 the low tax borough	London Borough of Hammersmith & Fulham HEALTH & WELLBEING BOARD 17 June 2013
TITLE OF REPORT: Out of Hospital Programme Update for Hammersmith & Fulham	
Report of: Interim Director of Adult Social Care and Chief Officer, H&F CCG	
Open Report	
Classification - For Information Key Decision: No	
Wards Affected: All	
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1. EXECUTIVE SUMMARY

The Report is an update on progress for the Out of Hospital (OOH) Strategy in Hammersmith & Fulham. It updates members of the Health & Wellbeing Board (H&WBB) on progress made by the CCG, Tri Borough and partners in delivering the OOH Strategy, identifying key achievements since the previous report whilst also considering the long term objectives.

The appendices attached within the report contain the detail for each area of update including in the OOH strategy.

2. RECOMMENDATIONS

Members are asked to consider the progress of the OOH Strategy for Hammersmith & Fulham and provide observations to the accountable officers and OOH Delivery Board.

3. INTRODUCTION AND BACKGROUND

The Out of Hospital Strategy for Hammersmith & Fulham is a key priority for the CCG in delivering its overall strategic and commissioning objectives.

Significant progress has been made in progressing the OOH strategy through partnership working under the governance of the Out of Hospital Delivery Board. This paper provides an update for members regarding key areas of progress. In particular, the report will describe progress for the following key areas;

- Shaping a Healthier Future (SAHF)
- Whole Systems
- Integration between Health & Social Care (CLCH & the Tri Borough)
- Establishing Urgent Care Boards
- Joint out of Hospital Schemes update
- Virtual Ward update
- Community Nursing Review update
- White City Collaborative Care Centre (WCCCC) update
- ICP update and plans for 13/14

The Out of Hospital Strategy is the CCGs delivery mechanism for its main strategic and commissioning objectives, including much of the QIPP Programme.

The OOH Strategy addresses the need to rebalance the whole system of care away from an over reliance on acute hospitals with a move towards greater use of primary and community based services. It is believed that this approach will reduce the demand on acute hospitals but more importantly will improve the quality of care provided to our residents/patients.

Key aims identified in the strategy are;

- To demonstrably improve outcomes for service users and their carers
- To improve Health and Social Care provision and ensure that patient experience is seamless
- To empower our patients to make choices regarding their own health and support them in managing their care.
- To address inequity in care and provide equitable access to care for the residents of Hammersmith and Fulham

4. PROPOSAL AND ISSUES

The Health & Well Being Board is requested to note the progress for the OOH strategy. Proposal and issues are identified in the main body of the report against each area of update.

5. OPTIONS AND ANALYSIS OF OPTIONS

There are no options presented with this update report, members are asked to note progress.

6. CONSULTATION

Key sections of the report relate to formal consultation of the Shaping a Healthier Future programme.

7. EQUALITY IMPLICATIONS

A full equality impact assessment has been undertaken for the Integration proposals for Hammersmith & Fulham (Tri Borough & CLCH) and presented to Cabinet in November 2012.











8. RISK MANAGEMENT

The Out of Hospital delivery Board will review all risks concerning project delivery.

LOCAL GOVERNMENT ACT 2000
LIST OF BACKGROUND PAPERS USED IN PREPARING THIS REPORT

No.	Description of Background Papers
1	Hammersmith and Fulham CCG Out of Hospital Strategy and North West London Shaping a Healthier Future, Hammersmith & Fulham Health and Wellbeing Strategy; LBHF Mandate for Adult Social Care.

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1.0 Strategic Overview 'Shaping a healthier future' (SAHF)

On 19 February 2013, the Joint Committee of Primary Care Trusts (JCPCT) agreed with all the recommendations put forward by the 'Shaping a healthier future' (SAHF) programme following public consultation. The programme addresses the need to rebalance the whole system of care away from an over reliance on hospital based care with a move towards greater use of primary and community based services. It is believed that this approach will reduce the demand and pressures placed upon hospitals but most importantly will enhance the quality of care for the residents of Hammersmith & Fulham.

