Shaping a healthier future

NHS
Ealing
Clinical Commissioning Group

Summary of progress under Shaping a Healthier Future

February 2015
www.ealingccg.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

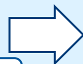
North West London's five year plan

- 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

Five year plan to date

2012-2014

- Consultation and decision making



2014 - 2019

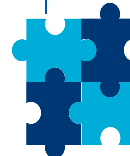
- Year 1 of implementation

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.

Whole systems integrated care



Coordinating care across commissioning bodies and providers

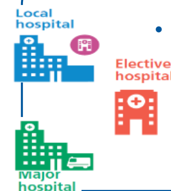
- People will be empowered to direct their care and support and to receive the care they need in their homes or local community.
- GPs will be at the centre of organising and coordinating people's care.
- Our systems and processes will enable and not hinder the provision of integrated care.

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 will allow us to develop centres of excellence which are able to achieve higher clinical standards and provide a more economic approach to the delivery of care

Shaping a healthier future

INTRODUCTION TO EALING

NHS

Ealing is London's third largest borough, which is located in the heart of west London. Ealing is a culturally and ethnically diverse borough.

Population demographics

- It is estimated that by 2020, Ealing's population will reach 369,000, with most of the increase due to a 14.8% rise in the number of people between 0 and 14 years old. There will be a 19.5% rise in the number of people over 65 years of age, and the number of people over 85 is expected to rise by 48%.
- Ealing is an ethnically diverse borough. Black and minority ethnic (BME) communities, including individuals of mixed ethnicity, made up 46% of the Ealing's total population in 2012. This compares to approximately 35% of Greater London's population.

- Ealing has an overall employment rate of 70%, which is slightly higher than the London average. However, Ealing also has areas of concentrated unemployment, with significant income inequalities. The ward of Dormers Wells is amongst the 1% most income deprived in the country.
- Life expectancy is 6.2 years lower for men and 3.9 years lower for women in the most deprived areas of Ealing than in the least deprived areas.

Overview

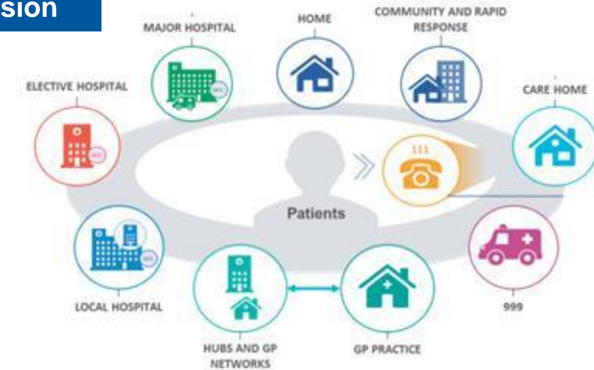
351,000
Local resident population

424,700
2014/15 health commissioning budget

11m invested in community and integrated services

- *The projected 2020 local resident population is 369,000.*
- *Current GP Registered population is 370,000*

Care provision



- **London North West Healthcare NHS Trust** and **Imperial College Healthcare NHS Trust** are the main providers of acute and specialist care
- **Ealing ICO (part of the London North West Healthcare NHS Trust)** provides the majority of community services.
- **West London Mental Health NHS Trust** provides mental health service

- 79 **GP** practices
- 50 **dental** practices
- 76 **pharmacies**
- 40 **care homes**

Health challenges

- The main causes of death are cardiovascular disease e.g. heart disease and stroke accounting for 31% of all deaths. This is followed by cancers or Neoplasms (30%) and respiratory disease (14%).
- Diabetes is most prevalent in the south west of the Borough in the networks of South Southall and Southall.
- Dementia and mental health problems are most prevalent in the central and east of the borough within the networks of Central Ealing, South Central Ealing and Acton.

CURRENT OUT OF HOSPITAL SERVICES

Ealing CCG has invested £11m[1] in 13/14 and 14/15 on increasing the number of community services and joining up health and social care.

