% of the total NHS budget, covering most general hospital services and all community services, including GP prescribing.

Primary Care Co-Commissioning

- Introduced in 2015 by NHS England.
- Policy aimed at managed transfer of some of NHS England's commissioning responsibilities to CCGs.
- Initial focus of the policy: to increase the involvement of CCGs in the commissioning and performance management of their own GP practices.
- During 2016 and increasingly from 2017 CCGs working in groups will also have a greater involvement in the commissioning of specialised services.
- Although CCGs are becoming more involved in commissioning specialised services, the responsibility for meeting the costs of specialised metabolic services will remain the responsibility of NHS England.

CCGs impact on metabolic services

- Specialist metabolic services wishing the transfer continuing prescribing of specialist feeds may sometimes find that GPs are reluctant to do so due to lack of expertise or concerns about the costs.
- CCGs have a legitimate role to manage both GP and hospital prescribing in their area and often collaborate with neighbouring CCGs to produce prescribing guidelines and formularies for all the prescribers in their area.
- GPs are expected to follow these guidelines and may in some circumstances refuse to prescribe some specialist feeds.
- Metabolic services should ensure they engage positively with their local CCG through their hospital chief pharmacist.
- Hospital drug and therapeutic committees usually have representation from the local CCG and in most areas there is a collaborative approach to producing a joint formulary that works for both hospital and community prescribers.

BACK TO PRESENTATION

Hospital Trusts

Annual contracts

- Agreed between commissioner and trust
  - Individual service requirements (including service specifications)
  - Activity levels
  - Payment mechanisms
- Single contract with NHS England covering all specialised services
- Individual contracts with all local CCGs for non-specialised services.

Funding

- Through combination of many separate payments
  - From NHS England for specialised services
  - From CCGs for non-specialised services
- Approach used to manage funding of individual services/ departments is an internal matter for the individual trust.

Payment and costs

- Various methods (for both specialised and non-specialised services):
  - National payment by results (PbR) tariffs that include both service and drug costs
  - Non-PbR payments for drugs that are excluded from PbR tariffs
  - Block contracts with a fixed annual or monthly amount for an entire service
  - Local tariffs agreed with commissioners to replace any of the above
- Actual payment received can be significantly higher or lower than the actual cost of providing the service (irrespective of payment method used).
- Drugs and specialist dietary products: funding received from the commissioner is usually higher than the actual cost as trusts are able to negotiate significant supplier discounts
- Some metabolic services/departments will be given information on their costs in comparison with the income received by the trust for the services provided.
- In other trusts, metabolic services and their department will be given a nominal operational budget with little or no visibility of the income generated

BACK TO PRESENTATION

Influencing the decision makers

Department of Health

- Influencing national policy or Ministerial level can realistically only be achieved by professional bodies and groups representing the interests of patients with specific conditions
- Easier to influence local individuals and groups than it is to make an impact at national level

Metabolic Disorders CRG (E06)

- Body that considers clinical evidence for the specialist services and receives representations from interested parties
- Main role is to produce detailed service specifications and policy documentation that is used across all services
- However, may be required to make recommendations on the configuration of services, including which centres should provide services
- Recommendations considered together with recommendations of other CRGs by NHS England, before being ultimately endorsed by the NHS England Board

NHS England commissioning teams

- May be an opportunity to influence local decision makers, through the national service specifications and policies used by NHS England regional and area commissioners in their contracting negotiations with NHS providers
- Expectation that all services comply with national service specifications and policies, but may be some room for local variation if services can provide commissioners with good cause to make local exceptions

Sustainability and Transformation Plan (STP) leads

- Responsible for a move towards population-based care
- Will design and implement a five year plan: Year 1- achieve financial stability across commissioning and provider sectors (including social care); Year 2: transform how and where care is provided to improver outcomes and spend

Single or groups of CCGs

- Responsible for prescribing by GPs and most other community services
- Legally able to stipulate which drugs, devices and special feeds can be prescribed in their area (often through Area Prescribing Committees, APCs)
- APCs spend most of their time making decisions about drugs, but increasingly covering specialist foods as part of measures to contain growth in local prescribing budgets

Hospital Trust specialist metabolic service

- Trust management team will want to ensure service is only providing activity it is being paid for by commissioners
- Will also want to ensure that staffing and others costs are being appropriately managed and kept to a minimum.

Summary for success

- Align your approach with national and local policy and applicable service specifications and commissioning priorities
- Provide a business case that make sense financially and demonstrates how investment will deliver a return that is seen as valuable to the commissioner.

BACK TO PRESENTATION

Prescribing responsibilities for metabolic treatments

Responsibilities

- Commissioning and paying for the provision of specialised metabolic services sits clearly with NHS England
- In some services specifications there are options for the transfer of responsibilities for prescribing metabolic treatments to CCGs.
- NHS England specialised services manual:
  - Specifies which treatments are the responsibility of NHS England to commissioning and fund
  - Circumstances under which the ongoing supply of treatments can be transferred to CCGs.

Prescribing

- In most areas of the country is covered by a Traffic Light System:
  - Provides clear indication of the prescribing responsibility to all potential prescribers of drugs and treatments
  - Usually based on the following colours:

    Black – product not recommended for prescribing by specialist centres or GPs

    Red – product recommended for prescribing by specialist centres only

    Amber – product recommended for prescribing by specialist centres and GPs where this has been initiated by the specialist centre.

    Green - product available for prescribing by specialist centres and GPs without initiation by the specialist centre
- For most specialised metabolic services, prescribing of specialist dietary products falls into the amber category.
  - Once the specialised metabolic service has identified the appropriate treatment and has established the patient on the treatment, the GP can be asked to continue prescribing with the CCG providing the payment for all subsequent supplies.
- Drugs for specialised metabolic conditions are usually in the red category
  - Specialised service should continue to supply the drug and NHS England will provide payment.

Chapter 1: Glossary of terms

Term	Definition
Commissioning	The process of prioritising, specifying, performance managing and paying for NHS care
NHS England	National body responsible to Parliament for the NHS in England. Also the commissioner of specialised services
Clinical Commissioning Group	Local bodies responsible to NHS England for the commissioning of the majority of NHS services
Programme of Care	One of six groups of specialised services commissioned by NHS England
Clinical Reference Group	Expert professional group of advisors to NHS England commissioners
Specialised	The specialist services that are commissioned by NHS England
Non-specialised	The specialised services that are commissioned by clinical commissioning groups
Specialist services	Includes both specialised and non-specialised services
Single operating model	The single structure and set of processes that NHS England uses to commission specialised services
Specialised services manual	Document containing the description of all specialised services commissioned by NHS England
NHS Improvement	Single national body formed from the merger of Monitor and the NHS Trust Development Authority
NHS Mandate	The document that contains the strategic priorities of the Government that must be delivered by NHS England
Area Prescribing Committee	Body containing one or more CCGs that decides which treatments can be prescribed in their area
Sustainability and Transformation Plan	Five year plans for 'placed based care' across 44 'footprint' areas
Regional Medicines Optimisation Committees	Proposed by NHS England: Four geographic committees set up to appraise non-NICE TA medicines

BACK TO PRESENTATION

Why do you need to understand your environment?

