

North West London Joint Health Overview and Scrutiny Committee

AGENDA

DATE: **Tuesday 5 December 2017**

TIME: **9.30 am**

VENUE: **Terrace Room, York
House, Twickenham,
Middlesex**

1. **JHOSC AGENDA - 5 DECEMBER 2017** (Pages 1 - 104)



North West London Joint Health Overview and Scrutiny Committee

Meeting Date:

Tuesday, 5 December 2017

Agenda

Meeting Time:

9:30 am

Meeting Venue:

Terrace Room - York House

A handwritten signature in black ink, appearing to read 'Paul Martin', with a horizontal line underneath.

Paul Martin, Chief Executive

Members

Councillor Mel Collins (Chairman)
Councillor Charles Williams (Vice-Chairman)
Councillor Shaida Mehrban
Councillor Ketan Sheth
Councillor Barbara Pitruzzella
Councillor Daniel Crawford
Councillor Theresa Mullins
Councillor Rory Vaughan
Councillor Sharon Holder
Councillor Vina Mithani
Councillor Michael Borio
Councillor Wil Pascal
Councillor John Coombs
Councillor Liz Jaeger
Councillor Jonathan Glanz
Councillor Barbara Arzymanow

Committee Administrator

Nicholas Garland Nicholas.Garland@richmondandwandsworth.gov.uk 020 8891 7201

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York House
Twickenham
TW1 3AA

27 November 2017

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Nese keni veshtersi per te kuptuar kete botim, ju lutemi ejani ne receptionin ne adresen e shenuar me poshte ku ne mund te organizojme perkthime nepermjet telefonit.

Albanian

এই প্রকাশনার অর্থ বুঝতে পারায় যদি আপনার কোন সমস্যা হয়, নিচে দেওয়া ঠিকানায় রিসেপশন-এ চলে আসুন যেখানে আমরা আপনাকে টেলিফোনে দোভাষীর সেবা প্রদানের ব্যবস্থা করতে পারবো।

Bengali

જો તમને આ પુસ્તિકાની વિગતો સમજવામાં મુશ્કેલી પડતી હોય તો, કૃપયા નીચે જણાવેલ સ્થળના રિસેપ્શન પર આવો, જ્યાં અમે ટેલિફોન પર ગુજરાતીમાં ઇન્ટરપ્રિટીંગ સેવાની ગોઠવણ કરી આપીશું.

Gujarati

اگر در فهمیدن این نشریه مشکل دارید، لطفاً به میز پذیرش در آدرس قید شده در زیر رجوع فرمایید تا سرویس ترجمه تلفنی برایتان فراهم آورده شود.

Farsi

إذا كانت لديك صعوبة في فهم هذا المنشور، فنرجو زيارة الإستقبال في العنوان المعطى أدناه حيث بإمكاننا أن نرتب لخدمة ترجمة شفوية هاتفية.

Arabic

اگر آپ کو اس اشاعت کو سمجھنے میں کوئی مشکل ہے تو، براہ کرم نیچے دیئے ہوئے ایڈریس کے استقبالیے پر جا کر ملیئے، جہاں ہم آپ کیلئے ٹیلیفون انٹرپرائیونگ سروس (ٹیلیفون پر ترجمانی کی سروس) کا انتظام کر سکتے ہیں۔

Urdu

ਜੇਕਰ ਤੁਹਾਨੂੰ ਇਸ ਪਰਚੇ ਨੂੰ ਸਮਝਣ ਵਿੱਚ ਮੁਸ਼ਕਲ ਪੇਸ਼ ਆਉਂਦੀ ਹੈ ਤਾਂ ਹੇਠਾਂ ਦਿੱਤੇ ਗਏ ਪਤੇ ਉੱਪਰ ਰਿਸੈਪਸ਼ਨ 'ਤੇ ਆਓ ਜਿੱਥੇ ਅਸੀਂ ਟੈਲੀਫੋਨ ਤੇ ਗੱਲਬਾਤ ਕਰਨ ਲਈ ਇੰਟਰਪ੍ਰਿਟਰ ਦਾ ਪ੍ਰਬੰਧ ਕਰ ਸਕਦੇ ਹਾਂ।

Punjabi

Civic Centre, 44 York Street, Twickenham, TW1 3BZ
42 York Street, Twickenham, TW1 3BW
Centre House, 68 Sheen Lane, London SW14 8LP
Old Town Hall, Whittaker Avenue, Richmond, TW9 1TP
Or any library

1. WELCOME AND INTRODUCTION

2. APOLOGIES FOR ABSENCE

To receive apologies for absence (if any).

3. DECLARATIONS OF INTEREST

To receive declarations of disclosable pecuniary or non-pecuniary interests, arising from business to be transacted at this meeting, from:

- (a) all Members of the Joint Committee;
- (b) all other Members present in any part of the room or chamber.

4. MINUTES

That the minutes of the meeting held on 20 April 2017 be taken as read and signed as a correct record.

5. MATTERS ARISING

Follow up from 20 April 2017 meeting –

1. NW London Sustainability and Transformation Plan: Equality Impact Assessment from North West London has been added to the Committee's work programme.
2. London Ambulance Service: Circulation of written response from LAS to address outstanding points and questions.
3. NW London Performance for Accident and Emergency:

- a. Details of new frailty service
- b. Written document from Ms Parker to cover the issue of benchmarking hospital performance at Ealing hospital and associated issues of the indicators for making changes and of communications with the public.

6. EXPLANATION OF THE ACCOUNTABLE CARE SYSTEM

- a) Relationship to STPs and objectives of ACS
- b) Which services are being targeted and how services will evolve:
 - Priority/at risk population assessment
 - Greater out of hospital care and GP hubs
 - Closure of Accident and Emergency Services
 - Future of ageing care
- c) Overview of how systems are integrated and providers collaborate to deliver care / commission services across health and care system
- d) How budgets are set
- e) Update on progress and challenges to date in rolling out across 8 areas of England

7. UPDATE ON HUBS

Overview of the objectives and role of GP Hubs and implementation plans.

8. UPDATE ON NHS MATTERS

- a) Improvements to local services
- b) Discussion on data needed to assess how changes are impacting on patient care

9. UPDATE ON ROYAL COLLEGE OF NURSING'S CONCERNS

The RCN has raised concerns with Councillor Collins about the STP engagement and consultation processes and that financial considerations may overshadow the effective delivery of care and potentially result in unsafe care.

The Committee to discuss the RCN's concerns and requests the Clinical Commissioning Groups to be ready to speak to the following issues:

- a. Clear evidence to support how STPS will improve patient safety, quality of care, workforce and financial balance
- b. STP plans are accompanied by a robust Equality Impact Assessment
- c. Meaningful engagement and consultation processes are put in place, including input from clinical staff
- d. Service delivery is prioritised above funding and use of resources monitored
- e. Workforce strategy and job security
- f. Capped Expenditure Process
- g. Reliance on admission avoidance
- h. Vacant posts in Community Nursing teams
- i. Changing shift patterns and removal of mini breaks for nurses

10. ANY OTHER BUSINESS

Discuss proposed dates for the next two JHOSC meetings, which are to take place prior to 31 March.

Proposed January 2018 date:

- Tuesday 23rd January – morning (0900-1230)

Proposed March 2018 dates:

- Tuesday 6th March – morning (0900-1230); or
- Tuesday 13th March – morning (0900-1230)

11. ATTACHMENTS

- a) Letter to Councillor Collins from Sharon Bissessar, Senior RCN Officer dated 3 August 2017

PRESENT

Members of the JHOSC

Councillor Mel Collins (LB Hounslow) (*Chair*)
Councillor Daniel Crawford (LB Ealing)
Councillor Theresa Mullins (LB Ealing)
Councillor Rory Vaughan (LB Hammersmith and Fulham)
Councillor Will Pascall (RB Kensington and Chelsea)
Councillor Charles Williams (RB Kensington and Chelsea)
Councillor John Coombs (LB Richmond)
Councillor Barbara Arzymanow (City of Westminster)

Others in Attendance

Martin Bowdler (Sector Engagement Manager North West London, London Ambulance Service NHS Trust)
Councillor Pat Healy (RB Kensington and Chelsea, *observer*)
Ian Johns (Assistant Director of Operations North West London, London Ambulance Service NHS Trust)
Clare Parker (Accountable Officer, CWHHE CCGs)
Dr Mark Spencer (Medical Director, NW London Shaping a Healthier Future)
Stephen Webb (Senior Corporate Communications Consultant, CWHHE CCGs)

1. WELCOME AND INTRODUCTIONS

Councillor Charles Williams welcomed JHOSC members and officers to Kensington Town Hall. He added that RB Kensington and Chelsea was a strong supporter of the North West London JHOSC and that he hoped that it would be a forum for constructive discussion about NHS plans and ways in which organisations like the London Ambulance Service could meet councillors without having to attend every borough's scrutiny committee.

2. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors Shaida Mehrban (LB Hounslow), Sharon Holder (LB Hammersmith and Fulham), Michael Borio and Vina Mithani (both LB Harrow), Liz Jaeger (LB Richmond) and Jonathan Glanz (City of Westminster).

Councillor Borio had been prevented from attending this meeting due to a recent bereavement and the Chair asked that the Committee's sympathy be conveyed to the Councillor.

3. DECLARATIONS OF INTEREST

There were none.

4. MINUTES OF THE MEETING HELD ON 20 FEBRUARY 2017

Consideration was given to the minutes of the meeting held on 20 February 2017. The Chair thanked Mr Lee Teasdale of LB Ealing who had prepared the minutes.

Matters Arising:-

(i) Minute 5 - Shaping a Healthier Future Outline Case Part 1

Ms Parker confirmed that whilst no official confirmation had yet been received from Central Government she could see no reason why the business case would not be approved in full.

Councillor Crawford stated he had seen a memo which suggested that (nationally) a number of business cases would not be approved. He was also concerned about the possible effect of the General Election on 8 June announced earlier in the week;

(ii) Minute 6 – North West London Sustainability and Transformation Plan

Mr Webb confirmed that the Equality Impact Assessment from North West London had been placed on the website the day before. He added that it was broadly similar in content to that of other STPs. Ms Parker confirmed to Councillor Crawford that she would expect this document to be scrutinised at a future JHOSC meeting. The Committee agreed that this be a future JHOSC item.

Resolved: That

- (i) The minutes of the previous meeting of the Committee held on 20 February 2017 be agreed as a true and correct record; and
- (ii) There be a future agenda item on Equality Impact Assessment.

5. LONDON AMBULANCE SERVICE

Mr Johns from the London Ambulance Service (LAS) introduced the main points of the presentation included in the agenda papers. They summarised that hard work and effective collaboration with partners had turned things round for the LAS in the last two years. Despite ever increasing demand for services the LAS was now one of the best

performing Ambulance Trusts nationally. The LAS had improved staffing levels compared with two years back with many of the new recruits coming from overseas.

Mr Bowdler and Mr Johns invited Committee members should they be interested to join an LAS crew for a shift.

Questions

The LAS representatives confirmed to Councillor Arzymanow that efforts were made to learn from other ambulance services, for instance the South Western Ambulance Service which was more advanced in respect of pathway services had been visited. The LAS representatives added that there would be 140 brand new ambulances in the next year replacing the older vehicles in the fleet (the fleet had approximately 400 vehicles in total). New vehicles were advantageous but in the chain of survival all elements needed to work together collaboratively, effectively and efficiently to give the best chance of a good outcome.

Councillor Arzymanow had also submitted some written questions. There would be a written response from the LAS that would include responses to these questions.

Councillor Crawford stated that a number of his constituents were employed by the LAS and they had reported to him an improvement in morale. Although supportive of the LAS he was concerned that according to the performance statistics contained in the presentation NHS Ealing CCG appeared to be the worst performing and he feared that outer London boroughs received a comparatively worst service. The LAS representatives stated that there were some specialist resources that were concentrated in Central London although the Trust attempted to provide a timely service to the needs of all Londoners. Councillor Crawford also asked about staff and the LAS representatives promised some updated figures regarding staffing in the supplementary paper.

Councillor Williams was informed that there had been a dramatic improvement in LAS staff retention. Also that his point about there being an increasing number of frail elderly people was well understood. The broader network around the GP was the key to success in looking after the elderly.

Councillor Vaughan was pleased to observe that there appeared to be more integrated working particularly with the Police when dealing with persons with mental health issues. Councillor Vaughan was also informed that there was mandatory support and mentoring to integrate new LAS recruits.

Councillor Pascall asked about the ability of the LAS to access patient records. The LAS representatives responded that this was work in progress and an ongoing challenge.

Councillor Mullins quoted from her own observations of Ealing Hospital and the LAS representatives agreed that handover delays (between ambulance and hospital) were the most complex and persistent issue they faced. This was a daily issue with the numbers varying from day to day and hour to hour. This was a common issue for ambulance services across London (and beyond) and there were systems in place to manage as best as possible.

The Chair raised two new points. Firstly, cross border co-ordination (with other ambulance trusts). The LAS representatives confirmed there are support networks with neighbouring ambulance trusts. Often the trusts were experiencing busy periods at the same time. Secondly, Wormwood Scrubs Prison. The LAS representatives were not aware of any particular difficulty but undertook to check the matter.

The Chair thanked the LAS representatives for their attendance and concluded it had been a very helpful session. It was reminded that there would in due course be a written response from the LAS to address outstanding points and questions. This would be circulated to all JHOSC members.

6. NORTH WEST LONDON PERFORMANCE FOR ACCIDENT AND EMERGENCY

Ms Parker introduced the North West London Accident and Emergency (A&E) Performance Report for the winter of 2016/17. It had been a very difficult period nationally for the NHS. North West London had continued to achieve A&E performance in line with or better than both London and England generally although it had not met the national standards consistently. Ms Parker drew attention to the detailed measures to improve A&E performance in each of the boroughs (as contained in section 2 of the report).

During the subsequent debate Ms Parker apologised that this report had only been circulated to Committee members on the day before the meeting.

Questions / Discussion

From his analysis of the performance report Councillor Coombs believed that more hospital beds were needed in North West London. Adult Social Care did not appear to have the necessary resources to care for people in the community. Dr Spencer disagreed believing that more community services were what was required. He stated that a new Frailty Service had been put in place alongside A&E, more details would be provided in due course.

Immediately prior to needing to leave the meeting at 11.30am Dr Spencer referred to a paper from Dr Michael Soljak of Imperial College

on the relationship between GP services and A&E. Dr Spencer would later provide the exact reference.

Councillor Mullins raised the issue of the future of Ealing Hospital. Ms Parker agreed the importance of consistent public communications. In this instance the message was that people should still continue to use Ealing Hospital.

Councillor Crawford also queried the contents of this performance report and what they meant for the future of Ealing Hospital. Ms Parker conceded that Type 1 performance at Ealing had slipped but she believed that this was not a consistent measure and all types of care needed to be considered. Ms Parker added that changes would only be made at Ealing Hospital (or elsewhere) when there was confidence of sufficient capacity to manage demand. Ms Parker also made the point that a range of information on A&E performance was published nationally.

[**Note:** Type 1 A&E department = A consultant led 24 hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients.]

Following on from the above Councillor Vaughan (and other contributions) raised the general issue of benchmarking. Ms Parker responded in summary that major changes would not be made without capital investment in hospitals. Therefore, no changes were likely in the near future. Charing Cross Hospital was confirmed in its present form until 2021. At Ealing Hospital, no changes were imminent and communications should make clear this message. North West London CWHHE CCGs was focusing on delivering the out of hospital strategy.

Councillor Williams stressed the need to reassure the public in line with Ms Parker's comments.

