Appendix 2 V2 - QIPP Plan Sep 2010 JHO8
QIPP Programme of Work and Projects

Workstream & Initiatives	Description	Gross Savings £000's 11/12	12/13	13/14	Total
Self Care and Patient Responsibility Aligned to QIPP Theme: Prevention and Staying Healthy; Long Term Conditions	This workstream falls into two parts: 1. a public health led programme of screening, health checks, vaccination and weight management 2. a suite of projects designed to improve patient's ability to self manage	(2,143)	(2,148)	(2,170)	(6,461)
Breast Screening Age Extension	Expand screening programme from 50-70 year olds to 47-73 year olds				0
Bowel Screening full year pickup	Continue bowel screening programme for 60-69 year olds in Oxfordshire, age extending to 70-74 year olds after prevalent round complete				0
Weight Management Adults	Continue to develop the local programme and services for the prevention and treatment of adult Obesity				0
Abdominal Aortic Aneurysm Screening	Roll out the AAA screening programme across Oxfordshire once an agreed Vascular Network is in place and national pilot funding has been secured				0
NHS Health Checks programme	Develop and improve existing targeted CVD checks, depending on national policy direction				0
Increase Retinopathy screening	Continue to improve uptake of diabetic retinopathy screening in Oxfordshire				0
Increased Chlamydia Screening	The Oxfordshire Chlamydia Screening Programme will continue to be developed to ensure improvement in screening opportunities for young people aged 15-24 years so that long-term effects of the infection are reduced				0
Targeted testing for HCV and testing and vaccination of HBV (through pharmacies)	Pilot to perform 48 viral hepatitis tests amongst the highest at risk group to assess the feasibility and efficiency of providing on demand testing of primarily hepatitis c but also hepatitis b in a pharmacy setting for IVDUs in Oxfordshire	(14)	(19)	(41)	(74)
Telehealth COPD pilot	A pilot study using equipment and services used to remotely monitor ~150 COPD patients in their own home	(110)	(110)	(110)	(330)
telehealth for CHF patients	Mainstream application of remote vital signs monitoring for CHF patients	(104)	(104)	(104)	(312)
self management skills development programme	An extensive programme of self management skills development for clinicians, patients and carers	(1,915)	(1,915)	(1,915)	(5,745)
Personalised Health Plans	An expected output of initiative N is that staff trained will have the skills and abilities to help patients develop and deliver personalised health plans.				0
CVD and COPD pathway based self management	Review COPD and cardiac care pathways and ensure pathways deliver optimal opportunities for improved self management				0
Primary Care Aligned to QIPP Theme: Primary Care Commissioning; Contracting / Prescribing	Enable patients to access appropriate services in a setting closer to home, ensuring the services offered are of the highest quality and demonstrate efficiencies and productivity.	(2,993)	(3,274)	(1,957)	(8,224)
Driving efficiency in Primary Care	o Develop productivity metrics o Review of enhanced services (ES) o Strengthen the contract monitoring functions o Develop a single point of delivery model for ES o Emergency Transport Avoidance o Patient access to online functions o Review of PMS contracts				0

