London Borough of Hammersmith & Fulham

Health, Adult Social Care and Social Inclusion Policy and Accountability Committee

Supplementary Agenda

Tuesday 7 July 2015
7.00 pm
Courtyard Room - Hammersmith Town Hall

MEMBERSHIP

Administration:	Opposition	Co-optees
Councillor Rory Vaughan (Chair) Councillor Hannah Barlow (Vice-chair) Councillor Natalia Perez Shepherd	Councillor Andrew Brown Councillor Joe Carlebach	Patrick McVeigh, Action on Disability Bryan Naylor, Age UK Debbie Domb, HAFCAC

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Date Issued: 01 July 2015

London Borough of Hammersmith & Fulham

Health, Adult Social Care and Social Inclusion Policy and Accountability Committee

Supplementary Agenda

7 July 2015

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Proposed acquisition of West Middlesex University Hospital NHS Trust by Chelsea and Westminster Hospital NHS FT

In Summary

- The key principle of the proposal is to:
  - Support care closer to home
  - Retain local A&E, maternity and core acute services on both sites
- In the Summer of 2012, West Middlesex University Hospital NHS Trust invited expressions of interest from potential NHS partners to work together to achieve foundation trust status
- Following a robust appraisal process West Middlesex selected Chelsea and Westminster Hospital NHS Foundation Trust as its partner in April 2013
- Although formally Chelsea and Westminster are the acquiring organisation, the decision represents the best option for securing the future of both organisations as major acute hospitals
- Both Trusts are facing the following challenges: sustainability due to size; financial challenge given a future NHS flat budget; increasing demand and acuity leading to operational pressures; higher quality expectations; rising patient expectations and an evolving shift to integrated care and new provider models
- By combining into a single, unified trust it will provide scale and catchment population to support other strategic and clinical partnerships; provides high-volume, high-quality local secondary services and underpin ongoing provision of tertiary services
- The two trusts share similar values and joining forces will increase the number of referrals and the population covered – bringing benefits for both patients and staff

Patient, Clinical and Research Benefits of the Acquisition

Patient and Population Benefits

- Support the ongoing clinical and financial sustainability of services on both sites, enabling patients and their families to continue accessing a wide range of acute, secondary and tertiary services locally

- New models of care will lead to tailored, patient-centric care pathways. The patient journey will be seamless and integrated, resulting in the best possible experience for patients and their families

- The integration will support the sharing of best practices across sites, building on CWFT's track-record, including the sharing of best practices on improving experience for patients and their families

- Acquisition will create a combined entity servicing eight local CCGs and a population of c.1.1 million, and will bring the benefits of the FT membership and governance model to this wider catchment.

Clinical Benefits

- Greater clinical size of the organisation will support a larger workforce and enable the implementation of safer, consultant-led care 7/7, in line with the latest clinical guidelines

- Greater clinical size in key service lines, such as orthopaedics, will enable improved clinical outcomes

- New services, such as access to a cardiac catheter lab, will enable inpatients who experience acute cardiac events (non ST-elevation myocardial infarction) to receive attention directly, without delays or transfer elsewhere, thus meeting key guidelines on intervention within 24 hours

Research Benefits

- Wider catchment area will increase patient access to research programmes, driving innovation and improved quality of care

- The greater size of the new organisation should boost patient volumes and thus the organisation’s ability to participate in leading, cutting-edge trials

Regulatory Process Update

- The Competition and Markets Authority (CMA) gave clearance in December 2014 for the acquisition The assessment process examined whether the integration of the two trusts would lead to a 'significant lessening of competition' or a reduction in access or choice of services for local people. The CMA contacted a range of organisations and individuals as part of their analysis.

- Acquisition presentations and background material have been provided to CCGs: Hammersmith & Fulham, Central London, Ealing, Wandsworth, Richmond, Hounslow, West London, Hillingdon and Harrow. Representatives from the Trusts have visited senior teams to address questions and concerns. Communications and engagement has also been undertaken with local Healthwatch groups, GPs and other stakeholders.

- Monitor, the Foundation Trust regulator, commenced their review of the proposals in February 2015, and this will conclude imminently. They will issue a risk rating which will be considered by the CWFT, who will make the formal decision to proceed.

- The formal sign-off process involves local clinical commissioning groups , Monitor, the NHS Trust Development Authority, the two trusts – including the Board of Directors and Council of Governors at Chelsea & Westminster Hospital NHS Foundation Trust

- Thereafter the application will be made to the Secretary of State for the transaction to take place on 1 September 2015.

Monitor Regulatory Framework – Four domains used by the regulator to assess the transaction

Domain 1: Strategy - Is there a clear strategic rationale for the transaction?

