The Office *of the*
Committee *for*
Health & Social Care

Secondary Healthcare Contract
Commissioning Intentions 2018

1. Purpose

The Committee *for* Health & Social Care has responsibility for determining how resources are prioritised in order to deliver the mandate given to it. HSC has ultimate responsibility to determine what services and treatments are provided to the local population, to what criteria and to what quality. An organisation also needs to determine how best to spend its time and effort in planning and developing services.

These commissioning intentions are derived from the Operational Plan of the Office *of the* Committee *for* Health & Social Care which sets out the priorities for its work programme and the planned investments and disinvestments for the coming year.

The purpose of this document is to set out those areas where the Medical Specialist Group's contribution as an organisation is seen as being critical to its ability to deliver key elements of the Operational Plan. Year on year the commissioning intentions may include a requirement to input into strategic planning, service redesign, developing and setting up new services and treatments or disinvesting in them. It can also include training.

2. Commissioning intentions for 2018

- Review and redesign of services and the care pathway for pain management (acute and chronic). (pages 2 – 6)
- Changing the prime method of offering bowel cancer screening. (pages 7 – 8)
- Reviewing and redesigning care pathways for cardiovascular disease. (pages 9 – 12)
- Operational Plan workup for specific investments being considered for 2018. (page 13)

3. Review and redesign of services and the care pathway for pain management (acute and chronic)

3.1 Why this has been identified as a priority

Health care need

Pain is one of the most common symptoms. Chronic pain has a major impact on people's lives, causing sleeplessness and depression and interfering with normal physical and social functioning. It is also feared as a possible symptom for patients with some disease such as cancer. Studies which have explored individuals rating of quality of life have resulted in some individuals rating death as a preferred state above life with severe pain.

In his annual report of 2008[1], the Chief Medical Officer of England estimated that 12% of the population experiences chronic pain which has lasted more than 6 months. Extrapolating this data to Guernsey this would equate to 7560 people; however this might be expected to be lower because of the demographics of Guernsey which in general is more affluent that that of the UK.

A more recent study[2], estimated that between one third and one half of the population experienced pain which lasted more than 3 months duration.

The incidence of pain increases with age. However the incidence of chronic pain has increased over recent decades above that which can be explained by aging alone. The reasons for this are unknown.

One third of all people who experience episodes of prolonged pain will not fully recover.

Estimates from the Office *of the* Committee *for* Employment & Social Security is that about £300,000 was spent on pain management in 2016 but this does not include dispensing fees to pharmacists.

[1] Chief Medical Officers Report: 150 years of the Annual Report of the Chief Medical Officer, Department of Health, Pages 33-40, 2008.
[2] A Fayaz et al, Prevalence of chronic pain in the UK: a systematic review and meta-analysis of population studies, BMJ Open http://dx.doi.org/10.1136/bmjopen-2015-010364

Back pain specifically has an impact on the economy. In 2016, the total number of work days lost to back pain among States employees was 4400. In total, 46,424 sick days as a result of pain were claimed in 2016, resulting in a total cost to the States of £5.7 million.

It has long been known that early intervention, namely that which happens in primary care and community services, has an impact on reducing progression to chronic pain. More recent evidence suggests that experiencing pain for prolonged periods results in changes in the brain. Namely changes to the neurons in the brain may play a role in the experience of chronic pain rather than the stimulus for pain alone. The implication of this is that what happens at the time of the onset of pain is critical to long term outcomes for many people.

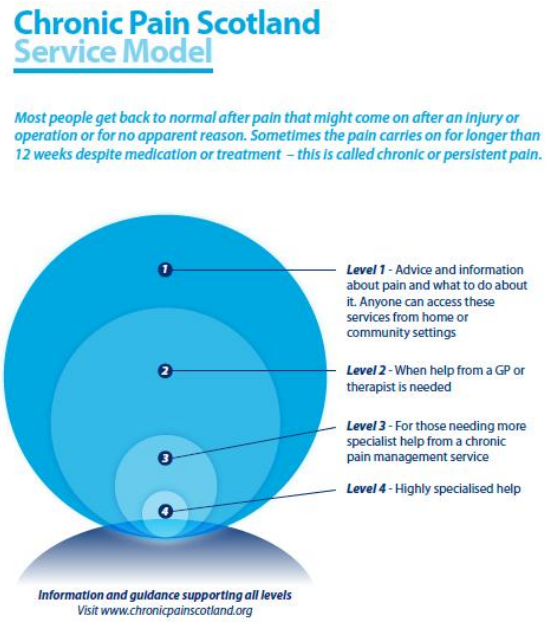
All countries report access problems to pain services. In Western countries, access is variable to specialist pain services, and also to multidisciplinary programmes of services to support patients to manage their pain.

