NHS
National Institute for Health Research

NIHR CLAHRC West Stakeholder Priorities for Health and Wellbeing

Update March 2015

Introduction

Soon after the publication of the NIHR CLAHRC West Stakeholder Priorities for Health and Wellbeing report in August 2014, the 7 Clinical Commissioning Groups (CCGs) in the West began to publish their five year plans. We also received feedback from stakeholders to indicate that they found the report useful, particularly the table format in which some of the information was presented, allowing for easy comparison across the CCGs. Therefore, we have updated the format and content of the CCGs' priorities for an overview of the thematic commonalities in their plans.

The appended table 'Stakeholder Priorities Update March 2015 - Thematic analysis of the seven CCGs' Five Year Strategic Plans' sets out the four main priorities and related strategies in the first column. Each CCG's approach is then outlined and summarised so that they can be read across and compared.

The first priority is the **prevention of avoidable deaths and ill health related to behavioural factors and wider social determinants**. This involves effectively supporting people to stay well and independent through adopting and maintaining healthy behaviours. Subthemes relate to self-management of long term conditions, building on locally based resources and providing care for people as close to home as possible as well as support for carers.

The second priority of **reducing health inequalities and protecting vulnerable groups** is closely linked to the first, but in terms of approaches and strategies more heterogeneous than the first. While many plans contain general and high-level aspirations to reduce inequalities, others identify particular groups such as the homeless, excluded children and young people, older people, refugees and minority ethnic groups in relation to particular services such as end-of-life care, improving access to earlier diagnosis of long term conditions and cancer, and better coordinating physical and mental health services. Services for people with learning disabilities, and safeguarding practices for children and vulnerable adults have been highlighted in most plans.

The third priority is **the development and capacity increase of integrated community support to avoid hospital admissions**. This priority covers a wide range of strategies including the expansion of primary care and community services in scope and availability, integration with home and social care, provision of services closer to home (including urgent care and some specialist services), and better care coordination for people with multi-morbid long term conditions, using a number of different approaches and tools including data integration and data sharing, personal health budgets, and development of patient-facing technologies and digital communication.

The fourth priority of **reducing demand on acute hospital services** is closely related to the third and cites strategies that seek to address current problems related to unplanned and inappropriate admission to hospital, safe and early discharge, ambulatory care, reablement/rehabilitation services as well as proactive management of inpatient bed capacity.

Where CCGs have highlighted priorities which have not been captured in the thematic analysis table because they are not shared across the geographical area, we have produced an additional list which identifies these in relation to the specific services cited.

University Hospitals Bristol NHS Foundation Trust
West of England Academic Health Science Network
NHS North Somerset Clinical Commissioning Group
Avon and Wiltshire Mental Health Partnership NHS Trust
Bristol City Council
NHS South Gloucestershire Clinical Commissioning Group
University of Bath
UWE Bristol University of the West of England
University of Bristol
Bristol Health Partners
NHS Bristol Clinical Commissioning Group
North Bristol NHS Trust

