Better Care, Closer to Home

Our strategy for high quality co-ordinated out of hospital care

Hounslow CCG
Letter from the Chair

As the Chair of Hounslow CCG I am committing to commissioning and delivering an out of hospital service that gives patients and our clinical colleagues confidence that care at home and in primary care will be high quality and responsive. At the moment variable quality of primary care services and poor co-ordination between services mean that more people end up in hospital than need to, or should do. The aim of this strategy is to change that.

Our CCG has already made great progress. For example, our Integrated Community Response Service is helping patients get home quicker and avoids unnecessary hospital admission. Our new Urgent Care Centre (UCC) is allowing A&E to focus on emergencies and we are improving primary care through our referral facilitation service and mentoring cells. We’ve also made great progress in getting practices, our UCC, community ophthalmology service and community diabetes service onto the same IT system, which will support greater integration in future.

We’ve still got further to go. This strategy reflects initiatives currently underway, but also reflects our plans for further changes to what we do and how we organise. It explains our continuous drive to improve performance and access in primary care and reduce inappropriate variation; how we are developing more joined up working by different clinicians to provide better care; and the increased role both IT and secondary care consultants will have in supporting out of hospital care.

As Chair and as a GP, I’m excited about these changes and how they will improve care for the patients I see each day.

Nicola Burbidge, Hounslow Clinical Commissioning Group Chair
Executive Summary

This strategy sets out how Hounslow CCG will deliver better care for people, closer to home. It focuses on care provided out of hospital and follows the launch earlier this year by NHS North West London of *Shaping a Healthier Future*.

1. The case for improving out of hospital services
   - Demand for care is growing as people live longer, chronic and lifestyle diseases becomes more common and the technology and interventions we use become more expensive
   - In order to meet this demand within the resources available we need to improve prevention, early intervention and care at home and reduce demand on hospitals
   - To make these improvements we need to transform primary, community and social care and the way they work together to improve access, quality and capacity. The CCG will work closely with colleagues in the Local Authority and local provider organisations to achieve this.

2. Our vision of how care will be different
   - Our vision is that all patients will feel secure in all care they receive out of hospital through effective and safe partnership between GPs, community and social care, hospital and consultants, with early intervention and care in the right setting.
   - Patients will have easier access to consistently high quality primary care
   - More consultant led planned care will take place closer to home, including if their home is a care home.
   - Patients will phone first for urgent care and more will be treated at home
   - Patients with long term conditions who need care from different services will receive one coordinated package of care
   - Care will be better coordinated when patients are being discharged from hospital

We have developed standards to hold ourselves and all providers to account for delivering high quality care out of hospital. We will also work to the standards laid out in the NHS Outcomes Framework and the Outcomes for Social Care.
3. How we will deliver better care, closer to home

Current and future initiatives will deliver this vision, for example:

- 24 hour Urgent Care Centre (UCC), 111 and single point of access improving access to GPs
- Consultant input and local pathways for physical and mental health driving up standards and consistency
- An expanded Integrated Community Response Service (ICRS) and new Ambulatory Care Service
- Getting all providers on our IT system, a new role of care navigators, individual care plans for patients and creating multi-disciplinary groups
- A new Reablement and Rehabilitation service

Some of these services are already running and delivering, such as the ICRS and the UCC. Others, such as the Ambulatory Care Service are new.

4. How we will work together

We have identified better coordination of services as a priority in order to improve care. We will do this by:

- Ensuring care is clinically led and consistent through leadership of clinical networks and GP triagers
- Fully informing all clinicians of diagnoses and treatment patients have received through our IT system, SystmOne
- Working in five geographical multi-disciplinary groups to ensure care is provided seamlessly across health and social care
- Close working with partners, for example having care navigators supporting patients using health and social care services effectively and commissioning some key services from the third sector
5. **Supporting the change**

In order make these changes we have identified 5 things we need to do to enable change:

- Involve, consult and inform patients and carers
- Develop GP leadership at all levels throughout Hounslow
- Have the right governance structure that develops ways of managing quality and develops our workforce
- Take our strong position in IT and estates further to make full use of its potential
- Use the right service specifications and incentives to support system-wide improvement

6. **Investing for the future**

- To deliver this vision we will invest £8-9 million in improving out of hospital care
- We will need more clinical staff and will develop a workforce plan that outlines the investment required in GPs consultants, nurses, social workers and therapists

7. **Next steps**

- By July 2012 we will have put in place appropriate governance structures to manage quality and to enable working in multi-disciplinary groups
- By October 2012 we will have implemented the Ambulatory Care Service and increased the roles of our Urgent Care Centre and our Integrated Community Response Service in preventing admissions
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1. The case for improving out of hospital services

In this strategy we are setting out our plans to transform out of hospital care. We need to do this because demographic changes are increasing demand on healthcare services and the resources available are not increasing at the same rate. As the population ages and the number of chronic illnesses rises the way we currently use hospital is becoming unsustainable.

Improving our out of hospital services will make care better and cheaper. By intervening earlier, joining up care better and supporting patients at home who are currently being admitted to hospital, we will be able to improve outcomes and patient satisfaction while spending less. Better care, closer to home is essential to maintain the quality of care in the face of increasing demand and limited resources.

We need to change the way we deliver care. At present access to care and the quality of care are variable across the borough. Improving the access, quality and scope of out of hospital services will require new ways of coordinating services, investment and greater accountability. Diagram 1 sets out reasons for transforming out of hospital care.

Further details are found in NHS North West London’s Shaping a Healthier Future, programme and the appendix to this document.

DIAGRAM 1

The residents of North West London have changing health needs, as people live longer and with more chronic and lifestyle diseases - putting pressure on social and community care.

Under our current model of care, we can’t afford to meet future demand. Hospital is too often seen as the answer and we need to have more planned care, earlier, outside of hospital.

However, this needs a transformation of primary, community and social care. Currently there is variation in both quality and access and standards must improve.
2. Our vision of how care will be different

Our vision is that all patients will feel secure in all care they receive out of hospital through effective and safe partnership between GPs, community and social providers and hospital consultants, with early care in the right setting. Patient and public concerns will be threaded through these five key areas.

We have developed this vision for improving out of hospital care across five themes as outlined in Diagram 2:

DIAGRAM 2

This will mean delivering across 5 key areas

1. **Easy access** to high quality, responsive primary care through a continuous drive to improve performance and access and reduce inappropriate variation, led by education and peer pressure with performance management when necessary.

2. **High quality elective care and well understood planned care pathways** with minimal numbers of attendances at secondary care to reduce the time patients have to take from their daily lives, through consultant led out of hospital care and detailed care plans sent to GPs and patients to enable local and self management.

3. **Rapid response to urgent needs** so that fewer patients need to access hospital emergency care. Telephone first – patients to know that this is the best way to good signposting to an efficient and seamless service. Patient education on how to get best value from their NHS. Palliative care to move to an elective service.

4. **Health and social care working together**, with the patient at the centre to proactively manage long term conditions, the elderly and end of life care out of hospital, resulting in patients feeling secure in referral into an effective and safe partnership between their GP, community providers and social services with consultant support.

5. **Appropriate time in hospital** when admitted, with early supported discharge into well organised community care.

This section outlines our vision of how care will change for patients across each of these five themes then sets out the standards we are using to hold ourselves to account. Section three describes how we will achieve our aims across the same five themes.

We have identified that lack of coordination between services sometimes limits the effectiveness of local services. We are aiming to achieve the five aims set out above through coordinating services better. Our ambition of a joined up system with strong links between each part is represented by Diagram 3. Section four sets out our plans achieving a more joined up system.
2.1 EASY ACCESS TO HIGH QUALITY RESPONSIVE PRIMARY CARE

Since April 2012, patients in Hounslow have 24 hour access to GP led primary care at our Urgent Care Centre. In future, patients will benefit from practices increasing availability of urgent appointments and appointments within 48 hours or as suitable for them, as a result of our programme to improve access. The proportion of mental health patients able to access care will increase due to the reintroduction of primary care mental health workers, working with multidisciplinary groups of practices. Residents of care homes and supported accommodation will benefit from the increased capacity these teams provide. Children and families will benefit from greater investment in community based services, e.g. in the wheezy childrens service.

Development opportunities for GP practices will drive up quality in primary care: through the increasing interactions between consultants and GPs, our HEAT (Hounslow Education and Training) events, through embedding peer mentoring in mentoring cells. We are adding to this by further developing the role of consultants in the community and launching multi-disciplinary case conferences, which are discussed in section three.
Diagram 4 sets out an example of how better access to primary care will change patients’ experiences:

**Diagram 4**

**Easy access to high quality, responsive primary care**

Claire is 36. She is a working mother who struggles to manage her work and home life. She has a young son, Jason who is 4 years old and has a fever.

