NHS South Worcestershire

Clinical Commissioning Group

5 Year Strategy

2013 – 2018

Progress in Year One 2013-14

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Message from the Chief Clinical Officer

Our First Year in Review

Our first year has seen the CCG move from a new organisation to one that is rapidly developing and taking on new challenges across South Worcestershire on an almost daily basis. We have a strong and effective team of clinical and supporting staff who have showed tremendous commitment to the organisation over this first year. We are now is good position to step back and reflect on what we have achieved up to now and importantly, plan for the future.

This reports sets out the key highlights across our four CCG priority areas in 13/14 and provides an update position on our key outcome measures we agreed to track progress against locally. This is a five year ambition and we would like to share what we have achieved in the first 12 months.

We have built increasing strong relationships over the past year not only with our GP members as our locality structures have matured but also with others across the local health and social care system. I believe the headlines we have set out can demonstrate this . As we move forward , we continue to face unprecedented demands on health services and will be required to embrace the future with strong leadership and energy with our partners to create a sustainable health care sytem in Worcestershire – one which truly feels integrated and working with the patient and carers at it's heart.

Many thanks for taking the time to read this report

Carl Ellson
Chief Clinical Officer

What we said....

In five years' time, compared to now, we intend to spend a greater proportion of our budget on:

Integrated "out of hospital" care, with relatively less going towards acute secondary care;

Avoiding the need for emergency admissions rather than dealing with the consequences after they have happened.

Our working principles will be..

- Quality, safety and clinical effectiveness comes first
- Prevention, early identification and early intervention is a golden thread
- Care and support is coordinated across the health and social care economy
- Health is made personal for each individual
- Maximum impact is gained from every health pound spent.

In our first year we identified four priorities that we would make a difference to the people we serve.

So, how did we do?

More independence for the frail elderly and those living with a long term condition

- ***Enhance the scope, coverage and quality of primary care services.***
- ***Promote & support self-management.***
- ***Maximising communication and improving patient flow.***
- ***Ensure rapid response to urgent needs.***
- ***Partner with patients to design care that is co-ordinated & planned in advance***

Discharge to assess - The Discharge to Assess pilot project went live in June 2014 and will help those who might need support on leaving hospital earlier, by arranging a care package to support them at home. Patients are given appropriate support at home until a full assessment can take place and longer term care package put in place in some cases.

Plans for opening a new Patient Flow Centre by 2014 The Centre will collect, review and act on all data from across the health and social care system related to bed and service capacity and demand. It will provide one single source of **real time** admission, transfer and discharge data that every organisation can access and act on. This will help us ensure that patients who no longer need acute hospital care can be transferred from a hospital bed to an appropriate community resource, including home, in a timely way.

Improving primary care management of people with Multiple LTCs

Three practices pilots a new way of working to improve care for people with long term conditions and prevent unnecessary admissions . Patients were identified using current risk stratification tools. A range of mode emerges involving longer consultation times with the GP /PN and joint consultations with other professionals such as pharmacists and DNs. Evaluation is currently taking place

Improving quality and supporting practices

This programme of work was major component of the CCG's Primary Care development strategy in 13/14 with an investment of over 300k ring-fenced for delivery . Every practice in the CCG has taken part in a series clinical and development visits to improve quality outcomes in primary care and identify needs across the four localities. The CCG has invested An approach that involved peer review, provision of meaningful benchmarking data and joint action planning has been a hugely successful programme for improving clinical care and influencing behaviour.

Integrated Community teams

A review of community services took place in conjunction with the health and care trust. As a result a business case was approved for additional recurrent investment of £1.1m to reconfigure and build capacity across existing services. The intention was to improve outcomes through introduction of an enhanced care pathway, improving 24/7 capacity and competency within the support offered following deterioration at home and early supported discharge from hospital in each locality A number of South Worcestershire wide services, including 1 WTE Community Consultant, expansion of the IV Therapy service in-reach to WRH have been put in place .

Care Standards Review programme

West Midland Quality Review Service undertook an assessment of standard s of care for LTCs across provider and commissioner organisations in Worcestserire. All standards were met as a minimum and many exceeds expectations . Further work was recommended in areas such as management of chronic neurological conditions , paediatric services and universal coverage of uptake of risk stratification tools.

