5 year
Health and Care Strategy for Worcestershire

NHS
Redditch and Bromsgrove
Clinical Commissioning Group

NHS
South Worcestershire
Clinical Commissioning Group

NHS
Wyre Forest
Clinical Commissioning Group

NHS
England

Developed with input from:

Worcestershire Health and Care NHS
NHS Trust

Worcestershire NHS
Acute Hospitals NHS Trust

worcestershire
countycouncil

Worcestershire's Voluntary and Community Sector

Proposed Final Version 2nd July 2014

Introduction

This document outlines the initial view of the Worcestershire five year strategy, as required by *Everyone Counts: Planning For Patients 2014/15 to 2018/9.* This version is near complete, but some updates will be required before it can be finalised.

Process for developing the 5 year strategy

The significant steps in the process for the development of this strategy have been:

- An initial presentation to the Health and Well Being Board on 11th March 2014. At this meeting we sought the Health and Well Being Board endorsement to the process and timeline so that a formal first draft could be submitted to NHS England on 4th April 2014.
- The Strategic Visioning Events on 8th and 9th April where all key stakeholders in the Health and Social Care economy came together to discuss challenges and future plans.
- A presentation to the Health and Well Being Board on 13th May to share the initial draft that was submitted on 4th April along with a proposed timeline for amending the next version to be submitted on 20th June.
- A facilitated discussion at the development session of the Health and Well Being Board on 18th June, following which the Board approved the Strategy for submission to NHS England on 20th June.
- The final strategy will be presented to the Health and Well Being Board on 22nd July 2014 so it should not be considered a final strategy until this process has passed.

There is a strategic working group covering all commissioners and providers, including Adult Services and Health, that has worked on the development of the strategy. Oversight of the development has been undertaken by the Strategic Partnership Group of the Health and Well Being Board. Input to the development of the strategy from parts of the VCS have come through these forums.

This document

The strategy outlines the ambitions that CCGs have identified for the six key NHS Outcome areas and a proposed set of vision statements that partners believe define the key aspects of what we are trying to achieve together. The way in which the strategy brings together existing and future plans in the system is identified on page 11.

We have identified the transformation programmes that we are currently working on in the health and social care economy. We recognise the enormity of the task ahead of us over the coming 5 years and realise that this document only gives us a high level blueprint to work from. As health and social care economy partners we aware that the detail under pinning this strategy needs considerable work over the coming months.

Introduction

Our five year strategy aims to achieve the core elements of the NHS England planning guidance, namely:

Requirement	What we have done to date:	What we plan to do in future
A completely new approach to ensuring that citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care	• Commissioners and providers have established extensive membership schemes and public and patient involvement groups, which are up and running. • Worcestershire County Council has a series of established consultative groups for older people, people with physical disability, people with sensory impairment and carers. A Learning Disability Partnership Board is in place with representation from service users and carers. • There is an extensive network of primary care patient participation groups established around local practices. • Healthwatch Worcestershire are full members of the HWB and of the Health and Social Care Strategic Partnership Group that will be leading the implementation of this Strategy. • The VCS Health and Wellbeing Sub Group have developed a linked pathway focusing upon the wellbeing, particularly prevention and early intervention.	• Transform the role of public and patients from one of "consultee" in engagement exercises to being central to the process of engagement from the start. • Roll out more widely the successful community engagement approach piloted in Worcester City, whereby members of the community were trained to undertake engagement on behalf of the CCG. • Worcestershire County Council is redesigning services end to end - from access to information and advice for all through to assessment, support planning and review for those eligible for long term support. We will work with service users to design the support people may need to access services in the future as well as co -producing key tools for assessment etc.
Wider primary care, provided at scale	• Established extended role for primary care through initiatives such as GP with WMAS and an enhanced role to support sub acute provision in community hospitals.	• Invest the £5 per head effectively to maximise the ability of the accountable GP to provide effective out of hospital care. • Explore opportunities for CCGs and NHSE to co-commission primary care.
A modern model of integrated care	• Developed the Well Connected Programme, become one of the 14 national pioneers, and become one of only 4 areas nationally to participate in *Windmill 2014: from vision to action*, • Invested in enhanced community services and virtual wards, including an expanded role for social workers to support a greater opportunities to provide care closer to home.	• Grasp the opportunity of being one of only 4 areas nationally to maximise the learning from the Strategic Visioning Events to explore the concept of segmenting the population to transform models of care.

Introduction

Our five year strategy aims to achieve the core elements of the NHS England planning guidance, namely:

Requirement	What we have done to date:	What we plan to do in future
Access to the highest quality urgent and emergency care	• Produced the county wide urgent care strategy and identified 14 key delivery projects, with the top three prioritised for immediate delivery.	• Deliver the projects to realise the ambition of the urgent care strategy, focusing on the 3 priorities – Urgent Care Centres, Patient Flow Centre, Discharge to Assess.
A step change in the productivity of elective care	• Acute Trust reconfiguration project. • Significant progress in the expansion of day case surgery • Focus on optimising elective throughput at the Kidderminster Elective Centre	• Surgical redesign which maximises utilisation of the physical environment including state of the art equipment. • Centres of Excellence –organisation of senior and more specialist clinical teams ensuring sustainable rota's and driving efficient high quality care and improving outcomes. • Workforce redesign and new ways of working delivering access to six day a week elective services and seven day a week for core emergency services. • Use of technological advances to improve the quality and efficiency of surgical services. • Significant expansion of work undertaken in community hospitals , including better use of the procedure suites in Malvern and Evesham Community Hospitals.
Children and young people have a healthy lifestyle	• Approximately 9,500 children with mental ill health in Worcestershire. Supporting mental health was ranked within the top ten priorities of the young people make your mark survey. • Levels of alcohol – specific hospital stays amongst those under 18 are worse than the English average. • The % of women who smoke in pregnancy is higher than the English Average.	• Children and young people will access appropriate, high quality mental health support and services that meet their needs in a timely manner. • More children and young people eating healthily and participating in sport regularly. • Redesigned school nursing services and drug and alcohol services in place, focusing on areas of highest need. • A decrease in health inequalities for children and young people across the county. • More young people are aware of the harm caused by smoking, drugs and alcohol.

The Health and Well Being Strategy

The Worcestershire Joint Health and Well Being Strategy sets the overall vision for health and well-being in Worcestershire:

> ***"Worcestershire residents are healthier, live longer and have a better quality of life, especially those communities and groups with the poorest health outcomes."***

All partners have signed up to this overarching vision and have been developing other strategies and plans within the context of it. This HWB document provides the reference point for the development of the five year strategy for the health and social care economy.

