Taking the lead

How clinical commissioning groups are changing the face of the NHS

NHS Clinical Commissioners

The independent collective voice of clinical commissioning groups

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Foreword

This report has its roots in a challenge I offered to the leaders of NHS Clinical Commissioners last year – and which they have taken up in full measure.

The challenge was simple. No-one is interested in utopian theories about how healthcare might be better organised. We have heard it all too many times before. Attention drifts. Eyes glaze over.

The case for CCGs has to be made in demonstrable results. Improved patient experience and improved clinical outcomes which are underwritten, rather than undermined, by greater cost efficiency.

That is what these case studies provide.

This is not the search for the Holy Grail. The report does not contain evidence of magic solutions. Those who believe in magic should stick to alchemy.

But it does provide hard examples of CCGs who have engaged with local clinicians and service providers to deliver service change which makes a real difference.

Furthermore, a collection of compelling case studies is more than a collection of anecdotes.

It allows the reader to identify common themes which can be applied elsewhere – not always in the same way but motivated by the same experience.

Some strong themes do emerge:

- joined-up NHS services deliver better care
- improved care is not just about the NHS – it needs to involve individuals, local authorities and community representatives
- clinicians can be effective champions of change
- patient empowerment is not an afterthought – it is a starting point.

But the importance of this report is not that it offers a unique new theory; it is "more unique" than that – it offers evidence.

And that is the most powerful argument that CCGs can muster to show that clinical engagement in commissioning (long talked about but rarely experienced) can make a real difference to people's lives.

Rt Hon Stephen Dorrell MP
Heath Minister 1990–92 and 1995–97
Chair of House of Commons Health Committee 2010-date

Introduction from NHS Clinical Commissioners: Clinical commissioning is making a difference

April 2013 saw the birth of a new type of commissioning in the NHS in England. Clinical commissioning groups were set up to be clinically led and to work collaboratively across communities, designing services built around patients, people and populations.

The stories in this report show the energy and enthusiasm with which CCGs have taken up this challenge. From the smallest CCGs to large-scale county-wide collaborations, they show the power that is unleashed when clinical leaders, local government, the voluntary sector and private providers work together. Our thanks go to everyone who helped us write them.

People's lives are changing as a result. In Oldham, for example, the CCG is working with the local council and a housing association to lift people out of fuel poverty, aiming to help 1,000 households stay warmer this winter and vulnerable people with long-term conditions to remain well enough to stay at home. In Leicester, health coaches are helping people with chronic lung disease to look after themselves. Regular phone calls and home monitoring make sure they know what to do if they become unwell.

CCGs are proving that the NHS can provide the services people want closer to their homes. In Corby, senior GPs now work part of their week in a brand new urgent care facility and local people no longer have to travel eight miles to A&E for an x-ray. In East London, people recovering from mental ill health can now be seen not in hospital but in their GP surgery.

Under the clinical leadership of CCGs, clinicians are now more likely to be talking to fellow clinicians. In Staffordshire and Stoke-on-Trent, for example, a GP worried about a frail elderly person at home can make a call to a nurse practitioner and together they can work out the best treatment plan. In Bassetlaw, consultants and GPs have together designed a new service to make sure people admitted to hospital in an emergency are rapidly assessed, treated and helped home again.

Others are finding new ways of working. In Lambeth, the CCG has gathered the views of over 800 people in a debate on how the NHS can provide the services local people need and remain sustainable. In Staffordshire, five CCGs are working with Macmillan Cancer Support to commission end-of-life care and cancer care that is built around the whole person for the whole of their journey.

These stories demonstrate how the NHS can become patient centred and sustainable. Not only do these innovations help people to stay well or prevent them becoming ill in the first place, they also allow the NHS to make best use of precious resources. They are driving down unnecessary admissions to hospital, speeding up the discharge of patients who no longer need a hospital bed, improving access to urgent care and, yes, saving lives.

What shines through is the reason that CCGs have achieved this when others struggled: clinical leadership. Put clinicians from different backgrounds around the table together and the discussion is about patients, first and last. Add local councillors and those patients become people and communities.

There are over 200 CCGs in England so the stories here reflect just a tiny fraction of the innovation out there. Nobody pretends that the task of creating a high-quality, cost-effective and sustainable NHS is easy. But the stories here show the appetite to make services the best they can be for patients is real – and when power is placed in clinicians' hands they can start to make it happen.

Summary

As we approach the first anniversary of clinical commissioning groups (CCGs), it is an opportune time to demonstrate their added value and critical role in leading improvement and innovation in the NHS.

NHS Clinical Commissioners (NHSCC), as the membership body of CCGs, has developed this report to highlight some of the early successes that our members have made to the lives of patients and communities across England following the Health and Social Care reforms. We wanted to show how our members are using a combination of their clinical and managerial expertise to shape transformative healthcare at a local level.

The 15 case studies within this publication bring local achievements to the national stage. They outline how clinical commissioners are working across boundaries, with their member general practices, health and social care providers, voluntary and private sector partners and, just as importantly, the people they serve, to drive long-term change for their communities. They are already delivering higher quality care that is better value for money.

The case studies show us how CCGs:

Integrate health and social care commissioning

- In Kingston, the appointment of a joint lead for the CCG and director of adult social care is driving integration and enabling vulnerable people to remain in their own homes
- In Northumberland, a new frail elderly pathway is identifying, assessing and meeting the needs of vulnerable older people in a way that is structured, consistent and joined up, helping them to stay at home longer

Understand local need and work at pace to find local solutions

- In Windsor, Maidenhead and Ascot and Leeds South and East, the CCG is working with care homes to improve the healthcare of residents, driving down the number of emergency admissions and ensuring high-quality healthcare for residents
- In Bassetlaw, GPs and hospital doctors have developed a seven-day consultant service in medical assessment that is reducing mortality and length of stay for people who are admitted to hospital in an emergency

Develop person-centred care

- In Leicester, people with chronic lung disease now receive personalised support to help them stay well. This is reducing the number of emergency admissions to hospital
- In North Staffordshire, clinicians can now talk to fellow clinicians to find alternatives to hospital for ill patients who do not need a hospital bed – and to make sure people leaving hospital can do so safely
- In Staffordshire, five CCGs are working with Macmillan Cancer Support to develop new care pathways built around the needs of people with cancer and people at the end of their life

Balance scarce resources to meet population need

- In Lambeth, over 800 people have joined the BIG Lambeth Health Debate to help the CCG commission sustainable services that meet people's needs
- In Barnsley, the CCG has worked with high street pharmacists to provide a minor ailments service for people who do not need a GP, making sure people get the right treatment at the right time
- In Hackney, people recovering from mental health issues can now be supported in primary care by trained GPs and mental health workers

Bring clinical leadership to complex issues

- In Corby, the CCG has worked with local GPs to develop a new kind of urgent care centre that is meeting local need and reducing demand for hospital A&E services
- In northern Devon, GPs have developed a falls prevention pathway that is bringing together the services across general practice and hospital care, making sure people at risk of falling get the help and advice they need
- In Norwich and central Norfolk, the CCG is working with acute hospitals, GPs, urgent care centres and the ambulance services to improve urgent care, reducing waits in ambulances and in A&E

Working with partners on the wider determinants of health

- In Oldham, the CCG is working with the local council and social housing providers to replace boilers and insulate homes, bringing people out of fuel poverty and improving their health.

NHSCC believes that to help CCGs improve outcomes for their populations, they need a commitment from national policy to have support, space and stability over the coming years to continue these successes and drive ambition for much more.

Developing a minor injuries service

Barnsley Clinical Commissioning Group

When Barnsley Council set out a couple of years ago to find out from residents what they wanted from local services, they were in for a surprise.

The council had worked with the charity Turning Point to train 22 local people in Dearne Valley – one of the most deprived areas of the borough – to become social interviewers. These people, in turn, asked over 600 local residents about their concerns and issues. "Where the local authority might have expected people to talk about anti-social behaviour or littering, one of the main messages to come back was that they had a problem getting an appointment with their GP – and that's what they wanted solved," says Barnsley CCG's chief officer Mark Wilkinson.

