North West London Sustainability & Transformation Plan (STP) Update

London Borough of Hammersmith & Fulham - Health, Adult Social Care and Social Inclusion PAC

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Contents

Part One

The NW London STP & the H&F Joint Health and Wellbeing Strategy

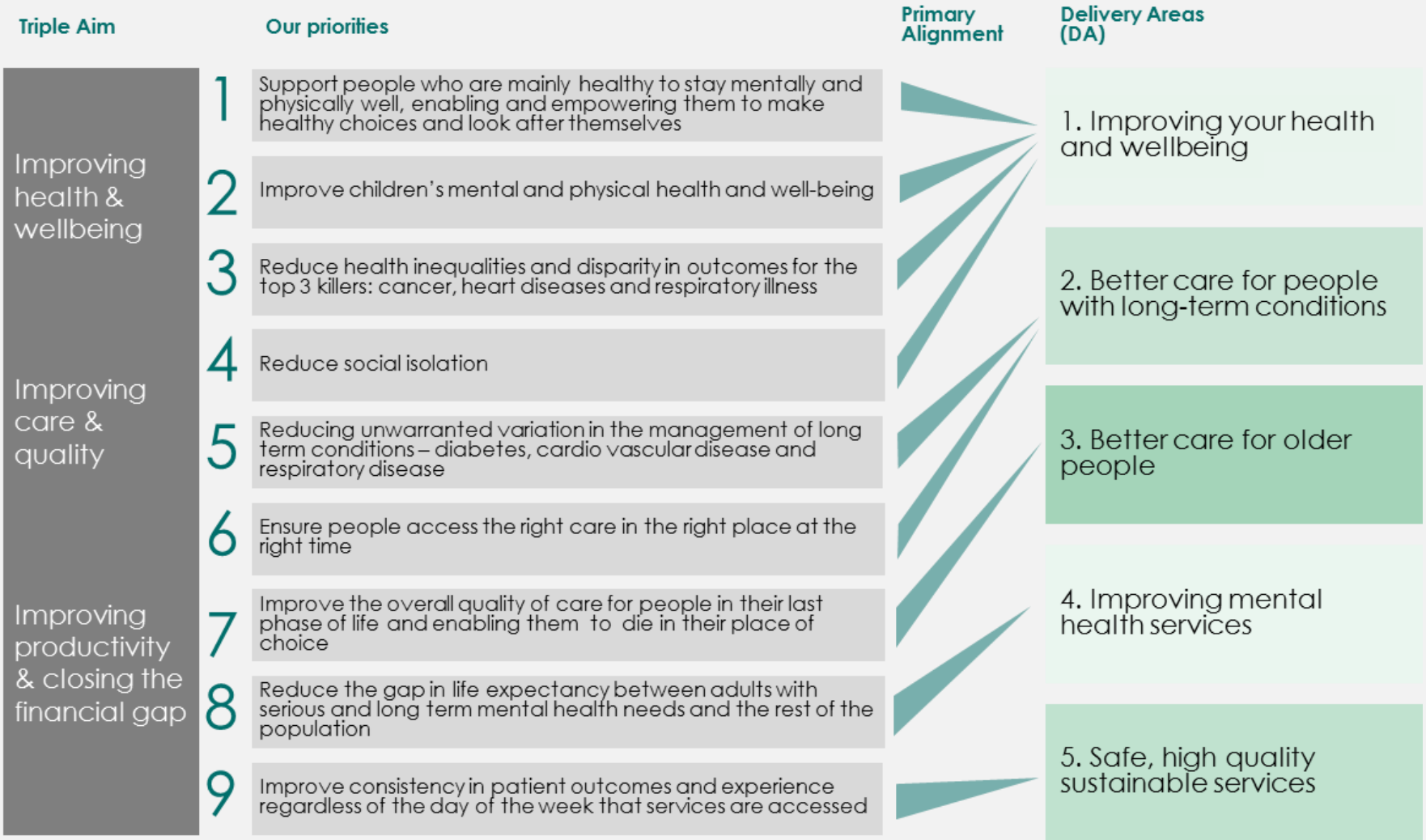
1. The purpose of the NW London Sustainability Transformation Plan

