NHS
Wandsworth
Clinical Commissioning Group

5 Year Plan for Out of Hospital Care for Adults – Doris' Story

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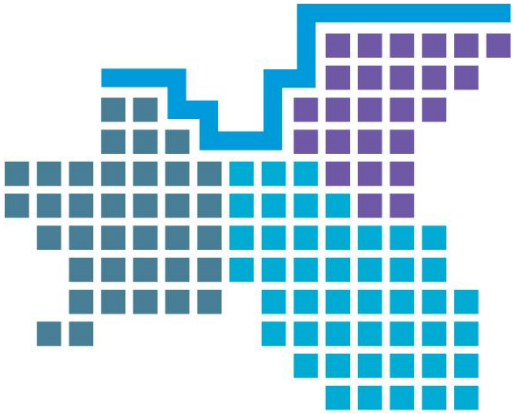

1. Introduction

1.1 Background

Providers and commissioners are facing an uphill struggle to provide high quality care to an ageing, growing and increasingly diverse population. There are very clear indications that the existing system is increasingly pressured, with A&E activity, outpatient appointments and emergency admissions on the rise nationally.

A system-wide transformation of acute and out of hospital care is needed to ensure that services are configured to best meet changing needs. More care, especially for patients with minor illnesses and long term conditions (LTCs), needs to be provided closer to home wherever possible. This will be achieved through improvements in the quality, capacity and consistency of care delivered out of hospital.

The aim of this plan is to describe the approach which Wandsworth Clinical Commissioning Group (CCG) will take in redesigning out of hospital services across the Borough. The plan will be an iterative one, which will evolve throughout the next 5 years as the CCG continues to engage and consult with patients, the public and other stakeholders.

The following narrative describes how out of hospital care in Wandsworth will be optimised for Doris, an elderly patient living in the Borough over the next five years. This document should be read in conjunction with the detailed plan which sets out the steps that will be taken throughout 2014/15 and 2015/16 to achieve our longer term aims.

1.2 Local Context

According to the Wandsworth Joint Strategic Needs Assessment (JSNA), in 2010 there were approximately 91,000 people with one or more LTCs living in the Borough. A refresh of the JSNA is due to be published in the next few months, however early drafts indicate that multiple long term condition prevalence has increased. According to the Projecting Older People Information System (2012) the population of over 65 year olds living in Wandsworth is set to rise by 42% by 2025: The Department of Health (2010) estimate that 3 out of every 5 people over 60 in England suffer from at least LTC, with the treatment and care of people with LTCs accounting for around 70% of total health and social care spend; the increased burden of ill health in Wandsworth over the next 5-10 years is therefore likely to be significant.

In 2013/14 the Planning All Care Together Programme served as one of the key vehicles through which Wandsworth CCG delivered significant change in the way that care for patients with LTCs is provided in the Borough. Other innovative initiatives such as the

Wandsworth Community Wards and the Falls and Bone Health Programme have also been critical in enabling Wandsworth to achieve the lowest overall emergency admission rates in the country.

Despite these successes, analysis shows that Wandsworth patients admitted to hospital with an LTC have a longer length of stay (LOS) than the national average (JSNA, 2010). For the over 70s population, Wandsworth has 16% more admissions per head than the South West London average and spends 33% more per head on non-elective acute care than Richmond CCG (which spends the least). It therefore remains clear that in order to deliver the system changes needed over the next 5 years at the pace and scale required; it is necessary to develop a more strategic, long term and joined up approach to the commissioning of health and social care in Wandsworth. This is particularly important in light of the financial constraints under which we are increasingly required to operate. To this end, our ability to demonstrate increased productivity across all areas of service redesign will be vital to ensure we can continue to meet the growing health needs of our population.

Integrated Care

There is a significant and growing body of evidence which suggests that achieving closer integration between health and social care is central to the challenge of improving outcomes for patients and service users and reducing pressures on secondary care. Curry and Ham (2010) state that integration is especially important for people with long term conditions (LTCs) and older people whose needs are rarely just 'medical' or 'social.'

