Healthy Future

NHS
Hammersmith and Fulham
Clinical Commissioning Group

Managing Director six month review

10 November 2015

Purpose

This paper provides a summary of the key areas of business led by the Managing Director and Chair for Hammersmith and Fulham CCG. It includes a summary of the main areas of work over the past six months, as articulated in our contracting intentions for 2015/16 and our strategic and organisational objectives for 2015/16.

Strategic objectives

1. Enabling people to take more control of their health and wellbeing through information and ill-health prevention
2. Securing high quality services for patients and reducing the inequality gap
3. Strengthen the organisation's infrastructure to help us deliver high quality commissioning
4. Working with stakeholders to develop strategies and plans
5. Delivering strategic change programmes in the areas of primary care, mental health, integrated care, and hospital reconfiguration
6. Empowering staff to deliver our statutory and organisational duties

Organisational Objectives

Each of the high level objectives below is underpinned by key projects, deliverables and benefits:

- Transforming Primary Care services
- Providing better care, closer to home
- Delivering Whole Systems Integrated Care, centred around the needs of service users and carers
- Transforming Mental Health services, through commissioning integrated, personalised and responsive health and wellbeing services
- Supporting our objectives through developing a strong culture of enabling patients, members and staff to deliver and realise the benefits of transformation

Transforming Primary Care services

Strategic objectives 2, 4 & 5

1.1 Out of Hospital Services

A suite of eighteen services are now live, via contracts with all practices and the evolving Hammersmith and Fulham GP Federation, delivering care from general practices for which patients would previously have gone to hospital. Between 1st July and 4th October, referrals – both intra- and inter-practice - have been increasing, with some examples below:

- 12,385 referrals for phlebotomy
- 7557 referrals for diabetes level 1 care
- 2444 referrals for case finding, care planning and case management
- 2306 referrals for high risk diabetes
- 165 referrals for anticoagulation initiation

By March 2016 activity will have ramped up to provide service coverage for the whole population.

1.2 Weekend Plus Service

Since 26th September, three practice hubs in the borough have been providing an additional 1.5 hours each week day and 12 hours each weekend of GP and practice nurse appointments. These are over and above the extended weekday hours provided by two thirds of the thirty one practices in the borough. These appointments can be booked by **any** practice within the borough, and both the patient's own practice and receiving practice can view and enter details into the patient record, illustrating the benefits of an interoperable IT system.

Over the first two weekends across the three sites there were:

- An additional 254 GP appointments booked
- 102 practice nurse appointments
- 23 patients accessed the phlebotomy service
- 24 patients were immunised against the flu
- 15 patients had a cervical smear

As part of this service, practice nurse time on three Autumn Saturdays will be dedicated to flu immunization, particularly for children aged 2, 3 and 4.

1.3 ***Prime Minister's GP Access Fund***

Formerly known as the Prime Minister's Challenge Fund, this fund is designed to improve access to general practice and stimulate innovative methods of primary care provision. The H & F GP Federation, which comprises all 31 practices in H & F, has been working on a number of areas as below:

- Optimising active practice engagement with patients, working with Healthwatch who have a lot of experience and expertise in this area
- Increasing practice engagement with the Community Independence Service to ensure that all appropriate patients can benefit from it
- Undertaking a pilot in which practices contact patients ahead of a booked appointment to understand whether a telephone appointment or appointment with another healthcare professional would be more appropriate for the patient
- Online Utilisation: increasing the number of patients accessing services e.g. repeat prescriptions online

1.4 ***Strategic Commissioning***

H & F CCG will undertake primary care joint co-commissioning with NHS England at a more local level – the Terms of Reference for this local group will go to the November Governing Body to be signed off. This will enable greater local influence in the commissioning of local primary care services. The Strategic Commissioning pan-London framework provides a new vision for general practice, in line with the Five Year Forward View, to develop care that is increasingly pro-active, coordinated and accessible. We are currently working across North West London to understand how we will continue to implement and embed the ambitious service and quality standards that this sets out for primary care.