These proposals are not just about changes to hospital care, they also aim to improve the care that residents receive outside of hospitals. The strategy proposes an investment of £190m to improve out-of hospital care in the whole of the North, West and Central London area by improving GP access, local health centres or 'hub's along with a focus for Health and Social care provision centred at the patients' own home.

1.1 Hammersmith and Fulham

For Hammersmith & Fulham the OOH and Strategy and Transformation teams will focus on;

- Developing plans for three sites to support five networks of care in the north, centre and south of the borough including the use of Charing Cross Hospital as a hub/health centre offering primary care, therapies and further diagnostic services.
- Developing satellite sites that will provide co-ordinating functions to ensure coverage of all five networks.
- Develop and Implement plans to increase the funding of out-of-hospital services by £17m a year.
- Support plans to redesign estate with capital investment of between £17-41m, including £15m local hospital services at Charing Cross Hospital, £1–25m in hubs/health centres (including Charing Cross Hospital), and up to £1m in primary care across the locality.
- Establishing a Non Elective Transition Workstream for Hammersmith & Fulham with focus on Hammersmith and Charing Cross Hospitals. The workstream will review progress for OOH development and progress made by the CCG and providers in developing new pathways for patients under the changes implemented by SAHF.
- Appointing a Zone lead to take forward the transition requirements of SAHF and support the CCG/OOH team.

1.2 Judicial and Independent Reconfiguration Panel Review (IRP)

An application for judicial review of the SAHF proposals has been made by Ealing Council, and this is now being progressed along with an independent reconfiguration panel review. The Secretary of State has also referred the programme to the IRP with full report by Sep 2013. All CCG's and providers have been informed of this through the Collaboration Board.

2.0 Whole Systems

It is recognised that patients and users of Health and Social care services across Hammersmith & Fulham increasingly experience fragmented services leading to duplication and confusion for residents. Whilst good progress has been made by the CCG, Council, Acute and Community services to develop improved collaborative working it is recognised that services need further development. The Whole systems approach supports the Health and Social Care system to operate a system of shared values, vision and objectives and therefore enabling Integrated care.

Our strategies share common patient-centred goals and themes around integrated care with a shared vision of providing better, more coordinated care for our populations. In keeping with this vision, the aim is to develop with patients, service users and carers a common framework of what integrated care means locally for patients/users and what measures the programme should use to evaluate successful delivery of patient-centred care.

Health and Social care partners are planning to undertake a mapping exercise with OOH programme leads to draw out the key linkages and themes. An initial workshop is proposed in mid June to launch the process

On 14th May, Norman Lamb Minister for Care and Support announced an invitation for local areas to submit an Expression of Interest to be 'pioneers' in demonstrating an innovative and ambitious approach to integrating care. The Department of Health is seeking 10 Pioneer sites across England, consisting of ambitious and visionary localities.

The following key messages can be taken from the announcement from the Minister;

- Integration is not an option – it is a requirement & person-centred care will become the norm across the health and social care system.
- All localities are required to develop plans for integration.

The proposed governance structure shared previously with the North West London Collaboration Board has been refined and initial meetings to establish the governance structure for the Board will be set up in June. Co-design work has kicked off in a number of areas; the programme is looking for support from CCGs and Local Authorities in providing leads to further progress the design work across each of the programme work streams.

3.0 Health & Social Care Integration

A key requirement in delivering the Out of Hospital Strategy is further improving the relationship between Health and Social Care provision. In November 2012 the H&F Cabinet & CCG Governing Body were presented with the full cabinet report proposal for the Integration of Adult Social Care and Central London Healthcare NHS Trust (CLCH). Since Nov2012 the Tri Borough Council along with the 3 CCG's (Central, West London and Hammersmith & Fulham) have developed further plans to review the Integration proposal and status to ensure the initiative meets the changing needs of Health & Social Care.

