NHS
Hillingdon
Clinical Commissioning Group

Primary Care Development Plan

November 2013 - March 2016

Contents

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Dated March 2014

Executive Summary

We need to transform how care is delivered because demographic changes are increasing demand on healthcare services and available resources are not increasing at the same rate. Services provided in primary care, and particularly those offered by local GPs are already under severe pressure. So that local people can continue to receive the same (or better) levels of service that they currently enjoy, we need to introduce new ways of working. By intervening earlier, joining up care and supporting patients at home, we will be able to improve outcomes and patient satisfaction, whilst delivering greater value for money.

Primary care encompasses all health care taking place outside hospital and is the cornerstone of the NHS. Primary care is generally the first point of contact that the vast majority of patients will have with a health care service. Primary care is multi-disciplinary and includes GPs, nursing services, dentists, opticians and community pharmacists.

This Primary Care Development Plan focuses on supporting GPs to provide sustainable primary care services. However, this will not be done in isolation and will depend upon strong links with all partners involved in patient care, which includes hospital and social care colleagues as well as voluntary sector services.

Background

The Hillingdon Clinical Commissioning Group (HCCG) set out its initial plans and vision for developing primary care in its 2012 Out of Hospital Strategy: 'Better Care, Closer to Home'.

The strategy describes how the delivery of care can be improved so that patients and carers benefit from a better experience and outcome. How the CCG will achieve this ambition is best summarised by the strategy's five goals:

Easier access to high quality, responsive primary care: HCCG pledge to ensure its patients; carers and residents have easy access to primary care achieving this by working together to extend the range of services offered in primary care.

Simplified pathways for patients requiring planned care: GPs will strengthen the process used to refer patients. This will ensure patients are placed in the most appropriate and convenient healthcare setting and, where possible, enable patients to access outpatients services closer to their home.

A rapid response to urgent healthcare needs: Where possible, the CCG will avoid admitting patients into hospital by creating 'virtual teams' who will be trained to respond and provide the required services without admitting the patient. The strategy also aims to target patients with conditions where effective management and treatment should reduce emergency admission to hospital (often known as Ambulatory Care Sensitive (ACS) conditions).

More integrated care for patients most at risk of becoming ill: The strategy aims to identify and provide better care for patients most at risk of becoming ill. This includes people with long-term conditions (e.g. diabetes), the frail elderly and those at the end of their life.

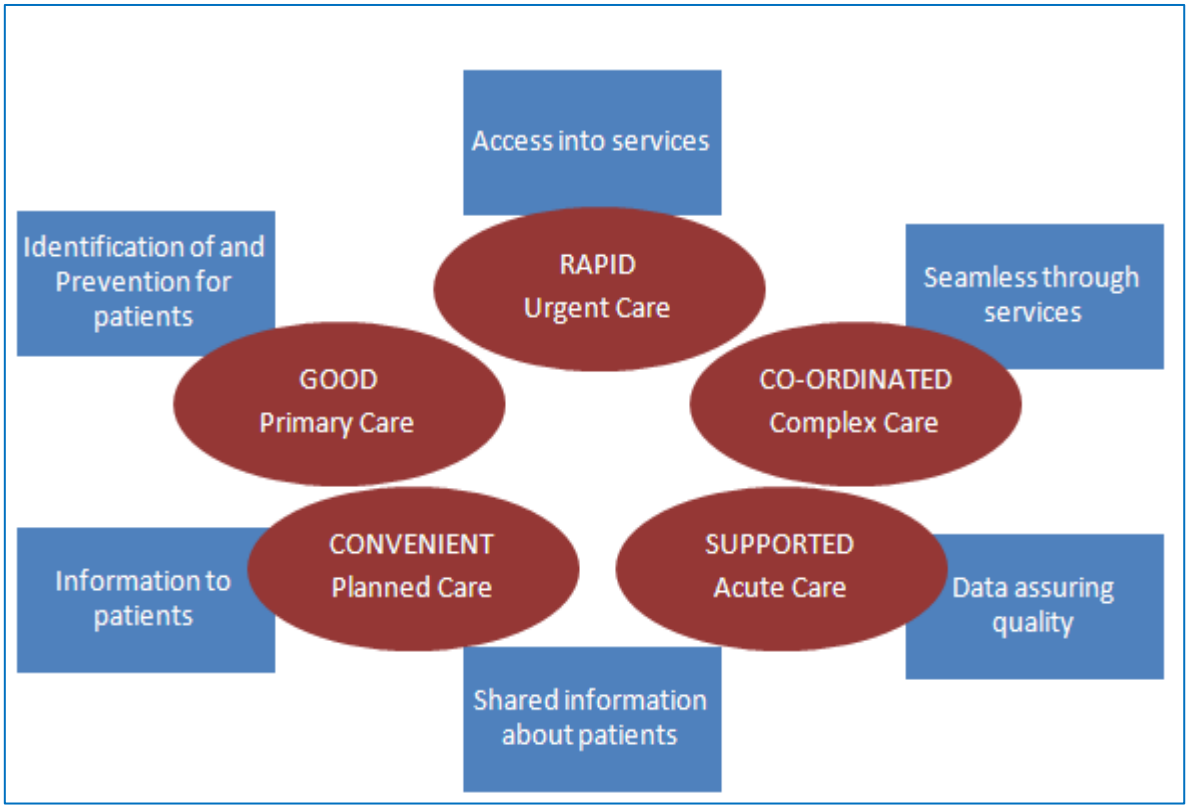
Appropriate time in hospital and support after discharge: Part of improving the patient experience and clinical outcomes is to ensure patients admitted into hospital stay for the right amount of time, and continue to receive care in the community when discharged.

