Item 3.1

Business Case

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Consultant Physician and Clinical Director for Diabetes and Endocrine Services

For East and North Hertfordshire Foundation NHS Trust
DIABETES INTEGRATED TELEHEALTH PROJECTS
Young people aged 16-30 with type 1 Diabetes
Older people with type 2 diabetes and Chronic Kidney Disease (CKD)

Date

28th November 2014
Introduction

Diabetes is reaching epidemic proportions, affecting 6% of the adult population with prevalence projected at 10% by 2025. Diabetes contributes to 10% of total NHS costs, currently £10billion per annum.

ENHCCG are committed to redesigning the Diabetes care pathway to build on the current commissioned services to support patients across primary and secondary care.

This proposal sets out an innovative approach to care for 2 high risk populations that consume important health resources with potentially avoidable hospital admissions and related morbidity. The proposal supports ENHCCG Local Ambition 2, enhancing recovery and preventing Diabetes associated complications.

1. **Young People aged 16-30 with Type 1 Diabetes**

All patients with type 1 Diabetes aged 16-30 who are not regularly engaged with care will be supported by a telehealth consultative model bolstered by monthly access to the youth worker. Evidence demonstrates better engagement and reductions in HbA1c levels and reduced emergency admissions with Diabetic Ketoacidosis (DKA) with this type of approach. The use of a youth worker has been demonstrated to be effective in re-engagement for care process measures in cases with End Stage Renal Disease (ESRD) on dialysis and following transplantation.

2. **Older people with Type 2 diabetes and Chronic Kidney Disease (CKD).**

Increased education and up-skilling of primary care and community teams to provide early, integrated and holistic care to complex patients ensuring they access the right care, in the right place at the right time.

All older patients with Diabetes and CKD will be identified by practices and have virtual consultant case review followed by a telehealth practice consultation. The Consultant and Diabetes Specialist Nurse will provide case by case clinical support, utilise telemedical support, and provide case discussions of high risk cases to support care and treatment planning.

Background

The challenge of managing Type 1 Diabetes in adolescents and young adults locally and nationally is a current stated priority. Data sources show 250 patients aged 16-30 are in need of a different care model as they are not currently attending clinics or practices, routine blood and retinal screening resulting in hospital admissions with diabetes emergencies. This group contribute disproportionately to long term complications and have the highest incidence of presentation with proliferative sight threatening retinopathy.

The National Diabetes Audit 2012/13 demonstrates that of approximately 130,000 patients under the age of 40, only 29.1% of patients with Type 1 Diabetes receive 8 of the recommended 9 care process.

Older Patients with Diabetes and CKD are recognised as often presenting too late with advanced renal failure, advanced foot complications, previously unidentified and correctable metabolic bone health issues and complex anaemia, and have an increased

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1 Audits, clinic non-attendance, GP practices Diabetes risk registers and emergency admission data
risk for emergency ambulance call out with hypoglycaemia. At least 1 in 3 of these patients is currently managed in isolation in primary care. Increasing rates of End Stage Renal Disease in this cohort of patients were reported in National Diabetes Audit.

### Rationale for Case

1. **Young people aged 16-30 with Type 1 Diabetes**
   - Poor attendance at out-patient clinics.
   - Medium and longer term complications from Diabetes.
   - 120 potentially avoidable emergency admissions with DKA annually.

2. **Older people with Type 2 Diabetes and Chronic Kidney Disease**.
   - National Diabetes Audit shows increasing incidence of end stage renal disease.
   - Highest risk for foot emergency admissions with long lengths of stay.
   - High prevalence not under specialist care and need to use non clinic based resources to support primary care.
   - Inappropriate Diabetes therapy selection with potential cost savings through rationalised therapy.
   - Major risk group for emergency hypoglycaemia ambulance call outs.

### Proposal

**Young people aged 16-30 with Type 1 Diabetes**

The total number of Young people aged 16-30 with Type 1 Diabetes in East and North Hertfordshire is estimated to be approximately 700. Younger adults and adolescents with type 1 diabetes have particular needs that are often less well suited to traditional models of care. Attendance at hospital and Community Diabetes clinics focused at this age group is poor.

Currently East and North Herts NHS Trust recorded 84 first attendances and 726 follow appointments sent out to young adults with Diabetes aged 16-25 over a 12 month period. The DM CPTTS register identified 351 young adults aged 19-30 of whom 61% did not attend or cancelled on at least 1 occasion over a 2 year period.

There are 109 young persons aged 16-19 attending the transitional adolescent Diabetes services (54 at QEII and 55 at Lister). The non-attendance rate for this cohort in 2013 ranged from 11.4 to 18.8%. These DNA rates are worse than the total adult age group (8-11%) but the implications are greater in terms of adverse outcomes and admission rates.

In addition 40 cases have been ‘discharged to the GP ‘as per current standard hospital clinic policy although these cases all require on-going specialist support that they have chosen not to access. In addition, where young people have been offered alternative attendance at the community Consultant clinics alongside Diabetes Specialist Nurses non-attendance has been demonstrated to be a continued issue.

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2 Attenders and non-attenders have been broken down further by locality and by individual practices should this be required.
Younger patients disengaged from on-going specialist support have been found to have the worst metabolic control and in turn poor Diabetes Health outcomes. The recent National Diabetes Audit revealed the continued high incidence of premature morbidity with DKA admissions, early severe complications and a high relative risk of premature mortality amongst younger women with Type 1 Diabetes. The cost to the health services from this vulnerable group is disproportionate.

The have been several initiatives that have sought to re-engage with this vulnerable group. The challenge is regular review and non-engagement is evident from the poor outcomes and associated costs. Psychologist-paediatrician controlled randomised intervention with hospital based input has yielded negative results, despite considerable cost. A more patient focused approach that recognises the overall life challenges is needed.

**Proposal for Support**

To establish a 2 year pilot that combines the youth worker role alongside a DSN led telehealth support scheme to demonstrate the beneficial impact on the following measures:

- Contact with a member of the health care team via the youth worker.
- Improved attendance for clinics, routine blood tests and other screening tests – including retinal screening.
- Reduction in hospital admissions with DKA – all DKA admissions reviewed by members of project team.
- Improvements in measurable biomedical measures.
- Improved Patient Experience

The Newham Model has been adopted to support this validated new approach:

- WTE youth worker and Diabetes Specialist Nurse. The youth worker and DSN will be tasked with identification patients aged 16-30 with Type 1 Diabetes at practice level identifying those who have no regular speciality clinic follow up or who have poor control. This will be linked with the Acute and HCT clinic activity measures, especially those with poor glucose control (HbA1c >75 mmol/mol) and/ or those with recurrent admissions with DKA and early onset complications.
- Project manager time to analyse outcome measures.
- Consultant session availability to liaise with the youth worker and DSN supporting the services and agree an individualised care plan (clinical sessions weekly shared between the 2 lead consultants on the project).

**Older people with Type 2 Diabetes and CKD.**

Older people with Type 2 Diabetes and CKD have a risk of progression to End Stage Renal Failure and are vulnerable to a host of other complications including cardiovascular disease, bone and foot health problems, and blindness from related retinopathy. In addition the glycaemic control of this cohort becomes more complex. There is abundant information that over tight glycaemic control leads to more risk of hypoglycaemia and a greater risk of adverse vascular outcomes. Alternatively, even at the point of End Stage Kidney Disease on Haemodialysis there is evidence of the need to ensure adequate blood glucose control (HbA1c levels controlled below a level of 8.5% (70 mmol/mol)) to reduce progressive renal and vascular complications including the same CVD outcomes that
increase with over intensive control.

Reliance solely on current QoF points in primary care (measurement of eGFR, HbA1c, lipids and blood pressure, and the process of retinal and foot checks) will not ensure that older patients with Diabetes and CKD receive the holistic care recommended by the American Diabetes Association Guidelines, (there are currently no comparable guidelines in the United Kingdom). This requires attention not just to standard measures of BP, lipids, glycaemia and processes of care for retinal and foot health, but the need to ensure FBC, calcium and vitamin D status, and the recognition that this cohort is at particularly high risk for foot complications requiring case identification and ready access as high risk to podiatry.

In addition it has been shown that there is a significant financial cost resulting from ambulance call outs with hypoglycaemia.

Proposal for Support

To support and up-skill primary care and community services. The Consultant and Diabetes Specialist Nurse will provide case by case clinical support, utilise telemedical support, and provide case discussions of high risk cases to support care and treatment planning.

Patients will be:

- Identified and managed early
- Receive optimised integrated care from Primary care, Consultant and Diabetes Specialist Nurse
- Advanced care planning will be commenced as appropriate

<table>
<thead>
<tr>
<th>Primary Care</th>
<th>Community Service</th>
<th>Acute Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>70/80% of Diabetes Care</td>
<td>10/20% of Diabetes Care</td>
<td>10% of Diabetes Care</td>
</tr>
</tbody>
</table>

Integrated and holistic care via optimised pathway delivered through DSN and Consultant for older patients with Type 2 Diabetes and Chronic Kidney Disease

The role of the project manager will be to enable data capture and analysis 2-3 days a week and liaison with Pathology to identify practice based register trends in decline in eGFR that require red flag signalling for specialist referral from primary care.

The integrated model will ensure:

- Increased identification of high risk foot problems leading to more proactive podiatric
input with less hospital admissions with active foot complications. Early podiatric input will be expected but managed with the revised foot care pathway.

- More effective glycaemia management of older patients with Diabetes with CKD enabling effective use of safer therapies and individualised targeting. This will facilitate more conservative glycaemic control in this cohort of patients.
- Identification of early measures of metabolic bone disease and anaemia with appropriate therapy.
- Earlier identification of progressive changes in renal function requiring timely specialist intervention.
- Prevention and reduction of long term complications and admissions to hospital due to complications and at end stage of the disease.