The Better Care Fund is a government initiative that will provide £3.8 billion nationally towards the development of joined up health and social care services in England. Wandsworth CCG have identified this as a critical enabler in their Out of Hospital Five Year Plan and have already made significant headway in agreeing the budgets and services that will be pooled with the Local Authority as part of this integration campaign.

1.3 Vision

The Wandsworth CCG '5 Year Plan for Out of Hospital Care for Adults' aims to both integrate and streamline out of hospital services care, improving patient satisfaction and quality of care and bringing services closer to the community. Ultimately we will make health care more efficient and therefore more sustainable as pressures increase in the long term.

The approach which Wandsworth CCG will take in making this vision a reality can be illustrated using a tiered service model (see Figure 1). In this model, primary care will take a pro-active and anticipatory approach to managing the majority of patients, whilst a variety of self-management programmes will be available to empower and give confidence to those

patients that need some additional support in managing their care at home. Rapid access, seamlessly integrated community services will be available via a single point of contact when required and whilst reliance on urgent care services should be significantly reduced, those services that exist will be more accessible and efficient, with linkages into all the other tiers of service.

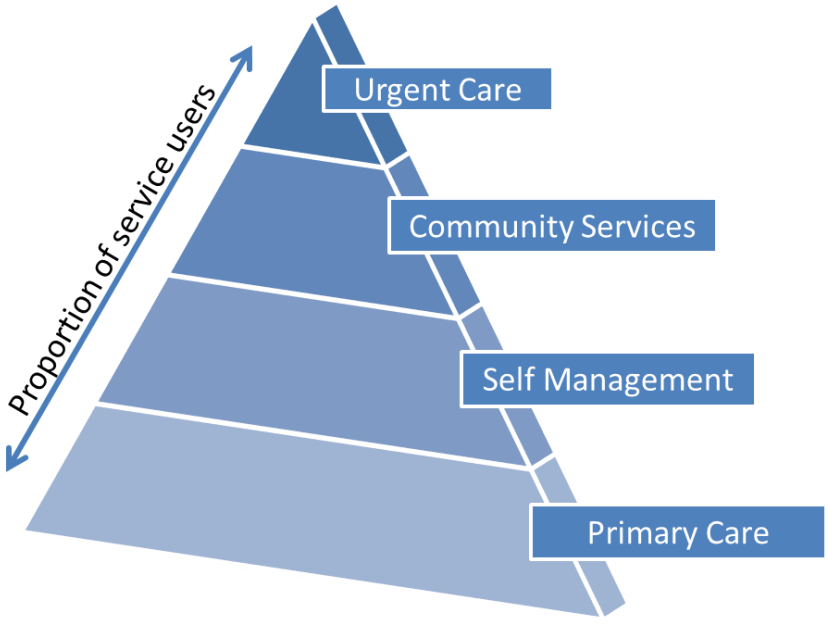

Figure 1. Wandsworth CCG tiered service model

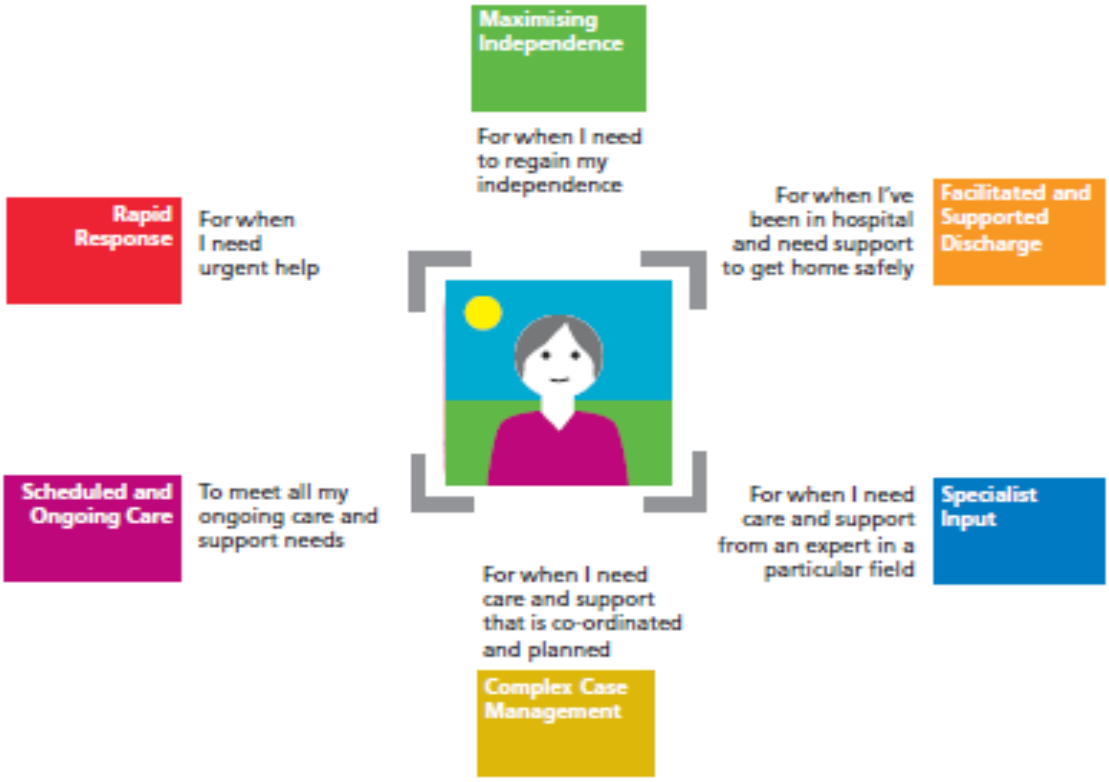

Figure 2. The world according to Doris – happy and healthy at home

Overall, the Wandsworth CCG '5 Year Plan for Out of Hospital Care for Adults,' comprising these 4 elements, will equip patients with the skills and confidence to be able to better manage their conditions at home, by providing high quality supporting services which place them at the centre of the health and social care system (see Figure 2).

The following narrative will illustrate our vision for services through the eyes of Doris, an elderly patient living in the Borough, who is deemed to represent the expanding group of patients with one or more LTCs, whose care this plan will primarily address. The account that follows will be backed up with a detailed service plan, setting out the funding requirements, the outcomes expected and the evaluation and reporting mechanisms that Wandsworth CCG will employ to make this plan a reality.