Rationale for the acquisition

- Provision of high quality services developed and maintained at both sites
- Alignment with commissioner strategies for sustainable services
- Capital development of the estate and service developments
- Funding of an Electronic Patient Record (EPR) system to drive integration and provide assurance on safety, quality and consistency of patient service
- Greater assurance on the financial sustainability of the Trust

Risks to the Trust if the acquisition is not approved

- Current service portfolio is not financially sustainable, with a number of sub-scale specialities and an over-dependence on specialities that contribute a surplus
- A standalone Trust is less resilient to changes in tariff, and has less opportunities for standardisation and cost efficiencies
- The Trust has a legacy Electronic Patient Records IT system which needs to be refreshed and improved in the next 3 years. Without this transaction, this would not be affordable

Key transaction risks and mitigations

- Financial settlement has been negotiated to support the new organisation to address key risks identified in the due diligence e.g. WMUH PFI, historic deficit and risk to CIPs
- Board has overseen development of Post Transaction Integration Plan to deliver integration. The first phase (pre-integration to day 100) has been successfully tested for clinical and cultural risks through the TDA Clinical Quality and Oversight Groups (CQoG) risk assessment process

Domain 2: Transaction Execution - Does the trust have the capability and plans in place to execute the transaction successfully?

Capability and Capacity

- Trust has identified a need to review the capacity of its Executive and senior management structures to address the increase and in size and scale of operations
- Over the last two years, all Board appointments have been made with the acquisition in mind e.g. the interim CEO and Chief People Officer, both of whom have a strong background in M&A within the NHS and wider public sector (N.B. The new Chief Executive scheduled to start on Sept 15th also has direct experience of successful NHS mergers)
- Indeed a new management structure is designed to increase the profile of key areas within the post-acquisition organisation, e.g. IM&T, Governance, Risk Management.

Delivery of the Transaction

- Phase 1: Safe Landing – Focused on a Safe Services Review: A 'Safe Services Review' will establish a safe and effective organisation to maintain high quality of care. The process will include a template to collate intelligence about individual services and discussions between clinicians on challenges and opportunities*
- Phase 2: First 100 Days – Focused on Stabilisation: Major changes to the clinical service lines will be kept to a minimum. Governance processes will be scaled across the new Trust, including Board / Committee structures and reporting mechanisms. Tracking mechanisms will be established and critical quality processes aligned
- Phase 3: Beyond 100 Days – Focused on Service Standardisation & Development: Initial integration of all service lines will take place during year one, including key policies, protocols and processes (with day 1 critical policies in place at launch), as well as best-

practice sharing, rota optimisation, and standardised operating procedures / clinical protocols

*TDA have led an assessment process to assure our approach to clinical risk and patient safety and this resulted in a green rating

Domain 2: Lessons learned from other Trusts which has shaped the Chelsea and Westminster approach to the Transaction

- Main lesson learnt from other transactions is the need to address clinical cultural buy- in:
  - Due diligence has shown that CWFT and WMUH are very similar culturally and have been involved in a lengthy acquisition process
  - Since the CMA decision there has been significantly closer working relationships and a shadow structure developed at WMUH
  - There have been 5 clinical summits to date (500+ clinicians attending) and an independent survey shows clinical engagement at both Trusts is in the top 20% nationally
- CWFT has invested significant time and effort reviewing lessons learned from other recent acquisitions (see below)

Lesson Learned	CWFT Response
Trust staff on acquired site sooner	CWFT have seconded 3 staff to WMUH: • Medical Director (September) • Operations Director (March) • Director of Nursing (May)
Bring clinicians together as early as possible	1. CWFT has instituted DIGs to bring together the Divisional leadership and wider service teams in each Division across each site to co-develop 2. Clinical Summits
Clinical due diligence and clear line of sight at detailed service level	Safe Handover Template replicated from RFH and DIGs used to ensure robust completion of templates
Real integration is a long-term project and will take years, therefore need to ensure the right structures are in place	1. Local site leadership in place 2. Flat structure proposed 3. Additional governance support identified
Single Medical Director provides non-viable span of control	Office of the Medical Director proposed including a Deputy MD at WMUH and associate MDs with designated portfolios
3 separate PAS systems	CWFT has rooted its negotiation strategy and clinical transformation around EPR and system and service standardisation

Domain 3: Quality – How is quality maintained or improved as a result of the transaction?

