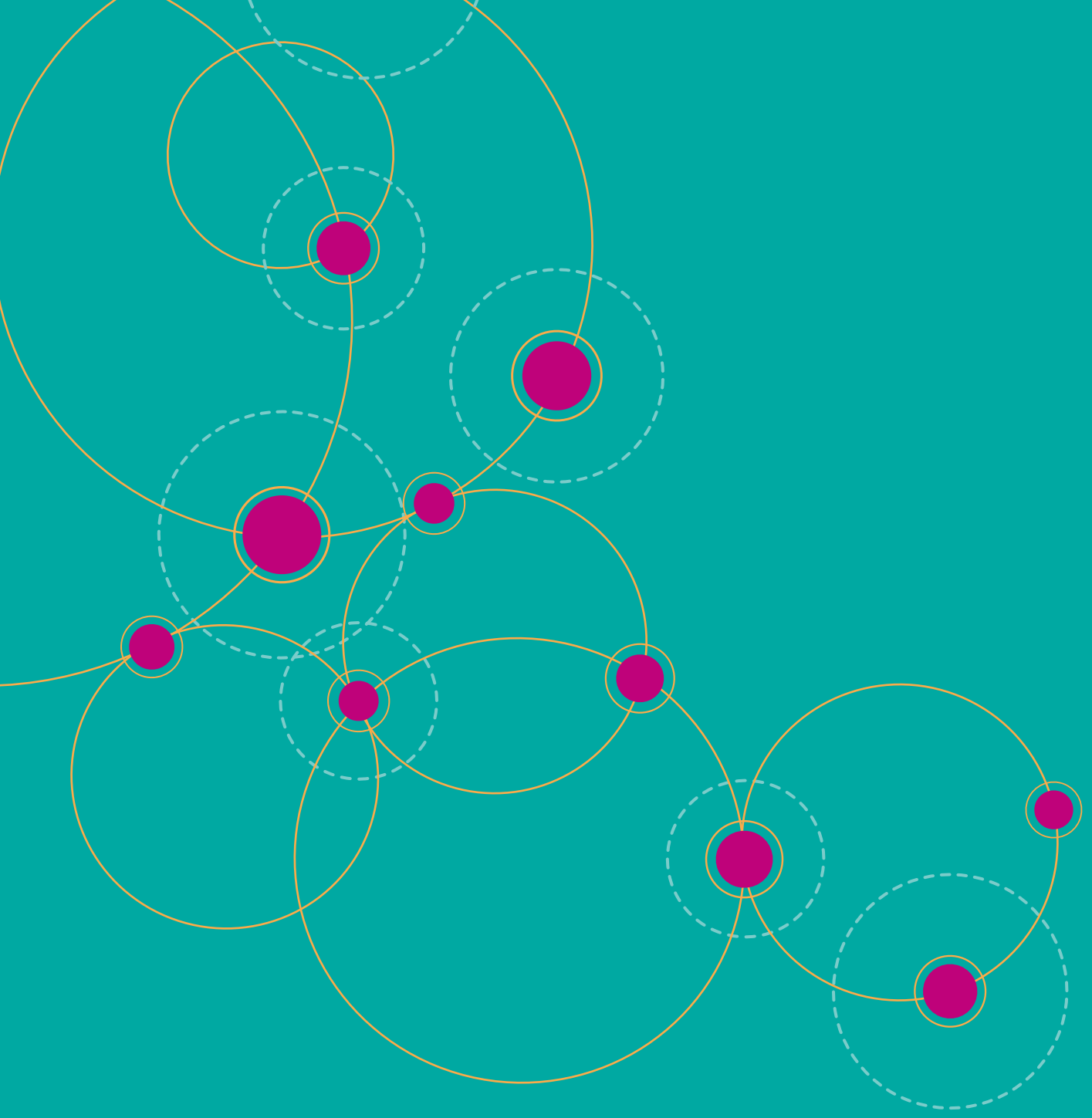
NHS

Thames Valley
Strategic Clinical Network
and Clinical Senate

# Road to 2020:
# The journey so far



# Contents

# Working with STPs and ICSs: **Highlights**

## Stroke

Hosting a stakeholder forum to make the case for a thrombectomy service in Oxfordshire to benefit stroke patients across the patch

## Maternity

Local Maternity Systems created for the BOB and Frimley STP footprints to improve maternity care for all women and their families

## Diabetes

Oxfordshire CCG Diabetes Case for Change has influenced the development of cases for BOB and Frimley STPs

## Cancer Alliance

Cancer Alliance will develop optimum pathways across the BOB and Frimley STP patches

## Clinical Senate

Smoking prevention recommendations that will benefit the whole population

## End of Life

ReSPECT workshops held to promote adoption of this new tool to improve end of life care for patients

## Prevention

Large scale training programmes for all staff in BOB and Frimley STPs to benefit from Making Every Contact Count (MECC)

## Mental health, dementia, neurology

Headache pathway developed and used to manage neurology referrals across BOB. This is now being used nationally

## Musculoskeletal

Organising and hosting a best practice event to establish what could be done at an STP level. Data packs shared, including benchmarking by STP, catalogue of best practice example, and RightCare and Public Health England information

## Long term conditions

Successful care and support planning training to upskill staff across both patches and enabling people to manage their conditions

# **Introduction:** What is the Thames Valley Strategic Clinical Network and Clinical Senate?


Acute Trusts: **4**

GP Practices: **274**

Thames Valley Population: **2.4 million**

Mental Health Trusts: **2**

Community Hospitals: **18**

# The Road to 2020

## Cancer

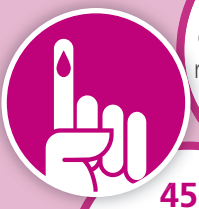
Reduce smoking prevalence to **10.8%** (a **30%** reduction)

**80%** of cancers staged

Additional **1,400** people surviving cancer for 10 years or more

## Diabetes

**4,400** more newly diagnosed patients receiving structured patient education



**450** fewer lower limb amputations across Thames Valley

Every GP practice in Thames Valley meeting **40%** achieving the three treatment targets

## Mental Health, Dementia & Neurology

**5,000** more people with Serious Mental Illness (SMI) receiving physical health checks

**90%** of individuals with dementia to have patient-centred care & support plans

**100%** of all acute hospitals in Thames Valley have all-age Mental Health Liaison services in A&E and inpatient wards

## Long Term Conditions and End of Life

(LTC) - **80%** of patients having care & support planning consultations

(EoLC) - **10%** increase across Thames Valley of death in place of usual residence

## Stroke

**200** fewer strokes in TV

**850** additional patients in TV experiencing stroke symptoms will be taken to a HASU for the first 72 hours of their stay in hospital

## Maternity

**1,300** more women to be seen by Perinatal Mental Health services in TV

Reduce stillbirths by **20%** (4.1 per 1000 in TV)

## Children

**3,000** more children seen in MH services in Thames Valley

Children with Eating Disorders **seen within 4 weeks/ 1 week for urgent cases**

# Cancer Alliance

In 2016, the SCN established the Thames Valley Cancer Alliance and published its ambitious five year cancer delivery plan, which is the Alliance's blueprint for locally delivering the national strategy Achieving World-Class Cancer Outcomes.[1]

**Established Thames Valley Cancer Alliance and dashboard**

**£9.07m** of cancer transformation funding secured

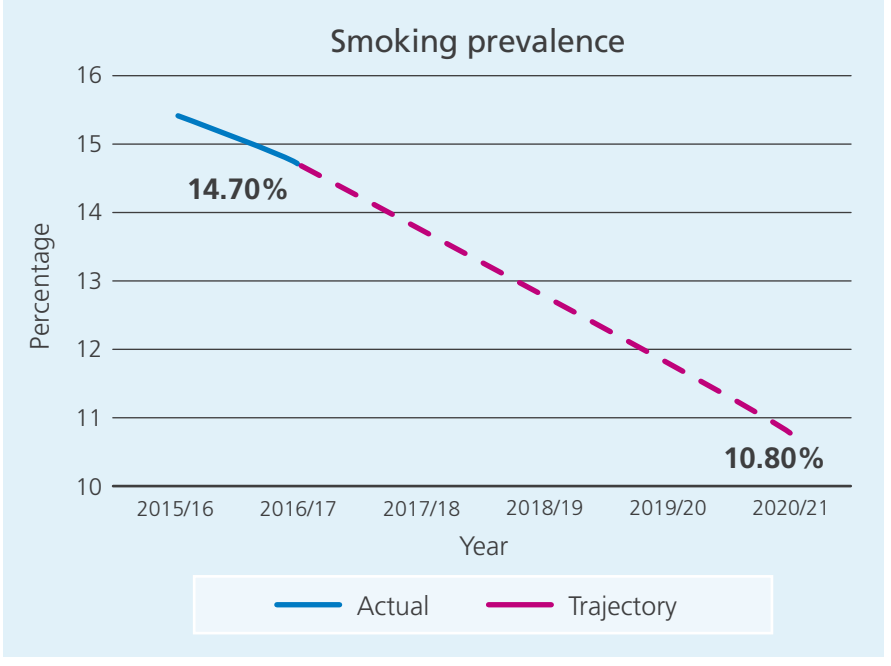
Significant increase in patients with a recorded cancer stage, now over **78%**

**3%** increase in numbers of cancer diagnosed at stage 1 & 2

## Thames Valley Cancer Alliance vision

To create a region that secures and delivers the best possible outcomes for every patient affected by cancer by working together to maximise resources, to deliver the best possible, clinically-led and patient driven health and social care so that every person affected by cancer in Thames Valley receives the best possible outcomes.

## Our journey so far




### Reducing smoking prevalence

Reduce smoking prevalence to **10.8%** (a **30%** reduction)

- Completed the review of community smoking cessation services across Thames Valley
- Developed and circulated annual calendar of prevention and awareness events to support systems with prevention initiatives
- Supported systems with collation of toolkits and supporting resources for national, regional and local campaigns.

## The journey ahead

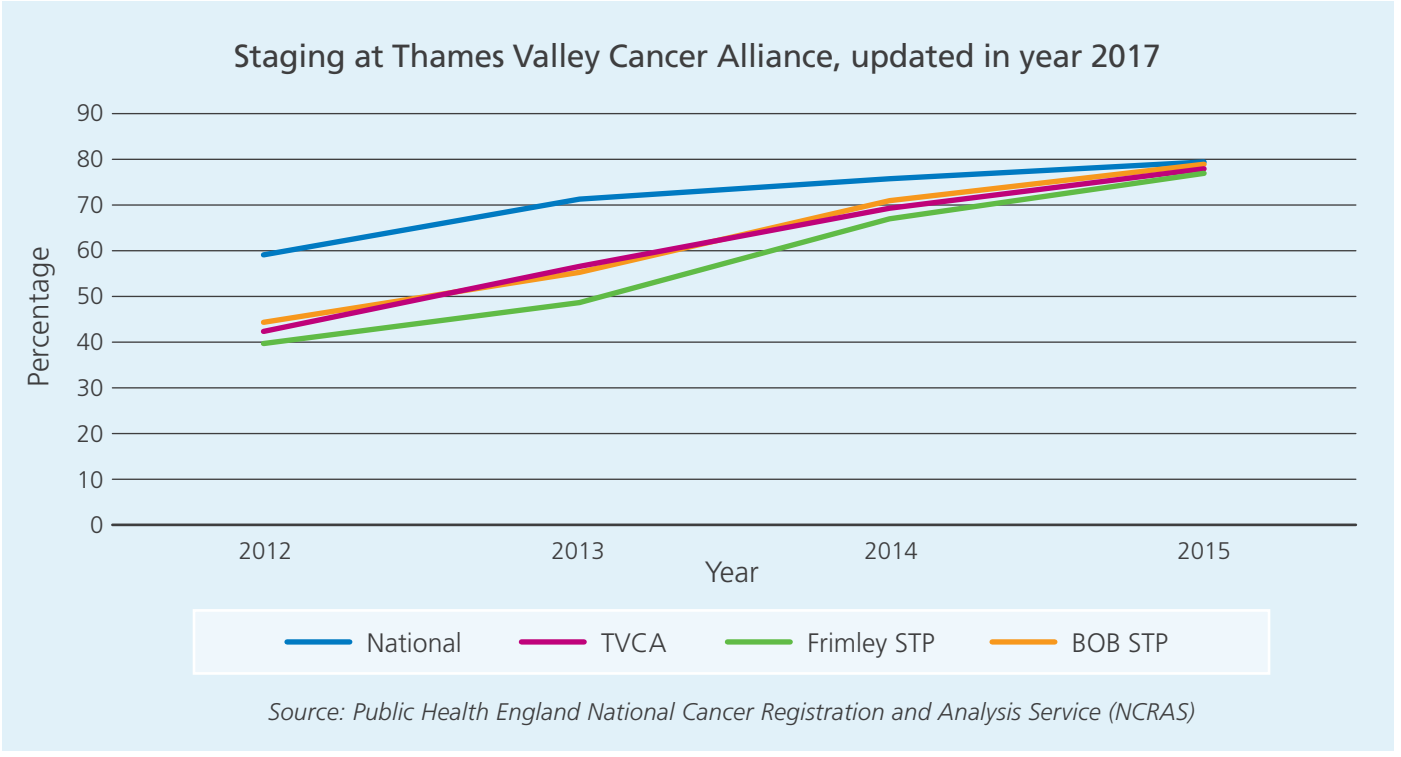
Planned activities include:

- Developing an Alliance-wide education strategy to support front-end staff (Making Every Contact Count - see page 43)
- Development of resource pack around lifestyle services to support secondary care to signpost benign two week wait patients accordingly.

# Accurate staging/ increasing cancer staging

Our focus continues to be on the benefits of diagnosing cancer at an early stage. Early diagnosis can increase chances of survival. Over the last three years, we strongly recommended within the SCN commissioning guidance that all CCGs include in their contracts with providers a local ambition to stage 80% of cancer diagnoses. The latest available data shows that following this effort, the Thames Valley Cancer Alliance has rapidly caught up with England, as charted below.

**80%**
of cancers staged



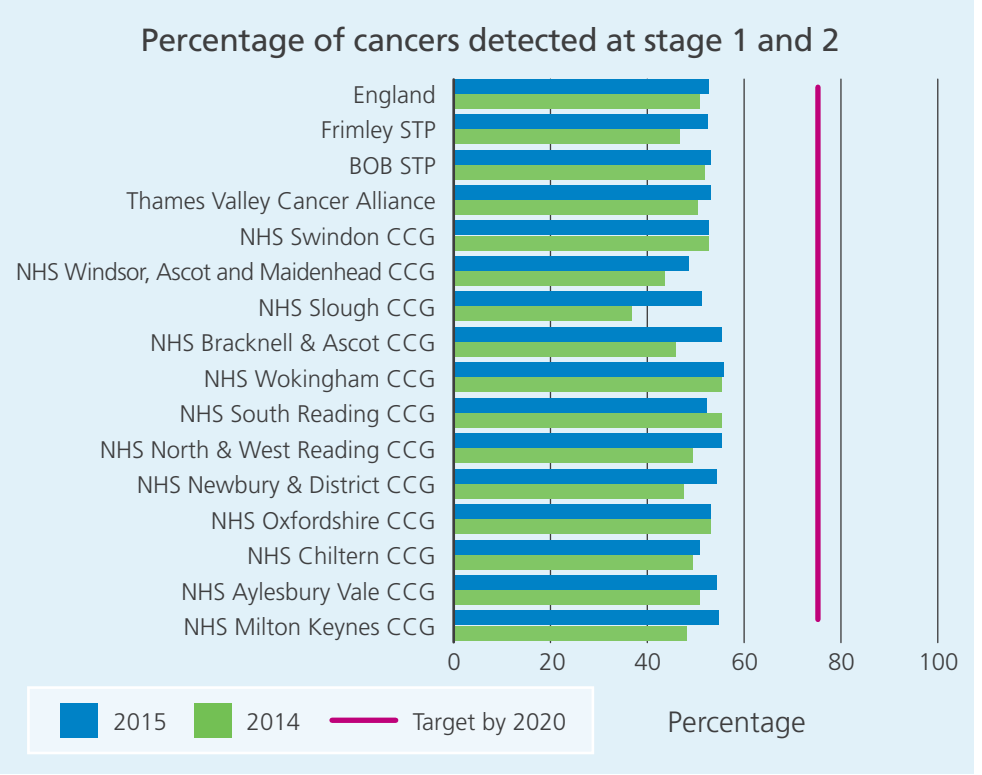

*Source: Public Health England National Cancer Registration and Analysis Service (NCRAS)*

## To achieve 80% patients with recorded stage

*Additional patients required per CCG

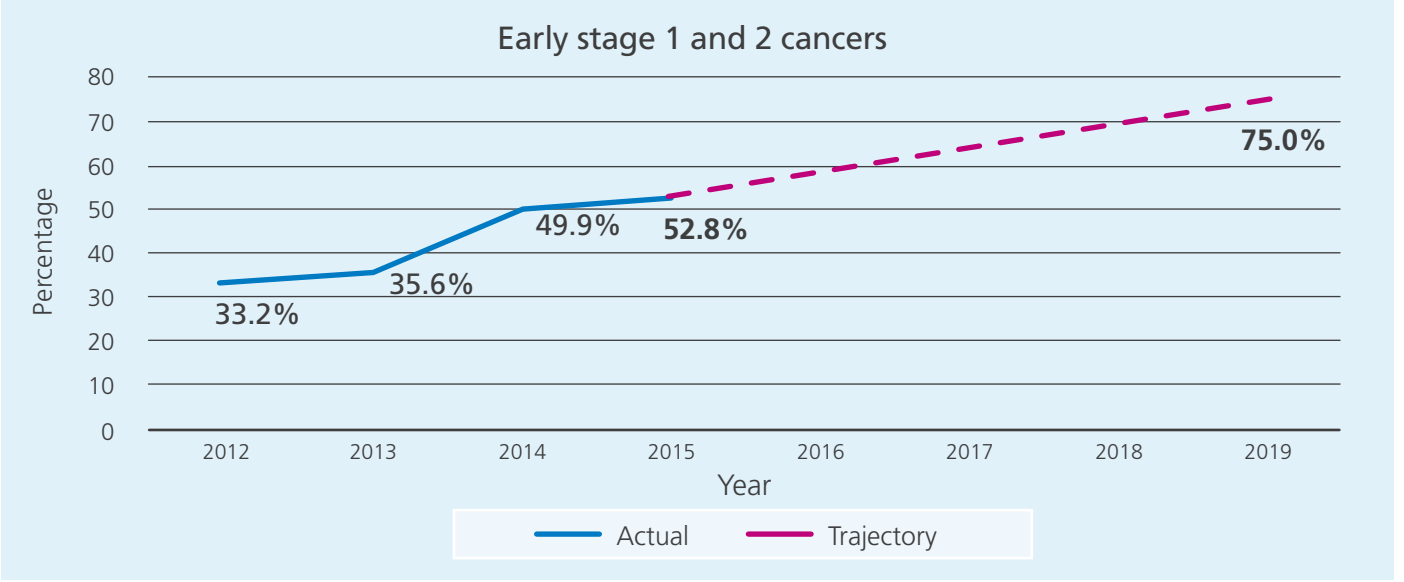
| | Previous | Now |
|---|---|---|
| Bucks CCGs | 380 | 51 |
| Oxfordshire CCGs | 95 | 0 |
| West Berks CCGs | 289 | 56 |
| East Berks CCGs | 311 | 86 |
| MK CCGs | 167 | 13 |
| Swindon CCGs | 44 | 0 |

The proportion of patients with cancer diagnosed at stage 1 or 2 disease can vary because of a number of factors, including the presence and uptake of national screening programmes. There are two major components of early detection of cancer: education to promote early diagnosis, and screening. The proportion of patients being diagnosed at stage 1 and 2 has also increased in Thames Valley and at a rate faster than the rest of the country. This is good evidence of system-wide working having a positive impact on patients, their families and the sustainability of the system.