- NHS has been facing increased financial and organisational challenges for the last 5 years
  - These challenges will continue to grow for the foreseeable future
  - Real terms investment in the NHS is falling whilst the demand for healthcare from and expanding and ageing population continue to rise
  - At the same time, the treatments and technologies that are available to the NHS continue to develop and provide additional cost pressures.
- These competing tensions of rising demand with falling real terms funding require a different kind of solution to be implemented across the entire NHS.
- The template for the future configuration of all NHS services is contained in the NHS England strategy document the Five Year Forward View and has been subsequently adopted as Government policy.
- The NHS operational planning and contracting guidance for 2017 to 2019 and Sustainability and Transformational Plans provide further detail on how all NHS organisations, including trusts will need to transform services to successfully meet the changes the service is facing.
- The most successful departments and trusts over the next five years will be the ones that can transform clinical services to adapt to a new environment having met a number of the following challenges:
  - Your trust total income will fall in real terms
  - The performance and quality of your services will be more open to public scrutiny
  - Your services will need to be fully compliant with national service specifications
  - Failing to meet these specifications will result in a drop in funding
  - The centralisation of some specialist services could require your service to grow or move
  - Your trust will need to work more closely with other trusts and primary care services

BACK TO PRESENTATION

Challenges to NHS

Next 5 years will be very challenging for all NHS services:

- Funding rising at below 1% per year
- Rising demands for additional and more complex healthcare must be delivered from a mostly fixed budget
- Meeting this demand can only be achieved through a combination of initiatives:
    - Increasing productivity so more work is done for the same cost
    - Improving the quality of services so some demand is prevented
    - Deciding not to provide some services or treatments

- Metabolic services will be required to adapt and evolve to keep up with the regional and national requirements for delivering the future configuration of specialised services
- Your trust will also need to meet the requirements of local commissioners
- Expected to work in close collaboration with a large variety of both local, regional and national stakeholders
- Need to quickly implement changes to services to maintain financial balance.

BACK TO PRESENTATION

Challenges to metabolic services

Specialist metabolic services will face a range of challenges over the next few years:

- Rising numbers of patients and new more costly treatments will make it difficult for the NHS and individual trusts to remain in financial balance.
- Inevitably, trusts will come under pressure from commissioners to constrain the costs of their services and treatments.

NHS England will seek to use several methods to maintain financial balance within specialist services:

- Centralising some services will reduce the number of approved centres
- Access to some treatments will be restricted
- Not all new service developments and treatments will be funded

In response to the requirements of commissioners, specialist trusts will need to focus on providing best value

- Collaborating with other trusts
- Reducing staffing costs within each centre to deliver services more efficiently.

BACK TO PRESENTATION

The big picture
Money

- Metabolic and most other specialised services have fared relatively well over the past 5 years
  - Budget for these services has grown significantly at a time when the overall NHS budget has remained flat
  - Largest part of the growth in funding for specialised services has been the drugs and other treatments
  - Staffing and infrastructure costs have grown at a much lower rate.
- However, the next 5 years will be very different for metabolic and other specialised services
  - Trusts and the wider NHS as Government funding for the NHS is rising at below 1% per year.
- Challenges of meeting rising demands for healthcare from within fixed budget in the next 5 years are described in the Five Year Forward View strategy
  - Size of the financial challenge is depicted by the QIPP gap diagram
  - It estimates that £30bn of additional healthcare demand will be faced by the NHS over the next 5 years.
- Hospital sector already greatly impacted by the financial challenges facing the NHS and these are set to escalate into 2017/18 and beyond
  - Many trusts are in financial deficit: their costs are greater than their income
  - Many are also carrying a financial debt from previous years
  - In the 2016/17 financial year all trusts were being expected to redress their financial balance: meaning they have had to reduce their costs in-line with their income.
- NHS policy affecting the financial position of trusts has been set out in the NHS Operational Planning and Contracting Guidance for 2017 to 2019. In summary this will have the following impact on metabolic services:
  - Payments will only be made for delivering services to national specification
  - Some payments will only be made where waiting times and other targets are met
  - Trusts must remain in financial balance or will be levied additional penalties
  - Trusts must deliver nationally identified savings in clinical staffing and running costs

BACK TO PRESENTATION

The big picture
Service transformation

- NHS strategy over the next 5 years will use a combination of QIPP approaches at a scale and pace that has not been seen by the service since its inception.
- Delivery of the strategy will be felt most significantly in hospital trusts across the country and will inevitably impact both the configuration and specification of metabolic services.
- One of the main delivery approaches for managing the rising demand for healthcare within fixed resources is the introduction of what is being called 'place based care' into the NHS.
    - Will require all NHS organisations and local authorities in natural geographies to work much more closely together to close the QIPP gap in their area.
    - The King's Fund have produced a briefing on place based care that gives more detail on the approach and the implications for the NHS.
- The place based approach will give rise to what are being called 'accountable care systems' (ACSs) across the country
    - These are made up of all providers including acute trusts, community services, GP practices and local authorities with some elements of CCGs and NHS England providing commissioning functions.
    - During 2016 all parts of the NHS are being required to plan for the introduction of ACSs and will be incentivised to do so through a combination of grant funding and performance payments.
    - Plans for introducing ACSs are called Strategic Transformational Plans (STPs) and have been completed through the second half of 2016. Each STP has been published separately, on its own website. An example is Northumberland, Tyne and Wear and North Durham which is published here.
    - STPs are overarching plans that integrate all the individual organisational plans in an area and describe how together they will deliver the aims of the Five Year Forward View.

BACK TO PRESENTATION

Your service challenges in detail

1. **Patients' increasing expectations of the NHS**
    - Will be able to access services quicker and more easily in future
    - Initiatives such as the cancer drugs fund are driving an expectation that patients will be able to access the latest treatments whatever the cost
    - Patients are also looking for services to be more convenient, perhaps located closer to where they live and be open for more hours even across all seven days.
    - Rising expectations and demands of patients pose significant challenges for commissioners.
    - NHS England, the commissioner for specialised services, has responsibility to implement the priorities contained within the NHS Mandate.
    - Services must also be funded and configured to deliver the requirements of the NHS constitution which sets out the service standards that patients can expect all providers to deliver.
2. **Demand for specialist services continues to rise**
    - Greater screening for metabolic conditions leading to increased numbers of patients been identified.
3. **Costs of individual treatments is rising**
    - Prospect of future genomic treatments posing a significant challenge to the funding of specialist services
4. **Commissioners must also find a way to introduce seven-day services across the NHS**
5. **Centralisation of specialist services**
    - Being seen by commissioners as a key component of the NHS strategy for specialised services over the next five years
    - Reducing the number of specialist centres may have a number of advantages from a commissioning perspective, but this will reduce access and convenience of patients and will be difficult for services to implement.
    - Inevitably commissioners will have to reduce the access to some specialist services or individual treatments in order to protect the provision of the most important services and treatments to stay within budgets for the overall specialised services portfolio.

Continued

BACK TO PRESENTATION

Your service challenges in detail (continued)

6. **Restricting access to some treatments**
   - Will be achieved through the mandated application of national service specifications and policies.
   - Specialist metabolic centres will only be funded for providing services in line with these specifications.
   - New services or developments of existing services will only be funded by prior agreement with commissioners.

From a service perspective, the key challenges of the next five years will be managing the clinical needs and expectations of patients, while securing enough income to pay for the services by meeting the requirements of commissioners. For metabolic clinicians, the key challenges will be to protect the clinician-patient relationship, whilst transforming the service as part of the wider changes that will affect the trust.

The key challenge for commissioners is to find a way to deliver the requirements of the NHS mandate from within a fixed amount of resources.

BACK TO PRESENTATION

Impact of current policy objectives

Metabolic services will inevitably feel the impact of national as well as local policy objectives over the next five years.

- Metabolic Services: specialist in nature, characterised by low activity volumes and high costs, will increasingly face the attention of commissioners.
- NHS England commissioning intentions for specialised services - overall policy objectives for the specialised portfolio:
  - Requirement to maintain financial balance within trusts
  - Expectation that all national service standards and performance measures will be delivered
  - All frontline services will be affected by these policies.

In recent years large increases in the cost of drugs and other specialised treatments has meant that the funding of staff time and clinical services has come under increasing pressure.

- Services will need to become more efficient and reduce their staffing costs so that more patients can access services at no additional cost to the NHS.
- Skill mixing, incl. introduction of additional prescribing roles, for dieticians for example, is one way services can reduce their staffing costs.

