

5 Year Plan for Out of Hospital Care for Adults

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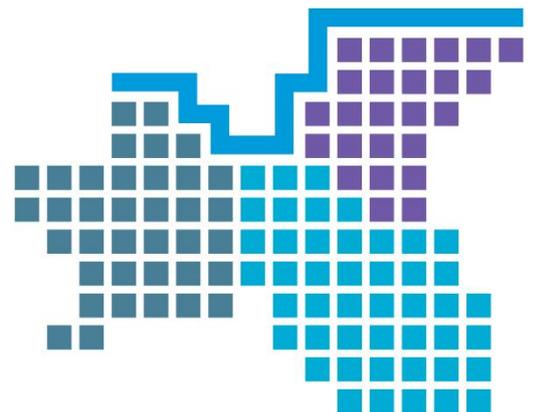


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Chapter 1. Introduction

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 under pressure, 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 document is a collation of all the work-streams related to out of hospital care for adults that are planned over the next 2 years. Business cases for each of the initiatives are available on request. This document should be read in conjunction with the narrative account entitled 'Doris' Story,' which describes how out of hospital care will be optimised for Doris over the next 5 years.

1.1 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.

The JSNA also tells us that the population of over 65 year olds living in Wandsworth is set to rise by around 42% by 2025. The Department of Health (2010) estimate that 3 out of every 5 people over 60 in England suffer from at least one LTC and 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 will 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.

1.2. 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 Local Government Association (2012) has published value cases on integrated care which demonstrate the quantifiable benefits. Waltham Forest have used risk profiling to result in a 20% reduction in emergency admissions and 14% reduction in elective admissions by using telecare monitoring, while Torbay is one of the most successful examples internationally, having achieved the following through their sustained drive for integration over the last 10 years:

- Average number of occupied beds fell from 750 in 1998/99 to 502 in 2009/10
- Emergency bed day use in in the 65+ population was 1,920 per 1,000 population in 2009/10 (compared with an average of 2,698 nationally)
- Lowest non-elective LOS in the South West and 4th lowest in the country
- 9% - 20% reduction in care home admissions

Evidence from these integration case studies indicates that sustained, whole system change is necessary to realise significant, quantifiable benefits. More pro-active, anticipatory primary care must be supported by joined up, integrated community and out of hours services, all of

which must be under-pinned by a culture which empowers people to be in control of their own health (The King’s Fund, 2011 and The Nuffield Trust, 2013).

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 work.

1.3. Vision

The Wandsworth CCG Five Year Plan for Out of Hospital Care for Adults aims to both integrate and streamline out of hospital services, 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 in 3 different ways (see Figures 1, 2 and 3).

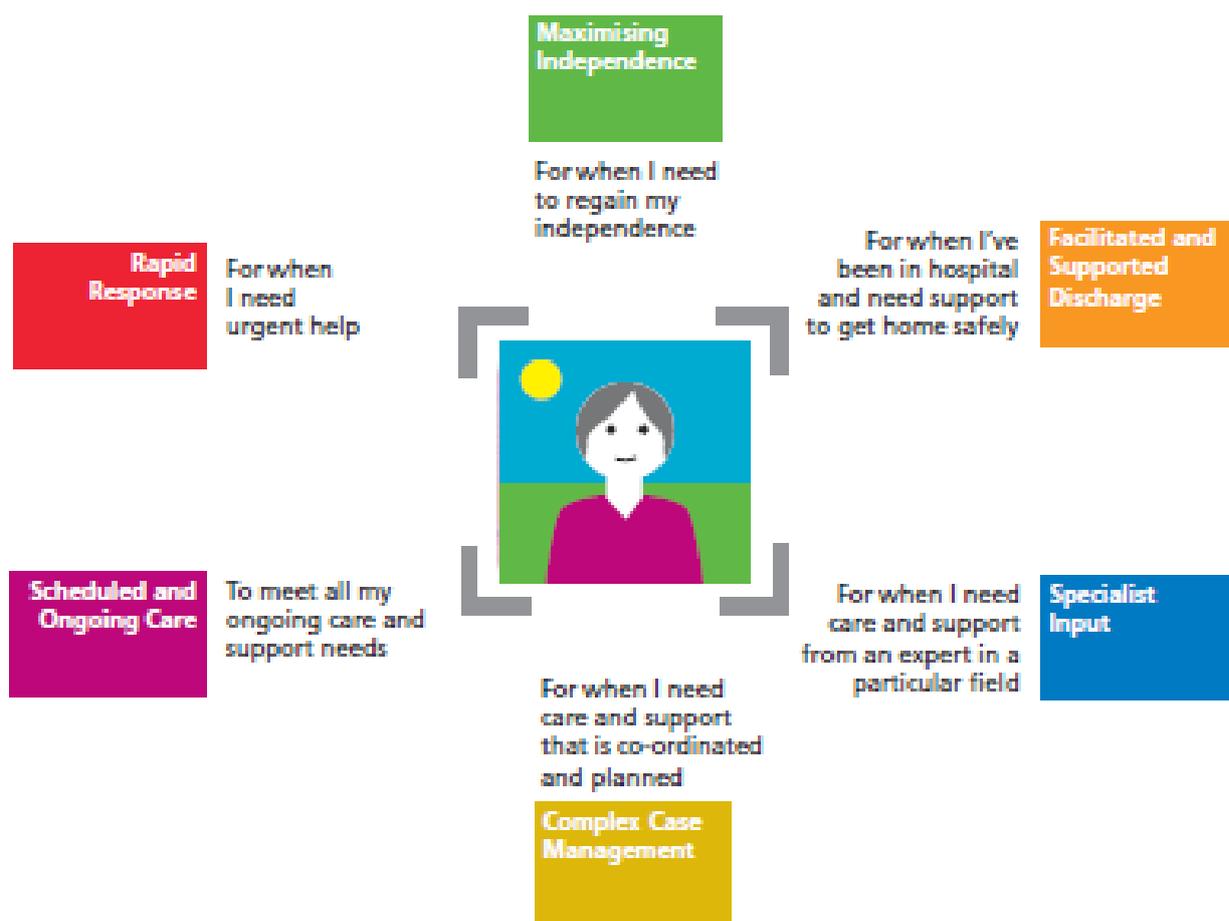


Figure 1. The world according to Doris – happy and healthy at home.