Councillor Crawford reiterated the concerns of his residents. Ms Parker responded that the strategy was to go ahead with reconfiguration but Councillor Crawford (and others) were quite right to test issues of capacity. If there was insufficient capacity, then it was not safe to make the proposed changes.

Councillor Pascall raised general issues of health prevention. In his view the NHS measured illness but not health. He queried what measures we had of the proportion of the population that was healthy.

In closing the debate, the Chair requested Ms Parker to produce a written document which would cover the issue of benchmarking and the associated issues of the indicators for making changes and of communications with the public.

7. NORTH WEST LONDON COMBINED CCG WORKFORCE STRATEGY

Due to the pressure of other business it was necessary to defer consideration of this item to the Committee's next meeting.

8. ANY OTHER BUSINESS

There was none.

9. ANNUAL GENERAL MEETING

The Committee considered whether it believed the JHOSC should continue its work for the next municipal year.

Resolved (unanimously): That the North West London Joint Health and Overview Scrutiny Committee continue in operation for the ensuing municipal year.

Councillor Collins then vacated the Chair and the Clerk from RB Kensington and Chelsea presided over the election of Chair.

Election of Chair

Councillor Collins was the only nomination for Chair received prior to the meeting. His nomination was seconded by Councillor Vaughan. There were no additional nominations received at the meeting.

Resolved (unanimously): That Councillor Mel Collins (LB Hounslow) be elected as Chair of the North West London Joint Health and Overview Scrutiny Committee for the ensuing municipal year.

Councillor Collins resumed the Chair and presided over the election of Vice-Chair. Members of the Committee thanked Councillor Collins for his past contribution to the JHOSC and looked forward to his future stewardship.

Election of Vice-Chair

Councillor Shaida Mehrban of LB Hounslow was the only nomination for Vice-Chair received prior to the meeting. She had submitted apologies for absence for this meeting.

At the meeting Councillor Williams added his nomination for Vice-Chair. His nomination was seconded by Councillor Coombs.

Prior to a vote on the matter it was confirmed by officers that there was nothing in the constitution of the JHOSC which prevented the Chair and Vice-Chair coming from the same borough.

In their consideration of who to be Vice-Chair Committee members expressed the view that the JHOSC would be a stronger body with broader representation.

Resolved (unanimously): That Councillor Charles Williams (RB Kensington and Chelsea) be elected as Vice-Chair of the North West London Joint Health and Overview Scrutiny Committee for the ensuing municipal year.

The meeting ended at 12.35pm.

Chair

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NW London JHOSC

5 December 2017

5.3a Front end frailty services in NW London

Introduction

The North West London Sustainability and Transformation Plan (STP) sets out how, by working together across North West London, we can improve people's health and wellbeing, giving them a better quality of life. The priorities identified for the area are based on the needs of our residents across our eight boroughs.

One of those priorities – which has been supported by all eight local authorities – is about providing better care for older people. By 2032, there will be a 40 per cent increase in people aged 65 and over. Currently, the NHS spends three times more on caring for a 75 year-old than a thirty year old, and this increases to five times more for over 80s.

To improve care for older people, the North West London health and care partnership is working together on:

- Getting the whole health and care system working together for older people
- Home from hospital
- Last phase of life
- Commissioning high-quality and effective care for older people

Starting our work

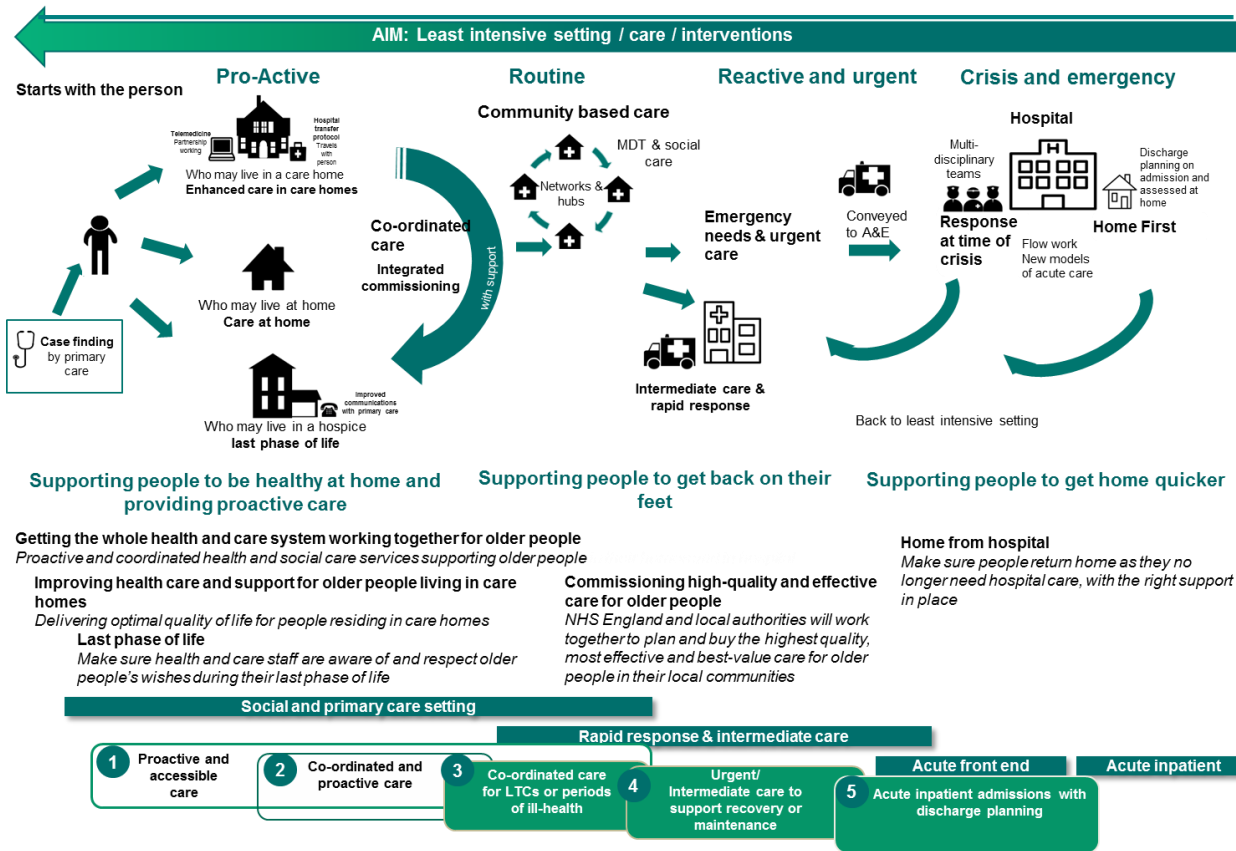
The older people's care programme launched on 18 November 2016 with an event to ask key stakeholders across health and social care, the voluntary sector and patients and carers what they thought the priorities of the programme should be, and how they thought the programme should work.

From this event, the older people's care reference group was formed, involving front line and management staff from hospital, community, primary and social care, voluntary sector organisations and a number of our NW London lay partners. This group has acted as a custodian of the older people's pathway and our expert panel to advise on programme priorities.

Older peoples care

The graphic below shows the older persons care pathway which NW London is looking to improve at every stage

For the current financial year, the older people's care reference group advised that a key priority should be improving the hospital based response for older people who go into crisis. (This is also referred to as front end frailty and response at the time of crisis.)



Older people in NW London

In NW London, we know that if you are 85 or older, you have a 70% chance of being admitted to hospital if you attend A&E, and are then likely to have an average unplanned stay of just over 10 days. Over this period, an older person whose resilience is reduced can be exposed to potentially life threatening infections, experience reduced mobility resulting in pressure sores and the loss of a significant proportion of their muscle mass, and overall have their chances for continuing living independently diminished.

We know that A&E teams are not well equipped to review the complex needs of older people and that they often medicalise the reduced physical, mental and social resilience of frail older people with the aim of making their condition better when in reality this is not achievable or treatment of a condition or symptom may be debilitating.

What we want to do differently

By getting hospital, community and social care teams working together differently, they can make a more holistic assessment of an older person's needs when they have reached crisis, and can draw on a wide range of health and social care support to offer an alternative to hospital admission where it is safe and appropriate to do so. When older people are admitted, having an early assessment by a multi-disciplinary team not only starts care delivery sooner but also commences planning for the older person's discharge, thereby reducing the chance of a long stay in hospital in circumstances where community-based packages of care need to be arranged.

How many patients could this benefit

In 2016/17, 71,000 people aged 65 and over were admitted to hospital in NW London. Around 23,000 of these admissions stayed in hospital for less than two nights and cost £22.8m. We can assume that a proportion of these people did not need to be admitted to hospital as their length of stay was so short.

What we have done in NW London so far

Since deciding on front end frailty as a priority, we have brought together senior geriatricians from across NW London to compare existing acute frailty models and share current practice and standards. They have developed a number of key standards for hospital frailty services, and agreed a single frailty scoring and assessment tool across NW London services – the Rockwood scale – which is now in use across a number of sites and helps to identify those people who could benefit from this type of intervention. These standards have been tested with key stakeholders including the intermediate care/ rapid response group and the older people's care reference group.

Frailty standards

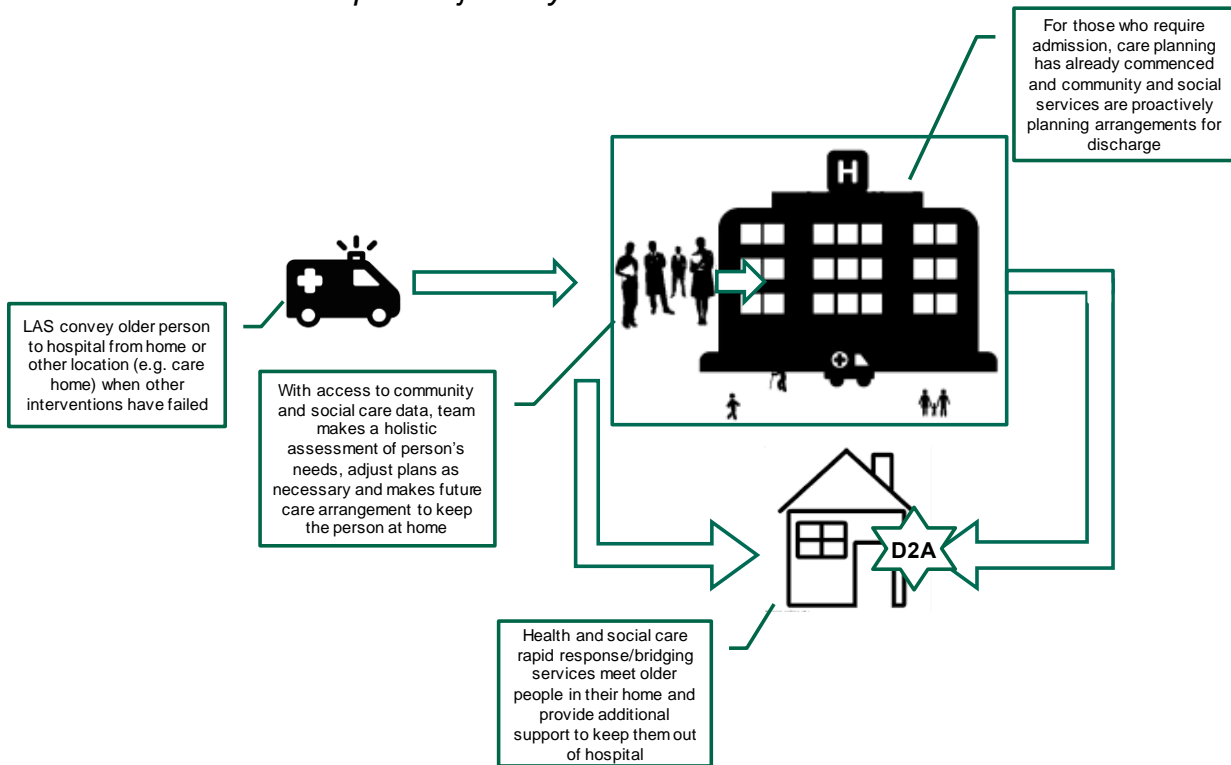
- All patients 65+ presenting at A&E in North West London will be screened for Frailty by A&E staff using a single frailty score – Rockwood Clinical Frailty Scale (CFS) 7. All patients identified as frail (those that score 5+) will be screened by a member of the Acute Frailty Team (Frailty nurse practitioner in A&E) to triage whether a full Comprehensive Geriatric Assessment (CGA) is appropriate, and in which setting this should take place.
- The full CGA may take place in a patient's usual place of residence, in a Rapid Access Clinic, or in an inpatient setting (including Frailty Units, medical/surgical assessment units, and care of the elderly wards).
- The frailty score will be reviewed to suit local services, and patients who present to A&E who are medically unwell would be excluded from front door assessment – being assessed as a default on inpatient wards.
- The Acute Frailty Team will work across the ED, short stay ED wards, acute medical and surgical admission wards - where the target LoS is <72hs. This team will supplement existing acute services. Education and raising awareness will be provided to all teams providing care to older people.
- The Acute Frailty Team would include:
 - Geriatricians or GP with a special interest with geriatrician supervision with appropriate expertise
 - Frailty nurse practitioners who will lead on screening patients, perform medication reviews and will work across the community/acute interface
 - Therapists (blended OT/PT) who will be able to take decisions/risk assessments regarding patient care and will work across the community/acute interface
 - Social care decision makers who will provide assessments, expedite funding decisions, and will work as trusted assessors across boroughs
 - Doctors in training will experience interface training, with a particular focus on GP trainees
- All members of the Acute Frailty Team can initiate CGA, with geriatrician oversight, and pull in other members of the team where appropriate. They will generate a clear action plan.
- The extended Acute Frailty Team will include:
 - Mental health practitioners
 - Pharmacists
 - Dieticians
 - Speech and Language Therapists

- Rapid response in reach services
- Voluntary services
- The Acute Frailty Team will have access to:
 - Patient information (primary care/social care/mental health e.g. EMIS/SystemOne, CoordinateMyCare, Framework 1 and RIO).
 - Referral pathways to mental health support at home.
 - Prioritised transport for Frail patients.
 - Multidisciplinary rapid access services for Frail patients (<48 hours, with priority access to diagnostics).
 - Local rapid response community services (ideally embedded in the ED).