Stakeholder Priorities Update March 2015

Thematic analysis of the seven CCGs' Five Year Strategic Plans

CLINICAL COMMISSIONING GROUPS	*Bristol*	*North Somerset*	*Bath & NE Somerset*	*Gloucestershire*	*South Gloucestershire*	*Wiltshire*	*Swindon*
PRIORITY 1 PREVENT AVOIDABLE DEATHS AND ILL HEALTH RELATED TO BEHAVIOURAL FACTORS AND WIDER SOCIAL DETERMINANTS. ACHIEVE THIS BY ENCOURAGING PERSONAL RESPONSIBILITY AND SELF CARE SUPPORTED BY TARGETED AND IMPROVED INFORMATION AND ADVICE.	**Prevent** people from dying prematurely by **promoting good health** and **reducing risky behaviours**. Provide **proactive care** to help people to **age well**.	Shift resources from services which treat illness **to those that prevent them**. Give people confidence and skills **to take care of themselves** and stay as healthy as possible. .	Increase the focus on prevention, **self- care and personal responsibility**	Increase the focus on **prevention and self-care** embedding this approach across our work plan.	**Reduce injuries due to falls** in the Frail Elderly and reduce **preventable sight loss for** older people and people with diabetes. Provide **parenting classes** to improve the knowledge and confidence of parents in caring for their **children when they are ill.**	Manage a major shift in focus and resources into **prevention** and care at, or close, to home. Help people to **avoid ill health** and increase their sense of **personal responsibility** Support vulnerable new families by providing **health promoting** parenting skills**.**	Train and encourage all care professionals to promote **self-reliance, self-care and prevention.**
a. Avoiding risks and promoting healthy living	**Reduce the prevalence of smoking,** reduce illicit tobacco availability and increase smoke free areas within the city.	Increase awareness of **responsible drinking** and reduce **alcohol** related harm.	Work with patients and carers to **educate, encourage and support them to stay healthy,** promoting lifestyles to reduce the risks of ill health.	Target specific areas such as weight management, **smoking cessation, reducing alcohol** harm and using **Healthy Living Pharmacies, Telecare and Telehealth**.	**Reduce alcohol harm** and double the capacity of **smoking cessation** services.	Provide **drug and alcohol support services** for families and carers. Use the **Better Care Fund** to provide **Health promotion and education programmes** about lifestyle to users of the enhanced primary care system.	Provide programmes to improve health, weight, exercise and further promote **smoking cessation** and **alcohol misuse** support. Increase access to library and cultural activities to **reduce isolation and loneliness** and to extend and **enhance quality of life**.
b. Self-care Self-management of acute and Long Term Conditions	**Provide self-management programmes for those with a long-term conditions using Telehealth/Telecare, Health apps/equipment** in conjunction with professional care**.**	Provide patients with long term care needs with a clear understanding **of what they can do to manage their own condition** and **prevent future illness**.	Develop alternative and more efficient models of care with **greater reliance on self-care and personal responsibility**	Provide people with support to build independence, knowledge, skills and confidence to **manage their own care.** Ensure that those with existing **long-term conditions** are provided with programmes that help them take control of their conditions, such as a much **greater use of technology to** provide information and support and also **remote monitoring and feedback** to support	Support local people to **achieve and maintain good health and wellbeing** and to monitor and **manage their own health** with appropriate support and education. Identify those at risk of developing a **long-term condition** and providing clear, comprehensible **information and support** for **self-care**.	Support people **to be well and independent**, and to **take control of their own care**.	Target interventions such as **24/7 condition line,** and **'expert patients' to** improve capacities for **self-care.**

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				independent living.			
c. Supporting Carers	**Treat carers and families as partners in care**, enable **access to 'carer breaks',** involve them in service planning through 'Bristol Carer Voice'.	While support for carers is highlighted as important, no specific priorities have been identified.	While support for carers is highlighted as important, no specific priorities have been identified.	**Develop a local 'Carers Charter'** to be implemented across all GP practices.	Encourage carers to come forward, **raise the profile of carers in practices, maintain the joint provision of short breaks** and **consider the provision of carers' health checks.**	Provide 'Carer Support' and identify carers as a group with 'increased need'.	**Increase access for carers to a range of services** that are flexible to their individual needs including relevant training and 'Community Navigator'[1] support.
PRIORITY 2 **REDUCE HEALTH INEQUALITIES & PROTECT VULNERABLE GROUPS** ***a. Service delivery to reduce in equalities***	**Focus on improving access to earlier diagnosis** for less advantaged groups of the population. **Collaborate with partners** such as Bristol City Council, the Health Inequalities Partnership, the Men's Health Forum and the Migrant Health Partnership to reduce inequalities in healthcare.	Ensure that systems are in place to **identify those people and families most in need of additional support to** reduce inequalities.	**Reduce the gap in the premature mortality rate** from selected causes for disadvantaged groups. **Improve the quality of Clinical Medicines Reviews[2] for our most vulnerable patients.**	Increase awareness of the **importance of promoting equality/reducing health inequalities within the CCG and across member practices.** Provide people who are particularly vulnerable with **additional support to enable them to take more control of their own health and wellbeing.** Engage groups, frequently referred to as **'seldom heard' by recruiting members of these communities to undertake engagement activities.**	Ensure **appropriate service delivery to the most vulnerable groups** and focus on six **priority neighbourhoods** with significantly higher rates of premature mortality for health interventions.	Plan and deliver services to **reduce inequalities** within our population.	Provide very vulnerable people with a **personalised care assessment, and meet the ongoing support needs that arise.** Develop strategies to support marginalised and vulnerable groups such as the **'Community Navigator'** initiative, the **'troubled families'** scheme, and the **Mental Health and Wellbeing Coordinators.**
b. Groups identified as 'vulnerable' or 'excluded' ***PRIORITY 2*** *(cont.)*	**Provide 'end of life care' for the homeless and those vulnerably housed.** **Improve the health** of vulnerable and excluded **children and young people.**	Ensure that provision contracts incorporate strategies to reduce **age discrimination**.	**Focus on supporting and safeguarding** the most vulnerable, at risk, frail or excluded citizens **as a matter of priority regardless of age.**	While support for vulnerable groups is highlighted as important, no specific priorities have been identified.	**Provide specialist paediatric nursing capacity** to work within or alongside the Community Services and the **Vulnerable Adults** team. **Improve access to mental health services and provide health checks** for vulnerable patient groups	Commission services to support the **homeless – hostels, refuges**, **temporary accommodation, teenage parents and the homeless**. Work in partnership with Wiltshire Council **to ensure that we can fulfil our specific responsibilities**	**Reduce the gap** in **life expectancy** between the most and least advantaged of our **male population to below 8 years**. **Work to meet the specific health needs of our growing population from minority groups.**