**Primary care has been difficult for some patients to access, putting pressure on other parts of the health system...**

<table>
<thead>
<tr>
<th>Claire comes home form work at 6pm to find her son has come back from nursery with a fever</th>
<th>Claire rings her GP but cannot get through. After several attempts decides to take Jason to her local A&amp;E</th>
<th>A&amp;E is crowded and there is long wait. The conditions are stressful and Jason’s condition worsens.</th>
<th>Treatment is transactional. Jason misses out on opportunity for broader child welfare e.g., staff do not make sure jabs up to date, check Claire is coping</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claire uncertain what best course of action is and who to contact</td>
<td>Stressful and time consuming process for Claire to find a solution</td>
<td>A&amp;E staff feel overwhelmed by flow of unscheduled patients</td>
<td>Claire grateful for treatment and idea of A&amp;E as place to get care is reinforced</td>
</tr>
</tbody>
</table>

**In future, patients will have better access to primary care and know how to get it...**

<table>
<thead>
<tr>
<th>Claire understands that 111 can direct her to the most appropriate care</th>
<th>She is relieved and reassured, feeling confidence in the system</th>
<th>Claire is reassured and feels confident to see episode through</th>
<th>Record is taken of the event and communicated to the family’s GP via SystmOne</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claire comes home from work at 6pm to find her son has come back from nursery with a fever and calls 111</td>
<td>She is given an appointment for 8.30pm at the Urgent Care Centre to see a GP</td>
<td>GP sees her son and has access to child’s (and family’s) health record, they check child over, look for rash and send home. They send record of attendance to Claire’s own GP</td>
<td>If it was something more serious (e.g. rash with query meningitis, then the GP could have given an injection of penicillin before sending on to paediatric unit)</td>
</tr>
</tbody>
</table>
2.2 HIGH QUALITY ELECTIVE CARE AND WELL UNDERSTOOD PLANNED CARE PATHWAYS

Our GP led referral facilitation service has already had a significant impact on patient referrals being directed to the most appropriate clinician first time and ensuring that all patients have the equal access to care. In future, we will widen our use of this service and develop our GP triagers to improve the consistency of care. This extension of the service will link with our practice outreach services e.g. anticoagulation hubs.

We have also started to increase the direct role of consultants in community care, for example, through our ophthalmology pathway, and in future more patients will access consultant led care in a local community health centre rather than having to attend hospital for outpatient appointments.

Hounslow already uses SystmOne to improve communication between clinicians. In future, SystmOne will allow all previous or planned contact with a healthcare professional to be visible to all relevant health and care providers, ensuring that patients do not have to repeat themselves to different clinicians. In addition, patients will be able to see their complete records. When a patient needs further care after discharge, detailed care plans will be sent to GPs and patients to enable local and self-management.

Diagram 5 sets out an example of how improved elective care will change patients’ experiences:
Paul is 43. He is in good health but has been experiencing severe discomfort in his knee following a recent bout of exercise.

Sometimes the pathway to receive planned care is complex and disjointed...

- Paul meets with his GP who is unsure of best treatment options and lacks equipment to diagnose.
- Paul is referred to an OP clinic for a scan.
- After two weeks Paul is called in for a follow-up appointment and receives second scan and is advised he needs a hospital appointment.
- Two weeks later Paul has not received a follow-up and returns to GP for further advice.
- Paul still does not understand what his treatment options are.
- Paul has to take time off work to attend.
- Paul does not have his results with him and his GP is unable to give further advice.

In future, the pathway will be simpler, understood by all clinicians and joined up...

- Paul meets with GP who discusses options and shares information about treatment and impact. Books patient for MSK assessment with community services.
- MSK specialist physio carries out assessment, including a scan at the diagnostic clinic and books Paul a hospital admission and discharge date. Treatment is recorded in GP records via SystmOne.
- Paul goes to hospital two weeks later for operation. He has a brief stay on the ward and is discharged with a rehabilitation plan.
- On arriving home receives an email from the hospital explaining plans for rehabilitation and treatment plan is recorded in GP records via SystmOne.
- Paul feels immediate progress is being made and information is efficiently passed between GP and consultant.
- Paul is reassured by the structured approach.
- His GP is able to check on Paul’s progress with rehab.

Paul is 43. He is in good health but has been experiencing severe discomfort in his knee following a recent bout of exercise.

Clearly understood planned care pathways that ensure out of hospital care is not delivered in a hospital setting.
2.3 RAPID RESPONSE TO URGENT NEEDS

The new 24 hour Urgent Care Centre and the Integrated Community Response Service, which are described in section three, have improved response to urgent needs in Hounslow. None-the-less, improvement in this area remains a key priority for Hounslow. In future, all patients will have 24 hour access to advice, out of hours services and booking an urgent care appointment through NHS 111. Practices will increase the availability of urgent appointments. NHS 111 will link to the LBH new emergency response service when it comes into place.

More patients will receive urgent care at home. Our Integrated Community Response Service will provide expert advice, diagnostics, treatment and necessary equipment allowing more patients to stay at home and avoid the need for admission. Our new ambulatory care service will allow patients previously needing secondary care to be treated at home. In addition, mental health patients will benefit from improved response at times of crisis, with intensive support to avoid hospital admission. We are increasing the efficiency of assessment and immediate onward care of patients who present at A&E or the UCC through having an enhanced psychiatric liaison service at the UCC and A&E. Patients will also benefit through a community psychiatric nurses specialising in cognitive disorder and dementia working in the Integrated Community Response Team and through the appointment of a consultant social worker for dementia, aligned with the West London Mental Health Trust pathway for cognitive impairment. Diagram 6 sets out an example of how improved rapid response will change patients’ experiences:
**Urgent care has been stressful when patients need support...**

- **Ethan’s wife is worried and calls an ambulance**
- **In A&E, the strange surroundings make Ethan even more confused and he becomes disruptive and aggressive**
- **While struggling, Ethan rolls out of bed and severely hurts his leg**
- **Hospital nurse are not sure how to deal with him, causing them stress**
- **Ethan becomes more dependent on care and regaining independence is unlikely**

**In future, we will meet patients’ needs at home...**

- **Ethan referred to ICRS by his GP. He has been unable to get out of his chair for the past few days. His wife is caring for him**
- **GP, social worker and physiotherapist from ICRS visit Ethan at home. They review his medication, move the furniture in his lounge and set up a hospital bed and pressure-relieving equipment**
- **Days 1–4 – cared for in bed with regular visits from nurses in the team**
- **Day 5 – confusion much improved. Eating and drinking well and wants to get out of bed**
- **Day 5 onwards – physio working with carers increasing patient’s mobility and exercise tolerance**
- **Stress is minimised and the people with the most appropriate skills are available**
- **Early intensive support accelerates recovery**
- **A smooth transition is made to a locally based multi-disciplinary care team**

- **Day 7 – Referred to community rehabilitation service**

**Urgent care has been stressful when patients need support...**

Rapid response to urgent needs so that fewer patients need to access hospital emergency care

Ethan is 84 and lives with his wife. He has usually stable Parkinson’s disease and walks with a stick. Recently he has developed an urinary tract infection which has led to him becoming confused.

In A&E, the strange surroundings make Ethan even more confused and he becomes disruptive and aggressive.

While struggling, Ethan rolls out of bed and severely hurts his leg.

Hospital nurse are not sure how to deal with him, causing them stress.

Ethan becomes more dependent on care and regaining independence is unlikely.

In future, we will meet patients’ needs at home...

Ethan referred to ICRS by his GP. He has been unable to get out of his chair for the past few days. His wife is caring for him.

GP, social worker and physiotherapist from ICRS visit Ethan at home. They review his medication, move the furniture in his lounge and set up a hospital bed and pressure-relieving equipment.

Days 1–4 – cared for in bed with regular visits from nurses in the team.

Day 5 – confusion much improved. Eating and drinking well and wants to get out of bed.

Day 5 onwards – physio working with carers increasing patient’s mobility and exercise tolerance.

Stress is minimised and the people with the most appropriate skills are available.

Early intensive support accelerates recovery.

A smooth transition is made to a locally based multi-disciplinary care team.
2.4 SOCIAL AND HEALTH PROVIDERS WORKING TOGETHER WITH THE PATIENT AT THE CENTRE

We have identified more coordinated care from different services as a local priority. In future, more people with long term conditions, or in the last 12 months of life, will have proactive care plans, developed with their carers and professionals meaning patients will not suffer from gaps in provision between services, and carers will have more support in their role. Everyone who has a care plan will have a named Care Coordinator, who will work with them support the delivery of their integrated care plan. The role of the Care Coordinator will be appropriate to their greatest care need, clearly defined and understood by the person and those involved in providing care. Care Coordinators will be the most appropriate professional for that person and will be employed as they are now through their usual employment arrangements.

A new role of Care Navigators will be introduced who will be highly knowledgeable about the local health and social care provision and responsible for ensuring patients find the right service and for linking them into local voluntary sector and faith groups, to build networks of social support for frail patients and their carers. They will work with GP practices and social workers.

More people will be supported in their homes by telehealth and telecare through collaborative working and pooled budgets between health and social care. Services to support social inclusion, including return to employment, access to supported housing and accessed to a range of day opportunities, including those access through personal budgets will be supported through partnership between the CCG and the Borough of Hounslow. Improved benefit and employment support services commissioned through section 256 money, which is spent by adult social care to improve health outcomes, will also help people with learning disabilities and people who are mentally unwell.
Diagram 7 sets out an example of how improved working together will change patients’ experiences:

**Diagram 7**

Providers (social and health) working together, with the patient at the centre

Laura, 75 years old smoker has recently been diagnosed with COPD and lives at home with her husband Jim.