Key outcome metrics:

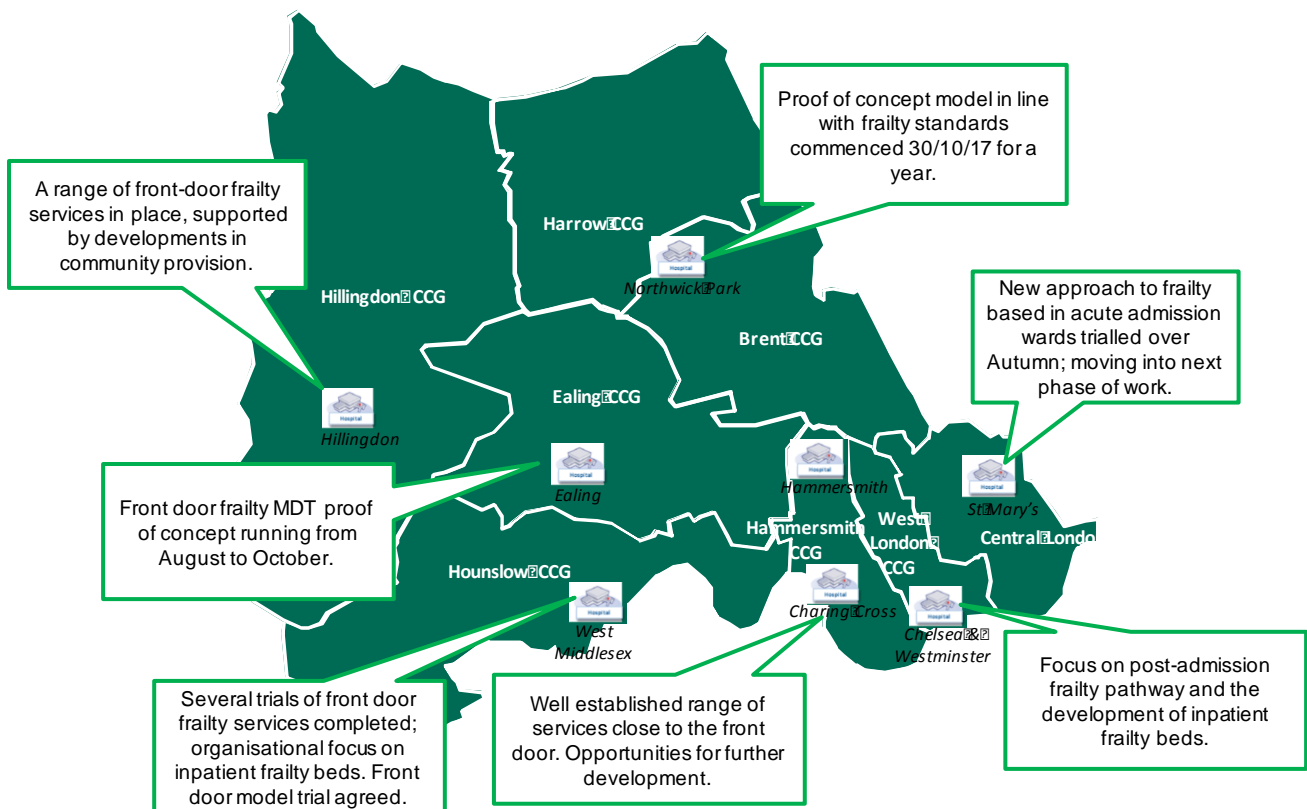
- # of frailty scores completed for 65+
- # patients screened by acute frailty team
- # of Comprehensive Geriatric Assessments (CGA) – initiated/reviewed/not needed
- Patient experience/satisfaction
- Staff experience
- Emergency admission rates for cohort
- Length of stay on Care of the Elderly (CofE) wards
- # seen by rapid access clinics
- # seen by Community Emergency Response Team
- Social care £
- Readmissions from acute care
- 4 hour ED performance
- Length of stay profile <72 hours
- Time from first contact to definitive care / senior clinical review
- Adherence to Advanced Care Plans
- Age based levels of independence and wellbeing
- Carer wellbeing
- Re-attendance rate
- Discharge directly from Medical Assessment Unit
- Use of medication: proportion of patients receiving sedatives
- Use of medication: proportion of patients receiving antipsychotics
- Mortality
- Discharge to usual place of residence / previous levels of function
- Falls per 100 bed days

What this means for the patient journey:



What is in place across NW London:

As of the beginning of November, we have a range of specialist multi-disciplinary services for older people at the front door of our hospitals in NW London.



We have worked particularly closely with a range of stakeholders across a number of sites to implement the model locally. We have undertaken a thorough review of baseline activity and data to understand the number of people who might benefit from this model which demonstrated an opportunity to improve care for older people, particularly those admitted for very short lengths of stay (less than 24 hours and 1-2 days).

We have established project rollout groups which have included CCG reps, geriatricians, therapies, A&E team, intermediate care, social care and senior management, and used extensive data analysis to determine demand, key pressure points in the day and potential impact on patient flow and A&E performance. These groups have agreed care pathways and developed the model for local implementation.

What we have learnt so far

Initial data from these sites demonstrates that a significant proportion of older people presenting at A&Es could benefit from the input of frailty teams and where older people have been seen by frailty teams, a larger proportion of older people have returned home rather than be admitted.

For example, at Northwick Park Hospital, over two weeks:

- 59 people have been seen by the frailty team
- 18 of whom have been discharged directly home and
- 39 of whom were redirected into short stay wards rather than long stay medical wards.

At Ealing Hospital, 70% of the older people who were seen by the service returned home with another 22% redirected into intermediate care services rather than being admitted to hospital. Around 50 older people a week could benefit at Ealing Hospital.

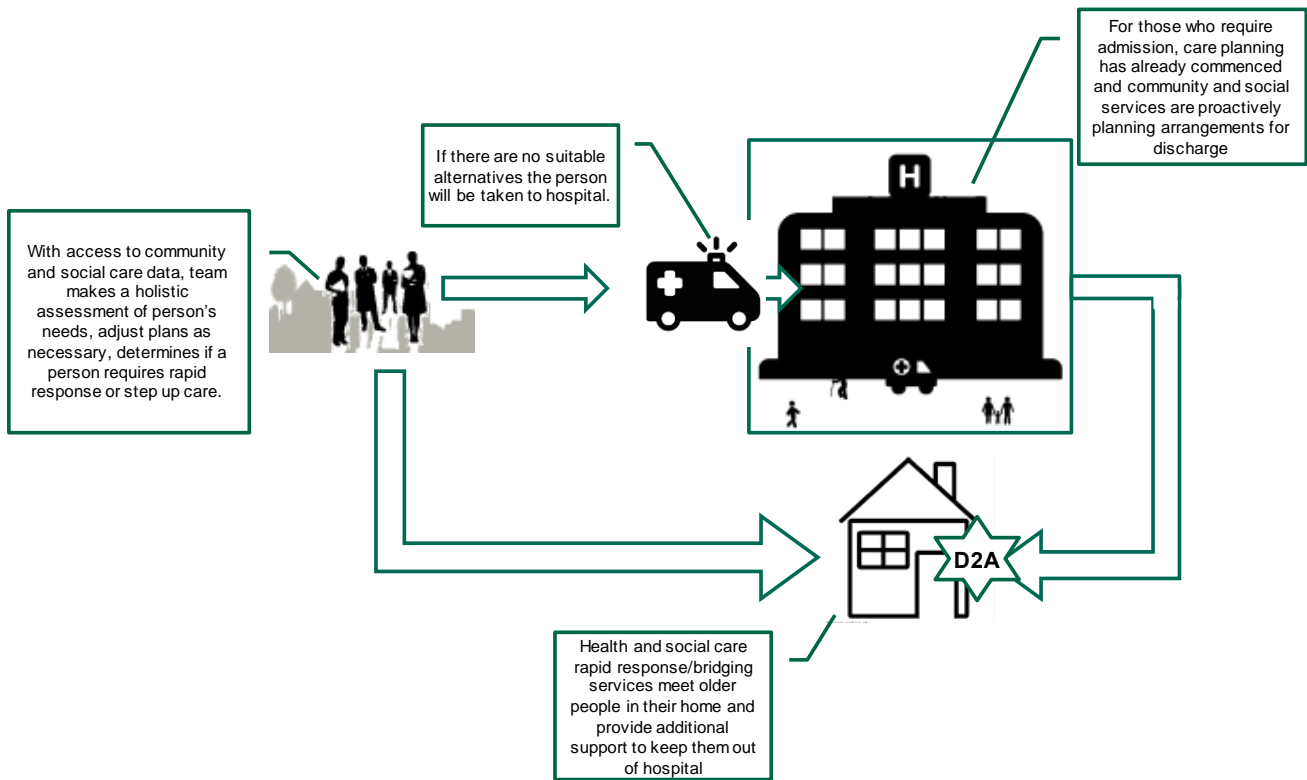
At all sites, we have seen a consistent pattern of when older people present to A&E, mainly in daytime hours from around 10:00 until 22:00, with the same pattern across week days and the weekend.

Through the project we have also learnt valuable lessons about what it takes to make these models work:

- Teams from across the hospital and community can work together to deliver an improved service for older people and making a difference for these patients
- Use of frailty scoring tools was helpful in identifying the cohort of patients who are frail but not acutely unwell and who would not necessarily benefit from hospital admission
- Clear governance and accountability structures are critical when multiple providers are working together, particularly on staffing and handover
- For this model to be effective, it needs consistent hours and resilient, sustainable staffing. The model relies heavily on staff groups where there are existing shortages (geriatricians, senior therapists) so models must seek to use these staff effectively as well as looking for alternatives

Expanding this approach outside hospital

While we initially identified this as a hospital-based model, the same principles and model could and should apply to a community setting as below. Locating the team in the hospital in the first instance addresses the needs of older people who currently present at A&E, up to 85% of whom arrive by ambulance, and provides strong infrastructure in which the team can operate. However, over time as our interventions in the acute and community settings become more effective, the model can shift to an out of hospital not only seeing older people at the point of crisis but supporting care and care planning before they reach that point, transitioning away from emergency care towards a semi-planned service.



Learning from around the country

There is evidence about the impact of such services from around the country including:



Sheffield: Put in place a dedicated 'Front Door Response Team' (FDRT) comprised of OT/PTs, a social worker and general and mental health nurses working alongside the medical staff, providing input to clinical assessments and focusing on what needs doing to get patients back home as soon as clinically possible. There was a 37% increase in patients who could be discharged on the same day or the following day. Combined with discharge to assess, 68 Care of the Elderly hospital beds were closed over a six month period. <https://www.england.nhs.uk/wp-content/uploads/2013/08/sheff-study.pdf>



Leicester: Developed an emergency frailty unit within the ED with robust pathways directing the care of frail older people throughout the first 24-hours; a dedicated area for assessment not subject to the 4-hour target; a dedicated team of geriatricians, nurses, 'primary care coordinators', therapists and strong collaboration with emergency physicians; direct clinical support for the care of frail older people throughout the ED; robust pathways out of hospital with community providers and social care. Although the number of attendances for people aged over 85 had risen, the number of admissions to wards had dropped over the first six months of operation by 10%.



Poole: Instituted a multi-disciplinary response that initiates Comprehensive Geriatric Assessment ("CGA") within the first hour that an older person is in the hospital via the Rapid Access and Consultant Evaluation (RACE) service. In combination with other frailty services, and working closely with community and social services, there has been a 50% reduction in the number of care of older people bed days.

The next 12 months

Over the coming year, our focus is to ensure effective models in all of the acute hospitals across NW London and to work with health and social care commissioners and providers in local areas as well as London Ambulance Service to introduce more proactive models in the community so that older people do not have to make the trip to hospital and their care needs are better anticipated before they reach a point of crisis.

Governance

This work forms part of our system-wide older people's care programme which reports to the delivery area board, chaired jointly by Carolyn Downs, the CEO of Brent Council, and Rob Larkman, Accountable Officer of Brent, Harrow and Hillingdon CCGs.

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Accountable Care in North West London

JHOSC

5 December 2017

Introduction

- The Five Year Forward View: Next Steps document published in March 2017, underscored the importance of health and care systems working together to improve patient outcomes, population health and efficiency & sustainability of health and care services.
- The policy direction is clear – we must go further faster on integrating care for our populations, using the Sustainability & Transformation Partnership (STP) and through them, the development of Accountable Care models, as a way of achieving this.
- This briefing pack provides a information on the key elements of accountable care working nationally and in North West (NW) London and seeks to address the key questions raised by the NW London JHOSC.
- It should be noted that Accountable Care is described in different ways by different people – to support a clearer understanding, we have also included **a glossary of the main Accountable Care terms** in Appendix 1 of this pack.

Our journey towards Accountable Care in NW London

As with the rest of the country, our services across NW London are under significant pressure with quality and financial management increasingly challenging. The lack of a co-ordinated approach across the whole system adds to this burden: health and social care services are delivered by a range of different organisations working separately to fulfil organisational goals and responsibilities. These responsibilities are not always aligned with each other which creates unnecessary boundaries that prevent professionals from working together to provide the kind of high quality, joined up support that people expect and want.

Integrating Care delivery

We have, since 2014, invested a great deal of time, energy and passion in creating and enabling providers and partners to work in more integrated ways for the benefit of our populations. We have been doing this under the umbrella of the *Whole Systems Integrated Care (WSIC) Programme* which has for the last 4 years been focussed on bringing together all the different parts of the health and social care system to work on the joint delivery of services. Integrated Care Teams are at the forefront of this work and these teams ensure better communication and sharing of relevant information to reduce duplication and confusion for individuals, carers and staff.

But to succeed in delivering sustainable change we have we recognised that we needed to remove the barriers to co-ordinated. That is why in 2015 we stated that:

“Our belief is that **high quality, integrated services** can best be delivered by **accountable care partnerships** which have developed appropriate models of care for their population; which are commissioned to deliver **clear outcomes** for the different segments of the population; which **share accountability** for achieving those outcomes and which **share financial risks** and benefits through a **capitated budget.**”

Our key goal has become to deliver Accountable Care within the lifetime of the current STP.

Relationship between STP, Accountable Care & SaHF

When it was first published in October 2014 NHS Five Year Forward View stated that:

- **The traditional divide** between primary care, community services, and hospitals - largely unaltered since the birth of the NHS - **is increasingly a barrier to the personalised and coordinated health services patients need.**
- **Long term conditions are now a central task of the NHS;** caring for these needs requires a partnership with patients over the long term rather than providing single, unconnected 'episodes' of care.
- **Increasingly we need to manage systems** – networks of care – not just organisations. Out-of-hospital care needs to become a much larger part of what the NHS does. And services need to be integrated around the patient.

The evolution of STPs

The Sustainability and Transformation Partnerships (STPs) are a product of this commitment to take an integrated system view of the challenges we all face. Following progress and developments in the Vanguard sites across England, the *Five Year Forward View: Next Steps* document published in March 2017 went one step further and set out an expectation that:

Accountable Care Systems will be an 'evolved' version of an STP that is working as a locally integrated health system. They are systems in which NHS organisations (both commissioners and providers), often in partnership with local authorities, choose to take on clear collective responsibility for resources and population health. They [will aim to] provide joined up, better coordinated care.

Alignment of STP, WSIC, SaHF & Accountable Care

The development of Accountable Care is an excellent strategic fit with our WSIC programme, the STP and the *Shaping a Healthier Future* (SaHF) ambitions. Our local plans and the national policy direction make it clear that to shift settings of care and to reduce the reliance on emergency or acute services, we must take a whole system integrated approach. Accountable Care is the manifestation of this requirement, providing new contract models and new payment mechanisms that enable and encourage a multiplicity of providers to work together to develop and provide new models of care (see also slide 20 for an overview of Accountable Care models).

What progress are we making?

- Since 2013, we have been developing and implementing population health care management (Whole System Integrated Care) in all CCGs with local authorities and provider organisations, based on population segmentation of those at highest risk of admission.
- As part of this, a commitment to creating Accountable Care Partnerships (ACPs) has been made; the provider community have responded well with particular progress in Hillingdon and the multi-provider partnership in Hammersmith & Fulham.
- Over the last 12 months we have agreed that we can best achieve our accountable care goals by taking a ‘bottom-up’ approach in each CCG area in NW London; this enables us to develop the conditions for success based on each local circumstances, relationships, challenges and opportunities.
- At the same time, we recognise that successful Accountable Care (AC) rests in taking a system wide approach and therefore we have also agreed there needs to be a level of consistency in key areas. Based on national and international best practice we have identified 17 *common elements* of successful accountable care working.
- Each CCG/area has agreed that we should work together to develop these *common elements* (our “ingredients for success”) which includes things like: consistent outcome measures; capitation methodology; data sharing approach; culture change.
- We aim to do this by abiding by our principle of a Whole System approach– we will identify and build the best practice approach to each common element as a system. We will draw on the work of WSIC and take learning from our more advanced boroughs as well as the national pilots and vanguards.

How will our approach evolve?

