Wandsworth Community Adult Health Services

Business Case

Part 1

Case for Change
Document Information

<table>
<thead>
<tr>
<th>Title:</th>
<th>Wandsworth CAHS Redesign Business Case</th>
</tr>
</thead>
</table>
| Purpose: | • Describes the rationale for redesigning community services in Wandsworth at this moment in time
• Describes what the proposed new model would look like
• Allows the WCCG Board to assess whether a redesign of community services is desirable, viable and achievable. |
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| Version Number: | 1.5 |
| Target Audience: | WCCG Board |
| Cross Reference: | Wandsworth CAHS Specification (referred to in this Business Case as the “Service Specification”). |

WCCG Engagement Meetings

<table>
<thead>
<tr>
<th>Event / Group / Board / Consultees</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical CCG Board</td>
<td>12th February 2013</td>
</tr>
<tr>
<td>Management Team Meeting</td>
<td>3rd July 2013</td>
</tr>
<tr>
<td>Locality meetings (Battersea, Wandle, South Wandsworth)</td>
<td>11th July 2013</td>
</tr>
<tr>
<td>Management Team Meeting</td>
<td>17th September 2013</td>
</tr>
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Document Approval Process

<table>
<thead>
<tr>
<th>Organisation / Board</th>
<th>Date Approved</th>
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</thead>
<tbody>
<tr>
<td>Wandsworth CCG Procurement Management Group</td>
<td>21st August 2013</td>
</tr>
<tr>
<td>Wandsworth CCG Management Team</td>
<td>17th September 2013</td>
</tr>
<tr>
<td>Wandsworth CCG Finance Resources Committee</td>
<td>20th September 2013</td>
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<tr>
<td>Wandsworth CCG Board</td>
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Executive Summary

Introduction

Wandsworth CCG contracts for the majority of community services through a single block contract with St George’s Healthcare NHS Trust, Community Division. The service specification to which this business case relates is for the majority of the adult community health services within the current block: the thirteen services that are in scope of the specification and the business case will be referred to throughout this document as Community Adult Health Services (CAHS). The thirteen comprise:

- Dietetics (all ages)
- DESMOND
- Community Nursing
- Primary Care Therapy Team (St John’s Therapy Centre)
- Intermediate Care Services
- Specialist Respiratory Nursing Service
- Specialist Heart Failure Nursing Service
- Specialist Leg Ulcer Nursing Service
- Specialist Diabetes Nursing Service
- Older People – Cardiac Rehab Nursing Service
- Community Pharmacy Asthma Support Project
- Older People – Oxygen bid
- Continence Service

It is relevant to note that the Falls Service is not considered to be in-scope as this service is commissioned by Public Health, however staff within this service will continue to be aligned to CAHS.

1.1 Case for Change

Wandsworth CCG has undertaken extensive engagement with stakeholders on the challenges and opportunities presented by the current service and contracting arrangements. The consensus view amongst the many stakeholders, including staff from St George’s Community Division, Social Services, local GPs and patient representatives who were consulted over a series of workshops, is that there are currently too many independently operating services that deliver care to the adult population in Wandsworth.

The current health service does not provide a cohesive or accessible service to patients in order to prevent readmissions to secondary care. In addition there are some specific service gaps that need addressing, such as lack of in-reach into nursing homes and inadequate responsiveness to urgent care situations, which can result in unnecessary A&E Attendances and unplanned secondary care admissions.
In addition to these internal service issues, there are also some external factors which need consideration. Demand for healthcare services is increasing, as people live longer but with more complex health problems than ever before. Continuing to treat patients in the most expensive setting, acute hospitals, is not only bad for patients but it is unaffordable and ultimately unsustainable.

The Out of Hospital Plan will need to bring a system wide transformation of acute and out of hospital care to ensure that our services are arranged so that they are people-centred and efficient. The management of long-term conditions is required to change so that services are based around the person. This will be presented to the board in March 2014.

1.2 Vision

The recommended vision for CAHS is to structure operational staff within seven interrelated functions, spread across the four Wandsworth localities. One function, Access and Coordination, will ensure there is only one simple and open access point into CAHS for patients and healthcare professionals alike. The other functions will be designed around the needs of patients e.g. a rapid response to an urgent healthcare situation but not one that needs hospital attendance; or maximising the patient’s independence; or facilitating a patient leaving hospital and settling back home.

Full implementation of the seven function design will transform CAHS into a more accessible, responsive, cohesive and transparent service.

If there was an estates “blank canvas”, staff would be physically located in a manner consistent with their function and locality (this “ideal set up” is described in more detail in the Service Specification). In reality the estates position is complicated. Further work and investigation needs to be done to examine the status quo, and feasible changes that can be made, to best serve a redesigned community services. Similar comments apply to the CAHS IT system and trying to ensure there is an interface between IT systems in GP Practices, secondary care and social services.

The recommendation is to proceed with the implementation of the seven function redesign model with the incumbent provider, St George’s Healthcare NHS Trust (SGHT) from April 2014. This recommendation is subject to the existing contract being extended for a further 24 months and is subject to agreed negotiation. During this time it would permit the Clinical Commissioning Group (CCG) and the Commissioning Support Unit (CSU), who are commissioned to act on the CCG’s behalf to manage the existing contract, to form a greater understanding of the day to day business of community services. A tendering process will be concluded within this 24 month period.

It is acknowledged that working with the Provider may still have its challenges. Section 6.4 outlines the risks associated with implementation which have been identified as potential
challenges moving forwards which will therefore need to be managed carefully to ensure implementation occurs efficiently.

However remaining with St Georges NHS Healthcare Trust (SGHT) as the current provider brings with it a significant benefit in that it will mitigate the risk at this stage associated with commissioning an untested external provider through a complex procurement process during a time when further clarification is needed of many issues surrounding Community services as identified within the Procurement summary (see Section 2).

1.3 Recommendations and Next Steps

In respect of this Business Case, WCCG Board is asked to:

- Agree that there is a case for reconfiguring CAHS and that it should be done as soon as possible
- Recognise that alignment to the Social Services Department, Wandsworth Borough Council (WBC), is a critical part of the implementation phase.
- Approve the proposed CAHS redesign model (through approval of the CAHS Redesign Service Specification);
- Note the non-recurrent implementation budget already secured (approved by WCCG MT in February 2013 as part of the Out of Hospital 2013/14 programme budget)
- Approve the procurement rationale as outlined in the procurement document.
- Endorse the recommendation to negotiate and extend the contract with SGHT for a two year period commencing April 2014.

If WCCG Board does approve the above recommendations, the suggested next steps are:

- To work in collaboration with Finnamore the appointed Management Consultants who are responsible for evaluating the implementation of the newly designed service.
- Identify an Implementation team which will be responsible for devising a governance structure. This will consist of Programme and Project managers working across both the Provider and CCG organisations.

