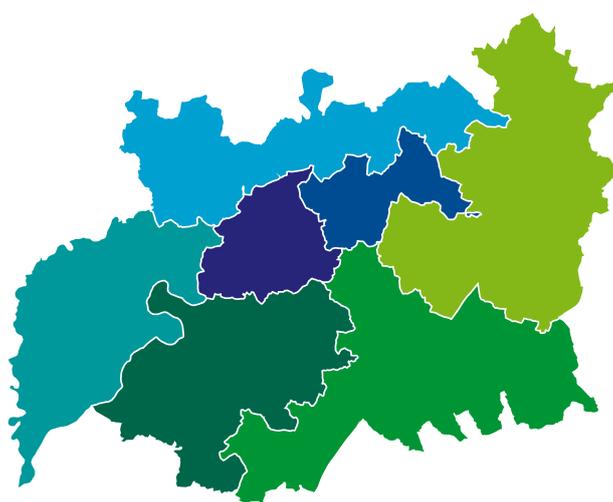


# Working for better health

Our plans for 2013/2014



## Welcome – working for better health

NHS Gloucestershire CCG puts GPs and other health professionals in the driving seat for the commissioning (buying) of health services to meet the needs of local people.

We are responsible for buying local NHS services such as emergency care services, operations or treatments that can be planned in advance and mental health services.

These services are provided by a range of 'provider' healthcare organisations, such as NHS Trusts.

Supported by experienced managers, we are bringing our knowledge of patient care to look at how services are planned and how the patient's journey through care can be improved.

We are a membership organisation (all local GP practices are members) and in our 7 localities, GPs and other clinicians are working with community partners to look at how we can best meet the health needs of local people and their communities.

You can read about some of the things we are doing to improve services and community support in this guide.

Best Wishes



Dr Helen Miller  
Clinical Chair



Mary Hutton  
Accountable Officer

1

## The key health priorities for our population

In Gloucestershire many people live long, healthy and active lives. Life expectancy (how long people live) is increasing and whilst this is a good thing, not everyone who lives longer does so in good health.

As life expectancy increases there will be more people living with illness or disability unless we can prevent those illnesses from happening, or help people to recover and maintain their independence.

This is why we are an active partner of the Gloucestershire Health and Wellbeing Board (our CCG Clinical Chair, Dr Helen Miller is the Vice Chair).

Led by the County Council, the Board has developed a Joint Health and Wellbeing Strategy to help tackle the challenges of the future and to support communities.

Following a public consultation last year (*Fit for the Future*), the Board agreed that their focus would be on the following five priority areas for improvement:

### Priorities

- Tackling health inequalities
- Improving mental health
- Reducing Obesity (promoting healthy weight)
- Improving health and wellbeing into older age
- Reducing the harm caused by alcohol.

A *Fit for the Future* delivery plan has been developed involving all organisations represented on the Board.

This includes a whole range of initiatives to make the most of the skills and expertise within communities, make connections and to support the most vulnerable.

Initiatives include developing dementia friendly communities, training programmes for 'front line' staff and 'community builders' to promote healthy lifestyles (including mental health) and a marketing programme with families and schools in communities where there are higher levels of childhood obesity.

2

## Local Public Health priorities

Using the latest intelligence available (Joint Strategic Needs Assessment – [www.jsna.gloucestershire.gov.uk](http://www.jsna.gloucestershire.gov.uk)), public health priorities have already been identified for each CCG locality. Many of these relate to the main priorities set out above.

The CCG's Locality Executive Groups (local GPs) are working with public health, local councils and other community partners to develop public health plans at a local level. This will help to inform what services and community support the CCG localities commission (buy) for their residents.

# Local Public Health priorities

## Tewkesbury, Newent and Staunton:

Covering Corse, Newent, Staunton, Tewkesbury

- Variations in health outcomes – cancer and lung disease (COPD)
- Childhood obesity
- Physical activity levels
- Sexual health.



## Cheltenham:

Covering Bishops Cleeve, Charlton Kings, Cheltenham, Hesters Way, Leckhampton, Prestbury, Springbank, Up Hatherley, Winchcombe

- Alcohol misuse
- Lung disease (COPD)
- Cardiovascular (heart) disease
- Falls in infants and older people
- Mental Health – suicide, self harm and social isolation and loneliness
- Smoking.