[1] 'Community Navigators' pilot - navigators work within an integrated team of health and social care professional to reduce emergency hospital admissions and prevent increased needs for care packages and to develop 'Swindon Circles', a targeted volunteer befriending service.

[2] "A structured, critical examination of a patient's medicines with the objective of reaching an agreement with the patient about treatment, optimising the impact of medicines, minimising the number of medication related problems and reducing waste". (Room for Review, 2002)

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REDUCE HEALTH INEQUALITIES & PROTECT VULNERABLE GROUPS *b. Groups identified as 'vulnerable' or 'excluded'*					including those with **learning difficulties**. Engage with the '**Prevent strategy'** for counter terrorism to protect vulnerable people from radicalisation which may lead to behaviour endangering their lives and/or the lives of others.	**for looked after children.** Understand the increased needs of particular groups such as **families, young people, the elderly, disabled persons and carers, the military, prisoners, black and minority ethnic groups, gypsies and travellers** and find ways better to meet these without increasing the inequality gap.	**Reduce the health inequalities** experienced by those **who provide informal care for others**. Engage with the '**Prevent strategy'** for counter terrorism. This involves early identification and raised awareness of vulnerable groups/individuals who may be coerced into extremist activities.
c. Physical and mental health care for people with Learning Disabilities	**Improve mortality and health outcomes** for People With Learning Difficulties using **mainstream health services** including Mental Health Services.	**Improve access to screening to reduce health inequalities** for people with Learning Disabilities and embed Mental Health support for this group into mainstream provision.	**Develop local response** in relation to the findings of the Confidential Inquiry into Premature Deaths of people with Learning Disabilities.	No specific priorities identified.	**Implement the recommendations** of the Confidential Inquiry into the Premature Mortality of People with Learning Disabilities Work jointly with Sirona and AWP to improve access to mental health services for people with learning disabilities.	**Ensure parity of esteem** for those with Learning Disabilities specifically in commissioned services and in accessibility to physical health services.	No specific priorities identified.
d. Reviewing standards of care for people with Learning Disabilities, particularly in Care Homes.	**Implement** the Winterbourne View[3] concordat recommendations with Bristol City Council and improve standards of care across residential & domiciliary services.	No specific priorities identified.	**Implement** Winterbourne View Report findings.	**Implement** strategies incorporating the findings of the Winterbourne View Report.	**Improve the quality of care** offered to people of all ages with learning disabilities or autism and **address** the areas identified in the Winterbourne View Report.	**Improve the quality of care** offered to people of all ages with learning disabilities or autism and **address** the areas identified in the Winterbourne View and national reports.	Shift towards **supportive living model with occupational and educational opportunities** for people with Learning Disabilities.
e. Safeguarding children and adults	Use a range of tools to **ensure that services are safe** by statutory safeguarding standards including, self-assessments, peer challenge, multi-agency working,	**Strengthen** the safeguarding of children and adults.	**Focus on supporting and safeguarding** the most vulnerable, at risk, frail or excluded citizens as a matter of priority regardless of age.	**Ensure partnership working is promoted** to safeguard children, young people and vulnerable adults within Gloucestershire.	**Ensure that all contracts include an expected set of safeguarding standards** for both adults and children.	Use current governance arrangements to **ensure that organisations provide a safe system that safeguards** children and adults at risk of abuse or neglect.	Ensure that providers have arrangements in place to **safeguard and promote the welfare of adults and children in line with national policy, guidance and locally identified areas**

[3] Transforming care: A national response to Winterbourne View Hospital Department of Health Review: Final Report https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf The report sets out the government's final response to the events at Winterbourne View hospital and sets out a programme of action to transform services for people with learning disabilities or autism and mental health conditions or behaviours described as challenging.

