NHS
Camden
Clinical Commissioning Group

Programme Mandate

Programme Name: Long Term Conditions and Cancer

Date: 23rd December 2013

APPROVAL

Approved by	Date
Long Term Conditions and Cancer Programme Implementation Group	18 December 2013
Camden CCG Programme Review Committee	16 October 2013 18 December 2013
Camden Governing Body	

DOCUMENT HISTORY

Version	Summary of Changes	Document Status	Date published
1	Aims, Objectives, Programme Plan	Draft	08/11/2013
2	Objectives, Outcomes, Programme Plan and Finances	Draft	18/11/2013
3	Programme Deliverables	Draft	22/11/2013
4	Updated objectives, structure, procurement plan following comments from PRC and PIG	Draft	23/12/2013

NHS Camden Clinical Commissioning Group

Programme Mandate

Long Term Conditions and Cancer

1. Vision

Through the Long Term Conditions and Cancer Programme we aim to work with partner organisations to ensure that:

- Prevention of LTCs and cancer is prioritised and effectively delivered
- People in Camden with a LTC or cancer will:
  - Receive high quality care
  - Have a good experience of services
  - Live as long and with as high a quality of life as their condition makes possible

Timeframe

The programme will be delivered over the next five years, finishing in March 2018 and will be reviewed annually.

2. Aims

Ensure that individuals with Long Term Conditions and Cancer have access to **consistent high quality services** to improve outcomes

Work closely with partner organisations to ensure that the **prevention** of long term conditions and cancer is prioritised and effective resources are in place

Improve **early identification** of people with a long term condition or cancer

Work across the health and social care system to implement **proactive care coordination** through the development of integrated services to effectively manage individuals with one or multiple LTCs

Develop value-based commissioning models to provide the best possible **value** for people with long term conditions, their carers and the wider health economy

Specific Objectives and Workstreams

Stroke

1. Reduce numbers of strokes by increasing the numbers of people with atrial fibrillation on anticoagulation (where treatment is appropriate) through delivery of an Atrial Fibrillation Treatment Improvement promote a systematic approach to reducing the incidence of stroke in Camden (Sept 13 – Mar 15)
2. Undertake Root Cause Analysis of all new admissions for new onset ischaemic heart disease and stroke to determine the demographic, lifestyle, treatment and service factors associated with onset of early CVD that could be managed better by (Oct 13 – Mar 15).

3. Pilot enhanced early supported discharge pathway in selected patients with stroke patients to examine where this delivers improvements in care quality and costs (Nov 13 – Jan 15).

Diabetes

4. Deliver Integrated Camden Diabetes service which will also support improved management of diabetes in primary care and patient self-management (Sept 13 – Apr 16)

Hypertension

5. Develop and deliver comprehensive hypertension action plan for Camden (Apr 15 – Mar 17)

Heart Failure

6. Successfully implement enhanced Integrated Heart Failure Service and further develop systems for integrating specialist, community and primary care management of Heart Failure (Apr 15 – Mar 17)

COPD

7. Further develop systems and capacity for integrating specialist, community and primary care management of COPD through the CICS COPD Service to reduce the number of emergency admissions (Apr 14 – Mar 16)

Other LTCs

8. Seek to extend good practice and learning from named conditions above to other long term conditions starting with community epilepsy services (Apr 14 – Mar 16)