The Council and CCG's along with CLCH are undertaking a number of positive steps to ensure the aspirations around integration become a reality and that all the organisations involved in this important work bring the right focus to bear. GP input and leadership is essential to delivering the health and social care integration programme and the partnership governance structures are being set-up to support this. Key areas of development to note include;

- A Partnership Board has been established and will include the 3 CCG Chairs and lead Cabinet Members for Adult Social Care (ASC). This is due to meet for the first time in early June (13th June). The Partnership Board will oversee both commissioning and service delivery led integration initiatives and will ensure these are aligned and work is coordinated.
- A jointly appointed interim Director for Adults Community Health and Social Care has been appointed by Tri-Borough and CLCH (with CCG input) to lead the community services integration Programme – Neil Snee has been appointed and a start date will be announced shortly.
- The jointly appointed interim Director will lead the work with Tri-Borough ASC, CLCH and GP Practices to develop plans to design an integrated targeted operating model.

The Tri Borough, CCG's and CLCH will provide further update in relation to the above actions and next steps in October 2013 and there will be a further update provided for Governing Body and Health & Wellbeing Board members.

4.0 Developing Urgent Care Boards

On 9th May NHS England issued important guidance on “Improving A&E performance”. This was in response to long waiting times in A&E departments in many parts of the country leading to not only poor quality patient experience but also impacting on patient safety and reduced clinical effectiveness. In particular the guidance reinforced the imperative to deliver the operational standard of 95% of patients being seen and discharged within 4 hours as set out in the NHS Constitution. National performance had deteriorated significantly over the last 6 months.

A deadline of the 31st May 2013 was set for each Health System to submit a plan covering:

- An urgent recovery programme with significant attention given by local and national commissioners and providers to all factors which can help recover the standards, (including clear performance management).
- A medium term approach to ensure delivery over the next winter period. This will include care system planning as well as a review of the levers and incentives in the system.
- In the longer term, the implementation of the urgent care strategy in order to deliver safe and sustainable services

The CCG responded to two key immediate requirements:

- An initial Recovery Improvement Plan for each Trust (at site level) produced, and agreed by the local Urgent Care Board, and sent to NHS England by 31 May
- Urgent Care Boards must be either established, or Terms of Reference revised, for each Trust, to be convened so that they can review and agree a draft Recovery Improvement Plan in line with 31 May deadline

Urgent Care Boards covering the three local Acute Providers with A+E departments will be in place by June 2013 and they will oversee both current performance and the medium and longer term approaches to the delivery of sustainable urgent care performance. For Hounslow and the West Middlesex Urgent Care Board is already in place and meeting and its terms of reference have been reviewed to ensure they meet the requirements in the latest guidance. A Tri-borough Urgent Care Board is being put in place covering Central London, West London and Hammersmith and Fulham CCGs and which will commence meeting in early June.

The Urgent Care Boards provide a forum for all partners to monitor progress against the Out of Hospital Strategy and to support problem solving for immediate, medium and longer term issues.

Appendices 4 & 5 provide the full detail for the A&E Recovery Plan and statement from Hammersmith & Fulham CCG and partners to NHS England.

5.0 Out of Hospital Schemes Update

The following updates are provided below regarding the OOH schemes currently being reviewed by the OOH Board.

5.1 Community Independence Service

The Community Independence Team is a newly formed service, joining the Hospital at Home Nurses and Therapists with the Social Care Reablement team. This integrated health and social care team is made up of Nurses, Occupational Therapists, Physios, Reablement Coordinators and Health and Social Care Assistants operating from 8am-8pm 7 days a week. This service forms a key function in delivering the Virtual Ward model across H&F as the service is already able to provide Integrated assessment and support to patients from Nursing, Therapy and Social Care professionals.

The service provides admission avoidance and early supported discharge for patients with integrated intermediate care support for up to 6 weeks. The service is able to respond rapidly to crisis referrals within 2 hours of telephone contact.

It should be noted that the service recently conducted a successful 8 week winter pressures pilot (February-March 2013) at Charing Cross Hospital, in reaching to support early discharge from A&E, MAU and downstream wards. During this 8 week period the team supported 45 patients to transition home, 73% from A&E/MAU and 27% from downstream wards. The CCG has awarded CIS funding to extend this pilot for a further a 12months which will be expanded to cover Hammersmith Hospital.

5.2 Health and Social Care Co-ordinator Project

The Health and Social Care Coordinator 12 month pilot will be coming to an end in June 2013. A formal evaluation of the pilot has commenced and the learning will be used to inform the future development of the role which will be aligned to the Virtual Wards.