The advent of the CCG in 2013 offered the chance to find some solutions. Working with a new area council set up by Barnsley Council in Dearne to devolve power to local communities, the CCG began to look at the options.

This is a complex issue that will take time to solve but there was a quick win to be made. With 20 per cent of GP workload typically minor ailments, could some of this be diverted to community pharmacy? "It was clear that community pharmacy had not been well developed in Barnsley – and there was an opportunity here," says Mr Wilkinson. During autumn 2013, the CCG worked with local pharmacists to develop a minor ailments service. It is a model that had worked well elsewhere and involves offering a service in the high street pharmacy for people who need some advice from a health professional but do not necessarily need a GP.

"There is real untapped potential here," says Mr Wilkinson. "If we can offer a service in community pharmacy on the same basis as primary care – so for example if people qualify for free prescriptions they still get them – then we can reduce the pressure on primary care."

Surveys with local people and consultation with pharmacists and GPs showed that there was the appetite for the service – but only if everyone was included and not just those on free prescriptions. Data from other minor ailment services in the region allowed the CCG to be sure it would be cost effective. By 1 December 2013, the service was up and running across Barnsley. Anyone with a minor ailment can get advice from the pharmacist. If they qualify for free prescriptions, they can get over-the-counter medicines paid for by the NHS; if not, the cost of the medicine should be less than a prescription charge. There are established protocols for pharmacists to refer patients needing medical help to the GP.

"Pharmacy is the profession trained to treat minor illness at degree level," says Barnsley CCG's lead pharmacist, Richard Staniforth. "We are making the best use of the resources we have by empowering pharmacists to treat minor ailments and breaking down the barriers that lead people to perceive that the GP practice is the first place to go when they need medical treatment."

Over the coming months, pharmacists will be providing feedback and data on patient experience and the extent to which they would otherwise have sought a GP appointment.

Dr Mehrban Ghani, CCG medical director and a local GP, says the beauty of the CCG was the speed with which it was able to implement the change. "Rather than sit in a committee, we were able to bring the clinical leaders in our community together to work out what needed to be done – and get on and do it quickly," he says. "With community pharmacy open 100 hours a week, this is going to make a real difference to the people of Barnsley."

Joined-up working

North East Essex CCG is working with Tendring District Council and the East of England Ambulance Service to train Careline workers to help people who have fallen at home. Elderly residents who have a Careline alarm (allowing them to summon help at the touch of a button) will no longer have to wait for an ambulance if they fall.

Alternatives to A&E

Wirral CCG has worked closely with patients to drive down the number of people attending A&E. Discussions with patient participation groups revealed that patients found it difficult to get a GP appointment so the CCG developed a new minor injuries service and increased the number of GP appointments. The service has proved popular.

“Rather than sit in a committee we were able to bring the clinical leaders in our community together to work out what needed to be done – and get on and do it quickly.”

Dr Mehrban Ghani, CCG medical director

Seven-day consultant care: improving care for patients

Bassetlaw Clinical Commissioning Group

One of the most important things hospitals can do to improve safety is ensure that there is always a senior doctor available to give advice. It has been proved time and again to save lives.

This "seven-day consultant-delivered" care is now on offer in a new assessment and treatment centre (ATC) at Bassetlaw Hospital. The result? Fewer patients now die in the hospital. Rather they get better and go home quicker.

Patients who come to the ATC are acutely unwell and often arrive in an emergency. Here they get an early expert assessment, a decision about their treatment and care plan within 12 hours and all their key diagnostic tests completed within 24 hours. They are also told when they can expect to go home. It is the sort of service that healthcare professionals want to deliver but often struggle to get right. There are too few consultants, for example, or the access to radiology, therapists or pharmacists is limited at weekends. It's beyond their control.

"If you look at the evidence it shows us that people admitted to a hospital in an emergency at night or at the weekend are more likely to die and that's partly to do with staffing and access to investigations," explains Dr Steve Kell, GP and chair of the CCG. That Bassetlaw has achieved seven-day consultant working is down to partnership, he says. When GPs took the lead on commissioning healthcare two years ago, they sat down with the hospital consultants to work out a plan to improve care. "Bassetlaw is a small hospital and has sometimes struggled to recruit doctors," he says. "When we got everyone around the table we quickly reached a consensus that patients needed rapid assessment, rapid access to diagnostics and prompt treatment."

Together, they came up with the idea for the ATC. The CCG agreed to refurbish a ward and pay for the hospital to recruit new acute physicians – consultants who are trained in dealing with acute medical emergencies rather than specialising in one disease area. They provide senior cover seven days a week. The ATC can access enhanced diagnostic services, therapeutic services (such as physiotherapists) and social care services to ensure everyone starts planning early for patients to go home safely.

In the two years since the ATC opened, hospital mortality rates for patients admitted in an emergency have come down by 22 per cent overall – and 25 per cent for those who are admitted at the weekend. The average length of stay has gone down from 7.9 days in 2009/10 to 6.5 days in 2012/13. This, says Dr Kell, means the investment was worthwhile.

"It's cost effective and has delivered improved quality," he says. The ATC is also helping GPs keep patients at home when they do not need to be in hospital, adds Dr Kell. "There is always a consultant that I can ring for advice about my patients," he explains.

Continuous improvement is built into the system with regular meetings between GPs and consultants reviewing medical admissions and looking for joint learning to improve the system. "The regular presence of senior staff has helped all staff to deliver good quality care for patients on the ATC and produced an environment for further learning and development," says Dr Tim Noble, clinical director for general and acute medicine at Doncaster and Bassetlaw Hospitals NHS Foundation Trust.

For Dr Kell, this partnership and co-design is proof that clinical commissioners are doing things differently. "If you talk to hospital managers and consultants they will tell you what they need to do to improve their hospital," he says. "It is important that we listen to them – and that we talk about patients rather than contracts. That's what the clinically-led CCG has been able to do – and it is what we will carry on doing."

Innovation

In November 2013, Oldham CCG asked member practices to pitch their innovation ideas to a Dragon's Den style panel. There were 48 pitches for the CCG's £600,000 innovation fund – and 23 received funding for their ideas.

Integrated working

Wakefield CCG is working with neighbouring North Kirklees CCG, as well as partners in hospital services and social care, to improve services for patients. They are making real progress. In one example, patients who call an ambulance but do not need to go to hospital are now referred to their own GP. It is not easy to make changes, say the CCG leaders, but at last clinicians are involved in designing services that work for patients.

Physician Dr Nick Mallaband, one of the senior doctors who work in the ambulatory care service and assessment and treatment centre at Bassetlaw

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Dr Steve Kell, CCG chair

Providing mental health services in primary care

City and Hackney, Newham and Tower Hamlets clinical commissioning groups

There is a group of people with mental health problems whose needs are often poorly met: people in recovery. They fall between stools when it comes to getting the right level of cost-effective care.

Now City and Hackney CCG, along with Tower Hamlets and Newham, have designed a new pathway in primary care, offering both mental health and physical health interventions and supported by community mental health workers. So far over 1,500 people's care has been provided in this way and more are set to join.

David Maher, programme director for the CCG, explains: "These are predominantly people who are stable following a period of treatment – the people recovering from mental health problems. Many of them have been languishing in services for some time because they are not unwell enough to need a bed or be seen by the home treatment team, but nor are they completely stable or confident enough to relinquish the support of community mental health teams entirely.

"We have put in place a structured programme of support that allows primary care to have the confidence to support them and patients to have the confidence to move to a different care setting."

Forty of the CCG's 44 GP practices are now assigned a community mental health worker, first to identify patients who might benefit and then work with those patients and the practices to develop individual recovery plans. The scheme is voluntary and each patient, their GP and psychiatrist must agree to take part. GPs take responsibility for providing depot injections (normally carried out by mental health specialists elsewhere) and prescriptions where needed, as well as an annual physical health check. The aim is to provide regular input to chart and support recovery.