Percentage of cancers diagnosed at stage 1 and 2

| | 2014 | 2015 | Increase |
|---|---|---|---|
| Thames Valley Cancer Alliance | 49.9 | 52.8 | 2.90% |
| England | 50.7 | 52.4 | 1.70% |
| BOB STP | 51.6 | 53.0 | 1.30% |
| Frimley STP | 46.4 | 52.3 | 6.00% |




# The journey ahead

Planned activities include:

- Continued collaboration with partners to improve public awareness of different cancer symptoms and encouraging people to seek care when these arise
- Providing training and education to primary care health workers so they can undertake accurate and timely referrals
- Ensuring people living with cancer can access rapid, safe and the most appropriate and effective treatment.

# Improving patient experience

## Enabling Swindon and Wiltshire head & neck cancer patients to receive care closer to home

**Current head and neck cancer (HNC) patient experience for those in Swindon and Wiltshire**


**New pathway of care for those with head and neck cancers due to commence in September 2018 ensuring that 65-70 patients a year will receive:**

- Care closer to home
- The benefit of co-located specialist staff at hospital site closer to home

**Proposed pathway diagram:**

| Group 1: Stages 1-2 | Group 2: Stages 2-3 | Group 3: Stages 3-4 |
|---|---|---|
| Minimal input needed, single type of treatment, good support | Limited surgery/unilateral radiotherapy, moderate needs, higher risk of recurrence | High complexity case and treatment. May have tracheostomy or treated with curative intent or other complications |
| Discharged to Great Western Hospital 4-6 months post treatment | Shared care for 6-12 months, and then discharged to Great Western Hospital | May be shared care months 6-12, or may keep at Oxford University Hospitals for 12 months before discharge to Great Western Hospital |

| Acting on the recommendations | The benefits to patients |
|---|---|
| Offering patients stratified follow up pathways | Sustainable, resilient pathway |
| Developing local specialist HNC teams | Reduction in long journeys to OUH |
| Increasing rehab staff and restorative dentistry services | Development of local specialised team which can be built on in future |
| Introducing a programme of learning opportunities | Increased patient education and focus on prevention of recurrence |

# Delivering the cancer strategy

The Alliance successfully secured £9.07m cancer transformation funding across three priority areas over two years:

| Area | Revenue | | Capital investment |
|---|---|---|---|
| | 2017/18 | 2018/19 | 2017/18 |
| Early diagnosis | £1,630,308 | £2,855,408 | |
| Recovery package | £1,044,626 | £968,201 | £55,000 |
| Risk stratified pathway | £173,850 | £300,355 | |
| Health Information Exchange (HIE) | £740,000 | £740,000 | £570,000 |
| Subtotal | £3,588,784 | £4,863,964 | £625,000 |
| Total per annum inc capital | £4,213,784 | £4,863,964 | |
| Total funding awards | £9,077,749 | | |

## Early diagnosis workstream incorporates three projects focused on:

- Diagnosing a high proportion of patients whilst their cancer is in the early stages
- Supporting achievement of cancer waiting time standards and improving patient experience by streamlining cancer patient pathways and by increasing diagnostic capacity.

## Recovery package workstream (includes risk stratified pathways) focused on:

- Consistent Alliance-wide delivery of the four elements
- Reduction in cancer recurrence amongst cancer survivors
- Providing a unique multifactorial package of care, integrating existing elements
- Identification of clear steps and support to help patients to 'truly' self-manage where able to.

## Health information exchange workstream focused on:

- Developing a single cancer database across the Alliance (integrating cancer systems, eg Infoflex and Somerset across the Alliance and with local trust-based electronic patient records to stop duplicate data entry and improve clinical safety)
- Developing tools to support self-care and improve patient experience
- Risk stratification and population health analysis
- Improving data capture and quality in trust-based systems.

## Our journey ahead

- Provision of additional triage, outpatient and diagnostic capacity to support the estimated additional patients across the Alliance area 2018/19
- Developing robust benefits tracking to ensure that expected vision is achieved from the funding provided, encompassing best practice and value for money to achieve a sustainable health system
- Provision of significant additional CT and MRI capacity and implementation of straight to test pathways
- Implementing recovery package across Thames Valley
- Implementation of Vague Symptoms Multidisciplinary Clinics across the Alliance in 2018/19.

[1] Achieving World-Class Cancer Outcomes: A Strategy for England 2015-2020 https://www.cancerresearchuk.org/sites/default/files/achieving_world-class_cancer_outcomes_-_a_strategy_for_england_2015-2020.pdf (last accessed 2nd February 2018)

# Clinical Senate

## Smoking: Stop before the Op


The cost burden of smoking attributable deaths and chronic illness is increasing to **£320m**

**8,000** smoking attributable admissions

Three to six-fold risk of pulmonary complications

Complications during and after surgery

With both the BOB and Frimley STP plans looking at the potential to 'stop before the op', the Thames Valley Clinical Senate undertook a review of the work carried out by the London Clinical Senate in 2014, Helping Smokers Quit, to identify learning and best practice. It also carried out a review of the local results of the British Thoracic Society (BTS) national audit (2016) into smoking cessation services in secondary care.

The Senate has identified opportunities to increase the smoking cessation interventions prior to a surgical procedure and has produced a set of recommendations.

They include:

- Ensuring that a consistent message is delivered across health and social care in the key time leading up to surgery when patients will be reflecting on their health
- Ensuring that all opportunities to discuss smoking with the patient are maximised including appointment correspondence
- Improving the recording of smoking status in patient notes
- Increasing the delivery of Very Brief Advice training to frontline staff
- Making pharmacotherapy available in the formulary.

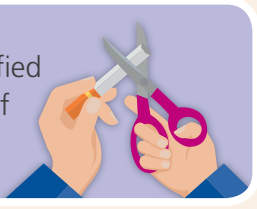
Conversations with Trusts to take this forward will commence in May.

British Thoracic Society

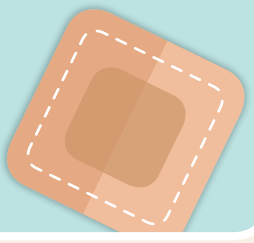
Thames Valley Clinical Senate undertook a review of BTS Clinical Audits in acute Trusts and found:

**33%** of inpatients were not asked their smoking status

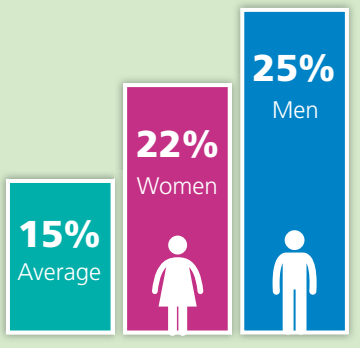
Only **25%** of identified smokers were asked if they wanted to quit



Only **2%** of current smokers were offered nicotine replacement



And... smoking prevalence in acute Trusts is **higher** than general prevalence



# NHS Bed Test

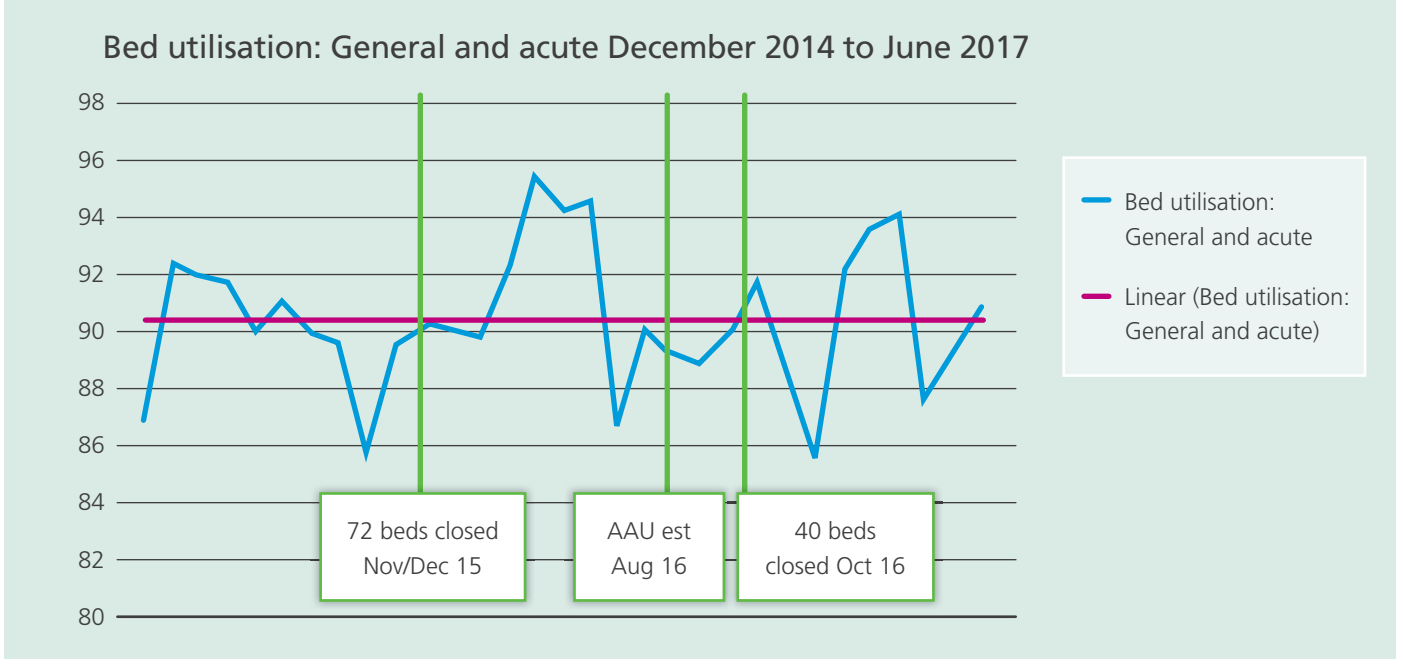
In 2017, the Senate was asked to apply the NHS bed test to the 110 beds that had been temporarily closed at the Oxford University Hospitals Foundation Trust (OUH FT) during the Phase 1 Oxfordshire Transformation. The NHS bed test came into force in 2017 and is an addition to the Government's four tests for reconfiguration proposals. It states that bed closures will only be supported if the organisation can demonstrate that it can meet one of the three new conditions as below:

1. Show that enough alternative provision is being put in place alongside or ahead of bed closures, and that a workforce would be there to deliver it and/or
2. Show that specific new treatments or therapies would reduce specific categories of admissions or
3. Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance with affecting patient care.

The Senate review focused on condition one as the applicable test in this case. The alternative services which were put in place included an ambulatory unit (AAU) which increased the number of patients that could be treated in hospital on a day basis, returning home overnight; and a new approach clinically led by a Liaison Hub which focused on transferring patients who no longer needed acute medical care from the hospital setting to into a nursing home bed while they awaited the next stage of their care.

To consider the case, the Senate undertook a review of literature, data and serious incidents and conducted a number of interviews and Q&A sessions with clinicians working within the new services. There was ample national and international evidence to support the provision and effectiveness of both the AAU and the Liaison Hub and the move towards the ambulatory care model was both clinically supported and well received by patients and GPs. A review of activity data showed that the Trust, despite continued growth in emergency activity, had been able to reduce the amount of time patients needed to spend in hospital and length of stay has been reduced for the over 65s.

The trend of bed use at the Trust, measured from December 2014 to June 2017, remained stable despite the growth in activity and whilst beds in the Trust were reduced by 110, this was matched by the purchase of a similar number of beds in the nursing homes.




There were concerns about the delays in the system around domiciliary care and the impact these delays were having on the Trust bed capacity, but the Senate found that a significant amount of work was being undertaken in the system to understand the reasons for the delays and to put solutions in place.

The Senate agreed that the principle of what the Trust was aiming to achieve with the new services should be supported and there was evidence that they were delivering benefits to patients in reducing admissions and length of stay.

# Vascular

In 2015-16, the vascular network underwent a reconfiguration to provide compliant Specialised Vascular Services across the Thames Valley. This work was led by the Thames Valley vascular network and its proposals were considered by the Clinical Senate to ensure that wider implications and co-dependencies were fully considered. The Senate supported the option for Buckinghamshire Healthcare NHS Trust to become a non-arterial vascular centre, as with the Royal Berkshire NHS with OUH FT as the arterial centre, and for all hospitals in the area to provide outpatient care. The Senate highlighted certain issues to be resolved within a six month timeframe, which included the provision of additional vascular beds at the OUH.

The Senate carries out reviews of its recommendations to ascertain the impact and benefit of its work and as part of this, undertook a review with the vascular network. Through this work, the Senate established that not all of the additional beds had been provided and that this was impacting on elective admissions. The Trust was invited to attend the June Senate meeting to update on the progress made in delivering the new pathway and to discuss the shortfall in beds. As a result of the discussion with the Senate, the Trust provided assurance that the additional beds would be supplied following the resolution of the current nursing shortfall. This requirement was considered to be part of the NHS Bed Test review.

# Thrombectomy

In May 2017, NHS England launched a public consultation on a proposition for introducing thrombectomy services across the country. Mechanical thrombectomy dramatically reduces the significant burden of disability caused by certain types of stroke by providing a more effective clot removal procedure, reducing the level and severity of damage caused to the brain. It also improves access to specialists for patients experiencing other types of stroke.[1] The cost savings to CCGs with the introduction of a thrombectomy service are £6.2m in year one, rising to £28.9m in year five, with additional savings arising outside the healthcare system, by reducing rates of disability and dependence in stroke survivors.[2]

The stroke network held a stakeholder forum earlier in the year to discuss the potential of a thrombectomy service in Thames Valley, and came to the conclusion that the best option for patients in TV and neighbouring areas is the establishment, as soon as possible, of a full service at the John Radcliffe Hospital. This has been commissioned by Specialised Commissioning.

The Senate will use its relationships and whole system view to focus on the development of the pathways including hospital transfers and post procedural care and consider unintended consequences. The work will involve stakeholder involvement within Thames Valley, Swindon and Milton Keynes and will be undertaken in early summer.

# Learning from reconfigurations

A formal role of the Clinical Senate is to carry out clinical reviews to inform the NHS England assurance process. The NHSE assurance is based on the Government's four tests for service reconfiguration and the Senate provides advice to NHSE on the clinical elements highlighted below:

## Four tests list

**The four tests from the Government's mandate to NHS England**

- Strong public and patient engagement
- Consistency with current and prospective need for patient choice
- A clear clinical evidence base
- Support for proposals from clinical commissioners

## Best practice checks list

**In addition to these four tests a range of best practice checks for service change proposals, these include:**

- Clear articulation of patient and quality benefits
- The clinical case fits with national best practice
- An options appraisal includes consideration of a network approach, cooperation and collaboration with other sites and/or organisations.

You cannot avoid a referral for judicial review but the way in which you go about your plans and consultation can help put you in a better position if this should happen. We have shared some learning from reviews to help those working in reconfiguration this year.


Make sure you know and understand your statutory requirements as they relate to reconfiguration at the outset.


Engage with your stakeholders and the Local Authority scrutiny process early – a Local Authority can refer to the Secretary of State for an independent review if they do not believe that they have been consulted adequately or if they consider the proposal is not in the interests of health services in the area.


Make sure your consultation is lawful; it should be undertaken at a formative stage of the proposals and you need to show how you have considered the feedback and applied it to the proposals.


Consultation: You need to be able to share a vision that provides a context for the service change that clearly communicates benefits for patients. It should address funding, transport and emergency care explicitly and openly and your implementation plans should be transparent and credible.


Make sure you have credible clinical endorsement for your proposals.


Take advice early from your lawyers, NHSE, Independent Review Panel and the Clinical Senate – you can work with the Senate from an early stage for independent clinical advice or to test your proposals.

[1] Consultation on Specialised Services clinical commissioning policies and service specifications, https://www.engage.england.nhs.uk/consultation/clinical-commissioning-consultation-may-2017/ (last accessed 4th December 2017)

[2] Thrombectomy in Thames Valley, presentation by Dr Matthew Burn to the Thames Valley Clinical Senate, November 2017.

# Diabetes network

At present, 9%, or £8.8 billion of the annual NHS budget is spent on diabetes care. 80% of this money is spent on preventable complications. Across Thames Valley, the cost burden of diabetes is £369m, and is expected to increase to £487m by 2035. The per patient cost for treating diabetes is £3,000, and the number of diagnosed patients in Thames Valley is set to increase by 44,723.[1] The impact of this is illustrated below:

| | Berkshire West CCG | Oxfordshire CCG | Buckinghamshire CCG | Bracknell And Ascot CCG | Slough CCG | Windsor, Ascot and Maidenhead CCG | North East Hampshire and Farnham CCG | Surrey Health CCG |
|---|---|---|---|---|---|---|---|---|
| Cost burden in 2016 | 92 | 126 | 105 | 23 | 35 | 29 | 39 | 17 |
| Cost burden by 2035 | 118 | 163 | 136 | 32 | 49 | 37 | 50 | 22 |
| No of diagnosed patients 2016/17 | 21,177 | 29,469 | 26,087 | 6,152 | 10,491 | 6,529 | 10,745 | 4,344 |
| No of diagnosed patients by 2035 | 27,240 | 38,117 | 33,910 | 8,399 | 4,386 | 8,413 | 13,727 | 5,487 |

Prevalance

| | Berkshire West | Oxfordshire CCG | Buckinghamshire CCG | Bracknell and Ascot | Slough | WAM | North East Hampshrie | Surrey Health |
|---|---|---|---|---|---|---|---|---|
| in 2016 | 30,513 | 42,063 | 34,978 | 7,771 | 11,792 | 9,550 | 12,943 | 5,755 |
| in 2035 | 39,249 | 54,407 | 45,467 | 10,610 | 16,171 | 12,306 | 16,535 | 7,269 |

Assessing the current picture and understanding the scale of the future challenge has been a vital part of the SCN's work this year, leading to the creation a number of cases for change. The first being for Oxfordshire, whose feedback and review confirmed the approach. Further cases for the Buckinghamshire and Frimley geographies have been produced, with Berkshire West due in April. The case for change for diabetes has been shared widely with networks and CCGs across the South region to support local examples being developed. It has been used by CCG clinical leads to raise the profile of diabetes across their organisations and executive teams. It has informed the local model of diabetes care and shaped future priorities of work.