Commissioners will expect metabolic and other specialised services to successfully manage the cost pressures of their own treatments

- The introduction of the Blueteq prior approval system and other contractual compliance measures by commissioners will require metabolic services to support efforts to reduce the costs of drugs and other treatments that are not included in national tariffs.

National tariff payments for specialised services are being revised from April 2017, including specialised top up payments that reimburse services that have to use more clinical time or other resources to treat patients with more complex conditions. Consultation on a 2-year tariff for 17/18 and 18/19 has been undertaken.

- More accurate costings measurements of individual services are being made to allow providers to be reimbursed for the actual costs of services.
- The proposals are expected to have a relatively large impact for some services and are planned to be phased in over the coming next few years in order to protect individual services from destabilising changes in funding in any one year.

Metabolic services, together with all other specialised service are currently commissioned by NHS England.

- During 2017 there is an expectation that groups of CCGs start to work more closely with NHS England to commission specialised services under the co-commissioning policy in preparation for a future transfer of some specialised services across the CCGs.
- The list of services that are being considered for transfer away from NHS England's responsibility is being prepared for ministerial consideration and may lead to metabolic services being commissioned by groups of CCGs at some point in the next 5 years.

BACK TO PRESENTATION

Impact of potential centralisation of services

Metabolic services will be expected to engage with proposals to centralise services in fewer centres over the next 5 years.

1. **National policy objectives:**
   - Improve the quality of services, improve operational efficiency, and reduce the long term costs of services
   - Will impose pressures on some smaller centres that - make it harder to remain viable.
2. **Move towards place based planning** and the creation of Accountable Care Systems (ACSs) will define the core of the national policy approach for the NHS throughout and beyond 2017.
   - Geographical footprint of each ACS will be determined by patient flows and the volume of activity that is undertaken by providers.
   - For generalist services, each ACS may typically include between 1 and 4 trusts and in some densely populated urban areas up to 10 or 12 trusts that are relatively closely located to each other.
   - Expected that much larger specialised services ACS geographical footprints will be described by the flows of patients accessing services in a small number of centres that are relatively far apart.
3. **The NHS England Vanguard programme:**
   - Designed to test the development of new care models across the NHS.
   - One part of the programme is focusing on collaborations between hospital trusts that will allow groups, chains or networks of individual organisations to come together to deliver services more efficiently that is possible at a single trust level.
   - Programme was launched in summer 2015 and currently includes several specialist services with the potential to expand to cover specialised services such as metabolics.
   - Trust collaboration vanguards will be developing three distinct models of joint working between multiple acute organisations:
     - **Accountable Clinical Networks** that bring together community, generalist and specialist services provided by multiple organisations. These networks could operate as ACSs on quite a large scale with a complete geographical coverage of their area.
     - **Franchising** of existing leading providers to allow high quality clinical leadership and expertise to be delivered across multiple locations. This model would allow specialist services such as metabolics to be provided in a number of trusts across the country under the branding and expertise of one or more recognised expert centres.
     - **Chains** of organisations sharing best practices and standard operating models. This concept builds on the recommendations of the Dalton Review published at the end of 2014. The review made a series of recommendations to drive change in the provider sector, including reducing the number of separate hospital organisations.

Continued

BACK TO PRESENTATION

Impact of potential centralisation of services (continued)

Taken together, the impact of all these policy objectives is intended to reduce the number of separate hospital organisations and to centralise the provision of the services that have smaller numbers of patients with higher operating costs. These policies will inevitably include metabolic services in their scope, meaning that individual services should be prepared to work with their own trust and commissioners to make the case for protecting metabolic services at your trust.

Potential impacts of centralisation of services:

1. Closure of smaller services (particularly in adult care) would require patients and carers to travel further to the IMD team. Some patients may choose not to travel, or even come off their diet altogether. Patient's management could reduce. This is of particular concern for certain patient types e.g. maternal patients

2. Out-of-hours care may reduce or be removed altogether due to staff shortages. Access to advice and care outside of traditional 9-to-5 is vital for many patients, and its reduction or removal could be detrimental to patient care.

The Lord Carter Review - Operational productivity and performance in English NHS acute hospitals: Unwarranted variations.

Published in February 2016, the report made 15 main recommendations for acute hospitals in England to be more efficient and save £5bn by 2020/21. The government have committed to full implementation of all recommendations in all hospital trusts in England.

Lord Carter advises trusts to work closely with their neighbouring hospitals, sharing services and resources to improve efficiency and reduce costs.

Acute care collaboration vanguards.

Created throughout 2016, 13 Acute Care Collaboration Vanguards have been announced by NHS England: each vanguard site setting about a programme of how it will create a hospital 'group', bringing together everything from back-office functions to clinical services.

Chapter 2: Glossary of terms

Five Year Forward View	The main strategic policy document for the NHS in England
NHS Planning Guidance	Annual detailed guidance and priorities issued to all NHS bodies
QIPP	National efficiency programme; stands for Quality Innovation Productivity and Prevention
Co-commissioning	Policy for increasing the involvement of CCGs in the commissioning of services alongside NHS England
Demand management	Any initiative that has the outcome of reducing the demand for NHS services, particularly hospital services
Place based care	Approach that involves all NHS organisations and providers in delivering integrated care to a particular geography
Accountable care system	A collaboration of all or most providers in a geography to deliver place based care
Accountable clinical network	A network of trusts that are collaborating to deliver care across their organisations
Accountable care organisation	Organisation resulting from the formal merger of the organisations collaborating in place based
Strategic transformational plan	5 year plan designed to deliver place based care in a particular geography
National tariff	The price paid by NHS commissioners for the delivery of NHS services by providers. Can include drug and treatment costs
Specialised top up	Payment in addition to the national tariff recognising the additional complexity of some groups of patients
Blueteq	National system for approving payments for drugs and treatments that are not included in the national tariff
Vanguard	Recognised group of NHS organisations that are collaborating in a particular geography to deliver new models of care
New models of care	More efficient and ideally less expensive patient pathways and configurations of services

New ways of working

Transformation, transformation, transformation...

- **NHS Commissioners & Providers Need New Solutions**
  - We need to harness innovation
  - Is this an opening for Pharma?
  - Better exploit the potential of Academic Health Science Networks
  - New Models of care (FYFV)
- **Integration**
  - Continued pooling of care budgets
  - Vanguards/Devolution?
  - New Organisations (e.g. Greater Manchester)
- **Drugs, Devices and Systems to Keep People Well**
  - Not just treat ill health
  - Medicines Optimisation
  - Drugs and interventions that save money and lives down-stream'. To deliver the Five Year Forward View within the anticipated financial landscape of the next few years, the NHS will have to consider new and different ways of doing things. Some of these will be quite radical and potentially unpalatable to many health economies.
- To deliver the Five Year Forward View within the anticipated financial landscape of the next few years, the NHS will have to consider new and different ways of doing things. Some of these will be quite radical and potentially unpalatable to many health economies.
- Sustainability and Transformation Plans (STPs) are the vehicle for the implementation of the Five Year Forward View. There are 44 'footprint' areas for STPs. Unfortunately, there is no central repository for each STP, but they can usually be found on a link from each CCG or Council website e.g. Northumberland.
- We will see in some economies the evolution of CCGs into Integrated Care Management and Delivery Organisations. The form will be different in each area, however the spirit contained in the FYFV is the binding force that will see some interesting models of delivery emerge.
- New vehicles for change are being invented and some of these are already starting to develop (e.g. Vanguard schemes, devolution and Multispecialty Community Providers'.
- The next two years could signal an evolution, particularly within the 'out of hospital' sector and the commissioning system in particular. Multispecialty Community Providers (MCP), whilst not being the only option to consider, provides a framework for some very interesting strategic re-modeling of care systems at a local (CCG and hospital) level.
- For metabolic services, it will be critical to understand how future services can evolve into a component part of wider and greater change. To do that, we need to identify the geographies that are already embracing these new ways of working and those areas that will need to change to survive.

