Warwickshire North Clinical Commissioning Group

NHS 70 YEARS OF THE NHS 1948 - 2018

Appendix B

Commissioning Intentions – *Progress Review*

Report to:	Warwickshire Adult Social Care and Health Overview and Scrutiny Committee
Date:	26 September 2018
By:	Andrea Green, Chief Officer Matt Gilks, Director of Commissioning
Purpose:	In the autumn of 2017, the CCG's 2018-19 commissioning intentions were presented to the Committee. The overall function of the commissioning intentions document is to drive delivery of the CCG's strategic aims. The current report provides an update to the Committee regarding the progress that has been made in relation to the delivery of the strategy, identifying the key achievements under each of our strategic work programmes.

Quality & Equality First

Contents

Background

Clinical Commissioning Groups

The three Coventry and Warwickshire Clinical Commissioning Groups (NHS Coventry and Rugby CCG, NHS South Warwickshire CCG and NHS Warwickshire North CCG) are clinically-led statutory NHS bodies responsible for the commissioning (planning, buying and monitoring) of most healthcare services for the people of Warwickshire. The CCGs operate within a financial budget set by the Department of Health.

Commissioning is the process by which CCGs ensure the best possible health outcomes for the local population. This involves assessing local needs, deciding priorities and strategies, and then procuring and contracting services from providers such as hospitals, clinics and community health bodies. It is an ongoing process and CCGs must constantly respond and adapt to changing local circumstances. CCGs are responsible for the health of their entire population, and measured by how much they improve outcomes.

National Context

In October 2014 NHS England published the *NHS Five Year Forward View* (5YFV).[1] This key policy document sets the context within which the CCG's strategy and other associated plans have been developed. The 5YFV articulates a clear vision of the future, in which greater emphasis is placed on prevention, integration (in other words, organisations, both Commissioner and Provider, within local health and care systems working together to meet the needs of and deliver the best care for patients) and putting patients and communities in control of their health. The 5YFV sets out a vision and collective view of how the NHS needs to change, what change might look like and how to achieve it.

Commissioning Intentions

All Clinical Commissioning Groups (CCGs) are required to develop and publish commissioning intentions which set out the annual priorities the CCG will focus on to ensure Health services maximise health outcomes for their local population, taking account of national and local imperatives. CCGs are required to develop and publish commissioning intentions on an annual basis and are published in September each year to give adequate notice to service providers of required changes.

The commissioning intentions identify how the CCG will translate its strategic aims into the commissioning of services. The main functions of commissioning intentions are:

- To notify service providers as to what services the CCGs intend to commission for the following year;
- To provide an overview of priorities for the coming financial year in line with national and statutory requirements.
- To drive improved health outcomes for our local populations; and
- To transform the design and delivery of care, within available resources.

2018/19 Commissioning Intentions

The 2018/19 Commissioning intentions were developed through engagement with clinicians, stakeholders and the public and in the context of the NHS '5 year Forward View' and local 'Better Health, Better Care, Better Value' priorities. They were also aligned with the priorities within the Coventry and Warwickshire Health and Wellbeing Board (HWBB) Strategy.

The resulting refreshed commissioning intentions were published in September 2017 and since then the CCGs have been working to deliver the priorities which are set out under six program areas.

As part of the process to produce commissioning intentions for 2019/20, a full stocktake of progress against the milestones has been undertaken. A summary of the programme areas and key achievements to date is included in the following pages of this report.

[1] https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

Our strategic work programmes

Our commissioning intentions are underpinned by six strategic work programmes, detailed in the table below. Underpinning each thematic work streams is a focus on self-care, which will help people live longer, more healthy lives. Our strategic work programmes reflect STP priorities, and articulates our vision, commitments, and high level ambitions to achieve the *'triple aim'* identified in the 5YFV.

Primary Care	Out of Hospital Care	Maternity and Paediatrics
Our commitment is to deliver increased opportunities for and encourage practices to work together to deliver improved services, improve access to general practice services and ensure general practice is strong enough and supported enough to continue providing services long into the future.	Our commitment is for fewer visits to hospital for patients with ongoing conditions and less time in hospital when you do have to stay, supported by more rehabilitation and ongoing support closer to home. We also want to develop multidisciplinary teams working across groups of practices to support the care delivered to frail and vulnerable adults.	Our commitment is for a maternity and paediatrics service delivering safe, kind, family-friendly, personalised care with improved outcomes for children, young people and their families.
Urgent and Emergency Care	**Planned Care**	**Mental Health**
Our commitment is to make it easier for the public to know which urgent and emergency care service to access, and when, for their particular need whilst delivering a consistent level of care.	Our commitment is to reduce delays in appointments with experts, for investigations and treatment. We will reduce the amount of unnecessary visits to hospital for follow up care. We will provide more care in the community and closer to home.	Our commitment is to deliver a proactive and preventative approach to reduce the long term impact for people experiencing mental health problems and support individuals and families to manage their mental health and wellbeing.
Self-care		
Our commitment is to provide a better connected health and care system that makes the most of the assets in our communities thinks prevention first and supports people to live well, for longer, accessing care when they need it.		

Self-care

What is self-care?

Self-care is about keeping fit and healthy, understanding when you can look after yourself, when to go to a pharmacist and when to get advice from your GP or another health professional. If you have long-term conditions, such as diabetes or cancer, self-care is about understanding that condition and how to live with it.

What we know

- Prevention is better than cure
- Our clinical and professional time with patients is short – it is our patients that spend the most time managing their conditions and we need to equip them with the knowledge, skills and resources to do this effectively and safely
- There are a wealth of resources and assets in our communities and across our partners that can support people to live well for longer
- Our workforce are our greatest asset and need to be supported effectively

What we are trying to achieve

A better connected health and care system that makes the most of the assets in our communities thinks prevention first and supports people to live well, for longer, accessing care when they need it.