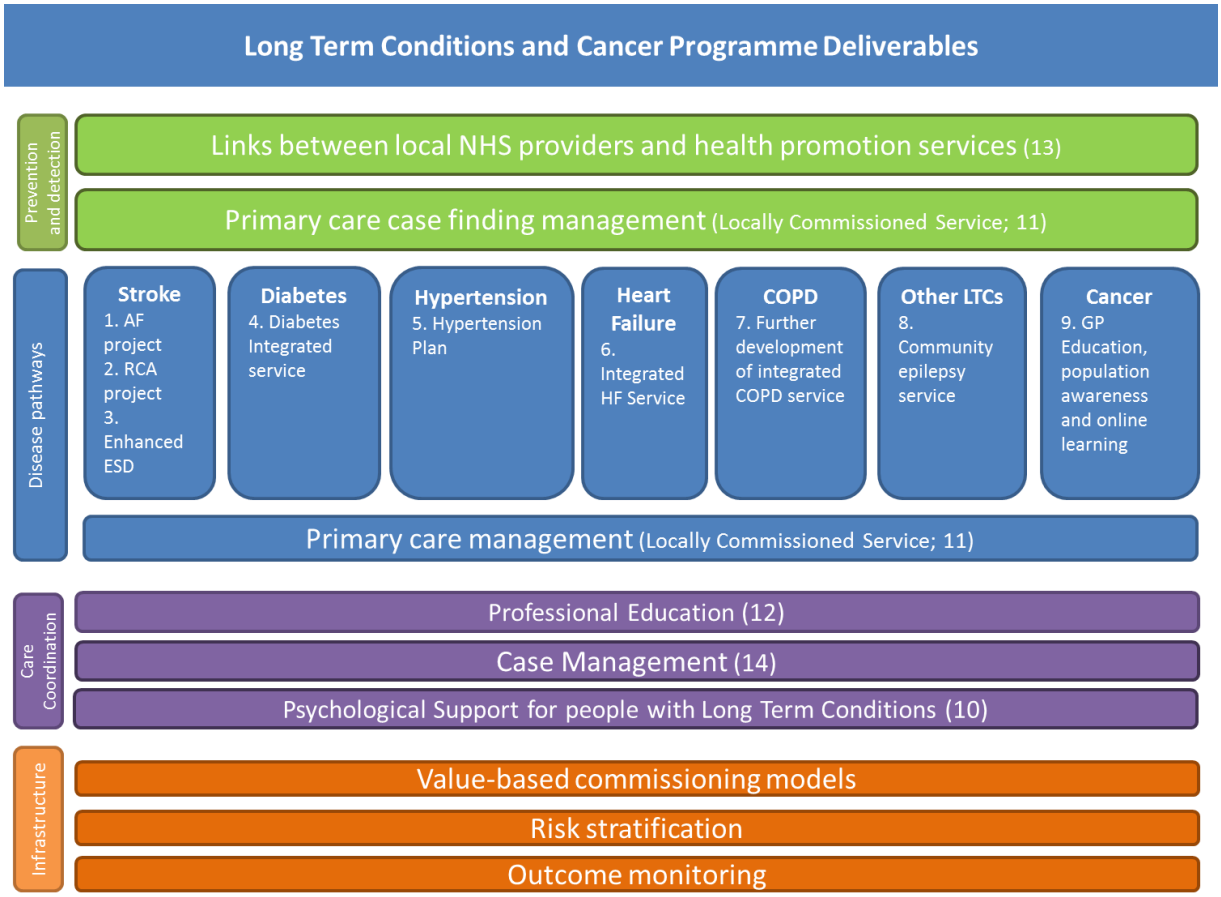
Cancer

9. Improve early identification of cancer through delivery of:
    a. an audit and GP education programme to support GPs to recognise and take action on cancer symptoms early (Apr 13 – Mar 16)
    b. a population awareness campaign for early recognition of cancer in partnership with the Public Health Team (Apr 13 – Mar 16)
    c. an online learning resource for GPs on early recognition of cancer symptoms (Jan 14 – Jan 15)

Cross-cutting objectives

10. Addressing poor outcomes for people with Long Term Conditions through improved psychological support service (Apr 13 – Mar 15)
11. Successfully implement Long Term Conditions Locally Commissioned Service to improve case finding and primary care management of LTCs (Sept 13 – Sept 14)
12. Develop and implement a primary care education programme to improve skills and capacity for identifying and managing LTCs, including skills in promoting lifestyle change (ongoing)

13. In conjunction with Public Health develop a mechanism to encourage referrals from CCG commissioned services to health promotion services (Apr 14 – Mar 17)
14. Embed the concept of case management for the most complex patients with multiple long term conditions with access to an MDT for the most complex patients to achieve coordinated, patient driven integrated care (Apr 14 – Mar 18)



Enablers:

- Establish processes for accurately and regularly monitoring progress on achievement of above objectives and for evaluation of delivery of high level outcomes through:
    a. Developing outcome measures dashboard and dataset to evidence change
    b. Establishing processes for regularly populating dashboard with accurate data
    c. Establishing structures and processes for regularly reviewing this information

- Resource programme to deliver all objectives
- Engage with all key stakeholders and develop an environment for integrated change

3. Programme Outcomes

Outcomes will be collected at several levels:

1. National outcome frameworks – the purpose of the programme
2. Objective-specific outcome measures – high level patient outcomes the objective aims to achieve
3. Objective-specific process measures – demonstrating that the project is achieving milestones
4. Project-specific process and outcome measures – demonstrating detailed progress