BACK TO PRESENTATION ···>

Reorganisation of pathology

Safety in numbers

For any service to thrive and survive in the emerging new NHS, it will need to prove that it is a net contributor to the provision of healthcare.

- If a service, such as metabolics, is not positively contributing to the financial and quality 'bottom lines' of a Trust, then consideration needs to be given to alternative methods of delivering a service. This could be:
    - One service shared / combined across several providers
    - Externalized / tendered services
    - Incorporating greater economies of scale – but avoiding any deterioration of perceived quality from referrers or other services.

Reorganisation of Pathology

In 2012/14, consideration was given to how pathology testing in hospitals could be redesigned. A regional blue-print was developed to identify several 'hub' centres to service a population of 3-6 district general hospitals and approximately 1 million patient populations. Two controversial regional reorganisations programmes in the Midlands and East of England were developed - including as a series of smaller projects.

- **Context:** Lord Carter of Coles' review of NHS pathology concluded savings of between 10 and 20 per cent could be achieved by consolidating services. All parties agreed reform is needed but pathologists and unions said the regional reorganisations could damage patient safety and may not deliver the projected cost savings.
- **Outcome:** Reconfigurations are faced long delays because of vested interests of staff seeking to protect their jobs, a lack of available capital and a new commissioning environment that is still bedding down. With more work likely to be outsourced, the cost of complex tests could rise as private firms seek to 'cherry pick' the more straightforward (and profitable) work. Reconfigurations will be increasingly locally driven following the demise of strategic health authorities.

Continued ···>

BACK TO PRESENTATION

Reorganisation of pathology (continued)

- The programme was initially done through a closed tender process where existing providers were encouraged to come together in a consortium that was able to respond to local needs. Interestingly, there was quite significant opposition from GPs on CCG boards fearing a deterioration in direct access services to primary care and from those providers who emerged as less likely to succeed in the competitive race for the local contracts.
    - Equally, those providers strong enough to host the service – or more frequently, operate in tandem with another large provider as part of a consortium – strongly favoured this solution seeing it as an income generator.
    - In the West Midlands, sub regional arrangements were implemented with those providers that had previously invested in the infrastructure for an expanded service.

Therefore, an ideal health economy may include an area that is driven by the need to reduce costs and / or improve services and is open to consideration of new ways of working together with at least on large service provider that has the infrastructure to support an expanded system and can see organisation opportunities (e.g. income generation) for itself in the near future.

Compelling story

Developing the compelling story

At its most simple, this is basically a compelling argument or reason that convinces the audience that something is true or that something should be done.

Building the compelling story:

- A compelling story will define ***why*** your service should change, expand and require investment:
    - It should be short and persuasive
    - Show that for a reasonable minimum effort there will be maximized benefits
    - Demonstrate that the project is worth the effort to undertake
    - Not undertaking the change may actually damage the Trust reputationally or economically
    - Consider federations or larger geographical areas/ patient populations.
- Include the ***value proposition*** and set it out in terms of:
    - Identifying the scope and approach of the proposal
    - The preferred vehicle for delivery
    - The size and value of the proposal (geography & financial).

Clinical champions

A clinical champion can be described as a clinician who voluntarily takes extraordinary interest in the adoption, implementation, and success of a cause, policy, program, project, or product. He or she will typically try to push the idea through entrenched internal resistance to change, and will promote or even evangelize the idea/project throughout the organization. Also called change advocate, change agent, or idea champion.

Clinical champions are typically active clinicians (from a range of professions including: GPs, pharmacists, dentists, nurses and allied health professionals).

These clinicians bring their own professional focus and, through their clinical networks, they encourage and lead innovation across professions and settings ensuring high quality, safe services are commissioned for the local population based on best available evidence. They can influence the trust's strategic plan, as well as having direct involvement with clinical pathway and planning groups and service review and redesign mechanisms.

Clinical champions are:

- Clinician leaders
- Front-line clinicians
- Change agents

Why are clinical champions needed?

- 70% of organisational change fails
- Lack of understanding of change management
- People are the most critical resource, supporter, barrier and risk when managing change
- An effective communication strategy is key
- Guiding principles of change management
  - Executive support is absolutely essential
- Change is usually bottom up
- A project plan that is adaptable is required
  - Commitment of people is vital

BACK TO PRESENTATION

OBC
Outline Business Case

In essence, this is a formal but relatively brief document that sets out in detail, the scope, costs, affordability, risks, probable procurement route (if applicable) and timetable of a project so that it could be approved by an authority (e.g. CCG or Trust)

An OBC should contain planning assumptions and revenue and capital costings.

- Policies, strategies, programmes and projects will only achieve their spending objectives and deliver benefits if they have been scoped robustly and planned realistically from the outset and the associated risks taken into account.
- The business case, both as a product and a process, provides decision makers, stakeholders and the public with a management tool for evidence based and transparent decision making and a framework for the delivery, management and performance monitoring of the resultant scheme.

The business case in support of a new policy, new strategy, new programme or new project must evidence:

- That the intervention is supported by a compelling case for change that provides holistic fit with other parts of the organisation and public sector– the “strategic case”;
- That the intervention represents best public value – the “**economic** case”;
- That the proposed Deal is attractive to the market place, can be procured and is commercially viable – the “**commercial** case”;
- That the proposed spend is affordable – the “**financial** case”;
- That what is required from all parties is achievable – “the **management** case”.

Continued

BACK TO PRESENTATION

OBC (continued)

Outline Business Case

Why is the business case development process important?

- The business case development process is key to public value in spending decisions, in terms of its scoping, options selection, delivery, monitoring and evaluation. The business case, therefore, must never be perceived or used as the vehicle for simply gaining approval for a proposal, because to deliver public value all five components need to be planned for with integrity and satisfied.
- Business cases should be developed over time. It is an iterative process and at each key stage further detail is added to each of the five dimensions. The level of detail and the completeness of each of the five dimensions of the Case are built up at different rates during the process.

For major spending proposals, there are three key stages in the evolution of a project business case, which correspond to key stages in the spending approvals process. These are the Strategic Outline Case (SOC), the Outline Business Case (OBC) and the Full or Final Business Case (FBC).

- Major Policies and Programmes often comprise of multiple projects for their delivery and require a Strategic Outline Programme (SOP) business case. This does not require a three stage approach. In these instances, the initial assessment of the cost and benefit information may be at a high level; however, the delivery of new policies and programmes usually requires the formation of sub-programmes and projects before firm spending commitments can be finalised and approved. It is important to note that "five case model" is a framework for "thinking" and that the supporting methodology is flexible and can be applied at both strategic (macro) and tactical (micro) levels.
- For minor spending proposals – relatively low value and non contentious items of spend for which pre-competed procurement arrangements exist – a one stage business development process using the Business Justification Case (BJC) can be used.

BACK TO PRESENTATION

Draft Staffing Review Business Case

Business Case for Additional Staff

Title	Proposal to Increase in Budget for xxxxx	**Organisation**	St Elsewhere NHS FT Metabolic Services
Author	xxx	**Name of contact**	Service Manager (IMD)
Date	xxx	**Contact Details**	**Email:** xxx.yyyy@nhs.net **Tel:** 01234 5678999
Review Date	xxx		

1. Introduction

Clearly state your value proposition upfront	• At the beginning of your proposal it is important to briefly and clearly state why your project is important and the main benefits • This is where you can show a link to existing business priorities e.g. the potential for the project to achieve an important strategic goal
Description of the project including any technical changes required and relevant planning issues	• Make it clear. Language will need to be adapted to ensure the decision maker understands the proposal. This is particularly important when the decision makers don't have a technical background
Briefly describe the way you have developed your business case proposal and the people who helped you prepare the proposal	• This can give the decision maker confidence that people with appropriate expertise and experience have contributed. Involve the right people

2. Current Service

Set out the status quo	• Why is this not satisfactory? • What has changed? (e.g. unfunded increase in activity) • Does this pose a risk & why? (e.g. stretched staff, shorter consultation time, increased risk of error. Also show what existing mitigations are in place to cope with this) • Use a visual graphic or simple table to show and emphasise the point being made

Continued

BACK TO PRESENTATION ···>

Draft Staffing Review Business Case (continued)

Business Case for Additional Staff

2. Current Service (continued)

Table 1.0 [example: set out your data. Show activity/costs have risen and that staffing has not increased (or even suffered cuts) to keep pace with demand]. [all figures are fictitious.]

