

# 2016-17 Business Plan

**Governing Body: 08  
March 2016**

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# Context and Next Steps

## Context

- This Business Plan was reviewed at the Governing Body seminar in September 2015
- Since then the 2016/17 Planning Guidance has been published. The guidance, and a summary of the guidance, were reviewed most recently at the Governing Body seminar of 01 March 2016. It outlines the requirement to develop two separate but interconnected plans:
  1. A local health and care system place-based **Sustainability and Transformation Plan**
  2. A one year organisation-based **operational plan for 2016/17** consistent with the emerging STP

Subsequent to the Governing Body seminar in September, H & F CCG has also been identified as part of the Wave 1 Rightcare Programme. This primary objectives of this national programme are to maximise value through reducing variation and increasing efficiency. Work is underway at a CCG and CWHHE level to identify the opportunity areas for our CCGs and these will be reflected in our operational plan.

## Next Steps

In order to reflect the revised planning requirements since September 2015, the existing 2016/17 Business Plan will be developed over coming weeks into the - narrative element of – operational plan, aligned with the companion finance and activity templates. The Governing Body is therefore asked to note the existing 2016/17 Business Plan and that further iterations will be developed over coming weeks. It will reflect our strategic objectives and vision and it is anticipated that it will reflect a population-based approach rather than service-line approach.

# North West London Vision

The NWL Vision builds on that set out by NHS England and has been developed in consultation with the people of North West London:

*“We want to improve the **quality of care** for individuals, carers and families, **empowering and supporting** people to maintain independence and **to lead full lives** as active participants in their community”*

Four overarching principles underpin the whole system NWL vision - that health services need to be:

1. *Localised* where possible
2. *Specialised* where necessary
3. In all settings, care should be *integrated* across health, social care and local authority providers to improve seamless person centered care
4. The system will look and feel from a patient’s perspective that it is *personalised*- empowering and supporting individuals to live longer and live well

# H&F CCG Vision

*'Building a healthier future for everyone in Hammersmith and Fulham'*

## H&F CCG Strategic Objectives

At a Governing Body meeting on 2nd June 2015, the following objectives were agreed:

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

# Priority areas

Theme	Projects	H&F CCG Strategic Objective	Personalised	Localised	Integrated	Specialised
<b>Better Care Fund</b>	BCF C1 Nursing and Residential care	2,5			✓	
	Joint Commissioning - Section 75	3,4,5			✓	
<b>Paediatrics</b>	Child and Adolescent Mental Health Services	2			✓	✓
	Connecting Care for Children	1,2			✓	
<b>Joint Commissioning</b>	Proactive care in care homes	2,5		✓	✓	
	Neuro-rehabilitation expansion	2,5		✓	✓	
	Personal Health Budgets	1	✓	✓		
	Intermediate Care Bed review	2,5		✓	✓	
	Dementia Day service review	1,2,4		✓	✓	
	Nursing & home care AQP	2			✓	
<b>Mental Health</b>	Dementia (Memory Assessment Service)	1,2,5		✓		
	Mental Health Transformation	1,2		✓		
	Improving Access to Psychological Therapies	1,2	✓	✓		
	Perinatal Mental Health Service	1,2,5	✓	✓		
	Shifting Settings of Care	1,2	✓	✓		
<b>Planned Care</b>	Ophthalmology	2		✓		
	Tissue Viability	1,2		✓		
	Community MSK service roll out	2,5		✓	✓	
	Community Gynaecology service roll out	2		✓		
	Cardio-respiratory community service roll out	1,2,5	✓	✓	✓	
	ENT community service – scoping	1,2,5		✓		
	Wheelchair service development	1,2,4,5	✓		✓	
	Cardio Vascular/CHD	1			✓	
	Centralisation of pathology service	4				✓
	Community Urology service	2		✓		
	Diagnostics	2,5		✓		✓
	Expansion of Out Of Hospital services	2,5		✓	✓	
	Diabetes	1,2,4,5		✓		
	Chronic kidney disease	1,2,4,5		✓		
	Orthopaedics	2,5				✓