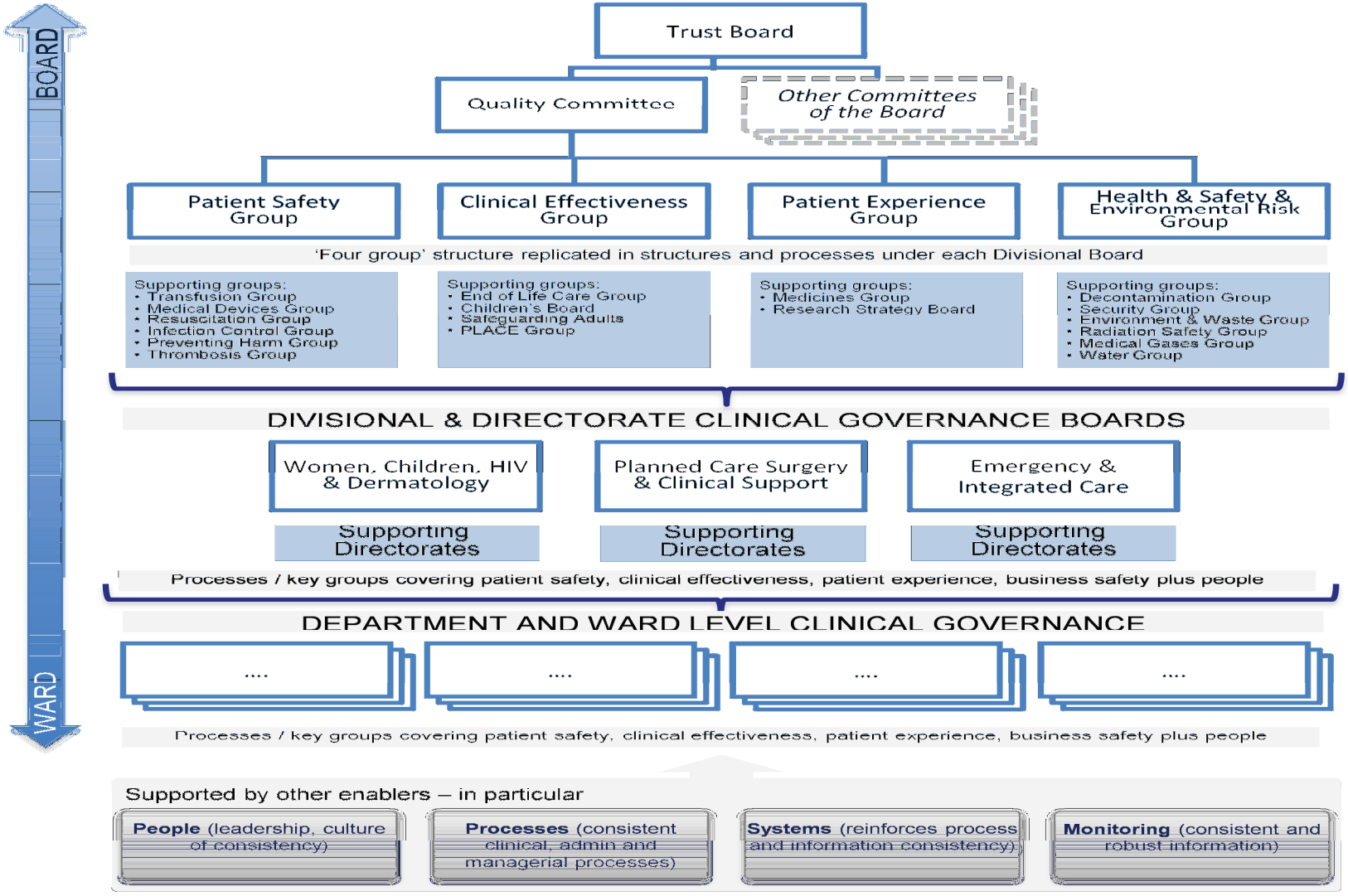
Delivery of the Trust's Quality Strategy is supported through:

- Robust and consistent quality and clinical governance processes
- Strong multi-disciplinary working between all staff, supported by the Clinical Governance Team
- Clarity of purpose for all staff on their roles and responsibilities for improving quality