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Driving Quality in Primary Care	o Develop quality metrics / dashboards o Develop standard services and quality expectations o Develop partnership working arrangements with public health and prevention services	(972)	(627)	(610)	(2,209)
Strategic Development	o Implement of models of shared practice management, back office functions and premises o Support a move towards larger practices o Develop of activity and population growth modelling				0
Pharmaceutical Needs Assessment	Used to determine the need for pharmacy services and control of entry to the market				0
Effective Medicines Management	o Continue implementation of cost reduction schemes o Enhancing the use of community pharmacies o Reduction in waste medicines	(2,021)	(1,347)	(1,347)	(4,715)
Regional Enabling Group- Pathology Modernisation	Pathway rationalisation / improved efficiencies; manage workload, volumes of tests and requests through direct access and reducing waste		(1,300)		(1,300)
Integrated Community Service Provision (ICSP) Aligned to QIPP Theme: Long Term Conditions (inc. Learning Disabilities)	Development of locality based integrated teams covering health and social care needs, supported by community resource units and extending case management and enhanced self-care for people with LTC	(2,647)	(1,979)	(1,764)	(6,390)
Integrated Community Teams	Staff with skills to assess health and social needs, develop plans and deliver care .				0
Community Resource Units (CRUs)	Support the delivery of care in community settings, through access to diagnostics, diagnosis, treatment, consultation, planning, day services, bedded areas to provide 'sub acute' care.				0
Virtual Ward	Support people in care homes through better planning, earlier detection of deterioration and timely intervention	(810)			(810)
Community Respiratory Service	Review respiratory services and increase access to pulmonary rehabilitation for patients with COPD	(400)			(400)
Learning Disability	Re-commission Community Learning Disability Teams and specialist inpatient services	(1,283)	(1,314)	(1,337)	(3,934)
Implementation of Diabetes Service		(154)	(665)	(427)	(1,246)
Acute Care Aligned to QIPP Theme: Emergency /Acute care flows	Development of community hospital sub acute capacity as alternative level of care for patients currently occupying acute capacity	(2,520)	(5,721)	0	(8,241)
Integrated Community Team	Development of community hospital sub acute capacity as alternative level of care for patients currently occupying acute capacity	(2,520)	(5,721)		(8,241)
Quick and Responsive Aligned to QIPP Theme: Emergency & Acute Care Flows; EOL	Access to right high quality care, in right setting at right time in an emergency or need for urgent medical attention. More care outside hospital and close to home settings, so reducing unnecessary admissions to Secondary Care, A&E attendances excess bed days and lengths of stay	(5,974)	(76)	(76)	(6,126)
Care Outside Hospital					0
Virtual Ward	Under 'ICSP' workstream brief				0
Hospital at Home	Emergency multi disciplinary diagnosis and triage supporting adults safely in normal place of residence	(2,786)			(2,786)
Delayed Transfer of Care programme	Includes Community Hospitals & adult assessment & enablement service				0

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Integrated Front Door					0
Single point of Contact	24/7 single phone number to access all urgent care - linked to 'phone first' message and scheduling of urgent care.	(2,581)			(2,581)
GP Co-location	Primary Care Service co-located by A&E	(101)			(101)
Roving GP Service	GP 8/24 roving between A&E major and admissions units	(430)			(430)
End of Life Care					0
Rapid Response Service	Short term care at home in a crisis to prevent emergency admission				0
Matron service	Patients supported at home until death – jointly with Macmillan Care				0
Workforce development	Opportunities to access high quality staff education across all sectors to support EOL initiatives				0
Early identification of patients	Increased use of the Gold Standards Framework and linking up service systems				0
Bereavement review	Comprehensive review of current need and provision to inform developments				0
EOLC and dementia work-streams	Ensuring best outcomes for dementia patients at the eol				0
Advance planning development	Developing staff competencies in advance planning and record keeping processes and sharing				0
SARC – Sexual Assault Referral Centre	Immediate counselling and support, physical treatment and central resource for advice for clinicians	(76)	(76)	(76)	(228)
Complex Care Aligned to QIPP Theme: Right care; long term care; self care; continuing care; Mental health (for dementia)	Managing the over-reliance on acute hospital care and placements in intensive residential and nursing care by personalising care pathways redesign, re-focusing on rehabilitation and preventative services, using technology and integrating provision	(2,150)	(624)	0	(2,774)
Dementia	o Early diagnosis for dementia o Improved dementia care in general hospitals o Targeting younger people with dementia, inc. learning disability o Older Peoples Mental Health Strategy o End of Life Care for Dementia	(287)	(574)		(861)
Stroke developments programme	o Re-design of Acute pathway at the Horton o Stroke Rehabilitation Development o Long-Term Care for Stroke	(240)			(240)
Personal Health Budgets Pilot (PHB)	Implementation of Personal Health Budgets for people eligible for NHS continuing care				0
Continence services redesign	Re-design approach to delivering bowel and bladder services projects	(100)	(50)		(150)
Fragility Fracture pathway re-design	o Development of integrated pathway o Pilot of new Hip fracture pathway o Secondary fragility fracture prevention o Fragility fracture treatment pathway o Non-conveyed fallers pilot	(1,523)			(1,523)
Development of responsive, skilled and productive rehabilitation	o Development of a Whole System Model for Rehabilitation in Oxfordshire o Review of County Intermediate Care Services (Oxfordshire Access and Enablement services) o To commission an Older Peoples Exercise, Health & Wellbeing Service				0

