West Hampshire
Clinical Commissioning Group

CCG Board

Date of meeting		23 May 2019	
Agenda item	9	Paper No	WHCCG19/054

South West and North and Mid Hampshire Local Delivery Systems Report (May 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 work within 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 West Hampshire Clinical Commissioning Group Board is asked to review the Local Delivery Systems report (May 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
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.
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Sponsoring director	Rachael King, Director of Commissioning: South West Jenny Erwin, Director of Commissioning: Mid Hampshire
Date of paper	14 May 2019

NHS
West Hampshire
Clinical Commissioning Group

Local Delivery Systems Report (May 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 Clusters in 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. The Clusters will become known as Primary Care Networks from 1 July 2019. All Networks will have an appointed accountable Network Clinical Director.

The Network Clinical Director will work 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 has recently been published which 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.

Six Network engagement events have been held, with three more planned. To date over 150 representatives from organisations and patient groups have participated and helped inform the development of the Network Plans.

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.

Supporting Healthier Lifestyles

The benefits of physical activity and outside space continue to be promoted. Red and Green Surgery in Waterside have built a community garden. Volunteers are developing the garden and a scheme is being progressed for professionals to be able to signpost patients to activities in the garden to support health and wellbeing.

A focus on promoting physical activity in the work place has commenced. Several GP practices took part in 10,000 steps a day in March, with 17 staff in Lyndhurst Surgery walking a total of 6,393,697 steps – an average of over 12,000 steps per day per person. West Hampshire CCG has formed a Couch to 5K running group.

The CCG has recently met with EnergiseMe, a national charity encouraging increasing physical activity uptake, to discuss ways in which the two organisations can work together. A GP practice in South West Hampshire is currently being identified to pilot a scheme to encourage and support inactive people with multiple long term conditions to begin to engage in activity.

Practices across WHCCG continue to collaborate with Weight Watchers to identify patients with a BMI >30 and invite them to a free 12 week course. Over 12,000 patient letters have been sent out. In Fordingbridge Surgery 164 new patients (16% of invites) enrolled and 55% of these completed the programme. A combined weight loss of 103 stone was achieved with average weight loss 8.8lbs; > 3% of body weight in 12 weeks. The Fordingbridge case study suggests the letter invite had success at targeting those with a Long Term Condition such as COPD, Diabetes (33% of those who completed) and more deprived communities (55% were from the 3 lowest LSOAs (Lower Layer Super Output (geographic) Area)). Gratton Surgery now offers a Weightwatchers session at Wednesday lunchtimes at the surgery which has proved popular with patients

NHS inclusion
Fulfilling Potential. Forging Success.

Inclusion, the commissioned Drug and Alcohol Support Service, have attended Locality meetings to raise awareness amongst GP practices of the local services available to support people. The availability of digital and telephone services for people who may be worried about early alcohol dependency were also highlighted.

Following the success of the Christmas Buddy the Healthy Elf campaign, West Hampshire CCG launched an Easter Hop2Health promotion. West Hampshire CCG staff were encouraged to take the Easter Bunny on healthy activities, and photos and messages were shared on Facebook and via Twitter to promote the benefits of a healthy lifestyle.

Both smoking cessation and weight management services are also being promoted through 'Fit for Surgery'. All practices have been issued with leaflets to help provide pre-surgical advice and support to improve post-surgical outcomes and reduce risk of complications. Promotional leaflets and event banners have also been produced to raise public awareness.

Immunisation and Screening

The promotion of immunisation and screening continues. Despite challenges, West Hampshire CCG flu vaccination uptake was higher than the national and regional (Hampshire and the Isle of Wight) uptake against the majority of risk groups.

