London Borough of Hammersmith & Fulham **HEALTH, ADULT SOCIAL CARE & SOCIAL INCLUSION POLICY & ACCOUNTABILITY** **13 SEPTEMBER 2017**	
PRIMARY CARE STRATEGY - JOINT HAMMERSMITH AND FULHAM CCG AND GP FEDERATION UPDATE	
Report of the Cabinet Member	
Open Report/ All Exempt	
Classification - For Policy & Accountability Review & Comment **Key Decision: NO**	
Wards Affected: All	
Accountable Executive Director:	
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1. EXECUTIVE SUMMARY

1.1. Hammersmith and Fulham CCG and the GP Federation have developed a joint strategy which sets out our shared vision for an integrated health and social care system, with primary care as the foundation for better population health across the borough. The Primary Care Strategy, which is currently undergoing internal governance, is due to be published in mid-September 2017.

1.2. This paper provides an update to the Health and Wellbeing Board on the following key aspects of the strategy, ahead of its publication:

1. Our vision for an integrated care system for residents in Hammersmith and Fulham and the key stages in achieving this
2. Strategy implementation work programme
3. Governance and next steps

2. RECOMMENDATIONS

2.1. The Health and Wellbeing Board are being to provide comment on the vision set out in this paper and to endorse the CCG working closely with Public Health, Children's and Adult Social Care teams to progress the implementation of its strategy.

3. INTRODUCTION AND BACKGROUND

3.1. Primary care in Hammersmith and Fulham is improving with greater access to more services, including enhanced support for mental health, warfarin monitoring and more diabetic care and support. However, the experience of care is still fragmented and inefficient for many of our local residents, particularly for people with complex needs whose care is provided by a number of different health and care professionals spanning primary care, community and acute organisations.

3.2. Over the past five months, the CCG and GP Federation have worked closely together and in consultation with local residents, GP members and other stakeholders to develop a strategy for delivering improvements in patients' experience of care and population health outcomes.

3.3. A series of public engagement events were undertaken (including two patient focus groups) which have helped to define local residents' wants and expectations of care from General Practice and the wider health and care system. *Appendix 1* provides a summary of our local engagement. The outputs from our engagement have been incorporated into the final iteration of the strategy.