## Gloucester City:

Covering Abbeydale, Churchdown, Gloucester, Hardwicke, Highnam, Hucclecote, Longlevens, Matson, Quedgeley, Saintbridge

- Alcohol and drug misuse
- Obesity
- Early deaths from cardiovascular (heart) disease, respiratory disease, cancer
- Mental health
- Smoking (including in pregnancy).



## Forest of Dean:

Covering Blakeney, Bream, Cinderford, Coleford, Drybrook, Lydbrook, Lydney, Mitcheldean, Newnham-on-Severn, Ruardean, Westbury-on-Severn, Yorkley,

- Obesity
- Alcohol misuse
- Poorer health outcomes in deprived communities, in particular for women
- Diabetes
- Smoking with chronic conditions
- Lung disease (COPD)
- Social isolation and access to services.



## North Cotswolds:

Covering Blockley, Bourton-on-the-Water, Chipping Campden, Moreton-in-Marsh, Northleach, Stow-on-the-Wold

- Social isolation and access to services, particularly older people
- Injuries and accidents (including road accidents)
- Dementia
- Excess winter deaths.



## Stroud and Berkeley Vale:

Covering Berkeley, Bussage, Cam, Dursley, Frampton-on-Severn, Minchinhampton, Nailsworth, Painswick, Stonehouse, Stroud, Uley, Wotton-under-Edge

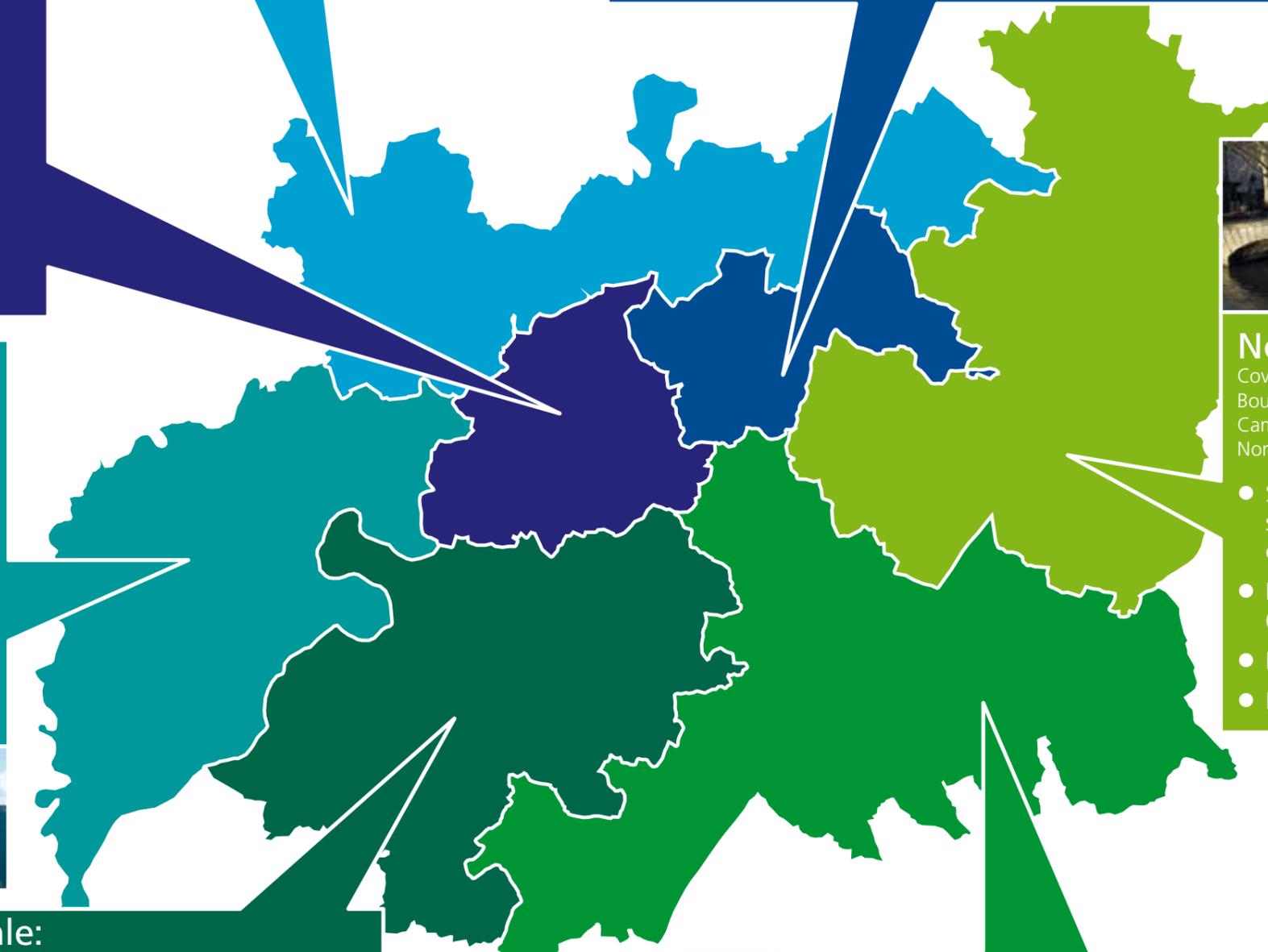
- Tackling isolation and loneliness
- Coronary heart disease deaths under 75 years
- Smoking (including in pregnancy)
- Intentional self-harm
- Dementia
- Rates of suicide.