# Priority areas

Theme	Projects	H&F CCG Strategic Objective	Personalised	Localised	Integrated	Specialised
<b>Primary Care</b>	Medicines Management	1,2,5	✓			
	Out of Hospital Services	2,5		✓	✓	
	Referral standardisation	5		✓		
	Primary care co-commissioning	5		✓		
	High cost drugs	1,2,5	✓			
	Medicine reconciliation post discharge from hospital	1,2,5	✓			
	Polypharmacy	1,2,5	✓			
	Primary care transformation	5			✓	
	Network plan investment	5			✓	
	Telephone triage for MSK	5			✓	
	Use of pharmacies- extended role of pharmacists	1,2,5	✓			
<b>Urgent Care</b>	Urgent Care re-procurement	2,5		✓		
<b>Whole Systems</b>	Social Prescribing pilot roll out	1,5	✓			
	Model of Care- Frail Elderly	1,2,4,5	✓	✓	✓	✓
	Cancer	2	✓			✓
	End of life Care	2	✓			✓
	Management of Long Term Conditions	1,2,4,5	✓		✓	✓
	Expanded primary care model	3,4,5	✓			
	Supported discharges	5			✓	
<b>Self Care</b>	Self management/Self care schemes	1,5	✓			
<b>Underpinning principles/enablers</b>						
<b>Quality</b>	Patient and Stakeholder Engagement	2		✓		
<b>Equity</b>	Equity	2			✓	
<b>Estates</b>	Estates review/strategy	3			✓	
<b>IT</b>	Digital Mental Health	1,2	✓			
	Assistive technologies	1,2	✓			
	Directory of voluntary services	1,5			✓	
	Innovation	1,2			✓	
<b>Workforce</b>	Workforce Development	6	✓			
<b>Transport</b>	Transport	3		✓		
<b>Efficiency</b>	Rightcare programme	1,2,4,5,6	✓	✓	✓	✓

# Appendix 1: Project headlines

Theme	Projects	Project Outline
<b>Better Care Fund</b>	BCF C1 Nursing and Residential care	<ol style="list-style-type: none"> <li>1. To create a co-located care home placement contracting team across health and social care</li> <li>2. To develop outcomes based specifications, maximise value and ensure appropriate and timely provision reduces pressure on hospitals and improves user outcomes</li> </ol>
	Joint Commissioning - Section 75	To review existing jointly commissioned services with s75, s76 and s256 partnership arrangements, ensuring that services provide best value for money
<b>Paediatrics</b>	CAHMS	Implementation of 'Future in mind' vision - improvement in provision of mental health services for young people - following the submission of transformational plan in October-15 including an eating disorder service for young people
	Connecting Care for Children	<ol style="list-style-type: none"> <li>1. Expansion of the Connecting Care for Children model beyond Parkview and North End practices, subject to project evaluation during 15-16</li> <li>2. Continuing implementation of the Children &amp; Care Act (planning and support for children with disability)</li> <li>3. Modernisation of community services e.g. potential move of child development team from hospital</li> <li>4. Re-commissioning and procurement of Speech &amp; Language Therapy for young children</li> </ol>
<b>Joint Commissioning</b>	Proactive care in care homes	<p>The progression of four work streams following agreement of the business case:</p> <ol style="list-style-type: none"> <li>1. Enhanced Medical Service reporting by GPs</li> <li>2. Consultant geriatrician support in homes</li> <li>3. Continuation of the IC Proactive Care service</li> <li>4. Extra Care Enhanced Medical Service Pilot</li> </ol>
	Neuro rehabilitation	Commissioning of 19 Level 2 neuro bed resource across Tri-Borough CCGs
	Personal Health Budgets	Continued provision of CHC PHB service and market testing to inform commissioning route for 16/17
	Intermediate Care Bed review	To have a joint strategy for the review, design and commissioning of Intermediate care beds across the Tri-borough
	Dementia Day service	Joint review of dementia day services with the Local Authority to determine future commissioning intentions, models of services and procurement of new services
	Nursing & home care AQP	Scoping work in 2015 for potential to join the AQP framework in future
<b>Mental Health</b>	Dementia (Memory Assessment Service)	Recommissioning of memory assessment service to offer an effective integrated approach Post diagnostic support for dementia
	Transformation	Transformation Business Case for approval by Sept GB
	IAPT	IAPT: achievement of mandatory targets for access, and expand IAPT service to include additional cohorts in line with NHSE's plans
	Perinatal Mental Health Service	Perinatal mental health service in place for all women who may experience a common mental illness (anxiety and depression) during pregnancy as well as those with a known mental health problem or those who develop severe mental illness
	Shifting Settings of Care	Supporting people with mental health problems to be seen closer to home