There are four priorities:

- Older people and the management of long term conditions
- Mental health and well being
- Obesity
- Alcohol

There are also three groups that will receive particular attention:

- Children and young people
- Communities and groups with poor health outcomes
- People with learning disabilities

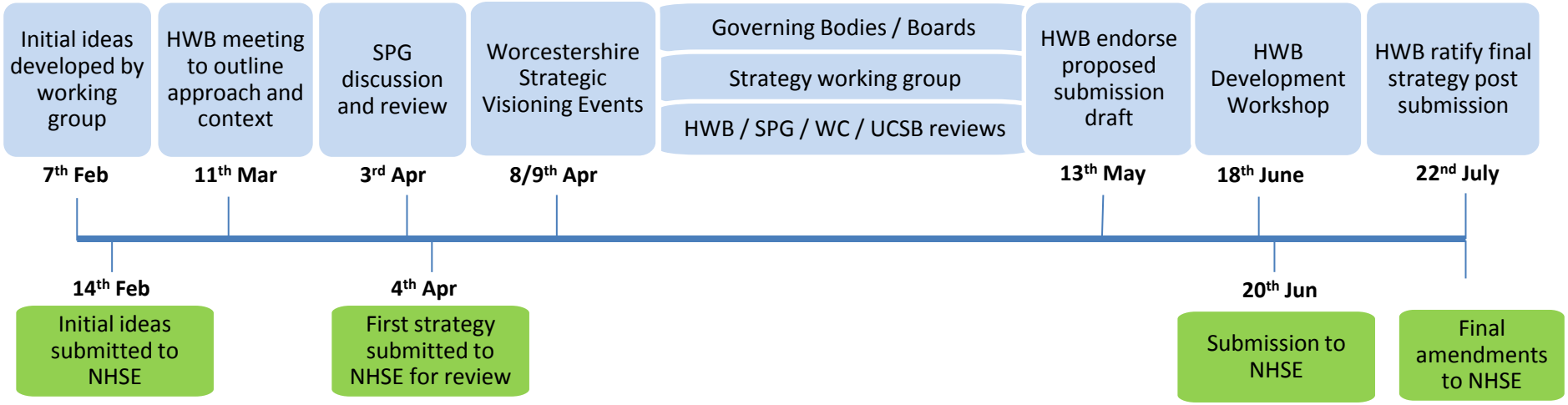
Action to improve health and well being is taking place against two key themes:

- **Building healthy communities** – ensuring that the environment, both built and natural, helps to support health and well being, particularly by addressing those areas where the environment is poor, crime and unemployment is high, and educational attainment is low. These factors are known to have a strong link to poor outcomes and can take generations to turnaround.

- **Improving health and social care** – with a clear aim to help people live independently for as long as possible, this is about ensuring coordination and joining up of care between all the various organisations that can make a positive contribution. Focus will be on three key areas (1) prevention (2) early identification of problems when they do arise and (3) effective intervention to stop them getting worse. There is also a strong emphasis on the need for people to take responsibility for their own health and care.

This strategy sets out a clear sense of direction for local partners to develop delivery plans and provides a robust framework for the development of the longer term plans being developed now. There is already evidence of good progress, for example through the Well Connected Programme and Pioneer Status, through the SWCGG Five Year Strategic Priorities and through all the developing CCG Commissioning Plans.

Developing the Strategy – a Timeline



Strategy working group

- David Mehaffey – Director of Strategy - SWCCG
- Mick O'Donnell – Head of Strategy – WFCCG and RBCCG
- Frances Martin – Programme Director – Well Connected
- Anne Clarke – Head of Adult Social Care –Worcestershire County Council
- Chris Fearns – Director of Strategy – Worcestershire Acute NHS Trust
- Sue Harris – Director of Strategy – Worcestershire Health and Care NHS Trust

Reporting to:

- Health and Well Being Board, via the Strategic Partnership Group

Accountable to:

- Individual organisation Governing Bodies and Boards

Our Five Year Strategic Plan on a Page

Worcestershire Joint Health and Well Being Strategy

Our vision for health and care in Worcestershire

You plan your care with people who work together with you to understand you and your needs, allow you control and co-ordinate and deliver services that support you to achieve the outcomes important to you.

- A seamless health and social care system delivering high quality, timely and effective care;
- As much care and support provided in or as close to people's homes as possible;
- Individuals and families will be able to take greater responsibility and greater control over their own health and care;
- Specialist hospital services, primary care and community care provided from high quality safe environments, with appropriate qualified, supported and skilled staff working across 7 days.
- Investment in prediction, prevention and early intervention where we can be confident that this will reduce future demand on services;
- Residents helped with technology supported self care to ensure that specialist resources are focused more effectively on those in most need;
- Reduced differences between social groups in terms of health and social care outcomes;
- A financially sustainable model of care that targets the use of resources in those areas that will have greatest impact.

Values and principles underpinning our health and care economy

Patients and the population come first, not organisational interests.	Organisations work together to deliver change, not in competition.	We work with a no blame culture where the focus is on finding solutions not blaming for problems.	We balance need for consistency across the county with the specific needs local populations.	All decisions considered in the light of the health and care needs of the population and the evidence base for what works.	We respect the views of the public, patients, service users and carers and ensure that they have an opportunity to shape how services are organised and provided.	We will work to deliver financial balance, sustainability and Value for Money in the delivery of services

The outcomes we are seeking to achieve

Additional years of life secured in conditions considered amenable to healthcare.	All people over 65 or those under 65 living with long term conditions (including children and young people) have their own coordinated care plan where the priorities set by the individual are supported by the care that they receive, resulting in improved health related quality of life.	Emergency admissions and length of stay reduced by managing care more proactively in other settings.	Safe and effective care secured and the proportion of people having a positive experience of care in all settings increased.	The need for long term residential and nursing care for all age groups is reduced by people being healthy and independently.	Parity of esteem for people suffering with mental health conditions alongside those with physical health conditions.

Worcestershire Joint Health and Well Being Strategy

Where do we want to be?

Strategic Outcome Statement	Where are we now	Where do we want to be in 5 years
Additional years of life secured in conditions considered amenable to healthcare. PYLL rate for 100,000**	**PYLL rate for 100,000** Redditch and Bromsgrove – 1,977 South Worcestershire – 1,893 Wyre Forest – 2,100	**PYLL rate for 100,000** Redditch and Bromsgrove – 1,681 South Worcestershire – 1,557 Wyre Forest – 1,785
All people over 65 or those under 65 living with long term conditions have their own personalised 'joined up' care plan where the priorities set by the individual are supported by the care that they receive, resulting in improved health related quality of life. (Average EQ-5D score)**	• Some joined up care plans in place with plans to improve • Separate statement of SEN, social care and health plans **EQ-5D Score** Redditch and Bromsgrove – 74.1 South Worcestershire – 75.4 Wyre Forest – 74.1	• 100% coverage of >65 and <65 with an LTC • All over 75s with a named primary care lead • SEN reform – 100% of C & YP with SEN with an integrated education, health and care plans. **EQ-5D Score** Redditch and Bromsgrove – 75.1 South Worcestershire – 79.9 Wyre Forest – 75.3
Emergency admissions and length of stay reduced by managing care more proactively in other settings.**	• Integrated Teams and Virtual Wards in place and starting to demonstrate impact **Emergency Admission Composite Indicator** Redditch and Bromsgrove – 2,317 South Worcestershire – 1,738 Wyre Forest – 1,541	• Shift in resource from acute to community achieved through 15% reduction in emergency admissions to acute hospitals and resources invested in BCF. **Emergency Admission Composite Indicator** Redditch and Bromsgrove – 1,920 South Worcestershire – 1,669 Wyre Forest – 1,530
Safe and effective care secured and the proportion of people having a positive experience of care in all settings increased.**	**Measure of people reporting poor inpatient care** Worcestershire Acute Hospitals – 155.2 **Measure of people reporting poor GP and com care** Redditch and Bromsgrove – 5.1 South Worcestershire – 4.8 Wyre Forest –5.8	**Measure of people reporting poor inpatient care** Worcestershire Acute Hospitals – 135.5 **Measure of people reporting poor GP and com care** Redditch and Bromsgrove – 4.8 South Worcestershire – 4.5 Wyre Forest – 5.5

***Technical definitions for these indicators are available on request*

Where do we want to be?