Reducing health inequalities

- ***Maximise opportunities across Primary Care and partners for prevention, early diagnosis and treatment of those at most risk of serious illness.***

- ***Support the building of community resilience so that people can increasingly take responsibility for their own, their communities' and their families' health and wellbeing.***

- ***Ensure access to specialist services is equal across communities and social groups***

Local practice initiatives – GP practices are increasingly been seen as central to supporting community health and well being in South Worcestershire . Partnerships with the Council Council and local voluntary sector organisations have developed in many areas with initiatives including:

- Improved access to digital information for patients in practices around financial and social support working in conjunction with the Citizen Advice Bureau
- Practice based carer support workers to help carers and their families access responsive and appropriate advice
- Age UK GP social prescribing pilots in selected practices enabling primary care services to refer patients with social, emotional or practical needs to a range of local, non-clinical services, often provided by the voluntary and community sector.

Strengthening Health community project commissioned in Worcester to improve our understanding of health behaviours and long term conditions within the wards of Rainbow Hill, Gorse Hill, Wardon.

This project led an approach whereby professionals and the community worked together to gather health intelligence –- truly co-productive . Over 300 surveys in the community were undertaken by local champions who then helped developed and run three health initiatives

The outputs of this project have given us a significant level of health need intelligence in these communities particularly around mental wellbeing , health aspirations and access to services

"As I grew up and lived in the area all my life, I wanted to be part of this and get involved, find out what other people in the community need. I want to make a difference to our community. What better way than asking local people what is really needed, rather than officials deciding what they think is needed." – Becky, current Community Champion

Engaging hard to reach communities in access to health services

Leaflets were adapted for people with lower levels of literacy and cultural sensitivities to support people from local travelling communities to access services in Worcestershire appropriately . This was led jointly with the Worcestershire Gypsy Romany Traveller Partnership with great success.

Better and faster urgent care

- ***Create a simple system in which patients know which option is the right one to choose in an urgent care situation.***
- ***Ensure that patients are only admitted when necessary and only stay as long as clinically appropriate.***
- ***Transform urgent care pathways, including better use of the full range of community and social care services.***
- ***Ensure 7 day service provision with equitable outcomes.***
- ***Share information more effectively to support patient care.***

GP with WMAS - SW CCG adopted a 7 day working approach having GPs on ambulances from 12 - 8pm daily. The specific aim was to provide high quality care closer to the patient's home, reduce the number of patients both admitted to hospital and attending hospital emergency departments as well as supporting WMAS.

In 2013-14 over 1000 people were seen by a GP following an ambulance callout

Is A&E for me App? - A new mobile phone app went live in 2013/14 which is the first of its kind in Worcestershire, designed to encourage members of the public to consider the options they have available before attending A&E.
It also includes a GPS function which allows users to find their nearest NHS services wherever they are in Worcestershire. The app has been produced as part of the Is A&E for me? Know your options campaign which aims to reduce pressures on busy A&E emergency services over the winter period .

It has since been downloaded over 1000 times and received a silver award in the Midland Pride Awards 2014.

Directory of Services App - we have invested in a countywide project has been initiated to develop a directory of services app (DOS) that will initially be targeted towards GPs to enable them quick and easy access to local health care services centred on admission prevention. It has been designed and is scheduled for roll-out in 14/15. The adoption of a digital solution is in line with the strategic priorities set out by NHS England which calls for an increased utilisation of technology in healthcare.

Urgent Care Centre - The first phase of the Urgent Care Centre (UCC) pilot commenced at the Worcestershire Royal Hospital site in June. This involves local GPs and hospital emergency medicine clinicians working together at the front door to ensure that people who attend A&E are seen by the most appropriate clinician in a timely way to get the best treatment.

The UCC operates from 12pm – 8pm 7 days per week and is covered by local GPs providing assessment and treatment. The aim is for an integrated service which brings together the expertise of both primary and secondary care practitioners in the provision of care in the service
We aim to achieve a 20% reduction in people admitted with an Ambulatory Emergency Care classified condition in 14/15

Extending Primary care access - SWCCG has in collaboration with SW Healthcare ltd summited a bid for the 2nd Wave of the Prime Minsters £100m Challenge fund for innovative and sustainable services to increase patients access to services. Outcomes will be know in 14/15, if successful the funds will support 12 hour opening Monday to Friday and some weekends for all patients registered in those practices.
24 practices in SW are also signed up to the Extended Access scheme. The aim of this scheme is for practices to provide appointments at times outside of normal opening hours

