Healthy London Partnership NHS

io Health

Social Prescribing & Expert Patient Programme Modelling

NHS Wandsworth CCG

Report is based on HES 2013/14, 2014/15, 2015/16 & 2016/17 data

07 May 2017

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DashBoard: http://www.i5health.com/SPDashboard.html

For further information please visit www.i5health.com/hlp.html or email hlp@i5health.com

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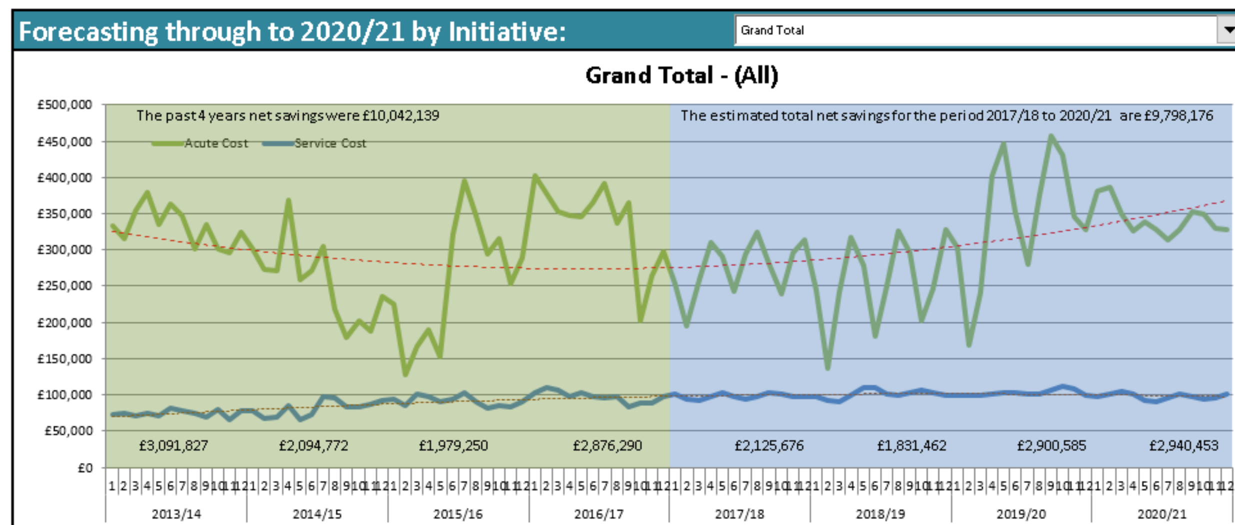
Executive summary

There is a growing body of evidence demonstrating the value of person-centred and community-centred approaches in terms of improved health & wellbeing, their contribution to NHS sustainability and wider social outcomes, which were reflected in all five London s 30 June STP submissions.

Much of the focus has been on the benefits of Social Prescribing and Expert Patients Programmes where policy-makers and commissioners have drawn inspiration from areas of good-practice who have evidenced a Return on Investment for the NHS.

You will find a cost calculator in the Excel spread sheet that allows you to enter an alternative service cost. For example the following diagram illustrates the opportunity for NHS WANDSWORTH CCG to reduce cost in secondary care by £9.8 million net over four years at a 100% success rate for all alternative SP services at a cost of £100 per patient per year, shown as a blue line in the diagram below.



The data in the London, STP and individual CCGs is designed to add value and practical assistance to STP development, activity and financial planning. The data is real patient data, extractable at a CCG level. It can be used for additional local analysis and exported to the Transforming Primary Care financial model to calculate the net benefits of a range of primary care initiatives.

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Explanatory Note about HLP Financial Modelling

There is a growing body of evidence demonstrating the value of person-centred and community-centred approaches in terms of improved health & wellbeing, their contribution to NHS sustainability and wider social outcomes, which were reflected in all five London s 30 June STP submissions.

Much of the focus has been on the benefits of Social Prescribing where policy-makers and commissioners have drawn inspiration from areas of good-practice like Rotherham. Rotherham have published evidence demonstrating the effectiveness of Social Prescribing in reducing patient s use of hospital resources by a fifth in the 12months following referral to a Social Prescribing scheme (September 2014). This translates into a potential positive financial return to commissioners within two years following the initial referral. It is on this basis that Social Prescribing was rightly included as one of seven primary care initiatives within the Transforming Primary Care (TPC) financial model, where the findings from Rotherham have been applied to London to provide forecast savings.

Level of investment in SP and EPP services is not presented here as each CCG will have differing current levels of investment in such services, differing levels of need, and might choose different models of delivery. The City and Hackney Social Prescribing service has a published evaluation which includes costs and return on investment and is included here as a potentially helpful example to reference.
http://www.health.org.uk/sites/health/files/UHSM%20final%20report.pdf

Within this slide pack you will find population health and financial modelling for Expert Patient Programmes, Social Prescribing and aggregated data for both at an individual CCG and STP level year on year until March 2021. The data included in this modelling applies fresh evidence from more recent good practice in City & Hackney (September 2015) and Bristol (March 2016). The data is extractable at a CCG level so will be available for additional local analysis and is available to be exported to the TPC financial model to calculate the net benefits of a range of primary care initiatives.

Both these areas of work are designed to add value and practical assistance to STP development, activity and financial planning.

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Introduction

Healthy London Partnership (HLP) is supporting London s Strategic Planning Groups (SPGs) to develop their Sustainability and Transformation plans (STPs) and, to that end, is recommending specifically the increased use of Social Prescribing (SP) and Expert Patient Programmes (EPP). HLP has been working with i5 Health to apply the Commissioning Opportunity (COP) module:

1. To identify, using a Population Health Management approach and existing secondary care data sets, the numbers of people who may benefit in London from SP and EPP initiatives by condition.
2. To calculate the return to the NHS in London on investment in implementing SP and EPP initiatives over a five year period to March 2021.

This report contains:

- Explanation of the Population Health Management and COP methodologies used
- Impact and Implementation matrix for SP and EPP
- Slides illustrating, on the basis of 2016/17 data, the numbers of patients in NHS WANDSWORTH CCG with specific conditions that could otherwise have benefitted from SP and EPP initiatives
- Detailed COP report (Unplanned/ Planned Care) for NHS WANDSWORTH CCG for 2013/14, 2014/15, 2015/16 and 2016/17 that include URL connections
- Interactive dashboards and heat maps.

An accompanying Excel Spreadsheet contains year on year population and financial forecasting for NHS WANDSWORTH CCG through to 2020/21 of potential savings arising from the use of SP and EPP initiatives. The Spreadsheet is fully interactive to enable planners to assess 'what if' scenarios.

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Population Health Management Methodology

SP and EPP impacts primary, community and acute healthcare by providing patients with activities and education within their clinical peer-group or with people with similar interests. A key objective is to activate the patient for better health outcomes resulting in reduced use of healthcare services.

Part of achieving the planned savings in the NHS in the near term is a reduction in acute spend by focusing on patients that receive avoidable care based on acute National Tariffs for which cheaper alternative services e.g. Social Prescribing and Expert Patient Programmes could be established. For this purpose, a Population Health Management approach comprising patients clinical history, current healthcare needs, acuity score and risk stratification has been used to identify suitable patients for various initiatives.

We have adopted 19 evidence-based initiatives referenced in the COP Report section in this report. Those initiatives are based broadly on patients with outpatient and inpatient activity, between 0 and 2 days length of stay, which are non-complex and do not require specialist services. Nevertheless, each initiative has specific criteria to identify target populations and the financial opportunity cost relating to the patients conditions (see Appendices 1 and 3). Those criteria are based on ICD-10 coding (see Appendix 2) and QoF 15/16 LTC definitions and are applied to acute clinical data (HES) to quantify the patients and their acute spend. A limited number of initiatives have similar criteria hence some patients may be counted more than once.

The patients identified in this report represent potential savings in acute care and do not include other savings relating to other care settings such as General Practice, Mental Health and Community largely down to historical issues associated with block contracts in case of the latter two settings.

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COP Methodology

COP is a methodology, based on secondary care data that matches successful interventions to patient groups using criteria specific to each intervention. This facilitates identification of care gaps in pathways or development of services and new models of care for the local health economy. The COP methodology supports healthcare organisations with reports that help deliver implementable schemes based on STP strategy and clinical needs of their populations. In particular, COP:

- Enables bottom-up, patient level, processing that matches patients to initiatives
- Calculates how many patients can benefit from an initiative
- Aggregates the current acute cost for treatment of those patients
- Assesses number of patients sufficient for a new initiative within the CCG/STP footprints
- Estimates the return on investment for each initiative
- Provides links to reference material of suggested initiatives
- Facilitates creation of what-if scenarios for modelling purposes
- Informs planning, evaluation and implementation
- Provides strategic reporting and real time monitoring

In the context of STP, a principal advantage of the COP reports is the overview they give to enable the orchestration of more synchronised and complementary improvement plans that are currently partly a function of funding and other financial incentives tied to KPIs of individual CCGs. The COP reports can help identify the variations, contribute to a constructive dialogue and highlight the possibilities for co-operation within the STP Footprint.