Doris' Story – April 2018

"I was talking to my daughter recently about the huge change there has been over the last couple of years in the care and support I receive. I am 85 years old, and have lived in Wandsworth for most of my life. The past ten years since my husband died have been a struggle. I have lived with diabetes for twenty years, and now have heart and breathing problems as well. If that were not enough, I've been getting a bit confused at times.

Since last year though, things have got a lot better. The main difference has been Penny. I think she is a nurse, and her main job is to co-ordinate the care I need. I still see some different people, but they all now seem to have an up to date picture of how I'm doing. I still regularly see a physiotherapist, and a social worker, and a mental health man has started to visit. They've recently added an extra carer visit, so I now see somebody who helps me with meals and things three times a day. Penny says that most of them are now based in an office nearby, so there is only one number we need to phone if there's a problem. The person who answers the phone is really helpful, and will always put me in touch with somebody if Penny is not there.

The great thing is that I've not had to go to hospital, except for appointments for the past twelve months. The year before I was taken in three times, twice in the middle of the night. When I got out of the ambulance and into hospital, nobody seemed to know much about me, and it looked to be a real struggle to make arrangements to get me home. They were also talking about me maybe needing to go into a care home, but that seems to have stopped now.

I see my GP every two months, and she says that this new system is fantastic. She works closely with Penny and her team, and says she knows I will get the help I need if there's a problem. She also says it makes her life a lot easier, and that Wandsworth does this better than most places. I always used to think the people I saw talked to one another. It's so much better now that they do."

2. How are we going to get there?

2.1 Primary Care Transformation

2.1.1. Case for change

'Clinical Commissioning Groups have a statutory duty to assist and support the NHS Commissioning Board in securing continuous improvement in the quality of primary medical services.'

