CCG name: HealthEast (NHS Great Yarmouth and Waveney CCG)		
Case study title: **Connected Care in Gorleston (CCiG)**		
CCG case study number: (specify 1 to 5)	*1* of 5	**Word length for this case study** **608** (up to a maximum of 3,000 words in total across the submitted case studies)
Does the case study provide core evidence?	Y	**If yes, state domain criteria by deleting as appropriate:** 1.1C, 1.2F, 2.2B, 2.3B, 3.2A, 4.2.1K, 4.3.1A, 4.3.1B, 6.2B
Does the case study provide supplementary evidence?	Y	**If yes, state for which domain criteria:** 1.1A, 1.2D, 1.3A, 1.4.2A, 1.4.2B, 2.1.1A, 2.1.1C, 2.2A, 3.1.1D, 3.1.3A, 4.2.1J, 4.2.2B, 4.2.2C, 5.1C,

Patient groups	**Please tick all relevant:**
• Mothers and newborns	
• People with need for support with mental health	
• People with learning disabilities	
• People who need emergency and urgent care	X
• People who need routine operations	
• People with long-term conditions	X
• People at the end of life	
• People with continuing healthcare needs	X

Context

Studies have demonstrated that the James Paget University Hospital Foundation Trust (JPUH), HealthEast's main acute provider, has disproportionate use of A&E services by Gorleston residents compared to the rest of the population of Great Yarmouth and Waveney. Many visits were inappropriate as a trip to their primary service provider would have been more appropriate to their clinical need (A&E Market Research September 2011). HealthEast also wanted to identify how we could work more effectively with patients to empower them to better manage their long term conditions in the community, contributing to reducing A&E attendances and admissions, and improving quality of life. We were also focused on strengthening community services and support.

To explore this subject, HealthEast secured funding from NHS East of England's Regional Innovation Fund in 2011 to pilot a new model of community led commissioning. A national charity, Turning Point, and HealthEast worked together to create a bespoke project aimed at people with long-term conditions (LTCs), within the defined geographical area of Gorleston.

Action
A team of 15 (ten completed the training) local people with experience of LTCs were recruited as Community Advocates. They were trained to conduct research with peers, recording experiences, needs and priorities of people living with LTCs and were paid for this work to recognise the importance of their contribution to the community and to HealthEast. 219 questionnaires were completed from patient interviews. Alongside this, senior researchers interviewed local clinicians to gather their views and experience of clinical pathways for patients with LTCs. An extensive paper based survey was also carried out to make sure a full picture of services accessed across the healthcare spectrum was gained.

Following the research phase Community Advocates were able to recommend how services can be improved to be more cost-effective, better support self-management and improve experiences and outcomes of care.

Impact
The objective is to secure the more appropriate utilisation of local health and social care services, improve satisfaction among users and reduce the costs of meeting the needs for LTCs. The result has been a sustainable mechanism for partner agencies to engage with people with long-term conditions and to co-produce services with them. We have also specifically identified the impact that social deprivation, isolation, housing and mental health challenges can have on patients with long term conditions. We will use this learning to further our work on addressing inequalities. And through this project, HealthEast has also been successful in opening up more opportunities for the future to work with colleagues from non healthcare organisations and the third sector.

The process has enabled HealthEast to gain a deep understanding the care pathways and experiences of people with long-term and mental health conditions in one of our most deprived communities. A framework for health and social care partners to work together with members of the community has been established. We are now undertaking a programme of service redesign in conjunction with service providers which will focus on:

- supporting self management
- sustainability
- connecting vulnerable people to information and resources
- access
- joined up services

Specific areas of work as a result of this project in the next three months are: discharge care planning, unplanned admissions to A&E and patient self management. This focused task and finish work will feed into our commissioning intentions for 2013/14.