Key actions are in place in relation to governance

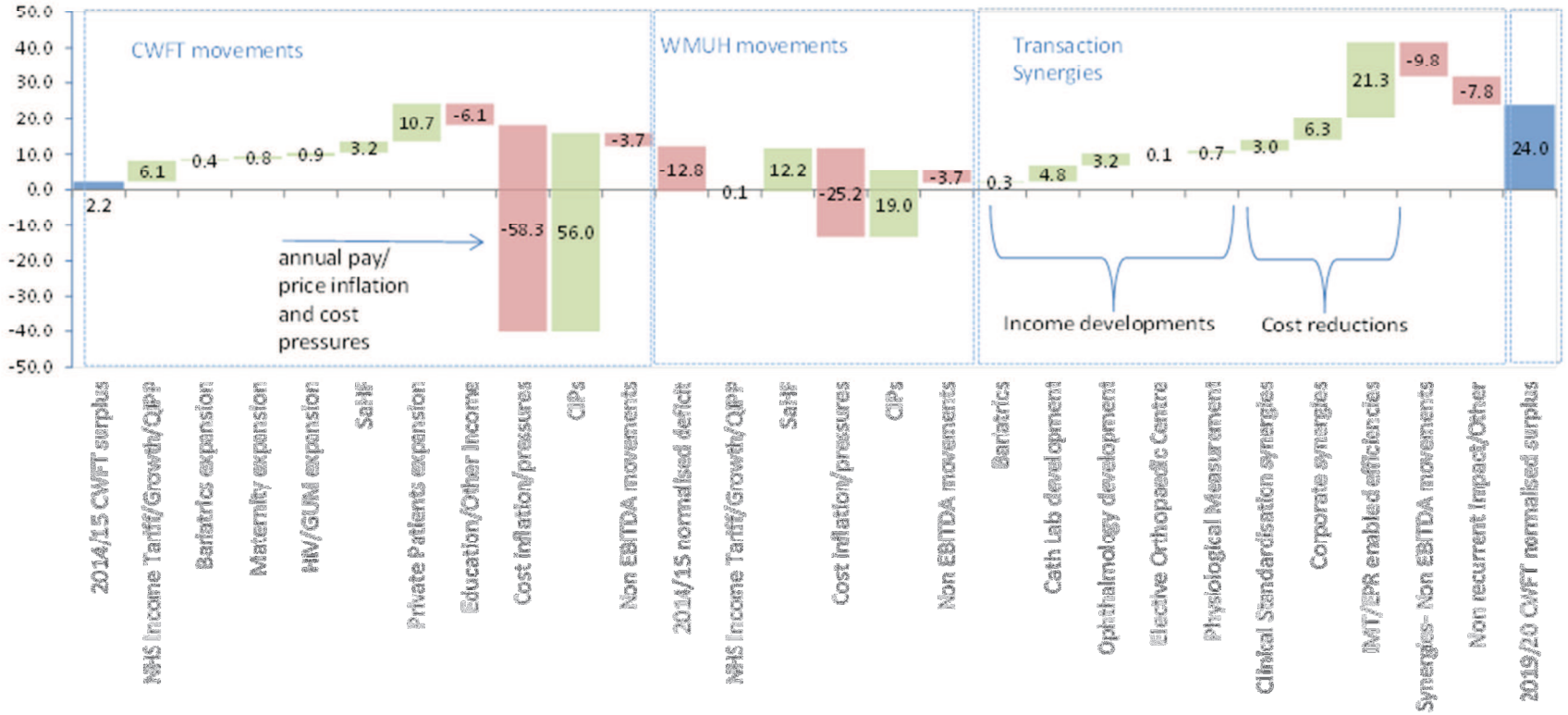
- A common framework has been introduced to Corporate and Divisional Boards to support effective quality management, providing assurances to the Trust Board
- Applied best practice recommendations to develop an aligned and relevant set of metrics
- Identified relevant and reliable management information to continually assess and mitigate quality risks
- Ensured that quality is embraced as a responsibility of every staff member
- Ensured clear roles and accountabilities in relation to governance and quality
- Continued to improve awareness and information for staff
- Involved and engaged patients, staff and other key stakeholders

Domain 3: Quality – Proposed Governance Framework



Domain 4: Finance - Does the transaction result in an entity that is financially viable?

CWFT (Combined organisation)
Surplus Bridge 2014/15 to 2019/20



Concerns for Chelsea and Westminster NHS FT if the acquisition does not proceed

Clinical Quality

- Difficulty in maintaining breadth of commissioner requirements with potential loss of services
- CW remains smaller player in population health which impacts upon focus upon integrated care developments, research and education
- Reduced scope to put in place sustainable quality improvement strategies with likely impact on CQC standards
- Steady decline in clinical outcomes and patient experience as investment in staff, estate and transformation reduces

Strategy

- SaHF drives 'hotter site' and non profitable services with reduced opportunity to develop specialist and other services
- Unlikely to be another acquisition opportunity that meets CMA tests (for C&W or for WM)
- Issues of sub scale clinical services not addressed
- History of good performance at WMUH struggling due to lack of scale