Our priorities

- Strengthening our partnership working with Public Health to promote healthy lifestyles
- Develop a social prescribing offer with the Local Authority that addresses the social issues of poor health
- Help people understand where they can access services and help when they need it, including making better use of our community and voluntary sector
- Ensuring prevention, self-care and digital approaches are built into all our pathways and work programmes

What we've achieved so far

- ✓ Held a successful diabetes awareness and management event, focused on how to eat and live healthily, manage the symptoms of diabetes and access support in their local communities
- ✓ Given more people access to education programmes around Type 2 diabetes in a variety of formats, such as short videos
- ✓ Commenced the rollout of the National Diabetes Prevention Programme
- ✓ Further expanded and continued to deliver the #onething campaign, which aims to promote healthy living by changing one thing
- ✓ Fitter Futures Warwickshire (FFW) has been commissioned to reduce obesity, improve healthy eating, improve mental well-being, increase physical activity levels
- ✓ Work to improve awareness and understanding of which services to use and when based on a person's needs
- ✓ There is a local push to improve uptake across the national screening programmes. In 2016 owing to poor local uptake CCGs identified Bowel Screening as its priority area

Diabetes

Improving care for patients with diabetes through education and support

INCREASED PATIENT AWARENESS

PREVENTING UNNECESSARY HOSPITAL ADMISSIONS

REDUCTION IN ILL HEALTH AND COMPLICATIONS

Helping people understand diabetes

Patient awareness and knowledge around self-management of diabetes, and their attendance at structured education programmes, was lower than expected.

A patient-centred approach to tackling the issues

- DESMOND (Diabetes Education and Self-Management for Ongoing and Newly Diagnosed) taster session held in the community attracting over 100 people from BME communities
- Paediatric diabetes awareness event held to support young people and parents
- Relaunch of patient information pack for those with newly diagnosed Type 2 diabetes
- Initial roll out of the NHS Diabetes Prevention Programme (NHS DPP) using trailblazer practices as a positive example
- Procurement of accredited Type 2 Diabetes Structured Education programme DESMOND) utilising national transformation funding
- Training specifically targeted at nursing and residential staff to better manage patients with diabetes in care homes
- Early development of a Coventry and Warwickshire wide diabetes website aimed at patients and staff

Diabetes specialists leading the way

The work has been driven and supported by members of the CCG diabetes transformation group, which is led by a Public Health consultant with support and involvement from local GPs with a Specialist Interest (GPwSI) in diabetes, hospital and community service providers, third sector organisations, Diabetes UK, patients and collaborative working with the CCG commissioning lead to implement ideas and proposals.

A whole-system improvement

Improved partnership and collaborative working will contribute to:

- Strengthening self-care and education provision for our patients
- Multi-disciplinary working with community pharmacists, secondary, primary care diabetes services
- Improved investment into local diabetes services
- Identification of patients at risk of diabetes
- Increased patient involvement and satisfaction
- Patients are referred and signposted to their GP and other local services to ensure they receive the right diabetes care at the right time
- Improved knowledge of all-sector services for patients and healthcare professionals

Improving patient outcomes

- Empowering patients to manage their diabetes and reduce their risk of complications
- Increased patient awareness of diabetes and satisfaction with service provision
- Commissioning point of contact available to local groups
- Supporting self-care and empowering patients through high quality education and self-care resources and education programmes
- Preventing unnecessary hospital attendances/admissions and supporting early discharge to skilled and knowledgeable primary care staff
- Reduction in ill health and complications

Primary care

What is primary care?

Primary care is generally the first point of contact for the healthcare system, acting as the 'front door' for the NHS. Primary care includes general practice, community pharmacy, dental and optometry (eye health) services.

What we know

- Patients want access to flexible services and same day appointments when it's urgent
- We spoke to over 600 members of the public and found the majority of people find it difficult to book an appointment and 76% would consider booking an appointment online

What we are trying to achieve

Increased opportunities for and encourage practices to work together to deliver improved services, improve access to general practice services and ensure general practice is strong enough and supported enough to continue providing services long into the future.

Our priorities

- Improve access to primary care to meet the needs of patients, including population growth and new housing developments and making use of new technology such as online consultations and two-way text messaging
- Actively encourage every practice to be part of a local primary care network and work together more collaboratively, expand and support their workforce and offer appointments with other health professionals, such as clinical pharmacists
- Supporting practices with their workload, using the national GP Five Year Forward View and High Impact Actions, sharing best practices to enable practices to deliver

What we've achieved so far

- ✓ The CCG became fully delegated to primary care commissioning in April 2018
- ✓ Two-way text messaging implemented to help reduce missed appointments and free up GP and practice staff time
- ✓ Recruitment campaign for GPs, nurses and practice staff developed to help attract people to the area, using funding secured for recruitment and retention, and received approval for the GP international recruitment scheme
- ✓ Supported training for GPs, nurses and practice staff e.g. improving cancer and diabetes education and awareness, prescribing courses, clinical correspondence training
- ✓ All our practices are CQC rated "Good" or higher
- ✓ A new telephone service called Consultant Connect allows GPs to phone local speciality consultants during a patient appointment to get advice and guidance, which has led to a 54% reduction in unnecessary hospital referrals (where a call connects)
- ✓ Developed a new service to called "Prescription Ordering Direct" to not only combat prescribing waste, but also improve services for local patients and ease pressure on general practice
- ✓ Same day GP consultations was launched in August 2018 to Warwickshire North patients through new extended access service
- ✓ New enhanced service for practices providing insulin initiation to avoid need to be referred into hospital
- ✓ Secured resilience funds to support general practice
- ✓ GP clusters are in development to help enable practices to work more closely together
- ✓ New end of life enhanced service which includes an electronic palliative care register to help improve care for those at the end of their life

GP Extended Access

NHS

GP Extended Access Survey

Coventry, Rugby and Warwickshire North

Why do we need to extend access to primary care?

- National requirements
- Helping people get appointments

National guidance from NHS England requires us to provide extended access to GP services such as appointments in the evenings and at weekends, ensuring everyone has easier and more convenient access to GP services.

