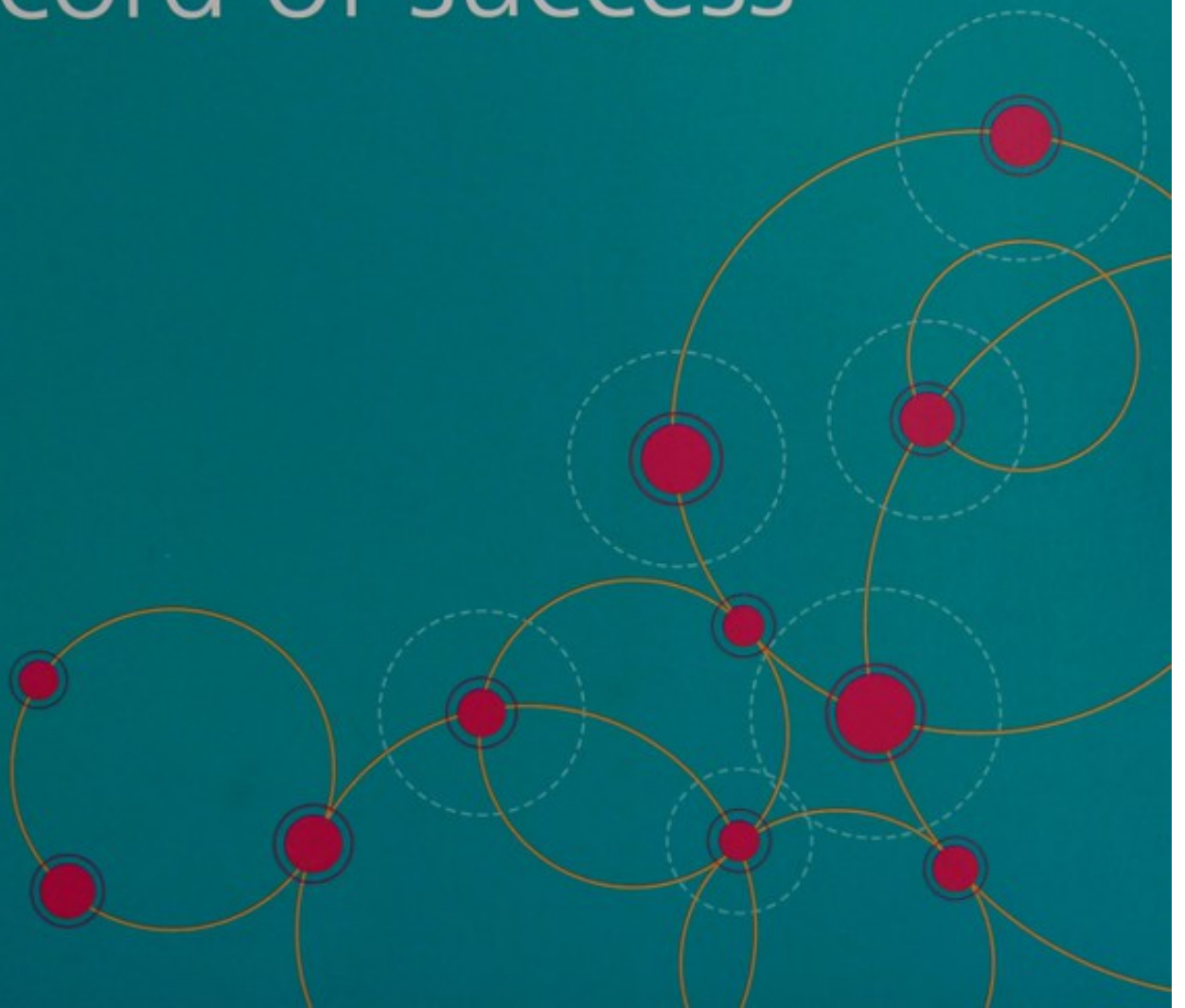
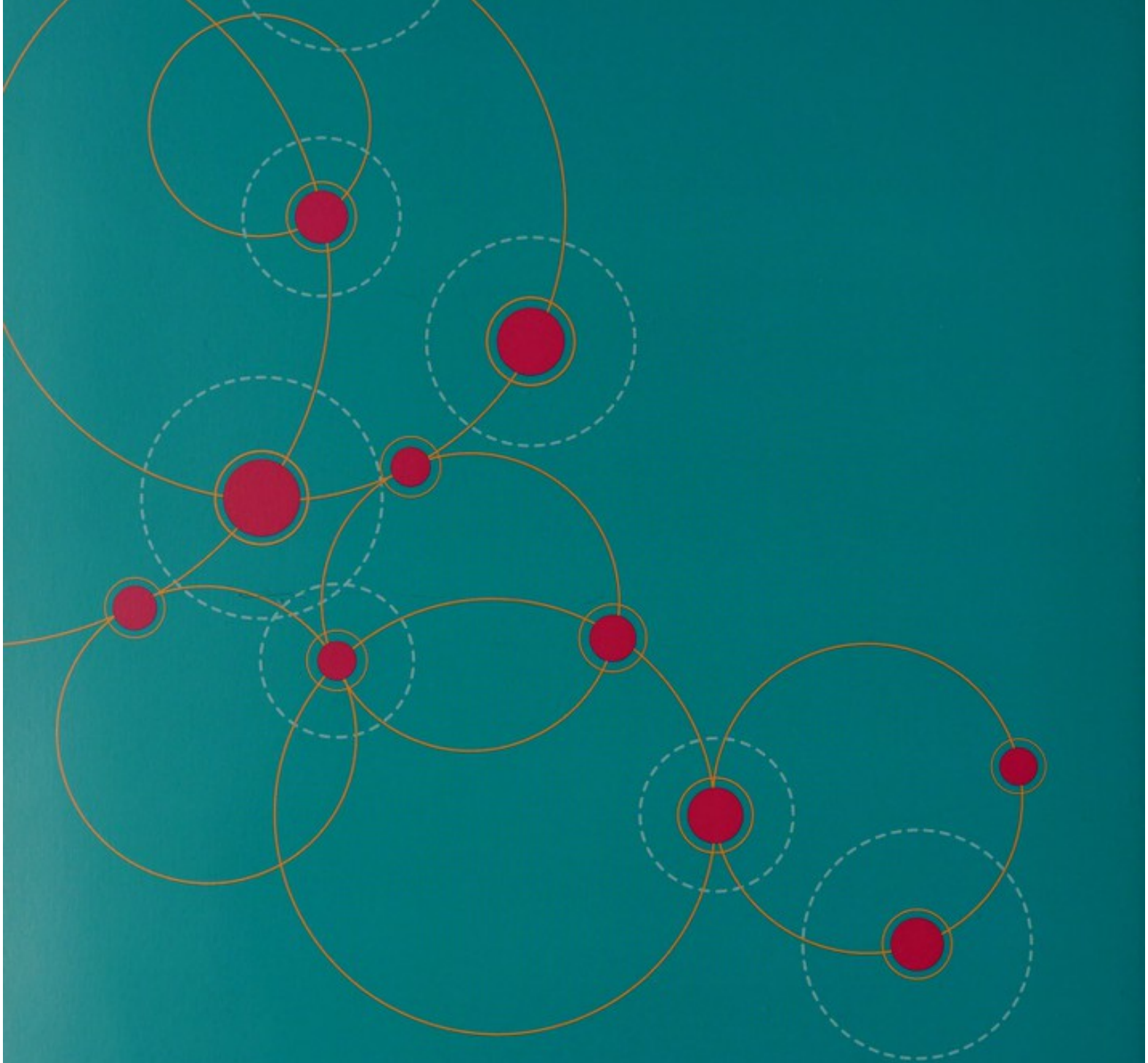
Making a difference : a record of success / NHS.