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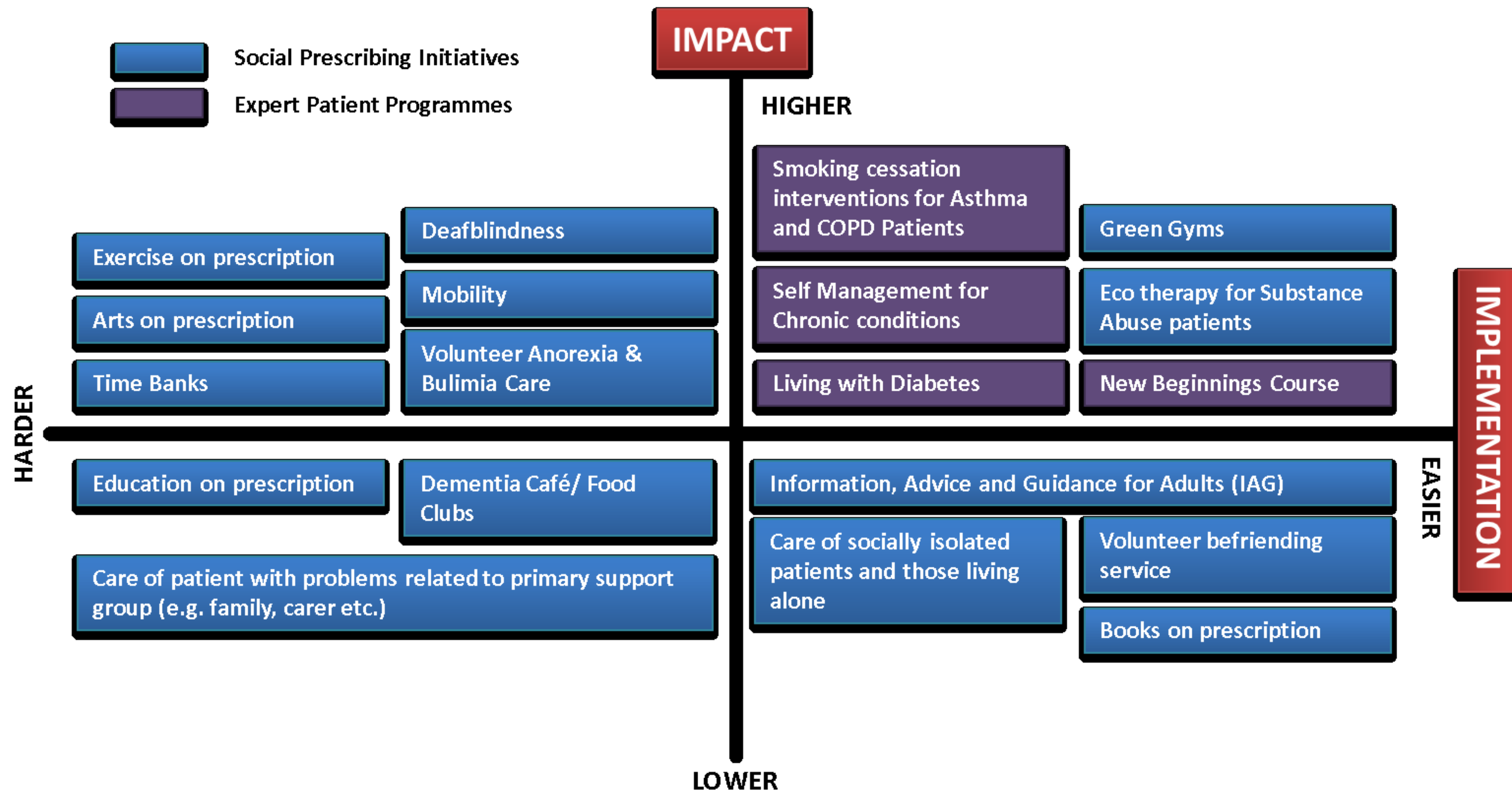
Impact and Implementation

Matrix indicates levels of impact and ease of implementation of the SP and EPP initiatives in the study.



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Social Prescribing

Social prescribing is a way of linking patients in primary care with sources of support within the community. It provides GPs with a non-medical referral option that can operate alongside existing treatments to improve health and well-being.

Targeted Patients for Social Prescribing: (For details of targeted Patients cohorts by Initiatives see Appendix 1)

- Patients with following conditions (For ICD-10 coding see Appendix 2)

  Controlled Diabetes
  Dementia
  Eating Disorder
  Falls, Mobility
  Joint problems including Arthritis and back care
  Learning Disabilities
  Mild and moderate Hypertension
  Mild and Moderate Mental Health Conditions: Depression, Anxiety, Reaction to stress, and adjustment disorders
  Mild Respiratory Conditions: Mild Asthma; Abnormalities of breathing
  Obesity
  Problems relating to Housing and Financing
  Problem related to employment and unemployment / Education and literacy
  Problem related to Primary support group
  Sense Impairment
  Social Isolation
  Substance abuse

- Patients with 0 to 2 day length of stay
- Patients with low acuity rate (non complex cases)
- Patients with general treatments for e.g. general surgery, general medication etc

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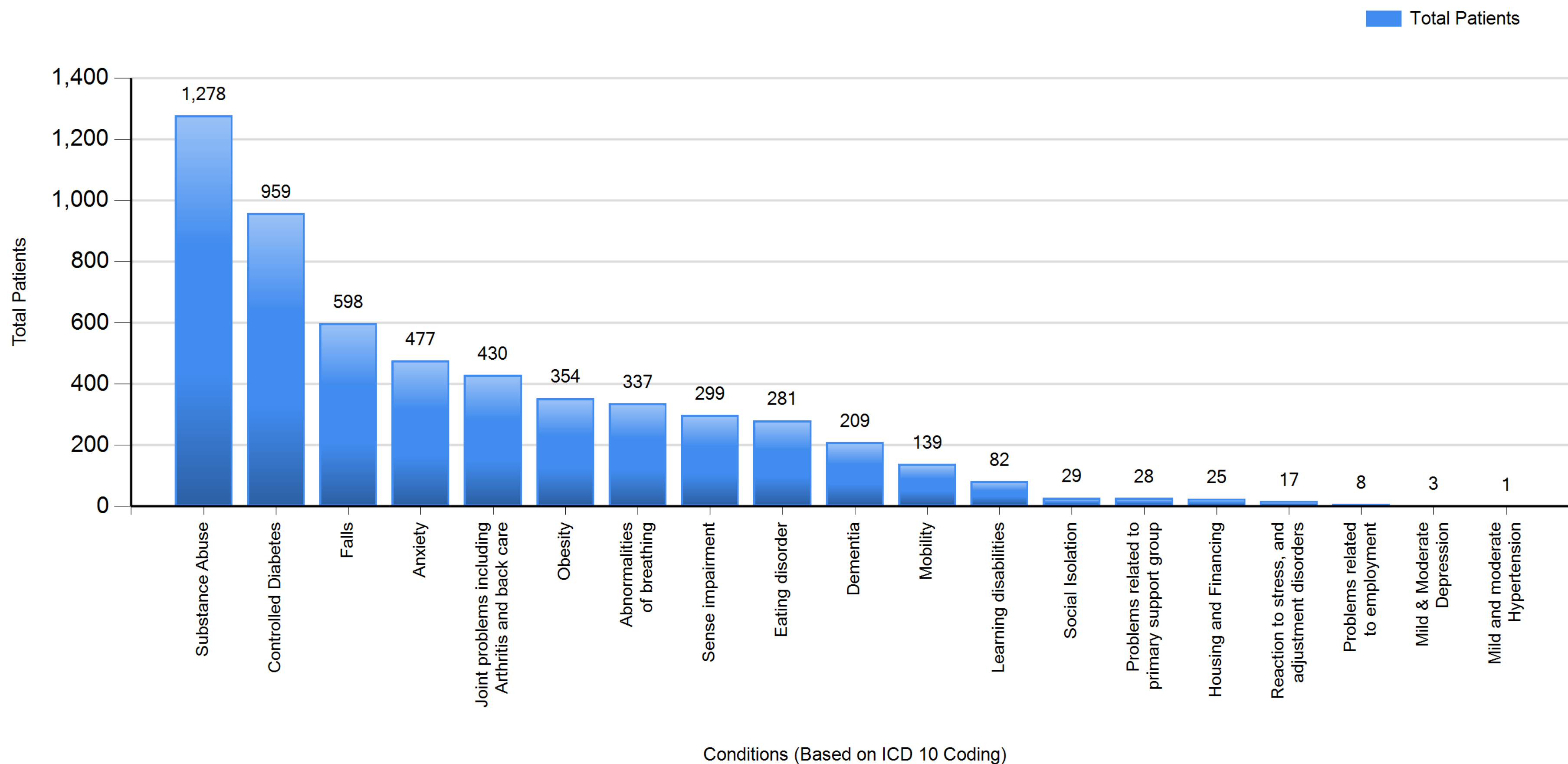
Social Prescribing

Chart shows number of patients admitted to hospital in 2016/17 by targeted condition for SP. The conditions have been identified using ICD 10 coding (See Appendix 2). There were over 2.5k patients that suffered from one or more of the top 3 conditions: Substance Abuse, Controlled Diabetes and Falls. (Data Source: HES 2016/17)