National Outcome Framework

NHS Outcomes Framework Objective	NHS Outcomes Framework Indicator
Reducing premature mortality from cardiovascular disease	1.1 Under 75 mortality rate from cardiovascular disease
Reducing premature mortality from respiratory disease	1.2 Under 75 mortality rate from respiratory disease
Reducing premature mortality from liver disease	1.3 Under 75 mortality rate from liver disease
Reducing premature mortality from cancer	1.4 Under 75 mortality rate from cancer
	1.4i & ii 1 and 5 year survival (all cancers) 1.4 iii & iv 1 and 5 year survival (breast, lung and colorectal cancers)
Enhancing the quality of life for people with long-term conditions	2 Health related quality of life for people with long-term conditions
Proportion of people feeling supported to manage their condition	2.1 Proportion of people feeling supported to manage their condition
Improving functional ability in people with long-term conditions	2.2 Employment of people with long-term conditions
Reducing time spent in hospital by people with long-term conditions	2.3.i Unplanned hospitalisations for chronic ambulatory care sensitive conditions
Improving recovery from stroke	3.4 Proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months

	Objective	Primary Process Measure	Primary Outcome Measure
1	Reduce numbers of strokes by increasing the numbers of people with atrial fibrillation on anticoagulation	Increase number of patients on AF register	Reduction in the number of people having strokes
2	Undertake Root Cause Analysis of all new admissions for new onset ischaemic heart disease and stroke	Analysis of all CVD admissions	Reduction in the number of people having strokes and MIs
3	Pilot early supported discharge pathway for 6 months	Number of patients treated by early supported discharge.	Reduction in the LOS post-stroke

4	Launch expanded Integrated Camden Diabetes service by early 2014	Increase in number of patients managed by diabetes service	Reduction in number of complications associated with diabetes
5	Develop and deliver comprehensive hypertension action plan for Camden	Develop and deliver the plan	Reduction in the number of people with hypertension
6	Successfully implement enhanced Integrated Heart Failure Service and further develop systems for integrating specialist, community and primary care management of Heart Failure	Increasing capacity to see patients with heart failure in the community	Increased life expectancy for people with heart failure
7	Further develop systems and capacity for integrating specialist, community and primary care management of COPD through the CICS COPD Service to reduce the number of emergency admissions	Increase capacity to enable patients with COPD to be monitored more frequently in the community	Reduction in number of emergency admissions for people with COPD
8	Seek to extend good practice and learning from named conditions above to other long term conditions	Increase capacity in the community to manage people who have epilepsy	
9a	Develop and implement an audit and GP education programme to support GPs to recognise and take action on cancer symptoms early by December 2014	Use results of audit to deliver targeted education sessions to all Camden GPs	Increase in the number of people diagnosed with cancer at stages 1 & 2
9b	Develop and implement a population awareness campaign for early recognition of cancer by December 2014	Deliver focused information on cancer symptoms to particular at risk groups	Increase in the number of people in target groups diagnosed with cancer at stages 1 & 2
10	Addressing poor outcomes for people with Long Term Conditions through improved psychological support	Increase in number of people with LTCs accessing psychological therapies	Reduction in avoidable admissions
11	Successfully implement Long Term Conditions LCS to improve case finding and primary care management of LTCs	Increase number of people on LTC practice registers	Increase in the frequency of monitoring for people with a LTC
12	Develop and implement a primary care education programme to improve skills and capacity for identifying and managing LTCs, including skills in promoting lifestyle change	Establish regular and sustained educational events, practice visits and peer reviews	Increase in diagnosis of LTCs Reduction in complications (and admissions) associated with LTCs
13	In conjunction with Public Health develop a mechanism to encourage	Increase the number of referrals to health promotion services by	Reduction in risk factors associated with long term conditions

	referrals from CCG commissioned services to health promotion services	NHS professionals	eg obesity, smoking, hypertension
14	Embed the concept of case management for the most complex patients with multiple long term conditions with access to an MDT	Increase the frequency of review of the people with the most complex conditions	Reduction in avoidable admissions