Developing the scheme was not without teething problems, says Dr Rhiannon England, the GP who commissioned it. For a start, patients were concerned about lack of specialist skills in primary care as well as potential loss of benefits. It has taken time for community mental health workers to adapt to primary care and for GPs to build up confidence in the community mental health workers.

"We have been able to get around the benefit issue and reassure patients that the specialist support and training is in place to help the GPs. The input patients receive is more frequent and much more recovery focused," she says.

Now confidence on all parts is high enough to see the model expand. Dementia advisers from the Alzheimer's Society are already working with primary care to support patients closer to home. More psychiatric liaison nurses are set to join practices to provide a link with the mental health trust that provided inpatient care for the patient – in the case of City and Hackney this is the East London Foundation Trust. "That's important because the secondary care provider must have confidence in these new pathways," says Mr Maher.

"We are also about to commission a group of former mental health service users to work with GPs and patients to help them navigate the support systems available outside hospital, such as employment support and benefits," he adds.

For Dr England, this is partly about providing a primary care service for people with a long-term condition, and partly about making best use of the resources at the CCG's command.

"We have struggled with our spend on mental health, which has been very concentrated on severe mental illness. Hackney has among the highest rates of psychosis in the country," she says. "We need to be looking at the mental health needs of the whole population. I am full of admiration for my colleagues who know that this is a good idea and have signed up for it."

Reducing variation

Bradford City and Bradford CCGs have produced a dementia map highlighting differences in rates of dementia diagnosis. Patients who are diagnosed early are more likely to receive the help they need. The map is intended to drive up standards across the district.

Collaboration in action

In West Yorkshire, ten CCGs are working together on a range of projects, including end-of-life care and dementia care. Care homes are a big focus and in Leeds West CCG named pharmacists now work with named care homes to improve the way medicines are prescribed for residents.

"We need to be looking at the mental health needs of the whole population. I am full of admiration for my colleagues who know that this is a good idea and have signed up for it."

Dr Rhiannon England, commissioner of new primary care pathway

A new service for urgent care

Corby Clinical Commissioning Group

Corby is a proud Northamptonshire town where people like to do things their own way. The CCG is no different and two years ago, while in shadow form, it commissioned a brand new kind of urgent care.

It is a model that Corby CCG chair Dr Peter Wilczynski believes is unique in the UK: a walk-in centre with diagnostics (including hospital standard pathology, x-ray and FAST ultrasound) linked to observation couches. In the language of NHS management, it aims to manage urgent care locally, redirect people away from the emergency department eight miles away at Kettering General and reduce non-elective admissions.

In the language of patients, it's somewhere you can get seen by a doctor within 15 minutes, seven days a week. You don't have to go anywhere else for an x-ray or ultrasound and you may even see your own GP on duty. As one local resident posted on the CCG's Facebook page: "Amazing service. Use it or lose it."

It's working well, says Dr Wilczynski. "We have reduced A&E attendances by our population by 16 per cent compared to the last year while attendances for the rest of Northamptonshire have gone up by 4 per cent," he says. Unplanned admissions are down 14 per cent and the centre has decreased zero day paediatric admissions by 18 per cent. In September 2013 the East Midlands Ambulance Service diverted 54 ambulances to the centre, and now it has started to attract people from a wider catchment area. "Around 20 per cent of the people who use us are now outside the Corby catchment area," says Dr Wilczynski. "They are choosing to drive past the local hospital to come to us."

Setting up the centre was a bold move that involved closing several local urgent care centres to commission the new centre from scratch, including the infrastructure, and asking providers to compete to run it. The contract was won by Lakeside Plus, a consortium of local GPs and the acute hospital. This has been one reason for its success, says Dr Wilczynski. "The organisation is run by experienced GPs and staffed by them alongside nurse practitioners and minor injuries nurses," he explains. "There is always one senior GP on call and working in the service who has appropriate urgent care training, including advanced life support."

Lakeside Plus employs some of the GPs; others are local GPs who work shifts at the centre having been released by their practices. The clinical lead, Dr Stuart Maitland-Knibb, is a GP who also works on the consultant rota in A&E. His team has developed a number of patient pathways designed to manage care that would otherwise require admission. He says: "We have created patient pathways with input from primary and secondary care that allow patients to be managed safely in the community. If a secondary care admission is required, we can start these on secondary line treatments as appropriate, for example prescribing a first dose of antibiotics."

Dr Wilczynski believes the model is scalable and transferable. "We think this is a model that could help commissioners address the current crisis in urgent care," he says. "But it is a model that requires substantial change in behaviour from general practice for it to work and requires senior GPs to work in the service. We have been able to achieve this here because the CCG is clinically led."

Innovation

Norwich CCG has supported GPs who are testing a new iPhone app to take high-quality digital pictures of skin blemishes that can be transmitted to specialists for review. The TELEDerm technology aims to provide GPs with a quick second opinion and help them make better decisions about referring patients to the hospital.

Direct access to specialist care

Doncaster CCG has funded a pilot scheme to allow cancer patients direct access to specialist care in the oncology department at Doncaster Royal Infirmary seven days a week. The aim is to reduce emergency admissions to hospital for these vulnerable patients.

“We think this is a model that could help commissioners address the current crisis in urgent care. We have been able to achieve this here because the CCG is clinically led.”

Dr Peter Wilczynski, CCG chair

Falls prevention

Northern, Eastern and Western Devon Clinical Commissioning Group

More older people suffer a fracture from a fall than suffer a heart attack or stroke – and the consequences can be both devastating for the individual and costly for the NHS.

Preventing them is complex. It involves councils offering preventive public health work, such as exercise classes for older people and home safety assessments to fix risks such as loose carpets. It involves GPs spotting people at risk of falling and hurting themselves. It involves specialist teams at hospital and long-term medication for people who have had a fracture, as well as rehabilitation to help them get back on their feet and stopping them falling again.

Now GPs in north Devon have developed a pathway bringing these services together so that people can get the right help at the right time, depending on their individual needs.

"It's not rocket science and the evidence is there about what works and what we all need to do across the system," says Dr Duncan Bardner, a GP in Bideford. "It's really about coordination." Over the last year he has worked closely with Northern Devon Healthcare NHS Trust and Devon County Council to develop this new falls pathway for patients registered at North Devon GP practices.

"What we were finding was that patients who had fallen were getting lost in the system," says Dr Bardner. "They might be seen after a first fall by social services, or in A&E or they might see their GP – but they were not being offered the right assessments or ongoing help to prevent another fall or fracture. Our pathway funnels people in the right direction."

GPs have developed a one-page, simple assessment form as a starting point. This helps health and social care professionals decide whether patients are at low or high risk of falling.

"Typically a low risk will mean they get advice and information from their GP, while a high risk will usually mean a referral to the complex care team, where the patient will be assessed by a rehab nurse or physiotherapist," says Dr Bardner. "The complex care team will then discuss the best treatment options with the patient – for example, a 12-week strength and balance class, home assessment or medical review." This brings all the existing services together and links to the county council's falls prevention strategy.

Northern Devon Healthcare NHS Trust has developed strength and balance classes to help boost the health, wellbeing and confidence of patients who suffer from falls or are afraid of falling. This will help to improve longer-term outcomes for the elderly group within the local communities by supporting ongoing falls prevention work, as well as helping tackle social isolation.

Jo Wayborn, therapy team lead in the Barnstaple complex care team, says: "Patients have described feeling a lack of confidence when they start the programme but then report that this steadily rises. They say they become able to do activities like walking outside, shopping and meeting friends and family, which they had not felt confident to do previously."

"It is not possible to say whether this has already reduced falls," says Dr Bardner. "What we measure is how many people have been referred to falls prevention services." In its first year, over 350 people were referred to the falls service following an assessment.