As well as identifying the current and future burden of diabetes, the case for change documents identify areas, and the scale of opportunity for potential and substantial cost savings.

| Case for change | Possible saving | Method |
|---|---|---|
| Thames Valley wide | £2.5m in three years | Reducing amputation rates to match the best performing CCG |
| Thames Valley wide | £1.6m in five years | 50% of patients achieving the three treatment targets |
| Buckinghamshire | £1m in three years | Reducing amputation rates to match the best performing CCG |
| Oxfordshire CCG | £1.7m in ten years | 50% of patients achieving the three treatment targets |
| Frimley STP | £1.3m in ten years | 50% of patients attending structured patient education |

## Network ambition

The Thames Valley diabetes network set itself three key ambitions to be achieved by 2020, centred on treatment targets, patient education and amputation rates. By 2020:

- At least 40% of patients with diabetes in every GP practice in Thames Valley will receive the three treatment targets on a regular basis.
- At least 50% of all newly diagnosed patients with diabetes will receive structured patient education.
- The amputation rate across Thames Valley will match that of the best CCG in England.

## Treatment targets

Data on treatment target achievement is gathered in the National Diabetes Audit. Practice participation for the latest 2016/17 audit was 100%. There remains wide variation across practices in achievement of the treatment targets. This remains an area of focus, as well-controlled diabetes plays a key role in improving outcomes and reducing complications.

*3 Treatment Target achievement for type 1 and 2 diabetes, by STP*

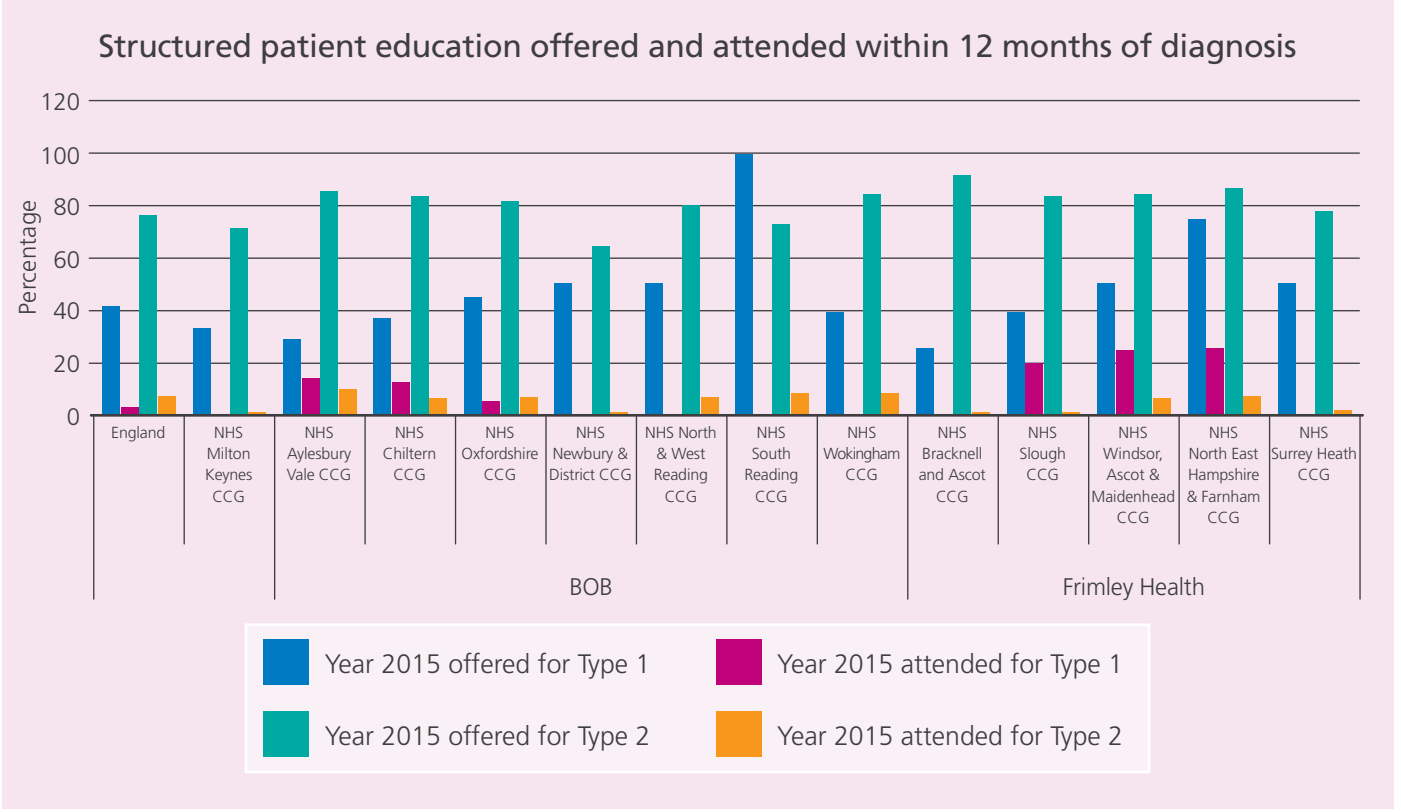
| Type | STP | CCG | % of patients achieving 3TT | Compare to last year 15/16 | Percentage of practices achieving less than 40% | No of people not achieved 3TT |
|---|---|---|---|---|---|---|
| Type 1 | | England | 19.0 | ↑ | | 131,585 |
| | | Thames Valley SCN | 21.8 | ↑ | 82.5 | 5,700 |
| | | NHS Milton Keynes CCG | 22.9 | ↓ | 85.2 | 640 |
| | BOB | NHS Aylesbury Vale CCG | 19.0 | ↓ | 100.0 | 555 |
| | | NHS Chiltern CCG | 20.5 | ↓ | 88.2 | 755 |
| | | NHS Oxfordshire CCG | 22.3 | ↑ | 84.3 | 1,635 |
| | | NHS Newbury & District CCG | 21.7 | ↑ | 100.0 | 270 |
| | | NHS North & West Reading CCG | 25.8 | ↑ | 70.0 | 245 |
| | | NHS South Reading CCG | 25.4 | ↑ | 50.0 | 235 |
| | | NHS Wokingham CCG | 22.1 | ↑ | 84.6 | 370 |
| | Frimley Health | NHS Bracknell & Ascot CCG | 21.8 | ↑ | 80.0 | 340 |
| | | NHS Slough CCG | 18.7 | ↑ | 68.8 | 305 |
| | | NHS Windsor, Ascot & Maidenhead CCG | 21.3 | ↑ | 82.4 | 350 |
| | | NHS North East Hampshire & Farnham CCG | 21.0 | ↑ | 100.0 | 545 |
| | | NHS Surrey Heath CCG | 17.6 | ↓ | 100.0 | 210 |

| Type | STP | CCG | % of patients achieving 3TT | Compare to last year 15/16 | Percentage of practices achieving less than 40% | No of people not achieved 3TT |
|---|---|---|---|---|---|---|
| Type 2 | | England | 41.1 | ↑ | | 1,435,080 |
| | | Thames Valley SCN | 41.5 | ↓ | 100.0 | 53,810 |
| | | NHS Milton Keynes CCG | 38.3 | ↓ | 59.3 | 6,435 |
| | BOB | NHS Aylesbury Vale CCG | 42.8 | ↓ | 33.3 | 4,670 |
| | | NHS Chiltern CCG | 44.3 | ↓ | 20.6 | 7,370 |
| | | NHS Oxfordshire CCG | 40.4 | ↑ | 42.9 | 14,140 |
| | | NHS Newbury & District CCG | 37.7 | ↑ | 60.0 | 2,375 |
| | | NHS North & West Reading CCG | 40.3 | ↑ | 60.0 | 2,225 |
| | | NHS South Reading CCG | 40.4 | ↑ | 43.8 | 2,760 |
| | | NHS Wokingham CCG | 41.6 | ↑ | 38.5 | 2,945 |
| | Frimley Health | NHS Bracknell & Ascot CCG | 44.2 | ↓ | 40.0 | 2,730 |
| | | NHS Slough CCG | 42.6 | ↓ | 37.5 | 5,200 |
| | | NHS Windsor, Ascot & Maidenhead CCG | 43.9 | ↑ | 29.4 | 2,960 |
| | | NHS North East Hampshire & Farnham CCG | 43.6 | ↓ | 34.8 | 4,830 |
| | | NHS Surrey Heath CCG | 41.2 | ↑ | 62.5 | 2,035 |

## Diabetic structured patient education

Diabetic structured patient education is a NICE-recommended intervention which enables those with diabetes to better manage their condition. Currently, only 7.1% of newly diagnosed patients attend these sessions nationally. It is recognised that data recording is an issue, however access to good quality education and information directly contributes to improved confidence, knowledge and self management.

The ambition is that by 2020, at least 50% of all newly diagnosed patients with diabetes will receive structured patient education. This will require significant focus.



## Footcare

Minor and major amputations are a significant complication of poorly controlled diabetes, and are costly procedures for the NHS. By 2020, the network plans for the amputation rate across Thames Valley to match that of the best CCG in England. This requires a reduction of 492 amputations across Thames Valley and Milton Keynes. The method of data collection has changed significantly from last year so direct comparison is difficult.

*Amputations per 1,000 people aged 17+ with diabetes*

| | | Apr 2013 - Mar 2016 (3 years data) | | | | Achieving the best CCG within TV (11.1 per 10,000 people) | | | Achieving the best CCG in England (9.5 per 10,000 people) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Major amputation (adjusted*) | Minor amputation (adjusted*) | Crude rate per 10,000 people | No of cases | No of cases to be reduced | No of cases | % reduced | No of cases to be reduced | No of cases | % reduced |
| | **Lowest CCG in England** | **3.0** | **7.2** | **9.5** | **50** | | | | | | |
| | **Highest CCG in England** | **21.3** | **45.4** | **57.0** | **161** | | | | | | |
| | **England average** | **8.1** | **21.0** | **29.1** | **25,527** | | | | | | |
| | NHS Milton Keynes CCG | 6.8 | 28.8 | 34.3 | 124 | 84 | 40 | 67.8% | 90 | 34 | 72.3% |
| BOB STP | NHS Aylesbury Vale CCG | 6.3 | 22.2 | 30.7 | 88 | 56 | 32 | 64.0% | 61 | 27 | 69.1% |
| BOB STP | NHS Chiltern CCG | 8.4 | 19.5 | 26.2 | 120 | 69 | 51 | 57.8% | 76 | 44 | 63.7% |
| BOB STP | NHS Oxfordshire CCG | 8.1 | 12.9 | 22.2 | 186 | 93 | 93 | 50.3% | 106 | 80 | 57.3% |
| BOB STP | NHS South Reading CCG | 9.1 | 15.3 | 24.1 | 37 | 20 | 17 | 54.1% | 22 | 15 | 60.5% |
| BOB STP | NHS Newbury & District CCG | | 18.7 | 25.2 | 33 | 19 | 14 | 56.1% | 21 | 12 | 62.3% |
| BOB STP | NHS North & West Reading CCG | 12.1 | 18.4 | 32.1 | 40 | 26 | 14 | 65.5% | 28 | 12 | 70.4% |
| BOB STP | NHS Wokingham CCG | 9.1 | 15.3 | 24.8 | 43 | 24 | 19 | 55.5% | 27 | 16 | 61.8% |
| Frimley Health STP | NHS Bracknell & Ascot CCG | | 9.6 | 11.1 | 19 | 0 | 19 | 0.0% | 3 | 16 | 14.1% |
| Frimley Health STP | NHS Slough CCG | 8.2 | 28.4 | 25.3 | 72 | 41 | 31 | 56.3% | 45 | 27 | 62.5% |
| Frimley Health STP | NHS Windsor, Ascot & Maidenhead CCG | 5.8 | 10.4 | 16.3 | 31 | 10 | 21 | 32.1% | 13 | 18 | 41.7% |
| Frimley Health STP | NHS North East Hampshire & Farnham CCG | 5.6 | 24.9 | 31.9 | 92 | 60 | 32 | 65.4% | 65 | 27 | 70.2% |
| Frimley Health STP | NHS Surrey Heath CCG | 11.7 | 18.6 | 30.4 | 37 | 24 | 13 | 63.7% | 25 | 12 | 68.8% |
| | **Thames Valley SCN** | | | | **793** | **442** | **351** | **55.8%** | **492** | **301** | **62.0%** |
| | **TOTAL** | | | | **922** | **526** | **396** | **57.1%** | **582** | **340** | **63.1%** |

*Note: *Directly (age & ethnicity) standardised rate of major amputations per 10,000 patients with diabetes*

To achieve the target amputation rate, the Thames Valley footcare pathway has been updated, and a suite of documents previously provided to each locality will be available on the SCN website by the end of April.

The documents that have been produced for each locality will assist in improving footcare across the pathway, and ultimately to reduce amputations. This includes a revised pathway, gap analysis, commissioner guide and latest data. Task and finish groups have been established in each locality to utilise these resources in driving improvements in footcare.

The Thames Valley clinical leadership group for footcare will be re-established in the Spring, and the SCN will be offering input to each task and finish locality group that was established following production of the materials.

# Transformation bids

2017 has seen the CCGs focusing on delivery of the transformation programme. The network provided and funded bid writing support, and Thames Valley secured a disproportionately high allocation of the money available. The bids focused on four areas: improving achievement of the key treatment targets, increasing the uptake of structured patient education, reducing the number of amputations by improving access to multidisciplinary footcare teams and reducing the length of hospital stays by improving access to inpatient support via specialist nursing teams. £1.5 million of this money will be used across the BOB STP. The network is now providing ongoing support and guidance to CCGs, individually and collectively, in delivering this programme of work.

## Patient structured education

Education features in all locality bids with addressing the hard to reach groups being a common theme. The network will be working with a number of CCGs providing resources and expertise to enable this work to reach a timely conclusion. Areas covered include increased BME community-specific education, increased staff training in order to deliver structured courses, and marketing the courses to the population.

All CCGs have signed up to the Diabetes UK pledge to increase patient education uptake. Data is now being tracked for uptake, with CCGs self-reporting via the national and regional dashboards.

## Treatment targets

All CCGs secured funding to support improved achievement of the treatment targets. Enabling people to improve their knowledge and confidence to self-manage their conditions reduces the risk of complications. All Thames Valley CCGs have adopted Care and Support Planning as the approach of choice in achieving self-management (see page 27).

## Inpatient care

People with diabetes have longer lengths of hospital stay, often associated with poor management of their diabetes. This funding focuses on increasing the input of specialist nurses to see patients and provide training and education of ward staff. Improved quality of care combined with reduced length of stay is anticipated from these bids.

These complications increase the amount of time people with diabetes spend in inpatients beds; their average excess length of stay is 0.8 days, costing the NHS £573 million per year.[2] A number of CCGs in Thames Valley have secured transformation bid money for diabetes specialist inpatient staff; diabetes specialist inpatient teams improve the quality of patient care and reduce costs by lowering the number of adverse events, the average length of stay, admission and readmission rates, and by increasing the number of day rate cases.

## Multidisciplinary footcare team (MDFT)

Complementing the Thames Valley work on footcare, two CCGs secured additional funds to enhance MDFT provision, including expansion of the service and increasing speed of assessment and treatment.

Currently, 80% of the current spend on diabetes is on the complications associated with it; achieving all three NICE treatment targets is key to avoiding complications.[3]

## Local progress

Through the transformation programme, CCGs are starting to see tangible improvements in patient care, such as the number of patients seen within 24 hours by the multidisciplinary footcare team, the number of inpatients seen by a diabetic nurse specialist and improvements in the 3 treatment targets and 8 care processes.

## Bucks HSJ spotlight

The HSJ has put together a guide on how to cut the cost of diabetes by increasing patient compliance with treatment, and upskilling primary care staff to reduce the diabetes burden on secondary care.

The guide highlights the work done in Buckinghamshire for the diabetes transformation programme. Aylesbury Vale and Chiltern CCGs have worked to provide care and support planning (see page 27 for more information on care and support planning) for each person with diabetes, improved access to psychological services, and are upskilling staff. They are targeting 50% of patients receiving structured patient education, up from a current rate of around 10%.

View the online guide, and Buckinghamshire's excellent work here: https://guides.hsj.co.uk/5687.guide

## Network leadership

Recognising the importance of strong clinical leadership, the network has established a CCG clinical leads group to set out and deliver a strategic ambition for diabetes care across the Thames Valley.

This complements the diabetes reference group which is the forum for the sharing of good practice, discussion of challenging issues, and setting out the Thames Valley position on key areas, and the network contribution to locality meetings and monthly transformation calls to support and assist with transformation programme delivery. The network has provided a position statement for the adoption of FreeStyle Libre, will be hosting a conference on how to achieve personalised, value-based outcomes for people with type 1 diabetes, to support CCGs in their thinking on the optimum model of care for people with type 1 diabetes. There will be a half day meeting on dietary challenges, to explore the contentious and complex issue of personal choice and dietary advice, aiming to reach a consensus across Thames Valley by all partners. The issue and opportunity of 'diabetes in remission' is recognised and the network is exploring the opportunity this could afford CCGs in offering a different model of care to free up primary care resources. A Thames Valley-wide definition and local audits to determine potential gain are work in progress.

[1] Diabetes - Case for Change Oxfordshire CCG: Thames Valley Strategic Clinical Network, June 2017

[2] Inpatient Care for People with Diabetes: The Economic Case for Change https://www.diabetes.org.uk/resources-s3/2017-10/Inpatient%20Care%20for%20People%20with%20Diabetes%20%20The%20Economic%20Nov%202011_1.pdf (last accessed 26 March 2018)

[3] Diabetes Case for Change – Oxfordshire CCG

# End of Life network

The end of life (EOL) network works with commissioners and providers to support them in the delivery of their strategic plans and ongoing work around improving end of life care for their population.

The network has been focused on a small number of key areas to support the ambition of increasing the number of deaths in the usual place of residence. This ambition sits alongside the drive to reduce unwarranted hospital admission in the last 90 days of life, and increasing the number of patients supported in their care by a robust electronic palliative care record.

The Choice Commitment (DH 2016) is the Government's response to the report by Choice Review (NCPC 2015) 'what is important to me' outlining six key declarations to improve quality of care, choice and control for patients and those important to them at the end of life. The Choice Review provided evidence of what was important to people at the end of life from hearing what the public wanted.

