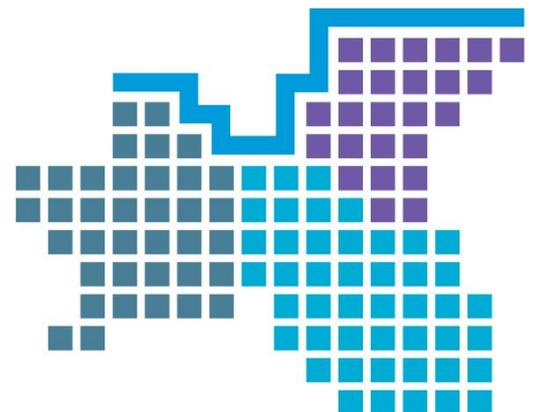


Appendix 1

Impact of 12-13 QIPP Programme

Ruth Eager (Wandsworth CCG)

23 May 2013



Impact of 12-13 QIPP Programme

A total of £8 million was invested in 12-13. This was a direct benefit of the successful delivery of the 11-12 QIPP programme. These investments were made to avoid costs, address cost pressures, to improve the quality of services and to generate savings. This last group were included in the QIPP programme where the savings could be evidenced and attributed to the scheme. These schemes have formed the basis of the monthly QIPP reports to the Board. Delivery of these schemes would be essential in order to invest in future priorities.

The Wandsworth PCT 12-13 QIPP programme has successfully delivered £10.8 million of cash releasing savings. This paper describes the development process of the programme and the benefits realised as a result of implementation.

The programme comprised 29 schemes which were categorised according to the national work streams as described in **table 1**. Individual projects of a contractual nature (some categorised as productivity some as procurement and others as running cost) are listed in **table 2** below. Those with a direct impact on services and patients are described in **table 3**.

This report will describe the impact of schemes which have a direct effect on services and patients. It will not detail ones which have released cash as a result of tendering negotiations (where services are equivalent), reductions in running costs nor schemes where monies are clawed back as a result of challenges to either activity or invoice values.

Table 1 – QIPP Delivery 12-13

BY QIPP CATEGORY 1	Gross Savings Target (£000s)	Gross Savings FOT (£000s)	Costs Target (£000s)	Costs FOT (£000s)	Net Savings Target (£000s)	FOT (£000s)	Variance (£000s)
Productivity	6,058	5,789	60	45	5,998	5,744	(254)
Integrated Care	3,143	3,089	1,455	994	1,688	2,096	408
Procurement	140	-	-	-	140	-	(140)
Demand Management	200	10	-	-	200	10	(190)
Running Costs	880	380	-	-	880	380	(500)
Clinical Overheads	145	94	72	31	73	64	(9)
Reducing Drug Spend	1,918	2,647	18	17	1,901	2,630	729
Unidentified	-	-	-	-	-	-	-
PROGRAMME TOTAL (£000s)	12,483	12,010	1,604	1,086	10,879	10,923	44

Table 2 – Schemes (13) of a contractual nature

Scheme	Description	Target value (£000s)	Realised value (£000s)
GP List Cleansing	This work was carried out in 11-12 and the sum realised in 12-13 is as a result of the phased nature of GP payments.	900	900
General Dental services	Tariff renegotiation for additional activity.	250	10
Secondary Care commissioning, KPIs and High Cost drugs	Claw back due to in year challenges and end of year performance against metrics for these three areas.	2736	2757
Budget Adjustments	A number of adjustment to budget lines where there had been significant underspend plus the potential claw back of over payment to cluster.	880	380
Management Cost Savings	Efficiency savings in community services management.	200	0
Community Dental Services	Re procurement of community dental services to yield efficiency savings.	100	0
Out of Hours (OOH) call Handling	Efficiencies in the procurement of one call handling service for OOH and 111 services.	140	0
Intermediate Care	Renegotiation of contract with provider as part of a larger review of intermediate services.	370	370
You're Welcome	Unused budget.	60	60
Drugs & Alcohol Services (DAAT) productivity	Redesign of services and re procurement productivity.	200	449
Specialist Commissioning	QIPP initiatives led by the specialist commissioners over a range of commissioned services.	834	834

Planning for 12-13

Planning for 12-13 began in September 2011 with a workshop attended by commissioning and public health staff, clinicians, providers the local authority and patient representatives. The aim of the QIPP workshop was to:

- Establish the context of QIPP in 12-13
- Ensure the right people were involved in the development of the programme.
- Outline the support that could be provided in terms of data/information, communication, finance and project management.

For 12-13 it was agreed that there would be a particular emphasis on the quality, innovation and preventative aspects of QIPP. A number of large scale programmes were identified which could form the core of the 12/13 QIPP programme. Larger interventions were required to deliver the fundamental step change needed to deliver significant improvements. They also have the benefit

of being easier to resource than a number of small, unconnected programmes. Whole programmes would also invite and promote greater involvement and integration of effort with other partners such as the Council.