Shaping a Healthier Future (SAHF) and the Out of Hospital Strategy

Since early 2012, North West London (NWL) has also been working to deliver the 'Shaping a Healthier Future' (SaHF) reconfiguration of hospital services across the sector. This includes ensuring that out of hospital care is of a suitable standard and capacity to deliver quality to patients potentially in different ways.

SaHF has agreed six standards (in blue) for the delivery of this care which overlay Hillingdon CCG's five strategic goals (in red) as follows:

Figure 1: Shaping a Healthier Future and the Out Of Hospital Strategy



Developing the Hillingdon Primary Care Plan

The aim is for patients to experience better care and achieve better outcomes through a deeper integration of service provision across primary care. To achieve these outcomes, the quality and standard of care needs to be consistent across all services and patient groups, with patients and carers (where applicable) encouraged to take ownership and an active interest in their healthcare needs.

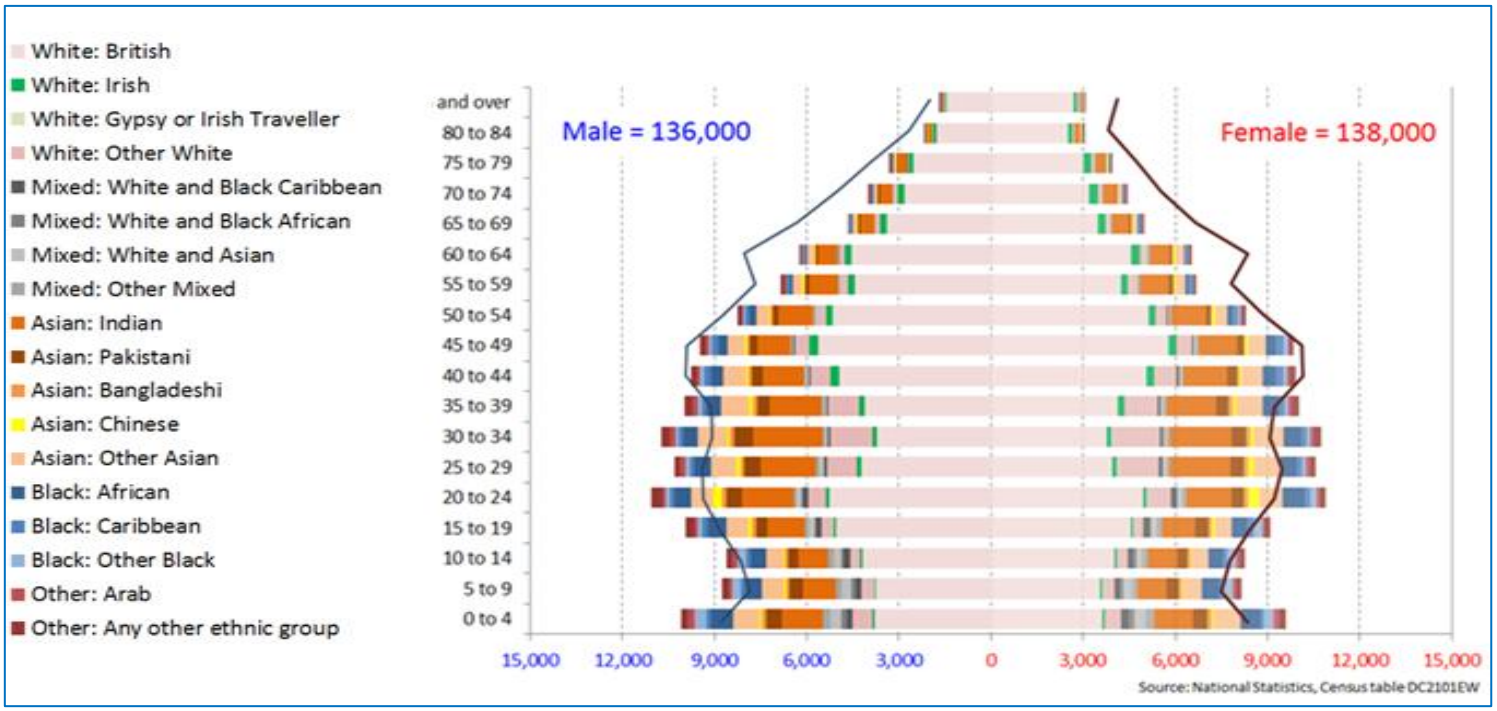
This plan focuses on how primary care can transform to deliver this vision and in particular, how general practice can remain at the centre of planning and co-ordinating that care.