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Carers	o Early identification, recording and signposting of carers o "Carers awareness" training o Design and deliver preventative breaks/respite to carers through primary care teams				0
Excess bed days in the +65 age group	Reduce the number of excess bed days in individuals / conditions who do not require 24 hours consultant level care				0
Continuing Healthcare	Implement actions to address performance and reduce costs				0
Planned – Normal Care Aligned to QIPP Theme: Planned	Ensure that care pathways provide evidence based interventions that maximise overall health gain, deliver improved productivity and value for money	(3,625)	(1,685)	(1,100)	(6,410)
Threshold Management	Review and agreement of treatment thresholds	(1,338)	(350)	(400)	(2,088)
Embedding a Referral Management Culture	embedding robust referral management processes in primary care	(250)			(250)
Diagnostic Testing	o Stopping tests of low clinical value o Changing the referral pathway (increasing/decreasing direct access) to support shifting activity from secondary care to the community	(500)	(500)	(500)	(1,500)
Productivity	o Completion of work on outlying specialties o Direct booking onto day case lists for GPs. o Shift activity from daycase settings to outpatients and reducing OP activity (C2C) o Reducing number patients discharged from secondary care after one OP appt o Non-emergency patient transport – implement revised eligibility criteria o Ramsay (ISTC) utilisation	(1,537)	(835)	(200)	(2,572)
Planned - Specialist Care Aligned to QIPP Theme: Planned Care	Ensuring improved healthcare outcomes for people with specialist rare conditions and those with cancer, cardiac or neurological conditions by having the right treatment from the appropriate provider and by integration with non specialist services	(3,641)	(3,190)	(3,220)	(10,051)
Neurological Conditions	Improving access to Community Neurology Services to support individuals living with a LTnC.				0
Cancer	Establishing a Community Chemotherapy Service Meeting national NCAG recommendations in acute oncology Implementing LAEDI (cancer local awareness and early diagnosis initiative) Investing in increased radiotherapy fractions Reducing excess bed days via the Enhanced Recovery Programme (ERP). Implementing 23 Hours Stay Model for Breast Cancer Surgery and use of Drains as the exceptior	(284)			(284)
Cardiothoracic & vascular Services	Transferring Cardiac Rehabilitation to Community settings	(200)			(200)
Collaboration with South Central Specialist Commissioning Group (SCG)		(3,157)	(3,190)	(3,220)	(9,567)
Mental health Aligned to QIPP Theme: Mental Health	Ensuring people can stay well, that when they become unwell, they will get better quicker and effective and appropriate interventions will be delivered in a timely personalised way	(706)	(281)	(281)	(1,268)
Keeping People Well - KPW:	Universal Well-Being service offering stepped care according to need and structured recovery service				0
Supported to Independent Living – SIL (includes ERMO & Aspergers):	Provide clear housing pathway to recovery and independence with alignment of funding	(496)	(281)	(281)	(1,058)

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Maximising Recovery Interventions and Outcomes - MaRIO (includes IAPT Phase 2):	Creating a clearer pathway through clinical services from early onset of symptoms to recovery	(210)			(210)
Improving Health & Well Being for All:	To promote mental well-being and prevent mild to moderate mental ill health				0
C&YP Aligned to QIPP Theme: Child health	Coordinated and integrated health and social care for infants, children, young people and their families in safe and familiar settings	(400)	(650)	0	(1,050)
Redesigning Paediatrics Services	Improving Urgent Care pathway & Expansion of Children's Community Nursing services	(250)	(400)		(650)
Community Equipment	Improving access for Children with Complex needs/disabilities placed either in or out of county who are Looked After Children				0
Children's Continuing Healthcare and cost-effective placements		(150)	(250)		(400)
Prevention and Early Intervention	Implementing Healthy Child Programme and safeguarding Weight management schemes Improving health outcomes by reducing the impact of risky behaviours Review and Improve the care pathway for young people who self harm Alcohol Initiatives Reducing inequalities in oral health in children				0
Maternity & Newborn Aligned to QIPP Theme: Maternity & Newborn	Modernising maternity services to ensure best clinical outcomes and a safe, sustainable and affordable maternity workforce	0	0	0	0
Reducing C-Section rates	Reducing variation rates across sites				0
Reducing unscheduled care	Adopt minimum set of operational standards, agree contract activity and standard service specification				0
Sustainable Maternity Workforce	Outcomes approach to workforce modelling and detailed work on skill mix, role definition and redesign				0
Enabling Aligned to QIPP Theme: System Enablers	System enablers	(1,538)	(1,222)	0	(2,760)
Review capacity and capability of workforce		(1,538)	(1,222)		(2,760)