Delivery of Hounslow CCG’s Out of Hospital (OOH) Strategy
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In order to meet the demands of a growing population with more long term conditions within the resources available, we need to improve prevention, early intervention and care at home.

We need to transform primary, community, hospital and social care and the way they work together to improve access, quality and capacity.

The vision for care in Hounslow is shared with our neighbouring CCGs in NW London - people, their carers and families will be empowered to exercise choice and control; GPs will be at the centre of organising and co-ordinating people’s care; systems will not hinder the provision of integrated care.

There are a number of interdependent programmes underway across North West London to deliver this:

- Primary care transformation
- Whole systems integrated care, including the Better Care Fund
- Shaping a Healthier Future

The diagram below shows the relationships between these programmes.

Hounslow CCG is making significant investments in out of hospital services to enable the reductions in activity in the acute sector that underpin the acute reconfiguration assumptions in Shaping a Healthier Future.
Shaping a Healthier Future

Whole Systems Integrated Care

- People with complex needs receive high quality multi-disciplinary care close to home, with a named GP coordinating care.

Primary Care Transformation

- People have access to General Practice services at times, locations and via channels that suit them seven days a week.

Self-management

- People are supported to self-manage and held together by resilience.

The relationship between the programmes is shown below.

- More health services available out of hospital, in settings closer to patients’ homes seven days a week.
- Community hubs
- More local diagnostic equipment
- Acute reconfiguration
- More specialised hospital care
- Less inappropriate time in hospital
- GP as lead for patient care
- Care delivery teams and time for care plans
- Groups of accountable care providers
- Local Authority and Social Care involvement
- Information systems and record sharing
- Less inappropriate time in hospital
- Capitated budgets
- Conveniences appointments
- Access via range of channels
- Assisting technology
- Family
- Carer
- Patient’s own GP practice
- Community support
- Urgent appointments
- Continuity appointments
- BCF
- PMCF
Transforming primary care

• 53 out of 54 practices in Hounslow taking part in Prime Minister’s Challenge Fund - covering a population of over 285,000 patients. Around £780,000 is available to Hounslow’s five networks to help deliver outcomes against urgent, continuity and convenient care. PMCF is helping GPs extend online access, for e.g. through rolling out electronic prescribing.

• **GP weekend opening** is now available in Hounslow - with one practice open each weekend in each of its 5 localities, open for 6 hours on Saturday and 4 hours on Sunday, all linked to 111. Five practices in Hounslow were open on Christmas Day, Boxing Day and New Year’s Day 2014. PMCF provides further opportunity to build on this.

• **44 practices are already offering telephone consultations** as an alternative to face to face appointments and **4 practices are offering email consultations** alongside conventional channels of patient access.

• **Primary care mental health services** have been enhanced with the introduction of primary care mental health workers who support GP practices to manage more complex mental health patients.

• 52/54 GP practices and all newly-commissioned community health services, such as the diabetes and heart failure services, now using **one IT system, SystmOne**, which standardises clinical records and in turn will aid integration between services.

• Along with Ealing CCG, we commissioned London Central and West Unscheduled Care Collaborative (LCWUCC) as the new **provider of GP out of hours services** across both boroughs. LCWUCC has been delivering the out of hours service on behalf of GP practices who have ‘opted out’ (15 GP practices in Hounslow) from providing this service directly since November 2014. The remaining ‘opted in’ practices will continue with their current arrangements.
Transforming primary care: out of hospital services portfolio

• Hounslow CCG, along with other CCGs in the Central London, West London, Hammersmith and Fulham, Hounslow and Ealing Collaborative agreed to commission a common out of hospital services (OOHS) portfolio, with standardised specifications and prices, to replace the previous Local Enhanced Services. This will ensure that all patients within CWHHE are able to access the same range of services.

• For Hounslow CCG, the total investment of £4.4m represents an increase of £2.3m on the 2013/14 LES budget.

• OOHS are being commissioned at a GP network level, with these new GP provider organisations or networks taking responsibility for ensuring that all patients within the network are able to access all the services.
Transforming primary care: out of hospital services portfolio

- Chiswick Locality is the first locality in Hounslow which has gone live with the following eight OOH services on a pilot basis:
  - Ambulatory Blood Pressure Monitoring
  - Anti-coagulation (levels 1 & 2)
  - Case finding, care planning and care monitoring
  - Wound care (simple and complex)
  - Near patient monitoring
  - Phlebotomy
  - Spirometry testing

- When fully implemented, the full range of services will include:
  - Diabetes (Level 1, High Risk & Level 2)
  - ECG
  - Homeless services
  - Mental Health services (Complex Common; Severe and Enduring)
  - Ring Pessary

- We expect to all services in place and 100% population coverage by 31 March 2016.
Transforming primary and community services

• We have commissioned a **community heart failure service** from West Middlesex Hospital to provide treatment for patients registered with a Hounslow GP who have a confirmed diagnosis of heart failure. The aim of the service is to increase access to specialist heart failure team advice for primary care colleagues and to support patients who have recently been discharged from secondary care or experienced heart failure. The service is delivered by two specialist heart failure nurses who are supported by West Middlesex Hospital consultants.

• We have also recently commissioned a new community **diabetes intermediate care service** with three distinct elements of service delivery that will go live in May 2015. The service includes care for intermediate patients with diabetes, foot protection, and patient education. The service will provide patients in Hounslow with a robust, safe and reliable community based diabetes service that meets their needs & improves their diabetic outcomes.

