NHS Swindon
Clinical Commissioning Group

SWINDON CLINICAL COMMISSIONING GROUP

Service redesign workshop report
2013-14

March 2014

1. Introduction

Swindon CCG has set out an ambitious program of service redesign workshops which aim to review all clinical services, conditions and specialities over a five year period. These workshops involve **public, patients, providers, partners** and **practices** in the co-design of our most commonly used services to ensure they continue to reflect the changing needs of the local population. The five sets of stakeholders **collectively provide the total picture of what currently happens** when a patient is cared for and where improvements can be made.

The aim of the CCG service redesign programme is to demonstrate through a range of review techniques that service change can be beneficial for public, patients, providers, partners and practices where it is based on improvement in quality and the elimination of unnecessary waste, delay, duplication, and ineffective practice, when supported by a collective understanding of the current position and its consequences (intended and unintended).

We apply the best approaches to the redesign of services, and seek to re-model these around best practice based on a collective understanding of the impact on each stakeholder, and our local understanding of *need* and *what works* in Swindon. The outcomes from the programme is the delivery of a continuous set of recommendations for service change over five years for consideration by the clinical leadership of the CCG, informed by best practice and benchmarking analysis.

This document gives an overview of the Swindon CCG service redesign workshops for 2013-14, along with their supporting actions plans.

2. Dates for service redesign programme 2013-14

6 June 2013	Cancer and radiotherapy service redesign workshop 1
12 June 2013	Ambulatory Care redesign workshop 1
21 June 2013	Dementia Service redesign workshop 1
26 July 2013	Paediatric service redesign workshop 1
3 September 2013	Orthopaedic service redesign workshop 1
19 September 2013	Urgent Care workshop and winter planning
20 September 2013	Diabetes redesign workshop 1
27 September 2013	Endoscopy redesign workshop 1
1 October 2013	Cardiology redesign workshop 1
18 October 2013	Ambulatory Care redesign workshop 2
7 November 2013	Cancer and Radiotherapy redesign workshop 2
19 November 2013	Dementia redesign second workshop 2
12 December 2013	Paediatric service redesign workshop 2
5 February 2014	End of life care workshop 1

3. Detail on each workshop progress

3.1 Cancer and Radiotherapy

Two workshops have been held during 2013 on 6 June and 7 November, during which long term and short term priorities were discussed and identified.

Objectives:

1. To agree for Swindon:
   - Where do we want to get to? (long-term priorities)
   - What are our quick wins? (short-term priorities)
   - How can we do things differently?
   - What are the challenges or barriers to our success?

2. Explore the whole concept of survivorship: to look at the services patients may wish to access, the types of information they will need and how survivorship care may be supported.

3. Review the national strategies and plan a way towards achieving the desired outcomes

What we heard:

For long-term priorities Swindon CCG and its providers will be looking at having more patient support networks for services for patients and service users and also GPs to focus more on survivorship. It was also agreed that there is a need to solve boundary issues to focus on potential new technologies, including reducing and removing certain services to shift spend in priority areas. There are also future plans to have a stand-alone cancer centre on the Great Western Hospital site which will include the following facilities/services:

- Comfortable treatment environment,
- Outpatients - including access to urgent appointments
- Diagnostics
- Minor procedures
- Day therapy
- Clear and accessible patient Information
- Pharmacy services
- Knowledgeable patients volunteering within clinical services, including survivors of cancer to support newly diagnosed patients and with increased care in the community with provide easy access back to the cancer team, these are some of the short-term priorities agreed.
- Orthopaedic/geriatricians will also be working with cancer team, and in addition will have medicine closer aligned to the cancer team.

What we did:

Since the workshops, NHS Swindon Clinical Commissioning Group (CCG) has worked closely with Oxford University Hospitals and Great Western Hospital Foundation Trust to promote the local delivery of radiotherapy in Swindon. The delivery of a local radiotherapy service is a key part of our strategy for improving cancer care for Swindon and Shrivenham patients. We believe that local provision of this vital service will transform the quality of modern healthcare delivered for diagnosed with cancer over the next few years and beyond, especially for those patients who will no longer have to make repeated trips to Oxford to receive radiotherapy.

This development of this service is fully supported by all GP practices in Swindon and Shrivenham, our MPs, the Health Overview and Scrutiny Committee and NHS England and we will be working closely with both hospital trusts to deliver a local service as soon as possible, with many details, including the financial support to make this happen as soon as possible yet to be finalised.