The pilot has been split into two phases. The first phase focused on contacting those patients who had been discharged from a non elective admission with a Section 2 or 5 notification. The second and current phase has extended the cohort to all patients discharged from a non elective admission from an Imperial Trust site. From August 2013, GP practices will be able to access a summary of the activity that the HSCC team had with their patient cohort during both phases of the pilot.

Actions to note

- Members will be provided with a full 12 month evaluation of the pilot post June 2013.

5.3 Hybrid Worker Health and Social Care Project

In February 2013 the Hybrid Health and Social Care Project introduced a new 12 month pilot service provided by Allied HealthCare which brings together basic health care and home care together, so that both elements can be provided in the home by a single 'hybrid worker'.

The pilot tests the benefits of providing integrated care at home and its ability to facilitate improvements in service user outcomes, system efficiency, release expert nursing capacity and a reduced reliance on hospital based care and long term care.

Currently Allied Healthcare are delivering approximately 320 hours of care per week to 19 patients. Each week 2-3 new patients are joining the scheme which has a maximum capacity of approximately 40 patients. This scheme forms particular relevance to the Virtual Ward initiative and Community Nursing Review as the initiative is intended to enable Registered District Nurses to relinquish tasks to unqualified nurses where a registrant is not required to perform them. The benefits of the scheme should enable increased nursing time for case management and the Hybrid Workers also offer continuity of care for patients based on an enablement model.

5.4 Dementia Project

Plans are being developed between Adult Social Care and West London Mental Health Trust for the configuration of an integrated dementia team, aligning social workers with the Cognitive Impairment Team and embedding dementia specialists within the integrated locality teams to be implemented later in the year.

In March 2013 CantabMobile was also implemented across 5 H&F GP practices as part of a pilot initiative to support screening for dementia. CANTABMobile is an early detection tool which delivers reliable early screening for diagnosis in memory variations and cognition. This tool provides easy to use IPAD based assessment to inform decisions about the need for care. In June the project team will conduct a review of the 5 practices to examine how the tool has been utilised and its ability to facilitate diagnosis, triage and onward referrals for patients with dementia.

5.5 End of Life Care (EOLC)

The quarterly End of Life Care Operational Group met in April 2013 to review EOLC activity over the last quarter. 138 patients had been fully transferred from Adastra based system to new System C by mid March. Since then there had been substantial use of new system with multi professional input specifically around placing community based patients on Co-ordinate my Care (CMC).

Historically data has often been boosted by Nursing Home residents being placed on the system however recent input has been for community patients living at home but the next phase of the programme will have particular focus on care homes to support efforts in reducing LAS conveyances and unnecessary admissions to Hospital. Where neighbouring boroughs/CCGs

activity on CMC appears to have plateaued, HF CCG members activity on CMC continues to rise which is a positive reflection of the hard work being undertaken by GP Practices and the wider network working for H&F EOLC patients. An audit of impact and use on CMC on patient preferences would support continued use of CMC.

All network representatives reported improvements in the take up and use of CMC and EOLC processes. The Inclusion of EOLC within the network plan has been welcomed with a strong financial incentive to build and share care planning and preference information via CMC for consented patients who are on practices' palliative care registers. There are still a few practices not using CMC and work is underway to work with these few remaining practices to ensure the initiative is offered to their patients.

Within acute settings both Specialist Palliative Care Teams (C&W/Imperial) have had training and have now been issued with login/usernames issued and have full access. CMC access by A&E departments remains a problem due to Information Governance issues. GP practices are reporting that discharge summaries are not being received quickly enough and this is more critical for a patient at End of life. Both issues are being taken forward by members of the operational Group.

5.7 Patient Self-Management

A key strategic and commissioning objective for the CCG is to drive forward plans to enable patients to make more ownership, responsibility and control of their Health and Social Care. The CCG has experienced significant success through initiatives such as the Expert Patient Programme but it recognises that these initiatives are isolated to condition specific concerns and therefore exclude significantly high number of patient groups.

The CCG is developing a programme of work to further expand the provision of the Expert Patient programme to go beyond the scope of condition specific initiatives and support patients in the general self-management principles of their condition.