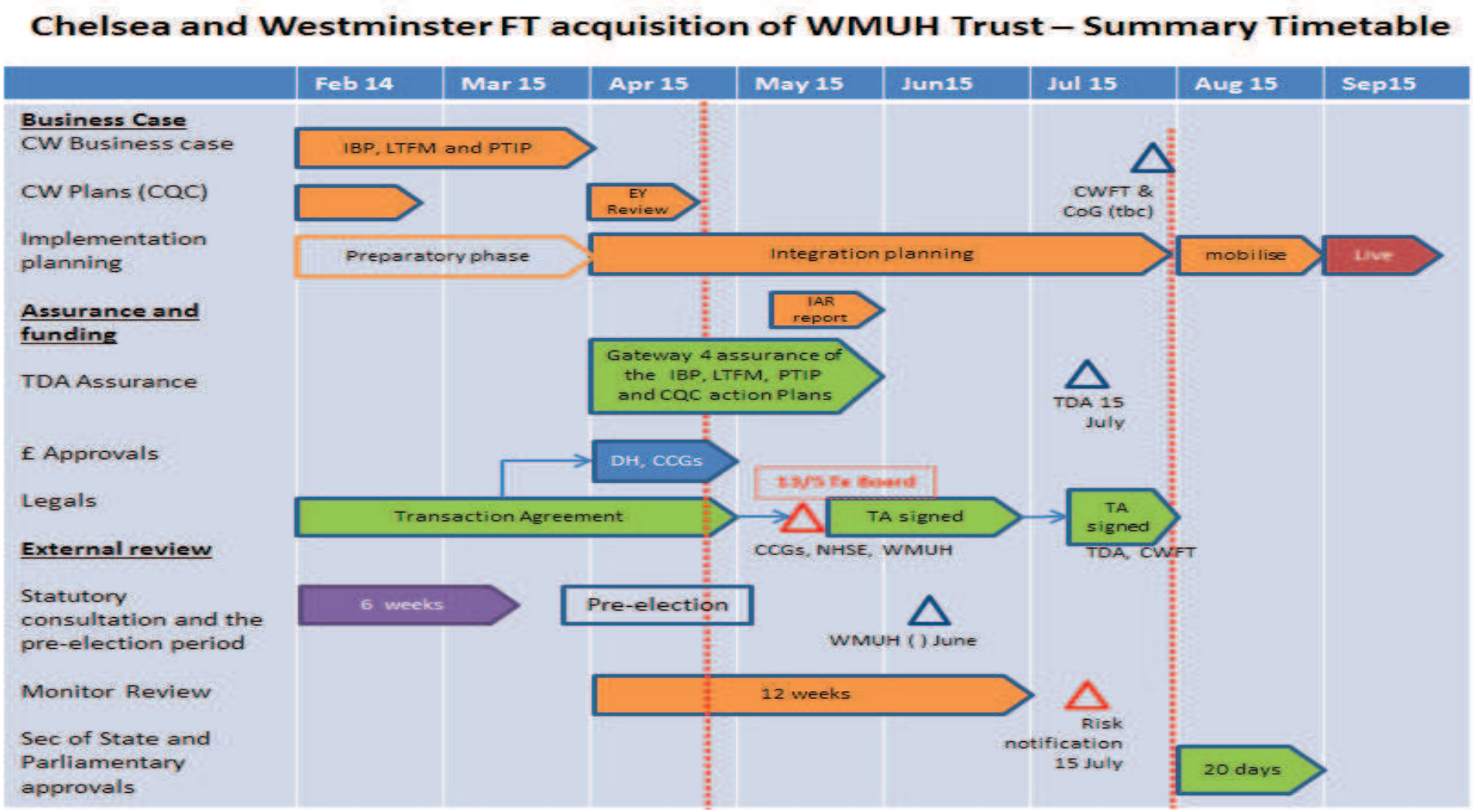
People

- No indication that current trend on retention of staff can be improved without step change in approach
- Failure to offer career development/sub speciality opportunities commensurate with London teaching hospital competitors
- Motivational impact on clinical (and other) staff engaged in integration plans

Finance

- S/A LTFM does not reach CoSR 3 and does not generate sufficient productivity opportunity
- Both CW & WMH unable to fully address deficit run rate (synergies and scale are key remedial measures)
- Loss of significant DH acquisition investment funding
- No bring forward of EPR implementation
- Adverse impact on liquidity (re-structure of loans contingent on transaction)

Timetable for Acquisition



	London Borough of Hammersmith & Fulham **HEALTH, ADULT SOCIAL CARE AND SOCIAL INCLUSION POLICY AND ACCOUNTABILITY COMMITTEE** **7 July 2015**
Primary Care Briefing – GP Networks, Network Plan 2015/16 and Out of Hospital Services	
Open Report	
Classification - For Noting **Key Decision: No**	
Wards Affected: Hammersmith & Fulham	
Accountable Executive Director: Managing Director, Hammersmith & Fulham CCG	
Report Author: **Janet Cree, Interim Managing Director, Hammersmith & Fulham CCG**	**Contact Details:** Janet.cree@nw.london.nhs.uk

1. EXECUTIVE SUMMARY

1.1 The purpose of this report is to provide information to Committee Members about the Hammersmith & Fulham GP Networks, GP Network Plan 2015/16, extended hours and Out of Hospital services. This is the first report on this topic to be shared with the Committee.

1.2 Hammersmith & Fulham's thirty one General Practices operate within five networks across 29 different sites. The practices have all signed up, for the fifth consecutive year, to the Network Plan 2015-16, which aligns incentives in primary care with achievement of the strategic aims and statutory requirements of the CCG. The headlines of the Network Plan are described within the paper, alongside an outline of the current extended hours provision and a description of the Out of Hospital services which the GP Federation will provide on a whole population basis, commencing in July 2015. Last year, all 31 practices in Hammersmith and Fulham formed a legal entity as a GP Federation.