EPaCCS effectiveness: *"Data from the South West on 3,012 EPaCCS patients and over 67,000 total deaths demonstrated differences in hospital death of 9.8% vs 33.9% for patients with cancer and 8.3% vs 49.9% for patients without cancer, respectively, on and off EPaCCS."*[1]

## Key areas of work

### Electronic Palliative Care Coordination Systems (EPaCCS)

The network is supporting the implementation and review of EPaCCS to improve communication, care planning and coordination at the end of life.

EPaCCS, a key tool within end of life care to support communication and coordination with all professionals involved in a patient pathway.

The focus has been on reviewing the robustness of their localised EPaCCs. Using a self-assessment tool (adapted from the South West EOL region) has highlighted the complexities and difficulties in ensuring patients care plans and reviews can be both viewed and updated.

It covers:

1. Who (health and social care professionals) on the patient's pathway has access to the system (read only or read edit permissions).
2. What information has been input to identify key EOL care priority needs, to support proactive planning and communicate what care has been put in place. (This supports 11 of the 60 Minimum Data EoL Set Information standard.)
3. Review: How many records have been updated in the last four weeks?

| Area | Initial scoping complete and in progress | Key gap identified | Level of functionality established | Phase 2 action for development |
|---|---|---|---|---|
| Buckinghamshire | Awaiting results | To be determined | Yes | Yes: 2018-19 |
| NHS Oxfordshire CCG | Scoping completed | Yes | Yes | Yes: 2018-19 |
| Berkshire West | Scoping completed | Yes | Yes | Yes: 2019-20 |
| Berkshire East | Awaiting results | To be determined | Yes | Yes: 2019-20 |

## Robust EPaCCs improve communication, care planning and coordination at the end of life

CCG SELF-ASSESSMENT

- Who has access to the system?
- What information has been input to identify key EOLC priority needs
- How many records have been updated?

DASHBOARD CREATED

- Avoiding in-hospital deaths
- Provides support and improvements for all professionals across the pathway

## Urgent and emergency care work

| STP | CCG | Proportion of all people admitted into hospital during the last 90 days of their life (2015) | Proportion of people who have three or more emergency hospital admissions during the last 90 days of life (2015) | Proportion of all people who died in hospital (2015) |
|---|---|---|---|---|
| | England | 67.7 | 6.9 | 46.7 |
| BOB | **STP - Buckinghamshire, Oxfordshire & Berkshire West** | 65.2 | 6.8 | 44.5 |
| BOB | NHS Aylesbury Vale CCG | 64.3 | 5.8 | 43.2 |
| BOB | NHS Chiltern CCG | 66.1 | 6.6 | 47.2 |
| BOB | NHS Newbury & District CCG | 61.3 | 5.4 | 51.6 |
| BOB | NHS North & West Reading CCG | 66 | 5.7 | 43.3 |
| BOB | NHS Oxfordshire CCG | 65 | 7.2 | 42 |
| BOB | NHS South Reading CCG | 69.2 | 7.4 | 48.4 |
| BOB | NHS Wokingham CCG | 65.2 | 8.1 | 45.4 |
| Frimley Helth | **STP - Frimley Health** | 65.5 | 6.9 | 47.2 |
| Frimley Helth | NHS Bracknell & Ascot CCG | 64.5 | 7.5 | 48.3 |
| Frimley Helth | NHS North East Hampshire & Farnham CCG | 67.1 | 6.7 | 42.5 |
| Frimley Helth | NHS Slough CCG | 66.5 | 7.8 | 57.2 |
| Frimley Helth | NHS Surrey Heath CCG | 63.6 | 7.3 | 41.1 |
| Frimley Helth | NHS Windsor, Ascot & Maidenhead CCG | 64.7 | 5.9 | 49.8 |

*Source: NEoLCIN-End of Life Care Sustainability and Transformation (STP) Tool (PHE (NEoLCIN) from NHS Digital HES linked to ONS Mortality Data)*

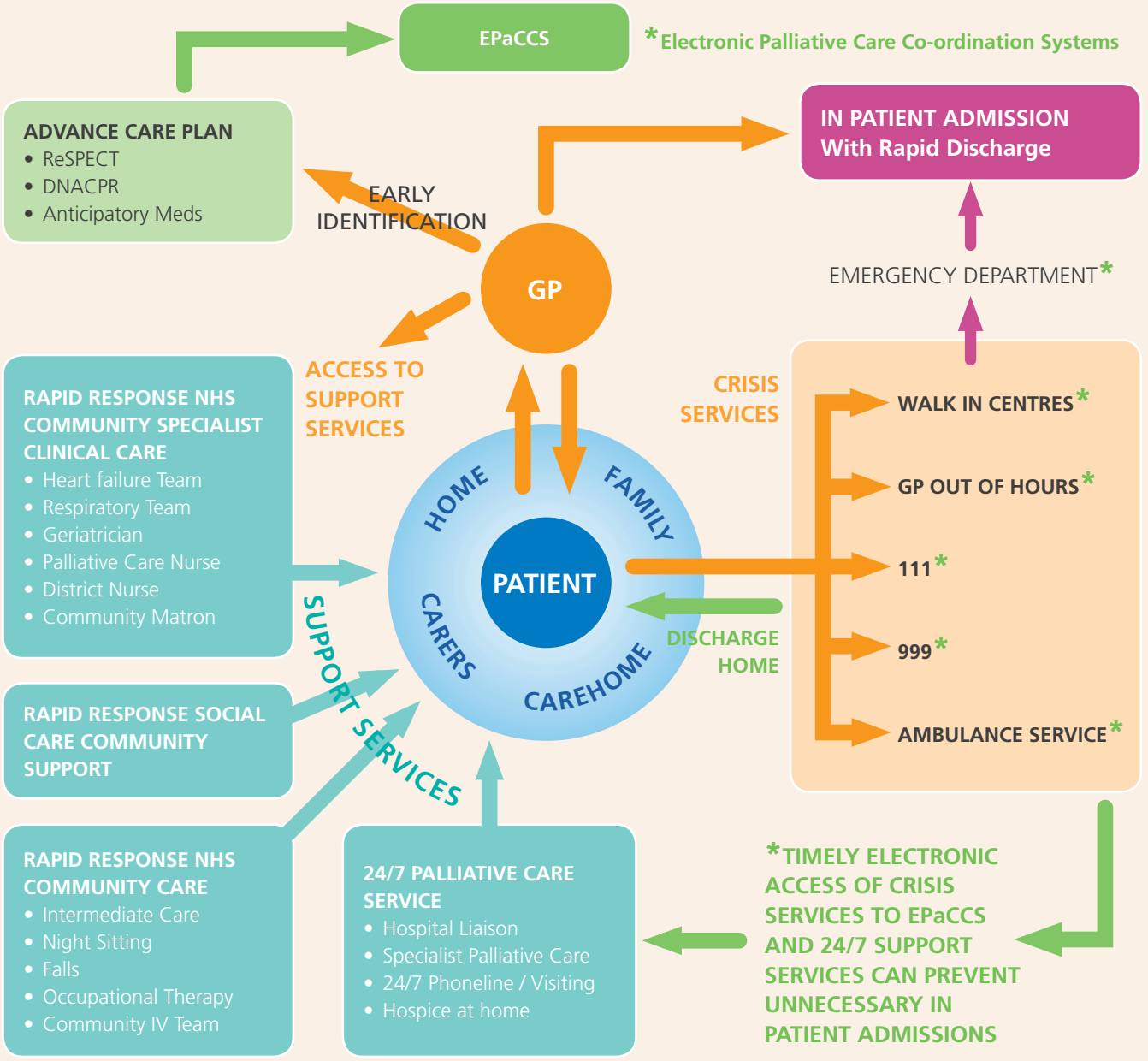
Key: Compare to England

- Higher than England value
- Similar to England value
- Lower than England value

## Supporting STP priority programmes

Setting out the contribution of end of life care to the priority programmes of cancer, mental health, primary care and urgent & emergency care (U&EC) is an ambition of the EOL team. The network has focused on U&EC, and developing an optimum pathway. This pathway illustrates the complexity and range of services, but shows where they work together: wrapped around the patient as well as supported by a robust EPaCC system. This will have a positive impact on the U&EC system and unwarranted emergency admissions.

### Optimum pathway for end of life care in urgent and emergency care




Recognised by the National EOL care NHS England programme as a model of good practice and used by the National Urgent and Emergency Care Team, the work was subsequently presented at NHS Expo 2017. It has been shared widely across Thames Valley with end of life and urgent & emergency care colleagues.

## Leading end of life

The network team continue to provide impartial, expert advice and support to CCG colleagues directly, and through contribution at locality meetings. The Thames Valley commissioner forum provides opportunities for the sharing of good practice locally and nationally, as well as exploring key topics in depth. In conjunction with Health Education England Thames Valley, a series of clinical workshops are offered to colleagues across the health and social care system, updating and challenging thinking in areas such as meaningful conversations at the end of life, ethical dilemmas around treatment options, human rights and considerations with capacity and decision-making.

## ReSPECT

The ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) process supports patients to have open and honest conversations with healthcare professionals, and to provide a summary of recommendations for a person's clinical care in a future emergency in which they do not have capacity to make or express choices.

Such emergencies may include death or cardiac arrest. The process is intended to respect both patient preferences and clinical judgement. The ReSPECT tool is used to capture the conversation and joint decision making.

The network hosted a half day workshop for commissioners and key stakeholders to hear more from key speakers about implementing ReSPECT. Learning and sharing of best practice from the event is now being rolled out by the Thames Valley end of life team, with the majority of localities signed up to this initiative.

The team is now supporting organisations and facilitating ways to enable the process to become an approach offered to all people in Thames Valley.

| Locality | Adoption of ReSPECT | Progress | Timescales |
|---|---|---|---|
| Berkshire West | Royal Berkshire Hospital<br>Berks West CCG<br>Berks West Community Provider | Full project plan with endorsement by governance and quality boards<br>CCG: actively going through executive boards to support rollout from Royal Berkshire Hospital (RBH).<br>Community- business case submitted | To go 'live' September 2018 as an electronic record: RBH<br>CCG and provider to aim to be in line with RBH launch date |
| Buckinghamshire | No | | |
| Berkshire East | In agreement and to go to CCG EOL Board for decision | Awaiting approval | Aim to be in line with RBH launch date |
| Oxfordshire | Awaiting for the digital/electronic solution to be available | | |

## Supporting the Choice Commitment

This work, by the network, supports the delivery of the six commitments outlined in the government document *Our Commitment to You for End of Life Care*:[2]

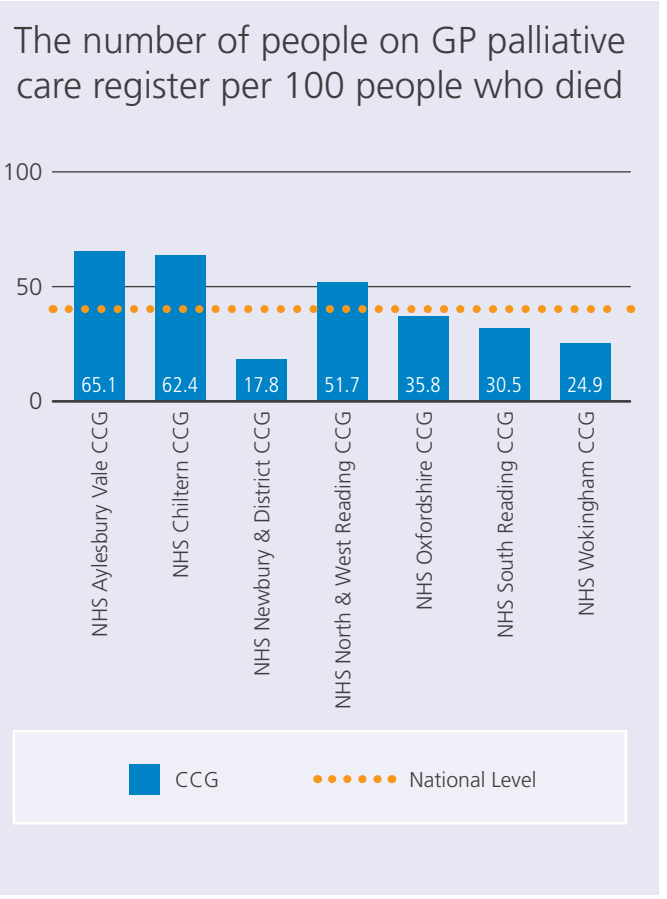
1. Have honest discussions about needs and preferences
2. Make informed choices about care, supported by clear and accessible information
3. Develop and document a personalised care plan
4. Share the personalised care plan with care professionals
5. Involve, to the extent that you wish, family, carers, and those important to you
6. Know who to contact if you need help and advice at any time.

These commitments provide a benchmark for the network to support locality work on personalised care planning and the implementation of personal health budgets (PHB) at the end of life. The EOL network works with the PHB national team to ensure commissioners are well informed about the opportunity of providing the population with more choice and control.

## Case for Change

The network is developing a locally based, bespoke case for change for each STP. Population changes in the next 5-10 years are expected to put significant pressure on resources. This will bring challenges to CCGs in the commissioning and provision of good quality end of life care. Population projections suggest a sharp increase in the over 75 years age group, and whilst the number of deaths in Thames Valley is currently rising slowly and is expected to rise more sharply over the coming years to 2035, and a review of ONS data (England and Wales) tell us approximately 75% of deaths can be predicted.[3]

The recently published NHS England end of life care Sustainability and Transformation Partnership support tool demonstrates not only are more people expected to die at an older age in Thames Valley and will be likely to have more complex needs and comorbidities that could increase the level and intensity of secondary care use at the end of life.[4] The table below, taken from the STP support tool, demonstrates the percentage of deaths in different settings per CCG, highlighting that hospitals are the main care setting for where patients currently die.


Drawing on the EOL STP data packs and analytics commissioning tool, the case for change will set out the future challenges and recommended initiatives that will provide a quality of care gain, as well as releasing capacity in other parts of the system. For example, Coordinate my Care (CMC) (the EPaCCS system used in London) demonstrated that from 2012-16, 32,000 care plans were created, and figures in 2015 showed that 79% achieved their preferred place of death. Among patients who created a CMC urgent care plan, just 18% died in hospital, with more spending their final days in their preferred place.[5]

## Looking forward

During 2018/19 the network will work with CCGs to complete the work on EPaCCS and continue to support local systems in the adoption of ReSPECT. We will publish the case for change for BOB and Frimley STPs, and set out the contribution of EOL care to the other STP priority programmes and actively share and promote to the STP programme leads.

The network will also lead the piloting of a 111 specialist palliative care service, in conjunction with South Central Ambulance Service and Thames Hospice. This nine month pilot will gather evidence to determine the impact of the provision of a 24/7 telephone advice line for clinicians and patients/carers. This work has the support and mandate of the BOB STP U&EC group and the evaluation will inform future commissioning decisions.

[1] Petrova M, Riley J, Abel J, et al Crash Course in EPaCCS (Electronic Palliative Care Coordination Systems): 8 years of successes and failures in patient data sharing to learn from. BMJ Supportive and Palliative Care. Published Online First: 16 September 2016. Doi: 10.1136/bmjspcare-2015-001059, http://spcare.bmj.com/content/early/2016/09/16/bmjspcare-2015-001059 (last accessed 20th November 2017).

[2] Our Commitment to You for End of Life Care: The Government response to the review of choice in end of life care, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/536326/choice-response.pdf (last accessed 24th November 2017)

[3] Predicting Death: Estimating the proportion of deaths that are 'unexpected' http://www.endoflifecare-intelligence.org.uk/resources/publications/predicting_death (last accessed 26 March 2018)

[4] End of life care in Thames Valley; Public Health report

[5] Coordinate My Care: a clinical solution to address NHS urgent care crisis? http://coordinatemycare.co.uk/cmc/wp-content/uploads/2014/06/cmc-opinion-article.pdf (last accessed 12th December 2017)

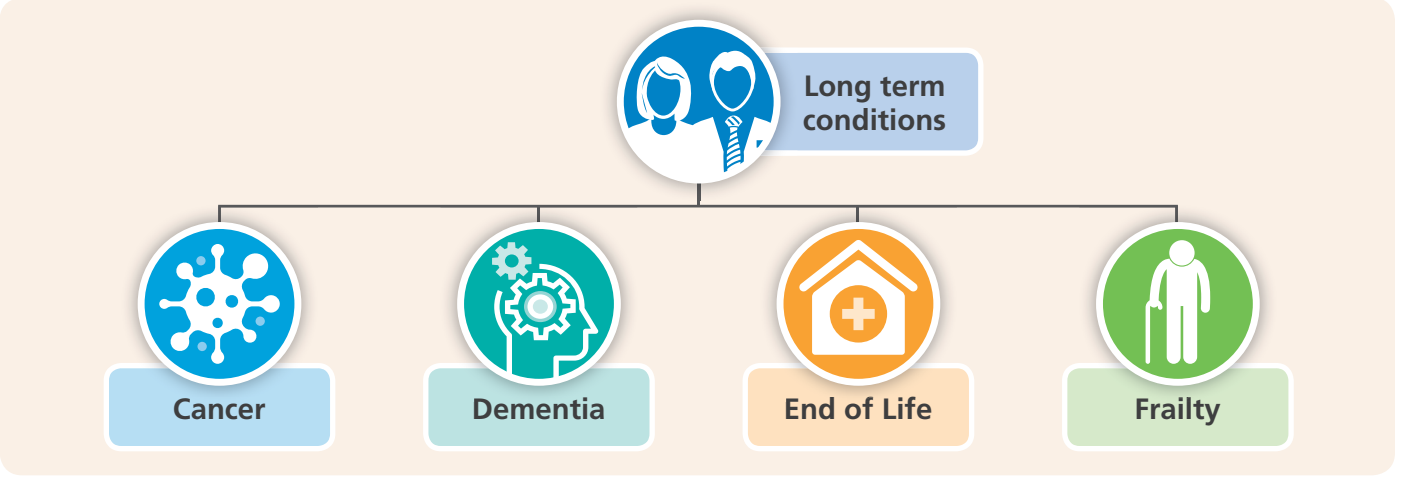
# Long term conditions

The long term conditions programme continues in its support of a person-centred approach to care. The common psychological approach across Making Every Contact Count (MECC), Shared Decision Making (SDM) and care and support planning is providing opportunities for wider collaboration.

Care and Support Planning (CSP) recognises that people who live with long term conditions (LTC) make the majority of the decisions that affect their lives themselves, spending relatively little time with a health and/or care practitioner.[1] Making the most of this time is therefore key, and the CSP approach supports this.

The initial focus of CSP for people with diabetes is being expanded for people with long term conditions, recognising that comorbidity is the norm for many people.