- NHS England's Five Year Forward View (FYFV) sets out a vision for the future of the NHS
- Local areas have developed a **Sustainability and Transformation Plan (STP)** to help local organisations plan how to deliver a better health and care service that will address the FYFV 'Triple Aims' of:

  1. **improving people's health and wellbeing**
  2. **improving the quality of care that people receive**
  3. **addressing the financial gap**

- This is a new approach across health and social care to ensure that health and care services are planned over the next five years and **focus on the needs of people living in the STP area, rather than individual organisations**
- This provides us in NW London with a unique opportunity to:
  - **radically transform the way we provide health and social care** for our population
  - maximise opportunities to **keep the healthy majority healthy**
  - **help people to look after themselves** and **provide excellent quality care in the right place when it is needed**
- The STP process also provides the drivers to **close the £1.4bn funding shortfall** and **develop a balanced, sustainable financial system** which our plan addresses

- We have developed **a set of nine priorities** that will enable us to achieve our vision and **fundamentally transform our system**
- We will focus on **five delivery areas** in order to deliver against these priorities at scale and pace



3. How the delivery areas fit with the joint health and wellbeing priorities in H&F

The triple aim	STP delivery areas	JHWS priority areas	STP Plans
Improving health and wellbeing Improving care and quality Improving productivity and closing the financial gap	**DA1** Radically upgrading prevention	**PA1** Ensuring children, young people and families get the best possible start	a) Enabling and supporting healthier living for the whole population b) Keeping people mentally well and avoiding social isolation c) Helping children get the best start in life
	DA2 Eliminating variation and improving LTC management	**PA2** Addressing the rising tide of long-term conditions	a) Delivering the Strategic Commissioning Framework and FYFV for primary care b) Improving cancer screening to increase early diagnosis c) Better outcomes and support for people d) Reducing variation by focusing on Right Care e) Improve self-management and patient activation
	DA3 Achieving better outcomes for older peoples		a) Improve market management and tale a whole systems approach to commissioning b) Implement accountable care partnerships c) Upgrade rapid response and intermediate care services d) Create an integrated and consistent transfer of care approach e) Improve care in the last phase of life
	DA4 Improving outcomes for children and adults with mental health needs	**PA3** Ensuring good mental health for all	a) Implement new models of care for people with serious and long-term mental health needs to improve physical and mental health and increase life expectancy b) Focused interventions for target populations c) Crisis support services d) Implementing Future in Mind
	DA5 Ensuring we have a safe, high quality sustainable acute services		a) Specialised commissioning to improve pathways from primary care and support consolidation of specialised services b) Deliver 7 say service standards c) Reconfigure acute services d) NW London Productivity programme
	Enablers	**PA4** Delivering a sustainable health and care system that is fit for the future	a) Estates b) Digital c) Workforce

4. What we've delivered for residents and patients here in H&F

DA1/PA1	DA2/PA2	DA3/PA2	DA4/PA3
Initiated a Child Health GP scheme whereby we've recruited seven GPs onto an education and leadership development programme, who will act as local champions for child health and help children to get the best start in life	Leading diabetes transformation programme on behalf of north west London CCGs following significant improvements within H&F in improving the consistency and quality of diabetes care within the borough.	Leading the Last Phase of Life Programme on behalf of NW London CCGs, initially focusing on improving the support provided to residents living in care homes through the introduction of a telemedicine support function across five CCGs due to go live early in 2017/18	Improving the support available through primary care by commissioning services for residents with complex common and severe and long-term mental health conditions via their registered GP
Supported diabetic patients to manage their own condition more effectively through the innovative use of apps that allow them to access education materials and interact with clinical teams	On-going development of out of hospital contracts within primary care to expand the breadth of services available to residents with long-term conditions closer to home.	Successfully rolled out a mobile IT platform within our Community Independence Service, ensuring staff working with our most vulnerable patients have real time access to Adult Social Care and Primary Care records	Linking the 24/7 mental health crisis support line in north west London to 111, allowing residents undergoing a mental health crisis to access appropriate specialist support via 111 without having to redial
Worked with SOBUS to successfully bid for grant funding to enable frequent users of Emergency Care to access alternative support			Successful introduction of a perinatal mental health service within H&F, caring for women from conception through to 6 months postnatally. A comprehensive evaluation demonstrated very positive feedback from women using the service, which the CCG is now considering for recurrent investment