Subject to the approval of the above recommendations, the vision for the future would be to review and procure the service during the 24 month period and to identify the requirements of the CCG once the service is better understood. A Procurement process will commence in April 2015, the contract will be awarded to the successful bidder whereupon a detailed contract will be established. Key performance Indicators (KPI’s) and outcome measures will be set. The CCG will be guided legally as to the duration that this contract can run. At the point of a new contract being awarded to the successful bidder, the expectation will be for a
vision to work towards a more robust integration with Social services, as this is the national drive from 2015/16.

2. Procurement Summary

Background

Community Services integrated with St Georges Healthcare NHS Trust (SGHT) in October 2010 following a formal tendering process where an external evaluation criterion was applied. It was evident following this process that SGHT scored significantly higher than the other two bidders. SGHT was therefore successfully awarded the Community Services contract.

Since the point of integration, to date both Wandsworth Clinical Commissioning Group (WCCG), as the successor body to Wandsworth Primary Care Trust (WPCT) who awarded the contract, and SGHT have experienced considerable change with implementation of the Health and Social Care Act 2012. Wandsworth CCG was authorised with no conditions on 1st April 2013. The CCG has commissioned the Commissioning Support unit (CSU) to manage the community contract and the acute contract with SGHT on behalf of the CCG.

The current community services contract is a block (i.e. a fixed sum with no variation for related to activity or other performance). Despite significant efforts over the three years since award of contract to SGHT, it has proved difficult to obtain detailed, costed performance data at a service level. The CCG has made clear its intention to contract with SGHT from April 2014/15 on the basis of a re-based contract, with a shadow tariff at service level.

It is essential to note that the only services that are being considered for this procurement advice involve Community Adult Health services (CAHS) which currently only form a part of Wandsworth Community services (ref list in the introduction). Following advice from Capsticks Solicitors assuming that a redesigned model for community services is agreed upon and approved, the next key question for the CCG is to consider the procurement options available to them.

It is apparent after taking specialist advice on procurement from Capsticks Solicitors and Solent Solutions Ltd that there are two main options available for the CCG to consider. They are as follows:
- **Option 1** Commission a new provider using an external procurement process.

- **Option 2** Implement the new model within the incumbent provider (SGHT);

With Option 2, there would be a contract extension from 1st April 2014 for a 24 month period to implement the redesigned Community services. During this term the CCG will be required to enter into a Procurement process with other interested Providers to ensure that the process is clear and transparent. During the 24 month term the CCG will work with SGHT as the incumbent Provider, subject to negotiations, to monitor activity and performance to begin the process of understanding the current service more comprehensively. This will include general activity and performance to determine if the service is providing a quality service that is value for money.

**Option 1 - Commission a new provider using an external procurement process.**

**Advantages**

- Material changes could be made to the contract. This would enable the CCG and Provider to be clear as to service provision and activity and reporting requirements from the outset.
- The CCG could also consider the opportunity to move from the current block contract to a cost and volume payment or tariff as is the case with acute contracts. This will enable the CCG to have a more transparent process for payment and to ensure that it is getting value for money.
- In addition as part of the development of a new contract, cost savings could be realised with the CCG by negotiating a more suitable tariff that is better value for money.

**Disadvantages**

- There is a risk in departing from working with the current provider (SGHT) at this crucial time whilst the service is not fully understood. Therefore there is justification for remaining in the short term of 24 months with the current provider, during which a procurement process will be undertaken.
- Awarding the contract to a new provider through a procurement process could result in a considerable delay for the CCG and CSU in forming a sound understanding of the service as the procurement process could delay this.
- A further delay should also be anticipated at the point the contract is awarded if the successful bidder is not SGHT as the new provider will require time to become familiar with the service prior to commencing any transformational change.
Option 2 - Implement the new model with the incumbent provider (SGHT).

Advantages

- Support from the Commissioning Support Unit to work collaboratively with the CCG to gain a greater understanding of the day to day business of community services
- Integrated IT systems. The IT system is being considered to look at methods to integrate between Primary Care and Social Services
- Estates can be considered over the next 24 months to obtain a more comprehensive understanding around utilisation of space and opportunities to realise further savings
- Integrated care pathways
- Social Services opportunities to build on pre-existing relationships
- Incumbent provider may become more focused and compliant due to threat of procurement process and fear of risk of losing the contract

Disadvantages

- Key performance indicators (KPIs) cannot be significantly adjusted
- Limited amendments and variations can be made to the pre-existing contract
- Incumbent provider may remain complacent and not deliver targets set

Recommendations and Next Steps

In summary the recommendation is to remain with the incumbent Provider (SGHT) for an extended period of 24 months with a contract variation. Just prior to signing an extension to the contract, the appropriate due process must be followed to alert other potentially interested parties of the intention to procure the service during the 24 month period. The notice will need to be displayed in the relevant journals and website and updated accordingly to ensure due process is adhered to according to the guidance provided by Capsticks Solicitors. During this period of 24 months, other interested parties will be invited to express an interest in the future procurement.

During the 24 month period, an implementation team would be recruited to commence the implementation process with the provider. This would be managed in a very efficient manner with tight timeframes and objectives and outcomes being set to ensure compliance and engagement from SGHT as the incumbent provider. In addition SGHT and the CCG would continue to work closely with Finnamore as the external evaluators to monitor the on-going success of the implementation of the service specification by the close monitoring of clinical indicators.
Capsticks have read this procurement summary and confirm in their legal opinion in relation to Procurement law that the CCG would be providing a strong and reasoned case to remain with the incumbent provider as the CCG has confirmed that external procurement at this point in time may lead to any/all of the following:

a. It would be detrimental to patient care;
b. Damaging to staff morale, which would also impact on patient care;
c. The business is not fully understood at this time following the transfer from the PCT;
d. The extension will allow Wandsworth CCG to correctly identify the services to be provided;
e. It will allow Wandsworth CCG to improve the KPI monitoring and performance management.

Capsticks acknowledge that the CCG within this summary also make several references to the fact that this is just intended to be for a 24 month period, during which time a procurement process must have been commenced, concluded, and a successful bidder awarded the contract.

Overall, the opinion formed by Capsticks is that the Procurement summary explains well, with robust arguments, why Wandsworth CCG wants to extend the contract.

It will allow Wandsworth CCG to have certainty over what services are provided and where they are provided from. It will also improve the KPI monitoring and performance management regime (subject to the caveats in their advice). This will ultimately also benefit any potential bidder for the Services as it will give them certainty as to what they will be bidding for.

Capsticks have also confirmed that Wandsworth CCG is not proposing any real changes to the Services Specification. CAHS currently provides 13 services and this is being consolidated into seven functions instead. The same services will be provided but will be grouped together differently.

Some staff may be required to work different hours but there will be no actual overall increase in those hours for the individuals affected. Capsticks confirmed that this advice was based on discussions with the employment lawyers.

