NHS
West Hampshire
Clinical Commissioning Group

CCG Board

Date of meeting		28 March 2019	
Agenda item	9	Paper No	WHCCG19/024

South West and North and Mid Hampshire Local Delivery Systems Report (March 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 progress against the core STP programmes and key priority work streams at a local delivery level, with a focus on: o new care models 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 (March 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 WHCCG 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	South West Hampshire Directorate Commissioning Team Mid Hampshire Directorate Commissioning Team
Sponsoring director	Rachael King, Director of Commissioning: South West Jenny Erwin, Director of Commissioning: Mid Hampshire
Date of paper	21 March 2019

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Local Delivery Systems Report (March 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.

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

Local Delivery Systems have been established to ensure local implementation of the six 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 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 2017-19.' 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 West and NHS 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.

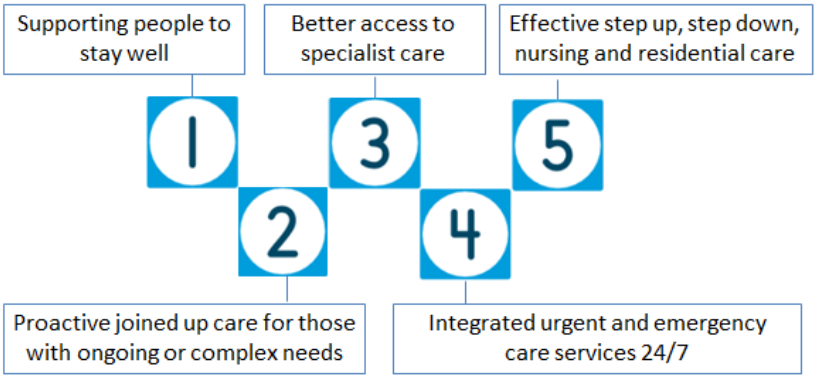
The Mid Hampshire Directorate is working closely with North Hampshire CCG to embed joint work programmes and delivery across North and Mid Hampshire. This includes the appointment of shared commissioning posts, agreed leadership roles across both CCGs and collaborative working with key partners from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

3. Delivering the Core STP Work Programmes

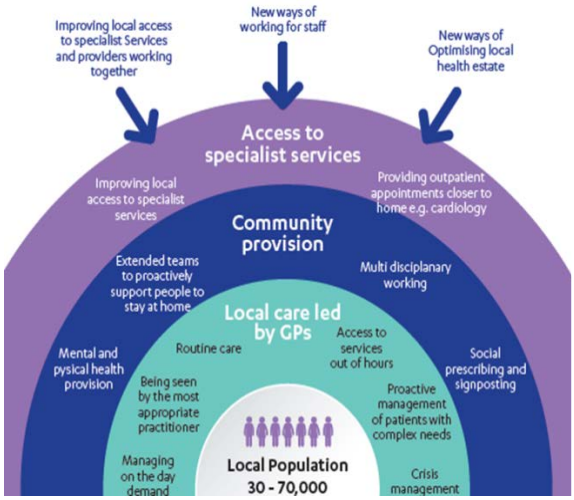
3.1 New Models of Care

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 cover populations of 30,000 to 70,000 and involve GPs working together with local acute and community services and the voluntary sector to provide joined up care. 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 thirteen Primary Care Networks (PCNs) in West Hampshire. Nine PCNs are in South West Hampshire and four in mid Hampshire. Each PCN have an appointed General Practitioner Lead who is working with a team to ensure local population needs are understood and services are in place to support local people. All PCNs are developing a two year PCN Plan by March 2019 which sets out their priorities for the delivery of new models of care based on the health and care needs of the PCN population and which support the sustainability of General Practice. The GP Contract Framework has also been published which will support the further development of PCNs over the next five years. The new Network Directed Enhanced Service sets out funding for Practices to form and develop Networks, as well as for additional workforce.