Strategic clinical networks
Clinical senates

Making a difference: a record of success





Contents

Strategic clinical networks: an introduction

Strategic clinical networks facilitate service improvement – by sharing clinical knowledge of healthcare systems – on four areas of major challenge:

- cardiovascular (including cardiac, stroke, renal and diabetes)
- maternity, children and young people
- mental health, dementia and neurological conditions
- cancer.

Strategic clinical networks work in partnership with commissioners (including local government), supporting their decision making and strategic planning, by working across the boundaries of commissioner, provider and voluntary organisations as a vehicle for improvement for patients, carers and the public. In this way, strategic clinical networks:

- reduce unwarranted variation in health and well-being services
- help build sustainable healthcare services for the future
- encourage innovation in how services are provided
- ensure patients and the public are integral to decision making
- provide expert clinical focus, advice, and leadership.

Clinical senates: an introduction

The 12 clinical senates in England support development of health services and delivery of high quality and sustainable care by providing independent, strategic advice to commissioners, supporting them to make the best decisions about healthcare for their populations. Clinical senates bring together professionals from a wide range of different health, public health and social care specialisms. They are not focused on a particular condition or patient group and take a broader, strategic view of the totality of health care in their regions. Impartiality ensures clinical senates provide advice in the best interests of patients and not professionals and organisations. The core of each clinical senate is its council which meets four to six times a year providing overall leadership and assurance of the advice which a clinical senate provides. Councils are supported by an assembly or forum, which are broad and diverse multi-professional groups, with patient and carer involvement.

These provide a breadth of knowledge and expertise to support the clinical senates' work. Clinical senates are also responsible for providing advice to inform NHS England's process for assuring service change. Guided by clinical senate councils, expert review teams are established to review the clinical evidence bases underpinning proposals. Through clinical leadership and engagement, clinical senates are an enabler of change and improvement.

Partnership working

Partnerships are fundamental to the work that we do.

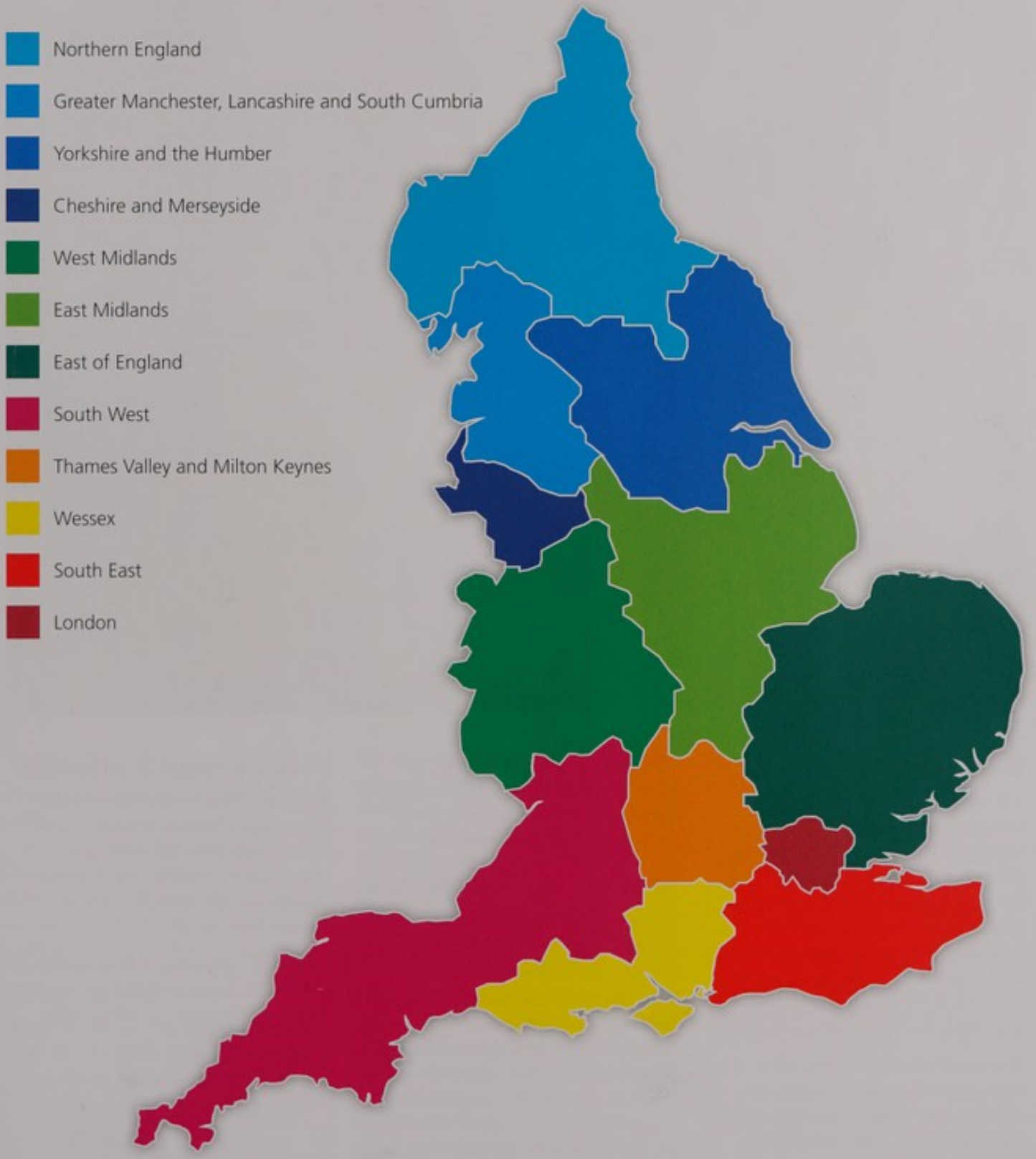
One of our main strengths is bringing together clinical staff, commissioners, patients, and the public from a variety of sectors.