Following the October submission of the NW London STP, work has focussed on the following:

GOVERNANCE

- **Establishing Delivery Area boards, Enabler groups and project groups that are fully representative** and have the skills and expertise required to successfully deliver the STP outcomes
- **Supporting statutory bodies to discuss and agree the STP** at statutory body meetings
- **Strengthening of STP governance arrangements**, to be overseen by the Joint Health and Care Transformation Group, and formalised by statutory bodies

PRIORITISATION

- **Developing plans across delivery areas**, setting out the drivers for change, proposals for funding, investment required and expected savings and benefits for each project to enable focus on delivering the areas with maximum impact, whilst further developing other projects
- **Establishing a prioritisation or phasing of projects** that has support from across all STP partners **to enable focus on delivering the projects with maximum impact** whilst further development of other projects
- **NHS England (NHSE) Transformation Funding** – bids were submitted on 18 January 2017 for the initial top priorities for 2017/18 and 2018/19 identified by NHSE; these covered cancer, mental health and diabetes

In developing our STP we have established a **joint governance structure** to:

- **strengthen working between health and local government**; and which
- ensures there is **strong political leadership** over the STP, with **joint accountability** for the successful delivery of the plan

JOINT NW LONDON HEALTH AND CARE TRANSFORMATION GROUP (JHCTG)

- **Oversees development and delivery of STP** in NW London
- **A multiagency forum** to develop plans to meet heath and care needs of NW London residents
- Representation from across **NHS and Local Government** (commissioners, providers, councillors and officers)

DELIVERY AREA (DA) PROGRAMME BOARDS

- Each DA is **overseen by a DA Board**, chaired by two SROs
- **DAs 1 to 4** are co-chaired by **senior representatives from NHS and Local Government**
- **DA5** is co-chaired by **senior NHS provider and commissioner representatives** (as focus is on ensuring safe, high quality, and sustainable acute services)

ENABLER GROUPS

- Workforce
- Digital
- Estates

- The five DAs are **supported by three enablers: workforce, digital and estates**
- These are joined by a number of **other specialist bodies including the NWL Clinical and Care Board** in advising the JHCTG

Part Two

Acute services

1. Investing in our acute services – SOC1 and SOC2

- In NW London, our STP builds on the clinically-led portfolio of programmes called *Shaping a Healthier Future* (SaHF)
- SaHF has undergone full public consultation, with outcomes approved by a Joint Committee of Primary Care Trusts (JCPCT) in 2013 and agreed by the Secretary of State for Health
- Last December we published a business case (SOC1) which supports both NW London's STP and SaHF vision
- SOC1 does not revisit the JCPCT decisions to designate hospital sites as major, local, elective or specialist hospitals.

What is SOC part 1?

- a technical document to secure **£513m** of capital to enable us to change the way we care for people by improving the quality and capacity of **primary, community** and **acute estates** in North West London
- makes the case to invest in primary care estate, out of hospital hubs, acute hospitals in outer NW London and the local hospital at Ealing, with an updated list of services at Ealing on which there will be further engagement

What is SOC part 2?

- a technical document to secure capital investment in the subsequent phase of SaHF delivery
- will make the case for investment in acute hospitals in the inner NW London, including Charing Cross

2. SOC1 – Ealing Hospital & out of hospital hubs

You asked us for an update on Ealing hospital

Our focus for the STP for the first two years:

- To develop the new proactive model of care across NW London
- To address the immediate demand and financial challenges.

Ealing Hospital

- Running parallel over the next two years we are looking at what services we want to provide at Ealing hospital
- Our preferred list is included in SOC1 (pages 59-60) and we will be engaging our local residents and patients on these services
- However no substantive changes will be made until there is sufficient alternative capacity out of hospital or in acute hospitals.

