South London
Cardiovascular and Stroke Network

QIPP Planner 2012-13

QIPP Planner is a tool designed to assist south London health commissioners to formulate QIPP plans for commissioning priorities in cardiovascular and stroke care, in line with:

- NHS Outcomes Framework 2012-13
- Public Health Outcomes Framework 2013-16
- Social Care Outcomes Framework 2012-13
- Quality Outcomes framework

Commissioning priority areas
Each commissioning priority has been developed and defined by clinicians and patients through working in partnership, facilitated by South London Cardiovascular and Stroke Network. Service specifications for pan-London cardiac surgery, vascular service provision and stroke are clinician-led, through the London Cardiovascular Project. South London cardiovascular work areas are clinician-led via South London Cardiovascular and Stroke Network work streams, with input from a patient panel and the Network patient and carer forums. Patient safety and the patient experience are explicit in each commissioning priority.

Cardiovascular disease
Cardiovascular disease remains the greatest cause of mortality in the UK causing 200,000 deaths per year. Cardiovascular disease (CVD) mortality rate in London for persons under 75 yrs was 75.3 per 100,000 (in 2007-09). Public health profiles. Download CVD profiles from the South East Public Health observatory website.

Click on a commissioning priority for a full list of projects:

Long term conditions

Medicines optimisation

Primary care

Right care

End of life care

QIPP procurement

For advice or assistance with QIPP planning contact Sara Nelson (cardiovascular care), Helen O'Kelly (stroke care) and Helen Williams (prescribing).

Long term conditions				
Project title	**Actions**	**Outcome**	**Strategic fit**	**Savings** **P= productivity** **C= cost saving**
Community/home-based cardiac rehabilitation programmes	• Improve the commissioning and performance monitoring of cardiac rehabilitation services • Ensure equitable access for a wide range of cardiovascular rehabilitation including acute coronary syndrome, heart failure and angina patients • Redefine how patients 'complete cardiac rehabilitation' according to the Dept. Health cardiac rehab commissioning pack • Ensure cardiac rehabilitation services accept all 'inscope' patients, including heart failure • Ensure service delivers continued long-term rehabilitation support for users and includes drug optimisation pathways • Ensure service specification and performance measures are in place for cardiac rehabilitation and heart failure patients • Link GPs community clinics, acute hospitals to cardiac rehabilitation services (clarify referral pathway) Consider links with social care	• Availability of cardiac rehabilitation services that accept heart failure patients and other 'in scope' patients as per Dept. Health commissioning pack • Reduction in use of unscheduled care / emergency admissions and readmissions • Improved quality of life through • Improved patient outcomes • Increased quality of care • Numbers of patients dependent on social care	• **Domain 1** Preventing people dying prematurely • Reduce mortality (OF 1) • Reduction in under 75 mortality from cardiovascular disease • **Domain 3** Enhancing quality of life for people with long term conditions • **QOF** CHD 6,8,9,10,14,12 • Improving access • Delivering care in the community as close to patient home as possible	• Cost benefit please use Dept. Health cardiac rehabilitation commissioning tool

