HEALTHIER PEOPLE,
BETTER FUTURE

NHS
Heywood, Middleton and Rochdale
Clinical Commissioning Group

# Annual Report Easy Read part 4.

## 1st April 2019 – 31st March 2020


**Buying services with our partners in a joined-up way**

**Buying services**


**Planned Care – page 2**

**Urgent Care – page 7**


**Mental Health – page 15**

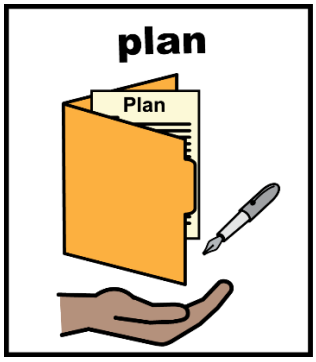
**Neighbourhood care – page 20**

## Difficult words.

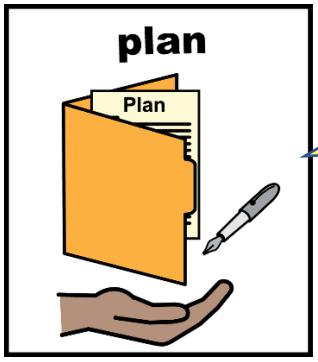
**In this report any difficult or unusual words will be in bold. The meaning of these words will be explained at the end of the report**

**Buying services**

**Buying services with our partners in a joined-up way**

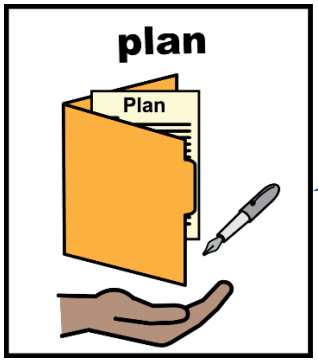



**Planned Care**



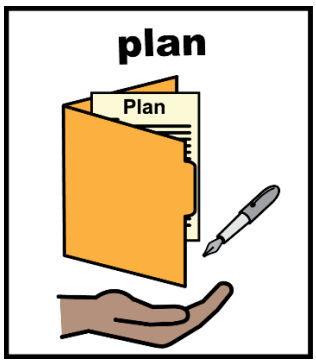

**Planned care**

We reviewed the **Integrated Elective Care Pathways (IECP)** programme to check how well it worked. We looked at the notes for 200 patients across the five special areas of **elective care**



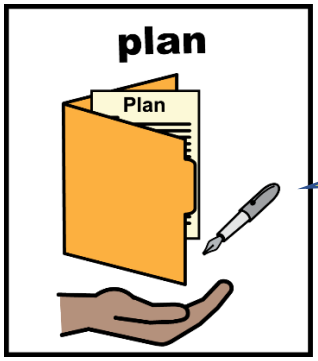

**Planned care**

We reviewed the entire planned care programme and started whole system types of work around breathing and heart conditions to give a better service and avoid patients going to hospital unless really needed.



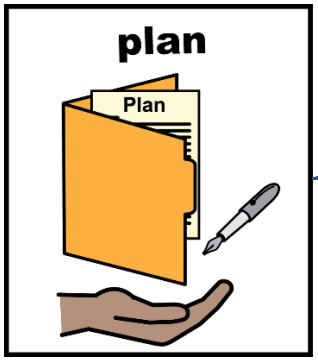

**Planned care**

Started a **Musculoskeletal (MSK)** triaging gateway for six MSK specialties (including the community pain service) to ensure patients are treated in the best way for their condition



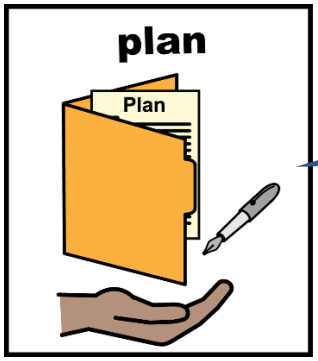

**Planned care**

We started consultant-based triage for referrals to blood related services to reduce outpatient attendances that were not really needed



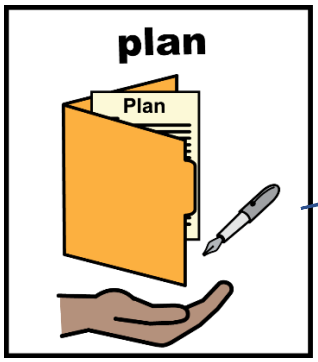

**Planned care**

Set up a **Planned Care Board** to make high level decisions for our planned care plans




**Planned care**

Identified savings of around £3.5m through redesigning a range of planned care programmes




**Planned Care**

**Planned care**

Keep building the big plan for patients with breathing based illnesses, to improve primary and community-based care and avoid unneeded visits We also want to tackle the rising rate of breathing related disease

**Looking forward**

Keep building the big plan for patients with **cardiovascular disease**, and put approved pathways and consultant led triage in place. This will give patients better health results.