<table>
<thead>
<tr>
<th>Urgent care has been stressful when patients need support . . .</th>
<th>In future, we will meet patients' needs at home . . .</th>
</tr>
</thead>
<tbody>
<tr>
<td>After visiting her GP, Laura is diagnosed with having a Stage 2 COPD and is put on an inhaler. After a period of no improvement Laura’s GP prescribes her a stronger dose</td>
<td>Laura is identified as a patient in need of an integrated care plan by her GP. Her care plan is made available to all health care professionals involved in her care</td>
</tr>
<tr>
<td>After a series of complications, Laura is referred to a respiratory physician. Laura’s visit is extended as the specialist does not have access to Laura’s records, and has no indication about the progression of Laura’s condition.</td>
<td>Laura is discussed by her GP at a case conference with a specialist pulmonologist. As a result her GP refers her for a course of pulmonary rehab and she is put on list for care navigator</td>
</tr>
<tr>
<td>Unexpectedly, Laura is admitted to A&amp;E and inpatient care for one week later with breathlessness</td>
<td>Nonetheless, Laura experiences complications, however on referral, her pulmonologist has access to Laura’s care records through full information to assess her progression</td>
</tr>
<tr>
<td>Laura is discharged to home, but her records and history are not available to either social care workers or district nurses during their follow up visits</td>
<td>Admissions to A&amp;E or interaction with social care are also supported by having her care plan accessible to all. Upon discharge the care plan recommends multi-disciplinary pulmonary rehab and self management. At start of next cold period, care navigator call to ensure she has taken rescue pack</td>
</tr>
</tbody>
</table>

**2.5 SUPPORTED DISCHARGE**

The Integrated Community Response Service now supports patients with complex needs to return home after they have been in hospital. Communication between the UCC and GPs demonstrates the improvements in communication we have made: as soon as one of their patients visits the UCC, GPs are notified and informed through our IT system if any follow up actions are needed. In future, a patient's GP and relevant providers will be notified when they are admitted and will be actively involved in coordinating their discharge plan (including any mental health provision, intermediate care and reablement) as well as continuing health and care needs.

Patients’ mental health needs will be addressed earlier by our new expanded and dedicated psychiatric liaison team in West Middlesex University Hospital, resulting in quicker discharge (more often to the patient’s own home). Improved provision in primary care for mental health will also support patients to return home earlier. In addition, patients will be supported following discharge by practice based mental health workers attached to surgeries. We recognise the key role that carers play and aim to develop an expert carers programme using NHS monies for social care. NHS monies for social care will also provide for more social workers to support smooth discharge from hospital.

Laura, 75 years old smoker has recently been diagnosed with COPD and lives at home with her husband Jim.

Urgent care has been stressful when patients need support . . .

In future, we will meet patients’ needs at home . . .
Diagram 8 sets out an example of how better supported discharge will change patients’ experiences:

**Diagram 8**

Appropriate time in hospital when admitted, with timely supported discharge into well organized community care

Brenda is 79. She is a complex elderly patient with both diabetes and COPD. She has recently fallen, fractured her hip and been admitted to hospital.

Urgent care has been stressful when patients need support . . .

- The duty doctor reviews her case and deems her fit to leave following physiotherapist review.
- However, the review happens on a Friday and physiotherapists are not available until Monday, leaving Brenda in hospital over the weekend.
- Additionally, nurses assume that discharge to a community hospital is needed, however the local hospital is full.
- Finally, after several further days in community hospital social care takes three weeks to organise a package of care for discharge.

In future, we will meet patients’ needs at home . . .

- When Brenda was admitted to hospital she was flagged as on the high risk patient register and her history was available to staff.
- Hospital staff feel less anxious as they have a support structure around the patient.
- Her care navigator is notified and discharge planning begins immediately.
- The duty doctor reviews her case and deems her fit to leave following physiotherapist review.
- The care navigator takes paper work off nurses, freeing their time to care for patients.
- Early intensive support accelerates recovery.
- Next steps are captured in a clear care plan and all pieces are in place for discharge when the time comes.
- First week after discharge, she receives daily visit by physiotherapist to stabilise her.

Next steps are captured in a clear care plan and all pieces are in place for discharge when the time comes.

2.6 STANDARDS TO MAINTAIN THE QUALITY OF CARE

Patients and the public need to be confident that when there are changes to where and how patients are cared for, we will hold ourselves to high clinical standards of care. In addition standards of care need to meet the standards outlined in the NHS Outcomes Framework and the Adult Social Care Outcomes Framework. Therefore, we have agreed standards that set our aspirations for the future. They emphasise the central role of the GP in the coordination and delivery of out of hospital care. The standards encompass both core primary care delivered by GP practices and, more broadly, care delivered outside of hospital. They aim to shift care delivery from more reactive unplanned care to proactive planned care.
NWL out of hospital standards

**DIAGRAM 9**

<table>
<thead>
<tr>
<th>Domains</th>
<th>The standards are covered in four key domains</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual Empowerment &amp; Self Care</strong></td>
<td>▪ Individuals will be provided with up-to-date, evidence-based and accessible information to support them in taking personal responsibility when making decisions about their own health, care and wellbeing</td>
</tr>
<tr>
<td><strong>Access convenience and responsiveness</strong></td>
<td>▪ Individuals will have access to telephone advice and triage provided 24 hours a day, seven days a week. As a result of this triage: ▪ Cases assessed as urgent will be given a timed appointment or visit within 4 hours of the time of calling ▪ For cases assessed as not urgent and that cannot be resolved by phone, individuals will be offered the choice of an appointment within 24 hours or an appointment to see a GP in their own practice within 48 hour</td>
</tr>
<tr>
<td><strong>Care planning and multi-disciplinary care delivery</strong></td>
<td>▪ All individuals who would benefit from a care plan will have one ▪ Everyone who has a care plan will have a named ‘care coordinator’ who will work with them to coordinate care across health and social care ▪ GPs will work within multi-disciplinary groups to manage care delivery, incorporating input from primary, community, social care, mental health and specialists</td>
</tr>
<tr>
<td><strong>Information and communications</strong></td>
<td>▪ With the individual’s consent, relevant information will be visible to health and care professionals involved in providing care ▪ Any previous or planned contact with a healthcare professional should be visible to all relevant community health and care providers, ▪ Following admission to hospital, the patient’s GP and relevant providers will be actively involved in coordinating an individual’s discharge plan</td>
</tr>
</tbody>
</table>
3. How we will deliver better care, closer to home

This section describes the key initiatives that will enable us to deliver our five strategic goals. Some of these initiatives are coming into place for Hounslow, and others are new for Hounslow and are part of work taking place at a wider level, for example NHS 111 and the North West London Integrated Care Pilot.

We have identified the key challenges we face in each of the five areas and the initiatives that will allow us to address these, which are set out in diagram 10.

### DIAGRAM 10

<table>
<thead>
<tr>
<th>Our vision</th>
<th>Issue we faced</th>
<th>Initiatives to deliver our vision</th>
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<tr>
<td>Easy access to high quality, responsive primary care</td>
<td>Access to Primary Care  - Poor access to GP  - Patients entering system in wrong place  - Inappropriate A&amp;E attendances</td>
<td>We are developing primary care by supporting GPs to improve access, improving education opportunities for clinicians, increasing GP access to consultants and increasing accountability for access and quality</td>
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<tr>
<td>Clearly understood planned care pathways that patients have confidence in</td>
<td>High quality planned care  - Inconsistent referral patterns  - Lack of options out of hospital</td>
<td>The Urgent Care Centre offers patients an alternative to A&amp;E for non-emergency urgent care</td>
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<td>Rapid response to urgent needs so more people can be cared for at home</td>
<td>Responsive emergency care  - Too many people going to A&amp;E  - Admission to hospital when care could be better at home</td>
<td>A joined up system of 111, out of hours provision and linked to the urgent care centre will direct patients to the right place in the system first time and stop inappropriate A&amp;E attendances</td>
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<td>Integrated care to proactively manage long term conditions and other at risk groups</td>
<td>Providers working together  - Care for LTCs more reactive than proactive  - Lack of coordination between community services</td>
<td>We develop a better access to mental health services through shifting settings of care in mental health</td>
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<td>Supported discharge into well organised community care</td>
<td>Support at discharge  - Lack of support for patients leading hospital  - Lack of coordination between community services</td>
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3.1 EASY ACCESS TO HIGH QUALITY RESPONSIVE PRIMARY CARE

3.1.a Improving access to GPs

- We will establish and then offer the best mix of appointment types for the local area (for example, emergency appointments, booked for the next 48 hours, booked over 48 hours in advance). We will set up master classes to enable practices to maximise the utilisation of patient appointments. GPs will review progress against benchmarks and work together in mentoring cells to improve access.

- We will explore better ways to triage patients, getting the right people to focus on the right things; we will provide master classes in using the practice work force most effectively. We will also develop new ways of communicating with patients. We will publish performance and ensure that practices are held to account to meet quality standards and patient satisfaction. We will support this with a workforce plan.

3.1.b All patients to 'phone before they go'

- From January 2013, a new phone number, 111, will direct patients to the most appropriate service for all calls 24 hours a day seven days a week, except for emergencies and appointments with their own GP as illustrated in Diagram 11

- This service will ensure patients are directed to the right service first time, for example transferring them to the ambulance service, providing clinical advice or directing them to their GP or a local pharmacy. The service will book people into the Urgent Care Centre to reduce their wait time on arrival.

- 111 will be connected to social care emergency responder service and the HRCH single point of access (described in section four), meaning a patient will be directed to the right service in one call. 111 will co-ordinate with GP Out of Hours and the Urgent Care centre out of hours, again using SystmOne to ensure that the information will be conveyed to the registered GP for patients seen out of hours.

- Urgent cases will be dealt with within 4 hours, whilst those whose needs are not urgent will be seen within 24 hours, or can have an appointment with their own GP practice within 48 hours or at a subsequent them convenient to them.

- We will ensure that any changes by LBH to their new advice, information and emergency responder and duty systems are linked to and understood by NHS 111 and vice versa.
111 will direct patients to out of hours services

3.1.c Convenient access to the Urgent Care Centre (UCC)

- Our new Urgent Care Centre at West Middlesex University Hospital provides a 24 hour GP led service for dealing with immediate urgent illness and injury that is not an emergency.