In 2016, Guernsey's specialist pain service carried out 2054 outpatient appointments for 1319 patients. Of these 546 were new patients over half of which (350) were identified as needing ongoing specialist chronic pain management in the form of a multidisciplinary programme.

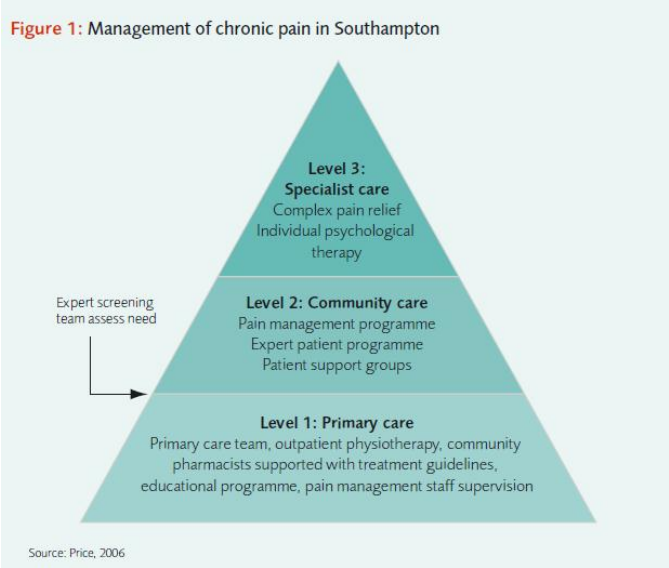
The failure to optimise the management of pain in the acute stage, when pain is prolonged, and for patients with chronic pain, there is a major impact on lives, health care costs and the economy.

Guernsey specific issues

The service model for pain services is illustrated by Chronic Pain Scotland [3] as follows:



The CMO Report presented a similar model for services:



[3] Health Improvement Scotland, SIGN 136: Management of chronic pain, *2013 http://www.sign.ac.uk/guidelines/fulltext/136/contents.html,*

Currently there are long waiting times in Guernsey for patients with chronic pain, which can be up to 15 months if they are being treated in the Primary Care and Secondary Care systems with no coordinated approach.

The proposed new service will provide for more complex pain presentations, thus optimising patient outcomes by ensuring faster returns to work and minimising disability, which in turn will reduce societal costs. Under the proposed new service, pain patients would undergo initial management and education within Primary Care for a maximum of 12 weeks. Those not improving or those that score highly on a psychosocial screening tool would then be more quickly referred to the chronic pain triage service. After appropriate consideration they would then be referred for counselling, nursing input, physiotherapy, occupational therapy or specialist medical intervention. It is envisaged that the new service, which has been designed based around extensive studies, will mean 75% of patients respond to immediate targeted treatment delivered by the triage team, while 25% of patients would require referral into a community based chronic pain management programme.

3.2 Alignment with strategic priorities

2020 Vision Strategic priorities		The Policy and Resource Plan	
✓	Addresses inequality or inequity	✓	Treat mental health with equal consideration and priority to physical health
✓	Enables people to lead independent life		Transform the health and social care system, across and in partnership with the public, private and voluntary sector
✓	Primary or secondary prevention	✓	Provide health and social care services that respect individual needs and promote independence and personal responsibility
		✓	Provide timely and appropriate diagnosis, treatment, support and care, based on need, for all those who need to access it
			Encourage and facilitate active lifestyles
			Improve awareness of the importance of health and wellbeing

3.3 Planned programme of work for 2018

- Review chronic pain services across the care pathway including external review.
- Develop a strategic plan for chronic pain services (adults and children).
- Introduce the UK national back pain care pathway.
- Develop KPI's which can demonstrate success of changes to the service.

3.4 Medical Specialist Group

Input required to strategic planning and implementation	
Service variation to MSG contract	

4. Changing the prime method of offering bowel cancer screening

4.1 Why this has been identified as a priority

Bowel cancer screening was introduced to Guernsey in 2009. Currently all individuals who are aged 66 are invited to undergo flexi-sigmoidoscopy.

Recently, technological developments mean that it is now possible to offer a less invasive method of screening at lower cost and with fewer risks to the population. This use of faecal occult blood is now far more discriminatory test then when the service was introduced with significantly lower false positives or negatives. This enables the higher risk, and more expensive, resource limited procedure of a colonoscopy to be offered only to those who have a positive result, reducing the morbidity attached to the procedure, and targeting only those who will most likely need further interventions to prevent progression of the disease, enabling early and effective interventions. This approach retains the benefits of screening, but with high discrimination of true positives. This will enable patients to be reviewed, where needed earlier, for colonoscopy, and further intervention with significant potential for improved outcomes, but at a much lower cost.