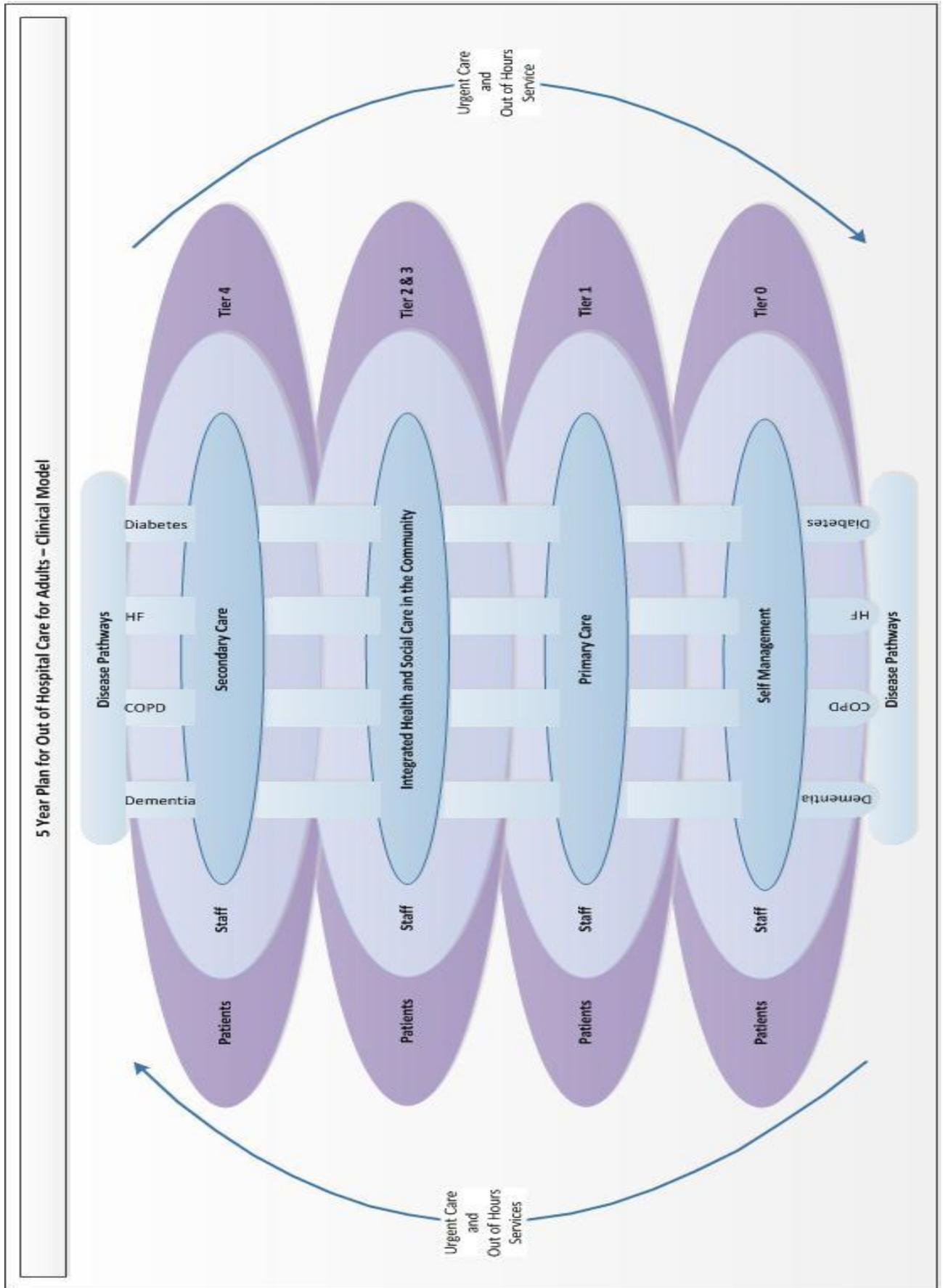


Figure 2. Clinical model for Out of Hospital Care in Wandsworth

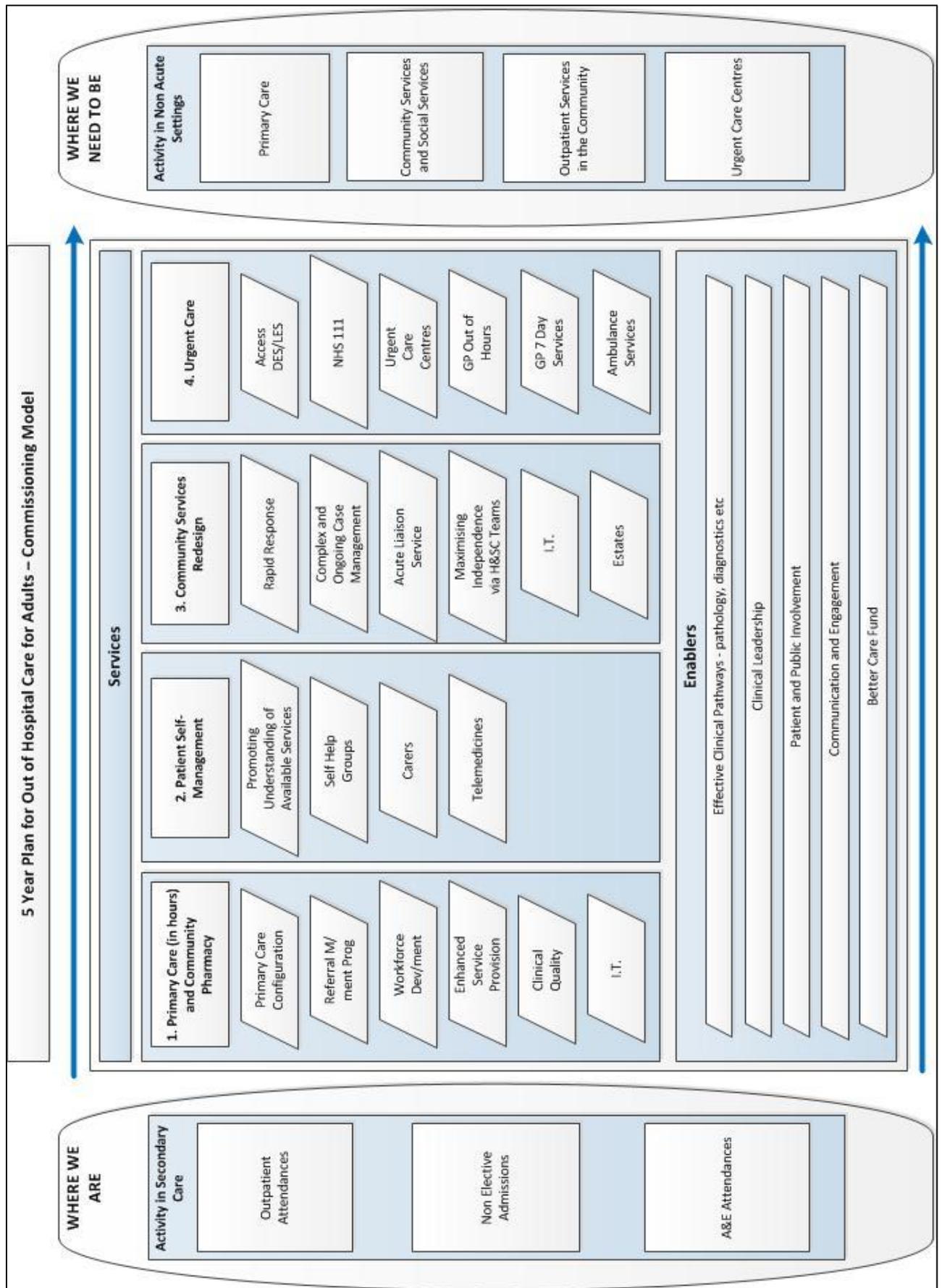


Figure 3. Commissioning model for Out of Hospital Care in Wandsworth

Figure 1. depicts our vision for out of hospital services from the perspective of Doris, an elderly patient living in the Borough. Analysis from North West London indicates that 70% of health and social care resources are consumed by 20% of the population – primarily older people with long term conditions and therefore Doris is deemed to represent the expanding group of patients whose care this plan will primarily address.

Figure 2. shows the future structure of out of hospital services in Wandsworth from a clinical perspective. Services and staff are structured into tiers with disease pathways flowing through each one. Each service tier interfaces closely with the others so that patients can move smoothly through each of them and be treated by the right people, in the right place and at the right time as far as possible. The urgent care and out of hours service is also linked into each of the service tiers so that patients can't slip through the gaps.

Figure 3. shows how the structure of out of hospital services might look from a commissioners perspective; demonstrating the shifts in activity that are required, the key areas of service redesign, the programmes of work and the enablers necessary to make these activity shifts a reality. The remainder of this document is structured into the 4 key out of hospital service areas identified in Figure 3. The project descriptions are followed by a section on the enablers required, details of projected activity and savings and finally, the governance structure for the plan and framework for evaluation.

Chapter 2. Services

2.1 Primary Care Transformation and Configuration

2.1.1. Evidence and Rationale for Inclusion

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 literature (The King's Fund (2012, 2013), NHS England (2013)) , General Practices are coming under unprecedented strain due to rising demand, the growing complexity of care required, 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 'Out of Hospital for Adults 5 Year Plan' 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. Overarching strategy

As referenced in the introduction, there is substantial evidence that integrated care, incorporating risk profiling and care planning as part of whole system change, has positive benefits on the health and social care system. Much of this evidence demonstrates that patients with multiple LTCs (often those who use the greatest amount of health and social care resource), benefit significantly from a joint care planning approach and from having a named GP or nurse at their local surgery whose focus is on keeping them well.

Over the next 5 years, Wandsworth CCG will continue to implement and evaluate this model of care, which has demonstrated significant improvements and efficiencies elsewhere in the UK. Case studies of the general practice care planning model from Cumbria and North West London (Reeve (2013) and The King's Fund (2013)) show that in order to successfully implement this model and address the myriad of other challenges facing general practice, it must be rolled out in combination with a series of other primary care initiatives:

Firstly, general practices must be given the opportunity to change the way they work – reducing waste and inefficiency. They need to be given the space to reflect on what needs to change and given support from expert change agents working within the practices.

Wandsworth CCG have already begun this process through investing in the Members Development Programme and Productive General Practice in 2013/14, however, to ensure that the improvements in practice are embedded and that changes made are sustainable, it is vital that this investment is maintained.

Secondly, an ongoing programme of workforce development is essential to ensure that staff have the right skills to deal with more complex patients effectively. The staffing model must be effective, meaning that the skills of practice nurses, HCAs etc. are fully utilised and that issues such as fluctuations in the workforce, use of locums etc. are recognised and addressed.

Finally, broader issues related to the configuration of general practice must be taken into account. Historically PCTs have commissioned enhanced services such as diagnostic tests from individual practices. Whilst this has been successful in increasing the range of services available to patients locally, it has also generated inequality, as smaller surgeries have

struggled to deliver these enhanced services for their patients. It is therefore intended that over the next 5 years, Wandsworth CCG will begin to contract enhanced services through a single GP Federation (of which all practices in the Borough will be members) and in this way the CCG can ensure they are commissioning an equal level of service across the Borough.

2.1.3. Summary of initiatives 2014-16

2.1.3.1. Enhanced Service Provision

In commissioning practices, the CCG hold up to 43 contracts of one particular enhanced service at a time. As a snapshot, in 2013/14 there are over 250 such contracts, each with administrative requirements both on behalf of the CCG and each individual practice.

In Wandsworth there are three Federations that operate a membership model for GPs as providers. The Federations deliver some outpatient services, and for 2013/14 have supported smaller practices in the attainment of the PACT LES through pooling administrative resources to a centralised function, allowing patients of those practices to benefit from the PACT LES.

As described in section 2.1.2, the proposed future model for Wandsworth will be to commission directly from a single Federation, as opposed to 43 individual practices.

Whilst the CCG does not have accountability for the clinical quality of practices, it is to be expected that practices will increasingly buy into the Federation model for some core contracting elements that could be centralised. Typically this would mean back-office functions and could encompass standardisation of key Care Quality Commission domains.

Individual practices will maximize returns (via the Federation minus admin costs) from enhanced services, which will increasingly become vital with narrowing margins from the core contract. Whilst the primary benefit for the CCG will be the full coverage of key initiatives to the Wandsworth population, which is not currently possible. Additional benefits include a reduction in not only CCG administration time, but in service re-design time in developing very detailed service specifications. Under this model, the CCG would define key performance indicators and outcome measures for the Federation to then enact.

Planning All Care Together Contract

In 2013/14 Wandsworth CCG launched the PACT LES – an innovative incentive scheme which aims to improve outcomes and quality of life for people living with long term and complex health conditions. Led by GPs and using evidence-based approaches in collaborative care planning, it provides a seamless approach to services and a greater role for self-management.

The 2013/14 PACT LES was offered to and has been signed-up to by all 43 GP Practices in Wandsworth, demonstrating broad support for the programme and its objectives.

The 2014/15 operating plan is largely unchanged from 2013/14 reflecting the ramp up in activity across the year. In order to apply the learning from 2013/14 and respond to current commissioning priorities and on-going service developments, the following additions will be made to the service specification for 2014/15:

- Named GPs for the most high risk, vulnerable patients
- Telehealth – supporting management of patients at home
- Bowel cancer screening follow up – supporting early detection of bowel cancer
- Cancer survivor review – to address side effects and legacy of disease and treatment
- Emergency admission discharge management – preventing deterioration and readmission
- London Ambulance Service (LAS)/Special Patient Notes – ensuring key information is available to LAS crews regarding vulnerable patients

Diagnostic LES Contracts

Following transfer of responsibility for commissioning primary care services from PCTs to NHS England, LESs are to be phased out by April 2014, although CCGs may still choose to commission such services to meet local need.

