NHS NORTH CENTRAL LONDON
QUALITY INNOVAITON PRODUCTIVITY & PREVENTION
CARE CLOSER TO HOME PROGRESS REPORT

Introduction

This report updates the Joint Health Overview and Scrutiny Committee (JHOSC) on the current Care Closer to Home programme as part of North Central London QIPP Plan. The report covers the following areas:

1. Scope of Care Closer to Home programme
2. Current progress across boroughs
3. Financial and non-financial benefits
4. Risks to the current programme
5. Future plans

Scope of Care Closer to Home Programme

North Central London has an ambitious QIPP delivery plan aimed at redesigning services and systems, improving quality and increasing productivity with the aim of realising £137m savings crucial to its financial recovery. Care Closer to Home is a fundamental part of that programme and aims to realise £4.922m savings for 2011/12.

Care Closer to Home as a concept has been around for many years from service redesign led by the previous Modernisation Agency to more recent Healthcare for London and the development of polysystems. The latter resulted in PCTs undertaking clinical engagement work across primary and secondary care, often working jointly with Practice Based Commissioners to develop new pathways and service specifications for community based services as an alternative to hospital based care, particularly out-patient based care. Indeed most of the initiatives within the 2011/12 Care Closer to Home programme have originated from teams within each of the 5 boroughs.

Care Closer to Home can be separated out into 3 key elements:

1. **Admissions Avoidance**: these initiatives aim to provide robust clinical and case management of patients to prevent either an admission or a re-admission. These initiatives require all elements of the whole system to work together: commissioning, primary care, community services, social care and secondary care in an integrated way. An example of this work is the development of "*Virtual Wards*". This concept originated in Croydon and identifies service users who are at risk of admission, using primary and secondary care data, applies risk stratification, and "*admits*" high risk patients

into the "*virtual ward*" which aims to assess, treat and stabilise service users, in their own home, using the skills of a multidisciplinary team (MDT). The MDT, made up of a number of local providers, undertakes "*ward rounds*" as part of its assessment and management until they are fit for discharge.

2. **Long Term Conditions**: there is a considerable body of work that demonstrates that earlier diagnosis, supporting self-care, more robust ongoing clinical management and providing rapid response to crises, when required, provides a better pathway for patients with long term conditions. Much of the focus has been on Diabetes, Chronic Obstructive Pulmonary Disease (COPD) and Heart Failure. Both Diabetes and CHD National Service Frameworks have been around for many years and therefore many PCTs developed services for those patients in previous years. However this is not consistent across the 5 boroughs and therefore this remains a key development for Care Closer to Home QIPP. Like Admissions Avoidance above, the development of community based services for patients with these 3 conditions require providers across primary, community, secondary and social care to work together to as part of an integrated team to achieve maximum impact for patients.
3. **Planned Care:** this encompasses the majority of the initiatives within the current Care Closer to Home programme and these do not require the level of integration outlined above for admissions avoidance and long terms conditions. Community based services have been developed for dermatology, cardiology diagnostics, oral surgery, ENT and Ophthalmology. These initiatives are very much about redesigning current out-patient services into lower costs setting.

In all above cases, redesign aims to better define the patient journey, taking account of best practice, and redefines what care takes place within primary, community and secondary elements as well as better defining the transitions between those elements.

Current Progress across the Boroughs

The following table highlights progress for each initiative within each borough

BOROUGH	INITTIAVE	START DATE	SAVINGS
BARNET	Cardiology	1st April 2011	£250,000
	Urology	1st April 2011	£201,000
	ENT	1st April 2011	£105,000
	Gynaecology	1st September 2011	£232,000
	Ophthalmology	1st July 2011	£107,000
	Admissions Avoidance	1st January 2012	£97,000
CAMDEN	Cardiology	1st September 2011	£96,000

	Anticoagulation	1st April 2011	£890,000*
	Dermatology	1st April 2011	£530,000*
	Dermatology	1st July 2011	£135,000
	Virtual Wards	1st April 2011	£200,000
ENFIELD	Gynaecology	1st September 2011	£189,777
	Colorectal	1st July 2011	£0
	Ophthalmology	1st September 2011	£140,777
	Virtual Wards	1st April 2011	£160,000
	Care Homes	1st April 2012	£75,000
HARINGEY	Dermatology	1st April 2011	£45,000
	Diabetes	1st April 2011	£47,000
ISLINGTON	Anticoagulation	1st April 2011	£300,000*
	Dental/Oral Surgery	1st April 2011	£284,000
	COPD	1st April 2011	£0
TOTAL			**£3,988,554**

*Savings already realised

Current work is focusing on implementing the above services and on developing monitoring of those already operational.

Stakeholder Engagement

The majority of Care Closer to Home initiatives has been developed within the boroughs and within PCTs. Clinical engagement with both primary care secondary care clinicians on specific initiative has been focused at a borough level and GP commissioners have often led those discussions. Cluster level clinical engagement has taken place and focused on the wider QIPP agenda rather than on very specific initiatives.