Strategic clinical networks and clinical senates work with the following organisations, who aim to improve health outcomes for local communities. By collaborating, we are able to achieve best value for money and maximum patient benefit, without duplicating efforts.

Developed from the East Midlands 'partnership wheel' www.emwheel.org

Map

There are twelve strategic clinical networks and clinical senates based around the country.



North

Cheshire and Merseyside Strategic Clinical Networks

Improving seizure management in Cheshire and Merseyside

What was the issue?

The National Audit of Seizure Management (2011 and 2013) highlighted unacceptable variations across England, Wales, Scotland and Northern Ireland in care for people attending accident and emergency following a seizure. It demonstrated that appropriate follow up offers an opportunity to reduce emergency attendance and improve quality of care.

The reports showed that a large proportion of patients with active epilepsy are not followed up in an epilepsy service, that assessments during acute admissions are often inadequate, and patients do not gain access to services after they have left the emergency department.

What we did

To address this, we prioritised the management of seizures and brought stakeholders including patients, clinicians and stakeholders to co-create a new consistent approach to managing seizures across Aintree, Arrowe Park, Warrington, Whiston, Southport and Ormskirk, Countess of Chester, and the Royal Liverpool hospitals.

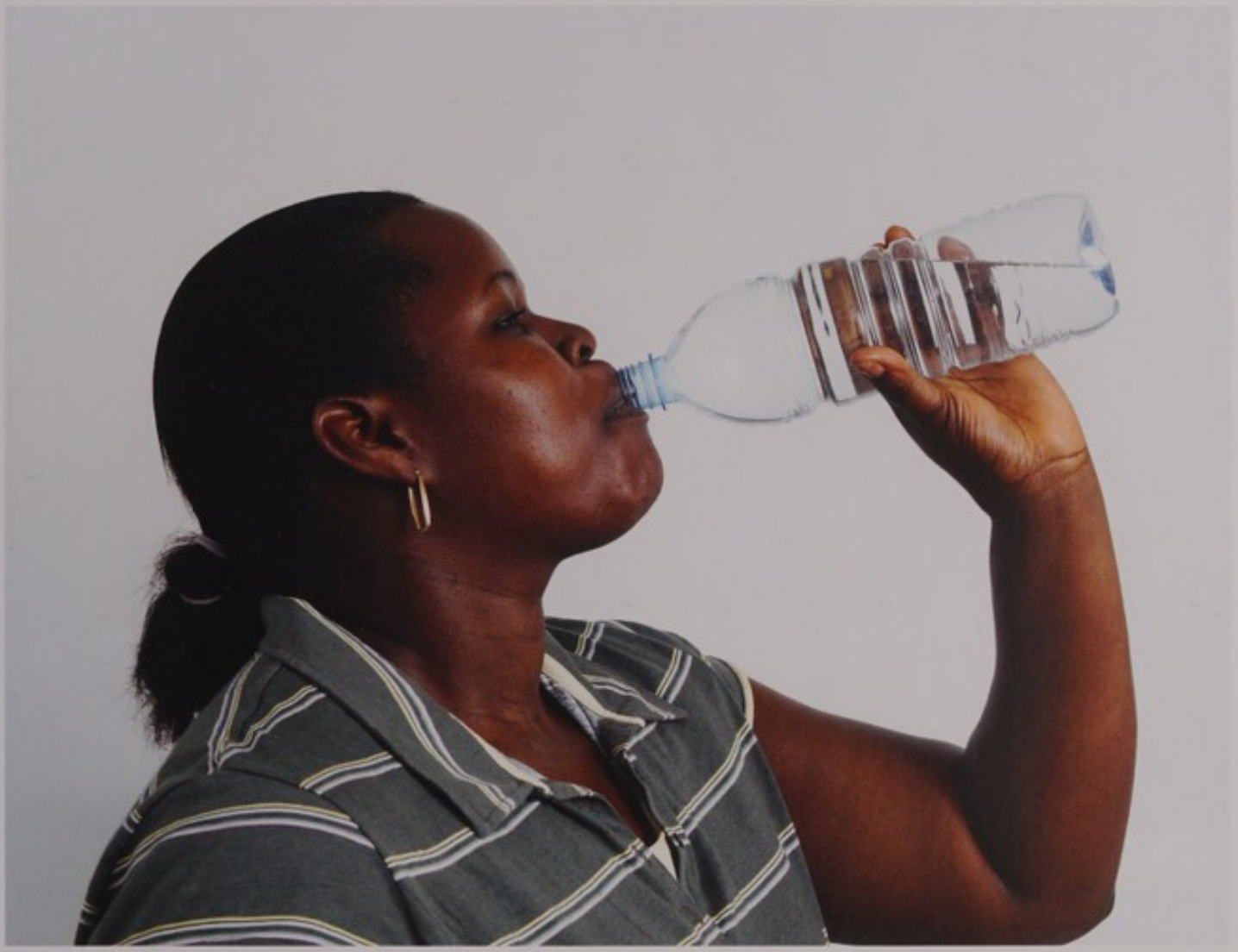
How we made a difference

All seven Cheshire and Merseyside trusts with emergency departments have adopted the pathway as part of a phased approach. Over the first six months, seizure referrals have increased by 59%.

Seizure management is now a national priority for strategic clinical networks working on neurological conditions.

Cheshire and Merseyside Strategic Clinical Networks

Developing an integrated pathway for impaired glucose regulation



What was the issue?

People with impaired glucose regulation are five to 15 times more likely to develop type 2 diabetes. Without intervention most people with impaired glucose regulation will develop type two diabetes within five to ten years.

What we did

Evidence shows that modest lifestyle changes can delay or even prevent the onset of type 2 diabetes.

We worked with a multi-stakeholder group of professionals and patients to oversee and develop an evidence-based pathway, guidelines and supporting materials for impaired glucose regulation. These have been implemented by clinical commissioning groups and local authorities across Merseyside.

Through the pathway, individuals identified as having impaired glucose regulation are given information leaflets about lifestyle changes and referred to specially trained primary care health professionals. They receive tailored one-to-one impaired glucose regulation lifestyle advice which includes help in setting achievable aims using an individualised goal planner. To ensure continuity of care, patients are recorded on the primary care impaired glucose regulation register and offered an annual review.

How we made a difference

To date, over 750 patients have been identified. 389 have been referred to the lifestyle hub by their GP, and 77% are undertaking or have completed the impaired glucose regulation lifestyle service pathway.

Greater Manchester, Lancashire and South Cumbria Strategic Clinical Networks

Developing and implementing an integrated care pathway for women who experience stillbirth

What was the issue?