Strategic Outcome Statement	Where are we now	Where do we want to be in 5 years
The need for long term residential and nursing care by all services reduced by people being healthy and independent for as long as possible.	Prevention and early help services for older people to be re-commissioned. Adult social care recovery and NHS rehabilitation services for older people in place but operating separately. Limited options to residential and nursing care for older people becoming more dependent. Permanent admissions of older people (aged 65 and over) to residential and nursing care homes 597.4 per 100,000 population.	Prevention and early help services for older people focused on preventing those most at risk requiring adult social care. Integrated adult social care recovery and NHS rehabilitation services in place funded from Better Care Fund offering a more streamlined and cost –effective service. Extra Care developed as an alternative to residential and nursing care for older people becoming more dependent. Permanent admissions of older people (aged 65 and over) to residential and nursing care homes 547.5 per 100,000 population.
Parity achieved for people suffering with mental health conditions alongside those with physical health conditions.	**IAPT treatment and recovery** Worcestershire – 5.8% treatment / 50% recovery **Dementia diagnosis** Worcestershire – 48.7%	**IAPT treatment and recovery** Worcestershire – 15.0% treatment / 50% recovery **Dementia diagnosis rate** Worcestershire – 67.0%
Made significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care	1 never event HSMR rate of 107, SHMI of 106, which are below the upper control limits Medication errors per 1,000 bed days of 0.52	No never events, HSMR and SHMI rates consistently at a level below the upper control limits as defined by NHS England. Medication errors per 1,000 bed days maintained at a level consistent with national guidance and thresholds.

The Health and Adult Social Care Strategic Partnership Group

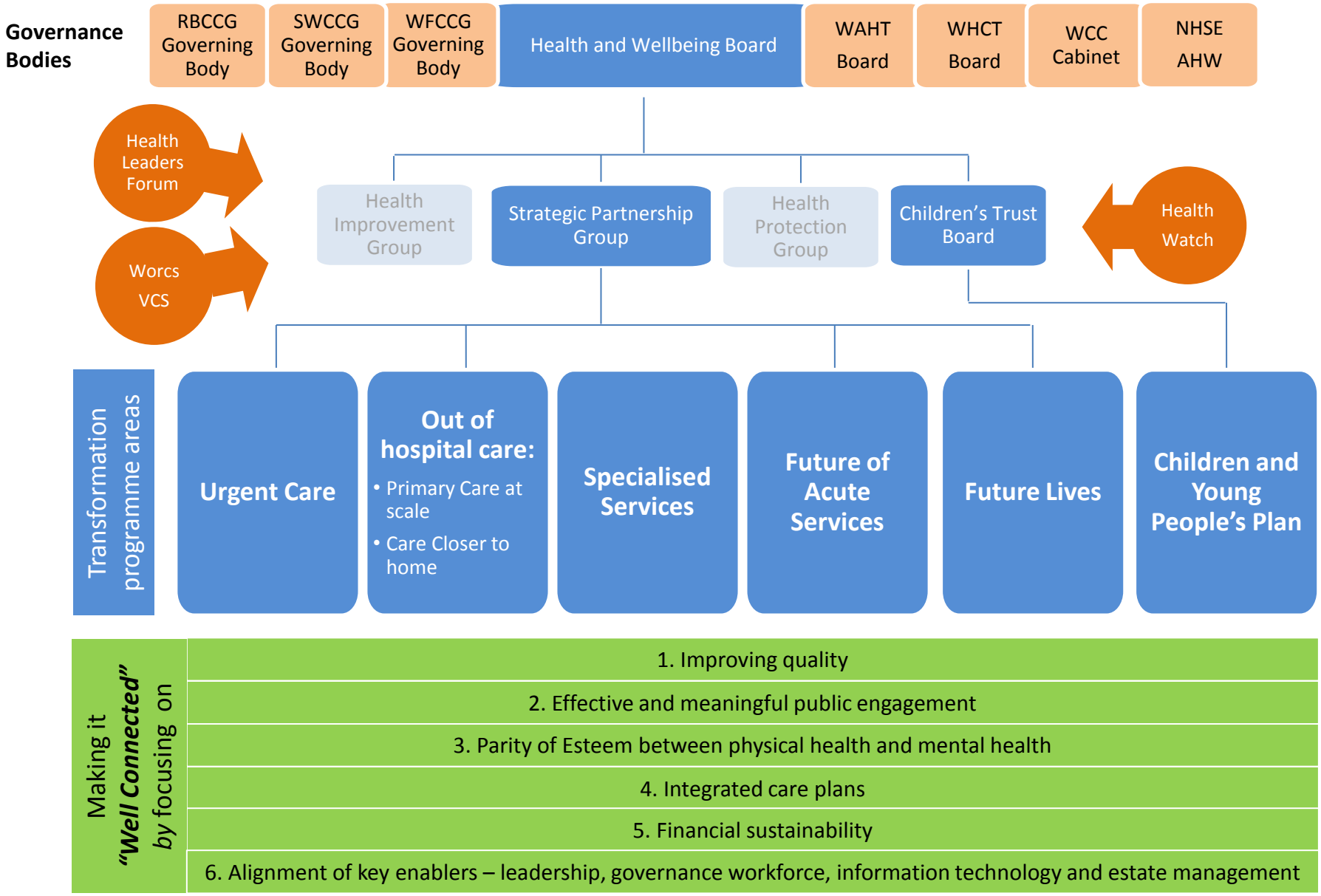
Through the development of this strategy partners have recognised the need to develop more integrated governance to oversee the delivery of the associated strategic transformation programmes. The Worcestershire Unit of Planning is in the fortunate position of having an effective Health and Well Being Board that is supported by an established Health and Adult Social Care Strategic Partnership Group (SPG).

In May the SPG agreed that work was required to bring the various strategic transformation programmes together under a single overarching programme and that the SPG should develop a role of being the overarching group for leadership, programme management, monitoring and assurance, and mutual influencing in order to ensure coordinated delivery. Further work is being undertaken to identify the specific actions required in order to move this forward.

In developing these options, the following principles are considered relevant:

- **One Strategy** – This strategy should bring together all of our strategies and plans for transformation of health and adult social care.
- **One change programme** - The strategic transformation programmes and projects that are in train or which have been identified as necessary to deliver this strategy should be brought together in one overarching programme, Well Connected, under a single programme management process.
- **Focus and priorities** – There should be an agreed number of top priority change projects, with identified delivery timeframes spread across the five years, which are the delivery subsets from the strategic transformation programmes
- **Enablers** – Critical cross sector enabler projects should be identified, properly resourced and ruthlessly managed for delivery.
- **Specifications** – Each strategic transformation programmes and project should have a clear specification that is signed of by the SPG.
- **Ownership** – All strategic transformation programmes and projects will have a clearly named Senior Responsible Officer and Project Lead.
- **Decision making -** Ultimate approval of strategic transformation programmes and projects and commitment of funding sits with the governing bodies and boards of the respective organisations. The role of the SPG is leadership, programme management, monitoring and assurance, and mutual influencing in order to ensure coordinated delivery

Governing the Delivery of the Strategy



Enabling Strategic Change - Well Connected

Well Connected is a collaboration between the County Council, the three Worcestershire Clinical Commissioning Groups, Worcestershire Health and Care Trust, Worcestershire Acute Hospitals Trust, NHS England Area Team, the voluntary sector (through Age UK Herefordshire & Worcestershire) and Healthwatch.