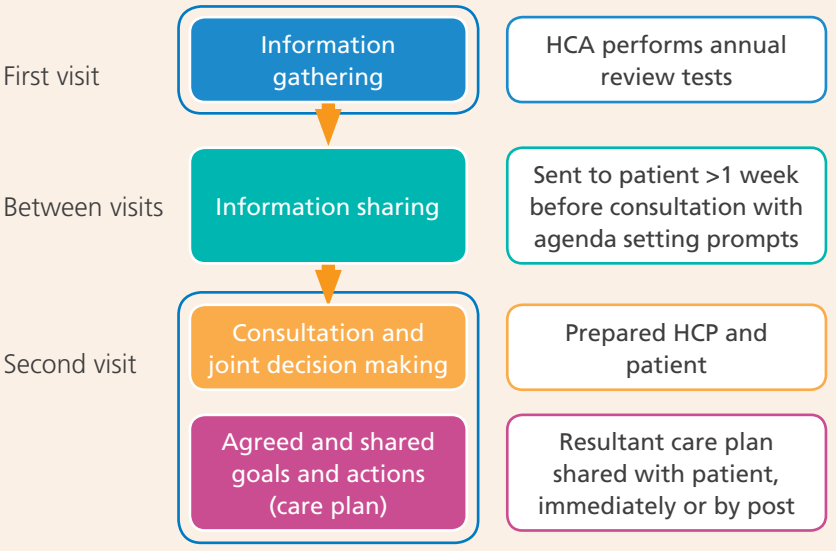
*"Personalised care planning is a collaborative process used in chronic condition management in which patients and clinicians identify and discuss problems caused by or related to the patient's condition, and develop a plan for tackling these. In essence it is a conversation, or series of conversations, in which they jointly agree goals and actions for managing the patient's condition."*[2]





A Cochrane Review has demonstrated that patients with long term conditions benefit from a person-centred approach to care; involvement in CSP shows indications of better physical health (better blood glucose level and lower blood pressure measurements among people with diabetes), reduced symptoms of depression, and improvements in people's confidence and skills to manage their health.[3]

## The four steps of CSP:[4]




## System benefits

- Reducing general practice running costs
- Reducing pressures on general practice staff
- Improving healthcare professional job satisfaction
- For people at the end of life, enabling the capturing of their preferences for treatment and place of care.
- Reduction in appointments due to a single patient review rather than multiple disease focused appointments.

# Adoption of CSP across Thames Valley

## Oxfordshire

Previously an area with very low CSP implementation, this approach is now being adopted as a core element to Oxfordshire's diabetes model of care. Interest from practices in adopting this approach has been positive with significant uptake of the training, which has been very well evaluated. The CCG has invested in post-training support to assist implementation.

Oxfordshire CCG has long term sustainability plans. There is an aspiration for CSP to be adopted across LTC, and the generic training provides practices with the resources to implement wider if they so wish.

## Buckinghamshire

Aylesbury Vale and Chiltern CCGs have actively progressed adoption of CSP as the norm for working with people with long term conditions, and so is a core component of the diabetes model of care within Buckinghamshire. Fifty percent of Aylesbury Vale practices have implemented this approach for LTCs, including dementia where the learning is being used as part of the Dementia Friendly Practices initiative led by the dementia network. The change, which also includes improved access to psychological services and an advice line for staff, has been featured in an HSJ article on How to Cut the Cost of Diabetes. See page 20 for more details on the HSJ article.

## Berkshire West

Care and Support Planning has replaced the annual review process for most people with diabetes with a care planning review. Eighty nine percent of practices are offering CSP for people with diabetes, and 28% of practices for people with COPD.

Percentage of practices delivering CSP for diabetes:

| | Practices trained in CSP | Practices delivering CSP | CCG sustainability in place | Evaluation in place |
|---|---|---|---|---|
| **Bucks** | | | | |
| Aylesbury Vale CCG | 18 | 100% | Yes | Yes |
| Chiltern CCG | 31 | 88% | Yes | Yes |
| **Berkshire West** | | | | |
| Newbury & District CCG | 10 | 100% | Yes | Yes |
| South Reading CCG | 20 | 70% | Yes | Yes |
| North & West Reading CCG | 10 | 80% | Yes | Yes |
| Wokingham CCG | 12 | 92% | Yes | Yes |
| **Berkshire East** | | | | |
| Slough CCG | 10 | 62% | Yes | No |
| Bracknell & Ascot CCG | 15 | 100% | Yes | Yes |
| WAM CCG | 18 | 90% | Yes | No |
| **Oxford** | | | | |
| Oxford CCG | 55 | 78% | Yes | In Progress |

Berkshire West has undertaken an evaluation of CSP using the Year of Care Quality Mark tool. Practices are evaluated against ten benchmarks for quality CSP.

This work has identified a number of 'beacon' practices that are the best performing for care and support planning. These 13 beacon practices, spread across Berkshire West, are also high achievers for diabetes care, with the majority in the top decile of achievement for the eight care processes.

Working with the beacon practices, Berkshire West is progressing the expansion of CSP to other LTCs during 2018-19.

## Berkshire East

In common with the rest of Thames Valley, Berkshire East have embraced care and support planning as a core component of their diabetes model of care, and the majority of practices have engaged in CSP training. The CCG has recently invested in post-training support and evaluation.

The LTC programme, in conjunction with Health Education England Thames Valley, continues to fund training for practices and train the trainer, providing advice and guidance to CCGs and to support trainers and facilitators across Thames Valley.

[1] Interpersonal Education in Person-Centred Care for Long Term Conditions

[2] Coulter A, Entwhistle VA, Eccles A, Ryan S, Shepperd S, Perera R. Personalised care planning for adults with chronic or long-term health conditions. Cochrane Database of Systematic Reviews 2015, Issue 3. Art. No.: CD010523. DOI: 10.1002/14651858.CD010523.pub2 http://www.cochrane.org/CD010523/COMMUN_effects-of-personalised-care-planning-for-people-with-long-term-conditions (Last accessed 11th December 2017)

[3] Coulter A, Entwhistle VA, Eccles A, Ryan S, Shepperd S, Perera R. Personalised care planning for adults with chronic or long-term health conditions. Cochrane Database of Systematic Reviews 2015, Issue 3. Art. No.: CD010523. DOI: 10.1002/14651858.CD010523.pub2 http://www.cochrane.org/CD010523/COMMUN_effects-of-personalised-care-planning-for-people-with-long-term-conditions (Last accessed 11th December 2017)

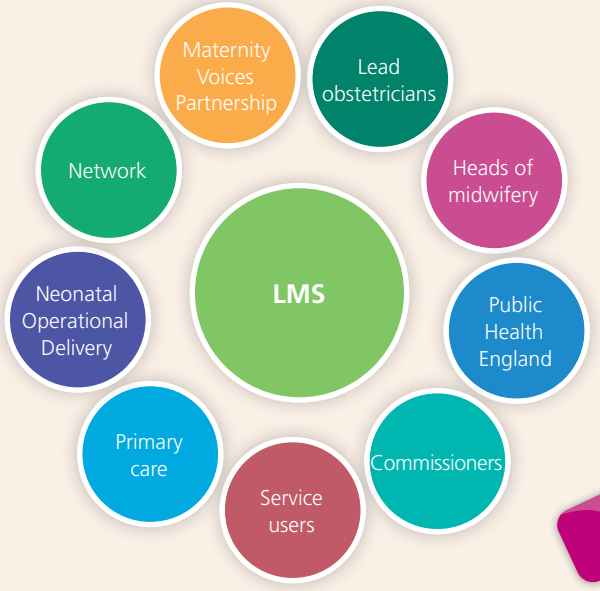
[4] Delivering Person Centred Care Through CSP in Berkshire West, February 2016 http://tvscn.nhs.uk/wp-content/uploads/2017/06/41-Claire-Scott.pdf (last accessed 9th April 2018)

# Maternity network

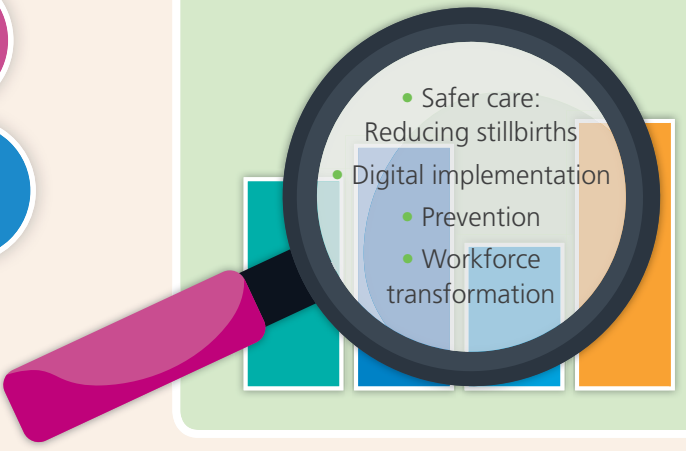
## Local Maternity Systems

The Better Births report set out the maternity transformation programme, and required that providers and commissioners of maternity services come together to form Local Maternity Systems, which will plan the design and delivery of services of populations from 500,000 to 1.5 million people.[1]

### TVSCN has established two Local Maternity Systems each comprising:




LMS Action Plans are in place to transform maternity services up to 2021, and aligning to STP goals to include:




## Better access to perinatal mental health services

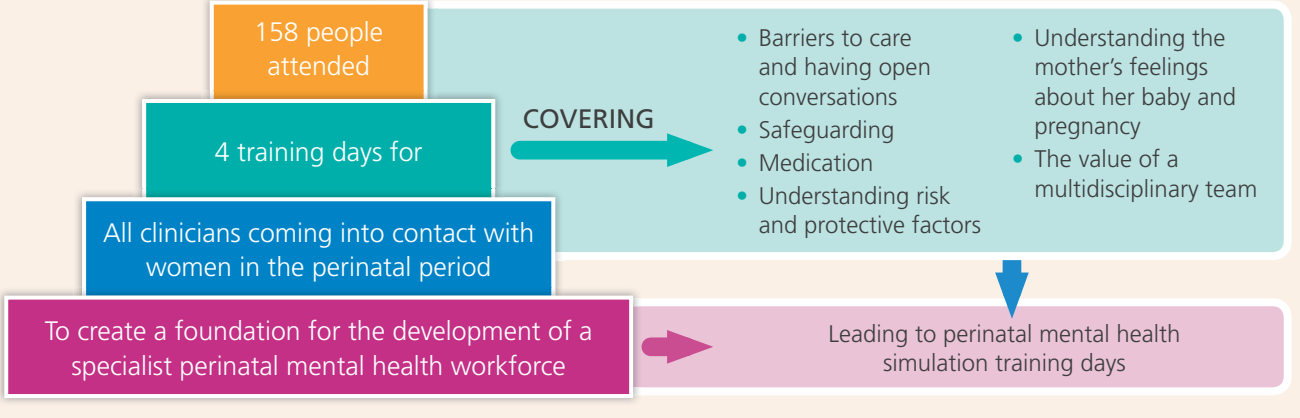
The national drive is for 30,000 additional women in England to be seen by perinatal mental health services, which equates to 1,338 women in Thames Valley (including 529 for Berkshire).

Following the successful wave 1 perinatal Community Service Development Funding (CSDF) for Berkshire, from 1 January 2017 a further 433 women across Berkshire have received additional interventions as a direct result of the National Perinatal Funding.

Women now have access to a perinatal psychiatrist, perinatal pharmacist and nursery nurses, and perinatal CBT therapy delivered in the woman's home alongside the clinicians who have provided a limited assessment and follow up service, prior to the national funding and who continue to provide interventions at home.

In order to enhance the provision of, and reduce variation in, perinatal mental health care for all women in the Thames Valley, the SCN perinatal mental health network has delivered training days, as described below:

### Perinatal mental health training days



Attendees came from all areas of the Thames Valley geography, and represented primary care, secondary care, health visitors, educational institutions, and public and third sector groups. The feedback from the attendees was excellent.

Following on from these sessions, the network is hosting simulation training days in early 2018, comprising of six clinical scenarios over the whole day, structured to develop a broad range of clinical and communication skills for working with women with complex health needs during the perinatal period.

## Perinatal mental health matrix

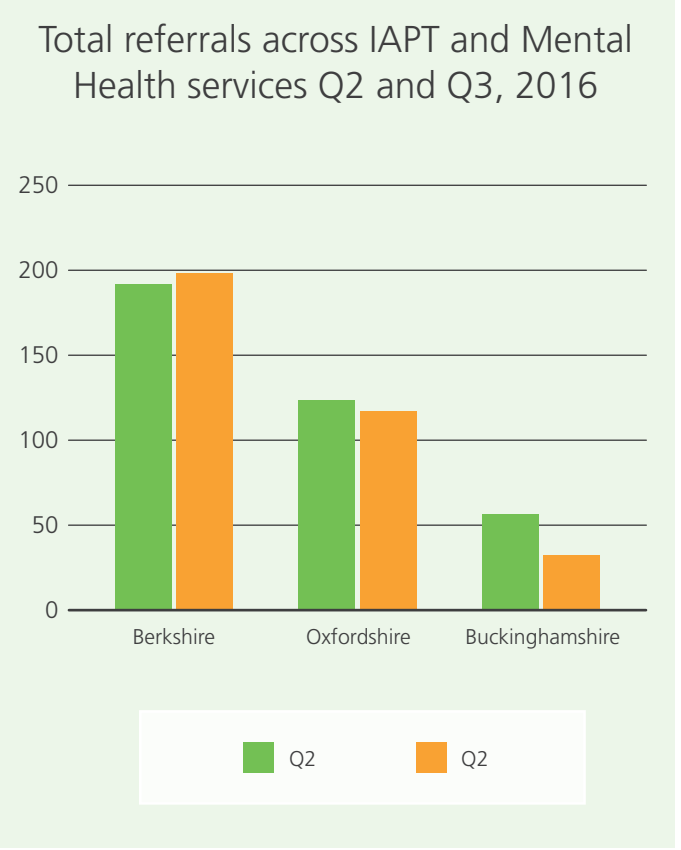
The SCN was delighted to launch the perinatal mental health matrix (PNMH matrix) in September 2017, modelled on the early interventions in psychosis (EIP) matrix, developed by the Oxford AHSN. It has been designed to evaluate the quality of perinatal mental health care provided by maternity, health visiting, secondary care mental health and primary care psychology (IAPT) services in the Thames Valley.

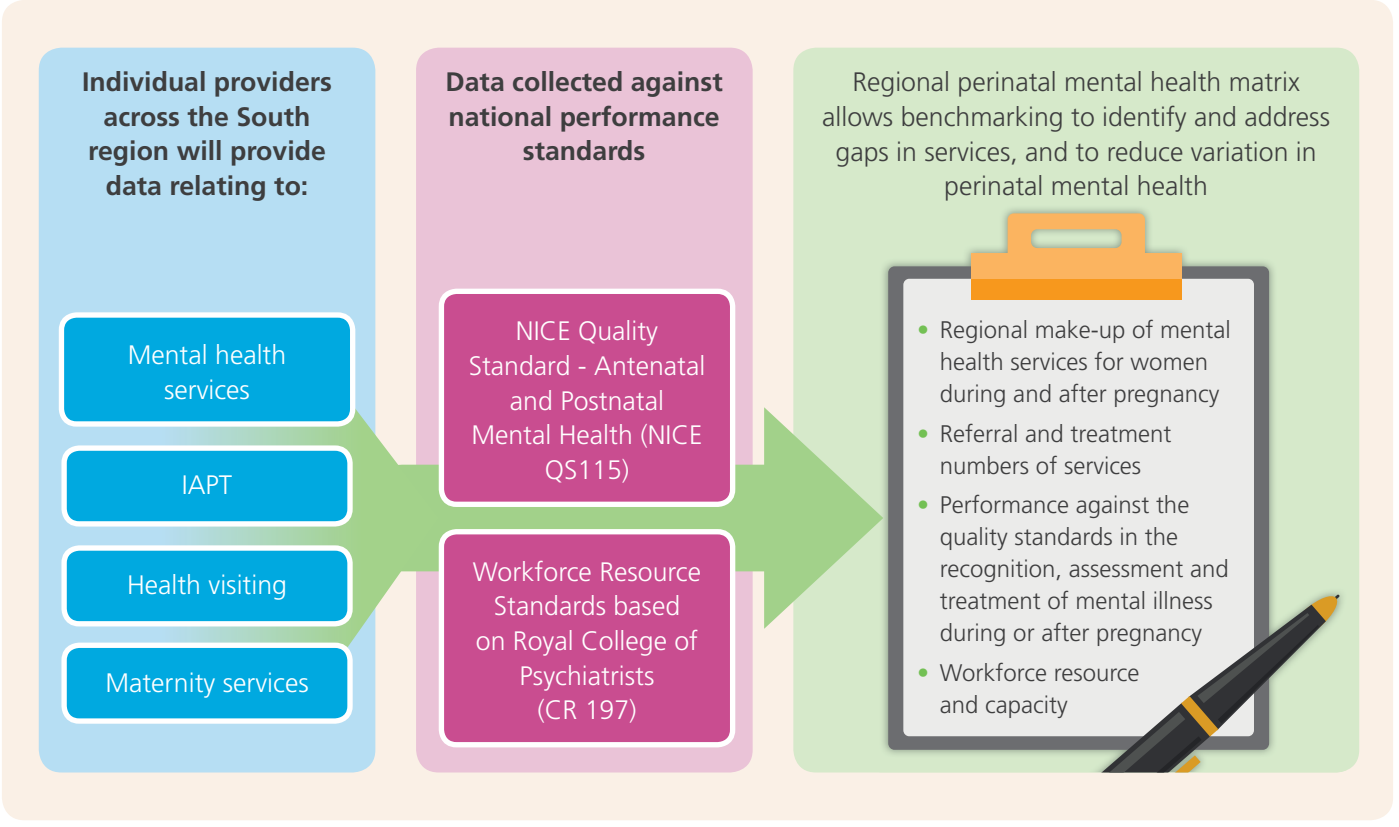
### Perinatal Mental Health Matrix NICE Quality Standard QS115

In 2016, the Thames Valley Strategic Clinical Network identified variation in the audit and data collection of services in contact with women in the perinatal period.

An online data collection matrix tool was developed. The matrix collects data measuring services against the NICE Quality Standard for antenatal and postnatal mental health (QS115) and the Royal College of Psychiatrists workforce standards (CR197).

Data is entered by maternity, health visiting, IAPT, specialist perinatal mental health and adult community health teams, and is collected on a quarterly basis. This enables comparison of data between teams and across the region, benchmarking against NICE standards. The roll-out across Thames Valley is nearing completion, and the next step is to roll out the matrix across the rest of the South region, starting in the South West.



## Improving stillbirth rates

The stillbirth rate in the Thames Valley SCN area has gone down from 5.2 per 1,000 live births to 4.6 per 1,000 live births. Our 2020 target is to reduce this further to 4.1 per 1,000 live births.

Saving Babies' Lives is a care bundle designed to support providers, commissioners and professionals to take action to reduce stillbirths.