2. RECOMMENDATIONS

2.1 The Committee is asked to note the report.

3. LIST OF APPENDICES:

Appendix A: Network Plan Breakdown

Appendix B: List of Out of Hospital Services

Appendix C: Our practice map and networks

4a. THE NETWORK PLAN

Background and Strategic context

The GP Network Plan has been in operation as a local improvement scheme for General Practice for the past four years. The Plan for 2015/16, to which all practices have signed up, is aligned to, and reinforces the work undertaken to support the following strategies:

- The North West London Out of Hospital Strategy
- Better Care Fund
- Whole Systems Integrated Care
- H & F CCG Operating Plan and Commissioning Intentions

The Plan is also aligned to schemes for acute and community providers and is focused on the following schemes:

i. Network Development and effective use of SystmOne, for example:

- Review of Medical Record Summaries
- Usage of Electronic Prescribing Service – Release 2 (EPSR2)

ii. Reduction in avoidable admissions, for example:

- Specific targets for referral to the Community Independence Service (CIS) and Older People's Rapid Access Clinic (OPRAC)
- Interaction and Responsiveness to the Community Independence Service

iii. Reducing the variation in referrals and improving the use of community pathways, for example:

- Ensuring appropriate use of the Single Point of Access for e.g. respiratory and gynaecology services

iv. Prescribing

The overall objective of this element is to improve the quality of prescribing in primary care while maintaining best value for money.

v. Quality

The Network Plan has been a successful tool for changing behaviour in Primary Care. It has provided practices with the opportunity to work collaboratively, meet to share best practice, and identify solutions to shared problems. This is helping to create a culture of integration amongst practices and paved the way for the successful formation of the GP Federation as a provider entity. It has had particular successes in the following areas: community services usage, reductions in avoidable non-elective admissions, prescribing improvements, care planning, and learning disabilities health checks. The CCG has agreed with its Governing

Body and Health and Wellbeing Board that its two local priorities for 2015/16 will be MMR2 and Diabetes Care Plans. These have therefore been included in the Plan.

vi. Operating Plan Targets

In 15/16, the CCG is mandated by NHS England to achieve specific operating targets relating to increasing dementia diagnosis and Improving Access to Psychological Therapies (IAPT), both of which will continue to be supported by the Network Plan.

Process

Network Meetings

Alongside practices receiving data that relates to their own practice performance, progress against each element of the Network Plan is also discussed at their monthly Network meetings. This provides the opportunity for both the CCG and other practices to review and, where appropriate, challenge practice performance and share best practice or solutions to improve performance.

The Network Plan for 2015/16 aims to build upon the successes of the plans of the previous four years and further strengthen the development of practices, networks, and the GP Federation as a provider organisation, whilst contributing to the wider objectives of the CCG. Progress is reviewed quarterly and reported to the Finance and Performance Committee, a sub-committee of the Governing Body.

4b. OUT OF HOSPITAL (OOH) SERVICES INCLUDING EXTENDED HOURS

Background and Strategic context

The development of GP networks has enabled the CCG to adopt a consistent approach to Out of Hospital (OOH) Services. The suite of Out of Hospital services (see appendix B) were developed as part of our clinically led programme to transform the quality of the NHS across North West London, delivering more care closer to patients' homes and ensuring consistently high quality services are available on a whole population basis. The collective ambition of the CWHHE CCGs is to move forward in increasing access to primary care services, in line with the objectives of the Prime Minister's Challenge Fund scheme underway across North West London, based around the principles of convenient care, accessible care, and urgent care availability.

A robust assurance process has been underway over recent months to ensure that practices and the Federation are ready to commence delivery of the OOH services, most of which will go live in July 2015.

Extended Hours

Current position regarding Extended Hours provision across Hammersmith and Fulham
In Hammersmith and Fulham, consists of the following:

1. 4 out of 5 practices, in partnership with LCW (a social enterprise organisation), providing urgent care access to all patients in the borough for 8 hours on a Saturday and Sunday

2. 20 practices providing planned care appointments outside of core hours (8am – 18:30pm) to their own patients under the Local Enhanced Service (LES).
3. 4 practices providing planned care appointments outside of core hours (8am – 18:30pm) to their own patients under the Directed Enhanced Service (DES) which is commissioned separately by NHS England
4. 3 Practices providing planned care appointments outside of core hours (8am – 18:30pm) to their own patients under their core APMS contract which again is commissioned separately by NHS England

The revised service is one of the Out of Hospital Services, and will provide appointments for the whole CCG population with GP network-based 7 day working (12 hours per weekday, 12 hours per weekend), for the purpose of delivering improved outcomes through routine and urgent care provision. Due to differing commissioning approaches in the past, practices within both H &F and CWHHE, currently deliver a range of differing provision. A standardised model has therefore been developed and will be rolling across CWHHE, ensuring that a high quality service model is implemented, whilst allowing for local variation to reflect local demand and circumstances. SystmOne, the single GP record system used across H&F, will be used to support referrals between GP practices and access to records for the extended hours service (with patient consent), thus ensuring continuity of care and ensuring the networked service is clinically safe.

The CCG is working with the GP Federation in seeking Expressions of Interest (EOI) from practices seeking to provide Extended Hours 'hubs' according to the new specification. The service will commence in the Autumn, in place of the existing weekend service. Work is also underway to review the Extended Hours provided by practice 'spokes', with a revised service anticipated to commence in April 2016.

The criteria for practices to provide either a 'hub' or 'spoke' extended hours service are described both in the service specification and in an assessment matrix, which includes both quantitative elements - such as existing opening times within 'core' contractual hours - and qualitative elements such as access and current performance across a range of indicators. Governing Body lay members have been involved in designing the EOI documentation and assessment matrix, and we are currently recruiting patient representatives to be involved in reviewing the submissions, and a non-CWHHE GP.