And here in Hammersmith & Fulham

- SOC part 1 includes capital investment into the Parsons Green Centre for Health and Social Care (£4.6million) as well as for primary care across the borough (£13.7million)

3. SOC2 – Charing Cross

You asked us for an update on Charing Cross hospital

- Our goal remains to transform Charing Cross into a local hospital, as set out in the original SaHF plan
- We will develop the business case, SOC2, and engage the residents of Hammersmith & Fulham on the services we will deliver on that site.
- However the immediate focus is on improving our out of hospital services and improving care for our frail elderly
- We have been clear that no changes will be made to Charing Cross until there is sufficient alternative capacity either in a community setting or in our other acute hospitals
- That means we wont see any planned changes to the A&E services currently being provided, during this STP period

We will continue to keep the Committee updated as we make progress

Part Three

Engagement

1. Current engagement

We have been doing pre-engagement work to understand:

1. How people want to communicate with us?
2. The language they want us to use

We developed a survey, tested with all NW London Healthwatch and patient groups, and have surveyed over 1,000 people in GP practices, hospitals and other public spaces across the eight boroughs finding:

- the public prefer to receive information through posters and leaflets, NHS websites and via social media;
- they prefer to make comments via email;
- the appetite for attending public meetings was limited (two-thirds so far said not interested)
- but the third who did want to attend public meetings said we should hold them in the early evening to allow people to come after work.

2. The next stage of our engagement

The Survey will help us shape the programme of events, materials and messaging and develop a full engagement plan, with a focus on getting feedback from the public on two key areas:

1. How we could invest in infrastructure in GP practices and the proposed out of hospital hubs in Hammersmith & Fulham

2. More detailed engagement and co-design of services aligned to the latest STP

The proposed activities for the full engagement strategy will be reviewed and developed following engagement and co-design with staff, patient representatives and key stakeholders including the local authority and Healthwatch.

We would like your thoughts and views to help shape this engagement

Appendix A – further detail on H&F STP delivery.

Delivery Area 1 - Radically upgrading prevention

- **Child Health Scheme**
  - Funded through a successful application to Health Education England (HEE) NW London for £120k grant for Partnerships in Innovative Education (PIE)
  - Co-ordinated through the H&F GP Federation
  - The 7 GPs recruited are currently finishing their inductions and will be co-designing their training, including additional clinical sessions working with local paediatric consultants
  - The GPs will also be undertaking the Quality, Service Improvement and Redesign (QSIR) programme to develop into child health leaders for the local child health networks
- **Apps for Patients with Diabetes**
  - Currently working with 4 practices to roll out the Vitrucare, providing patients with a platform that integrates with their electronic health record to manage their condition
  - The initial focus will be for patients with diabetes but with a patient focussed design that allows guidance to be provided for multi-morbidities to those living with more than one long term condition (LTC)
  - Dynamic Health Systems, the provider of Vitrucare, have reached an agreement to host the Patient Activation Measure within the platform providing the opportunity to deliver patients with appropriate information to their level of activation through the software
  - Also working with the NW London Digital team to pilot three apps, which provide structured education for people with diabetes, as an alternative to in-person educational programmes
- **Frequent user of Emergency Care**
  - A joint programme of work using the shared resources of health, social care and voluntary sectors to provide support to frequent users
  - Developed in partnership with Sobus and wider voluntary sector organisations through the Providers of Older Peoples' Services forum
  - HEE NW London Urgent Care Initiative funding received (£20k) to develop specific, multi-professional approaches based on the individual needs of different cohorts with frequent utilisation of health services

Appendix A – further detail on H&F STP delivery.

Delivery Area 2 - Eliminating variation and improving LTC management

- **Leading diabetes transformation programme on behalf of NW London CCGs following significant improvements within H&F in improving the consistency and quality of diabetes care within the borough.**
  - Programme director in post to coordinate the work, currently drafting a comprehensive programme plan with set timescales. Currently awaiting outcome of bid submitted to NHSE on 18th January for transformation funding. Separate bid also submitted for STP funding across the whole footprint of NW London.
  - Since the OOH services have gone live in H&F;
    - % people receiving 9 key care processes has increased from 24.4% to 46.5%
    - % people with a care plan reviewed <15months increased from 16.4% to 62.6%

- **On-going development of out of hospital contracts within primary care to expand the breadth of services available to residents with long-term conditions closer to home.**
  - Currently there are 4 Out of Hospital Services that provide greater support to patients that have a long term condition – these are Diabetes, the Mental Health services, Anti Coagulation and the monitoring of patients on specific drugs relating to arthritis. In addition to these services, our practices proactively care plan patients that are at most risk of having an emergency admission into hospital, many of whom will also have a long term condition. Additional Out of hospital services are being considered for development(e.g. greater management of Asthma for example) which will also serve to provide care for patients suffering with other specific long term conditions with care closer to home.