### Impact assessment

#### Annual cost of two year pilot:

1. Consultant sessional salaries X 6 PAs £74K
2. Band 7 DSN WTE £44K
3. WTE Project manager Band 6 £36K
4. Youth Worker WTE Band 4 £25K
5. IT support £27K
6. Additional running costs £10K

Annual cost per annum £216K

Whilst the project aim is to ensure the two patients groups with diabetes care is optimally managed to reduce longer term complications associated with the disease there are some potential cost savings

1. Reduced DKA admissions £42,390
2. OPD appointment efficiency £20,000
3. Hypo ambulance call outs £79,595
   (excludes reduced ambulance costs)
4. Foot admission savings £60,000
   (estimated range of savings £40-80K)
5. Drug cost savings £10,000

Total estimated savings per annum £211,985

#### Quality

Outcomes identified below.

#### Stakeholder Engagement

Patient champions will be engaged to support the implementation.

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3 Full details available on request.
## Outcomes

### Short Term (over 2 years)
- Reduced hospitalisation for older cohort re: hypoglycaemia, foot disease.
- Reduced targeted DKA admissions in adolescent-young adult cohort where this is identified.
- Conservative management of stable moderate control elderly CKD with reduced drug costs.
- More efficient use of hospital OPD appointment slots and OPD sessions in HCT.
- Improved quality of life for patients.

### Longer term
- More effective patient focused engagement with established use of new technologies as alternative to traditional models of care.
- Integrated and holistic care provided to older patients with Type 2 Diabetes and CKD
- Reduced progression of end stage renal disease.
- Reduced micro (later macro) vascular complications in Type 1 Diabetes.
- Enhanced productivity and less sickness absence of those of working age.

### Impact on activity/ costs
- Reduced DNA rates and less hospital admissions. Reductions in ambulance call outs for hypos.
- Impact on quality – patient safety, experience, clinical effectiveness.
- Young people aged 16-30 with Type 1 Diabetes can be assessed for impact of telehealth and youth worker support.
- Savings from OPD, ambulance and admissions will be determined and compared to baseline.

### Outcomes Measures and Evaluation

1. **Young people aged 16-30 with Type 1 Diabetes** - Each of 250 cases will have an individualised care plan. Access and engagement with the DSN via Skype and the youth worker meetings will be assessed. Hospital admissions, attendance for blood testing, retinal screening, use of blood glucose monitoring, improvements in blood glucose control, quality of life measures will all be demonstrably improved according to the individual patient needs identified in the care plan.

2. **Older people with Type 2 Diabetes and CKD** - Practice register will be established for this cohort, Individualised care planning re: HbA1c targets and options for change of therapy with less expensive treatments if relaxation in glycaemic control required. Measurement and identification of need for treatment of metabolic bone and anaemia. Reduction in ambulance hypoglycaemic call outs. Earlier identification and onward referral for progressive CKD to specialist services. Reduced admissions or ambulatory
care of foot complications identified proactively.

Baseline measures will be audited

- Number of young adults taking up support- minimum of 10% of at risk group
- Baseline and post service changes in individualised care plan improvements
- Number of CKD cases in practice where changes in management – 20%
- Ambulance call outs for hypos reduced – 20%
- Reduced DKA admissions – 20%
- Reduced hypo admissions- 20%
- Reduced foot admissions – 20%
- QoL measures
- Patient Experience

Deliverability

- East and North Herts NHS Trust will secure services of the consultant time through backfill of 6 sessions for 2 years. Fixed term consultant post for 2 years.
- Project manager and Band 6 DSN employed through acute trust.
- Youth worker through acute trust or seconded from social services.

Risks and mitigation

<table>
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<tr>
<th>Risk</th>
<th>Mitigation</th>
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<tr>
<td>Securing personnel within time frame to start</td>
<td>Adequate run in time to start project in early 2015</td>
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<tr>
<td>Take up from young people</td>
<td>Youth worker and Expert patient to initiate early contact. Local press publicity</td>
</tr>
<tr>
<td>Workforce issues</td>
<td>Secondment if necessary</td>
</tr>
<tr>
<td>Risk around timescales</td>
<td>Project timeline mapping – adequate run in till project starts in 2015</td>
</tr>
<tr>
<td>Cost of project</td>
<td>Considered important pilot and exemplar of innovative care in National Work Programme under direction of the National clinical directors for Diabetes and CYP-Transition in NHS England</td>
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4 Data audited through ambulance and hospital baseline audit HRG-HES data and practice based data.
### Timeline/Key Milestones

1. Proposal finalised by end of November
2. Presentation and approval at the Organisational Performance and Delivery meeting December 2014
3. Advertisement of posts – January 2015
4. Interviews for posts – March/April 2015
5. Start of project June 2015 for 2 years

### Formal Sign off process

<table>
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<td>Date of Executive/Governing Body Approval:</td>
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East and North Herts CCG

Business Case

Business Case

Community Respiratory Specialist Service – Including Respiratory Nurse Specialists & Pulmonary Rehabilitation
Author: Jill Catchpole

CCG Contact

Dr Martyn Davies, East and North Herts Clinical Commissioning Group (E&NHCCG) Respiratory Lead Dolphin House, Ware
Dr Ash Shah, General Practitioner, Hatfield - Wrafton House Surgery
Dr Rachel Joyce, East and North Herts CCG Medical Adviser

Date
3/10/11

<table>
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<th>Reviewer</th>
<th>Action</th>
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<td>Dr A Shah</td>
<td>Review and Comment</td>
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<tr>
<td>V2</td>
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<td>Dr M Davies</td>
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<td>Dr R Joyce</td>
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<td>V5</td>
<td>17/11/14</td>
<td>Teresa Maczugowska</td>
<td>Review and Comment</td>
</tr>
<tr>
<td>V6</td>
<td>26/11/14</td>
<td>Amanda Flower</td>
<td>Review and Comment</td>
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1.0 Introduction & Summary

1.1 Respiratory disease is a major cause of disability and the third leading cause of death in England. It is one of the main reasons for emergency admission and accounts for significant NHS spend. 1 in 50 adults has chronic obstructive pulmonary disease (COPD) and 1 in 14 asthma.¹

1.2 COPD accounts for a major proportion of respiratory disease, in terms of disability, mortality and emergency admissions. For an average practice of 10,000, of the adult caseload ‘around 1.6% of this population, or around 128 people, would be diagnosed with COPD.’² There is a relatively low 10 year survival rate following diagnosis at approximately 50%.³

1.3 Evidence is “One in eight people over 35 has COPD that has not been properly identified or diagnosed, and over 15% are only diagnosed when they present to hospital as an emergency.”⁴ Late or under diagnosis has a strong link with hospital admission for exacerbations.⁵

1.4 An initial community service review, under Dr Martyn Davies, the Respiratory Clinical Lead, identified:—

- A lack of specialist community respiratory nurse service capacity, with fragmented and inequitable provision across the CCG
- Under resourcing of the Home Oxygen service which was only able to support about 1/3 of oxygen users
- Pressures on the pulmonary rehabilitation to meet increasing demand

These issues were identified as contributing to:

- High and increasing levels of hospital admission and failure to realise the potential to discharge early
- Lack of effective clinical and operational management of home oxygen and failure to realise potential cost savings
- Waiting times for Pulmonary Rehabilitation Services that were above NICE guidance

Additionally the quality team identified high levels of 30 day mortality associated with East and North Herts Hospital Trust

1.5 This document proposes to establish redesigned community respiratory nursing and pulmonary rehabilitation services to work with core services to deliver integrated multi-agency respiratory care pathways. The services would be for all adults with respiratory diseases but the majority of work would be with patients with COPD, hence the focus within the document. The proposals have been designed by a stakeholder group, to ensure optimal use of existing core and specialist services and to address:

- The need to improve clinical outcomes, e.g. reducing mortality
- Identified issues within the current pathway: education, training and support for early and accurate identification of respiratory disease, effective community management of avoidable admissions, early discharges and home oxygen, together with improved access to pulmonary rehabilitation
- Principal gaps in service across end to end pathways, including community respiratory nursing and capacity within pulmonary rehabilitation

1.6 Financial modelling suggests investment in community respiratory services will offer value for money. The proposal is to test the model over a 2 year period with a phased roll out and robust evaluation at 1 and 2 years to ensure an evolving model in line with CCG strategic developments.

1.7 The Long Term Conditions Board, are supporting this case for an integrated Community Respiratory Service.

¹ http://customer.instantatlas.com/NHALL/profiles/profile?profileId=14&geoTypeId=17&geoIds=06K
2.0 Background

2.1 Proposal Development
Following the outcomes of the respiratory review a multi-agency respiratory stakeholder group has developed a proposal to improve clinical outcomes and provide a viable alternative to hospital care for respiratory patients through a re-design of respiratory pathways which would

- promote early identification, self-management and intervention - helping people to stay well longer
- move appropriate care currently in acute care to the community
- utilise and upskill primary and community care services to ensure maximized potential to support the patient population

In order to deliver improved clinical outcomes, investment in community respiratory nursing and pulmonary rehabilitation services is required. These services would operate as a facilitator of integrated respiratory care across acute, primary and community health and social care services and offer value for money. This model supports the National Outcomes Strategy for COPD and Asthma 2011 aim to move away from largely reactive episodic hospital care to a systematic, pro-active community and patient centred approach rooted in primary care but underpinned by a multi-disciplinary management, particularly of COPD, supported by rapid access specialist respiratory practitioners and clinical leadership.

2.2 East and North Herts CCG Strategic Fit
Respiratory disease is a CCG commissioning priority. This business case links to

- the Commissioning Plan
  - Reducing current levels of variation, empowering patients to self-manage, reducing admissions for acute exacerbations
- the Strategic Plan
  - Develop Integrated Pathways for COPD, East and North Herts Trust Respiratory CQUIN, Self-Management & PHP provision in primary care

This case supports the priorities by making the case to commission a service for people with respiratory disease that:

- Improves health outcomes through admission avoidance and early discharge by effective, extended community service delivery
- Ensures an integrated, equitable approach long term condition and self-management, acute exacerbations and end of life care across primary, acute, secondary and community care using holistic pathways which are based on NICE guidance

2.3 National Evidence Base
2.3.1 The Inhale CCG Profile Atlas reports only 60% of COPD cases are diagnosed. Local evidence indicates variable diagnosis with recorded prevalence below that expected and some correlation between low prevalence and high admission rates, e.g. in Upper Lea Valley.