It is the means by which the key transformation programmes that affect the whole health and social care economy are brought together into a single coordinated work structure. The Health and Well Being Board sets the leadership agenda and executes this through the Strategic Partnership Group. There is a Well Connected steering group that organises the day to day partnership working to turn the Health and Well Being Board's vision into reality for the people of Worcestershire.

Through the publication of 'Integrated Care and support: our shared commitment' the Department of Health (with all major national partners) set an ambition to transform people's experience of health and care by integrating services; putting individuals at the centre of planning their own care; and making divisions between organisations invisible to service users. The opportunity to be 'Integration Pioneers' was received with eagerness by senior leaders, patient and carer representatives and staff across our organisations, and in November 2013 the Worcestershire *Well Connected* Programme was named as one of only 14 National Integration Pioneers.

The Focus of Well Connected is on older people and management of long term conditions in all age groups. Older people and those with long term conditions (whether children, adults or older people) rely on health and adult social care services to live their lives as normally as possible and account for a significant proportion of expenditure both by the local NHS and the Council. It is therefore particularly important that we focus on how the system is going to respond to their growing needs.

There is clear agreement between all Worcestershire partners that we need to rethink the way we provide services for older people we need to make greater efforts to prevent problems arising, identify them early and intervene to avert crises. This will include doing more to encourage and empower individuals, families and communities to take greater responsibility for their own health and care. We also need to do more to create seamless pathways between services. In so doing we will be able to shift the balance away from avoidable and expensive hospital based services and improve the quality of care.

Enabling Strategic Change - Well Connected

We intend to:

- Place a greater emphasis on prevention and early help to avoid future ill health, disability and social problems; and
- Deliver on-going integration and improvement of the quality and value for money of health and social care.

In order to do this we have identified six major transformation programme areas:

- **Urgent Care**: Implementation of the Worcestershire Urgent Care Strategy, incorporating 14 delivery projects under the oversight of the Urgent Care Strategy Group.
- **Out of Hospital Care**: Two key areas of focus are incorporated here – implementing actions that will deliver primary care at scale and ramping up the provision of Care Closer to Home through enhanced community services and extended use of community hospitals.
- **Specialised Services**: The specialised commissioning strategy is to concentrate services on clinically and financially sustainable centres of excellence with standards of care that are applied equally across England. Through the execution of this strategy, some of many of those services are likely to be commissioned from providers outside of Worcestershire.
- **Future of Acute Services**: As with specialised commissioning, executing this strategy will result in changes to the way in which current services are provided locally, particularly in women's and children's services and urgent care.
- **Future Lives**: This programme is about responding to the changing social care landscape at a time when budgets are reducing in real terms when demographic changes suggest they should be increasing.
- **Children and Young People**: This strategy is particularly reliant on the delivery of objective 2 of the Worcestershire Children and Young People's plan – ***"Helping children to be healthy".***

Prevention and early intervention is a theme that runs through all these programmes and is a vital part of our whole delivery plan. Through the Well Connected infrastructure and governance arrangements, there are a number of key enablers that are being developed to support the joined up delivery of these programmes:

- **Improving Quality** - A focus on delivering change to improve quality
- **Effective and Meaningful Public Engagement** through joined up public involvement and communications.
- **Achievement of parity of esteem** between mental health and physical health to ensure that those with mental health needs have the same opportunities to access services and live physically healthy lives as those without mental health needs.
- **Integrated Care Plans** by developing a common approach across all health and care providers who serve Worcestershire's population.
- **Financial Stability** through development of the Better Care Fund and segmenting how we commission and provide services to different groups of patients
- **Alignment of Key Enablers** to support effective joint working, such as aligning financial incentives, leadership development, governance, workforce development, information technology and estate management.

The major transformation programmes

The Urgent Care Strategy

All partners across Worcestershire have agreed an Urgent Care Strategy to be implemented from April 2014 onwards. The vision for the strategy is:

> ***"To ensure the people of Worcestershire have access to the right urgent care service that is of a consistently high quality and which is available 24 hours a day 7 days a week".***

The strategy sets out to achieve the following principles:

- **Admission prevention and avoidance** - Enhance out of hospital urgent care services so we can avoid an emergency admission where possible. We must develop effective and simplified alternatives to hospital admission across seven days. This is especially important for patients with complex needs and chronic illness.

- **Right care, right time, right place** - Treat with the best care in the best place in the fastest time. A simplified system whereby patients are able to access expert diagnosis and assessment in the setting that is most appropriate to their clinical needs. Access to senior clinical decision making, as early in the patient journey as possible, seven days a week.

- **Effective patient flows** - Promote rapid discharge to the most appropriate place for recovery in a planned manner. We must focus on supporting patients to leave hospital seven days a week. Effective discharge planning can reduce length of stay and readmission and is therefore a vital element of emergency care. A safe supported discharge relies on effective integration of primary, community, secondary and social care services which should be available seven days a week and include the out of hours periods.

The strategy has established six objectives which will help to realise the vision and the principles:

- Create a simple system in which patients know which option is the right one to choose in an urgent care situation.
- Put primary care at the heart of urgent care provision.
- Ensure that patients are only admitted when necessary and only stay as long as clinically appropriate.
- Enhance and transform urgent care pathways, including better use of the full range of community and social care services.
- Ensure 7 day service provision with equitable outcomes.
- Share information more effectively to support improved patient care.

The Urgent Care Strategy

14 delivery projects have been agreed, with executive sponsors and project managers identified. The governance arrangements have been identified with the Urgent Care Strategy Group performing the programme board role and the Urgent Care Operational Group undertaking the programme steering group role.

Delivery Projects

- Demand, capacity and simulation modelling for urgent care
- Develop and deliver a frail & elderly strategy
- Paediatric Emergency care project
- Deliver the seven day working strategy
- Deliver the benefits from the patient flow programme
- Urgent Care Centres in Worcester and Redditch
- Delivery ambulatory care pathways without hospital admission

Delivery Projects

- Improved access to primary care urgent appointments
- Develop an enhanced role for community hospitals, including MIUs
- Deliver enhanced community services and virtual wards
- Procure an integrated NHS 111 and GP OOH solution
- Urgent care workforce plan
- Mental health urgent liaison services
- Health inequalities

Out of Hospital Care

We want to deliver the best possible healthcare in the right setting, at the right time.

This means making improvements to health services in hospitals, as well as closer to home. Out of hospital care includes all those services provided in community settings such as in people's home by community nurses, at GP's surgeries and in health centres.

Our aim is to develop services in the community and focus on self-care, early diagnosis and high quality management of long term conditions, and the diagnosis and treatment of those with ambulatory emergency conditions in the community when appropriate. This enables our acute hospitals to focus on patients who are critically ill and those who require specialist investigations and interventions.

We will do this by reducing reactive and unscheduled care and to develop more planned care earlier. The key areas of action will be:

Primary Care at Scale
We will support easier access to high quality, responsive primary care to enable out of hospital care to be the first point of call for the people across Worcestershire.

Care Closer to Home
We will develop clearly understood integrated planned care pathways which deliver in the community using a multidisciplinary approach. These pathways will standardise care processes to ensure quality of care for patients is high. To enable these pathways to be developed there will a transfer of care, such as outpatient services from central acute hospital settings into community settings.

We will also proactively manage people of all ages with long term conditions, people who are frail because of their old age and people at the end of life stage in out of hospital settings, in or near people's homes. To work this will need a comprehensive response 7 days a week to avoid admissions which could be clinically treated without an acute hospital admission. Different providers will work together in multidisciplinary groups to offer seamless integrated care for patients.to enable people to stay in their homes and, following a hospital admission, to receive rehabilitation and home support as quickly as possible.

