Papers for the STP Programme Board meeting

16 May 2017

The following papers from this meeting follow:

Sustainability & Transformation Programme Board
AGENDA
16 May 2017
17:45 – 19.45hrs
Lindfield Road, The Charis Centre,
Town Barn Rd, Crawley RH11 7EB

	Time	Item Description	Presenter
1.	17:45	Welcome and Introductions	MW
2.	17:50	Cancer Alliance Update	Paula Head/ Fiona McKinna
3.	18:20	Future of Primary (Enc 3)	Richard Brown
4.	18:50	Digital Workstream Update	Wilson Sharpe / Mark Watson
5.	19:10	STP Leadership & Work Programme 2017/2018	DM / MW
6.	19.40	Letter from Stroke Association (Enc 6)	MW
7.	19.45	Next steps/ Close	MW

Time and Date of next meeting is:- Tuesday 27 June 2017 (17:45-19:15), Jury's Inn, 1010 Stroudley Road, Brighton, BN1 4DJ

Where is General Practice now?

- Rising expectations
- Rising demand
- Ageing population
- Shrinking resources
- Increasing multi-morbidity
- Negligible GMS increases
- No more GMS contracts – all APMS
- Workforce crisis
- Another reorganisation underway
- NHS is trying to transform general practice?
  - But does it know what it wants?

How to save money…?

- Reduce demand
  - Self-care, education, alternative services to NHS
- Reduce referrals
  - Enhance general practice
  - Ration care
- Deliver pathways more cheaply
  - Non-elective (unpredictable) or elective (predictable)
  - Redesign whole pathway, or components
  - Fewer contacts, or fewer investigations
  - Use cheaper staff, location, consumables
- Enhance efficiency
  - Better IT, better admin

The 5YFV Question(s)

- How can General Practice be made sustainable?
- Can transformation be made to work for General Practice (as well as the wider system)?
- What form should at-scale transformation take?
  - I am going to argue it should be
    - Collaborative and inclusive
    - Owned by its practices
    - Place-based and geographically coherent

An example: RGPA

- October 2014
- All 28 practices, 205K patients, place-based
- PMCF Wave 2 – Hubs and localities, Flying RAT
  - Resilience
  - Interoperable IT, Health Help Now
  - Workforce
- New systemic opportunities
  - Population-based care
  - Non-elective and elective care pathways

What this has led to…

- Physical Health OBC
  - Outcomes Based Commissioning
  - RCCG attempt at ACO
  - GP Federation a ‘fixed point’
- Joint Venture with Community Services
  - Partially-integrated MCP (with federation benefits)
  - Not all MCPs are the same…
- Mental Health OBC
- CCG Pharmacy contract

Examples of Other Projects…

- Practice Support
- Physio First
- Pharmacy First
- New Clinical Pathways
  - Diabetes
  - Dermatology
  - MSK
  - COPD Pathways

Other Consequences…

- Other SWL GP Federations
  - Kingston, Wandsworth, Sutton, Merton, Croydon
  - same place-based model
- SWL GP Federation Collaborative
  - First met December 2015
  - Operate under MOU
- STP Engagement
- STP Plan
  - Localities and Hubs across SWL
  - Shift of care

RGPA System Plan

- Level 1
  - Delivery by practices
- Level 2
  - Delivery by practices working together in localities
- Level 3
  - Delivery by Federation with Community Services
  - Hospital support for some services
  - This is where Outpatients should sit
- Level 4
  - Delivery by Hospital
  - Only delivering the care that only it can deliver

Take Home Points

- Working at scale can be made to work for General Practice
- Place Based Federations are an attractive model
  - Built quickly, don't require new contractual models
  - Widely distributed ownership
  - Support existing practices
  - Maintain traditional virtues of General Practice
  - Attractive to commissioners (require a supportive CCG)
  - Deliver major systems transformation
  - 'Savings share' from this reinvested in General Practice

Fin

Dear Michael,
Thank you for your time on 23rd February 2017; it was a pleasure meeting with you and hearing the detailed plans for the Sussex and East Surrey Sustainability and Transformation Footprint. I write to you with regards to our detailed conversation regarding community stroke services across Surrey and the stroke strategic review.