The training and research process has built the capacity of local people to redesign and contribute to services around long-term conditions, and has established a model which can be applied to different client groups and areas in Great Yarmouth and Waveney. We are working with local lower tier authorities in Norfolk and Suffolk to roll this out further.

CCG name: HealthEast (NHS Great Yarmouth and Waveney CCG)		
Case study title: Provision of an integrated Lower Urinary Tracts (LUTs) Service		
CCG case study number: (specify 1 to 5)	*2* of 5	**Word length for this case study** **525** (up to a maximum of 3,000 words in total across the submitted case studies)
Does the case study provide core evidence?	Y	**If yes, state domain criteria by deleting as appropriate:** 1.1C, 2.2B, 3.2A, 3.3C, 4.3.1B, 6.2B
Does the case study provide supplementary evidence?	Y/N	**If yes, state for which domain criteria:** 1.1B, 1.2D, 1.2F, 1.3A, 3.1.3A, 4.3.1A,

Patient groups	**Please tick all relevant:**
• Mothers and newborns	
• People with need for support with mental health	
• People with learning disabilities	
• People who need emergency and urgent care	
• People who need routine operations	X
• People with long-term conditions	
• People at the end of life	
• People with continuing healthcare needs	

Context

This case study sprang from a GP initiative which was reviewed by HealthEast's retained GPs, and brought up to date by involving secondary and community clinicians to deliver innovative service change. It also demonstrates how we have spread learning from Waveney into Great Yarmouth, and improved choice, access and equity for our patients.

The process began when a member practice brought to the attention of the HealthEast executive team quality issues with the Lower Urinary Tract service on offer to its patients. As a result of the concern raised a urology speciality group was established in late 2010 to conduct a clinical review of the service. The findings revealed a disparate service; not well understood in primary care nor cost effective to commission. It consisted of a very small service run by a community services provider at a rural community hospital which could see only a maximum of six patients per week; the majority of whom were referred by the neighbouring GP practice. The service was delivered by a Health Care Assistant overseen by a nurse specialist. The majority of patients across the rest of Great Yarmouth and Waveney were referred directly to a Consultant Urologist at JPUH. This was considered by the clinical review group to be an inappropriate use of consultant time which did not offer value for money.

Action
During a clinical summit, held in September 2010 GPs, a mutual agreement was reached that a clinically robust, more accessible pathway for patients could be achieved by working together to redesign the referral process.

HealthEast developed an integrated LUTs pathway in partnership with JPUH Urology Consultants and ECCH Specialist Nurses.

The key aspects of the pathway are:

- a clear referral route via Choose and Book
- discharge back to GP with a clear management plan or, if acute care is necessary, direct referral from the LUTs nurse to the JPUH Urologist
- a choice of community based clinics and shared clinical protocols across both providers.
- Nurse-led clinics with supervision arrangements in place

The Planned Care Programme Board worked with HealthEast's retained GPs to promote the service to primary care. This work included development of Quick Pages (at a glance, one page pathways that can be accessed on HealthEast's website by clinicians), discussion at Clinical Referral Leads and Protected Time for Learning training sessions and distribution of the pathway and associated referral templates.

Impact
The new LUTs pathway began in April 2012, supporting a much improved patient experience and is more straightforward for clinicians to use. We have delivered a 'one stop shop' with a new specialist service which does not require patients to go through the standard referral route. The reputation of this service across primary care is much improved and demonstrates HealthEast's desire to work in an integrated way, developing local services for our patients and delivering patient choice.

The changes have allowed a £21k saving to be built into the 2012/13 contract (based on reduced consultant appointments and an equivalent increase in nurse-led locally agreed price).

HealthEast has managed the 2012/13 contracting round of £130m, and LUTs in just one example of the strength of clinically led commissioning.