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	monitoring practice and direct observations.		Implement the GP-based domestic violence and abuse training support and referral programme, strengthen GP engagement with safeguarding children and adults.				**of concern.**
PRIORITY 3 **DEVEOLP AND INCREASE CAPACITY IN, AND ACCESS TO, PRIMARY CARE SERVICES WITH INTEGRATED COMMUNITY CARE SUPPORT.** **WORK TO AVOID HOSPITAL ADMISSIONS.**	**Deliver community based and primary care led services which are integrated, supported by local networks** and accountable through the Better Care Fund Board. **Provide pro-active care planning,** incorporating later life, mental health and social isolation to enable access to high quality services at the right time and place. **Provide multi-disciplinary case management** for those suffering with a long-term conditions to reduce rates of hospital admissions and improve vascular outcomes for stroke, atrial fibrillation and reduce diabetic amputations.	**Deliver flexible services** based on the needs of the individual patient. Ensure service providers **understand the local population and work collaboratively** with other health, social and voluntary care providers to develop new services. Promote models of care **where primary and secondary care professionals work together** and consultants can **provide education, training and feedback to other professionals on an ongoing basis.**	Deliver **enhanced, seamless primary, community and mental health services on 24/7 basis where required** around clusters of populations delivering **'care closer to home'** Develop integrated Long Term Condition management (focusing initially on Diabetes). Commission **safe, compassionate care pathways** for frail older people. Support patients and their carers through the system with help from 'Navigators and Volunteers'.	Develop new pathways to improve continuity of care and reduce duplication with professionals working closer together to **coordinate care**.	**Improve identification of, and support** provided by GPs and care homes to patients at risk of hospital admission.	Deliver all services in Wiltshire in an integrated way, led by primary care working with our social care partners, to move care out of hospital where appropriate and to **reconfigure community services.**	**Strengthen links across sectors with community services** e.g. Community Navigator, virtual ward, community matron, and enhanced diagnostics. **Support those with multiple conditions** – by providing multi-disciplinary consultations and support to GPs, either in outpatients or home visits, using tele/video conferencing. **Commission improved support** for medication review, therapists and psychiatric liaison.
a. Community Provision	Provide access to **Geriatricians in a community** setting with multi-disciplinary case and compassionate management **for the frail elderly.**	Tailor care for **frail people with multi-morbidities** to individual needs, in particular people in **residential or nursing homes.**	Offer community based services **supported by specialist and hospital** services.	Maximise the use of **voluntary and community** services (social prescribing). Increase the availability of out-of-hours support **for older people** with **mental health issues**, in their normal place of residence.	Provide **community services 24/7** and **develop care plans for individuals with complex needs.** **Implement community based outpatient clinics** in line with patient needs. Increase the provision of high	**Develop further community and home based services as credible high quality alternatives** to the current default of acute inpatient care. Provide Housing related support and a **community alarm** service for **the frail and elderly**	Develop integrated community services, **wrapped around the individual, accessed and co-ordinated through primary care teams.** Develop **extended skills** in community teams **to manage higher**

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					quality nursing care which is integrated with the rest of the treatment they receive from their GP. Introduce a range of community based urgent and semi-urgent services to support frail elderly people, to help them remain medically stable in their own homes. Work with the care home project team to develop and support nursing homes to better manage residents with long term conditions, expanding services provided to patients in care homes, including by GPs.		**acuity patients** e.g. IV antibiotics**.** **Increase the support offered to those with long term conditions** through expert patient programmes, web based information and seven day call centres, 'Community Navigators' and the voluntary sector. Promote advice by phone (NHS 111), enhanced community pharmacy services, enhanced GP home visiting and GP 'at the scene' services[4].
b. Primary Care	Enable integrated **primary care input to Emergency Departments.**	Continue to support **groups of practices** who wish to develop **alternative models of care.** Extend access to GPs and improve integration with **Out Of Hours service** and **a range of Urgent Care** providers offering **services close to home 24/7.**	Support primary care practices to **reduce unwarranted variation in management and outcomes for patients**, in particular those on selected long term conditions primary care disease registers. Embed the **new integrated urgent care** centre and **out-of-hours services** model and review the role of the **minor injury unit** in light of the new service model and **NHS 111**.	Provide access to the full range of **core and enhanced primary care** provision for everyone, delivered by **individual GP practices or an intra-practice** working model. **Simplify access to urgent primary care** to avoid unnecessary use of emergency hospital care.	Provide **Primary** care **support 24/7** for patients with complex needs or approaching end of life and allow GP's to refer for advice rather than an appointment. Improve communication between GPs and Community Geriatricians to **provide better co-ordinated care.** **Support ambulant people with acute health needs in primary care.**	**Expand Primary Care Services and provide services 24/7**. Identify and manage patients with chronic conditions in primary care, **supported by care co-ordinators.** Develop improved care pathways for long term conditions **with a primary care led approach** using diabetes as the prototype in year one, followed by Congested Heart Failure, Cardiovascular Disease and / or COPD in year two. **Reduce unwarranted variability in referrals and prescribing.**	Work with primary care teams **to stream large numbers of patients requesting one off consultations for minor ailments through GP Urgent Care Centres,** releasing more time in primary care. Set up **three new urgent care centres.**

[4] This refers to the implementation of a dedicated GP home visiting service operating 08.00 to 20.00 seven days per week as an enhancement of our existing and successful GP at the Scene scheme which sees GPs working with the ambulance service to avoid patients needing to be conveyed to hospital unless necessary.