The resident population of the five CCGs is c.1.1 million and in 2014/15 there were 17,967 people who had been diagnosed with a stroke. In the same period there were 1,478 admissions recorded on the Sentinel Stroke National Audit Programme.
Atrial fibrillation is a known risk factor for stroke and it is estimated there could be an additional 9900 people with undiagnosed atrial fibrillation in the CCGs

More people are surviving stroke than ever before, over a third will have communication difficulties and nearly half need help with daily living activities. With the right support many stroke survivors can regain speech and mobility enabling them to regain independence. Every patient who is able to go back home after a stroke and is fully independent in his/her daily life leads to savings for the NHS and social care

The Stroke Association has had a service for 7 years across Surrey for five Stroke Support Workers who empower stroke survivors and their carers to manage their care. The Stroke Support Workers focus on increasing the skills of the stroke survivor to self-manage, engage in peer support groups and be enabled to control the care they want and need, whilst maintaining or regaining their independence at home. To date in total we have supported 3,150 people and their families at an annual cost of £57,000.

Below are some of the statistics and impacts we have made in the last year:
In the last quarter alone we supported 202 beneficiaries and 30 carers with 730 unmet needs identified with stroke survivors this year.
From the needs assessments our coordinators complete with stroke survivors, our staff have completed 977 actions that led to 1854 outcomes across the year, almost 2 outcomes per action. The outcomes that had the highest correlation to our actions were: Increased ability to self-manage, Increased independence, Increased feelings of reassurance, Reduced carer stress, Increased understanding of Stroke and Adoption of healthier lifestyle.
This year we have made 188 referrals to other organisations. We have benefited from 61 hours of support from volunteers who helped us provide in-reach into hospitals, support stroke survivors in groups and provided peer support.
We have awarded 19 grants to the sum of £ 4779.19 for stroke survivors. Some of these items have included gym membership, a short stay, new mattresses, food vouchers and an oven.
We have provided 465 visits and in total 1146 counts of calls, mail outs, emails, liaising with or on the behalf of a stroke survivor.

Attached along with this letter are two case studies to provide context to the requirements needed and help received

The Stroke Association's contract to provide services across Surrey terminates on Friday 29th September, which will leave stroke survivors in the county with no specific support to help them with their recovery.
The impact of this is that individuals will not get the support needed to make the best recovery possible and many will continue to be reliant on health and social care services. Stroke survivors will also not get support to manage their health or to reduce their risk of a second stroke, which will in turn increase demand for acute services.

We understand there have been a number of attempts through the stroke strategic pathway review which has been ongoing since 2015 to find the best solutions for the Surrey population. However, this has focussed on the acute element and little has been addressed around long term/community support for stroke survivors. The failure to date of this review to provide clear evidence and positive results for the stroke population of the five CCGs, as well as recent changes to the Sustainability Transformation Footprints in Surrey Heartlands, the knock on effects of changes to stroke in High Wycombe and the cuts to Virgin Care ESD, have all continued to provide uncertainty and concern for the stroke population.

The Stroke Association would therefore recommend a proposed action for:

1. A stroke specific community presence which is needed to ensure the needs of stroke survivors and their families is understood and that the physical and emotional long term impacts of stroke including those with communication issues (one in three) is met.
2. A stroke specific community presence which works in parallel with ESD and acute community based rehab to support health and social colleagues by reducing the burden on them, as stroke survivors and their families will get the required level of community and home based support.
3. Propose that a county wide service is maintained for a minimum of two years to provide stability and certainty for stroke survivors. The current service is strongly focussed on helping stroke survivors and their family prepare for the changes that happen because of a stroke, with information about stroke, practical advice and emotional support and these needs to develop to build greater resilience into the community and be flexible to the populations needs.
4. A community service is commissioned and in place ready for the end of September 2017 to ensure there are no gaps in provision and to ensure ongoing care for stroke survivors and carers.

Surrey Case Study: October-December 2016
Runnymede/Spelthorne (and temporary cover for Reigate, Banstead and Redhill) Carolyn Cheetham

Client: Mrs G is a widowed sixty year old lady who lives alone (with her beloved cat) in a second floor flat. There are two flights of stairs to the flat and no lift. Mrs G lives in the area I was temporarily covering. She had her stroke in August 2016 and was in the acute hospital for two weeks and a rehab unit for a further two weeks. She has a daughter who lives fairly close by and visits quite regularly but she also has two young children. Mrs G's son lives in Japan.
Mrs G's stroke left her with left sided weakness in her arm and leg. Visual problems, fatigue, slurred speech, emotionalism and a lack of co-ordination.

