Shaping a healthier future

NHS
Hammersmith and Fulham
Clinical Commissioning Group

Summary of progress under Shaping a healthier future

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www.hammersmithfulhamccg.nhs.uk

Shaping a healthier future

SHAPING A HEALTHIER FUTURE

NHS

Shaping a Healthier Future (SaHF) will transform services for 2 million people across North West London

Why the system needs to change

- Health and care needs to be delivered differently to reflect our growing and ageing population with more long-term conditions
- One in four patients find it difficult to see a GP when they need to and many end up in A&E unnecessarily
- We have more A&E departments per person than other parts of the country
- There are too few specialists in hospitals to provide high-quality round-the-clock care
- We are working from inadequate NHS facilities
- We are working within an increasingly tight budget

North West London's five year plan

- Design a system which better supports patients and gives them more control and input over their own care
- Prevent people from dying prematurely
- Enhance quality of life for people with long-term conditions
- Help people to recover from episodes of ill health or following injury
- Ensure that people have a positive experience of care
- Treat and care for people in a safe environment and protecting them from avoidable harm

Five year plan to date

2012-2014
- Consultation and decision making

2014 - 2019
- Year 1 of implementation

Mental health and wellbeing

Improving mental and physical health through integrated services

- Transformation of services to be responsive to needs of patients and communities as well as easy to access and navigate.
- Care provision as close to home as possible, with GPs at the heart of care, where and when it is needed.
- Improving the lives of service users and cares, promoting recovery and delivering excellent outcomes, including health and social care, employment, housing and education.

Whole systems integrated care

Person-centred, proactive care joined up around the needs of the person

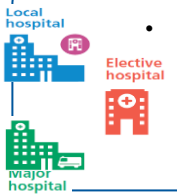
- People will be empowered to direct their care and support and to receive the care they need in their homes or local community.
- GPs will be at the centre of organising and coordinating people's care.
- Our systems and processes will enable and not hinder the provision of integrated care.

Primary and community care

Transforming out-of-hospital services and improving access to GPs

- Providing more local input into primary care commissioning; improving access to GPs whilst being able to move money around the health economy more quickly.
- Putting the right support in place to nurture and grow GP networks so they are able to deliver sustainability in the long term.
- Developing a primary care estates strategy that takes into account hub and GP estate requirements and support implementation of plans to deliver the required estates changes of need.

Hospital reconfiguration



- Delivers a major shift in care from within a hospital setting to an out-of-hospital setting so more people are treated closer to their homes. The concentration of acute hospital services will allow us to develop centres of excellence which are able to achieve higher clinical standards and provide a more economic approach to the delivery of care.

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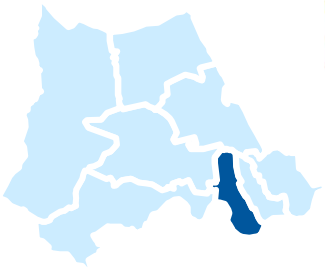
HAMMERSMITH AND FULHAM



Hammersmith and Fulham is a small, but densely populated borough with 180,000 residents living in 6.3 sq. miles. The borough has a large proportion of young working age residents, high levels of migration in and out the borough, and ethnic and cultural diversity.

Population demographics

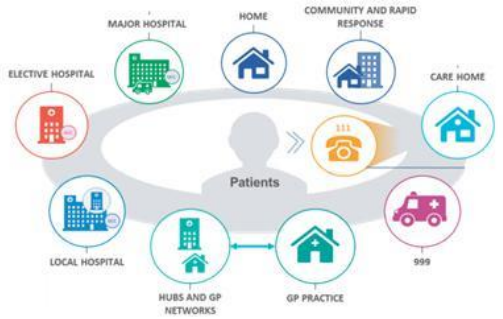
- The age profile of the borough is common to other inner city areas in that it has a very large young working age population and relatively fewer children and older people.
  Compared to London overall, the borough has the 5th lowest proportion of children, 4th highest proportion of young working age residents and 9th lowest proportion of people over retirement age.

- One in four of the borough's population were born abroad. The population in the borough is socio-economically and culturally diverse.
- One third (32%) of the population are from Black, Asian and minority ethnic (BAME) groups.

- Life expectancy for men in Hammersmith and Fulham is lower than London and England. The difference in life expectancy between affluent and deprived areas in the borough – 7.9 years – is broadly similar to the national average.
- Life expectancy for women in the borough is lower than London and England. The difference in life expectancy between affluent and deprived areas is similar to the national average, at 5.4 years.

Care provision

- 30 **GP** practices
- Approximately 42 **dental** practices
- 40 **pharmacies**
- 4 **care homes**



- More than 90% of contacts with the health service take place in the community, involving general practice, pharmacy and community services.
- **Imperial College Healthcare NHS Trust and Chelsea & Westminster NHS FT** are the main providers of acute and specialist care.
- **Central London Community Healthcare (CLCH)** provides community nursing and therapies and **West London Mental Health Trust** provides mental health services

Overview

198, 000
Local registered patient population

£245m
2014/15 health commissioning budget

Health challenges

- The principle cause of premature (<75) and avoidable death in Hammersmith and Fulham is cancer, followed by cardiovascular disease (which includes heart disease and stroke).
- Mental health is the most common reason for long term sickness absence, and several of the wards in the deprived parts of the borough fall into the 20% highest in London for incapacity benefit/ ESA claimant rates for mental health reasons.

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CURRENT OUT OF HOSPITAL SERVICES

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Hammersmith and Fulham CCG has invested £6m[1] in 13/14 and 14/15 on increasing the number of community services and joining up health and social care.