• A new **ambulatory emergency care service** is available at West Middlesex Hospital for patients who need urgent hospital care but which doesn’t require a UCC or A&E. Patients will be assessed, diagnosed and treated on the same day where possible. The service can refer patients into the weekend opening service if appropriate.
Integrating health and social care – Whole Systems Integrated Care

- The CCG is working with partners including London Borough of Hounslow, 5 GP Networks, WMUH, HRCH, WLMHT, voluntary organisations and patients, service users and carers as an Early Adopter of the NW London Whole system Integrated Care programme.

- Hounslow’s programme will target people with one or more long term conditions and people with dementia and other organic brain diseases over 16 years of age. This covers over 60,000 people.

- At the end of 2014, whole systems integration simulation events were held, which brought together health and social care workers, lay partners, patients, carers, and third sector representatives, to discuss current system works, co-design how a new system could look and how theirs and other professional’s roles would align in it.

- Work is in progress across most of the milestones for delivery of WSIC, including data sharing capability, shared care planning and GP locality network development.

- Delivery of WSIC is co-dependent on delivery of primary care transformation, out of hospital services portfolio and the Better Care Fund.
**Better Care Fund**

- Better Care Fund available for Hounslow Council and CCG in 2015/16 is £16,898,000. This is not new money and requires significant changes in health and social care economy, to a more preventative agenda with less reliance on statutory services.

- As our work and engagement in this area has evolved, we have been able to identify a number of common challenges for those in greatest need, which if addressed, would genuinely transform their quality of life and wellbeing. The illustration below highlights some of these challenges.

- We will work with WMUH to understand the positive impact of the BCF on preventing unnecessary admissions to hospital.
Better Care Fund

There are a number of overarching themes to the Better Care Fund plan:

- Help people self-manage and provide care navigation
- Invest in reablement and rehabilitation through an Integrated Community Recovery model
- Invest in locality based social work
- Universal Information, advice and signposting
- Integrate NHS and social care systems around the NHS Number and through a single point of access across health and social care
- Integrated dementia services
- Seven day working in localities for GP services and hospital social work teams supporting community provision
- Personal Care Framework commissioned to replace existing traditional homecare services
- Implementation of the Care Act, supporting the additional costs of implementing the act for local authorities is a requirement of the BCF.
- Protection Adult Social Care, including the need to support carers
- Care homes, both in relation to GP cover and support and quality monitoring.
- Care Plans for over 75s through primary care and co-ordinated care
Integrating health and social care – Better Care Fund

• We have introduced the Integrated Community Response Service (ICRS) - a team of GPs, nurses, a mental health nurse, a handyman and a social worker is available from 7am to 7pm seven days a week. It provides patients over the age of 18 with help within two hours of the service being called. The team works to prevent people going into hospital or a care home when they could be looked after in their own home. The team also provides support at home to allow people to return home from hospital more quickly.

• We are redesigning our rehabilitation and reablement service model and pathway to provide, alongside the Integrated Community Response Service, a Community Recovery service: a combination of reablement and community rehabilitation, which will work with individuals who have lost their independence through illness or accident and support them to build confidence, regain skills and to self-manage their health conditions and medication. The service will introduce patients to assistive technologies such as Telecare and Telehealth.
Integrating health and social care – Better Care Fund

- **Social workers and GPs are working together in pathfinder localities.** Two localities (Feltham and Great West Road) are piloting this initiative with the existing locality multi-disciplinary groups. From April 2015 this will be rolled out across all five localities. Our multi-disciplinary teams work with the voluntary, community and independent sector to support highest risk patients to ensure they can access all the services they need, self-manage their conditions and proactively ask for help, so they remain healthy, independent and well.

- The evaluation of the **Care Navigator Service** has highlighted the benefits of the scheme and shown areas for future development. These scheme is being developed by bringing together learning from the pilot scheme and learning from simulation events and whole systems planning. The scheme will be co-designed and have full engagement with members of the Patient and Carer Reference Group throughout the procurement process.
Integrating health and social care – Better Care Fund

- GPs are undertaking clinical sessions in care homes at weekends reducing admissions to hospitals from care homes at weekends.

- The Council and the CCG have jointly procured an integrated recovery-focused Personal Care Framework to provide people with effective, quality and appropriate health and social personal care at home as an alternative to traditional homecare.

- Additional social work capacity, including presence in Emergency Departments, is an integral part of BCF plans to support the acute sector. Additional hospital social work capacity will ensure that more section 2s are dealt with within 48 hours which will significantly reduce the number of delayed transfers of care. We are have remodelled the hospital service to extend social care to 7 days per week, and ensure that weekend discharges are enabled and that homecare packages under the new Personal Care Framework are able to be set out of normal office hours. This will be initially funded through systems resilience funding from November 2014, and will be funded through the Better Care Fund from April.
Next steps – 2015/16

- We will be developing plans to commission a non-emergency patient transport service to support the shift of services from hospital to community setting. This will help patients access new community and primary care services, and in turn reduce non-attendance rates.

- We will be developing the integrated community paediatric hubs to reduce outpatient paediatric referrals and improve access to paediatrics in the community. Core elements of the hubs will be: regular joint clinics (GP and consultant) at GP practices, regular multi-disciplinary team meetings, improved access to acute paediatric advice, and parental support.

- Work will be done on clarifying the urgent care pathway across 111, UCC and GP access including weekend opening.

- We will also be looking at the further development of the GP weekend opening initiative.