Risk Group	Aged 65yrs +	At risk aged 6mths - 64yrs	Children aged 2yrs	Children aged 3yrs	Pregnant women (all)
Achieved Apr-Dec 18	75.60%	53.40%	61.20%	63.20%	55.30%
Ambition	75%	55%	48%	48%	55%

Cervical screening has been prioritised. All practices in West Hampshire CCG promoted Jo's Campaign in January and also National Cervical Screening week. Latest coverage figures for cervical screening for 2018/19 demonstrate an improvement when compared with the same period in 2016/17, with the number of practices with <75% coverage for women aged 25-49yrs reducing from 22 to 15 and for all women a reduction of 8 to 5.

Social Prescribing

Social prescribing is designed to support people with a range of social, emotional and practical needs to improve their health and wellbeing. A range of social prescribing initiatives are in place across West Hampshire CCG, including:

- St Johns Winchester, Hand in Hand Scheme (funded by St John's Winchester charity) is a scheme to relieve social isolation and loneliness amongst older people and help them retain choice and control through personal support and practical help for individuals and their carers. The purpose of this pilot is to complement and be a 'follow on' service from the Proactive Care Team. The service started in November 2018 and went live across the 3 Winchester City Practices in February 2019 with 2 employed Wellbeing Co-ordinators, 21 trained volunteers, and 50 referrals from March to April 2019.
- Unity (formerly Test Valley Community Services) social prescribing in Andover (funded by Simply Health) is aimed at anyone over 18 years of age, who is a patient at one of the participating five Andover Practices and are socially isolated (for whatever reason). It is particularly targeted at those patients who are high users of front line NHS services for reasons that are social rather than medical. This scheme has not seen the expected number of referrals due to the lack of volunteers supporting the Link Worker. The pilot has been running since May 2018 and ends in June 2019 with 1 Link Worker and 1 administrator. A volunteer campaign is underway to recruit and train 10 volunteers.

The benefits of social prescribing have been recognised at a national level with funding allocated to employ 1wte Social Prescribing Link Worker in each Primary Care Network from 1 July 2019.

West Hampshire CCG continues to support the establishment of Timebanks, which are designed to mobilise communities to give and receive support within their community using a currency of time credits. The Totton Timebank continues to plan events and recruit new members and is exploring partnership working with the Totton Men's Shed. A new Timebank in Eastleigh is in the final stages before launch.

National Diabetes Prevention Programme (NDPP) 'Healthier You'

NDPP is a national programme for people at risk of developing Type 2 diabetes. Following an initial assessment, people attend a programme where they learn more about nutrition and diet and engage in activity sessions to help lose weight. Since the programme commenced during 2017, over 2,689 people living in West Hampshire have joined the programme. Making changes can help lower a person's risk or even stop them developing Type 2 diabetes.

Typical Type 2 Diabetes Risk Factors:

- Being over 40 and white, or over 25 and African-Caribbean, Black-African, Chinese or South Asian
- A family history of diabetes
- If you are overweight
- If you have high blood pressure
- If you have a history of a heart attack or stroke
- If you have a history of schizophrenia, bipolar illness or depression, or if you are receiving treatment with anti-psychotic medication
- If you've had polycystic ovaries, or gestational diabetes

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.

Supporting vulnerable people and those with complex need - Frailty

Frailty Support Team–South West Hampshire: Community Health Service Redesign Finalists 2019

The Frailty Support Team has been implemented across the seventeen GP practices in West New Forest, Totton and Waterside localities. The model builds on current commissioned services within Lymington New Forest Hospital, Extended Primary Care Teams and is based around natural communities within this defined geographical area.

The Frailty Support Team is delivered by Southern Health NHS Foundation Trust in partnership with local GP Practices, South Central Ambulance Service and Hampshire County Council Reablement Teams offering both reactive and proactive support. The Reactive element is a multi-disciplinary team providing urgent triage Monday to Friday (new referrals) for individuals with decompensating frailty and who require urgent same day assessment and management to enable them to remain at home. In addition the Proactive element of the service is working with care homes to enable early identification of people, individual care planning, and medicines reviews with pharmacists, as well providing training sessions (e.g. falls prevention, dementia support, re-positioning) to help those living with frailty.