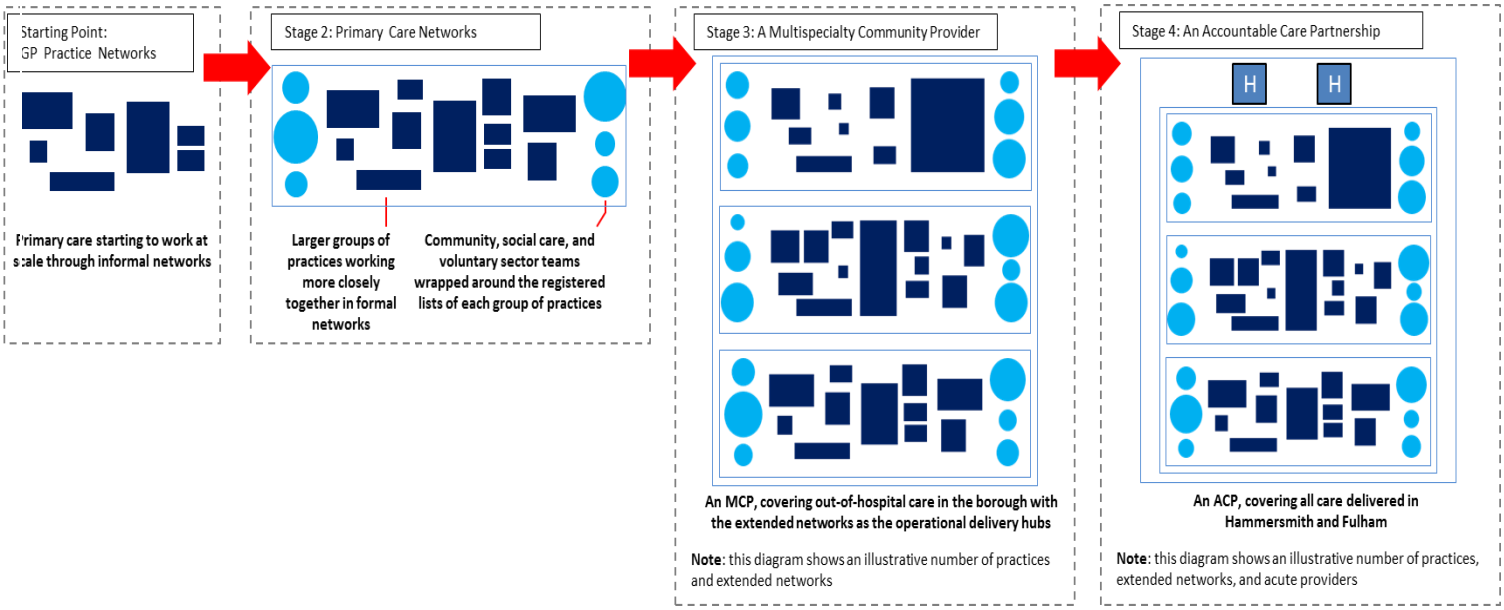
4. KEY CONSIDERATIONS

The stages of local transformation

4.1. The strategy, which builds on the Whole System Integration Care programme, sets out our ambition for achieving a more unified and co-ordinated care system for local residents. This will be achieved by:

1. Reinvigorating existing General Practice networks to become 'primary care networks' which will deliver services at scale for the benefit of local residents
2. Bringing primary care networks together into a unified approach to community based care – this will be through the platform of a Multispecialty Community Provider (MCP); a place based model of integrated care which serves the whole population
3. Adding hospital-based services to the MCP for a co-ordinated, outcome-based borough-wide approach to all care which we describe as 'accountable care'

Figure 1 illustrates the stages in our journey towards achieving our end-point ambition for accountable care



4.2. The characteristics of each stage of our transformation journey and the benefits that local residents can expect to see as a result of the strategy are summarised below:

4.3. *Stage 1: Reinvigorating existing General Practice networks to become 'primary care networks' which will deliver services at scale for patients*

- Practices will work in larger established networks to provide services at scale for the local population. Patients will be able to access a wider range of services provided by practices within the networks through inter-practice referrals.
- Primary care networks will work towards reducing variation and unnecessary admissions /referrals through an agreed common set of outcomes and quality standards
- A shared workforce will be established across primary care networks: this will enable practices to address their workforce issues more comprehensively than when working alone, including recruiting for a wider range of roles across multiple practices

4.4. *Stage 2: Bringing primary care networks together into a unified approach to community based care – this will be through the platform of a Multispecialty Community Provider (MCP)*

- Principles of joint working will be well established through integrated community care teams
- The integration of services around the needs of local residents will be extended across health and social care under a 'one person, one service, one team, one budget' approach
- Broader multi-disciplinary teams will be established bringing together all expertise to deliver better population health outcomes

- Links with the voluntary sector will be established to increase the services available locally

4.5. *Stage 3: Adds acute services to the MCP for a co-ordinated, outcome-based borough-wide approach to all care – this is accountable care*

- Improved patient access to community and specialist care closer to the patient's home
- Community-facing consultants delivering services linked to the management of long term conditions
- Greater focus on driving better health outcomes for local residents with payment systems linked to this

Appendix 2 provides two examples of how patients with long term conditions and mental illness will benefit from the strategy.

Strategy Implementation Work Programme

4.6. The following work streams have been defined to support the implementation of the strategy:

PROVIDER DEVELOPMENT	COMMISSIONING AND CONTRACTING
High level deliverables:	***High level deliverables:***
▪ Reconfiguration of existing GP networks into 'primary care networks' and development of new ways of working at scale	▪ Development and implementation of commissioning and contracting plans for the new primary care 'wrap-around' offer
▪ Assessment of the maturity and readiness of primary care at scale organisations to take on the delivery and leadership of community-based care under an MCP. (The North West London Collaboration of CCGs have developed a tool to facilitate this exercise)	▪ Development of MCP and ACP commissioning strategy and plans setting out how the CCG will procure an MCP and ACP contract for award and mobilisation
▪ Development of system leadership - supporting providers to establish an MCP/Accountable Care Partnerships	▪ Implementation of MCP contract
▪ Implementation of system enablers (i.e. workforce, estates and digital technology) in line with the General Practice Forward View	