**Looking forward**

**Looking forward**

Explore the chances within the **elective** care programme for streamlining the care journey at lower cost and closer to patient's homes

**Looking forward**

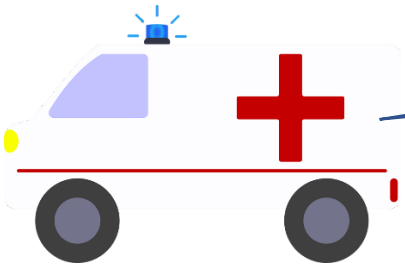
Start patient follow up asked for by the patients and virtual clinics to manage demand, and reduce extra costs

**Looking forward**

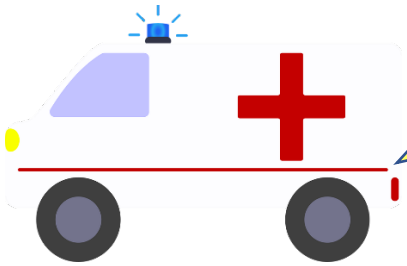
Review **ophthalmology** to manage demand more effectively

**Looking forward**

Work towards the move of planned care into the **Local Care Organisation** contract in 2021-22.

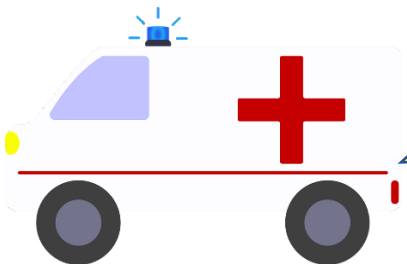


**Urgent Care**



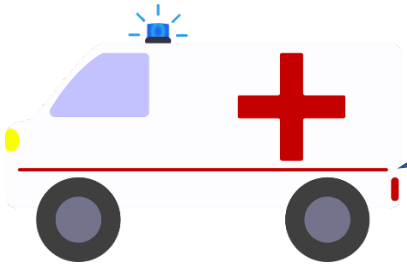
**Urgent Care**

The new **Ambulatory Care Unit** (ACU) was set up in June 2019. The new service offers same day emergency care to patients at Rochdale Infirmary. This means that patients are tested, diagnosed, treated and can go home the same day



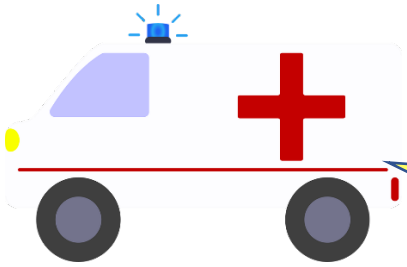
**Urgent Care**

With partners we once more bought the GM Integrated Urgent Care **Clinical Assessment Service (CAS).** The service aims to create a 24/7 secondary care triage and testing service by moving less serious 999 and 111 calls as early as possible.



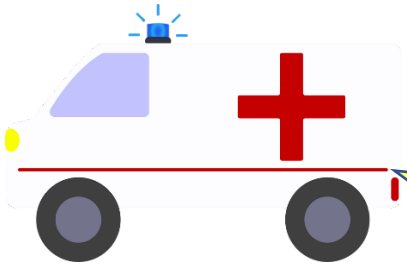
Urgent Care

The **CAS** will merge community, primary, mental health and social care services connecting patients to community services rather than hospital emergency departments



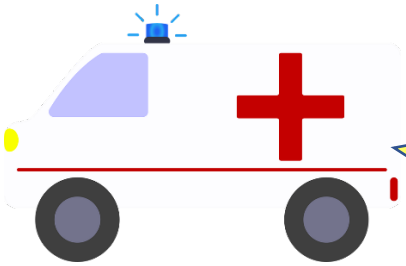
Urgent Care

Between November 2019 to March 2020 we can now sift patients at the front door to the Urgent Care Centre (UCC), to guide less serious urgent