- Our Urgent Care Service will see 83,000 patients each year.

- This will reduce usage of A&E by 70%.

- The UCC is integrated with GP Practices through IT: staff at the UCC have shared access to the primary care IT system, SystmOne, which means that they can view and update patient records. It also means that GPs are fully informed about concerns, decisions and treatments and can ensure follow-up where necessary.

- The UCC will be connected with 111, which will direct patients to services and book them appointments where appropriate.

- The service works closely with the Integrated Community Response Service (ICRS) to ensure patients receive care from the appropriate health care team in the best location.

- The UCC will be connected to the GP Out of Hours service

- Investment in children’s mental health and early family support tier 2 services will prevent attendances at A&E and subsequence admission to tier 4 services.

The ICRS will work with the GP Out of Hours provider and with the ambulatory care service, supporting people with urgent care or complex needs to stay at home.
3.1.d Shifting settings of care in mental health

- Investment in primary care through the reintroduction of primary-care mental health workers attached to Multidisciplinary Groups of Practices will provide early intervention for people with mental health problems and support the early identification of people with dementia. This will enable more patients to be discharged from Community Mental Health Teams and be managed in primary care.

- We are commissioning provision of a same-day phone access to consultant advice and a one-stop shop for senior clinician assessment and opinion with discharge back to the GP, with a care plan. This will support GPs to reduce referrals to secondary care and enable patients to be managed in primary care.

- Hounslow is looking to enhance its primary care service, by improving rapid access to consultants and increasing the support available to GPs and patients from community psychiatric nurses and support workers.

- We will improve data available to GPs and commissioning managers to enable analysis of patient care, for example, of prescribing and length of stay in hospital, and comparison of performance in Hounslow with external benchmarks.

- We are introducing community psychiatric nurses to primary care, and enhancing the advice and expert support provided by consultants for GPs; we have already arranged availability of a psychiatric consultant from West London Mental Health Trust to be available to answer questions or discuss cases with GPs from 12pm-2pm Monday to Friday, to support them caring for patients.

- We are continuing the development of our IAPT service, including supporting people who have psychological problems as a result of neuro-disability.

- To support better primary care for mental health patients we will offer training for non-specialist primary care clinicians. Diagram 12 sets out the key parts of this initiative:
Ways we are improving provision support of mental health patients in primary care

3.2 HIGH QUALITY ELECTIVE CARE AND WELL UNDERSTOOD PLANNED CARE PATHWAYS

3.2.a Referral Facilitation Service

- The Referral Facilitation Service (RFS) uses local GPs to ensure all referrals are following locally agreed referral guidelines and thresholds for referrals.

- The RFS provides a system to monitor, process and control referrals from all sources and to all providers in order to improve quality and consistency.

- The RFS results in planned care that is standardised, ensuring that patients are on the right pathway, and that all providers are complying with agreed local guidelines.
3.2.b Role of consultants in community settings in raising standards

Consultants will play a key role in ensuring that out of hospital care is delivered to high standards. They will do this in three main ways:

- By ensuring consistency and standards across the system: for example, by providing leadership to clinical networks (groups of local experts in a particular disease area, including specialist nurses and therapists), developing care pathways, and providing guidance and leadership on new developments in a disease area.

- By providing input into the care of individual patients: by advising other clinicians (by phone or email) and participating in case conferences at MDG level. For example, mental health consultants are available to take calls from GPs at set times of the day.

- By providing direct care for patients in community clinics, for example, the new ophthalmology service.

3.2.c Integrated Rehabilitation and Reablement Service

- By getting the LBH Assessment and Reablement team (ART) with the HRCH Community Rehabilitation service to work together we will develop a new integrated rehabilitation and reablement service will enable us to provide multi-disciplinary care to a wider range of patients.

- The service derives from two existing teams the assessment and reablement team from LBH and the community rehabilitation team from HRCH who will provide coordinated health and social care support for patients at home for up to six weeks following discharge from hospital or the ICRS team.

- They will work with patients with less complex needs than those seen by the Integrated Care Response Service (ICRS), or will follow on from them.

- They will support the early discharge of patients from hospital and will provide step up and step down care for patients at home.

- The service will provide early intervention in order to address problems when they are less serious and reduce the use of hospital services.

- There will be a particular focus on stroke and falls rehabilitation for this service to further develop the work of the stroke and falls co-ordinator.
### 3.3 RAPID RESPONSE TO URGENT NEEDS

#### 3.3.a The Integrated Community Response Service (ICRS)

- Provides care at home for patients who would otherwise need to go to A&E or be admitted to hospital within the next 24 hours.
- Supports patients to go home from A&E or AAU when they would otherwise need to be admitted to hospital.
- Supports patients to go from hospital to their chosen setting when they need support beyond core services.
- Provides an assessment of needs and intensive multi-disciplinary support at home for up to seven days for complex patients, for example, those with two or more diseases, followed by referral onto core community services.
- Made up of a multi-disciplinary team of nurses, occupational therapists, physiotherapists, mental health nurses with expertise in cognitive impairments, social workers, a handy man and a GP.
- Supports people to recover at home and to be independent, rather than relying on hospital.

#### Examples of patients who have benefited from the ICRS

**DIAGRAM 13**

<table>
<thead>
<tr>
<th>Harriet is 82. She has had three recent previous A&amp;E attendances and one short hospital admission in the previous five months related to falls. She lives alone and was supported by a friend who had recently died. She suffers from significant deterioration in short-term memory and safety awareness. A&amp;E referred Harriet to the Integrated Community Response Service after she had three falls in three days, two involving stairs and one involving a gas fire. There were major concerns about the safety of her home environment, but Harriet made the choice to return, despite the risk. The team worked with Harriet to agree to home adaptation to reduce risk of stairs and she accepted emergency placement whilst work was being completed. Having spent two weeks in a residential home, on review she expressed desire to stay in residential care, as she now realised how risky life was at home and felt much more comfortable in a safer environment.</th>
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<tr>
<td>Georgiana is 77. She has spent some time on the intensive therapy unit. Previously she had been independent in all areas of life with support from her son for shopping. On discharge Georgiana was being managed in bed. She was reliant on two carers and manual handling equipment to get in and out of bed. She was incontinent as she was unable to get to toilet without help. Due to her activity level she lacked appetite. She was referred to the Integrated Community Response Service on discharge. A daily visit from a physiotherapist or occupational therapist helped her to improve her transfer ability. By the sixth day she was able to sit out during the day and able to transfer herself to commode, meaning she was no longer incontinent. She was also able to get out of bed with the assistance of one person. Her appetite was much improved due to increased activity levels. The social worker in the team reviewed her package of care and reduced it from two to one carer, four times a day. A referral was made onto Community Rehabilitation Service for on going rehabilitation, aiming for the patient to walk short distances at home with a walking frame and to be able to make a hot drink and snack independently.</td>
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3.3.b Ambulatory Care Service

We will commission a one stop shop service at WMUH, the Ambulatory Care Service, led by the Emergency Care Consultant (ECC). The philosophy of the team will be “how can I look after this patient at home?”

The ECC will discharge most patients back to the community with extra support, smaller numbers of patients will be kept in overnight or referred to the medical “on take” team.

- Patients will be assessed where X-rays, blood tests and consultant input are available.
- GPs, the UCC, A&E or ICRS will refer patients to this service.
- The benefit for patients is that, having received diagnosis and specialist input, they can be supported to remain in their own homes.
- The service will extend in the future to children and surgical patients

3.4 SOCIAL AND HEALTH PROVIDERS WORKING TOGETHER WITH THE PATIENT AT THE CENTRE

3.4.a Develop existing IT to enable more integrated care

- The primary care IT system, SystmOne, which clinicians in Hounslow use, will be developed further to give all providers in health and social care appropriate access to patients' records and to use and up to date records in real time.

- The SystmOne is currently used by all GPs in the borough, in the UCC, in the community diabetes service and in the community ophthalmology service. Community health services, child health, and drugs and alcohol services will all start using it in the near future.

- Later this year, it will be possible to link up with the hospital system, Real Time. Social care and community health care Co-ordinate My Care system could be linked in to the system by 2013. West London Mental Health will also use SystmOne.

- By 2013, patients will be able to see their complete record.

- Developing our IT systems in this way means better informed clinical decision-making, and ultimately supports the development of a single care plan for patient, rather than multiple plans from each provider of care.
- It will also allow CCG-wide reporting of information and inform commissioning decisions.

3.4.b  Risk stratification, care planning and case conferences: Roll out of the Integrated Care Pilot across Hounslow

- We are establishing five multidisciplinary groups of GP practices across Hounslow, which will work together with their local community health and social care teams, supported by a lead consultant to identify and review patients at risk of becoming ill. Initially their focus will be on diabetic patients and the over 75s and plans are in place to extend it to patients with COPD and patients with CHD. This is a roll out of the pilot already taking place in Chiswick.

- GPs will identify the patients who are at highest risk of unscheduled admission to hospital and who could therefore benefit from more proactive care. IT could be used to support this process.

- The practice nurses will co-develop a care plan with the patient and carer (where appropriate), ensuring all the services that the patient needs are working together.

- A new Care Navigator (see below) will support the highest risk 150 patients and will ensure that that they can access all the services they need, self manage their conditions and proactively ask for help, and that their carer is supported.

- Case conferences will bring together hospital specialists, GPs, community health providers, social workers, mental health specialists and others to discuss how best to provide for complex patients. Case conferences will also develop clinicians' knowledge of conditions and the roles other services can play.