The following Section 3 describes the services currently provided within Community Services Wandsworth that are considered to be in scope and out of scope of the specification.
3. Definitions and Scope

This section describes what is meant by “CAHS” for the purposes of this document and also sets out the scope of the redesign of Wandsworth CAHS and this Business Case. Finally it describes the relationship between health and social care services in Wandsworth.

3.1 Definitions

CAHS is generally understood as referring to health services provided to patients out of a general practice or hospital setting. For the purposes of this document it principally applies to Community (District) nursing and therapy services. CAHS can be provided in a range of locations from health centres to community hospitals but are principally delivered in the patient’s own home. CAHS are provided alongside and in support of general practice and typically includes district nursing, physiotherapy and other specialist nursing services.

The type of tasks carried out by Community services staff might include:

- Administering medications;
- Monitoring patient’s biometric data and well-being;
- Wound care;
- Intravenous therapy;
- Providing emotional support and practical advice to patients and their families; and
- Teaching basic caring skills
- End of life care
- Therapy services and reablement
### 3.2 In Scope

The following table sets out what is “in scope” of this Business Case (and the Community Adult Health Service Specification) and the rationale why that is the case:

<table>
<thead>
<tr>
<th>Service</th>
<th>Provider</th>
<th>Commissioner</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Dietetics (all ages)</td>
<td>SGHT</td>
<td>WCCG</td>
<td></td>
</tr>
<tr>
<td>2 DESMOND</td>
<td>SGHT</td>
<td>WCCG</td>
<td></td>
</tr>
<tr>
<td>3 Community Nursing</td>
<td>SGHT</td>
<td>WCCG</td>
<td></td>
</tr>
<tr>
<td>4 Primary Care Therapy Team (St John’s Therapy centre)</td>
<td>SGHT</td>
<td>WCCG</td>
<td>Service includes physiotherapy and occupational therapy. Service includes Rapid response physiotherapy and domiciliary physiotherapy.</td>
</tr>
<tr>
<td>5 Intermediate care services</td>
<td>SGHT</td>
<td>WCCG</td>
<td>This excludes the intermediate care bed services</td>
</tr>
<tr>
<td>6 Specialist Respiratory Nursing Service</td>
<td>SGHT</td>
<td>WCCG</td>
<td></td>
</tr>
<tr>
<td>7 Specialist Heart Failure Nursing Service</td>
<td>SGHT</td>
<td>WCCG</td>
<td></td>
</tr>
<tr>
<td>8 Specialist Leg Ulcer Nursing Service</td>
<td>SGHT</td>
<td>WCCG</td>
<td></td>
</tr>
<tr>
<td>9 Specialist Diabetes Nursing Service</td>
<td>SGHT</td>
<td>WCCG</td>
<td></td>
</tr>
<tr>
<td>10 Community Pharmacy Asthma Support Project</td>
<td>SGHT</td>
<td>WCCG</td>
<td></td>
</tr>
<tr>
<td>11 Older people - Oxygen Bid</td>
<td>SGHT</td>
<td>WCCG</td>
<td></td>
</tr>
<tr>
<td>12 Older People - Cardiac Rehab Nursing Service</td>
<td>SGHT</td>
<td>WCCG</td>
<td></td>
</tr>
<tr>
<td>13 Continence Service</td>
<td>SGHT</td>
<td>WCCG</td>
<td></td>
</tr>
</tbody>
</table>

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1 Service Specification in the table refers to the “Wandsworth CAHS Specification” document.
3.3 Out of Scope

The following section sets out what is “out of scope” of this Business Case and the rationale why that is the case. The main reason for a service commissioned by WCCG to be out of scope is because the service is either specialist, for children, bed based, acute (e.g. all services located at Queen Mary’s Hospital (QMH)) or a day hospital. Non-WCCG commissioned services are also out of scope.

3.3.1 WCCG Commissioned Services

The following community services commissioned by WCCG are out of scope:

<table>
<thead>
<tr>
<th>Service</th>
<th>Location</th>
<th>Provider</th>
<th>Commissioned</th>
<th>Rationale and Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Demobilisation Post acute neuro-rehabilitation</td>
<td>In patients home and various Community Clinics</td>
<td>SGH</td>
<td>WCCG</td>
</tr>
<tr>
<td>2</td>
<td>Podiatry</td>
<td>SGH</td>
<td>WCCG</td>
<td>A5</td>
</tr>
<tr>
<td>3</td>
<td>Bed Based Community Services</td>
<td>Various - e.g. Ronald Gibson House/Intermediate Care Beds (QMH) / Elderly Rehab Beds (QMH)</td>
<td>SGH</td>
<td>WCCG</td>
</tr>
<tr>
<td>4</td>
<td>Physiotherapy Classes</td>
<td>QMH (Banbury Gym)</td>
<td>SGH</td>
<td>WCCG</td>
</tr>
<tr>
<td>5</td>
<td>Day Hospitals</td>
<td>QMH (Bryson Wing)</td>
<td>SGH</td>
<td>WCCG</td>
</tr>
<tr>
<td>6</td>
<td>In-Patient Neuro Rehabilitation Team</td>
<td>QMH (Guyron Holford Ward)</td>
<td>SGH</td>
<td>WCCG</td>
</tr>
<tr>
<td>7</td>
<td>Amputee Rehabilitation</td>
<td>QMH (Guyron Holford Ward)</td>
<td>SGH</td>
<td>WCCG</td>
</tr>
<tr>
<td>8</td>
<td>Community Hospital Beds</td>
<td>QMH (Mary Seacole Ward)</td>
<td>SGH</td>
<td>WCCG</td>
</tr>
<tr>
<td>9</td>
<td>Neuro Rehab Services (Orthotics)</td>
<td>SGH</td>
<td>WCCG</td>
<td>A5</td>
</tr>
<tr>
<td>10</td>
<td>Speciality Clinic</td>
<td>QMH (Virtual Clinic)</td>
<td>SGH</td>
<td>WCCG</td>
</tr>
<tr>
<td>11</td>
<td>Physiotherapy Outpatient</td>
<td>QMH</td>
<td>SGH</td>
<td>WCCG</td>
</tr>
<tr>
<td>12</td>
<td>Wheelchair Services including rehabilitation engineering</td>
<td>QMH</td>
<td>SGH</td>
<td>WCCG</td>
</tr>
<tr>
<td>13</td>
<td>Wandsworth Community Neurological Team (WCNT)</td>
<td>Si</td>
<td>SGH</td>
<td>WCCG</td>
</tr>
<tr>
<td>14</td>
<td>Various childrens services (e.g. MyHealth, Health Visiting, Neuro Team)</td>
<td>SI</td>
<td>SGH</td>
<td>WCCG</td>
</tr>
<tr>
<td>15</td>
<td>Early Supported Discharge for Stroke Patients</td>
<td>SGH (Atkinson Morford Wing)</td>
<td>SGH</td>
<td>WCCG</td>
</tr>
<tr>
<td>16</td>
<td>Short Term Assessment Rehab (STAR)</td>
<td>SGH (A&amp;B)</td>
<td>SGH</td>
<td>WCCG</td>
</tr>
<tr>
<td>17</td>
<td>Physical and Learning Disabilities</td>
<td>Springfield Hospital</td>
<td>SGH</td>
<td>WCCG</td>
</tr>
</tbody>
</table>