Appendix A – further detail on H&F STP delivery.

Delivery Area 3 - Achieving better outcomes for older peoples

- **Leading the Last Phase of Life Programme on behalf of north west London CCGs, initially focusing on improving the support provided to residents living in care homes through the introduction of a telemedicine support function across five CCGs due to go live early in 2017/18**
  - There are approximately 25,000 people who are in the last 12 months of life in north west London. Many of these people are currently cared for by unplanned services such as A&E's and emergency admissions to hospital. Research shows us that approximately 25% of all hospital beds are occupied by people in the last phase of life and that 40% of those people have no clinical need to be in hospital.
  - The Last Phase of Life Programme seeks to provide pro-active and holistic support to people in the last phase of life and their carers and families. In the first instance, we are focusing on introducing a telemedicine support function to care homes, providing 24/7 instant access to experienced clinicians able to provide reassurance and agree treatment plans with care home staff and residents.
  - Following the introduction of the telemedicine service, we will be seeking to expand support to care more effectively for those people in their own homes, some of which may receive care from district nursing or home care services, and some of which may receive informal support from friends and relatives.

- **Successfully rolled out a mobile IT platform within our Community Independence Service, ensuring staff working with our most vulnerable patients have real time access to Adult Social Care and Primary Care records**
  - Clinicians working in the Community Independence Service (CIS) have consistently fed back difficulties in caring for patients without having mobile access to their primary care and Adult Social Care (ASC) records. This has now been addressed through work initiated by Hammersmith & Fulham CCG to introduce mobile access to a newly created CIS module on SystmOne.

Appendix A – further detail on H&F STP delivery.

Delivery Area 4 - Improving outcomes for children and adults with mental health needs

- **Improving the support available through primary care by commissioning services for residents with complex common and severe and long-term mental health conditions via their registered GP.**
  - From 1st April 2017, both of these mental health services will be provided by all GP Practices in Hammersmith and Fulham, meaning that patients' practices will manage both the physical and mental health care of patients. H&F GP Federation's Community Provider Education Network (CPEN) is developing a programme of education to enable practitioners to further enhance their skills in managing patients with mental health needs; 5 GPs in the borough have undertaken a diploma in Mental Health with 3 Pharmacists also having undertaken a diploma to support greater management of mental health prescribing. In addition the CEPN has developed an Education Hub for Mental Health, which will act as a centre for excellence providing education and support for practices across the borough for the on-going delivery of these services.
- **Linking the 24/7 mental health crisis support line in NW London to 111, allowing residents undergoing a mental health crisis to access appropriate specialist support via 111 without having to redial.**
  - Since NHS 111 was launched in 2012, there has been no formal arrangement with mental health crisis services in relation to the referral process.
  - To improve care for people with a mental health crisis, Mental Health Commissioners from the Clinical Commissioning Groups (CCGs) have agreed that all patients presenting to 111 in a crisis situation should be warm transferred to the appropriate mental health crisis hub for further assessment and direction.
  - The scheme is currently finalising its development and standard operating procedures and hopes to start in early March
- **Successful introduction of a perinatal mental health service within H&F,** provided by West London Mental Health Trust across H&F, Ealing and Hounslow. The service provides care for women from conception through to 6 months postnatally. A comprehensive evaluation showed the following;
  - 736 referrals were received
  - 395 people seen in the first 8 months, 112 in H&F
  - Predicted numbers of women based on national estimates of prevalence across the 3 CCGs with severe mental illness is 30. The service has seen 85 (partially due to Queen Charlottes's seeing women with an increased level of need as a tertiary centre)
  - Training delivered to 600 staff members including midwives, GPs and Improving Access to Psychological Therapies (IAPT)staff