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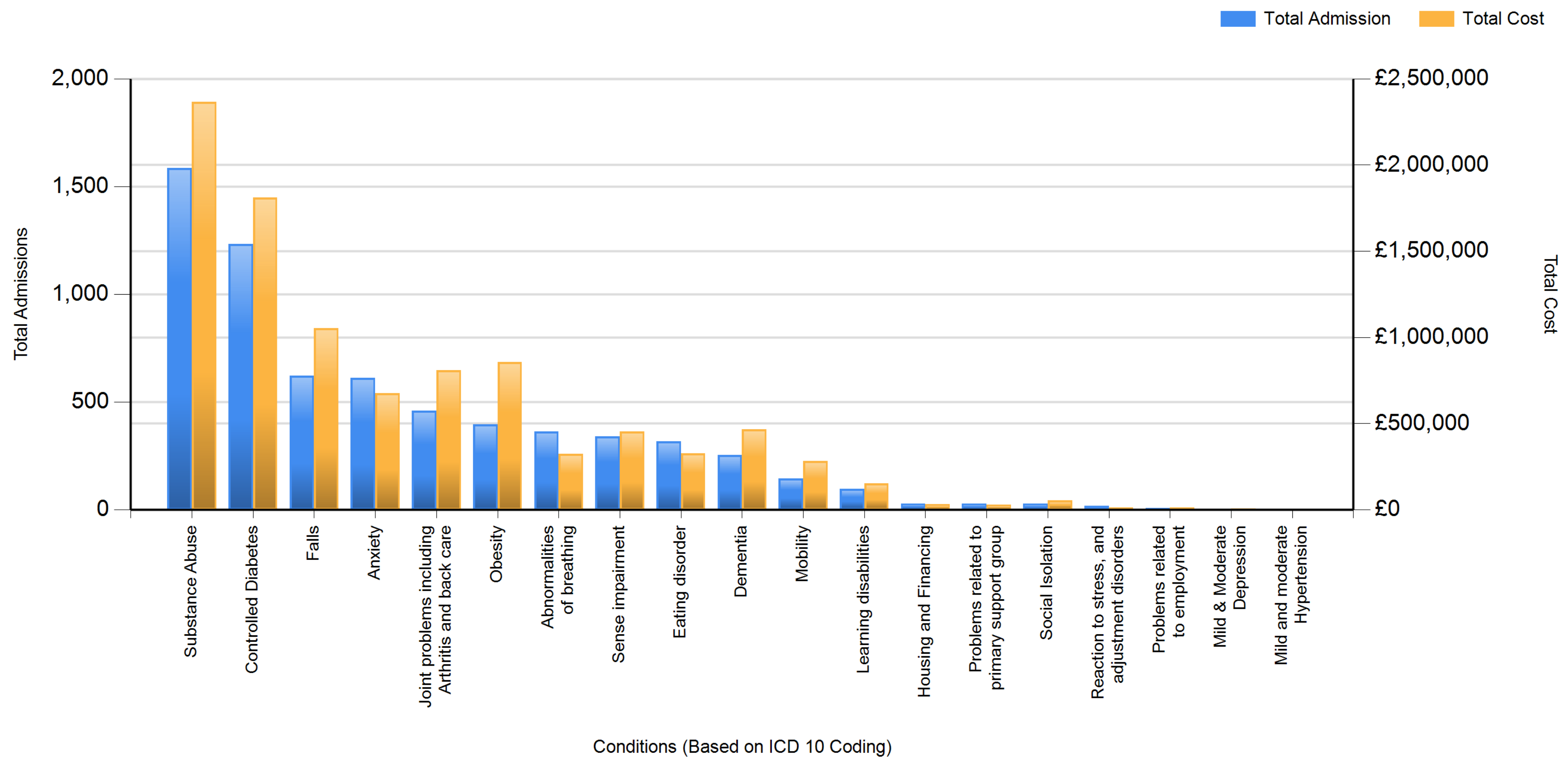
Social Prescribing

Chart shows number of admissions to hospital of patients in previous chart for 2016/17 by targeted condition for SP and associated acute costs. By far the highest costs per admission were for Substance Abuse, Obesity and Falls. (Data Source: HES 2016/17)



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Social Prescribing: List of Initiatives

Targeted Initiatives: (For details of targeted Patients cohorts by Initiatives see Appendix 1)

- Arts on Prescription
- Books on Prescription
- Deafblindness
- Dementia Cafe/ Food Clubs
- Ecotherapy for Substance Abuse patients
- Education on Prescription
- Exercise on Prescription
- Green Gym
- Information, Advice and Guidance (IAG)
- Mobility
- Primary support group problems (e.g. family)
- Social Isolation
- Time Banks
- Volunteer Anorexia & Bulimia Care
- Volunteer befriending service

With specific reference to this SP and EPP exercise, patient cohorts with LOS of 0-2 days and with Low Acuity have been targeted. These are the cohorts that will be the most responsive to the initiatives. That is not to say there can be no effect on patients with large numbers of co-morbidities and High Acuity but the existence of the pressures such patients will be under could limit the impact within Primary and Secondary care.

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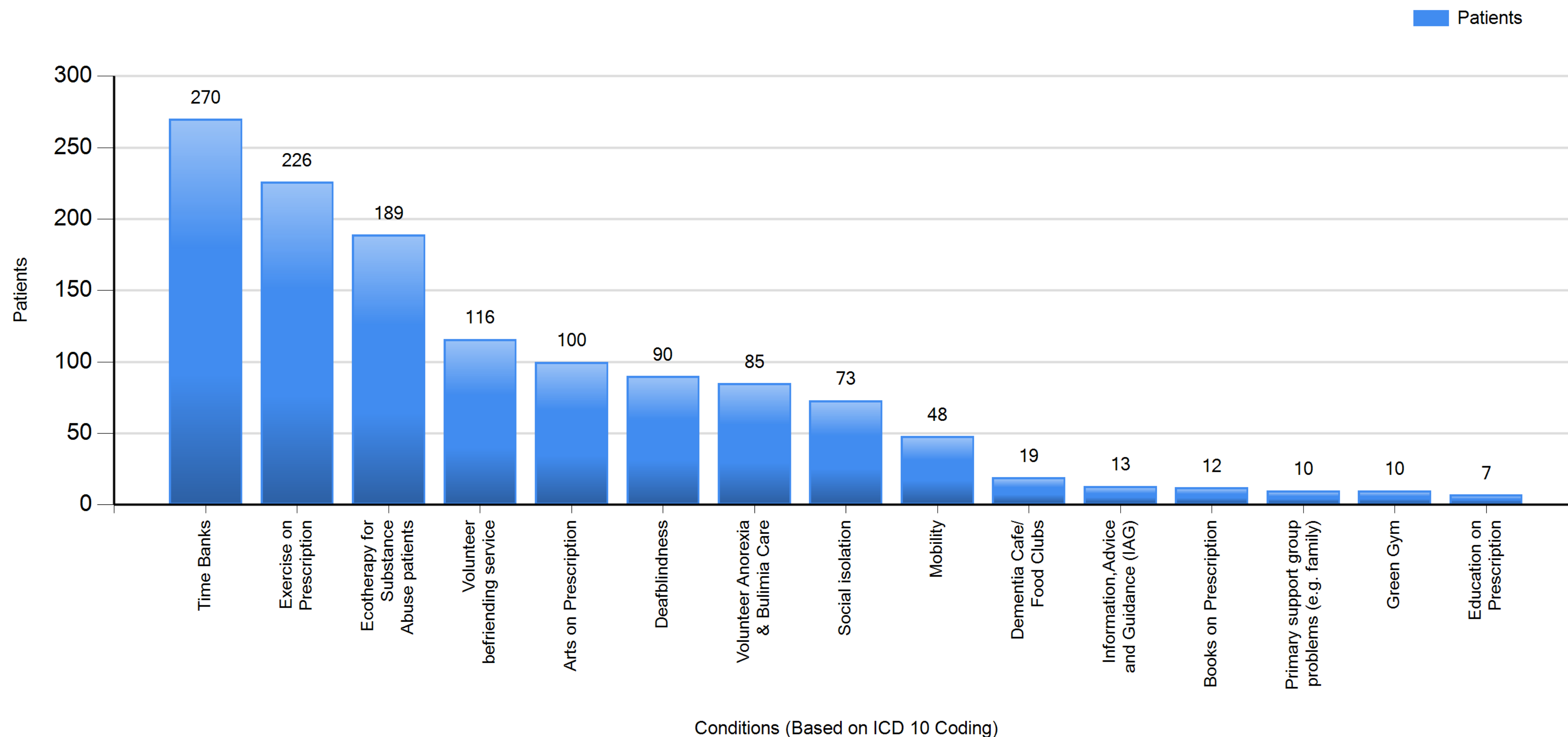
Social Prescribing: Unplanned Care (Non-elective Admissions)

Chart shows number of patients admitted Non-electively to hospital in 2016/17 that would have benefitted from specific SP initiatives should they have been available. The cohorts and conditions of patients for these initiatives are set out in Appendix 1. Time Banks and Excersice on prescription are, by far and away, the biggest initiative proposed. (Data Source: HES 2016/17)



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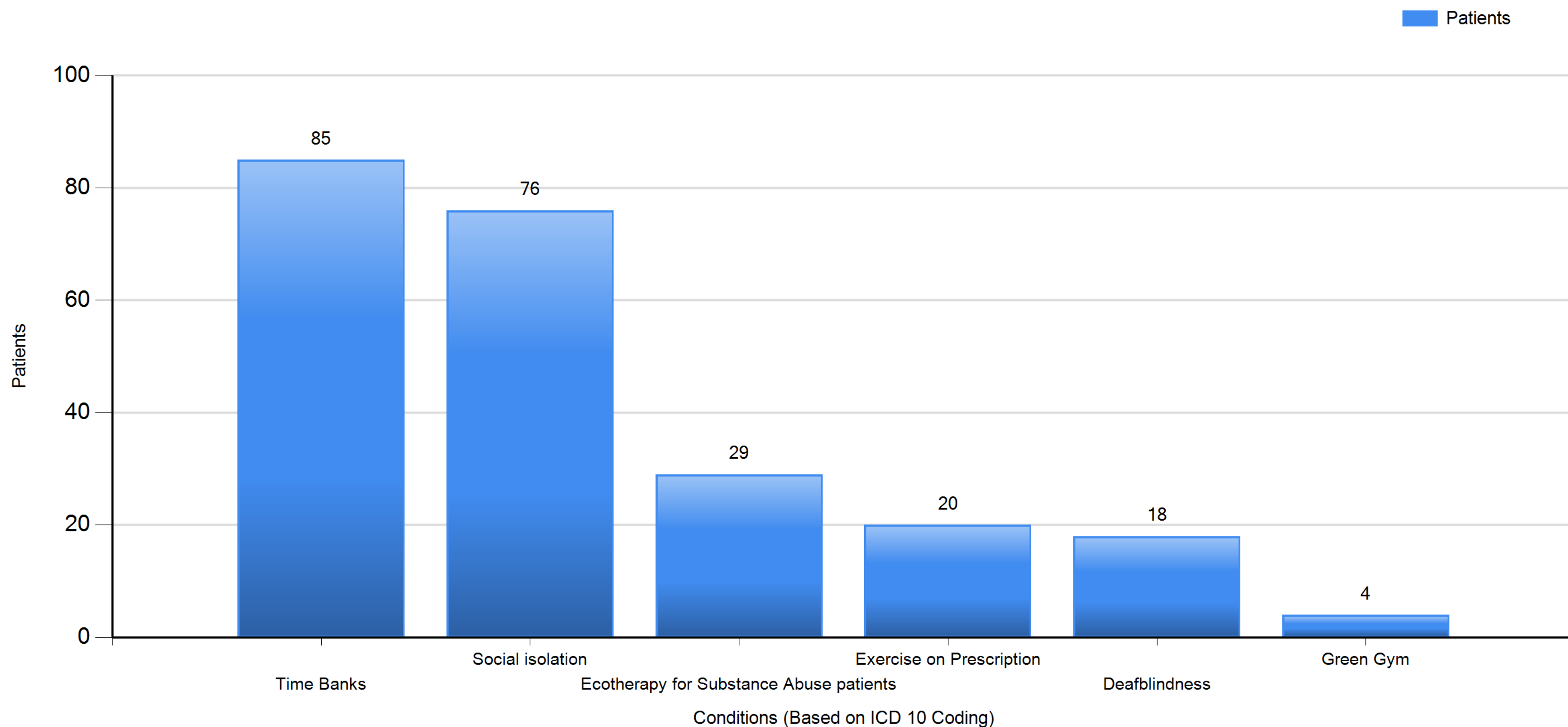
Social Prescribing: Planned Care (Elective Admissions)

