West Hampshire
Clinical Commissioning Group

CCG Board

Date of meeting		28 November 2019	
Agenda item	7	Paper No	WHCCG19/114

South West and North and Mid Hampshire Local Delivery Systems Report (November 2019)

Key issues	The Sustainability and Transformation Partnership (STP) for Hampshire and the Isle of Wight defines seven core programmes focused on transforming the way both physical and mental health care is delivered. Alongside this are four enabling programmes to create the necessary infrastructure, environment and capabilities to ensure successful delivery. These programmes form the shared system delivery plan for transformation in Hampshire and the Isle of Wight and are at the heart of the CCGs strategic priorities. Local Delivery Systems have been established to ensure local implementation of the seven core programmes for a defined population through collaborative working. This report sets out an update on: • the establishment of Local Delivery Systems within West Hampshire • progress against the core STP programmes and key priority work streams at a local delivery level, with a focus on: o new care models through the implementation of five key interventions o urgent and emergency care, including effective patient flow and discharge so that people only remain in hospital for the acute phase of their illness or injury, with timely transfer or discharge and the right support to maximise their independence
Strategic objectives / perspectives	This paper addresses the following CCG strategic objectives: • Ensure system financial sustainability • Ensure safe and sustainable high quality services • Work in partnership to commission health and social care collaboratively • Establish local delivery systems • Develop the CCG workforce

Actions requested / recommendation	**The Board is asked to review the Local Delivery Systems Report (November 2019) including the associated work programmes in relation to commissioning new care models, primary care transformation and quality initiatives in West Hampshire's localities.**
Principal risk(s) relating to this paper	Any risks are captured within the Directorate and corporate risk registers, together with mitigating actions.
Other committees / groups where evidence supporting this paper has been considered	Local Delivery System Boards Clinical Cabinet West Hampshire CCG Board
Financial and resource implications / impact	There are no financial and resource implications arising from this paper
Legal implications / impact	There are no legal implications arising from this paper.
Privacy impact assessment required?	No
Public / stakeholder involvement – activity taken or planned	The paper includes an update on the communications and engagement activities undertaken within the local delivery systems.
Equality and diversity – implications / impact	This paper does not request decisions which impacts on equality and diversity.
Report author	Rachael King, Director of Commissioning: South West Jenny Erwin, Director of Commissioning: Mid Hampshire
Sponsoring director	Rachael King, Director of Commissioning: South West Jenny Erwin, Director of Commissioning: Mid Hampshire
Date of paper	20 November 2019

NHS
West Hampshire
Clinical Commissioning Group

Local Delivery Systems Report (November 2019)

1. Introduction

The Sustainability and Transformation Plan (STP) for Hampshire and the Isle of Wight defines six core programmes focused on transforming the way both physical and mental health care is delivered. Alongside this are four enabling programmes to create the necessary infrastructure, environment and capabilities to ensure successful delivery. These programmes form the shared system delivery plan for transformation in Hampshire and the Isle of Wight and are at the heart of the CCGs strategic priorities.

Local Delivery Systems have been established to ensure local implementation of the six core programmes for a defined population through collaborative working.

6 Core STP Work Programme

- Prevention at scale
- New Care Models
- Effective patient flow and discharge
- Solent Acute Alliance
- North and Mid Hampshire configuration
- Mental Health Alliance

This report sets out an update on:

- the work within Local Delivery Systems within West Hampshire CCG
- progress against the core STP programmes and key priority work streams at a local delivery level, with a focus on:
  - new care models through the implementation of the five core components of the integrated care model
  - urgent and emergency care, including effective patient flow and discharge so that people only remain in hospital for the acute phase of their illness or injury, with timely transfer or discharge and the right support to maximise their independence.

2. Working in Local Delivery Systems

There are two Local Delivery Systems across West Hampshire.

2.1 South West Hampshire Local Delivery System

The South West Hampshire Local Delivery System covers the four localities of West New Forest, Totton and Waterside, Eastleigh Southern Parishes and Eastleigh North and Test Valley South with a total registered population of 346,164. This area constitutes the South West Directorate of NHS West Hampshire CCG.