The large scale programmes suggested were:

- Falls Prevention
- Reducing the impact and occurrence of alcohol related disease
- Mental Health – reducing acute admissions and providing better support in the community
- Redesigning sexual health to improve primary care provision and integrate RSH and GUM

It was agreed to build the QIPP programme around investment in three large scale pieces of work that focussed on quality and prevention. These were;

- Alcohol - Interventions for high risk and hazardous dependent drinkers, increased support in the community, additional support for clinicians in primary care.
- Falls and Bone Health- An expansion of the integrated falls service and fracture liaison service, increased resources for the management of bone health
- Sexual Health – Extended HIV testing and additional Long Acting Contraception coverage

It was agreed that plans would extend over three years and it was anticipated that the impact of this work would extend over several years. Presentations were made to locality groups and to the clinical reference group (CRG) leads. The CRG's were seen as key to the delivery of 12-13 QIPP and the development of the 13-14 programme. The lessons learnt from 11-12 on planning, resourcing, communication, data collection, monitoring/measuring and stakeholders/leadership were written up and circulated widely.

The 12-13 schemes not included in **table 2** above are listed in **table 3** with description of patient and service benefits.

Table 3 – Schemes (16) impacting on services and patients

Scheme	Description	Target value (£000s)	Realised value (£000s)
Forensics	Regular assessment of out of borough and high security placements, patients are reviewed more frequently and their care packages adjusted to suit their changing health and rehabilitation needs.	690	871
Prescribing	A programme to encourage the most cost effective use of medicines. Based on clinical evidence, the medicines management team have a work programme supported by use of Scriptswitch, to ensure cost effective use of medicine – switching where appropriate, not prescribing where no clinical evidence exists and increased prescribing for prevention.	1800	2500
Community Ward	Through use of the risk stratification tool, and by observation in secondary and primary care, high risk and high need patients are identified and supported to manage long term conditions. By doing this emergency attendance and admissions are reduced.	293	567

Scheme	Description	Target value (£000s)	Realised value (£000s)
Falls & Bone Health	This programme seeks identify patients at risk of poor bone health and promote good bone health in at risk patients through tools such as education, exercise and prescription of medicines for bone health. Further support is provided for patients at risk of falling and those who have already fallen, though exercise and balance classes and medication review.	313	696
GP Referral Management	A programme to increase the quality of GP referrals into secondary care and promote the full use of community based services. It is supported through education and training of clinicians, practice based software to present national and local guidance, care pathways and referral templates, and formalised peer reviews with trained practice leads.	200	10
Alcohol	A range of secondary and primary care service to help harmful and hazardous drinkers manage their health better, including brief interventions, education for reducing impact of alcohol on pre-existing long term conditions and assisting hazardous drinkers engage with health care services.	65	363
Urgent Care Centre	The establishment of an urgent care centre at the front of St George's A&E will triage and divert patients appropriately - back to their GP (registration with a GP), through to the urgent care centre to be seen by general practitioners – or onward to A&E for more specialist care. All patients seen out of A&E will be treated at lower tariff rates.	271	86
Rapid Diagnostic Pathways	The development and use of the Rapid Diagnostic Packages (RDP) at Queen Mary's to provide a quicker and more convenient pathway for patients	18	13
24 Hour Ambulatory Blood Pressure Monitoring (ABPM)	In response to NICE guidance, the provision of ABPM in a primary care setting. Treating patients closer to home and at a lower tariff.	55	51
Shift of Care & Any Qualified Provider (AQP)	Provision of Dermatology and MICAS services within the community. AQP is The commissioning of services through any qualified provider. Providing increased patient choice and savings through the restructuring of treatments and price.	81	0
Diabetes Service Redesign	The shift of appropriate patients from secondary to primary care for monitoring.	12	0
LAS Alternative care Pathways	Through the use of agreed pathways, patients are conveyed to alternate setting of care rather than A&E.	180	50

Scheme	Description	Target value (£000s)	Realised value (£000s)
Sexual Health	Procurement of the Termination of Pregnancy services, increased HIV rapid testing and increase in the uptake of long acting reversible contraceptives (LARC)	80	(36)
111 Activity	Introduction of the 111 service leading to a reduction in the use of A&E as patients are referred to alternative services e.g. Out of Hours.	59	0
Pelvic Floor Service	Shift from consultant led clinics to nurse consultant clinics supported by multidisciplinary teams.	24	0

12-13 Patient and Service Benefits

This is a description of how patients and or services have benefited from the implementation of projects which also achieved cash releasing benefits.

Forensics

The rationale behind this scheme was to assess patient placements and, where appropriate, move them closer to Wandsworth (where they were out of borough) and to ones more suited to their on-going rehabilitation.

15 forensic patients and one high cost mental health patient have had their placements reviewed and been moved to a more appropriate setting as a result. This move recognises their improvement in health and allows them to make progress in their rehabilitation. Often the move have resulted in a placement closer to home which has further advantages for both the patient and their families.