At the moment, Wandsworth CCG commissions general practices across the Borough to deliver 6 diagnostic LESs which were inherited from the previous PCT commissioners. A review of these LESs is due to be completed by March 2014, the aims of which are to:

- Review the existing LESs and to develop new service specifications in line with the standard NHS contract which reflect current national guidance
- Review data / information available from a variety of sources, to help to understand whether the existing LESs are having the intended impact
- Identify whether there is still a need to commission some or all of these tests in Primary Care and make recommendations to the CCG on proposed changes
- Determine whether there are other tests that could be carried out in Primary Care
- Ensure that access to services is equitable for patients across the three localities in Wandsworth
- Ensure that there are agreed mechanisms in place including named individuals responsible for the on-going monitoring of the service specifications once the review has been completed

Outcomes and Evaluation

As referenced above, there is strong evidence that integrated care systems deliver outcome, experience and quality benefits to service users, as well as significantly reducing activity and expenditure in secondary care. Furthermore, the evidence shows that care planning and coordination are critical components of an integrated care system.

We have worked with clinical leaders and service redesign teams to map benefit delivery for key elements of the 5 year programme (including the PACT contract), linking commissioning interventions through a series of intermediate benefits to the service user outcomes – which combine to deliver outcomes at system level.

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 service users with complex needs and manage them out of hospital. Over a longer trajectory, the interventions will also reduce total demand for all care services through improving wellbeing and maximising individual capability as described above (see section 4 for details of projected activity and savings).

2.1.3.2. Workforce Development

Workforce development is about having capable, confident and skilled teams and ensuring sustainability. Development of the primary care workforce will be vital in realising our ambitions for out of hospital care in Wandsworth; ensuring that staff are capable to provide the level of care required to keep complex patients out of hospital for as long as possible.

Although the following sets out our aims and objectives for workforce development over the next 2-5 years, due to migration of staff and other changes inherent in the workforce itself, it is essential that a plan for workforce development is fully embedded into business as usual and is considered to be a core part of the on-going strategy of the CCG.

Over the course of the last 18 months, a training needs analysis was conducted and used to identify gaps in skill mix. A series of well attended training programmes were commissioned for member practice staff as a result, however it is clear that more needs to be done to ensure that individual programmes form part of a joined up, coherent strategy.

The aims of the workforce development strategy are to:

- Embed workforce redesign and workforce innovation within organisational culture for quality purposes

- Support innovative workforce models into all parts of general practice and CCG environments
- Ensure that we are demonstrating the value and impact of effective workforce planning and skill mix
- Ensure support and learning development for managers and their staff
- Ensure that staff have the opportunities to develop as commissioners, leaders and managers
- Maintain competences and knowledge and provide supporting materials to enhance the skills of all staff
- Develop links with educational establishments to encourage newly qualified staff into the Borough
- Normalise continuing professional development in to working lives of member practice and CCG staff, facilitating the same
- Create an environment where staff feel valued and supported

In addition, the workforce development team will continue to work closely with the Clinical Reference Groups and other CCG project leads to create a joined up approach to training and education across the Borough.

Key initiatives that will be rolled out 2014-16 (as identified in the primary care training needs analysis 2013) are as follows:

- Minor illness training – expanding the role of the Health Care Assistant (HCA) to help prevent A&E attendances and free up GP and nurse time to see more complex patients
- Clinical supervision and appraisals training: supporting the identification of gaps in skill sets, improving communication between practice staff; supporting development of skills within practice teams
- Recruitment and retention events – encouraging new staff into the Borough and into primary care based roles (with particular emphasis on practice nurses and HCAs; due to current capacity problems)
- Long term condition specific workforce development

In 2013/14, funding for workforce development was provided through HESL. A member of the team has enquired as to whether funding can still be accessed. It is suggested that a core duty of the workforce development team in the future, should be to explore alternative funding options for training and education.

2.1.3.3. Improving Clinical Quality

Members Development Programme

The Members Development Programme 2014-15 aims to build on the work done within practices through the 2013-14 scheme and through the GP Engagement Scheme in previous years. It will look to support practices in improving the quality of the services they deliver through engagement of the whole practice team, and supporting delivery of key CCG targets. The scheme will also aim to further engage and develop practices as both commissioners and as providers.

In 2013-14 Wandsworth CCG invested in the Productive General Practice Programme (PGPP), an improvement scheme through which practices are supported to review their modes of working and develop more efficient and effective processes. A core component of the Members Development Programme is to give whole practice teams the ability to take time out of their day to day routine and engage with service improvement programmes such as PGPP. Although feedback indicates that many practices have made improvements in the way that they work over the past year, the PGPP evidence indicates that embedding real and sustainable change must be an on-going process and therefore it is essential that investment in the Members Development Programme continues.

GP Support Team

Despite various initiatives designed to engage practices in Wandsworth in quality improvement, no specific needs analysis has been carried out on an individual practice basis to identify quality improvement needs. As such, the GP Support Team will provide additional support to practices, with specific regard to quality improvement. This support will be provided by a multidisciplinary team with experience of primary care, education and embedding quality, to ensure all practices are supported to provide high quality primary care services.

Engagement and compliance with the GP Support Team model will be part of the entry criteria for the Members Development Programme.

Outcomes and Evaluation

Specific outcomes and benefits are difficult to quantify for this programme of work, however, dependant on the areas of need identified by practices themselves and by the GP support team, outcomes for these quality improvement initiatives may include:

- Improved quality in primary care
- Reduction in inappropriate A&E attendances
- Reduction in inappropriate referrals
- Sharing of good practice

- Embedding a process of continuous quality improvement in practices
- Greater awareness and understanding in practices of quality standards
- Improved SI reporting
- Decreased complaints

In addition, these two schemes will form the key vehicle through which the CCG will achieve on its primary care based quality premium targets in the years to come and are important mechanisms in engaging CCG member practices in the commissioning agenda.

As mentioned previously, a targeted approach to improving quality in general practice and supporting them to change the way they work is a key enabler for other out of hospital initiatives that primary care are expected to deliver on i.e. the PACT contract, and therefore they must be viewed as part of the same transformation package.

2.1.3.4. Referral Management Programme

The Wandsworth CCG referral management programme is a suite of initiatives which together seek to support GPs in making high quality referrals and to improve the patient pathway and experience.

Over the past 18 months savings have been identified through the use of Kinesis and although it is difficult to quantify savings as a result of education and peer review, feedback from 39 participating practices has been positive; 70% of education session attendees reported that they felt more confident in managing patients in the community for the conditions we have focussed on. An Outpatient Incentive Scheme is currently being piloted and early results indicate that significant savings could be realised if this pilot is rolled out more widely in 2014/15.

Over the next 5 years the programme will continue with various expansions that will support the drive to reduce outpatient activity in Wandsworth: i.e. extending Kinesis to include more providers; adapting the peer review model to engage smaller practices more effectively; working with the GP Support Team to engage practices with above average referral rates and roll out of a clinical decision support software which will encourage use of appropriate pathways and guidelines.

NB: Although it has not been possible to identify an actual decline in outpatient activity as a result of the referral management programme to date, the context of the programme must be considered. Initiatives in Wandsworth, such as the community ward have actually been shown to increase outpatient activity, as patient care becomes better managed. In addition, it is not possible to identify whether the trajectory of outpatient activity would have been steeper had the programme not been in place.

Effective Clinical Pathways

Although we can identify some success in reducing GP referrals through the referral management programme, Wandsworth PCT have historically struggled to realise any large scale shifts in activity from outpatients to the community setting.

Over the last 6 months a scoping exercise has been carried out to identify key specialties where benefits could be realised from re-locating them to the community. As a result, 6 projects have been identified for roll out in 2014-16, consisting of the following:

1. Managing stable patients in the community

Wandsworth CCG has developed community pathways for some LTCs (such as Chronic Obstructive Pulmonary Disease (COPD) and diabetes) but for many, the patient's treatment plan is managed by the acute provider and the patient attends regular follow-up appointments with their consultant at hospital. If the patient's condition is stable, then it is feasible for treatment to be managed in the community, provided there is adequate support and guidance for the GP and a clear escalation pathway to acute care should the patients' condition change.

This model could be developed for several conditions at one provider and then expanded to other conditions at multiple providers. There are a number of options that could be incorporated into the managing stable patients model:

- Telephone follow-ups by a GP and/or community nurse led clinic
- Kinesis/telephone contact for consultant advice
- Advice and guidance document store (created jointly between a consultant and a GP working group)
- Use of the Croydon model for pre-follow-up patient assessment (PatNav)

The cost of the service would be run at £60 per patient/per appointment, instead of the acute follow-up appointment tariff of £80 per patient/per appointment.

2. Pre-operative assessments

The purpose of a Pre Operative Assessment (POA) is to determine patients' fitness for anaesthesia and to optimise patients prior to elective surgery. Currently all POA for Wandsworth patients are conducted at the acute provider. A successful pilot of POA has recently been implemented at Croydon CCG where day case hernia patients have their POA at their surgery via a nurse led service. In addition to the service in Croydon, there are a number of initiatives within the UK where pre-operative assessments are managed by a nurse led service.

The cost of the service would be run at £50 per patient/per appointment, instead of the acute POA appointment tariff of £200 or £80 per patient/per appointment. For the pilot conducted in Croydon, a first attendance £200 appointment was saved for each POA conducted in the community.

3. Pathology

Data from St Georges indicates that there is a clear upward trend in spend on pathology for Wandsworth CCG. In 2012/13 total spend at SGH was slightly above £5 million. Projections for 2013/14 indicate this will increase by approximately 11.7% to around £5.8million.

The 3 headline work streams included in the pathology project are:

- A balanced scorecard and incentive scheme supported by an educational programme and a suite of guidance documentation for GPs
- Implementation of a web-based ordering system for tests
- A review of the existing 6 diagnostic LESs to determine scope for increasing the range and volume of tests undertaken in primary care and improvements to the specifications

These work streams aim to produce the following benefits:

- Making the cost of tests visible at the point of requesting tests and through benchmarking across Wandsworth practices
- Ensuring the test results go back to the requesting clinician, therefore reducing delays and the need for unnecessary repeat testing
- Greater consistency in requesting behaviour of clinicians in line with guidance.
- To stem the 11.7% increase in spend on tests, projections for years 2 to 5 to be reviewed following evaluation of year 1 pilot
- Care closer to home for the patient. Commissioning services in primary care rather than in an acute setting is also likely to be less costly to the CCG

4. Musculoskeletal (MSK)

In our current system, the services that deliver MSK care in the community (MICAS) are disjointed, inefficient and slow. There are more steps on the patient's journey than necessary and this drives down efficiency in terms of time, capacity and cost. We struggle to attain our 18 week referral to treatment (RTT) targets and patients and clinicians report dissatisfaction and less than ideal Patient Reported Outcome Measures.