## South Cotswolds:

Covering Cirencester, Fairford, Kemble, Lechlade, Rendcomb, Tetbury, South Cerney

- Injuries and accidents
- Access to services
- Dementia
- High levels of admissions to hospital for cancer and diabetes
- Excess winter deaths.



## Making services work better

We are ambitious to improve the way that services work and to work in partnership to develop community support.

Many of the initiatives to use NHS resources better or improve the patient's journey through care come from our clinical programmes, working in partnership with a range of health and community partners.

These programmes have been set up to look at particular conditions e.g. Cancer, Respiratory Care. We also have programmes looking at urgent care, planned care (operations and treatments that can be planned in advance) and diagnostics (skills and equipment that help to identify what illness or injury you have).

Some of the initiatives already underway are described below:

### Expert advice to help avoid hospital visits

Patients in Gloucestershire are now receiving expert medical help more quickly, thanks to the extension of the advice and guidance service for GPs.

The service, which has come about from partnership working with the Hospitals Trust, means that GPs can now get a second opinion on a patient's condition from a hospital specialist by sending a secure electronic advice request message.

This message may include scanned images, diagnostic results or relevant previous correspondence. The hospital doctor reads the GP's electronic message, and responds within three days, including attachments such as proposed treatment plans or links to other resources where appropriate.

It means that patients can often be treated by doctors in their local GP surgery, avoiding the need for a hospital visit.

Patients whose condition is more serious will still be referred to hospital, and this service means that hospitals can concentrate on treating these patients.

Advice and guidance services for GPs are already in place for children (paediatrics) and for people with diabetes, skin conditions (dermatology) and kidney conditions (nephrology). It will also be introduced soon in other specialties, including Ear, Nose and Throat and Rheumatology.

### Diagnostics – increasing choice and improving the patient experience

We are giving patients a greater choice of where and when they receive diagnostic tests. These are tests that help identify what condition or illness a person has.

Increasingly, patients are able to have a greater range of tests, such as endoscopy, ultrasound, CT and MRI scans at community hospitals and other locations in the community.

This is helping to improve the patient experience and in many cases speed up the patient's journey through care.

Once they have been referred, patients receive pre-test information, the test is carried out at a time and place of their choosing and the GP receives the report.

The GP then discusses the findings with the patient and if the condition can be managed by the GP then this speeds up care and treatment further.



Dr Caroline Bennett, outside North Cotswolds Hospital

### Improving emergency and urgent care services

Like elsewhere in the country, Gloucestershire is currently experiencing significant pressure within emergency care services (e.g. Hospital Emergency Departments) at peak times and we are working closely with local providers to ensure patients continue to experience good quality, timely care and treatment.

We are currently taking a number of actions, including:

- making full use of our telephone advice service for health professionals on available services e.g. community services
- development of our joined up community health and social care teams to support people in the community and at home (see next section)
- increasing the available number of beds in

### Joining up care and community support

Looking to the future, we want to join up care by developing community teams further and helping people to build on their skills.

The teams will include GPs as well as different professional groups such as social care, nursing and physiotherapy.

They will provide care and support to patients in their own homes and the community according to the individual's needs.