For 13-14 the work will continue with the focus shifting to high cost mental health and learning disability placements. Forensic commissioning will become the responsibility of NHS England

Prescribing

The volume of prescriptions has been steadily rising year on year while costs have fluctuated depending on the terms negotiated for drugs through the Proprietary Price regulation Scheme. New terms were introduced in 2009 to ensure that the NHS can purchase proprietary medicines on reasonable terms but despite this costs continue to rise as new drugs and technologies being brought to the market are consistently more expensive than the drugs they replace. Waste of unused or partially used medicines is estimated at £30 million per annum in England and this does not include waste through ineffective use (patient non-compliance) and the prescribing of drugs of limited clinical value.

The medicines management team develop a work plan each year that encourages prescribing of cost and clinically effective drugs and encourages the reduction of waste. The work plan for 12-13 included the promotion of generic versions of medicines and the most cost effective presentation (and source) for specially formulated medicines. The plan also contained prevention initiatives/investment that would increase costs – such as the increased prescribing of bone sparing agents to complement the falls and bone health programme but would achieve long term health benefits for patients. Between Feb 2012 and Feb 2013 over 200 additional patients were started on bone sparing agents and 100 patients started calcium and vitamin D.

The Scriptswitch tool used to advise GPs on cost effective prescribing choices as well as local and national guidelines offered an average of 33465 acute challenges and 2175 repeat challenges per month with acceptance rates of 34% and 15% respectively. Scriptswitch has the added advantage of providing GPs with information related to their drug choice together with local and national agreements about the drug's use, such as the most appropriate setting for initiation and patient safety issues.

For 13-14 the workplan will be refreshed using the latest intelligence around new drugs and licenses and will be supplemented by new initiatives on the use of enteral nutrition and fortified foods in care homes. Scriptswitch will continue to be used as an advice tool in practices to inform prescribing decision.

Community Ward

The Wandsworth Community Ward (WCW) was originally started in 2011 and developed out of the virtual ward. In line with the national drive to develop integrated, multi-disciplinary working across the health and social care sectors, and in conjunction with the voluntary sector, Wandsworth Clinical Commissioning Group has commissioned CSW to deliver Wandsworth Community Wards' (WCW) in order to;

- Identify patients that may benefit from an integrated multi-disciplinary approach to their care
- Ensure a collaborative approach to assessing and managing patient's health and social care needs
- Provide for on-going continuity of care.

The principal aim of WCW is to prevent hospital admissions and to keep patients safe and healthy at home. WCW offer the following services;

- Long term/chronic condition management
- Acute interventions
- Safe supported discharge from hospital

Initially the project had experienced difficulties in recruiting. It was only monitored as part of QIPP in 2012 when, as staff came into post, referrals into the service began to rise. During the course of 2012-2013 patient numbers rose from 20 to 200 at any one time with a total of 291 patients benefiting from the service.

Since November 2012 the savings in avoided attendances and admissions and the reduction in length of stay, directly attributed to the ward were first calculated. The methodology for the calculation still needs refining but there is confidence that the figures evidence savings through a reduction in attendances and admissions and reduced length of stay. Alongside these reductions an increase in outpatient appointments can be seen as patients are stabilised.

The benefits to patients in being able to remain at home or return home earlier can be illustrated in the two case studies provided by the service.

Case 1 – Advanced nurse Practitioner (ANP acute visit)

A local GP requested the Community Ward ANP to visit Mrs. T, a delightful 101 year old. She had developed a wheezy cough over the last 24 hours and was generally unwell. Her private carer was concerned and had called the GP. Mrs. T lives alone in a beautifully maintained flat. She had an audible wheeze and was short of breath, and this was unusual for her. She was assessed and examined in a systematic way and diagnosed as having an exacerbation of asthma. Given her

acute condition, a hospital admission was considered. 'Please no, I want to stay at home' was her response. Treatment was commenced at home with the carer's help, nebulised salbutamol was administered with good effect and Mrs. T was started on a 5 day course of steroids and antibiotics. The patient knew she was poorly yet remained adamant she did not want to go to hospital. Her daughter was consulted and happy for her mother to be managed at home. The respiratory nurse specialist agreed to visit Mrs. T later that day and a follow up visit was arranged the following day.

Mrs. T made a full recovery and was grateful for what she called 'the hospital at home'.

Case 2 – Community Ward “in-patient”

Mr. F is a 76 year old, living in sheltered accommodation. He was referred from hospital to the Community Ward. His profound low blood pressure, secondary to his Addison's disease, was making him dizzy and prone to falls. He had developed hospital acquired pneumonia during his stay which had delayed his discharge. The hospital team was keen to get Mr. F home to avoid any further hospital complications. The Community Ward visited daily, monitored his lying and standing blood pressure and adjusted medication accordingly. His medication was titrated until the dizziness and falling was resolved. The family acquired a blood pressure machine and monitored Mr. F's blood pressure over the first week end at home. The Endocrinology Consultant kindly made himself available to take calls from family and advise changes to the medication as necessary.