Table 1 Expected and Predicted East and North Herts CCG Prevalence Rates 2011: Source Inhale Atlas Report

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http://customer.instantatlas.com/NHALE/profiles/profile?profileId=14&geoTypeid=17&geoid=06K
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2.32 The benefits of treatment are reduced and healthcare costs increased if people are diagnosed either late or when admitted to hospital. Evidence from Commissioning for Value Pack published in November 2014.

2.33 Acute exacerbations are associated with worse quality of life, faster disease progression and increased mortality. Rapid treatment of exacerbations improves outcomes, resulting in faster recovery and fewer hospital admissions. Hospital at home schemes prevents hospital readmissions by between 10% and 30% e.g. Salford Community Respiratory Team.

2.34 About 60% of home oxygen users have COPD. Effective home oxygen services ensure oxygen prescriptions meet changing patient needs. Long-term oxygen can improve survival rates by around 40% but about 30% of people on home oxygen derive no clinical benefit.

2.35 Pulmonary rehabilitation is effective in reducing readmissions rates, improving health-related quality of life and cost-saving. One study showed an overall cost saving of £152 per patient per pulmonary rehabilitation programme.

2.36 The NHS Institute for Innovation and Improvement identified COPD as a condition where there is demonstrable benefits in terms of reduced readmissions and cost-saving.

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10 http://customer.instantatlas.com/NHALE/profiles/profile?profileId=14&geoid=17&geoid=06K
evidence for ambulatory care and reduction in admissions of between 20 – 30%. Community respiratory services targeted at supporting patients at home and minimising lengths of stay have reduced the number of emergency admissions for people with COPD by at least 20%.11

2.4 Current Respiratory Service Provision in East and North Herts CCG

2.41 There are approximately 8900 patients on the COPD practice registers. Recorded prevalence rates of 1.5% are below national average.

2.42 Primary Care

The E&N Herts CCG Commissioning Framework 2014/15 supports primary care to identify and manage of COPD through provision of self-management and personal health plans. Practices and localities show variability in:

- Prevalence recording and admission rates
- Knowledge, skills and resources to identify patients, support early and accurate diagnosis and manage exacerbations
- Management of Home Oxygen lists e.g. referral for review
- Practice Nurse Spirometry training – assessment and interpretation
- Ability for rapid access to social care services

2.43 Acute and Secondary Care Services

- Approximately 1500 COPD spells in 2013/14. Average Length of Stay: 7 days & 81 patient spells exceed trim point
- 27% of COPD admissions were weekend admissions
- 23% of people with COPD had 2 or more admissions, 1 patient: 25 admissions
- Respiratory out-patient attendances 2013/14:15,343 5,016 Firsts and 10,327 follow ups

Table 2: Three Year COPD Admission Trend & 2013/14 Admissions by Provider: Source Mede-analytics

<table>
<thead>
<tr>
<th>Year</th>
<th>Spells</th>
<th>Patients</th>
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<tbody>
<tr>
<td>2011-12</td>
<td>980</td>
<td>620</td>
</tr>
<tr>
<td>2012-13</td>
<td>335</td>
<td>255</td>
</tr>
<tr>
<td>2013-14</td>
<td>116</td>
<td>87</td>
</tr>
<tr>
<td></td>
<td>67</td>
<td>43</td>
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Table 3: Admission data for Selected Respiratory Disease across the CCG

Source Mede-analytics

Acute Consultant quote: ‘staying in is better for the patients as services are not available in the community’
2.44 Hertfordshire Community Trust (HCT) Community Specialist Respiratory Services

Current Block contract spend for nursing and pulmonary rehabilitation (including TB nursing) is £487,718

- **HCT Community Respiratory Nursing**

There is limited capacity within the services, inequity across E&N Herts CCG and a reliance on single practitioners. It is thus unable to respond in a timely manner. The nurse service has been primarily focussed in Welwyn and Hatfield, the Home Oxygen service is CCG wide. The service has delivered training and developed care pathways for Home-first. In Lower Lea Valley COPD admissions reduced following the introduction of Home-first.

a) **HCT Respiratory Nursing Establishment:**
   - Respiratory Nurse Specialist (0.4wte clinical- 0.3management)
   - Home Oxygen Nurse (1.0wte)
   - TB Nurse Specialist (0.8wte) – all ages, subject to negotiations regarding commissioning arrangements

b) **HCT Nursing Referral Activity:**

<table>
<thead>
<tr>
<th>HCT Respiratory Service Line</th>
<th>Referrals</th>
<th>Waiting times</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Oxygen</td>
<td>309</td>
<td></td>
</tr>
<tr>
<td>Respiratory Medicine</td>
<td>13</td>
<td>Average wait 6 weeks</td>
</tr>
<tr>
<td>Respiratory Nursing (excludes TB)</td>
<td>204</td>
<td></td>
</tr>
</tbody>
</table>

Community Matrons (non-respiratory specialists) informally estimate 50% of their workload includes respiratory disease (data cannot isolated to support this view). There are no standard competencies for core community teams to support respiratory disease and thus variability

- **The Community Home Oxygen Service**

This is a reactive service for about 1/3rd of oxygen users, staffing is insufficient to proactively identify patients for review. The current outturn prediction for home oxygen for 2014/15 is £711,103, with evidence of increasing costs.

Table 4: Average Cost per Day of Oxygen Services (Source Medicine Management Team)
Pulmonary Rehabilitation(PR)

384 group PR places are commissioned from HCT per annum. SEPT West Essex Community Services provide approximately 30 places per annum paid on a cost per case basis. The PR model includes assessment, group intervention and education from a range of professionals including IAPT. Completion rates are at the regional average of 63%. 610 referrals were received 2013/14, below the predicted levels (750-1150 places) based on population and prevalence. Patient feedback supports the benefits of PR ‘best thing that has happened’

2.45 Business case and project interdependencies

a) Acute Respiratory Services

The project is linked to acute respiratory service CQUIN developments, including East and North Herts Hospital Trust ‘HOT’ clinics and the Acute Chest Team (ACT). This will provide community Respiratory Consultants clinics and support equivalent to 4 community sessions per week. This is dependent on the establishment of 9 Consultants at East and North Herts Trust, which is subject to an internal business case.

b) Home-First Roll Out

Home-first provides the infra-structure to support an integrated model of respiratory provision. Evidence from Lower Lea Valley is there appears to be a HomeFirst effect on COPD admissions. The locality witnessed a 5.8% reduction during the first year compared to 2011/12 and a 22.8% reduction during 2013/14 compared to the 2012/13. Whilst this cannot all be attributed to HomeFirst it certainly is a coincidence as all practices with the exception of 2 saw a reduction in admissions.

Not all localities have HomeFirst and the planned rollout over a further 2 year period impacts the respiratory project as consideration is required to ensure equity of care.

c) End of Life and Ambulatory Care Projects
3.0 Rationale for Case

Evidence For Change

Respiratory disease places cost burden on the CCG. Much of this is associated with in-patient and home oxygen costs. Evidence from studies reported through NICE, The British Thoracic Society and IMPress\(^\text{12}\) indicate community respiratory teams and pulmonary rehabilitation can reduce hospital admissions, oxygen spend and facilitate early discharge, which improve clinical outcomes.

3.1 The Clinical Case

3.11 The Health and Wellbeing in Hertfordshire report for Respiratory Disease in Hertfordshire\(^\text{13}\) highlights from ‘2007 to 2010 NHS East and North Hertfordshire CCG had a higher mortality rate than both the regional average and NHS Herts Valleys CCG’. SHMI rates for respiratory disease continue to be high at East & North Herts Trust and an RCP Peer review is planned for February/March of next year.

3.12 The local prevalence rates for COPD suggests a risk of late diagnosis associated which is associated with poor health outcomes as under-diagnosis limits early access to treatments which slow progression and reduce risk of hospital admission.

3.13 In months 1-3 COPD admission rates were 11%, compared with a national average of 7.7%. Asthma admissions in Stevenage and Welwyn and Hatfield were above national average.

Table 6: NHS East & North Herts CCG COPD Activity Month 3 YTD 2014/15

Source Long Term Conditions Pack

3.14 Weekend COPD admissions in 201/14 were 27% of activity and 28% of cost. Current community respiratory services are 5 day only.

3.15 Readmission rates for 2013/14 were 23.8%, improved community services could maintain at people at home

\(^\text{12}\) http://www.impressresp.com/
Table 7: Readmission rates in the year 2013/14 Source: Mede-analytics

<table>
<thead>
<tr>
<th>Total Patients with included Diagnosis Codes</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No of Patients with 2 admissions</td>
<td>143</td>
</tr>
<tr>
<td>No of Patients with 3 or more admissions</td>
<td>96</td>
</tr>
</tbody>
</table>

3.16 The 709 patients on oxygen in July 2014 suggest high levels of sub-optimal oxygen therapies. A proactive service would improve identification and reviews, outcomes which cannot be realised by the current single practitioner service.

3.17 Referrals for community respiratory physiotherapy are increasing. Pulmonary rehabilitation although primarily offered to patients with COPD will accept other suitable respiratory conditions.

3.16 The 709 patients on oxygen in July 2014 suggest high levels of sub-optimal oxygen therapies. A proactive service would improve identification and reviews, outcomes which cannot be realised by the current single practitioner service.

3.17 Referrals for community respiratory physiotherapy are increasing. Pulmonary rehabilitation although primarily offered to patients with COPD will accept other suitable respiratory conditions.

Pulmonary rehabilitation improves quality of life in COPD patients.\(^\text{14}\) There is a shortfall in CCG commissioned Pulmonary Rehabilitation Group places based on evidence suggesting need for 750-1150 places. HCT are commissioned to provide 384 places, they received 610 referrals in 2013/14, with waiting times from referral to group ranging from 12-22 weeks. A community respiratory team is likely to further increase pulmonary rehabilitation referrals.

3.2 The Financial Case (Appendix 1 COPD Value Pyramid from Colin Sach)

3.21 The Health and Wellbeing in Hertfordshire report for Respiratory Disease in Hertfordshire\(^\text{15}\) states ‘For the financial year 2009-10, the programme spend on respiratory disease per 100,000 population in ‘East and North Hertfordshire PCT (roughly matches NHS East and North Hertfordshire CCG) it was slightly higher. For the specific conditions, COPD spend per 100,000 was lower in …East and North Hertfordshire….than the England average. The programme spend for asthma was slightly higher in East and North Hertfordshire PCT…..compared to the England average per 100,000.’