According to the Primary Care Case for Change (2013) General Practices are now under unprecedented strain due to rising demand, higher expectations and tighter financial settlements. There is a need to change the way that primary care currently operates if it is to have the capacity and the skill to manage complex, high risk patients effectively in the community and support the drive to reduce expensive and unsustainable secondary care activity.

Transforming primary care has therefore been identified as a critical enabler to the overall '5 Year Plan for Out of Hospital Care for Adults' and will be key to ensuring that our vision of 'better care and a healthier future for Wandsworth' can be realised.

NB: For the purposes of this paper the term primary care will be used to refer to general practice services only.

2.1.2. Vision

Doris' experience of Primary Care - May 2018

"I rang my GP Practice the other day because my hip has been hurting again – it's never been quite right since I fell a few years ago. My daughter often pops in to see me during the day so I was really pleased when the receptionist said I could have an evening appointment that week.

I see my GP for regular check-ups anyway as I have quite a few health problems – he goes through my care plan with me and my list of medicines to check how I am managing and always explains things in a way that I understand. I used to have to go to the hospital to have various tests done but it has been so much easier since the practice started doing these themselves. Often I don't even need to come in to the practice to get my results but speak to my GP on the telephone instead.

On this occasion my GP said that I might need a referral to outpatients, he said that he was going to email a consultant for some advice and would call me the next day to let me know what was suggested. As it turns out I do need a referral to orthopaedics; my GP explained the process to me over the phone and asked which hospital I would like to go to. I always say I trust him to make the best decision about where I go but it is nice to be asked!"

In 2013/14 Wandsworth CCG introduced the Planning all Care Together (PACT) Contract, an innovative programme, which supports GPs to be able to spend more time with their most vulnerable patients. Evidence from elsewhere in the UK shows that this 'care planning' approach can significantly reduce the number of times a patient has to be admitted to hospital in an emergency when rolled out as part of an integrated health care system. Over the next 5 years, Wandsworth CCG will continue to implement and evaluate this model of care as a core part of the out of hospital plan.

To ensure that general practices have the capability and capacity to meet the challenges facing them and to manage more complex patients effectively in the community; Wandsworth CCG also plan to invest in a series of workforce training and education events and a quality improvement programme which will help to raise the bar of quality in general practices across the Borough.

2.1.3. Expected Outcomes

Over the last 12 months, management consultants Finnamore have worked with clinical leaders and service redesign teams to map benefit delivery for key elements of the five year programme, linking commissioning interventions (such as the PACT contract) to service user outcomes.

Through this benefit mapping process we can identify that the value of the PACT LES to Wandsworth CCG is twofold; The interventions will enable community based services – in particular the redesigned Community Adult Health Services (CAHS) – to accommodate patients with complex needs and manage them out of hospital. Over a longer time period, the interventions will also reduce total demand for all care services through improving wellbeing and maximising the capability of individuals to self-manage, as described below.

2.2 Patient Self-Management

2.2.1. Case for change

Self-management and the drive to increase choice, control and personalisation has been a consistent feature of NHS policy since 2000. Recent key policy documents include:

- The DH Operating Framework 2013/14 where the key indicators include measuring whether people feel supported to manage their own condition;
- QIPP: Quality, Improvement, Productivity and Prevention 2012: QIPP has identified self- care/shared decision-making as one of three key principles which it considers to be the fundamental features of all best practice long term condition care programmes both in the UK and abroad.

In addition there is a growing body of evidence demonstrating the positive impacts that self-management can have; on patient experience and quality of life, on adherence to treatment and medication and on reducing demand for health care resources through reductions in unplanned hospital admissions, (The Health Foundation (2011), Challis et al (2010), Purdy (2010)

2.2.2. Vision

Doris' experience of Self-Management - June 2018

"I recently went on an expert patient course to help me manage my long term health issues. My GP told me about it and it really has inspired me to take control of my conditions and learn what I need to do to stay healthy and independent for as long as possible. The course was run by a lovely lady who also had experience of living with long term health problems, which meant I could really relate to her.

