Reinvestment initiative	Description	Amount invested 2018/19	Expected change in demand	Communication with affected partners	Success measure
Alcohol Liaison Team	Alcohol Care Team at RCHT, led by a Consultant Gastro-enterologist with designated time, who will collaborate across the hospital, community services, primary care and Cornwall Council (Commissioned substance misuse services), to develop a coordinated alcohol prevention and treatment programme. The Alcohol Liaison Team will coordinate systematic interventions by applying brief interventions and the alcohol specialist practitioners will co-ordinate the care for alcohol related admissions where indicated, to ensure care and treatment plans are in place for people known to the MDT. The Alcohol Liaison Team also ensure that there is a systemised approach to ensuring that Brief Intervention for Alcohol are used in the non-elective setting in all ward areas for all appropriate patients.	£100,000	1. Reduce acute alcohol related hospital attendances, admissions, outpatient appointments and readmissions by delivering brief interventions to patients assessed as binge/hazardous drinkers who present as non elective admissions with an alcohol related issue and to reduce alcohol consumption to safe and healthy levels. 2. To reduce acute length of stay for appropriate patients and ensure appropriate referral to community based resources. 3. To systemise and mainstream the use of Brief Intervention Advice for appropriate patients in ED/MAU settings and across all adult wards where indicated.	RCHT i.e. Trauma & Orthopaedics, Gastroenterology, General Surgery, etc Addaction General Practitioners Safe guarding team Community services, voluntary sector, public health, health promotion Pharmacists who are participating the community based IBA scheme Cornwall Council	Commissioners have arranged for an external appraisal of the service to be co-ordinated by Cornwall Council Public Health, covering the following objectives: 1. What did the original commissioning (QIPP) set out to do – specify the original measures agreed 2. To what extent has this been achieved? Design according to what is received of original brief. 3. Benchmarking against best practice of ALTs elsewhere (including Derriford and Devon as well as wider afield). Public Health England to assist. 4. Audit against the original brief, best practice benchmarking and costs/value for money. 5. Include: Stakeholder feedback – A&E department, Psych Liaison, patients, Community and residential alcohol services, commissioners. When finalised, the Terms of Reference for the external review, project plan, outcomes and recommendations will form appendices to this Service Specification. Draft Initial Timetable: Design phase: 1 February - 13 March, including updated literature review; Test design with commissioners and team leads 6-20 March Audit and review 20 March – 31 March Write up 3 -14 April Draft for consultation 21 April. Final: 4 May. Commissioners agreed to the continuation of the service on this basis, tracking performance monthly and repeating the audit at month 6, informed by the outcome of the external review. Key Service Outcomes are likely to be influenced and affected by the results of the external review, and therefore may be subject to amendment during 2017/18.
Care Home Admission Avoidance Nurses/Nurse Practioners	This service was initially providing 1.8wte Nurse Practitioner support into care homes. The investment has remained in the system and flexed according to demand. Initially the service supported 12 care homes as a pilot and then as evidence demonstrated impact this was increased to 40 care homes-working with community dementia liaision teams and SWAST to target those care homes most in need of admission avoidance support. As demand in the system changed, this investment remained but the resource changed to supporting admission avoidance at ED and providing extra capacity in the community respiratory and acute care at home teams through winter and support services seeing frail patients thereafter.	£90,600	**To reduce:** avoidable admissions from care homes safeguarding incidents in care homes number of IP deaths resulting from care home admissions **To provide:** clinical leadership to the system on implementing frailty standards and care planning in care homes support to care homes in safeguarding support to care homes in significant event audits care home standard operating policies for pathways themed analysis at ED of avoidable admissions practical support to enable turnaround at ED	Engagement via care home providers via provider forum virtual team meetings with CFT and SWAST clincial staff surveys to care home staff and GPs on success of service discussion at GP locality meetings on benefits discussion at whole system resilience group on most beneficial shift of resources during winter pressures	Data on: safeguarding incidents IP deaths from care homes admissions number of people on EOL pathway medication reviews and care plans implementation of care pathways
Primary Care Dementia Practitioners	This new service was based on learning from implementing several primary care based integrated care models for people with dementia. Initial prime investment was provided by CQUIN and national Dementia Challenge funds totalling £400k from 2012-13. From 2014-15 commissioners commited to an additional annual recurrent figure of £358K to ensure continuity of care was provided from point of diagnosis through to EOL. This supported 9 new PCDP posts. This service was delivered in all areas excluding East locality. East Locality had the investment below:	£286,000	1. Reduced avoidable admissions of people with dementia from community setting 2. Improved timeliness of diagnosis and care coordination 3. Improved care coordination and enhanced primary care capacity and capability	On-going communications with affected GP practices, locality based engagement sessions by provider, GP locality presentations by commissioner, engagement with system via countywide	Data collected on diagnosis, assessment/treatment response times, patient feedback on experience, numbers of referrals to residential care, numbers of UTI/chect infections reported, numbers of people supported to die at home. Continued investment continues based on activity and impact.
Camborne and Redruth Community Hospital Primary Care Centre and other schemes under GP Access	Primary Care and GP services based in Camborne and Redruth Community Hospital and weekend clinics in Helston. Services offer walk in GP appointments and latterly routine booked appointments for those with urgent and routine problems during the in- and out-of-hours period evenings and weekends. Provides an alternative to accessing other healthcare including A&E attendance. Part of the national drive to improve access to GP appointments.	£673,000	Provides urgent primary care to prevent patients needing to go to an MIU or A&E	Established Service but developments discussed with RCHT and CFT as well as OOH.	Recuced demand in MIU/A&E
Psychiatric Liaison	Service works with those in ED with a Mental Health condition to prevent admission and support a quick turn around. Support is also available on discharge to ensure information is shared and plans in place to prevent re-admission	£605,000	Reduction in acute admissions	Service based in RCHT and commissioned from CFT	Reduction in acute admissions
Learning Disability Hospital Liaison	Service works with those in ED with a Learning Disability to prevent admission and support a quick turn around. Support is also available on discharge to ensure information is shared and plans in place to prevent re-admission	£90,000	Reduction in acute admissions	Service based in RCHT and commissioned from them	Reduction in acute admissions
CFT Home Treatment Team	Home Treatment team respond to those mental health patients in or nearing crisis to help treat them in the community and prevent acute admission or attendance at A&E	£372,000	Expected reduction in demand	Established Service and commissioned from CFT	Reduction in acute admissions
West Cornwall Hospital Urgent Care Centre investment	Provision of GP medical cover to West Cornwall Urgent Care Centre.	£318,000	Prevention of ED attendnaces and acute admissions	Service commissioned from RCHT	Reduction in acute admissions

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Eye Casualty	Eye casualty service takes patients out of the ED stream and provides emergency eye care.	£658,000	Prevention of ED attendances and acute admissions	Service commissioned from RCHT	Reduced ED attendances and admissions
Weekend Ultrasound for TIA	Peninsula Ultrasound are commissioned to undertake ultrasounds at weekends to support the emergency TIA clinic. This reduces need for non elective admissions and ED attendances	£35,000	Prevention of ED admissions	Service used by RCHT	Reduced ED Admissions