As a CCG want to offer a joined up service to patients, ensuring extended access forms part of the wider system approach, especially urgent care services. The CCG aims to make the best connections for patients and staff to get the best possible outcomes.

How do we make extended access a success?

- More convenient appointments
- Having enough staff
- Making sure appointments are used
- Making sure patients are aware of extended access
- Making better use of technology and online
- Reducing inequalities
- Better integration of services

Engaging with local communities

From February – June 2018 we engaged with patients and the public in Coventry, Rugby and North Warwickshire about improving access to GP services. 716 people including those from seldom heard groups, who often struggle to access GP services and give their views. The responses will be used to plan delivery of services in the most appropriate locations.

Below are highlights of some of the responses received

The majority of people (55%) find it difficult to book an appointment or speak to their practice over the phone.

If you needed to see a GP immediately, how important would the following be to you?

Seeing your preferred GP	39%
Seeing a GP at a different local practice/location	43%
Being able to speak to a GP	65%
Seeing any healthcare professional (Nurse/ Pharmacist etc.)	48%
Being able to speak to any healthcare professional (Nurse/ Pharmacist etc.)	63%
Ability to have a face to face appointment	61%
Ability to have an appointment online (e.g. via Skype)	35%
Ability to have an appointment via telephone	32%
Being seen at a time most convenient to me	46%
Location of GP practice	51%
Accessibility of the building (e.g. parking, wheelchair friendly, etc.)	35%

Which mode of transport do you use most often to get to your GP practice?

Car – drive yourself	63%
Car – someone else driving	6%
Public transport	4%
Walking	23%
Other (e.g. bicycle)	1%
Don't know/unsure	0%

76% of people would consider booking an appointment via an online booking system if available to them.

Over 50% of people would consider online GP consultations.

In the last twelve months 50% of people approached their local pharmacy for advice and/or treatment.

Out of Hospital care

What is out of hospital care?

Out of hospital care is about making sure we treat as many people as possible outside of hospital, providing care closer to home and in the community, in order to help people stay healthy, independent and improve quality of life and recovery after a period of ill health.

What we know

- Patients want to access more joined up services in their local communities
- Patients want to access the right support first time, every time
- People want to receive the support they need to maximise their independence, wellbeing, quality of life and potential for recovery after an episode of ill health.

What we are trying to achieve

Fewer visits to hospital for patients with ongoing conditions. Less time in hospital when you do have to stay, supported by more rehabilitation and ongoing support closer to home. We also want to develop multidisciplinary teams working across groups of practices to support the care delivered to frail and vulnerable adults.

Our priorities

- Improve the quality of life for people with long term conditions through support, education and care closer to home when appropriate
- Identify people most at risk of ill health or hospital admission
- Better coordinate the care of people with complex problems via joined up hospital and community services and provide a rapid response to escalating health needs

What we've achieved so far

- ✓ A contract was awarded for the new out of hospital model, being delivered by Coventry and Warwickshire NHS Partnership Trust and South Warwickshire NHS Foundation Trust
- ✓ We have set up "working together/design" boards, comprised of key stakeholders such as local authorities, community and voluntary sector and patients and public, to help shape the future of out of hospital services
- ✓ An integrated single point of access has been implemented
- ✓ Place based teams have been mobilised and operational in rural north Warwickshire and Bedworth
- ✓ New Rapid Response at Night Service for End of Life care **f**or residents who are nearing the end of their life, as well as promoting it through frontline staff, visits and presentations to care homes and GPs, we have helped reduce the anxiety and isolation that some people may feel during the night.
- ✓ Two community based end of life beds commissioned and operational from April 2018
- ✓ Ten GP practices have signed up to use an end-of-life IT system (CASTLE Register) to support end-of-life patients to facilitate multidisciplinary working through access to a shared record containing key clinical information
- ✓ The social prescribing service continues to operate successfully in the local area, helping patients by linking them in with resources and support in the community
- ✓ New enhanced service for proactive case management of vulnerable and frail people to help them avoid unnecessary hospital admission and improve patient experience

Out of Hospital

DEVELOP INTEGRATED SINGLE POINT OF ACCESS (ISPA) TO HELP ENSURE PATIENTS ARE OFFERED THE RIGHT SUPPORT FIRST TIME, EVERY TIME.

PLACE BASED TEAMS WILL BE DESIGNED TO SERVE POPULATIONS OF 30-50,000 USING MULTI-DISCIPLINARY TEAMS

LOCALITY HUBS WILL PROVIDE SPECIALIST SERVICES AND SUPPORT STAFF THROUGH TRAINING AND DEVELOPMENT

What is the Out of Hospital programme?

The Out of Hospital programme is about making sure we treat as many people as possible outside of a hospital setting. For the first two years this will be focused on the 5% of service users who use the most services and are likely to be our most frail and elderly.

The programme will make sure we provide the best care we can, and in the most cost effective way. This means doing more to 'join-up' care available in the community with care available at hospital. It also means working much more with our partners who have a host of valuable skills and who need to be part of our team.

What we have commissioned

The CCG, working with Coventry and Warwickshire NHS Partnership Trust and South Warwickshire NHS Foundation Trust as the lead providers, is looking to deliver the outcomes listed below.

The providers have involved a wide range of stakeholders, such as local authorities, community and voluntary sector and patients, through a series of "working together/design" boards.

1. People are encouraged and supported to optimise their health and wellbeing
2. People will be treated in a safe, effective and appropriate way to avoid harm
3. People will be better supported in their rehabilitation after a period of ill health
4. More personalised care will be provided for people approaching the end of their lives to maximise their independence
5. People have an excellent experience of care
6. Organisations are designed so that individuals within them can work together more easily.

How will these services be better?

Our vision is:

- For people to receive the support they need to maximise their independence, wellbeing, quality of life and potential for recovery after an episode of ill health.
- To empower individuals to stay healthier for longer within their local communities
- To do all we can to promote prevention of ill-health, particularly doing more to target help for frail and vulnerable people and people with long term conditions such as diabetes or heart trouble
- To provide rapid response to escalating health needs
- To provide timely, supported discharge with an emphasis on promoting recovery and re-ablement
- To operate within clear consistent pathways of care including working with voluntary and community groups.