Whole systems integrated care

- The **Community Independence Service** brings together health and social care staff to help people stay in their own homes and to support them in getting home from hospital quicker if they do need to be admitted. There were 776 referrals to the service up to January 2015.

  A **Care Homes Pilot and Integrated Care Programme** brings health and social care professions together with care home staff to look at reasons for ambulance call outs and admissions to hospital from care homes. The teams have looked in particular at preventing falls and managing medication. Data from the third quarter of 2014/15 shows that 3 care homes had seen a reduction in the number of residents needing admission as a result of the scheme.
- The Older People's Rapid Access Service provides comprehensive geriatric assessment within short time frames. This enables patients to access investigations and specialist opinion and remain cared for at home.

Primary care transformation

- **Primary Care Plus** has been set up to offer enhanced services for patients with mental health needs, including more GP support.
- **Weekend opening** has started across Hammersmith and Fulham - with 5 practices open each weekend (9am – 4pm Saturday and Sunday) seeing patients from any practice in the borough..
- We are investing in other ways of **increasing access to GPs** for patients. Currently 25 practices offer telephone consultations, 19 practices offer online appointment booking and all 30 offer longer appointments to those that need them.
- Hammersmith and Fulham CCG is investing in the **primary care buildings** needed to deliver more services for residents in, or close to, their own homes including:
  - A new health and wellbeing centre at White City which recently opened.
  - Plans for health and wellbeing centres at Charing Cross Local Hospital and Parsons Green in south of the borough.

Additional one off investments

- We have delivered a new IT system for all GPs in the borough which improve the efficiency of GP and Community Nurse access to results and patient records.

Community Out of Hospital services

- The two **urgent care centres** at Hammersmith Hospital and Charing Cross Hospital moved to 24/7 operation since June 2014.
- A **community gynaecology service** has been set up, and a **community ophthalmology service** will start during 2015/16. Both mean more people can be treated nearer to their home.
- GP practices are being supported in providing end of life care through the recruitment of an **end of life** care coordinator and community matron. Staff are coordinating patient care through End of Life meetings enabling patients to live as comfortably as possible. 308 patients have been added in the last 12 months and 669 registered in total.
- 30 GP Practices have come together to deliver **18 new community services** to a common standard for all patients in the borough with some starting in February 2015. Services include 24-hour blood pressure monitoring in the patients home, anticoagulation services for those on blood thinning medication and complex wound management.

Mental health and wellbeing

- A **psychiatric liaison service** is now in place providing mental health support to people already being treated for physical health conditions. It provides patients with a single point of access and support when they go home.
- **Integrating Mental Health** to ensure people receive the most appropriate care, closer to home. So far we have invested in 4 Primary Care Mental Health Workers that support GP Practices to manage more complex mental health patients in the community.
- North West London was the 2nd area nationally to have its action plan approved for the groundbreaking **Mental Health Crisis Care Concordat**, ensuring better, joined up, care for people experiencing mental health crisis.

1. Note: Additional expenditure on 'out of hospital' services and infrastructure, spent since the start of SaHF. This is expenditure on primary and community care services, provided outside of acute, intended to reduce demand on the acute sector, i.e. to reduce non-elective or elective admissions, in-hospital outpatient appointments, and A&E attendances. Also includes investment in supporting infrastructure. Project costs are excluded.

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FUTURE OUT OF HOSPITAL PLANS

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Whole systems integrated care

- We will continue to invest in an expanded, single Tri-borough Community Independence Service (CIS) to provide rapid response and in-reach to hospitals, enabling patients no longer needing acute care to go home. Increase investment in **neuro-rehabilitation community support** and bed based intermediate care in the community to support recovery and return to independence.
- We will develop ways to support people to **self-manage** including peer support programmes, with a particular focus on those with chronic lung disease, Cancer, Diabetes or Dementia.
- **We will work to extend Personal Health Budgets** to adults with long-term conditions to give people more choice and control over how they are supported.
- We will work with the public health team to develop supportive and resilient neighbourhoods and communities across Tri-borough.
- We will work to provide additional support from pharmacists and physiotherapists for people in care homes across health and social care to enable better focus on outcomes, maximise value and reduce need for hospital admissions and LAS call outs.

Primary care including hubs

- Building on the success of the Parkview hub, we are actively pursuing the development of a second hub in the south of the borough to provide additional range of services closer to home
- Continue to **invest in organisational development** for the newly formed GP Federation, equipping them with the skills and capacity to work together to deliver services at scale.

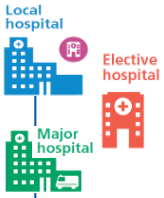
Mental health and wellbeing

- Urgent care in NWL has undergone extensive redesign for which we have achieved national recognition. In 2015/16 we will embed the urgent care work through a single point of access and by merging of existing teams. We will continue are work with other agencies including Metropolitan Police.

From April 2015:

- We will ensure there is a **Child and Adolescent Mental Health Services (CAMHS) p**rofessional available 24 hours to respond to crisis.
- We will have extended and co-produced maternal mental health service (perinatal).
- We will work to ensure people with **learning disabilities** have equal access to mental health services.
- We will develop a NWL mental health and wellbeing strategy across North West London. This will involve partnership working across health and social care and other partners.

Community Out of Hospital services



- Integrated Home Care services: the CCG and the local council are working together to specify a new **home care service model** and pathway, with a focus on regaining independence following a stay in hospital.

We also plan to:

- Invest in a new community ophthalmology service to improve convenience and experience for patients.
- Invest in a new **community musculoskeletal service** to reduce wait times and improve patient experience.
- Increase provision of **community cardiology services** in line with best practice.
- Invest in **education and self-management support for diabetes patients**, making best us of technology and providing integrated mental health support.