3.22 Evidence from restructuring of oxygen services in Herts Valley suggests savings of 18% each year for the first 2 years.

3.23 Evidence is effective community respiratory services reduce admission costs by 10-30%. The admission costs for East and North Herts CCG in 2013/14 (excluding A&E attendance) for COPD in a Primary or Secondary Diagnosis was £4,542,701 or £3,998,218 excluding activity where the primary diagnosis was not a respiratory condition. Admission costs associated with other Asthma, TB and Broncheastasis was £1,259,931.

3.24 Prescribing costs are increasing\(^\text{16}\). Evidence is prescribing costs can be managed by appropriate prescribing, inhaler usage etc results in fewer admissions\(^\text{17}\).

\(^{14}\) http://summaries.cochrane.org/CD003793/AIRWAYS_pulmonary-rehabilitation-for-chronic-obstructive-pulmonary-disease
\(^{16}\) http://atlas.hertslis.org/IAS/Custom/Resources/RespiratoryDiseasesPDF.pdf
3.3 Best Practice Models of Respiratory Care

The stakeholder group identified the best fit model to meet the need of East and North Herts residents is an integrated tiered service which

- Maximizes the use of existing non specialist resources through provision of a robust training and education programme and rapid access to specialist advice and support to manage individual patients in the community
- Supports early and accurate diagnosis
- Provides specialist clinicians to manage those with complex needs and support admission avoidance and early discharge
- Ensures equity across East & North Herts localities
- Initially focuses on adults and COPD but includes all appropriate respiratory diseases in the longer term
- Is supported by local integrated pathways of care and standardized information and management plans
- Addresses issues of rapid access to social care support
- Excludes redesign of TB services (potentially subject to separate commissioning arrangements)

To deliver this model, benchmarking of current community workforce indicates a shortfall in community respiratory resource.

4.0 Proposal

4.1 Service Aim

Provide a holistic person centred service which delivers improvements in clinical outcomes for patients diagnosed with respiratory disease, ensuring that clinicians across the pathway have the competencies to deliver the right services, in the right place and at the right time to meet patient and carer needs. The emphasis is on community services which support self-management plans, reduce avoidable A&E attendances/admissions and facilitate early discharge from in-patient care. The service to be provided in line with evidence-based guidance.
4.2 The Model of Community Provision

The stakeholder group identified the core components of a community respiratory service integrated with existing service as:

a) Supporting practices and the community in early and accurate identification of respiratory disease, exacerbations and management of complex patients

b) 7 day rapid and equitable access to specialist respiratory community support services offering a viable alternative hospital care

c) A flexible specialist nurse pool able to respond rapidly, support others and deliver a range of respiratory services including home oxygen and meet fluctuations in demand

d) Supporting self-management and standardizing information and personal health and action plans

e) Provide proactive services particularly in relation to identifying home oxygen users, complex patients and those at end of life

f) Timely provision of pulmonary rehabilitation

The model developed from utilises and up-skills existing services Appendix 2: Team roles and responsibilities within the tiers of service.

The stakeholder group identified that this model would be applicable to a range of respiratory conditions and offer value for money. The group has committed to develop a range of integrated pathways, policies and procedures to support implementation.

4.21 The Specialist Community Element of the Model

The community specialist service would provide ALL of the following, working in partnership with the acute Consultant out-reaches:

- Structured education and training programmes for community and primary care
- Locality based multi-disciplinary clinics, peer support and attendance at relevant practice and locality meetings
- Complex disease management across the pathway, in partnership with primary & secondary care – joint clinics
as appropriate

- Rapid specialist community assessment, advice and support services, with partners to support admission avoidance and early discharge
- A proactive oxygen and nebulizer assessment & review system including patient identification.
- Multi-disciplinary pulmonary rehabilitation and specialist physiotherapy that promotes optimal self-care.
- Identification of patients in last year of life and integration with existing community, palliative and end of life care services.
- Clinician and patient telephone support and telemedicine triage, if appropriate.
- Support for communication between acute, primary and community care on a patient’s condition and any treatment recommendations including robust plans for general practitioners to provide ongoing follow up once optimal care has been achieved.

4.3 Delivery of the Proposed Model

4.3.1 Primary, community and secondary care have been engaged in the development of proposals and pathways to support engagement in changing practice to support delivery. This is being supported by Commissioning Framework and CQUIN proposals for 2015/16

4.3.2 Whilst many of the key components of the respiratory service are deliverable within existing services, delivery of improved clinical outcomes and thus value for money is dependent on

- Establishing a larger pool of Community Respiratory Nurse Specialists able to support existing teams
- Improving timely access to pulmonary rehabilitation

4.3.3 It is recognised that a phased mobilisation of the proposed model will be required based on potential to recruit and train respiratory nurses. This provides the opportunity to test and evaluate the model of delivery and staffing assumptions and make appropriate alterations.

4.3.4 Due to the range of developments within the CCG and to ensure strategic fit it is proposed to test the specialist model over a 2 year period, finalising the specialist model to align with the completion of HomeFirst roll out.

4.3.5 Community Specialist Nurses

Benchmarking for nursing indicates that 10-12wte community respiratory nurses are required to staff a specialist community model; this would require an additional 8.6-10.6wte respiratory nurses beyond current community establishment to deliver 7 day services.

Given the evident impact of HomeFirst two potential models for delivery have emerged

a) Bespoke delivery: Establish 10wte Community Respiratory Nurse Specialists to work in partnership with existing services.

b) An Integrated model with HomeFirst: with a smaller team of Community Respiratory Nurses working with up-skilled Community Matrons already in/projected to be in HomeFirst. This was felt to be a viable and sustainable competency based model.

Initial calculations were taken matching 1 respiratory and 1 community nurse. This would require 5.4wte nurses, an additional 4wte above existing establishment.

Following external critical friend advice, together with consideration of timescales for HomeFirst roll-out, these figures were amended. Advice has been that the 5.4wte would be insufficient and 7.4wte nurses were advised, an additional 6.0wte. The phased roll-out of HomeFirst would indicate the potential to review and reduce the level of specialist nursing overtime, dependent on community team up-skilling and outcomes.
### 4.36 Pulmonary rehabilitation: 5 day Service

The options to address the identified shortfall in pulmonary rehabilitation places are:

<table>
<thead>
<tr>
<th>Current service</th>
<th>Option 1: No change</th>
<th>Option 2: Bespoke Delivery</th>
<th>Option 3: Integrated HomeFirst</th>
<th>Option 3a: Integrated HomeFirst (roll out)</th>
</tr>
</thead>
<tbody>
<tr>
<td>WTE</td>
<td>WTE</td>
<td>WTE</td>
<td>WTE</td>
<td>WTE</td>
</tr>
<tr>
<td>Band 8a Nurse</td>
<td>0.70</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Band 7 Nurse</td>
<td>1.00</td>
<td>0.00</td>
<td>4.00</td>
<td>4.00</td>
</tr>
<tr>
<td>Band 6 Nurse</td>
<td>0.00</td>
<td>0.00</td>
<td>4.60</td>
<td>0.00</td>
</tr>
<tr>
<td>Band 3 Admin</td>
<td>1.00</td>
<td>0.00</td>
<td>1.50</td>
<td>1.50</td>
</tr>
<tr>
<td></td>
<td>2.70</td>
<td>0.00</td>
<td>10.10</td>
<td>5.50</td>
</tr>
</tbody>
</table>

4.4 Proposed Community Service Structure

4.41 The community respiratory service would have rapid access to support from Respiratory Consultants and acute care services.

4.42 The service would flex across the CCG reflecting fluctuations in locality demand. The service would ensure a daily rapid responder for admission avoidance and early discharge and include leads in at minimum COPD, asthma & home oxygen.

4.43 All nurses to be advanced respiratory practitioners with access to prescribing and able to provide home oxygen assessment and review.

4.44 Pulmonary rehabilitation to provide group and individual interventions, working with others to ensure maximised uptake and completion.

4.45 Services to work closely with social services, to address care needs and have strong links with IAPT to manage anxiety.

### 4.5 Options for delivery:

The options are presented as separate nursing and pulmonary rehabilitation units allowing for a mix and match approach to commissioning.
### 4.51 Community Respiratory Nurse Service