End of Life

Improving care for patients nearing the **end of their life**

HELPING PEOPLE PLAN FOR DEATH IN A POSITIVE AND SENSITIVE WAY

IMPROVING THE INTEGRATION OF AND COMMUNICATION BETWEEN SERVICES PROVIDING END OF LIFE CARE

A NEW RAPID RESPONSE OUT OF HOURS TEAM HELPS PEOPLE COPE WITH ANXIETY AND ISOLATION DURING THE NIGHT

Approaching the end of their life can be a terrifying and isolating experience for people and those who care for them. Integration between services supporting these patients hasn't always been as good as it could be, meaning care felt disjointed. This could often lead to a frustrating experience in an already stressful time, particularly if the patient was in unfamiliar surroundings, such as a hospital, rather than their own home.

A number of positive new initiatives to improve patient outcomes and experience

- A number of workshops and training events were run for a wide range of staff, with a focus on communication skills, end of life planning, managing pain and symptoms
- Creation of a new Rapid Response at night service for end of life patients, offering support to patients, reducing the anxiety and isolation some people feel during the night
- A new electronic palliative care system, known as the CASTLE register, to share information quickly between the services caring for a patient to make care smoother
- A number of "end of life" beds were also commissioned in the community, helping care for people closer to home and out of hospital, where appropriate
- Support for carers has been enhanced, helping them to better cope with looking after someone approaching the end of their life

Working together to improve end of life services

To ensure the best care for patients approaching the end of their lives, and begin to better integrate services, a number of organisations have come together to develop these new initiatives:

- NHS Warwickshire North CCG
- George Eliot Hospital NHS Trust
- South Warwickshire NHS Foundation Trust
- Mary Ann Evans Hospice
- Myton Hospice
- Marie Curie
- Warwickshire Carer Wellbeing Service
- Warwickshire County Council
- Primary Care

> "We feel blessed that during the very isolating night-time hours, the team delivered much needed encouragement and support to us. We hope that this rapid response service not only continues in the north Warwickshire area, but also becomes available to everyone caring for a terminally ill person at home."
>
> **Family of a terminally ill resident**

What are the outcomes

- Families and patients are better supported
- At end of life, symptoms and pain are better managed
- Care is better coordinated through a new electronic register
- Patients have better access to clinical leadership through the appointment of a new Consultant in Palliative Medicine at George Eliot (commencing August 2018)

Maternity and paediatrics

What are maternity, children and young people health services?

Maternity, children and young people services cover a wide range of different services, such as antenatal care, support during and after birth, neonatal care, community and hospital paediatric services, GP services for parents and children and mental health services for parents and children.

What we know

- We need to work together across health and social care to develop a local response to the “Better Births” National Maternity Review and ensure services are safer, more personalised, kind, professional and more family friendly
- Ensure women at risk of premature delivery receive the right care in the right place at the right time leading up to the birth of their child
- We need to improve services for Vulnerable Children (including Looked after Children)

What we are trying to achieve

Deliver safe, kind, family friendly, personalised care with improved outcomes for children, young people and families.

Our priorities

- To reduce the numbers of stillbirths and neonatal deaths by 20% in 2021 and 50% in 2025
- Achieve 20% of women receiving continuity of carer during pregnancy, as set out in the NHS England maternity operating plan
- Increase access to specialist perinatal mental health services
- Continue working in a multi-disciplinary way across the Local Maternity System (LMS), which includes CCGs, primary and secondary care and the local authority, to deliver the aims of the national Better Births review

What we’ve achieved so far

- ✓ Helped over 1,500 parents understand the importance of safe sleeping for babies and promote parent and baby health
- ✓ Set up a pilot programme between local hospitals to ensure Coventry and Warwickshire women and babies are not transferred out of area
- ✓ Improved mental health support for children and young people
- ✓ The CCG has facilitated collaborative working between UHCW, GEH and SWFT has ensured that Warwickshire women and babies are not transferred out of area
- ✓ Working with other local CCGS, we have published our Local Maternity System plan, the overall aim of which is to ensure mothers and babies receive the best quality of care
- ✓ A large-scale engagement exercise has asked mothers, mothers to be, families, carers, front-line staff and the community and voluntary sector to share their views on maternity and paediatric services, the results of which will help strategic commissioners and providers plan the future of services

Urgent and emergency care

What is urgent and emergency care?

Urgent and emergency care covers appointments which need urgent, same day and unplanned contact. This includes some types of GP appointments, as well as visits to Accident and Emergency (A&E), walk-in centres or urgent care centres.

What we know

- Patients find it difficult to know which services to use when e.g. NHS 111 vs urgent care centre vs A&E
- Patients want to understand and access the right type of urgent care service in an emergency to ensure they get the best care when they need it most

What we are trying to achieve

We are trying to make it easier for the public to know which urgent and emergency care service to access and when for their particular need whilst delivering a consistent level of care.