The South West Hampshire Local Delivery Board consists of partner organisations from NHS West Hampshire CCG, Hampshire County Council, University Hospitals Southampton NHS Foundation Trust, Southern Health NHS Foundation Trust, General Practice and the Local Medical Committee. The Board oversees the delivery against the core STP programmes and has identified key transformation priorities set out in the 'South West Hampshire Local Delivery System Transformation Plan 2017-20.' The priorities are being implemented as part of the new models of care programme.

Task and Finish Groups have been established and involve wider stakeholder and public engagement reflecting the complex nature of patient flows into Dorset, Wiltshire and Mid-Hampshire within the system.

The South West Hampshire Local Delivery System has strong working relationships with Southampton City.

2.2 North and Mid Hampshire Local Delivery System

The North and Mid Hampshire Local Delivery System cover the two localities of Winchester and Andover in West Hampshire together with North Hampshire CCG. The Mid Hampshire Directorate of NHS West Hampshire CCG has a population of 216,548 which combines with North Hampshire CCGs population of 226,000.

The Local Delivery System Board consists of partner organisations alongside NHS West and North Hampshire CCGs, Hampshire County Council, Hampshire Hospitals NHS Foundation Trust, Southern Health NHS Foundation Trust, General Practice and the Local Medical Committee. The Board oversees the delivery against the core STP programmes and has additionally identified key transformation priorities in relation to elective, non-elective and outpatient care.

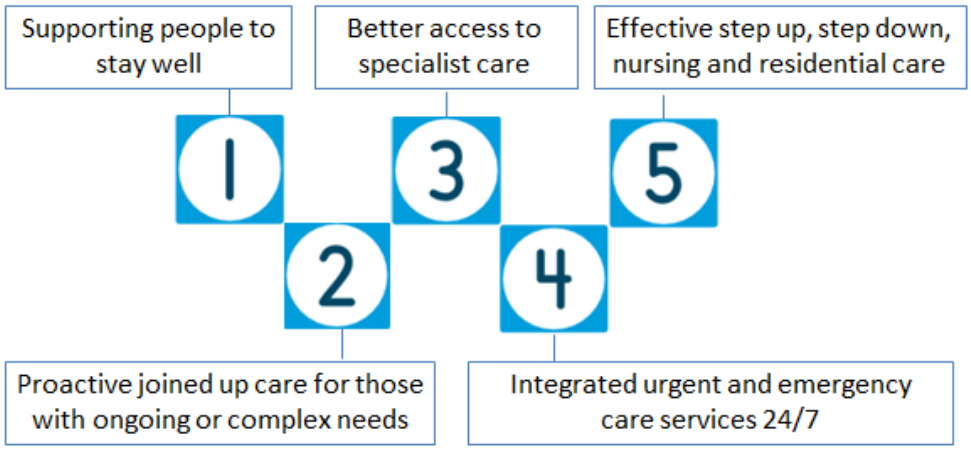
The Mid Hampshire Directorate is working closely with North Hampshire CCG to embed joint work programmes and delivery across North and Mid Hampshire. This includes the appointment of shared commissioning posts, agreed leadership roles across both CCGs and collaborative working with key partners from provider organisations.

3. Delivering the Core STP Work Programmes

3.1 New Models of Care

The aim of the New Models of Care Programme is to improve the health, wellbeing and independence of the population and to ensure the sustainability of General Practice. The Programme consists of five core integrated care components, shown below, which are focussed upon prevention, early intervention and, increasingly, local delivery of care. Critical to this is the work being implemented at a Locality level, as well as the development of Primary Care Networks, which will be the building blocks of local delivery systems. Key areas of work for each of the New Models of Care Programme components are outlined below.

Integrated Care Model



Primary Care Networks:

There are 13 Primary Care Networks within West Hampshire. These are groups of GP Practices with populations of 30,000 - 50,000 working together alongside acute, community and the voluntary sector to deliver joined up care for local people.

All Networks have appointed a Network Clinical Director.

Each Network Clinical Directors is working with a local team to ensure local population needs are understood and services are in place to support local people. The priorities for delivery are based on the health and care needs of the Network population and the difference these will make (to local people, the sustainability of general practice and the wider system) will be set out in an agreed Network Plan.

The GP Contract Framework supports the further development of Primary Care Networks over the next five years. The new Network Directed Enhanced Service (DES) sets out funding for Practices to form and develop Networks, as well as for additional workforce to support new ways of working and the provision of care at a Network level. The priority for 2019-20 is the appointment of a Social Link Worker and Clinical Pharmacist per Network.

