Agenda item

Health and Wellbeing Board

30th October 2017

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.

The report provides updates on:

- NHS RightCare Programme
  - Musculoskeletal (MSK)
  - Respiratory
  - Circulation – Cardiovascular disease (CVD)
- Cancer
- Diabetes
- Locality delivery model

2. Recommendations

2.1 That the HWBB notes the progress made towards these priorities.

3. NHS Right Care Programme

3.1 The NHS RightCare approach aims to maximise value by a three phased approach:

3.1.1 Highlighting the top priorities and best opportunities to increase value by comparing Walsall against comparable CCGs from across England.

3.1.2 Design optimal care pathways to improve patient experience and outcomes.

3.1.3 Deliver sustainable change by using systematic improvement processes.

3.2 **Musculoskeletal (MSK) -** Walsall has an established orthopaedic clinical assessment service (OCAS). However, it is not consistently used across the borough and OCAS and other physiotherapy services have presented a fragmented pathway for patients. The RightCare programme for MSK identified a need for an intermediate service that will provide a single point of access for all MSK conditions. This service is required to triage, assess, treat and provide onward referral for patients with MSK conditions.

3.3 The service started 2nd October 2017, and performs a referral management function that should ensure that patients are referred to the most appropriate service and managed according to agreed pathways.

3.4 **Respiratory** - the Pathway Review took place from January to April 2017, working with consultants, GPs, nurse leaders, providers of community care, public health, medicine management, NHS RightCare, Health Watch, patient representatives and commissioners. There are estimated to be 10,714 Walsall people with chronic obstructive pulmonary disease (COPD), however only 7,500 of these are on the COPD register.

3.5 Primary Care management of COPD is generally good with the exception of flu vaccination uptake for respiratory patients. There is a considerable opportunity for an increase in Care Plans for respiratory patients and an investigation into higher than average prescribing spends. Walsall's estimated COPD prevalence is 10% higher than our comparator CCGs, which equates to 986 more people.

3.6 To reduce emergency admissions for respiratory patients a redesign of community respiratory services is currently underway to help support complex respiratory patients in the community. The aim is to start a phased delivery of this service from January 2018. In conjunction with this new community model the delivery of a redesigned Pulmonary Rehabilitation Service is planned to

assist reducing emergency admissions by supporting patients in their self-care management.

3.7 **Circulation – Cardiovascular Disease (CVD)** - the Pathway Review started in May 2017 working with consultants, GPs, nurse leaders, providers of community care, public health, medicine management, NHS RightCare, Health Watch, patient representatives and commissioners. If Walsall were the same as the best 5 of our comparable CCGs 7,134 more people would be a healthy weight and 9,813 more people would eat '5 a day'. There is an identified opportunity within Heart Disease but further exploration will be carried out to understand the pathway and opportunities.

3.8 A public consultation has recently been undertaken regarding a proposal to convey all stroke patients across Walsall to the Hyper-Acute Stroke Unit at New Cross Hospital.

3.9 Primary Care management of Atrial Fibrillation (AF) is currently good compared to our peers but there is room for improvement both for patient outcomes and patient care. Consequences of Untreated AF:

- AF is a major cause of stroke, heart failure, sudden death, and hospitalisations
- Having AF increases a person's risk of stroke by five times
- 20-30% of all strokes are attributable to AF and 5% of strokes are a first presentation of untreated AF
- AF-related strokes are more severe and survivors face greater disability and less chance of returning to an independent existence
- 20-40% of AF patients are hospitalised every year placing a large burden on in-patient beds and hospital flow
- An irregular heartbeat can also increase the strain on the heart, and this in turn can lead to heart failure
- Half of patients who receive a diagnosis of heart failure will not survive for more than 5 years

3.10 In February 2017 new oral anticoagulants (NOAC) guidelines were implemented, supporting prescribers in primary care with the initiation and monitoring of NOACs. So far this has had a negative effect on prescribing spend but has importantly improved the management of stroke prevention in primary care.

3.11 Walsall Healthcare Trust is leading an Atrial Fibrillation (AF) project with partners across the STP area. The proposal is to develop an integrated pathway for referrals into secondary care.

4. Cancer

4.1 The CCG has been working with Walsall Health Care Trust to improve early diagnosis. Earlier this year we started to deliver:

- GP direct access to colonoscopy
- One stop jaundice clinic
- Iron deficiency anaemia clinic

4.2 As part of the approach to improve early diagnosis Walsall CCG was also successful in securing funding to deliver a pilot project targeting 20 practices with lowest bowel cancer screening uptake.

- 1 in 20 people will develop bowel cancer during their lifetime
- Regular bowel cancer screening reduces the risk of dying from bowel cancer by 16%
- Walsall is above national average for emergency presentations for colorectal cancer

4.3 The project was launched in March 2016 led by Dr Joo Ee Teoh and was collaboration between Walsall CCG, Macmillan, Cancer Research UK, Public Health Walsall Council, Bowel Cancer Screening Centre at New Cross Hospital and Walsall Healthcare Trust. This project went live on 1st March 2016 and to date; an extra 2527 patients have had interventions from their GP practices. Of the extra patients interventions nine abnormal tests have been identified with one of the patients' stories below:

4.4 **Patient story**;

Richard who is 61 years old and from the borough took the test last year - here is his story.