Some of the changes I need to make are going to be quite difficult to stick to but I am certain that the action plans we came up with and the friends I made on the course will support me. The course lead also told us about a website where we can find out about lots of different community support groups. I am going along to my first one at our local church next week.

I am amazed at how much technology there is available now to help me manage my health at home. I get automatic reminders about all my appointments and even when I don't have an appointment in the diary, I get reminded that I need to make one when my check-ups are due. My GP has also arranged for me to have one of these little telehealth boxes; I put my daily test results into it and they get sent off to a team of doctors and nurses who can check if I am doing ok."

The last 12 months have generated significant learning around what a successful self-management programme should consist of. As a result of this learning, the Wandsworth Self-Management programme has been redesigned for 2014/15, with key elements of the proposal as follows:

- Comprehensive informatics systems and access to information around local resources both traditional both in the community, voluntary sector and nationally
- Peer support networks through self-help groups and other mechanisms
- Involvement of the assets and the resources in the Community and voluntary sector
- Supporting self-management training (SSMT) for healthcare professionals
- Education and training that allows lived experience tutoring for professionals
- Condition-specific programmes for education for the public also with lived experience
- Using technologies to deliver access to resource and information and training
- Recognising the specific needs of critical groups such as carers, faith, cultural and community groups and isolated individuals

It is expected that these service elements will be delivered via an internal team called the Wandsworth Self-Management Service Hub. The Hub will provide a single point of contact for residents of Wandsworth and health and social care organisations to be signposted to and access the full range of self-management resources and will emulate some aspects of the original Wandsworth Care Line service.

A major role of the Hub team will also be to market the self-management service, ensuring a broad programme of community engagement across Wandsworth as well as organising courses and ensuring they are attended by patients who are ready to self-manage.

2.2.3. Expected Outcomes

As described in section 2.2.1, increasing patient self-management underpins the projected benefits of a number of the redesign elements of this plan. Outcomes from the self-management services will not therefore be delivered in isolation, but will support the overall aim of the 5 year plan to reduce secondary care usage.

Specific benefits to patients expected as a result of this investment into self-management are as follows:

- Enhancement to quality of life as a result of better disease management
- Care in the home promoting greater patient independence
- Reduction in patient anxiety and improved confidence to self-manage
- Reduction in unnecessary and inconvenient travel/visits
- Improved medication compliance and management of complex drug regimens

2.3 Community Services Transformation

2.3.1. Case for change

It is well recognised in the literature that as populations age, they experience more complex health issues and demand for healthcare increases. Continuing to treat patients in acute hospital settings is therefore not only inappropriate for patients but is more expensive and so ultimately unsustainable.

The consensus view from stakeholders in Wandsworth Borough is that the current adult community health service needs to be more cohesive and accessible to enable patients to stay in their own homes for as long as possible. There are also key service gaps which result in unnecessary A&E attendances as well as unplanned emergency admissions.

Transforming Community Adult Health Services has therefore been identified as essential in achieving our ambitions for out of hospital care.

2.3.2. Vision

Doris' experience of Community Adult Health Services - July 2018

"My care co-ordinator Penny has made such a difference to me over the past couple of years. She is always on the other end of the phone when I need her and makes sure I know who I can contact to get help when she isn't in the office. She helps me keep my care plan up to date and is great at making sure that everyone I see has an understanding of how I'm doing.

Last winter I caught a nasty cold and my breathing problems became worse. The GP that I saw recommended that I should be admitted to hospital for a while but I really didn't want to leave home. Instead Penny was able to organise a meeting where a team of doctors, nurses and social workers discussed my care and agreed to provide me with support so that I could be treated at home with regular visits from a variety of professionals. I am back to normal now and so grateful to the whole team for working together to help me stay at home despite the obstacles."

Over the next 5 years Wandsworth CCG intends to work closely with Wandsworth Borough Council to redesign community health and social services so that excellent care can be delivered in people's own homes wherever possible, by a multi-professional, multi-agency, local health and social care team.