Other key work streams include;

- Further pathway development using the ICP in a patient centred approach
- Establishing an improved befriending service for patients in the High Risk category to have the support when required but build on self-help where possible.
- Establishing peer mentors for patients
- Improving the uptake of Direct Payments
- Increasing carers support forums
- The implementation of Telecare and Telehealth

5.7 OOH Programme Leadership

In January 2013 a new OOH Programme Manager was appointed for Hammersmith & Fulham. Given the scale and scope of the OOH Strategy the CCG is also in the process of appointing to the following key roles.

- Deputy OOH Programme Manager/QIPP Delivery Manager
- OOH Project Lead for Mental Health Services
- OOH Project Lead for IT
- OOH Project Lead for Planned Care
- OOH Project Lead for the White City Collaborative Care Centre

The CCG OOH team will also work closely with the newly appointed zone lead for SAHF in Hammersmith and Fulham along with the Strategy and Transformation Team.

5.8 Governance

The OOH Delivery Board which is joint chaired by the Chair of H&F's Governing Body and Martin Waddington Director for LBHF will monitor all aspects of the OOH Strategy including scrutiny of the above OOH schemes and emerging OOH themes. Updates the H&F Governing Body and H&WB Board will also be presented as required or on a minimum of a quarterly basis.

Appendix 6 provides a summary of all OOH programmes reviewed through the OOH Delivery Board in June 2013.

6.0 Virtual Wards

6.1 Principles of a Virtual Ward

The Virtual Ward model is anticipated to be an enabler to deliver reductions in Acute activity by supporting the principles of improved case management and care co-ordination, therefore complimenting the H&F Out of Hospitals strategy, QIPP and the CCG's Commissioning Intentions. The initiative is a joint Health and Social Care scheme. It is anticipated to operate in similar fashion to inpatient wards, using similar multi professional staffing, systems and daily routines, except that the people being cared for stay in their own homes throughout. Key Principles include;

- Home Based Care
- Multi-Disciplinary Teams
- The same administration system/paperwork
- An enablement model for specific periods of time/intervention based on optimum outcomes for the patient
- Effective risk stratification to Identify patients at High Risk of admission to Hospital
- Ensuring people have access to the right person at the right time
- There is a focus on preventative/early intervention based care – wherever possible to support avoiding hospital admissions
- The model is expected to reduce the length of a hospital stay when admission is necessary by supporting the discharge process
- Reduce the need for complex care packages and institutional placement such as Nursing Homes
- Avert crises by providing the right amount of care when needed
- Co-ordinate communication by providing a named person for all contact
- Access will be facilitated by professionals and in some models patients
- The VW's is anticipated to operate a SPA system for access

6.1 Virtual Ward Working Group

In May 2013 the CCG established a working group to develop a Virtual Ward model for H&F based around the Network footprint. The purpose of the working group was

to consider the general purpose and function for Virtual Wards in Hammersmith and Fulham, consider models of operation and to determine next steps towards model development and implementation. The working group consisted of;

- GP's
- CCG OOH Team
- Acute Consultant (Imperial)
- Acute Service Manager (Imperial)
- Social Care Managers (Tri Borough)
- Service Manager (Central London Community Healthcare NHS Trust)
- Head of Nursing (Central London Community Healthcare NHS Trust)
- Practice Nursing staff

The group set out to agree the principles of a Virtual Ward model and plans for implementation.

6.3 Proposed Team Composition

The Virtual Ward model will be implemented through a multi professional team with a joint working agreement for Phase 1. Evaluation of the model is intended to inform future service development for a more formal provider requirement and service specification being devised. The team is based on the already established Community Independence service with improved links to GP's and specialist staff.

Team composition includes;

- GP's
- Community Nurses
- Social Workers & Reablement staff
- Therapists
- Access to specialist Dr's in Acute settings
- Close links to specialist services such as Mental Health professionals CPN, SW's.

6.4 Benefits Realisation

The anticipated benefits of Virtual Wards include;

- Improved case co-ordination and case management leading to prevention of crisis and admission to Hospital.
- Better outcomes for patients
- Reduced duplication of assessment and more seamless referral
- Improved workforce efficiency
- Improved Information sharing or shared access/Inter-Operability.