Developing a pathway like this has been made possible by clinical commissioning, he says. "As clinicians, we have much greater awareness of how the system works for patients. Clinical commissioning has given us not just permission to make change but also the time to do it."

Caring for carers

NHS Vale of York CCG has worked with GP practices to create 'carer champions' after an audit showed that York Carers' Centre provides support to around 3,500 carers but only 1,700 people had registered themselves as someone who cares for another person with their GP. The champions will help ensure carers get the information they need to help them.

Integrated health and social care

Leeds South and East CCG is working with partners in local hospitals and the local authority to deliver joined-up services for patients. A formal 'transformation board' is overseeing a wide range of work, and in 2013 the rate of emergency admissions of patients aged over 65 was slashed by two thirds.

“As clinicians, we have much greater awareness of how the system works for patients. Clinical commissioning has given us not just permission to make change but also the time to do it.”

Dr Duncan Bardner, GP and CCG board member

Joining up health and social care

Kingston Clinical Commissioning Group

Consider the plight of Mrs Jones. She's 90 years old and lives alone. Her vision is failing and she has a colostomy as well as regular dialysis for her kidney failure. Recently, she has started to stumble and fall. Care workers visit daily as does her daughter in law – but is it time for more support? An additional two visits a day would cost £5,000 a year and a residential home placement even more – and besides, she would really rather live independently.

Mrs Jones (not her real name) lives in Kingston Upon Thames in Surrey, where health and social care teams from the CCG and local authority now work jointly under the managerial leadership of David Smith, who is both chief officer of Kingston CCG and director of adult social services for The Royal Borough of Kingston Upon Thames.

Here the joint "Kingston at Home" team was able to treat Mrs Jones as a person – not a collection of symptoms and problems. They arranged referrals to the stoma care team and to the sensory team to see if they could help with seeing aids and advice. The occupational therapy team came in to help with a bathing seat and walking aids. The team discussed with Mrs Jones whether she would like a falls detector. And they organised 72 hours a year of carer support relief care to support her daughter in law.

This is the sort of package of care that sounds so simple – and yet in practice is so difficult to deliver. It is a package that not only saves money but also helps Mrs Jones to carry on living independently. Mr Smith argues that his appointment is starting to make integrating health and social services easier in Kingston. Some of this is intangible. For example, he has been able to develop working relationships in both local government and within the NHS to encourage a more cooperative culture. "That's very hard to measure," he says.

It is a culture that has allowed some practical changes to take place. Social workers and community nurses now work in a single social enterprise where they work side by side with shared budgets. As Mr Smith says: "Because there is one pot of money, we are no longer negotiating with different departments about spending."

This means they work jointly not just on devising the sort of care package that helped Mrs Jones to maintain her independence but also on reablement services – the packages of care that enable often frail elderly people to be discharged safely from hospitals to their own home.

"By joining up community nursing and social care we have been able to dramatically reduce the number of people who are discharged from hospital to council-funded residential homes," says Mr Smith. The borough has moved from being one of the worst to one of the best in this respect. "Through this kind of joint working we have been able to introduce some real innovation with more telecare and telehealth packages," he adds. "We are now supporting some people with very, very complex needs to stay in their own homes."

The next step is to move to collaborative commissioning in which the council and CCG work jointly to buy the services the whole population needs. Local GPs and councillors set up an integrated commissioning collaborative this winter.

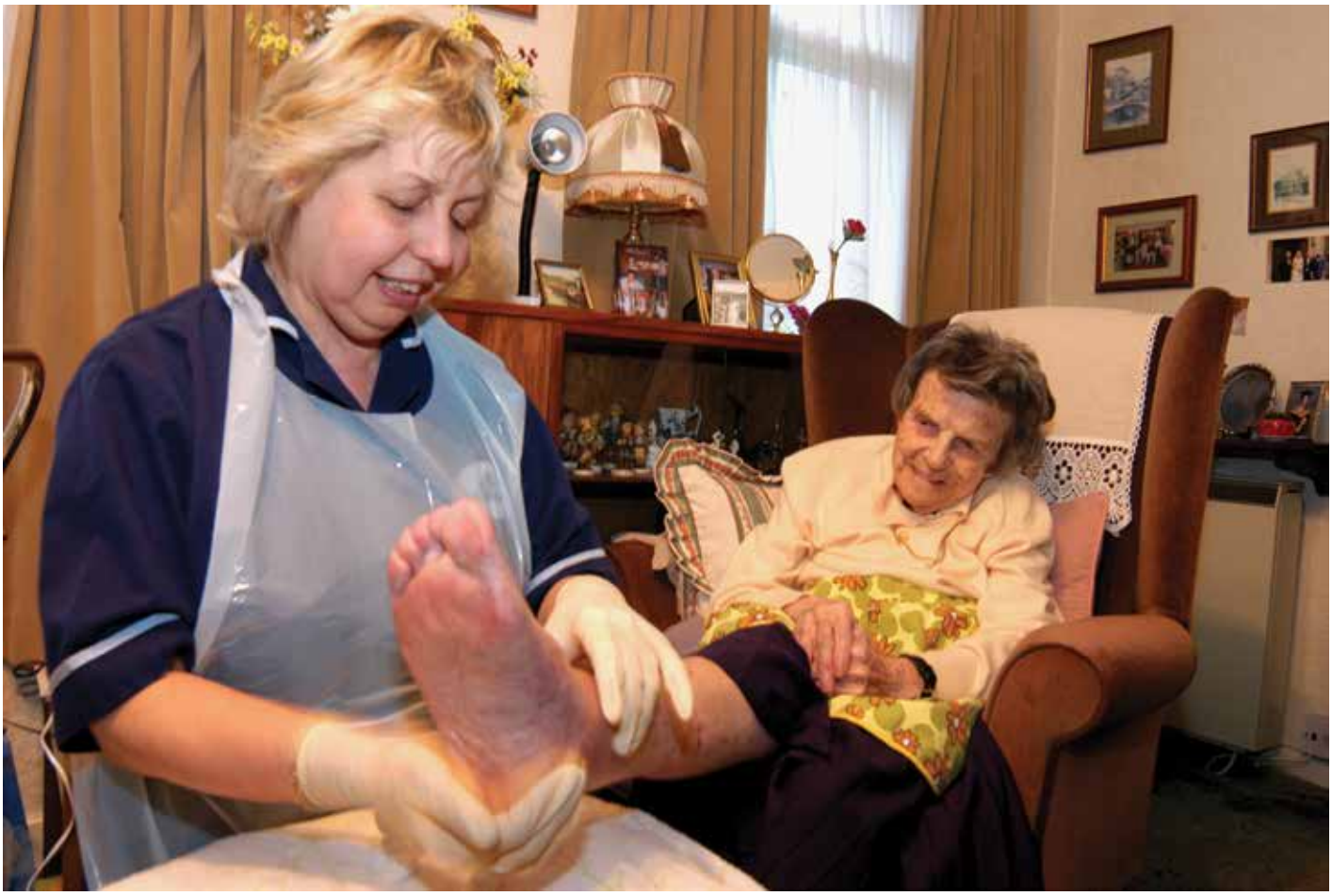
Mr Smith does not pretend that this will be easy. There are differences in funding, accountability and governance to overcome. "There are some knotty problems we have to crack," he says. "But we know this is the right thing to do, so just having the clinical leaders and the councillors around the same table and talking means we will have some success."

Working with the voluntary sector

East Lancashire CCG is working with the charity Parkinson's UK to appoint a Parkinson's disease specialist nurse. The charity has agreed to fund the role for two years before the CCG takes it on. The nurse will run clinics, carry out home visits and support hospital-based nurses.

Supporting primary care

Wirral CCG has invested in primary care so that all GP practices now have in-house physiotherapy, Citizens Advice services and alcohol workers, meaning patients can get the services they need closer to home. The CCG has also commissioned a new cognitive behavioural therapy service, reducing waiting items and increasing patient satisfaction.



"We know this is the right thing to do, so just having the clinical leaders and the councillors around the same table and talking means we will have some success."