Wandsworth envisage that these teams will be co-located in 4 localities across the borough and will operate seamlessly, 7 days a week to provide person centred, pro-active case management of adult service users. This will be achieved through a reorganisation of the existing services into functions, as shown in Figure 2.

Staff will work across each of the functions to ensure continuity of care and each function will contain an out of hours component, accessible via a single point of contact to ensure maximum effectiveness.

2.3.3. Expected Outcomes

As a result of this redesign Wandsworth expect that Doris will be supported to remain in her own home for as long as possible, her contacts with the hospital will increasingly be planned in advance and she will receive faster access to domiciliary care.

Evidence from elsewhere in the UK suggests that this will result in fewer A&E attendances and emergency admissions, fewer nursing and residential placements with comparatively more resources available for home based support. The Better Care Fund will be used to provide impetus to the investment plans over the next few years.

2.3 Urgent Care and General Practice Out of Hours

2.4.1. Case for change

Improving access to Primary Care has been a government priority since 2008 when the Directed Enhanced Service (DES) for Extended Hours was introduced. For 2014/15 the DES seeks to promote greater innovation in how practices offer extended hours. Although the detail is not yet known, NHS England is keen to explore new ways of offering access to services in order to better meet the needs of the local population.

Wandsworth CCG recognises that general practitioners play a crucial role in co-ordinating chronic disease management, health promotion, diagnostics and early intervention and as such are the bed-rock of a cost-effective healthcare system. Redesign of the way in which and timeliness in how and when primary care medical services are accessed is therefore a lynch-pin for the success of the major transformational change to out of hospital care that is envisaged over the next 3-5 years.

Whilst the emphasis on extended opening hours stems in part from the assumption that faster access to general practice will result in fewer A&E attendances and expensive hospital admissions. It is also acknowledged that this care may not always be required within the normal “core” working hours and interventions will take place from providers that are possibly not familiar with the patient. It is therefore essential that an effective, accessible and seamlessly integrated out of hours and urgent care service is available to prevent the most vulnerable patients from slipping through the gaps (NHS England, 2013).

2.4.2. Vision

Doris’ experience of Urgent Care – August 2018

To be honest I haven’t needed to go into hospital at all over the last 12 months (except for planned appointments). Obviously Penny has made a big difference but also being able to see my GP during the evening and at weekends has improved things and I feel more confident knowing that the practice will give me an on the day appointment if I need it.

The one time I did start to feel really poorly at night, I called 111; the lady I spoke to asked some very simple questions and put me through to a healthcare professional almost immediately. They decided that a GP needed to come and visit me at home and I was so impressed with how quickly she arrived. Not only that, she already knew all about me and my conditions and was able to access my medical records to see what medications I was taking.

I have a friend who has been to our local urgent care centre recently having had a fall. She said it was so much better than going to A&E – she didn’t wait long at all to see a doctor and that once they had patched her up, they were able to book her an appointment at her own GP surgery later that week for a follow up.

In 2013/14 Wandsworth CCG launched an integrated 111, urgent care and general practice out of hours service which also includes; a single point of contact, through which healthcare professionals can access the Wandsworth Community Adult Health Service, Co-ordinate my Care, a system which enables better co-ordination of care for patients at the end of their lives, provision of in-hours GPs at the St George's Urgent Care Centre along with out of hours GPs at a number of community clinics operating until 10pm each day of the week.

The CCG will continue to develop and improve this model through a review and re-launch of an access to primary care contract which will; enable better integration between in hours primary care and the out of hours service, support the drive for seven day working in general practice by increasing the number of practices offering weekend and evening appointments and make it easier for patients to obtain an urgent appointment at their local surgery when needed.

2.4.3. Expected Outcomes

Over the next 5 years Wandsworth CCG expects that the integrated urgent care and out of hours model will reduce the pressures on local A&E departments by ensuring that patients are able to access high quality alternative services rapidly when needed.

Patient experience will improve as the various urgent care services operate seamlessly to ensure that they are treated in the right place, at the right time and the number of ambulance call outs will be reduced, leading to an overall improvement in response times. As a result of better linkages between services, unnecessary emergency admissions should also reduce leading to a decrease in the number of frail elderly patients occupying hospital beds unnecessarily.