6.5 Next steps

Key points and actions from the 28th May Virtual Ward Working Group include;

- All in attendance (GP reps from each Network, CLCH community nursing staff, CCG staff, council staff) agreed the principles of the Virtual Ward which "is a group of health care professionals who together are responsible for meeting the health and social care needs for all patients registered with a group of practices that are part of the network" and that it aligned closely to the notion of a Whole Systems approach.
- It was agreed that the Community Independence Service model has been working well in managing those patients at risk of admission to hospital or discharged needing intensive support. It was agreed that this service should be integral to the rollout of a Virtual Ward model in

H&F and should receive greater investment to increase the capacity of the service.

- The CLCH community nursing services team already work with the CIS and it was stated that the interface between the two is strengthened particularly given the fact that district nursing is being aligned to Networks and that each network will have an attached community matron (being recruited to)
- It was proposed that Networks would manage the Virtual Ward and would be supported by Health and Social Care Coordinators given that the existing Health and Social Care Coordination project will be coming to and end (June)
- It was recognised that Networks will need to consider additional GP resource to support the Virtual Ward. The Working Group will submit a service specification and business case for consideration to the CCG's Investment Committee in due course and the model has been reviewed at the CCG Governing Body Seminar on the 4th June 2013
- The Working Group acknowledged that access to specialist services including consultants is key; the Psychiatry hotline was given as a good example. It was suggested that ICP MDG could be developed to incorporate new innovative ways to use and access consultant time.

Proposals for the Hammersmith and Fulham Virtual Ward

- Regular 'virtual' MTD ward rounds
- Core team 'as standard':
 - GP
 - Health and social care coordinator
 - Nursing
 - Therapy
 - Social care
- Core team co-located
- Specialist support 'as required' from acute and mental health providers

Whole System Integrated Care will develop a commissioning framework to support the concept of a virtual ward, including:

Population

- Modelling support to understand what population would most benefit from integrated care and what outcome can be expected

Workforce

- What additional and type of capacity is required to achieve outcomes

Financial

- What would a capitated budget look like for a virtual ward network

The diagram illustrates the integration of various services into a virtual ward network. It features a central 'Social care' triangle (red) connected to a 'GP network' circle (blue), a 'Community' rectangle (blue), and an 'Acute' rectangle (blue). Dashed lines connect 'Social care' to 'Mental health' (grey rectangle) and 'Acute' (blue rectangle). Solid lines connect 'GP network' to 'Community' and 'Community' to 'Acute'.

Appendix 7 provides details from the Virtual Ward Working Group

7.0 Community Nursing Review

Throughout May 2013 the CCG and Strategy and Transformation team undertook the first phase of a Community Nursing review in conjunction with GP's and CLCH. The exercise consisted of a scoping period to understand the current issues and concerns expressed around Community Nursing, supported by a questionnaire and subsequent workshops.

The next phase of the review involved the development of a Service Development & Improvement Plan SDIP (Appendix 8) The SDIP focuses on the delivery of Key objectives set for CLCH by the CCG's with the intention of improving the Community Nursing Service.

The CCG outlined the following areas of delivery for CLCH;

7.1 Adopt the design principle of networks and distributed delivery and organisation of services around patient registration using the NHS number as an identifier. CLCH will be required to reconfigure Nursing Teams to the alignment of GP Networks across H&F. GP's will have direct links to the Networks Matron, Team leader and will be provided with the Nursing workforce configuration supporting practices.

Rationale: This change will enable a number of services including General Practice, Community Nursing and Social Care to better co-ordinate care around the specific needs of the patient, to empower the patient, carers and family to improve patient experience and outcomes.

Actions

- Agree a timetable for co-locating community nursing teams to enable improved contribution to local networks.
- Agree a timetable for linking all CLCH service contributions to networks.
- Agree common standards for responsiveness (and a method of auditing them)

Timescale- completion by Sep 2013.

7.2 Over 2013/14 migrate district nursing services to a single clinical IT system enabling One Patient, One Record, One Plan.