Our priorities

- Work with patients to help them understand the types of care available in an emergency and which ones to access i.e. providing information via GPs
- Ensure patients have the necessary information to understand and access the right type of urgent care service in an emergency to ensure they get the best care when they need it most
- Established a single point of access which will give access to all rapid response community services

What we've achieved so far

- ✓ Part of the "Ask NHS" app programme, allowing people to check symptoms and be directed to the most appropriate services for their needs through an app available on smart devices
- ✓ We've begun exploring options to enable NHS 111 to book people directly into GP extended access appointments
- ✓ Urgent Primary Care Assessment (UPCA) was established in January 2018 to help patients avoid unnecessary admissions to hospital
- ✓ Robust winter pressure campaigns conducted to help patients understand which services to use during the busy winter months and get the right care for their need
- ✓ Completed a second round of engagement for the redesign of stroke services, with the public and key stakeholders were involved in extensive engagement about the redesign of stroke services, and feedback is being reviewed as part of a final proposal for improvements
- ✓ Working with general practice and AGE UK to identify those who attend A&E regularly but would receive more appropriate care for their needs in other settings to help them feel less isolated and better supported

Stroke

Improving standards of care for stroke victims

IN 2016-17, JUST OVER 1,200 PEOPLE IN COVENTRY AND WARWICKSHIRE HAD A STROKE AND WERE TAKEN TO ONE OF OUR THREE LOCAL HOSPITALS

THERE WERE OVER 15,000 STROKE SURVIVORS ON LOCAL GP REGISTERS

OVER 320 PEOPLE WERE DIAGNOSED WITH A "TRANSIENT ISCHAEMIC ATTACK" (TIA), SOMETIMES CALLED A "MINI-STROKE"

The challenge we face

Current stroke services in Coventry and Warwickshire are providing a good standard of care, but they are not meeting national guidance. They can also offer different levels of care depending on where a person lives. Initial engagement around improving stroke services in the area had taken place previously, and some key themes had come out of that, such as the need for a greater focus on rehabilitation and to minimise any impact of changes to travel.

How we responded

Between June and July 2017, the CCG helped lead a second major phase of engagement around further proposals for improving stroke services, which incorporated a focus on rehabilitation. This engagement comprised of face to face meetings, radio interviews, presentations at the local Health Scrutiny Committees and a survey, all of which helped to gather vital feedback from patients and the public which will help inform the future of proposals for improving stroke services.

An independent impact assessment was also carried out, to understand the impacts of the proposals on travel, health and equality groups.

Who we worked with

The three Clinical Commissioning Groups have been working in partnership with:

- Local doctors, specialist nurses and therapists
- Stroke consultants
- Stroke survivors
- West Midlands' Clinical Senate
- Patient and public group chaired by the Stroke Association
- National experts
- Patients, members of the public

Your feedback matters

We have taken all the views and expanded our original thoughts for a future service into a proposal that now includes some targeted stroke prevention and a comprehensive and equitable specialist stroke rehabilitation service following a stroke.

An action plan has also been developed and work is underway to address the travel concerns; this includes looking at increased car parking and improving access to community and public transport services.

Our vision

Suspect stroke › Ambulance straight to specialist hyper acute stroke unit at University Hospital Coventry. › Early supported discharge with rehabilitation and home or bedded rehabilitation, tailored to their needs.

Planned care

What is planned care?

Planned care is any treatment that isn't an emergency and usually involves pre-arranged appointments in hospitals, community settings and GP practices. Planned care covers services such as minor operations, routine tests and treatment for long-term conditions such as cancer.

What we know

- Health services for planned care aren't always as efficient as they could be
- There is low uptake of the cancer screening programme, including; breast, bowel and cervical cancers

What we are trying to achieve

Reduce delays in appointments with experts, for investigations and treatment. Reduce the amount of unnecessary visits to hospital for follow up care. Provide more care in the community and closer to home.

Our priorities

- Improve the advice given to GPs around when to refer patients to hospital to help reduce unnecessary appointments and improve patient experience
- Improve the flow of hospital care to avoid duplication and unnecessary hospital visits
- To support patients to live well with cancer through the implementation of the Macmillan recovery package
- To increase knowledge of the benefits of cancer screening across all population groups
- Patients with diabetes receive the right support in accessing the right education and self-care resources to self-manage their condition and live well

What we've achieved so far

- ✓ Supported the development of over 160 non-clinical "Cancer Champions", who support their local community, particularly seldom-heard groups, to highlight the importance of cancer screening and promote self-care and management
- ✓ Set up the "Consultant Connect" service for Nuneaton, Bedworth and north Warwickshire, which allows GPs to telephone local speciality consultants to get advice on how best to refer patients across a number of specialities, such as cardiology, diabetes, paediatrics and geriatric medicine, reducing the number of unnecessary hospital visits – we are also looking at replicating this service in the Coventry and Rugby areas
- ✓ Community Dermatology Service launched in May 2018 offering clinics from Nuneaton, Coleshill and Atherstone
- ✓ New ambulatory ECG service delivered in local GP practices
- ✓ Atrial Fibrillation Pathway Redesign launched to provide better diagnosis, initiation and management in primary care
- ✓ Fitter Futures Warwickshire (FFW) has been commissioned to reduce obesity, improve healthy eating, improve mental well-being, increase physical activity levels
- ✓ We have been working with other local CCGs to develop our response to the national cancer strategy
- ✓ Funding secured to procure support from Macmillan Cancer Support to recruit a Programme Manager who is now leading the implementation of the "Living with and beyond cancer" programme

Cancer

Raising awareness of the importance of **cancer screening**

IMPROVED PARTNERSHIP

MORE EFFECTIVE CANCER SCREENING

EARLIER DIAGNOSES

Improving primary care cancer education

The CCG is responsible for cancer prevention and the Primary care cancer education network as part of the wider Coventry and Warwickshire Better Health, Better Care, Better Value programme.

A robust new programme

The CCG continues to work with partners such as the West Midlands Cancer Alliance, Macmillian Cancer and Cancer Research UK, and has:

- Delivered a successful Coventry and Warwickshire lung cancer education event in March 2018, seeing attendance from over 300 local GPs
- Distribute cancer information packs to practices across Coventry and Warwickshire
- Continue to promote bowel, breast and cervical screening
- Promote bowel screening through a range of primary care initiatives
- 72% of GP practices across Coventry and Warwickshire have signed up to Bowel Screening GP endorsement
- Established a Coventry and Warwickshire wide lung cancer pathway group
- Development of a Primary care cancer strategy
- Established a Coventry and Warwickshire cervical screening working group
- Develop a training programme for non-clinical cancer champions for community and GP practice staff
- Identified clinical cancer champions working in Primary care
- Funding secured to improve participation in bowel screening programme in low uptake practices
- Commissioned a new diagnostic test to support early diagnosis in particular non-cancerous bowel growths that may in time become cancerous

Working together in support of the local health economy

Public Health, local GPs specialising in cancer and the CCG have worked together to drive and support the work, implement ideas and put forth proposals.