David Smith, CCG chief officer and director of adult social services, The Royal Borough of Kingston Upon Thames

Engaging with our communities

Lambeth Clinical Commissioning Group

One of the ambitions for clinical commissioning groups was to put clinicians at the head and people at the heart of the NHS. That is just what Lambeth CCG spent the summer of 2013 trying to achieve in a wide-ranging public engagement programme that is now being used to inform its five-year commissioning strategy.

Dr Adrian McLachlan, CCG chair, explains: "As a new CCG we chose in the first half of our first year to make real our intention to do things differently, embody the values of our new NHS and to take up the 'no decision about me without me' challenge."

Between July and October 2013, Lambeth CCG engaged more than 800 local people in discussions on the future of health in Lambeth. There were meetings, events, online surveys and discussions, social media campaigning and more, as GPs met with local people and partner agencies to talk about improving health, improving the NHS, reducing inequalities in health and making the money work harder.

"We set out quite clearly up front, as we perhaps have never attempted before, the scale of the challenge facing the NHS in terms of rising demand and flatlining funding," says Dr McLachlan. "We called upon people to think through with us how we might jointly and creatively address ourselves to the challenge not simply to sustain a viable local NHS, but also to make sustainable improvements."

The conversations, whether face to face, online or on paper, were lively and showed understanding and ownership of the issues by patients, carers and stakeholder groups.

"We heard strong support for a focus on prevention; an ask for a different way of working with people and communities; ideas for securing better value for money; frustration at a fragmented system and a challenge to make integration real; and concerns about variation in access to services, quality, safety and outcomes," says Catherine Flynn, the CCG's engagement manager.

The views fed into a new strategic vision for NHS Lambeth CCG. Next comes the task of finalising the CCG's five-year strategy from April 2014 and translating this into a two-year operating plan, with ongoing and meaningful engagement an integral part. So while it is too early to judge whether the CCG will deliver on its vision to make care person centred, integrated, preventive, consistent, innovative and value for money, the success of its engagement can be measured.

Local resident Karen Hooper says: "I am a member of a very small patient participation group and I believe we have added to our numbers because Adrian came to our event. Local people felt that someone was listening to them."

Ms Flynn says the CCG has found a new way of working alongside local people. "We have reached large numbers of people and reached target groups effectively. We know that Lambeth people are now more aware of the challenges facing their NHS and we know too that they have an appetite for co-creating solutions," she says. "We have established links with some groups that we did not already have and have strengthened our channels of communication and the quality of relationship with others we already knew – and so we come out of the BIG Lambeth Health Debate with stronger foundations for the ongoing engagement with our communities."

As for Ms Hooper, she says she is now more confident and more informed. "I am now realising the importance of an integrated approach to health and slowly understanding how we can do this. As a patient I feel more confident now to address other frustrations in the system."

Patient engagement

Bury CCG has set up a 12-member patient cabinet chaired by its patients champion to make sure it involves local communities in planning and commissioning health services.

Rapid response

When Kingston CCG found that a high number of carers were calling an ambulance rather than wait for a routine visit from their GP, they developed a new service. Now carers who are worried about their loved one can call an emergency nurse service for advice on whether they are safe to wait or need a visit to A&E.

"I am now realising the importance of an integrated approach to health and slowly understanding how we can do this. As a patient I feel more confident now to address other frustrations in the system."

Karen Hooper, local resident

Improving health services for care home residents

Leeds South and East Clinical Commissioning Group

The NHS does not have a good track record in meeting the healthcare needs of people in care homes. Leeds South and East CCG has set out to improve this – and is showing early promise.

It began with a healthcare needs analysis focusing on elderly (over 65 years) patients resident in a care home who were registered with Leeds GP practices. This highlighted a four-fold variation between practices for A&E attendances, non-elective activity as well as a lack of planning for end-of-life care. The analysis also identified potential to release resources of around £450,000 from short stay acute admissions, excess bed days, and prescribing.

This led to a pilot project with three practices in Leeds in 2012, led by the shadow Leeds CCG. The aim was not only to improve the standard of care offered to residents but also to standardise the service across the city.

The practices implemented more proactive people-centred care plans that include professionals and carers as well as residents to ensure that the health needs of patients are met. The plans aimed to anticipate any potential health problems that could result in preventable hospital admissions. The evaluation demonstrated a 17.5 per cent reduction in A&E admissions and a 13.5 per cent reduction in non-elective activity overall.

Now the project has been rolled out to 16 practices with patients registered in 24 care homes. A service level agreement came into effect on 1 April 2013 and aims to improve quality of care to patients in care homes, optimising their wellbeing and quality of life by:

- ensuring that care is provided in the most appropriate setting and care plans are documented
- reducing avoidable hospital attendances and admissions
- ensuring safe, appropriate and cost-effective prescribing of medication
- ensuring care home staff has access to practice services, advice, support and guidance in order to meet the needs of the patients
- encouraging a multidisciplinary approach to care of residents utilising other providers of healthcare and social care to ensure appropriate patient placement and treatments
- ensuring that the quality of care provided meets national and local standards
- providing competent adult safeguarding
- involving patients and carers in developing the enhanced care services
- promoting the Gold Standard Framework for End of Life Care.

A robust performance framework has been established with quantitative and qualitative data collected on a quarterly basis. This includes demographics, number of patients occupying a care home bed per practice, number of A&E attendances and the number of unplanned admissions.

Qualitative monitoring includes the number of patients newly registered and seen within two weeks, the number of patients eligible for annual review, and the number of patients discharged from hospital and seen within two weeks.

There is also a patient experience element to the project. This includes patient, carer, care home and practice satisfaction surveys, monitoring of incidents/safeguarding issues, complaints and compliments, along with auditing of the number of care plans completed and the recording of a patient's preferred place of death. As part of the SLA agreement, practices have to attend a number of training and education sessions being provided.

Dr Samantha Browning, clinical lead for long-term conditions for NHS Leeds South and East CCG, says: "We are delighted to be able to offer the enhanced care homes scheme to a greater number of practices. The pilot project demonstrated that there was a correlation between the enhanced support provided and a reduction in hospital admissions. We also recognise the value of understanding patient need and feedback to further develop the service. This is why we are currently running a survey aimed at patients, carers and healthcare professionals."

With the current extended enhanced care home scheme in its infancy, it is not yet possible to provide more up-to-date statistics on the effect this has had on hospital admissions but the early signs are promising.

Working with the voluntary sector

National charity Stonewall is working with five CCGs to develop a health champion programme. The CCGs are: East and North Hertfordshire CCG, Northern, Eastern and Western Devon CCG, Nottingham City CCG, Tower Hamlets CCG and Wirral CCG. Each CCG will get free support to develop health services for lesbian, gay and bisexual people.

“The pilot project demonstrated that there was a correlation between the enhanced support provided and a reduction in hospital admissions.”

Dr Samantha Browning, clinical lead for long-term conditions

Helping people to take care of themselves

Leicester City Clinical Commissioning Group

People with chronic obstructive pulmonary disease (COPD) live with a lifelong, chronic condition. In 2012 Leicester City CCG tested a new care model in a bid to reduce the number of hospital admissions for these vulnerable patients – one that puts the person at the centre. The results were so positive that – approaching its first anniversary – it has been scaled up from an initial 50 patients in December 2012 to 400 patients in winter 2013.

The model combines shared decision-making using a new COPD patient decision aid, health coaching and telehealth monitoring. Community respiratory nurses direct the care with each patient receiving at least 50 hours of proactive clinical care – compared to an average of five hours in the old, reactive model in which patients went to the GP or hospital when they were ill.

The results show that this approach keeps people well enough to stay out of hospital. During the first six months of the pilot study, 87 hospital admissions were averted and the unscheduled admission rate fell from an average of 3.29 per person to 1.24. In just 26 weeks the service delivered cost savings of £353,000 and significantly improved patient experience. Almost a third of patients (30 per cent) said they felt better.