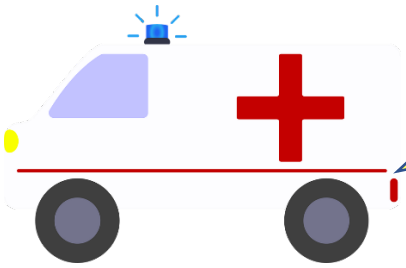
Urgent Care

Increased weekend capacity of the **PNP** service to help the urgent care centre. The service manages less serious patients while building patient confidence to care for minor ailments at home



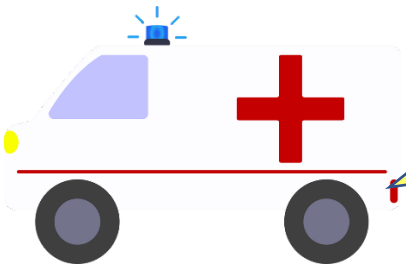
**Urgent Care**

Adult Social Care delivering the night sitting service which helps carers overnight for those patients who attend A&E at Fairfield and UCC at Rochdale to return home safely when it has been determined that they do not need to stay in hospital.



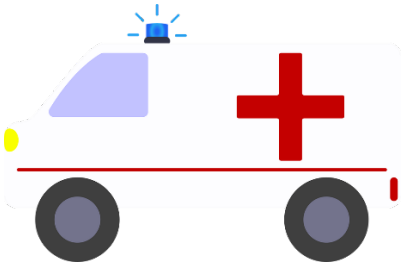
**Urgent Care**

Increased capacity of **Discharge to Assess** to support the 'Home in a Day' initiative during winter pressures. The scheme is a therapy led service facilitating discharges from both Rochdale Infirmary and Fairfield General Hospital.



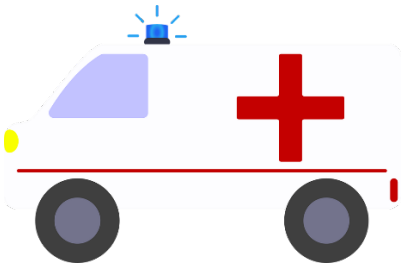
**Urgent Care**

Working with other commissioners, we reviewed the existing Private Patient Transport services (non-emergency). From the results we planned a new responsive local service that can change to meet demands.



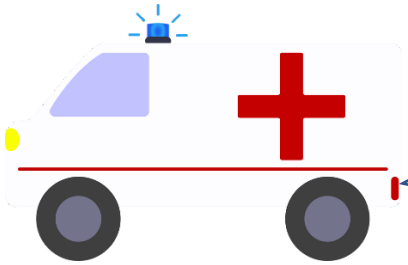
**Urgent Care**

We and providers reviewed the NHS 111 and the **NHS Pathways Directory of Services System.** We have updated the system with the latest services to make sure patients are pointed to the best service for their care needs



**Urgent Care**

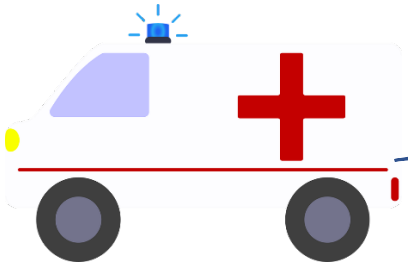
We have built a planning tool to help planning and respond to local growths in demand. It will help us understand the pressures across primary, acute, social and community care. This will let us and providers work together to aim resources better to manage patient demand.



Urgent Care

Our **HMR Emergency Assessment and Treatment Team (HEATT)** car is still working with the ambulance service to care for and help patients to remain at their own homes, avoiding A&E and possible hospital admission.

.



**Urgent Care**

Urgent Care

**Looking Forward**

Looking forward

**Looking forward**

After a review we knew we needed to change the urgent care service for our patients. During 2020-21 the Rochdale Urgent Care programme, along with elements of primary and community care, will transfer into the **Local Care Organisation**. This will let us work within a wider budget with partners to improve clinical care, improve access and reduce **duplication**.

**Looking forward**

Rochdale Infirmary urgent care centre wants to become an Urgent Treatment Centre (UTC) by August 2020. Urgent treatment centres are GP-led, open at least 12 hours a day, every day. Appointments that can be booked through 111 or through a GP referral.

**Looking forward**

The centres can diagnose and deal with many of the most common ailments seen at A&E. They are intended to ease the pressure on hospitals, leaving other parts of the system free to treat the most serious cases.