Whole systems integrated care

All CCGs across North West London including Ealing are committed to more integrated health and social care:

- **Better Care Fund** supports integrated health and social care, with care provided in the most appropriate setting and with the funding resources fully aligned to need. Examples of initiatives funded by the BCF are:
  - **Healthy at Home -** To create a wholly integrated pathway of services and care for the older persons in Ealing, and help individuals remain at home and receive any care required in a home or community setting
  - **GP Based Care Coordination -** With the use of Care Planning, Care coordination, and Care Navigation, ECCG will develop individualised plans to support patients in managing their care, and navigating their way through the complex health and care system
- **Intermediate Care Service (ICE)** is a hospital admission avoidance scheme that aims to reduce non-elective and A&E attendances. It has led to the introduction of 7 day working, from 8am to 8pm, as well as direct pathway referrals from other services e.g. LAS
- **Adult Social Care**, which includes winter resilience to support 7 day working, is to increase weekend duty support for hospital care management services and supported discharges
- **Integrated Care Pilot** aims to empower patients to self-manage and supports early interventions and reablement. In 2013/14, 8,642 care plans were created. The target for 2014/15 is 20% of the elderly (over 75s) Ealing population, which equates to 3,776

Community Out of Hospital services

- **Urgent care developments**: 24/7 Ealing Urgent Care Centre co-located at Ealing Hospital since July 2011.
- **Rehabilitation services** for older people after falls and fractures to help reduce re-admission to hospital.
- **Pulmonary rehabilitation:** GPs refer qualified patients on the COPD long term conditions register for pulmonary rehab services
- **Primary care services for nursing homes**: A GP service for nursing home residents aims to reduce the levels of A&E attendance and non-elective hospital admissions.
- **Community palliative care:** The CCG, along with Hounslow CCG, funds the Meadows House Hospice to provide care for patients near the end of life.
- **Musculoskeletal services**: outpatient, follow-up and radiology tests are now being delivered in a community setting.
- **Community transport pilot** is being carried out in response to patient and public concerns, and aims to test transport services for those experiencing difficulty in attending appointments in the community and acute services.
- Following the completion of a competitive tender, **tele-dermatology** is now provided in the community for outpatient and follow-up appointments.
- **Diabetes:** A new community outpatient service for stable Type 2 diabetes patients is provided in multiple community locations, meaning patients don't need to go to hospital for outpatient appointments.

1. 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.

CURRENT OUT OF HOSPITAL SERVICES

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Mental health and wellbeing

- **Liaison psychiatric services** are in place to support patients in mental health crisis, and provide a supported discharge service to help reduce length of stay and delayed transfers of care.
- We are **Shifting Settings of Care** for mental health patients, to reduce the number of patients in the care of West London Mental Health Trust. The scheme focuses on transferring patients back to a primary care setting, with additional support to help patients avoid the need for re-admission
- North West London was the 2nd area nationally to have its action plan approved for the ground-breaking **Mental Health Crisis Care Concordat**, ensuring better, joined up, care for people experiencing mental health crisis.

Primary care transformation (including OOH hubs)

GP practice

Care network

Health centre

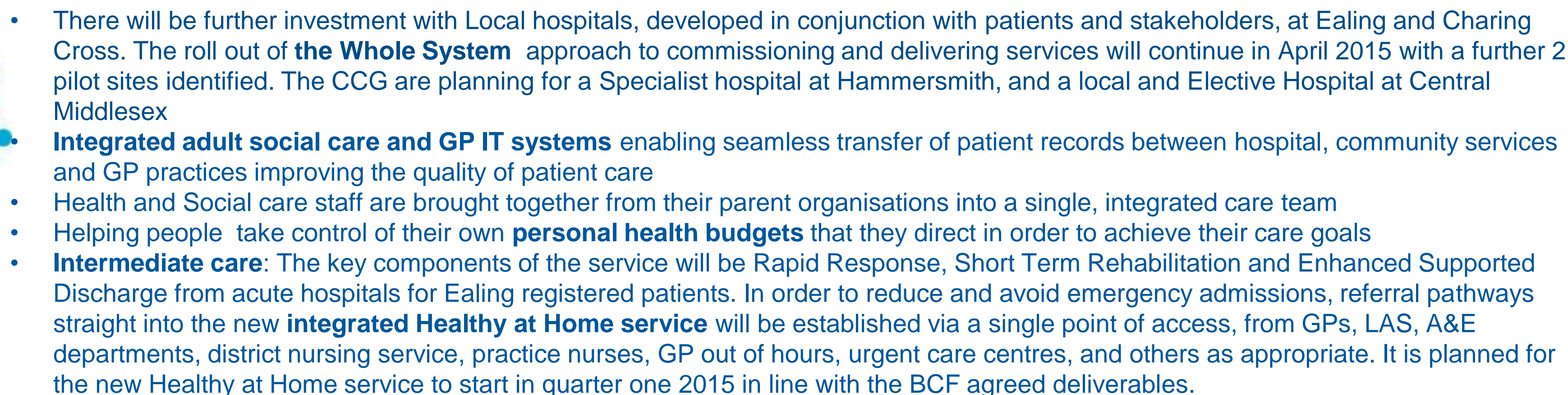
- **Extended Hours**: all 79 GP practices are working to extend their practice hours. There are three GP practices open for 4 hours on a Saturday and 4 hours on a Sunday, with bookable appointments via 111.
- **Efficient appointments**: we have invested in 63 practices which offer telephone consultations as an alternative to face to face appointments and 52 offer longer appointments where needed. 74 out of 79 practices have also moved to a unified IT system in order to improve communications and start share functions.
- **Training of the primary care workforce**: Following on from the success of the Ealing Structured Training Programme, we have started an annual programme of training for the primary care team.