"We wanted to be able to give our patients access to qualified, specialist advice services so that we can shift the balance and focus from a model that responds to illness to one which promotes health and wellbeing," says the CCG's head of implementation, Emma-Jane Roberts. "The health coaching service provides the continuity for these patients to ensure that they maintain the improved self-management of their condition."

It starts with the CCG and GPs identifying the patients who would most benefit – usually because of previous frequent hospital admissions. Patients are then invited into the service with Telecare UK providing and installing the SPIRIT Healthcare Clinitouch system where appropriate.

Totally Health provides patients with a two-way health coaching service that supports them across their total care pathway. These health coaches are registered nurses who help patients manage their condition by providing mentoring and support via phone calls, alongside telehealth monitoring. They talk about staying warm in winter, for example, and check whether patients are taking their medicines correctly and that they know what to do if they become unwell. For example, each patient had an individual "symptom response plan" and over half (54 per cent) put this into action when their symptoms worsened.

The model also links the primary care and secondary care patient record so clinicians can have a full overview at any time. Hospital doctors can see the patient's history if they are admitted and the GP and community nurse can see what happened in hospital. Dr Durairaj Jawahar, GP and lead for COPD for Leicester City CCG, says: "Our patients get the support of managing their own condition at home. We know patients are happier and recover quicker when their care is managed at home. We are really pleased that the scheme is working and the project has enabled patients to avoid a hospital stay."

Now the model is set to expand. This winter, 150 patients will receive the full telehealth and health coaching package and 250 newly diagnosed COPD patients will receive health coaching.

Leicester City CCG believes that taking an integrated approach to case management using health coaching and telehealth promises major long-term patient benefits in the management of multiple long-term conditions. "A real advantage of dovetailing the health coaching into the telehealth scheme and beyond is that it provides a service that can offer true patient-centred care for those who have several long-term conditions," says Ms Roberts.

Dr Jawahar credits the success of this integration to clinical leadership coupled with the freedom to innovate that CCGs enjoy. "As a result we are now delivering clinically effective care, with better outcomes and which patients love," he says.

Working with the voluntary sector

Norwich CCG is working with over 50 voluntary groups and charities to find the best way to spend over £500,000 of ringfenced funding to best effect, especially in support of older people, carers, end of life and mental health. Dr Chris Price, CCG chair, said: "Voluntary groups and charities do a magnificent job, supporting people with health problems, so we were keen to get their views on how they can deliver great patient services with the budget we have. This is a real co-production exercise we can all be proud of."

“Our patients get the support of managing their own condition at home. We know patients are happier and recover quicker when their care is managed at home.”

Dr Durairaj Jawahar, lead for COPD

Transforming urgent care

Central Norfolk clinical commissioning groups

In the winter of 2012, Norwich's urgent care system was not unusual in facing rising demand – and struggling to meet it. Today the demand is still rising but there are no longer queues of ambulances outside the hospital or of patients inside the A&E. The story of this turnaround is, essentially, one of clinical leadership.

Jonathon Fagge, chief executive officer of Norwich CCG, recalls the scenario he and colleagues found in 2012. "There were poor relationships between providers, they did not seem to be operating efficiently and everyone tended to point the finger of blame elsewhere," he says. "So we got everyone together in a room, asked them to bring their problems and solutions and develop some ideas that were based around not the organisations but around the patient pathways."

What emerged from this has become known as Operation Domino – a name that captures the links between the parts of the system and how it must operate as a whole if it is to stand up. It is a long-term investment and redesign strategy to improve urgent care across Norwich and parts of Norfolk that involves three Central Norfolk CCGs, the local acute and community care providers, the county council public health and social care departments and, latterly, the local mental health trust.

So starting at the front door of the hospital. Last winter, there were 70 to 80 ambulances a month waiting for more than one hour outside A&E at Norfolk and Norwich University Hospital; now it is sustainably down to one or fewer a month. That's been achieved by introducing a hospital/ambulance liaison officer – 24/7 paramedic cover to liaise between the hospital and the ambulance service to manage patient flows and reduce delay.

Inside the front door of the emergency department is now a nurse-led service that is able to put together teams ready to meet patients as they arrive, reducing delays in the department. Moving further back, the hospital has now replaced beds in the medical assessment unit with trolleys, introducing a 12-hour limit on the time patients can stay there and therefore generating faster throughput.

So far so good – and these changes have had a dramatic impact on ambulance delays and waiting times for ambulances and a marginal impact on A&E waiting times, says Mr Fagge.

The next domino in the line is the back door of the hospital and this, he says, is extremely complex. "We invited some Six Sigma analysts to help us understand how and where queues develop," he said. "They identified 14 pinch points."

Now the CCG and hospital are working to tackle these. A single health and social care assessment is on the way, for example, and other measures are in place. "Together as a local system, we have introduced early supported discharge packages, where patients go home with a package of therapy and other support, including a Red Cross volunteer," says Mr Fagge. "We have also begun to discharge patients with continuing healthcare requirements to community hospitals beds for their needs to be assessed there, rather than in the acute setting."

The next big plan – which the partners in Central Norfolk are proposing to pilot in the New Year – is a new primary- and community-care led urgent care centre alongside the main A&E. "This will move the minor illness workstream from the A&E as well as the frail stream – the people the ambulance service bring in because they are worried about them. It will be a pre-A&E safety net," says Mr Fagge.

Transformation on the scale achieved in Norwich is built, he says, on clinical leadership that fosters partnership working. "When you have managerially-led organisations, inevitably you have an organisational approach to problems. When you have clinically-led organisations, you are driven by the clinical needs of the patient. That's what we have here – and that's what drives change."

Working with the community

Christchurch Commissioning locality, part of Dorset CCG, has established a 175-strong health network that brings together the local council, community partnership, voluntary sector and local people to help it develop good services for local people.

End-of-life care

Warrington CCG has delivered a strong focus on end-of-life care. Now 43 per cent of residents die at home, compared to 40 per cent nationally, and 80 per cent of nursing home residents die in their preferred place of care. This is just one example of emergent and innovative thinking driven by everyone now speaking a "common language", say CCG leaders.

“When you have managerially-led organisations, inevitably you have an organisational approach to problems. When you have clinically-led organisations, you are driven by the clinical needs of the patient. That’s what we have here – and that’s what drives change.”

Jonathon Fagge, chief executive, Norwich CCG

Frail elderly care pathway

Northumberland Clinical Commissioning Group

Joe is 93 years old and lives alone. Most of his friends and family locally have passed away, his only daughter lives hundreds of miles away and he is becoming increasingly frail.

Joe (not his real name) lives in Northumberland and when his daughter called his GP to say she was worried about him, the doctor was able to mobilise a wide range of help and support through a new frail elderly care pathway.

"This was a man I had looked after for ten years," says Dr David Shovlin, his GP and director of unplanned care for Northumberland CCG. "I visited him at home to do a medical assessment and yes, I was able to review what medicines he was taking for his heart condition and arthritis, and prescribe an antidepressant as well as get him some social care support.

"But I also had time, for the first time in the ten years I have known him, to sit down and have a chat. This was a man who had been evacuated from Dunkirk, captured by the German Army and escaped from a prisoner of war camp across Austria. It was the first time he had been given the freedom to talk about these things to me. I think the service we have designed in Northumberland has created the space to reintroduce some of the humanity between patients and healthcare professionals."

Northumberland CCG's frail elderly service brings together primary care, the community and hospital services at Northumbria Healthcare Foundation Trust and social services at Northumberland County Council. It was designed in consultation with patients and carers who described the care they wanted – joined up and with them at the centre.

It starts with health professionals – whether in the community, primary care or in hospital – identifying a frail elderly person who is at risk of going to hospital in an emergency. These might be people who have called out the emergency out-of-hours GP or wound up in hospital after a fall. Each patient receives a structured assessment that covers things like how able to get around they are, whether they are at risk of falling and injuring themselves, are they eating enough, are they depressed or lonely, are they becoming forgetful? They receive the same assessment regardless of which healthcare professional carries it out or where they carry it out.