Component 1: Supporting People to Stay Well

Supporting people to take greater control of their health and well-being and to make healthy lifestyle choices.

Immunisations and Screening

All of our Localities have identified increased uptake of screening and immunisation as a continuing priority with a focus on shared learning and reducing variation in uptake rates across practices. NHS England and personalised practice packs have been distributed to Practices to support the development of targeted action plans. A focus at Primary Care Network level is being encouraged with Networks being able to apply for STP funding to support innovative approaches to increase uptake rates.

Practices continue to focus on cervical screening. From October 2019 there will also be a focus on breast screening specifically targeting women who have not attended screening before (first timers and non-attenders). National guidance is awaited.

Supporting Healthier Lifestyles

All of our localities have reviewed the impact of 2018-19 keeping people active and well programmes and used these to inform 2019-2021 priorities and planning. Each Primary Care Network has identified 'Staying Well' as a priority. West Hampshire CCG is working with practices to promote Self Care Week in November.

Following positive feedback from the WW (Weight Watchers) collaboration, GP Practices have the opportunity of writing to patients with a BMI>30 again later in the year.

A move from Get Hampshire Walking to broader physical activity is underway with a specific focus on targeting inactivity. Fordingbridge Surgery will shortly be working with Hampshire County Council on an initiative to work with patients with multiple Long Term Conditions.

Social Prescribing

Social prescribing is designed to support people with a range of social, emotional and practical needs to improve their health and wellbeing. In addition to services and activities highlighted in previous reports Primary Care Network's have been actively recruiting social link workers. Each PCN will be targeting patients according to local need and looking at the most effective way to develop the service.

GPs on a Bike in Andover

GPs at Andover Health Centre have signed up to become 'GPs on a Bike' after participating in an exciting social enterprise scheme set up by the Royal College of General Practitioners Wessex Faculty. The Andover practice purchased a reconditioned postal bike for the doctors to use when making patient house calls across the town, saving on fuel costs and playing a part in protecting the environment. It is hoped the sight of doctors riding around town will promote the benefits of regular exercise and a healthy lifestyle as well as increasing visibility of GPs and their work within the local community. The navy blue bike is personalised, signposting it belongs to a 'GP on Call', so the public is aware of the important public service being provided and sending out an important message about the health benefits of keeping active.

The bikes are old postal bikes which have been saved from landfill, recycled and rebuilt by offenders in HM Prisons across the UK. Offenders are given the chance to obtain a certificate of bike maintenance, boosting their skills, confidence and likelihood of gaining employment, which is a key step to preventing repeat offences.

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As this is a social enterprise, in addition to helping save the environment and boosting employment opportunities, when GPs buy a bike, they also give a bike. For every bike bought, another is sent to Malawi, where The African Workshop employs eight local people to repair and service the donated bikes from Britain. The bikes are then sold to Malawians who can travel to work, transport goods to market and travel miles to school or college. Bikes in Malawi can be life transforming and often mean an income for life.

Dr Richard Crane, the GP responsible for acquiring the bike commented: *"It is great to be able to get out and about without using a car. Not only is the bike reducing the carbon footprint of the practice, it is an opportunity to get* some exercise during the long working day and to support some great social initiatives at the same time."

Component 2: Proactive Joined Up Care

For people with on-going or complex need, teams of professionals in each cluster will work together to provide tailored support. This includes the use of technology.

Each person will have a care plan which meets their goals and needs and a named care co-ordinator. People will be assisted to manage their own conditions and to use their skills, social networks and local community support to help meet these needs. Enhanced care will be provided to care home residents. The teams can rapidly access care to enable people to remain at home when they are unwell or need additional support.

Increased access to local care

Intermediate Integrated Care

West Hampshire Clinical Commissioning Group, Hampshire CCG Partnership, Hampshire County Council and Southern Health NHS Foundation Trust have been working in collaboration to ensure the development of a standardised approach and 'core offer' for integrated intermediate care service provision across Hampshire based on the '3 Rs' pillars:

Rehabilitation: the restoration, to the maximum degree possible, of an individual's function and/or role, both mentally and physically, within their family and social networks and within the workplace where appropriate.

Reablement: the active process of an individual regaining the skills, confidence and independence to enable them to do the things for themselves, rather than having things done for them.

