

Health and Wellbeing Board

10th April 2018

Title: Walsall Plan “Our Health and Wellbeing Strategy 2017-2020”

Priority 7: Remove unwarranted variation in healthcare and ensure access to services with consistent quality

Priority 8: Enable those at risk of poor health to access appropriate health and care, with informed choice

Priority 12: Deliver prevention and intervention through health and care locality delivery models (link to STP)

1. Purpose

1.1 The purpose of this report is to provide an update on progress relating to priorities 7, 8 and 12 with updates on the following key priority areas:

- Stroke Services
- Access to Primary Care
- Cancer
- Diabetes
- Locality Delivery Model

2. Recommendations

2.1 That the HWBB notes the progress made towards these priorities and approves the programmes of work.

3. Stroke Services

3.1 During 2017 the CCG consulted on a proposal to change the stroke pathway for Walsall patients that would see all stroke patients across Walsall going to the Hyper-Acute and Acute Stroke Unit at New Cross Hospital. Stroke rehabilitation would continue to be provided in Walsall. Following the public consultation the proposals were also subject to review by the West Midlands Clinical Senate, which supported the proposed changes.

3.2 The proposal has now been approved by Walsall CCG and by both of the provider trusts involved and the new pathway will be implemented from 11 April.

3.3 This is an important change, implementing well establish clinical best practice, which will improve outcomes for people in Walsall.

4. Access to Primary Care

4.1 The GP Forward View provides a commitment to improve out of hour's access for patients by increasing capacity through a network of locality primary care access hubs.

4.2 Walsall CCG did not receive any National funding for Extended Access in 2017/18, however STP wide money for winter pressures was received and Walsall CCG worked with local GPs to set up a GP extended hours winter service. The scheme provides GP and HCP appointments that can be booked via telephone including NHS 111 from three hubs at:

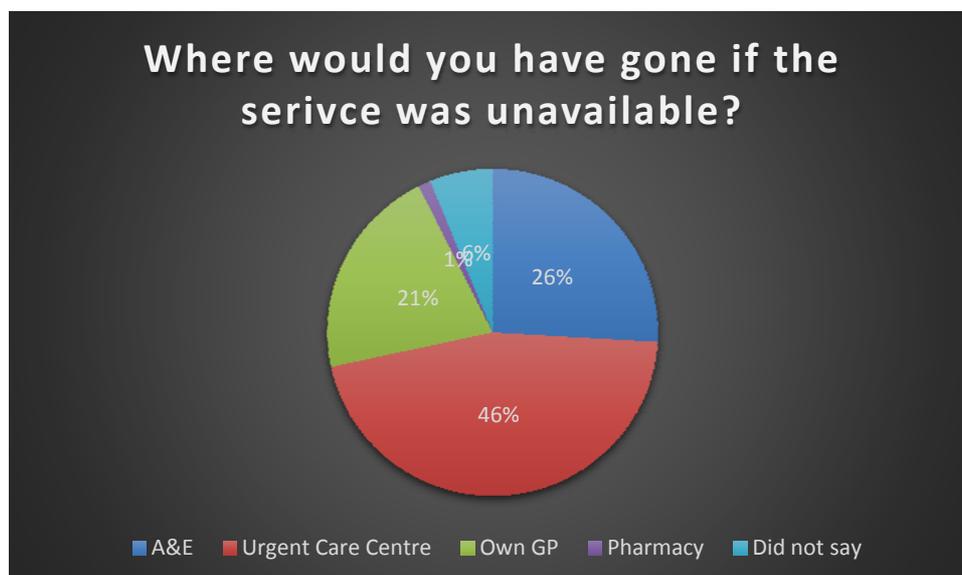
Hub 1 – Pinfold Health Centre, Bloxwich

Hub 2 – Broadway Medical Centre

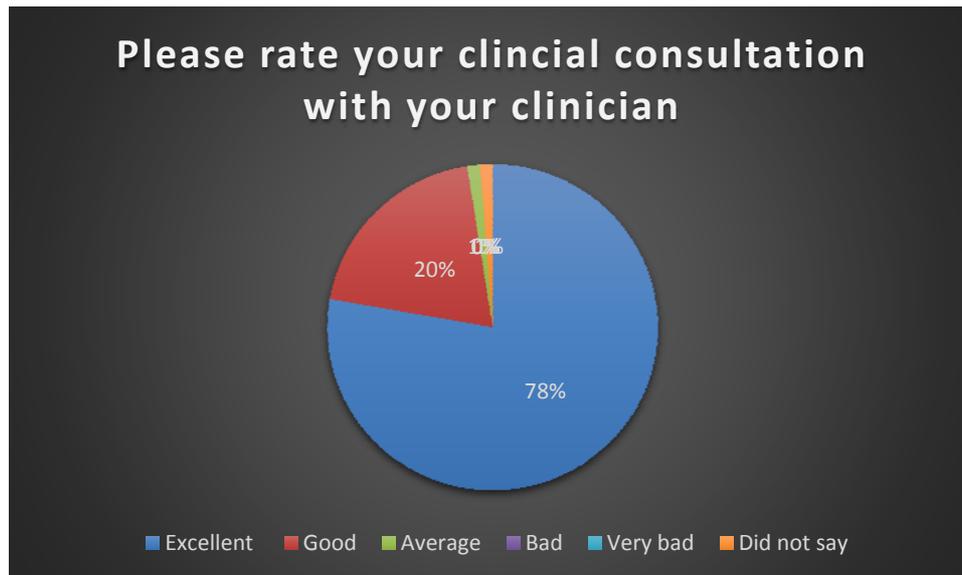
Hub 3 – Darlaston Health Centre, Darlaston