"If patients are identified as high risk in any of the assessment areas, then they get a more detailed medical assessment," explains Dr Shovlin. In Joe's case, he prescribed antidepressants and a vitamin supplement and organised for carers to visit regularly.

It is not just a one-off intervention that the service offers. "Patients at risk are also put on our register in primary care and we hold monthly meetings with GPs, community nurses and social workers to discuss their care." These meetings can also include community geriatricians or pharmacists if needed.

Since its introduction (alongside some other changes) over a year ago, Northumberland has seen a steady fall in emergency admissions from a peak of around 3,500 a month in April 2012 to just over 2,500 a month in June 2013. Before the frail elderly pathway was introduced, Northumberland had higher than the average number of emergency admissions to hospital – many of them for conditions that could or should be treated outside hospital. Now it's on track for having lower than the average number.

Dr Shovlin says: "It's putting these frail, elderly people on our radar and joining up the care they need and focusing it around them so that we can identify and meet all their needs appropriately and consistently." It is a change made possible by putting clinicians in the lead and enabling them to put patients and their needs at the centre.

So yes, the pathway is value for money and yes, patient feedback shows patients like it. As for Joe, he has not been in hospital since that chat with Dr Shovlin.

Improving mental health services

Dartford, Gravesham and Swanley CCG in Kent is to increase the number of psychiatric inpatient beds by 34 and develop three centres of excellence for mental health in a bid to improve services for people in crisis.

Community mental health

Eight CCGs, led by Blackburn and Darwen CCG, have developed a network of specialised community/home treatment services for mental health and dementia across Lancashire. This is reducing the need for hospital care, improved outcomes and choice for patients, and has led to savings of £9 million.

“It’s putting these frail, elderly people on our radar and joining up the care they need and focusing it around them so that we can identify and meet all their needs appropriately and consistently.”

Dr David Shovlin, director of unplanned care

Reducing fuel poverty to improve health

Oldham Clinical Commissioning Group

Last winter was miserable for Oldham resident Sandra Badby. She couldn't afford to heat her home properly and then to cap it all her boiler broke down. This winter looks less bleak. She has a new boiler and solid wall insulation, courtesy of Oldham Warm Homes. She says: "My old boiler broke down and my house was already freezing, so when I heard about a scheme for a new replacement boiler and wall insulation I was over the moon. My house is now really warm and my bills have come down."

A joint initiative between Oldham Council and Oldham CCG and delivered by social housing provider Keepmoat, this is a "whole system, whole place" approach designed to bring people out of fuel poverty and reduce ill health. Around one in five households in Oldham – 18,000 – can't afford to heat their homes properly.

"We know that in Oldham we have high rates of respiratory disease because of our industrial past and smoking," says Kathryn Taylor, the CCG's clinical director for respiratory and a nurse practitioner at Woodlands Medical Practice. "Last winter there were 520 excess deaths and a high proportion of these were felt to be from cold-related illnesses such as asthma, chronic lung diseases and heart problems."

A cold winter means more people turning up in A&E and more people dying.

"We know that there are lots of frail or vulnerable people who cannot afford to heat their homes and they are living in damp housing or with one room heated and the rest of the house freezing cold," says Ms Taylor. "The CCG has a vested interest in supporting this project, given that fuel poverty can and does have a huge impact on people's health – especially if they are vulnerable, have a long-term condition or a disability."

Warm Homes is investing £200,000 this winter in 1,000 homes, providing new boilers, insulation and, in some cases, helping with debt reduction so people can keep warm. The CCG expects to save £300,000 a year in reduced hospital admissions and social costs; households are expected to save £450 a year each. It was launched in August 2013 – ahead of the autumn fuel hikes – and by November had already reached over 300 homes. More than 240 homes had received free heating upgrades and 47 had external solid wall insulation fitted.

Oldham residents access the scheme in a number of ways. Some people are finding out about Warm Homes through local publicity. Some come via their GP or practice nurse and others through the joint health and social care teams that visit vulnerable families at home.

Every household referred to the service or wants support receives an individual assessment to identify what type of support they need to get out of fuel poverty. Residents who are not in fuel poverty can still access support through the service through the energy company green levy money.

Dr Ian Wilkinson, chief clinical officer of Oldham CCG, says this is just one way in which the CCG is able to take a new approach to public health: "Warm Homes Oldham is just one example of how as a CCG we are striving to achieve our triple aim of improving population health across Oldham, by commissioning the highest quality services near to the patient, in an integrated fashion and at the best value for money. It's also a big part of the CCG's joint work with our social care partners on public service reform, enabling us to join up health and social care services, putting patients firmly at the centre of what we do."

Working with local people

North East Hampshire and Farnham CCG is working with the Gurkha Integration Fund in a unique project to develop an education programme for Nepalese people diagnosed with Type II diabetes. This population is vulnerable to it; unpublished research suggests up to 7.5 per cent of the 4,000 Nepali people aged over 18 and registered with a GP are affected. The majority of the estimated 10,000 to 12,000 Nepali people living locally are not English speakers. This project is engaging with a local group of Nepali people who have diabetes, or care for people with diabetes, to develop a structured education programme for this population.

“The CCG has a vested interest in supporting this project, given that fuel poverty can and does have a huge impact on people’s health – especially if they are vulnerable, have a long-term condition or a disability.”

Kathryn Taylor, CCG clinical director for respiratory

Avoiding unnecessary hospital admissions

North Staffordshire and Stoke-on-Trent clinical commissioning groups

On a Friday afternoon this autumn, GP Mark Williams visited two elderly patients. One had low blood sodium and the other had not been able to pass water for some hours. Neither was an emergency – but both needed urgent treatment beyond a home visit.

As the duty doctor, Dr Williams simply did not have an hour to spend with each patient, calling the admissions unit to find a bed or organising blood tests. His default option might have been to call an ambulance. Instead he was able to call the North Staffordshire and Stoke Hub and hold a clinician-to-clinician conversation about the best course of action for each patient.

"The advanced nurse practitioner at the Hub arranged for a blood sample to be taken to the hospital and to get the results, and the next day organised admission to the community hospital for one patient. She arranged admission to the medical assessment unit for the other," says Dr Williams.

Both patients got the right treatment in the right place first time.

The Hub was commissioned by two CCGs – North Staffordshire and Stoke-on-Trent – and is provided by Staffordshire and Stoke-on-Trent Partnership NHS Trust as a way of easing pressure on frontline staff. It has been up and running since September 2013 and the weekly figures show that it is making a significant impact. In one week in November it took 158 referrals from professionals seeking an alternative to hospital admission for urgent care patients. Of these, 138 were managed without a non-elective admission, including 95 per cent of the 68 GP referrals and 97 per cent of 38 referrals from ambulance crews.

Sue Turner, integrated service manager who developed the Hub with senior commissioning manager Gemma Smith, explains how it works. At the front end are senior clinicians taking calls from GPs, ambulance crews, district nurses and social workers who have a patient with an urgent need that could be managed without an admission, or need input to support the discharge of a patient from hospital. They organise acute attendance or admission for the referring clinician as necessary.

Behind the scenes, Hub coordinators facilitate referrals and call in community resources where needed. They also have sight of social care capacity.

"We take a call and discuss the clinical indicators and work out the best way forward and whether we can identify other resources that might be available," says Ms Turner. "Because we have an overview of the demand and capacity, we can stagger admissions where this is needed and where it is safe to do so." This takes pressure off hospital acute admissions units.

The Hub follows a number of principles. Patient safety is paramount, of course, and the referring clinician remains in charge of making decisions. It is not – and will not become – a care provider. "This is a virtual service," says Dr Williams, who is also clinical lead for the Hub.

