Agenda item 8(a), (b) and (c)

Health and Wellbeing Board

3 December 2018

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)
    - Neurology
    - Genito-Urinary
    - Trauma and Injury
- 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.

In 2017/18 we focussed on:

- Musculoskeletal
- Respiratory
- Cardiovascular/Circulation.

During 2018/19 we have continued to implement the plans for the first three areas and have also started work on a further three areas:

- Neurology
- Genito-Urinary
- Trauma and Injuries

3.2 Musculoskeletal (MSK)

This took the form of implementation of a physiotherapist led triage process for acute referral pathways for orthopaedics, pain management, spinal/back, and rheumatology. This was a discrete implementation of a service change that took effect from October 2017 and has led to a more streamlined process and consistent community service pathways.

Other elements of this programme include implementation of a national pain management pathway by April 2019, information and advice for self-management and shared decision making, and GP education to support use of the referral management service and raise awareness of referral criteria and new pathways.

3.3 **Respiratory**

A review of respiratory services identified an opportunity to improve patient outcomes/ experience by more effective integration of the elements of the pathway. This can be achieved by:

1. Preventing people getting respiratory episodes by improving flu uptake of respiratory patients, supporting smoking cessation and referring to Pulmonary Rehabilitation Service.

2. Placed Based Team providing ongoing appropriate support for patients with respiratory conditions; to include education, condition specific care plans in order to support and encourage patient self-care.

3. Joint working between Rapid Response, Specialist Respiratory Team and Placed Based Team. To agree and implement clear pathway protocols to ensure appropriate case management for referrals; to include shared key worker processes for shared case management, home visiting and attendance at MDT as appropriate.

4. Establishing protocols for referral/discharge to Primary Care including provision of specialist advice and guidance when required/requested.

5. The Acute Respiratory Team providing support for patients with respiratory conditions attending the emergency department to prevent admission to an in-patient bed.

6. Respiratory Consultants working closely with Specialist Nurse Teams to provide advice and support, and ensure identification of patients for consultant support

This scheme is currently being implemented with planned benefits in terms of better co-ordinated community care and reduced hospital activity from the start of the coming financial year.

3.4 **Circulation – Cardiovascular Disease (CVD)**

NHS RightCare analysis identified that if Walsall were the same as the best 5 of our similar CCGs 7,134 more people would be a healthy weight and 9,813 more people would eat ‘5 a day’. There is an opportunity to save within the elective spend, however the non-elective and prescribing spend is considerably better than our peers which could explain the higher elective

spend. The main area of focus is the development of a community cardiology pathway to support arrhythmia and heart failure patients in the community to reduce ED attendance and hospital admissions.

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.

The review identified an opportunity to improve patient outcomes/experience by a more effective integration of the elements of the cardiology service, to improve patient flow across the whole system. The development of a 'single channel of access' to triage cardiology referrals is currently underway (iCardio). The phased implementation will provide connected support for cardiology patients across secondary, community and primary care; through the locality placed based community teams, MDTs and establishing a Dyspnea service to support diagnosing and managing care for patients with unexplained shortness of breath.

This model will also link with rehabilitation and lifestyle services.

3.5 Neurology

A workshop was held with Locum Neurologist, Care Group Manager, CCG Clinical Lead and Lead Commissioner to discuss the opportunities identified in the Rightcare Pack and explore options for pathway changes and implementation. Possible options include a headache pathway, community provision for patients with medically unexplained conditions, and functional neurological disorder. There was also discussion of improving access to psychological services to support patients with this diagnosis.

3.6 Genito-Urinary

Work has been undertaken with the Lead Consultant for Urology to discuss opportunity identified in the Rightcare Pack and explore options for pathway changes and implementation. Possible options include changes to community pathway and role of Community Continence Team, 'option grids' for enhanced shared decision making, links to frailty for UTIs and closer working with the gynaecology team.

3.7 Trauma and Injuries

Osteoporosis has been identified as the main area for further work, with a particular focus on earlier detection and treatment of the disease.