Key:
- QMH - Queen Mary’s Hospital
- SGH - St George’s Hospital
- SJ - St John’s Therapy Centre
- WBC - Wandsworth Borough Council
- AC - Acute Service out of scope
- DH - Day Hospital out of scope
- SS - Specialist Service out of scope

3.3.2 Non-WCCG Commissioned Services

The following community services not commissioned by WCCG are out of scope, although we recognise the need to align the proposed new model with these services:

<table>
<thead>
<tr>
<th>Service</th>
<th>Location</th>
<th>Provider</th>
<th>Commissioned</th>
<th>Rationale and Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Telecare</td>
<td>In patients home</td>
<td>SS</td>
<td>WBC</td>
</tr>
<tr>
<td>2</td>
<td>START (Department)</td>
<td>In patients home</td>
<td>SS</td>
<td>WBC</td>
</tr>
<tr>
<td>3</td>
<td>First Response</td>
<td>In patients home</td>
<td>SS</td>
<td>WBC</td>
</tr>
<tr>
<td>4</td>
<td>Key Life Service</td>
<td>In patients home</td>
<td>SS</td>
<td>WBC</td>
</tr>
<tr>
<td>5</td>
<td>PASS/ACT Teams (e.g. ACT West Wandsworth, ACT Battersea, ACT Charnock, Tooting and Earlsfield)</td>
<td>In patients home</td>
<td>SS</td>
<td>WBC</td>
</tr>
<tr>
<td>6</td>
<td>Home from Hospital (DF)</td>
<td>In patients home</td>
<td>AGE UK</td>
<td>WBC</td>
</tr>
</tbody>
</table>

Key:
- SS - Social Services
- WBC - Wandsworth Borough Council

*It is relevant to note that the Wandsworth Integrated Equipment Services (WICES) budget is a jointly pooled budget that is led by Wandsworth Borough Council (WBC)*
3.4 **Health and Social Care**

The case for seamlessly joined up health and social care is self-evident: better coordination will see improved care and support, fewer people falling through the cracks and a drop in patients needlessly admitted into hospitals. The current Government is committed to making integrated health and social care a reality from 2015/16.

Opportunities have been seized at more joined up working between WCCG and Wandsworth Borough Council in the last few years, including establishment of the Health and Wellbeing Board at a strategic level along with a Joint Commissioning Unit for contracting of services. Attempts at operational joint working have also been made with the social workers employed as part of the Community Ward, as well as effective working between Intermediate Care Services and the START team.

However, real opportunities for more joined up working “on the ground” is yet to be fully exploited. It is intended that this model can harness these opportunities.

Wandsworth Borough Council (WBC) is responsible for the provision of Adult Social Services and has recently undergone a restructure of their establishment. The restructure will be completed before any redesign of community services begins.

For the purposes of the redesign of community services it has been agreed that redesigning Adult Social Services is “out of scope” (as set out in the previous section). However discussions have taken place with WBC to ensure that the restructured Wandsworth Adult Social Services staff model is “aligned” with the proposed redesigned Wandsworth CAHS and will bridge effectively at the operational level.

Details of exactly how the “alignment” will work are the subject of on-going discussions between WCCG and WBC management. Areas that are being considered are social workers hot-desking from CAHS premises and senior health staff being able to deliver social care packages as “trusted assessors”. More details of the “alignment” are described in the “Bridging the Gap between Health and Social Care Services” paper.

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2 Please see “Bridging the Gap between Health and Social Care Services” paper.
4. Case for Change

This section provides a brief history of CAHS in Wandsworth and sets out the problems and issues with the current service. It also describes how environmental challenges are placing different and increased demands on community services.

In summary, this section aims to answer the question: “what is the rationale for redesigning the way CAHS are provided in Wandsworth, and why do it now?”

4.1 Background

Wandsworth CAHS was historically part of Wandsworth Primary Care Trust (PCT), known as the PCT’s “provider arm”. The Department of Health set a deadline of September 2010 for PCTs to “externalise” their provider arms, either through vertical integration with acute or mental health trusts or by becoming independent Community Services Foundation Trusts.

In December 2009 NHS Wandsworth’s board selected St George’s Healthcare NHS Trust as the preferred partner Community Services Wandsworth to integrate with. The aim of this was to improve patient experience and outcomes by linking community care and hospital care more closely.

The Better Services, Better Value review (BSBV) was launched in 2010 in south west London in response to a range of challenges such as; financial pressures, more people living with long term conditions and not enough senior doctors available round the clock in some vital services. BSBV is looking at how health services in south west London is being provided generally, and “out of hospital” care is a vital element of this review.

Planning All Care Together (PACT) was a programme launched in Wandsworth in 2012/13 as a response to BSBV (This was later renamed as the ‘Out of Hospital Plan which will be presented to the Board in March 2014’). Its aim was to initiate a programme of work aimed at improving out of hospital care for adults over a 5-year period and thereby improving the patient experience, improving healthcare quality and reducing the use of secondary care resources.

A key mandate of the Out of Hospital Plan is to look at how CAHS were provided in Wandsworth and develop an improved model. The result of this work was an initial draft of the “Wandsworth CAHS Specification” that was taken to the WCCG Board in February 2013.
4.2 Stakeholder Engagement

The following stakeholder engagement process has occurred over a 12 month period (See Appendix 1).

4.3 Existing Service Issues

While acknowledging the very hard work of the vast majority of staff working for Wandsworth CAHS there are some fundamental systems and process issues at the heart of CAHS in general that predicate against patient centred care in the community.

4.3.1 Fragmented Services

Wandsworth CAHS has continually been added to over many years without a strategic oversight by commissioners which has resulted a large number of disparate, independently operated services or 'silos' developing.

The multitude of services often means no healthcare professional takes ownership for a patient referral and it can take some time before it is clear who will be assessing the patient. The current configuration of CAHS fosters an “independent services” mentality with sometimes competing agendas and blurred referral pathways. This means that some of the current systems and processes do not work effectively and patients can fall between the gaps.

End of Life Care (EOLC) is a good example of services not being well coordinated, resulting in inadequate service delivery. This is due to the fact that a number of professionals have been involved such as district nurses and specialist nurses but there has not been an identified key worker assigned to ensure the process of delivering care for EOLC patients is delivered in a consistent and coordinated manner. Please see service specification Figure 16 for further detail.