# Appendix 1: Project headlines

Theme	Projects	Project Outline
<b>Planned Care</b>	Ophthalmology	Mobilisation of new community ophthalmology service provided by ICHT and partners
	Tissue Viability	Commissioning CLCH to provide an H&F TV service
	Community MSK	Further development of the service in support of the Out of Hospital Strategy
	Community Gynaecology service	Ensuring on-going delivery of the benefits of the new community service which commenced 1st March 2015
	Cardio-respiratory community service	In support of the Out of Hospital Strategy, a new Cardio-respiratory service will go live in 2016
	ENT community service	Scoping of OP procedures/attendances currently carried out in secondary care to scope the potential for a community based service
	Wheelchair service	Collaborative reprocurement to cover assessment, rehab and wheelchair delivery services
	Asthma	Scoping of current service with the aim to review alongside wider management of Long Term Conditions
	Cardio Vascular/CHD	Consideration of cardiac community specialist nurse as a way of preventing admissions
	Centralisation of pathology service	Being explored on a Collaborative level
	Community Urology service	There is currently a pilot service at two practices supported by Imperial. Evaluation at the end of pilot name date to determine next steps e.g. extension or commissioning of new community service
	Diagnostics	Demand management of diagnostics, both pathology & radiology. Diagnostic cloud as an enabler
	Expand OOH services	Potential expansion to be determined following 6 months review of current contract in March 16
	High street opticians	While NHSE currently commissions community opticians, there may be potential for extended optician roles: <ol style="list-style-type: none"> <li>1. Sign posting to other services</li> <li>2. Direct access for cataract surgery</li> </ol>
	Diabetes	Implementation of Collaborative Diabetes Strategy
Chronic kidney disease	Working with provider to establish: <ol style="list-style-type: none"> <li>1. Comprehensive CKD guidelines - issued</li> <li>2. Supported discharge from follow-up of appropriate patients</li> <li>3. Email advice line go live</li> <li>4. Primary care education programme</li> </ol>	
Orthopaedics	<ol style="list-style-type: none"> <li>1. Improve the quality and efficiency of elective orthopaedic care and improve efficiency</li> <li>2. Reduce variation in procedures, prostheses costs, infection/complication rates and readmissions</li> </ol>	