Effective communication and joint working between the hospital team, family members, the intermediate care team and the Community Ward resulted in Mr. F being safely managed at home.

For 13-14 the ward will benefit from additional support of dedicated pharmaceutical advice. Use of TeleHealth services by WCW patients will continue and be expanded where appropriate. An evaluation of the service is being conducted by external consultants. It will provide a more robust method for evaluating the impact of investment on both patients and health service use.

Falls & Bone Health

Publication of the Falls Prevention, Management and Bone Health Needs Assessment in 2011 concluded that

“While Wandsworth PCT has a relatively young population and the 65 years old and over population is projected to remain constant over the next 5-10 years, for those that do live in the borough there is need around falls and their prevention. Non-hip fractures have been increasing year on year since 2005-06 for both men and women. Considering that research shows that around 50% of people 65 and over that suffer a non-hip fragility fracture go onto have a hip fracture, this is an important factor pointing to the need for intervention strategies. Most recent data shows that admissions for fracture of neck of femur is continuing to increase and is likely to carry on due to non-hip fragility fractures increasing and the population changes expected in 20 years.”

It was agreed that a large scale preventative piece of work would be undertaken to reduce falls and fractures and improve bone health. The falls and bone health initiative had the following aims

- Extension to the existing integrated falls service
- Extension to the fracture liaison service
- Increased capacity for dexameter scans
- Better coordination and communication across the related services
- The establishment of an alternative pathway for the London ambulance service
- Increase public awareness of services and promotion of good bone health

A steering group was established to oversee and coordinate the work. This group comprised commissioners, clinicians, service providers, local authority and patient representatives.

A delayed start to the work has meant that the full year activity has not been realised, however, nearly 1800 patients (an increase of 800) have been referred to and assessed by the fall service with over 1000 (an increase of 300) of these benefiting from the exercise classes. Nearly 500 patients have been referred to the new bone health service with approximately 300 of those benefiting from Bone Boost classes. In addition there have been 300 cases found by the fracture liaison service which is a modest (50) increase on the previous year but achieved without additional capacity. In the first 9 months the project has evidenced a decrease of over 250 patients being admitted to hospital as a result of having fallen.

The steering group have produced a patient information leaflet to raise public awareness of falls bone health and the services available to help.

The Falls Prevention and Bone Health Steering Group have been fortunate to have a patient representative on the group over the past two years.

The patient representative was instrumental in

- Ensuring that the care pathway has been developed with the patient and public's point of view in mind.
- ensuring that all the relevant services are working together e.g. primary and secondary care, pharmacists, London Ambulance Service, Public Health, the voluntary sector and more. From the patients' perspective, poor communication between services can cause stress, misunderstanding and uncertainty.
- Ensuring that patients and the public are fully aware of all falls and bone health services available in Wandsworth and understand how these services can be of benefit to them. This will enable patients to feel confident and relaxed about their care.

Patient satisfaction surveys of those attending classes at the integrated falls service are summarised below together with a sample of comments made.

For 13-14 the steering group is in the planning stages of a Well-being service specifically targeting patients in care homes, many of which will have dementia. The group has also recognised that, whilst the typical patient accessing falls and bone health services is in the over 65 range, there are a number of younger Wandsworth residents at risk of poor bone health and potential fractures. A community pharmacy LES is planned to assess and identify patients in the lower age ranges who might also benefit from these services.

Project Feedback

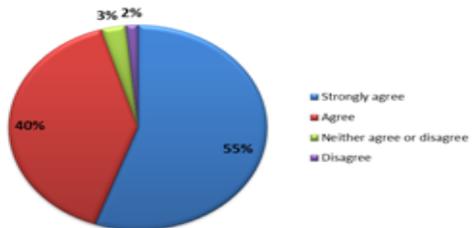
Falls & Bone Health – Patient Survey Nov 2012 (79 patients 65 responses)

Being often just one gentleman “they” always make me as feel included as possible and give me confidence to try things I may not have done at home

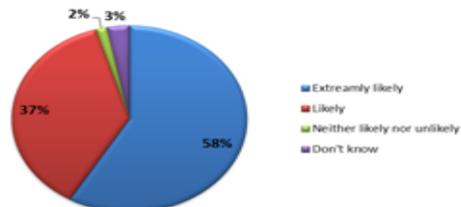
My balance has improved since having the exercise

I am more than content with the services supplied to me

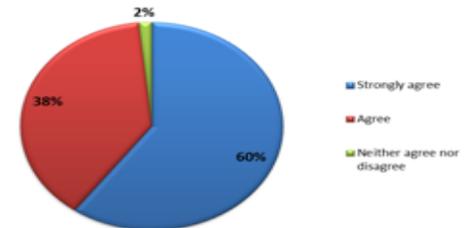
Overall I was satisfied with the standard of treatment I received



How likely are you to recommend the service to friends or family if they need similar care or treatment?



