Shaping a healthier future

NHS
Hillingdon
Clinical Commissioning Group

Hillingdon

Summary of progress under Shaping a healthier future

May 2015
www.hillingdonccg.nhs.uk

Shaping a healthier future

SHAPING A HEALTHIER FUTURE

NHS

Shaping a Healthier Future (SaHF) will transform services for 2 million people across North West London

Why the system needs to change

- We have a growing and ageing population with more long-term conditions
- One in four patients find it difficult to see a GP when they need to and many end up in A&E
- We have more A&E departments per person than other parts of the country
- There are too few specialists in hospitals to provide high-quality round-the-clock care
- We are working from inadequate NHS facilities
- We are working within an increasingly tight budget.

Hillingdon CCG five year plan

- Design a system which better supports patients and gives them more control and input over their own care
- Prevent people from dying prematurely
- Enhance quality of life for people with long-term conditions
- Help people to recover from episodes of ill health or following injury
- Ensure that people have a positive experience of care
- Treat and care for people in a safe environment and protecting them from avoidable harm

Hillingdon CCG five year plan to date

2012-2014
- Consultation and decision making

2014 - 2019
- Year 2 of implementation

Mental health and wellbeing

Improving mental and physical health through integrated services.

- Transformation of services to be responsive to patients needs and easy to access and navigate.
- Care provision as close to home as possible, with GPs at the heart of care, where and when it is needed.
- Improves the lives of users and cares, promoting recovery and delivering excellent health and social care outcomes, including employment, housing and education.

Integration of care

Coordinating care across commissioning bodies and providers

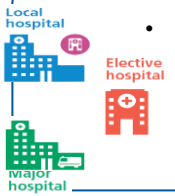
- People will be empowered to direct their care and support and to receive the care they need in their homes or local community.
- GPs will be at the centre of organising and coordinating people's care.
- Our systems and processes will enable and not hinder the provision of integrated care.

Primary and community care

Transforming out-of-hospital services and improving access to GPs

- Provides more local input into primary care commissioning; improves access to GPs whilst being able to move money around the health economy more quickly.
- Puts the right support in place to nurture and grow GP networks so they are able to deliver sustainability in the long term.
- Develops a primary care estates strategy that takes into account hub and GP estate requirements and support implementation of plans to deliver the required estates changes of need.

Hospital reconfiguration



- Delivers a major shift in care from within a hospital setting to an out-of-hospital setting so more people are treated closer to their homes. The concentration of acute hospital services in order to develop centres of excellence which are able to achieve higher clinical standards and provide a more economic approach to the delivery of care.

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INTRODUCTION TO HILLINGDON

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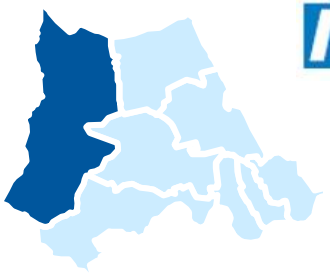
Hillingdon is the second largest of London's 32 boroughs, made up of 22 wards it covers an area of 42 square miles.



Population demographics

- The population is most heavily concentrated in the centre of the borough. By 2021, the overall population in Hillingdon is expected to grow by 8.6% to 320,000
- This future increase is mainly due to an expected 10% rise in population under 15 years and a 15.4% rise in the population of those 75 years and over.

- Hillingdon is an ethnically diverse borough with around 30% of the population from black and minority ethnic communities (lower than the London average 35%).
- The largest ethnic community is the Asian community, with the Indian community forming 13% of the total population.

- Hillingdon is a relatively affluent borough, however there are varied levels of deprivation.
- The south and the central regions of the borough have higher deprivation, with areas falling in the 20% most deprived quintile nationally, and a significant number of areas have children living in poverty.
- The north of the borough is semi-rural, with large sections protected by green-belt regulation.

Overview

290,000
Local resident population (mid 2014)

£

£312m for 2014/15
£348.2m for 2015/16
Health commissioning budget

£14m investment in community and integrated services

Care provision

- **The Hillingdon Hospitals NHS Foundation Trust** provides hospital services.
- **Central and North West London NHS Foundation Trust** provides community nursing, therapy services and mental health services.

- **48 GP practices**
- **42 dental practices**
- **63 pharmacies**
- **61 care homes**

Health challenges

- Rates of diabetes, hospital admissions for alcohol-related harm and tuberculosis rates are all higher than the England average.
- There is an expected rise in the over-75 year old population over the next ten years and as a consequence, it is expected that there will be an increase in rates of conditions such as dementia.
- Hayes and Harlington locality has the most significant health challenges.

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OUT OF HOSPITAL CARE

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Hillingdon CCG has invested £14m[1] in 13/14 and 14/15 on increasing the number of community services and joining up health and social care.

Integration of care

- **Integration of Care Planning**: Giving patients with long term conditions a care plan that considered all their health and social care needs; keeping people healthier for longer and reducing the need for hospital care. Unmanaged long-term conditions are a major cause of emergency admissions to hospital; so better support through care plans is an essential part of reducing pressure on hospital services. We have so far supported nearly 13,000 patients with care plans.
- **New Health and Social Care Coordinators** and **Primary Care Navigators** help deliver care plans for people with long term conditions and signpost patients to health services in Hillingdon.
- **Home Safe** - A joint team with staff from the hospital, community nursing and Age UK to help people regain their independence after a serious illness or accident – helping speed up discharge from hospital.