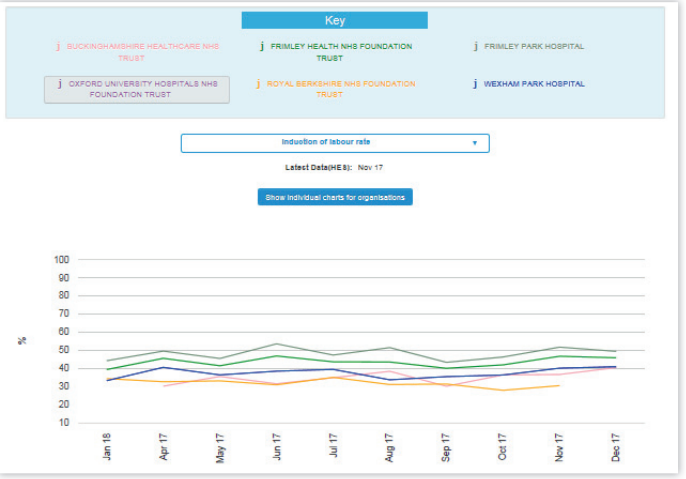
| Buckinghamshire NHS Trust | | Frimley Health Foundation Trust | | Oxfordshire Foundation Trust | | Royal Berkshire Foundation Trust | |
|---|---|---|---|---|---|---|---|
| 2016 | 2017 | 2016 | 2017 | 2016 | 2017 | 2016 | 2017 |
| Element 1: Reducing smoking in pregnancy | | | | | | | |
| | | | | | | | |
| Element 2: Risk assessment and surveillance for fetal growth restriction | | | | | | | |
| | | | | | | | |
| Element 3: Raising awareness of reduced fetal movement | | | | | | | |
| | | | | | | | |
| Element 4: Effective fetal monitoring during labour | | | | | | | |
| | | | | | | | |

*Progress of Trusts in implementing the four elements of the care bundle*

Key: Completed and ongoing; Partially completed and action plan

## Regional maternity dashboard

In June 2016, the Heads of Midwifery and Lead Obstetricians agreed to establish a regional maternity dashboard. The dashboard uses Trust local data and also extracts the Hospital Episode Statistics (HES) data to compare national submissions to local data, for accuracy. The dashboard went live for data submission in April 2017, and to allow for data inaccuracies it will be piloted for a year, and will run concurrently with local maternity dashboards. The aim ultimately is for one dashboard to be used as it allows for services to benchmark against each other, and understand good practice and areas for improvement. It will be used from April 2018 as the data source for the BOB and Frimley LMS.




[1] https://www.england.nhs.uk/mat-transformation/ (last accessed 20th November 2017)

# Mental health, dementia and neurology network

## All age mental health

### Crisis care

#### Mental health liaison and psychological medicine services

In line with the Mental Health Five Year Forward View ambition to ensure that no acute hospital should be without all age mental health liaison services in both A&E and inpatient wards, the SCN produced a benchmarking report[1] on service provision in BOB and Frimley which highlighted:

**All Thames Valley acute hospitals are:**

- ☑ Providing on-site mental health teams in hospital 24/7
- ☑ Offering close day-to-day working with medical teams
- ☑ Focused on education, training and supervision of all staff
- ☑ Fostering a culture of holistic, integrated care for the patient

N.B. while some local service models differ, plans are in place for ALL acute Thames Valley sites to comply with Core 24 standards by 2020

The Thames Valley SCN mental health network will continue to support STP developments in crisis care by working with commissioners and providers to further identify good practice in areas such as:

- Enhanced workforce and skill mixes to match specific local needs, such as drug & alcohol services and self-harm clinics
- Improved response times after referral
- Extended services for all ages
- Further integration with acute hospital teams
- Future plans for service development and service measuring.

#### Out of Area Placements: a partnership solution

The Thames Valley mental health network is supporting their Operations and Delivery colleagues to achieve the Mental Health Five Year Forward View goal of eliminating the practice of sending people out of area for acute inpatient care by 2020/21. By providing its networking capability, the SCN has worked with its key mental health providers to participate in learning events through NHS England's national team. A stocktake was developed which highlighted that whilst there is a mismatch between anticipated and current levels of Out of Area Placements (OAP), or what constitutes an appropriate or inappropriate OAP, the report also described the positive work in local providers to support reduction and the initiatives in place to drive the improvement.

By harnessing best practice from across the country, providers are engaging in learning from Cheshire and Wirral NHS Partnership NHS Foundation Trust[2] who have addressed this through:

- Streamlining the inpatient care pathway
- Developing specialist rehabilitation skills and staff to facilitate discharge planning
- Harnessing teams and partnerships across the health economy to enable discharge and support to ensure bed availability and throughput of those that are inpatient > 40 days

This work has seen a reduction in the average length of stay for:

- Inpatient rehabilitation by 35 days
- Secure services by 18 days

# Addressing the physical health needs of those with serious mental illness

NHS England state that by 2021, those on the SMI Register should be receiving an additional 280,000 physical health checks across England. While national benchmarking is provided to support delivery in 2018-19, in Thames Valley this could require our local system to increase physical health checks to the scale of:

| | | | Percentage of people receiving a full annual physical health assessment on the GP SMI register | | Delivering physical health assessment | |
|---|---|---|---|---|---|---|
| | | SMI prevalence (QOF) 2016/17 | 30% | 60% | Primary care 50% | Secondary care 10% |
| | **England** | **534,431** | **160,329** | **320,659** | **267,216** | **53,443** |
| | BOB STP | 14,092 | 4,228 | 8,455 | 7,046 | 1,409 |
| | Frimley Health STP | 5,791 | 1,737 | 3,475 | 2,896 | 579 |
| BOB | NHS Aylesbury Vale CCG | 1,611 | 483 | 967 | 806 | 161 |
| BOB | NHS Chiltern CCG | 2,519 | 756 | 1,511 | 1,260 | 252 |
| BOB | NHS Oxfordshire CCG | 6,093 | 1,828 | 3,656 | 3,047 | 609 |
| BOB | NHS Newbury & District CCG | 836 | 251 | 502 | 418 | 84 |
| BOB | NHS North & West Reading CCG | 907 | 272 | 544 | 454 | 91 |
| BOB | NHS South Reading CCG | 1,234 | 370 | 740 | 617 | 123 |
| BOB | NHS Wokingham CCG | 892 | 268 | 535 | 446 | 89 |
| Frimley Health | NHS Bracknell & Ascot CCG | 912 | 274 | 547 | 456 | 91 |
| Frimley Health | NHS Slough CCG | 1,487 | 446 | 892 | 744 | 149 |
| Frimley Health | NHS Windsor, Ascot & Maidenhead CCG | 1,137 | 341 | 682 | 569 | 114 |
| Frimley Health | NHS Surrey Heath CCG | 571 | 171 | 343 | 286 | 57 |
| Frimley Health | NHS North East Hampshire & Farnham CCG | 1,684 | 505 | 1,010 | 842 | 168 |
| | NHS Milton Keynes CCG | 1,952 | 586 | 1,171 | 976 | 195 |

*In "Implementing the Five Year Forward View for Mental Health" [2] and the "NHS Operational Planning and Contracting Guidance 2017-19" [3], NHS England stated that "CCGs should offer NICE-recommended screening and access to physical care interventions to cover 30% of the population with SMI on the GP register in 2017/18, moving to 60% population from the following year".*

*In line with refreshing NHS Plans for 2018/19, CCGs will be provided figures on the numbers of people on GP practices' SMI Registers. This will enable development of a robust quarterly trajectory for each CCG throughout 2018/19 and beyond. (Due April 2018)*

## Improving joint working across primary and secondary care

Joint working between primary care and secondary mental health providers is essential to improve physical healthcare for people living with SMI.

NHS England's proposed approach to trajectory setting for the delivery of physical health checks will be based upon:

**50%** of people with SMI register in *primary care* + **10%** of people with SMI register in *secondary care* = Achieving **60%** in total from 2018/19 *Min 280,000 people nationally

Evidence suggests that the benefits of systematic approaches to offering physical health checks are:

- Communication of the strategic aim of the physical health check ambition and hardwiring the 'why' to frontline staff
- Creating stronger communication and connection between primary and secondary care to ensure recording of completed physical health checks are captured by NHS Digital
- The view of service users on what constitutes a physical health check, so as to address concerns or preconceptions
- A revised approach to education and training on approach, needs of user and access to training to support the conversation.

## A comprehensive cardio-metabolic risk assessment in line with the NHS health check

BMI, blood pressure and pulse, blood lipids including cholesterol, blood glucose, lifestyle including diet and exercise, smoking status (enquiry about presence of cough, wheeze or breathlessness), and alcohol use. Approved risk assessment tools such as the QRISK Tool can be used to assess cardio-metabolic risk. Further details on the comprehensive checks can be found in the relevant NICE guidelines.

## Where indicated, relevant national screening programmes to be delivered or followed up

Cervical and breast cancer screening for women and bowel cancer screening for men and women.

## Medicine reconciliation and monitoring

Ensuring medication remains up to date and accurately recorded and is cross checked with all electronic records. Conduct any additional medication monitoring according to the particular Summaries of Product Characteristics (SPC) e.g. Lithium level, U&Es, LFTs, prolactin, ECG if indicated during this review.

## General physical health enquiry

Medical and family history, sexual health including use of contraception, substance misuse assessment (illicit or non-prescribed drug use), oral health assessment and any indicated physical examination.

Proactive engagement and psycho-social support may be required to ensure people with SMI access checks/ interventions and follow-up care including personalised care planning.

Follow-up interventions may include implementation of NICE guidelines for: Smoking cessation, Obesity, Hypertension, Lifestyle intervention, Diabetes, Lipid modification, Drug misuse, Signpost to cancer pathway.

While data for the region suggests positive work is being undertaken, the ambition to achieve the large increase in numbers of physical health checks requires a shift in discussion and partnership.

## Physical Health in SMI: A networked approach


### Increasing Access to Psychological Therapies

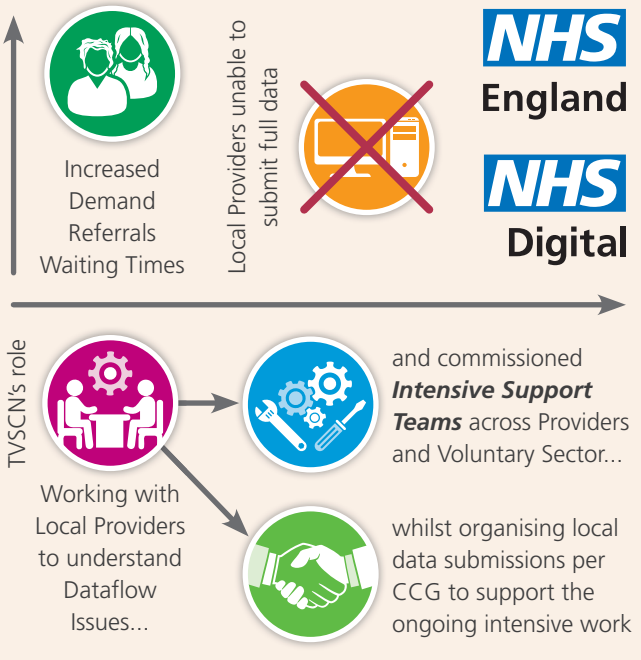
Increasing Access to Psychological Therapies (IAPT) is a key component of the Mental Health Five Year Forward View, and local STP plans. 20% (1 in 5) of over 65s living in the community is affected by depression, however, despite IAPT services being open to all adults, older people are underrepresented amongst those accessing services.

Regional transformation funding has been in place for the past year to support the implementation of the integrated IAPT programme, the new service set up last year for patients suffering with long term conditions and depression. Current activity levels of the IAPT service for the long term conditions cohort of between 6.8-8% suggests that there is scope to address an improvement in quality for those patient groups that would benefit from the therapy.

# Children's mental health

Good mental health is vital to give children and young people the opportunity to grow up happy, safe and healthy. The vision for the Thames Valley is to empower children and young people to be resilient, have good mental health, and if they need help, the knowledge that they can access high quality, timely services.

To enable this vision, accurate data is crucial to ensuring access to services.

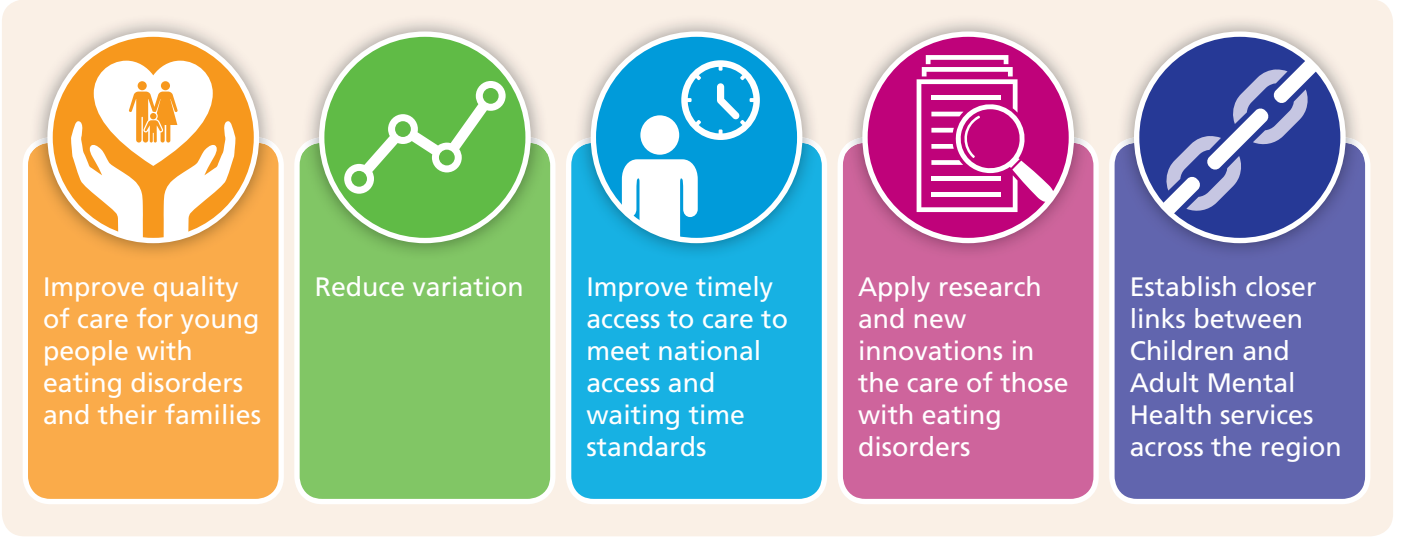



Intensive support is being offered in four key areas:

- Data completeness
- Capacity and demand: how to manage waiting time
- Pathway design (eg lean pathways, what does good look like)
- Value for money: investment/productivity.

## Children and young people's eating disorder services in Thames Valley

This year has seen newly established eating disorder services going live across the Thames Valley. As with any new service, it is essential to provide support and networking opportunities:




## Eating disorder service performance

| | 12 months (July 2016 - Jun 2017) | | 12 months (Oct 2016 - Sept 2017) | | | 12 months (July 2016 - Jun 2017) | | 12 months (Oct 2016 - Sept 2017) | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Urgent | | | | | Routine | | | | |
| Providers | Total number of completed pathways | % within 1 week | Total number of completed pathways | % within 1 week | Changes from the previous | Total number of completed pathways | % within 4 weeks | Total number of completed pathways | % within 4 weeks | Changes from the previous |
| Berkshire Healthcare NHS Foundation Trust | 27 | 62.96% | 29 | 65.52% | ↑ | 39 | 84.62% | 54 | 85.19% | ↑ |
| Oxford Health NHS Foundation Trust | 49 | 79.59% | 50 | 82.00% | ↑ | 314 | 77.39% | 329 | 82.07% | ↑ |

*Source: NHS England/statistical-work-areas*

[1] Mental Health Liaison Services – Berkshire, Oxfordshire, Buckinghamshire STP, Frimley STP and Milton Keynes, No health without mental health. TV SCN report, October 2017

[2] Complex recovery assessment and consultation - Cheshire and Wirral Partnership NHS Foundation Trust - NCCMH http://positivepracticemhdirectory.org/nccmh/complex-recovery-assessment-consultation-cheshire-wirral-partnership-nhs-foundation-trust/ (last accessed 29th January 2018)

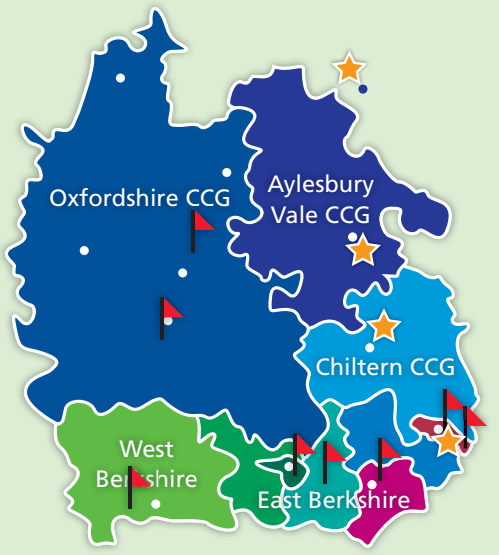
# Dementia: Building capacity and capability through clinical leadership

Supporting the SCN's ambition to create distributed leadership across the Thames Valley, the mental health network have taken the successes of the initial Dementia Friendly Practices pilot scheme, and expanded it out to the remaining Thames Valley CCGs.

This year (2017/18) has seen eight new GP practices working towards becoming exemplar dementia friendly surgeries to create pockets of learning and leadership within each CCG region.

## The crucial role of clinical leaders

Creating a supportive environment and investing in our clinical leaders has allowed us to focus not only on the process changes of the programme, but also on improving the skills of our leaders. We convened quarterly action learning sets for colleagues to share successes, challenges and learning to take back to their practices. This support has contributed to increased ownership of 'on the ground' issues and created greater visibility of dementia as a subject at CCG level.




**Phase 2 (2017-18):** Developing 8 Exemplar Dementia Friendly GP Practices to develop clinical leadership

**Phase 1 (2015-16):** Developed 4 Dementia Friendly GP Practices to implement SPACE principles

## All clinical leads supported by the SCN and Health Education England programme have been trained to tier 2 with dementia skills. 80% of their practice staff have tier 1 dementia skills.