Providing better care, closer to home

Strategic objectives 1, 2,4 & 5

2.1 Transforming planned care

In addition to the out of hospital services being provided in general practice, there are a number of other services where we are moving activity out an acute setting and into the

community. As an example, we recently commissioned a community gynaecology service to increase patient access and experience, reduce waiting times and ensure that patients are seen by the most appropriate clinician in the most appropriate setting. The service went live on 1st March and is delivered from Parkview and Charing Cross sites. Since April-15, there has been a consistent reduction in first outpatient activity in an acute setting, and – in line with plans – an increase in the number of appointments delivered in a community setting.

2.2 ***Specialist Neuro-rehabiliation Service***

The CCG, on behalf of Hammersmith and Fulham, Westminster, and Kensington and Chelsea is commissioning nineteen additional level two Neuro-rehabilitation beds. The key outcomes for patients and the system impact of commissioning this additional capacity include:

- Providing positive experiences of care and financial savings by reducing unwarranted delayed transfers in care
- Improved long term outcomes for patients due to timely and effective treatment to support recovery from injury
- Reducing additional cost in the acute hospital costs associated with increased Length of Stay in hospital
- Reducing long term (continuing care) costs due to a measurable reduction in long-term care dependency

2.3 Community Ophthalmology Service

The new Community Ophthalmology service will go live in November. This service is an excellent example of partners from multi-agency organisations – Imperial and Chelsea & Westminster NHS Hospital Trusts, H&F GP Federation, and high street opticians - working together to deliver an end-to end care pathway. The new community service will:

- Be consultant led
- Allow transfer of existing clinical management of stable ophthalmic cases from the acute setting
- Carry out clinically appropriate outpatient procedures
- Improve knowledge of NHS health professionals around the management of eye diseases through development and implementation of education programmes for GP, optometrists, opticians, nurses and other practitioners on the agreed clinical pathway

- Improve the education of patients regarding self-management of their condition
- Improve patient satisfaction through delivering a quick, accessible and high quality service

The estimated proportion of care shifted from hospital eye services to the community ophthalmology service is: 50% of first appointments, 60% of follow-up appointments and 50% of procedures

2.4 Urgent Care

We are working in partnership with the north west London Urgent and Emergency Care Network to deliver the national vision for an integrated urgent care system, starting in 2016/17 with the re-procurement of a new 111 service, which will mean an increase in clinical expertise and greater coordination between urgent care services. We continue to work with Imperial College Healthcare NHS Trust to further develop ambulatory care services, to provide easily accessible specialist input without the need for a stay in hospital.

Whole Systems Integrated Care

Strategic objectives 1, 2, 4, 5 & 6

3.1 Community Independence Service

The Community Independence Service provides an integrated, holistic service that cares for individuals within their own homes who are at risk of unnecessary emergency admission, and early, supported discharge for those recovering from a period of ill health. The service comprises the following services:

- **Rapid response** - for urgent help to support acute illness in the community when it is safe and appropriate to do so (response within 2 hours)
- **In-reach** - giving the support people need to return home from hospital as soon as they are fit to do so
- **Rehabilitation** - supporting people to get well after a physical illness or manage a long term condition, and to lead independent lives
- **Reablement** - using rehabilitation and/or social care as required, to help people to remain in their own homes and lead independent lives

Between April 2015 and the end of September 2015 there were:

- 1794 patients referred to the service – for example from GPs, A & E, London Ambulance service
- 450 rapid response cases
- 677 in-reach cases
- 667 rehab cases
- 782 patients starting reablement, 621 of who have completed
- Increased GP medical cover within the service from 3 sessions to 9 sessions per week

Based on the above five months, patient experience feedback is:

- 94.18% of service users rated the overall experience as 'excellent' or 'good'
- 96.14% of patients felt that the staff 'definitely' treated them with dignity and respect
- 84.98% of service users were 'definitely' satisfied with how quickly they were seen

The next step is completion of a comprehensive review of the service to inform its design on 2016/17. This review will involve group interviews with both providers and health and social care commissioners, 1:1 interviews with GPs, and an understanding of how the service is delivering the benefits articulated in the original business case.