It is normal practice for there to be a charitable fundraising appeal that would normally assist with raising funds to purchase the Linear Accelerators (the radiotherapy treatment machines) and we anticipate that this will soon become a well-supported local charity when fundraising commences. Swindon CCG would like to thank all those who are working so hard to make this a reality for the residents of Swindon & Shrivenham and the surrounding area.

3.2 Paediatrics

Two workshops have been held during July and December 2013. The purpose of the first workshop was to begin looking at how to improve child health outcomes through service redesign. The starting point was to use this workshop to look at ways to reduce paediatric emergency admissions. This workshop was an opportunity to start conversations, gain an understanding of what is happening and how we can move forward. While the second workshop focused on children with long-term conditions such as epilepsy and diabetes, children with complex conditions and thirdly, children who self-harm.

Objectives:

- To develop a shared understanding of current situation
- To gather the information needed to make effective decisions information
- Looking at potential opportunities and how to move forward

What we heard:

Key messages identified from the workshop included:

- there has been an increase in A&E attendances amongst 0-4 year olds
- The largest increase in attendances were coded under "No Investigation with no significant treatment"
- There was also an increase in Paediatric non-elective admissions.

The top 5 HRGs (Healthcare Resource Groups – ways of coding treatments) were viral infections, acute upper respiratory tract Infection and common cold, infectious and non-Infectious gastroenteritis without CC, asthma or wheezing and ingestion poisoning or allergies.
Following the feedback from the workshop it was agreed that there was a need to focus on three key areas: **pre-admission, acute care and discharge from hospital**.

What we did:

As a result of the workshop discussions a new children's clinic was agreed. The four month pilot service started on Monday 13 January 2014, and will be open from 5pm-8pm Monday to Friday evenings so that parents and carers of children up to 11 years old are able to get immediate health advice and support in times of peak demand.

The staff at the new service will diagnose common childhood conditions, and prescribe any necessary medicines. This will save parents an unnecessary trip to the emergency department of GWH, which should be used for emergencies only. The children's clinic is being run alongside a parent and carer educations programme which will help parents to identify key childhood illnesses and know which health services are most appropriate.

This pilot service will be evaluated in May 2014 to assess its effectiveness in helping to support urgent care in Swindon.

3.3 Cardiology

Objectives:

On 1 October 2013, Swindon CCG held its Cardiology workshop. The objective of the day was to discuss the following aspects of the service:

- Quality
- Productivity (elimination of unnecessary waste, delay and duplication, and ineffective practice)
- Cost

The three elements which taken together represent value for money, through analysis of the current situation, comparison with practice elsewhere, and the generation of new ideas and innovation.

What we heard:

We had representation from a number of representatives in Swindon including, Swindon Borough Council, Great Western Hospital, and GP practices.
An action plan was developed from the day which includes the following next steps:

- Review the need for a 24 hour tape monitoring service in the community
- Review the need for an ECG service in the community
- Need to look at how patients are followed-up and referral pathways i.e. AF, Arrhythmias, NICE95, Optimise, etc.

What we did:

Following extensive discussions with our providers and members, Swindon CCG introduced a new brain natriuretic peptide (BNP) GP testing service on 1 January 2014, this test can be used to identify the risk of a patient having heart failure without the need for a hospital appointment.

3.4 Ambulatory Care

On 12 June 2013 and 18 October 2013, Swindon CCG held its Ambulatory Care (AC) workshops. The objective of the workshops were to discuss the following:

Objectives:

- To review current Ambulatory Service provision (defined as the 49 medical conditions, plus emergency Paediatric and Surgery conditions that can be rapidly diagnosed and treated as a short-stay patient) to look for the opportunities for improvement in quality, productivity (elimination of unnecessary waste, delay and duplication, and ineffective practice) and cost (the three elements which taken together represent value for money), through analysis of the current situation, comparison with practice elsewhere, and the generation of new ideas and innovation.
- agree a common definition of Ambulatory Care
- developing a model of care for the frail elderly
- agree ownership of actions

What we heard:

We had representation from a number of representatives in Swindon including, GP practices, SEQOL, the Great Western Hospital, Wiltshire Clinical Commissioning Group, BMI Healthcare, South-West Ambulance Service, Swindon Borough Council and Prospect Hospice. Public and patient representatives attended from Healthwatch Swindon, Swindon Carers Centre, Swindon Older People's Form and Age UK Wiltshire.

