NHS
Hounslow
Clinical Commissioning Group

Sovereign Court
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By Email

Mr Mansifield QC
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Dear Mr Mansfield QC

NHS Hounslow Clinical Commissioning Group submission

I am writing to you and your colleagues on your inquiry on behalf of NHS Hounslow Clinical Commissioning Group (CCG). I will set out in this letter evidence which I hope will help the inquiry to understand why Hounslow CCG, which I chair, continues to support the transformation of the healthcare landscape in North West London as detailed in the Shaping a Healthier Future programme (SaHF). We are convinced that SaHF, in conjunction with the CCG's Out of Hospital strategy, will ensure the population of Hounslow and the patients of our member GP practices receive the most appropriate healthcare in the most appropriate setting.

Some background information about Hounslow's population
As of the beginning of January 2015 Hounslow's 54 GP practices have a *registered* patient population of 299,928. It is one of the most rapidly growing boroughs in London with growth of 12% predicted by 2020. Hounslow's population is also expected to change its age profile, with the over-65 age group expected to grow by 18% in the same time frame. Hounslow CCG has the same geographical boundaries as its predecessor Primary Care Trust (PCT).

Life expectancy at birth for men and women is 79.5 and 83.3 years respectively. However, healthy life expectancy at birth for men is 60.8 years, significantly worse than England as a whole, and before the age of retirement. For women, 63.2 years of healthy life is expected at birth. Increasing healthy life expectancy (in relation to life expectancy) will help improve wellbeing in the borough and decrease health and social care costs. The main causes of early death in Hounslow are cancer, heart disease and stroke. Around 1,674 premature deaths in people aged under 75 years occurred in the borough between 2010 and 2012. In many cases, several years of health and social care input preceded the early death.

The main preventable causes underlying these premature deaths are smoking (currently 30,000 smokers in the borough), inactivity and obesity (an estimated 63% of adults in Hounslow are overweight, 29% are 'inactive' and less than 10% use outdoor spaces for exercise or health), and alcohol misuse (Hounslow is significantly worse than England as a whole for alcohol-related hospital admissions). There are currently around 14,000 people

with diabetes in the borough, and an estimated 5,000 undiagnosed cases of diabetes, of which a high proportion will be closely linked to obesity. Without major changes, preventable ill-health and these early deaths will continue and may even increase in the borough. (London Borough Hounslow Public Health Commissioning Strategy 2014-18)

Hounslow is one of the most diverse populations in London. In the 2011 census the three most common ethnicities were white British, Indian and Pakistani. Hounslow has a number of recently emerging populations including Afghan, Algerian, Bulgarian, Burmese, Romanian and Sri Lankan communities and very recently the Nepalese population has grown significantly.

More than half of Hounslow's population lives within the lower half of the national scale of deprivation; and approximately 1800 of the local population live in an area which is ranked among the 10% most deprived in England, while about 6000 live in areas in Hounslow ranked in the 10% most deprived in London. Deprivation is not the same as poverty. Data from HM Revenue and Customs indicates that 28% of children in Hounslow live in poverty, higher than the national average of 21%, but lower than the overall rate for London of 31%. The proportion of children living in poverty ranges across Hounslow's wards, from 12% (Hounslow South) to 40% (Isleworth). Both poverty and deprivation have significant impacts on the health and wellbeing of individuals.

Detailed information on the demographics and health needs of Hounslow's population is contained in the Joint Strategic Needs Assessment (JSNA) produced by the Public Health Department of the London Borough of Hounslow. The JSNA is used by Hounslow CCG and the London Borough of Hounslow to develop our joint Commissioning Intentions.

Hounslow CCG consulted widely on SaHF

The CCG has supported SaHF since its inception. The CCG and its predecessor PCT firmly believe that SaHF will improve the health of the Hounslow population. The CCG included the planned transformation in its Communication and Engagement Strategy in late 2011 and signed the Memorandum of Understanding in August 2012 with the seven other shadow North West London CCGs.

The London Borough of Hounslow Health Scrutiny Panel was updated on the planned North West London Acute Transformation on a number of occasions from 2011 onwards with March 2012 being the first panel meeting scrutinising the Shaping a Healthier Future strategy.

The CCG has undertaken significant, on-going engagement and consultation on SaHF both with its GP members and with a range of patients, carers and members of the public. The full programme of engagement prior to decision making is detailed in appendix B of the SaHF Decision Making Business Case. More recently engagement has been undertaken in a range of ways including at the CCG's AGM, joint Commissioning Intentions consultation and Whole Systems Steering Group.

Hounslow CCG has a two-pronged approach to improving services for patients.

1. the implementation of our Out of Hospital Strategy
2. the implementation of acute service reconfiguration.

We firmly believe one cannot be delivered without the other. Our Out of Hospital strategy has evolved through our Whole Systems Integrated Care, Better Care Fund and Prime Minister's Challenge Fund programmes.

Our achievements so far and our plans for the future

In June 2011 we implemented the Integrated Community Response Service (ICRS) - a team of GPs, nurses, therapists, a mental health nurse, a handyman and a social worker available from 7am to 7pm seven days a week. ICRS provides patients over the age of 18 with help within two hours of the service being called. The team provides rapid assessment and intervention and aims to prevent people going into hospital or a care home when they could be looked after in their own home. The team also provides support at home to allow people to return home from hospital more quickly. In July 2014 we further enhanced this service by including an additional care pathway from London Ambulance Service directly to ICRS.