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
<th>Recurrent</th>
<th>Non Recurrent</th>
<th>Total Additional Funding Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 1</td>
<td><strong>No change</strong> No investment in specialist staff with reliance on acute and secondary care to support the management of respiratory disease. Primary care supported primarily by non-specialist primary care and community staff.</td>
<td>£0</td>
<td>£0</td>
<td>£0</td>
</tr>
<tr>
<td>Option 2</td>
<td><strong>Bespoke Community Respiratory Service (7 day service)</strong> A dedicated pool of 10 wte respiratory nurses supported by Consultants with administration and management. Nurses will have range of specialist skills including home oxygen assessment and have post graduate qualifications. There will be a 7 day daily rapid responder for admission avoidance and early discharge support. They will work closely with primary and community care teams, to proactively identify and manage complex and at risk patients. They will carry an independent caseload and provide locality based community clinics and MDTs, education and training. Nurses would hold a clinical caseload of the most complex patients.</td>
<td>£507,362</td>
<td>£109,000</td>
<td>£616,362</td>
</tr>
<tr>
<td>Option 3</td>
<td><strong>Respiratory Nurse Service and Home First</strong> 5.4 wte pool of respiratory nurses with co-dependency on HomeFirst &amp; Community Staff (plus management and administration) with single point of access, working in partnership with Home-first, primary care and community teams. Nurses will have range of specialist skills supported by post graduate qualifications. Each Nurse will be able to undertake home oxygen assessments. This service will primarily focus on education and training and supporting existing teams to identify and manage appropriate patients in the community, including those at risk of admission and able to be discharged. It will provide rapid access to advice and support, developing management plans and Multi-disciplinary team meetings to provide support to those directly providing care. Additionally, they will carry a small caseload of highly complex patients and undertake specialist assessments e.g. nebulizers. The service will work in partnership to develop Home-first team and community team capacity and support admission avoidance and early discharge.</td>
<td>£280,360</td>
<td>£104,000</td>
<td>£384,360</td>
</tr>
<tr>
<td>Option 3a</td>
<td><strong>Respiratory Nurse Service and Home First - Allowing for roll out</strong> 7.4wte pool of respiratory nurses with co-dependency on HomeFirst &amp; Community Staff. Option 3 amended to Option 3a following external consultation. However model remains as above.</td>
<td>£398,180</td>
<td>£106,000</td>
<td>£504,180</td>
</tr>
<tr>
<td>Option</td>
<td>Nurse Wte</td>
<td>Extra Nurse Resource</td>
<td>For</td>
<td>Against</td>
</tr>
<tr>
<td>--------</td>
<td>-----------</td>
<td>----------------------</td>
<td>-----</td>
<td>---------</td>
</tr>
</tbody>
</table>
| No change | 0 wte | 0 wte | No additional costs | Failure to maximize clinical outcomes  
No community services to manage complex patients – demand on out-patient services  
High & increasing rates of admission  
Late diagnosis & sub optimal management  
Increasing waiting times for nursing  
Increasing oxygen costs  
Limited impact of the 4 Consultant Community Sessions |
| Bespoke Community Respiratory Service (7 day service) | 10 wte | 8.6 wte | Maximize potential to provide equality and integration across the pathway and provide business continuity  
Maximize potential for rapid response & number of patients managed in community  
Maximize admission avoidance and early discharge  
Reduce length of stay and readmissions  
Maximize potential clinical outcomes and optimize medicine management  
Optimize oxygen service provision & savings  
Improve patient and carer experience and support | Highest cost, although calculations suggest 20% savings would make cost neutral  
Community and primary care may not maximize their potential to manage cases.  
Risk of silo working and lack of flexibility |
| Respiratory Nurse Service and Home First | 5.4 wte | 4.0 wte | Increases establishment in the community | Insufficient establishment to meet rapid responder requirement for admission avoidance and early supported discharge, maintain education and training and ensure 2 year projected rollout of HomeFirst  
External advice suggests insufficient |
| Respiratory Nurse Service and Home First - Allowing for roll out | 7.4 wte | 6.0 wte | Maximizes use of existing resources and builds skills in the community  
Fits with CCG strategy  
Sustainable model  
Evidence that model has worked in Lower Lea Valley  
Value for money  
Reduced number of clinical visits for patients with co-morbidities | Potential negative impact on other condition service users accessing HomeFirst due to increasing respiratory demand  
Risk of Nurse and System stretch with focus on admission avoidance and discharge which would negatively impact oxygen and education work reducing overall impact in the long run  
Some potential community patients will be admitted to hospital  
Less potential to link to localities  
Insufficient numbers to be certain of HomeFirst effect |
4.52 Pulmonary Rehabilitation

This relates to the exercise and education elements of sessions, excluding respiratory nurse education costed above Option D to increase to maximum potential places required is excluded as it is not felt to be valid.

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
<th>Recurrent Funding Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option A</td>
<td><strong>No change</strong></td>
<td>£0</td>
</tr>
<tr>
<td></td>
<td>Continue to provide 384 places for pulmonary rehabilitation over 5 sites</td>
<td></td>
</tr>
<tr>
<td>Option B</td>
<td><strong>600 Pulmonary Rehabilitation places</strong></td>
<td>£93,100</td>
</tr>
<tr>
<td></td>
<td>Increase Pulmonary Rehabilitation places to 600 based on current demand</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Increase the number of places to meet current demand and reduce waiting times.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Introduce sessions in the Bishop’s Stortford area.</td>
<td></td>
</tr>
<tr>
<td>Option C</td>
<td><strong>750 Pulmonary Rehabilitation Places</strong></td>
<td>£165,500</td>
</tr>
<tr>
<td></td>
<td>Increase Pulmonary Rehabilitation places to 750 based on minimum predicted demand</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Increase number of places to meet predicted demand based on improvements in the community pathways will increase referral rates and demand. This will include sessions the Bishop’s Stortford area.</td>
<td></td>
</tr>
</tbody>
</table>

### Pulmonary Rehabilitation Options Appraisal

<table>
<thead>
<tr>
<th>Option</th>
<th>For</th>
<th>Against</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option A</td>
<td><strong>No change</strong></td>
<td>No additional costs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Referral trends suggest increasing demand which will not be met – increasing waiting times and increasing Sub-optimal interventions will increase risk of readmission and whole service impact Failure to maximize value for money</td>
</tr>
<tr>
<td>Option B</td>
<td><strong>600 Pulmonary Rehabilitation places</strong></td>
<td>Meets current demand and thus reduction in waiting times Increases number of venues and addresses Stort Valley gap</td>
</tr>
<tr>
<td>Option C</td>
<td><strong>750 Pulmonary Rehabilitation Places</strong></td>
<td>Meets national guidance on places required Maximizes the potential to provide flexible service and reduce waiting times Potential to meet increasing demand Potential to participate in staff education sessions – training Home-first staff Maximize potential clinical and financial outcomes</td>
</tr>
</tbody>
</table>

4.53 Recommendations

The recommendation of clinical leads is

a) Community Nursing

Option 3a: Delivery of this option maximizes the use of existing services but provides the most flexibility to evolve with developments across the CCG e.g. HomeFirst. The model is potentially cost neutral, if 10% of admissions are avoided and cost savings if the national average for admissions is reached
b) Pulmonary Rehabilitation

Option C: 750 Pulmonary rehabilitation places. This level is required to support group and individuals and shift care to community

Investment required: £165,500

Impact assessment

Finance

Costing model assumes use of existing Community Respiratory Services. Costs below are based on additional resource requirements:

<table>
<thead>
<tr>
<th>Respiratory Service</th>
<th>Additional Funding</th>
<th>Option 1: No change</th>
<th>Option 2: Bespoke Delivery</th>
<th>Option 3: Integrated HomeFirst</th>
<th>Option 3a: Integrated HomeFirst (roll out)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£</td>
<td>£</td>
<td>£</td>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td>Band 8a Nurse</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Band 7 Nurse</td>
<td>0</td>
<td>181,640</td>
<td>181,640</td>
<td>272,460</td>
<td>272,460</td>
</tr>
<tr>
<td>Band 6 Nurse</td>
<td>0</td>
<td>175,002</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Band 3 Admin</td>
<td>0</td>
<td>33,720</td>
<td>33,720</td>
<td>33,720</td>
<td>33,720</td>
</tr>
<tr>
<td>Pay</td>
<td>0</td>
<td>390,362</td>
<td>215,360</td>
<td>306,180</td>
<td>306,180</td>
</tr>
<tr>
<td>Non Pay</td>
<td>0</td>
<td>117,000</td>
<td>65,000</td>
<td>92,000</td>
<td>92,000</td>
</tr>
<tr>
<td>Sub Total Recurrent</td>
<td>0</td>
<td>507,362</td>
<td>280,360</td>
<td>398,180</td>
<td>398,180</td>
</tr>
<tr>
<td>Non recurrent</td>
<td>0</td>
<td>109,000</td>
<td>104,000</td>
<td>106,000</td>
<td>106,000</td>
</tr>
<tr>
<td>Total Required</td>
<td>0</td>
<td>616,362</td>
<td>384,360</td>
<td>504,180</td>
<td>504,180</td>
</tr>
</tbody>
</table>

- Pay costs are based on mid-point of grade and include employers’ on-costs (NI and Pension).
- Non pay assumes 30% overheads.
- Non recurrent costs include training, computers/tablets, clinical equipment (4 ISTAT machines, stethoscopes, nebulisers, hand held spirometers, pulse oxi, BP and thermometer kit), portable travel kits with emergency drugs.

<table>
<thead>
<tr>
<th>Pulmonary Rehabilitation</th>
<th>Additional Funding</th>
<th>Option A: No change</th>
<th>Option B: 600 Places</th>
<th>Option C: 750 Places</th>
<th>Option D: 1,000 Places</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£</td>
<td>£</td>
<td>£</td>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td>Staffing</td>
<td>0</td>
<td>71,100</td>
<td>130,500</td>
<td>190,400</td>
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<tr>
<td>Education &amp; Exercise</td>
<td>0</td>
<td>22,000</td>
<td>35,000</td>
<td>60,000</td>
<td>60,000</td>
</tr>
<tr>
<td>Total Required</td>
<td>0</td>
<td>93,100</td>
<td>165,500</td>
<td>250,400</td>
<td>250,400</td>
</tr>
</tbody>
</table>

- Pay costs are based on mid-point of grade and include employers’ on-costs (NI and Pension)
- Existing capacity is 24 courses with 16 places per course
• Additional education and exercise sessions include speakers per 1 hour session, travel costs, leisure centre hire and equipment per new venue
• Each educational session requires 1 respiratory nurse, 1 dietician, 1 pharmacist or physiotherapist and 1 IAP

Quality
See Appendix A
The Stakeholder Group has identified that this proposal meets the key areas for service improvement required to deliver the stated aim.