	2010/11	2011/12	2012/13	2013/14	Totals
Actual Spend					
Activity	449,561	472,625	511,659	568,000	2,001,845
Pay	102,978	101,105	100,412	95,667	435,455
Year on Year Increase £					
Activity		23,064	39,034	56,341	118,439
Pay		-1,873	-693	-4,745	-7,311
Year on Year Increase %					
Activity		5.13%	8.26%	11.01%	24.40%
Pay		-1.82%	-0.69%	4.73%	-7.23%
Patient Nos.					
Actual	2,575	2,713	3,348	3,530	12,166
Year on Year Increase Nos.		138	635	182	955
Year on Year Increase %		5.36%	23.41%	5.44%	34.20%

Continued ···>

BACK TO PRESENTATION

Draft Staffing Review Business Case (continued)

Business Case for Additional Staff

3. Reasons (for the increase in Activity)

Use your data	• Set out the irrefutable logic derived from your data • Where possible/applicable, set out why the change (e.g. increase in activity) has occurred (e.g. new treatments now available therefore wide cohort f patients are treatable, etc.)

4. (What has the service done to implement) Cost Reductions

Decision takers/funders are always keen to see what you have done to manage the situation prior to requesting more funding	• Quantify as many of the costs and benefits as you can so that your business case proposal is complete • Describe & quantify all business costs & benefits • Worksheet: whole of business costs and benefits • Other resources?

5. Proposal/Options

Describe the funding/support you are seeking	• Ensure that you are clear on the type of funding you require. Consider a range of funding options • When seeking more funding, set out how and why this helps the organisation deliver (some of) its key targets. In particular, focus on savings and income generation opportunities • This is a clinical service. Do not forget to spell out the improved outcomes and reduced risks associated with the proposal or preferred option
Set out any options considered **Please note: funders / decision takers want to know that you have looked at other solutions before requesting more funding**	• Ensure that you are clear on the type of funding you require. Consider a range of funding options

Continued

BACK TO PRESENTATION ···>

Draft Staffing Review Business Case (continued)

Business Case for Additional Staff

5. Proposal/Options (continued)

Option	Description	Advantages	Disadvantages
1. Do nothing	Continue with current status quo	None	Budget continues to be over spent
2. Minimum	Reduce further the amount/type of service/ products to stay in budget	• Reduction in costs • Stay in budget	• Need of patient not being met • Increase in complaints • increased clinical risk
3. Alternative	Explore charging payment from patients for non-core services.	• Patient takes responsibility • Generates income	• May reduce patient numbers • May not have costs benefit
4. Optimum	Increase budget to meet requirements in line with increasing patient numbers	Improved patient care and rehabilitation	Increased financial costs

List all non-quantifiable costs and benefits e.g. safety and reputational benefits	• Even where you cannot fully quantify costs and benefits you should describe them. Do not assume that the decision makers will know about additional benefits even if they are obvious to you • Describe & quantify all business costs & benefits • Worksheet: whole of business costs and benefits
Cost / benefit analysis to implement the opportunity	You may use simple payback, NPV, IRR etc. Whichever is required.
List all quantifiable costs and benefits e.g. costs saved, activity avoided / increased. Wider project costs and benefits	• Quantify as many of the costs and benefits as you can so that your business case proposal is complete. • Describe & quantify all business costs & benefits • Worksheet: whole of business costs and benefits • Other resources?

Continued ···>

BACK TO PRESENTATION

Draft Staffing Review Business Case (continued)

Business Case for Additional Staff

6. Risks

Analysis of project risks (e.g. financial, operational)	• Describe the project risks and how you will manage them • Identify project risks and develop strategies to manage them
How results will be monitored	This can give the decision maker confidence that you will follow through on your project and demonstrate the benefits if achieved. Monitor, verify and promote successful projects

7. Conclusion

- **Briefly** summarise the paper
- Set out why the preferred option/proposal is the best way forward for the organisation.
- Ensure you have proved the argument/proposition that you set out in the introduction?

8. References

BACK TO PRESENTATION

Commissioning

Who, When and Where?

It is important to understand what we mean by commissioning. The term is often used interchangeably with contracting, purchasing or procurement.

Commissioning is a broad concept and there are many definitions. The Audit Commission captures the key elements:

"Commissioning is the process of specifying, securing and monitoring services to meet people's needs at a strategic level. This applies to all services, whether they are provided by the local authority, NHS, other public agencies, or by the private and voluntary sectors."

- In CCGs, the decisions on commissioning are usually taken by finance or commissioning committees. However, pharma will hardly ever get direct access to these decision takers – so the way forward here is to influence those that recommend decisions to those committees. These are usually the commissioning teams (including the director of commissioning and individual commissioning or programme managers).
- Most changes are implemented from the start of a new contractual year (April – March). Negotiations for the costs, quantities and major service changes are usually negotiated between January and March – therefore any agreement to alter services (costs, specifications or structures) ideally needs to be finalised before these negotiations begin in earnest.
- Both commissioners and providers are required to set out their "Commissioning Intentions" in early autumn. These need not be in detail, but any significant changes need to be announced by October 1st in order to comply with mandatory requirements for six months' contractual notice for such changes.
- Depending on local relationships and the financial health of the local health economy, these negotiations may be quite challenging and adversarial in nature. Both parties are obligated to deliver the requirements of the NHS Operational Planning and Contracting Guidance 2017-2019 and remain in financial balance. These discussions are frequently escalated to senior / chief officers to finalize.
- Therefore, in an ideal scenario, Nutricia would have been working with commissioners and providers in the months leading up September in order to produce an outline specification that could be considered by the appropriate commissioning decision taking body in order to feature within the commissioning intentions process for the following years contracting process.

BACK TO PRESENTATION

Annual Planning Cycle
NHS Commissioning

At its simplest, commissioning is **the process of planning, agreeing and monitoring services**.

- However, securing services is much more complicated than securing goods and the diversity and intricacy of the services delivered by the NHS is unparalleled.
- In truth, **commissioning is not one action but many**, ranging from the health-needs assessment for a population, through the clinically based design of patient pathways, to service specification and contract negotiation or procurement, with continuous quality assessment. *(NHSE: Dec 2014)*
- The way this is done is sometimes expressed as a 'commissioning cycle' – usually an annual pattern of actions or requirements identifying the individual steps.