- SystmOne underpins co-ordination by ensuring that all clinicians have up to date patient information and that GPs are notified when follow up action is needed.

- The key benefit for patients will be improved outcomes since they will receive earlier and more coordinated intervention

The role of multidisciplinary groups:

Multidisciplinary groups are made up of primary care, social care and mental health staff. They share a database of patients, which they can utilise to identify the patients most at risk of hospital admission (known as “risk stratification”). The multidisciplinary group has agreed clinical pathways of proactive interventions to keep people out of hospital and through a regular process of work planning; each patient will
have an integrated care plan, developed in consultation with them.

High risk patient cases are discussed at monthly case conferences by the members of the multi-disciplinary group. There will also be regular performance review meetings to hold different providers to account, evaluate the effectiveness of local care pathways and propose key investments to close gaps in care delivery. An IT tool is being procured which will automate much of the data for the ICP, including risk assessment, work planning and messaging between providers. Providers will be reimbursed for the care coordination activities (work planning, case conferences and performance reviews) done to deliver Integrated Care.

3.4.c Care navigators

- Care navigators will take on a new role, which will connect up health and social care providers, working proactively to ensure that patients receive all the care that they need, in a well-coordinated way.

- They are likely to be responsible for a case load of about 150 patients and will be responsible for ensuring that the patient and their carers feel confident in the out of hospital environment.

- Care Navigators will need to have an excellent local knowledge of health and social care provision. They will work with the voluntary sector and faith groups, which will play a role in building networks of social support. There are volunteers in the borough who already carry out some aspects of this role and we will work closely with them.

- GPs, social services and the hospital will be able to refer people to Care Navigators for help. They will be accessible to patients, carers and clinicians via the single point of access. They will work with support brokers for people who have a personal budget.

- We will learn from the successful implementation of similar projects in Wakefield, Hammersmith and Fulham and Torbay in setting up this service when we are determining recruitment, grade and employment issues.

- We will need to determine the number of Care Navigators needed, their location in the Borough and to whom they will report.

- Care navigators will work closely with health advisors and health trainers, working as part of the Health and Wellbeing Strategy on the prevention agenda, and thence reporting to the Health and Wellbeing Board.
3.4.d End of Life Care

- We are committed to increasing the proportion of people dying in their place of choice. To achieve this we will effect rapid decision making that ensures patients die in their place of choice through:
  
  - Increasing support to care homes
  
  - Providing a programme of education and workforce development
  
  - Improve care planning so the right multi-disciplinary team can be brought together at the right time, including specialist palliative care and palliative care professionals as well as to voluntary organisations to support families, carers and core services.

- We can also use IT tools to support end of life care, linking with SystmOne. We are creating a borough wide End of Life Care Register, which will include people's wishes on their preferred place of death.

- IT tools such as Coordinate My Care, the Gold Standards Framework and the Liverpool Care Pathway help to integrate providers who are working with patients nearing the end of life.

- IT tools support professionals in developing a single care plan for patients that co-ordinates their needs from different services.

- Patients and carers benefit by receiving more choice, and are confident about the care and support that they receive in the months before death and that families and carers receive following bereavement.

- To support families with bereavement services.
3.4.e Care for patients with long term mental health needs

- An agreed pathway will transfer responsibility for care from community mental health teams to GP practices. This will include setting criteria for the transfer of responsibility, a case review to confirm criteria have been met and joint work between the community mental health team, the GP and the patient to develop a care plan, linking with the NWL mental health strategy.

- As part of the ICP we will undertake pro-active screening and identification of patients with common mental health problems

- We will provide psychological therapies tailored to long term conditions and the frail elderly, in primary care settings:

- We are commissioning an employment support service for people with mental health problems.

- There will be more specialist clinical provision within the Integrated Community Response Service and the cognitive impairment team for dementia and end-of-life care as well as improved support for carers.

3.5 SUPPORTED DISCHARGE

Our development of primary care, joint rehabilitation and reablement service, investment in social care discharge teams and clinicians working together through the ICP will all drive better supported discharge.

3.5.a Integrated Rehabilitation and Reablement service

- The reablement team from the London Borough of Hounslow working with the community rehabilitation team from Hounslow and Richmond Community Healthcare Trust will provide patients with joined-up discharge support and clear advice to on what to expect after hospital and whom they can contact if they feel unwell.
3.5.b **Supporting social care discharge teams**

- Developing the right social care package at discharge can mean that discharge needs to be delayed even through a patient’s health would allow them to leave hospital. In collaboration with LBH, we will invest NHS monies for social care to provide additional social workers in Hounslow to support discharge from hospital.

- We are also working with local housing services, which play a key role in supporting patients return to their homes. We will work with the borough in developing a strategy for older peoples housing.

3.5.c **Psychiatric liaison service**

- The psychiatric liaison service will provide assessment and where appropriate treatment for patients with significant mental health needs in acute settings (outside specialist mental health units), train and support other hospital staff to enable them to support patients’ mental health needs and provide integration with other parts of the health system including GPs.

- The service will improve coordination with out of hospital care providers and housing services, meaning a higher proportion of patients can be discharged directly to their own homes or placed locally.

- The service will both help patients stay at home rather than being admitted to hospital, and return home earlier following time in hospital.
4 How we will work together

To achieve our vision will require new ways of working within the CCG. We are focusing on six areas, as set out in Diagram 14.

A further key part of how we work together will be empowering patients and carers as described in section 5.1; including patients and carers as experts in their family member’s condition, in care planning and coordination, so that the care provided is not a series of disconnected events, but is rather an agreed plan.

DIAGRAM 14

1. Care will be clinically led and consistent, through the leadership of clinical networks and GP triagers
2. All clinicians will be fully informed of all diagnoses and care a patient has received in the past
3. Care will become more coordinated, through clinicians and social workers working together in multi-disciplinary team
4. We will work with our partners, such as social care, to ensure care is patient focused
5. Workforce development will enable us to meet new demands out of hospital
6. In order to deliver more care out of hospital we will need to develop our estates
4.1 CARE WILL BE CLINICALLY LED AND CONSISTENT

We will ensure that care is clinically led and is consistent in two main ways:

- **Through the leadership of clinical networks**: for example, the diabetes network in Hounslow brings together consultants, GPs, GP with special interest, public health, pharmacists, specialist nurses and a member of the public/service user. The diabetes clinical network has improved care through liaising with the Diabetic Retinal Screening Service (DRSS). A collaborative approach has ensured that the number of patients referred to the service has increased. More diabetic group education sessions have been commissioned to support both established diabetics and those at risk of diabetes. There has been a step change in the number of patients attending these.

- **The use of GPs to triage referrals**: when a referral reaches a GP triager at the Referral Facilitation Service (RFS) the referral is reviewed using locally agreed referral guidelines, feedback is provided as appropriate, and it is directed to the most appropriate care setting. As a result, the patient sees the right person in the right setting, as represented in Diagram 15.

**Diagram 15**

Referral reaches a GP triager at the Referral Facilitation Service (RFS)

Using locally agreed referral guidelines, the referral is reviewed, feedback provided as appropriate, and it is directed to the most appropriate care setting

As a result, patient sees the right person in the right setting, first time
4.2 ALL CLINICIANS WILL BE FULLY INFORMED OF ALL DIAGNOSES AND CARE A PATIENT HAS RECEIVED IN THE PAST

- GPs and the Urgent Care Centre can today already provide joined up care using SystmOne, which enables them both to see and update patients' records. For example, a GP at the UCC will be able to see a patient's existing condition and prescribe appropriately. The patient's GP will be able to see what treatment he or she has received, note that a follow-up appointment is required and the practice receptionist will arrange an appointment.

- In future, patients, carers and all relevant providers will have access to their records. Patients will be able to see their complete record, appointments and prescriptions and their care plan. A district nurse, for example, could view a patient's record and see which other services are providing care. The patient's GP will be able to see all the care that is happening, ensuring greater accountability and transparency for other providers of care.

Our IT will ensure all care is informed

DIAGRAM 16

Today, GPs and the Urgent Care Centre provide joined up care using SystmOne

- The GP at the UCC can see that Stephen's medical record
- This knowledge informs his decision on what to prescribe
- Stephen's GP receives notification of Stephen's visit, including the prescription and that he will need a follow up appointment
- As a result the GPs receptionist calls Stephen and books an appointment

In future, patients, carers and all providers will be able to access records

- Patients can view their record, their appointments and prescriptions, their care plan
- District nurses can view patients' care plan and which other services the patient is interacting with
- GPs can view all care that is happening, creating greater transparency and accountability for other providers of care
4.3 CARE WILL BECOME MORE COORDINATED, THROUGH CLINICIANS AND SOCIAL WORKERS WORKING TOGETHER IN MULTI-DISCIPLINARY GROUPS

- In Hounslow today, the Integrated Community Response Service is one team but members retain their own professional and organisational identities.

- In future, new roles and ways of working will increase coordination within localities, while still maintaining professional and organisational identities. There will be five geographically multi-disciplinary groups (MDGs) across Hounslow. Diagram 17 shows the professions that will in future be represented within multi-disciplinary groups and highlights where joint working is new.

In multi-disciplinary groups professionals will work together in new ways

MDGs will increase coordination of care through care planning. Our aim is that all diabetic patients and half of our elderly patients will receive care plans. Once a year the patient will meet a single primary care representative who will work with them to produce a proactive plan of care for the coming year. It will be based on clinical pathways, and IT will enable all relevant providers to have access to it. This shifts the focus of care from being reactive to planned and allows a single view of an individual’s care for all providers.
The locations of the five multi-disciplinary groups are set out in Diagram 18. These groups are the same as the London Borough of Hounslow’s area committees, which are responsible for monitoring council services and making local decisions. These common boundaries raise the possibility of closer working together in the future, including management of combined budgets.