• Equality of service provision
• Quality of Life - Clinical Intervention – Improvements in access to Respiratory Specialists in the Community
• Education – Improved skills and knowledge in primary and community care to support early identification & management

Integration across the respiratory pathway will maximize use of existing resources

Activity
Savings Assumptions:

<table>
<thead>
<tr>
<th></th>
<th>Saving Assumption Reduction 10%</th>
<th>Saving Assumption Reduction 20%</th>
<th>Saving Assumption Reduction 30%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spell admissions</td>
<td>£276,017</td>
<td>£552,035</td>
<td>£828,052</td>
</tr>
<tr>
<td>A&amp;E attendances</td>
<td>£63,415</td>
<td>£126,831</td>
<td>£190,246</td>
</tr>
<tr>
<td>Outpatient attendances</td>
<td>£31,224</td>
<td>£62,448</td>
<td>£93,672</td>
</tr>
<tr>
<td>Home oxygen - savings</td>
<td>£128,000</td>
<td>£128,000</td>
<td>£128,000</td>
</tr>
<tr>
<td>Prescribing</td>
<td>tbc</td>
<td>tbc</td>
<td>tbc</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>£498,657</td>
<td>£869,313</td>
<td>£1,239,970</td>
</tr>
</tbody>
</table>

• Savings assumptions are based 10-30% of admissions
• Admissions include spells where COPD ICD codes are primary diagnosis or secondary diagnosis with respiratory related primary diagnosis. Of the total admission costs (£3,998k), savings assumptions are applied to 100% share of costs associated with patients with multiple admissions (£1,841k) and 50% share of costs associated with patients with only one admission (£1,078k).
• Of the total spell admissions (£3,998k), 31% (£1,251k) relates to readmissions of which 51% (£638k) is within 30 days and subject to a tariff refund. This adjustment has been factored in to the spell admission savings figures above.
• Conversion rate of A&E attendances to admissions is currently 30%. Applying this conversion rate on 1,498 spells equates to approximately 4,993 A&E attendances, giving an estimated total A&E attendance cost related to COPD of £634k based on an average A&E PbR tariff of £127.
• Total 2013-14 OP attendances on treatment function code 340 (respiratory medicine) is 15,343 of which 5,016 are firsts and 10,327 are follow ups. Assuming one attendance (first) per COPD related admission, this equates to 30% (£312k) of the total firsts spend (£1,041k).
• Home oxygen spend savings are estimated at 18% of 2014-15 forecast outturn and assumed for two years.
• Home oxygen intervention savings are based on interventions monitored over a 6 month period and doubled for full year.
Stakeholder Engagement

The Model has been developed through a Respiratory Stakeholder Group and consultation with patient representatives and the voluntary sector, including Breathe-easy and Carers in Herts.

Providers have highlighted the community issues impacting on admissions, discharge and out-patient attendance as

- Lack of access to community respiratory specialists to manage medications and complex presentations
- Lack of pro-active reviews
- Variable knowledge and skills within primary and community care
- Requirement to manage respiratory conditions and oxygen reviews which could be undertaken in the community
- Lack of rapid access to social and end of life care
- Waiting times and access to pulmonary rehabilitation

Patient engagement is on-going with collection of patient stories. Patients consistently raise the benefits of pulmonary rehabilitation.

Outcomes, Measures and Evaluation

Evaluation of the service will be a combination of qualitative and quantitative measures as follows:

<table>
<thead>
<tr>
<th>Patient &amp; carer outcomes</th>
<th>General Practice &amp; Community Service</th>
<th>Financial Perspective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfaction with the service. Improvement or stabilisation of symptoms. Better understanding of their medication, illness and symptoms, leading to better compliance. Rapid access to specialist services Potential to remain in own home, preserving autonomy and personal choice. Family and carers feel better supported. Appropriate and timely referral and management of End of Life</td>
<td>Better care of patients with respiratory disease, with improved clinical outcomes. Better recording of QOF and accuracy of diagnosis and implementation of COPD management plans. Improved compliance with medication and optimal prescribing Improved number of oxygen assessments and reviews and assurance on appropriate use Increased access to specialist advice, education and training Compliance with NICE Guidance Shift from acute to community care and proactive management Increased referrals to and uptake of pulmonary rehabilitation Reduced mortality</td>
<td>Up to 20% reduction in predicted outpatient appointments. Up to 20% reduction in predicted hospital admissions and occupied bed days. Up to 20% reduction in predicted A&amp;E attendances. Improved control and assurance of value for money for people on Long Term oxygen therapy and reduction in annual costs.</td>
</tr>
</tbody>
</table>

Deliverability

The local providers (ENHT,HCT) will be consulted regarding potential for collaborative

The options for delivering are

a) 2 year pilot, aligned to Homefirst roll out, with negotiated lead provider
b) Full implementation through locally negotiated partnership working by current providers with defined lead accountable provider
Whilst the business case presents the case for a CCG wide model of care, it is recognised that a phased roll out will be required based on staff recruitment and training. Welwyn and Hatfield have expressed interest in being an initial site. A phased implementation will provide the opportunity to amend the model based on evaluation of implementation.

### Risks and mitigation

<table>
<thead>
<tr>
<th>Risk / Issue</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>RISK: Recruitment to posts</td>
<td>If there is a delay in recruiting to posts a phased implementation will be agreed.</td>
</tr>
<tr>
<td>RISK: The project does not realise the anticipated secondary care activity reductions.</td>
<td>Development of integrated care pathways including all stakeholders</td>
</tr>
<tr>
<td>RISK: Primary care continue to refer patients to hospital or assess project as increasing workload</td>
<td>Development of education and training packages and community consultant sessions to provide support to primary care and change culture Robust communication and locality visits to support better outcomes and therefore less GP demand</td>
</tr>
<tr>
<td>RISK: RCP recommends model or level of service at variance with business case</td>
<td>The model and staffing has been discussed with the strategic Clinical Network who provided advice.</td>
</tr>
</tbody>
</table>

### Timeline/Key Milestones

- **December 2014**: Business case presentation to
- **January 2015**: Business case amendments and decision re investment
- Implementation is dependent on preferred option

### Formal Sign off process

- Date of Programme Board Approval:
- Date of Executive/Governing Body Approval:
## Appendix A

### Integrated Impact Assessment Tool

#### Stage 1

The following assessment screening tool will require judgement against all six areas of risk in relation to quality and against the nine protected characteristics relating to equality. Each proposal will need to be assessed whether it will impact adversely on patients / staff / organisations.

Where an adverse impact score greater than eight is identified in any area, this will require a more detailed impact assessment to be carried out, using the escalation proforma.

If the assessment is negative, you must calculate the score for the impact and likelihood and multiply the two to provide the overall risk score. Insert the total in the appropriate box.

**Title of scheme:** Community Respiratory Service

**Project Lead for scheme:** Dr Rachel Joyce/Dr Martyn Davies

**Brief description of scheme:** This pilot project will provide integrated community provision for patients with respiratory disease who have difficult symptoms and those who have had or at risk of multiple hospital presentations/admissions

<table>
<thead>
<tr>
<th>Duty of Quality</th>
<th>Y/N</th>
<th>Risk Score</th>
<th>Comments</th>
<th>Mitigating actions required</th>
<th>Monitoring mechanisms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Could the proposal impact negatively on any of the following:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Compliance with NHS Constitution</td>
<td>N</td>
<td></td>
<td>Meets values and principles of NHS Constitution includes all respiratory disease, is patient centred and focussed on quality. Proposals have been developed and will be implemented by integrated team. Services will be developed in line with safeguarding frameworks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Partnerships</td>
<td>N</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Safeguarding children or adults</td>
<td>N</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NHS Outcomes Framework</th>
<th>Y/N</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Could the proposal impact negatively on the delivery of the five domains:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Preventing people from dying prematurely</td>
<td>N</td>
<td></td>
<td>Implementing NICE Guidance for COPD supports prevention of premature death[^18]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Enhancing quality of life</td>
<td>N</td>
<td></td>
<td>The London Respiratory Team COPD ‘Value’ Pyramid highlights added QALYs.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Y/N</th>
<th>Risk Score</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Helping people recover from episodes of ill health or following injury</td>
<td>N</td>
<td></td>
<td>The service focusses on early diagnosis, identification and rapid response which have shown to reduce the impact of disease[^19]</td>
</tr>
<tr>
<td>4. Ensuring people have a positive experience of care</td>
<td>N</td>
<td></td>
<td>The service is patient centred and promotes safe care in the community and increases access to pulmonary rehabilitation &amp; specialist services identified by local patients as improving care</td>
</tr>
<tr>
<td>5. Treating and caring for people in a safe environment and protecting them from avoidable harm</td>
<td>N</td>
<td></td>
<td>National guidance &amp; clinical judgement will be used to determine whether to manage patients at home[^20]</td>
</tr>
</tbody>
</table>

**Access**  
Could the proposal impact negatively on any of the following:  
- Patient Choice - N  
- Access - N  
- Integration - N  
  
**Strategy**  
Could the proposals impact negatively on the CCG’s strategic objectives  

**Duty of Equality**  
Could the proposal impact negatively on any of the following protected characteristics:  
1. Age  

---  
<table>
<thead>
<tr>
<th></th>
<th>Y/N</th>
<th>Risk Score</th>
<th>Comments</th>
<th>Mitigating actions required</th>
<th>Monitoring mechanisms</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td>Disability</td>
<td>N</td>
<td>N</td>
<td>partnership with any service supporting young people with an education health care plan or SEN aged 18-25</td>
<td>children as appropriate</td>
</tr>
<tr>
<td>3.</td>
<td>Race</td>
<td>N</td>
<td>N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Religion or belief</td>
<td>N</td>
<td>N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Sex</td>
<td>N</td>
<td>N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Sexual orientation</td>
<td>N</td>
<td>N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Gender re-assignment</td>
<td>N</td>
<td>N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Pregnancy and maternity</td>
<td>N</td>
<td>N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Marriage and civil partnership</td>
<td>N</td>
<td>N</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Name of person completing assessment:** Jill Catchpole  
**Position:** Commissioning Development Manager  
**Signature:**

**Reviewed by:** Signature:  
**Date of review:**
East and North Herts CCG – Review of MSK and options for Commissioning

Dr Rachel Joyce, East and North Herts CCG Medical Adviser

Summary

The current MSK service was set up on a block contract without a clear service specification or pathways. There is significant duplication of services, with patients with musculo-skeletal conditions ‘bouncing around’ the system, often being seen by many different practitioner and specialists before seeing the right one.

The current block contract in addition does not appear to offer value for money.

It is recommended that the service is re-procured to provide an integrated service with clear pathways and referral criteria; and joint MDTs with secondary care. It is also recommended that this integrated service includes psychological services integrated with the local pain services, as per national recommendations.

Background

ENHerts CCG has a block contract for a Musculoskeletal Service (MSK) with HCT. There is also a separate block contract for physiotherapy.

The MSK service consists of Extended Scope Physiotherapy Practitioners (ESPs), who have an extended competency set, who are able to undertake interventions such as joint injections and order investigations such as MRIs.