Understanding Hillingdon

Hillingdon has the second largest area (116 km2) of London's 32 boroughs with the 13th largest population. The overall size of the population for the London Borough of Hillingdon was estimated to be 285,000 in 2013[1]

The population pyramid below shows the age and sex distribution of the 2011 census population estimate for Hillingdon. The lines around the outside of the pyramid show how Hillingdon's population would look like if it were to follow the distribution for England. The legend to the left, correlated to the pyramid provides a picture of Hillingdon's diverse population.

Figure 2: Hillingdon population demography (2011)

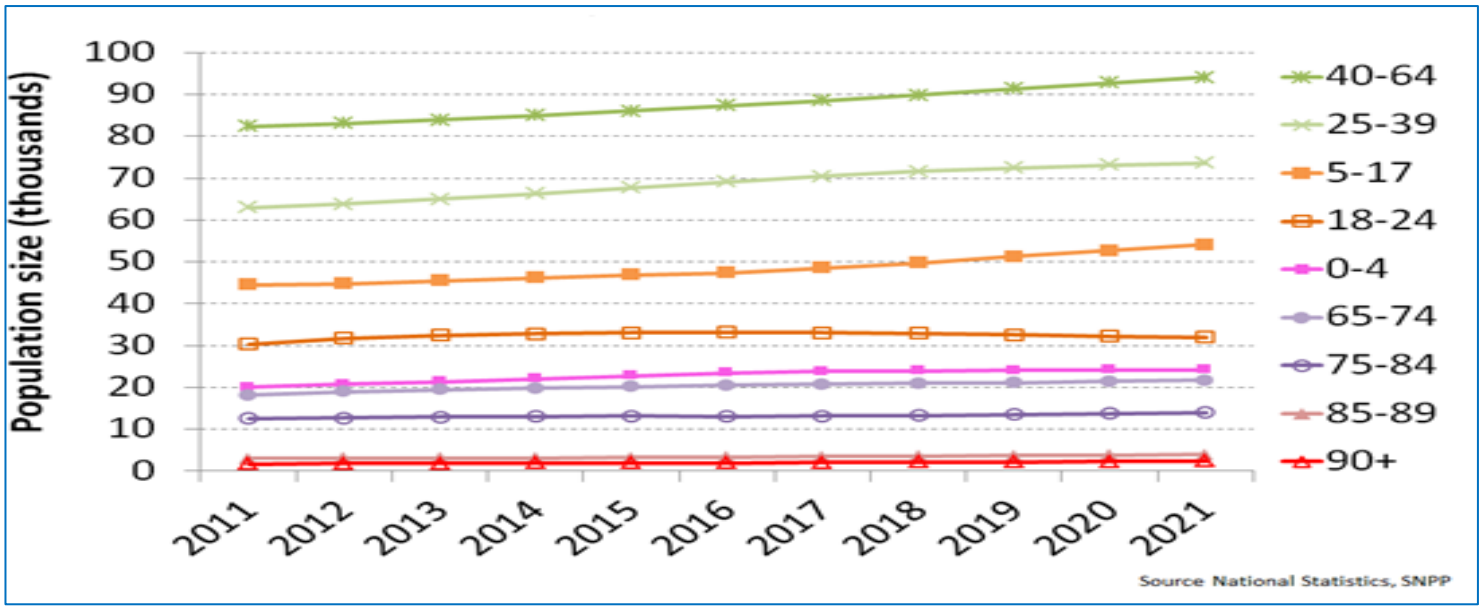


From the population pyramid above we can see that the proportion of the population aged 0-10yrs and 20-40yrs is greater in Hillingdon than in England. Also note that the proportion of the population aged 45+ is lower in Hillingdon than in England. 35,000 are aged over 65 years.