Governance and next steps

4.7. Hammersmith and Fulham GP Federation Board to review and agree Primary Care Strategy on the 4 September 2017

4.8. Hammersmith and Fulham CCG to publish Primary Care Strategy following Governing Body sign off (12 September 2017) – pending the outcome of this

meeting the CCG will provide hard copies of the strategy for the Health and Wellbeing Board (13 September 2017)

4.9. A joint CCG and GP Federation Programme Management Office (PMO) to be established to oversee the operational delivery of the work streams aligned to the strategy

4.10. The progress of primary care network configuration to be reviewed with GP members and next steps to be agreed for the development of new ways of working - 21 September 2017

4.11. CCG and GP Federation to continue developing partnerships, ensuring links with the Local Authority Adult Social Care, Children's and Public Health teams

5. CONSULTATION

5.1 As previously stated, a series of public engagement events were undertaken (including two patient focus groups) which have helped to define local residents' wants and expectations of care from General Practice and the wider health and care system. *Appendix 1* provides a summary of our local engagement. The outputs from our engagement have been incorporated into the final iteration of the strategy.

6. EQUALITY IMPLICATIONS

6.1 A series of public engagement events were and patient feedback. For example, a request to see greater emphasis on mental health needs alongside physical health needs has been incorporated into the strategy.

7. LEGAL IMPLICATIONS

7.1 There will be contracting implications in the eventual formation of accountable care and the CCG will ensure that it adheres to all appropriate contractual guidance.

7.2 It is worth noting that NHS England has recently published guidance on Accountable Care Partnerships. The CCG will work with NHS England to incorporate this guidance into the development of its contracting approach for accountable care, to ensure that local integration agreements reflect the national view in terms of the level of integration required between primary care and the wider system to deliver effective integrated care.

8. FINANCIAL AND RESOURCES IMPLICATIONS

8.1 There are no direct financial implications. An increasingly integrated way of working is anticipated to enable more effective use of resource through improved care co-ordination and the diminishing of organisational boundaries.

9. IMPLICATIONS FOR BUSINESS

9.1 *Not applicable*

10. RISK MANAGEMENT

10.1 The CCG has engaged with stakeholders and residents in order that their views can inform development of the strategy to facilitate understanding of primary care within the borough.

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

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1.			

*[**Note:** Please list only those that are not already in the public domain, i.e. you do not need to include Government publications, previous public reports etc.] Do not list exempt documents. Background Papers must be retained for public inspection for four years after the date of the meeting.*

LIST OF APPENDICES:

- *Appendix 1 – Local Engagement for Strategy Development*
- *Appendix 2 – Patient example highlighting the benefits of accountable care for a patient with mental illness*
- *Appendix 3 – Patient example highlighting the benefits of accountable care for a patient with multiple long term conditions*

APPENDIX 1:
Hammersmith & Fulham – Local Engagement for Strategy Development

Stakeholders / Forum	Dates
Hammersmith and Fulham GP Members Meeting	27th April 2017
Hammersmith and Fulham GP Members Meeting	7th June 2017
Patient Reference Group (which included representation from Healthwatch as well as LBHF and community and Voluntary sector organisations)	15th June 2017
Practice Managers Forum	5th July 2017
Primary Care Strategy Patient Focus Group	10th July 2017
Primary Care Strategy Patient Focus Group	27th July 2017

APPENDIX 2:

Patient Example 1

To highlight benefits of Accountable Care for a patient with mental illness

ROD SMITH: Age 53. Diagnosed with Schizophrenia aged 24. Lives with sister, but often sleeps rough especially when drinking. Prescribed small dose of regular tranquiliser.