- Our accountable care ambitions are firmly rooted in the work completed as part of the WSIC programme. During this programme over 200 individuals from providers, partners, commissioners, patients, carers and the public across NW London participated in a series of workshops and events to co-produce a set of principles and tools designed to support organisations to deliver fully integrated care across NW London.
- As well as ideas and options for care delivery, tools were developed to support the emergence of Accountable Care Partnerships across NW London – this included a blueprint for the development of the key elements of accountable care including: **new care models** (ie out of hospital care), **population segments & prioritisation** and **how budgets might be set**. Full details of this work and the recommended approaches can be found at <http://integration.healthiernorthwestlondon.nhs.uk/>
- The following slides provide more detail on the approaches being taken to develop:
 1. New Care Models
 2. Priority Population segments
 3. Capitated budgets

What are the new care models being developed by CCGs¹?

- ✓ **Brent** is working towards an Alliance arrangement as a precursor to an **MCP** model and investing in the expansion and development of Whole Systems (WSIC) model of care planning
- ✓ **Harrow health and care partners** have committed through an internal Memorandum of Understanding (MOU) to develop an Accountable Care model as a vehicle to deliver Whole Systems Integrated Care for a segment of the over 65s population in Harrow. The likely contractual approach will be an Alliance Agreement in shadow form from April 2018
- ✓ The **Hillingdon ACP** focus is currently based on testing a new model of integrated care for over 65s (with one or more long-term conditions, including frailty and social isolation). During 17-18 they have been testing a new contractual approach (shadow capitation) for this population group. This will expand in 2018/19.
- ✓ **Central London** is working with Westminster City Council and partners to implement accountable care from April 2019, delivered via an **MCP**. The journey to **MCPs** will be through Primary Care Homes (**PCH**) and through the Westminster Partnership Board for Health and Care made up of commissioners, the Local Authority and providers.
- ✓ The focus for **West London** is on re-commissioning and re-contracting all of the integrated services (in particular *My Care, My Way* and the *Community Independence Service*) into a single service entity in 2018 with the intention of working toward an **MCP** in 2020.
- ✓ **Hammersmith & Fulham** are working to a wraparound contract from April 2018 that includes out of hospital services and PMS commissioning intentions. They are working with their GP networks towards the development of Primary Care Homes and more widely with the area's Accountable Care partners on an **MCP/PACS**-type model from 2019.
- ✓ **Hounslow** is intending to let a wraparound contract with outcomes from April 18 that includes the out of hospital services, including the new asthma specification and their Primary Medical Services commissioning intentions. They are progressing development of an **MCP** model by 2020.
- ✓ **Ealing** are letting a wraparound contract – the *Ealing Standard* with the access element from October 2017 and fully from April 2018. They are currently developing a business case and procurement to support a single contract for out of hospital services, an integrated community services provider, from 2018.

¹See Appendix 1 for a glossary of the Accountable Care abbreviations (in **bold**) used in this slide

Priority population segments & how these are being determined

- We are taking a phased approach to implementation of accountable care contracts, starting with priority population segments for outcomes-based incentives, then moving over time (which could be several years) to all population segments and eventually to a fuller capitated payment model.
- **The initial focus for outcomes-based incentives will therefore be on a small number of population segments.**
- The intention is that this will deliver some benefits of integration more quickly, and enable all of us in the system to test approaches to implementation.
- We have considered which population segments to prioritise against a range of criteria, which are summarised in the table below:

Criteria for Consideration of Priority Population Segments

1. Alignment with STP priorities and delivery areas
2. Alignment with local borough priorities
3. Likely to provide significant benefits from integration (eg due to current care fragmentation; spend in relation to population)
4. Broad scope (eg spans acute, mental health, community, primary and social care) so likely to benefit from integration
5. Ability for providers to mobilise for the early stages of accountable care delivery
6. Person-centred – delivering outcomes and achieving goals for a population, rather than condition or organisation focused
7. Potential to provide a 'ripple' of benefits for other population segments – eg through focus on prevention

Our priority population focus

- The over 65s has been identified as a clear priority for NW London commissioners, especially in relation to outcomes for the frail elderly. We also envisage early opportunities for mental health and planned care pathways to be part of the initial areas of focus.

Why over 65s

- There are compelling reasons why this group is being prioritised by CCG areas:
 - The over 65s & frail elderly often experience highly fragmented services across multiple providers
 - The average cost per capita of services for the over 65s is £3,842 compared with £985 for the 18-64 population – over three-times higher.
 - There is a forecast rise of 13% in the number of people over 65 in NW London from 2015 to 2020. Between 2020 and 2030, this number is forecast to rise again by 32%.
 - Nearly half of our 65+ population are living alone, increasing the potential for social isolation
 - 42.1% of non-elective admissions occur from people 65 and over

Other priority areas of focus

- We also view outcomes for adults with serious and long-term mental health conditions as a priority, as although this is a smaller population group there are benefits from increased integration; furthermore significant progress has already been made through the Like Minded programme which wish to continue and sustain.
- Finally, we see benefits in testing accountable care approaches across specific pathways, such as diabetes which is currently an area of focus proving to be a highly successful across NW London.

Setting the budget for accountable care

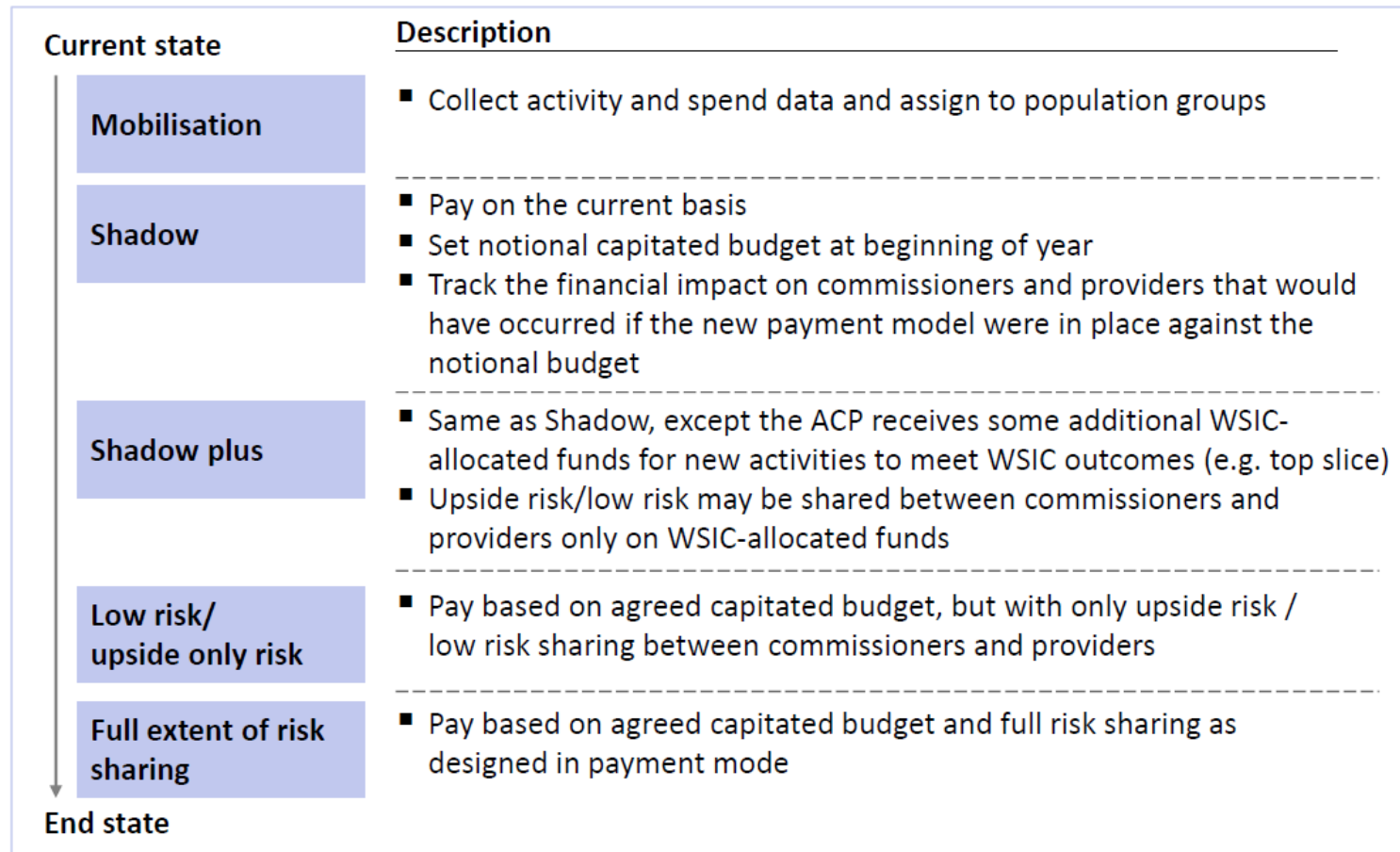
Our CCGs are still in the initial stages of accountable care development and even our most advance area (Hillingdon) are still working through the challenges and requirements associated with setting budgets in new ways.

Regardless of the current stage of development, the CCGs continue to use the WSIC programme recommendations as the framework for setting budgets. This framework recommends that:

- *The initial value of the accountable care budget should be calculated on the basis of current commissioner spend, using CCG programme budgets and current contract values, for the whole population.*
- *Over time, it will be beneficial to develop accurate budgets for individual population segments, from providers' actual costs. In order to do this, providers will need to agree to the principle of open book accounting with their partners and commissioners; developing trust and commitment is a necessary pre-requisite to this and is therefore currently an area of focus for our CCGs.*
- *CCGs may find it helpful to develop a risk-adjusted approach to capitation, where average price per patient is adjusted for a series of risk factors to produce an individual or limited range of prices for each registered patient. There are examples of this from elsewhere and the WSIC work provides some modeled examples from which we can learn.*
- *A capitated budget can be adjusted to take account of:*
 - *Pre-agreed growth rates in the size of the population*
 - *Pre-agreed changes in the demographic make-up of the population*
 - *Pre-agreed changes to the inflation and productivity improvement assumptions*
 - *Actual changes in the numbers of patients assigned to particular population segments or risk-adjusted groups*

How we expect capitated budgets to develop & evolve

- The key to success will be a staged development of the capitated approach and a set of pre-agreed regular checkpoints to ensure budgets align with need and desired outcomes.
- The early termination of the *UnitingCare Partnership* contract in Cambridge, serves to further highlight the importance of pre-agreed adjustments at pre-specified review points during the contract period.
- The approach therefore needs to follow the WSIC capitation model set out in the diagram below:



Provider integration & collaboration – a case study

Hillingdon CCG is leading the development of our (currently) most advanced accountable care model in NW London. Their experiences help illustrate how we are all seeking to develop and support the integration of services and the bringing together of providers in a partnership.

Overview

The **Hillingdon ACP (Hillingdon Heath Care Partners)** comprises a single GP confederation, voluntary sector federation, community and acute providers. The service for >65s care is live, and there is an integrated model across primary, community and acute care, built around care connection teams.

The integration of services

Key features of the Hillingdon model of care:

A primary care focused model of care, integrated multi-disciplinary teams wrapping delivery of care around local communities, supporting GPs to care for their local populations. 15 primary care based care connection teams based with small groups of GP practices using risk scores to identify people at risk of needing acute care and putting in preventative care planning and support. Community geriatricians supporting assessment and specialist support and treatment where needed.

More use of third sector social support- an emphasis on prevention of ill health- keeping older people independent, fit and healthy for longer. Using Health Coordinators and PAM assessment to support people into activities that will maintain their own health

Delivery of outcomes that people tell us matter to them; better quality of coordinated care plans and delivery, keeping people in their own homes longer. Outcomes framework agreed with CCG and now being tested.

Reductions in pressure on the acute hospitals with lower unplanned attendances and admissions and shorter stays when admission is needed. Frailty pathway including rapid response, assessment and 'Discharge to Assess' implemented across the system.

The provider collaboration

Integrated HHCP Provider Board across the 4 partners with an alliance agreement to work together. Integrated operational service management and delivery teams with joint posts across acute and community care. Shared financial, performance and quality reporting across the system developing and supported by a core ACP development team.

Progress since April 2017

389 admissions have been avoided through anticipatory care

1,218 people provided with access to information and advice, support from voluntary groups, health coaching and befriending.

718 patients have had PAM assessments conducted, of which **186** have improved scores indicating improved motivation and self-management.

Update on ACS Wave 1 pilots across England

The Vanguard & ACS sites

- The drive for accountable care developments has been spearheaded nationally through the Vanguard programme.
- Over the past 18-24 months fifty areas around England covering more than five million people have been working to redesign care; more recently the Vanguard approach has been expanded to incorporate 8 Wave 1 Accountable Care System (ACS) areas
- The Vanguards and ACS sites have focused on:
 - Better integrating the various strands of community services such as GPs, community nursing, mental health and social care, moving specialist care out of hospitals into the community
 - Joining up GP, hospital, community and mental health services
 - Linking local hospitals together to improve their clinical and financial viability, reducing variation in care and efficiency
 - Offering older people better, joined up health, care and rehabilitation services
 - Bringing together local NHS organisations, often in partnership with social care services and the voluntary sector, building on the learning from the Vanguard's integrated care model approach

A different emphasis from regulators

- To support on-going development and implementation of STP plans, the NHS England and NHS Improvement have a agreed Sector Control Totals for health services – this is the financial plan in aggregate that the health sector within STP areas needs to achieve.
- Additionally, CCGs are increasingly being asked to work collectively to ensure a shared, systemwide approach to tackling the challenges in health and care services.

Evidence from the Vanguard sites in England

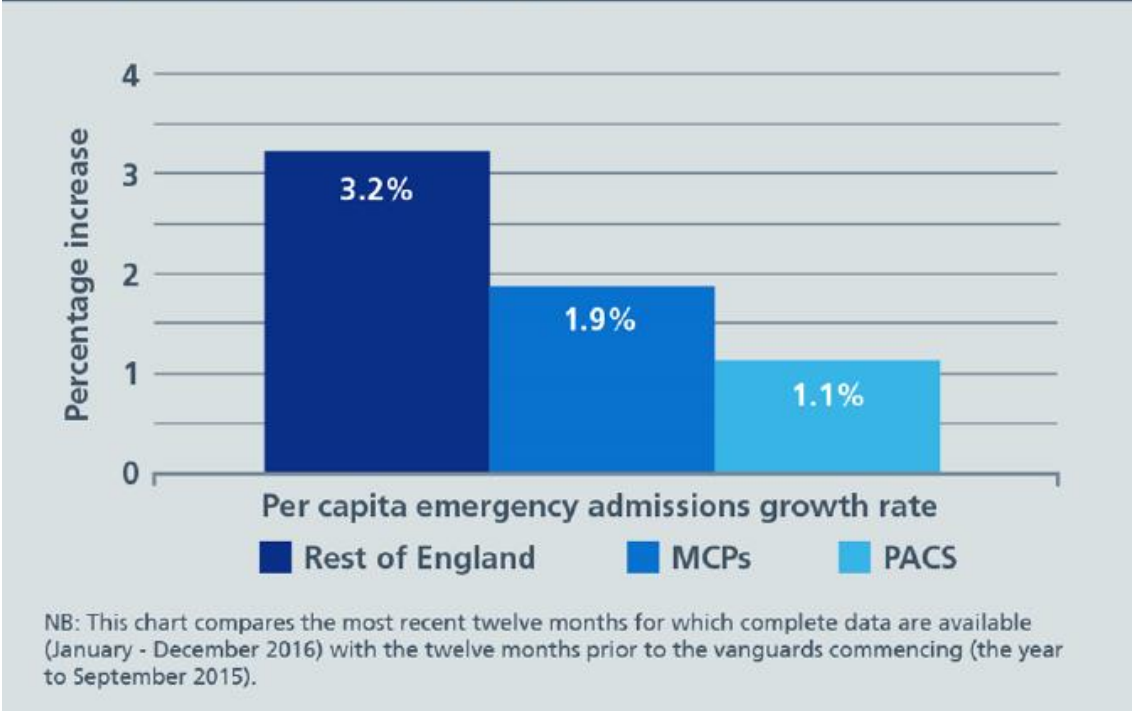
Although still relatively early days the data from the Vanguard sites is extremely encouraging.