Compared with London, the proportion of the population aged 15-25yrs is greater in Hillingdon and the proportion of the population aged 25-40yrs is lower. The proportion of males and females aged 45+ in Hillingdon is similar to the London average.

[1] National statistics, census-based sub-national population projections (SNPP)

Figure 3: Hillingdon population size 2011 – 2012



Age bands that are expected to increase by more than 100 per year on average are:

- 0-4 by an extra 440 per year
- 5-17 by an extra 970 per year
- 25-39 by an extra 1150 per year
- 40-64 by an extra 1200 per year
- 65-74 by an extra 330 per year

In Hillingdon, the population of children aged 0-17 is projected to increase by approximately 1,300 per year. One of the driving forces behind the projected increase is the year on year increase in the number of live births that has been experienced since 2001. By 2021, the overall population in Hillingdon is expected to grow by 16% to 320,000.

For a full breakdown of Hillingdon's demographics and healthcare needs visit: http://www.hillingdon.gov.uk/jsna

About Hillingdon Clinical Commissioning Group (HCCG)

On 1st April 2013, the Hillingdon Clinical Commissioning Group (HCCG) formally replaced the Primary Care Trust (PCT) as the statutory body responsible for the planning and delivery of health care services in the borough as part of a nationwide reform under The Health and Social Care Bill.

Locally, and in its simplest translation, this change means that General Practitioners from across Hillingdon's 48 GP surgeries now hold responsibility for most of the planning, designing and paying for the NHS services in Hillingdon.

This includes planned and emergency hospital care, rehabilitation, most community services, and mental health and learning disability services.

Membership of the HCCG is made up of Hillingdon's 48 GP practices with its Governing Body comprising of nine elected members. In its current form, this comprises of three GPs per locality (Hayes and Harlington, North Hillingdon, and Uxbridge and West Drayton). It is chaired by Dr Ian Goodman; vice chaired by Dr Tom Davies, and includes three lay members whose portfolios cover Patient, Carer and Public Engagement, Finance and Audit and Remuneration.

The Governing Body is further supported by members from the executive team that also serve Brent and Harrow CCG, North West London Commissioning Support Unit and a team of clinicians and managers that hold responsibility for commissioning a range of health services for the local population.

Hillingdon Clinical Commissioning Group Vision

Crucial to successfully commissioning outcomes and primary care transformation will be HCCG's ability to engage with its community. From service providers and internal stakeholders, to patients and public in and around Hillingdon, the HCCG will work together to achieve its local vision:

"Through clinically focused commissioning, HCCG will be recognised for delivering a high performing, good quality collaborative and cost effective acute and community based health system for the residents of Hillingdon, within an environment that works to raise quality of care, supports clinicians and is satisfying for all staff and members".

Alongside the budget responsibilities, the formation of the HCCG means that GPs and clinicians can and will share their professional skills within the organisation and working collaboratively, will become the key drivers for improving health outcomes through the commissioning of high performing and cost effective services.

Patients of Hillingdon's GP practices will benefit greatly from the new integrated model of care. By GPs holding the budget for the majority of services provided, together with their access to specific skills and professional expertise means GPs will be able to explore and discuss all available treatments both with the patient and clinical professionals; this is expected to have a positive impact on reducing health inequalities.

GPs' active engagement with patients and carers will also reduce inappropriate use of services, and ensure that those who need to access health services continue to do so, but in the right setting and for the appropriate duration.

Primary Care Provision: Supporting organisations

In addition to the services commissioned and supported by the Hillingdon Clinical Commissioning Group pharmacies, optometrists and dentists also provide primary care services all of which are supported by the following organisations:

- **NHS England** is the independent body that holds all primary care provider contracts. It monitors individual providers' performance against contractual obligations.

- **The Local Medical Committee (LMC)** remains the local support and advice organisation elected by local general practice. It represents general practice and is supported in London by London wide LMCs. There are also local committees for optometrists, dentists and community pharmacists.

- **London Borough of Hillingdon (LBH)** is responsible for commissioning and holding the contracts for social care and public health services. It has a constituent-elected Council of local councillors and chairs the Health and Wellbeing Board.