4.2 Alignment with strategic priorities

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			Encourage and facilitate active lifestyles

	Improve awareness of the importance of health and wellbeing

4.3 Planned programme of work for 2018

- Produce a detailed implementation plan to move over from one method of screening to another.
- Implement service change.

4.4 Medical Specialist Group

Input required to strategic planning and implementation	
Service variation to MSG contract	

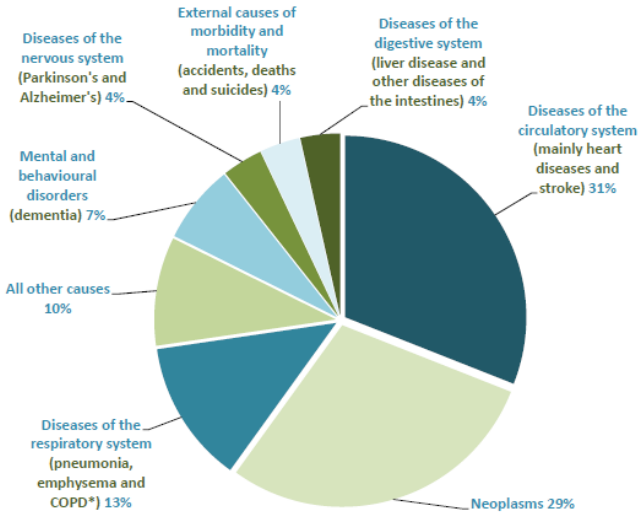
5. Reviewing and redesigning care pathways for cardiovascular disease

5.1 Why this has been identified as a priority

Health care need

The Committee *for* Health & Social Care is establishing a long term programme of strategic development for programmes of care. It will begin with cardiovascular disease.

Figure 9: Leading causes of death in Guernsey/Alderney, 2013–15, men and women combined (chapter group level of the ICD-10).



Coronary heart disease is the main cause of premature death. 57% of deaths due to this cause in those under the age of 75 years are considered preventable.

Prevention can be primary (reduce the risk of developing a disease), secondary (reduce the impact of the disease once it has developed) or tertiary (reduce the impact of complications once they appear).

Guernsey already has the following relevant strategies relating to cardiovascular disease:

- Tobacco Control Strategy
- Health Weight Strategy

There is ongoing work on developing a comprehensive strategy for exercise.

The Health Profile for Guernsey and Alderney 2013 - 2015 reported that the main cause of death is cardiovascular disease.

Guernsey specific issues

HSC need to undertake a systematic analysis of service gaps across the care pathways including identifying inequities of access to primary and secondary prevention for those groups who are most likely to develop heart disease either because of deprivation or because of genetic factors (familial hypercholesterolemia).

HSC is aware that some of the care pathways for management could be improved. Many patients are sent off island acutely, who could be managed on island. Cardiac disease was responsible for a 100 of the 234 transfers in 2016.

Capital Air transfers for 2016

Reason for transfer given	Number
Acute Coronary Syndrome	22
Acute Angina	1
Acute MI	5
Acute Nstemi	1
Acute Stemi	1
AF (Atrial fibrillation)	1
Angiogram	4
Aortic Valve Replacement	4
Coronary Artery Bypass Surgery	2
Cardiac Event	1
Cardiac Surgery	1
Cardiology	4
Chest Pain	1
Complete Heart Block	1
Endocarditis	1
Heart Block	3
Heart Failure	2
Myocardial infarction	27
Non-ST-elevation myocardial infarction	12
Pacemaker	3
Post MI	1
Unstable Angina	2
TOTAL	**100**

5.2 Alignment with strategic priorities

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		✓	Encourage and facilitate active lifestyles
		✓	Improve awareness of the importance of health and wellbeing

5.3 Planned programme of work for 2018

- Redesign of the acute coronary care pathway with the view to avoid transfers to the UK.

- Establish a Cardiovascular Disease Working Group to take forward in the longer term care pathway reviews.

- Cost savings identified will then be reinvested into cardiovascular disease. In order to identify the priorities for investment, a needs and gap analysis will be undertaken covering:

  - Prevention
  - Management in primary care
  - Identifying and supporting those most at risk of dying early from coronary heart disease
  - Community services (such as exercise programme for those at risk)

- Secondary care management
- Tertiary care management
- Cardiac rehabilitation
- Palliative care

5.4 Medical Specialist Group

Input required to strategic planning and implementation	
Service variation to MSG contract	

6. New investments to be considered for 2018 funding

Every year there will be a rolling programme to assess potential service developments which will require input from MSG in order to develop business cases and ensure that there are fully worked up implementation plans (including assessing impacts on other services such as primary care or off island services). Those funded may also result in changes to services.

6.1 Medical Specialist Group

Service development	Operational Plan	Implementation Plan	Contract variation to services provided