Recovery: a personal, unique process of changing one's attitudes, values, feelings, goals, skills, and roles. It is a way of living a satisfying, hopeful and contributing life even with limitations caused by the illness.

'In-reach' Co-ordinators from Southern Health NHS Foundation Trust and Hampshire County Council have been working in Southampton University Hospitals NHS Foundation Trust to proactively identify those patients who could benefit from intermediate care and to facilitate discharge. This ensures that patients do not remain in hospital longer than necessary and receive the support they need in the community.

In Winchester a forerunner 'Local Access Point' is being trialled which provides a single point of access for health and social care referrals (and triage) for integrated intermediate care. This will support a more coherent approach to providing care for those who have both health and social care needs, and in Basingstoke a forerunner integrated community team is being implemented to enhance in-reach into Basingstoke hospital, which supports people who can be safely discharged with additional support, including rebuilding individual's confidence and strengthening their personal networks to return home as quickly as possible.

In South West Hampshire, the 'Local Access Point' forerunner site for South West Hampshire has been identified and will be based in the Totton Hub. This will enable both health and social care teams to be co-located together to enable delivery of urgent intermediate care within 2 hours or 48 hours for all other referrals to people in their own homes for up to 6 weeks.

Frailty Support Team:

NHS Elect Awards 2019/2020

The Frailty Support Team (South West) have supported over 2,700 people to remain at home through the provision of urgent home visits enabling rapid assessment, diagnosis and treatment, together with the provision of care packages to support people to remain at home. This has reduced unnecessary hospital admissions, as well as reducing pressure on GP Practices through saving approximately 5,000 hours of GP time. The positive impact of partnership working by the Frailty Support Team has been shared and the service was recently selected as a Finalist in the Laing Buisson Health Awards 2019 in the 'Health Outcomes Award' category held on 13th November 2019 and has also been selected as a Finalist for the NHS Elect Patient Experience and Quality Improvement Awards 2019 under the 'Excellent Teamwork' category. The winners will be announced at the NHS Elect National Conference on 5th December 2019.

Component 3: Better Access to Specialist Care

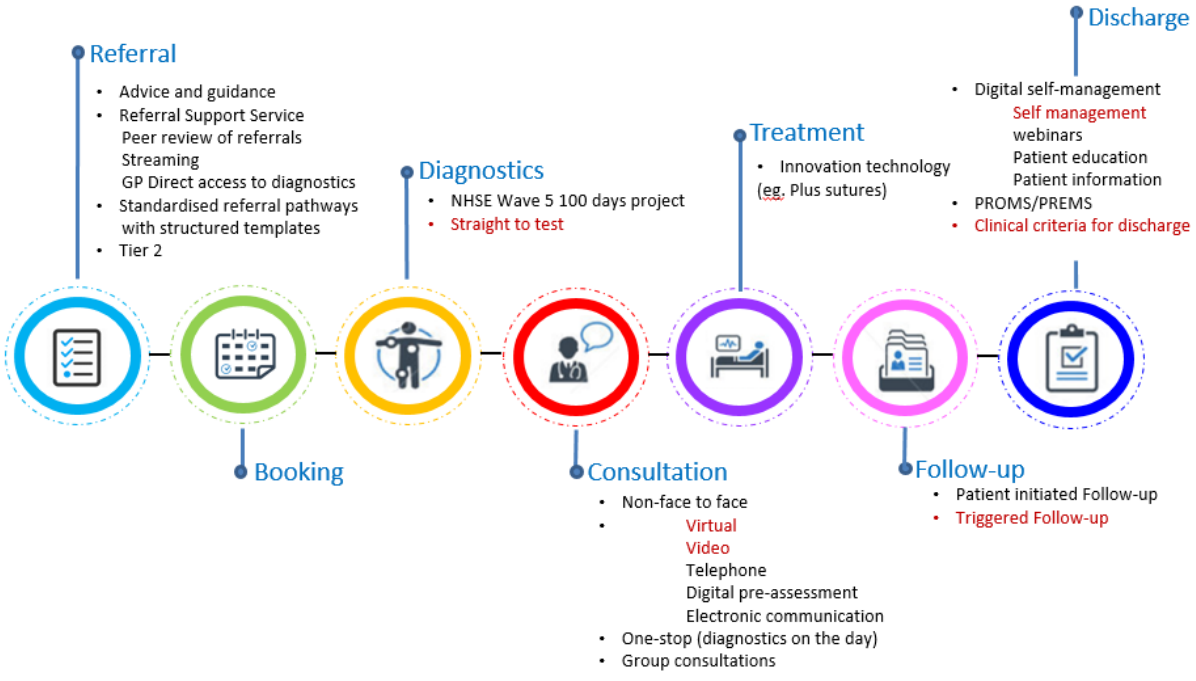
Specialists will work with General Practices providing expert advice and guidance and joined up, proactive care to support the management of people with long term conditions and complex need. Variation in the quality of care will be reduced.