An action plan was developed from the day which includes the following next steps:

- The need to create a single database of all available care/health services to communicate services available
- Review AC services commissioned across community and acute providers to remove duplication and communicate services. Is the patient in the right place.
- Explore how tele-health is currently used by SEQOL and understand success and options for further use.
- Continue with risk stratification and Care home project, SEQOL.
- Provision of IV (intravenous) therapy in the community to support early discharge.
- Review hours of AC services.
- Closer working relationships between GP's, acute providers and community.
- Faster access to diagnostics

What we did:

- We have developed a pathway which accepts patients from LAMU (Lambourne Ambulatory Medical Unit) to SwICC (Swindon Intermediate Care Centre) for ambulatory patients, which will prevent an admission to GWH in appropriate cases
- Supporting Swindon Borough Council in creating a single source of services available to all appropriate audience including patients – this is called 'my care, my support' and will be launched in April/May 2014
- We are working with GP practices to identify high risk patients through our risk stratification program and are prioritising them for medication reviews by the GP or pharmacist
- We have increased the Swindon 'GP on an ambulance' scheme to increase the level of community out of hours support, which should help to avoid unnecessary admissions to Great Western Hospital

3.5 Dementia

On 19 November, Swindon CCG held its largest ever workshop with over 100 service leaders, patient representatives and clinicians attending. Two patient groups attended, including Singing for the Brain, in which local dementia service users demonstrated the wider health benefits of the Alzheimer's Society led group. This was a follow-up to a workshop held in June which identified some of the priorities for improving dementia services in Swindon.

Objectives:

- To gain stakeholder input into the Swindon dementia strategy
- To assess how we can improve earlier diagnosis in Swindon
- To review national models of best practice and to assess their potential for implementation locally

What we heard:

We had workshops from the following:

- **Eden Alternative –** Eden encourages people to think differently and before you can change culture, we need to change ourselves, requiring a change in mindset or paradigm shift.
- **Supporting Culturally Diverse Groups with Dementia -** Dementia does not discriminate
- **Person-centred approach** founded by Tom Kitwood –every experience of Dementia is unique to the person and care should be tailored by understanding the individual
- **Using dance and movement to engage with people with Dementia** this therapy helps people with Dementia because the mind and body are interconnected
- **Circles of Support -** develops practical ways for people with Dementia to remain connected with family and community life
- **Living well with Dementia Groups** – how we can have difficult conversations – how should we help people?
- **Assistive Technology** Alzheimer's Society - information on assistive technology for people with Dementia:
- **Life Story Work** - helps people to capture their stories so that those that support them, can understand them better. Any format including memory boxes, collage on walls to illustrate life.
- **Care Home Liaison** - they work to improve the service of care and maintain placements by providing support and advice for care homes struggling to cope.

The attendees of the workshop discussed how we could improve public and professional awareness of dementia and reduce stigma. The attendees agreed that by raising awareness and understanding of dementia, that this would encourage people to engage with services earlier and lead to improved outcomes and quality of life.

Swindon CCG have identified in response to the above discussion that some level of understanding and public education does exist. Swindon Borough Council's Advice and Information Hub, situated in Sanford Street, Swindon will also be able to help with promoting awareness of dementia.

What we did:

Following feedback from Swindon CCG's workshops, a Dementia Strategy has been developed for the purpose of improving the quality and provision of dementia services provided to the people of Swindon and Shrivenham, with the aim of improving outcomes and quality of life. There has also been a Dementia Steering Group set-up in Swindon, in which Swindon CCG together with our provider partners are in the process of developing specialist services within the community, so that we can reduce the need of some patients having to attend an acute setting, which may not be clinically appropriate for them.

3.6 Diabetes

On the 20 September 2013, Swindon CCG held its first diabetes alongside the diabetes clinical network.