Background: Prior to her stroke Mrs G had been signed off from work and from driving as she has a fairly rapid cognitive degenerative condition and her memory is extremely poor. She suffers from depression and is waiting to be rehoused as she struggles to manage the stairs to and from her flat. She told me her husband who died in the last couple of years always sorted out all of their finances and she was 'useless at handling money.'

Issues Identified

- Financial worries
- Housing
- Psychological Issues
- Pre-stroke health issues
- Lack of social interaction
- Transport

Goals:

- Improve her financial situation
- Obtain a blue badge so she could go out with her family
- Take part in some social activities.

Actions:

Financial Issues: Mrs G had completed the first stage of the PIP application process but asked me to help her complete the form due to her visual problems as well as her memory issues. This was completed and she is now waiting to hear when her medical assessment will be. She was able to send off lots of information regarding not only her stroke but also her other medical conditions (she is diabetic). Mrs G was also worried about her electricity payments as she said they were taking a lot of money. After I had taken her to CAB (see debt section) she made an appointment for someone from her energy company to visit her to discuss ways to keep her bills low.

Housing: At present she is still in the same flat but just before Christmas had heard that she should be near the top of the housing list when they had received a final piece of paperwork from her. The rehabilitation physiotherapist and the occupational therapist from the locality team have written to housing to support her case to move. I will review this with her in the New Year to see if she requires anymore support as this move is essential for her effective re-ablement.

Emotional issues: When I visited this lady in late October she hadn't heard from the psychiatric nurse and when I suggested we should follow this up she said that she would wait as she was sure they would contact her. At my second visit she still hadn't heard and she showed me the name of someone who had visited her in hospital (Clinical Psychologist) but unfortunately there wasn't a contact number. I managed to track her down and she told me she had asked the GP to refer to CMHT as the client had had suicidal thought in hospital. She also advised me to contact the neuro-rehab team who had been supporting Mrs G since her discharge from hospital and write to the GP to see if the referral had been made. I did all of these things but the GP never replied and she had only seen the physiotherapist from the rehab team and had now been discharged.

I strongly advised Mrs G to contact her GP (when her daughter had popped in) which she did but he only gave her telephone advice and told her to increase her medication. I then had a phone call from the OT at the locality team and she was also very concerned about her emotional health and had rung the GP surgery. When Mrs G still hadn't heard from the CMHT I rang her and strongly advised her to make a GP appointment and actually visit him to discuss a referral as she wasn't feeling any better even though he had adjusted her medication. I will review this in the New Year to see if she has visited to try and ensure that there isn't any further delay in the transferring of care.

Pre-stroke health issues: I was concerned that this lady wasn't eating properly as I knew she was struggling financially and also I wasn't sure she was motivated to prepare herself meals.

Debt: I received a phone call from the SCT (OT) on a Wednesday late afternoon saying that she had visited Mrs G about installing some equipment and she had suddenly disclosed that the bailiffs were coming the following Monday as she was in debt with her council tax. She said that Mrs G was very worried about this and could I help her. I rang Mrs G and discussed with her and agreed to take her to the Citizens Advice Bureau (CAB) the next day. Unfortunately, when we got there the drop in (which was advertised on their web-site) was actually on the previous day. Luckily after ringing around we found another CAB which did have a drop in that morning and we visited them. They managed to speak to the bailiffs and reassured them that they were now involved and would be helping this lady sort out her debts. Another appointment was made for her to go and apply for council tax benefit and in the New Year she has another appointment to help with further debts. Hopefully, with her debts sorted out and if she is allocated some PIP payments she will be able to manage better. After the visit to the CAB the service user said that I had been the most helpful of all of the people that she had recently come into contact with as people often say they will do things but don't always follow it through. Hopefully the client users experience of our service has been a positive one.
Whilst we were at the CAB I broached the subject of getting a voucher for the Foodbank which she did and a friend took her down the next day to collect some food for her and her cat. They also gave her a small amount of money that she could use for her electricity. I hope by acting immediately at this crisis point for this lady I was able to provide excellent on the ground care centred around the individual

Social Interactions: This lady has been referred to the local coffee mornings run by volunteers for the Stroke Association and she is waiting to hear from them. At present I am unsure how she will get there as she is unable to pay for any transportation but I am hoping that her daughter may be able to take her there and back.

Blue badge: Shortly before Christmas we sent off the application for a blue badge which would really help this lady as she is frightened of falling and needs someone with her when she is out walking.