Engagement with patients and the public has also focused at a borough level. PCTs have undertaken various levels of engagement and formal consultation with their residents on either very specific initiatives or on their strategy for care closer to home (e.g. a primary and urgent care strategy). Some boroughs have engaged with patients specifically on the development of pathways and service specifications. In addition there has been cluster wide discussion with LINKs as part of the wider QIPP agenda.

Some of the initiatives have been jointly developed between local borough health and social care teams to ensure an integrated approach to both development and delivery e.g virtual wards.

Financial and Non-Financial Benefits

Care Closer to Home aims to realise savings from the above initiatives of **£4.922m.** In addition, the programme has been asked to realise a further **£1.5m** savings from

additional initiatives. Most of the savings are due to the fact that services are redesigned and delivered at lower costs than current Payment by Results national tariff system and therefore the above table represents the net savings after the costs of providing the community based service.

As stated previously most of the above initiatives were developed within PCTs during 2010/11 with some further planning and implementation during 2011/12. Services can be commissioned via one of 3 routes

1. Contract variation with current provider
2. Any Willing Provider (Any Qualified Provider)
3. Invitation to tender (ITT)

Boroughs have undertaken the range of those options and hence there are different start dates for services. For areas that have been severely delayed then an assumption is applied that zero savings will be achieved for 2011/12. Monitoring of activity and finance for both the community based services and the remaining acute Trust based service will be undertaken as part of a wider monitoring tool to ensure savings are being realised. The monitoring tool includes elements of the non-financial benefits of those initiatives to ensure a full QIPP approach.

Included within the monitoring tool are the following **non-financial** benefits:

1. Clinical Outcomes	
%age of people feeling supported to manage their condition (EQ-5D/questionnaire)	
# Admissions Following Discharge from Community Service	
%age of referrals from community services to acute provider	
RAG Status for Clinical Outcomes	
2. Process Outcomes	
# Complaints	
Avg Response Time to Complaints	
# Complaints completed within NHS national requirements	
# Did Not Attend (DNAs)	
%age of patients seen by the service and referred back with management plan to GP	
RAG Status for Process Outcomes	
3. Other Outcomes	
%age of ethnicity recorded	General

The Financial and Non-Financial indicators will form a generic minimum dataset across all the initiatives as well as there being service specific outcomes. This dataset

will then be reported monthly, from July 2011, to capture performance all community based services that have commenced. Services will have "service-specific" outcomes which will also be monitored as part of QIPP performance management.

Risk to the Current Programme

The programme is ambitious and comprises a wide range of initiatives as outlined above. Most of the services have now commenced and will be monitored in terms of activity, finance and outcomes, the rest require to be operationalised. The outstanding areas are being project managed to ensure they meet their start date.

The most significant risk lies with achieving the £4.922m core savings and the £1.5m savings form additional projects. To meet both of those discussions have taken place with all borough teams and agreement to expand across NCL those service developments already operational within some of the boroughs. In particular:

1. Cardiology: development of community based cardiology clinical assessment and diagnostic service with a view to increasing treatment modalities
2. ENT: development of community bases assessment and treatment services for a specified range of ENT conditions
3. Gynaecology: development of community bases assessment and treatment service for agreed range of gynaecological conditions
4. Oral surgery: expansion of the dental referral management service and the development of community based Intermediate Minor Oral Surgery service (mainly wisdom tooth extraction).

The risk lies with the challenge of ensuring implementation this year particularly in achieving clinical leadership and sign up within consortia and Trusts to support and drive forward the developments and on achieving procurement and contracting route that is able delivery implementation during 2011/12.

In addition, cluster developments are taking place to develop plans to assist Trusts in the reduction of re-admissions within 30 days, part of the 2011/12 Operating Framework. Boroughs have worked with their whole system to identify opportunities for investment as part of the Re-ablement funding. This work will be further developed with Trusts to agree areas for investment this year in order to enable Trusts to reduce re-admissions.

Future Plans

NHS North Central London is currently developing its 4 year QIPP plan in line with all other London clusters. Part of this work will be working with all key stakeholders to develop areas for redesign. Some of these initiatives may be focused around very specific conditions;

1. Ophthalmology: particularly NICE approved glaucoma referral refinement service
2. Rheumatology: patients with a variety of inflammatory conditions could be managed within community based services
3. Heart Failure: both in assessment of breathlessness, integrated with COPD breathlessness assessment, and in the management of stable HF patients
4. Urology: the development of community based services which are integrated across primary, community and secondary care

In addition, work is underway to develop initiatives aimed at reducing re-admissions to hospital within 30 days of a discharge. For 2011/12, the focus may need to be on increasing capacity within re-ablement initiatives to ensure reductions for this year. In the medium to long term then sustainable change requires whole system change.

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