I had confidence in the person that treated me.



I am very happy with the services provided. I would be happier if I could go every week. Thank you very much.

The sessions have been useful and it would be good to have a printout of the worksheets

I am so impressed by the two who facilitate this: always cheerful, always encouraging, create a friendly informal atmosphere but work us hard!

GP Referral Management

The referral management programme was introduced to support GPs in referral decisions. It combines a number of initiatives with the aim of improving the quality of GP referrals, reducing the number of inappropriate referrals and ensuring that GPs and patients have access to the most up-to-date information on local services and pathways. The programme combines the use of education and training with peer review and access to online consultation with secondary care consultants.

The programme took a year to develop with extensive consultation taking place with GPs and patient representatives at various workshops. Education sessions and peer reviews began in the autumn of 2012 and Kinesis (on line consultant consultation software) was launched at the end of October 2012 with 5 specialities. A further 7 have been added in March 2013. Details of the three active elements of the programme are provided below.

Educations Sessions:

GPs were asked to suggest subjects for education sessions. To date, sessions have been held on 'Managing Uncertainty' and 'Paediatrics'. Both sessions have been successful with an average of 84% of Wandsworth practices attending. Results from the GP evaluation forms are given below:

Managing Uncertainty:

1. 77%* would recommend this session to other GPs (please note: the other 23% did not answer the question).
2. 92%* felt that what they had learnt from the session would help them with managing uncertainty in the future.
3. On a scale of 1 to 5 (1= waste of time & 5 = good use of time) 69%* gave the session a '4' and the other 31%* gave a '5' (8%) and a '3' (23%).

**Please note that the percentage shown is from those who completed the evaluation forms.*

Paediatrics:

1. 100%* would recommend this session to other GPs.
2. 86%* felt that what they had learnt from the session would help them with paediatrics in the future.
3. On a scale of 1 to 5 (1= waste of time & 5 = good use of time) 66%* gave the session a '4' and the other 33%* gave a '4'.

**Please note that the percentage shown is from those who completed the evaluation forms.*

Peer Reviews:

A quarterly peer review process has been set up to provide a learning environment for GPs to discuss referral topics. The peer review topics are selected from GP feedback and suggestions from acute providers. By the end of quarter 3 peer reviews had covered:

First peer review: Referral quality

Second peer review: Paediatrics and Dermatology

Third peer review (currently in progress): Musculoskeletal

The peer reviews have also enabled the GPs to give comments on the programme, below are some examples of their feedback:

1. "I/We feel that the principles of the RMP are being embedded in GPs work"
2. "We shared knowledge about appropriate pathways, access to investigations, and entitlement to treatment"
3. "We have daily meetings with doctors where we share concerns regarding patients and referrals – this has made a big difference to the way we work"

Software:

Kinesis, the online consultant advice software has been live since 24 October 2012. Kinesis started with 5 specialties, and a further 7 were added as part of phase 2 in March 2013.

Up to 21 April 2013, 38 Wandsworth practices have accessed the system with a total of 277 advice request messages being sent to consultants. From this we can see that 152 saved referrals have been recorded, which equals a total saving of £28,120. Use has now risen to an average of 6 per day and if these levels are sustained it is estimate that over 800 referrals could be avoided in 13-14 and patients managed in primary care as a result.

We have received comments on Kinesis from the GPs via the feedback button on Kinesis and from

The peer review sessions, please see some examples of this feedback below:

Via feedback button:

1. "Excellent, concise and factual"
2. "I think it will be a useful service which could avoid hospital admissions and delay in management"
3. "THIS IS A FABULOUS SERVICE! It is so helpful to be able to get very quick and personalised advice. Thank you!"

Via peer reviews:

1. "The advent of the Kinesis system has been an excellent way to ensure that referrals are made appropriately and in a timely manner. Invaluable advice has been gained from the use of this system".
2. "We look forward to using the new specialty areas on Kinesis"
3. "We have encouraged GPs to start to use Kinesis – Dr T is the Paediatric Consultant who is a valuable resource to contact about paediatric issues. It may well mean that formal referrals can be avoided through the use of this resource. The specialties available through Kinesis are increasing so hopefully we can start to use this more"

For 13-14 the programme will continue to expand the number of consultants available. Consultants from both Chelsea and Westminster and Kingston hospitals are in discussion with the project lead and their participation is planned for 13-14.

The referral pathway software has been trialled over 12-13. The trial revealed issues that the providers have so far failed to resolve. Further discussion will take place over 13-14 towards developing either a workable or an alternative solution. This enabler was the key to providing GPs with up-to-date information on local pathways and services and will help to ensure patients are positioned correctly within a pathway and have choice and access to all services available.

Alcohol – Admissions Avoidance

This alcohol QIPP program was developed at the request of NHS Wandsworth's management team to reduce alcohol related risk and shift the response to alcohol related harm from secondary to primary and community care. This followed the Joint Strategic Needs Assessment which highlighted the fact that alcohol related hospital admissions had increased. The highlights of the alcohol programme are summarised below.