	• Clarify implementation of post discharge tariff • Further information on service development re-design			
Hypertension - ensure care developed to meet NICE guidance NICE CG127	• Develop pathways to identify, manage and improve drug optimisation and management of complex cases. As per NICE guidance and including use of ambulatory blood pressure monitoring • Ensure risk assessments carried out on newly diagnosed hypertensive's • Commission community care services to provide first line management of care • Consider adding pulse check to pathway to link with stroke prevention and improve identification of atrial fibrillation • Investigate potential for use of new technology	• Improved commissioning of hypertension services • Improved quality of hypertension services • Improved performance monitoring of hypertension services for sector wide comparisons • Improved joint working with secondary care for complex cases • Reduced use of secondary services • Early identification of atrial fibrilation to reduce strokes incidence	• **Domain 1** Preventing people dying prematurely • Reduce mortality (OF 1) reduction in under 75 mortality from cardiovascular disease • **Domain 3** Enhancing quality of life for people with long term conditions • Provide care closer to home • **QOF:** CHD6, PP1, PP2, BP1, 4, 5 record 11, record 17 increased quality of care	• Reduction in outpatient costs • Saving on cost of cardiac events of £450,000 per 1000,000 population • Implementing NICE hypertension guidelines • *Watch BP Home A* claim prevents 22 strokes per 100,000 people screened • Cost of fatal stroke £3036, cost of 12 lead ECG £36 (NICE CG127 plus 5% inflation adjustment) • Diagnostic costs of *Watch BP Home* £5.32 per patient • Cost saving between £3,520 - £4041 in patient with CHADS scores 5-6
Lipids management - ensure services developed to deliver NICE guidance	• Commission community care services to provide first line management of care • Develop pathways to ensure appropriate diagnosis and management of complex cases and familial hypercholesterolaemia in line with SLCSN and NICE guidance	• Improved commissioning of lipid services • Improved quality of lipid services • Improved performance monitoring of lipid services for sector wide comparisons	• **Domain 1** Preventing people dying prematurely • Reduce mortality (OF 1) reduction in under 75 mortality from cardiovascular disease -appropriate care for long term conditions	• Reduction in outpatient costs • Reduction in long term care over time

	• Further info on lipids on the SLCSN website	• Improved joint working with tertiary centre • Reduced use of secondary services • Reduced complications in later life • In quality of care	• **Domain 3** Enhancing quality of life for people with long term condictions • **QOF:** CHD 8, Stroke 8 • Improving access delivering care in the community as close to patient home as possible	
Arrhythmia - ensure primary care services developed to deliver optimal therapy	• Assess potential for developing and commissioning community based services to diagnose and treat atrial fibrilation • Develop and implement atrial fibrilation referral pathways • Develop a formal local network and pathways for accessing arrhythmia nurse specialists • Consider joint appointments with secondary care • Agree commissioned service to manage arrhythmia patients using SLCSN arrhythmia traffic light referral system and atrial fibrilation patients according to recognised pathway (e.g. SLCSN atrial fibrilation pathway) using combined approach with primary, secondary and tertiary care • Improvements in ECG services by commissioning interpretation services for local GPs • Review ECG recording and interpretation competencies and consider benefits of ECG telemedicine to support general practice	• Improved quality of arrhythmia services • Improved performance monitoring of arrhythmia services for sector wide comparisons • Improved joint working • Improved knowledge of primary care staff • Engagement across whole pathway to improve outcomes in terms of timely access to most appropriate service and reduction in variance across practices and localities • Reduction in stroke events – acute and rehab costs	• **Domain 1** Preventing people dying prematurely • Reduce Mortality (OF 1) reduction in under 75 mortality from cardiovascular disease -appropriate care for long term conditions • **Domain 3** Enhancing quality of life for people with long term conditions • **QOF:** AF1, AF5, AF6, AF7 • Provide care closer to home • Reduced use of secondary services • Reduction in mortality • Increased quality of care	• Reduction in outpatient costs • Reduction in emergency admissions • Reduce length of stay and readmission rates • Atrial fibrillation – detection and optimal therapy in primary care • Telemedicine to interpret ECGs in primary care