A key mandate of the Out of Hospital Plan is to look at how Community MSK services are provided in Wandsworth and develop an improved model of musculoskeletal services which is more integrated, delivered by the right skill mix and close to patients home.

- The new service specification will integrate the specialties into a single MSK service, introducing consultant led rheumatology outpatients
- The Community MSK Service will form part of a wider MSK pathway covering GP care, community MSK and acute interventions with the clinical scope of Orthopaedics, Rheumatology , Chronic Pain , Community MSK, Primary Care management e.g. Hip & Knee Scoring system
- The proposed model will be designed to put financial efficiencies into the service provided, but also to integrate the MSK services, providing a more effective and efficient service for patients based on outcomes

The cost of the service would be:

Orthopaedics

- New: £86 per patient/per appointment (acute tariff of £108 per patient/per appointment)
- Follow up: ££70 per patient (acute tariff of £86 per patient/appointment)

Rheumatology

- New: £174 per patient/per appointment (acute tariff of £217 per patient/per appointment)
- Follow up: £80 per patient /per appointment (acute tariff of £100 per appointment)

5. Dermatology

Skin conditions are the most frequent reason for people to consult their GP with a new problem. It is the strategic vision of Wandsworth CCG for services to be provided as near to patients as clinically appropriate and to adopt a stepped care model which is integrated into primary care. This means that patients can access high quality services quickly and be seen locally by the most appropriately skilled healthcare professional to meet their needs. Commissioning of the Intermediate Level 3 Dermatology service in 2014/15 will seek to reduce the number of referrals to acute dermatology services. This will include making practical improvements to the existing services to achieve the reduction in referrals to outpatients. These improvements would be consistent with best practice implemented locally and elsewhere.

The aim of the service will be to provide a one stop primary care led dermatology service where patients with dermatological or low risk skin cancer conditions can be diagnosed and treated in the community by a range of appropriately trained and accredited dermatology staff working as teams to include consultants, dermatology specialist nurses, GPwSIs, PhwSIs.

The cost of the service would be:

- New: £108 per patient/per appointment, instead of the acute appointment tariff of £135 per patient/per appointment
- Follow up: £64/per appointment, instead of the acute appointment tariff of £82 per patient/appointment

6. Ophthalmology

A rapid review of the ophthalmology community services has revealed that the current service requires further investigation and an in depth review to ensure that the future model of care is clinically safe, more efficient and fit for purpose to cope with the increasing demands for eye health for the population of Wandsworth. It is widely acknowledged that the aging population and advances in the new treatments for eye care has led to a rapid increase for the demand for the services.

Phase One:

The Wandsworth Community Intermediate Clinical Centre (CICC) service model as is based on the principle that when stable hospital follow-up patients are diverted into a community care setting. It frees up capacity in hospital for new patients, thus shortening waiting times and improving quality and safety for patients who may suffer harm by waiting too long for their diagnosis, assessment and treatment. The skill mix of the CICC is tailored to the needs of the patients so optimum impact is achieved.

Phase Two:

If agreed by the Wandsworth CCG Board, a whole community ophthalmology model of care can be designed and piloted in collaboration with the current provider and informed by the evaluation and 'lessons learned' from phase one.

The cost of the service would be:

- New: £86 per patient/per appointment, instead of acute appointment tariff of £102
- Follow up: £70/per appointment, instead of acute appointment tariff of £87

Outcomes and Evaluation

The Referral Management Programme and Effective Clinical Pathways Project will be measured in the following ways:

- By tracking trends in SUS outpatient data
- By tracking trends in referrals via the EMIS read code report
- By tracking the number of referrals saved through Kinesis

It has been agreed that further scoping and analysis work needs to be conducted for the following 5 effective clinical pathways projects before they can be rolled out in Wandsworth:

1. Managing Stable Patients in the Community
2. Pre-Operative Assessments
3. Dermatology
4. Ophthalmology
5. Musculoskeletal

For each of these projects, service specifications need to be worked up along with clinical guidance and the CCG needs to ensure that contract management capacity is available to ensure that the shift in activity is reflected in acute provider contracts. As such it has been assumed that savings for the 5 projects in question will not begin to be realised until 2015/16.

High level milestones for 2014/15 will be agreed with individual project managers so that progress towards implementation can be robustly monitored. In the meantime, the current community dermatology, ophthalmology and MICAS service providers will be expected to implement an action plan to resolve present issues and enhance provision where necessary.

The pathology incentive scheme is expected to go live in April 2014 and hence the activity and outcomes have been incorporated into the savings projections for 2014/15.

2.1.3.5. Disease Specific Primary Care Work-streams

Cancer initiatives:

Best Practice Pathway for Ovarian Cancer

Ovarian Cancer is the leading cause of gynaecological cancer in the UK and up to 70% are diagnosed at a late stage. This poor outcome was generally put down to the lack of symptoms but recent studies have shown that most women do have symptoms prior to diagnosis. As most women are currently diagnosed at a late stage, earlier diagnosis could improve survival outcomes.

The current NICE guidelines suggest that a Ca125 blood test is initially carried out by GPs on patients in whom they suspect a possible diagnosis of Ovarian Cancer. If this result is

over 35iu/ml then a Trans-vaginal Ultrasound Scan (TVUSS) is advised. However, the best practice commissioning pathway suggests that both Ca125 and TVUS should be carried out simultaneously and a referral made if either is positive, in order to increase the rates of cancer diagnosed at an earlier stage.

By reducing the threshold for investigation of symptoms and increasing the diagnostic rate of investigations significantly more patients will be diagnosed at an earlier stage and via the appropriate referral process.

Best Practice Pathway for Colorectal Cancer

Colorectal cancer is the third most common cancer in Wandsworth in both men and women, incidence rates rose by approximately 17% between 2001 and 2011.

The NICE guidelines show the criteria for urgent referral for 'high risk' patients. However, half of patients with colorectal cancers will not have these 'high risk' symptoms and therefore not fit the criteria for urgent referral hence taking longer to diagnose and thus having poorer outcomes.

The best practice commissioning pathway for early detection recommends that, for patients with the appropriate symptoms, the lower age limit of referral should be reduced to 45 years old by 2015 and that referral should be made by GPs to a 'Diagnostic service' – a designated referral centre which will then triage referrals to the most appropriate diagnostic test which will be booked directly.

The increased cost of implementing this pathway would be in reducing the lower age limit to 45 years old. This is predicted to be around £61,502 based on figures from NHS England and the fact that Wandsworth already has a service for those aged 50 and above.

It is vital to point out that these are patients with symptoms that would be investigated anyway but at a later stage. Just one patient diagnosed with stage 1 rather than stage 2 colorectal cancer would save over £5,000.

CVD Initiatives:

Improving and Enhancing Case Finding in Primary Care

This project aims to ensure that the identification of patients with high CVD risk becomes routine practice

The NHS Health Check covers about 15 million adults between the ages of 40 and 74, but there are still a considerable number of people at risk of CVD who need to be assessed and managed. There is a need to develop a rolling programme within primary care to ensure that patients at high risk of CVD are identified and appropriately managed.

The funding will be used to:

- Continue the Chronic Kidney Disease (CKD) audit initiated in 2013/14 to identify patients who are at risk of developing CKD and ensure that the management of these patients becomes routine practice
- Ensure those patients identified as being at high risk of CVD in their NHS Health Check receive an annual follow-up to manage their condition

24 Hour ECG Pilot

In 2011/12, six 24 Hour ambulatory ECG devices were purchased as part of a 2% non-recurrent investment bid submitted by Wandle Local Commissioning Group to pilot a 24 Hour ECG diagnostic service within general practice with the following aims:

- To reduce the number of referrals into secondary care services and waiting times for 24 Hour ECG services
- To provide a diagnostic service which is closer to patients homes
- To conduct an audit focusing on the quality of commissioned diagnostic services

Investment is required to pilot a 24 Hour ECG service within primary care for 6 months 2014/15 and then commission as part of the new Diagnostic AQP contract if the initial pilot is successful.

Falls and Bone Health Initiatives:

Enhanced Medicines Use Reviews

Hampshire and Isle of Wight currently commission community pharmacies to target service users with osteoporosis. The purpose is to provide medicine use reviews, improve medicine uptake and compliance, to identify medications that may contribute to falls risk and to refer to patients GP for further assessment and management.

Funding is requested to:

- Commission community pharmacies to provide an enhanced Medicine Use Review (MURs) service focusing on falls and bone health
- Commission Webstar for data collection and payment purposes

Prescribing of Denosumab in the Community

NICE recommends Denosumab as a possible treatment for preventing bone fractures in some postmenopausal women with osteoporosis. Denosumab may be prescribed for patients who have not had a bone fracture caused by osteoporosis, if the patients GP

believes that the individual is at risk of having a fracture and the individual cannot take Alendronate and either Risedronate or Etidronate.

The objective of this project is to enable the commissioning of Denosumab (currently a hospital only prescribed drug) to be prescribed within the community. This would reduce the amount of time that patients have to spend visiting the hospital and may also result in an increase in medication compliance, as patients will be able to access the medication locally.

The resultant increase in community prescribing costs should be off-set against a reduction in hospital prescribing costs.

Respiratory Initiatives:

GRASP COPD Missing Millions Identification and Treatment Optimisation Programme

The GRASP toolkit contains two audits which the practice can run at a time convenient to them. The first audit looks at patients already diagnosed with COPD as data suggests that up to 30% of patients on COPD registers may be inaccurately diagnosed and sub-optimally treated. Ensuring accurate diagnosis can improve outcomes, help manage demand and reduce waste, using the results from a combination of airflow obstruction using Spirometry.

Around 835,000 people are currently diagnosed with COPD in England but there are estimated to be around a further 2,000,000 people who are undiagnosed and living with the disease. Studies have shown that many patients have had repeated consultations for respiratory problems over the years prior to their diagnosis, suggesting that there is scope to identify and modify the disease at an earlier stage.