Better Care Fund

From 2015, the CCG and London Borough of Hillingdon (LBH) will be legally required to commission more health and social care using the jointly funded 'Better Care Fund'. Integrating both commissioning and provision will therefore be mutually beneficial.

On 20 December 2013 the government announced the pooling of £3.8 billion in 2015/16 – known as the Better Care Fund – to encourage the local NHS and social care to work together more closely. This provides opportunities for Hillingdon Council and CCG to work together on a five year plan from April 2015, to improve health and social care and provide care that is better coordinated. Here in Hillingdon the Better Care Fund will equate to over £15 million.

We know that in Hillingdon, the number of people age 65 years and over is growing, and it is essential that the Better Care Fund is put to the best possible use to support people with health and care needs, and to make sure services work in an integrated way and deliver what is important to people who use them.

A plan for the Fund must be in place by March 2014 for sign-off at Hillingdon's Health and Wellbeing Board.

The national conditions set out the things that each plan must consider, such as 7-day services, steps to improve data sharing and providing more joined up care. However there will also be as much flexibility as possible in the model of care locally to ensure we meet the needs of people in Hillingdon.

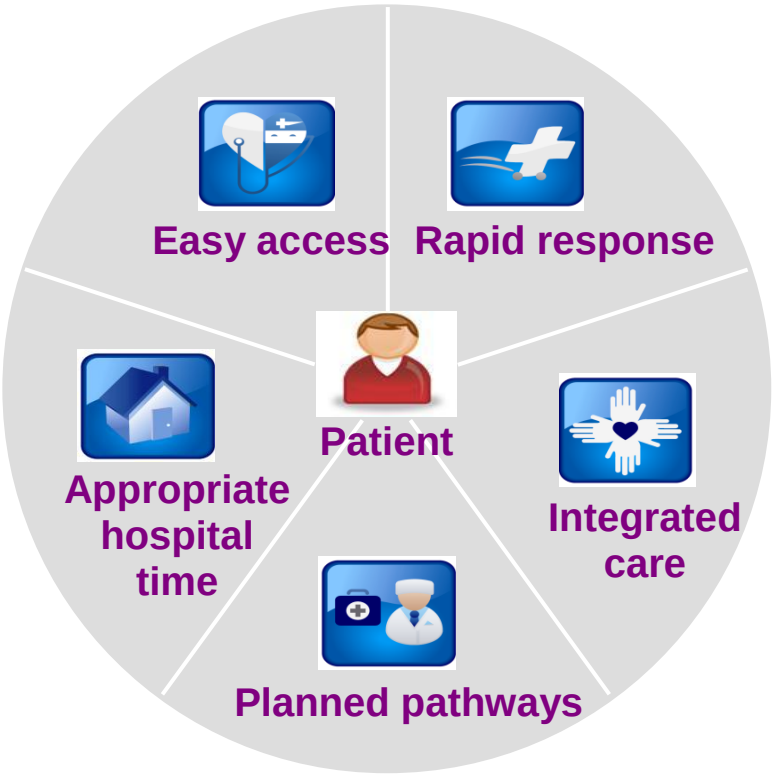
In addition to the national conditions, Hillingdon plan to focus the better care fund initially on people over 65 years with a specific focus on residents over 75 years who are frail or more susceptible to ill health.

These priorities are in line with the existing Hillingdon Clinical Commissioning Group and Health and Wellbeing Board Strategies for a healthier Hillingdon.

HCCG Commissioning Intentions: Principles

In 2012/13 HCCG identified a set of core commissioning principles and will continue to apply them in 2014/15:

- ✓ Commission high quality, clinically effective care, with a robust evidence base
- ✓ Demonstrate and evidence equality and consistency in access to services and health outcomes within Hillingdon that continues a reduction in health inequalities
- ✓ Work with other commissioners where integrated commissioning will deliver innovative and effective healthcare solutions in line with the commissioning strategy
- ✓ Work with providers to co-design an affordable integrated care system, with an increased focus on OOH care
- ✓ Develop patient and public engagement that ensures meaningful public involvement in commissioning
- ✓ Achieving financial balance and a viable local health economy within existing and future resources, with particular emphasis on robust contract monitoring across the entire contract portfolio
- ✓ Commission care in line with health needs as identified by the JSNA and in line with the health and wellbeing strategy
- ✓ Commission services that continue to move toward outcome-focused care, driven by the NHS Outcomes Framework with a key quality focus on the care and treatment of vulnerable adults.