The alcohol programme was developed with three distinct strands.

Reducing alcohol related admissions and improving clinical outcomes

A service was commissioned to provide interventions for hazardous and harmful alcohol users with high repeat attendances and admissions. The aim was to improve their general standard of health and encouraging them to engage with health services. The intended outcome was to reduce their emergency attendances and admissions (including length of stay) and improve clinical outcomes. Over the course of 12-13 the service expects to engage with over 26 patients (20 in first nine months) which is a decrease on the previous year (where 42 patients engaged with the service) and fails to meet the targets set for the service for 12-13, despite having achieved a reduction in secondary care contact.

Increased primary care engagement with the alcohol harm reduction agenda

A third Fresh Start clinic opened at the end of October 2012, ensuring a service in all three localities. A total of 585 patients were referred and 141 did not attend, and 359 had onward referrals to other services. Of the 444 patients who attended the Fresh Start clinics 140 have completed detox and 70 of those remain abstinent after 3 months.

Reducing alcohol related behavioural and health risk amongst higher risk groups

Assertive outreach with higher risk groups which included offender, street drinker and rough sleepers. This initiative was reported in January as being on target for caseload volume.

A more comprehensive Board Report on the Alcohol programme is available.

For 13-14 the alcohol programme will continue with funding divided between the CCG and the local authority. The CCG will be funding an alcohol liver disease nurse at SGH together with the interventions for harmful and hazardous drinkers. The local authority will take responsibility (through the DAAT) for the remainder of the programme.

The pathway review for alcohol liver disease will inform the wider strategy for preventing liver disease and treating existing patients with the condition. The key recommendation from the evaluation of the assertive case management for repeat attenders has been that the service is reviewed and strengthened through greater clinical input and alignments with the IDAS service.

Urgent Care Centre

There had been a sustained historical trend of continued annual attendance growth at the St George's A&E Department. It was agreed that this level of growth and associated costs was unsustainable in the current economic climate. The Urgent Care Centre (UCC) was commissioned, as part of the new St George's Hospital emergency department, to operate with a fundamental change in philosophy, culture and mind-set about how patients were dealt with when they attend A&E departments to avoid this trend continuing.

The service was to be focussed equally, on providing high quality care to patients, and safely redirecting appropriate patients to be treated outside the emergency department, such as at their own GP Practice.

The Urgent Care Centre (UCC) opened at the front of St George's Hospital (SGH) in the latter half of 2012. The UCC integrated the Tooting Walk in Centre and SGH A&E minors into one service.

It was expected that the UCC would reduce the number of patients attending the new SGH emergency department and reduce the number of admissions from new SGH emergency department.

A patient navigator was provided within the service. Their function was to redirect patients, where possible, back in to primary care services, facilitating GP appointments and registration with a practice where patients were unregistered. Patient Navigator activity began in October 2012. By March 2013 over 1500 Wandsworth patients were redirected out of hospital and back into primary care services. In addition 14 patients were registered with Wandsworth GP practices out of a total of 71 new registrations.

Projects with little or no evidenced outcomes to report for 12-13

Queen Mary's Hospital Rapid Diagnostic Pathways (RDPs)

Wandsworth and Richmond PCTs have been committed to releasing efficiency savings from Queen Mary's Hospital (QMH). Local GPs have worked with the management team at QMH and consultant colleagues to continuously update pathways and booking systems, generating clinical efficiencies that reduce the cost base and increase the quality of service product offered. The increased activity (through activity shifts) improves hospital utilisation which, in turn, reduces overheads for the provider.

The development and use of the Rapid Diagnostic Packages (RDP) at Queen Mary's provides a quicker and more convenient pathway for patients. In 11-12, 2476 patients benefitted from an RDP and target activity was set at 2631 for 12-13. At month 10 (January) 2418 patients had received an RDP with a forecast of 2879 for the full financial year, an increase of 403 on the previous year. Development of new RDPs at Queen Mary's halted in 12-13 use of existing packages increased. In 11-12 the increased activity was achieved through the shift of activity from other secondary care centres. The ACU are currently working through the analysis for 12-13 to determine if the increase has been due to activity shift or increased demand.

24 Hour Ambulatory Blood Pressure Monitoring

New NICE guidelines on the clinical management of hypertension in adults were recommended the use of ambulatory blood pressure monitoring in over 98% of those with suspected hypertension. Numbers requiring this test were likely to increase due to increased numbers identified for blood pressure monitoring from health checks and an increased prevalence of hypertension due to an aging population and changing risk factors. This service, traditionally provided by secondary care, was moved into primary care through the purchase of equipment for GP Practices and the introduction of a local enhanced service.