The second audit on the GRASP COPD toolkit supports this by:

- Identifying patients potentially missing a COPD diagnosis code
- Identify patients at risk of developing COPD
- Providing several pre-set filters to prioritise those patients most likely to need a review (supports Telehealth)

National evidence has shown that up to a 10% of people with COPD are diagnosed when they present to hospital in an emergency.

- If the disease is diagnosed early (when the rate of lung function decline is at its fastest) the deterioration of the lungs can be modified with treatment and slowed down by the use of less expensive therapies, as it costs 10 times more to treat severe COPD than mild COPD

- Earlier diagnosis therefore greatly increases survival, and the NHS Outcomes framework includes a specific indicator for respiratory disease 'Under 75 mortality rate from respiratory disease' in domain one - preventing people from dying prematurely

Wandsworth has an estimated 4,000 people with undiagnosed COPD and spent in excess of 1.3 million on COPD admissions in 2010/11. The average cost for a COPD non elective admission is £1,900 (taken from NICE COPD Costing guidance). Therefore if we diagnosed all COPD patients before they presented as an admission a saving of £760,000 would be possible.

Substance Misuse Initiatives:

Addiction to Prescribed Medicine - Benzodiazepine Treatment Pilot

National data suggests that over 1.5 million people in the UK are dependent on Benzodiazepines either prescribed or sought illicitly. The risks associated with the long term use of hypnotic drugs have been well recognised for many years. These include dependence, falls, accidents, cognitive impairment and withdrawal symptoms.

Data collated from the Wandsworth CCG medicines management team suggests that an estimated 2,900 people in Wandsworth are being prescribed Benzodiazepines (and 'z drugs').

The overall aim of the service would be to reduce the number, reduce the dosage and more actively manage patients in receipt of prescriptions for Benzodiazepine, Z drugs, opiate based analgesics and over-the-counter medicine through the delivery of a specialist primary care based service (as modelled by the Bradford Bridge Project). The pilot would be delivered within primary care by tier 3 specialist nurse practitioners (potentially employed by primary substance misuse treatment provider within the Borough). It is expected that recruitment of clinical nurse specialists would commence in April 2014, with the project to be operational by July 2014.

Outcomes of the project would include:

- Progressive reduction in the percentage of long-term Benzodiazepine users that manage to quit or significantly reduce their use in months
- Improvements in mental health as a result of the service including reduction in anxiety and depression, improved confidence and self-esteem, improved relationships and social functioning
- Reduction in secondary health issues as identified in initial assessment (including management of chronic disease and undiagnosed illness)

2.2 Patient Self-Management

2.2.1. Evidence and Rationale for Inclusion

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 3 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) and Purdy (2010)).

The overwhelming consensus from think tanks such as the King's Fund, Nuffield and the Health Foundation is that care planning is a key component in improving outcomes for people with long term conditions. The 2011 final report for the Year of Care states "that effective care planning consultations rely on three elements working together in the local healthcare system: an engaged, empowered patient, working with healthcare professionals (HCPs) committed to a partnership approach, supported by appropriate/robust organizational systems." It goes on to emphasise the need for each element to be strong; missing or weak elements reduced the potential benefits to little or no benefits. This is further evidenced by the Nuffield evaluation of the North West London integrated care pilot.

In Wandsworth, the PACT contract (formerly the PACT LES) is the key vehicle through which the CCG is engaging GPs in the above mentioned care planning approach. The importance of self-management is recognised in the PACT contract, both in providing patients with the knowledge and skills to manage their long-term conditions and enabling GPs and healthcare professionals to support their patients to do so. The delivery of a comprehensive self-management framework is therefore seen as vital to the delivery of the '5 Year Plan for Out of Hospital Care for Adults' as it underpins the success of a number of the core elements of the plan.

2.2.2. Summary of Initiatives 2014-16

2.2.2.1. Wandsworth Self-Management Programme

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 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 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
- Self-management training for the public
- Supporting self-management training 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
- Behaviour change and motivational interviewing techniques for professionals
- Recognising the specific needs of critical groups such as carers, faith, cultural and community groups and isolated individuals

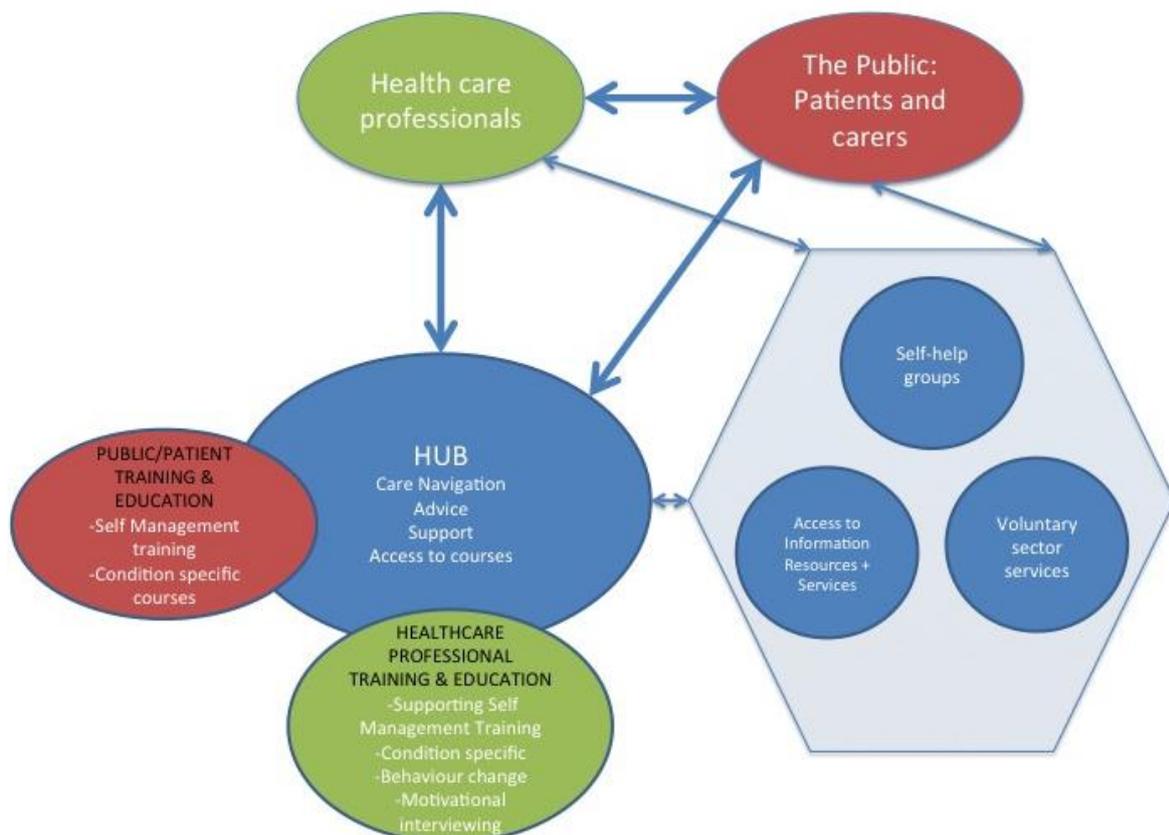


Figure 4. Shows the proposed structure of the Wandsworth Self-Management Programme.

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 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 (see figure 4).

NB: A business case detailing the individual elements of the self-management programme will be submitted separately for further scrutiny.

2.2.2.2. Disease Specific Self-Management

From 2014/15 it is expected that the Wandsworth Self-Management Hub will take a more central role in the co-ordination and implementation of the various self-management initiatives currently operating through clinical reference groups (CRGs). It is hoped that this will provide a more joined up and strategic approach to the commissioning of self-management services across the Borough.

Cancer Initiatives:

Pauls Cancer Centre

A cancer specific self-management programme is currently being delivered by Paul's Cancer Centre. This has been delivered over the last 12 months with non-recurrent funding through the CCGs BIG funding programme.

The centre has developed its own self-management method which has achieved good results, bearing in mind the small population it serves.

The National Cancer Survivorship Initiative (NCSI), developed jointly by the Department of Health and Macmillan, has gathered evidence that 20-30% of people treated for cancer have serious long term effects, and one in 6 are unable to work. Emotional problems such as depression are also common. Paul's Cancer Support Centre's Self-Management Programme, backed up by the Wandsworth Macmillan Information & Education Service, provides effective responses to the needs articulated both here at the Centre and nationally.

Target beneficiaries are people with cancer (90%) although the activities are offered to a smaller percentage of carers and family members (10%). In addition, Paul's Cancer Centre run a 'Mindfulness -based Stress Reduction' course aimed at health professionals in Wandsworth, to enhance their understanding of this way of working.

Exercise on prescription for patients with cancer

There is more and more emerging evidence of the benefits of physical activity for patients with cancer. The evidence shows that exercise can have a very beneficial effect in improving multiple cancer symptoms and treatment side effects such as cancer related fatigue, anxiety and depression, bone mineral density loss and weight gain, as well as significantly increasing overall quality of life. Evidence also shows that exercise can lead to a significant improvement in reducing relapses of breast cancer and colorectal cancer by 67% and 50% respectively and increasing survival by reducing cancer specific death by up to 49% for breast cancer survivors and overall death by 51% in patients with prostate cancer. (The importance of physical activity for those living with and beyond cancer. A concise evidence review, Macmillan Cancer Support).

Currently Exercise on Prescription is available in Wandsworth for multiple long term conditions, but not for those just with a diagnosis of cancer.

Patients with breast cancer have a relapse rate of around 22% (Cancer Research UK); this means of the 160 diagnosed each year, 35 patients are likely to relapse during their lifetime. Based on a cost of relapse of around £25,000 (Kamon et al, 2007), the potential savings are around £575,000. This is obviously based on all breast cancer patients taking part however even if only one relapse was prevented each year, this would represent £25,000 savings.

Patients would be assessed before starting exercise by a trained professional and asked to complete anxiety and depression and quality of life scores. They would also be required to answer specific questions regarding current symptoms and their personal hopes for what the exercise will achieve. This would be repeated at the end of their program and then again after 6 months.