This should mean:

- a reduction in the number of hospital and care home stays, as appropriate
- greater clarity on who is involved in a person's care
- improved communication between professionals helping to ensure that services are better co-ordinated and timely, and;

### Dementia friendly communities and improving diagnosis rates

We are working with local partners to tackle dementia and make a real and meaningful difference to people's lives.

Gloucestershire already has a joined up Memory Assessment Service that provides support to both GPs and local communities and rolling education programmes for carers and health care professionals.

We also have a team of community dementia nurses and dementia advisors working closely with GPs and providing invaluable support to patients across the county.

the community

- improving arrangements for getting patients home from hospital when medically fit.

We are also working with the provider of the new NHS 111 telephone service to ensure further improvements in the advice and signposting to services that patients receive outside of normal GP surgery opening hours.

A number of steps have been taken which include increasing the number of call handlers and clinical advisors and further training which will continue.

Paramedics are working closely with call advisors to make sure that ambulances are sent appropriately. In addition to this, call advice is being regularly reviewed and audited to ensure continuous learning.



Local Area Co-ordinator, Julia Horsfall and Dr Charles Buckley

- improved links to wider community support.

We are also seeing the development of the 'Local Area Co-ordinator' role.

Using their networks and local knowledge, the co-ordinator can draw on wider community support and help people to improve their health and wellbeing and reduce isolation – this could be anything from organising a trip to a lunch club or joining up with a local arts group.

Other work has been done to bring together district councils, volunteers and community groups to establish a network of Memory Cafes, offering people with dementia and their carers social opportunities to come together and share experiences in a supportive environment.

Diagnosis rates in Gloucestershire are steadily increasing meaning that more people with dementia and carers are benefiting from the range of support available.

## Care Home support

A key priority for us is to work closely with community partners, including the County Council, Gloucestershire Care Services and Gloucestershire Care Providers Association to ensure that a joined up approach is taken to providing care in local care homes and to improve the consistency and quality of that care.

We know that providing high quality preventative care (and not just reactive care) brings benefits to the individual and also means less people have to go in to hospital.

This is especially important given the growing elderly population and people with increasingly complex needs.

We are developing a pilot 'Enhanced Service' provided by local GP Practices in care homes. This will support more proactive, preventative care including regular 'ward rounds' to each Care Home, assessment of residents, medication reviews and review of hospital visits.



## Cancer Services – focusing on prevention as well as treatment

We recognise that prevention is vitally important and we will be supporting a range of public campaigns (e.g. Be Clear on Cancer) and awareness initiatives as well as monitoring the county's screening programmes.

A top priority for us is to promote early diagnosis and we are currently looking at ensuring widespread use of Cancer Action Plans in GP surgeries supported by an education programme.

We are working to ensure timely access for people to diagnostics (to identify whether a person has cancer or not) and treatment and to ensure waiting time targets are met for the benefit of patients.

Our programme of work also looks at the length of hospital stays, the number of follow up appointments patients need, health outcomes from care and treatment and the patient experience.

## Joining up Respiratory care

The Gloucestershire Respiratory Team will involve bringing together existing community and hospital-based healthcare professionals to become a more integrated (joined up) service.

This will further improve the quality of care for people with lung disease (COPD), reduce duplication in care, support the on-going development of respiratory services as well as supporting GPs and GP surgery staff.

A full set of evidence based guidance (e.g. checking inhaler technique, referral to stop smoking service/rehabilitation) is being introduced to support people with this long-term condition to live as independently as possible. It will improve the quality of information and advice people receive, reduce the amount of time people need to spend in hospital and reduce the likelihood of people having to go back into hospital.

All this will be on top of the new home oxygen service that will be a key part of the Gloucestershire Respiratory Service.

## Investing in Diabetes care

We continue to invest in the community diabetes service, resulting in:

- increased (timely) access to community education programmes for people newly diagnosed with Type 2 diabetes
- training, education and support to primary care (GP) teams and
- support to people with complex needs, including care plans and medicine reviews.



## Improving the health and wellbeing of people with a Learning Disability



We are committed to improving the health outcomes for people with learning disabilities and ensuring they receive equal access to services and care.

Working with GPs across all our localities, we will support a joined up approach between health

and social care and other services providing a community based network of support.

Our work in 2013/14 includes:

- ensuring mainstream services are able to fulfill their duties to people with a learning disability. We will do this by ensuring they make reasonable adjustments to make their services accessible to all and by providing important health information in an easy read format
- making sure the right training is available to individuals supporting people with a learning disability in the community, as well as to professionals, so that they carry out their work to a high standard
- the formation of a health and social care intensive community support service for people with complex and challenging behaviour
- increasing the number of people receiving an annual health check and a health action plan.