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c. Medicines	**Use prescribing incentive schemes** where indicated and manage high cost and excluded drugs efficiently. **Provide prescribing decision support software to promote high quality, cost effective prescribing.** Reduce medication related hospital admissions.	Embed pharmacists in GP practices. Ensure the safe use of medicines and unwanted variation in prescribing and **realise the benefits of Electronic Prescribing.**	Roll out Electronic Prescribing Service across the health community and continue work on getting best value from CCG commissioned high cost drugs. **Encourage the safe use of medicines** including the appropriate utilisation of antibiotics.	**Make medicines optimisation a central element in the development of integrated care pathways.** Increase prescribing driven by **proactive identification and management of long term conditions with patient input.** Reduce the amount of wasted medicines. .	**Expand the role of the practice support pharmacists** to reduce variation in prescribing.	**Reduce unwanted variation in primary care prescribing** by optimising medicines use. **Help patients to better understand their medication regime and reduce medicines wastage.**	Promote changes in medical practice where there is both qualitative and financial benefit from **medicines optimisation.**
d. Public Involvement and Patient Experience	**Patients' priorities** will be central to the development of new services.	**Ensure providers demonstrate engagement** with parents/ carers, children and young people.	Develop the role of the CCG's newly established Patient and Public Involvement Group, 'Your Health, Your Voice'. **Enable a greater focus on patient engagement and participation** to bring about change in clinical practice.	**Define 'quality outcomes' with patients**, using responses from individual citizens and representatives of communities.	**Use patients' feedback and involvement** to improve service design, delivery, and performance management.	**Engage with Patient Participation Groups (PPGs) linked to GP practices** across Wiltshire, Local Area Boards and a Service Users' Network to improve the acceptability of services.	Continue to engage with patients and the public (PPI) in the design and delivery of local health services to improve the quality of health services. Increase the number of patients who when surveyed say **their experience of local healthcare was neutral to positive to 90%.**
e. Personal Health Budgets	Instigate a **change in the utilisation of adult social care** with an increase in Personal Budgets and direct payments.	**Consider ways of improving services** (including allowing patients to choose their provider, for example by using Personal Health Budgets).	Encourage the use of Personal Health Budgets where appropriate.	Consider how Personal Health Budgets can be implemented at a continuing healthcare level for both adults and children and work towards the development of **a collaborative multi-organisational approach.**	Ensure eligible patients (e.g. long term conditions including dementia) **have the option** of a Personal Health Budget giving control over tailored health and wellbeing services.	Refine Personal Health Budgets process **so that they become an 'opt out' rather than an 'opt in'.**	Enable more **people to be in control of the funding of their own care** through Personalised Health Budgets and to be experts in their own conditions so that they can make informed choices over both improving their own health and health and social care interventions or treatments.
f. Data integration through shared IT platforms	**Install a common IT platform** across all providers with access to medical records through 'Connecting	**Provide a single electronic care plan** for people with complex care needs, accessible by all the people that need to	**Use integrated care records to share information** so that patients 'tell our story only once.	**Improve the continuity of care and communication across the health community through integrated care records** to	Support the use of 'Connecting Care' to share medical records for the safe and effective delivery of care across the whole health community.	Enable and develop systems for **shared data and information** and joint assessment. **Increase the use of technologies**	Pilot the Consultant Link and the roll out of the Virtual Follow Up Clinic Scheme. **Provide access to better information for**