4.3 The service commenced on the 23 December 2017. Each hub has been providing evening and weekend appointments with a GP and HCA (ANP, nurse prescriber and/or nurse) other roles such as clinical pharmacist and physician associates can be utilised in the model. Patient have been able to make appointments direct with the service between 8am – 9am weekdays, 10am -3pm weekends and 11am – 1pm bank holidays. With appointments available Weekdays 2.5 hours every evening Monday to Friday (6.30pm - 9.00pm) weekends 5 hours on Saturday and Sunday (10am – 3pm) and bank holidays (11am – 1pm).

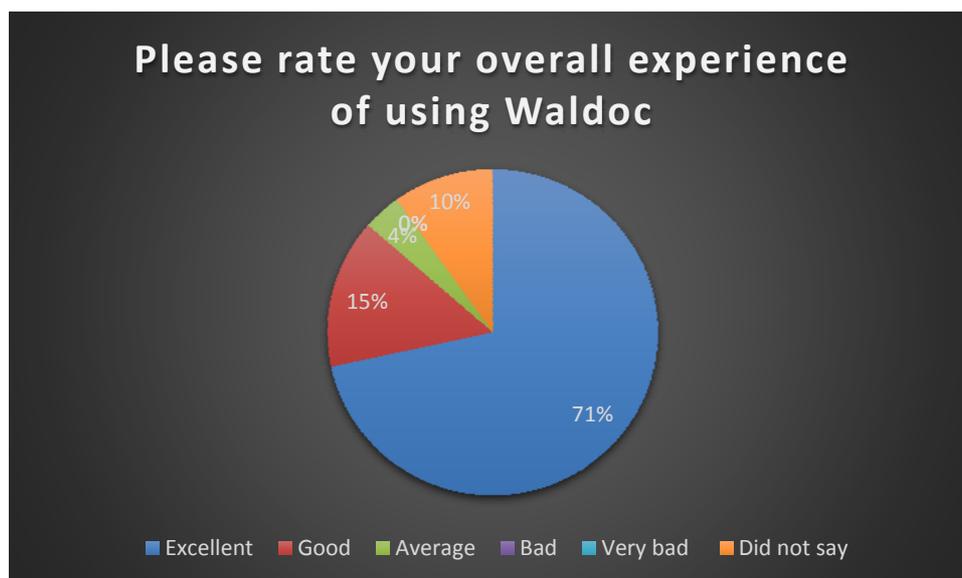
4.4 Patient feedback from the service has been very positive. The data below shows the result of a patient satisfaction survey undertaken for one week during February (responses received from 81 out of 439 patients seen in the three hubs during the survey period):



Majority of patients (46%) would have visited the Urgent Care Centre if the service was not available, followed by visiting A&E (26%) and own GP (21%)



The vast majority of patients rated their consultation with their clinician as excellent (78%) or good (20%), this was similar to last month (85% excellent and good 11%.)



The majority of patients rated their overall experience as either Excellent (71%) or Good (15%).

5. Cancer

5.1 Walsall Healthcare NHS Trust continues to achieve the 62 day national waiting time standard for cancer services. CCG performance to date this year, however, is a little below the national standard. To address this we have been working with Walsall Healthcare Trust improve compliance with the national 38 day standard for tertiary referrals. This work is being supported across the West Midlands by the Cancer Alliance.

6. Diabetes

6.1 In 2017/18 NHS Walsall was successful in securing national funding for four work streams:

- Increase attendance at structured education programmes
- Increase achievement of the 3 NICE recommended treatment targets
- Expand the diabetes inpatient specialist nursing service (DISN)
- Expand the multi-disciplinary foot care team (MDFT)

NHS England has now confirmed Year 2 funding for the programme.

6.2 Increase attendance at structured education programmes

6.2.1 Four workshops for general practice clinicians were delivered during September/October with very positive outcomes and increased referrals have been seen as a result. Work is underway to develop GP practice clinical system searches to provide data on prevalent diabetic patients who have not attended structured education since diagnosis and offer them the opportunity to attend as well as those who are newly diagnosed. We are expecting to see an increased number of referrals during 2018/19 as a result.

6.2.3 WHT are working with the University of Wolverhampton for formal accreditation of the locally developed Diabetes&Me programme.