Stillbirth is a devastating diagnosis when it occurs. National evidence shows that a significant number of parents do not feel listened to, do not have their concerns taken seriously, or experience poor care. A local audit highlighted that in spite of national guidance, only 8% were informed they could feel passive movements of the baby after a diagnosis had been made, and only 25% were given a choice regarding their management.

What we did

We developed an integrated care pathway to assist midwives and doctors to implement the best practice outlined in the Royal College of Obstetricians and Gynaecologists' guidance: Late Intrauterine Fetal Death and Stillbirth. All 13 maternity units within Greater Manchester, Lancashire, and South Cumbria have now adopted this pathway.

How we made a difference

Although audit work is ongoing, it is anticipated that the pathway will optimise management, reduce variation in care, and encourage a compassionate and holistic care at diagnosis. This means a better experience for women (and their partners) as well as an agreed way of working for clinicians.

Greater Manchester, Lancashire and South Cumbria Clinical Senate

Providing independent clinical advice for assurance

What was the issue?

The Clinical Senate were asked to review the strategy and deliver plans for North Lancashire Clinical Commissioning Group's Better Care Together programme. Credible independent clinical advice was needed to allow NHS England and Monitor to support progression of the programme to its next phase.

What we did

A multi-disciplinary review team performed a desktop review which found that the programme was ambitious, encouraged engagement, and was committed towards leadership transparency. However, there were concerns about wider challenges in providing rural health services, the need to make clinical standards explicit, unclear methodologies, and areas where more detailed plans needed to be developed.

The analysis meant that the Clinical Senate could recommend not just particular actions, but suggest detailed timescales.

How we made a difference

The report was a key piece of information that allowed NHS England to decide to progress the programme, with confidence that clinical safety and sustainability had been considered.

The Clinical Senate has continued to forge positive working relationships with the Better Care Together leaders, as a critical friend, which has been a valued partnership.

> "The Clinical Senate took a very thoughtful and constructive approach to their review of the Better Care Together programme across Morecambe Bay. We valued the independence and clinical expertise"
>
> **Dr John Howarth,** Clinical Leader, Better Care Together

Northern England Strategic Clinical Networks

Understanding persistent physical symptoms and functional neurological disorders: pathways, services, and experience

What was the issue?

Persistent physical symptoms and functional neurological disorders are 'persistent bodily complaints for which adequate examination does not reveal sufficient explanatory structural or other specified pathology' (Royal College of General Practitioners, 2011).

The average length of time from symptom onset to diagnosis is five years and includes multiple hospital appointments, tests and procedures. The implications for well-being, quality of life, and cost to the economy are huge: the annual NHS cost in England is £3.1 billion (2008/9) with a further £5.2 billion attributable to lost productivity. The conditions account for 20% of GP appointments and half of outpatient clinic visits are for symptoms with no physical cause.

Local knowledge of available expertise and clinical skills in dealing with these conditions are influential in treatment pathways and access to appropriate care.

What we did

- Developed the stepped care approach for functional disorders
- Published functional conditions commissioners' guidance pack
- Worked with the Northern Association of Persistent Physical Symptoms (NAPPS) and the academic health science network to develop a resource pack and map
- Developed the ActiveME smartphone app for activity management in chronic fatigue syndrome/ME, in partnership with Dr Esther Crawley and the Royal National Hospital for Rheumatic Disease NHS Foundation Trust. It won the NHS Innovations North Bright Ideas in Health technology award.

How we made a difference

The referral map highlights the expertise available in Northern England for the management of three conditions. It provides clinicians with a list of clinical services, third sector resources, research centres and individuals who have expertise in the research or management of these conditions.

The resource pack will provide useful advice for recognising persistent physical symptoms, engaging patients, making a diagnosis, and optimal medication.

Northern England Clinical Senate

Reviewing high risk acute pathways in North Cumbria

What was the issue?

Cumbria Clinical Commissioning Group and University Hospitals of North Cumbria planned to change high risk acute pathways for urgent and emergency percutaneous intervention, acute stroke, acute gastro intestinal bleeds and emergency high risk medicine. They requested the Northern England Clinical Senate to review these changes to ensure the proposals were clinically robust

What we did

We conducted a two day visit to the acute hospitals within the trust, working with commissioning and provider colleagues. This included experiencing the journey patients might have to make and providing constructive, transparent feedback that emphasised the positives.

How we made a difference

The report was so well received that a further pathway review was requested for respiratory care.

Yorkshire and the Humber Strategic Clinical Networks

Improving dementia diagnosis rates across Yorkshire and the Humber

What was the issue?

The Prime Minister's Challenge on dementia included an ambition that 67% of people estimated to be living with dementia would have a formal diagnosis by March 2015.

Studies have shown that patients and family carers want to know that they have dementia. A diagnosis means access to timely medication, social, therapeutic and financial support, and access to specialist palliative care in a timely manner. A diagnosis helps services to adapt care and communication to meet the needs of the individual and to provide relevant information for the patient and carer.

At the end of July 2014, within Yorkshire and the Humber, there was a large variation, with only one clinical commissioning group meeting the 67% diagnostic rate ambition. The gap between the number of patients on the register and the 67% ambition was over 6,300 patients in the area.

What we did

Working in conjunction with Yorkshire and the Humber Commissioning Support Unit, we developed a dementia quality toolkit for use within primary care. It was designed to generate a list of patients who were not currently on the GP practice dementia register but who had a coded entry on the GP practice system that might be indicative of dementia.

A pilot indicated that practices who used the toolkit increased dementia diagnosis between 6% and 44%. It was then rolled out across Yorkshire and the Humber and other northern strategic clinical networks.

How we made a difference

At the end of March 2015, the dementia diagnosis rate was 65.2%. Both West Yorkshire and South Yorkshire and Bassetlaw had exceeded the ambition at 68.1% and 68.5%, as had 12 out of 22 clinical commissioning groups. North Yorkshire and the Humber's rate is at 59.1% – a 9% increase compared to the end of July 2014.

Across Yorkshire and the Humber, 547 practices – over 75% – ran the toolkit and in some clinical commissioning group areas this exceeded 95% of practices.

The number of patients diagnosed with dementia within Yorkshire and the Humber increased by 3,092 patients between July 2014 and March 2015. The online survey indicated that over 3,000 patients were added to these registers as a direct result of a practice running the dementia quality toolkit.

Yorkshire and the Humber Clinical Senate

Providing independent clinical advice for Northern Lincolnshire's hyper acute stroke service proposals

What was the issue?