Rationale

- i) To improve patient care, patient experience and outcome.
- ii) To improve patient safety by the professionals involved in an individual's care contributing to a single patient record.

- iii) To empower patients by enabling an individual's goals and views to be consistently available to those contributing to an individual's care.
- iv) To improve the level or value chain co-ordination by adopting a common and auditable approach to workflow.
- v) To enable activity monitoring and the demonstration of VFM.

Actions

- Agree a timetable and alignment for co-location with migration to IT platform; agree timetable as above.
- Agree and adopt a common workflow methodology in order to minimise risk of information loss, error and delay and the consequent risk to patient care and safety.

Timescale- We would require one pilot Network to have a single system in place by Sep 2013, with full roll out by Sep 14 or earlier if possible.

7.3 Recognise the principle of GP's being the clinically accountable co-ordinator of care and the presumed focus of resource allocation and prioritisation for service contributions.

Rationale – the current norm of patient experience is of fragmentation and service incoherence with no one clearly responsible and accountable for the coordination of care. The vast majority of patients with community nursing needs and or social care needs also have medical needs.

Actions

- Agree and deliver weekly reports at practice, network and CCG level current lists of registered patients including information about nature of intervention, intended duration of intervention, source of referral.
- Agree, as part of the move towards a virtual ward approach, a process by which an individual with multiple needs can be discussed on a timely basis.
- Agree targets for community nursing teams to support care planning and case management with GP's.

Timescale – by July 2013.

7.4 Establish an improved system to support Governance and Patient Safety monitoring.

Rationale; to deliver a consistent approach to system error reporting and adopt common Quality reporting software and methodology;

Actions

- Agree reporting tool and timetable for roll out.

- Agree improved governance arrangements aligned to networks/practices with a focus on learning and incident avoidance based around a quality framework.

7.5 Consumables: Provider to achieve improved efficiency around consumable expenditure with a target set for 20% reduction in key areas.

Rationale - Areas of increased expenditure/cost pressure include; dressings, nutritional supplements, continence products and equipment prescribing.

- Agree revised practice and processes around prescribing, authorisation and stock take/management in order to achieve efficiency savings.
- Agree to have regular updates on expenditure/utilisation broken down by Network and provided on a monthly basis.

Timescale – by June 2013

7.6 Demonstrate improved responsiveness and Improved Case Management.

Rationale – In support of our Out of Hospital strategy we would anticipate improved community nursing responsiveness and case management to meet H&F admission avoidance targets. Targets need to be aligned to commissioning intentions set for acute services with community services being a key enabler for delivery. To enable improved case management we would require regular nursing review of patient care plans with complete transparency around caseloads.

Actions

- Agree targets linked to responsiveness of community nursing teams around admission avoidance and align to networks.
- Agree targets for care planning reviews.
- Agree process for sharing caseload information to inform workforce planning and demonstrate activity shift from acute to community services.
- Agree monitoring process by teams and networks.

The SDIP will be monitored through H&F's Out of Hospital Delivery Board along with the new Joint Partnership Board including the Tri Borough and CCG's.

8.0 White City Collaborative Care Centre

8.1 Building Development

The WCCCC construction continues to make good progress and remains on schedule for completion in April 2014, the programme is supported by the fortnightly working group meetings with the design team where all aspects of the Construction phase requirements are suitably addressed. Since the previous update for Governing Body members there has been a change to the design of function for the changing places toilet at the WCCCC. The Local Authority with charitable partners have agreed to fund changes to the changing places facility in order to provide access for residents using the adjacent park. Costs are estimated to be around £21K and the Council have agreed to fund capital costs from S106 funding.

8.2 Clinical Services

Current and expected clinical services are being mapped to the space available within the new building to establish room utilisation, service demand and capacity. CLCH are working well to map services from current locations and more support has been offered to Chelsea & Westminster NHS Foundation Trust to enable Child Development Services at St Dunstan's Clinic to be mapped to the new facilities in the new centre. The outcome of this mapping may require a review of lease and licensing arranging with and between providers as the degree of room use by providers is clarified.