## Further improvements in Mental Health services

We are working closely with providers to further improve mental health services for our population and improve the service users' journey through care.

Initiatives include:

- enhancing mental health services in GP surgeries to support rapid access to mental health support closer to home
- extending current hospital liaison teams to enable comprehensive assessment of a patient's mental and physical health
- improving access to psychological therapies, including for children and young people.

## Local service priorities

The GP locality Executive Groups have been developing their commissioning (buying) plans and priorities for 2013/14, working closely with public health, local councils and the CCG clinical programmes.

Here is a snapshot of some of the local priorities and initiatives already underway or planned:

### Gloucester City:

Population of approximately 161,020 people

- Agreed a local community plan for care to improve services and support
- Working with care homes to improve the quality of care, improving team work and co-ordination of more pro-active and planned GP medical support
- Working to strengthen Integrated Community Teams – collaboration between groups of GP surgeries to further develop joined up community teams
- Improving Diabetes education and advice – a project is underway in Gloucester to ensure more practice staff have the knowledge and skills in the right areas
- Working with hospital colleagues to agree how local GPs and nurses can help with local A&E pressures
- Commissioning a review of immigrant population health needs, which will help to inform how local services can continue to meet the needs of all people in the City.

### Tewkesbury, Newent and Staunton:

Population of approximately 41,591 people

- Focus on Respiratory care (e.g. lung disease) to ensure effective care of patients locally, reducing the number of emergency hospital admissions
- Develop enhanced primary care (GP support) within care homes
- Work with local schools and colleges to increase awareness of sexual health services, with a focus on Chlamydia.

### Cheltenham:

Population of approximately 148,912 people.

- Recent production of a Locality Development Plan with public health and other partners
- Working with care homes to improve the quality of care, improving team work and co-ordination of more pro-active and planned GP medical support
- Improving Diabetes education and advice – ensuring more practice staff have the knowledge and skills in the right areas
- Ensuring that patients with lung disease (COPD) and Asthma have appropriate care plans for medication and community support – reducing emergency admissions to hospital
- Developing ways of improving access to primary care (GP services) – all practices have developed action plans and are reviewing and sharing information on what has worked well.

### North Cotswolds:

Population of approximately 27,897 people.

- Integrated Community Teams – collaboration between groups of GP surgeries to further develop joined up services
- Improving care for older people: more joined up with care homes, encouraging the use of dementia advisors and introducing a support programme for the health and wellbeing of carers
- Improving support and advice to patients with diabetes in GP surgeries to encourage healthy living
- Working to increase the number of patients able to access new and follow up outpatient appointments at North Cotswolds Hospital, Moreton-in-Marsh or the George Moore Community Clinic in Bourton-on-the-Water e.g. gynaecology, neurology and paediatrics.

### Forest of Dean:

Population of approximately 61,910 people.

- Project work with public health and local partners to address social isolation particularly amongst older people and access to community networks
- Working to deliver weight management support
- Addressing the variation in management of COPD (lung disease) and improving outcomes
- Developing a project with public health to understand and improve poor health outcomes for more deprived women
- Continuing to work with Forest of Dean District Council on social prescribing projects e.g. weight management and exercise sessions.

### South Cotswolds:

Population of approximately 56,276 people.

- Developing community services through Integrated Community Teams (joined up health and social care teams)
- Improving early diagnosis and recording of patients with dementia and looking at how people can be better supported in the community by working with health and social care partners
- Supporting extended diabetic services by ensuring that a GP and nurse from each practice has dedicated training.

### Stroud and Berkeley Vale:

Population of approximately 118,695 people.