**Looking forward**

**Looking forward - our 10-point plan for urgent care.**


We are working with the **LCO** on a 10-point Urgent Care Strategy, this includes (see next boxes)


Introduction of a single point of access (for example, one phone number or web address) for patients

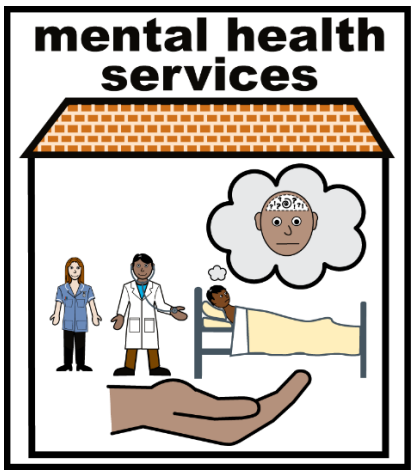

Introduce reliable triaging across the whole system to ensure patients receive the best care for their condition in the best setting possible


Introduce “primary care same day emergency hubs” in Rochdale to offer additional urgent care

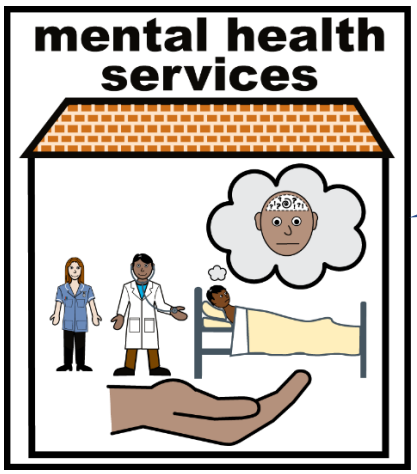

Build our intermediate tier of services (Intermediate Care) to make sure we have adequate **step up and step-down** services. This will include both home based and bed-based care, and include a two-hour Rapid Response service


Make sure we have sufficient community-based capacity in place to manage patients with long term conditions and prevent their illness getting worse and avoiding an emergency admission to hospital.


**Mental health services**




Trainee Mental Health counsellors now based in each primary care network




In the last year we have seen a good reduction in the number of our patients being admitted to hospital outside our area.


Rochdale's Dementia United Partnership steering group has been built up and is well attended by all local partners within the borough. The group focuses on key issues for our area and has a plan to move these issues forward


Training for primary care staff, social care staff and care home staff is being built by the **Primary Care Academy** to improve the diagnosis rates within the borough.


The Alzheimer's Society plans to introduce its Dementia Connect service within the borough during 2020 bringing the Dementia Advice service to more people in more ways.


We set up a joint primary care /secondary care service of physical health checks to ensure patient health needs are met, reducing the significant gap in life expectancy between people with severe and enduring mental illness.


Looking forward.

**Looking forward**

Deliver an integrated third sector service that helps an all age early intervention and low-level support offer across neighbourhood teams.

**Looking forward**

Put in place a programme budget approach for mental health secondary care beds, reducing all non-specialist out of area beds.

**Looking forward**

Continue to review mental health **Delayed Transfers of Care (DTOCs)** one of the things that makes hospital stays longer. There has been a huge focus on this work during 2019-20. This includes an active approach to identifying barriers to discharge.

**Looking forward**

Build clear mental health learning disability buying responsibilities for NHS HMR CCG to inform future buying plans, especially around ADHD/Autism Spectrum Disorder (ASD)

**Looking forward**

We will try to plan a better all age local mental health access service, helping those in crisis much better than ever before. We will concentrate on our community mental health team's, services that aim at getting involved earlier and **IAPT** therapies.

Neighbourhoods

Neighbourhood

Neighbourhood

We have carried on building HMR's 6 **Integrated Neighbourhood Teams (INTs)**, which deliver community services to local areas. Mental health practitioners are now core members of all 6 teams

Neighbourhood

We launched the MyCOPD app, where people with **Chronic Obstructive Pulmonary Disease (COPD)** can get lifestyle advice to help improve their health and quality of life.

**Neighbourhood**

We launched the MyDiabetes MyWay app, a tool for people with diabetes giving reliable, accurate information and tools to help people manage their health better

**Neighbourhood**

We made improvements to local falls and frailty checks – more people are now routinely checked for their risk of frailty and falls and can get advice or therapy to help prevent falls

**Neighbourhood**

A test of the Tier 3 weight management service has shown the service helps people to maintain weight loss, stops them from needing surgery and improves their health.

**Neighbourhood**

We brought in new ways of finding out about patients' experience of using our community services, and the difference that getting the service has made to their lives.