The NICE template predicted that approximately 400 tests would be carried out per quarter given Wandsworth's hypertension prevalence and population size. 349 patients had been referred into the service by 13 practices during Q1 and Q2. This resulted in a cost avoidance of £20k over the first 6 months of the year with the additional benefits of patients being treated closer to home and increase in the accuracy of the diagnosis of hypertension. Predictions for the year end indicate that the anticipated benefits will be realised with the expected increase in volume of referrals. Data on actual activity to end of March has not yet been validated.

Shift of Care, Diabetes Service Redesign and Any Qualified Provider (AQP)

Shift of Care

Shift of care was originally introduced as part of the out of hospital initiative. Out-patient clinics were provided in the community at reduced tariff. This was originally done in 2010-11. The shift of care work had already released savings in 2011-12 and without an increase in the shift of activity, or a further reduction in tariff no additional savings could be realised. However, patients have benefitted by having services closer to home.

At quarter 3 the dermatology service had provided 1466 new patients appointments (and 389 follow up appointments). This indicates a potential for over 1700 firsts and 550 follow up by the year end.

The MICAS service had provided 1130 new patients appointments (and 365 follow up appointments). This indicates a potential for over 1500 firsts and over 500 follow ups by the year end.

Diabetes

An audit of diabetes patients in secondary care revealed that there approximately 900 patients who could be moved from secondary care services into community or primary care settings of care for monitoring. Although work has already started on the redesign the new proposed tiered model of care will not be implemented until the 3rd quarter of 13-14. Therefore no benefits were evidenced in 12-13

AQP

The goal of AQP is to enable patients to choose a qualified provider where this will result in better care. A choice of provider is expected to drive up quality, empower patients and enable innovation to support the delivery of QIPP. In addition, patients also benefit access of services closer to home and reduced waiting times. Importantly extending choice provides a vehicle to improve access, address gaps and inequalities and improve quality of service where patients/clinicians have identified variable quality in the past.

In 12-13 the PCT agreed to offer MSK services for neck and back to any qualified provider. As the service was not offered for all body parts, the disaggregation of data in order to inform baselines was not possible. In addition, one provider failed to comply with the provision of the minimum data set and this compromised monitoring of the full service provision.

All three projects were effectively removed from the 12-13 QIPP programme as either there would be no cash released or it could not be evidenced in 12-13.

For 13-14 AQP will be expanded to cover all body parts and podiatry services. Adherence to the provision of the minimum data set will be a requirement of all providers in order that performance monitoring can be done. Continued investment is being made in project management support and the development of systems to automate the monitoring process. This will enable the work, both activity and outcomes to be monitored effectively for 13-14

London Ambulance Service (LAS) Alternative Care Pathways

The redirection of patients from A&E departments to alternative care pathways – Urgent Care Centres and Walk in Centres was a London wide initiative. Activity was very low in the first half of the year and this was reported as due to the LAS concentrating on Olympic preparations and the events themselves. Unfortunately activity failed to pick up. In particular the Wandsworth Falls Alternative Care Pathway, despite being agreed, was not implemented.

For 13-14 Wandsworth will continue to monitor figures but it will not be part of the QIPP programme. More work will be done to encourage the use of the falls Alternative Care Pathway.

Sexual Health

Following the paper on the re-organisation of sexual health services, a project manager was appointed to develop an action plan and business case for service redesign. The project manager began with a stock take of all available sexual and reproductive health services and matching those to the needs as defined in the JSNA. From this a number of QIPP initiatives were proposed and a business case prepared for the following initiatives;

- Commissioning of additional LARC in areas of high teenage pregnancy
- Increase in the number of rapid HIV tests carried out
- Renegotiation of the termination of pregnancy services (TOPS)

It was recognised that cash releasing savings would only be realised from the renegotiation of TOPS and the introduction of a new combined sexual health tariff which was being discussed London wide. Neither of these things happened. However, approximately 200 patients benefitted from the fitting of long acting contraceptives and the A&E HIV Pilot at St George's hospital was carried out in Q4. Early indications showed that acceptability by patients was high, however logistical issues prevented uptake of testing. After discussion with SGH it was agreed that the pilot should continue in the Acute Medical Admissions Unit (AMU). Responsibility for this work moved to the Local Authority in April of this year.

111 Activity

The introduction of 111 is a national scheme and was originally set to reduce A&E attendances and admissions through the redirection of patients to other services. For this reason it was put in the QIPP programme with savings estimated from national predictions. However, during the course of the year an evaluation of the first year of four pilot sites conducted by the University of Sheffield (published August 2102) which found that

“.....there was no statistically significant change in emergency ambulance calls, emergency department attendances or urgent care contacts/attendances.”

And amongst its conclusions were the findings that

“One year after launch, the pilots had not delivered the expected benefits in terms of improving satisfaction with urgent care or improving efficiency by directing patients to urgent rather than emergency care services. There was evidence of a reduction in calls to NHS Direct but an increase in emergency ambulance incidents.