Chart shows number of patients admitted Electively to hospital in 2016/17 that would have benefitted from specific SP initiatives should they have been available. The cohorts and conditions of patients for these initiatives are set out in Appendix 1. For the Planned Care category, Time Banks and Social Isolation are the major initiative. (Data Source: HES 2016/17)



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Expert Patient Programme

The Expert Patients Programme (EPP) is a six-week self-management course for anyone living with a long-term health condition or impairment. Support of patient self-management is a key component of effective care and improved patient outcomes. Self-management support goes beyond traditional knowledge-based patient education to include processes that develop patient problem-solving skills, improve self-efficacy and support application of knowledge in real-life situations that matter to patients.

Targeted Patients for Expert Patient Programme:(For details of targeted Patients cohorts by Initiatives see Appendix 3)

- Patients with one or more chronic long term condition such as such as diabetes, arthritis, chronic obstructive pulmonary disease (COPD) and heart disease.
- Patients with 0 to 2 day length of stay
- Patients with low acuity rate (non complex cases)
- Patients with general treatments for e.g. general surgery, general medication etc

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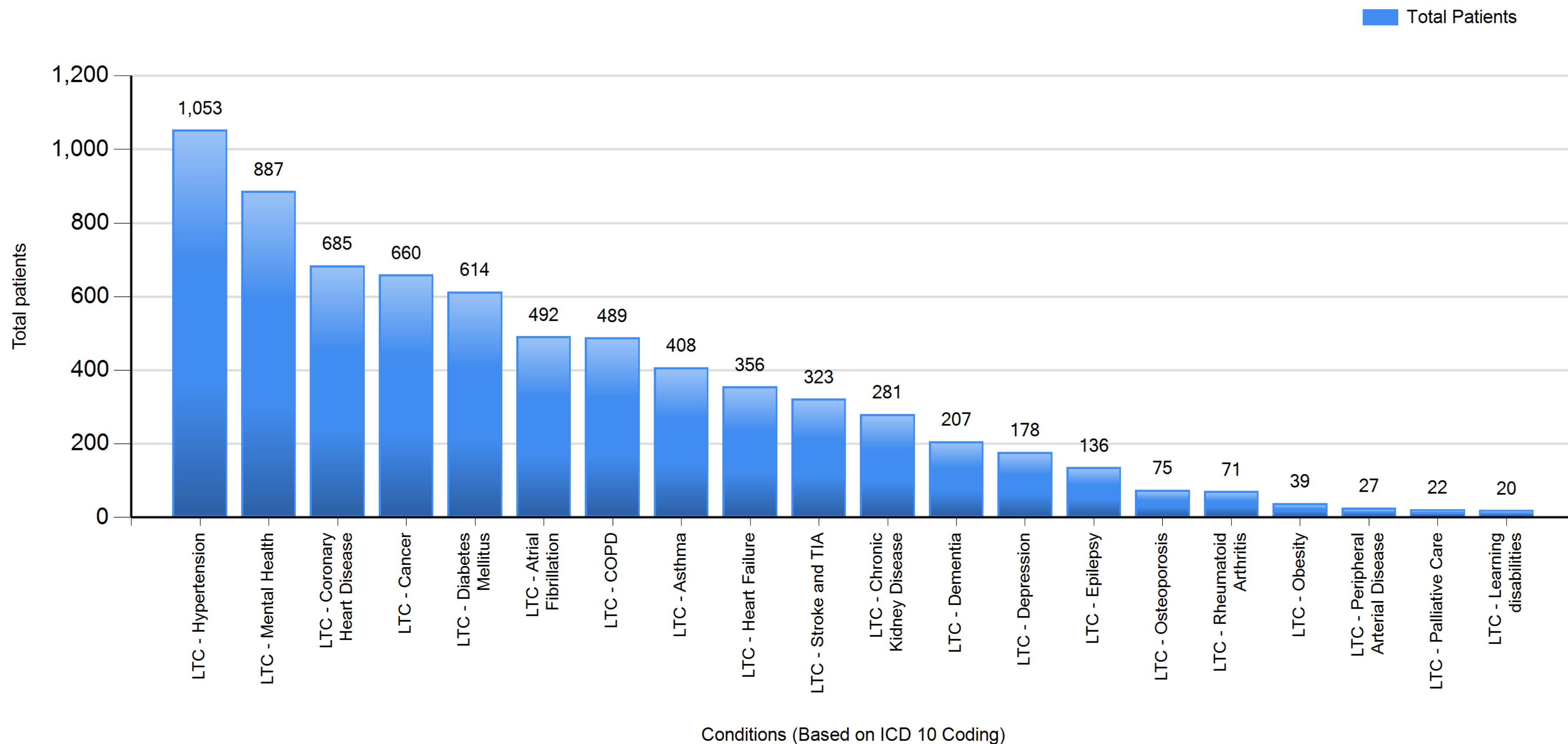
Expert Patient Programme

Chart shows number of patients admitted to hospital in 2016/17 by targeted condition for EPP. The conditions have been identified using ICD 10 coding and QoF 15/16 LTC definition. Hypertension, Mental Health and Coronary Heart Disease together account for over 2.5k patients that could benefit from EPP. (DataSource: HES 2016/17)



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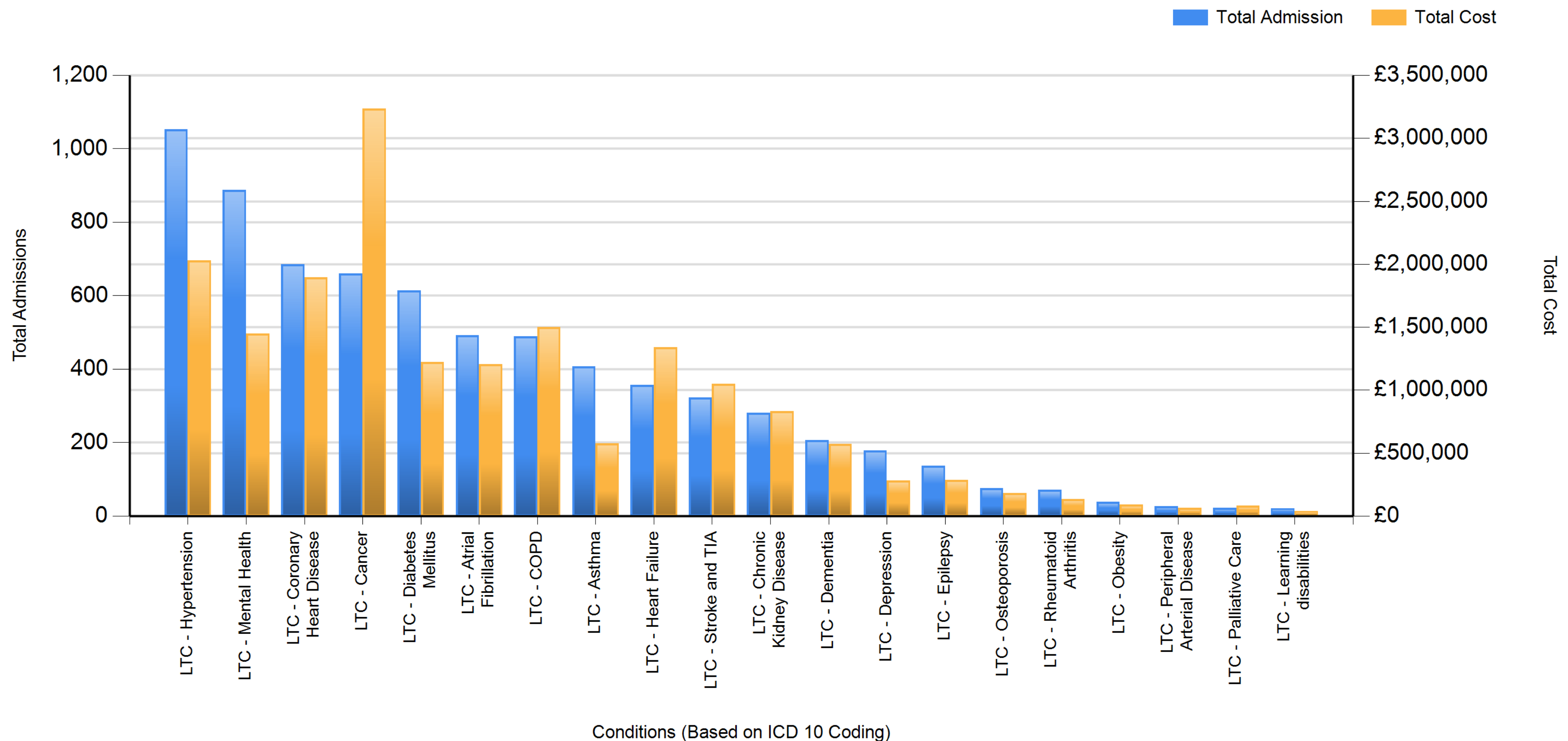
Expert Patient Programme

Chart shows number of admissions to hospital of patients in previous chart for 2016/17 by targeted condition for EPP and associated acute costs. By far the highest costs per admission were for Cancer, Heart Failure and Stroke whilst the lowest were for Hypertension and Mental Health. (Data Source: HES 2016/17)



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Expert Patient Programme: List of Initiatives

Targeted Initiatives:

- Living with Diabetes (Non-Elective and Outpatient activity reduction)
- New Beginnings Course (Non-Elective and Outpatient activity reduction)
- Self Management for Chronic conditions (Non-Elective and Outpatient activity reduction)
- Smoking cessation interventions for Asthma and COPD Patients (Non-Elective activity reduction)

With specific reference to this SP and EPP exercise, patient cohorts with LOS of 0-2 days and with Low Acuity have been targeted. These are the cohorts that will be the most responsive to the initiatives. That is not to say there can be no effect on patients with large numbers of co-morbidities and High Acuity but the existence of the pressures such patients will be under could limit the impact within Primary and Secondary care.