There is a variable update of the MSK service across practices and localities, with variable anecdotal feedback from GPs, and uncertainty if the service is cost effective. At various stages of the service it appears the need for consultant input has been raised, but not delivered. A service review from 2-3 years ago recommended a redesign including consultant sessions, but this was not implemented. Anecdotal reports suggest the original block contract was also intended to include medical input.

The service specification is imprecise, without clear pathways or staffing requirements. The service currently operates in isolation from secondary care, despite the fact that a large proportion of patients will subsequently be referred to secondary care services.

Current contract

Due to a lack of specificity in the contract it took a long time to ascertain exactly what the contract value/activity and service comprised. However the following was eventually ascertained:

- MSK contract £428,000 block
- MSK activity approximately - 2468 contacts per annum - £173.42 per contact, including interventions but NOT radiology.
• N:FU approx 1:0.4
• No defined pathways, no referral criteria.
• Staffing of entire service is 1 WTE Specialist Services Lead + 2.65 ESPs (uncertainty if maternity and sick leave is covered)

NB
1. In contrast, the physio contract £1,363,000 block, activity - 50,382 contacts per annum –ie £27.05 per contact; N:FU approx 1:2.9. Further work is being undertaken to improve the waiting times for the physiotherapy service, which is not covered in the rest of this paper.
2. Secondary care outpatient tariffs in related specialities in contrast are shown in the table below:

<table>
<thead>
<tr>
<th>Specialism</th>
<th>1st Attendance tariff</th>
<th>Follow-up tariff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain management</td>
<td>195</td>
<td>103</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>247</td>
<td>114</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>138</td>
<td>81</td>
</tr>
<tr>
<td>General surgery</td>
<td>162</td>
<td>94</td>
</tr>
</tbody>
</table>

Retrospective Audit

The CCG requested a retrospective pathway audit over a three month period. The following was found:

• 454 patients
• Most common conditions (72% of total) referred were:
  – knee (138 patients),
  – low back pain (119 patients) and
  – shoulder problems (69 patients)
• Over 60% were referred to secondary care after being seen
  – 34% after 1 appt, rest after investigations and FU appt.
  – Includes 76% of knees, 88% of shoulders.
• 47% had investigations – 35% having MRI, 6% X ray and 5% Ultrasound.
• Patients who had investigations had subsequent follow up appointments to review the investigations – ie lack of one stop service.
• 44% were sent to physiotherapy.
• Injections were given to approximately 17% of patients - half of the shoulder patients (1/3 of whom were still referred on to secondary care), and most of the wrist patients. No other patients were offered injections (supporting the argument that the average price per patient in the MSK service is higher than comparable services, as the interventions).
Stakeholder Feedback

The following feedback was received from stakeholders who were met during the review period:

- Lack of medical/surgical support to the ESP practitioners.
- Lack of integration of MSK service with orthopaedics/spinal/pain services leading to duplications of appointments and delays in diagnosis and treatment for patients referred into MSK.
- Orthopaedics – large numbers of back pain patients are being seen in general orthopaedic clinics inappropriately- patients who should be referred elsewhere (MSK, physiotherapy, pain services, spinal services), and subsequently have duplicated appointments and delays.
- Pain/orthopaedics: Patients may be referred too late for pain management turning conditions esp back pain into chronic conditions unnecessarily.
- GPs/secondary care: Lack of clarity of what the MSK service offer. Concerns re duplication/unnecessary appts due to lack of clarity.
- Variation in MRI scanning of knees – Radiology say too many MRIs when plain X ray should have been performed instead (especially a GP issue).
- Variation in interventions and skills in primary care.
- Spinal surgery in particular (but also orthopaedics) capacity is limited, so ensuring right patients only in clinics is required.
- Clear pathways could avoid duplication of both MSK and secondary care, getting the right patients to the right service in a timely fashion.
- Pain service does not include psychology element despite this being recommended in national clinical guidelines. Evidence shows early intervention from psychological services specialising in pain can avoid unnecessary consultations and interventions and prevent patients from becoming chronic pain sufferers. Some are referred to an intensive programme at the RNOH as there is no local service, others receive suboptimal management.

PMO and subsequent pathway development

PMO discussion agreed to continue work on three main pathways – back, knee and shoulder (largest three pathways). These are all now in draft and are in the process of being finalised.

HCT have been notified that there is a service redesign underway and that the service may be re-procured.

When/if introduced, the pathways will ensure a streamlined journey through the MSK/orthopaedics/spinal/physiotherapy/pain management system, with the right patients being seen by the right practitioners with no more consultations than necessary (particularly by clarity on when to undertake investigations), and clear referral thresholds.

All the pathways include the need for MDTs between secondary care consultants and the MSK service. The clinicians are attempting to set up ad hoc MDTs but these are not required in the specification or job plans and so far have not taken place.
Pain Psychology Business Case

Best practice clinical guidelines and commissioning guidance from the Royal College of Anaesthetists and Faculty of Pain Medicine states that “The aim of the Pain Management Service is to provide patients with persistent disabling pain a timely service that delivers skilled multidisciplinary interventions to reduce or remove the cause(s) of pain and/or enable patients to manage their pain with psychological and behavioural support that aids functional rehabilitation.” And staffing of the service should include “Specialist pain management clinical psychologists providing cognitive and behavioural therapy and other psychological interventions, individually or in a group setting.”

The ENHT pain service does not include psychological input. The Trust have submitted a business case (Annex 1 and 2) to develop such a service with a suggested tariff. Further negotiation may be needed to ensure the most cost effective approach for such a pathway, but the evidence base is good and the clinical principle of psychology is generally accepted as a facet of an effective pain service.

It should be noted that at present there is no pain or spinal surgery service at PAH, therefore ENHT provides this service for the vast majority of ENHCCG patients.

Way forward/ recommendations

To ensure optimal clinical and cost effectiveness, to minimise unnecessary appointments, ensure that patients are seen by the most relevant practitioner, are offered the most effective interventions (or are offered the most effective advice) and that those at high risk of developing chronic pain are managed effectively early on, it is recommended that the MSK service is re-procured with:

1. A tariff rather than a block;
2. Clear and auditable pathways and referral criteria specified in the contract (NB there is still some work to be done on other pathways and further discussion needed on psychology pathway);
3. Pathways to be placed on Map of Medicine and for all appropriate referrals from CCG practices to be managed along these pathways (eg back pains referred to general orthopaedic clinics instead redirected according to the back pain pathway);
4. MDTs with relevant secondary care consultants (also described in the pathways)
5. A psychology specialist service within the pain service for appropriate patients (as described in the pathways).

As this requires integration of the MSK service with secondary care, the new service should be an integrated service, which could be provided by either HCT or ENHT (or another provider), possibly with subcontract arrangements.

A decision is needed on this and how this should be procured, including:

1. Overall agreement with the recommendations as described above
2. Re-tendering
3. Piloting (ENHT only, HCT only, partnership with lead provider?)
4. Other?
5. Tariff setting

Annex 1, 2, 3 – Psychology business case attachments
**Proposed Pain Management Protocol – Psychology**

Individual Pain Management Therapy (PMT)

(Completion of pain-related questionnaires can be sent out to patient at time of scheduling appointment and brought completed to initial appointment/assessment)

**Session 1 (45 mins)**

Assessment

- Clinical Interview
- Spouse/Partner Interview where appropriate

**Session 2 (45 mins)**

- Behavioural Observation (Assessment of Pain Behaviour)
- Assessment Feedback

**Session 3 (45 mins)**

Psycho-education about pain

- Discussion about the impact of pain on patient’s life
- Helping patient understand the pain cycle
- Setting goals for treatment

**Session 4 (45 mins)**

- Diaphragmatic breathing
- Progressive muscular relaxation training
- Visualization training

**Session 5 (45 mins)**

- Automatic Thoughts and Pain
- Cognitive Restructuring
- Problem-solving

**Session 6 (45mins)**

- Stress/Anger Management
- Pacing/physical activity
- Pleasant activity scheduling
- Sensory refocusing and other specific cognitive pain management strategies

**Session 7 (45 mins)**

- Relapse prevention
- medication issues
- Sleep
- Effect of pain on interpersonal relationships/work
- Review of Program and Feedback

All sessions will be followed by Homework exercises. The seven Session model can be adapted to a Group format with a minimum of 6 patients per group and maximum of 10. For the Group sessions allocated time would ideally be 90 mins. A further option may be that patient identified in the Assessment who appear to have significant psychosocial factors affecting their pain condition, may be offered either 7 Group and 7 Individual sessions or 14 Individual sessions.

Professor Andrew R. Kuczmiarczyk
Consultant Clinical Psychologist
Specialist in Cognitive Behavioural Therapy and Behavioural Medicine
Psychology Pain service to provide Multi-disciplinary Chronic Pain Service for East and North Hertfordshire NHS

Background

The Chronic Pain service currently receives 1,700 referrals a year, with conditions ranging from spinal pain, neuropathic pain (nerve pain), visceral and widespread musculo-skeletal pain syndromes. There has been a steady increase in referral over the years, managed currently by 4 chronic pain consultants, most with a part-time (60%) commitment.

The prevalence of psychological impact (ie depression/anxiety), and exacerbation of pre-existing mental health history in those with chronic pain is in the range of 20-25% which is in line with national data. Untreated psychological aspect are well known to have a detrimental impact on perception of pain, the outcomes of medication trials, outcomes of spinal interventions and spinal surgery.

In line with current national recommendations for Pain Services, and the commissioning document for Pain services produced by the British Pain Society, Chronic Pain services should all provide psychological assessment and psychological services.

In May 2014, our agreement with Hertfordshire Partnership Mental health trust to provide a Consultant Clinical Psychologist with interest in chronic pain ended, due to restructuring and redundancy.

Whilst regrettable, this allows us the opportunity to readdress the provision of psychology provision to provide an integrated unit within the trust, and we have identified the expertise of Band 8C consultant clinical psychologists.

Role of Clinical Psychologist

1) Psychological assessment in those with chronic pain conditions.
   i) This will be an essential part of the new low back pain pathway, with those psychological (yellow flag) symptoms that are a key component to address chronicity in pain syndrome.
   ii) Role in treating those with pelvic pain disorders, and fibromyalgia, and functional bowel disorders

2) Individual patient psychotherapy/ CBT session.- Depression management. Relaxation therapies/distraction techniques, working on negative cognition, beliefs and attitudes

3) Group Based psychotherapy sessions– Useful for those with less severe psychological health. Also useful as top up sessions in those who have had previous individual sessions and need top-up.