Out of Hospital Care – Primary Care at Scale

Worcestershire as a whole is comparatively well served by GPs, particularly in Wyre Forest, when looked at in the context of the national averages. However, this should not be interpreted as meaning that GP resourcing in Worcestershire is not a challenge.

The sustainability of GP practices across Worcestershire, as elsewhere in England is a key challenge with many doctors are approaching retirement age and others are choosing to pursue "portfolio" careers where only a proportion of their working week is spent in a traditional primary care role. Furthermore, the number people seeking to become GPs is declining and CCG member practices often cite difficulties in appointing Partners as a key challenge.

Area	GPs per head	
Wyre Forest	0.83	(1 per 1,209)
South Worcestershire	0.80	(1 per 1,286)
Redditch and Bromsgrove	0.75	(1 per 1,337)
NHS England area team average	0.77	(1 per 1,295)
NHS national average	0.74	(1 per 1,350)

Member practices across all three CCGs frequently quote difficulties in coping with the increased demands, resulting in working patterns well in excess of the traditional general practice working week. The expected population growth coupled with a shortage in GPs means that services and structures have to change.

Primary Care is often describes as the cornerstone of the NHS with the GP as the first point of contact for the majority of care. There has been a huge increase in demand for services over the past decade and although generally patient satisfaction with services is high they consistently raise problems with access to appointments and quality of Out of Hours (OOH) services. The NHS is not alone in facing economic restraint and a future funding gap has been identified. This alongside increasing demand will require commissioners and providers to consider new ways of delivering healthcare.

However, Primary Care is ideally positioned to become an 'at scale' delivery unit for new ways of providing with innovative clinicians who are willing to make changes and work differently. New models are emerging in Worcestershire which will help to promote this "as scale" working. For example at 66 practices across Worcestershire now share a common IT platform and in South Worcestershire all 31 of 32 practices have signed up to a single Primary Care Federation (Stay Well Healthcare). Many practices now share premises, some cross refer between each for services and some are exploring merger opportunities. In Wyre Forest work is underway to explore the potential for "super practices" by bringing individual providers together and in Redditch and Bromsgrove there are smaller groups working together in a cooperative manner. CCGs are currently scoping the potential for an enhanced primary care 'offer' that builds on current initiatives such as the £5 per head funding to support proactive care for older people and the emergency admissions enhanced service.

This model will require that we deliver consistent, high quality primary care at scale, integrated with other community care services and resources and SWCCG are working with the NHS England Arden, Herefordshire and Worcestershire Area Team to explore opportunities to co-commission the services, If a suitable approach is agreed then it will enable greater integration of commissioning across primary, community and secondary care and provide additional levers for the CCG to transfer a greater proportion of care from secondary to primary care – hence delivering the "Primary Care At Scale" objective.

Out of Hospital Care – Primary Care at Scale

The underpinning principles for primary care within the AHW Area Team to ensure delivery are:

1. Primary care continues to be an effective **first point of contact** for patients
2. There remains a **common core offer** of high quality, patient-centred primary care
3. There is an increasing role in **active case management** and supporting patients to manage their own care
4. **Appropriate onward referrals** are made through planned pathways
5. **Record keeping is shared** through the use of integrated clinical systems to enable the effective management of all registered populations.
6. Primary care supports the **continuous improvement** in health outcomes across the five domains of the NHS Outcomes Framework through the use of innovation and technology.
7. Primary care is delivered by **appropriate services** with seamless transition ensuring the optimisation of primary care, assessment and diagnosis, enhanced recovery, re-ablement and rehabilitation of all scheduled and unscheduled care, seven days a week
8. **Partnership working** is developed with the Local Professional Networks in order that patient experience and clinical leadership drive the commissioning agenda, securing higher-quality health services
9. There is a **balance between standardisation and local empowerment in prioritising service development** to meet local needs
10. **Reducing health inequalities** i.e. through health promotion and commissioning services in the right locations with the right skill mix to meet patient needs.

Objectives from Arden, Herefordshire and Worcestershire Area Team Primary Care Strategy 2014-2019 include:

- To improve access to primary care for both in hours services (commissioned by NHSE) and out of hours (commissioned by CCGs). This will include exploring use of alternative approaches such as telephone, internet and email and by practices considering how they will respond to meeting the needs of their population 7 days a week.
- To reduce variation in quality of care delivered and raise standards.
- To commission value based, sustainable services along agreed clinical pathways for best outcomes for patients.
- To support the changes to the urgent care system to make 7/7 working a reality across the whole system.
- To drive changes to the primary care system to deliver prevention and early intervention based on patients taking more in control of their own health.
- Ensure business continuity through Primary Care Support transition.

Out of Hospital Care – Care closer to home

Each year in Worcestershire over 62,000 patients receive community treatment from the 1,400 community NHS staff currently delivering care. The service is provided across Worcestershire (an area of approximately 500 square miles, with a population of 550,000, over 140,000 (24.7%) of whom are aged over 65) and sometimes across borders into neighbouring counties.

More recently, increasing pressure to care for more people out of hospital, an ageing population and an increasingly challenging financial picture have pushed for a more fundamental redesign of care.

Nationally there is an emerging consensus about the impact that community services can have and what is needed to improve their effectiveness. The main steps identified are:

- Reduce complexity of services
- Wrap services around primary care
- Build multidisciplinary teams for people with complex needs, including social care, mental health and other services
- Support these teams with specialist medical input and redesigned approaches to consultant services – particularly for older people and those with chronic conditions
- Create services that offer an alternative to hospital stay
- Build an infrastructure to support the model based on these components including much better ways to measure and pay for services
- Develop the capability to harness the power of the wider community.