Additional one off investments

- **New primary care IT system**, used by 74 Ealing GP practices, aims to ensure that all providers, either use SystmOne or are fully interoperable with this system.
- **Prime Ministers Challenge Fund (PMCF)**: GP practices in Ealing are grouping in 7 Networks and have established a single Federation. The Federation have started a review of current systems and processes in individual practices, to understand the infrastructure gaps.
- **Non-Acute Winter Schemes Allocation**: GPs providing on the day appointments/walk-ins, a morning duty clinician scheme, home visits earlier in the day, and extending hours. This is in line with the Prime Minister's Challenge Fund, Out of Hospital strategy and SaHF.

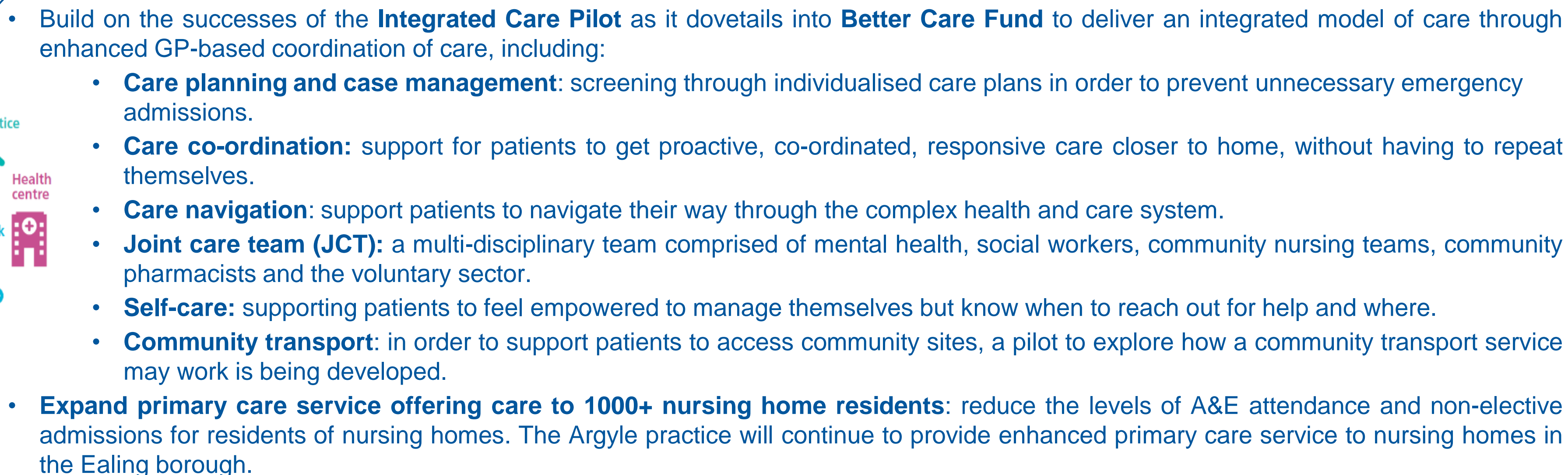
FUTURE OUT OF HOSPITAL PLANS

Whole systems integrated care



- There will be further investment with Local hospitals, developed in conjunction with patients and stakeholders, at Ealing and Charing Cross. The roll out of **the Whole System** approach to commissioning and delivering services will continue in April 2015 with a further 2 pilot sites identified. The CCG are planning for a Specialist hospital at Hammersmith, and a local and Elective Hospital at Central Middlesex
- **Integrated adult social care and GP IT systems** enabling seamless transfer of patient records between hospital, community services and GP practices improving the quality of patient care
- Health and Social care staff are brought together from their parent organisations into a single, integrated care team
- Helping people take control of their own **personal health budgets** that they direct in order to achieve their care goals
- **Intermediate care**: The key components of the service will be Rapid Response, Short Term Rehabilitation and Enhanced Supported Discharge from acute hospitals for Ealing registered patients. In order to reduce and avoid emergency admissions, referral pathways straight into the new **integrated Healthy at Home service** will be established via a single point of access, from GPs, LAS, A&E departments, district nursing service, practice nurses, GP out of hours, urgent care centres, and others as appropriate. It is planned for the new Healthy at Home service to start in quarter one 2015 in line with the BCF agreed deliverables.