### 2017

- Eight clinical leaders trained in tier 2
- 80% of practice staff trained in tier 1

- Clinical lead appointed dementia lead for CCG
- Clinical lead nominated for National GP Innovation Award for work in dementia

- Improved diagnosis rates observed and improvements supported

### 2018

Development of a holistic toolkit to support post-diagnosis across clinical requirements and practical living

Use simulation training for senior leaders to experience dementia and build the case for focus across all CCGs

Clinical leadership forum to promote evaluation and positive developments region-wide

Extended tier 1 training rolled out to localities

### Toward 2020/21

Increased training opportunities in both classroom and simulation

Ensure national target is exceeded across CCGs

DDR rates

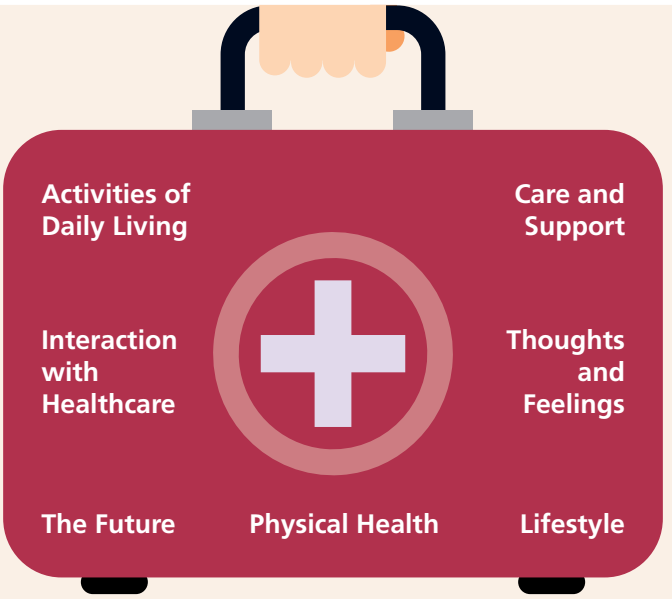
Clinical leaders supported by TVSCN and embedded as CCG clinical leads

Care planning approach to be embedded across region, utilising toolkit and clinical leadership

## Postdiagnostic support and care plans

This calendar year will see the SCN develop a toolkit to support a systematic approach to care planning.

This work will aim to provide those undertaking care plans with the right prompts to ensure support post-diagnosis. This will aim to support the national requirement of 90% of all patients having a care plan to support them, and will include:




## Leadership delivers results: Dementia diagnosis rates

| CCG | Sept 2016 (%) | Sept 2017 (%) | Overall change | DFP Practice | Apr 2017 (%) | Nov 2017 (%) | Change |
|---|---|---|---|---|---|---|---|
| NHS North & West Reading CCG | 69.8 | 64.2 | ↓ | K1 | 52.8 | 55.63 | ↑ |
| NHS South Reading CCG | 72.8 | 65.5 | ↓ | | | | |
| NHS Bracknell & Ascot CCG | 67.1 | 68.1 | ↑ | K2 | 51.93 | 66.47 | ↑ |
| NHS Aylesbury Vale CCG | 70.5 | 70.8 | ↑ | | | | |
| NHS WAM CCG | 68.9 | 71.6 | ↑ | K3 | 77.94 | 108.61 | ↑ |
| NHS Oxfordshire CCG | 67.8 | 67.8 | ↔ | K4 | 53.76 | 62.86 | ↑ |
| NHS Milton Keynes CCG | 64.5 | 67.6 | ↑ | K5 | 63.1 | 71.61 | ↑ |
| NHS Wokingham CCG | 64.2 | 65.5 | ↑ | K6 | 94.32 | 89.62 | ↓ |
| NHS Newbury & District CCG | 60.9 | 62 | ↑ | K7 | 59.91 | 65.92 | ↑ |
| NHS Slough CCG | 60.2 | 66.4 | ↑ | K8 | 70.9 | 64.21 | ↓ |
| NHS Chiltern CCG | 66.4 | 63.9 | ↑ | | | | |

# Upskilling the workforce through training and education

Workforce shortages, and new ways of shaping the future workforce continue to be an issue for the health system nationally. While this debate continues, the SCN has positioned itself, in partnership with HEE, as a regional convenor of specialist and generic training to build confidence in the existing workforce. This is highlighted by the work ongoing in mental health:

### Primary care

- GP psychiatry study days
- PPEPCare/PPIPCare mental health training
- Dementia: Tier 1 training
- Perinatal mental health training: Generic
- Making Every Contact Count training (STP wide)

### Specialist training

- Dementia: Tier 2 training
- Perinatal mental health training: specialist
- Making Every Contact Count training (Provider wide)

### Simulation training - innovative approach

- Creating different training models outside of traditional classroom-based
- Simulation training in dementia and perinatal mental health

## Case Study: PPEPCare - Partnerships ensuring positive mental health in children and young people

It is widely accepted that mental health problems in early life can have enduring long term issues across the life course. To ensure a focus on early support and empowering all parts of the system to acknowledge and better support young people in their mental health at as early a stage as possible is crucial.

PPEPCare is a partnership approach across Berkshire, Buckinghamshire and Oxfordshire to train staff in education and primary care to recognise and better understand common mental health issues using psychoeducation and psychological techniques, such as cognitive behavioural frameworks.

### Strategic Context

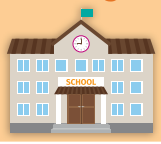
**Future in mind**
Promoting, protecting and improving our children and young people's mental health and wellbeing

**Transforming Children and Young People's Mental Health Provision: a Green Paper**

**PPEPCare training modules delivered in 2016/17**

- Low mood and depression
- Anxiety
- Self-harm
- Behavioural difficulties
- Eating disorders
- Mental health difficulties

**Staff in educational settings**



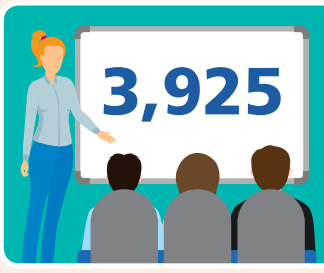

**School nurses**

**Primary care staff**

**Local Authority staff**

### Success of the programme:

**Between 2016 and 2017**




3,925 people have been trained in 153 sessions across Berkshire, Bucks and Oxon

Each component of the training was evaluated and shown to increase skills and confidence for attendees by a minimum of two points on a ten point scale

TVSCN continue to support the training in 2018/2019 - the programme is also adapting delivery to include promoting resilience in children and young people and autism spectrum disorder

# Neurology

## Headache pathway

In Oxfordshire CCG, 1 in 3 referrals to neurology outpatients is for headache, and 66% of all headache referrals could be managed in the community. Following on from work to support the CCG to produce the Oxford Headache Pathway, the network has created a generic Neurology Case for Change, summary document, and slide set which advises CCGs on developing a revised headache pathway. This will mean appropriate care closer to home, reduced costs and faster access to specialised help for patients. The materials produced by the network have been used in the national NHS RightCare framework for migraine and other headache disorders, which lay out a gold standard to guide commissioning decisions across the country. This work has also featured in the forthcoming report Society's Headache: The socioeconomic impact of migraine produced by the Work Foundation.

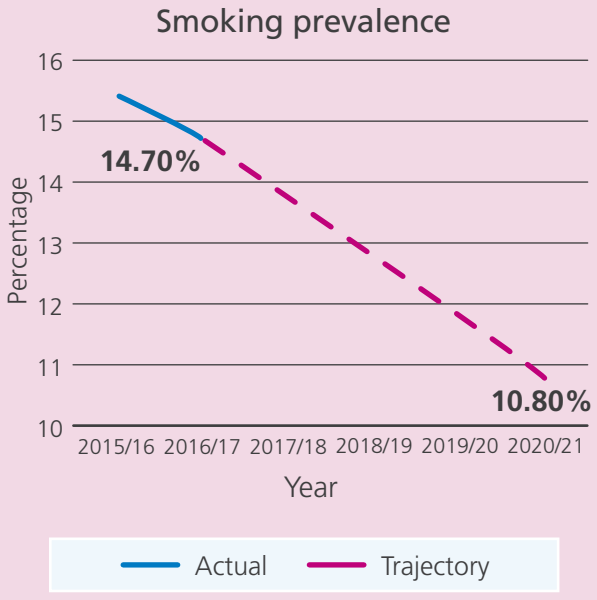
# Prevention

## Prevention and population health

For practitioners and the people we work with, health promotion, the importance of better self-care and a focus on prevention of ill health are core foundations for a healthier, happier population. The TVSCN and Clinical Senate have spent the past year supporting our CCGs, STPs and the emergent Integrated Care Systems in bringing these areas to the fore.

## A Senate and networked approach to smoking prevention

### While smoking prevalence is reducing...




### We know that, in acute trusts for example

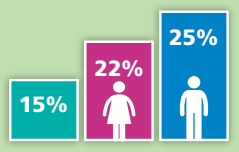
TV Clinical Senate undertook a review of BTS Clinical Audits in acute trusts and found:

**33%** of inpatients were not asked their smoking status

Only **25%** of identified smokers were asked if they wanted to quit

Only **2%** of current smokers were offered nicotine replacement

Smoking prevalence in acute trusts is higher than general prevalence




### And in the BOB STP area, just over 50% of smokers come from routine and manual workers categories, yet the percentage of those groups accessing services are low, especially in Oxfordshire

Smoking for routine and manual (R&M) workers

| Local Authority | Number of R&M workers July 16/ June 17 | Prevalence of those R&M workers who smoke March 16/April 17 | Approximate number of smokers | Percentage of smokers from routine and manual workers |
|---|---|---|---|---|
| Buckinghamshire | 67,300 | 26.8% | 18,036 | 57% |
| Oxfordshire | 87,600 | 24.6% | 21,550 | 51% |
| West Berkshire | 21,800 | 21.9% | 4,774 | 46% |
| Reading | 24,000 | 30.4% | 7,296 | 53% |
| Wokingham | 15,700 | 8.8% | 1,382 | 19% |
| BOB STP | 216,400 | | 53,038 | 50% |

## The journey ahead

**Cancer Alliance**

Education strategies in secondary care on prevention

**STPs supported by Health Eduction England & TVSCN**

1,000s more health and wellbeing conversations

**TVSCN & Clinical Senate**

Develop a network approach to address both secondary care prevention interventions and routine and manual workers

# Obesity

In April 2017, Thames Valley SCN was delighted to host Professor Susan Jebb OBE from University of Oxford Nuffield Department of Primary Care to deliver a webinar on brief interventions for weight loss in primary care settings. Key to her department's recent findings were:


The webinar and Q&A can be accessed here: http://bit.ly/2yCi4KL and the transcript here: http://bit.ly/2hi6Nrz

# Making Every Contact Count

Making every contact count (MECC) is an approach to behaviour change that utilises the millions of day to day interactions that organisations and individuals have with other people to support them in making positive changes to their health and wellbeing.

Through support from Health Education England and the TVSCN, BOB and Frimley STPs are upskilling over 110 multidisciplinary staff across provider trusts to take on a MECC champion role so as to be at the forefront of offering:


These champions will contract with their organisations to undertake onward training and upskilling events (Frimley Health) as well as build communities of action around MECC (BOB).

# Wider determinants and population health

## The building blocks of population health


**Places as systems:** it is in the interaction between these elements of the system that change can be delivered

# Population health

Through late 2017 and early 2018, Thames Valley SCN and Clinical Senate have been supporting local systems by helping to bring out the many differing definitions that currently exist around population health. An event was held in February 2018, attended by senior CCG and ICS leads, to hear from regional and national leaders on the exciting work being undertaken not only in the world of data and informatics, but also opportunities for towns to build health and wellbeing into their communities, as well as embracing the power of social networking for health and opportunities for the health app sector. All presentations and our latest Population Health publication can be accessed at the TVSCN website: http://bit.ly/2huYB7b

## Health literacy

A person whose levels of health literacy are low or average may have less ability to:


In October 2017 we invited Professor Jo Protheroe (GP and Chair of Health Literacy UK), Jonathan Berry (NHS England) and Mandy Wardle-McLeish (Community Health and Learning Foundation) to discuss health literacy as an essential element of the prevention and self-care agenda. Key to this is the message:

### Health information is too complex for...

**43%** of people

**61%** of people when the information requires maths skills

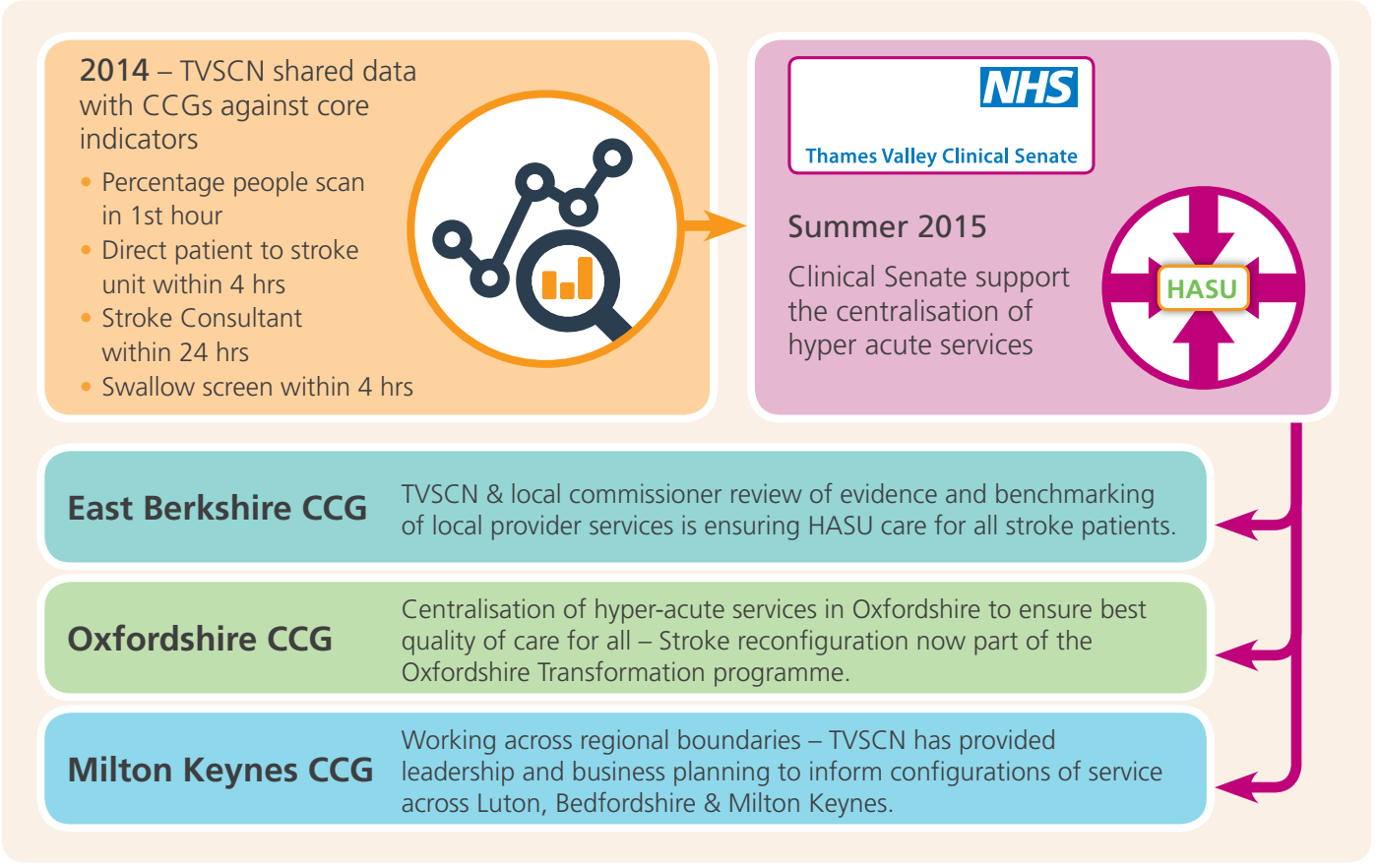
STPs and the emergent Integrated Care System (ICS) architecture are learning from webinars such as this, alongside the national work undertaken since 2015 which saw evidence and best practice being developed leading to, in 2017:

- An STP level learning programme on health literacy being tested and developed in Greater Nottinghamshire STP, to develop a health literate decision support framework which can be transferred and implemented in other emergent integrated care systems.
- Health Education England have designed a toolkit which makes available a range of strategic and practical interventions towards improving health literacy: http://bit.ly/2H25F3n

# Stroke network

## Hyper acute stroke services

In line with the ambition in Thames Valley to improve hyper acute stroke services and to centralise them, all HASUs in Thames Valley now have an A or B team-centred score. In addition, approximately 500 additional patients experiencing stroke symptoms are taken to a HASU for the first 72 hours of their stay in hospital.




**SNNAP Scoring summary (Team-centred Total KI level)**

| Period (Quarter) | Jan-Mar 2014 | Jan-Mar 2015 | Jan - Mar 2016 | Dec - Mar 2017 |
|---|---|---|---|---|
| Wycombe General Hospital | D | A | A | A |
| Milton Keynes General Hospital* | D | E | D | C |
| John Radcliffe Hospital | C | B | B | A |
| Royal Berkshire Hospital | A | B | A | A |
| Frimley Park Hospital | C | B | A | A |

*Note: A SSNAP scoring system has been derived to provide a summary of performance based upon results for 44 key indicators which are grouped into 10 domains covering key aspects of stroke care. For Domains 1 – 10, the scores have been calculated and given a performance level (A-E). A is the best level and E is the worst.*

** Note: Hospital does not have hyper acute stroke unit*

# Hypertension and atrial fibrillation

The network has developed a cardiovascular disease (CVD) prevention programme in conjunction with Oxford Academic Health Science Network (AHSN), and using an evidence base provided by Public Health England (PHE).