Compared to their 2014/15 baseline **both PACS and MCP vanguards have seen lower growth in emergency hospital admissions and emergency inpatient bed days than the rest of England.**

Comparing the most recent twelve months for which complete data are available (January-December 2016) with the twelve months prior to the vanguard funding commencing (the year to September 2015), **per capita emergency admissions growth rates were: PACS vanguards 1.1%, MCP vanguards 1.9%, versus the non-vanguard rest of England which was 3.2%.**

Alternatively taking the full financial year April 2014-March 2015 before the vanguards were selected as the baseline period, **per capita emergency admissions growth rates were: PACS 1.7%, MCPs 2.7% and rest of England 3.3%.** Vanguards such as Morecambe Bay, Northumberland and Rushcliffe are reporting absolute reductions in emergency admissions per capita. As intended, the benefit has been greatest for older people. The Care Homes vanguards are also reporting lower growth in emergency admissions than the rest of England, and meaningful savings from reducing unnecessary prescribing costs.

Figure 6: MCP and PACS vanguards have seen lower growth in per capita emergency hospital admissions than the rest of England



Appendix 1

Glossary of Accountable Care Terms

Glossary of Accountable Care terms (1)

Introduction

People use different words and acronyms to describe accountable care developments across England – this not only reflects the developing thinking but also how the model is being adapted by local areas to suit local needs. To support a clear understanding, we have set out below the main terms and how we are using see them in NW London.

Accountable Care - our view & interpretation

In NW London our goal is to ensure we have the right functions in place before we settle on a form or contract model. We see Accountable Care as a function that:

- Brings together a number of providers who will take the lead for developing new models of integrated care.
- Brings provider partners together take joint responsibility and control for the cost and quality of care for a defined population within an agreed budget.
- Can ultimately take many different forms ranging from fully integrated systems to looser alliances and networks of hospitals, medical groups and other providers – our goal is to support providers achieve the ‘form’ that best suits our context across NW London.

Glossary of the main Accountable Care terms

Accountable Care System (ACS): refers to localities (usually STP areas) that have joined together to develop new care models and ultimately new commissioning models. ACSs are likely to have multiple types of Accountable Care models within their areas (ACPs, MCPs, PACS etc – see next slide). *In this way, we see the North West London STP as an emerging Accountable Care System.*

Accountable Care Organisation (ACO): this is an organisational form of accountable care working. In this model, the contract for services sits with a single ACO that is formed of multiple providers; it is a model used in many parts of the world. NHS England refer to ACOs as one possible contract form that local systems may choose to adopt. *This is not in our plans for NW London*

Glossary of Accountable Care terms (2)

Accountable Care Partnership (ACP): this is like an ACO but does not seek to form a new/separate organisation. Instead, providers come together in a partnership under alliance contracts or similar arrangements and providers will for the most part, continue with other functions and responsibilities outside the ACP agreement. *This is the model recommended by those involved in designing the Whole System Integrated Care approach for NW London.*

Accountable Care models: There are a number of approaches providers can take to develop an Accountable Care way of working. The models vary in scope and in the range of partners – but all work from the premise that integrated care, shared budgets and joint accountability improves outcomes for local populations. There are three main models being developed across England:

1. **Multi-specialty Community Providers (MCPs)** – comprising GP primary care, community services; could also include Mental Health and Social Care
2. **Primary and Acute Care System (PACS)** – principally comprising GP primary care and Acute providers; could also include Mental Health, community and Social Care partners
3. **Primary Care Homes (PCH)** – comprising partnership of GP practices over populations of around 30-50k; although predominantly primary care, practices can partner up with community and local authority providers. PCH is often used as a stepping stone to MCP or PACS models.

Nationally, the expectation is that that these accountable care models will ultimately be contracted under an initial ACO or ACP type contract in the next 2-3 years.

Appendix 2

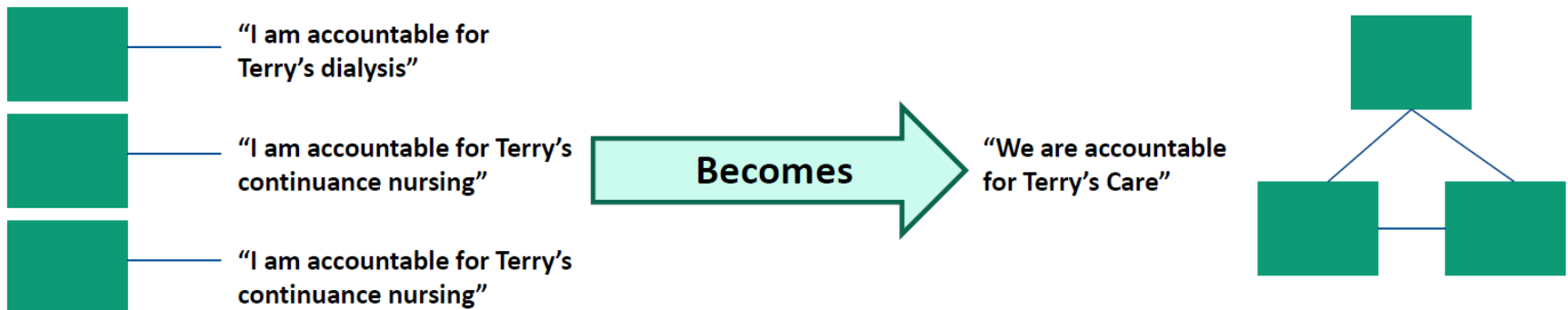
Why Accountable Care?

A bit more context

The problems we are trying to solve through an Accountable Care approach

- **Fragmentation:** People seeking care frequently require support from a range of different providers, such as hospitals, intermediate care, primary care, mental health clinics, nursing's homes. The current fragmented commissioning & delivery system offers uneven quality of care, missed opportunities for the right care in the right place at the right time, and ultimately poor outcomes
- **Misaligned incentives:** Too often our organisations face a different set of constraints and incentives, and consequently each part works to optimise its own performance without fully understanding or assessing the impact on patients or other parts in the care delivery system
- **Duplication of Efforts:** Without understanding the total patient story, providers duplicate efforts and interventions leading to an over consumption of health resources
- **Unclear Access:** With numerous entry points into the system, patients and clinicians are often unclear on how to access the best care available or how to coordinate care to maximize their health outcomes; this often leads people to present at hospitals.
- **Workforce:** With fragmentation, duplication and operational constraints comes a workforce challenge – we cannot staff or resource all the services we need to provide, leading to gaps in provision or unsustainable staffing costs
- **Long Term System Sustainability:** All of the above drives up expenditure and contributes to the long term unsustainability of the NHS

The diagram below illustrates the system transformation we are seeking:



Key features of accountable care systems that help address these problems

Accountable Care is nationally and internationally recognised as an effective response to modern health and care challenges. Numerous accountable care organisational forms exist across the world but successful systems – regardless of their funding or delivery models – share common features:

- ✓ They are built around a GP **registered population**
- ✓ They work from **Outcomes Based Contracts** – providers take control, commissioners become much more strategic
- ✓ They use **whole population budgets** for a defined population and/or geography
- ✓ They are commissioned to deliver outcomes with **contracts of at least 10 years** in length - to support long-term investment and realisation of benefits
- ✓ They are inclusive of **the functions most** necessary to deliver those outcomes – including mental health, social care & other local authority services (ie to address wider determinants of health)
- ✓ The providers are equally accountable for end-to-end care of the population
- ✓ They **function at a scale** that is sufficient enough to hold clinical and financial accountability for a population
- ✓ They take full responsibility for **making decisions on resource allocation** and performance within the accountable care partnership
- ✓ They embed **service users in decision-making** and in governance

For more information...

For more information please contact:

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NW London JHOSC 5 December 2017

7 Update on progress of community hubs

Introduction

When we refer to a community hub, we are meaning a physical building in the community which will enable a wider range of services to be available to patients than would typically be offered in a smaller GP practice.

Within these buildings we will bring together a wide range of professionals and services. Some GP practices will move into these hubs. Others will make use of the wider range of services for the benefit of their patients.

Objective and role of hubs

The key feature of SaHF is an interconnected model of care in which:

- most clinical activity takes place in the community, enabled by out of hospital hubs where services are co-located and primary care is delivered at scale
- acute services are reconfigured to ensure better quality care and clinical sustainability, while also achieving financial sustainability. This is principally achieved by concentrating valuable clinical capability across fewer sites

Community hubs are designed to bring together NHS and social care services in one place. Hubs will join-up services for residents, reducing the need, time and cost of multiple appointments in different places. This is especially important for older people, and people with one or more life-long illnesses.

A range of services will be on offer within the building, including GP services, mental health and social care.

The joined-up care provided by hubs will help to keep people as well as possible; avoid unnecessary hospital visits and; get people home from hospital quicker as soon as they are well enough.

Anticipated benefits and how hubs will contribute

Benefit	Hub contribution
Primary Care at scale	Hubs will: <ul style="list-style-type: none">- form the centre of a Primary care model that supports all GPs in the area covered by the hub whether they are providing care in the hub, a local GP practice or off site e.g. in nursing homes- tackle the public's number one NHS concern by making it easier to see a GP through seven-day extended access to primary care,

	and provision of same-day appointments.
Hub and spoke approach to primary care education	The Hub promotes investment in the skills of nominated primary care educators with responsibility for primary care skills across the locality and provides a focal point for analytical work on practice performance. The spoke is designed to strengthen relationships with GP practices outside the hub improving engagement and thus increasing GP performance
Increased patient engagement with primary care, (through new patient transport services and extended primary care opening hours)	<p>The additional time available to staff can be used to see more patients and to spend more time with those who need it. This will improve the management of higher risk patients reducing the risk of deterioration and subsequent admission</p> <p>Reducing the barriers to accessing primary care will increase the uptake by patients who can then be managed in primary care rather than their first episode of care being an acute admission</p> <p>Increased patient attendance increases engagement strengthening compliance with care plans reducing the risk of deterioration and subsequent admission</p>
Reduced risk of patient harm	Improved quality and co-ordination of care will reduce the risk of conflicting treatment (e.g. drugs) and reduce NEL admissions that are caused by this
Access to a full range of health and social care input, including social prescribing	Improved social care input will support the management of the patient's medical conditions reducing the risk of deterioration and subsequent admission
Increased self-management	Active participation by the patient in the management of their condition will increase the success rate reducing the risk of

	deterioration and subsequent admission
Improved facilities	<p>Significant improvement in the quality of the NW London Primary care estate to improve physical access as well as the fabric of the building. Practices in the north and east of England are five times more likely to be rated outstanding by CQC inspectors than those in London, exposing a 'history of lack of investment' in the city. The hubs will greatly improve the primary care estate.</p> <p>More flexible working patterns and better rotas to provide 7 day services and an improved ability to recruit and retain staff</p>
Patient Experience	The hubs will become a new locality focus for patients enabling care closer to home for a wider range of services. The overarching benefit to the flow in hospitals from the reduced demand will also impact on reduced waiting times in hospital and hence also improving the patients' experience of hospital care.
Hospital performance	Hubs will reduce demand on hospital A&E attendances and associated emergency admissions. This will have a direct bearing on emergency performance against the 4hr standard. The reduction in demand will also alleviate overall hospital flow with further impact to reduce cancellation of elective operations and hence also supporting RTT and Cancer standards performance.

Implementation Plans

NLW already has a number of hubs in place. There are for example hubs at the St. Charles and Parkview sites. These were developed prior our bid for capital for the SaHf programme.

Within the SaHF programme, across NW London we are bidding to the Department of Health and Her Majesty's Treasury to fund a total of 27 hubs within the overall SOC1 capital case for £513m. This capital case is progressing through approval process which we hope will conclude within the next few months. This will need to be approved before the Treasury and DH release any funds for hubs.

Each hub will additionally require approval of a specific business case detailing its benefits and costs.

Each of these hub business cases which will go through CCG Governing Body approval prior to being submitted for NHSE approval.

The business cases for each hub will also go through an engagement process with local people.

The business cases for each of these hubs are at different phases. The table in appendix 1 shows current progress of the hubs and expected completion dates.

Evidence to support the development of hubs

The JHOSC has previously asked questions about the evidence base to support the reduction in non-elective activity that can be delivered through hubs. This question was also raised during the NHSE and NHSI assurance process for SOC1. The paper at appendix 2 sets out our summary of the evidence, which was prepared and used during the assurance process and subsequently accepted by NHSE and NHSI.

Appendix 1

Hub Progress Summary

Note: Current status relates to the three stage process being followed: 1. Project Initiation Document (PID), 2. Option Appraisal (OA) then 3. Outline Business Case (OBC)

CCG/Borough	Hub	Estimated capital cost incl VAT & inflation £'000	Indicative Funding/Delivery Route	Proposed services*	Current Status of Project	Target Opening Date
Brent	Wembley Centre for Health and Care	2,449	NHS Capital	Ophthalmology, cardiology, integrated diabetes service, long term condition management, CAMHS, community mental health (dementia), integrated nursing, physiotherapy, local authority/health and wellbeing, ultrasound, community services, phlebotomy, WiC, enhanced primary care	PID not yet commenced	1 Dec 2018
Brent	Willesden Centre for Health and Care	4,455	NHS Capital	Ophthalmology, cardiology, integrated diabetes service, long term condition management, CAMHS, community mental health (dementia), integrated nursing, physiotherapy, local authority/health and wellbeing, X-ray, ultrasound, community services, phlebotomy, WiC, enhanced primary care	PID not yet commenced	1 April 2022
Central London	Central Westminster (site to be identified)	4,920	The NHSE Estate and Technology Transformation Fund ETTF/NHS Capital	Dermatology, cardiology, pulmonary rehab, ophthalmology, diabetes services, dietetics, paediatric	OA IN DEVELOPMENT	1 April 2020

Appendix 1

				services, MSK, SALT, community services, falls prevention, integrated nursing, community champions/health trainers, phlebotomy, enhanced primary care		
Central London	Church Street	14,732	Westminster City Council/NHS Capital	Dermatology, cardiology, pulmonary rehab, ophthalmology, diabetes's services, dietetics, paediatric services, MSK, SALT, community services, falls prevention, integrated nursing, community champions/health trainers, phlebotomy, enhanced primary care	OBC IN DEVELOPMENT	1 April 2022
Ealing	Ealing East	21,152	LIFT	Cardiology, dermatology, diabetes, gynaecology, MSK and orthopaedics, ophthalmology, respiratory, rheumatology, ECG, midwifery, IAPT, CAMHS, community mental health (cognitive impairment/dementia), community services, phlebotomy, enhanced primary care	OBC IN DEVELOPMENT	1 Nov 2019
Ealing	Ealing North	14,613	LIFT	Cardiology, dermatology, diabetes, gynaecology, MSK and orthopaedics, ophthalmology, respiratory, rheumatology, ECG, midwifery, IAPT, CAMHS, community mental health (cognitive impairment/dementia),	OBC IN DEVELOPMENT	1 April 2021