Another area of fragmentation is in respect of referral criteria which are, on occasions, too restrictive for many of these “independent” services. There is sometimes the impression that services are using referral criteria to exclude patients from care rather than deliver it. There can be a lack of a “yes” culture and a difficulty in accepting responsibility for patient care.

By their own acknowledgement, CAHS staff do not always understand what services are available for patients, so it is safe to assume that patients (and other healthcare professionals) referring in to CAHS are going to struggle. Through engagement with a wide range of stakeholders, it has become clear that there is a lack of clarity as to service provision available, and referral routes, across all staff groups.

As identified by staff working within CAHS, Local GPs and Social Services staff participated in workshops to assist with redesigning a new model of care. During these meetings it was
identified by staff present that there are simply too many independent services currently operating under the overall banner of “CAHS”.

4.3.2 Staffing

Clinical

All CAHS staff currently work within teams and are located within different estates across Wandsworth and do not have opportunities to come together as a large multi-disciplinary team. This means that some of the current systems and processes do not work effectively as there is too much “siloed” working and that significant information does not always reach the right professionals involved and does not get dispersed appropriately. This can create issues for staff who do not manage to form a clear picture of a patient’s on-going needs and interdependencies amongst services.

In the current structure, staff are generally aligned with disease-specific pathways. This does not always serve patients with complex care needs and multiple long term conditions well.

The Rapid Response team (part of the Community Ward) operates a skeletal service of only four Advanced Nurse Practitioners (ANPs). The non-recurrent funding of the Community Ward has made it hard to recruit staff, which has meant difficulties in establishing an effective service that is always responsive within two hours of referral.

Administration

Currently there are 13 services operating independently that all have their own administration staff. There is a perception amongst CAHS staff that some work more productively than others. There is therefore inconsistency in the standards of the administration staff which affects the overall productivity of the teams.

There are currently no administrative staff available over the weekend.

Interaction with other healthcare services

Secondary Care

Currently secondary care providers, in particular St George’s Healthcare NHS Trust (SGHT), have a perception that it is difficult to discharge patients back into the community (especially when the bed based services are going into black or red status (i.e. available beds are limited).

CAHS have a perception that secondary care discharge patients in a reactive way rather than pro-active and feel this can often prove to be unsafe particularly if this is leading into a
weekend when there is a reduced community staff presence. Patients are then put at risk of being re-admitted to hospital due to a failed discharge.

Patients are also not currently routinely reassessed once they are at home to determine if their care package is appropriate or needs revising. Often it does need changing but the patient can only truly be assessed in their home environment, especially in relation to using equipment. This again can often lead to re-admission to hospital.

**General Practice**

GPs critically depend on community services to deliver healthcare to their most vulnerable patients. The overwhelming consensus from GPs is that while individual staff and some services are very good, overall access to community services is unsatisfactory and that referral pathways can be contradictory and confusing. There are often many services that GP’s do not know about and find difficult to access even if they do. There is significant duplication of services and poor communication between them. GPs identified rapid mobilisation of community and social services as being a key enabler to assisting them in potentially preventing many admissions.

**Nursing Homes**

Currently CAHS do not provide any in-reach work into Nursing Homes (except Tissue Viability Specialist Nurses who act only in an advisory capacity), which could possibly aim to reduce high A&E attendance rates and unplanned emergency admissions from them.

**Social Services**

Currently there is a fragmented working relationship between health care and Social services. Often it can take several days (and sometimes longer) for Social Services staff to complete assessments resulting in the patients having to be readmitted to hospital.

**Out of Hours**

Therapists at the present time operate a 09:00 to 17:00 service Monday to Friday.

- This is a limited service and does not accommodate the needs of patients and their carers.
- Unable to address patients’ needs (preparing meals, etc) outside of the core hours.
Infrastructure

Estates

All CAHS staff currently work within teams that are physically located in different places in Wandsworth. These teams (with the exception of the community ward staff) do not have the opportunity to come together as a large MDT. This means that some of the current systems and processes do not work effectively as there is too much “siloed” working.

In addition the estates status quo is very opaque in terms of who operates from where and how many desk spaces are used.

At the present time there are many small estates utilised by Community services which are not occupied to the full potential. Therefore, throughout the 24 month period during the implementation process, it is envisaged that by facilitating more remote working for staff through the utilisation of laptops and tablets it will be possible to lean the number of estates down to identify more useful premises for staff to work out from.

The requirements will be for at least four large locality offices for the Locality teams to base themselves in and operate out from, and to deliver the weekly multidisciplinary meeting. In addition this large space will be used to base Locality team administrators. The CCG will endeavour to work closely with the provider during implementation to agree the estates that would be suitable to operate the service from and also identify opportunities for potential savings from current estates that are no longer required.

IT

At the present time CAHS, GP Practices, secondary care providers and Social Services are all using different IT systems which do not interface with each other. This does not help foster relationships between these different services and on occasions has proved to be a risk to patient safety as crucial information has not been transmitted to relevant staff.

There is also currently no IT scheduling system in CAHS to book clinical staff appointments.

Contract and Performance

The current CAHS contract is a “block contract”. This essentially means payment is not activity related and it is very difficult to understand the costs of specific services to enable any sort of value for money appraisal to be carried out. Activity by service line and by staff is also opaque.
The lack of transparency over activity means proper contract management and performance evaluation is hard to effect. In addition key performance indicators in the contract are relatively meaningless and do not improve the quality of the service. There is also limited emphasis placed on not delivering or performing or measuring activity as there are no contractual penalties if the provider fails to do this. It is the intention, prior to any formal procurement process commencing, to reconsider the method of financially contracting these services with a view to moving from a block contract to cost and volume. A decision will be determined at a later date.

4.4 Environmental Challenges

Improved healthcare means that people are living longer. The 2011 Census revealed that there are approximately 27,000 people aged over 65 years old currently living in Wandsworth\(^1\). It is projected by the year 2030 this number will have increased by 26% to 33,600\(^4\).

People are also living with more long-term conditions and complex health problems than ever before – such as diabetes, obesity or respiratory problems, cancer and heart disease. Three out of every five people aged over 60 in England suffer from a long-term condition, and as the population ages, this proportion is likely to rise. Certain lifestyle factors are also contributing to increased prevalence of diabetes, hypertension, Chronic Obstructive Pulmonary Disease (COPD) and Coronary Heart Disease (CHD).

At the same time the cost of providing care the way we do now continues to rise. However, there is no proportionate increase in funding available to meet this increasing need. In fact, there have been real term reductions in NHS budgets in the last few years.

Hence healthcare services, and especially community services, that are a key service treating the elderly and patients with LTCs, will have to work more efficiently and more effectively to treat more people in a more affordable way and without losing out on quality.

Changing technologies (e.g. the advance of Telehealth / mobile devices) also provides a new opportunity for community services to be delivered in a different and more effective way.