West Hampshire CCG is delighted that the Frailty Support Team has been shortlisted for a HSJ Award, with the winner being announced on 23 May 2019. The team also attended the Milford-on-Sea AGM and the Academic Health Sciences Conference on Ageing to talk about the service.

Countess Mountbatten Hospice

In April this year, a new bereavement service at Countess Mountbatten Hospice was launched, as one of a number of new services planned. Bereavement Volunteers have been trained and an art therapist appointed.

In addition, a full review of clinical services at Countess Mountbatten is being undertaken by an experienced Consultant Palliative Care Nurse. This is to ensure that in future, local people can access the full range of specialist palliative care services in line with best practice.

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+.

Service Redesign: Outpatient Transformation

Our programme of work aims to implement a service model that delivers services for 'the modern outpatient', making best use of clinical and financial resources and reducing activity in traditional hospital settings. It aims to improve access to services for patients by encouraging new ways of working, such as improving access to specialist opinion for GPs, avoiding unnecessary referrals where possible. As one of the outcomes from Outpatient Transformation, 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. The Outpatient Transformation programme also looks at a wider range of treatment options for patients such as patient initiated, nurse led and telephone follow-up appointments and one-stop appointments.

The programmes with University Hospital Southampton (UHSFT) and Hampshire Hospitals NHS Foundation Trusts 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 5 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 their 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.

West Hampshire CCG is currently in the process of mobilising an Ophthalmology community service which will allow patients the ability to be treated with low risk chronic and acute eye conditions at a local optical practice without the need to travel to hospital. 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 greater acuity.

Community Dermatology introducing 'SLIC' Pilot

General Practitioners in South West Hampshire are now able to refer to a Single Lesion Investigation Clinic (SLIC). A referring GP can identify a patient suitable for this pathway and book them directly into a SLIC where they will receive an appointment to be seen by a trained Health Care Assistant (HCA). Clinics are being held in Bursledon, Lymington and Romsey. During the appointment, the HCA will take a patient history and high quality photographs of the lesion via bespoke software, for which the patient will have consented. Photographs of the lesion will be sent to triaging NHS Dermatology Consultants who will decide on the most appropriate pathway. Pathway decisions will be made and actioned within three working days. Patients should see significant benefits in using this Service as they will access earlier diagnosis, treatment, minor procedure or onward urgent referral as deemed necessary. The service will be fully evaluated.

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 best use of clinical and financial resources.

Musculoskeletal (MSK) First Contact Practitioner (FCP) Pilot

Mid Hampshire are piloting the introduction of a MSK First Contact Practitioner Service. The pilot commenced on 1 May 2019 in the Andover Primary Care Network and will run for six months. Patients in Andover can be seen by a first contact practitioner without having to see their GP and can access the service by contacting their GP Practice. The first contact practitioner will triage the patient and also provide self-care advice and initial support with exercise. Patients can be seen for a maximum of two appointments before being discharged with self-care advice or referred on for more extensive treatment by the community physiotherapy service. The model has been based on the service which was established in Nottingham and it is expected that the pilot will see similar outcomes; this includes most patients being managed within the FCP service (70%) without the need for onward referral. The service will be fully evaluated.

Fibroscan Pilot

The community Fibroscan service will be piloted for one year across the 18 practices in Mid Hampshire with a view to evaluate and roll out the pilot to the whole of West Hampshire CCG after 12 months. The service is an innovative way to risk-stratify patients for liver disease so that patients are detected earlier and are given support and advice to reverse liver damage and reduce the risk of developing advanced fibrosis or cirrhosis of the liver in the future. The new service will also identify those patients with more severe liver disease who would not have been diagnosed until they were demonstrating more severe symptoms. This service should reduce the likelihood and severity of complications and mortality of patients with liver disease, improve health outcomes for patients through early intervention and reduce pressures on Hampshire Hospitals Foundation Trust. The pilot went live on 1 April 2019.