Walsall has an established Osteoporosis Nurse Service (ONS) which covers a number, but not all, of the elements that would be provided by a full Fracture Liaison Service. The CCG and Trust are looking at options to expand the current ONS into a full Fracture Liaison Service.

Around 3,000 people are currently receiving bone strengthening medication as a result of osteoporosis, but very few have been entered on to the Osteoporosis Register. The CCG will work with primary care to ensure that all patients with Osteoporosis are entered on the register, and to increase the number of patients identified and entered on to the register. This will mean a higher number of people receive bone strengthening medication and DEXA scans, thus reducing the incidence of falls and fractures.

3.8 **Cross Cutting Work**

There are other areas of work (i.e. Frailty, and End of Life) that will contribute to the implementation of these Delivery Plans. Equally, the pre-existing work on the previous Rightcare Delivery Plans (MSK, Respiratory, and Problems of Circulation) will also contribute, and so it will be important to ensure that there is co-ordination across the work-streams to prevent duplication of effort.

4. Tuberculosis

4.1 The CCG has secured national funding to deliver a testing and treatment programme to support the testing of people for latent TB. Since April 2018, 9 GP practices have undertaken latent TB screening. The project manager has providing on-going TB awareness raising to primary care and local community groups to encourage take up of the programme.

5. Diabetes

5.1 **The national NHS Diabetes Prevention Programme (NDPP)** is an 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 NDPP site level reporting has confirmed the following data:

No. patients referred	941
No. patients dropped out pre-IA	374
No. patients dropped out at IA	55
No patients dropped out post IA	4
Active referrals (inc. completers)	508

5.4 The NHS England contract with the current provider will end in July 2019. Procurement is taking place for a new provider. The Black Country STP has submitted a proposal to NHS England with information that will help providers to consider how best to structure their bid to meet local requirements.

5.5 **Diabetes – National Treatment and Care Programme:** as previously reported 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.

5.6 NHS England has provided two-years funding: 2017/18 and 2018/19 with the potential for reduced funding in 2019/20 for MDFT and DISN; which has yet to be confirmed.

5.7 Reported achievements to date are as follows:

Three NICE Treatment Targets

- improvement of 1019 patients meeting all three treatment targets (3% improvement)
- improvement of 1149 patients with cholesterol ≤ 5
- improvement of 1532 patients with blood pressure ≤ 140/80 mmHg
- improvement of 421 patients with HbA1c ≤ 58 mmol/mol
- implementation of the RCGP quality improvement tool in the care of diabetes and familiarization with using those quality improvement tools

Structured Education

- an increase in the number of patients being referred to structured education from 802 to 1070
- a rise in the number of patients attending structured education from 331 to 543
- an improvement in the standardized recording/EMIS coding of attendance at structured education from 1.06% to 31.05%
- improved communication between GPs and the Manor hospital
- training for a GP and practice nurse diabetes lead for each GP practice

DISN

- 6-day service introduced
- Increased clinics on Thursdays and Fridays
- Daily contact with the admissions ward, AMU, T&O and surgical assessment
- Introduction of 'Bio-Connect' which provides access to the blood sugars of all patients; identified patients are visited the same day
- Continuous training for different cohorts of staff ie ward staff, junior doctors, FY1

MDFT

- Establishment of new foot protection team with new clinics starting in December
- Orthotist in post with foot ware fitting within 14 weeks of referral
- Working with fracture clinic to introduce total contact casts for patients
- Working with tissue viability to advise on heel protection
- Continuous foot assessment training available for GP practice, Manor hospital, pharmacy, nursing and care home staff.

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 Place based teams are established in each of the four Walsall localities and there is an on-going programme to realise the benefits of more integrated working; as an example of this, a trial is currently being run in the West Locality of a single referral and outcome form. Community respiratory nurses are also now being incorporated into the teams.

6.3 At the end of October there were 12 practices running GP led multi-disciplinary team meetings, giving coverage of 23% of practices and 25% of the Walsall population. A further four practices were planned to start in November and one in December.

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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