## Hypertension interventions

Nationally, hypertension costs the NHS £2bn a year, and accounts for 13% of visits to GPs. As a high risk factor for stroke, preventing and treating hypertension effectively is essential. There are currently 228,816 undiagnosed cases of hypertension in Thames Valley:

**Hypertension: Diagnosed and undiagnosed and QOF prevalance**

| STP | CCG | % of people with hypertension have been diagnosed | GP range from | GP range to | No of adults (age 16 and older) with undiagnosed hypertension | Diagnosed hypertension prevelance 2016/17 | Compared to previous year |
|---|---|---|---|---|---|---|---|
| | England | 59% | | | | 13.83 | ↑ |
| | Thames Valley SCN (including NHS Milton Keynes CCG) | 57% | | | 228,816 | 12.41 | ↑ |
| | Thames Valley SCN | 57% | | | 203,511 | 12.43 | ↑ |
| | BOB STP | 57% | | | 164,064 | 12.60 | ↑ |
| | Frimley Health STP | 57% | | | 68,474 | 12.49 | ↑ |
| BOB | NHS Aylesbury Vale CCG | 59% | 47% | 77% | 19,494 | 13.60 | ↑ |
| BOB | NHS Chiltern CCG | 58% | 43% | 72% | 32,238 | 13.36 | ↑ |
| BOB | NHS Oxfordshire CCG | 57% | 24% | 79% | 65,430 | 12.31 | ↑ |
| BOB | NHS Newbury & District CCG | 57% | 46% | 62% | 11,229 | 12.83 | ↑ |
| BOB | NHS North & West Reading CCG | 59% | 45% | 75% | 10,135 | 13.41 | ↔ |
| BOB | NHS South Reading CCG | 54% | 25% | 69% | 11,383 | 10.15 | ↔ |
| BOB | NHS Wokingham CCG | 58% | 39% | 63% | 14,155 | 12.43 | ↑ |
| Frimley Health | NHS Bracknell & Ascot CCG | 56% | 39% | 72% | 12,742 | 11.89 | ↑ |
| Frimley Health | NHS Slough CCG | 56% | 39% | 69% | 12,658 | 12.01 | ↑ |
| Frimley Health | NHS Windsor, Ascot & Maidenhead CCG | 55% | 36% | 73% | 14,047 | 11.41 | ↑ |
| Frimley Health | NHS North East Hampshire & Farnham CCG | 59% | 45% | 77% | 20,102 | 13.45 | ↑ |
| Frimley Health | NHS Surrey Heath CCG | 58% | 52% | 64% | 8,925 | 13.66 | ↑ |
| | NHS Milton Keynes CCG | 57% | 43% | 73% | 25,305 | 12.21 | ↑ |

*Source: 1) CVD primary care intelligence pack, published in July 2017 for diagnosed and undiagnosed hypertension*
*Note: This table shows hypertension prevalence estimates created using data from QOF hypertension registers 2014/15 and undiagnosed hypertension estimates for adults 16 years and older. 2014. Department of Primary Care & Public Health, Imperial College London*
*2) QOF 2016/17 for prevalance*

The SCN and Senate are investing in interventions in both the prevention and detection of hypertension:

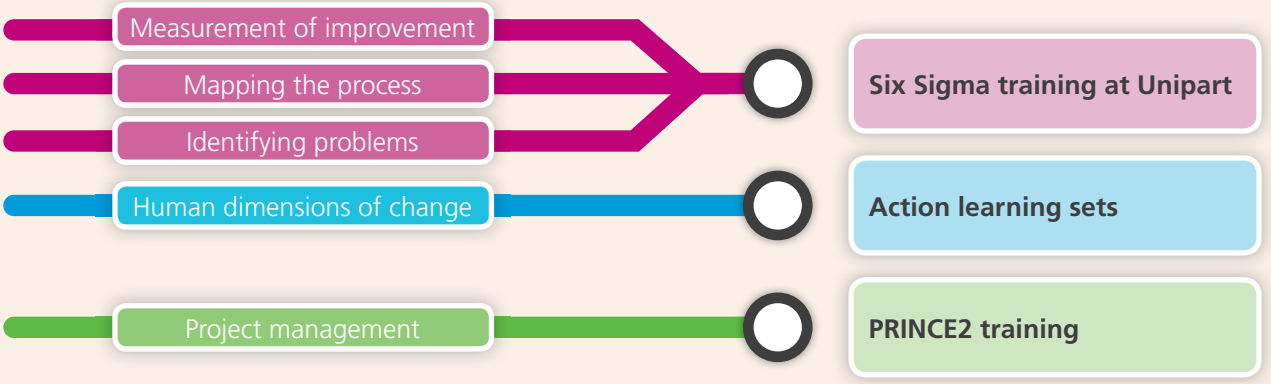
- Increasing clinical leadership around the detection of high blood pressure
- Supporting healthy lifestyle choices through the adoption and spread of care and support planning
- Education around brief interventions in obesity (see page 43 for more information on our brief interventions webinar)
- Reducing smoking (see page 42 for the Senate and Cancer Alliance's work on smoking reduction)
- GP education on physical health for people with serious mental illness.

# The SCN and Senate team

## How we work together and with others

### We learn together

We mapped what we wanted to learn about service improvement tools, and then arranged training




We also set up Lunch & Learns to capitalise on expertise already held within the team

**Minute taking**

**Email management**

**Demystifying healthcare databases**

**Behaviour change**

### We take wellbeing seriously

Weekly team lunches

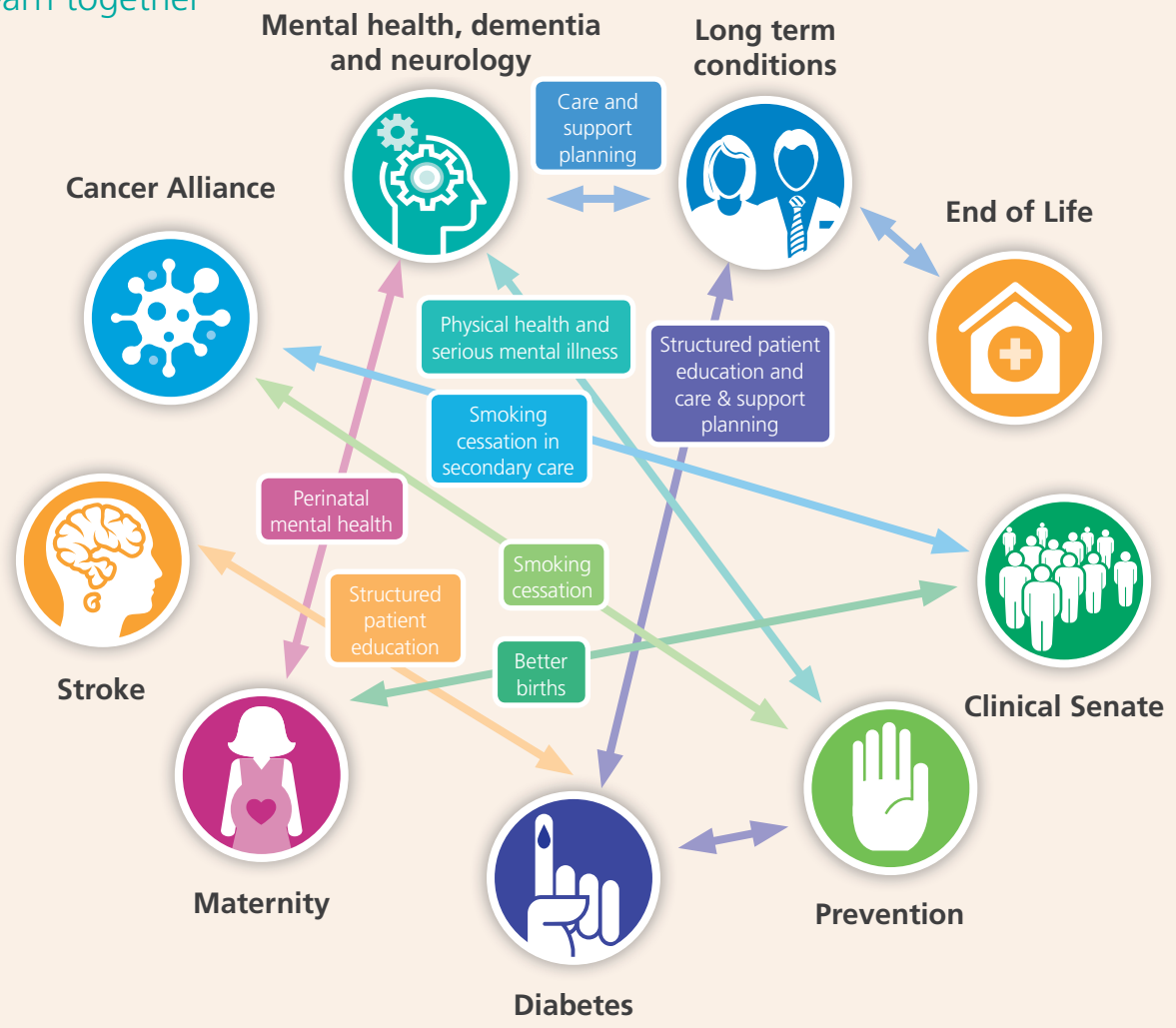
Lunch and team building games

mhfa mental health first aid england

Mental health training and resources

Volunteering in the community

## We learn together




## Stakeholders define our work programme

### Mental Health

- IAPT workshops and IAPT service leads /patient reps
- Dementia commissioners forum
- Children and young people's mental health strategic group
- Mental health commissioners forum
- Perinatal mental health network

### Senate

- Senate Council

### Maternity

- TVCN children & maternity commissioners managers group
- TVCN maternity service users group
- TVSCN Head of Midwifery and lead obstetrician group
- Local Maternity Systems

### Cancer Alliance

- Trust cancer managers
- Expert advisory group
- CCG GP & management leads
- Trust cancer lead clinicians
- PODGs
- Cancer executive group
- Cancer transformation groups

### End of Life

- Commissioners forum

### CVD and Diabetes

- Diabetes reference group
- Clinical leadership group

# Contact Us


Aarti Chapman, Associate Director
aarti.chapman@nhs.net
07825 448275

## Clinical Senate

Wendy McClure, Clinical Senate Manager
wendy.mcclure@nhs.net
07810 636279

## Cancer Alliance

Monique Audifferen, Cancer Alliance Manager
monique.audifferen@nhs.net
07920 233264

Lally Widelska, Quality Improvement Lead – Prevention and Early Diagnosis
alexandra.widelska@nhs.net
07730 379871

Pei Ying Lo, Administrator
peiying.lo@nhs.net
01138 248713

## Mental Health, Dementia and Neurology

James Carter, Senior Network Manager
james.carter1@nhs.net
07879 488139

Carolyn Hinton, Quality Improvement Lead
carolyn.hinton@nhs.net
07918 368469

Sylvie Thorn, Quality Improvement Lead – Dementia
sylviethorn@nhs.net
07568 431571

Mel Gabbi, Quality Improvement Lead – Children's Mental Health
melanie.gabbi@nhs.net
07808 517302

Sarah Fishburn, Quality Improvement Lead – Perinatal Mental Health
sarah.fishburn1@nhs.net
07730 381189

Carole Padbury, Business Support Officer – Mental Health, Dementia and Neurology
carole.padbury@nhs.net
01865 963810

## Maternity

Rebecca Furlong, Network Manager – Maternity
rebecca.furlong@nhs.net
07717 320353

Debbie Jackson, Business Support Officer – Maternity
debbie.jackson9@nhs.net
01865 963823

## Diabetes and Cardiovascular Disease

Julia Coles, Senior Network Manager – Diabetes and Cardiovascular Disease
julia.coles1@nhs.net
07825 448208

Frances Fairman, Head of Clinical Programmes – Stroke
frances.fairman@nhs.net
07918 368485

## End of Life and Long Term Conditions

Julia Coles, Senior Network Manager – End of Life and Long Term Conditions
julia.coles1@nhs.net
07825 448208

Gina King, Quality Improvement Lead – End of Life
gina.king1@nhs.net
07990 803221

Alexander Beckett, Business Support Officer
alex.beckett@nhs.net
01138 253328

## Project team

Charlie Cooper, Quality Improvement Lead
charlotte.cooper2@nhs.net
07730 379757

Daniella Dzikunoo, Quality Improvement Lead
daniella.dzikunoo@nhs.net
01138 255563

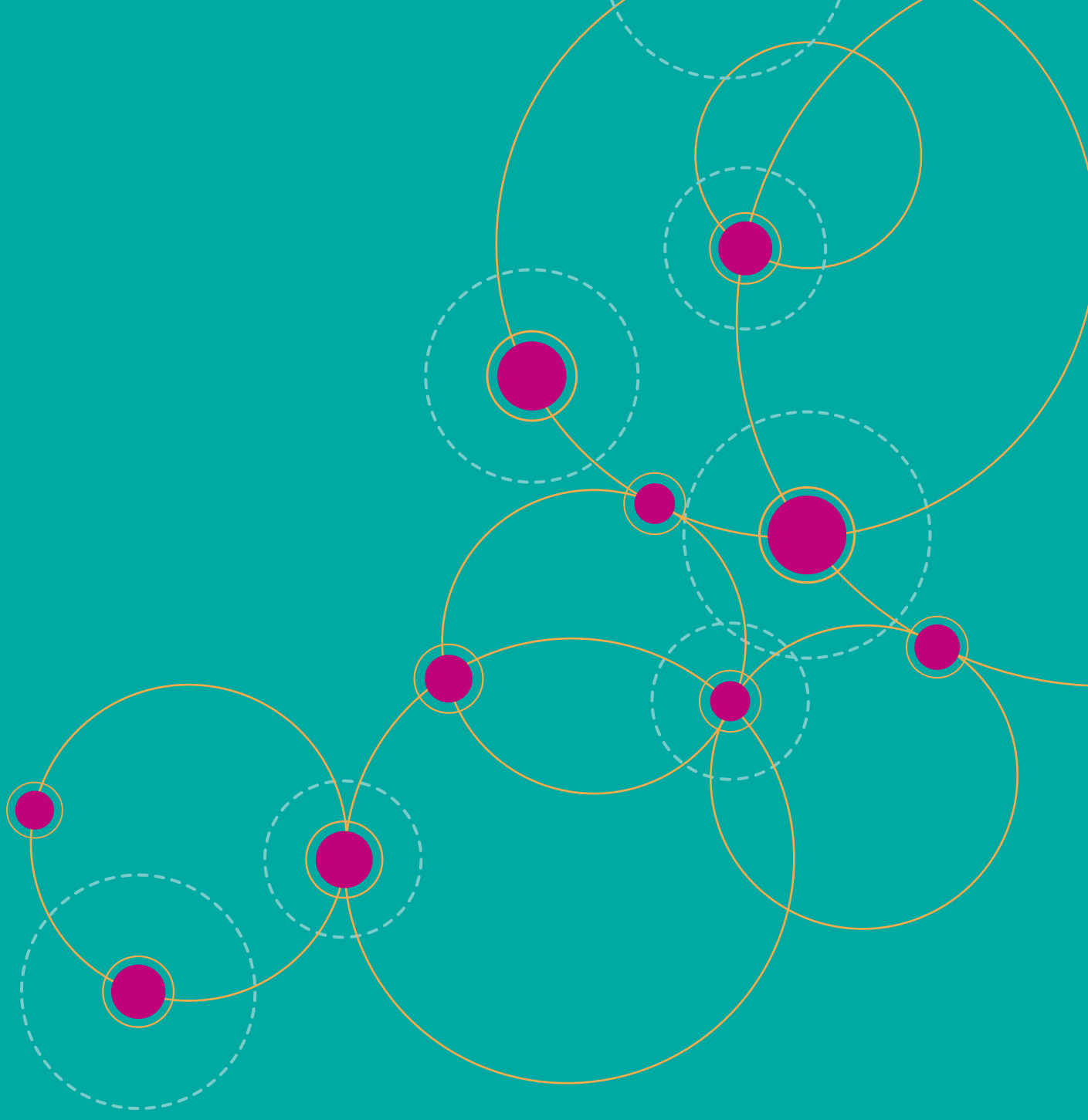
## SCN and Senate Support

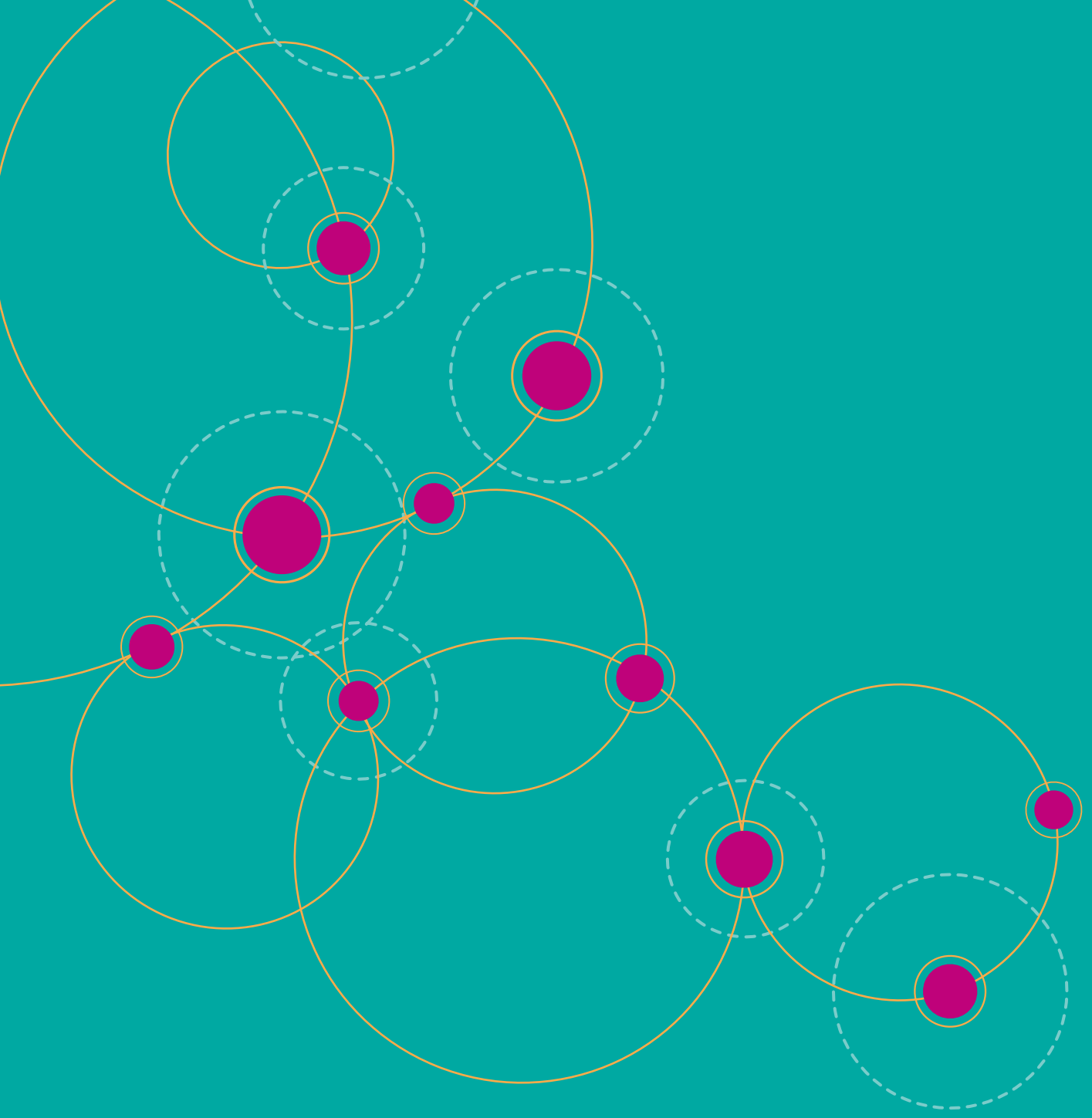
Rachael Demain, Business Office Coordinator
rachael.demain@nhs.net
01865 963875

Tahira Aslam, Senate Support Officer
tahira.aslam@nhs.net
01138 248015

## SCN and Senate Communications

Carla Hodge-Degler, Business Support Officer – Communications
carla.hodge-degler@nhs.net
01338 251755





http://tvscn.nhs.uk/
http://tvsenate.nhs.uk/