Increasingly care will be provided locally, reducing the need to travel. This will be supported by the development of local hubs (either virtual or co-located) serving populations of 30,000-70,000 and area hubs serving populations of 100,000+.

Outpatient Transformation

Our programme of work aims to continue the implementation of a service model that delivers services for the 'modern outpatient', making best use of clinical and financial resources and reducing footfall in traditional hospital settings. The programme of work is across a number of specialties, improving pathways between primary, community and secondary care services. It aims to improve access to services for patients by encouraging new ways of working, such as improving access to specialist's advice for GPs, avoiding unnecessary referrals and trips to the hospital where possible. The scheme is also looking at a range of ways for patients to be appropriately followed up after treatment, such as, patient initiated, nurse led and telephone follow-up appointments and well as one-stop appointments.

The programmes with University Hospital Southampton (UHSFT) and Hampshire Hospitals NHS Foundation Trusts (HHFT) focus on implementing one-stop assessments, digital pre-assessments, video clinics and straight to test appointments.



The release of the NHS Long Term Plan supports the development of the NHS' digital capability to reduce hospital visits by up to a third over the next five years. Plans are currently underway to re-design outpatients across South West Hampshire so patients can be consulted by a hospital clinician without the requirement to travel to hospital, making the services more practical for patients and families. University Hospital Southampton is a Global Digital Exemplar Trust with recognised expertise in delivering digital projects and programmes and is seeking investment from NHS England to enhance their digital platforms which can be piloted and tested before being replicated in other Trusts across Hampshire and the Isle of Wight.

As one of the Outpatient Transformation enablers, the CCG has implemented the Referral Support Service in West Hampshire to help support General Practice when it comes to making referrals and getting patients to the right care first time. .

Minor Eye Conditions

Since July 2019 West Hampshire CCG has commenced the implementation of a Minor Eye Conditions Service which aims to see and treat patients with simple low risk eye conditions. People can now access care through telephone booking of appointments at a number of local optical practice (Opticians) without the need to travel to hospital eye casualty departments.

Conditions that can be seen under the service include:

- Red eye or eyelids
- Dry eye, or gritty and uncomfortable eyes
- Irritation and inflammation of the eye
- Significant recent sticky discharge from the eye or watery eye
- Recently occurring flashes or floaters
- In-growing eyelashes
- Foreign body in the eye

This service is a new NHS appointment service which has been made available for people of all ages – adults and children, across West Hampshire and Southampton who have problems with their eyes. Not only does this mean patients will be able to receive ophthalmic support and care closer to home but will also reduce pressure on hospitals, enabling them to focus on treating patients with serious and complex eye conditions such as cataracts, diabetic retinopathy or glaucoma.

Community Dermatology

West Hampshire has commissioned a Community Dermatology Service within the South West Local Delivery System for a number of years to see and treat a number of common dermatological conditions (excluding cancers). The service is highly valued by patients, referrers and local consultants.

From October 2019, About Health Ltd started providing a single point of access to all non-cancer dermatology services, ensuring that the patient sees the right clinician, in the right place at the right time. Plans are also being developed to introduce Isotretinoin initiation in the community service for moderate to severe eczema in the New Year.

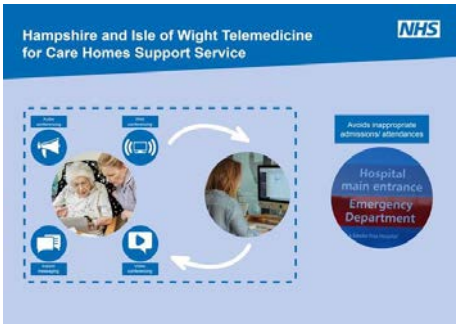
Service Redesign: Day Case to Outpatient Transformation

Work is continuing with providers to review simple procedures (in line with best practice) which could be performed in a lower acuity setting than day-case facilities. This initiative is currently focusing on carpal tunnel decompression surgery, some skin excisions and some injections which traditionally have been done in day case theatre. This frees up day case theatre capacity and delivers services safely but in a different setting, making the best use of clinical and financial resources.