CCG name: HealthEast (NHS Great Yarmouth and Waveney CCG)		
Case study title: The introduction of intensive case management to Southwold		
CCG case study number: (specify 1 to 5)	3 of 5	**Word length for this case study** **601** (up to a maximum of 3,000 words in total across the submitted case studies)
Does the case study provide core evidence?	Y	**If yes, state domain criteria by deleting as appropriate:** 1.1C, 2.3B, 3.2A, 4.2.1K, 4.3.1A, 6.2B
Does the case study provide supplementary evidence?	Y	**If yes, state for which domain criteria:** 1.2D, 1.2F, 1.3A, 1.4.2B, 3.1.1D, 4.2.2A

Patient groups	**Please tick all relevant:**
• Mothers and newborns	
• People with need for support with mental health	
• People with learning disabilities	
• People who need emergency and urgent care	
• People who need routine operations	
• People with long-term conditions	X
• People at the end of life	
• People with continuing healthcare needs	

Context

Southwold Surgery look after a practice population with a very high proportion of elderly patients. The patients in many cases are very elderly and many have long term conditions requiring active treatment. As a result of their age many patients have non-medical needs which impact on their treatment and their ability to live an independent life. Whilst deprivation is not a general problem many patients are also carers eg an elderly wife looking after and ill and elderly husband.

As a result, prior to the introduction of case management, Practice Based Commissioning (which evolved into HealthEast) identified many patients accessed primary care frequently, often when their long term conditions showed exacerbations, and emergency admissions to secondary care were high and rising. Because of the social needs of the patients some admissions were forced because of an inability to look after themselves. Sometimes the admission of an elderly carer would enforce the admission of a dependent spouse to care.

Because of the geographical isolation of Southwold from the nearest acute hospital admission to secondary care often causes hardship to the spouse and family of patients.

The Southwold population is discrete and looked after almost exclusively by one practice.

Action
Regional funding was secured for this pilot, Practice Based Commissioners seconded a supernumerary and autonomous part time case manager (a senior district nurse) and a part time social worker to the practice to introduce case management. This involved case finding, coordination of the work of community health and social services teams looking after local patients and when necessary, intensive case management of individuals and their dependents. These staff worked very closely with practice staff, being signposted to patients in need of management and eventually highlighting back to practice patients who required specific and additional medical care.

The two case managers could also access directly social care packages of care or support.

A number of case finding techniques were piloted, including the predictive risk modelling software PARR, but the greatest impact was derived from close working with the practice and multidisciplinary communications between health and social care professionals.

Such was the qualitative and financial benefit of the introduction funding for the posts were made permanent after a year.

Impact
The impact of the new service was immediate. Emergency GP attendances and emergency hospital admissions fell significantly. This was in marked contrast to other parts of the PCT where emergency admissions were rising. This trend has been validated by the Public Health department and the University of East Anglia.

The service enables HealthEast to tailor care for patients with terminal conditions, and focuses on empowering those patients to die at home with dignity.

Patient satisfaction with the service has been high and qualitative benefits to patient wellbeing are well documented. GP satisfaction with the service is also marked.

Financial savings in the order of £400K per year have been shown against a cost of £80K for the two case management staff. As the confidence in the benefits of the change grew funding was moved from the secondary care budget to the practice budget.

As a result of this pilot, case management has been rolled out across the area by the HealthEast team. As effective commissioners, we saw the value of this project and rolled it out, with different models for different areas, tailored to meet the needs of our communities. So the model has remained the same for rural areas, and has been adapted by local community services to take into account the different needs of patients living in urban areas. Patient satisfaction, quality improvement and financial savings have been shown as a result.