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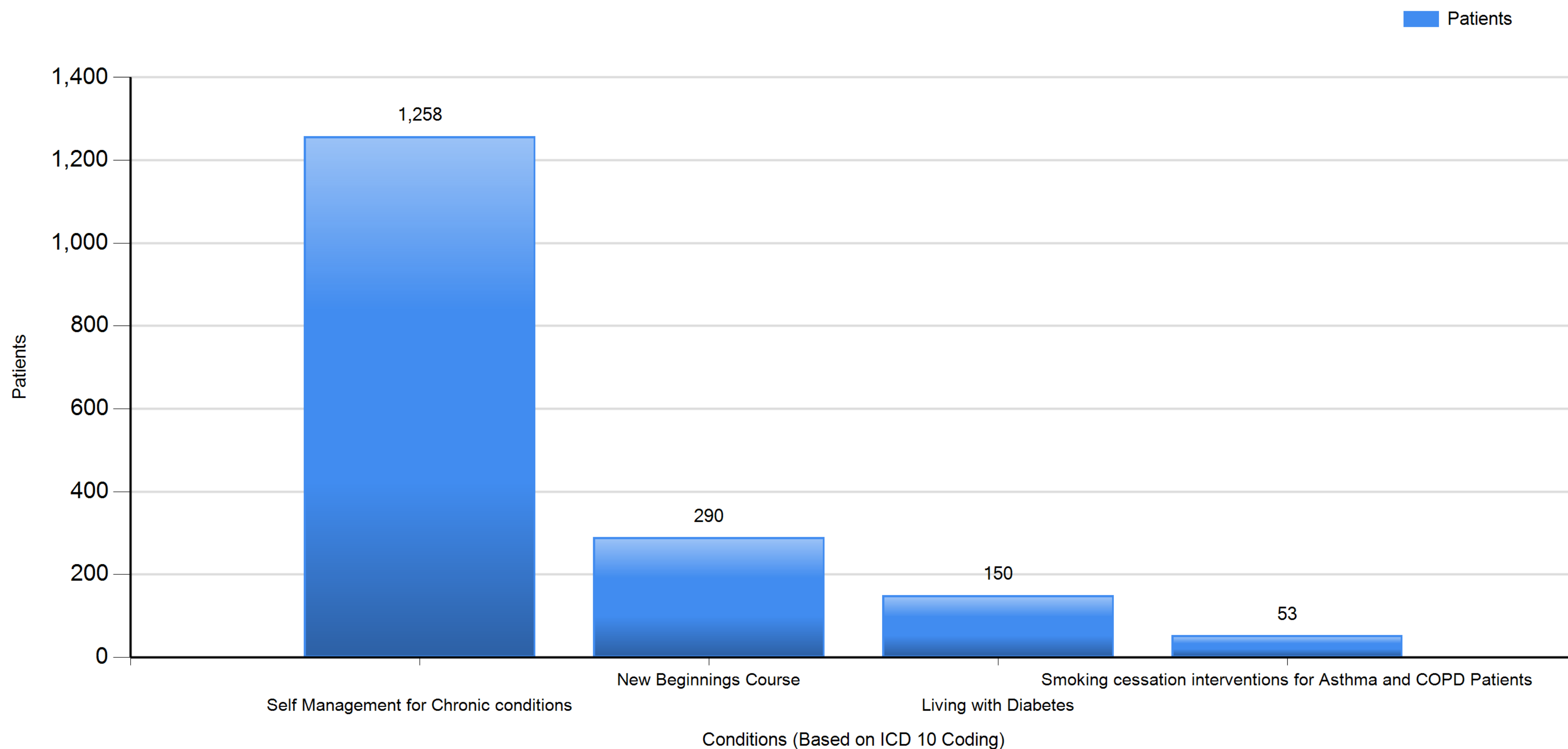
Expert Patient Programme: Unplanned Care (Non-elective Admissions)

Chart shows number of patients admitted Non-electively to hospital in 2016/17 that would have benefitted from specific EPP initiatives should they have been available. The cohorts and conditions of patients for these initiatives are set out in Appendix 3. The Self Management for Chronic conditions initiative could reduce acute costs by around 20% at a minimum.



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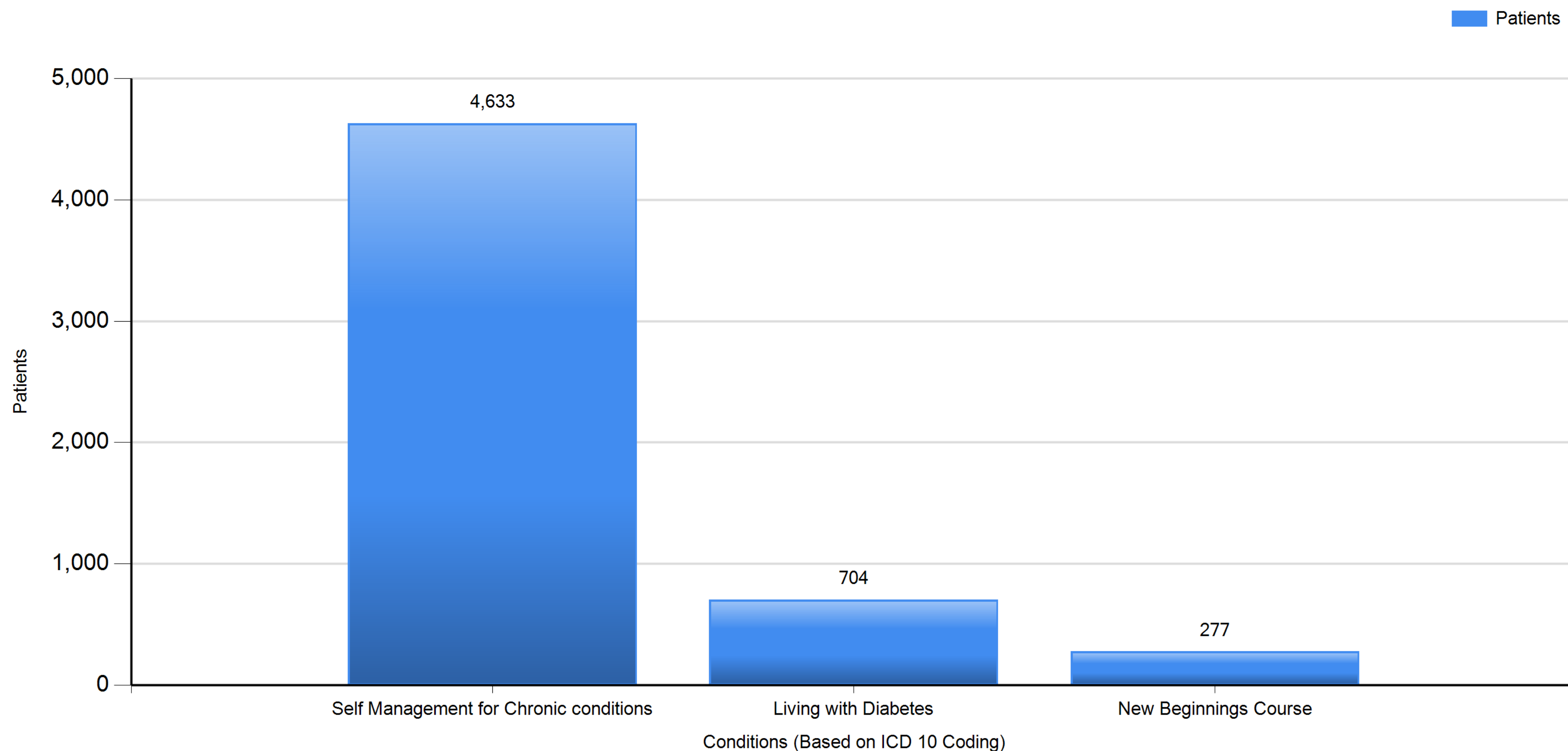
Expert Patient Programme: Planned Care (Outpatient Appointments)

Chart shows number of patients attended outpatient appointment in hospital in 2016/17 that would have benefitted from specific EPP initiatives should they have been available. The cohorts and conditions of patients for these initiatives are set out in Appendix 3. As in the case of Planned Care, the Self Management of Chronic conditions initiative can have a considerable effect on the local health economy.



