NHS Guildford and Waverley
Clinical Commissioning Group

Guildford & Waverley CCG has a population of 210 000 and is in the wave 3 authorisation stage. Surrey's population is projected to rise over the coming decade, with notable increases in the number of older people particular in Waverley. This will have a major impact on service planning, as older people are more likely to experience disability and long-term-conditions. Part of the challenge will be to ensure the right preventative and support services are in place so older people can remain independent for as long as possible.

Scope

During October and November 2012, Alison was tasked with reviewing the CCG's under-performing unscheduled care QIPP and making recommendations to rapidly 'operationalise' the strategy achieve the required savings by March 2013. This was a short piece of work to be achieved in time for the permanent unscheduled care people being transferred into the CCG in December as part of the NHS reforms.

Guildford and Waverley's key objectives in developing Frail Elderly services in this area are summarised below:

- To introduce early, proactive monitoring and support at home to Frail Elderly patients in order to reduce unnecessary activity across multiple care settings – including prevention of avoidable hospital and nursing home admissions;
- To improve the Frail Elderly service user experience by improving overall health and wellbeing and reducing disparities in health outcomes between groups, through prevention and early intervention;
- To improve the service user experience through integration of services which are delivered at the right time, in the right place, by the right providers;
- To deliver high quality home-based care to re-establish and/or maintain the independence of Frail Elderly service users;
- To increase cost-effectiveness across the system in relation to the primary, community, and social care workforce by testing this type of new and innovative method of delivering care;
- To reduce the rate of unplanned hospital admissions, readmissions, and average length of stay for Frail Elderly patients, and to realise associated savings on acute hospital costs;
- To reduce the rate of permanent admission to nursing homes;
- To proactively support older people at risk and adults with complex needs in their home by promoting and aiming to maintain independence.

Method

- To review the Frail Elderly QIPP plans
- To engage staff in reviewing progress and rapidly mobilising change.
- To deliver an improvement plan with prioritised recommendations and associated cost savings that would achieve the £1.5m savings required by March 2013.

Outcomes:

Review of the Frail Elderly QIPP plans as well as linked LTC and End of Life improvement plans. Engagement with key stakeholders to establish key successes, challenges and opportunities.

Delivery of a whole health economy frail elderly workshop with stakeholders from acute, community, primary care and social services involved the Frail Elderly pathway. Reviewed progress and prioritised actions for rapid improvements to achieve cost savings Dec 12 – Mar 13.

Delivery of an improvement plan with prioritised recommendations and associated cost savings