3.2 Care Homes Pilot

A pilot including four care homes and four extra care homes has been extended until March 2017 on the basis of an impressive qualitative and quantitative evaluation. The care model offers a multi-disciplinary team including GP, pharmacy, physiotherapy, mental health, social care, geriatrician, palliative care and community nursing working to deliver the following:

- Care co-ordination through multi-disciplinary team meetings held regularly at the care home
- Development of wider skill sets for care home staff through training
- Delivering interventions and support for staff around falls managements and medication review/management
- Development of pro-active care plans, led by Primary Care
- Capacity building and partnership working

The evidence of delivery of the pilot against the main KPIs is as below:

Key Performance Indicator	Change
Falls	↓ 35%
LAS Call Outs	↓ 10%
LAS Call Outs from Falls	↓ 26%
A&E Attendance	↓ 16%
Hospital Admissions	↓ 4%
Out of Hours Call Outs	↑ 82%

In addition, the quantitative evaluation identified annual medication savings of £168,662 and annual savings resulting from reductions in the areas above of £106,549. The qualitative evaluation identified further benefits from the pilot as:

- Care homes having direct access to health services
- Timely assessments and shared decision making
- Continuity of care and avoided admissions
- Inter professional working – particularly the care coordination/MDT meetings

3.3 Whole Systems Integrated Care

A multi-agency Partnership has been in place for six months, comprising representation from: H & F CCG, Adult Social Care, Public Health, SOBUS, Central London Community Healthcare, Imperial & Chelsea and Westminster acute trusts, H & F GP Federation, West London Mental Health Trust, and patient representation. We have taken the learning from the two Whole Systems Simulation events earlier this year where patients and stakeholders explored current systems and how they would like care to look and feel different in the future. A system-wide Business Case will be taken to the Finance and Performance Committee in November to enable plans to be tested over the remainder of the year with a number of practices to baseline the current workforce and operational model, and make specific investments in additional roles/functions as required, with a fuller roll out in 2016/17. Senior leaders from across the system will attend the Change Academy Programme, providing training across clinical, mental health, social and self-care areas. We

have been actively engaged in the system-wide work around transitioning to an Accountable Care Partnership, to enable us to commission streamlined care across health and social care boundaries.

Transforming Mental Health

Strategic objectives 1,2, 4 & 5

4.1 Mental Health Transformation Programme

We have a large Transformation Programme underway in mental health which covers the following areas and largely focuses on mental health services outside of our bedded inpatient services in secondary care. This includes:

- Urgent Care – in September H&F, in collaboration with Ealing and Hounslow CCGs approved investment for West London Mental Health Trust (WLMHT) to develop a single point of access for secondary care services and to expand the current Crisis Resolution Home Treatment Teams to provide a 24/7 service, closer to home for people in crisis. This development is very much in line with the Mental Health Crisis Concordat
- Shifting Setting of Care/ Planned Care – this work streams includes the implementation of out of hospitals service specifications for GP practices, development of our primary care mental health services, the redesign of planned services in secondary care and the repatriation of patients placed out of area back to local services. This work stream also oversees the planned, safe transfer of stable patients with severe and enduring mental illness from secondary care to primary care, our full year planned trajectory is 240 and we are on track year to date to deliver this
- Dementia – we are in the process of developing our service specification for a memory assessment and support service, this will provide people living with dementia and their families/ carers with an increased amount of support pre/ post diagnosis. As part of this work stream we are working closely with the Local Authority around the parallel review of Day Services to ensure that pathways are integrated and streamlined wherever possible
- Perinatal Mental Health Services – in July the CCG, in collaboration with Ealing and Hounslow has approved the establishment of a pilot which will increase the

services available for women to support psychosocial wellbeing of herself, her infant and her family and to prevent mental illness during the antenatal period until the first six months of the post natal period

We continue to see strong performance in some of our other out of hospital services, namely 'Back on Track', our Improving Access to Psychological Therapies (IAPT) service, who continue to meet their access and recovery targets. For Quarter 2, the service achieved access performance of 4.10% and recovery rates of 50%.