	• Commission training programme to upskill primary care staff and ECG interpretation skills • Optimise medical treatment. Consider developing local anticoagulation services			
Heart failure: Ensure primary care services developed to deliver best practice standards	• Commission heart failure Services to ensure care is managed via a single integrated pathway through primary, secondary and tertiary care in accordance with current evidence and best practice guidelines. See SLCSN commissioning guidance and financial analysis • Commission diagnostic and treatment pathways (GP algorithm – diagnosis of heart failure) and access to NT-proBNP as a rule out test and echo and specialist assessment according to NICE CG108 (ie 2 weeks and 6 weeks) for early accurate diagnosis, cost effective use of tests, and optimisation of treatments • Consider use of Commissioning for Quality and Innovation (CQUIN) payment framework to ensure all heart failure patients (admitted to both cardiology and non-cardiology wards) are referred to the heart failure service • Implement key performance indicators with Service Level Agreement (SLA) minimum data set and quality standards in heart failure and benchmark cardiac rehabilitation across the sector	• Improve commissioning of heart failure services • Improve quality of heart failure services • Improve performance monitoring of heart failure services for sector wide comparisons • Improve joint-working	• **Domain 1** Preventing people dying prematurely Reduce Mortality (OF 1) reduction in under 75 mortality from cardiovascular disease • **Domain 3** Enhancing quality of life for people with long term conditions • Provide care closer to home • Increased quality of care • Improve patients outcomes reduction in mortality • **QOF**: HF1, HF2, HF3, HF4	• Reduce length of stay and readmission rates • Kent tele-health pilot *(p4)* reported cash savings of £1,878 per patient and Dept. Health whole system demonstrator sites have also shown 20% reduction in emergency admissions and 45% mortality rates

	• Consider cautious use of tele-health see (development of remote monitoring processes for cardiac devices			
Stroke six month reviews	• Commission six month stroke reviews - as per National Stroke Strategy quality standards - to prevent complications of atrial fibrilation untreated hypertension	• Improved patient outcome and satisfaction • Improved support and satisfaction for carers • Reduced duplication between services • Early identification and treatment of issues e.g. medication, pressure sores • Potential to reduce hospital appointments and admissions • Prevention of carer breakdown • Opportunity to reduce dependency • Reduce adult services care package & care home placements	• **Domain 3** Helping people to recover from episodes of ill-health or following injury • Key indicator for NHS Operating Framework and Commissioning Outcomes Framework • Improving access • Increased quality of care • Improve patients' quality of life through improved patient outcomes	• Potential to limit costs due to complications from stroke, including readmissions • The National Stroke Strategy (2007) estimated that nationally, at full implementation, approximately 200 strokes would be prevented each year and 300 stroke survivors would retain their independence. This would result in a saving of an estimated £12 million
Improving stroke community rehabilitation including early supported discharge	• Review /establish specialist early supported discharge service and enhance borough based community neurorehabilitation teams where appropriate • Promote the benefits of investment in a suitably staffed, specialist and flexible workforce. Potential for early supported discharge/community neurorehabilitation teams to integrate with acute teams • Assess demand and capacity, capability, workforce/skill mix,	• Care closer to home • Improve patient/carer /family satisfaction and outcomes • Reduce length of hospital stay and care home/inpatient admissions • Streamlined pathway, reduce duplication, consistency for patients and staff. Flexible, responsive and efficient workforce. Joint approach to education and training • More efficient use of acute resources – improved pathway flow	• **Domain 3** Helping people to recover from episodes of ill-health or following injury • Improving access • Delivering care in the community as close to patient home as possible • Increased quality of care • Improve patients quality of life through improved patient outcomes	• Cost efficiency and clinical effectiveness, retention of staff, improve productivity • Camden's early supported discharge team demonstrated savings in excess of £200,000; declared due to a reduction in the need for non-elective bed days and ongoing social services packages of care. This equates to £83,000 per 100,000 population

	outcomes and overall productivity of non-acute services • Annual assessments of early supported discharge/community teams		• Link stroke specific services with overall strategy i.e. hospital at home, long term conditions, integrated health and social care model	• Savings may be made if early supported discharge services are commissioned to take patients directly from hyper-acute stroke unit – saving the stroke unit tariff spell
Improving access to psychological support for stroke patients	• Investment in benefits of psychological support	• Improving access • Increased quality of care • Improve patients quality of life through improved patient outcomes	• **Domain 3** Helping people to recover from episodes of ill-health or following injury • Key indicator for NHS Operating Framework and Commissioning Outcomes Framework	• Reduce costs, retention of staff, improve productivity • Evidence is expected from NHS Improvement in December 2012 that will outline a cost-benefit case