North East Lincolnshire and North Lincolnshire clinical commissioning groups had developed an interim model for their hyper acute stroke services which centralised the service at their Scunthorpe site. The clinical commissioning groups needed to review that decision and develop a longer term solution for the service. We were asked to consider the following options for the long term delivery of the service:

- Decentralise the service providing the stroke service in Grimsby and Scunthorpe
- Centralise the hyper acute stroke service on the Scunthorpe General Hospital site
- Centralise the hyper acute stroke service on the Diana Princess of Wales site
- Decommission the Northern Lincolnshire service

What we did

We worked with commissioners to agree a terms of reference for the review, established a bespoke working group to consider the evidence, provided a thorough review of the options and provided our recommendations in a report to commissioners. Over 30 clinicians were involved in the review, providing independent advice.

How we made a difference

Our independent scrutiny reassured commissioners that the decision was in the best interest of patients. We offered a broad perspective which considered other issues aside from the Northern Lincolnshire geography. This included consideration of the potential impact on related services, and how these proposals related to the wider commissioning strategy of the Yorkshire and Humber stroke review.

Midlands and East

East Midlands Strategic Clinical Networks

Preventing cardiovascular disease in primary care

What was the issue?

Responsible for 23% of premature mortality in the East Midlands, cardiovascular disease is also a major cause of disability. We focused on preventing strokes in patients with atrial fibrillation, as they are five times more likely to have a stroke than those without the condition. Anticoagulation reduces atrial fibrillation related stroke by up to 70%, however, many patients are not on this effective treatment.

What we did

We made the case for change and worked with all 19 clinical commissioning groups in the East Midlands to deliver improvements in the identification and management of atrial fibrillation in primary care, through individualised slide sets and infographics on atrial fibrillation, quantifying the potential for improvement and signposting best practice examples.

The atrial fibrillation slide side was described by Huon Gray, National Clinical Director (Cardiac) NHS England, as "really excellent work and [a] very informative slide pack".

How we made a difference

By May 2015, all clinical commissioning groups in East Midlands had implemented an atrial fibrillation upskilling programme improving GP diagnosis and management of atrial fibrillation.

In 2013/14, improved management of atrial fibrillation is estimated to have prevented 122 strokes and 40 deaths across the East Midlands, reducing care costs by £1.45m.

East Midlands Clinical Senate

Commissioning services for an ageing population and those living with frailty

What was the issue?

Commissioning services for an ageing population and those living with frailty needs to change. The emerging evidence around frailty, the existing evidence for comprehensive geriatric assessment and the absolute need to provide holistic person centred care for everyone, particularly older people, mandates that change. The issues is pressing as the over 65 population living across the East Midlands will increase by 43% by 2030.

What we did

The Clinical Senate brought together clinicians with an interest in this area and produced a report to support commissioners. It recommended:

- Commissioned services for older people should include an assessment that helps to identify individuals who have frailty
- Intervention for older people who have frailty should be evidence based
- The management of older people with frailty should include comprehensive geriatric assessment
- When people living with frailty show functional decline or suffer crises, the health and social care response must be quick, comprehensive and multidisciplinary, delivered as close to home as judged safe and effective by a senior, responsible decision maker
- The care and management of people living with frailty should promote autonomy, be least restrictive, allow choice, and provide rehabilitation and reablement, wherever possible.
- The vision, strategy and detailed plans of commissioners should be enhanced by the involvement of patients, carers and experienced health and social care professionals.

Included within the report were East Midland's examples of good practice

How we made a difference

The report highlighted to commissioners key issues and examples of good practice to support their commissioning of services for frail older people. If illness based, condition specific pathways continue to be commissioned, services for our most vulnerable population, the frail and elderly, will be fragmented.

East of England Strategic Clinical Networks

Preventing suicides in the East of England

What was the issue?

In line with national directives including 'No Health Without Mental Health' and the 'Suicide Prevention Strategy for England', reducing suicide has been a key priority for the network.

All suicides are preventable – the ambition is to create a culture shift away from 'there was nothing we could have done' in order to save lives. 91% of patients in England who died by suicide had seen their doctor in the previous 12 months.

What we did

We established four pathfinder sites in East and North Hertfordshire, Cambridgeshire and Peterborough, Mid Essex, and Bedfordshire. The elements of their approach were: establishing an openness, willingness and confidence to explicitly talk about suicidal thoughts, facilitating the removal of an individual's access to a means of suicide, and establishing alternatives to suicide through the creation of robust safety plans.

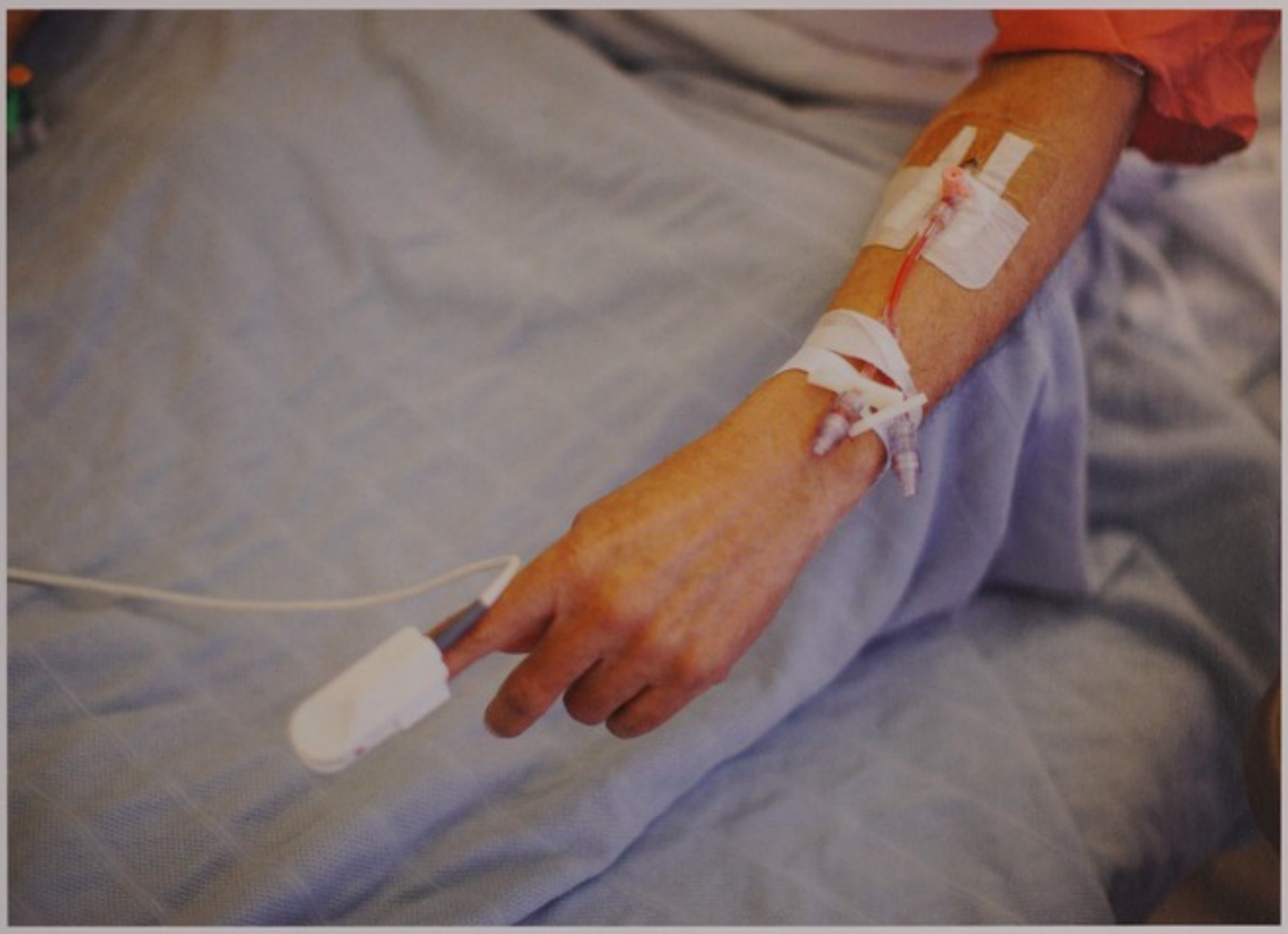
A focus of this work was training professionals in suicide prevention. GPs are a common point of contact for individuals who die through suicide but receive little mandatory training in this area. All four sites provided suicide prevention training sessions, including for GPs, practice nurses and receptionists.