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 focus on promotion and support of healthier lifestyles was supported by the creation of 'Buddy the Healthy Elf' who featured during December in West Hampshire's social media campaign. Every day during December pictures and updates of Buddy taking control of his health from doing a Park Run and contacting Quit 4 Life to checking his medication and limiting his mince pie intake, were tweeted and posted on Facebook and websites across the CCG and beyond.

The evaluation of the CCG's 'Buddy the Healthy Elf' healthier lifestyles campaign, which ran in December 2018, has been completed and concluded that overall the campaign was effective and recommended repeating the campaign for 2020.

Weight Management Courses

West Hampshire GP Practices have signed up to collaborate with Weight Watchers and are writing to their patients with a BMI >30 to offer a free Weight Watchers course. The sending of letters has been phased to manage demand but initial uptake has been high. The CCG continues to support practices to take up the support of Weight Watchers. In the West locality, seven of 17 practices have already participated, with excellent results, and six are in the process of getting set up. The aim is for each practice in the CCG is to send out the letters.

Six practices within Mid Hampshire have also been working with Weight Watchers. Gratton Surgery is hosting a Weight Watchers session at their surgery and this has proved popular. Friarsgate Surgery has found that 91% of members lost weight, with 55% having a weight loss of more than 5% of their initial body weight.

Get Hampshire Walking

Get Hampshire Walking has developed into a broader physical activity campaign. Physical activity is important for everyone, and the recently published 2019 issue of Forget Me Not has a focus on supporting people with dementia and their carers to stay active. Forget Me Not is the yearly New Forest dementia newsletter jointly produced by WHCCG and the New Forest District Council, and this issue features articles on New Forest Sailability and accessible healthy walks.

Social Prescribing

Totton Time Bank
Strengthening Our Community

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.

In Winchester work is on-going with St John's Winchester (a local charity) to embed their 'Hand in Hand' scheme into the Mid Hampshire Healthcare (MHH) Proactive Care Team in GP Practices to integrate non-medical and medical services, supporting individuals, carers and families who need support and practical help. The focus will be around older people who live in Winchester City. The scheme went live across the Winchester City GP Practices in February 2019.

In Andover, work is taking place with 'Unity' to support their social prescribing pilot (funded by Simply Health) by embedding a care/link worker into the Andover GP Practices. The Unity Link worker has been embedded into the Proactive Care Team based in the Andover GP Practices so that referrals from the Proactive Care Team and GPs can be made into the service directly (with prior patient consent). The pilot went live at the end of May 2018 and is funded until June 2019.

Component 2: Proactive Joined Up Care

For people with on-going or complex need, teams of professionals in each Primary Care Network 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

HSJ VALUE AWARDS 2019

The Frailty Support Team has been implemented across the seventeen GP practices in West New Forest, Totton and Waterside localities. The model is building on current commissioned services within Lymington New Forest Hospital, Extended Primary Care Teams and 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 etc.) to help those living with frailty.

West Hampshire CCG is delighted that the Frailty Support Team has been shortlisted for a HSJ Award.

Dementia

The 'magic table' comes to Ringwood

The Tovertafel, invented in the Netherlands, is a 'magic table' which displays images in the shape of leaves, bubbles, fish, and more. The shapes respond to motion and anyone can enjoy playing with the pictures and making them move.

Tovertafel can be played with friends, family and carers, providing an opportunity for people with dementia to have fun taking part in an activity with others.

Tracey Cotterill takes residents from Bickerley Green Care Home to the Tovertafel at the Trinity Centre in Ringwood, and says,

"Even residents who are initially shy or hesitant are fascinated by the moving images on the table. There is lots of laughter and oohs and aahs and they physically engage with the activity. We particularly enjoy the leaves and ladybirds, and the paint balls that build up a painting. The reasonable cost enables me to visit regularly with different residents who have varied need and abilities."

Trinity Centre's Tovertafel can be hired by the hour and is also fun for children and other groups.