Medicines optimisation				
Project title	**Actions**	**Outcome**	**Strategic fit**	**Savings** **P= productivity** **C= cost saving**
Implementation of NICE guidance on NOACs / optimisation of oral anticoagulation for stroke prevention in atrial fibrilation	• Implementation of SLCSN NOAC guidance to maximise stroke outcomes • Optimise oral anticoagulation – focussing on patients on nothing or aspirin to maximise health gains • Decommissioning of anticoagulant service activity as demand falls due to introduction of new agents	• Increased percentage of patients' receiving appropriate anticoagulation treatment • Decrease in strokes and related healthcare costs • Reduced risk of double paying	• **Domain 1** Preventing people dying prematurely • Reduce mortality (OF 1) reduction in under 75 mortality from cardiovascular disease -appropriate care for long term conditions • **QOF:** AF1, AF5, AF6, AF7	• C – cost savings overall if appropriate uptake of NOACs and maximised use of warfarin; and activity is appropriately decommissioned in current anticoagulant services
Implementation of NICE heart failure drugs guidance	• To update current network guidance and incorporate new drugs/licensing	• Decreased hospitalisation and decreased mortality	• **Domain 1** Preventing people dying prematurely • **Domain 3** Helping people to	• C – cost savings from improved quality of care and prevention of increased

			recover from episodes of ill-health or following injury	morbidity/mortality
Management of prescribing risks (clinical & financial)	• Development of simvastatin guidelines to support the implementation of the Medicines and Healthcare products Regulatory Agency (MHRA) simvastatin guidelines • Positioning of new drugs entering into the health economy	• Supporting the implementation of MHRA warning and drug safety alerts • Maximise patients outcomes and maintain patient safety • Supporting the maintenance of financial control/balance	• **Domain 3** Helping people to recover from episodes of ill-health or following injury	• Cost savings and productivity
Generic statin prescribing	• Ensure maintenance position of generic statins within guidance and focus on ensuring appropriate use of branded agents such as ezetimibe and rosuvastatin	• Cost containment in line with national/local guidance	• NHS London Prescribing Indicators	• Cost savings
ACE – implementation of NICE guidance: prasugrel TA182) and ticagrelor (TA236)	• Ensure use of high potency antiplatelets in appropriate patients presenting with acute coronary sydrome, in line with SLCSN guidance	• NICE implementation • Admission avoidance	• **Domain 1** Preventing people dying prematurely • **Domain 3** Helping people to recover from episodes of ill-health or following injury • Reduce mortality and readmissions	• Prasugrel: prevents 1 re-hospitalisation per 100,000 population • Costing template

Primary care				
Project Title	**Actions**	**Outcome**	**Strategic fit**	**Savings** **P= productivity** **C= cost saving**
Commission single integrated heart failure pathway	• Commission /develop a single integrated heart failure pathway through primary, secondary and tertiary care, based on current clinical evidence and best practice guidelines	• Improved commissioning of heart failure services • Improved quality of heart failure services • Improved performance monitoring of	• **Domain 1** Preventing people dying prematurely • Reduce mortality (OF 1) reduction in under 75 mortality from cardiovascular disease	• Pathway improvement financial analysis tool

	• SLCSN guidance: heart failure service commissioning	heart failure services for sector wide comparisons • Improved joint working • Accurate diagnosis – cost effective tests, • Best use of heart failure specialist services • Admission avoidance	• **Domain 3** Enhancing quality of life for people with long term conditions • Reduce re-admission	