**Neighbourhood**

We worked with the **Community Neuro-Rehab** service to improve the rehabilitation service and make it easier for more people to get **neuro-rehab** in the Rochdale We improved the checking of people in private **neuro-rehab** placements outside Rochdale and are helping them to get back to their home.

**Looking Forward**

**Neighbourhood**

**Looking forward**

Next year we will build closer working relationships between Integrated Neighbourhood teams and the partners they work with locally. This will mean fully joined up working in neighbourhoods with adult social care and **primary care networks.**

**Looking forward**

Continue to work collaboratively with **local care organisation** to ensure community services such as diabetes continue to help individuals to keep well at home as much as possible

**Difficult or Unusual words.**

**Integrated Elective Care Pathways (IECP) -** a single way to get into services for all the specialities and a joined-up process for patients. All partners in planned care will work together to ensure there is one way to get into the service for all and that every patient has the best care for their planned treatment.

**Elective care –** future treatment that is planned by clinicians and patients.

**Musculoskeletal (MSK) –** conditions involving the bones and muscles

**Planned Care Board –** a group of partners who work in planned care to ensure a joined up, effective approach to patient care.

**cardiovascular disease -** Cardiovascular disease is the name for the group of illnesses of heart and blood vessels and include: hypertension (high blood pressure) coronary heart disease (heart attack) cerebrovascular disease (stroke).

**Elective -** planned

**Ophthalmology -** Ophthalmology is a branch of medicine and surgery which deals with the diagnosis and treatment of eye disorders

**Local Care Organisation -** A Local Care Organisation is a new type of public sector organisation joining  together NHS hospital services, community health, mental health services, primary care and social care services

**Ambulatory Care Unit** (ACU) - The **Ambulatory Care Unit** (sometimes called ACU) is a new service, which offers same day **care** to patients at the hospital. This means that patients are assessed, diagnosed, treated and are able to go home the same day, without being admitted into hospital overnight.

**Clinical Assessment Service (CAS). -** A clinical assessment service (CAS) is a service that sits between others and gives better clinical expertise in assessing a patient than would normally be expected of a referring clinician (such as a GP)

**PNP -** Pediatric Nurse Practitioners (PNPs) health care providers who are dedicated. to improving children's health

**Discharge to Assess -** Where people who are clinically stable and well and do not need to be in hospital but may still need care services are provided with short term, funded support to be discharged to their own home (where appropriate) or another community setting.

**NHS Pathways Directory of Services System -**  is a central directory that is joined up with with NHS Pathways and is automatically opened if the patient does not require an ambulance or by any attending clinician in the urgent and emergency care services.

**HMR Emergency Assessment and Treatment Team (HEATT) –** An emergency vehicle and specially trained paramedic focused on intercepting 999 calls from adults to provide community support away from A&E wherever appropriate

**LCO –** Local care organisation (see above)

**Step up and step-down –** these are units for patients who are ill or have been ill and need treatment but don't need to be in hospital and cannot stay at home for some reason. The unit cares for the patient in the short term until they are fit to return home.

**Primary Care Academy -** a project to help prepare people for a career in primary care, particularly those who do not want an academic challenge.

**Delayed Transfers of Care (DTOCs**) - occurs when a patient is ready for discharge from acute or non-acute care and is still occupying a bed.

**IAPT -** The Improving Access to Psychological Therapies (IAPT) programme began in 2008 and has changed the treatment of adult anxiety disorders and depression in England. IAPT is an ambitious programme of talking therapies. In the past year more than one million people used IAPT services to help deal with their depression and anxiety, and better manage their mental health.

**Integrated Neighbourhood Teams (INTs) -** These are teams made up of different professionals who work together to care for people in their

locality. There are 6 core neighbourhood teams across the Rochdale borough which consist of district nurses, community matrons, community nurses, therapists, general practices, social care and third sector services.

**Chronic Obstructive Pulmonary Disease (COPD**) - is the name for a group of lung conditions that cause breathing difficulties. It includes:

- emphysema – damage to the air sacs in the lungs
- chronic bronchitis – long-term inflammation of the airways

**Community Neuro-Rehab -** The Community Neuro Rehab Team is a community based multi skilled and specialist neurological rehabilitation team which gives advice, help and treatment to those with an acquired brain injury, stroke or neurological condition

**Primary care networks.** a group of GP Practices that joins together so each one can talk to or work with other parts of the group or the whole group to form a larger body and deliver a better service.