Engagement with patients and providers remains an important process to help ensure the building feel right with services providing patients with a good experience of care. A second diabetes workshop was held in May to support the development of an integrated diabetes model for patients living in the north of the borough. CCG White City Lead Dr Peter fermie was supported by GP Diabetes lead Dr Tony Willis together and Diabetes Consultant Nick Oliver from Imperial. The workshop attended by 25 people focused on how a joined up model of diabetes services could be constructed to provide patients with a good experience of care. Further workshops are now needed to support providers to identify what needs to change in order to support co-ordinated care.

Discussions are ongoing with the GP Practices on developing models for delivering patients with a good experience of GP reception services including improved access and information.

Sylvie Pierce who has been leading the engagement and service development workstream will be taking a three month sabbatical from mid-May 2013 and the WCCCC Board has been asked to consider suitable resources to continue the productive and vital engagement work that Sylvie has shaped. Work has started to develop a job description for a centre manager and this will go to the next WCCCC Board in June. Hana Charlesworth, Communications Officer has developed a proposal for a competition to name the Health Centre that will run from Mid-June to the end

of August. The public will be invited to submit proposals with a mixed panel agreeing the final name to be announced in mid September at the White City Festival.

The Council and CLCH have now met to agree the use of the 56 office desks located on the first floor within the Council's designated area. Mobile working and hot-desking arrangements alone will not provide sufficient space for all CLCH children and adult services staff based at the current White City Health Centre and off site office space may need to be considered.

8.3 Key Areas of Focus

- **IT at WCCCC:** The level of co-ordination between services will determine the IT resources that will be needed to enable agreed models of co-ordination. The WCCCC Board have agreed for each provider IT platform to be installed to the WCCCC building with the ability to integrate systems as appropriate in line with strategic objectives.
- **Patient Experience:** The CCG recognises that it needs to work with providers to develop an improved patient experience at the WCCCC. This workstream had been supported by Sylvie Pearce Director of Earth Regeneration up until May 2013. The CCG have now appointed Tim Pullen (Project Manager) to support this area of development.
- **Office Space:** As detailed above there is significant progress in this area with most providers now beginning to specify requirements. This area of work will continue to be scrutinised by the WCCCC Board.
- **Increasing GP Access:** The CCG is reviewing all estate options under the remit of SAHF and in doing so will understand the potential for improved access at the health centre hubs for patients across Hammersmith & Fulham.
- **Health & Wellbeing Hub:** A working group has been established to review the potential for improved health and wellbeing activity at the new WCCCC. The group is reviewing the potential for the site to support improved access for patient education initiatives such as the Expert Patient Programme. Other areas of focus include; an information hub, a carers clinic, medicines management group and patient peer/mentors.

9.0 Integrated Care Pilot Update

Over the last 18 months the Integrated Care Pilot (ICP) has been established across the locality of Hammersmith and Fulham. It has the potential to be a core enabler of network development and wider integration if appropriately aligned to the CCG's vision.

Feedback with both commissioners and providers has indicated that the next year of pilot needs to be characterised by both wider efforts to further integrate care, and a much more localised and bespoke model needs to be developed at CCG level. In Hammersmith and Fulham the vehicle to do this is through the Out of Hospital Strategy.

Specifically in 2013/14 the ICP Pilot will:

- Change the ICP from a centralised to a de-centralised model based on the commissioning intentions and strategic objectives of the CCG.
- Align the ICP to the CCG's Out of Hospital Strategy and Board Governance process for oversight of project delivery.
- Acknowledge the lessons learned from the ICP thus far and recommendations for changes to the IT infrastructure and review of risk stratification process and patient groups for focus in 2013/14.
- Measure the Quality of Care Planning
- Support the CCG developing an Innovation fund review mechanism at a local level.
- Support the development of the ICP's alignment to developing integrated services along with the Virtual Ward, MDG and Network structure for Hammersmith and Fulham.

The CCG recognises that the ICP has become an important mechanism for driving forward service integration, particularly through the establishment of Multi Disciplinary Groups (MDG's). The CCG wants to build on the success of integrated working by extending these principles to the development of the Virtual Ward model and ensuring that the initiative is developed alongside the ICP/MDG framework.

Appendix 9 provides the ICP Business Case for 2013/14 submitted to the H&F Governing Body in April 2013.