Right care				
Project title	**Actions**	**Outcome**	**Strategic fit**	**Savings** **P= productivity** **C= cost saving**
Prevention of early stage cardiovascular disease	• Develop and deliver care pathways for early stage cardiovascular disease in line with NICE CMG45 • An integrated approach to commissioning should be developed alongside health and wellbeing boards in line with priorities identified in Joint Strategic Needs Assessments to enable primary care services to develop and deliver local care pathways for prevention and treatment of early stage cardiovascular disease • Monitor compliance with the coronary heart disease, atrial fibrilation, diabetic, renal and stroke registers: Suggested performance improvement 10% year on year, reduction in exception reporting by	• Cost saving from improved primary care management of pre surgical vascular illness and screening will reduce need for unscheduled inpatient intervention, result in proactive management, reduced emergency acute surgical interventions costs of long term care • Improvement in morbidity identification and treatment of atrial fibrilation reduction in stroke events reduced acute and rehab costs • Primary prevention of stroke through increased identification of atrial fibrilation (known under diagnosis of silent AF) to enable patients to be set on correct management pathway	• **Domain 1** Preventing people dying prematurely▲ • Reduce mortality (OF 1) reduction in under 75 mortality from cardiovascular disease -working in partnership to improve primary prevention▲ • Increased healthy life expectancy (PHO1)▲ • Reduced differences in life expectancy and healthy life expectancy between communities (PHO 2)▲ • Delaying and reducing the need for care and support▲ • Social care outcomes framework (SCOF 2)▲	• Invest to save potential to reduce incidence of modifiable risk factors • Integrated commissioning and benchmarking tool

	practices Consider decommissioning services with poor uptake or no evidence of clinical outcomes • Risk factor identification and management of the 9 modifiable risk factors.[1] Consider disinvestment from services with poor uptake or no evidence • Identification, stroke risk stratification ($CHADS_2$ or CHA_2DS_2VASc scoring - use of GRASP-AF tool or similar) of patients with atrial fibrilation, improve management, and appropriate anticoagulation • Manual pulse check prompts in all long-term conditions monitoring templates • Local opportunistic screening initiatives • Promote stroke risk stratification of atrial fibrillation patients using recognised scoring tool (e.g. GRASP-AF or similar) • For further info on GRASP AF • Abdominal aortic aneurysm screening programmes are developed for go live April 2013. These should be planned in collaboration with local vascular	• Increase in numbers of patients at risk of stroke prescribed anticoagulation to reduce risk of stroke (known under prescribing of warfarin) • Decreased morbidity & mortality from stroke with associated financial implications • Acute and rehab costs • Increased compliance with New QOF atrial fibrilation indicators • Numbers needed to treat (NNT) for 1 year to prevent 1 stroke is 37 for primary prevention and 12 for secondary prevention. NNT for 1 year for mixed population consisting primary and secondary prevention is 25	• Improved outcomes of people who are at risk of cardiovascular disease (QOF PP1PP2, NM26)▲ ▲Indicates these points of strategic fit are also applicable to other commissioning project areas	

[1] NICE CMG45. Page 14

	networks to enable good risk management processes ease of integration and effective financial and clinical governance arrangements			
Diabetes NICE quality standards for structured education for diabetes	• Commission structured education for diabetic populations to help understanding of disease and avoidance of future complications Reduced lower limb amputations • Reduction in retinal ablation therapies • Increased use of collaborative care planning	• Reduced emergency admission for patients with diabetes with hypoglycaemia/ketoacdosis	• **Domain 3** Enhancing quality of life for people with long term conditions • Plus ▲	• NICE commissioning guide: type 2 diabetes patient education programme
Transfer of NHS Health Checks programme into local authorities in 2013/14	• Aim to find the missing patients, assess risk to improve outcomes and quality though improved processes in primary care and ensuring smooth transition of NHS Health Checks programme into local authorities in 2013-14 ensuring organisations ensuring organisations meet the 20% target of offered	• Improved outcomes	• Partnership working • Invest to save • **QOF:** PP1, PP2 • Plus ▲	
Improve GP usage of transient ischemic attack (TIA) clinics for high risk patients	• Implement local referral management pathways to TIA clinics – treatment for high risk cases within 24 hours reduces risk of stroke by 80% (National Stroke Strategy, 2007). Requires urgent referral by GPs, which is not currently uniform • GP education and improved links with acute service to improve referral process	• Improved diagnosis and prevention • Improved access to early treatment reduce number of < 24 hour admissions	• **Domain 1** Preventing people dying prematurely • Reduce mortality (OF 1) reduction in under 75 mortality from cardiovascular disease • **QOF:** STROKE 1, 6, 7, 8 12, 10,13	• 16 strokes prevented per 100 patients treated • Five year cost of stroke estimated at £18,300 (NICE, 2008) and cost of an outpatient tariff of £548, this equates to a saving of £238,000
Improve primary care management of chest pain and reduce the use of unnecessary testing	• Ensure services are commissioned and primary care referral pathways developed for open access chest pain clinics which comply with NICE	• Improved management of care by delivering care as per best practice guidelines	• **Domain 1** Preventing people dying prematurely • Reduce mortality (OF 1)	• Reduction in charges £75 for exercise testing (CG95) (plus inflation)