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	Care'.[5] **Increase interoperability** to meet service priorities e.g. electronic discharge summaries and clinic letters.	see it, including the patient ('Connecting Care'). Increase the use of **digital technology and social networking** to make it easier **for people to give their views**. Ensure web-based **information is more easily available** and easier to comment on. **Develop the use of technology solutions to patient care** including telemedicine and non-face to face appointments.	**Enable remote monitoring information and feedback to support independent living** for people with long term conditions.	inform clinical decision making without compromising data protection. **Develop the use of digital communication** in primary care, for example email, text messaging, and 'Skype', to help patients understand more about their health and take more responsibility.		such as virtual support chat rooms, advice & guidance and signposting/ awareness raising and assistive technology.	**patients and carers about conditions** using web and social media.
g. Integrated Palliative Care	**Coordinate integrated pathways for patients with 'end of life' needs** which support the individual and their family/carers holistically. Allow more people to die where they choose and **achieve a 5% reduction in the number of known palliative care patients dying in hospital.**	Support children and young people with life limiting conditions at the end of their life **to die in the place of their choice.**	**Increase the number of people who die in the place of their choice.** Embed Electronic Palliative Care Coordination System (EPaCCS) across all organisations with all 'end of life' patients having advanced care and 'do not attempt pulmonary resuscitation' orders in place.	**Review clinical pathways** for specific conditions from prevention to end of life.	Improve the quality of palliative care in the community so that **most people achieve their preferred place of death with 24/7 palliative care cover.**	Develop a **community based, consultant-led** palliative care service. **Support people to be cared for and die in their preferred place of care,** ensuring respect and dignity is preserved both during and after the patient's life.	Develop Palliative Care provision so that everyone can **receive their preference for where they wish to be cared for in the last stages of their life**. Review our practice and equipment to ensure this can happen.
PRIORITY 4 **HOSPITAL BASED SERVICES:** **REDUCE AND CENTRALISE ACUTE CARE WITH EARLIER, COMMUNITY SUPPORTED DISCHARGE AND REDUCED UNPLANNED ADMISSIONS.**	Improve joint working across health and social care to enable hospitals to only care for people who are **genuine acute admissions.**	**Reduce reliance on acute hospital care** particularly the use of Emergency Departments by **increasing support in the community**. Ensure that **hospital based episodes of**	**Shift investment from acute and specialist services to** community and primary care for example with 'Acute Home Visiting' for children and adults with long term conditions.	Ensure that patients receive specialist care when appropriate with **a hospital stay for the shortest possible time when necessary.**	**Reduce overall unplanned admissions by half annually by 2019.** **Avoid unnecessary diagnostic tests** and **multiple appointments** by using good access to hospital services in the local	**Ensure access to Acute Care for 'good reason' only** and where acute care is one-off or infrequent, there should be **formal and rapid discharge.**	Provide rapid access to specialist healthcare with **specialist services available locally** for those with rare or life limiting conditions, such as radiotherapy for cancer treatment available locally and at weekends.

[5] 'Connecting Care' enables authorised professionals from local organisations to see a single electronic view of specific, up-to-date, clinical information and care plans via the delivery of a 'clinical portal', eliminating the need for people to give repeat histories or have repeat tests.

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		care provide the maximum impact in supporting patients.	**Reduce the demand on acute services** by increasing the delivery of MSK services in primary and community settings, **enabling the secondary care sector to focus on patients with more complex conditions needing specialist services.**		community settings. Work with NHS England to commission an **arterial centre** with the new Southmead Hospital, providing a **centre of excellence in vascular care**. North Bristol NHS Trust to achieve the **24/7** Clinical Standard by 2016/17. Ensure local hospitals consistently meet standards for **stroke care**, including treatment for **at least 80% of people in a specialist stroke unit**.		Ensure that at least **95% of patients are offered the choice of a specialist centre** if they require one**.** .
URGENT AND EMERGENCY CARE	Integrate **primary care input to Emergency Departments** (specifically North Bristol Trust). **Reduce emergency occupied bed days** by **30%.** Manage medical and surgical emergency presentations through **ambulatory care units** where appropriate to **avoid admission to hospital.**	Provide **appropriately accessed,** clinically **sustainable** Major Emergency Centres with consistently high quality safe care **24/7.** Use **senior clinical decision making** capacity effectively across care pathways. Explore opportunities to **develop ambulatory care pathways** that work across primary and secondary care.	Ensure the **on-going development of the urgent care system** is integral to the development of 'out of hospital' services to support the frail elderly and people with long term conditions to **ensure pathways are joined up**. Address urgent care challenges, including **4 hour A&E response times, ambulance response times, and eliminating mixed sex accommodation**.	**Treat serious or life threatening emergencies in centres with the very best expertise and facilities.** Focus on the community model of managing urgent care with the **roll-out of Integrated Community Teams**, including a Rapid Response Service and integrated discharge to reduce overall length of stay. **Further develop ambulance services** so they are better equipped to treat patients at the point of contact.	Ensure that the emergency departments only see **patients who are clinically appropriate, and patients with primary care needs are redirected to their GP.** Maximise the proportion of urgent care delivered outside hospital with **fewer unplanned trips to hospitals.**	**Streamline components of urgent care provision** (Primary Care, A&E, Walk in Clinics, Minor Injury Units, 111 and Out of Hours). **Identify patients vulnerable to unplanned hospital admission and build support around them to prevent this** using the Simple Point of Access (SPA) admission avoidance service.	Reduce emergency hospitalisation admissions, **shift emergency admissions into planned or ambulatory care.** Enable patients to be managed in their own home through the SEQOL (Social Enterprise Care Providers) 'GP at scene' model.
a. Inpatient capacity management	Reduce acute hospital capacity through **reduced occupied bed days.** Develop assertive 'pull' through the system to **reduce time people spend**	Review the **numbers and types of beds available** and ensure these meet the needs of the population.	**Reduce the number of bed days** occupied as a result of avoidable infection	No specific priorities identified.	No specific priorities identified.	Increase productivity and effectiveness of acute care with a **reduced reliance on solutions that require people to be in hospital beds** and provide an **enhanced recovery programme.**	**Improve avoidable infection control** to free beds. Reduce the number of patients who are ready to leave hospital but are yet to go.