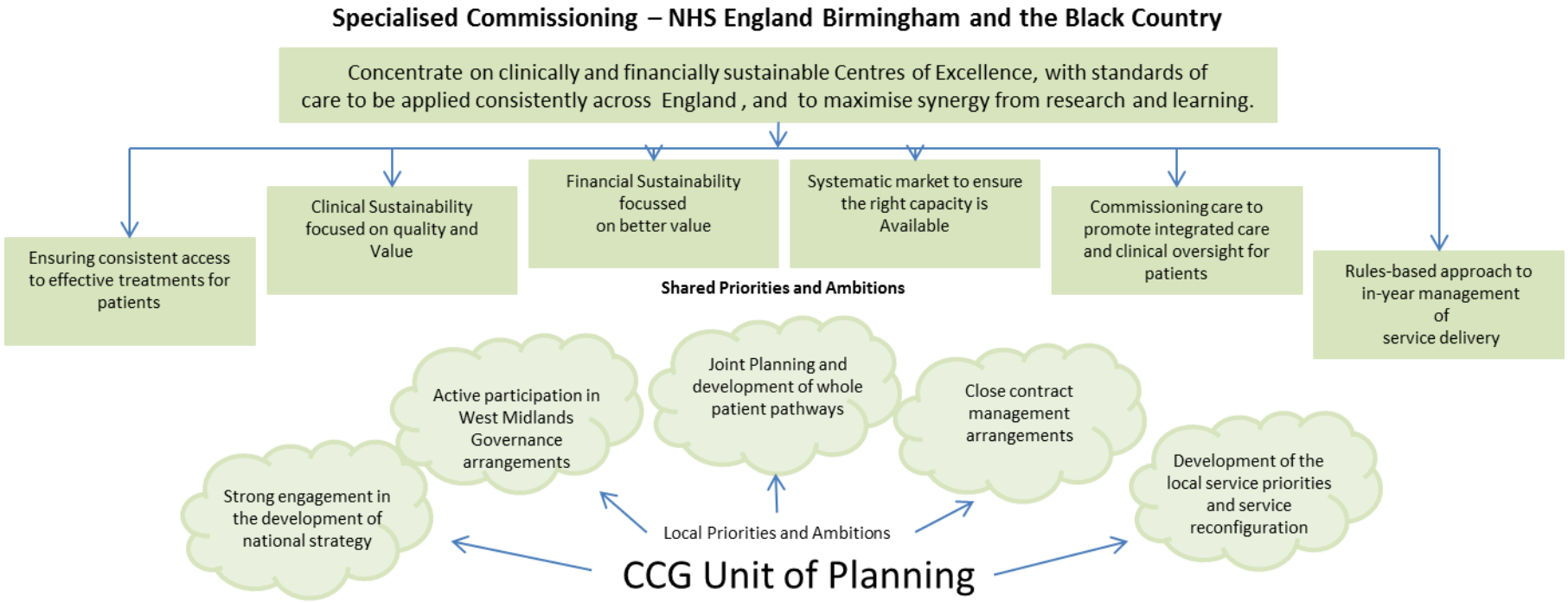
Improving the management of long-term conditions and multi-morbidity should reduce the demand for hospital care and improve patients' quality of life. There are also opportunities for more preventive interventions to meet people's needs for social care. All this requires the co-ordinated deployment of multidisciplinary teams of experts as well as the close involvement of patients and their carers in setting goals and planning care. An important first step is to simplify the pattern of services, creating larger community teams with a shared set of skills that would include some staff with more specialist knowledge. These specialists are still required (for example, in areas such as tissue viability, Parkinson's disease, respiratory problems, incontinence, palliative care) but may focus more on education, support, and providing input in the most complex cases.

This approach requires locality-based teams that are grouped around primary care and natural geographies, offering 24/7 services as standard, and complemented by highly flexible and responsive community and social care services.

Specialised Commissioning

CCGs have the statutory responsibility to commission, or make arrangements to have commissioned, the full range of healthcare for their population with the exception of specialised services for which now NHS England has accountability for. For Worcestershire's patients, specialised commissioned in delivered by the NHS England Birmingham and Black Country Team.

As part of the 'Call to Action', NHS England is developing a five year strategy for specialised services, which will be published in April 2014. This will address the service specific objectives for the next five years, overarching strategic objectives for the provision of a system of specialised healthcare as a whole and the impact of co-dependency between service areas.



Executing this strategy will have implications for Worcestershire's commissioners, providers and patients, particularly where specialised services that are currently provided within the county are moved out of county.

Acute Hospital Services in Worcestershire

Progressing this review is a fundamental to the delivery of a sustainable health and social care economy over the next five years. Without a revised model the health economy is certainly not financially or clinically sustainable. With the model the clinical case has been agreed but there are still major financial challenges to be overcome.

However, when these are addressed the system will be much stronger:

- A more co-ordinated and integrated urgent care system with a single Major Emergency Centre, along with an Emergency Centre and a network of "local" Minor Injury Units.
- Centralised emergency paediatric care and consultant led maternity services, along with by a midwifery led unit.
- Centralised services such as stroke and cardiac care, certain aspects of emergency surgery and other highly specialised services where it is only safe to provide them from one centre.

There is a process and roadmap identified for taking the recommendations from this review forward. With action in this area the acute trust will be well placed to work towards the objective in the planning guidance of a 20% step change in the efficiency of elective care. Activities will include:

- Surgical redesign which maximises utilisation of the physical environment including state of the art equipment
- Centres of Excellence –organisation of senior and more specialist clinical teams ensuring sustainable rota's and driving efficient high quality care and improving outcomes.
- Workforce redesign and new ways of working delivering access to six day a week elective services and seven day a week for core emergency services.
- Use of technological advances to improve the quality and efficiency of surgical services.

Future Lives

The changing landscape of social care presents a number of significant challenges for the health and social care economy in Worcestershire. The County Council is facing real terms cuts in social care budgets at a time when demographics suggest that increased funding is required. The efficiency challenge for the Council, working jointly with local partners is significant and one that should not be underestimated. Our strategy must ensure that any service redesign recognises the implications of reduction to social care support and the impact that will have on the wider health system.

The integration of some health and social care budgets by 15/16 will also provide some challenges and we need to ensure that any changes support the delivery of an integrated, whole system approach to care. The new Care Bill will consolidate all existing legislation under which adult social care is delivered and introduces reforms in funding and charging for care and support. The Care Bill is to be implemented in two stages - April 2015 for changes in overall duties for wellbeing, assessment, eligibility etc, April 2016 for the reform of funding and charging for care.

Adult social care will need to transform in order to meet these new statutory duties. Worcestershire County Council has embarked on a new programme of work called Future Lives: Pathways to Independence. This is a major change programme in Adult Social Care over the next three to five years that will ensure that the Council can continue to offer high quality services, meet the requirements of the Care Bill and other national legislation, and contribute to the Council's financial challenges. Future Lives will review and reform of all aspects of adult social care. It will result in new models of care that promote health and independence, increase choice and control and reduce the need for long term services by maximizing the impact of our investment in prevention and recover. It comprises four programme areas:

- **Keeping Well** - This work has a focus on enabling self-management through high quality information and advice, identifying needs that might benefit from early help - such as loneliness, risk from falls and cold weather and ensuring that support is available through communities and neighbourhoods.

- **Assistive Technology –** Work will continue with providers of telecare, telehealthcare and telecoaching to maximise the use of technology which can support individuals to keep well and independent and which also maximise the efficiency and productivity of statutory services.

- **Recovery -** This work will result in redesigned service to promote recovery and a return to independence. it will usually be delivered at home

- **New Models of Care -** will review our approach to assessing, arranging and providing adult social care and consider how we can improve the timeliness and quality of assessments, promote choice and control and improve quality and productivity.

Children and Young People's Plan

The Children and Young People's Plan sets out a vision for:

"Worcestershire to be the best place it can be for children, young people and their families."

This means that children and young people in Worcestershire:

- Are safe
- Are healthy
- Feel valued and respected
- Achieve success
- Are happy and fulfilled.

Within the Worcestershire five year strategy, our interest is in the delivery of focus area 2 – ***helping children to be healthy.*** In order to do this, the following priorities from the Children and Young People's Plan as relevant to the five year strategy for health and care:

- Supporting families who are at risk of abuse, using drugs or alcohol or suffering from mental health difficulties.
- Making sure that there are people to help children and young people who find life hard, have a disability and aren't able to have a say.
- Giving everyone the chance to be healthy.

In order to achieve these aims the following actions will be taken:

- Provision of a clinically effective CAMHS service available 24 hours a day, 7 days a week for urgent cases.
- Sustainable CAMHS service for children with learning difficulties and/or disabilities will be put in place, along with effective transition protocols for 16/17 year olds.
- Commissioning of evidenced based and equitably available speech and language therapy services.
- Commissioning of effective and appropriate services for children with disabilities, including eligibility for short breaks, the shape of overall provision and equipment services.
- Effective planning and joint commissioning of services to reduce duplication and improve quality in order to reduce the impact of health inequalities, particularly in areas of high deprivation.
- Support to the delivery of the health and well being strategy in a way that is relevant to children's and young people.
- Implement the Worcestershire healthy weight and healthy lives strategy and action place, including the infant feeding plan.
- Deliver the Worcestershire sexual health strategy, including teenage pregnancy.
- Develop a strategy for childhood accident prevention.