This has enabled:

- Improved and continued partnership and collaborative working
- Improved knowledge of cancer related issues across primary care, allowing them to use cancer screening tools more effectively
- Earlier diagnoses and referral of potential cancer patients
- Working with Secondary care colleagues to ensure appropriate referral of potential cancer patients
- Making available the use of FIT in primary care in symptomatic patients outside the 2ww referral process (according to NICE 2017 guidance)

Improving patient outcomes

The work has been instrumental in improving patient experience and screening of cancer. It has also:

- Improved cancer outcomes for the local population in the long term
- Raised awareness of the importance of all cancer screening
- Increased the uptake of cancer screening
- Reduce inequalities in cancer screening, promoting early diagnosis and improved patient outcomes for all in Coventry and Warwickshire

Consultant Connect

NHS

Involving patients in decisions about their care

INVOLVING PATIENTS IN DECISIONS ABOUT THEIR CARE

7 SPECIALITIES CURRENTLY COVERED

54% REDUCTION IN UNNECESSARY HOSPITAL REFERRALS

Many referrals into local hospital can be avoided

Sometimes, a GP may needs to refer a patient to a consultant at the local hospital who specialises in a particular health issue, such as cardiology or diabetes.

This process can take a number of weeks and can sometimes lead to patients having to make unnecessary trips to hospital, which can be a frustrating and costly experience.

Real-time advice and guidance leads to a patient-centred approach

The CCG, working with George Eliot Hospital, introduced a telephone advice and guidance service called Consultant Connect. This system gives local GPs a direct line to speciality consultants at the hospital. The consultant can talk through the patient's case with the GP and patient together over the phone and provide advice and guidance on the best course of action.

Consultant Connect currently covers the following specialities:

- Cardiology
- Diabetes & Endocrinology
- Gastroenterology
- Geriatric Medicine
- Gynaecology
- Paediatrics
- Urology

Building links between GPs and local hospitals

NHS Warwickshire North CCG worked closely with George Eliot Hospital and a number of local GPs to introduce this service.

Improving patient outcomes and experience

Since being introduced, Consultant Connect has helped to reduce a significant number of unnecessary referrals to hospital:

- **54%** of connected calls result in the patient not needing to be referred to hospitals
- **8%** of those who are still referred don't need to be admitted
- **5%** of calls have resulted in specific diagnostic tests being arranged over the phone, removing the need for the patient to first visit hospital to book the test

These improvements have led to more immediate positive outcomes for the patient, less stress and hassle associated with visiting hospital and greater peace of mind in many cases. It also gives patients the chance to be more directly involved in decisions about their care.

Mental health and learning disabilities

What are mental health and learning disability services?

Mental health services look to support those suffering from mental health difficulties, such as depression, suicidal thoughts and dementia. Learning disability services look to support those with learning disabilities, such as autism, attention deficit hyperactivity disorder and others.

What we know

- We need to improve diagnosis rates for people with dementia
- We know people with a mental illness have a poorer quality of life
- Too many people with leaning disability and/or autism are in mental health hospital provision

What we are trying to achieve

A proactive and preventative approach to reduce the long term impact for people experiencing mental health problems and support individuals and families to manage their mental health and wellbeing

Our priorities

- Increase dementia diagnosis rate and improve access to support
- Increase number of people accessing talking therapies
- Improves services for people experiencing first episode of psychosis.
- Reduction in out of area mental health and learning disability placements
- Improve the system's response for children and young people in crisis.
- Continue to reduce hospitalisation of people with a learning disability and/or autism.

What we've achieved so far

- ✓ Improved services for children and adolescents, including dramatic reductions in wait times, with numbers waiting over 12 weeks for follow up appointments reduced from 86 in August 2017 to 17 in May 2018
- ✓ Implemented a new service to adults with suspected autism or attention deficit and hyperactivity disorder
- ✓ Secured funding to support suicide prevention, for example through the creation of "safe havens"
- ✓ Opened Atherstone Community Hub offering parent drop-ins, training, and base for community outreach staff. Nuneaton Hub to open Summer 2018
- ✓ Roll out of the Dimensions Tool enabling families and referrers to sign post to appropriate support and opportunities
- ✓ Successful first year for the Mental Health in A&E CQUIN (Commissioning for Quality and Innovation) and looking to expand provision in year 2, helping to reduce avoidable mental health admissions and improve discharge planning for patients
- ✓ Improving access to psychological therapies for people with long-term conditions
- ✓ 12 employment advisors secured to help people with mental health needs find and stay in work
- ✓ Commissioned new community services for people at risk of admission including a pilot intensive support service for children and young people with learning disabilities and/or autism; intensive support for adults with autism and forensic community support for adults.
- ✓ Developed a system-wide recovery plan for the Transforming Care Partnership with a focus on admission avoidance and discharge.

Appendix 1 - How we've supported our member practices

Below is a highlight of the work we've undertaken to support our member practices in responding to the General Practice Forward View and the 10 High Impact Actions for Primary Care.

High Impact Actions

How we've responded to the General Practice Forward View

Model of care:

End of Life Care – We are actively involved in the development of an End of Life improvement plan which includes personalised care planning, shared records, better education, training and 24/7 access to services and creation of a rapid response service for people in crisis

The contract to provide out of hospital services closer to home goes live in April 2018

Our Governing Body GP leads have been involved in setting the KPIs for out of hospital to ensure primary care is reflected.

Working Together/design boards have been launch and are a key vehicle for the CCG and local GPs to influence delivery and deployment for out of hospital delivery.

Two-way text messaging – A funding application for a two-way text messaging service has been submitted. Two-way text messaging helps to reduce DNA rates, reduce cancellations and free up GP and practice staff time.