To find out more, please call the Trinity Centre on **01425 461440**, email contact@trinityringwood.co.uk or visit https://tovertafel.co.uk

A Tovertafel for Lyndhurst

Hartwood House care home in Lyndhurst is fundraising for a Tovertafel for residents and looks forward to sharing it with the wider community.

Forget Me Not is the yearly dementia newsletter jointly produced by WHCCG and the New Forest District Council, designed to support New Forest residents with dementia and their families. With a circulation of 3000, the newsletter is full of useful information, including a page of key contacts for those who may not be comfortable getting online. 2019's edition includes articles on accessible sailing, healthy walking, telecare, support for carers and more, and aims to give readers a sense of the huge amount of dementia-accessible resources available in the Forest.

Chronic Obstructive Pulmonary Disease (COPD) in Andover

Andover has a much higher incidence of COPD than many other parts of West Hampshire. The COPD project is aimed at addressing high intensity users and developing truly integrated models of care to support the Out of Hospital model. The current system pathways have been mapped across primary, secondary and community care services to enable a patient centred pathway to be designed across the whole system. The Admission Avoidance service is for patients who have an acute exacerbation of COPD and aims to stabilise, build confidence in self-management, educate and prevent hospital admission.

Mid Hampshire are currently designing a COPD Diagnosis Bundle with services to be rolled out in primary care to ensure accurate diagnosis, education at point of diagnosis and improve self-management.

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, WHCCG 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 South West Hampshire system is part of the NHS England Wave 5 Elective Transformation programme which was launched on 18 October 2018. This was a 100 day challenge, focussed programme of work to improve processes, productivity and patient experience within Neurology, Radiology and General Medicine (Endocrinology).

The results of the Wave 5 will be collated between regional participants and published by NHS England for use within the Elective Care Transformation Programme. The project has already resulted in alternative, innovative ways of working and has; improved treatment pathways, implemented virtual clinics meaning patients are not having to travel to hospital and improved the collaborative working between General Practice and the acute hospital, with consultants offering more advice to our GPs preventing unnecessary referrals. The learning will also inform the development of the outpatient transformation programme in 2019/20.

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.

Community Fibroscan: Mid Hampshire

A Community Fibroscan service will start on the 1st April 2019 for a one year pilot. The service will identify patients who are at risk of developing chronic liver disease. Patients will be seen by a specialist nurse who can provide lifestyle advice, signposting and referrals to other services if required.

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 the Avon Valley. Work is also ongoing to develop an Urgent Treatment Centre at Andover War Memorial Hospital through existing providers working together.

The new integrated model will commence from 1 July 2019.

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.

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 Primary Care Network 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.

Intermediate 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.

To support the delivery of the new model, service specifications (including outcomes for delivery) have been developed for;

- A single point of triage and access
- Home based rehabilitation/reablement support – including rapid response
- Community bed based rehabilitation/reablement support

Each system is reviewing current service provision against the agreed service specifications, with phased implementation of the new model from 1 April 2019.

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 2018/19 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.

Both systems achieved the required 26% reduction in patients staying in hospital greater than 21 days by the end of 2018.

The Onward Care Programme has now been established in North and Mid Hampshire with the aim to ensure that no patient stays longer in an acute or community bed based care than their clinical conditions and care programme demands by investing in and redesigning capacity to care for patient in a more appropriate and cost effective setting and improving discharge planning and processes.

The North and Mid Hampshire Onward Care Programme aligns to the national 8 high impact changes and will drive delivery of the national set ambitions:

- By March 2020, deliver a 40% reduction in long stay patients (from baseline March 2018)
- Continue to make progress on reducing delayed transfers of care (DTOC) to achieve and maintain a national average DTOC position of 4,000 or fewer daily delays, with local targets to be set for 2019/20 through Better Care Fund (BCF) Plans.

A draft plan is being developed with operational staff across all partners; governance is being refreshed for final sign off at the North and Mid Local A&E Delivery Board and ownership at the North & Mid Hampshire LDS Board. This programme aligns to the Hampshire wider Patient Flow Programme.