6.2.4 A programme of visits to GP practices is in progress to ensure they have a supply of Diabetes&Me booklets for new diagnosed patients and to reinforce the referral process.

6.3 Increase achievement of the 3 NICE recommended treatment targets

6.3.1 GP practices are rolling out the Royal College of General Practitioners (RCGP) Quality Improvement workshops. Four workshops were delivered with practices receiving data packs for their achievement of the 3 NICE recommended treatment targets. A clinical lead and analyst have been working closely with GP practices to support them with improvement plans.

6.3.2 The latest analysis showed just over 500 more patients reaching 3 NICE treatment targets - an increase of about 1.6%. This in line with the CCG's projected increase of about 1.5% over 12 months and we are optimistic that we will continue to see improvement in this important measure of service effectiveness.

6.4 Expand the diabetes inpatient specialist nursing service (DISN)

6.4.1 All new posts have been recruited to and in place. The team now consists of 4 full time DISNs, 1 WTE admin and 0.6 WTE transition link nurse post (originally a dietetic post). New clinics commenced in December 2017 and a referral alert system is being established for patients attending A&E.

6.5 Expand the multi-disciplinary foot care team (MDFT)

6.5.1 The community diabetes team has been working with GP practices to advise and foot assess all over aged 40 diabetics. A root cause analysis of those patients who have had an amputation is being undertaken to identify themes and lessons learnt.

6.5.2 The number of peripheral arterial disease assessment clinics has increased from one per month to eight per month. All podiatrists have been trained in the complications of arterial disease and the need to refer for an assessment particularly those with diabetes.

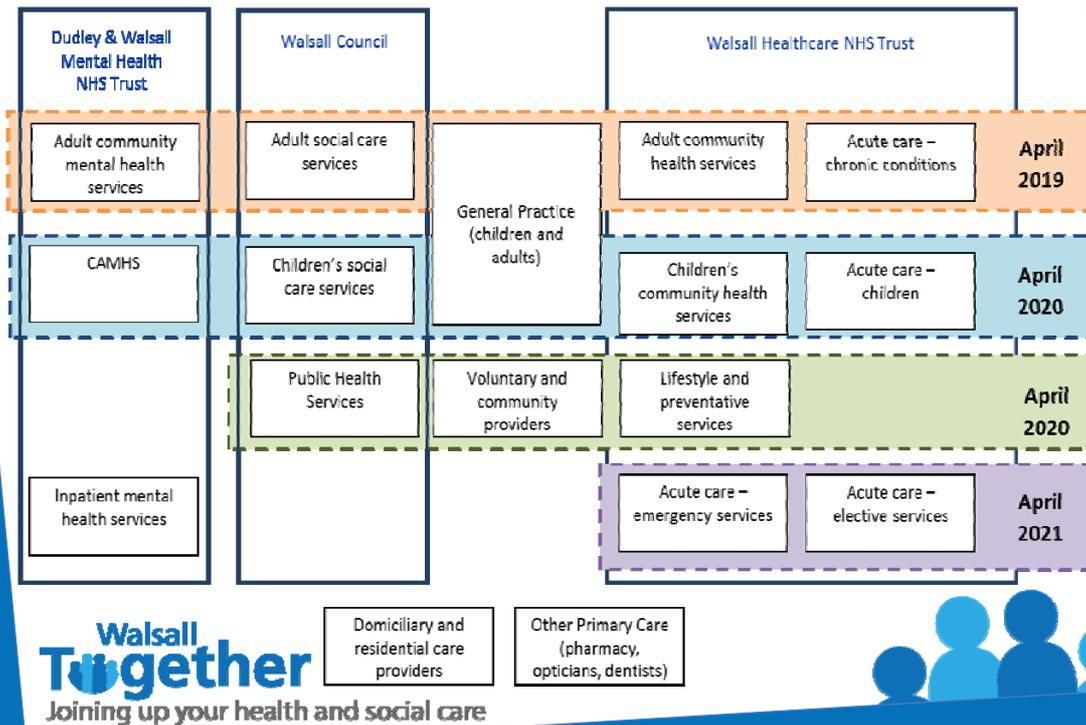
6.5.3 The podiatry team has also received additional training in how diabetes can affect kidneys and what to look for in terms of blood results, vascular complications.

7. Local Delivery Model

7.1 Good progress has been made in the development of our local delivery model for place-based care. Through the Walsall Together programme a proposal has been agreed to establish a provider alliance that will bring together the main health and care providers in Walsall to support the delivery of integrated services.

7.2 The schematic below provides a summary of the proposed development of the alliance model, which we are aiming to have in place from April 2019.

Systematic Approach



8. Implications for Joint Working arrangements:

- 8.1 Financial implications: risk from lack of sustainability funding
- 8.2 Legal implications: none at this time.
- 8.3 Other Resource implications: none at this time.
- 8.4 Safeguarding implications: none at this time

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