"I must admit when the original kit came in the post, I ignored it – but then a week or so later my GP rang to check if I'd received it and sent it back? She said it was very important and that she was encouraging every one of my age who belonged to her surgery to return the completed kit, so I did.

It wasn't difficult, so don't be put off – just get it done. It's a good job I completed mine because within a couple of weeks I got a letter to say that there were some 'anomalies' and I was advised to have them investigated. I was then invited to have a colonoscopy at New Cross Hospital which I'll be honest, was a bit uncomfortable, but it was very important procedure because it gave the medical staff an idea of what and where the problem was. The tiny

camera picked up a small tumour - a sample of which was send to a pathology lab and was later confirmed as an early stage cancer tumour.

"It's not great to hear you have cancer, but the nurses and surgeons were all so reassuring. They were fantastic. They explained that by doing the test I had probably given myself the best prognosis because my particular cancer had been detected early.

I had a straightforward operation to remove the tumour. It took me about a month to recover, but that's nothing when you think what could have happened if the disease had gone untreated. I have since been told by my surgeon that I am likely to make a good recovery. Now it's all over I'm so relieved that I took the test and so very thankful to my G.P for making sure that I did".

4.5 The success of the bowel screening pilot project has helped Walsall CCG to secure further funding from NHS England for phase 2 which will be implemented from November 2017 to all Walsall GP practices.

4.6 Walsall CCG is also working with Walsall Health Care Trust to develop plans for the implementation of stratified follow-up pathways for stable breast, prostate and colorectal cancers. This involves stratifying patients for follow up according to their risk can ensure that patient needs are better met and that resources are used more efficiently. At the end of treatment, patients no longer have routine follow up appointments. Instead they are educated to self-manage their condition, but if they do have any worrying symptoms, concerns or issues they are able to contact the Trust via a dedicated helpline.

5. Diabetes

5.1 **The national NHS Diabetes Prevention Programme (NDPP)** is a new initiative led by NHS England, Diabetes UK and Public Health England. The programme commenced with a phased national roll out in spring 2016 with the capacity for up to 20,000 people at risk of developing diabetes to access an evidence based behavioural intervention programme to reduce their diabetes risk. This will roll out to the whole country by 2020 with an expected 100,000 referrals available each year after. Walsall CCG has been successful in rolling out wave two of the NDPP, which started on 1 April 2017 and will run until March 2019.

5.2 As part of the programme NHS England fund a behavioural intervention for patients who are at high risk of developing diabetes and meet the criteria for referral. The referral pathway is through GP practice registers and opportunistic case finding and NHS Health Checks. The NDPP behavioural

intervention is underpinned by three core goals: weight loss; achievement of dietary recommendations; and achievement of physical activity recommendations.

5.3 The programme is in its early stages in Walsall and we are limited by the number of patients who can be referred into the programme: notwithstanding this early indications are positive and we are seeing referrals from GP practices to Living Well Taking Control, the provider of the behavioural intervention.

5.4 In December 2016 CCGs were invited to bid for national funding from the **Diabetes – National Treatment and Care Programme** and Walsall CCG was successful in receiving funding for the following four areas:

- Increasing achievement of the 3 NICE Treatment Targets
- Expand the Diabetes Inpatient Specialist Nursing Service (DISN)
- Expand the Multi-Disciplinary Foot Care Team (MDFT)
- Increase the number of Structured Education places for patients newly diagnosed or with prevalent diabetes.

5.5 NHS England has provided funding for 2017-18 with the potential for further funding in 2018-19 which should be confirmed shortly.

5.6 As a response to the investment in diabetes care in acute and primary care settings work started on 1 April 2017 towards achieving:

- Roll-out the Royal College of General Practitioners '*Quality Improvement in the care of people with diabetes'* programme to GP practices in Walsall to increase achievement of the 3 NICE Treatment Target and improve health and wellbeing as more people reach those targets.
- Expansion of the existing DISN service to enlarge the team's capability to cover all wards and areas within the Manor Hospital and potentially provide more seamless diabetic are across the Borough as part of a fully integrated pathway.
- Expansion of existing MDFT and Foot Protection Team (FPT) in Walsall will facilitate more effective monitoring of the 35% of moderate or high risk diabetes patients and the 5% with active ulcers and infection.
- Increasing the number of structured education places available for people with diabetes; increasing attendance through training for clinical staff, better communication and implementation of standardised recording of attendance.

6. Locality Delivery Model

6.1 As reported previously to the Board, a local delivery model for adult and older adult health and social care community services is being implemented as part of the Walsall Together programme.

6.2 The main focus of the project currently is the development of a consistent approach across the borough to multi-disciplinary team working at team/locality and at GP-practice level to co-ordinate care for people with more complex needs and with multi-professional input to their treatment and care.

7. Implications for Joint Working arrangements:

7.1 Financial implications: risk from lack of sustainability funding

7.2 Legal implications: none at this time.

7.3 Other Resource implications: none at this time.

7.4 Safeguarding implications: none at this time

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