5. Conclusion

This report has been provided in response to a request by the Committee to receive some information on the GP Networks and Out of Hospital services. It has described the locality structure and Network Plan for 15/16, and the suite of Out of Hospital services which will be provided by the GP Federation on a whole population basis, providing accessible and high quality care and outcomes.

Appendix A: Network Plan Element Breakdown

Element	Processes / Requirements
Prerequisites to Network Plan	Attendance at monthly Network Meetings
	Have a lead GP and deputy
	Attendance at Members' Meeting
	Practice Nurse Attendance at tri-borough Practice Nurse forums
	Use local information systems available: - WHYSE – Business Intelligence Portal accessible to CCG staff and GP Practices - Extranet
Element 1 - Network Development and Effective Use of SystmOne	Share best practice
	Understand performance for all elements
	Discuss External Peer Review of referrals
	Discuss Case Review of Virtual Ward patients
	Improved use of Read Codes (Q1 in comparison with Q4)
	Usage of Electronic Prescribing in Q3 and Q4
Element 2 - Reduction in the variation of Referrals	Create referral plan for each targeted specialty
	Conduct monthly audits of focus specialties
	Feedback Quarterly at Network meetings on outputs of audits
	Identify variance of referral behaviour between clinicians
	Ensure processes are in place for using correct referral pathways
	Attend Education Sessions
	Identify areas where education should be targeted
	Promote appropriate use of diagnostics available
	Promote appropriate use of Out of Hospital services
	Encourage use of consultant hotlines
Element 2 - Using Community Services	Ensure 100% of referrals are made to Gynaecology single point of referral
	Conduct quarterly Clinical Audit of those patients who have attended secondary care but are a) not urgent/2 week waits and b) have not been triaged by community service
	Ensure 100% of referrals are made to Respiratory single point of referral
Element 3 - Avoiding unnecessary Non-elective Admissions	Identify at-risk patients using appropriate tools and or SystmOne Frailty Index
	Review Non Elective Admissions
	Review A&E Attendances
	Hold quarterly meetings with Virtual Ward team
	Undertake Case Review of potential Virtual Ward patients
	Follow-up patients who have been referred from other sources
	Identify patients appropriate for OPRAC service
	Incorporate Care and Crisis Plans into patient records

	Follow guidance on managing Long term conditions as detailed within plan
Element 4 - Improving the Quality of Prescribing	Meet with Prescribing Link Pharmacist
	Review data provided by Medicines Management team to identify savings
	Maintain use of North West London Formulary
	Identify areas where savings can be made
	Meet Prescribing Expenditure target
	Review data provided to prioritise Quality Indicators
	Quality Indicator 1 - Quantity of antibiotics
	Quality Indicator 2 - Recommended 1st line antibiotic items as % of all antibiotic items (top 11)
	Quality Indicator 3 - Quantity of oral Non Steroidal Anti Inflammatory Drugs prescribed
	Quality Indicator 4 - Quantity of Omega 3 acid supplements
	Quality Indicator 5 - advice on dose of simvastatin co-administered with amlodipine or diltiazem
Element 5 - Operating Plan Targets	IAPT: access, recovery rates and waiting times
Element 5 - Local Quality Premiums	MMR2 – increasing percentage of eligible population covered
	Diabetes Care Planning – increasing number of patients with care plans

APPENDIX B - OUT OF HOSPITAL SERVICES

Ambulatory Blood Pressure Monitoring

Anti Coagulation (Level 1 – Monitoring)

Anti Coagulation (Level 2 – Initiation)

Case Finding, Care Planning and Case Monitoring

Complex Common Mental Health

Complex Wound Care

Simple Wound Care

Coordinate My Care

Diabetes (High Risk)

Diabetes Level 1)

Diabetes (Level 2)

ECG

Extended Hours

Homeless service

Near Patient Monitoring (Methotrexate monitoring)

Phlebotomy

Ring Pessary (gynaecological procedure)