Objectives:

- To become an example of national best practice
- To provide joined up care
- To empower and inform our patients
- To allow our patients to take control of their health and condition
- To ensure when intervention is needed that the process is rapid and efficient
- To identify the quick wins i.e. implementable by April 2014

What we heard:

We had representation from a number of representatives in Swindon including, GP practices, Pharmacy services, the Great Western Hospital, SEQOL and Diabetes UK. We heard the following key points from delegates:

- There is a massive spend on Diabetes drugs but achievement is very low; it has to be that we are missing something because it cant be that the drugs are not working.
- Estimate at least 1000 people undiagnosed with Diabetes in Swindon
- Current prevalence at 5.9%, and projected to 7.3% by 2020 and 8.3% by 2030.
- 80% of Type 2 could have been avoided or delayed if the right steps were taken!
- WWW.THEDTEAM.ORG – a diabetes blog set up by Mark Walton, who spoke at the event "This blog helps me and hopefully others deal with Diabetes".
- Need to better management of the Swindon Diabetes website: www.swindondiabetes.co.uk
- We should be encouraging patients to look at the 15 things what they should be asking their GP (Diabetes UK Checklist)

What we did:

An action plan was developed from the day which includes four priorities regarding the next steps:

1. Identifying and delivering key initiatives that are already happening
2. Sharing best practice and so that it becomes predominating practice
3. Using social marketing and social media to engage with patients
4. Simplifying the referral route to make navigation and access for patients easier

3.7 Endoscopy

On the 27 September 2013, Swindon CCG held its Endoscopy workshop.

Objectives:

- To provide a local direct access community service
- Develop a method to manage the costs associated with the implementation of NICE guidance to move from Barium Enema to Colonoscopy where appropriate
- Understand capacity and how we manage demand
- How we integrate the bowel screening service
- What can we do to support patients manage their condition in the community

What we heard:

An action plan was developed from the day which includes the following next steps:

- Need to agree process of referring on from AQP providers to our acute providers to ensure endoscopy does not need to be performed again at acute. Integrated pathway required from referral to completion of treatment.
- 30% of GP consultations are for GI problems most of which are managed in primary care. We need to think creatively about how we can help manage those patients with long term conditions i.e. chronic bowel disease.
- Patients need to be provided with information about providers so that they can make an informed choice as to where to have their procedure done. This should be based on clinical need.
- Review the need for a 24/7 service and how we would communicate to patients it would be normal to have procedures performed on Saturday/Sunday. To Invite RMC and Public health to next meeting.
- Invite patients with long term conditions such as Crohn's Disease or Colitis or patients who have received treatment to a follow on workshop.

What we did:

- Met with current providers to map what a potential future community pathway for endoscopy which could increase the quality of patient experience
- Learning from other locations where community access pilots are taking place – Bristol and Cirencester
- Discussing with our providers about the benefits of primary care testing, which could see more referrals for Irritable Bowel Syndrome (IBS) going to dietetics, educations and cognitive programmes.

3.8 End of Life care

On 5 February 2014, Swindon CCG held an End of Life (EoL) workshop. A range of organisations attended including local providers including Prospect Hospice, voluntary and charitable providers such as Marie Curie, Swindon Borough Council, GPs and three carers of patients who are current or past end of life service users.

Objectives:

Currently, NHS Swindon Clinical Commissioning Group (CCG) commission End of Life (EoL) care from a number of providers operating different models of service. The aim of the workshop was to explore the opportunities of a coordinated approach for adult EoL patients, through a single coordination point, with providers of care delivering integrated personal service.

What we heard:

The workshop was able to capture ideas, suggestions, in terms of how greater integration can be achieved. Please see below some of the suggestions made:

- Consortium approach:
    - Champions to identify what each service provides and then working together on a structured agenda to achieve the vision – could include a pilot scheme
- A system capable of providing a rapid response
    - Provide rapid response to patient needs by collecting data, mapping the points where patients come into contact with services such as inputs, outputs and outcomes.
- The creation of a care coordinator role
    - Someone to support the patients throughout their End of life journey. A role with a certain set of skills, knowledge and values to improve patient care.
- Personalised advanced care planning
    - A new end of life register to work with all GP practices. To use a clear patient leaflet to set out to public about care plans. To deliver end of life care planning education to staff across all specialities.

What we did:

With regards to some of the points raised above, the CCG has focused on a solution for information technology and condensing paper forms, including information governance. Swindon CCG have been working collaboratively with its healthcare providers to submit a bid to NHS England to fund the development of IT software, which will link with local electronic information systems as a possible solution for the integration of IT health/social care systems.

Swindon Borough Council, have been working closely with Swindon CCG in order to offer an Advice and Information Hub, which will be situated at Sanford House, Sanford Street, Swindon. The advice and information hub, will offer people of Swindon and Shrivenham, to access information regarding health and social care. There will be experienced staff working within the hub, who will be able to assist people with their individual concerns.