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\(^1\) 2011 Census: KS102EW Age structure, local authorities in England and Wales


4.5 Strategic Fit

The table below illustrates how redesigning CAHS fits with the WCCG corporate and strategic objectives as well as the National Outcomes Framework 2013/14:

<table>
<thead>
<tr>
<th>Redesigning Community Services - Strategic Fit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Wandsworth CCG Corporate Objectives – 2013/14</strong></td>
</tr>
<tr>
<td>Objective 1: Commission high quality services which improve outcomes and reduce inequalities</td>
</tr>
<tr>
<td>Objective 2: Make the best use of resources, continually improve performance and deliver statutory responsibilities</td>
</tr>
<tr>
<td>Objective 3: Continually improve delivery by listening to and collaborating with our patients, members, stakeholders and communities</td>
</tr>
<tr>
<td>Objective 4: Transform models of care to improve access, ensuring that the right care is delivered in the right setting</td>
</tr>
<tr>
<td>Objective 5: Develop the CCG as a continuously improving and effective commissioning organisation</td>
</tr>
</tbody>
</table>

| **Wandsworth CCG Commissioning Strategy Plan – 2012/13-2014/15** |
| Strategic Goals: |
| Reduce health inequalities through helping people to live longer and healthier lives, particularly those living in Wandsworth’s most deprived communities |
| Support young people to take control of their own health earlier, so they continue to make healthier choices throughout their lives |
| Educate people about mental wellbeing, sexual health, drugs, alcohol and obesity. Help prevent and diagnose earlier and improve services. |
| Improve access, quality and choice of service provision across all care pathways and in appropriate settings |
| Improve the quality of life of people living with long term and complex health conditions and their carers by improving the quality, range and choice of services and giving them information to better manage their own health |

| Key Strategic Initiatives / Commissioning Priorities: |
| Prevention, screening, early diagnosis and awareness initiatives |
| Sexual health |
| Substance Misuse (drugs and alcohol) |
| Children’s Services |
| Urgent Care/older People |
| Long term conditions |
| Borough Specialised Commissioning |
| Supporting initiative: QIPP |

| **NHS Outcomes Framework 2013/14** |
| Domain 1: Preventing people from dying prematurely |
| Domain 2: Enhancing quality of life for people with long term conditions |
| Domain 3: Helping people to recover from episodes of ill health or following injury |
| Domain 4: Ensuring that people have a positive experience of care |
| Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm |

Based on the evidence set out above, is that the current configuration of CAHS in Wandsworth is not fit for purpose and there is a clear case for change. Furthermore, given the environmental challenges, this change needs to commence expediently and maintain momentum.
5. Business Options

This section aims to set out what the business options available to WCCG are in respect of CAHS.

The following options were included in the options appraisal.

1. Option 1 - Do nothing
2. Option 2 - Seven function re-design Model - Full Implementation (phased approach)
3. Option 3 – Seven function re-design Model – Partial Implementation

5.1 Option 1: Do Nothing

The previous section (Section 4) concluded that there was a clear case for redesigning CAHS provision in Wandsworth and to do it as soon as possible. It is considered that taking no action will leave the following issues unaddressed:

1. The opportunity to demonstrate value for money through the evaluation of effective outcome measures
2. Preventing the operation of silo fragmented services.

5.2 Option 2: Seven Function Redesign Model – Full Implementation (phased approach)

A number of workshops were conducted. CAHS staff, GP’s, Social services and patient representatives were invited to attend a series of five workshops. The workshops focused on what a good package of care would look like for a fictional patient called Doris, and then mapped what it would take for this to be achieved.

During these workshops it was identified that the care that is currently being delivered to patients fell into seven main categories. The categories therefore formed the platform on which the seven functions were designed and the work described that would be delivered by each function.

The seven function model was reviewed with Finnamore, external management consultants and Bailey & Moore, external finance consultants, and was concluded to be the most viable based on evidence.

The seven function redesigned community services model (full implementation) is described in detail in Section 6.
Figure 2: Patient Overview of the New System

Advantages

The advantages of this model are set out in more detail in Section 6. In summary:

- CAHS would become a more accessible and responsive service, from both a clinical and a patient perspective, delivering care in the right place at the right time; and by the right people, doing the right things in the right way;
- The model focuses on improving care for the most vulnerable patients, especially those with comorbidities;
- Avoids a partial implementation which might not lead to the “wholesale” changes required and will not be sufficient to address the internal and external challenges described in Section 4.3 and 4.4.
- The new model fits well with other strategic Out of Hospital initiatives in Wandsworth (e.g. the PACT Local Enhanced Service specification for GPs);
The clear outcome measures that will be identified with the provider over the 24 month period will inform the CCG of what they will be requiring from a successful bidder. This will therefore help the CCG to outline as part of the procurement process the deliverables that will be expected. This can be made explicit within the procurement process. Finnamore will work closely with the CCG and the provider to optimise the evaluation of the service through the appropriate management of KPI performance.

Disadvantages

- The main disadvantage is the fact that the change proposed is so comprehensive that it will require dedicated transformational change management to make it happen.
- Radical change of working practices for staff who will need support with organisational and transformational change.
- It will take time for the appropriate HR and recruitment processes to conclude.

5.3 Option 3: Seven Function Redesign Model – Partial Implementation

The seven function redesign model (partial implementation) means implementing some of the seven operational functions but not all of them e.g. just the Rapid Response and Access and Coordination functions.

The Rapid Response function and the Facilitated and Supported Discharge function are considered to be the most cost-effective functions to implement on the grounds that Rapid Response will endeavour to produce a reduction in non-elective admissions, likewise the Facilitated and Supported Discharge function will endeavour to produce similar cost savings through the promotion of early supported discharge.

Advantages

- Less work to implement and less disruption to existing service so more chance of timely and effective implementation.

Disadvantages

- Will not address many of the current service issues e.g. too many and disparate existing services;
- The seven function redesign is designed to be a complete solution and partial implementation could undermine the key idea of making a redesigned community service an easy to access, patient centred service.
• All functions are considered to be interdependent and therefore to achieve the best outcomes for Rapid Response and Facilitated and Supported Discharge all functions should be implemented.

Options Appraisal

As part of the on-going consultation process, six professionals from a variety of staff groups within Wandsworth Community Adult Services were requested to consider their preferred option of implementation.

A further option was considered. This was the integrated care pathway model, which involves considering specific aspects of care such as older people’s services, musculoskeletal services and diabetes services to name but a few. The approach taken is for commissioning to identify a variety of providers to manage these pathways independently. The provider would be responsible for the entire provision of care for the speciality which would need to incorporate the whole pathway from Primary care to community through to acute.

Although it is recognised that this is a topical issue at the moment and an approach that some CCG’s are adopting, it was felt this was not appropriate for Wandsworth CCG for several reasons.

- It would continue to produce silo working.
- Siloed working would impact on the patient receiving a holistic service.
- Older patients often experience several co-morbidities and complex care needs which need to be managed together.