BACK TO PRESENTATION

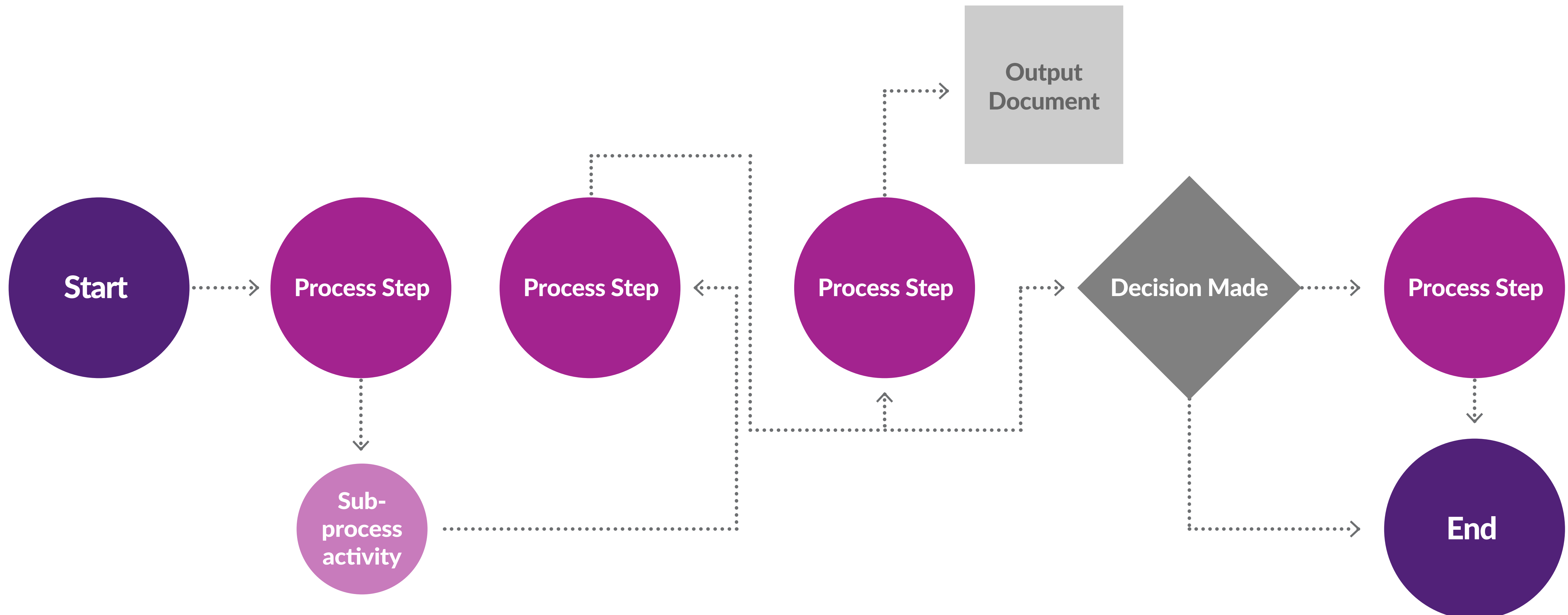
Data Collection Grid

Metric	Type	Operational Definition of Metric	Data Source	Reporting Frequency	Who	References ("how-to")	Metric Publication (post-project)	Comments
Cost savings	Cost	Negotiation Savings: (previous Dell discounted price - current Dell discounted bundle price) x bundle volume purchased PLUS Conversion Savings: conversion change x (avg non-bundle price - bundle price)	Sci Quest Dell Purchase data	Monthly	Brian Hutchinson	Brian Hutchinson to develop "how to" document & insert link to file here	Final Report Purchasing Site Link on AE Site APR Site	
Campus adoption	Volume	% of personal computers purchased, including Apple, that are UW-Preferred bundles	DoIT Tech Store Apple purchase data	Monthly	Brian Hutchinson	Brian Hutchinson to cite the appropriate Dell contact & method of communication	Final Report Purchasing Site VCFA presentations Admin Council presentations	
Product quality	Quality	Vendor warranty returns, expressed as a total number, and percent of total PCs	Report requested of Dell	Quarterly	Brian Hutchinson	Insert link to "Survey Overview" document here	APR site	
Customer satisfaction rating (process)	Quality	Overall purchaser satisfaction rating of the purchasing experience (net promoter score) from the computer bundles survey	Computer Bundles Survey	Feb '14, then TBD by process owner	Lori Voss / Susanne Matschull			
Customer satisfaction rating (products)	Quality	Overall purchaser satisfaction rating of the computer bundles selection (net promoter score) from the computer bundles survey	Computer Bundles Survey	Feb '14, then TBD by process owner	Lori Voss / Susanne Matschull			

Continued

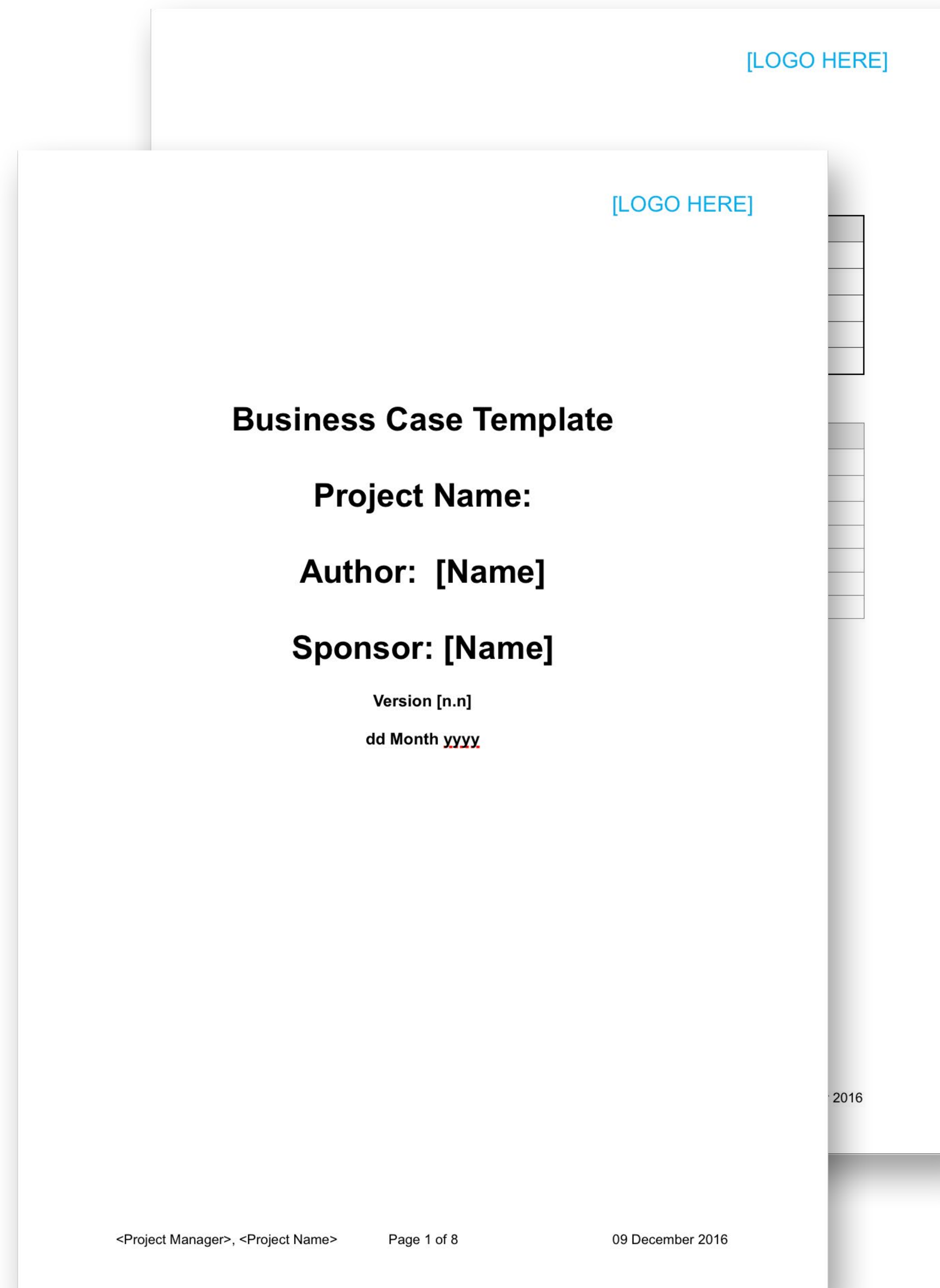
BACK TO PRESENTATION

High Level Process Flow



BACK TO PRESENTATION

Full Business Case Template



[LOGO HERE]

Business Case Template

Project Name:

Author: [Name]

Sponsor: [Name]

Version [n.n]

dd Month yyyy

<Project Manager>, <Project Name> Page 1 of 8 09 December 2016

BACK TO PRESENTATION ···>

Data Collection Plan

The key to a successful approach to building a business case or proposal is to create a compelling story or proposition. To do that, a methodical and logical collection, use and application of data is critical. To do this, you will need to develop an approach to collecting and using data to guide your thinking.