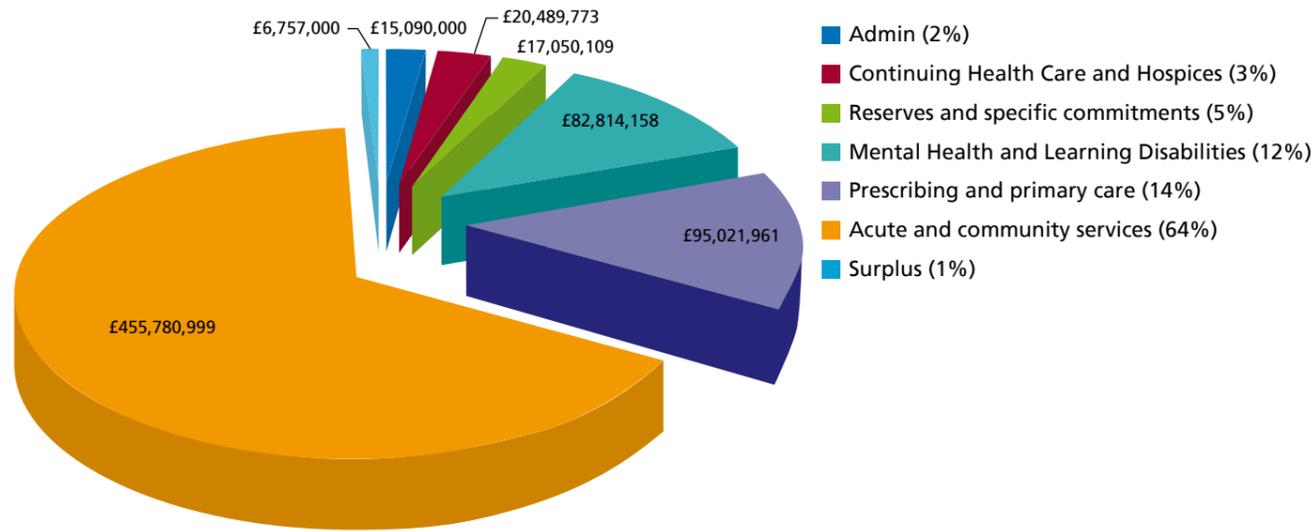
- Dementia – increasing awareness amongst the population and healthcare professionals to support early diagnosis. Working with council, voluntary organisations, carers and the individual to help people stay independent and in their own homes for longer
- Living Well – development of the Local Area Co-ordinator role in Cam and Dursley
- Supporting older patients in the locality who may be unsteady/confused e.g. chest and urinary tract infections. This includes tests and diagnosis within primary care (GP surgeries) and community hospitals and community team support at home.

## Do you have views about local health priorities in your local area?

If so, please complete the form at the end of this guide (or on-line via our website) and your feedback will be shared with your locality GP Executive.

5

## How your money is used 2013/2014



“We have an important responsibility to ensure that we achieve the best possible health outcomes for our population within the resources available.”

“This chart shows our overall spend for 2013/14 and how our £693 million commissioning budget is used.”

*Accountable Officer, Mary Hutton*

## Standards people can expect from the services we commission (buy)

We are committed to commissioning (buying) high quality care and support that meets the needs of the individual and our local communities.

The NHS constitution sets out rights for patients, public and staff. It outlines NHS commitments to patients and staff, and the responsibilities that the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively.

We will take account of this constitution in our decisions and actions. You can read a copy at: [www.gov.uk/government/publications/the-nhs-constitution-for-england](http://www.gov.uk/government/publications/the-nhs-constitution-for-england)

We also have our own Constitution that guides the way we work. This is available on our website in the publications section.

6

## Getting involved and having your say

We are very keen to listen to your views and there are a number of ways you can get involved in our work.

This includes:

- Taking part in a working group
- Attending occasional focus groups or workshops
- Commenting as part of an engagement or consultation exercise e.g. complete a survey or attend a local ‘drop in event’
- Attending our public Governing Body Board meetings
- Joining a Practice Participation Group at your local GP surgery
- Visit the Information Bus when it is in your area.



If you would like to talk to someone about these options, please e-mail: [GLCCG.consultation@nhs.net](mailto:GLCCG.consultation@nhs.net) or telephone: 0300 421 1594

## Feedback Form

Please share your views about local health priorities in your local area. Either:

- 1 email your comments to: [GLCCG.consultation@nhs.net](mailto:GLCCG.consultation@nhs.net), or
- 2 Print, complete and send your form to:

FREEPOST NO: RTEY-EBEG-EZAT

PPE, NHS Gloucestershire Clinical Commissioning Group, 5220 Valiant Court, Gloucester Business Park, Brockworth, Gloucester GL3 4FE

The feedback will be considered as part of priority setting for 2014/15.

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*Gloucestershire  
Clinical Commissioning Group*

*Joined up care*  


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