Therefore this model of care was excluded from an options appraisal.

5.4 Recommendation

Option 2, the full seven function redesign, is the recommended option. The implementation process will be clearly outlined and negotiated with the successful provider. Work will commence approximately five months ahead of implementation to ensure that it is done in a planned and efficient manner.

Section 6 sets out proposals for what the redesigned seven function community services model would look like from an operational perspective.
6. Proposed Operating Model

Section 4 concluded that there was a clear case for redesigning community services provision in Wandsworth and to do it as soon as possible. Section 5 looked at the business options and recommended full implementation of the “seven function redesign model (full implementation)”. This section aims to describe this proposed model.

6.1 Overview

The proposed new operational model for CAHS in Wandsworth is set out in detail in the “Wandsworth Community Adult Health Service Specification” document. The diagram below provides an overview of the proposed operating model:
As can be seen above, the proposed operating model is centred around the following seven functions:

- Access & Coordination
- Rapid Response
- Facilitated & Supported Discharge
- Maximising Independence
- Complex Case Management
- Scheduled & On-going Care
- Specialist Input
Each of the above functions will operate across four Wandsworth geographical localities, West Wandsworth; Central Wandsworth; South Wandsworth; Battersea, as per the current localities operated.

The new model will provide an additional benefit as it has been designed with more opportunities for additional integrated working between mental health and social services. The purpose of which is to work more collaboratively drawing on the expertise of other professionals to address unmet needs in the patients cared for by CAHS.

6.2 Seven Functions

Access & Coordination
To provide initial call handling for any health or social care professional or patient/service user. Includes call handling; information gathering; using information to determine next steps and appropriate onward referral.

Rapid Response
Responding within two hours to an emerging care need for patients not necessarily known by CAHS - to prevent an admission into hospital or nursing/residential care wherever safe. The response will include a rapid, multidisciplinary assessment and intervention focusing on care provision and treatment in the community. Responding to either an urgent health need or a breakdown of care.

Facilitated & Supported Discharge
Supporting people to return home as soon as possible following a stay in hospital and arranging the services to facilitate this. CAHS will in-reach into hospitals to proactively manage discharges in a timely way and ensure that the necessary services are in place to safely be at home.

Maximising Independence
Focussing on maintaining someone in their own home as independently as possible. The care is person centred and goal orientated, focused on rehabilitation/reablement and delivered by a combination of professional groups working together to common aims.

Complex Case Management
People with complex needs will experience care which is planned collaboratively across primary, secondary, community health and social care. Care will be coordinated and seamless and be led by an appropriately qualified case manager. The care currently being
provided by the Community Ward and to a certain extent the Intermediate Care Team will be encompassed by this function.

Scheduled & On-going Care
This function provides for those who require on-going home-based care but whose needs do not require multi-disciplinary case management. The care will be task orientated and will include regular review. Care of this type is currently predominantly provided by the community/district nurses in conjunction with the patient’s regular GP and by individual social services staff.

Specialist Input
Delivering care where specialist clinical skills are essential – such as that provided by specialist diabetic nurses for example. This function will also ensure links to specialist teams that are outside of this specification such as mental health teams, ensuring a seamless, coordinated pathway between community services and these specialist teams.

6.3 Benefits
The key benefits of the proposed operational service model are set out below.

Fragmented Services

Seamless and consistent service:
By organising the service into functions the multitude of existing services should be reduced to just one service with seven closely interrelated functions. This should mean the overall service operates a lot more seamlessly avoiding the issue of teams working in silos. All four localities will have access to the same professionals so there should be an equitable and consistent service across Wandsworth. This approach to working will promote a more positive experience for the patient.

Enhanced coordination:
Within the new model CAHS will have on-going responsibility to work with the End of life care (EOLC) hub.
The nurses with particular responsibilities falling within the Complex Case Management and Scheduled and On-going care functions will inevitably have patients who are nearing the end of their life included within their caseload. There will also be a Community Matron assigned to every patient and their family identified as requiring end of life care to act as point of contact to support them through what is often a highly emotionally charged period of time.

Staff communication:
By moving all staff into four localities working in functions it will mean that barriers to working will be removed as staff will understand each other’s roles better. By doing this, patients should have access to all staff working within the function. Information about the patient should be more accessible across functions for more efficient working.

**Streamlined referral criteria:**
There will be limited referral criteria making access into services more straightforward, this will present the patient from bouncing around CAHS and the patient should be reviewed in a timely manner by the appropriate professional. The service will become a “yes” service rather than a “not us” service.

**Staffing**

**Clinical**

**ANPs and Physician Assistants employed to improve responsiveness:**
The establishment of ANPs/Physicians Assistants, alongside other identifiable suitable staff, will be doubled which means that all patients will be reviewed within 2 hours. The Advanced Nurse Practitioners/Physicians Assistants will act as Trusted Assessors to allow them to assist in arranging care packages, on behalf of Social Services, which benefits both Health and Social care. However, this will not discharge Social Services’ statutory responsibility of care. This will mean a care package can be organised within 6 hours of assessment rather than waiting over 24 hours, by which the time the patient has often had to be admitted to hospital due to a social care issue.

A cost of an ANP per visit is cheaper than an A&E attendance so, although ANPs are an expensive resource, longer term this should prove more cost effective.

**Specialist staff in key areas of health need:**
In addition there will be new dementia specialist nurses and psychology support.

**Administration**

**Improved access and skills:**
Co-ordination/Administration staff will be co-located within the four locality teams and will have a wider skill set to perform the extra tasks expected of them (e.g. call handling).

**Increased Administration working hours:**
There will also be Administration Staff available at the weekend.
Interaction with Other Healthcare Services

Secondary Care

Effective discharge system:
There will be a CAHS team based in SGHT who will pre-empt discharges by working closely with SGHT ward staff. They will then coordinate the patient’s safe discharge through liaison with one of the functional teams in the patient’s locality.

The discharges will be planned and coordinated effectively with all staff being able to plan discharges around capacity for the day e.g. if there is high staff sickness in a particular locality staff in CAHS can be moved around to work in another locality team to accommodate this.

Improved post-discharge assessment:
All patients discharged from secondary care will be followed up over a 2 week period post-discharge to ensure the patient has an appropriate care package in place or if any amendments are required.

It is hoped communication will improve between CAHS and secondary care and confidence will develop by placing a team in SGHT. If this model is successful it can be expanded to other local secondary care providers, such as Kingston Hospital.