Primary care including hubs



- Build on the successes of the **Integrated Care Pilot** as it dovetails into **Better Care Fund** to deliver an integrated model of care through enhanced GP-based coordination of care, including:
  - **Care planning and case management**: screening through individualised care plans in order to prevent unnecessary emergency admissions.
  - **Care co-ordination:** support for patients to get proactive, co-ordinated, responsive care closer to home, without having to repeat themselves.
  - **Care navigation**: support patients to navigate their way through the complex health and care system.
  - **Joint care team (JCT):** a multi-disciplinary team comprised of mental health, social workers, community nursing teams, community pharmacists and the voluntary sector.
  - **Self-care:** supporting patients to feel empowered to manage themselves but know when to reach out for help and where.
  - **Community transport**: in order to support patients to access community sites, a pilot to explore how a community transport service may work is being developed.
- **Expand primary care service offering care to 1000+ nursing home residents**: reduce the levels of A&E attendance and non-elective admissions for residents of nursing homes. The Argyle practice will continue to provide enhanced primary care service to nursing homes in the Ealing borough.

Source: *Ealing CCG Commissioning Intentions 2015/16*

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FUTURE OUT OF HOSPITAL PLANS

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Mental health and wellbeing

- **Urgent access and care:** Urgent care in NWL has undergone extensive redesign for which we have received national recognition. The CCG will ensure that the needs of a range of currently under-served groups are met (including, but not limited to: the needs of those in transition from Children and Adolescent Mental Health Services (CAMHS), those with a learning disability, and those with personality disorder and severe behavioural disorders). Implement expediently any remaining performance improvement to deliver the NWL mental health access standards.
- **CAMHS**: Deliver equitable access to sustainable, high quality, productive and efficient CAMHS services, wherever a service user resides in North West London. Jointly commission Behavioural Support Teams for children and adolescents with learning disabilities. Jointly commission training and public education programmes with public health partners and safeguarding boards.
- **Dementia** The CCG is developing an integrated health and social care dementia pathway with joint responsibility shared between the CCG and Local Authority.
- **IAPT**: Significant transformation and increased capacity in IAPT services. Implement the recommendations from the pan-London work led by the Anna Freud Centre on the coordination of children and young people's IAPT specifically in relation to building capacity in voluntary and community sector organisations (VCSOs) to deliver early intervention mental health support for children and young people.
- **Learning disabilities**: For those with learning disabilities and their families, following on from the **Winterbourne View Concordat**, implement recommendations from the national guidance from the recently established Joint Improvement Programme and NHS England National Expert and Advisory Group.
- **Perinatal**: Commissioning intentions for perinatal services, as with dementia services will be informed via the process of a strategic review across all 8 CCGs which also commenced in Q2 2014/15. This will continue through to 15/16, where the CCG wish to see continued implementation of the Shaping Healthier Lives 2012-15 core initiatives including: Urgent Care, Liaison Psychiatry and Whole Systems/Shifting Settings

Community Out of Hospital services

- **Out of Hospital services** :The CCG aims to put General Practice at the heart of provision and co-ordination of patients in and out of hospital setting, placing the patient at the centre of their own care. Priorities include ensuring all Ealing patients have equity of access to commissioned services, improving quality, and reduced variation within primary care. The OOHS programme supports all of these priorities working across Ealing as a GP Federation.
- **Increasing outpatient and elective services in the community**: The CCG has identified **cardiology, respiratory, gynaecology, paediatrics** as areas where outpatient activity requires high levels of clinical expertise, but relatively little equipment; therefore can be delivered outside of hospital settings and closer to patients' homes.. The CCG is preparing a number of schemes focused on moving activity from acute to community, with the financial and benefits assessment to be finalised by the end of February 2015.

Primary care transformation (including OOH hubs)

- **Out of Hospital Services**: current service provision over and above core services in primary care is not consistently provided across the whole population. By April 2015, the Federation of practices will start to implement a suite of 18 services, which are over and above the core contract, ensuring coverage across the whole population by April 2016. This will include extended hours during the week and at least 12 hours over the weekend. This comes as a result of the re-commissioning of Local Enhanced Services in 14/15. At the heart of this work is the intention to improve the quality of general practice and reduce the known variation
- **Improved estates**: Ealing is investing in the primary care estate needed to deliver more services in an out of hospital setting. Three out of hospital hubs at Ealing Local Hospital and North and East Ealing are planned to deliver extended access to integrated care to patients across the borough.