The primary economic analysis based on the pilot site activity identified a low probability of cost savings to the emergency and urgent care system. However, a simplistic analysis of the national implementation of NHS 111, with the service replacing the NHS Direct 0845 service and handling

all GP out of hours calls, showed that NHS 111 may result in cost savings to the NHS. This is based on considerable assumptions and limited cost data. “

Therefore, on this basis it was decided to remove 111 from the QIPP programme until savings could be conclusively evidenced from Wandsworth CCG data. The ACU are currently coordinating the analysis of emergency attendance and out of hours activity and it is hoped that this can be used to evidence the effect of the 111 service.

Pelvic Floor Service

Following collaboration with St Georges and Sutton & Merton a new incontinence pathway has been agreed and a nurse consultant clinic supported by a multidisciplinary team (MDT) was jointly commissioned with Sutton & Merton PCT. Despite the possibilities of an increase in the follow up rate (as some referrals will need to go to MDT and then on to specialist consultant), savings were expected through a reduced tariff. A significant improvement in the patient experience was also expected through quicker referral to the correct specialty. Recruitment issues at St George's hospital prevented this service from being offered in 12-13. Sutton & Merton have since decommissioned the service. Wandsworth CCG is awaiting the outcome of SGH recruitment.

QIPP 13-14

Planning & Delivery

Wandsworth have been fortunate that the large scale three year plans for Alcohol and Falls & Bone Health, put in place during 12-13 are delivering to target. These projects, together with prescribing and the community ward, form the back bone of the 13-14 Wandsworth QIPP programme.

Early in 12-13 it was agreed that QIPP should be embedded in the work of the CRGs. The establishment of the Business Intelligence Group also ensured that invest to save projects were clearly identified in one forum and could automatically be incorporated into a rolling QIPP Programme.

The target set for QIPP is a cash release of £9.8 million. The programme, which was approved by the board as part of the operating plan, is summarised below in **table 4**. The planned over performance militates against risk to delivery.

Future development of QIPP projects will be through the work of the CRGs. Monitoring of QIPP will be done through the proposed delivery group, where productivity savings as well as outcomes for patients will need to be evidenced as part of the metrics set for the project.

Quality

Metrics have been established for all investment projects. These are proportionate to the investment being made and will include quality and patient experience where possible. These will be monitored on a monthly (or more appropriate basis) and more detailed reports will be required on a themed basis. In addition, regular quarterly meetings have been arranged with the PALs and Complaints team to ensure there are no issues relating to the QIPP initiatives.

Risks to Plan

A detailed table of risks and mitigations at a project level was published in the operating plan. On a programme level there are risks associated to the delivery and/or evidence of savings. These are

- *Lack of NHS numbers in SUS data*. This has traditionally been used to supplement the top level analysis of secondary care activity to attribute affect directly to a project. This is particularly important when a number of projects seek to impact on the same thing. In particular, the community ward analysis had relied on this approach to evidence savings in secondary care and NHS numbers will be vital if the analysis is to extend to primary and social care. The proposed work around has yet to be trialled, but on first glance it will increase the work required in order to produce the current reports.
- *EMIS data extractions* are no longer possible. This effects the monitoring of a number of primary care initiatives some of which fall under the QIPP programme.
- *The newly proposed delivery group* will be performance monitoring all projects. It will take time to be established and there is a risk that the current granularity of data and information would be compromised due to the volume of CCG projects being monitored

Table 4 - QIPP Plan 13-14

PROJ. DESCRIPTION	NET SAVINGS			NET FOT (RAG RATED) (£000s)	SLIPPAGE COMMENTS:
	Net Savings Target (£000s)	FOT (£000s)	Variance (£000s)		
Prescribing	2,675			G	
Community Ward	1,414			G	
GP Referrals	97			A	Delays in implementation of referral pathway software could impact on delivery
Falls and Bone Health Programme	273			G	
Admission avoidance for harmful & hazardous drinkers	428			G	
Urgent Care Centre Navigator	246			G	
Other LTC work	250			R	Rehabilitation projects still in negotiation with provider. Tariff yet to be agreed which will impact on savings potential
KPIs and Challenges	2,400			G	
High Cost Drugs	100			G	
Mental Health & LD HCP (including some forensics)	500			G	
Continuing Care Packages	370			G	

PROJ. DESCRIPTION	NET SAVINGS			NET FOT (RAG RATED) (£000s)	SLIPPAGE COMMENTS:
	Net Savings Target (£000s)	FOT (£000s)	Variance (£000s)		
Budget Adjustments	333			G	
Other efficiency savings	400			G	
Management Cost savings - QMH	500			A	Still in negotiation
OOH call handling	300			G	
Translation Services	200			A	Still in procurement stages
Pathology Full year	150			R	Slippage in scheme will result in reduced savings
AQP	100			A	Increased demand for services could mitigate against productivity due to restructuring of treatments and price.
Mental Health Review	500			R	Still in negotiation
Dementia	117			R	Memory assessment service will start mid-year
Unidentified	-			R	Not relevant
	11,353				