How we made a difference

Training sessions demonstrated that doctors felt more confident dealing with patients who were suicidal.

West Midlands Strategic Clinical Networks

Utilising cancer data to inform commissioning decisions



What was the issue?

Despite the wealth of cancer data available in the West Midlands, it was not being widely used to inform cancer service commissioning decisions or when monitoring quality outcomes. This meant there was a failure to proactively understand population cancer health needs at a clinical commissioning group level.

What we did

Working with clinical commissioning groups and specialised commissioning, we developed an integrated, searchable tool for all West Midlands clinical commissioning group populations. It allowed clinical commissioning groups to benchmark themselves against other closely related groups, based on socio-demographic data.

How we made a difference

The ability to compare clinical commissioning groups was not possible with most of the current online tools. It is important to understand whether commissioned services lead to good or bad outcomes for the population. This data also allowed to highlight best practice and to ensure that decisions are made by using robust data.

"Thanks – this is so useful: I can't thank you enough."
Anonymous

"Just echoing from Dudley Clinical Commissioning Group our thanks to you for this."
Dudley Clinical Commissioning Group

West Midlands Clinical Senate

Reviewing hepatopancreatobiliary cancer services in the West Midlands

What was the issue?

Within the West Midlands, there were four key issues related to hepatopancreatobiliary cancer services:

- Not all of the providers were improving outcomes guidance compliant – the rigorous standards of specialised commissioning which came into effect in April 2015 and meant the current provision was unsustainable.
- There were capacity constraints at University Hospital Birmingham and volume problems at University Hospitals Coventry and Warwickshire, and University Hospital North Staffordshire.
- Concerns were raised by external advisors about the radical nature of surgery undertaken by referral centres performing liver resection.
- The current relationship between these organisations was a major obstacle to progress.

Improving outcomes guidance compliance could only occur through collaborative working with all three units in the Midlands, in order to take advantage of their expertise and resolve the capacity issue.

What we did

To ensure the provision of high quality, equitable care to patients, a Clinical Senate Council member was used to chair the working group and a review team and panel were established.

Seven options were proposed. It was agreed that a two centre site was sustainable, by amalgamating University Hospitals Birmingham and University Hospitals Coventry and Warwickshire. It was recommended that the University Hospital North Staffordshire should increase liver surgery and patient flow increase from Wolverhampton.

How we made a difference

All three units are working more closely together in order to capitalise on expertise and resolve the capacity issue. The result will be the best provision of care for patients within the West Midlands.

London

London Strategic Clinical Networks

Improving London's mental health commissioning across primary care

What was the issue?

In London, 90% of people with a mental disorder are cared for entirely within the primary care sector. Mental health problems form a large and growing proportion of primary care presentations: 1 in 3 GP appointments involve significant mental health issues. With nearly 11% of England's annual secondary care budget now spent on mental health, it is essential that commissioners have the confidence and ability to develop effective and efficient services to transform the lives of people with mental health problems.

What we did

We produced clinical commissioning guidance to provoke and support commissioners in delivering evidence based interventions and achieve the best outcomes for patients. A Commissioner's Guide to Primary Care Mental Health details ten lessons derived from international, national and regional case studies, covering community based care, proactive well-being, accessible services and coordinated mental healthcare.

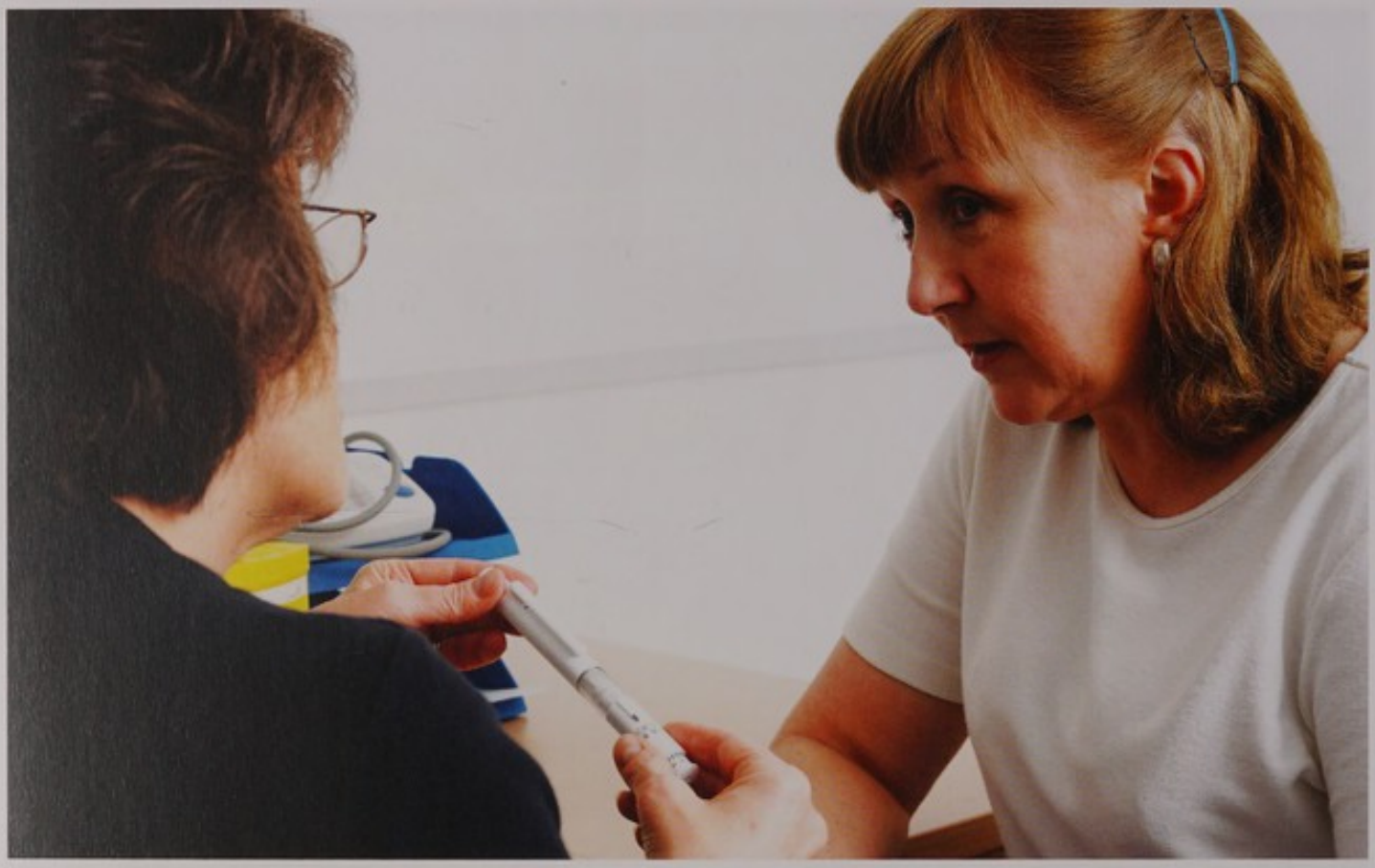
In collaboration with UCLPartners, we brought together mental health leaders from London clinical commissioning groups to develop and deliver a knowledge based leadership programme.