Tier 2 Services – Cardiology

West Hampshire CCG is working with Hampshire Hospitals and Mid Hampshire Healthcare to implement an Integrated Cardiology Service that will direct patients to the most appropriate location for their care. The new pathway will see GPs making cardiac referrals to the Integrated service, and after the referral has been jointly reviewed by a hospital consultant and a specialist GP, the patient will be asked to attend either a hospital appointment at Winchester or Basingstoke, or to see a Nurse or specialist GP for tests at a location that is closest to them. By setting up this joint service, a single point for all cardiology referrals will be created. This supports:

- The consultants and specialist GPs to make fully informed decisions on the patients' healthcare.
- The hospital consultants, working with the specialist GPs, will work to increase the GPs understanding of cardiac conditions and how to treat them within the GP practice. This means the patient may not get an appointment at the hospital, but will be asked to attend a second appointment with the GP to discuss their on-going care.
- The use of services local to the patient saving the patient time.
- More people being treated in the community, which helps to reduce hospital waiting times allowing the consultants to see those most in need of their care, quicker.

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 recently announced the award of contracts for Extended and Urgent Primary Care Services and Urgent Treatment Centres. The contracts have been awarded to local providers experienced in providing both urgent and non-urgent healthcare in the following locations:

- Winchester: Awarded to Partnering Health Ltd (PHL)
- Hedge End: Awarded to Eastleigh Southern Parishes Network (ESPN), a GP Federation
- Romsey and Totton: Awarded to Tri-Locality Care (TLC), a GP Federation

The Extended and Urgent GP access services will bring together the existing Out of Hours GP services and the extended GP access into one joined up service offering routine and urgent evening and weekend appointments bookable through GP practices or by calling NHS 111.

The Urgent Treatment Centre at Lymington New Forest Hospital brings together the above GP services with the Minor Injuries Unit. The contract has been awarded to Partnering Health Ltd (PHL) and will include a GP hub in Ringwood serving Avon Valley.

The new integrated model will commence from 1 July 2019. West Hampshire CCG has been working with local patients on the communication plan to make sure local people know how to access the right help in a timely manner.

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. Professionals within the Clinical Assessment Service include GPs, mental health practitioners, pharmacists and social workers.

High Intensity User (HIU) – Demand Practitioner

West Hampshire CCG is working collaboratively with South Central Ambulance Service (SCAS) to effectively manage the care and activity of High Intensity Users. These are people who frequently access urgent care services.

A Demand Practitioner is working with individual patients, primary care and other agencies to offer support and alternatives to ringing for an ambulance. This offers an opportunity to connect with patients who have contacted SCAS more than 10 times in the last year to complete (with consent) a personalised management plan and to establish pathways in partnership with other services to support their health care needs in the community.

By meeting health care needs in a more planned way, this work aims to improve the quality of care for these patients and their families and safely reduce the utilisation of ambulance services and A&E attendance enabling a more cost effective approach to unscheduled care activity.

SCAS is currently working with a cohort of 25 patients who have management plans in place and commenced a second cohort of 25 patients in March.

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

A key focus remains on the review of long stay and 'hard to place' patients with complex needs, together with developing plans to strengthen intermediate care provision. Both systems have Effective Flow and Discharge Plans in place for 2019-20 which are being actively implemented. Plans have been informed by the recommendations of the Newton Europe Review and Hampshire Care Quality Commission Report and immediate actions focus on:

- Earlier multi-disciplinary team working in arranging the most complex discharges
- Regular and consistent long stay patient reviews
- Embedding Discharge to Assess practices
- Increasing the availability of discharge services across 7 days a week
- Increasing social care support to community hospitals to reduce community delays and improve flow
- By March 2020, deliver a 40% reduction in long stay patients (from baseline March 2018).