3. Enablers

3.1 Patient and Public Involvement

Patient and public involvement (PPI) is a core duty of the CCG and has been embedded throughout each of the work-streams that have inputted into the '5 Year Plan for Out of Hospital Care for Adults.' This engagement work has been carried out through a variety of mediums including:

- PPI representation on CRGs
- Presentations and workshops with locality patient groups
- Workshops with the general public
- Patient surveys

- Community roadshows

To ensure that the level of engagement continues, the PPI team at the CCG, in conjunction with the PPI Reference Group, has identified the following areas of focus for 2014-16:

Initiatives	Activities	Outcomes
Patient and Public Involvement (PPI) in Commissioning Strategies and Planning.	Roll out of innovative engagement processes (e.g. Patient Panels, Deliberative Events, Focus Groups, Online Surveys) to obtain patients views and service user feedback to inform the priorities and development of the Commissioning Strategy Plan of the CCG.	Patient voice and their experience inform commissioning decisions and integration of services.
PPI in the CRGs and Locality Developments.	Training/conference/workshop of Patient Representatives to develop their competency on effective PPI and their representation of the patient voice at different levels. This supports the CCGs strategic requirement for individual and collective participation e.g. Call to Action for patient and public participation.	Visible PPI in service specifications of commissioned services and in the performance management of contracts.
Seldom Heard Groups (Grant scheme to support involvement of seldom heard groups: Men's health Groups).	Support further 10 community and seldom heard groups with the view to develop their skills and capacity to run activities to increase awareness of issues experienced by specific groups and increase their engagement with community services.	Improved patient experience and access of community services to maintain care. Embedding of equalities and diversity into PPI.
Community road shows.	Work with an independent provider to run community road shows to raise awareness of and obtain feedback about Wandsworth community services (10 further road shows for 2014).	Reduction in emergency hospital admission and maintaining quality care in the community.
Embedding of equalities and diversity into CCG works.	Training to support staff competency on equalities and diversity and on carrying out equalities impact assessment. Ensure the embedding of equalities and diversity into all Board Reports and commissioned services.	Reduce health inequalities in access to community services by diverse population with higher and complex needs.
Youth Health Jury resources + Facilitator.	Roll out series of monthly "health jury" meetings and focus groups to engage young people.	Improved patient experience and access of community services by young people.
Peer mentoring project- Children and Young People.	Commission an independent provider to provide training on peer mentoring. The training is aimed to develop the skills of young people through the Youth Health Jury membership to enable them support other young people to develop their resilience, self-esteem and confidence. 25 young people trained per school in 10 schools for the one year and roll it out in other schools for the following year.	Improved patient experience of young people in access of community services. Reduce admission of young people in acute mental health services.

In addition to this investment into PPI in commissioning, we want to ensure that feedback is captured throughout the patient and service user experience of out of hospital care in Wandsworth. Examples of how we are doing this include:

- Launch of the Make a Difference (MAD) button – which enables GPs to raise minor concerns from patients about providers directly with the CCG
- Piloting of the Friends and Family Test across general practices, with a view to roll out to all services if pilot results are positive. This test is already used extensively at St Georges Hospital on impatient wards and in A&E
- Patient experience surveys conducted across all areas of service re-design

The '5 Year Plan for Out of Hospital Care for Adults' is an iterative document and can be revised as required. As part of the quality strategy, a series of workshops will be held during 2015/16, through which additional feedback from patients, the public and other key stakeholders will be captured and used to inform development of the next iteration of this plan.

3.2 Clinical Leadership and Localities

The CCG is a membership organisation and as such needs its members to contribute as fully as possible to commissioning high-quality and cost-effective services. Each of the initiatives in this out of hospital plan have been developed by clinical leads and a core requirement for the successful implementation of this plan will be for the current level of clinical input to be maintained.