Link up with persistent pain physiotherapy in community so that mental health needs are addressed before entry into a pain rehab programme
Clinic Locations
1) Lister Hospital
2) QE 2 Hospital
3) Hertford County

Clinical Psychology Provision

Estimated Patient Volume
1) Referral via Pain consultant clinics (ie 20% of Pain service referral) – 340 new patients

Psychology Clinical template:

Psychology clinics
1) Initial assessment and 1st CBT/psychotherapy session – 45 minutes
2) 6 Further individual CBT/psychotherapy sessions – 45 minutes
3) Each clinic will be 3 hours clinical time, with 45 minutes for admin component
4) Therefore 4 patients per clinic
5) Each patient will be allocated 7 sessions in total

Group based programme.
1) 6 week in duration

Issues

The treatment function code for clinical psychology is 656 = what is the tariff price.
If no national price is available what can we agree as code for:
1) Individual psychology OPA
2) Group based sessions
Stroke ESD Implementation

**Description:**
The implementation for stroke early supported discharge from hospital for stroke survivors with mild to moderate disability and 6 month post stroke reviews for all stroke survivors.

*Project Implementation Lead: Andrew Godfrey*

**Objectives:**
Provide access to ESD for 40% of stroke survivors discharged from in-patient care and specialist 6 month reviews for all patients.
Reduce risk of death and dependency.
Reduce length of in-patient stay & improve patient flows.
Improve functional outcomes and odds of living at home.
Improve patient and carer satisfaction.

**PROJECT SUMMARY**

**Achievements/Commentary:**
- Initial roll-out complete. Service live and admitting.
- Revised effort model to reflect better than expected recruitment.
- Performance metrics provisionally agreed. Evaluation framework out for comment.
- Staff Induction went well with good feedback.
- Homecare provider in place but still recruiting to roll. Has enough in place to deliver. Specialist training for delivery.
- Majority of posts recruited to.
- Team based at Robertson House.
- Bi-weekly multi-agency meetings undertaking reflective practice.
- Stroke Association developed a report around WS6 around future provision of information and advice.
- Stroke Association contract being recommissioned by April 2015.
- Draft next stage project plan developed.

**RISKS AND ISSUES**

<table>
<thead>
<tr>
<th>RAG</th>
<th>Risk/Issue</th>
<th>Description / mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Issue</td>
<td>Patient identified by ward as having no needs discharged home and then referred to social care for support. Proposed policy that all patients being discharged home should be contacted by ESD.</td>
</tr>
<tr>
<td>A</td>
<td>Risk</td>
<td>No full time ESD co-ordinator onsite in PAH could lead to lack of engagement. West Essex have an ESD service so understand process. Workshop in December to agree process.</td>
</tr>
</tbody>
</table>

**Previous**

**Current**

**Forecast**

**Completed by: Jill Catchpole & Andrew Godfrey**

**KEY MILESTONES**

- Apr 14-Project Initiation, planning and implementation
- October 2014: ESD Go-live roll out
- Jan 15: PAH launch and engagement with other out of area acutes.
- Jan 15: Co-locate Stroke Association with ESD team
- Jan 15: Six Month Reviews begin
- May15: Commence evaluation
- April 15: Carers in Herts Caring with Confidence Course
Community Stroke Project

PROJECT SUMMARY

Description:
The review and establishment of community stroke pathways to support the implementation of best practice to improve clinical outcomes and delivery of seamless care. The project has expanded into supporting related work-streams such as PAH HASU discussions, review of acute CQUIN etc

Current Objectives:

- Support the implementation of Early Supported Discharge
- Support the implementation of 6 month Reviews for all stroke survivors
- Establish HCT/mental health psychology pathway interface
- Review HCT 2014/15 CQUIN and establish 2015/16 scheme
- Review and develop stroke pathway evaluation tools & performance measures
- Develop stroke leadership group to coordinate commissioning & provision
- Keep abreast of stroke PAH HASU developments
- Undertake stroke delegated tasks

New: Establish new TIA referral system for PAH in primary care

Review the Community Information in the Commissioning for Value paper

Redefine stroke project for 2015

KEY MILESTONES

- Oct 2014: ESD Go Live - achieved
- Dec 2014: Established mental health/HCT psychology pathway interface
- Dec 2014: Draft JSNA
- Jan 2015: ESD role out to Princess Alexandra Hospital
- Jan 2015: 2015/16 Stroke CQUIN
- Jan 2015: New PAH TIA referral system operational
- Jan 2015: Stroke Leadership Group Operational – whole pathway work-plan and project proposals to be formulated

Completed by: Jill Catchpole

ACHIEVEMENTS/COMMENTARY

Achievements:
Developed pathways within HCT to support delivery of stroke care, including psychology. Introduced stroke community KPI, co-produced with service users – now reporting
Addressed significant gaps in community services through business case – ESD & 6 month reviews now in roll out & on target led by HCC project management team
Worked in partnership with HCC to coordinate voluntary sector offer & develop information e.g. Carers in Herts to run a Stroke Caring with Confidence Course in April
Mental Health pathway for RAID-CMHT- HCT being piloted

Commentary:
Community Stroke Project developments from the original community stroke business case are in implementation.
Performance at the Acute Stroke Units dipped but both East & North Herts & PAH Hospital Trust have robust action plans in place. East & North performance is predicted to improve with January data.
Next stage integrated stroke project proposals being discussed with stakeholders and formulated, to include whole pathway and to be presented in Feb 2015
Potential GP Clinical lead identified

RISKS AND ISSUES

<table>
<thead>
<tr>
<th>RAG</th>
<th>Risk/Issue</th>
<th>Description / mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk</td>
<td>Delay in PAH HASU Decision E&amp;NHHT want confirmation to plan for uplift</td>
<td>West Essex CCG Board presentation of business case re PAH HASU options - Dec 2015, E&amp;NHCCG unsighted. Last HASU and West Essex Stroke Board cancelled - waiting for update from ambulance service on outline models. Still planning for April 2015</td>
</tr>
<tr>
<td>Risk</td>
<td>Stroke Pathway Project</td>
<td>Priorities for and redefinition of Stroke project needed to guide next steps through stroke leadership group</td>
</tr>
<tr>
<td>Issue for agreement</td>
<td>PAH TIA Clinic changing to electronic referral system only</td>
<td>West Essex CCG &amp; PAH changing to electronic referral pathway from 3rd Dec 2014 to improve quality and appropriateness of referrals. Requested E&amp;NH adopt same system for PAH. PAH will double run fax and electronic system until agreed date. Discussed with comms and GP engagement timeline drafted. Proposed start -19/01/15</td>
</tr>
<tr>
<td>Issue</td>
<td>Commissioning for Value paper Stroke elective spend</td>
<td>Paper suggests high elective spend, which required local interpretation. Working with David Hodson to review and understand data</td>
</tr>
</tbody>
</table>
Skin Health Pathway Redesign Project

**PROJECT SUMMARY**

**Description:**
The Skin Health pathway revision is aimed at identifying best practice for referral and optimising the use of the skin health service for conditions that can be optimally managed in the community so that secondary care capacity is freed up to manage the more complex skin pathologies and, the urgent and 2 week wait referrals where cancers are suspected.

**Objectives:**
- Encourage GPs to identify and manage lesions that can be removed in primary care - within appropriate clinical governance requirements.
- Encourage GPs to refer only those that are clinically appropriate to a ‘see and treat’ clinic.
- Deliver a more cost effective pathway by referring appropriate patients to the Skin health service rather than secondary care.
- Deliver the release of capacity in Secondary care so that they are able to better manage their 2 week waits.
- To integrate the skin health pathway into Map of Medicine.

**KEY MILESTONES**
- Agree proposal for offering choice
- Sign off of referral guidelines and pathway
- Re-draft TOR for implementation group
- Baseline data for 3 month period to support evaluation of impact to be agreed.
- Implementation plan to be revised to reflect a 2-month trial of pathway roll out in one locality and prompt evaluation thereafter.
- North Herts locality roll out to commence 1st December 2014.
- Venue change proposal to be deferred until rolled out to all 6 localities
- Evaluate outcomes of pathway redesign

Completed by: Jill Catchpole

**ACHIEVEMENTS/COMMENTARY**
- Regular meetings of Task and Finish Group established.
- Roll out in North Herts for 2 months starting 1st December, dependent on sign of by HMMC and Rachel Joyce
- HCT have estimated need for 10 additional clinic sessions to support North Herts roll out
- Impact evaluation in the 1st week of February, with a view to promptly roll out to all other 5 localities.
- Triage activity log, Time and motion study to be undertaken to support information and data gathering and enable the understanding of the impact of pathway change on demand and capacity management
- Implementation plan revised
- Referral guidelines in final revision

**RISKS AND ISSUES**

<table>
<thead>
<tr>
<th>RAG</th>
<th>Risk/Issue</th>
<th>Description / mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>R</td>
<td>Capacity to deliver change, potential</td>
<td>Insufficient information on potential shift in activity back to community. It is unclear if HCT have the capacity to cope with pathway changes until this is fully understood. HCT may need support to train and accredit more GPSIS. Mitigation: Plans underway to develop triggers and build in contingencies into project delivery plan.</td>
</tr>
<tr>
<td>I</td>
<td>No agreed date to enforce the pathway</td>
<td>No date set for return of in-appropriate referrals to secondary care, which was in the original rollout plan Mitigation: test model in North Herts &amp; agree date in stakeholder group. Map of medicine roll out will support implementation</td>
</tr>
<tr>
<td>I</td>
<td>Change to PMO decision re UBRN pathway</td>
<td>Stakeholder group highlighted risk with PMO decision re dummy appointments on maintaining worklist – Mitigation: HCT will continue to generate a 2nd UBRN with the GP Practice. Jo Burlingham to raise at Clinical Strategy day 3/12/14. Agree comms to GPs to address concerns</td>
</tr>
</tbody>
</table>

Date of Update: 26th October 2014