Community Out of Hospital services

- We have **redesigned and implemented seven planned care pathways** across musculoskeletal, ear nose & throat, gynaecology and urology services. This has lead to a reduction of approximately 2774 first outpatient appointments and approximately 7397 follow up appointments.
- **Community dermatology service**: a new consultant led service running from three locations across the borough, giving patients faster access and more choice of locations convenient for them. Opthalmology is also now operating as a community based service.
- **Rapid Response service:** receives referrals from A&E, GPs, London Ambulance Service and Care Homes and currently supports five people a day to avoid unplanned admission via A&E.
- **Co-ordinate My Care:** A tool for patients with terminal illnesses that allows them to share decisions and wishes about their care with all health and care services supporting them. The tool supports patient choice, helps avoid hospital admissions and supports people to have a comfortable death. The tool is now available across Hillingdon.

Additional one off investments

Information Technology improvements: all Hillingdon GPs now use the same IT system making it easier to implement changes across all practices.

Practice Commissioning Improvement (PCI) programme: Mentoring and Coaching programme to help underperforming practices improve.

Mental health and wellbeing

- **Psychiatric liaison service** and **home treatment service** for adults and older adults.
- **Rapid Response service** for patients with urgent mental health needs. The team supports patients by providing mental and physical health, and therapeutic care in community settings.
- **Integrating Mental Health** – shifting care to ensure people receive the most appropriate care, closer to home.
  - *125 patients now receiving support from general practice* (excluding *Child & Adolescent Mental Health Services*, Mother & Baby community services, specialist teams and memory services).
  - *Additional investment in Child & Adolescent Mental Health Services, Perinatal and IAPT (improving access to psychological therapies) services.*

Primary care transformation (including OOH hubs)

- **Convenient access to GPs** - 96% of practices offer electronic prescription services. 84% of practices offer online appointment booking. 76% of practices offer consultations via telephone with 84% of practices using telephone triage by clinicians. 9 practices offer early morning and late evening appointments ranging from 7.30am to 8.30pm.12 local practices are now open on Saturdays.
- **Urgent Care Centre** opened in Oct 2013, providing a 24-hour GP led service for minor illnesses and injuries. Since then, 100,932 patients (Oct 13 – Dec 14) have used the service. The service sees approx 60% of people walking into A&E.
- **GP networks** are developing to offer a wider range of care from general practice. Programmes are being developed to offer 24 hour blood pressure monitoring, respiratory reviews, diabetic care, wellness programmes and targeted clinics for those currently using A&E and Urgent Care Centres (to provide alternative care through GPs).
- **Improved estates** - Hillingdon is investing in the buildings needed to deliver more services in an out of hospital setting closer to home.
- **Productive Practice** - GP networks participating in a programme designed to create capacity in general practice through more efficient working.

Investment note: Additional expenditure on 'out of hospital' services and infrastructure, spent since the start of SaHF. This is expenditure on primary and community care services, provided outside of acute, intended to reduce demand on the acute sector, i.e. to reduce non-elective or elective admissions, in-hospital outpatient appointments, and A&E attendances. Also includes investment in supporting infrastructure. Project costs are excluded.

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FUTURE OUT OF HOSPITAL PLANS

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Integration of care

- **Improve integrated case management of Long Term Conditions** through key components of the Integrated Care Programme (ICP). LTC related A&E attendances are believed to account for approximately 50% of all A& E attendance. Developing integrated care pathways to support LTC management is expected to reduce emergency admissions by 300 a year, first outpatient appointments by 750 and follow up appointments by 1950.
  - **Enhanced risk assessment**, including health and social care risk stratification tool, and proactive early identification of people with susceptibility to falls, dementia and social isolation .
  - **Extend care planning** to all people with complex health and care needs; and include people with medium risk who will benefit from care planning and introduction of self-care pathways.
  - **Multi-disciplinary teams** regularly meeting at a local level including: nursing, pharmacy, social care, mental health, third sector with General Practice at the centre. Care-coordinators as a first point of contact for patients and carers with the role of coordinating all patients' activities.
  - **Develop an open access IT platform** to share real-time information enabling joined up care for patients receiving help from several services.
- **Expand Rapid Response service,** including embedding social care, operating over seven days, and creating a single intermediate care team which will include dementia, reablement, community rehabilitation, equipment, telecare and homecare.
- **Expand the Early Supported Discharge service (Home Safe)** to specialty wards for older people in addition to the Acute Medical Unit of THH. Establishing a service that operates at scale for patients across the borough.

Primary care including hubs

- Establishing different models of care for different groups of patient (e.g. working population, patients with complex needs) to make care more tailored to their needs and to reduce avoidable use of urgent care/A&E.
- GP master classes and training opportunities for primary care staff to build skills and capacity within general practice; supporting the shift to more care and support available outside of hospitals.
- Expand and improve the provision of online services for patients, including extending online access to medical records and the availability of online appointments.

Mental health and wellbeing

- **Deliver Year 2 of our Joint Mental Health Strategy with London Borough of Hillingdon:** for mental health we will redesign and invest in the following:
  - Urgent care,
  - Child and adolescent services,
  - Dementia,
  - Older adults services
  - Acute inpatient beds and
  - Learning disabilities.

These changes will improve access for patients, especially those in crisis, reduce waiting times and improve early detection of Dementia so users and carers can get the support that they need at an early stage.

Community Out of Hospital services

- We are **developing three "Hubs"** across the borough. These hubs will provide a base for the delivery of Out of Hospital services and the delivery of integrated care. The first hub has been developed in the south of the borough at the Hesa Centre; with two further hubs identified.
- **Enhance intermediate care services and provide seamless community services** including review and realignment of community services to emerging GP networks.
- **Improve care of people in nursing and care homes,** including advanced care planning and increased clinical support and skills development with the benefits of managing the care of residents within the care home and preventing unnecessary attendance at or admission to hospital.
- **Extend recently redesigned community based services** (MSK, ENT, gynaecology and urology) to be available from more sites across the borough.