CCG name: HealthEast (NHS Great Yarmouth and Waveney CCG)		
Case study title: System Leadership Partnership		
CCG case study number: (specify 1 to 5)	4 of 5	**Word length for this case study** **556** (up to a maximum of 3,000 words in total across the submitted case studies)
Does the case study provide core evidence?	Y	**If yes, state domain criteria by deleting as appropriate:** 4.2.1K, 5.1C, 6.1D
Does the case study provide supplementary evidence?	Y/N	**If yes, state for which domain criteria:** 1.1A, 1.1B, 1.3A, 1.4.1A, 1.4.2A, 2.1.2B, 2.1.2C, 3.1.1C, 3.1.1E, 5.2A, 5.3A

Patient groups	**Please tick all relevant:**
• Mothers and newborns	X
• People with need for support with mental health	X
• People with learning disabilities	X
• People who need emergency and urgent care	X
• People who need routine operations	X
• People with long-term conditions	X
• People at the end of life	X
• People with continuing healthcare needs	X

Context

HealthEast chairs and runs the Great Yarmouth and Waveney System Leadership Partnership (SLP). This is a well established group, bringing together all the senior key players, at Chief Executive and Chair level, from health, social care and the voluntary sector, and includes commissioners and providers in the local health economy.

The vision for our local health economy over the next five years is to deliver improvements in care and outcomes for our patients and the public whilst maintaining financial stability. To deliver this against the backdrop in the reductions in public expenditure overall and the efficiencies required in the NHS, local authorities and our partners, we needed local leaders to invest time and attention on the objectives of our integrated strategic work programme and deliver the expected outcomes. The SLP is our forum for this work, closely aligned to our two Health and Wellbeing Boards, with a strong local focus. It is particularly important as HealthEast spans two county council boundaries, and therefore the need for close joint working is critical. The SLP also provides a forum for strategic issue resolution across the whole health economy eg leadership development, unplanned care, choice and personalised care, plus delivery of the QIPP agenda.

The SLP was set up in September 2010, and HealthEast took over leadership of the group in April 2012.

Action
During 2012/13, the SLP has embarked on a highly practical workplan, promoting integration and harnessing the 'assets' within communities to help them to help themselves, reduce social isolation etc. This is exemplified by our successful Connected Care project in Gorleston and in the work we are doing jointly with Norfolk and Suffolk County Councils in connection with their Ageing Well initiative, which includes a strong element of prevention.

We work through the bi-monthly SLP meetings and a range of focused task and finish groups.

Following on from this work, we have now enlisted the help of other senior staff in all organisations represented at the SLP to share our learning, joint working and joint commissioning further than these specific projects across Great Yarmouth and Waveney.

Impact
Norfolk County Council has said *'We would like to work with HealthEast, as an early leader in the new system, to model and demonstrate to others how CCGs can shape the Board's agenda and working style so that it becomes a forum where major service changes can be brokered and tested, and clinical influence can be brought to bear on wider public sector partners whose policies and actions can have a long-term influence for good on the health of local population.'*

Suffolk County Council has been encouraging the Suffolk CCGs to set up a similar model, as it sees it as an effective and practical mechanism to foster partnerships and speed integration.

A further real benefit of this group has been the explicit and open way in which the SLP has embraced the patient and third sector voice at this forum. Both patients and voluntary services representatives are equal partners with senior players from across the health and social care sector, with a genuine place at the 'top table', getting their voice heard in a senior strategic context. HealthEast believes it is crucial to have this level of real involvement and engagement if we are to effectively deliver clinical commissioning and clinical transformation across Great Yarmouth and Waveney.

CCG name: HealthEast (NHS Great Yarmouth and Waveney CCG)		
Case study title: Quality management of an acute provider		
CCG case study number: (specify 1 to 5)	*5* of 5	**Word length for this case study** **698** (up to a maximum of 3,000 words in total across the submitted case studies)
Does the case study provide core evidence?	Y	**If yes, state domain criteria by deleting as appropriate:** 1.1C, 2.2B, 3.2A, 4.3.1B
Does the case study provide supplementary evidence?	Y	**If yes, state for which domain criteria:** 1.1D, 3.3B, 3.3H, 4.2.1B, 4.2.1C, 4.2.1D, 4.2.1E, 6.2B, 6.4G

Patient groups	**Please tick all relevant:**
• Mothers and newborns	X
• People with need for support with mental health	X
• People with learning disabilities	X
• People who need emergency and urgent care	X
• People who need routine operations	X
• People with long-term conditions	X
• People at the end of life	X
• People with continuing healthcare needs	X

Context
In March and April 2011, following adverse newspaper publicity during the winter months, HealthEast started to receive informal reports from local surgeries about quality and safety at JPUH. Previously, JPUH had enjoyed high levels of community support. We recognised that the tone of conversation in the consulting room about the Trust had changed.