CVD Initiatives:

Cardiac Rehabilitation:

This service supports patients and their carers to be empowered to live as full a life as possible after diagnosis or an acute event. This includes both patients and carers having their needs assessed as well as care plans produced and kept under review.

There is a range of evidence to demonstrate the importance of emotional and psychological support throughout the care pathway but particularly for those with long term care needs.

The rehab service focuses, in particular, on 2 key areas as follows:

- Develop long term support for patients with CVD and their carers
- To commission appropriate emotional and psychological support

Diabetes Initiatives:

DIMPLE – Diabetes Improvement through Mentoring and Peer-led Education

This is an existing scheme that is working successfully in Hammersmith and Fulham CCG. It aims to improve and spread self-management to those with or at risk of T2 diabetes; supporting those with diabetes along with a strong preventative focus. This involves 4 main areas of focus: involvement of volunteer members of the community; the prevention and/or management of symptoms and risk factors; access to appropriate medical services and patient compliance and ability to self-manage condition.

Delivery of this is through the development of 3 roles:

- I. Diabetes Champions – training local volunteers to raise awareness in their community. They will share key health messages to bring about more awareness and influence changes in behaviour
- II. Diabetes Peer Educators – building upon the X-Pert scheme, educators work alongside clinicians and therapy teams delivering on-going education events to diabetes patients and those at risk
- III. Diabetes Peer Mentors – the redesign project is shifting patients from acute care and some of these will be repatriated to primary care; if not now, then in the future

Evidence from Hammersmith and Fulham:

During the initial 18 months project period over 5,000 people in Hammersmith & Fulham and Harrow were reached through over 200 events with over 70% from BME communities. 51 champions were trained.

Out of 41 public event attendees subsequently interviewed:

- 95% claimed to know more about the causes of diabetes
- 90% claimed to know more about the symptoms of diabetes
- 82% claimed to be more physically active
- 74% claimed to have shared the information they had acquired
- 74% claimed to have changed their diet
- 68% claimed to be more aware of the range of diabetes services locally

The Social Return on Investment (SROI) was assessed as £11.36 for each £1.00 spent.

Respiratory Initiatives:

COPD Care Checklist Leaflets Development:

Development of a patient information leaflet that supports patients in understanding their care and what care is expected for a COPD patient. This leaflet will provide individualised information to patients within the NICE COPD Quality Standards, using a checklist approach.

Pulmonary Rehabilitation Service

This service includes a community COPD liaison physiotherapist post funded by the CCG. The aim of the COPD physiotherapist will be to provide evidence-based respiratory care both independently and as part of a specialist team to provide an integrated pathway to ensure that patients can be managed safely in a primary care setting. This will be achieved by regular assessments and treatments in the home environment and identifying patients at high risk of exacerbation. Those patients identified will receive immediate assessment and treatment (aim within 48hrs) to identify strategies that can manage exacerbations at home.

Evidence shows that:

- One life was saved for every 6 treated and one admission avoided for every 4 patients treated (Cochrane review 2009, updated 2011, cited IMPRESS Guide to PR)
- 3 month re-admission rate reduced from 33% to 7%
- Reduced Length of Stay
- Reduced healthcare costs
- Pulmonary Rehabilitation is well within the range of costs per QALY which is deemed cost effective and can generate savings by NICE

Translated Versions of Booklets BLF

To provide translated versions of the British Lung Foundation Self-Management Packs and patient handbooks. Previously we have purchased these in English; however, it would be beneficial to have a limited number of these booklets in various languages to support patient self-management across the Borough.

Stroke and Neuro Rehab initiatives:

Stroke Exercise Classes

The CVD Outcomes strategy suggests that one area where there is evidence to support the use of a service designed for one specific CVD client group for the benefit of another is cardiac rehabilitation. A recent Canadian study has found that patients who suffered a transient ischemic attack or minor disabling stroke benefitted from a cardiac rehabilitation programme. While cardiac rehabilitation services in this country are still rather patchy, there

are some cutting edge programmes which have diversified to provide physical activity programmes not only to help patients recover from an acute episode but also to help others with risk reduction. I.e. improving physical activity levels to reduce cholesterol and blood pressure levels and helping patients to manage their weight better.

Self-management life after stroke services in the community

This service includes 6 month reviews, information, advice and support service and an Aphasia service.

There is a national requirement that we have stroke 6 months reviews in place and that the relevant data is collected as part of the SSNAP audit; it is also a requirement of the Stroke Quality Standards. Currently we do not have any other way of meeting this requirement so it is essential that this service continues in the future.

Substance Misuse Initiatives:

Physical Activity for Substance Misuse Service Users

Air football has been up and running in Wandsworth since October 2012. It is a sports-based personal development programme for individuals involved in drugs and alcohol and/or criminal/anti-social behaviour. Air Football has had a positive impact on the lives of the clients who attend. Self-reported data from the clients show that:

- 80% of Players have reduced their drug taking
- 52% players stating that it reduced their alcohol intake
- 68% reduced offending
- 80% helped with their recovery
- 82% reduced smoking
- 80% felt an improvement in their depression
- 95% felt more confident
- 78% felt less angry

Whilst Air Football is proven to have positive effect on this client group 90% of the client group that attend this activity are male. The Substance Misuse CRG therefore propose to roll out a physical activity programme taking place once a week for 2 hours (Zumba, circuits, step classes) that would attract both male and female substance misuse clients.

2.2.2.3. Tele-medicines

A mandate from the Government to the NHS Commissioning Board in April 2013 requested that “significant progress be made towards three million people with long-term conditions being able to benefit from telehealth and telecare by 2017; supporting them to manage and

monitor their condition at home, and reducing the need for avoidable visits to their GP practice and hospital.”

Telehealth helps provide quality care for patients within the home; enabling patients to feel more engaged with clinical staff and experience a reduction in anxiety. Evidence demonstrates that it also supports patients to adhere to self-care regimes through telephone-based coaching and remote patient monitoring of vital signs.

In June 2013, Tunstall Healthcare UK Ltd were appointed by Wandsworth CCG to develop Telehealth services supporting patients with long term conditions such as Heart Failure, Diabetes and COPD. This involves embedding the Telehealth technology within care pathways and building links to Community Services Wandsworth (CSW).

The investment that Wandsworth CCG made into telehealth in 2013/14 covered the purchase of 1000 units of equipment as well as a 2 year Tunstall management contract which includes technical triage, installation services, the provision of a service desk and telehealth uptake clinics. This management contract will finish at the end of 2014/15 and therefore throughout the next financial year, Wandsworth CCG must consider whether to renew this contract, or look at other approaches to ensure that the equipment is managed and maintained.

NB: The telehealth equipment has a lifespan of 5 years with implicit depreciation costs of 20% per annum. Robust evaluation of the impact of this technology will be essential in helping the CCG to decide whether or not to invest again.

2.2.3. Outcomes and Evaluation

As described in section 2.2.1, increasing patient self-management underpins the projected outcomes of a number of the redesign elements of this plan. Outcomes from the self-management services described above 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

Over the last 12 months, management consultants Finnamore, have worked with clinical leaders and service redesign teams across the CCG to map benefit delivery for key elements of the five year programme, linking commissioning interventions through a series of intermediate benefits, to the service user outcomes. The Wandsworth Self-Management Programme and telehealth services will contribute to the overall benefit delivery picture through this process.

2.3 Community Services Transformation

2.3.1. Evidence and Rationale for Inclusion

WCCG currently contracts the majority of its community services via a block contract with St George's Hospital.

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. This is all unsustainable in the long term.

As described in the introduction, evidence from North West London and Torbay shows that the provision of integrated care is especially important for people with multiple LTCs and the elderly when it comes to keeping them healthy and at home for as long as possible.

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

2.3.2. Summary of Initiatives 2014-16

2.3.2.1. Community Adult Health Services (CAHS)

In September 2013 a detailed service specification and business case for the redesign of community adult health services across Wandsworth was approved by the CCG Board.

The proposed redesign is modelled on the successful Wandsworth Community Wards programme which sees operational staff being spread into the 7 interrelated functions, located across the Wandsworth localities:

The 7 functions will be:

- Access & Co-ordination – Call handling for any health or social care professional and patient queries
- Rapid Response – Respond to any emerging care within 2 hours
- Facilitated & Supported Discharge – Supporting patients to be able to be discharged from hospital as soon as and safely as possible

- Maximising Independence – Focus on maintaining someone in their home for as long and as independently possibly
- Complex Case Management – Complex cases will experience care that is collaboratively provided from the community to secondary care
- Scheduled & On-going Care – This is for patient who require on-going home based care but do not need to be cared by a multi-disciplinary team
- Specialist Input – Delivering care where specialist skills are essential. This will allow for continuous communication and involvement of specialist teams who fall outside the specification such as mental health teams

In addition, IT services will be aligned to ensure GP's, secondary care and social services all have access to the same information and are able to operate seamlessly to provide the best patient care.

Roll out of the new service specification is due to commence in April 2014, with St Georges Hospital remaining the provider organisation. It is anticipated that the CAHS programme will become part of the Better Care Fund in 2015/16 which will be a significant step in the development of integrated health and social care teams (this is subject to further discussion with Wandsworth Borough Council).

2.3.2.2. Pathway Specific Redesign

Dementia Initiatives:

Behaviour and Communication Support Service

Aims of the service are:

- To train and support staff to manage behavioural and emotional difficulties experienced by people with dementia living in care homes
- To provide intensive psychosocial interventions as first line treatment as per National Dementia Strategy and NICE Guidelines
- To support the appropriate use and reductions of antipsychotic medication for people with dementia living in care homes

This service is currently being run as a 6 month pilot, which is due to end in Q1 of 2014/15. Activity and outcomes data is currently being collected and an evaluation will take place towards the end of the pilot to assess whether it has been successful and should be rolled out more widely.

End of Life Care (EOLC) Initiatives:

End of Life Care Coordination Hub

The end of life care CRG would like to commission an integrated, outcomes-based service that improves the coordination and utilisation of services and resources across sectors to provide more joined-up care for end of life care patients. This will better enable a fast-response service to step-up and step-down delivery of care to meet patient needs.