Prescription Ordering Direct (POD) to help reduce waste and increase quality of prescribing.

Social Prescribing – We have invested money into a social prescribing model, which enables GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services

Consultant Connect – **A new telephone advice and guidance system** which enables local GPs to call a team of local specialty consultants to seek appropriate advice in Cardiology, Gynaecology, Urology and Diabetes

Prevention and self-care – We are working with Warwickshire County Council and Public Health Warwickshire to support a new initiative which enables GPs to refer to physical activity and weight management support for children and adults.

Improving access to general practice:

We are currently planning an engagement campaign around access to GP services to understand what this means to our local patients, practice staff and partner organisations, in order to ensure the end model reflects feedback from these crucial stakeholders. Keep an eye out for more information on this important initiative and how you can get involved.

Workforce and workload:

We will be investing in a mentoring scheme for Practice Managers and **providing stress management** and **personal resilience training.**

Training needs analysis carried out across all practices to identify needs and opportunities and match them with appropriate courses available

Successful application for **£100k** of resilience money for **2017/18** which will **support** workforce issues – recruitment of GPs, and filling gaps in other staff areas

Primary Care Workforce Strategy Delivery

- Understand current workforce
- Understand gaps and identify requirements
- Deliver plan to address gap

Implementation of a Central Policy Library – **Helps save time**, encourages a consistent, standardised approach and **supports CQC**

Implementation of Clinical Correspondence Management Training across all 27 practices, helping staff to better and more efficiently manage correspondence to free up capacity and time

We have submitted an application for funding to attract international GPs to the area to support our workforce

Independent audit commissioned for QOF prevalence and data quality – Register health checks, data quality and read code training **in all 27 practices**, supporting practices to identify QOF prevalence issues, improve patient care and **increase practice financial sustainability**

We have been successful in securing places for local nurses on nurse prescribing courses

Appendix 2 – Commissioning intentions engagement summary

This year we have engaged on our commissioning intentions with:

- Our CCG Clinical Executive Group
- Our CCG Governing Body
- Local Health and Wellbeing Boards
- Our local Healthwatch organisations
- Patients, public and community and voluntary sector groups
    - We asked for feedback, ideas and thoughts on the commissioning intentions at our annual general meeting
    - Over 200 people, including patients, community and voluntary sector groups and our member practices, have responded to an online survey focused on our commissioning intentions
    - At their request, we have provided paper copies of the survey to community groups
    - We have raised awareness of our commissioning intentions via social media
    - We have discussed our commissioning intentions at many face to face meetings and engagement sessions with specific groups or communities
    - We have engaged on any plans for service changes and will continue to do so (including, where appropriate, going through a formal consultation process)
    - We have held our providers to account by ensuring they seek service user feedback to evaluate and influence how services are provided and delivered

We will continue to involve patients and the public to help guide and inform our work, understand the impact and assess the benefits being delivered to our population.

Our commissioning intentions survey

This year we conducted a survey with our patients, public, member practices and other key stakeholders, asking them to share with us their thoughts, feedback and ideas

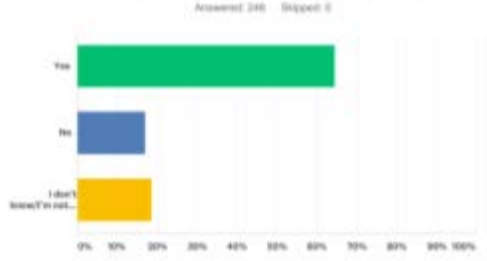
In total, 250 people completed the survey and provided us with a wealth of new insight into the wants and needs of our local population across each of our key work programmes.

Participants were provided with the information found earlier in this document and asked two questions per work programme:

- Are we focusing on the right things for this work programme and
- What are your ideas, feedback, thoughts and opinions about this work programme? Consider what else we need to focus on, as well as what you think works well and what you'd like to see improve

Some of the feedback we received is included in the main document, and below is a breakdown of the answers to whether or not we were focusing on the right things. Where people have answered “I don’t know/I’m not sure”, it is by and large due to them not having any experience or interaction with that aspect of the healthcare system.

Q1 Are we focusing on the right things to improve primary care?

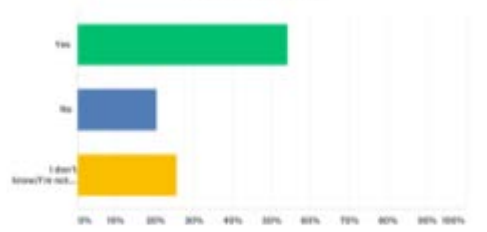


ANSWER CHOICES	RESPONSES	
Yes	64.52%	160
No	16.94%	42
I don't know/I'm not sure	18.55%	46
TOTAL		248

Q3 Are we focusing on the right things to improve maternal, child and young people health?

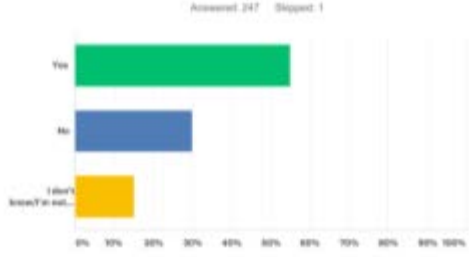
ANSWER CHOICES	RESPONSES	
Yes	49.39%	121
No	14.29%	35
I don't know/I'm not sure	36.33%	89
TOTAL		245

Q5 Are we focusing on the right things to improve out of hospital care?



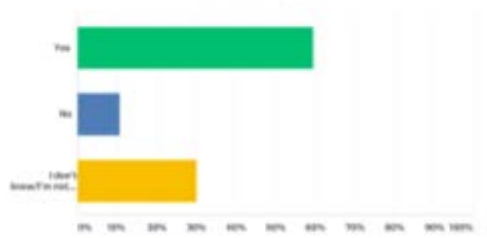
ANSWER CHOICES	RESPONSES	
Yes	54.25%	134
No	20.24%	50
I don't know/I'm not sure	25.51%	63
TOTAL		247

Q7 Are we focusing on the right things to improve urgent and emergency care?