In the South West, the CCG is working with Southern Health Cardiology Outpatient service at Lymington Hospital and in collaboration with the Academic Health Science Network in developing primary care access to simple diagnostics and tailored advice and guidance for GPs through the use of innovative technologies which enable investigations and monitoring, reducing the dependence on secondary care services. The project aims to 'go live' with a number of GP practices by the end of the year.

Developing telemedicine support to people in Care Homes in North and Mid Hampshire

In the North-Mid, following a successful bid for funds to develop a Telemedicine Support Service, the CCGs are working with care homes and Hampshire Hospitals to provide virtual clinical support to residents. The aim is to prevent visits to Emergency Department (ED), admissions to hospital and reduce demand for Primary Care services in and out of hour's services. It is proposed that the service will provide advice via audio/visual/chat capability conferencing. The hub will be located on the Royal Hampshire County Hampshire site and is intended to go live in April 2020 and will be rolled out over a two year period



Digital Support for Care Homes

The North and Mid system have collaborated with the Hampshire Care Association and successfully bid for £40,000 to recruit one whole time equivalent 'Digital Champion' to support care homes to achieve 'Standards Met' of the Data and Security Protection Toolkit ((DSPT)necessary Information Governance), sign up to and utilise NHS.net. This was awarded by Social Digital Care.

The Digital Champions will provide intensive one to one support to care homes to ensure that they comply with each element of the DSPT. This will mean care homes will be able to safely access other systems and services that will improve care for residents, for example, the Care and Health Information Exchange (CHIE) and The Hampshire and Isle of Wight (HIOW) Care Home Telemedicine Support Service.

Component 4: Integrated Urgent and Emergency Care

People will be encouraged to make the right choices at the right time, with access to self-help information and advice and guidance to make informed decisions regarding the support they need when they are feeling unwell. Access to NHS 111 online will be launched this year.

GP Practices will increasingly work together to provide access to same day care, with more services available online and provided in the evenings and at weekends. Urgent care services will be joined up and access simplified.

Integrated Urgent Care

The bringing together of urgent care services to simplify access for patients and ensure they are seen by the right clinician, in the right place and at the right time for their needs is progressing. West Hampshire CCG has awarded contracts for Extended and Urgent Primary Care Services (known as Appointments+) and Urgent Treatment Centres with services commencing on 1 July 2019. The contracts have been awarded to local providers experienced in providing both urgent and non-urgent healthcare in the following locations:

Appointments+

- Winchester: Awarded to Partnering Health Ltd (PHL)
- Botley: Awarded to Eastleigh Southern Parishes Network (ESPN), a GP Federation
- Romsey and Totton: Awarded to Tri-Locality Care (TLC), a GP Federation
- Ringwood: Awarded to Partnering Health Ltd (PHL) as part of the Urgent Treatment Centre service

Urgent Treatment Centre

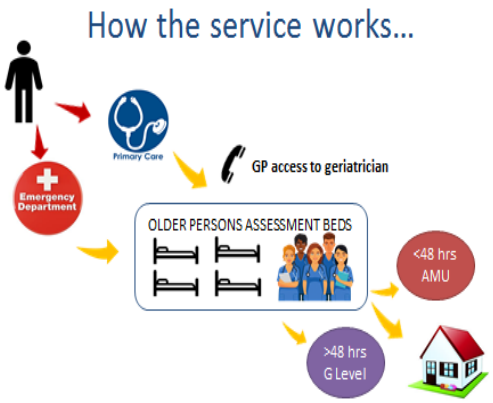
- Lymington: Awarded to Partnering Health Ltd (PHL)

The Appointments+ service brings together the previous Out of Hours GP services and the extended GP access into one joined up service offering routine and urgent evening, weekend and bank holiday appointments. Patients are able to see a GP, nurse, physio or mental health practitioner which can be booked via GP practices or calling NHS 111.

The Urgent Treatment Centre at Lymington New Forest Hospital brings together the above GP services with the Minor Injuries Unit.