Supporting our objectives through developing a strong culture of enabling patients, members and staff to deliver and realise the benefits of transformation

Strategic objectives 1, 2, 3, 4, 5 &6

5.1 Patient and Public Engagement

Over the last six months the CCG has delivered on agreed Patient and Public Engagement priorities including:

- ensuring there is lay coverage of all CCG sub-committees and involvement at each stage of the commissioning cycle
- using more accessible language
- attending various health awareness events across the borough
- developing our working relationship with Healthwatch

Specific examples include: our work in collaboration with North West London CCGs on the wheelchair procurement that is aiming to transform and co-design wheelchair services by working together with service users and key stakeholders; committing to enable people to take control of their health and wellbeing through working in partnership with people with long term conditions, their carers and the wider community to co-design a self-management commissioning framework and re-commission the Expert Patient Programme.

Going forward, we will ensure that patients and public know more about what we do. We will be out in the borough interacting with residents, patients, service users, carers and the community and voluntary sector. We will work with community and voluntary sector organisations to engage patients in seldom heard groups. We will further develop Patient Participation Groups at GP practices and will work together with local partners to ensure we

engage with the prevention agenda, for example through the very active flu campaign we are delivering.

5.2 ***Empowering staff and members to deliver our statutory and organisational duties***

We have held a number of lunch and learn sessions, on topics ranging from primary care co-commissioning, plain English, Whole Systems, equalities and Twitter. We issued contract intentions to providers 30 September 2015 and have developed succinct business plans that set out H & F's key objectives, the benefits they will achieve, how the benefits will be measured and what resources are required to deliver them. We will produce a public- facing prospectus in early 2016 so that our residents and service users understand what we are aiming to achieve and can hold us to account for doing so. **W**e held a 'Breaking the Cycle' event, which saw a combination of information-sharing and educational sessions across the CWHHE collaborative and locally in H & F, some of which we were delighted to host at St Paul's Church in Hammersmith. We started with an interactive session on our strategy and transformation plans, and then did some detailed work on how we can work most effectively and efficiently across H & F, Central and West CCGs. H & F staff committed themselves fully to the event and we agreed concrete actions and ways of working both within H & F and with our partners. There were opportunities for personal development and increased understanding of health and wellbeing both within and outside of the workplace.

5.3 Technology and IT

Electronic Prescription Service (EPSR2)

HFCCG was the first within the collaborative where all 31 GP Practices went live with EPSR2. EPSR2 enables prescribers, such as GPs and practice nurses, to send prescriptions electronically to a dispenser, such as a pharmacy, of the patient's choice. This makes the prescribing and dispensing process more efficient and convenient for patients and staff.

Diagnostic Cloud

All HFCCG GP Practices are live with a single diagnostic record for their patients using the 'Diagnostic Cloud'. This system enables GPs to request pathology tests and view results,

thereby speeding up access and avoiding unnecessary duplication of tests that have already been undertaken.

5.4 Estates

Good quality strategic estates planning is vital to making the most of service transformation, and will allow us to maximise use of facilities, deliver value for money, and enhance patients' experiences. We are therefore producing a high quality local estates strategy by December in collaboration with a wide range of local stakeholders - including the wider public estate – which will enable us to gain maximum value from NHS resources and reduce wastage.

5.4 Patient Transport Services

A Patient Transport Services Steering Group has been established, which will develop Quality Standards and Key Performance Indicators by March 2016. We will pro-actively engage with service users to understand patient experience and inform the quality indicators.

CCG Leads

	Clinical Lead	**Managerial/Governing Body Lead**
Primary Care Transformation	Dr James Cavanagh and Vanessa Andreae	Helen Poole, Trish Longden
Better care, closer to home	Dr Amy Wilson	Kathleen Sadler, Toby Hyde
Whole Systems Integrated Care	Dr Tim Spicer	Janet Cree, Helen Poole
Mental Health Transformation	Dr Beverley Macdonald	Kathleen Sadler
Enablers	Dr Tony Willis (IT)	Jane Wilmot, Janet Cree