**Diagram 18**

- Case conferences will help different professionals in the five MDGs to provide more coordinated care. Care providers and practitioners in each pathway will meet monthly for three hours to review and solve complex patient needs. This improves the quality of care that patients receive and is a key professional development opportunity.

- Case conferences will be attended by GPs, an Acute Specialist, one Mental Health Specialist, one Social Care Specialist and one Community Health Specialist, all of whom will be reimbursed for their time. The GP representing their practice at the MDG will be different from the GP representing the practice in the mentoring cell. In this way education and good practice will be spread more widely across the participating practice. GPs will present complex cases from their practice at the meeting and receive input from all present.

- Working in MDGs will help clinicians to coordinate service provision and enable joint development of services locally. GPs will be able to refer their patients to other GPs if they do not provide a particular service in their own practice. For example, in some MDGs, all GP practices will offer certain services, for example
anti-coagulation, to its patients, while in other MDGs the same service will be provided to patients from a small number of practices. Diagram 19 illustrates this.
Working in multi-disciplinary groups will increase referrals between practices

DIAGRAM 19

For example, in some MDG every practice offers anti-coagulation to its own patients, in other MDGs anti-coagulation services are available to all patients from a small number of hubs.

GP able to advise wider range of patients through direct access to consultants

Inter-practice referrals within the locality make better use of GP skills

Greater role for practice nurses in long term condition management

Ensures entire population is offered service locally

Potential to jointly develop services offered locally

1 Outreach care is used to describe provision of a service in the community that is not provided by every GP practice and is available to the patients from practices not providing the service.
4.4 WE WILL WORK WITH OUR PARTNERS TO ENSURE CARE IS PATIENT FOCUSED

We will work more closely with our partners, using the infrastructure developed through our improved IT, the Integrated Care Pilot and using care navigators. Some examples are set out below.

**Working with acute and mental health providers**

- The greater role of consultants in the community, ensuring consistency and standards, providing input to the care of individual patients and providing direct care to patients in community clinics as set out in section 3 is a major way in which our partners in the acute sector will contribute to delivering our out of hospital strategy.

- Improving the integration and communication between primary and secondary care; by using “Book and Ask” to create an efficient system of planned care, providing greater clarity for referral pathways.

- The single point of access for all health providers, which will transfer information between providers through SystmOne and increase coordination of care for patients.

- We are developing the transfer of patient information necessary for continuous care between primary and secondary care, for example by maximising the potential of SystmOne linking with mental health and acute clinical systems, which will particularly improve discharge planning.

**Working with Hounslow and Richmond Community Healthcare**

- Hounslow and Richmond Community Healthcare (HRCH) will provide a single point of access seven days a week from 7am to 7pm for all community referrals which will be triaged to ICRS and core community services.

- HRCH will play a key role in the Integrated Care Pilot, which will support better integrated health and social care and closer coordination through MDGs.

- Combing HRCH’s rehabilitation team with LBH’s reablement team, is a set towards creating more coordinating out of hospital care.
Working with the London Borough of Hounslow

- The Local Authority play a crucial role in providing domiciliary care services with and on behalf of the CCG, including commissioning and procuring a medication administrative service
- A Social Care single point of access is being developed as part of the adult social care review and will be in place by 2013
- The 111 service will link with the health and social care single point of access and deal with calls outside these times
- Use of NHS monies for social care to support carers and to employ more social workers, including in the hospital discharge team and a consultant social worker, and improve the care for patients with long term conditions or who have had a stroke
- We are working with Hounslow Council on a shared agenda of reducing dependence on bed based services and supporting people to live in their own homes as well giving local residents choice, and control over their care

Working with Hounslow Health and Wellbeing Board

- The HWBB will provide guidance for our commissioning by describing how we will be more pro-active in preventing illness, promoting self-management and reducing the impact and burden of diseases. For example, it will describe plans to increase the number of people helped to stop smoking, increase the number of NHS health checks, tackle obesity locally and increase the uptake of screening, so our OOH strategy continues to be developed in line with the Health and Wellbeing Strategy.

Working with the voluntary sector and faith groups

- As outlined in the previous section, Care Navigators will work between GPs and social care to ensure patient care is coordinated across the pathway, ensuring that patients are aware of who is able to support them and supporting decisions on commissioning services from the voluntary sector
- We will commission services and work together with the voluntary sector and faith groups as part of wider programme to promote health and well being
### 4.5 WORKFORCE DEVELOPMENT WILL ENABLE US TO MEET NEW DEMANDS OUT OF HOSPITAL

We will develop a workforce plan by September 2012 in order to meet the needs of this strategy once the consultation process is complete. This plan will include a workforce analysis and will then describe; how to make best use of existing skills across providers and the voluntary sector to meet future needs and how to develop the new skills needed in our workforce. Below, we summarise how we intend to develop our workforce through creating new roles, disseminating expertise and providing training and investment. Our steps to develop GP leadership in the CCG are set out separately, in section five.

- The key new role we are creating to coordinate care is the new role of Care Navigator for our highest risk patients in the Borough. Care Navigators will be pivotal in ensuring that health and social care providers work in close collaboration to ensure that patient receive coordinated care.

- Our consultants in the community programme will spread skills and knowledge to the primary care workforce. We commission community services which are consultant-led so that patients get an excellent service. In addition, learning from the specialists can be shared with GPs, through the Integrated Care Pilot, referral feedback, guideline development and direct interaction and education programme.

- For example, All the services we have commissioned have a significant emphasis on primary care education as part of the core service delivery. For example, the consultant-led community ophthalmology service is required to support the education of GPs and optometrists in Hounslow – so that primary care management of eye conditions improves over time.

- In future, we will develop expertise through rotating staff between specialist and locality based teams. Specialist staff will be transferred out of acute settings and rotate among teams. Members of specialist teams, such as the Integrated Community Response Service, Ambulatory Care Service and Heart Failure teams will rotate with staff in locality teams. In this way teams will develop their skills and working relationships in order to deliver better care in different settings as shown in Diagram 20.
In future, we will focus on providing training and development the following key areas in order to increase the skills of our different professional groups to deliver enhanced out of hospital care:

- Providing an education and development programme for practice nurses, training them to offer a wider range of services (e.g. chronic disease management and flu vaccination).
- Developing the capabilities of our Healthcare Assistants so that they are able to carry out technical procedures (e.g. ECG scans, ear syringing and audiometry).
- Developing the skills of our CCG and practice managers so that they are effective at coordinating and facilitating patient practice groups, our MDGs, mentoring cells, monitoring outcomes from practices and developing strong relationships with local stakeholders.
- Supporting the integration of community health and social care staff to provide better coordinate rehabilitation and reablement service.
- Increasing the number of social workers in the system.
- Developing core community nursing in accordance with the needs to find in our workforce analysis.

4.6 IN ORDER TO DELIVER MORE CARE OUT OF HOSPITAL WE WILL DEVELOP OUR ESTATES

Our plans to move care out of hospital and into community settings mean that more space will be need in the community.

It is embedded in the CCG goal of shifting any primary and intermediate care from secondary care to out of hospital. Whilst the development of networked MDGs will require continued improvement in estate it is not only about a physical infrastructure developed by strategic use of capital over five, but also about a clinical expertise infrastructure. Current clinical leadership in Hounslow will be supplemented through this work.
Over the five year period 2009 – 2013 we have been working to an estates strategy that has seen the development of Heart of Hounslow, Feltham and Brentford.

- We will continue to deliver against the estates strategy that develops two further sites, West Middlesex and Heston with a programme of work to update Chiswick Health Centre, improving capacity.

- The estates strategy outlines the plan to develop a primary care centre on the West Middlesex hospital site. Several local practices have expressed an interest in moving to this site. As a modern campus WMUH site is ideally suited to provide a range of service not necessarily part of acute hospital service portfolio allowing it to be an important part of the out of hospital strategy.

- At Heston Health Centre we will develop provision of services to support the surrounding population, which have been identified as particularly high focus of deprivation and health need. Heston no longer has the capacity to deliver modern primary care services from it and it needs total redevelopment to support the delivery of effective primary care.

- As we increase the range of services delivered out of hospital, using sites such as Heston and Chiswick to provide care to the local population becomes increasingly important. Diagram 21 shows the largest primary care facilities in Hounslow:

- We will undertake a space utilization survey ensuring services are well co-ordinated across our estate and our estate is effectively used.

**Diagram 21**

**Locations of local hubs in Hounslow**

- 2009-2013 we have made major investment in estates at Heart of Hounslow, Feltham and Brentford.

- 2013-2015 we plan to develop West Middlesex as a site for primary care and Heston Health Centre.
5. Supporting the change

We need to address five main enablers of change in order to bring about our vision of better care, closer to home. These are set out in Diagram 22:

DIAGRAM 22

1. Engage patients and carers
   - Involve, consult and inform patients and carers

2. Develop our leadership
   - Develop GP leadership within Hounslow

3. Agree on how we will be governed
   - Monthly dashboard showing performance and targets
   - Process for holding ourselves to account for these targets

4. Put in place the right information tools
   - Unified IT systems providing shared records leading to better patient care and transparency on performance

5. Develop the right contracts and incentives
   - Align contracts and incentives of all providers, to ensure system-wide coherence of behaviour and spend

This section sets out how we will address with each of these issues
5.1 ENGAGEMENT WITH PATIENTS AND CARERS

Engagement with patients and carers is essential to deliver improvements to services. In our Engagement Strategy we set out in more detail how we will improve in this area.