Appendix 1

				community services, phlebotomy, enhanced primary care		
Hammersmith and Fulham	Parsons Green Health Centre	4,814	NHS Capital and ETTF	Midwifery, MSK, audiology, dietetics, OT, diabetes, community dentistry, chronic disease management, sexual health, SALT, children services, community services, phlebotomy, WiC, enhanced primary care	OA IN DEVELOPMENT	1 April 2019
Harrow	The Pinn	675	Operational Capital	ADHD, paediatrics, gastro, MSK, dermatology, piles clinic, rheumatology, cardiology, heart failure nurse, falls, diabetes, adult community services, Xray, ultrasound, phlebotomy, WiC, virtual ward, enhanced primary care	PID not yet commenced	1 July 2018
Harrow	NE Locality Belmont/Kenmore	15,191	London Borough of Harrow/OPE	Community rehab, community mental health, diabetes clinic, asthma clinic, ophthalmology, memory clinics, cardiology, ultrasound, physiotherapy, adult community services, phlebotomy, WiC, enhanced primary care	OBC IN DEVELOPMENT	1 April 2020
Harrow	Alexandra Avenue	2,696	LIFT	Paediatric physio, paediatric OP, paediatric audiology, antenatal, asthma clinic, gastro, coronary heart disease, cardiac nursing, ENT, adult community services, children's community services, community dental, physiotherapy, AAA screening,	PID not yet commenced	1 Sept 2018

Appendix 1

				optometry, retinal screening, IAPT, spinal MSK, continence clinics, phlebotomy, WIC, enhanced primary care		
Hillingdon	North Hillingdon	5,669	NHS Capital	Ophthalmology, MSK, urology, rheumatology, ENT, gynaecology, respiratory, diabetes/endocrinology, cardiology, dermatology, neurology (headaches), community mental health	OA IN DEVELOPMENT	1 April 2020
Hillingdon	Uxbridge and West Drayton	11,050	Third party developer	Ophthalmology, MSK, urology, rheumatology, ENT, gynaecology, respiratory, diabetes/endocrinology, cardiology, dermatology, neurology (headaches), community mental health, community services, enhanced primary care	OA IN DEVELOPMENT	1 April 2020
Hounslow	Chiswick	1,000	ETTF	Physio, SALT, community mental health (IAPT, dementia care and cognitive therapy), community services, phlebotomy, enhanced primary care	OA IN DEVELOPMENT	1 April 2019
Hounslow	Brentford/West Middlesex	10,210	NHS Capital	Physio, SALT, community mental health (IAPT, dementia care and cognitive therapy), community services, phlebotomy, enhanced primary care	OA IN DEVELOPMENT	1 Dec 2020
Hounslow	Heart of Hounslow	1,720	LIFT	Audiology, SALT, OT, Physio, Paediatric Care/ Child Development, CAMHS,	PID IN DEVELOPMENT	1 Dec 2018

Appendix 1

				Community Rehab, LD services, Optometry/Retinal Screening, Ocular Prosthetics, Dermatology, Midwifery, Pain Management, Dietician, Sexual Health, Breast Screening, pain management, community dental service, community services, phlebotomy, enhanced primary care		
Hounslow	Heston	15,894	LIFT	Community mental health (IAPT, dementia care and cognitive therapy), community services, phlebotomy, enhanced primary care	OBC COMPLETE	1 July 2019
West London	St Charles reduced	3,952	NHS Capital	Paediatric services, MSK, dermatology, cardiology, diagnostic services, diabetes services, respiratory services, enhanced diagnostics (ECG/ultrasound), children's services, community services, phlebotomy, enhanced primary care	OA IN DEVELOPMENT	1 Oct 2019
West London	South Locality	12,712	Third party developer/ETTF	Paediatric services, MSK, dermatology, cardiology, diagnostic services, diabetes services, respiratory services, enhanced diagnostics (ECG/ultrasound), children's services, community services, phlebotomy, enhanced primary care	OBC IN DEVELOPMENT	1 April 2020

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OUT-OF-HOSPITAL HUB PRODUCTIVITY

1. Background

The new Out of Hospital (OOH) service model, including primary care, is a core component of the Shaping a Healthier Future (SaHF) programme.

As well as improving the quality of patient care and patient experience, the changes to primary and integrated care will reduce the level of acute hospital based activity, so enabling the transformation of acute services and a reduction in the beds used to deliver those services.

This reduction in activity and beds is a key driver for the financial plans for both the CCGs and the Trusts. Notably, the majority of the reduction in beds is achieved in the first 5 years of implementation of SOC part 1 and is a key element of the NW London Sustainability & Transformation Plan (STP).

This inter-relationship between the 'out of hospital' and 'in-hospital' transformation, as well as the inter-relationship with the NW London STP, are the reasons that the proposed capital expenditure is presented as a single SOC.

2. Summary of the OOH Hub Financial case

The investment needed for the hubs is outlined in the Financial Case - of particular note:

- 18 OOH Hubs require investment to become fully operational between 2017-8 and 2023-24
- Total capital expenditure is projected at £ 141m (after deducting £ 7m of surplus land sales income) of which £ 95m is required from DH.
- The phasing of the funding requirement reflects the estate development plans that drive the schedule of operational start dates for the hubs
- Property site selection for the 7 new hub buildings is fully aligned with the One Public Estate initiative to maximise the integration with non-health based services and to minimise the overall funding required
- The recurrent impact on the CCG I&E positions is an overall benefit of £ £38m pa across the 8 CCGs
- This results in an NPV of £ 523m using a rate of return of 3.5%

Sensitivity analysis has shown that the overall benefit can drop to £ 19m pa before the NPV reaches breakeven, though as this is an average some hubs will have a negative NPV at that point

2.1 Details of property disposals

- | | | |
|---|----------|------------------|
| • Lisson Grove Health Centre | - £ 1.3m | - owned by CLCH |
| • Action Health Centre | - £ 2.0m | - owned by LNWHT |
| • Greenford Green Health clinic | - £ 0.9m | - owned by LNWHT |
| • Kenmore land | - £ 0.2m | - owned by NHSPS |
| • Northwood and Pinner Community Hospital | - £ 3.0m | - owned by NHSPS |

3. Summary of the hub facilities

Services	Hub Facilities
Primary Care	An estimated 47 practices will operate from the new/refurbished facilities
Integrated Care	Space for MDT teams to meet and care plan appointments with patients
Mental health	Community mental health services enabling integration of care for physical and mental health conditions
Therapist services	Physiotherapy, SaLT, Occupational Therapy
Diagnostics	Bloods, ECG, Spirometry in all hubs, X-ray in some (legacy of existing facility)
Outpatients	Procurement of new hub based OP pathways e.g. clinical nurse led

4. Benefits generated by the OOH service model

The new model of Primary and Integrated care will address the areas listed below.

Driver	Delivery mechanisms
Reduced unwarranted variation in primary care	Standardisation of operating processes through primary care 'at scale' and through 'hub and spokes' approach
Consistent team-based Model of Care;	Multi-Disciplinary Teams (MDTs), including social care and mental health
Long Term Care planning and case management with improved co-ordination of care	GP led care plans Case managers co-ordinating care Multidisciplinary care
7 day extended access	Greater availability of primary care

Addressing these areas will result in both qualitative and quantitative benefits for patients and staff.

The NW London CCGs set out their plans for delivering future services in their Strategic Service Development Plans (SSDPs). In developing these strategies, it became clear that the current condition and location of the great majority of the primary care estate was not good enough to support the full implementation of, and realisation of all the benefits of, the new model of care. To address this, SOC part 1 includes investment in primary care facilities (£69m) (which is in the Do Nothing option and the SaHF investment option) and 18 OOH hubs (£ 141m).

The investment in these OOH hubs when combined with the four that are already fit for purpose and the five to be based on acute hospital sites creates a network of primary care services. Detailed analysis, completed as part of SSDPs, suggests that 27 hubs are required. The hubs are critical to addressing the current challenges with primary care estate – both its poor condition and a lack of capacity for current and future population projections – but will also enable the delivery of a new clinical model with wider qualitative and quantitative benefits.

5. Summary of Qualitative benefits generated by the OOH & Hub service model

Benefit	Hub contribution
Primary Care at scale	Hubs will: <ul style="list-style-type: none"> - form the centre of a Primary care model that supports all GPs in the area covered by the hub whether they are providing care in the hub, a local GP practice or off site e.g. in nursing homes - tackle the public's number one NHS concern by making it easier to see a GP through seven-day extended access to primary care, and provision of same-day appointments.
Hub and spoke approach to primary care education	The Hub promotes investment in the skills of nominated primary care educators with responsibility for primary care skills across the locality and provides a focal point for analytical work on practice performance. The spoke is designed to strengthen relationships with GP practices outside the hub improving engagement and thus increasing GP performance
Increased patient engagement with primary care, (through new patient transport services and extended primary care opening hours)	The additional time available to staff can be used to see more patients and to spend more time with those who need it. This will improve the management of higher risk patients reducing the risk of deterioration and subsequent admission Reducing the barriers to accessing primary care will increase the uptake by patients who can then be managed in primary care rather than their first episode of care being an acute admission

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	Increased patient attendance increases engagement strengthening compliance with care plans reducing the risk of deterioration and subsequent admission
Reduced risk of patient harm	Improved quality and co-ordination of care will reduce the risk of conflicting treatment (e.g. drugs) and reduce NEL admissions that are caused by this
Access to a full range of health and social care input, including social prescribing	Improved social care input will support the management of the patient's medical conditions reducing the risk of deterioration and subsequent admission
Increased self-management	Active participation by the patient in the management of their condition will increase the success rate reducing the risk of deterioration and subsequent admission
Improved facilities	<p>Significant improvement in the quality of the NWL Primary care estate to improve physical access as well as the fabric of the building. Practices in the north and east of England are five times more likely to be rated outstanding by CQC inspectors than those in London, exposing a 'history of lack of investment' in the city. The Hubs will greatly improve the primary care estate.</p> <p>More flexible working patterns and better rotas to provide 7 day services and an improved ability to recruit and retain staff</p>
Patient Experience	The hubs will become a new locality focus for patients enabling care closer to home for a wider range of services. The overarching benefit to the flow in hospitals from the reduced demand will also impact on reduced waiting times in hospital and hence also improving the patients' experience of hospital care.
Hospital performance	Hubs will reduce demand on hospital A&E attendances and associated emergency admissions. This will have a direct bearing on emergency performance against the 4hr standard. The reduction in demand will also alleviate overall hospital flow with further impact to reduce cancellation of elective operations and hence also supporting RTT and Cancer standards performance.

6. Summary of Quantitative benefits generated by the OOH & Hub service model

The table below shows that the majority of savings achieved through implementation of the OOH & Hub model is by avoiding emergency (NEL) admissions

OOH & Hub I&E recurrent impact in 2025/26	£m pa	Further Details
Property costs	11.3	Additional capital charges, depreciation, 3 rd party rent costs, LIFT charges etc. arising from the investment in new facilities and the expanded space required
Outpatient savings	(4.8)	20% reduction in tariff based on changes to pathways, e.g. specialist nurse led clinics, and supported by the CCG experience in Hillingdon. NB: as the CCG will bear the hub property cost rather than the supplier, the net saving is 11% across all 8 CCGs
NEL Admissions avoided	(44.7)	Benefits of co-location as an increment over the saving that can be achieved by implementing the model of care in existing facilities. See following slides.
Net saving	(38.1)	

The SOC does not include other benefits that the hubs could enable that are outside of the scope of the SaHF programme and these include,

- Economies of scale for GP practices co-located in a hub, e.g. shared reception
- Increased efficiency/productivity for primary care mental health services

7. Risks of not proceeding with hub investment

Implications for Primary care

240 (66%) of 370 GP practices operating in NW London are rated category C or worse. The demand for services in primary care has grown by 16% over the seven years from 2007 to 2014, but there has been limited investment in the estate. Without investment in the hubs, GPs will not be able to meet growing patient demand and A&E attendances will continue to increase, putting additional demand on hospitals and increasing A&E waiting times

Our GP and nurse workforce supply is the lowest in London. We have 1,093 GPs, 473 practice nurses and 273 clinical support staff, with an average list size of 5,560. We have 379 GP practices, with 31 sites open at weekends. Hubs will enable us to make best use of a limited workforce.

Implications across NWL

The hubs enable c. 22,000 NEL admissions to be avoided, if this cannot be achieved then the pressures on A&E departments would increase significantly as it equates to an average of 61 admissions per day across NWL. None of the NWL Trusts currently meet the 95% target.

The additional admissions would equate to around 130 beds that would have to be added to the planned acute hospital bed base.

Therefore not investing in OOH Hubs would prevent the reconfiguration of Ealing Hospital set out in the consultation unless there is significant additional capital expenditure by the acute trusts over and above the capital set out within the business case. The Financial Case sets out the improvement in the Trusts financial position of £ 95.6m resulting from the CIPs that are in part enabled by the delivery of CCG QIPP. The shortfall in CCG QIPP because of the lack of investment in the OOH hubs will therefore reduce the trust CIP delivery increasing the pre-reconfiguration deficit.

We have also been through an extensive and high-profile public consultation and our proposals were endorsed by the Secretary of State for Health. We will not be able to deliver these plans without the requested capital.

8. Modelling of the Emergency (NEL) admissions avoided by the hubs

The initial modelling of the benefits to be delivered by the hubs has been based on a top down assessment by the NW London Collaboration of CCGs and the senior clinicians working on the SaHF programme.

The core assumptions of the modelling are:

- the CCGs have estimated the proportion of their NEL QIPP that can be delivered by the new Primary and Integrated model of care
- although some of the benefit of implementing the model of care may be implemented without the hubs, an essential component may only be delivered with the hubs
- all QIPP is delivered recurrently in the year it is first included in the CCG financial plan
- no QIPP delivered before the hub is operational is subsequently attributed to the hubs
- hubs do not contribute to the NEL QIPP admission avoidance until the capital development is complete

8.1 Clinical involvement & sign-off

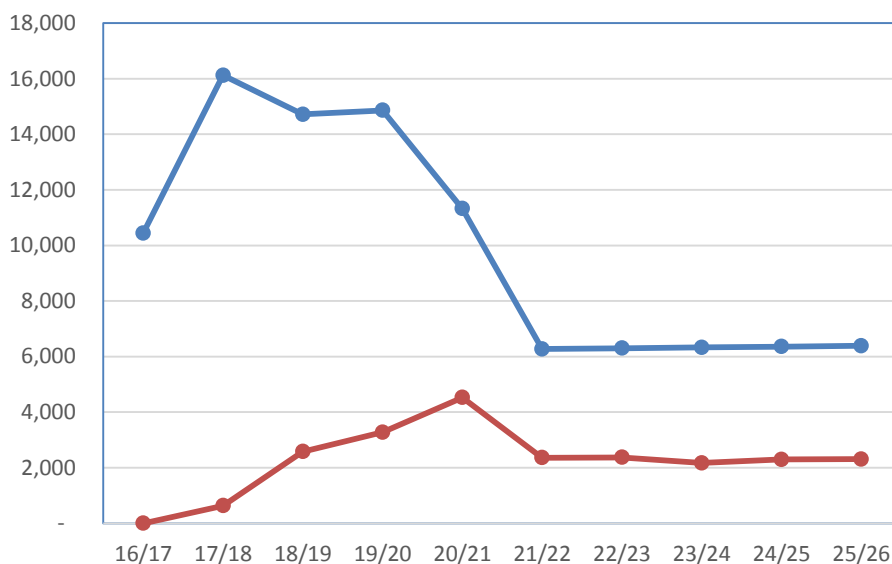
The modelling has involved and has been supported by both the NW London CCG Chairs and the Medical Directors of the SaHF Programme. It has also been reviewed by the SaHF Clinical Board.