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Commissioning Opportunity	Initiative	Outcome	Assumption	References	Fin Year	Current Spend			Opportunity/ Reduction		
						Patients	Activity	Cost	Patients	Activity	Cost
Social Prescribing	Arts on Prescription	Provision of better patient care and reduction in emergency admissions.	Community Arts Service for Patients with Mild and Moderate Mental Health conditions such as Depression, Stress and Anxiety. Activities included: arts and crafts core workshops (six months); specialist workshops in creative writing, cooking, gardening, photography and walking the labyrinth (run over 8-10 weeks); events and outings; and exhibitions and public artwork.	http://tinyurl.com/z4cmszd http://tinyurl.com/zmjv827 http://tinyurl.com/jsognx5 http://tinyurl.com/j4y64lu http://tinyurl.com/jaqfjlf http://tinyurl.com/ho5fa3y	2013/14	559	614	£703,644	158	181	£118,982
					2014/15	442	525	£498,516	135	177	£91,222
					2015/16	630	772	£602,099	169	193	£98,416
					2016/17	468	484	£581,527	100	104	£74,201
	Books on Prescription	Improved Self management and better patients outcomes.	Provision of self-help books to patients from booklist based on cognitive behavioural therapy (CBT) step-by-step techniques, to assist adults in managing own health and wellbeing for range of common mental health conditions. Scheme set up alongside bibliotherapy reading groups in libraries.	http://tinyurl.com/z3h827k http://tinyurl.com/he8gx6e http://tinyurl.com/grcegxm http://tinyurl.com/jp3ubha http://tinyurl.com/hzpuqe9	2013/14	582	635	£561,591	17	19	£10,960
					2014/15	597	690	£544,945	5	5	£2,030
					2015/16	643	768	£480,526	14	14	£6,516
					2016/17	506	529	£501,473	12	12	£8,665
	Deafblindness	Improving sociability, communication skills, making social connections and reducing Non-Elective hospital admissions.	Sense is a service for people who are deaf and/or blind and/or experience other sensory impairments; it provides support and services to live more fulfilling and independent lives. A diverse range of activities and services are offered such as daily living skills, opportunities for voluntary work, arts and crafts, swimming, gym use, shopping and eating out.	http://tinyurl.com/haubj5n http://tinyurl.com/httysmd http://tinyurl.com/hfn54pz	2013/14	185	192	£232,942	93	97	£83,078
					2014/15	177	188	£212,781	98	104	£78,428
					2015/16	176	203	£137,878	89	100	£46,672
					2016/17	149	156	£164,607	90	92	£72,809
	Dementia Cafe/ Food Clubs	Reducing unnecessary Emergency Admissions and better patient outcomes.	Implementation of Dementia Cafes/ Food Clubs where patients, carers and professionals meet for social interaction, informal talks and peer support.	http://tinyurl.com/jnz5gpy http://tinyurl.com/jbchalh http://tinyurl.com/zjftgmk http://tinyurl.com/o697amk	2013/14	206	227	£281,272	19	21	£12,481
					2014/15	153	177	£155,679	13	16	£3,067
					2015/16	254	298	£249,893	28	33	£14,097
					2016/17	179	194	£274,805	19	20	£15,549

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Commissioning Opportunity	Initiative	Outcome	Assumption	References	Fin Year	Current Spend			Opportunity/ Reduction		
						Patients	Activity	Cost	Patients	Activity	Cost
Social Prescribing	Ecotherapy for Substance Abuse patients	Reducing Non-Elective admission of Patients with Low Acuity by offering a single service that can support the patients with Substance Abuse.	Increase support for Substance Abuse patients by implementing Ecotherapy, which will improve mental and physical health and wellbeing by supporting people to be active outdoors e.g. doing gardening,animal assisted therapy, food growing, environmental conservation work, physical exercise in a natural environment and involvement in conservation activities.	http://tinyurl.com/jsp4l9y http://tinyurl.com/hvr6444 http://tinyurl.com/zxafqcq http://tinyurl.com/zq5rdtd	2013/14	671	740	£755,012	279	293	£190,171
					2014/15	669	769	£672,011	243	274	£131,284
					2015/16	609	707	£458,381	224	240	£110,618
					2016/17	497	525	£547,813	189	193	£135,788
	Education on Prescription	Increases in self-esteem and confidence, sense of control and empowerment.	Education on Prescription consists of referral to formal learning opportunities, including literacy and basic skills. It can involve the use of learning advisers placed within educational establishments, day services, mental health teams or voluntary sector organisations to identify appropriate educational activities for individuals and support access. Patient workshops with supporting handbooks can be provided on a range of subjects such as gardening, photography, painting and pottery.	http://tinyurl.com/z5orhsk http://tinyurl.com/hebb7fx http://tinyurl.com/jp3ubha http://tinyurl.com/gsl5sds	2013/14	59	75	£19,658	3	4	£1,454
					2014/15	54	72	£35,869	9	11	£6,150
					2015/16	63	78	£57,493	3	4	£2,434
					2016/17	38	38	£39,266	7	7	£5,668
	Exercise on Prescription	Improved psychological wellbeing, physical and social interaction, and help with weight loss. Non Elective admission reduction.	Specially trained instructors understand which exercises are safe and appropriate for people with a range of health conditions such as Falls, Mild Asthma, Weight Control, Joint Problems, Controlled Diabetes etc.They offer support in developing an activity routine to improve health, in partnership with Public Health and leisure centres. Sessions are mainly gym based but some centres offer Tai Chi, Aqua classes, balance classes for fall prevention and swimming.	http://tinyurl.com/j6obacp http://tinyurl.com/jlj6xoz http://tinyurl.com/zhdqtjh http://tinyurl.com/jp3ubha	2013/14	1,389	1,527	£1,134,997	309	319	£265,329
					2014/15	1,448	1,720	£933,911	210	242	£123,091
					2015/16	1,400	1,546	£846,140	304	335	£183,397
					2016/17	1,243	1,319	£1,024,700	226	241	£196,561

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Commissioning Opportunity	Initiative	Outcome	Assumption	References	Fin Year	Current Spend			Opportunity/ Reduction		
						Patients	Activity	Cost	Patients	Activity	Cost
Social Prescribing	Green Gym	Reducing Non-Elective admission of Patients with Low Acuity.	Activities for people with learning difficulties - often with help from local community (e.g. provision of derelict land for allotment and planting vegetables). Support network of Volunteer-based organisations to take practical action locally and provide access to training and skills development opportunities.	http://tinyurl.com/goc9tju http://tinyurl.com/zq5rdtd http://tinyurl.com/zgjqhoj	2013/14	62	72	£78,304	31	37	£31,094
					2014/15	68	75	£78,788	27	28	£22,874
					2015/16	66	69	£54,521	24	24	£20,375
					2016/17	46	46	£53,625	10	10	£14,539
	Information,Advice and Guidance (IAG)	Provision of better patient care and reduction in Non-elective admissions.	Community geriatrician, domiciliary care when needed for housebound patients and crisis and recovery house service made available to provide expert clinical opinion, clinical support and supervision by Community teams. Enhancing quality of life for people with care and support needs (Patients are enabled to find employment when they want, maintain a family and social life, contribute to community life and avoid loneliness and isolation)	http://tinyurl.com/ztrtv7u http://tinyurl.com/jsognx5 http://tinyurl.com/jp3ubha http://tinyurl.com/odkf8wm http://tinyurl.com/m3udl3a http://tinyurl.com/jaqfjlf	2013/14	37	49	£16,856	11	14	£5,586
					2014/15	31	42	£23,311	14	19	£9,597
					2015/16	56	71	£45,290	18	21	£7,870
					2016/17	31	31	£33,668	13	13	£4,982
	Mobility	Reducing unnecessary Emergency Admissions and better patient outcomes.	Community Navigation team to assess patients with mobility issue at home or in community. A reablement service could provide hospital aftercare and assistance with day-to-day activities such as washing and dressing; the team could help them apply for Mobility Scooter Grant to facilitate the communte to GP pratice.	http://tinyurl.com/jsognx5 http://tinyurl.com/jp3ubha http://tinyurl.com/jaqfjlf	2013/14	246	261	£601,013	96	98	£97,761
					2014/15	169	184	£371,995	58	64	£30,113
					2015/16	230	317	£355,492	78	87	£44,931
					2016/17	150	150	£361,426	48	48	£47,068
	Primary support group problems (e.g. family)	Provision of better patient care and reduction in Non-elective admissions.	Community Navigation Service to link patients with groups, services and activities that can help improve their health and wellbeing - including sources of social, practical and emotional support.	http://tinyurl.com/l9kte47 http://tinyurl.com/jsognx5 http://tinyurl.com/jp3ubha http://tinyurl.com/pqftv35 http://tinyurl.com/zmjhewp http://tinyurl.com/jaqfjlf	2013/14	58	73	£40,817	20	22	£6,273
					2014/15	50	67	£51,842	20	25	£4,671
					2015/16	48	58	£27,316	17	19	£1,333
					2016/17	35	37	£37,712	10	10	£5,027

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Commissioning Opportunity	Initiative	Outcome	Assumption	References	Fin Year	Current Spend			Opportunity/ Reduction		
						Patients	Activity	Cost	Patients	Activity	Cost
Social Prescribing	Social isolation	Provision of better patient care and reduction in Non-elective admissions.	Additional care at home by Integrated team including social care support, mobile wardens, generic workers, district nurses, paramedics and Community psychiatric nurses.	http://tinyurl.com/jp3ubha http://tinyurl.com/k9lhyqg http://tinyurl.com/jsognx5 http://tinyurl.com/8u949j6 http://tinyurl.com/jaqfjlf	2013/14	391	420	£846,334	158	166	£154,706
					2014/15	347	392	£795,537	117	132	£87,870
					2015/16	368	496	£661,012	127	140	£80,880
					2016/17	236	241	£610,072	73	73	£67,200
	Time Banks	Aimed to empower residents to improve their health and wellbeing, enhance community health and achieve a cohesive and mutually reliant community. Reduction in Non-Elective admissions.	Increase social support for patients with symptoms of depression and isolation by implementing Time Banks service which will allow patients to deposit time they spend helping others and calls on that time when they need help. Time Bank builds core economy of family and community by valuing and rewarding work, and recognising all manner of skills (e.g.baking cakes or providing company on a walk).	http://tinyurl.com/z9g9e63 http://tinyurl.com/zvhopf9 http://tinyurl.com/jp3ubha http://tinyurl.com/j7hnwmj	2013/14	537	582	£510,303	335	358	£268,549
					2014/15	551	635	£508,229	316	351	£218,881
					2015/16	585	699	£421,362	318	361	£174,534
					2016/17	456	474	£453,718	270	274	£212,903
	Volunteer Anorexia & Bulimia Care	Better patient management and reduction in Emergency admissions.	Volunteer-led peer support groups and online support groups can play significant roles along with professional education programmes, helpline support services and carer and patient engagement efforts in combating eating disorders.	http://tinyurl.com/hkj6luq http://tinyurl.com/jyz6xyu http://tinyurl.com/jzyd5h2	2013/14	173	185	£244,256	96	105	£65,847
					2014/15	155	171	£226,041	89	98	£66,973
					2015/16	147	189	£148,182	78	95	£46,743
					2016/17	129	135	£155,158	85	88	£64,162
	Volunteer befriending service	Reduction in social isolation and loneliness, support for hard-to-reach people and reduction in unneccessary hospital admissions.	Volunteer befriending service provides companionship & emotional help and support to continue hobbies and personal interests; facilitates opportunities to participate in leisure and social activities; gives support with regular activities e.g. shopping; and ensures a break for carers.	http://tinyurl.com/haubj5n http://tinyurl.com/jp3ubha http://tinyurl.com/j3g626v	2013/14	206	225	£163,188	119	125	£81,740
					2014/15	227	258	£173,535	113	127	£58,255
					2015/16	251	314	£151,478	131	151	£62,723
					2016/17	202	206	£160,651	116	116	£69,785