The aims of the EOLC Coordination Hub are:

- To reduce inappropriate hospital admissions for this group of patients
- To facilitate more timely discharge of EOLC patients home, if that is their wish
- To ensure robust care plans and resources are in place to maintain patients at home, if that is their choice
- To improve quality of care and patient/family/carer experience
- To enable more patients to achieve their preferred place of care/death
- To enable the community nursing service to deliver a fast-response service to EOLC patients across a 24 hour period to meet changing needs
- Improve equality of access to end of life care services to all patients and their supporting families. Inclusion of people who are dying from conditions other than cancer, such as dementia, advanced frailty and co-morbidities, and people whatever their ethnic and social background and the Seldom Heard Groups.

Savings have been calculated using the 'NICE Commissioning and benchmarking tool: End of Life Care for Adults' (using estimated figure of 600 deaths preceded by hospital admission and £300 per excess bed day).

- Reduction in current levels of hospital admission ending in death by 10% = £190k
- Increase in current proportion of patients discharged before death by 10% = £109k

It is estimated that there will be approx. 200 – 250 patients on the Hub caseload at any one time. This is based on:

- There are 150-200 fast-track continuing care patients per year
- There are circa 200 patients on the community Specialist Palliative Care CNS caseload. This number will include the majority of all EOLC patients with a prognosis of 12 weeks or less in Wandsworth

Integrated Health Care Assistant Role

Through their initial training and on-going development, HCAs will develop an enhanced understanding and experience of the nature and context of end of life care beyond that of a generic community HCA or domiciliary carer; enabling them to provide a different level of both physical and psychological support to patients and their family/carers.

The aims of this project are to deliver integrated and skilled care to patients at home via a generic HCA role providing health, personal care, carer support and elements of social care to end of life patients and their families; to reduce the risk that care breaks down where complex symptom and/ or social care needs make home management otherwise difficult to sustain/deliver.

Projected savings:

Cost of HCA service commissioned via the Co-ordination Hub will be subsidised at circa 50% by the Marie Curie Nursing Service. This provides an opportunity for substantial savings on cost of CHC care for EOLC patients via this Hub HCA service compared to the generic nursing agencies currently commissioned by the Continuing Health Care team.

There will also be a saving of clinical time across the system through providing a one-stop shop and support for GPs/Health Care Professionals in caring for the patient, relieving clinicians from administrative tasks.

Volunteer Project at Trinity Hospice

This project is part of a range of commissioned services and initiatives under the "EOLC system" umbrella, designed to deliver holistic and joined-up care to EOLC patients in Wandsworth. This initiative works in conjunction with other community services to support patients at home, prevent inappropriate admission to hospital and support discharge home. It seeks to provide additional elements to commissioned services through the voluntary sector to support the CCG OOH strategy.

Aims of the service as follows:

- To support the reduction in inappropriate/unwanted hospital admissions for this group of patients
- To facilitate more timely discharge of EOLC patients home
- To improve quality of care and patient/family/carers experience
- To improve use of resources across all sectors
- To enable more patients to achieve their preferred place of care/death
- To reduce social isolation often experienced by some EOLC patients
- To improve coordination of volunteer input to Wandsworth EOLC patients
- To build on existing relationships between Trinity Hospice and community nursing services, GPs, continuing care etc.
- To provide holistic support and companionship to EOLC patients/families

There will be an initial team of 30 trained volunteers; patient numbers and activity will depend on referrals and patient needs.

Falls Initiatives:

Integrated Falls and Bone Health Service

Recent reviews and guidelines suggest multi-disciplinary falls assessment and intervention, including exercise, should be considered alongside osteoporosis diagnosis and management to reduce the number of falls and fall-related injuries (NICE, 2004; Skelton & Todd 2004; DoH 2001; DoH 2007).

To ensure patients who have sustained a fall in the past year and/or are concerned about falling in the future, receive falls risk assessments and are referred into evidence based falls prevention exercise programmes where appropriate. Funding is required to sustain the expansion of the “falls” element of the service ensuring that 2063 patients are referred to the service per year and access B+OOST and/or home exercise classes.

Pharmacist Support Role

Osteoporosis is typically a chronic, asymptomatic condition requiring long-term treatment. However, even when diagnosed, osteoporotic patients do not usually perceive any clinical benefit from taking their medications. A study concluded that approximately 50-75% of women who initiate any type of anti-osteoporosis drug therapy (Bisphosphonates, Calcitonin, HRT, SERM) are no longer persistent 12 months after initiation of the treatment.

This programme is designed to ensure pharmaceutical provision is available within the community to support medicine use and compliance, in particular relation to patients with bone health conditions.

Age UK Handyperson Service

The handy person service supports older people living in Wandsworth remain safe and secure in their home environment and to maintain independent living for as long as possible.

Fracture Liaison Service

Studies from the UK and abroad consistently report that half of hip fracture patients have a history of previous fragility fracture and that osteoporosis treatment from the time of the first fracture in these patients will prevent around half of subsequent hip fractures. The Fracture Liaison Service is a proven at identifying patients at risk of hip fractures.

The integrated Fracture Liaison Service (both within the acute and community), proactively case finds patients who have had fragility fractures in the past or are at risk of osteoporotic

fractures. The Fracture Liaison Service also investigates bone density, starts drug and other treatments to reduce the risk of a future break and liaises directly with falls services to monitor and maintain medication adherence.

This service is evaluated and performance managed in accordance with the KPIs in the service specification.

Wandsworth Housing Adaptations and Repairs Forum (WHARF)

This service ensures that a single point of contact service is available to frontline health and social services professionals to support vulnerable individuals at risk of falls, to signpost and refer them on to falls prevention and housing services where appropriate.

2.3.3. Outcomes and evaluation

The evaluation of the CAHS redesign programme will be supported by management consultants Finnamore as part of the overall Out of Hospital Strategy.

All other services outlined in section 2.3.1 have KPIs set out within their individual service specifications against which they will be monitored and evaluated.

KPIs for individual elements of the CAHS service are currently under development, however savings for the programme have been estimated using the same benefits mapping approach described in section 2.2.3.

2.4 Urgent Care and GP Out of Hours

2.4.1. Evidence and Rationale for Inclusion

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.

CCGs have a statutory duty to assist and to support NHS England in securing continuous improvement in the quality of primary medical services. 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, as people are living for longer with long term and often multiple conditions, more complex care in the community is necessary. 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. Summary of Initiatives 2014-16

2.4.2.1. Improving Access to Primary Care Contract

The Improving Access to Primary Care enhanced contract for 2014/15 will be offered to general practices as a one year pilot building on the Urgent Care Local Enhanced Service 2013/14. Introducing more flexibility in how and when additional hours are provided and by whom, the service specification also encourages a move towards increased use of online facilities such as booking appointments and ordering repeat prescriptions. Integrated system working is supported by the service specification as it includes more emphasis on the use of special patient notes and the review of post event messages which follow a 111 contact. Progress is being made for 111 services to be able to book appointments directly into the practices system if deemed clinically appropriate.

2.4.2.2. Supporting 7 Day Working

Wandsworth CCG is supporting the move to seven day working by increasing the flexibilities of the enhanced service contract 2014/15 as described above.

Funding that has in the past been used for various extended hours schemes across Wandsworth, is to be re-distributed in 2014/15 to each locality in an equitable fashion for the provision of additional access on Saturdays and Sundays. It is anticipated that these extended hours will be used for both routine and urgent appointments and located in 3 or 4 centres across the borough provided by the GP Federations or a suitable alternative provider.

2.4.2.3. NHS 111, Out of Hours, Single Point of Contact and Urgent Care

Currently the majority of general practices in Wandsworth are open during core hours, with some extended hours until mid-evening, if care or advice is required outside of these times patients are triaged by either 111 or the out of hours service provider. At this time, both services are provided by Harmony.

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; a communication 'gateway for primary health and social care professionals to access a range of community services within Wandsworth or other sites agreed by commissioners
- 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
- provision of out of hours GPs at a number of community clinics operating until 10pm each day of the week

2.4.2.4. Providing a Seamless Service

As mentioned in section 2.4.1, it is of vital importance that patients receive timely, appropriate and safe treatment, regardless of when and where they have a consultation with a health professional. Ultimately a patient should be treated seamlessly without the need for delaying treatment or asking them to be seen a few hours later by another health professional that is familiar with their care plan.

Evidence shows that continuity of care leads to better outcomes, increased patient satisfaction, more personalised decisions on care, effective care out of hospital and early diagnosis (NHS England, 2013).

One of the primary aims of procuring an integrated 111, urgent care and out of hours service was to ensure greater harmony between these services and present a seamless patient pathway. Key enablers include: the review of Special Patient Notes (SPN), the provision of a single point of contact and full access to the patient's electronic records for the out of hours clinicians.

The Improving Access to Primary Care 2014/15 enhanced contract also supports this seamless working by incorporating a clause stating that any provider signed up to the contract will review all SPN's held by the out of hours providers and update or delete where appropriate.

2.4.3. Outcomes and Evaluation

The following criteria will be used as measures of success for the Improving Access to Primary Care Enhanced Contract:-

Improved Patient access to primary care – Number of appointments outside core hours	Measured on template
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Improved patient satisfaction	Monitored via the national patient survey and /or practice survey monkey
Increase in number of Special Patient Notes	Measured on template
Review of Special Patient Notes	Measured on template
Improved Patient access to primary care - Electronically	Measured on template
Booking Requests from 111 service	Measured on template
Redirection Appointment requested	Measured on template

At the end of the pilot year, robust evaluation will take place and feed into future commissioning decisions. This could include further innovations around seasonal flexibilities, in house capacity and different modes of consultation.

The NHS 111 service in Wandsworth is a nationally negotiated 2 year pilot with some local additions. A new 111 service specification is being developed as part of the NHS 111 London Learning Programme and is expected for 2015/16. Wandsworth CCGs integrated service specification is monitored on a monthly basis via a large number of key performance indicators, details of which can be found in the NHS Wandsworth NHS 111 Service Specification v8.0.

Since its launch in Wandsworth in November 2012, Co-ordinate My Care has been funded centrally by NHSE (London) as part of the roll-out of 111 across London. It has been confirmed that this arrangement will continue for a further year with effect from 1 April 2014 but with no confirmation of funding beyond 31 March 2015. **As such, there is the potential for a cost-pressure from 1st April 2015 that is being flagged here.** At this stage, the likely funding requirement is unknown. Previous estimates have been in the region of £50,000 for Wandsworth.