A Data Collection Plan organises and documents the what, who and how around a team's activities, ensuring that accurate, reliable and complete data is captured.

A basic data collection plan may be used to capture data for the team's use early in a process (see Worksheet 1, below). It may be necessary to refine or even redevelop this plan as you work through your data capture – and any difficulties associated with that.

- First identify what and why you are trying to change
  - What elements of your business relate to what you are seeking to change?
- Ensure the evidence will help build your business case
  - If, for example, the focus was on changing clinical pathways alone then financial data may not be relevant. However, if you are seeking to redesign your business, then finance along with outcomes will be critical.
  - It may take more than one attempt to gather correct data to a usable level of detail and quality
- Examine the outputs from your service (e.g. patient contacts, consultations, tests and diagnostics, etc.
  - Are all current activities known and charged for?
  - Are all patient contacts / clinical time being charged for?
- Understand which other hospital services utilise/are reliant on metabolics:
  - Capture all service requests for metabolic services
- What specialties and HRGs is each activity associated with
  - What are the direct / attributable costs of staff time /resources and consumables?
  - Can any activity be charged for separately?
- Once you have determined the scope of the exercise, individual activities will need to be identified and defined in order to achieve consistency and reliability.
- Pay due regard to statistical relevance. Ensure your data pool is not over-sized or (worse) unreliable because of too few data entries.

Worksheet 2 (excel spreadsheet) sets out a basic data collection template with example activity categories and definitions. NB: each service will need to review data collection methodologies and definitions tailored to that service.

Add new data lines and data periods as required.

Continued ···>

BACK TO PRESENTATION ···>

Data Collection Plan (continued)

Worksheet, Part 1

Data Collection Plan Worksheet, Part 1

Identify each of the data collection methods you could use for your data collection and complete the matrix.

Department: ______________________ **Project:** ____________________________

Subject Area	WHAT DATA COLLECTION METHOD?	WHEN WILL DATA BE COLLECTED?	WHO WILL COLLECT DATA?	HOW WILL THEY NEED TO DO?
-	*Identify which data collection method will be used (survey, interview, observation, record review)*	*Describe the timing and frequency of data collection, including when it will be complete*	*Identify who will be responsible for collecting the data*	*Describe the steps they will take to complete the data collection*
Track Staff Daily Routine	E.g. Direct observation. The Team will use the time and motion survey tool that Julie has been developing.	E.g. The plan is to begin collecting the data in mid-January and completing the data collection no later than March 31st.	E.g. Julie will shadow each team member will complete a daily tracker. This will add to staff duties but not be onerous.	E.g. Team members agree on the descriptions of activities with Julie and how to record the data, (i.e. time taken / number of activities).
Patient Telephone Contacts	E.g. Survey. The team will record all telephone contacts with patients recording length of phone call and outcome	E.g. This will be a two month sample survey from 1 May to 30 June	E.g. All team members. Each team member is responsible for collecting their own data.	E.g. A short proforma / aide memoir will be developed to capture call start and finish times,
PBR Data	E.g. data / record review A three-year data trawl from the hospital (not service) data to identify charged activity (i.e. inpatient / outpatient) numbers and values.	E.g. once. As soon as 15/16 data is complete (mid May)	E.g. Hospital data team	E.g. interrogation of all activity charged and paid for by commissioners

Continued ···>

BACK TO PRESENTATION ···>

Data Collection Plan (continued)

Worksheet, Part 2

Data Collection Planning Worksheet, Page 2

Subject Area	**HOW** WILL THEY BE TRAINIED IN COLLECTING THE DATA?	**HOW** WILL DATA COLLECTED BE MONITORED?	**WHO** WILL MONITOR THE DATA COLLECTED?	**HOW** WILL YOU KNOW THE DATA SET IS COMPLETE AND CORRECT?
-	*Describe the steps to prepare them for the data collection*	*Identify how the data collection process will be monitored for quality, consistency and completeness*	*Identify who will monitor the data collection for quality, consistency and completeness*	*Identify what measure(s) will indicate a correct and complete data set*
Track Staff Daily Routine	E.g. Julie will demonstrate the tool and tracker to each team member	E.g. Julie will complete trackers for each team member / day and every Friday at 4pm and enter onto database.	E.g. Julie.	E.g. every Tuesday, Julie will crosscheck with individuals diary and clinical roster, etc. to analyse for inconsistencies / errors.
Patient Telephone Contacts	E.g. Julie will develop the proforma and demonstrate to all team members. Suggest 2 days testing before going live.	E.g. Julie will collect trackers every Friday at 4pm and enter onto database.	E.g. Julie.	E.g. Julie to cross check with individuals diary and clinical roster, etc, to analyse for inconsistencies / errors.
PBR Data	E.g. not applicable	E.g. not applicable	E.g. not applicable	E.g. not applicable

Continued ···>

BACK TO PRESENTATION ···>

Data Collection Plan (continued)

Data Collection Methods

Direct observation

Physical/visual examination and recording of defined events, features, etc.

- Pros: Often the most reliable method – accurate, complete, consistent
- Cons: Time consuming

Record/data review

Physical/visual review of records and extraction of defined data

- Pros: Fairly reliable method – similar accuracy and consistency to direct observation
- Cons: Can be time consuming to find records. Missing records limit completeness

Interview

Verbal questioning of subject matter expert (or other) to gather defined information

- Pros: Can provide more complete context and descriptions
- Cons: Time consuming to complete one-to-one interviews. Provides a limited perspective

Survey

Provide a defined and structured query/form to be completed by subject matter expert (or other)

- Pros: Can be completed with minimal effort and turnaround
- Cons: Reliant on schedule of person responding. Prone to introducing incorrect, incomplete and/or inconsistent information

Continued ···>

BACK TO PRESENTATION

Data Collection Plan (continued)

Enhancing Data Collection Through Surveys

Accuracy

- Understandable documentation of definitions and instruction on data reporting process
- Yes/no responses
- Pre-defined pick-list of responses with no/limited open responses
- No open entry fields; limited comment or notes fields
- Field cross-tabulations (e.g., attribute = no, quantity > 0)

Completeness

- Understandable documentation of definitions and instruction on data reporting process
- Response required to save/close/move to next page
- Shade or x-out cells with no data reported
- Establish required response date; follow-up promptly after missed date to establish new committed date
- Sort data on fields to identify missing values

Consistency

- Understandable documentation of definitions and instruction on data reporting process
- Yes/no responses
- Pre-defined pick-list of responses with no/limited open responses
- Formatted response fields
- Field cross-tabulations (e.g., attribute = yes, no quantity entered)

Cautions

- Inconsistency may be an indication of limitations in the data reporting process or definitions documentation
- Default value (pre-filled) fields can lead to inaccuracy if there is no response
- Required response fields can lead to no survey complete.

BACK TO PRESENTATION ···>

Main Metabolic HRG Codes and Tariffs

HRG4+ 2016/17 National Prices and National Tariff Workbook

KC – Metabolic Disorders
K – Endocrine and Metabolic System

Scope and Composition

Subchapter KC covers all metabolic disorders in adults aged 19 years and over. It includes activity undertaken in an inpatient and day case setting.

Subchapter KC comprises:

- € Fluid and electrolyte disorders
- € Inborn errors of metabolism disorders

All diagnosis-driven activity relating to the treatment of children (aged 18 years and under) groups to an HRG in Chapter P Diseases of Childhood and Neonates, in line with the requirements of the Casemix Design Framework.