We will empower carers through an expert carer programme. Carers will be involved in the development of care plans, meaning that care stops being a series of dislocated events and become a continuous process. Carers will be able to use the support of care navigators, particularly for dementia patients, meaning that carers will acquire greater expertise of how to access care, and have better access to respite.

Each MDG will hold a quarterly standards review meeting and there will be patient involvement in this meeting.

Diagram 23 shows our commitments to patients on how their views will inform decision making and how they will be kept informed about changes we are making:

**DIAGRAM 23**

<table>
<thead>
<tr>
<th>Our commitment</th>
<th>How we'll deliver</th>
</tr>
</thead>
</table>
| You'll be involved   | The HCCG Board will have 2 patient representatives and meet in public
|                      | All local clinical networks will have a patient or public representative
| You'll be consulted  | We'll create a patient engagement group, including GPs and practice managers to drive change
|                      | We'll ensure that each multi-disciplinary group will have a patient group
|                      | We will pilot an online consultation forum
|                      | We will hold events to consult on key issues, such as commissioning intentions and our Out of Hospital strategy, working in partnership with LINK (Health Watch) and other patient, user and carer groups |
| You'll be informed   | We'll set out the standards we are aiming for and report to you how the CCG, localities and individual practices and care providers are performing against them |
|                      | We'll explain what is changing, why it is changing, and how your input shaped decisions
5.2 DEVELOP OUR LEADERSHIP

We see developing GP leadership as an essential part of driving up standards of care. We will use mentoring cells to provide peer-to-peer learning, challenge and support to drive workforce development and informs commissioning and service redesign. Mentoring cells provide opportunities to disseminate learning - for example, on standards, care pathways and templates produced by clinical networks. They also provide challenge and support, for example by peer review of referrals and prescribing patterns and connecting experienced practices with those that need support. In future, multi-disciplinary groups will also provide a key forum for developing GP leadership and their working with other organisations. Diagram 24 summarises different professional development opportunities for GPs.

**Diagram 24**

<table>
<thead>
<tr>
<th>Who participates</th>
<th>How it develops staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mentoring Cells: GPs from 6 practices, a prescribing advisor and a commissioning support manager</td>
<td>Peer review of performance and opportunity to learn from best practice and plan to address issues</td>
</tr>
<tr>
<td>Clinical networks: Consultants, specialist GPs, other key stakeholders</td>
<td>Create clinically led, locally owned clinical pathways and referral criteria</td>
</tr>
<tr>
<td>HEAT¹ events: GPs, practice nurses and practice managers</td>
<td>Quarterly training opportunity, for example may focus on referrals for a certain speciality, which are followed up in a later mentoring cell event</td>
</tr>
<tr>
<td>Cross borough open briefings: GPs (optional)</td>
<td>Enables GPs to discuss latest thinking for the commissioning team</td>
</tr>
<tr>
<td>Multi-disciplinary groups: GPs², consultant, social services, community services</td>
<td>Discuss specific patients to learn from multi-disciplinary perspectives and coordinate care</td>
</tr>
</tbody>
</table>

¹ Hounslow Education and Training
² In each practice, one GP will attend mentoring cell and another their multi-disciplinary group
5.3 GOVERNANCE AND PEER REVIEW

GPs have overall responsibility for their patients’ care. The CCG practice leads in the nine mentoring cells are responsible for peer review within their cell. The Chair of the CCG board is responsible for ensuring clinical governance, monitoring outcomes and providing clinical leadership. Information flows between these three levels, providing opportunities for all practices to contribute to commissioning decisions.

Improvements in performance will be led through benchmarking GP activity, practice by practice, education and peer review, developing leaders of the MDGs, developing our GP triagers for the referral facilitation service and making best use of our integrated IT system, SystmOne. We will establish a clear clinician-led system of peer review through our mentoring cells and our buddy system to ensure that performance is transparent and all practices meet high standards. The five steps of our peer review system are set out in Diagram 25:

**DIAGRAM 25**

<table>
<thead>
<tr>
<th>Steps in local performance management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Establish clear commitment and plan to raise clinical standards</strong></td>
</tr>
<tr>
<td>• Clinicians are committed to the concept of meeting quality standards</td>
</tr>
<tr>
<td>• Patients have expectations of really high quality care from all primary care clinicians, articulated by quality standards</td>
</tr>
<tr>
<td><strong>2. Establish clear targets and indicators to measure progress</strong></td>
</tr>
<tr>
<td>• Select key performance indicators, which should include should include referrals to out patients and non-elective admissions for long term conditions</td>
</tr>
<tr>
<td>• Develop a holistic, balanced scorecard across all aspects of performance e.g. quality, access, referrals etc</td>
</tr>
<tr>
<td>• Set targets and thresholds by network and practice to define different levels of performance</td>
</tr>
<tr>
<td><strong>3. Review performance effectively</strong></td>
</tr>
<tr>
<td>• Transparent monitoring process to track performance against stated goals</td>
</tr>
<tr>
<td>• Performance dashboards cascaded down from the CCG, including current performance vs. targets</td>
</tr>
<tr>
<td>• Publish regular scorecard of performance by practice</td>
</tr>
<tr>
<td>• Display practice performance against borough and CCG peer group benchmarks</td>
</tr>
<tr>
<td><strong>4. Peer review of performance</strong></td>
</tr>
<tr>
<td>• Where performance is strong identify how it can be shared for wider benefit and celebrated</td>
</tr>
<tr>
<td>• Constructive dialogue with under performing practices to pinpoint problem areas</td>
</tr>
<tr>
<td>• Develop practical and proactive solution to address challenges, with named responsible persons</td>
</tr>
<tr>
<td>• Establish clear plan of action with deadlines and metrics to track performance improvement</td>
</tr>
<tr>
<td>• Regular reporting on progress and consequences for poor performance agreed</td>
</tr>
<tr>
<td><strong>5. Rewards, incentives and consequences</strong></td>
</tr>
<tr>
<td>• Explore payment to mentoring cells or practices on achievement of targets</td>
</tr>
<tr>
<td>• Requirement for mentoring cells to evidence what they have achieved against agreed plans to secure payment</td>
</tr>
<tr>
<td>• Agreed consequences for continued under performance, including escalation to CCG board on the first instance, and ultimately to NCS</td>
</tr>
</tbody>
</table>
A series of **review meetings** will take place to measure performance and encourage robust performance dialogue. GP practices will carry out day-to-day monitoring of performance. Mentoring cells will review clinical performance and benchmark against others in the CCG and the peer group on a monthly basis. On a quarterly basis they will review reports on priority areas, including prescribing, which will then go to the CCG board. The CCG board will receive overall quarterly performance updates. Diagram 26 illustrates this process. In order for this process to be effective we will develop performance metrics to measure progress in the four main dimensions of quality, access and responsiveness, coordinated health and social care and financial sustainability. A similar process will pertain to the 5 MDGs.
5.4 INFORMATION TOOLS

All GPs, the Urgent Care Service and community diabetes service have SystmOne in place, enabling electronic information sharing that underpins integrated and clinically safe care. The implementation of SystmOne allows, with patient permission the health professional caring for the patient to see and use the GP record of any patient registered in Hounslow for planned and urgent care.

In future we will extend our IT to be compatible across providers and visible to patients as set out in section three. The benefits we hope to realise by more effective information sharing are set out in Diagrams 27 and 28 below:

DIAGRAM 27

<table>
<thead>
<tr>
<th>What better information sharing will achieve</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Real-time shared records inform providers and link GPs, community, acute and mental health teams leading to improved clinical decision making</td>
</tr>
<tr>
<td>2. Transparency of information gathered will help us drive up standards across Hounslow</td>
</tr>
<tr>
<td>3. Planned care becomes more consistent as</td>
</tr>
<tr>
<td>• Referrals follow precisely defined pathways</td>
</tr>
<tr>
<td>• GPs have access to granular reporting on referrals</td>
</tr>
<tr>
<td>4. Urgent care becomes better informed as</td>
</tr>
<tr>
<td>• All information input by GP is visible to staff at UCC</td>
</tr>
<tr>
<td>• Care is visible to GP and prompts are given for follow-up actions</td>
</tr>
<tr>
<td>5. Long term care becomes more pro-active through</td>
</tr>
<tr>
<td>• Risk stratification of patients by GPs</td>
</tr>
<tr>
<td>• Care plans are put in place</td>
</tr>
<tr>
<td>• Enabling regular check-ups and early intervention</td>
</tr>
<tr>
<td>• Decrease repetitive investigation and prescribing</td>
</tr>
</tbody>
</table>

DIAGRAM 28

1. Real-time shared records inform providers
   - GPs: Diagnose and prescribe
   - Consultants: Advise and treat

2. Planned care becomes more consistent
   - GPs input case details into SystmOne
   - Referrals follow precisely defined pathways

3. Urgent care becomes better informed
   - All information input by GP is visible to staff at UCC
   - Care is visible to GP and prompts are given for follow-up actions

4. Long term care becomes more pro-active
   - GP risk stratifies patients
   - Care plan in place and shared
   - Regular check-ups and early intervention
5.5 CONTRACTS AND INCENTIVES

As we introduce new services and new ways of working, we need to ensure that the contracts and incentives that we have in place will facilitate them, and reinforce the behaviours we want to see. Diagram 29 shows the new types of contracts, incentives and behaviours that we will use to achieve our targets across our five themes, including investment like care navigators.