Commissioning intentions 2014 and beyond

The focus of the commissioning intentions remains:

- ✓ managing more patients with **mental health** issues in general practice
- ✓ providing better co-ordinated services for the **elderly with co-morbidities** including dementia
- ✓ enabling **children** to access appropriate services closer to home

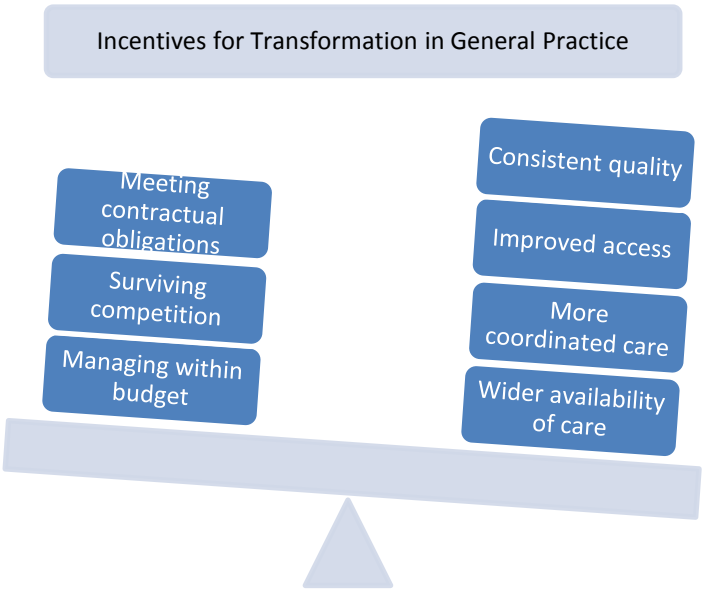
The CCG's highest hospital spend is in these three patient groups and the population of under-fives in particular is predicted to increase over the next few years.

The priority population needs by morbidity are **hypertension** (related to diabetes), mental health issues and the third of people in Hillingdon who have **multiple morbidities** (many of whom are elderly).

The mutual benefits for GPs and the CCG

The primary driver for GPs to work differently is the opportunity that this way of working will provide better access to care for their patients and carers which in turn will improve patient experience and outcomes.

Other contributing motivators for GPs to this new way of working, include the increasing contractual demands on general practice, the competition for primary care contracts and the decreasing practice budget.



The protection of local primary care is paramount. If GPs are to concentrate more of their time on complex patients, other health and social care professionals will need to be deployed, co-ordinated and trained to navigate the system on behalf of patients, provide simple treatments and understand people's social, mental health and other support needs.

Transforming Primary Care

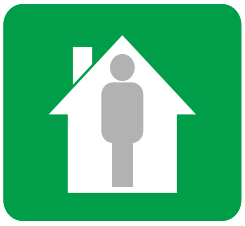
In order for the CCG to fully integrate care provision for patients and carers, and deliver this integrated model of care closer to the patient's home, CCGs must work together to support and develop primary care in the same way acute and community care markets are developed by healthcare commissioners.

Improved care, closer to home

Out of hospital care means bringing some planned care services out of the hospital and into the community. However, for the most part, the CCG has re-negotiated these care pathways, delivery models, settings and tariffs with The Hillingdon Hospital (THH) to provide services as part of a continuum of care that stretches into acute, hospital-based care where required.

However, providing out of hospital care to patients will mean providing better quality, more accessible, more joined up care to more people in the primary and community setting preventing the need for hospital attendance.

With the ever-changing demands and shifts in healthcare, sometimes this means bringing more healthcare professionals to the patient, like hospital consultants, or working more closely with colleagues, like those from social services, or improving access, with opening hours or access to diagnostics.



Enabling more patients to be seen in the primary care setting

Transforming primary care and delivering out of hospital care is about keeping more people in the community and enabling more care to be provided there. With the right support, GPs and the staff that already work in general practice will be able to increase the number of patients they see, reducing the need for these patients to attend hospital appointments.

This is what we mean by transforming primary care and to achieve this, there will be a need for enablers, such as improvements to the primary care estate and development of information technology. There will also be workforce training requirements, for example practice nurses being offered specialist chronic disease management training.

Integrated care: Proof of concept

The 'Integrated Care Programme' (ICP) originated as an Inner North West London initiative and was adopted in Outer North West London in 2011/12. ICP has already established good working relationships between local care providers to discuss care plans for patients who are being seen in a range of health and social care services. National policy is now driving a requirement for health and social care commissioners and providers to be more

integrated in how they plan and deliver services and ICP will be a key driver in delivering improved outcomes for people with complex health and social care needs as well as acting as the foundation for the development of integrated care in Hillingdon..