How we made a difference

A Commissioner's Guide to Primary Care Mental Health formed a library of best practice, and a source for commissioners to contact, advise, and champion others. It has been downloaded nationally and internationally, including Australia, America and the United Arab Emirates. The material features within academic teachings of the University of Birmingham.

London Strategic Clinical Networks

Diffusing the diabetes time bomb in London: improving detection, delivery, and management of care



What was the issue?

Diabetes has been recognised as a growing problem for the NHS with prevalence set to rise to more than 700,000 by 2030. There are an estimated 475,000 Londoners diagnosed with diabetes, and a further 200,000 people could be living with diabetes by 2025.

In 2012/13, London diabetes prescription costs were more than £109m – not including treatment costs.

What we did

We used HbAlc testing as the preferred diagnostic method to enable more patients to be identified and for them to manage their conditions better.

In conjunction with the Health Innovation Network Academic Health Science Network, we produced a toolkit to address the causes and low uptake of structured education for people with type 2 diabetes and to provide guidance on how to make high quality structured education easily accessible across the UK.

We also published Footcare Services for People with Diabetes: Guidance for Commissioners, which details the provision of a foot service for people with diabetes according to best practice guidance. This guide and service specification builds on recommendations in the Cardiovascular Disease Outcomes Strategy, and responds to the challenges and aims of the Five Year Forward View.

How we made a difference

The toolkit has been accessed more than 5,500 times.

The footcare service specification has been sent to key stakeholders across all London trusts: medical directors, chief nurses, clinical leads for diabetes and heads of podiatry services. In the first month, it was downloaded more than 1,100 times.

London Clinical Senate

Helping smokers quit: adding value to every clinical contact by treating tobacco dependence

What was the issue?

The programme addresses many of the challenges set out in the NHS Five Year Forward View, breaking down barriers in how care is delivered and addressing the health and well-being gap. Smoking kills one in five Londoners and costs the NHS in London more than £400m. In the capital, there are 1.2m people who still smoke. Smoking is the greatest single cause of avoidable death and health inequalities. It accounts for over half of the difference in risk of premature death between social classes.

What we did

The Helping Smokers Quit programme promotes evidence-based care of people who are tobacco dependent. It encourages all clinicians to know the smoking status of each patient they care for and to have the commitment to help smokers to quit through direct action or referral.

The programme engaged key leaders from across London in the programme board, utilising their leadership and influence to create behaviour change. We have drawn on clinical expertise from the London Respiratory Network and linked with directors of public health and the Greater London Authority to form a multi-organisational delivery team. Initially, all NHS provider trusts, clinical commissioning groups, and directors of public health were surveyed, to understand their current commitment to stop smoking services.

Guidance has been created to support trusts to adopt new practices such as using carbon monoxide monitors as a motivational tool and adding new nicotine replacement therapy items to their formulary.

From March 2015, we asked every London trust and clinical commissioning group to sign up to its CO4 campaign, which has four elements:

- Having the 'right' COnversation for every patient and staff member who smokes that gives him or her a chance to quit, referring if necessary.
- Make routine desktop exhaled carbon monoxide (CO) monitoring by clinicians possible: "Would you like to know your level?"
- COde the intervention so we can evaluate effectiveness - including death certification.
- COmmission the system to do this right: so right behaviours are incentivised systematically.
- Learning from maternity services and mental health trusts implementing CO4 will be shared across London.

How we made a difference

The promotion of the very brief advice training, which takes just 20 minutes to learn and 30 seconds to deliver, provides a new language for clinicians. Patients will now be offered a solution to treat their addiction rather than a traditional paternalistic approach. This small investment of clinical time with every patient contact would improve outcomes and lead to significant savings for the health system.

South

South East Strategic Clinical Networks

Section 136: piloting an alternative place of safety

What was the issue?

At the Policing and Mental Health Summit the Home Secretary announced that the Richmond Fellowship would pilot an alternative place of safety for people detained under Section 136 of the Mental Health Act.

Sussex has amongst the highest numbers of Section 136 detentions of any police force area. This is because Sussex faces particular challenges in their coastal towns: due to Gatwick airport and the national rail links, high numbers of people from neighbouring counties frequent Sussex when experiencing a mental health crisis.

Sussex police have also faced particular local challenges when accessing health-based places of safety – one key issue has been the thresholds for intoxication which often exclude access to health-based places of safety and leaves the police with little alternative but to use a custody suite.

What we did

We helped to facilitate stakeholders through the challenges of working together within a specific timeline in the pilot, and commissioned its evaluation with NHS South East Commissioning Support Unit.

How we made a difference

Network facilitation enabled the agreement of standard operating procedures between police, ambulance, mental healthcare, out of hours care and Richmond Fellowship staff, to provide a consistent and patient centred approach to an individual suffering from a mental health crisis.

South East Clinical Senate

Reviewing the clinical co-dependencies of acute hospital services

What was the issue?