Making the Transformation Programme "Well Connected"

Improving Quality – The Worcestershire Framework

In the light of the Francis report, there has been a coordinated and sustained focus on putting quality at the heart of everything we do. Commissioners and providers alike have worked together to ensure that the approach to quality in Worcestershire is focussed on three key areas:

- Ensuring effective quality assurance of all services
- Creating a Culture of Quality In Worcestershire
- Redesigning current models of care and care pathways to improve the safety and effectiveness of services and improve the user experience

Key aspects from the **quality assurance** processes include:

- Visibility within services - undertaking announced and unannounced visits to create improvement plans with the providers
- Quality dashboards for each organisation to monitor key aspects of quality facilitating monitoring of quality indicators in areas such as infection prevention ,mortality and workforce.
- Service concerns reporting from Primary Care that is captured and turned into improvement plans with the providers
- Quality walkthroughs, engaging groups of clinicians and service users to walk a particular pathway and create an improvement plan from the findings
- Listening to patients and the public and working with providers to improve experience

Work undertaken to create a **culture of quality** has included the development of a "Culture Of Quality" programme. This has included a series of workshops and subsequent action planning sessions aimed at improving relationships between organisations to facilitate improvements in quality. An agreed vision has been jointly been developed by partners to focus on continuous improvement:

"Worcestershire working together, aspiring to deliver the highest quality care"

The third aspect of the approach is to **redesign of current models** of care and care pathways. The local approach is clinically led and involves primary care, acute, community health and social care services to deliver improvements. The most significant piece of work undertaken to date is the Improving Patient Flow Programme, which is a key aspect of the urgent care strategy.

A forward plan has been developed based on the learning from Francis/Hard Truths , Berwick, Keogh and Clwyd reviews and this has provided all partners with a clear sense of direction for improving quality over the coming years.

Effective and Meaningful Public Engagement

Effective and meaningful public engagement through co-design and co-production is one of the key drivers for our strategy.

Co-production and co-design is way of working whereby citizens and decision makers i.e. people who use services, family carers and service providers work together to create a decision or service which works for them all. The approach is value driven and built on the principle that those who use a service are best placed to help design it.

Partners in Worcestershire are committed to developing the plans which underpin this strategy by co-producing them with service users and with the professionals who deliver services. Partners will ensure that co-production and design activities are set up to encourage participation from:

- Local communities
- 'Easy to overlook' groups, taking into account factors such as:
    - physical accessibility, for example for older or frail people
    - perceptions, for example disadvantaged young people
    - social expectations, for example children and young people who are often not considered as appropriate to be engaged with and who themselves often do not expect to be taken seriously
    - working people

- Partners will use the right channels and materials to engage with different groups such as:
    - public facing versions of documents,
    - Information formats such as:
        - easy read,
        - other languages,
        - Braille or audio,
        - face to face contact with groups where preferred

Commissioners and providers already have their own mechanisms for engaging with the public and service users in Worcestershire. What we need to do now is to effectively bring the messages from these individual processes together to, wherever possible, present a single view of the public and patients that we can use to drive service change and transformation going forward.

Parity of Esteem Between Mental and Physical Health

Poor mental health is the largest cause of disability in the UK. It's also closely connected with other problems, including poor physical health and problems in other areas like relationships, education and work prospects. There is an ambition for the NHS to put mental health on a par with physical health and in Worcestershire we want to reflect the importance of mental health in all of our planning. We recognise that we will have to commission care pathways across the life span that focus on upstream interventions; integrating physical and mental health and social care to support and promote recovery.

This commitment will ensure we place the same value on mental health outcomes as physical health and capitalise on the economic benefits of systematically implementing best practice across the County. This will include ensuring service users access the:

- Right information
- Right physical health care
- Right medication
- Right psychological therapies
- Right rehabilitation, training for employment
- Right care plan addressing Recovery; lifestyle housing, work, self management
- Right crisis care

All of the interventions, initiatives and strategies will aim to give the same priority to addressing and preventing mental health problems as they do to addressing and preventing physical health problems. In 14/15 we will work across the economy to identify measures of success and set ambitious targets for delivery which will include the reduction of increased mortality and morbidity experienced by those with severe mental illness, guaranteeing the same level of choice and control in relation to support and care interventions and ensuring patients receive timely and appropriate access to mental health services.

Integrated Care Plans

Our vision for health and care in Worcestershire

You plan your care with people who work together with you to understand you and your needs, allow you control and co-ordinate and deliver services that support you to achieve the outcomes important to you.

A key element of making our vision real is the development of personalised care plans. Our ambition is that the plan will be 'owned' by the individual and supported where needed by a member of their family or someone acting as a care coordinator under the auspices of their GP team. The person and everyone involved in providing care and support will be able to access and contribute to the individual's care plan.

This ambition is supported by recent policy:

1. Inclusion of Accountable GP role for registered patients aged 75 and over, in GMS contract regulations
2. Introduction of the Unplanned Admissions Enhanced Service
3. Funding to commission additional services which will further support the accountable GP in improving quality of care for older people
4. Better Care Fund condition
5. The Care Act

- but most importantly with the views of our patients, service users, carers and representatives of voluntary and community organisations.

As slide 8 above "All people over 65 or those under 65 living with long term conditions have their own personalised 'joined up' care plan where the priorities set by the individual are supported by the care that they receive, resulting in improved health related quality of life. (Average EQ-5D score)"

Through our existing work to improve end of life care, care home project and risk stratification and virtual ward schemes many people in Worcestershire already have a personalised care plan. Focusing on those who have the most complex needs we will work at pace to scale up delivery and to use technology solutions to support greater care coordination .

Sustainable Finance - The Better Care Fund

The Department of Health has provided funding to support integrated working between health and social care since 2011/12. The clear expectation from the Government is that this funding is used for social care purposes which benefit health and improve overall health gain through jointly agreed plans.

In the June 2013 Spending Round the Chancellor of the Exchequer announced the creation of the Better Care Fund to support the integration of health and social care. The funding is described as: "a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities".

Although not 'new' money, the Better Care fund sets an ambitious challenge to integrate health and social care. The scale and scope of the Better Care Fund will be determined by the Health and Well-Being Board in line with the following national conditions:

- Plans to be jointly agreed
- Protection for social care services (not spending)
- As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
- Better data sharing between health and social care, based on the NHS number
- Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional
- Agreement on the consequential impact of changes in the acute sector

In Worcestershire the focus for intervention from the Better Care Fund will be to support people who are currently, or who are at risk for becoming, heavily dependent of health and adult social care services to live their normal lives. Kaiser Permanente in California has achieved significant success in identifying high risk people in their population and managing them intensively to avoid admissions. Their model has been studied in depth (and similar models have developed elsewhere) and key learning for the UK includes the concept of population risk segmentation and early intervention.

A small proportion (c.5%) of high risk people each individually account for a disproportionately large amount of NHS and social care service utilisation (c.40%). We know there is both a key need and an opportunity to integrate commissioning processes and budgets to commission coordinated proactive care for this group of people. Our approach to this is to start by being clear on the different needs of service users and how we can best respond to those needs.