3.9 Orthopaedics

On Tuesday 3 September 2013 Swindon CCG held an orthopaedics workshop. A number of organisations attended including a range of local providers, local GPs, Swindon Borough Council and members of the public.

Objectives

The objective of the workshop were to develop a common understanding of the future demand, understand and review the opportunity for redesign of current pathways of care and to learn the lessons from joint pain services for the redesign of other services or specialties.

We know that joint pain is one of the services most likely to face significant growth, and this patient group are most at risk of prolonged hospital stay, complications or infections. There are material opportunity to benefit from self-care and preventative care programmes which should be explored.

What we heard:

This workshop broke down the delegates into the five part of the referral process, each discussing what good looks like for each part of the referral process. Below is a key point from each discussion

- Self-care
    - The MATs service can have longer discussions with patients which is what patient require and they may be able to prescribe in the future and offer injections under the current PGD.
- Primary Care to Referral Management
    - We need clear referral routes; direct access to diagnostics/consultants and encouragement of lifestyle changes.
- Initial Consultation Through to Pre-Assessment
    - Decision making aids and patient groups (at Primary Care/MATS/Physio) vs holistic collaborative approach by the MDT. Need to provide supported guided pathways and provide further information to the patient.
- Admission to Advanced Recovery
    - Swindon should be empowering patients to make informed decisions regarding their care and assisting them by providing a “one stop shop” Multi-Disciplinary Team consultation.
- Post Discharge
    - Could GP and patient Skype consultant/surgeon if there is a joint meeting needed? This happens on some of the Scottish Isles post-op.
    - GWH confirmed that the hip and knee information packs are available via their internet website: www.gwh.nhs.uk. They do include the 8-12 week post-discharge period. There is a need to go back to nurse-led/physiotherapist led clinics, while information packs and books are general – clinics can look at individual goal-setting.

What we did:

- When the CCG procure the MATS service providers will be assessed against a number of quality standards including providing a simple and clear referral pathway for patients
- Through the risk stratification process and community navigator program, he CCG have been raising awareness and improving patients' understanding of the risk factors that could lead to surgery.
- The CCG will commission a single model for integrated discharge
- CCG has revised commissioning for back pain in line with national guidance and are awaiting a business case to establish a Swindon Combined Integrated Psychology and Physiotherapy service, which can help patients to live with pain.
- Swindon CCG is supporting a number of lifestyle campaigns being run by Public Health to encourage healthy living.

4. Feedback from workshops and how we have changed our approach

4.1 Evaluation forms

For every workshop undertaken, the CCG asks delegates to fill out an evaluation form covering four questions:

- Did you have enough information beforehand
- Did the format of the day allow for you to feedback
- Was the content informative and relevant
- Any other comments

4.2 Changes to our workshops

While it is not possible to list all feedback received, the CCG has listed the changes it has made to the design and content of the workshops based on feedback received, so that they are effective and productive for both delegates and the CCG:

- **Involvement of users and carers** – not enough in first workshops
    - the involvement of users and carers in the dementia and diabetes workshop was seen by many attending as very powerful and helped to focus attention on the reality of improving services for patients
    - we now ensure a range of patients, carers and patient groups attend each workshop and involve patient groups at the design phase of the events to ensure that we are able to get maximum value from patient input on the day
- **Energy and input of delegates on the day** – could be increase, some workshops lacked engagement
    - we have improved the facilitation of workshops by introducing Ice-breakers and Re-energisers to ensure energy remains high throughout the day
- **Location of the workshop** – venue not appropriate for workshop and difficult to access
    - workshops have been moved to a better venue with better access and improved layout
- **Improved agenda** - the agenda needs to be flexible enough to change without causing confusion, ideas and features fall out of the workshop that may reset the agenda
    - more structured and focused sessions during the day, with flexibility to adapt to important discussion on the day
- **Briefing pack Slides** – difficult to understand and too much detail given
    - improvements made to layout of slides
- **Pharmaceutical company input** - feedback received from some workshops regarding the lack of involvement of pharmaceutical companies and how we should harness them in as part of the workshop and generate opportunities for them to fund specific initiatives
    - Pharmaceutical companies are involved in each workshop where their input is required and is felt to be beneficial, as part of an overall strategy for engaging with the pharmaceutical industry.