Delivering different types of care

The CCG's goals cover care offered to patients that could be delivered differently in this joined up, primary-care-led system. This includes:

- Patients who don't have long term conditions who are mostly managed within primary care but need appropriate access to high quality care.
- Patients living with long-term, chronic, complex conditions and require co-ordination of their care across multiple organisations and staff groups.

When planned specialist care is necessary, appointments should be conveniently located and provide all the necessary diagnostics, treatment and advice.

In addition to this:

- Exacerbations can be planned for and dealt with rapidly often outside the A&E department.
- Urgent short term care needs can be provided by rapid response community teams.
- If people's care is managed in hospital for a period of time, the primary and community services should continue to support that care and plan for the transition back out of hospital.



Improving patient experience and outcomes

National and local strategies describe a relationship between patients, carers and healthcare professionals that involves patients and carers more in decisions that affect their care and respite care.

Underpinning this relationship is a need for various types of information, data and records to be more readily available and shared:

- Service and condition-related information consistently available to patients and carers to inform their choice and ability to self-manage.
- Data collected and analysed more effectively to identify patient need, benchmark the quality of services and ensure good outcomes for patients.
- Patient notes shared across providers of care to allow patients to transition more smoothly through the system.
- The 'Coordinate my Care' database is already well used by Hillingdon GPs to share end of life care plans.

The CCG's Information Technology (IT) Strategy is being finalised to underpin the move to more joined up and co-ordinated care provision.

Supporting investment in community estate

Alongside the reconfiguration of how services are provided closer to home, there are business cases being developed for the primary care estate.

- Each CCG has identified 'hubs' for the delivery of some out of hospital care. NWL is supporting the development of business cases for which services these might house.
- Hubs might house primary and community care services where economies of scale, diagnostics, neutrality, transport or capacity are an issue for GP practices or pharmacies.
- NWL estates planners are also working with NHS England to identify investment opportunities in primary care premises.
- The 'Strategic Service Delivery Plan' is being drawn up to underpin the 'hub' business cases.

March 2016: the face of General Practice

In order to meet the needs of the entire patient population and in particular to focus on better co-ordinated and delivered care for the elderly, children and those with mental health needs, primary care will need to deliver:

Consistent, high-quality primary care

This will be achieved by ensuring all GP Practices are:

- ✓ All GP practices are signed up to the CCG's vision and fully engaged as members in the realisation of that vision.
- ✓ All GP practices delivering core services to a minimum standard with equity of access and quality provision assured across the CCG population.
- ✓ All GP practices following the planned care pathways.

Improved access to routine and urgent primary care

This will be achieved by ensuring all GP Practices are providing 8am-8pm access through:

- ✓ Improved access to routine primary care including availability of appointments, telephone triage, telephone consultations, use of Skype and text messaging.
- ✓ Extended access to routine primary care in the evenings and at weekends to bring about seven day access to care.
- ✓ Better use of urgent primary care via 111, urgent care centres and out of hours services.
- ✓ Increased streamlining and efficiency through use of cross-service appointment booking.

GPs at the centre of the patients care

The CCG will strive to achieve this by:

- ✓ All GP practices participating in a GP-led network.
- ✓ GPs being at the forefront of co-ordinating and managing the care of patients particularly those with on-going and complex healthcare needs.

Extended primary care teams (including social services)

These primary care teams will bring together community workers across health and social care. This will benefit patients and carers because:

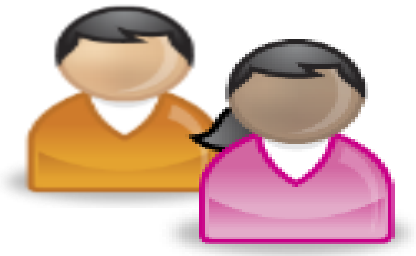
- Primary care teams will be based in and around GP practices
- Networks will include practice nurses, healthcare assistants, community nurses (of all types), other allied health professionals such as therapists and social workers.

- Mental health specialists will be working more closely with and more available to primary care and practice staff will be better trained in mental health needs.
- Relationships with the voluntary sector will be strengthened and a wider knowledge of what they offer will inform care provision and sign-posting.

Community-outreach hospital teams (including geriatricians and liaison psychiatrists)

The work provided by consultants and specialist nurse practitioners will be delivered in the community.