In addition, an increased variety of clinicians are now working within the NHS 111 Service to provide a clinical assessment service to ensure that patients can access specialist advice where this is needed. Patients calling NHS 111 may now (where required) be called by a clinical professional within the Clinical Assessment Service such as a GP, mental health practitioner or pharmacist.

Same Day Emergency Care



One of the many ambitions of the NHS Long Term Plan is for all hospitals with a 24 hour emergency department to ensure patients presenting at hospital with relevant conditions are rapidly assessed, diagnosed and treated without being admitted to a ward and if clinically safe to do so, to go home the same day.

Same Day Emergency Departments are now in place within both University Hospitals Southampton and Hampshire Hospitals.

ImprovED

Hampshire Hospital NHS Foundation Trust have been working with Southern Health NHS Foundation Trust, South Central Ambulance Service, Hampshire County Council and the local Clinical Commissioning Groups to improve how patients are managed when accessing urgent and emergency care in North and Mid Hampshire and ensure patients receive treatment at A&E departments within 4 hours. This programme of work has focused on the Emergency Department processes, internal hospital processes and how the wider health and social care providers work together to give patients the best possible care. Benefits to date include news ways of working to support operational staff to identify barriers and implement change, and implementation of national good practice. Further improvements are planned as ED performance is currently below target.

Transforming Emergency Care Collaboration (TECC)

Plans to re-design access to the Winchester Emergency Department remain under development. The aim of the service re-design is to improve access to emergency care for the public; ensuring people get the right care, at the right time, in the right place.

To support the development of proposals, a system wide 'urgent care' audit is due to be undertaken capturing both clinical presentations and patient behaviours. The purpose of this audit is to understand what the urgent care needs of our local population are including the rise in Emergency Department demand, and how we can best meet these needs. The audit will help inform the opportunities for service development and inform our future urgent care strategy.

High Intensity Users

South Central Ambulance Service (SCAS) continue to roll out the successful high intensity user programme which is currently working with the 98 highest users of 999 and ED services. The Demand Practitioner works with the patient, their GP and other relevant health and care services to put in place an agreed management plan aimed at preventing inappropriate calling of emergency services and conveyances to hospital. Since the pilot started 12 months there has been a 30% decrease in See, Treat and Convey (STC) amongst the first cohort of patients. The Demand Practitioner continues to work with existing high users in all cohorts, with new service users added to their caseload every quarter.

Component 5: Effective Step Up and Step Down, Nursing and Residential Care

If a person's health deteriorates, they will know what to do and who to contact. Teams of professionals in each Cluster will be able to quickly respond to avoid preventable hospital admissions and ensure people are supported to remain at home or as close to home as possible. This will include rapid access to assessment, diagnostics, specialist advice and step up and step down beds.

If admission to hospital is required, people will only remain for the acute phase of their illness or injury, with timely transfer or discharge. Care at home will always be the default for care delivery (Home First), with people supported to recover and regain maximum function, independence and wellbeing.

Effective Patient Flow and Discharge

The key focus of the Onward Care Operational Group remains reducing length of stay and decreasing the number of patients on all sites with delays to their transfer of care. Both systems have Effective Flow and Discharge Plans in place, with the focus on the NHS England 8 High Impact Changes; Early Discharge Planning, Systems to Monitor Patient Flow, Multi-disciplinary/multi-agency discharge teams, Home first/discharge to assess, Seven day service, Trusted Assessor, Focus on choice and Enhancing health in care homes.

Some of the improvements planned are;

- Addition of 3 new agencies to the HCC care provider framework
- Additional reablement beds over the winter period
- A Trusted Assessor on site at RHCH from January
- Operational improvements to the Brokerage Process
- Increased Social Workers on site at weekends for assessments
- Improvements to the CHC process
- Reduction for patients waiting for reablement through the IIC work and forerunner projects
- Reduction in delays for patients transferring to community beds
- New schemes approved to support patients to go home safely without a wait - this includes working with our local voluntary organisations – to date circa 70 patients have been supported through by British Red Cross for both Southampton City and West Hampshire patients and 4 patients with persistent/resolving delirium have been discharged to a nursing home for a short stay to recover.

Winter Planning

Both systems have comprehensive winter plans which set out the actions taken to increase capacity over the winter period to manage the predicted surges in demand. Delivery of the plans is overseen by the System Operational Delivery Groups and A&E Delivery Boards.