Chapter 3. Enablers

3.1 Patient and Public Involvement

3.2.1. Evidence and Rationale for Inclusion

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

3.2.2. Outcomes and Evaluation

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.
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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.

3.2.3. Equality and Diversity

Wandsworth CCG is steadfast in its commitment to the Equality and Diversity agenda and is dedicated to making local services accessible to all the diverse communities that make up Wandsworth. To this end, each of the project leads involved in the out of hospital plan has been asked to consider the potential impact of their work-streams on all communities and complete an Equality Impact Assessment (EIA) where appropriate.

See appendix A for a summary of the EIAs completed in relation to the ‘5 Year Plan for Out of Hospital Care for Adults.’

3.2 Clinical Leadership and Localities

3.1.1. Evidence and Rationale for Inclusion

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 Department 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

Session numbers for each of the clinical leads are determined by evidence of how much clinical input is required and this may vary throughout the year. In 2014/15 it is expected that the sessional rate for clinical leads will increase by 14% to take into account the requirement for practices to pay pension costs to locum doctors.

In addition to clinical leadership through CRGs, the 3 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.

From 2014/15 the locality teams will also be responsible for a 'locality investment budget' (previously FURs) which will further the bottom up approach to commissioning across the Borough.

3.1.2. Outcomes and Evaluation

Each CRG and locality reports annually to the CCG board, which includes a recap on actions in the previous 12 months and plans for the following 12 months. These in-depth

focus areas give board members the opportunity to ask questions and seek clarifications on proposals.

In addition, each group maintains work plans and project workbooks for the financial year which are updated outside of the CRG by the GP chair and commissioning manager.

Clinical leadership and localities are direct enablers to savings within projects, and are therefore not counted separately.

3.3 Communication and Engagement

3.3.1. Evidence and Rationale for Inclusion

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. The objective is to develop a campaign to support this which is;

- Clearly different and higher impact than the old DH 'Choose Well' style campaign
- Evidence based and targeted at specific groups
- Based on insight from patients and representative samples of the public of Wandsworth
- Flexible to accommodate different messages according to the priorities identified
- Designed to have a life-span of longer than just winter
- Able to demonstrate value for money in the context of linking behaviour change to a reduction in A&E attendances

3.3.2. Outcomes and Evaluation

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>).

A specific implementation plan will be developed with Wandsworth CCG. However the campaign could be delivered at any time of the year, and with a very short lead-in time after the project spec is agreed. A suggested timeline for a winter campaign is outlined below:

Key tasks	Timescale
Project spec agreed	Spring 2014
Social marketing research project/ pitch process to assess campaigns	Spring 2014
Campaign proposals finalised and presented to WCCG Board	Summer 2014
Campaign agreed	September 2014
Campaign delivered	November 2014 – January 2015
Overall campaign evaluation	January 2015

3.4 Project Management

3.4.1. Evidence and Rationale for Inclusion

To support the roll out of various elements of the out of hospital strategy, a number of project leads have put in requests for short term project management support.

In the past, employment of contractors on a short term basis has been instrumental in the rapid work up and implementation of CCG and PCT projects. Whilst this has been in part due to limits placed on management costs and a lack of internal expertise in some areas i.e. EMIS; it could be argued that this short term approach has led to a loss of organisational knowledge, where project handovers have not been as in-depth as required. In some cases the lack of continuity of support may also have led to underperformance of projects once the contractor has left the organisation.

Never the less, due to constraints on head count within the CCG, it is clear that additional project management support will be vital in the implementation of this plan, enabling us to begin delivering improvements in care and generate the savings expected as rapidly as possible. The various requests for project management support have therefore been pooled and it is proposed that a central project management resource is formed by employing whole time individuals on fixed term contracts, which will not only cost less but also deliver better continuity of support.

Chapter 4. Finance, Activity and Savings

4.1 Summary of costs

Figure 5 shows a summary of the expenditure in 2013/14 for each of the service areas described in this plan, along with the new recurrent and non-recurrent investment required in 2014/15 and 2015/16 for full roll out.

Financial Year	New Investment Recurrent (£000s)	New Investment Non Recurrent (£000s)	Total Investment
2014/15	1,437	5,949	7,386
2015/16	1,018	5,230	6,247

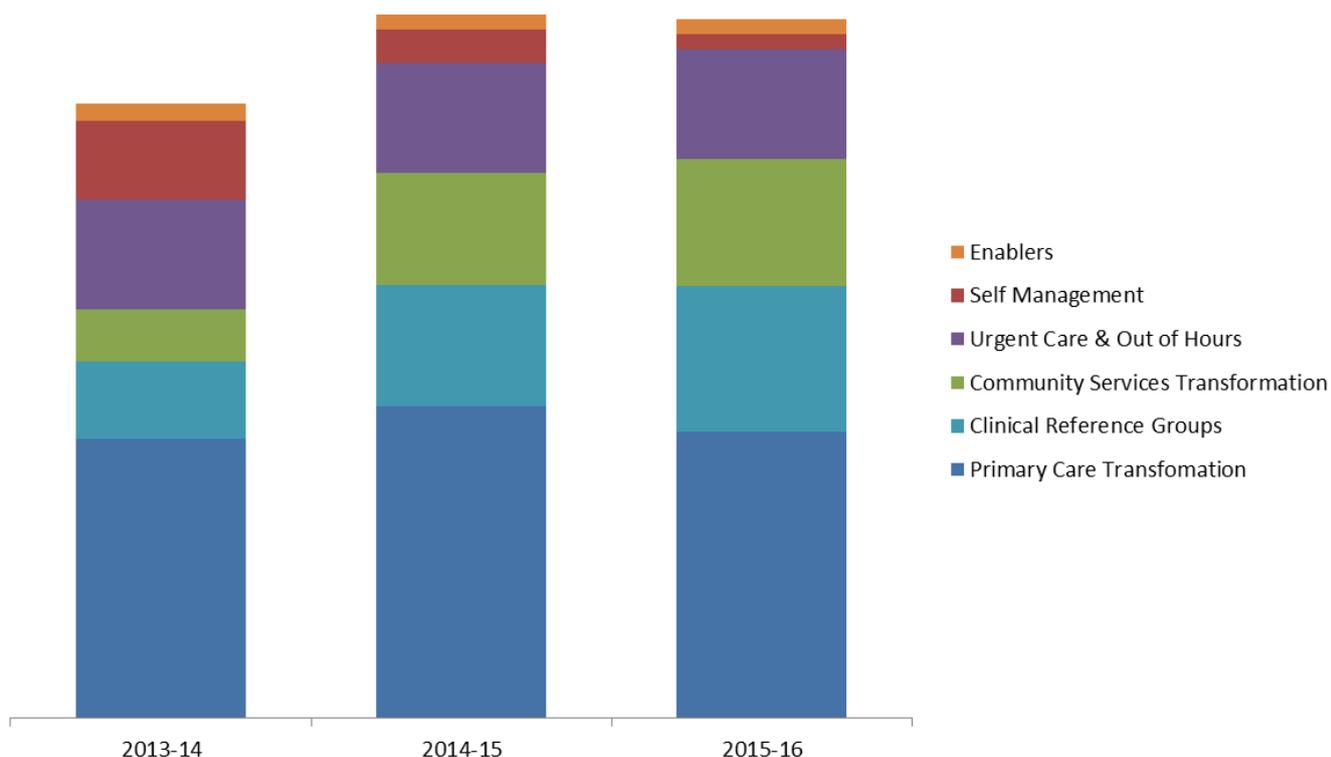


Figure 5. Investment required for implementation of the out of hospital plan over the next 2 years.

4.2 Projected Activity and Savings

Work to quantify reductions in acute activity as a result of the out of hospital programme and define activity trajectories against a 'do-nothing' scenario is currently on-going. However, current projections of activity correlated against savings, indicate that the programme will become self-funding as of year 2 (2015/16).

Chapter 5. 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.

Due to the large number of initiatives incorporated within this programme of work and the potential for duplication in assigning benefits at individual project level, it has been agreed that the overall plan will be monitored on a monthly basis against a set of metrics developed to reflect the overarching aims (see chapter 6).

This monitoring will be incorporated into the regular reporting 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.

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

For the purposes of assurance, individual project managers will be expected to maintain a project workbook, updated on a monthly basis to capture the following:

- Progress against agreed key performance indicators (KPIs) and project milestones
- Budgetary information and savings (if relevant)
- Attainment against relevant National Outcome Framework indicators
- Exception reporting (where relevant)

The Out of Hospital programme manager will be responsible for collating these into a single out of hospital update which clearly identifies areas of slippage and potential risk along with mitigating actions. The South West London Collaborative has recently developed a reporting tool which may be suitable for this.

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 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.

Chapter 6. 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 (as described above, the South West London Collaborative has recently developed a reporting tool which may be suitable for this).

No	Key Performance Indicator	Metric
1.	A&E Activity	All A&E Attendances
2.	A&E Activity	All UCC Attendances
3.	Outpatient Activity	All First Outpatient Appointments (general and acute)
4.	Outpatient Activity	GP Outpatient Referrals
5.	Outpatient Activity	GP First Outpatient Attendances
6.	Non Elective Admissions	All Non-Elective Admissions (excluding maternity)
7.	Non Elective Admissions	CAHS Indicator 2.6 (Ambulatory Admissions)
8.	Non Elective Admissions	CAHS Indicator 2.7 (Avoidable Admissions)
9.	Non Elective Admissions	CAHS Indicator 3.1 (Epilepsy and Diabetes)
10.	Non Elective Admissions	CAHS Indicator S1 (Injuries and Accidents)
11.	Non Elective Admissions	CAHS Indicator S2 (Miscellaneous)
12.	Length of Stay	To be defined

The out of hospital plan as a whole will be monitored on a monthly basis against the 12 activity metrics set out above. 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, each of the projects within the out of hospital plan have been mapped against the NHS Outcomes Framework indicators and against the 7 areas of quality highlighted in David Nicholson's letter to commissioners (dated October 2013 (see appendix B)). 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.

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