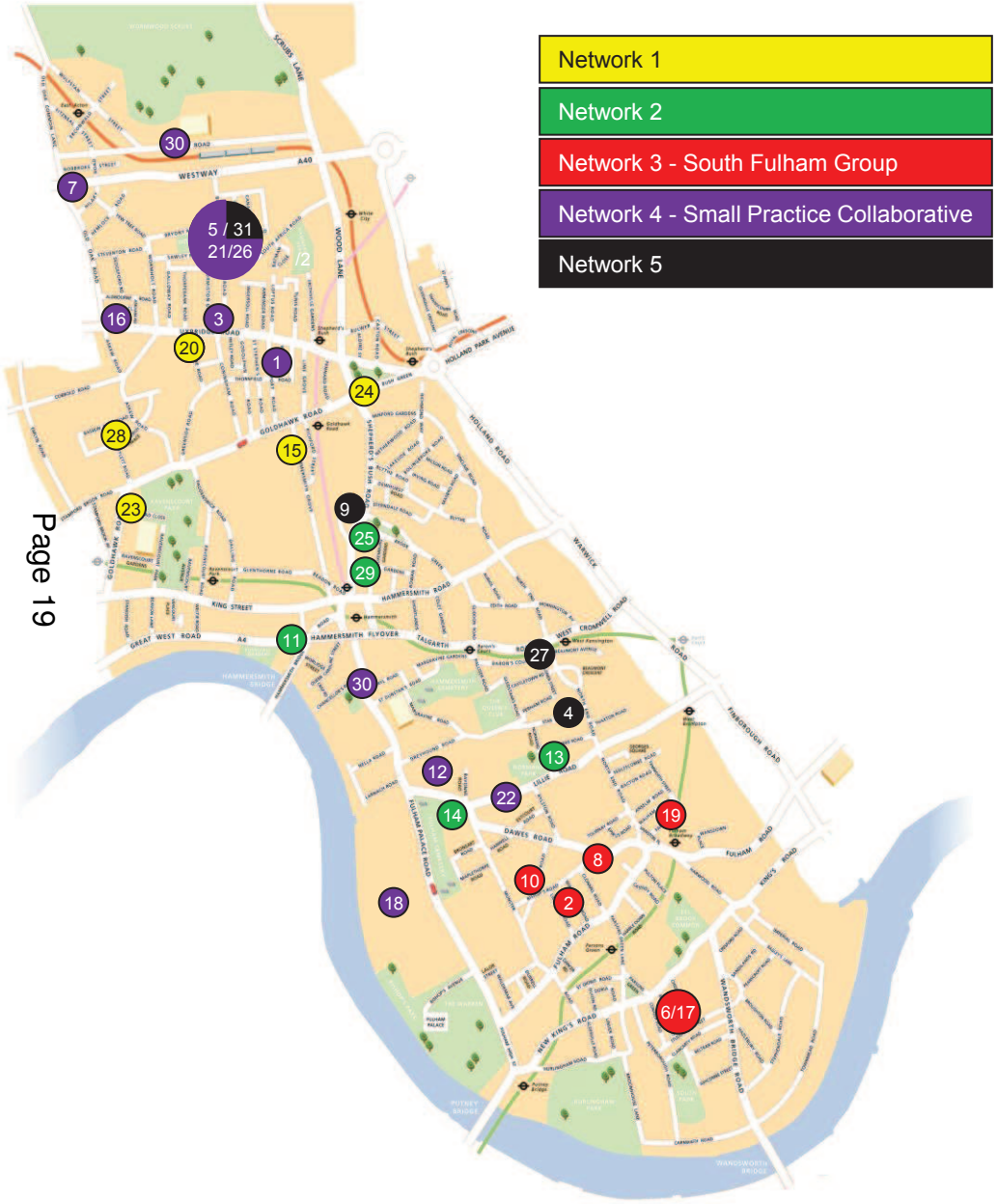
Mental Illness - (Level 1)

Mental Illness - (Level 2)

Spirometry Testing

APPENDIX C - Map (attached as separate document)

H & F GP Networks Jan 2015



Conan	15. Richford Gate Medical Centre	10,315	40,446
	20. The New Surgery	4,956	
	23. Park Medical Centre	7,981	
	24. The Bush Doctors	11,377	
	28. Ashchurch Surgery	5,817	
Joe	11. Hammersmith Bridge	9,329	40,831
	13. Dr Jefferies, 139 Lillie Road	3,124	
	14. Dr Jefferies, 292 Munster Road	12,786	
	25. Brook Green Surgery	4,012	
	29. Brook Green Medical Centre	11,580	
Joe	2. Ashville Surgery	8,956	36,754
	6. Bridge House (Dr Das & Partner)	2,245	
	8. Cassidy Road Medical Centre	3,931	
	10. Lillyville Surgery	7,394	
	17. Sands End Clinic	7,512	
	19. Fulham Medical Centre	6,716	
Conan	1. Old Oak Surgery	3,821	41,876
	3. Shepherd's Bush Medical Centre	3,547	
	5. Parkview Practice (Dr Hasan & Canisius)	3,587	
	7. Westway Surgery (Dr Dasgupta & Partner)	3,519	
	12. Fulham Cross Medical Centre	1,915	
	16. The Medical Centre (Dr Kukar)	5,309	
	18. Palace Surgery	4,169	
	21. White City Medical Centre (Dr Kukar & Dr Mirza)	1,616	
	22. Salisbury Surgery	1,453	
	26. White City Medical Centre (Dr Uppal) - Second site in Southall, E	7,051	
	30. Hammersmith & Fulham Centres for Health - split over 2 sites	5,889	
Joe	4. The Lillie Road Surgery	7,875	30,135
	9. Sterndale Surgery	4,461	
	27. North End Medical Centre	14,838	
	31. Canberra Medical Centre	2,961	
	Total	190,042	