Improving quality and safety

- ***Commission healthcare in collaboration with patients and the public***
- ***Continue to improve the patient experience of care.***
- ***Drive quality improvement through observation of practice and patient contact***
- ***Ensure poor performance, poor quality or poor outcomes are not repeated through a programme of continuous improvement.***
- ***Ensure that the right patients are in the right beds to maximise the impact of specialist care, paying special attention to vulnerable groups***
- ***More people enabled to have a discussion about their choices for care at the end of life.***
- ***Create a culture of quality, openness, transparency and candour across care system.***

Worcestershire Stroke Service – In line with recommendations of the Worcestershire Health Overview and Scrutiny Committee in 2012 we have expanded the stroke unit at Worcester Royal Hospital to provide a Hyper Acute Stroke Unit (HASU), acute stroke ward, two additional consultants, specialist stroke nursing team and additional physiotherapy, dietetic and occupational therapy support. From July 2013 anyone calling an ambulance for FAST stroke symptoms has been taken to Worcestershire Royal Hospital for treatment. Anyone presenting with a suspected stroke at the Alexandra Hospital will be transferred to Worcestershire Royal Hospital for specialist treatment. Centralisation of stroke services has improved patient outcomes and ensures an effective clinical pathway is in place. In recognition of the improved performance the Trust's stroke team were shortlisted for a National Health Service Journal, Value in Healthcare award 2014.

The Stroke Friends and Family Test - Designed to capture the experience of stroke patients receiving treatment in Worcestershire, the FFT and asks patients and their families about their experience of care at three specific stages of their Stroke care pathway. Through the FFT stroke pathfinder, we developed a more accessible way for stroke patients to provide feedback. We used a combination of pictorial touchscreen technology (iPads with volunteer assistance) and other communication tools specifically developed as a conversational aid for patients who have difficulty with speech or cognitive impairment. The feedback provided by patients, their families, friends and carers will be used to identify areas for improvement. Feedback from the project is due to be referenced in the Nursing Times and Nursing Standard.

Better Together – Established in March 2013 Better Together enables patients and the public to work together with SW CCG to understand, develop and monitor local health services. 250 members have joined better together and numbers continue to increase each month. There are several levels of membership, depending on how involved individuals wish to be.

Quality Assurance (QA) Visits –. Every provider and care home within the South Worcestershire boundaries has received at least one QA visit in 2013/14, with some receiving multiple. Visits are conducted by members of the Quality Team, local health economy representatives, GPs and volunteers and involve discussions with both patients and staff.

Hydration – We have invested in a countywide hydration campaign which focusses on educating health and social care staff about the importance of maintaining and monitoring their residents fluid levels. Dehydration is one of the risk factors for falls in older people and is associated with a number of adverse effects including pressure ulcers, cognitive impairment and AKI (Water UK 2005) which affects around one in five people admitted to hospital as an emergency and many elderly patients (NHS Kidney Care 2012).

Infection Prevention Strategy – The final draft of a countywide Worcestershire Infection prevention strategy has been produced for approval. It has been designed for use across healthcare providers and is scheduled for sign off in 2014/15.

Right patients right beds – we have commissioned extended hours for the CAMHS home treatment team to enable children and young people to remain within their home until a suitable Tier four placement becomes available. Monitoring of patients in out of area placements including those with learning disabilities is closely monitored to reduce the number of out of area placements in 2014/15.

Safeguarding Patients –Robust commissioning of safeguarding services is in place across the health economy with quarterly safeguarding reporting .QA visits to Providers of NHS services identify areas of concern, themes and good practice and Prevent Strategy (DH) rolled out across health as per NHS contract.

Clinical Management Plans (CMP) - This aims to enhance quality of care for care home residents by improving the coordination and management of care through the CMP. This is an individualised patient plan produced on admission to a care home and updated within two weeks of an acute hospital admission. CMPs are available for any health care clinician treating the patient and includes details of a residents care needs and preferences in regards to end of life care. The project has resulted in the production of 1800 CMPs in 2013/14.