Hot on the heels of these reports came the Care Quality Commissions (CQC) Dignity and nutrition inspections, and then an escalating series of CQC visits and warnings.

HealthEast's concerns were:

1. Quality of care and patient safety in commissioned services
2. Lack of Trust management clarity about exactly what the problem was
3. A degree of denial about the scope and depth of the challenges within JPUH
4. No effective action being taken within JPUH

Action
We therefore raised the issue of quality of care at JPUH with our Clinical Leads groups. These groups comprise a GP lead from each practice plus a practice manager. Concerns were raised

regarding discharge arrangements, medicines reconciliation, and quality of care for complex frail and elderly patients with multiple long term conditions.

HealthEast raised these concerns with Trust management via informal links and formally through the contract meeting itself, and supported the PCT Cluster with clinical contract leadership, both in face to face meetings with the Trust and through clinical reviews of Trust action plans.

Through this process it became clear the Trust had deeper problems that were not being resolved. We therefore took the following actions:

- Increased unannounced visits by HealthEast clinicians and prioritised involvement of clinical leaders. Ward-based 'Go and See' reviews were undertaken by seven of our key clinicians (Chair, Accountable Officer, Deputy Chair, Director of Clinical Transformation, two retained GPs, our Palliative Care Nurse Programme Manager and Prescribing and Medicines Management lead), with immediate feedback to the Trust and in summary form to the Board and also the contracting team. This was agreed with the JPUH and played into their management team action planning

- New clinical feedback forms introduced to harvest the feedback from patients to their GPs in an accountable manner. While the process had started following informal feedback from GPs, we felt the need for more formal and accountable feedback. This led to the introduction of our 'Yellow Card' provider feedback scheme modeled on the MHRA (medicines reporting) scheme

- In conjunction with the PCT Cluster, we entered a formal contractual challenge with the Trust

- One to one contacts between our Chair (Lead Clinician) and Accountable Officer and the Trust management were stepped up

- Informal space was made for ongoing discussion at Clinical Leads meetings (and also Part 2 of the Board) to feed back to front line clinicians and also to continue to hear more informal concerns from the consulting room (which may not meet the specific requirements of the yellow card scheme)

- HealthEast called the Medical Director of the JPUH to account at HealthEast Board meetings on several occasions during the last year

Impact:

- Recognition of scale of challenge at Trust, resulting in the development of a detailed action plan. We supported the Cluster Quality team in delivery and scrutiny of the action plan. Completion of these actions resulted in demonstrable improvements in patient care in the provider and de-escalation of CQC concerns. For example, on 27 June the CQC announced that JPUH is now compliant with Outcome 4: care and welfare of patients, and the warning notice issued in April 2012 has been lifted. NHS Midlands and East have recognised this by saying: 'The CCG has shown considerable commitment to date engaging with the Trust to drive improvement' (CCG Authorisation: Regional Report: June 2012)

- Large scale managerial change at the Trust (due in part to HealthEast's intervention)

- Development of a group of clinicians able to undertake provider quality assessment visits; this expertise did not previously exist

- New Medicines Reconciliation procedure between the Trust and surgeries has been agreed and promulgated via HealthEast

- We are planning a learning event with our Board, local CCGs and possibly more widely (currently under discussion) to identify lessons learned for commissioners; we hope to forge further links with regulators (CQC and Monitor) through this.