	Guidance Chest pain of recent onset CG95) Management of stable angina-cg126 • De-commission open access exercise testing	• Reduce unnecessary testing for patients	reduction in under 75 mortality from cardiovascular disease	
Reduction in the use of repeated diagnostic tests (in patient and outpatient)	• Ensure organisations signed up to and use the electronic referral and transfer systems for image and test results • Reduce the number of repeated echos, angiography and other investigations at the tertiary centre	• Reduction in expenditure on outpatient activity		• Reduction in outpatient/diagnostic expenditure
Development of remote monitoring processes for cardiac devices	• Consider introducing remote monitoring for cardiac implantable electrical devices	• Improved access to diagnostics	• **Domain 1** Preventing people dying prematurely • Reduce mortality (OF 1) reduction in under 75 mortality from cardiovascular disease	• Remote monitoring for cardiac devices: Benefits of reduced hospital-based surveillance • Estimated Savings per 100,000 £33,300

End of life care				
Project title	**Actions**	**Outcome**	**Strategic fit**	**Savings** **P= productivity** **C= cost saving**
Heart Failure and stroke	• End of life care- aim to increase in the number of patients who die at home • Commission pathways to ensure use of Gold Standards Framework and Liverpool Care Pathway	• Increased numbers of heart failure and stroke patients who are at the end of their life dying in place of choice	• National End of Life Care • End of life care strategy: Promoting high quality care for all adults at the end of life - Department of Health	• Quality rather than savings

QIPP Procurement				
Project title	**Actions**	**Outcome**	**Strategic fit**	**Savings** **P= productivity** **C= cost saving**
Smarter procurement of devices to reduce variation in device performance and cost	• Compare usage and spend on cardiac devices and prices paid • Review regions contracting arrangements • Ensure NICE guidance is followed appropriately • Investigate smarter procurement that reflects how the companies operate i.e. they approach trusts at end of sales quarter • Look at development of procurement hubs allowing purchasing of increased volumes to secure a better price • Undertake proper assessments of long term outcomes of expensive devices for items such as diagnostic electrophysiology study equipment, radiofrequency and other forms of cardiac ablation • Cardiac resynchronisation therapy • Pacemaker lead extraction using special equipment • 3 dimensional navigation system mapping catheters • Cardiac valves and pacemakers are in tariff	• Implantation, revision and renewal of cardiac defibrillator • Reduction in spend against 2011/12 baseline • Reduction in prices variation • Reduction in variation of usage across providers • Reduction in expenditure on cardiac redo • Reduction in number of outpatient appointments • Reduction of variation in pathways • Increased clinic capacity • Reduced waiting lists • Increased productivity	• Long term conditions agenda	• Remote monitoring of cardiac devices: Benefits of reduced hospital-based surveillance £33,000 per 100,000 population • Evidence review (2009) Implantable cardiac devices with remote monitoring facilities

	• (ICD), CRT-D and aortic stents are excluded from tariff and have locally negotiated tariffs • Negotiate price reductions for battery changes or repositioning of failed devices as this procedure doesn't have the same level of complexity • Consider use of remote monitoring of cardiac devices using tele-monitoring			