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	in acute beds.						
b. Admissions and Discharge	Ensure that patients are admitted on the **day of their surgery not the night before**. Support patients to **recover and restore their** independence as quickly as possible.	Ensure that the whole system works together to get **patients home as soon as possible with a plan for ongoing care.** Provide for patients requiring rehabilitation /reablement with services these closer to home.	Avoid hospital admissions and **provide integrated reablement and hospital discharge.**	Admit patients **on the day of their surgery not the night before**, and engage **enhanced recovery programmes** reduce bed days.	Admit people to the most appropriate hospital setting for **the shortest time possible and transform rehabilitation, recovery and reablement services** to shorten hospital stays.	Move care from **inpatients to day** case and day case to **outpatient procedure**.	Switch **inpatient surgery to day-case surgery, moving Great Western Hospital progressively from 80% of surgery as day surgery to over 85%.** **Reduce** the norm for medica**l length of stay by 10% by 2019**.

NIHR CLAHRC West Stakeholder Priorities Update March 2015

Specific CCG priorities not covered by thematic analysis

CHILDREN & YOUNG PEOPLE

BRISTOL

- Manage the growing demand for children's services.
- Reduce risk taking behaviour which impacts on children & YP's health.
- Reduce childhood obesity.
- Improve access to health services & experiences for children with complex health needs.

NORTH SOMERSET

- Support children and young people to stay as healthy as possible and develop the confidence and skills to take care of themselves and better manage long term conditions.
- Move all major urgent and emergency paediatric care to the Bristol Children's Hospital (UHBristol) where services will provide safe, evidence based care and a positive experience for children and young people.

BANES

- Ensure that when problems emerge, children and parents are able to access help as early as possible.
- Ensure professional support for children, young people and families work together to eliminate duplication, reduce the number of times that individuals have to 'tell their story'.

SOUTH GLOS

- Ensure there is independent specialist clinical advice to Enhanced Commissioning Framework for children, including those with mental health problems, Learning Disabilities or behavioural problems.

MATERNITY SERVICES

BRISTOL

- Improve maternal health & reduce infant mortality rates
- Reduce risk taking behaviour which impacts on health
- Improve emotional health & wellbeing Increase satisfaction with place of birth
- Reduce rates of infant mortality.
- Increase breastfeeding rates.

NORTH SOMERSET

- Increase breastfeeding rates.
- 'Children, Young People and Maternity' is a 'Programme of Work.'

BANES

- Work with providers and Wiltshire CCG as lead commissioner to embed the newly procured maternity service.
- Work with providers, GPs & health visitors to agree and implement pathways ensuring close communication.
- Review ambulance transfers and transfers from community centres to hospital care.

SWINDON

- Anticipate that demand for Maternity Services may rise at a faster rate than most areas (along with orthopaedics and cancer services).

CANCER

BRISTOL

- Reduce the mortality rate of people with cancer under the age of 75.

- Enable earlier diagnosis of cancer to increase the scope for successful treatment.
- Support public health partners to reduce incidence of cancers preventable by primary (lifestyle) & secondary (screening) work.
- Cancer champion training programme
- C-DAPT (Cancer Diagnostic Pathways Improvement Project)
- Two week wait pathway for Cancer of Unknown Primary (CUP)
- A&E direct cancer referral to consultant

BANES

- Work with the newly appointed Macmillan GP to develop shared care and primary care support for cancer patients. This will focus on early diagnosis and cancer survivorship following treatment.
- All Cancer 2 week waits

GLOS

- Develop primary care to help achieve early diagnosis of cancer thereby resulting in better clinical outcomes and lives saved.
- Improve health outcomes for patients, but also to reduce some of the requirement for complex and invasive treatments.