HRG Codes / Tariffs

HRG Code	HRG Name	Combined day case/ordinary elective spell tariff (£)	Non-elective spell tariff (£)
KC04Z	Inborn Errors of Metabolism	238	2,350
KC05A	Fluid and Electrolyte Disorders 70 years and over with Major CC	1,866	3124
KC05B	Fluid and Electrolyte Disorders 70 years and over with Intermediate CC	400	1,896
KC05C	Fluid and Electrolyte Disorders 70 years and over without CC	279	1,117
KC05D	Fluid and Electrolyte Disorders 69 years and under with Major CC	1,069	2,669
KC05E	Fluid and Electrolyte Disorders 69 years and under with Intermediate CC	405	1,465
KC05F	Fluid and Electrolyte Disorders 69 years and under without CC	335	471

Outpatient Prices

Treatment function	Treatment function name	WF01B First Attendance - Single Professional	WF02B First Attendance - Multi Professional	WF01A Follow Up Attendance - Single Professional	WF02A Follow Up Attendance - Multi Professional
302	Endocrinology	189	189	189	189

Continued ···>

BACK TO PRESENTATION

Main Metabolic HRG Codes and Tariffs (continued)

HRG4+ 2016/17 National Prices and National Tariff Workbook

PK – Paediatric Diabetology, Endocrinology and Metabolic Disorders
P – Diseases of Childhood and Neonates

Scope and Composition

All diagnosis-driven activity relating to the treatment of children's (aged 18 years and under) diabetology, endocrinology and metabolic disorders groups to an HRG in this subchapter, in line with the requirements of the Casemix Design Framework.

Subchapter PK does not include neonatal critical care or paediatric critical care – these are covered in Subchapters XA Neonatal Critical Care and XB Paediatric Critical Care, respectively.

No changes have been made to this subchapter.

HRG Codes / Tariffs

HRG Code	HRG Name	Combined day case/ordinary elective spell tariff (£)	Non-elective spell tariff (£)
PA25A	Major Gastrointestinal with CC	2,270	2,650
PA25B	Major Gastrointestinal without CC	1,352	1,103
PA26A	Other Gastrointestinal with CC	1,487	1,054
PA26B	Other Gastrointestinal without CC	828	551

Outpatient Prices

Treatment function	Treatment function name	WF01B First Attendance - Single Professional	WF02B First Attendance - Multi Professional	WF01A Follow Up Attendance - Single Professional	WF02A Follow Up Attendance - Multi Professional
252	Paediatric Endocrinology	385	385	186	200

BACK TO PRESENTATION ···>

Input into prescribing choice decisions

Influencing prescribing committees

The majority of NHS organisations have joint Area/Regional Prescribing Committees. The make-up of these committees will vary from area to area, but they will commonly represent a health economy's CCG(s), secondary and tertiary NHS trusts, and community providers. The committee's remit is to make decisions on pharmaceutical products to be included (and excluded!) from the local health economy's formulary. It therefore has the power to influence prescribing choices as a result of its decisions.

A common feature of the committee's process, will be consult with key stakeholders prior to making any decision. Consultation comments received from senior clinicians are potentially powerful.

The following is an example response to an Area Prescribing Committee's consultation on removing lidocaine plasters from the prescribing formulary. It is provided as a template to consider when responding to consultations on pharmaceutical formulary decisions in your specialty.

Sample letter

Dear XYZ Area Formulary Committee,

Proposal to remove lidocaine plasters from the XYZ Formulary

Paragraph 1: State your request
Further to your proposal to remove lidocaine plasters from the XYZ Formulary, I wish to submit some expert comments. I wish to submit a request to retain lidocaine plaster within the XYZ Formulary for specialist initiation only.

Paragraph 2: State your interest and expertise
Within my role as consultant lead for the XYZ Pain Clinic at Anywhere Hospital, I am frequently exposed to a growing number of refractory cases who have already been down the NICE/XYZ neuropathic pain guidelines, (including TENS and capsaicin).

Paragraph 3: State your argument to the proposal
Your current proposal to remove lidocaine from the XYZ Formulary is largely based upon NICE guidelines [CG173], which I submit are specifically aimed at non specialist settings and only cover pharmacological treatments. There is no discussion or suggestion as to what one does if the NICE/XYZ guidelines fail. In addition, your costing is based against existing neuropathic pharmacological guidelines, which clearly will have been exhausted and are thus irrelevant!

Continued ···>

BACK TO PRESENTATION ···>

Input into prescribing choice decisions (continued)

Paragraph 4: Give the clinical reasoning to your case
There is no costing comparison against the only other options (as the neuropathic guideline have failed) which include polypharmacy (gabapentin/pregabalin and anti-depressants and opiates and perhaps ketamine in combination) with or without intervention procedures (nerve blocks/day case), prolonged psychological interventions and no costing comparison against highly specialised treatments which include spinal cord stimulation. I would be grateful if you could reassess the request, with the above factors included.

Paragraph 5: Present a patient story and how the recommendations would adversely affect the outcome
To further support my case, I wish to highlight the case of a young man with metastases in his fingers. He had one amputated but was not fit enough for amputation of another when he developed severe pain in it. The palliative care team struggled to gain pain relief for him with only limited benefit. The application of a lidocaine patch gave total pain relief and enabled us to vastly reduce his opioids and facilitate his discharge home. He had several weeks of quality life before he deteriorated further. In the last days of his life the pain in the finger increased and he needed additional increases in opioids but his mother reported he continued to gain pain relief from the lidocaine and so she continued to apply it until he died. His mother informed me that the plaster made a huge difference to his quality of life during the last period of his life.

Paragraph 6: Present any health economics to support your argument
I submit to you that retaining lidocaine plasters for specialist initiation only will be an effective solution to refractory cases which will also be at substantial less cost to the NHS and our patients than combination alternatives. Based on the current service I estimate that there will be x patients per year suitable and requiring lidocaine plasters at an annual cost of £xx,000 versus the alternative which would cost £xxx,000.

I will be happy to present in person to the committee if you feel this is necessary.

Kind regards

Name

Title

BACK TO PRESENTATION

General Practice

- For metabolic services, the prescribing of specialist dietary products falls into the amber category. This means that once the specialised metabolic service has identified the appropriate treatment and has established the patient on the treatment, the GP can be asked to continue prescribing with the CCG providing the payment for all subsequent supplies.
- CCGs have responsibility to stipulate which drugs, devices and special feeds can be prescribed in their area and they make these decisions in groups called Area Prescribing Committees (APCs).
- Sometimes find that GPs are reluctant to do so due to lack of expertise or concerns about the costs.
- GPs are struggling with increased demand / workload and limited capacity. CCGs want primary care to do more work so that less activity goes into the acute sector. CCGs will rarely be generous in paying for primary care to undertake what may be considered to be within the remit of good primary care.
- General practice is not seen as financially profitable or lucrative as it was with many new GPs preferring to be salaried employees rather than partners in the business of a practice. Some areas find recruitment difficult – adding to an over-burdened workload.

Drivers

- Increasing capacity in practice
- Decreasing GP workload
- Increasing income into the practice

Blockers

- Increased demands on practices – especially if not adequately funded / reimbursed

Solutions

- Make GP working life easier
- Decrease burden on primary care prescribing to lessen GP workload.
- Alternate prescribing arrangements?
- Or increase payments to Practitioners to incentivise participation and interest in service area

Chapter 4: Glossary of terms

Five Year Forward View	The main strategic policy document for the NHS in England
NHS Planning Guidance	Annual detailed guidance and priorities issued to all NHS bodies
QIPP	National efficiency programme; stands for Quality Innovation Productivity and Prevention
Vanguard	Recognised group of NHS organisations that are collaborating in a particular geography to deliver new models of care
New models of care	More efficient and ideally less expensive patient pathways and configurations of services