# Appendix 1: Project headlines

Theme	Projects	Project Outline
<b>Primary Care</b>	Medicines Management	1. Building on previous years work to identify and implement savings opportunities, deliver reducing medicines related harm intervention, and further embed prescribing decision support software 2. Deliver medicines optimisation agenda as agreed in business case being worked up in Autumn of 2015
	Out of Hospital Services	Co-location and expansion of out of hospital services
	Referral standardisation	Assessment of variation in referrals to establish best practice and consistency
	Primary care Co-commissioning	Progress co-commissioning arrangements with NHSE
	High cost drugs	Explore if the cost of administering drug by providers differs
	Medicine reconciliation post discharge from hospital	Reconciliation of medication post discharge from hospital to check if any changes were intentional and that GP records are updated
	Polypharmacy	Review of patients on multiple medications for health gain (getting patients to use medicine better)
	Primary care transformation	New model of care, aligned with Whole Systems
	Network plan investment	Review of network plan investment and outcomes to determine best use of resources
	Telephone triage for MSK	To be explored for cost and benefit analysis
	Use of pharmacies- extended role of pharmacists	Model to consider including pharmacists in practice/UCC, and active sign posting by practices to other services.
<b>SaHF</b>	SaHF	Linked to further changes made in year regarding services at Charing Cross site and expansion of Paediatric capacity at St Marys
<b>Urgent Care</b>	Urgent Care Centre	1. Review of GP Out of hours, UCC and 111 services. Potential reprocurement exercise 2. 111 contract - realignment of costs
<b>Whole Systems</b>	Social Prescribing	Pilot to run for 15 months including a three month evaluation as part of a broader programme of work for WSIC
	Model of Care- Frail Elderly	The Community Independence Service seeks to provide an integrated, holistic service that cares for individuals within their own homes who are at risk of unnecessary emergency admission, and to provide early, supported discharge for those recovering from a period of ill health
	Cancer	1. Increasing diagnostic capacity 2. More work to be done with community pharmacists in order to support people
	End of life Care	Promoting the use / refresh of Co ordinate My Care together with focus on education and training. Optimise role of Macmillan Cancer GP
	Management of LTCs	1. Address variation in primary care to improve outcomes and realise savings through systematised delivery of best practice and medicines optimisation resulting in fewer admissions, slower disease progression and reduced complications. 2. Scope ability to drive improvements in LTC management by incorporating contracting, education and training, data analysis and patient input, with a focus on 6-8 long term conditions including diabetes, CKD, respiratory (COPD/asthma), cardiovascular and mood disorders. 3. Engage with Imperial College Health Partners to support a programme of delivery

# Appendix 1: Project headlines

Theme	Projects	Project Outline
<b>Whole Systems</b>	Expanded primary care model	Full year effect of expanded primary care model as part of Whole Systems Programme, including development of Parsons Green hub and phase 2 of Parkview project
	Multi Disciplinary Groups	MDG function to be subsumed into the Whole Systems primary care programme
	Supported discharges	Continued focus on discharge of acute patients in home-based services and community facilities, including continued expansion of 7 day social workers in hospital wards and in-reach function of CIS
<b>Self Care</b>	Self management/ Self care	Community champions and practitioners bringing behavioural changes, standardised information, social prescribing, primary care navigators
<b>Underpinning principles/enablers</b>		
<b>Quality</b>	Patient and Stakeholder Engagement	Hammersmith and Fulham has an active programme of patient, carer and user involvement that ensures participation in a wide variety commissioning work streams. The CCG intends to strengthen current arrangements to ensure a wider range of participation and engagement activities that will further enhance the current engagement programmes
<b>Equity</b>	Equity	Delivery of services that are equitable in quality and access generated by quality impact assessments undertaken and monitored throughout the project life cycle, standard contracts, integrated IT services, setting of minimum standards for providers
<b>Estates</b>	Estates review/strategy	Development of schemes at Milson Rd, Parsons Green and Bush Doctors, as well as a potential recovery house and campus facility at White City
<b>IT</b>	Digital Mental Health	We will form part of the London wide procurement of a digital Mental Wellbeing Service
	Assistive technologies	1. Long term conditions self monitoring e.g. tele-health 2. Potential IT solutions for improving cancer screening
	Directory of voluntary services	Sign posting patients to community voluntary sector programmes/organisation which can support patients in managing their health and wellbeing, which will help keep patients out of hospital
	Innovation	Encourage innovation in delivery of care 1. Delivery in non-traditional ways e.g. Skype consultations 2. Smartphone apps for parents (e.g.: children with asthma) 3. Online tutorials for education (e.g.: asthma)
<b>Workforce</b>	Workforce Development	1. Roll out of training programmes funded by HENWL and workforce developments identified under WSIC 2. Understanding of the workforce modelling being undertaken by S & T and local application in H & F
<b>Transport</b>	Transport	Improved patient transport and better information on provider transport arrangements