SOUTH GLOS

- Reduce the number of premature deaths in people under the age of 75 from cancer.
- Improve early detection of cancer rates.
- Develop tools to support referrers.
- Develop end of treatment summary following cancer treatment to ensure clear communication between secondary care, primary care and the patient.
- Continued support of the National Cancer Survivorship Initiative helping people to live with and beyond cancer.

WILTSHIRE

- Patients to be seen by a specialist within a maximum of two weeks from GP referral for urgent referrals where cancer is suspected.
- Development of a local Survivorship programme in partnership with MacMillan, including a shift of care from acute to community.

SWINDON

- Promote screening and awareness programmes being run nationally in coordination with NHS England
- Bring radiotherapy to Swindon at a new centre on the Great Western Hospital campus with 7 day access.
- A review of our model of care and delivery for the 15-25 age group.
- Improve our under 75 mortality rate for cancer,
- Implement the Cancer Survivorship programme

MUSCULOSKELETAL

NORTH SOMERSET

- Scope Musculoskeletal services for review

BANES

- Redesigning musculoskeletal pathways to achieve clinically effective services.

GLOS

- Explore Shared Decision Making through the Musculoskeletal (MSK) programme to ensure a consistent, formalised approach across the care.

SOUTH GLOS

- Develop a new contracting model for the MSK pathway (including spinal) as a priority initiative for the CCG's Promoting Independence programme.

SWINDON

- Musculoskeletal Assessment and Treatment Service (MATS) procurement - improving specialist triage services for patients to improve access and pathways within musculoskeletal services.

RESPIRATORY MEDICINE

BANES

- Develop clinical model for IMPACT (community COPD service) to support patients with non-cystic fibrosis bronchiectasis in the community in conjunction with Sirona and RUH.
- Focus on reducing acute admissions for children with respiratory conditions, through the re-design of urgent care pathways across our system.

GLOS

- Integrate specialist teams within respiratory services. The future planned delivery of respiratory services will see bold, innovative and exciting changes over the next 5 years.
- Develop a suite of self-care/self-management tools to support those people with respiratory illnesses who are able and motivated to do so.
- Provide early specialist access and/or opinion to respiratory services.

SOUTH GLOS

- Review respiratory services, including home oxygen and pulmonary rehabilitation, to ensure adherence to NICE guidance.
- Establish admission avoidance schemes within the community setting for patients with chronic obstructive pulmonary disease (COPD)
- Identify patients with COPD via primary care diagnostic spirometry.
- Develop a work programme for pulmonary rehabilitation.

SWINDON

- Intervene with the number of patients who were identified as being routinely admitted to hospital for observation and care.
- Borough Council Stop Smoking programme to be extended over the next two years as both are proven to deliver real health outcome and economic benefits.

CARDIOLOGY & HEART FAILURE

SOUTH GLOS

- Continue BNP blood test service, which is used after history taking and physical examination to help rule out heart failure.
- Eliminate unnecessary cardiology appointments for patients who do not have heart failure and deliver a quicker diagnosis for the cause of breathlessness.
- Improve management of patients with heart failure - BNP testing is now available to GPs.

SWINDON

- Work to put the concept of 'consultant link' in to practice (immediate telephone access substituting for outpatient clinics, successfully piloted in Bristol with huge patient experience gains and savings - 68% of outpatient appointments reducing from £200 to £65);
- Develop expert GPs in cardiology at locality or CCG level as presented by a GP already working this model in the North of England, with potential for further clinic reduction;
- Introduce a Medical Treatment and Assessment Unit (MTAU) and new protocol for admission through rapid access chest pain pathway based on clinical audit, reducing admissions where indicators stabilise naturally in six hour period

HEALTHY ENVIRONMENT

BRISTOL

- Create a high quality and well-connected built and green environment, and manage the health impacts of Climate Change
- Achieve a healthier, more sustainable, more resilient food system for the city to benefit the local economy and the environment. Carbon reduction and sustainable developments are corporate responsibilities and is an inherent part in the new CCG's commissioning and corporate performance. The Climate Change Act (2008) gives the legal framework to ensure that a legally binding target of at least an 80% cut in greenhouse gas emissions by 2050 (baseline 1990) is delivered.
- Manage increasingly erratic weather conditions with the main risk of flooding locally. We need to influence providers to consider the risks associated with flooding and to take measures to minimise service disruption due to flooding. We need to work with NHS England to consider doing the same with primary care premises.