- Consultants and ward-based staff will be communicating with, advising and visiting their primary and community-based colleagues.
- Acute teams will be based in and around GP practices and networks at least part of the time, including consultants, specialist nurses and allied health professionals.
- Relationships between primary care and the acute sector will be strenthened, as will an understanding of each other's working practice to ensure a consistent approach to patient care in a community-based setting.



Care will be arranged and informed by multi-disciplinary joint working

Building on the work of the integrated care pilot, health and care colleagues will meet together to jointly plan cross-organisation patient care.

- The ICP currently has multi-disciplinary group meetings across the different localities where generic care plans have been designed for patient groups to ensure best practice and joined up provision.
- Specific cases (anonymised) are discussed at meetings to inform both the care givers and their patient and carers, and also share service knowledge with others.
- The ICP can be built upon to ensure care plans are individual, live documents retained in general practice and used by all health and care staff. The ICP will continue to shape around emerging GP networks.
- All GP practices participating in multi-disciplinary care planning at practice or network level.

Care Co-ordinators and Care Navigators

Named co-ordinators or navigators for all patients who need them:

- Care co-ordinators tend to describe the clinical staff who manage a patient's care, like community matrons or community psychiatric nurses. They deliver care themselves and understand the system to ease referrals and ensure care packages from others.
- Care navigators tend to describe staff who are experienced but may or may not be clinical, like the Age UK navigators based in general practice. They work closely with patients to understand their holistic health care and support needs and signpost them to appropriate services often in the third sector.
- Mental health navigators are specialists in mental health issues either from having worked in the field and / or lived with, or cared for someone with, mental health issues.

Information for patients, carers and staff regarding services: self-care

- Information for patients and staff of what services are available to whom and at what time. This information does exist on the directory of services underpinning the 111 service but is yet to be fully shared with others and not available to patients. Linked websites can inform people of changing information but crib cards and advertising are also important.
- Information for patients on self-care and management where GPs and the primary care team have access to a wealth of information to assist and advise their patients.

Primary Care Enablers

To drive all these changes in primary care, the CCG will also be working on a number of key enablers which are summarised below. Actions associated with these enablers have been drawn into a plan of action covering the next 2 years.

Data for quality benchmarking and commissioning decisions

By 2016, primary care will have access to information systems holding data that shows who is being treated where and with what outcome. Primary care teams will also be able to identify practice variation and gaps in services.

Shared patient records for clinical decision making and appointment booking

By 2016, electronic patient records can be easily accessed and added to as appropriate:

- GPs will hold and be able to share electronic patient records (with the patients' consent)
- Technology will be in place that will embed patient records into other IT platforms or more services will use the GP EMIS web platform, or information will be shared via clouds or data hubs.
- Information sharing agreements including patient consent will also be established.

Improved estate, including three 'hubs'

Investment in primary care estate to allow adequate room and equipment for out of hospital service delivery, by the end of 2014 there will be:

- Plans for primary care premises investment through NHS England
- Business case for hub development in one of the three localities in the borough.

GP-led Provider Networks

Networks of GP practices and other provider staff will be working together for the practice population:

- GP practices volunteer to form networks based around allegiances to ensure trust and working relationships within the network.
- All commissioned services to be aligned around the networks.
- Care co-ordinated around practice patients and more delivered in GP practice and 'hub' premises.
- Better communication and integrated working between GP practice and partner providers.
- Increased access to non-hospital based diagnostics.

Workforce training, up-skilling and recruitment

Increased workforce with generalised skills and specialist input, this will be achieved by:

- More GPs with special interests and skills.
- Ensuring general community-based roles for geriatricians and psychiatrists.
- Up-skilling practice nurses, pharmacists and allied health professionals.
- Recruiting care navigators.

Support reading

Shaping a Healthier Future – a programme of hospital reconfiguration and support for North West London
http://www.healthiernorthwestlondon.nhs.uk/

Whole Systems Integrated Care – a programme of work which now has national Pioneer status for integrated working
http://www.nhsiq.nhs.uk/improvement-programmes/long-term-conditions/integrated-care.aspx

National Examples and Resources

King's Fund
http://www.kingsfund.org.uk/projects/integrated-care-making-it-happen

NHS Alliance
http://www.nhsalliance.org/manifesto/

NHS Improving Quality
http://www.nhsiq.nhs.uk/improvement-programmes/long-term-conditions/integrated-care.aspx

Primary Care Commissioning
http://www.pcc-cic.org.uk/general-practice