Transformational Investments

An outline of the proposed investments for each year of the programme is below

Long Term Conditions and Cancer Programme Budget 2013 - 2018								
		Business Case Number	2013/14	2014/15	2015/16	2016/17	2017/18	Project total investment
1	AF Project	21	250,436	250,436	0	0	0	**500,872**
2	RCA Project	38	524,558	0	0	0	0	**524,558**
3	Enhanced Early Supported Discharge	37	0	0	0	0	0	**0**
4	Integrated Camden Diabetes service	26	242,897	456,715	456,715	0	0	**1,156,327**
5	Hypertension		0	50,000	50,000			**100,000**
6	Integrated Heart Failure Service		0	0	400,000	300,000	300,000	**1,000,000**
7	Integrated COPD Service		0	350,000	216,667	216,667	216,667	**1,000,000**
8	Other integrated services - community epilepsy		0	100,000	100,000	0	0	**200,000**
9	Audit and GP education programme to support GPs to recognise and take action on cancer symptoms early	24	383,000	150,000	150,000	0	0	**683,000**
	Population awareness campaign for Cancer	7	92,000	150,000	150,000	0	0	**392,000**
10	Psychological support to patients and educate practices about medically unexplained symptoms		263,812	263,812	0	0	0	**527,624**
11	LTC Locally Commissioned Service	56	0	0	0	0	0	**0**
12	GP and Practice Nursing education programme		0	50,000	50,000	20,000	20,000	**140,000**
13	Referrals from CCG commissioned services to health promotion services		0	100,000	150,000	100,000	0	**350,000**
14	Case management & MDT for complex patients with multiple LTCs		0	200,000	200,000	200,000	200,000	**800,000**
	Programme Management (incl pay)		10,416	200,000	200,000	200,000	200,000	**810,416**
	TOTAL PLANNED SPEND		**£1,767,119**	**£2,320,963**	**£2,123,382**	**£1,036,667**	**£ 936,667**	**£ 8,184,797**
	Of WHICH FUNDING ALREADY AGREED THROUGH BUSINESS CASES		**£2,746,370**	**£1,651,891**	**£1,398,652**	**£ 763,812**	**£ -**	**£ 6,560,725**

Notes:

1. Additional investment from disaggregated Camden Integrated Care Services budget to be included in funding for objectives 4, 6 and 7
2. Programme management costs estimated pending disaggregation request CICS budget

3. QIPP

At the core of the Long Term Conditions Programme is the need to drive change to deliver the best value from every NHS pound invested. Value in this context is defined as the relationship between the quality of the patient's outcome in relation to the cost of delivering that outcome. This will require a reduction in people admitted to hospital with services better provided in the community combined with innovation and investment in local community based services.

Work is currently underway to baseline costs and outcomes in preparation for delivering improved outcomes and value at reduced cost. The reallocation of resources from hospital care will focus on a reduction in non-elective admissions, outpatients, accident and emergency attendances and length of stay.

Modelling will be over a three year period in order to triangulate findings and ensure that Camden has a solid foundation for delivering outcomes and value. A three year trajectory for delivery will provide assurance and a framework for monitoring progress.
Four projects plan to deliver most savings:

Objective	Workstream Name	Investment (1 year)	Estimated annual activity savings (on 2012/13 baseline activity)	Net Financial Benefit to System	Timeframe when productivity realised
	Cancer emergency admissions	£112,500	50 admissions	£37,500	March 2017
	Asthma and COPD emergency admissions	£60,300	107 admissions	£117,054	March 2016
	Angina emergency admissions	£0	27 admissions	£21,891	March 2017
	Reduction in Strokes	Investment already made	20 admissions	£400,000	March 2016
				£576,445	

TO BE UPDATED ONCE DETAILED QIPP MODELLING COMPLETED

Procurement Plan

The procurement plan will be appropriate to the project – it is anticipated that through the development of value-based commissioning through capitated and bundled payments, different procurement methods and timeframes will be used. Any procurement will be undertaken using local and national procurement guidance and within the CCG's scheme of delegation.

Investment	Procurement method to be used	Procurement duration	Estimated start date of service
Approved Investments (Committed)			
Atrial Fibrillation	Contract Variation	Completed	
Root Cause Analysis	Contract Variation	Completed	

Enhanced Early Supported Discharge	Contract Variation	Completed	
Diabetes	Pilot then open tender	6-8 months	April 2015
GP Education – Cancer	Contract Variation	Completed	
Population Awareness - Cancer	Contract Variation	Completed	
Online learning - cancer	Open Tender	2-3 months	January 2014
Psychological Support for LTCs	Contract Variation	Completed	
Pipeline Investments (Uncommitted)			
Epilepsy	Contract Variation	2 months	
Heart Failure	Pilot then open tender	6-8 months	April 2016
COPD	Pilot then open tender	6-8 months	October 2015
Case Management	Contract variation	2 months	