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Commissioning Opportunity	Initiative	Outcome	Assumption	References	Fin Year	Current Spend			Opportunity/ Reduction		
						Patients	Activity	Cost	Patients	Activity	Cost
Expert Patient Programme	Living with Diabetes	Non-Elective admissions reduction and better patient outcomes.	Implementation of seven weekly session of Expert Patient Programme course Living with Diabetes for patients with type 2 diabetes. This course includes diabetes specific information within the essential topics for managing any long-term condition outlined in the Expert Patients Programme.	http://tinyurl.com/zm33qs7 http://tinyurl.com/zbt7umm http://tinyurl.com/joavpty http://tinyurl.com/hveh59e	2013/14	681	771	£1,028,156	150	154	£148,028
					2014/15	665	802	£913,511	123	140	£86,729
					2015/16	727	926	£838,083	145	165	£104,376
					2016/17	620	702	£934,156	150	152	£127,043
	New Beginnings Course	Non-Elective admissions reduction and better patient outcomes.	Implementation of seven weekly session of Expert Patient Programme course New Beginnings for patients living with, or in recovery from, a mental health conditions. The course aims to help individuals to manage and adapt to the issues they encounter in daily living.	http://tinyurl.com/zm33qs7 http://tinyurl.com/zbt7umm http://tinyurl.com/joavpty http://tinyurl.com/hveh59e	2013/14	559	679	£476,286	430	480	£272,116
					2014/15	523	660	£379,001	382	462	£199,170
					2015/16	547	664	£320,565	421	472	£179,267
					2016/17	388	418	£328,406	290	299	£165,144
	Self Management for Chronic conditions	Non-Elective admissions reduction and better patient outcomes.	A six-week self-management course for anyone living with any long-term health condition or impairment to educate patients on dealing with pain and fatigue; Managing depression and other difficult emotions; Preventing falls and improving balance; Relaxation and exercise; Dietary recommendations; Physical activity; Communicating with family, friends, health professionals and social services.	http://tinyurl.com/zm33qs7 http://tinyurl.com/zbt7umm http://tinyurl.com/joavpty http://tinyurl.com/hveh59e	2013/14	5,045	5,697	£6,237,702	1,446	1,548	£1,307,412
					2014/15	4,807	5,812	£5,227,789	1,403	1,609	£932,888
					2015/16	5,009	5,979	£4,666,492	1,393	1,522	£960,242
					2016/17	4,130	4,518	£5,066,970	1,258	1,303	£1,130,524

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Commissioning Opportunity	Initiative	Outcome	Assumption	References	Fin Year	Current Spend			Opportunity/ Reduction		
						Patients	Activity	Cost	Patients	Activity	Cost
Expert Patient Programme	Smoking cessation interventions for Asthma and COPD Patients	Improved outcome and Non-Elective Admissions prevention	Psychosocial interventions comprise treatment strategies such as counselling, self-help materials, and behavioural treatment. Pharmacological interventions comprise nicotine replacement therapy (NRT) or nonnicotine pharmacotherapy.	http://tinyurl.com/otac3or http://tinyurl.com/oq69ue4 http://tinyurl.com/gv82wwq	2013/14	348	387	£853,445	86	95	£72,524
					2014/15	379	433	£921,859	82	87	£64,993
					2015/16	343	464	£705,689	48	59	£33,133
					2016/17	215	229	£470,107	53	55	£45,950

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Commissioning Opportunity	Initiative	Outcome	Assumption	References	Fin Year	Current Spend			Opportunity/Reduction		
						Patients	Activity	Cost	Patients	Activity	Cost
Social Prescribing	Deafblindness	Improving sociability, communication skills, making social connections and reducing Elective hospital admissions.	Sense is a service for people who are deaf and/or blind and/or experience other sensory impairments; it provides support and services to live more fulfilling and independent lives. A diverse range of activities and services are offered such as daily living skills, opportunities for voluntary work, arts and crafts, swimming, gym use, shopping and eating out.	http://tinyurl.com/haubj5n http://tinyurl.com/httysmd http://tinyurl.com/hfn54pz	2013/14	219	252	£273,398	55	55	£75,184
					2014/15	205	219	£293,373	36	41	£55,900
					2015/16	198	213	£216,248	29	29	£40,403
					2016/17	182	186	£237,446	18	18	£37,138
	Ecotherapy for Substance Abuse patients	Reducing Elective admission of Patients with Low Acuity by offering a single service that can support the patients with Substance Abuse.	Increase support for Substance Abuse patients by implementing Ecotherapy, which will improve mental and physical health and wellbeing by supporting people to be active outdoors e.g. doing gardening,animal assisted therapy, food growing, environmental conservation work, physical exercise in a natural environment and involvement in conservation activities.	http://tinyurl.com/jsp4l9y http://tinyurl.com/hvr6444 http://tinyurl.com/zxafqcq http://tinyurl.com/zq5rdtd	2013/14	698	797	£1,106,362	34	37	£66,641
					2014/15	764	949	£1,219,563	40	43	£78,442
					2015/16	633	754	£916,970	67	79	£86,352
					2016/17	468	550	£730,825	29	29	£54,223
	Exercise on Prescription	Improved psychological wellbeing, physical and social interaction, and help with weight loss. Elective admission reduction.	Specially trained instructors understand which exercises are safe and appropriate for people with a range of health conditions such as Falls, Mild Asthma, Weight Control, Joint Problems, Controlled Diabetes etc.They offer support in developing an activity routine to improve health, in partnership with Public Health and leisure centres. Sessions are mainly gym based but some centres offer Tai Chi, Aqua classes, balance classes for fall prevention and swimming.	http://tinyurl.com/j6obacp http://tinyurl.com/jlj6xoz http://tinyurl.com/zhdqtjh http://tinyurl.com/jp3ubha	2013/14	831	929	£780,880	33	34	£38,734
					2014/15	991	1,220	£847,968	30	30	£29,653
					2015/16	960	1,153	£767,168	21	21	£20,007
					2016/17	711	767	£632,249	20	20	£26,613

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Healthy London Partnership (HLP)

For: NHS WANDSWORTH CCG

Social Prescribing and Expert Patient Programme

Commissioning Opportunity	Initiative	Outcome	Assumption	References	Fin Year	Current Spend			Opportunity/Reduction		
						Patients	Activity	Cost	Patients	Activity	Cost
Social Prescribing	Green Gym	Reducing Non-Elective admission of Patients with Low Acuity.	Activities for people with learning difficulties - often with help from local community (e.g. provision of land for allotment and planting vegetables). Support network of Volunteer-based organisations to take practical action locally and provide access to training and skills development opportunities.	http://tinyurl.com/goc9tju http://tinyurl.com/zq5rdtd http://tinyurl.com/zgjqhoj	2013/14	68	82	£79,187	8	8	£9,219
					2014/15	68	74	£126,947	11	13	£8,278
					2015/16	58	63	£69,478	8	8	£13,062
					2016/17	42	43	£46,320	4	4	£8,428
	Social isolation	Provision of better patient care and reduction in Elective admissions.	Additional care at home by Integrated team including social care support, mobile wardens, generic workers, district nurses, paramedics and Community psychiatric nurses.	http://tinyurl.com/jp3ubha http://tinyurl.com/k9lhyqg http://tinyurl.com/jsognx5 http://tinyurl.com/8u949j6 http://tinyurl.com/jaqfjlf	2013/14	227	230	£234,387	68	68	£58,622
					2014/15	265	318	£264,337	121	143	£82,581
					2015/16	222	239	£184,934	110	118	£63,557
					2016/17	175	184	£343,800	76	81	£46,329
	Time Banks	Aimed to empower residents to improve their health and wellbeing, enhance community health and achieve a cohesive and mutually reliant community. Reduction in Elective admissions.	Increase social support for patients with symptoms of depression and isolation by implementing Time Banks service which will allow patients to deposit time they spend helping others and calls on that time when they need help. Time Bank builds core economy of family and community by valuing and rewarding work, and recognising all manner of skills (e.g.baking cakes or providing company on a walk).	http://tinyurl.com/z9g9e63 http://tinyurl.com/zvhopf9 http://tinyurl.com/jp3ubha http://tinyurl.com/j7hnwmj	2013/14	560	605	£744,043	108	118	£158,591
					2014/15	549	626	£752,257	127	153	£185,252
					2015/16	505	600	£740,910	111	138	£203,838
					2016/17	423	497	£649,408	85	125	£191,323
Expert Patient Programme	Living with Diabetes	Outpatients appointments reduction and better patient outcomes.	Implementation of seven weekly session of Expert Patient Programme course Living with Diabetes for patients with type 2 diabetes. This course includes diabetes specific information within the essential topics for managing any long-term condition outlined in the Expert Patients Programme.	http://tinyurl.com/zm33qs7 http://tinyurl.com/zbt7umm http://tinyurl.com/joavpty http://tinyurl.com/hveh59e	2013/14	4,349	7,921	£454,928	574	623	£34,518
					2014/15	5,310	9,779	£497,938	744	774	£39,183
					2015/16	5,762	10,722	£512,740	919	979	£44,528
					2016/17	4,211	7,954	£408,933	704	742	£36,806

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Healthy London Partnership (HLP)