General Practitioners

Since the point of integration, SGHT have employed GP practitioners as part of CAHS and embedded them to work within the community wards. The Community wards have been operating for approximately four years. They are acknowledged by staff, patients and independent evaluators as a unique and significant element of the Wandsworth model’s success. In order for the team to be multidisciplinary, the inclusion of medical staff is essential. GPs being employed directly by CAHS ensure that their focus is entirely on supporting the staff and systems needed to improve and sustain effective community services. CAHS staff often need assistance for a patient case-load that is across practice boundaries and this can be difficult to do without dedicated medical support. GPs in the community ward provide a leadership role analogous to a consultant in a hospital ward. They also provide an effective interface between CAHS and medics in primary and secondary care. Enabling access to the GP resource by all the community staff instead of only the community ward staff was identified as a key enabler to more co-ordinated community services.

Quality, Innovation, Productivity and Prevention (QUIPP) analysis of the community ward has demonstrated savings above the cost of GPs being employed.
**Nursing Homes**

**Clinical care provided in Nursing Homes:**
All functions, with the exception of the Scheduled On-going Care, will provide in-reach work into Nursing Homes.

The Rapid Response function shall assist with blocked catheters or minor complications, which will avoid unnecessary attendances to A&E.

Other functions, such as Maximising Independence and Complex Case Management, will provide education to nursing home staff about how to manage complex long term care patients effectively.

**Alignment of Nursing Home staff with CAHS staff:**
One staff member of each Nursing Home will become the CAHS point of contact. This staff member will lead on the management of care for patients requiring CAHS support and will help improve working relationships between themselves and the Nursing Home to help reduce A&E attendances and emergency admissions to secondary care.

**Educating of Nursing Home staff by CAHS staff:**
The education provided by CAHS staff will also help Nursing Home staff to feel more confident and competent to manage complex care patients with multiple LTCs.

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**Out of Hours**

It is intended that the new CAHS service will become a responsive 24/7 service. Whilst it is acknowledged that not all services have a need to operate all the time, the focus will be centred around having the availability of specific functions to meet the needs of the patient.

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**Infrastructure**

**Estates**

**Co-location of staff:**
Estates will be reviewed as part of the CAHS business case to try to co-locate certain healthcare staff to support more effective working and to avoid delays in communication.
wherever possible. There will also be opportunities to look at more remote working with potential provision of laptops or tablets. Staff will, for example; be able to complete a patient’s notes in the home setting rather than having to travel back to the office.

**IT**

Alignment of IT systems:
On commencement of contract negotiations WCCG will express their desire for the Provider to utilise EMIS web as their IT system which will match to the IT systems already in place in local GP practices. The intention is that this will assist with more effective working relationships with local GP’s and in addition will look towards setting up an interface between CAHS and secondary care providers so patient records can be shared for e.g. between the Rapid Response function and A&E (for example ‘Complex Event Processing Software, CEP, which is currently being piloted in SGHT). This will promote more seamless working where joint management plans can be shared between relevant healthcare professionals.

**Contract and Performance**

Performance indicators:
The contract will include Key Performance Indicators (KPI’s) for each of the seven functions and there will be much greater transparency around reporting of contract activity as per the advice note from Capsticks.

Transparency over contract management:
Moving forward with implementation of the new model, there will need to be a clear change management plan which will need to approved by the CCG Management team. There will need to be close working between the CCG and the provider services with project managers interfacing from both organisations. A joint monthly meeting will be organised. This meeting should include membership from key representatives from within both CAHS and the CCG which will include members of the, clinical governance from both organisations, relevant directors and GP’s from Primary care. It is essential that this meeting takes place to evaluate on an on-going basis the progress of implementation and any on-going operational issues that impact on the quality and safety of the new model of working for Adult Community Health Services. The meetings will take the form of Clinical Commissioning Reference Groups (CCRG’s) and Clinical Quality Reference Groups (CQRG’s).

During the implementation phase it is essential that this meeting continues with vigour as this will provide the CCG with an understanding of the quality of the service and whether the
SGHT are currently providing a service that is value for money. The meeting is chaired by Dr Angelique Edwards a local GP from Wandsworth who is the Clinical lead for Community services.

6.4 Risks

The main risks, and mitigation actions, associated with the recommended community services model are set out below:

<table>
<thead>
<tr>
<th>No.</th>
<th>Risk</th>
<th>Mitigation</th>
<th>Individual(s) Responsible for Risk Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Changes to staff Job Descriptions will involve a lengthy and complex staff consultation process</td>
<td>Good HR resources, planning and process</td>
<td>Assistant Director, Older People and Neurological Rehabilitation Services</td>
</tr>
<tr>
<td>2</td>
<td>Changing the current</td>
<td>Joint working with the</td>
<td>Assistant Director, Older</td>
</tr>
</tbody>
</table>
|   | Estates model to match the operational structure is important but tricky given the opaqueness of the status quo | Provider and NHS Property Services | People and Neurological Rehabilitation Services
|   | provider and NHS Property Services |   | • Programme Manager
|   | People and Neurological Rehabilitation Services |   | • Director of Delivery and Development
| 3 | Implementation of aligned IT system | Joint working with the Provider. | • Programme Manager
|   |   |   | • Clinical IT Lead Wandsworth CCG
| 4 | Delay in the process of implementation leading to a postponed commencement date beyond 1st April 2014 | Programme and project managers to meet in Autumn 2013 to identify key milestones and outputs. The implementation process will be managed as a project with key objectives to ensure implementation is managed efficiently and ongoing risk at deviating from the expected timeframes and milestones are identified as a risk to both the CCG and the Provider boards with action plans to address this acted upon in an efficient expeditious manner. | • Programme manager
|   |   |   | • Project manager
|   |   |   | • Project support worker

### 7. Conclusion

Following several workshops carried out over the summer and autumn of 2012 it was identified that Adult Community Services Wandsworth delivers a fragmented service. Therefore there was an identified need for a new redesigned model of care.

The CCG will need to consider the Procurement advice note from Capsticks Solicitors and the argument summarising the reasons why it is suggested that it would incur less risk to remain with SGHT as the incumbent Provider with a 24 month contract extension from 1st April 2014 subject to agreed negotiation. In April 2015 the CCG will then need to consider a full procurement process once the quality of services is better understood and there will be
more understanding if the current service is providing value for money under the current block contract.

This extended period of 24 months will place the CCG in a more favourable position for entering into a Procurement process to procuring CAHS. This will ensure better clinical outcomes and a cost effective service. The CCG will work closely with the CSU to negotiate the contract extension and any minor variations that are required especially in relation to implementation and KPI reporting requirements. Finnamore Consultants will work with the Provider and the CCG to assist with the monitoring of performance and activity during this time in order to evaluate the service implementation with the new specification.

Following an options appraisal, it is evident that the favourable option will be to implement the full seven function model with a phased approach. Although implementation will commence officially from the 1st April 2014, the CCG will begin to work with the Provider staff with the support of Finnamore to start preparing staff for transformational change. There will be additional work that can commence once contract negotiations begin, subject to the board approving the specification and the business case to scope out with the Provider the appointment of an implementation team at the earliest opportunity. In addition an implementation plan will need to be devised with clearly defined milestones that will need to be reached during the 24 month period.