**"Supporting our population to improve and optimise their own personal health by encouraging self-care and commissioning high quality integrated health care"**

## Key Improvement Interventions

### OUT OF HOSPITAL SECTOR

#### Wider Primary Care at scale

**Robust Approach to management of long term conditions**

- Increase screening of COPD
- Improved Diabetic Care:
  - Increase % of diabetics receiving nine key care processes to 60%.
  - Enable patients to self-manage their care by increased use of care planning and patient accessible ECLIPSE IT programme.
  - Increase use of specialist diabetic nurses and community diabetologist to run virtual clinics in the community.
  - Increase HCP education in diabetes at virtual clinics and specific training sessions.
  - Diabetics encouraged to increase exercise through "Beat the Street" campaign.

**Improved Support to People Near the End of Life**

- Integrate records systems between GPs, Westcall and Community Nurses through the interoperability gateway
- Increase by 10% Practice notifications to Westcall of patients expected to die in the next year (this incorporates processes to support people to die at home). This will help ensure that those who want to die at home have full support to achieve that choice

#### Redesign model of Integrated Care

**Improve the physical and mental health of the population and those with long term conditions**

- Increase exercise in the population e.g. through "Beat the Street" an initiative to increase physical activity through self-motivation and long term changing of habits. Schools and specific patient groups will be targeted to participate in walking competitions to embed exercise into daily routine.
- Improve the mental health of the population through increased access to psychological therapies and "Beat the Street".
- GPs to provide increased support to care homes with each patient having a care plan and a 6 monthly review.
- Provision of community nurse for the elderly.

**Reduce the incidence of healthcare related infection from C. Difficile and MRSA**

- Delivered through effective infection control and reduction of anti-biotic prescribing in primary care.

**Work with NHS England on continuous quality improvement in Primary Care**

### URGENT CARE SYSTEM

#### Access to the highest quality Urgent and Emergency Care

**Improved Support to Frail and Elderly Patients:**

- Implementation of the Hospital at Home scheme to provide 7 days intensive consultant-led support to patients who otherwise would have been admitted.

**Ensure Sustainability of Improved A&E Performance and Embedding of A&E Pathways**

**Embed Use of Urgent Care Dashboard**

**Continue to Develop NHS 111 and Connect it to Health and Social Care Hub**

### HOSPITAL CARE

#### Step change in the productivity of Elective Care

**Reduce the Higher than Average Intervention Rates for Musculoskeletal Conditions**

- Expanded use of shared decision making aids e.g. for hip and knee replacements.
- Review of the MSK pain pathway
- A more systematic application of threshold policies for elective procedures.

**Reduce the Incidence of Healthcare Related infection from C. Difficile and MRSA**

- Delivered through effective infection control and reduction of inappropriate anti-biotic prescribing in hospital.

#### Specialised Services in centres of excellence

**Review and improve patient pathways for ophthalmology.**

**Work with providers on continuous quality improvement.**

## 7 Ambitions

- Additional years of life for people with treatable physical and mental health conditions
- Improved quality of life for people with Long Term Conditions
- More integrated care outside hospital
- Increased proportion of older people living independently at home
- Positive experience of care outside hospital
- Increased positive experience of care
- Progress towards eliminating avoidable deaths

Engage Public and Empowered Patients

Improving Quality

Increasing Financial Stability