London Borough of Hounslow social workers and GPs are working together in localities. Two pathfinder localities (Feltham and Great West Road) are piloting this initiative with the existing locality multi-disciplinary groups. From April 2015 this will be rolled out across all five localities. Our multi-disciplinary teams work with the voluntary, community and independent sector to support highest risk patients to ensure they can access all the services they need, self-manage their conditions and proactively ask for help, so they remain healthy, independent and well.

GPs are undertaking clinical sessions in care homes at weekends to help reduce admissions to hospitals from care homes. At least one GP surgery per locality has been open at weekends and bank holidays for over a year. Further innovations facilitated through the Prime Minister's Challenge Fund include 8am – 8pm opening in each locality and supporting patients to interact with GPs by expanding the use of the internet. NHS England has reported 98% of Hounslow practices are offering the facility to make appointments and order repeat prescriptions online.

The London Borough of Hounslow and the CCG have jointly procured an integrated recovery-focused Personal Care Framework to provide people with effective and appropriate high quality health and social personal care at home as an alternative to traditional homecare or people having to go unnecessarily into nursing or residential care.

Additional social worker capacity, including a presence in our Emergency Department in West Middlesex University Hospital, is an integral part of Better Care Fund plans to support the acute sector. Additional hospital social worker capacity will ensure that more Social Care assessments are completed within 48 hours. This will significantly reduce the number of delayed transfers of care. We have remodelled the hospital service to extend social care to 7 days per week, and ensure that weekend discharges are enabled and that homecare packages under the new Personal Care Framework are able to be set outside of normal office hours. This has been initially resourced through Winter Resilience 14/15 pump priming funding since November 2014, and will be funded through the Better Care Fund from April 2015.

Hounslow CCG has agreed to commission an Out of Hospital Services (OOHS) portfolio, with standardised specifications and prices, to replace the previous Local Enhanced Services (LES). This will ensure that for the first time all patients are able to access the same range of services across Hounslow.

For Hounslow CCG, the total investment of £4.4m represents an increase of £2.3m on the 2013/14 LES budget. OOHS are being commissioned at a GP locality (network) level, with these new GP provider organisations taking responsibility for ensuring that all patients within the locality are able to access all the services. Chiswick Locality is the first in Hounslow which has gone live with the eight OOH services including anticoagulation (levels 1 & 2) and case finding, care planning & care monitoring.

When fully implemented, the full range of services will include: diabetes (level 1, level 2 and high risk); anticoagulation (level 1 & 2); care planning; wound care (simple and complex); near patient testing; phlebotomy; spirometry; Co-ordinate My Care (end of life care planning); electrocardiogram tests; homeless services and mental health services (transfer of care and managing complex common mental health issue); and ring pessary.

We have commissioned a Community Heart Failure Service from West Middlesex Hospital to provide treatment for patients registered with a Hounslow GP who have a confirmed diagnosis of heart failure. The aim of the service is to increase access to specialist heart failure team advice for primary care colleagues and to support patients who have recently been discharged from secondary care or experienced heart failure. The Consultant-led service is delivered by two specialist heart failure nurses who are supported by West Middlesex Hospital clinicians.

We have also recently commissioned a new Community Diabetes Intermediate Care Service with three distinct elements of service delivery that will go live in May 2015. The service includes care for intermediate patients with diabetes, foot protection, and patient education. The service will provide patients in Hounslow with a robust, safe and reliable community based diabetes care that meets their needs and improves their health outcomes.

A new Ambulatory Emergency Care Service using the patient's GP record is available at West Middlesex Hospital for people who need urgent hospital care but don't require an urgent care centre or A&E attendance. Patients will be assessed, diagnosed and treated on the same day where possible with follow up outpatient appointments where necessary. The service can refer patients into the weekend opening service if appropriate.

In partnership with the London Borough of Hounslow we have plans to continue to invest in Out Of Hospital care with a total investment of £16.9m in 15/16 under the Better Care Fund. This will be in programmes, such as:

- Helping people to self-manage and providing care navigation
- Investing in reablement and rehabilitation through an Integrated Community Recovery model
- Investing in locality based social work
- Providing universal Information, advice and signposting
- Integrating NHS and social care systems around the NHS Number and through a single point of access across health and social care
- Integrating dementia services
- Seven day working in localities for GP services and hospital social work teams supporting community provision
- Investing in care homes, both in relation to GP cover and support and quality monitoring.
- Rolling out Care Plans for over 75s through primary care and co-ordinated care

We are redesigning our rehabilitation and reablement service model and pathway to provide, alongside the Integrated Community Response Service, a Community Recovery Service: a combination of reablement and community rehabilitation, which will work with individuals who have lost their independence through illness or accident and support them to build confidence, regain skills and to self-manage their health conditions and medication. The service will introduce patients to assistive technologies such as Tele-care and Tele-health. This further integrates social and community care.

In conclusion
I would like to confirm that Hounslow CCG remains fully committed to the SaHF programme. By delivering on our Out of Hospital programmes we are providing the appropriate settings for patient care that will deliver the positive outcomes envisaged under SaHF.

The proposals have been fully scrutinised by local clinicians from across the health system, an Independent Review Panel, the High Court and the Secretary of State. The CCG continues to believe the SaHF programme is absolutely necessary to secure a sustainable and safe health service in North West London in the long term.

Yours sincerely

Nicola Burbidge
Chair
NHS Hounslow Clinical Commissioning Group