Ambition: Improving Quality and Patient Safety

Area		Baseline 12/13	13/14 outturn	Ambition 17/18	Comment
Fewer serious healthcare incidents and no "never events"		94.90% 2	95.00% 0	>96.0% 0	
Fewer healthcare acquired infections		289	255	<200	
Improved patient experience of care	recommend		95.93%	>95%	Methodology changed(% likely to recommend and % unlikely - new ambition to >95% and <5% respectively)
	not recommend		1.38%	<5%	
More people who die in their chosen place of care		46%	47.70%	50%	% dying in place of residence

Ambition:Reduce health inequalities

Area	Measure	Baseline 12/13	13/14 outturn	Ambition 17/18	Comment
	Potential years of life lost (PYLL) from causes considered amenable to healthcare	1913(m) 1735 (f)	2113(m) 1878(f)	1853(m) 1650(F)	Ambition is based on best quartile for England
Improved healthy life expectancy for all	Years of life lost for children and young people	male and female	NA	NA	baselines not published yet- National data only
	Life Expectancy at 75	11.3(M) 13.3(f)	11.7(m) 13.5(f)	12.5(m) 14.4(f)	
Narrower gaps between the best and worst levels of health	Premature Mortality under 75's from major causes of death per 100,000 population	CVD 57.3 Resp 22.9	54.7 21.1	50.0 20.9	Best quartile for England Best quartile for England
	Liver Disease	15.2	15.5	11.8	Best quartile for England- correlates with increase in admissions with liver disease
	Cancer	117.5	115.4	112.9	Best quartile for England

Ambition: More Independence

Area	Measure	Baseline 12/13	13/14 outturn	Ambition 17/18	Comment
Ensure more people are able to live independently, with support to help them safely manage their own health needs	Health related quality of life for people with long term conditions: (range from 0 to 1 with 1 being good)	0.76	0.77	0.85	
	Health related quality of life for carers: range from 0 to 1 with 1 being good)	0.81	0.82	0.9	
	Emergency hospital admissions for chronic ACS conditions (per 100,000)	653	589	500	new measure replaces Crisis admissions >75's
	Percentage of people who feel supported to manage their condition	74%	67.20%	80%	
Help people achieve a full recovery where possible, or where this is not possible to help them reach their new way of life more quickly after illness or injury	Permanent admissions to residential and nursing homes (per 100,000 population)	621	628	600	
	Proportion of people at home 91 days after discharge from rehab	77%	76.60%	80%	
	% people over 65 who have a care plan in place following an in patient episode (specific to exacerbatory conditions, falls, stroke ,MI and UTI's	NA	NA	NA	To be confirmed in year 1 with Acute Trust (audit)

Ambition: Better and faster Urgent Care

Area	Measure	Baseline 12/13	13/14 outturn	Ambition 17/18	Comment
Fewer avoidable urgent care admissions	A&E Attendances (WAH)	60,890	61,609	<55,000	
	Emergency Admissions Through A&E	13,221	13,643	<11,900	
	GP direct Emergency Admissions	8,848	8044	<8,000	
	A&E 4 hour wait	88.90%	90.50%	>95%	
Rapid access to the most appropriate emergency healthcare option	Use of Minor Injury Units (South worcester only)	19,611	19,805	>21,000	
	8 minute ambulance response standard(Red1 and 2 average)	74%	72.80%	>75%	
	Primary care urgent appointments/consultations	<24hours	<24 hours	<4 hours	audit 10 practices required to verify in yr 2

So where should we focus our efforts going forward?

- Urgent care- admission avoidance ,enhancing community support at home and proactive support for the frail
- 7 day working - across more clinical services particularly diagnostics
- Preventing ill health(focus on alcohol and obesity)
- Working with partners to build our community assets to continue to reduce the health inequality gap
- Doing more to reduce avoidable harm and infection rates in hospitals

Closing Remarks and looking forward

The NHS is reaching a defining moment, driven by the pressures across all services, to transform and respond to the challenges raised by an ageing population, technological advances, increased public expectations and increasingly tight resource constraints.

Change is needed to ensure that we can provide services for those who need them now and in the future. We firmly believe we have chosen the right priorities to focus our efforts on over forthcoming years in South Worcestershire .

This review of progress has shown many positive impacts in year one but also shows us that we must maintain momentum in areas where progress is more challenging.

The challenge is no unique to Worcestershire. NHS England published a document "The NHS belongs to the people: A call to action" in 2013 and more recently the Five Year View in 2014, both set out the national context and the direction for the future . There clearly is a huge opportunity to drive integration and engage in a community wide response to building sustainable services for our population fit for the future. In South Worcestershire we are committed to this.

Ahead lies an opportunity for all NHS organisations county and District councils and voluntary organisations to work together that embeds integration and delivers more care outside the traditional hospital setting. Perhaps one of the greatest challenges of all to enable communities and individuals to take responsibility and control of their own health and wellbeing in the future. To do this they will need our full support.

I hope you have found this review useful and feel you have a sense of what we have achieved in year one of the strategy . If you have any comments, views or questions please let us know.

Carl Ellson

Chief Clinical Officer