For: NHS WANDSWORTH CCG

Social Prescribing and Expert Patient Programme

Commissioning Opportunity	Initiative	Outcome	Assumption	References	Fin Year	Current Spend			Opportunity/Reduction		
						Patients	Activity	Cost	Patients	Activity	Cost
Expert Patient Programme	New Beginnings Course	Outpatients appointments reduction and better patient outcomes.	Implementation of seven weekly session of Expert Patient Programme course New Beginnings for patients living with, or in recovery from, a mental health conditions. The course aims to help individuals to manage and adapt to the issues they encounter in daily living.	http://tinyurl.com/zm33qs7 http://tinyurl.com/zbt7umm http://tinyurl.com/joavpty http://tinyurl.com/hveh59e	2013/14	1,559	4,290	£80,859	240	279	£10,930
					2014/15	1,959	5,633	£111,831	287	306	£10,419
					2015/16	2,126	6,012	£110,801	339	360	£9,148
					2016/17	1,477	3,978	£82,127	277	296	£7,933
	Self Management for Chronic conditions	Outpatients appointments reduction and better patient outcomes.	A six-week self-management course for anyone living with any long-term health condition or impairment to educate patients on dealing with pain and fatigue; Managing depression and other difficult emotions; Preventing falls and improving balance; Relaxation and exercise; Dietary recommendations; Physical activity; Communicating with family, friends, health professionals and social services.	http://tinyurl.com/zm33qs7 http://tinyurl.com/zbt7umm http://tinyurl.com/joavpty http://tinyurl.com/hveh59e	2013/14	26,052	70,466	£4,376,104	3,960	6,110	£336,128
					2014/15	31,896	90,656	£5,010,344	4,907	7,256	£362,624
					2015/16	35,415	100,196	£5,283,679	5,760	8,682	£415,794
					2016/17	28,185	80,374	£4,319,588	4,633	6,944	£331,899

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Appendices

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Appendix 1 - Social Prescribing: Patients cohorts by Initiatives

Initiatives	Patient Cohorts
Arts on Prescription	Patients (All Ages) with the following: • One or more Conditions: Anxiety, Depression (Mild/Moderate), Reaction to stress and adjustment disorders • Low Acuity (combination of Risk Stratification, Polypharmacy and Patient History) • Non-Elective admissions • 0 to 1 Length of Stay
Books on Prescription	Patients (All Ages) with the following: • One or more Conditions: Anxiety, Bereavement, Obsessive Compulsive Disorder, Panic, Post-natal depression, Sleep Disorder • Low Acuity (combination of Risk Stratification, Polypharmacy and Patient History) • Non-Elective admissions • 0 to 1 Length of Stay • Treatment: General Surgery/ Medicine
Deafblindness	Patients (All Ages) with the following: • One or more Conditions: Disorder of Ears and Disorder of eyes • Low Acuity (combination of Risk Stratification, Polypharmacy and Patient History) • Non-Elective/ Elective admissions • 0 to 2 Length of Stay • Treatment: General Surgery/ Medicine
Information, Advice and Guidance (IAG)	Patients (Age 18 onwards) with the following: • Condition: Problems related to housing and economic circumstances • Low Acuity (combination of Risk Stratification, Polypharmacy and Patient History) • Non-Elective/ Elective admissions • 0 to 1 Length of Stay
Primary support group problems (e.g. family)	Patients (Age 18 onwards) with the following: • Condition: Adjustment disorders, Problems related to primary support group, including family circumstances • Low (combination of Risk Stratification, Polypharmacy and Patient History) • Non-Elective/ Elective admissions • 0 to 1 Length of Stay

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Appendix 1 - Social Prescribing: Patients cohorts by Initiatives (Cont.)

Initiatives	Patient Cohorts
Dementia Cafe/ Food Clubs	Patients (Age = Elderly) with the following: • Conditions: Dementia • Low Acuity (combination of Risk Stratification, Polypharmacy and Patient History) • Non-Elective admissions • 0 to 2 Length of Stay
Ecotherapy for Substance Abuse patients	Patients (Age 18 onwards) with the following: • One or more Conditions: Mental and behavioural disorders due to psychoactive substance use • Low Acuity (combination of Risk Stratification, Polypharmacy and Patient History) • Non-Elective/ Elective admissions • 0 to 2 Length of Stay
Education on Prescription	Patients (All Ages) with the following: • One or more Conditions: Problems related to education and literacy, employment and unemployment, housing and economic circumstances, • Low Acuity (combination of Risk Stratification, Polypharmacy and Patient History) • Non-Elective admissions • 0 to 2 Length of Stay • Treatment: General Surgery/ Medicine
Exercise on Prescription	Patients (All Ages) with the following: • One or more Conditions: Falls, Mild Asthma, Obesity, Joint problems, Back pain, Diabetes Type2, Mild Hypertension, Abnormalities of breathing • Low Acuity (combination of Risk Stratification, Polypharmacy and Patient History) • Non-Elective/ Elective admissions • 0 to 1 Length of Stay • Treatment: General Surgery/ Medicine
Green Gym	Patients (All Ages) with the following: • Condition: Patients with Learning Disabilities • Low Acuity (combination of Risk Stratification, Polypharmacy and Patient History) • Non-Elective/ Elective admissions • 0 to 2 Length of Stay

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Appendix 1 - Social Prescribing: Patients cohorts by Initiatives (Cont.)

Initiatives	Patient Cohorts
Mobility	Patients (Age 18 onwards) with the following: • Condition: Abnormalities of gait and mobility • Low Acuity (combination of Risk Stratification, Polypharmacy and Patient History) • Non-Elective • 0 to 1 Length of Stay
Social Isolation	Patients (All Ages) with the following: • One or more Conditions: Problems related to social environment • Low Acuity (combination of Risk Stratification, Polypharmacy and Patient History) • Non-Elective/ Elective admissions • 0 to 1 Length of Stay
Time Banks	Patients (Age 18 onwards) with the following: • One or more Conditions: Depression (Mild/Moderate), Social Isolation, Impaired mobility, Problems related to education and literacy, employment and unemployment, housing and economic circumstances, Obesity. • Low Acuity (combination of Risk Stratification, Polypharmacy and Patient History) • Non-Elective/ Elective admissions • 0 to 2 Length of Stay
Volunteer Anorexia & Bulimia Care	Patients (Age 18 onwards) with the following: • Condition: Eating Disorder • Low Acuity (combination of Risk Stratification, Polypharmacy and Patient History) • Non-Elective admissions • 0 to 2 Length of Stay
Volunteer befriending service	Patients (Age 18 onwards) with the following: • One or more Conditions: Depression (Mild/Moderate), Social Isolation, Problem related to lifestyle • Low Acuity (combination of Risk Stratification, Polypharmacy and Patient History) • Non-Elective admissions • 0 to 1 Length of Stay • Treatment: General Surgery/ Medicine

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Appendix 2 - Social Prescribing: ICD-10 Codes

Condition	ICD 10 Code
Abnormalities of breathing	R06.*
Anxiety	F41.*
Controlled Diabetes	E11.*
Dementia	F03.*
Eating Disorder	F50.*, R63.*
Falls	Between W00.* and W19.*
Joint problems including Arthritis and back care	M24.*, M25.*
Learning Disabilities	F70.*, F71.*, F80.*,F81.*
Mild and Moderate Depression	F32.0, F32.1, F33.0, F33.1, F33.8, F33.9
Mild and moderate Hypertension	I12.9
Mild Asthma	J45.2, J45.3
Mobility	R26.*
Obesity	E66.*
Problem related to Education and literacy	Z55.*
Problem related to employment and unemployment	Z56.*
Problem related to Primary support group	Z63.*
Problems relating to Housing and Financing	Z59.*
Reaction to stress, and adjustment disorders	F43.*
Sense Impairment	H90.*, H91.*, H94.*, H53.*, H54.*
Social Isolation	Z60.*, F40.1, F40.2
Substance abuse	Between F10.* and F19.*

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Appendix 3 - Expert Patient Programme: Patients cohorts by Initiatives

Initiatives	Patient Cohorts
Living with Diabetes	Patients (Age 18 onwards) with the following: • Condition: Patients with type 2 diabetes • Low Acuity (combination of Risk Stratification and Patient History) • Non-Elective admissions • Out Patients Appointments (First Attendances without follow-up) • 0 to 2 Length of Stay
New Beginnings Course	Patients (Age 18 onwards) with the following: • One or more Conditions: Mental Health Conditions • Low Acuity (combination of Risk Stratification and Patient History) • Non-Elective admissions • Out Patients Appointments (First Attendances without follow-up) • 0 to 1 Length of Stay
Self Management for Chronic conditions	Patients (Age 18 onwards) with the following: • One or more Conditions: Long term conditions from QoF Register e.g. Asthma, COPD, Cancer, Dementia, Hypertension, Heart Failure, Obesity etc. • Low Acuity (combination of Risk Stratification and Patient History) • Non-Elective admissions • Out Patients Appointments (First Attendances without follow-up) • 0 to 1 Length of Stay
Smoking cessation interventions for Asthma and COPD Patients	Patients (Age 18 onwards) with the following: • One or more Conditions: Asthma or COPD with Smoking Diagnosis • Low Acuity (combination of Risk Stratification and Patient History) • Non-Elective admissions • 0 to 1 Length of Stay

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Appendix 4 - Data Sources

- HES data was used due to the inclusion and exclusion requirements for Population Health Management rules as shown in Appendix 1 and 2.

  HES APC PbR Costed Spells 2013/14, 2014/15, 2015/16, 2016/17

  HES APC Episodes 2013/14, 2014/15, 2015/16, 2016/17

  HES A&E PbR Costed 2013/14, 2014/15, 2015/16, 2016/17

  HES OP PbR Costed 2013/14, 2014/15, 2015/16,2016/17

- QoF 2014/15 LTC ICD 10 Definition only. The actual registers were not utilised due to fuller information held in the HES data
- London DataStore - 2015 round population projections http://data.london.gov.uk/demography/population-projections/
- Average increase in ETO prices - National Tariff Payment System: A consultation notice https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/487361/National_Tariff_Information_Workbook_2016-17_18_December_2015__3__amended.xlsx https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499594/2016-17_national_tariff_statutory_consultation.pdf

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