9. Overall proportion of QIPP from OOH Hubs requiring investment

**Table 4: NEL admissions
avoided attributable to hubs**

Hub NEL Activity savings	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	Proportion
Total activity (spells) - in-year	10,441	16,123	14,715	14,861	11,324	6,274	6,300	6,327	6,355	6,384	
Total activity (spells) - cumulative	10,441	26,565	41,279	56,140	67,465	73,738	80,038	86,366	92,721	99,106	100%
Hub enabled. - cumulative	-	631	3,171	6,450	10,948	13,292	15,645	17,804	20,067	22,378	22%
Other sources. - cumulative	10,441	25,934	38,108	49,690	56,517	60,446	64,393	68,562	72,654	76,727	78%

In-Year NEL QIPP activity



Includes:
OOH hubs requiring investment (18)

Excludes:
OOH hubs not requiring investment (4)
Hubs on acute sites (4/5)

CCG estimation of the impact of the drivers of the model of care

The model of QIPP delivery through the new model of primary and integrated care was presented to NW London CCG managers and clinicians in October 2016.

CCG's confirmed the proportion of their QIPP to be delivered through the opportunity areas identified in the GE analysis that was undertaken in 2015/16 recognising that this represented a top-down estimate pending the development of the specific pathways to address each driver (opportunity area).

Split of Recurrent QIPP at 2025/26

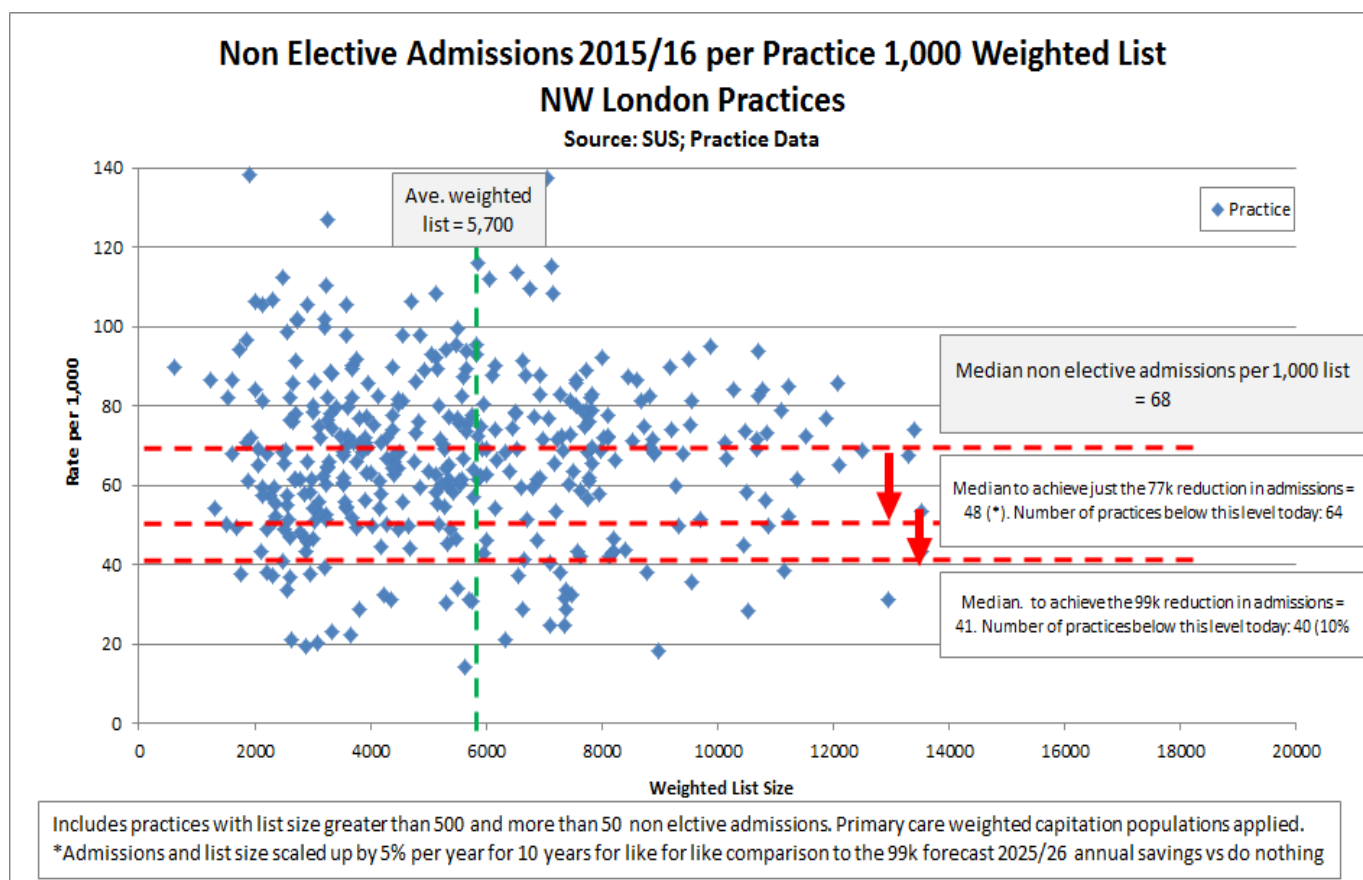
NEL admissions driver	Hub	Total
Reducing unwarranted variation in primary care	(5,500)	(22,000)
Consistent team based models of care	(7,000)	(27,000)
Long-term care planning and case management	(6,000)	(24,000)
7-day extended access to primary care	(4,000)	(18,000)
Other		(8,500)
TOTAL	(22,500)	(99,000)

10. Evidence in Support of the Scale of Opportunity for Non-Elective Admission Reduction

Analysis of the variation of the rate of non-elective admissions by GP practice has been used to test the scope for improvement. Based on 2015/16 data and extrapolating this to 2025/26 enables like for like comparison with the reductions in admissions proposed within the SOC.

Using 2015/16 admissions data and applying practice weighted populations provides the rate of admission per practice.

Applying growth the extrapolated total NEL Admissions for NW London for 2025/26 is 241,662 (before improvements).



Key features:

- The points on this chart represent each GP practice across NW London.
- The vertical axis is the number of non-elective admissions per 1,000 patients. We have used a weighted practice list which adjusts for variation in demographics.
- The horizontal axis represents the size of the practice in terms of its total weighted list size.
- The green line is the average list size per practice.

The three red lines are:

- The median number of non-elective admissions per practice per 1,000 patients, ie this is the average rate of non-elective admissions per practice.
- The next line down represents the movement in the average required so that the total non-elective admissions would reduce by 77,000. This equates to the benefit of just implementing the OOH new model of care
- The lowest red line represents where the median would need to be to achieve the total gain being proposed of 99,106 non-elective admissions.

40 Practices (10%) are already performing at or better than the lowest red line. This means 40 practices already achieve the level of non-elective admissions that all practices would need to average in order for NW London to attain the reduction of 99,106 non-elective admissions.

Using similar analysis of this data we can also show that if all practices improved to the upper quartile position (54 admissions per 1,000 weighted list size), the overall improvement would be c. 57,000 non-elective admissions.

11. Evidence base supporting the relative contribution of the capabilities of NEL savings

Driver 1: Reducing unwarranted variation in primary care (estimated 5,500 admissions avoided)

How hubs enable the admissions reduction	Relative contribution (admissions avoided)	Evidence
Physical co-location facilitates the adoption of standardised care pathways and protocols (i.e. co-located in the hub versus fragmented across regional practices)	80% (4,500)	<p>Evidence in favour of standardised care pathways</p> <ul style="list-style-type: none"> The London based primary care strategic commissioning framework sets out the case and supporting evidence for standardising primary care. The report highlights that reducing variation in assessment and referral thresholds and standardising around best practice agreed with secondary care clinicians reduces admissions¹ A literature review by the Centre for Policy and Ageing profiled several studies demonstrating statistically significant reductions on readmissions and outcomes (e.g., 66% of studies in the Van Herck et. al literature review reported a positive effect on clinical outcomes)² Patients in disease management programmes in Germany had fewer complications and incurred lower costs³ The National Audit Office found that patients receiving all recommended care pathways for diabetes varied by 30-76% across CCGs, with variation across GP practices within CCGs thought to be even higher. Standardisation of care leads to lower admissions and other adverse health events. For example, patients with diabetes of a GP Federation in North East Essex put on the integrated diabetes pathway had a 10% year on year reduction in hospital attendances and decreased readmissions of up to 32%^{4,5,6}

¹ NHS England. "Transforming Primary Care in London: A strategic commissioning framework." 2014

² Centre for Policy and Ageing, "The effectiveness of care pathways in health and social care," May 2014

³ Stock S et al. "Germany Diabetes management programmes improve quality of care and curb costs," Health Affairs 2010

⁴ National Audit Office. *The management of adult diabetes services in the NHS: progress review.* October 2015

⁵ HSJ Solutions. "Integrated Pathway Hub enables management of diabetic patients."

⁶ Diabetes UK. "Prime contracting in North East Essex: Commissioning and GP federation to deliver a vertically integrated care pathway." Service redesign case study 2: August 2015.

How hubs enable the admissions reduction	Relative contribution (admissions avoided)	Evidence
<p>Continued: Physical co-location facilitates the adoption of standardised care pathways and protocols (i.e. co-located in the hub versus fragmented across regional practices)</p>	<p>Continued:</p>	<p>Evidence that co-location in hubs facilitates standardisation</p> <ul style="list-style-type: none"> Nothing specific to UK hubs, given limited research on polyclinics to date, however international examples point to opportunity. For example, ChenMed has standardised its processes and infrastructure to reduce errors and maintain efficiency, while co-location in hubs (physicians and staff sit in open plan when not with patients) increases regular peer-review of treatment decisions⁷
<p>Patients transport to hubs is provided, which increases care plan adherence</p>	<p>20% (1,000)</p>	<ul style="list-style-type: none"> DNAs have reduced by 98% with transport to and from the St Charles hub with benefits also seen in Ealing ChenMed has a fleet of 60 multi-passenger vans serving its 36 multi-service primary care centres in 25 different cities. Up to 75% of ChenMed’s elderly patients take advantage of the courtesy shuttles. ChenMed’s centres are large specially-built hubs able to offer 85% of a patient’s care needs under one roof; the shuttle service is likely feasible due consolidation of primary care centres per city⁸

NB: The relative contribution percentages have been estimated with the input from senior clinicians and reflect the relative impact of the different factors rather than detailed numerical analysis

⁷ Nuffield Trust. “Transforming general practice: what are the levers for change?” (2015). Available at: https://www.nuffieldtrust.org.uk/files/2017-01/1484141771_transforming-general-practice-levers-change-web-final.pdf

⁸ Physician-Led Clinics Offer Integrated, Coordinated Care to High-Risk Seniors Under Capitated Contracts, Leading to Strong Performance on Quality Metrics, Low Inpatient Use, and High Patient Satisfaction”, <https://innovations.ahrq.gov/profiles/physician-led-clinics-offer-integrated-coordinated-care-high-risk-seniors-under-capitated>

Driver 2: Consistent team based models of care: Providing continuity of care (estimated 7,000 admissions avoided)

How hubs enable the admissions reduction	Relative contribution (admissions avoided)	Evidence
<p>Consistency of primary care physician and multi-disciplinary team</p> <ul style="list-style-type: none"> Specialist clinicians, palliative care, mental health clinicians, case managers, health and social care assistants, therapists, adult social care are all available on site or could be called upon for input <p>Twice daily MDT meetings will occur at the hub by co-located staff to discuss / plan for each patient individually</p>	<p>40% (2,500)</p>	<ul style="list-style-type: none"> February 2017 Health Foundation report identifies a 6% reduction in NEL admission where patients receive care from the same GP over an extended period. The paper's findings were based on inconsistency in care in both large hubs and smaller practices⁹ The Health Foundation paper found that larger GP practices in England had less consistency of primary care physician. However, evidence from ChenMed shows that large hubs can have consistency of care and reduce its hospital admissions and beddays The ChenMed model, which delivers 48% fewer hospital days per 1000 persons aged 65 than the NHS average, has a dedicated GP for each patient and a much smaller list size per GP (350-450 vs NWL average of 1,700)¹⁰. ChenMed patients are aged 50+ and ChenMed operates out of 36 purpose-built multidisciplinary hubs The Health Foundation paper also acknowledges that larger practices might ensure continuity of care in ways that their scale did not measure, such as through deliberate management of care by several GPs, and involvement of nurses and other health professionals working in a team based approach. Their recommendations include a team-based approach to care in larger practices (which a hub) might offer to confer benefits of continuity of care at the team level Taken together, the Health Foundation recommendations and the ChenMed evidence suggest the savings could be achieved by improving continuity of care through small practice teams through a hub model of care in NWL: 6% savings versus a do nothing non-elective admissions projection in NWL of 241,000 admissions equates to roughly 14,500 in annual admissions savings (not adjusted for the continuity of

⁹ Deeny et. al, "Reducing hospital admissions by improving continuity of care in general practice", Health Foundation, February 2017

¹⁰ McKinsey case study based on HES APC 2015/16 (c/o NHS Digital) and Commonwealth Fund - Transforming Care: Reporting on Health System Improvement (March 2016)

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Clinical Commissioning Groups

		<p>care already present)</p> <ul style="list-style-type: none"> North Norfolk’s integrated community team found that co-location within a GP practice was particularly helpful for team integration required for effective joint patient reviews and coordination of referrals (a significant proportion being to community-based resources). The programme saw a 3% reduction in emergency admissions with a primary diagnosis of a long-term condition within the first year of service.¹¹ Further evidence of the teams was reported in the media as reducing hospital admissions by people with a long-term condition by 13.9% in the 9 months since the team was operational.¹² Multi-Agency Safeguarding Hubs for safeguarding response for children and vulnerable adults exhibit real-time information sharing, decision making and communication and have overall better evidence of joint working than virtual links or the status quo for multi-agency work¹³
<p>Access to specialist input that would not be available in small GP practices (enables more pro-active input at an earlier stage to prevent deterioration and subsequent admissions)</p>	<p>30% (2,000)</p>	<ul style="list-style-type: none"> North East Essex integrated pathway hub created a single Diabetes Specialist Team consisting of consultants, specialist nurses, a GP, specialist midwife, dietician and podiatrists. Associated with a 10% year-on-year reduction in hospital attendances by diabetic patients¹⁴ Portsmouth’s MISSION COPD initiative integrated specialist assessment and treatment in primary care through one-stop weekend clinics hosted in GP practices, leading to an 100% reduction in hospital admissions¹⁵

¹¹ Local Government Association. *Service Integration and the Workforce*. 2014.

¹² Eastern daily press. “North Norfolk community care programme reducing hospital admissions” 14 January 2015, available at: http://www.edp24.co.uk/news/health/north_norfolk_community_care_programme_reducing_hospital_admissions_1_3917421

¹³ Home Office. *Multi Agency working and information sharing project. Final report*. July 2014.

¹⁴ HSJ Solutions. “Integrated Pathway Hub enables management of diabetic patients.”