Outcomes:

A lot of the outcomes are still pending as the client is waiting to hear about her PIP application, her request to be rehoused, her blue badge application and also she hasn't yet attended the coffee morning. However, her access to greater financial support has been improved by applying for council tax benefit and there is a plan in place to help her manage her current debts so she doesn't get approached by the bailiffs again.

Her emotional health is still very fragile and she still requires support with this which I hope she receives in the New Year. I will be in telephone contact with this client until I am sure she is getting the support she requires.

Summary

It is hoped that this client achieves all of the goals early in 2017. If she attends the coffee morning and likes it it might be that she would like to go to some other activities that run locally as well. However, until she has some disposable income to be able to pay for transport and costs for this she is unlikely to be able to access them so this might be an ongoing goal for some months.

This case was quite complex because it required effective working relationships with a number of other organisations and staff. To help this client I have had to liaise with the GP, rehabilitation team, clinical psychologist, occupational therapist at social care as well as staff at the Citizens Advice Bureau. Although this client has many hurdles to face over the coming months and years it is hoped that our services input has smoothed out some of the problems that were arising and stopped them from becoming overwhelming.

Surrey Case Study: December 2016
Karen Bothe: Stroke Support Worker (Surrey Heath and Woking)

Client

Mr C is a gentleman in his 70s. He had 2 strokes in 2015. He lives alone. I supported him for just over a year.

Background

Prior to his stroke, as an independent man, he enjoyed an active life with a few friends. He enjoyed cycling and fishing. He has family living close by. He had two strokes close to one another, affecting his left side and leaving him with mobility issues. Mr C was feeling socially isolated, and as a result, he was suffering from low mood.

When I first met Mr C, he had suffered his first stroke. He was very determined to recover and return to his usual activities. He was very keen to know about healthy eating and exercise. I gave the factsheet on these subjects and welcome pack, which includes information about preventing a stroke. ***Prevention of admission to care or residential homes***

A few weeks after my first visit, I was informed by the Early Supported discharge team, Mr C had suffered another stroke. This stroke affected both sides. He is struggling emotional and feeling lonely.

Issues identified

- Mobility
- Social Isolation
- Transport
- Housing
- Finances

Actions

Mobility: Mr C can walk short distances only. I researched and provided information on scooter options.

Social Isolation: I encouraged Mr C to attend the local Stroke exercise group. This is a weekly exercise group, for stroke survivors. There is the option to join the group, to meet socially for coffee after the exercise group. This would give him the social interaction he needed. I also researched local day centres to give further social opportunities. I provided information about a free helpline for older people Silverline, to help reduce feeling isolated at home. I was concerned about his low mood and encouraged him to discuss how he was feeling with his GP.

Transport: I provided information about the local community transport.

Housing: To help with cleaning his home, I made a referral to Hometime, AGE uk cleaning service. I made a Social Care referral for an Occupational Therapy assessment. I supported Mr C by completing his application for alternative ground floor accommodation.

Finances: Attendance Allowance was applied for. I completed a Life after stroke grant to help with the cost of the mobility scooter.
Involving other agencies – *A workforce culture which enables effective collaborative working relationships*

Outcomes
Increased safety and dignity – In the beginning, when he was very low, he didn't want any support and he didn't reject the service. I periodically checked to see how he was doing. I think offering a person centred service, gave him the safety and dignity to get help when he was ready to ask. *Provide excellent on the ground care centred around the individual*

Increased understanding of stroke – I provided Mr C with all the factsheets, he was interested in, to help with his understanding of stroke.

Adoption of a healthier lifestyle – Mr C achieved a happier and healthier lifestyle with his new scooter, which allowed him to return to some of the activities he previously enjoyed. *Effective reablement*

Increase ability to self manage – when I met Mr C after his second stroke, he was very low with little interest in anything. He was very low and I was concerned about him. By being there to support him, over time, he began to call me and make requests for help; this increased his ability to self-manage.

Increased independence – His new mobility scooter has increased his independence. This enables him to be independent, to get out of his house, travel on the train/bus and return to activities.

Reduced emotional distress – Climbing the stairs to his first floor flat was proving very difficult, especially with shopping to carry also. As much as it was a dilemma to leave his home, moving to a ground floor accommodation would alleviate much physical and emotional distress.

More access to financial support – Mr C is now in receipt of Attendance Allowance.

Increased feelings of reassurance – Mr C has come a long way since we started working together last year. He seems more confident in knowing what he wants and making it