Patients increasingly have multiple medical conditions that require the input of a range of specialists, diagnostics and treatments to be available for effective inpatient care. Designing systems for such care must address this need through a detailed understanding of the clinical interrelationship between services. This is then a platform to consider the different ways these services be provided – both within individual hospitals and between them. This requires better coordination and cooperation between provider organisations to underpin agreed clinical models.

The Sussex clinical commissioning groups requested generic, evidence-supported clinical advice on the necessary relationships between acute hospital services to inform their future local discussions and planning.

What we did

We provided a review of the evidence base for the critical codependencies of acute inpatient services. We also identified core groupings of services required to be based on the same hospital site – such as hospitals with emergency departments receiving all acute adult patients require onsite acute and general medicine, acute surgery and critical care.

How we made a difference

We have completed the most comprehensive clinical review to date of the interdependencies between a wide range of acute hospital based services. It provides a baseline from which to have detailed local discussions about codependencies and colocations and to explore different ways in which services could be delivered if not physically based on the same site.

South West Strategic Clinical Networks

Reducing major amputation in diabetes patients: the role of peer reviews

"From the clinical commissioning group's perspective, I have felt that this is an extremely useful exercise and one that we would welcome for other specialities experiencing difficulties"

Deputy Director of Clinical and Collaborative Commissioning

"Many thanks for getting me involved in this process. The opportunity for networking and the learning experience and cross pollenisation of ideas is fantastic"

Consultant orthopaedic surgeon

What was the issue?

Amputations are twice as likely for patients in the south west than in London with 768 amputations taking place last year as a result of diabetic complications. Figures show persistent high rates of minor and major lower extremity amputation rates in those with diabetes in the south west region.

What we did

120 clinicians took part in a standardised peer review of foot care services for diabetes patients across all 14 acute trusts and 11 clinical commissioning groups in the region.

The aims of the review were to:

- understand variation in practice
- establish compliance with NICE CG119
- identify and spread good practice
- make recommendations for change and improvement.

Each clinical commissioning group area review included:

- patient and carers
- clinical commissioning group commissioners
- acute trust management
- community podiatry team
- multidisciplinary team.

A standardised formal report was sent within 21 days of the review. Each report included:

- summary findings
- clear recommendations
- suggested timeframe and responsible organisation.

How we made a difference

Since the reviews were completed in April 2015 there has been improved access to podiatry. Multidisciplinary teams have been set up with job planning for specialist involvement.

Thames Valley and Milton Keynes Strategic Clinical Networks

Reducing variability of stroke provision in Thames Valley and Milton Keynes

What was the issue?

There is significant evidence that all stroke patients should be taken to and treated in a hyper acute stroke unit for the first 72 hours. This is proven to reduce mortality and morbidity.

What we did

We worked with clinical commissioning group leaders to understand their significance and importance of SSNAP audit data. We also supported commissioners with defining the characteristics of excellent stroke services for their local geography and provided impartial clinical advice on options for improving patient outcomes. As a result, a clinical commissioning group has recommissioned their stroke services and patient flows, taking into account the evidenced quality and improvement gains. Two further clinical commissioning groups are developing business cases with the intention of changing provision by September 2015.

How we made a difference

For two years, a clinical commissioning group and a trust had worked towards improving stroke services in their region. With minimal improvements noted over that period, we brought the two organisations together with national leaders to review stroke services and build consensus around the need for change.

Through strong clinical leadership, we worked with the Thames Valley Clinical Senate to debate the benefit of the London model for the Thames Valley geography. Commissioners were given the information and support to effectively challenge inadequate stroke provision in their region.

Thames Valley and Milton Keynes Clinical Senate

Responding to the Heatherwood and Wexham Park Hospital acquisition

What was the issue?

Frimley Park NHS Foundation Trust, an out of area hospital, acquired Heatherwood and Wexham Hospital, in the south of Thames Valley. The acquisition was supported by NHS England and local clinical commissioning groups. Whilst this was a financial transaction, it did not include detail about possible changes to clinical pathways or clinical ambition. It was reasonable to expect that the new provider would need to make changes to improve the viability of the acquired hospital but without the detail of their clinical ambitions it was not possible to assess what impact these changes might have on the sustainability of services and patient access across the wider Thames Valley geography. The Clinical Senate was asked to undertake a risk assessment of the potential changes resulting from the acquisition.

What we did

We consulted with the Thames Valley Strategic Clinical Networks clinical directors to obtain a response to the high level of ambition shared in the outline business case. We held a Clinical Senate assembly conference to obtain wider responses to the vision shared with us by Frimley Park. We received 221 responses from the event: 75% reflected a concern about the impact on existing services and whether they would be patient focused.

We held four clinical stakeholder forums – which were each attended by 50 delegates. From this work were able to develop recommendations.

How we made a difference

Our work demonstrated to partners the clinical interdependencies within trusts and their neighbouring organisations, raising the importance of whole system sustainability. We ensured that the patient was the focus of developments rather than individual organisations. The work was proactive and enabled the system to have a planned and joined up approach.

Wessex Strategic Clinical Networks

Reducing unplanned hospital presentations for children and young people

What was the issue?

The UK has one the highest mortality rates for children aged 0-4 years in Europe (Lancet, 2014). In addition, urgent care service demands for children is increasing year on year across the UK. The urgent care pathway is complicated for parents to navigate: this is demonstrated by local data showing an increasing proportion of parents presenting directly to accident and emergency and increasing number of zero bed-day admissions to hospital. Children under 5 years of age represent the bulk of this activity.

What we did

Our approach was to focus on improving the quality of care delivered across the urgent care pathway in order to reduce unnecessary acute presentations to healthcare professionals.

By collaborating with key stakeholders from across Wessex including parents, GPs and frontline doctors, we identified examples of good practice in urgent paediatric care delivery as well as areas of improvement. We collected data relating to urgent care activity through the NHS South Commissioning Support Unit and analysed by Public Health England Wessex.

Identified areas for improvement included:

- the development of standardised resources for parents
- clear signposting for parents about when and where to access urgent care
- the developing of evidence based pathways for common paediatric presentations for use across primary and secondary care services.

How we made a difference

In collaboration with local GPs, community nurses, and front line hospital doctors we developed Wessex-wide resources for parents and clinical pathways for healthcare professions: **www.healthiertogetherwessex.nhs.uk**

We have also produced educational material for use in Sure Start centres and a two day course on acute paediatrics for GPs and GP trainees. We are working with Health Education Wessex to introduce teaching on common paediatric presentations and appropriate health-seeking behaviours into the undergraduate curriculum for pharmacists, nurses, midwives and health visitors.

We are actively promoting this approach to primary care and secondary care staff across Wessex.

Urgent care data is being prospectively collected to evaluate the impact of our approach; we are also evaluating the impact of the various strategies used in Wessex. This data will inform a strategy and vision document for the delivery of paediatric services across Wessex.

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