We currently have a number of Clinical Reference Groups (CRGs) that are clinically led by a Wandsworth GP. In addition, there are two Locality Pathway GPs for each CRG whose role it is to reflect the needs of the locality in the CRG plans. At any one time we have more than a dozen CRGs, which are multi-disciplinary in design, as well as other clinically led task & finish style groups

The function of CRGs has been documented by the Dept. of Health as being a good practice model and we have had wide-ranging success with the model so far, for example:

- clinicians designing a comprehensive referral management programme
- local GP leadership of the development and design of the SGH Urgent Care Centre
- GP leadership of the implementation of the 111 service which drew national praise and has been put forward for regional innovation awards

- effective input into acute contracting of SGH to ensure clinical quality is at the heart of services commissioned
- a substantial reduction in the number of new fallers owing to a complete end-to-end pathway which was developed by a number of clinicians

In addition to clinical leadership through CRGs, the three locality managers, plus admin support, are the CCG frontline to primary care. Working with the locality lead GPs, they keep members engaged in the CCG, seek out new opportunities for member development, direct queries and manage and co-ordinate the locality patient groups.

3.3 Communication and Engagement

The delivery of an effective communications campaign will be vital to realising Wandsworth CCGs vision for out of hospital care. As the national (and not consistently evaluated) 'Choose Well' campaign has been discontinued, Wandsworth CCG has the opportunity to develop a fresh campaign approach to encourage appropriate use of services, building on best practice, insight and targeted communications and engagement activities to deliver behaviour change.

The overarching aim of the campaign in Wandsworth would be to reduce the number of individuals from the general population and targeted groups using acute services inappropriately and to encourage use of alternative services and self-management.

Evaluation of an existing campaign of the type envisaged for Wandsworth in 2014/15 showed that **40%** of residents recorded recognition of the campaign, with **58%** saying that it would make them likely to change their behaviour should they need to access urgent care services (http://www.wandsworthccg.nhs.uk/newsAndPublications/Pages/YellowMenEvaluation.aspx).

4. Governance

A programme management approach, employing both clinical and managerial leadership will be used to oversee progress of all the initiatives within the out of hospital plan.

The overall plan will be monitored against a set of quality, activity and patient satisfaction metrics developed to reflect the overarching aims. Reporting against these metrics will be incorporated into the monthly monitoring cycle for the CCG Delivery Group. The out of hospital programme manager will be expected to attend the Delivery Group meetings as required to discuss any performance issues and provide relevant narrative.

Progress updates will also be provided at the following meetings:

- Clinical Leads Meeting: Monthly progress update
- CCG Management Team: Quarterly progress update
- CCG Board: Annual update

As set out in section 3.1, feedback from patients and the public has been central in the development of this out of hospital plan and the CCG has made significant provision to ensure that patient experiences are captured and reflected throughout the implementation process of individual initiatives over the next 5 years. In addition a series of workshops will be held during year 2, through which feedback from patients, the public and other key stakeholders can be captured and used to inform development of the next iteration of this plan.

5. Monitoring and Evaluation

As described in the previous chapter, a robust reporting and monitoring system will be implemented to provide the CCG Board and key stakeholders with assurance about progress in implementing this plan.

Each of the initiatives will be (or already have been) allocated KPIs against which they will be monitored and evaluated (these will be agreed in conjunction with the business intelligence team). Project managers will be responsible for developing and updating project workbooks, which set out the achievements against these KPIs on a monthly basis, as well as the key project milestones, the expected and actual investment and any savings forecasted for the project.

Management consultants Finnamore have been commissioned to support the CCG in evaluating the large scale investments outlined in this plan and the Out of Hospital programme manager will be responsible for collating the project workbooks into a single out of hospital evaluation framework.

The out of hospital plan as a whole will be monitored on a monthly basis against a set of overarching KPIs, agreed in conjunction with the performance team. Activity trajectories are currently being mapped using baseline data, which will enable rapid evaluation of the plan against the expected activity at any given point in time.

In addition, a series of quality related KPIs are currently being worked up which will enable the CCG to evaluate the overall impact of the plan on quality of care and patient experience.

6. References and Further Reading

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