Sustainable Finance - The Better Care Fund

We have identified four groups of service user, each of which requires a different approach to the commissioning and provision of services:

Group One

People who are **normally healthy** but sometimes need some form of health or social care support, either through a planned or an emergency event, from which they fully recover and return to their previous way of life

Group Two

People who have a **one off significant event** that results in them from moving from group one to group four and remaining there for a considerable time or for the rest of their lives.

Group Three

People who have a **"rising tide" of health of social care needs** (which could be preventable) resulting in them moving from group one to group four and remaining there for a considerable time or for their rest of their lives

Group Four

People who are **normally unwell** and require some form of on going health and social care support to live their everyday lives.

Type of care required
Irregular and time limited

Type of commissioning approach
Population wide needs planning (X A&E attendances, X births, X GP appointments)

Type of contract
Per event or activity (PbR), structured as now. Paid for by activity volumes.

Financial risk ownership
Held by the commissioner

Group 2
The immediate treatment of the one off event is treated as group one, before the patient moves across to be treated as a group four patient for the remainder of their treatment.

Group 3
For the early stages of the rising tide the patient would be treated within group 1 but, there would come a time when they move across to group four if the local health and social care system is unable to maintain their on going health.

Type of care required
Frequent and on going from multiple agencies

Type of commissioning approach
Person based planning (X visits per week)

Type of contract
Capitated contract, commissioned from alliances, paid for on outcomes.

Financial risk ownership
Shared between commissioner and provider

Case studies are provided in appendix 1 to illustrate the type of person that would be relevant to each group.

Sustainable Finance - The Better Care Fund

It is the people in group four that typically constitute the 5:40 group. However, the it would be a missed opportunity if the Better Care fund only focused on the people in group four. Patients in group three (ie those at risk of having significant and prolonged health and care needs without some form of risk stratified and targeted intervention) in particular could benefit from improved quality of life and at lower cost through more integrated commissioning and providing.

The core strategy required to enable this group of patients to be supported effectively is:

Commissioning:

To create a genuinely pooled budget for the health and adult social care and to use this to commission integrated services.

This would mean that the contributions from the CCG and the Council budget were combined with shared accountability and decision making and risk/benefit sharing of any overspends or underspends.

The services for this group of people would be commissioned on a capitated basis whereby a total value is made available to a provider (or group of providers) to design the most effective services (in terms of cost and quality) around the patients needs.

CCG Commissioners would no longer purchase hospital care from one provider, community care from another, neither would they need to have complex coordination arrangement with the separate commissioners for primary care or those that commission social care.

Providing

In the same way as commissioning would change, the nature of provision would also need to change.

Separate providers would need to come together in federations, alliances, joint ventures, through prime contracting arrangements etc.

Commissioners would specify the outcomes they wanted for the patient cohorts and would identify the resource that they will make available to pay providers to meet those outcomes.

Providers would then design the services they believe are required to best meet those defined outcomes and would receive the entire budget to put those services in place. If the cost of provision exceeds the budget then the provider carries the majority of the risk, if the cost is less than the budget then the provider obtains the benefit and the commissioner carries the majority of the risk (subject to suitable risk sharing agreements).

Alignment of enablers

Key to the successful delivery of our 5 year ambition are a number of cross cutting themes and enablers as shown on slide 11 above:

Leadership
A component of our national Pioneer support is participation in the Systems Leadership programme. This is a ground-breaking collaboration between Public Health England, National Skills Academy for Social Care, NHS Leadership Academy, Virtual Staff College, the Local Government Association (LGA), the Leadership Centre, the Department of Health (DH) and local public services in places, which helps create the conditions for the development of solutions to intractable issues through leadership development. With Public Health England funding a tailored transformative offer to meet the demands of each Pioneer has been made available.

Governance
As slide 11 above the Health and Well-being Board has agreed that whilst not removing the accountability of the respective Governing bodies of partner organisations, revised governance arrangements are required to support the delivery of the 5 year strategy, particularly with the developing Better Care Fund and an increasing use of polled and aligned budgets.

Workforce
Ensuring we have a workforce with the skills and expertise to deliver care and support and our strategic ambition for the our health and social care community is vital. We are working with the Regional Local Education and Training Board (LETB), Arden Herefordshire and Worcestershire Local Education and Training Council (LETC) Skills for Health, Skills for Care and local providers of education and training and are working towards establishing an integrated workforce plan for the future.

Information technology
A Well Connected IT Group with representation from all partner organisations has been meeting since 2012. It has identified a number of pilots and developments to link individual parts of the system together. Within Worcestershire there are currently multiple organisations running multiple IT systems many of which are operating in silos. An independent solution architect has been appointed through the Pioneer network to identify technical solutions to information sharing and rationalisation of the information systems currently in use. Sound Information Governance is critical and through the Pioneer support programme solutions to facilitate cross system information sharing are being explored.

Case Studies

Group 1 - Daud, 11

Daud is a fit, active and healthy young boy who was knocked over by a car, suffering a nasty broken leg and a minor head injury. He lives in a rural village more than 20 miles from the hospital and his parents are reliant on public transport to move around when leaving the village. After being ambulanced to A&E and treated for his injuries he spent 10 days in hospital recovering. On discharge he will be need a wheelchair for at least 4 weeks until his leg is strong enough to enable him to use crutches. He will also need an intensive course of physiotherapy to help him recover full mobility but he is ultimately expected to make a full recovery. He attends school by walking 1 mile to the bus pick up followed by a 40 minute bus journey each way.

Group 2 - Kieran, 55

Kieran runs a small haulage company, using three trucks to go to markets in Birmingham and the north of England 6 days per week. His wife, Caroline, runs the company administration from home in three days per week giving her time to also look after her elderly mother. Kieran and Caroline have two children away at university. Their daughter, Karen, is undertaking a law degree, whilst their son Jack is studying marketing and logistics and hopes to come home to help to grow the family business when he graduates. Three weeks ago, Kieran suffered a major stroke. He is now in hospital and is about to be discharged. He has major right-sided weakness and is having physiotherapy and speech and language therapy to help him to recover as much as he is able. However, he is not expected to regain full function and is likely to be a wheelchair user for the foreseeable future.

Group 3 - Mary, 78

Mary lives with her husband Doug and has a strong family network within a 5 mile radius. Both her and her husband have been active all their lives, they still enjoy looking after their grandchildren and participating in community events. Last year Mary was diagnosed with Alzheimers and there has been a marked deterioration in her cognition over the last few months. She has become very confused whilst out shopping on her own and when Doug has gone out to visit friends and she has been in the house on her own. The GP is aware and has been very supportive, referring both Doug and Mary for an assessment around support/respite.

Group 3 – Karolina, 16

Karolina is sixteen years old and currently lives with her brother and their aunty as their mother died when she was young, and their father has no contact as he has returned to Poland. Karolina has a history of self-harm, including a suicide attempt which resulted in an emergency hospital admission, and is at risk of sexual exploitation. School attendance has been poor though Karolina is now taking some GCSEs. Several agencies have been involved in her care including CAMHS and Children's Social Care and family support services.

Group 4 - Susan, 28

Susan was born with a moderate learning disability and requires support in all aspects of daily living, especially around self care and self awareness. She has been exploited by people in the past and this remains a risk to her independence as she has no family members involved in her care and support. She has a range of activities which she needs support to engage with and particularly enjoys his volunteer placement which may lead to paid in employment in time. Susan has diabetes and asthma and her health needs are normally managed through the community nursing team but she has experienced several hospital admissions over the last few years, mostly out of hours or at the weekend.