ANSWER CHOICES	RESPONSES	
Yes	55.06%	136
No	29.96%	74
I don't know/I'm not sure	14.98%	37
TOTAL		247

Q9 Are we focusing on the right things to improve planned care?

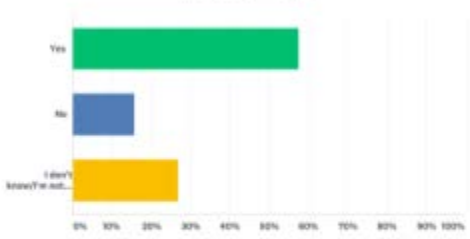


ANSWER CHOICES	RESPONSES	
Yes	59.35%	146
No	10.57%	26
I don't know/I'm not sure	30.08%	74
TOTAL		246

Q11 Are we focusing on the right things to improve out mental health and learning disability services?

ANSWER CHOICES	RESPONSES	
Yes	51.43%	126
No	24.90%	61
I don't know/I'm not sure	23.67%	58
TOTAL		245

Q13 Are we focusing on the right things to improve self-care?



ANSWER CHOICES	RESPONSES	
Yes	57.61%	140
No	15.64%	38
I don't know/I'm not sure	26.75%	65
TOTAL		243

A sample of what our public has told us

Primary Care	Out of Hospital	Maternity and paediatrics
• "Ensure that GP has appropriate information and links to refer people on to support. E.g. Mental Health support / weight management" • "Better access outside of the 9-5 hours Mon-Fri is definitely needed urgently" • "Better IT so that referrals to other services can be dealt with quickly instead of relying on the post" • "More communication to the public about when to seek which service (GP / Pharmacy / A&E)" • "Our GP offers telephone appointments. Excellent!" • "Better integrated working and communication with other health professionals and voluntary sector organisations" • "Need to improve self-help and self-management as a step before GP access. This would reduce pressure on surgeries" • Priorities should include addressing inequalities in access and inequalities in outcomes for patients in some communities in Coventry. Providing greater access of those who are able to navigate the system well will not address this inequality.	• "Having one notes system for health and social care would vastly improve efficiency and reduce duplication across both services" • "Out of Hospital care should become the main focus of all NHS partnerships. Partners working collectively to reduce hospital admissions as this is the best outcome for patients and will improve the long term prospects for older people in particular" • "More out of hospital "clinics" based in local hubs within the clusters to give better access for patients. E.g. memory assessment, minor surgery, audiology, micro suction, dermatology, mental health navigators" • "More patient experience stories will give a clearer picture on quality and delivery. improve system wide working" • "Improve communication between hospitals and GP surgeries" • Address linkages to other determinants of health such as housing, finances and person centred solutions for the multiple issue people experience.	• More needs to be done to support women who want to breast feed • More support throughout pregnancies - especially around the MH effects on parents. The difficulties of caring for a demanding baby and how to manage lack of sleep. This can be worked into the safer sleeping programme to expand the service to 'safer parenting' • Better education on healthy diet for families / young children • For NHS maternity staff to have a better understanding of safeguarding and what it means to work alongside Children's social care • More prevention advice would be good, how to stay healthy during pregnancy, how to cope during first few weeks etc • Ensure community and hospital antenatal services are joined up. Ensure patients are provided with explanations for decisions being made. Support people to remain physically and mentally healthy during pregnancy. • To keep continuity with the same Midwife for patients during their pregnancy

Urgent and emergency care	Planned care	Mental health
• "Transport to out of hours facilities difficult for many villagers if no access to a car. this penalises young families and the elderly population who live in rural areas where public transport has been reduced or removed" • "I think a lot more could be do educate people about the appropriate places to get help. A surprising number of people don't seem to know that a pharmacist can provide advice on minor ailments and discuss drugs and any issues with them. There needs to be a much more streamlined process when someone is admitted to hospital via the GP route". • "A triage service at A&E to redirect non-urgent cases to urgent care/GPs so that urgent cases are dealt with immediately". • There should be a focus on understanding why some patients have repeated re-admission to hospital and ow they could be supporting in other ways to avoid this.	• "More convenient options for out of working hour appointments. People of working age are a large proportion of the population and finding suitable appointment can be difficult. Some venues due to parking issues require and extra 30-45 mins out to enable time to park and walk to clinic. More flexible venues, more flexible hours. General increase promotion of benefits of screening". • "Planned care - great opportunities for prevention messages to be delivered - make every contact count" • "More prevention and self-care advice in one place which is easy to use" • "Improved communications once patients in system" • "Keep it as local as possible. Hard to travel when you have a chronic condition". • "Good idea to have virtual follow up appointments - saves time/parking at hospital. Like the idea of GPs being able to speak to consultants. Too many people are referred to consultants where there is no further action required".	• "The number of mental health beds across all areas are too few. They need to either be increased, or better bed management solutions put in place to prevent MH patients being inappropriately treat in acute medical beds". • "IAPT is a very good service, but appears under resourced. Increase overall in resource to work with dementia diagnosis at an earlier stage to maximise chance to use compensatory techniques for longer and look at assistive tech options" • "More knowledge and training on how these disabilities affect a patient and the impact of a hospital visit/stay can have on that patient. How to support those patients with identified difficulties. Sensitivity and understanding of diversity through training is needed for all staff" • "Increased awareness and training in Primary Care of signs and symptoms of early psychosis. Training and resource support for GP's to diagnosis dementia in uncomplicated dementia, AND support for ongoing aftercare, medication etc. Secondary care mental health workers working in cluster hubs, providing a faster and more pro-active support for patients with less severe illness, who may otherwise have to wait 6 months for an appointment through the SPE".

Appendix 3: Performance, key messages from the 2018 Annual Report

Full details of our performance, key messages and financial information can be found in both our full and summary annual reports here:

https://www.warwickshirenorthccg.nhs.uk/About-Us/Key-Documents/Annual-Report