Its steering group includes not just the CCG and member practices but also local authority partners, the West Midlands Ambulance Trust and local acute and community services providers. Recently, Hub clinicians have been integrated into the ambulance service's Telemed 999 call handling team to provide advice to ambulance crews and directly divert non-urgent care to care closer to home. It also sits firmly within the CCGs' other commissioning plans – for example investment in intermediate care services and the frail elderly care service.

It is slowly gathering pace – it has been introduced slowly with training and support to different groups. Week by week the numbers using it are rising. Next on the horizon is work with nursing homes and the GPs who are responsible for them.

"The crucial thing about the Hub is that it enables people to get the right treatment in the right place at the right time by supporting clinician-to-clinician conversations," says Dr Williams. That's a change made possible by putting clinicians in the driving seat of commissioning.

Innovation

Portsmouth CCG and Portsmouth City Council are making £100,000 available in grants to help older people live independent lives at home and prevent them being admitted to hospital. The grants will allow the council and CCG to test out new models by funding pilot schemes.

“The crucial thing about the Hub is that it enables people to get the right treatment in the right place at the right time by supporting clinician-to-clinician conversations.”

Dr Mark Williams, GP

Transforming cancer care and end-of-life care

CCGs in Staffordshire and Stoke-on-Trent

Five CCGs across Staffordshire are collaborating with Macmillan Cancer Support to transform cancer care and end-of-life care across the entire county. It is still early days for this ambitious programme but already there is a clear vision, a solid model on which to move forward and a robust evaluation plan to keep check on progress.

Justine Palin, who is the programme's director, explains why the partners feel the programme is needed. Currently, she says, cancer care and end-of-life care are not commissioned as a package but in chunks that do not necessarily relate to the way that patients use – or need – the NHS. The result is that little attention is paid to areas such as communication between care providers, and as a result care feels fragmented.

"This programme is about ensuring person-centred care within integrated work between health and social care," she says. "We want to move to integrated pathways for cancer care and end-of-life care with better patient experiences and better outcomes."

The programme began in late 2012 when Macmillan Cancer Support funded a partnership with five CCGs: North Staffordshire, Stoke-on-Trent, East Staffordshire, Cannock Chase and Stafford & Surrounds. The broader programme brings in not just these six players but also Public Health England, NHS England and the local authorities (including the health and wellbeing boards) in Staffordshire and Stoke-on-Trent.

Together, they aim to commission care right across the patient journey. For instance, in cancer this means encompassing prevention and health promotion, ensuring early diagnosis and prompt treatment and following on to survivorship or end-of-life care.

With this in mind, there are three core components to the programme. The first is to co-design the pathways so that they offer the best outcomes for patients. This work is already underway with clinicians and patient champions.

The second is to change the way services are commissioned so that there is a "prime provider" for cancer care and for end-of-life care. Ms Palin explains what this means: "The idea is that for the first time one organisation can be held to account for ensuring that the entire patient experience and outcome is the best they can be."

She is not wedded to any specific model for how this "prime provider" might be constituted; it could be a consortium of organisations or one organisation that sub-contracts to others, for example. The aim is to offer these contracts for competitive tendering and have the prime providers in place by 2015.

This brings us to the third component: supporting the prime providers to manage the change involved in making this massive shift. There will be pump-priming money for the first two years to support change but beyond that, the providers are expected to become self-funding through the work they carry out and the outcomes they deliver for patients.

Much of this is new and the programme is slowly feeling its way forward, working with organisations such as Monitor and NHS England. The programme has been given "integrated care pioneer" status by NHS England and is one of the 14 national pioneer sites, giving it access to additional advice and support from over 40 partners.

There is no blueprint for this work and the partners are keen to incorporate learning as they move forward and have commissioned ongoing evaluation. "It is very exciting and a true example of partnership working with the voluntary sector, NHS and local government," says Ms Palin. "We know we do not have all the answers and we know that this will be very complex. But we also know we have a lot of support for what we are trying to achieve for the people of Staffordshire and Stoke-on-Trent."

Community engagement

Northern, Eastern and Western Devon CCG is working with John Lewis to find out what makes great customer satisfaction and how this is linked to high staff morale – and how to translate this to benefit patients.

“This programme is about ensuring person-centred care within integrated work between health and social care. We want to move to integrated pathways for cancer care and end-of-life care with better patient experiences and better outcomes.”

Justine Palin, programme director

Reducing very short stay admissions by care home residents

Windsor, Ascot and Maidenhead Clinical Commissioning Group

Care home residents are vulnerable, elderly and often ailing people who deserve the highest quality of consistent care. Windsor, Ascot and Maidenhead – with 48 care homes of all shapes and sizes and 1,130 beds – faces a larger challenge than many in providing this.

So in the summer of 2013, Windsor, Ascot and Maidenhead Clinical Commissioning Group (WAM CCG), the Royal Borough of Windsor and Maidenhead and Berkshire Healthcare Foundation Trust committed to a long-term programme of joint work with care home managers and staff.

Right from the start, all partners agreed to focus on reducing the number of inappropriate, very short stay admissions to local hospitals by care home residents. Everyone agreed that calling an ambulance to transfer residents to A&E should be avoided wherever possible.

In a few short months, and with lots of hard work on all sides, there has been significant progress – the number of short stay, non-elective care home admissions was down 14 per cent this summer (April to September) compared to last and a number of new services are now in operation, including:

- a dedicated 'hotline' number for care homes to a trained call handler
- a rapid access community clinic to provide assessment and treatment for care home residents with an acute condition but not requiring secondary care facilities
- training and education on end-of-life care for nursing, residential and learning disability care home staff
- best practice advice and guidance newsletters on medication issues
- tailored support for GP practices.

One key development is an information dashboard that cross references all 48 care homes against all GP practices, hospital admissions and a range of other key measures such as falls, medicine management concerns, safeguarding issues and out-of-hours GP call outs. It is being used to identify trends and issues and supports partners to take a proactive approach to solving them.

"The impact on our non-elective admissions to acute hospital from care homes for zero- and one-day length of stay has been remarkable," says Dr Adrian Hayter, WAM CCG chair. "We have also monitored a very rewarding trend in the reduction of non-elective admissions associated with chronic conditions such as asthma and diabetes that, if treated appropriately in primary care, should not require acute admission."

Care homes have been active partners, says Seona Douglas, head of adult social care, Royal Borough of Windsor and Maidenhead. "Their contribution has been invaluable, particularly innovation project work on falls avoidance, treating pressure sores, and better hearing services for care home residents." The groundwork and practical ideas will be translated into education and training for staff across many care homes in 2014.

On 23 October 2013, the care homes hosted an event, New Dimensions for Dementia Support, attended by Terry Butler CBE and Melanie Henwood OBE, independent evaluators for the Prime Minister's Dementia Fund. The varied programme included projects on:

- training for care home staff on how to deal confidently with challenging behaviour and reducing the use of anti-psychotics – with exceptional results and many heart-warming case studies you can find on the WAM CCG website
- investment in facilities and reminiscence therapy
- improved dementia screening and building links with dementia support services in the community.

Jayne Reynolds, locality director for Berkshire Healthcare Foundation Trust, says: "We know that there are no quick fix answers to raising quality standards and reducing the variation between patient experiences. It will require sustained effort over an extended period but we have already shown that progress can be made quickly when everyone works together." The development of CCGs and clinical leadership has enabled this.

(More information and case studies can be found at the WAM CCG website, **www.windsorascotmaidenheadccg.nhs.uk**, in the caring for the elderly section.)

Avoiding hospital admission

Wiltshire CCG has set up an advice line for health and social workers who want to avoid admitting people to hospital. In its first three weeks, 22 out of 24 referrals were treated in the community, saving an estimated £88,000.

"We know that there are no quick fix answers. It will require sustained effort over an extended period but we have already shown that progress can be made quickly when everyone works together."

Jayne Reynolds, locality director, Berkshire Healthcare Foundation Trust

Further information and acknowledgements

If you would like to speak to NHS Clinical Commissioners about this report or any of the case studies, please contact Julie Das-Thompson, senior policy lead at **office@nhscc.org**

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