Currently:	Anticipated benefits of Accountable Care:
• Has been discharged from follow up by psychiatrist • Under care of Community Psychiatric Nurse (CPN) but frequently fails to attend • Rod feels he is a nuisance to his sister who works from home. He tries to get out from under her feet and spends a lot of time wandering the area, smoking, and sometimes sleeps rough for days or weeks at a time. • Rod sometimes forgets to take his medication. Over the years there have been a couple of crises that have required urgent visits by a psychiatrist. • Rod doesn't like his current medication. His GP would like specialist advice on an alternative but Rod is reluctant to visit the psychiatrist • Rod seems to develop chronic bronchitis rather suddenly. The GP recommends an urgent hospital investigation but knows that Rod is unlikely to attend for all the necessary appointments	• CPN is available to see patients locally in one of the GP practices that forms part of a small, local health and social care network, and can visit patients at home when necessary. • The Primary Care Collaboration includes various local community organisations. The CPN has referred Rod to a health and social care coordinator. After a discussion Rod has joined a local allotment group and finds he enjoys gardening. He has also joined an art group and smokes and drinks much less. • The Primary Care Collaboration employs pharmacists who routinely monitor repeat prescribing systems including Rod's usage of medication. They can use the shared computer system to leave messages for GP colleagues, the CPN and to ensure that someone contacts Rod to check on his wellbeing • The GP and consultant can both access Rod's medical record and hold a 'virtual clinic' where they discuss the case by video link while both viewing the record at the same time. They agree on a plan of action including a trial of a modern medicine with fewer side-effects. • There is a multidisciplinary diagnostic service in the local hospital where the staff includes GPs from Rod's local GP network. A care navigator keeps him informed as the day progresses with various investigations. • The chest specialist and GP compare notes and can exclude cancer. They make a record in Rods clinical notes and agree with Rod that he will attend for follow up with his GP rather than the hospital

APPENDIX 3:

Patient Example 2

To highlight benefits of Accountable Care for a patient with multiple long term conditions

DANUTA SALEEM: Age 79. Widow. Lives alone. Suffers from diabetes, chronic kidney disease, high blood pressure and mild heart failure. She has been admitted to hospital recently following some falls. She tries to help her struggling daughter with cash, leaving her with little money of her own to feed herself properly.

Currently:	Anticipated benefits of Accountable Care:
• A heart failure nurse visits Danuta at home, but sometimes Danuta needs to attend the hospital for tests. She tries to combine visits to her GP for diabetes or blood pressure review with days when her daughter is available. She can also usually co-ordinate her hospital visits to the kidney specialist every three months to suit her daughter. She sometimes misses her appointments • Danuta frequently needs hospital admissions, for heart failure or worsening of her kidney condition. • Currently, communication between health care professionals and social care is typically in the form of letters. • There are frequent mix-ups over medication, when for example one of the specialists recommends a change, but the letter arrives late at the GP surgery • Danuta's daughter is re-housed to another borough with the birth of her child, and Danuta becomes increasingly isolated. A neighbour suggests she discuss the issue with social services. She is offered a weekly visit to a day care centre but feels that would not suit her • Danuta's daughter is increasingly pre-occupied and it becomes more difficult for Danuta to access help or get equipment. • Danuta sees a GP she has not seen before who is a little concerned to hear about Danuta's financial support for the daughter. The GP doesn't want to cause a fuss and lets the matter slide	• Local GPs and social services are combined in an integrated care service. The team is based in one of the GP practices. The combined team ensures that the same, suitably trained nurse can provide home visiting for all the various specialist needs in a single, regular visit. The nurse can discuss Danuta's case regularly with each of the specialists in virtual clinics where both have access to the same, shared record system. Hospital visits become less frequent • An integrated team as well as shared records allows for better planning and anticipation of crises, especially by making use of pharmacists who keep track of medication usage. When crises do occur, they can usually be managed by a community support team that visits Danuta several times daily including the use of mobile diagnostic equipment. • With health and social care combined in a single, local organisation, communication is much easier using a shared record and regular meetings. • All the specialists involved have access to the GP record, and changes to medication are more immediate. Also each integrated local care network will include pharmacists who can regularly review prescribing and raise issues with the doctors or nurses involved. • Integrated health and social care makes it easier for the nurse and social care to share information. With more emphasis on prevention and with better communication, this situation is anticipated much earlier, and a local housing solution is found which allows Danuta's daughter to continue providing some support. • Whenever help is required, it is accessed by a single phone call to the same number each time. Danuta knows her care navigator very well, and since payments for equipment come directly from a single, unified budget personalised help and equipment can be accessed much quicker. • The care navigator is able to connect Danuta to a local visiting service. One of their volunteers is Polish and subsequently visits Danuta regularly to chat in her native language. • The GP is very familiar with their social care colleagues who now work in the same team. They are able to have an informal discussion and the nurse who visits feels able to raise