**DIAGRAM 29**

<table>
<thead>
<tr>
<th>Target</th>
<th>Behaviors this will require</th>
<th>Reimbursment to support this</th>
</tr>
</thead>
<tbody>
<tr>
<td>Easy access to high quality, responsive care</td>
<td>Improve access</td>
<td>Meeting minimum primary care requirements</td>
</tr>
<tr>
<td>Simplified planned care pathways</td>
<td>Improve satisfaction</td>
<td>Penalties for failing to meet requirements</td>
</tr>
<tr>
<td>Rapid response to urgent needs</td>
<td>Reduce Outpatient attendances</td>
<td>Peer review/referral management system</td>
</tr>
<tr>
<td>Integrated care for LTC and elderly</td>
<td>Elective admissions</td>
<td>Inter-practice referrals</td>
</tr>
<tr>
<td>Appropriate time in hospital</td>
<td>Reduce A&amp;E attendances</td>
<td>111, UCC, extended hours</td>
</tr>
<tr>
<td></td>
<td>Improve reliability</td>
<td>Walk-in centres</td>
</tr>
<tr>
<td></td>
<td>Reduce NFL admissions</td>
<td>Coordination ratings</td>
</tr>
<tr>
<td></td>
<td>Increase integration</td>
<td>Care plans</td>
</tr>
<tr>
<td></td>
<td>Increase proactive care</td>
<td>Discharge coordinator</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Co-ordination with social care</td>
</tr>
</tbody>
</table>

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NHS Hounslow CCG
6. Investing for the future

This strategy has started to lay out our vision for a fundamentally different model of care. To deliver our vision we will make significant investments in staff and estates across different settings of care. This section describes an initial estimate of the investment needed in order to realise our plans of supporting patients and providing them with better care out of hospital and to make the savings on acute care necessary to budget within our resources. In the coming months we will complete business plans to develop more concrete plans in conjunction with our partners.

Patients will be able to receive care in a variety of settings. When possible, care will be at home, or close to home but if patients require more specialised care they will have to travel further. GP practices will continue to offer core primary care services, while sometimes GP practices working together in a local network can offer additional expertise and capacity for more appointments. In addition, depending on local needs, some existing community sites will provide additional services locally, serving as a support “hub” to local integrated teams. The services offered at these hubs vary depending on local needs and infrastructure, ranging from bases for multidisciplinary teams working together to “one-stop” local centres for GP appointments, diagnostics, and outpatient appointments.

We have broadly outlined the investment we will aim to make in services delivered at home, in GP practices and hubs over the next three years as investment shifts from the hospital to the out of hospital sector. The investment represents investment in service provision. In addition to this we will make capital investment in our estates and seeding investment in our IT provision and organisational development. Initial estimate on the scale of investment is £8 – 9m by 2015. Investment will be across community services, and in general practice and in health centres – hubs.
The staffing and investment identified in the figure above is indicative based on CCG strategic plans and is dependent on the release of funding from acute providers as activity transfers from acute settings to community settings. Specific investments will be agreed through the normal planning and governance processes of the CCG and as such the production and agreement of robust business cases demonstrating both value for money and affordability to the CCG.

The reductions in acute activity planned by the CCG are consistent with and reflected in the acute PCBC base case modelling.

The scale of the workforce requirements are a challenge to the system. This additional capacity is unlikely to be met by investing in additional people alone. Simply providing more of the same is not the answer for the future.

What will be needed is for providers to commit to better, smarter ways of working to improve productivity. In addition, we will consider how to support staff from the acute sector to transfer their skills into working in the community. This strategy lays out the level of our ambition and the scale of the challenge. Writing and implementing a workforce plan is one of the key challenges for the delivery of this strategy to be successful.

Similarly, we will review existing space available in the community and wherever possible look to use space better to deliver future care. We know that we do not currently use our existing space as well as we could.
Together these changes mark major challenges we face over the coming years. We are committed to tackling them, to make the vision described in this strategy a reality.
7. Next steps

In this strategy, we have set out an ambitious vision for transforming out of hospital care in Hounslow. We need to move quickly to implementation in order to make early improvements for patients and to make the scale of the savings that are needed by 2014/15.

7.1 FIVE IMMEDIATE STEPS

Our immediate steps to implement the strategy involve broadening support and participation in the strategy and deepening the detail of key areas in our plans. These steps are set out in diagram 31

Setting up an Out of Hospital Board from leaders of health and social care in the borough will support joint planning and priorities to deliver solutions the work across the health and social care economy.

It is also essential to start implementing initiatives early so the start to realise savings. Our priority here is to write business cases and implementation plans for ambulatory care, the roll out of the ICP and development of the rehabilitation and reablement service. In parallel we will create business cases for our proposed estates developments at WMUH and Heston in order that we have the facilities to deliver.

In order for our strategy to succeed we need to involve patients early on and therefore completing and implementing our public engagement plan will be another of our early priorities.

One of the greatest challenges in delivering the strategy will be training and recruiting the right work force. In order to plan for this, by September 2012 we will have completed an audit of workforce skills across providers and identified where our out of hospital workforce will be drawn from and what steps we will need to take to develop staff moving to new roles and recruit and train staff where we have skill gaps.

As these initial steps are underway, we will develop a financial recovery plan for 13/14 and 14/15 underpinned by Out of Hospital strategy and public health analysis, to determine financial stability across the health and social care system in Hounslow. This will feed into our commissioning intentions for 13/14.

Work on the enablers - patient involvement and communication, governance, contracts and incentives, IT and professional development - will take place in parallel with the creation of business cases for the new initiatives.
Diagram 31 summarizes the five immediate next steps we will take:

**Diagram 31**

Five immediate steps critical to success of strategy

<table>
<thead>
<tr>
<th>Crucial step</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong> 12/13 budget is set in line with strategy</td>
<td>✔</td>
</tr>
<tr>
<td><strong>2.</strong> Strategy is endorsed by:</td>
<td></td>
</tr>
<tr>
<td>† Health and Wellbeing board</td>
<td>✔</td>
</tr>
<tr>
<td>† CCG board</td>
<td>✔</td>
</tr>
<tr>
<td>† All practices</td>
<td>✔</td>
</tr>
<tr>
<td><strong>3.</strong> Performance framework is agreed by CCG (including metrics, targets, thresholds and escalation process)</td>
<td>✔</td>
</tr>
<tr>
<td><strong>4.</strong> Appropriate governance structures in place to deliver the strategy including an Out of Hospital Board made up of health and social care leaders to implement the strategy</td>
<td>✔</td>
</tr>
<tr>
<td><strong>5.</strong> Supporting plans in place to deliver strategy including</td>
<td>✔</td>
</tr>
<tr>
<td>† Public engagement plan</td>
<td>✔</td>
</tr>
<tr>
<td>† Workforce development plan</td>
<td>✔</td>
</tr>
<tr>
<td>† Key business cases</td>
<td>✔</td>
</tr>
</tbody>
</table>
7.2 IMPLEMENTING INITIATIVES

Some of the initiatives described in this plan have already been implemented and are delivering results. Work has started on developing business cases for some while the detailed planning for others will come later in the year. Diagram 32 sets out our timetable for delivering these initiatives. In the diagram their introduction is divided into four phases: planning the initiative; implementation, which is when the service starts operating; ramp up, which begins when the initiative starts to reduce the demand placed on hospital services and steady state, which is when the scheme is fully realising its potential. We are aiming to bring our initiatives to the steady state phase as quickly as possible in order to make savings early.

### DIAGRAM 32

<table>
<thead>
<tr>
<th>Initiatives</th>
<th>2012 Q2</th>
<th>2013 Q1</th>
<th>2013 Q2</th>
<th>2013 Q3</th>
<th>2013 Q4</th>
<th>2014 Q1</th>
<th>2014 Q2</th>
<th>2014 Q3</th>
<th>2014 Q4</th>
<th>2015 Q1</th>
<th>Cumulative gross savings plan (£m)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-elective</strong></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>12/13 13/14 14/15</td>
</tr>
<tr>
<td>Rapid response teams</td>
<td></td>
<td>Planning and design</td>
<td>Delivery 34%</td>
<td>Implementation</td>
<td>Delivery 81%</td>
<td>100% delivery by March 2015</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Integrated care case management</td>
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<td>4 10 13</td>
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<tr>
<td>Contractual savings</td>
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</tbody>
</table>

| **Out-patient** |        |         |         |         |         |         |         |         |         |        | |
| Planned care pathway redesign |        | Planning and design | Delivery 72% | Implementation | Delivery 92% | 100% delivery by March 2015 |
| Access to specialist opinion |        |         |         |         |         |         |         |         |         |        | 5 7 7 |
| Reprovision in community |        |         |         |         |         |         |         |         |         |        | |
| Referral facilitation and peer review |        |         |         |         |         |         |         |         |         |        | |

| **A&E** |        |         |         |         |         |         |         |         |         |        | |
| UCC |        | Planning and design | Delivery 51% | Implementation | Delivery 86% | 100% delivery by March 2015 |
| Redirection to primary care |        |         |         |         |         |         |         |         |         |        | 1 2 2 |

| **Elective** |        |         |         |         |         |         |         |         |         |        | |
| Minor elective procedures in community |        | Planning and design | Delivery 21% | Implementation | Delivery 77% | 100% delivery by March 2015 |

**SOURCE:** Commissioning Service Plan, 1st December 2011, QIPP plans 15th December 2011, QIPP revision; NHS DSU; CCG finance teams