¹⁵ HSJ Solutions case studies on Portsmouth Hospitals Trust and Wessex AHSN, Nottingham CityCare Partnership and Whaddon Medical Centre

North West London Collaboration of Clinical Commissioning Groups

<p>Co-location with Community Health, Voluntary sector and Social Care services to support end-to-end care management</p>	<p style="text-align: center;">20% (1,500)</p>	<ul style="list-style-type: none"> Evidence for social prescribing is mixed, however the Rotherham Social Prescribing Initiative evidence suggests admission avoidance rates of up to 25% among those who are connected to funded community and voluntary initiatives (see lever 3 below for further details)¹⁶ Patients of Canada’s multidisciplinary primary-care Community Health Centres which offer holistic health and social services to address wider determinants of health, had a 21% lower emergency department visit use than expected for their (typically deprived) patient group (50% lower in rural CHCs)¹⁷
<p>Point of care diagnostics offered e.g, ECG, blood tests, Spirometry etc.</p> <ul style="list-style-type: none"> Enable better management of the patient’s condition, reducing risk of deterioration and subsequent admission An adverse diagnostic result in outpatients is likely to lead to an admission that would be avoided if the result is seen in primary care and an intervention plan created there 	<p style="text-align: center;">10% (1,000)</p>	<ul style="list-style-type: none"> ChenMed uses 36 specially built primary care centres that offer 85% of all of a patient’s care needs, including diagnostics and specialist assessments, under one roof^{18,19} Innovative approaches to bring diagnostics to GP practices such as mobile CT unit and spirometry for lung health checks in Nottingham or DVT scanning in Milton Keynes reducing hospital visits and increasing early diagnosis of cancers, while improving patient experience and reducing anxiety²⁰

NB: The relative contribution percentages have been estimated with the input from senior clinicians and reflect the relative impact of the different factors rather than detailed numerical analysis

¹⁶ Dayson C & Bashir N. The social and economic impact of the Rotherham Social Prescribing Pilot: Summary Evaluation Report (2014) Available at:

<http://www.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/social-economic-impact-rotherham-summary.pdf>

¹⁷ Institute for Clinical Evaluative Sciences. “Comparison of primary care models in Ontario” (2012), available at: <http://www.ices.on.ca/~media/Files/Atlases-Reports/2012/Comparison-of-primary-care-models-in-Ontario/Full%20report.ashx>

¹⁸ Physician-Led Clinics Offer Integrated, Coordinated Care to High-Risk Seniors Under Capitated Contracts, Leading to Strong Performance on Quality Metrics, Low Inpatient Use, and High Patient Satisfaction”

¹⁹ Physician-Led Clinics Offer Integrated, Coordinated Care to High-Risk Seniors Under Capitated Contracts, Leading to Strong Performance on Quality Metrics, Low Inpatient Use, and High Patient Satisfaction”

²⁰ HSJ Solutions case studies on Portsmouth Hospitals Trust and Wessex AHSN, Nottingham CityCare Partnership and Whaddon Medical Centre

Driver 3: Long-term care planning and case management (estimated 6,000 admissions avoided)

How hubs enable the admissions reduction	Relative contribution (admissions avoided)	Evidence
Integrated care plan management	50% (3,000)	<p>Evidence in favour of integrated care plan management</p> <ul style="list-style-type: none"> Two systematic reviews of individualised care planning found an average reduction of hospitalisations of ~23%²¹ The international evidence base on the impact of case management is mixed. However there are several promising local NHS cases of care management suggesting reductions in non-elective admissions by 17-37%^{22,23,24} <p>Evidence that co-location improves integrated care plan management</p> <ul style="list-style-type: none"> Care plan management through multi-disciplinary teams can be done “virtually”, however evidence suggests that co-location provides greater productivity King’s Fund suggests that the status quo case management is not able to reach a sufficient number of people to make a difference Three of Ontario’s top-rated Family Health Teams rely on multidisciplinary open space layouts to facilitate corridor consultations and impromptu real time case management discussions through easy access to person for referral or consultation. Patients have also noticed improved information sharing and coordination in co-located practices²⁵

²¹ McKinsey and Company. *The evidence for integrated care*. 2015

²² NHS England. Right Care Casebook series 2016 (Slough CCG)

²³ King’s Fund Community services: How they can inform care. 2014 (Wigan Integrated Neighbourhood Teams project case)

²⁴ Our Healthier SEL Consolidated Strategy Draft v2.0 (2015) (Bexley Case Management Multidisciplinary Team configuration)

²⁵ Conference Board of Canada. An extended evaluation of the Family Health Team (FHT) Initiative. 2014

How hubs enable the admissions reduction	Relative contribution (admissions avoided)	Evidence
Delivery of self-care programmes for specific conditions to increase the number of expert patients.	30% (1,500)	<ul style="list-style-type: none"> Expert patient programme typically saves one inpatient admission per participant per year as well as reduced A&E, GP and outpatient visits²⁶ - An interprofessional healthcare environment, such as one created through co-location of health and social care services, tends to have patients with enhanced self-care understandings²⁷
Access to social prescribing available through the multi-professional teams at the hubs	20% (1,000)	<ul style="list-style-type: none"> Rotherham’s Social Prescribing initiative (piloted 2012-14) found a reduction of 14-21% in inpatient admissions among a subset of patients. Reductions were even higher for patients referred on to a funded voluntary/community activity (up to 25% reduced inpatient admissions) The pilot also found similar reductions in A&E and outpatient attendances.²⁸ There is no direct quantitative evidence tying together social prescribing, hubs/service co-location and admissions avoidance. However, it is noted that co-location of services (e.g. through a hub approach) increases the portfolio of services available for social prescribing²⁹ Co-location- of community Wellbeing Officers into Halton GP practices has enabled social prescribing to be conducted with people most at risk of an avoidable admission. The community wellbeing officers can identify the 2% of patients most likely to have an NEL admission to target for intervention through their participation in the multidisciplinary team meetings and reviews. They can then target their provision of psychosocial support to the most vulnerable patients³⁰

NB: The relative contribution percentages have been estimated with the input from senior clinicians and reflect the relative impact of the different factors rather than detailed numerical analysis

²⁶ Expert Patients Programme “Self-care reduces costs and improves health – the evidence”, 2010

²⁷ Canadian Health Services Research Foundation. “CHRSF Synthesis: Interprofessional Collaboration and Quality Primary Care” 2007

²⁸ Dayson C & Bashir N. The social and economic impact of the Rotherham Social Prescribing Pilot: Summary Evaluation Report (2014) Available at: <http://www.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/social-economic-impact-rotherham-summary.pdf>

²⁹ NIHR School for Public Health Research. “Does co-locating GPs and welfare advice improve health and reduce strain on the NHS?” (2016). Available at: <http://sphr.nihr.ac.uk/wp-content/uploads/2016/02/Pioneering-New-Approaches-SPHR-NIHR-Does-co-locating-GPs-and-welfare-advice-improve-health-and-reduce-strain-on-THE-NHS.pdf>

³⁰ HSJ Solutions. “Clinical commissioning group achieves 67% improvement in mental health and wellbeing of vulnerable patients through better access to community wellbeing services in primary care

Driver 4: Seven day extended access to primary care (estimated 4,000 admissions avoided)

How hubs enable the admissions reduction	Relative contribution (admissions avoided)	Evidence
<ul style="list-style-type: none"> Estimate that 3 million primary care appointments will be available annually in the hub (we roughly estimate 1-2 million of these are incremental) Additional out of hours hub capacity in primary care directly substitutes some care that would have led to an admission <p>Hub capacity also indirectly reduces admissions by improving care management (i.e. reduces the unmet need for primary care and specialist care)</p>	<p>100% (4,000)</p>	<ul style="list-style-type: none"> Recent NHS research estimated 5.77 million (99.9% confidence interval = 5.49 to 6.05 million) of A&E attendances were preceded by the attending patient being unable to obtain a general practice appointment or a convenient appointment, comprising 26.5% of unplanned A&E attendances in England in 2012-2013³¹ NHS rapid review of evidence from 4 Central London practices found that 7 day services resulted in a drop of 9.9% weekend hospital admissions. We can assume that the levers contributing to this reduction were through a) increased availability to see GPs and b) expanded hours of access, both of which will be offered through the hub model³² Department of Health 2013 report estimating that at least 1/5 of admissions could be managed effectively in the community Other regions are recognizing the potential of hubs to extend access to urgent and emergency primary care: <ul style="list-style-type: none"> Greater Manchester has several innovative examples of enhanced services to extend access to primary care for priority populations through co-location, such as a partnership with the Carers Forum in the City of Manchester for Sunday appointments. Impact evidence not available³³ Northumberland ACO is reconfiguring its emergency

³¹ Cowling TE et. Al, "Access to general practice and visits to accident and emergency departments in England: cross-sectional analysis of a national patient survey." British Journal of General Practice, 2014

³² NHS. "Can trends in public behaviour be changed? Moving from A&E to GP attendances." (2016). Available at: <https://www.myhealth.london.nhs.uk/sites/default/files/Rapid%20review%20-%20Behavioural%20insights.pdf>

³³ Greater Manchester Health and Social Care Strategic Partnership Board "Transformation theme 2 – Primary care reform delivery", February 2017

		<p>care by co-locating 24/7 secondary care services in 8-10 primary care hubs³⁴. Reconfiguration is underway and impact has not been measured</p>
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NB: The relative contribution percentages have been estimated with the input from senior clinicians and reflect the relative impact of the different factors rather than detailed numerical analysis

Summary of modelling findings

The key findings of the modelling undertaken are:

- CCG QIPP plans estimate 99k in recurrent avoided admissions over 10 years, 22k of which are estimated to be enabled by the hubs.
- McKinsey supported this work with a comprehensive review of available literature. This has added significant evidence which supports the case for the benefit of hubs and reinforced the lack of empirical evidence of a quantified causal link from the individual improvement interventions and the reduction in NEL admissions.
- The initial modelling of the benefits to be delivered by the hubs has been based on a top down assessment by the NW London CCGs and the senior clinicians working on the SaHF programme. The modelling is supported by the NW London CCG Chairs, the Medical Directors of the SaHF Programme, and has also been reviewed by the SaHF Clinical Board.
- Analysis of the variance of NEL admissions by practice within NW London demonstrates the scale of improvement required is currently being achieved by the top performing 41 practices (10% of total practices)
- Using similar analysis of this data we can also show that if all practices improved to the upper quartile position (54 admissions per 1,000 weighted list size), the overall improvement would be c. 57,000 non-elective admissions.
- The variation analysis and comprehensive compilation of supporting evidence provides a compelling case for need and benefit of the hub proposal.

³⁴ McKinsey case study

NW London JHOSC

5 December 2017

8a Improvements to local services

Introduction

Local services, or out of hospital care, broadly describes those services which are based in the community rather than in a hospital. This includes GPs, community nurses, local clinics and many of the social care services provided by local authority colleagues.

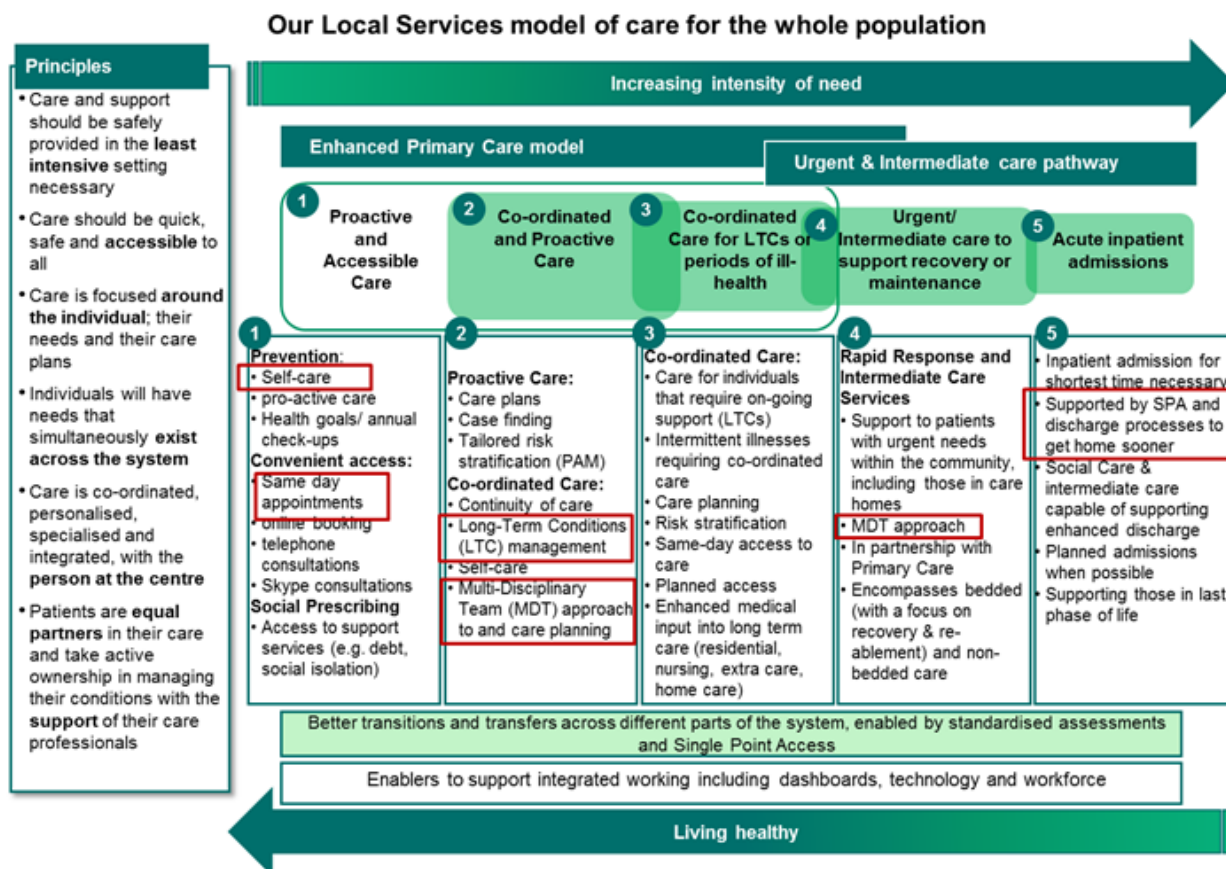
We are working with primary care to make sure that people know how to stay well and that they keep well as long as possible. However, we know that the quality of care varies across NW London and that where people live can influence the outcomes they experience. When people do need care, we want to eliminate unwarranted variation to give everyone access to the same, high quality services wherever they live. We also want to make sure that the care they receive is joined up, whether it's in hospital or out in the community.

Significant progress has already been made meaning that last month we provided 14,000 more GP appointments in NW London; nearly 50,000 residents suffering from diabetes now have a care plan to help them better manage their condition; Hillingdon's integrated care approach has contributed to a 10% reduction in hospital admissions and over 600 patients were supported to leave hospital earlier than they would have previously through Home First.

In this paper, we are highlighting six key areas (shown in red on the table below) to provide more detail on our plans and how patients are already benefitting.

Our vision for local services in NW London

The diagram below sets out our 'model of care' – the principles by which we are making our improvements and the services and approach to care that we will be taking.



To achieve this, we will make sure the following is in place across NW London:

- Online booking for primary care appointments
- A Single Point of Access for Intermediate Care and Rapid Response Services
- Weekend GP appointments
- Tailor-made care; care plans, accessible by whole multi-disciplinary teams (MDT) so that patients only have to tell their story once
- Care that is planned with people who work together to understand the individual and put them in control; support addresses physical and mental needs in tandem.
- A single common discharge process to make stays in hospital as quick as possible, with patients receiving assessments and care where they need it
- At least 7000 GP appointments per week, available throughout the week
- State of the art primary care hubs – providing a range of community services in one convenient place
- Care homes have direct access to local community treatment teams avoiding unnecessary hospital admissions

What the improvements will mean for patients



Marion has diabetes, and her care plan has been tailored to suit her needs. As she wrote her own health goals with her care coordinator, Marion has a good understanding of her condition and how to manage it. Marion has a high patient activation measure (PAM) score; she is able to manage her own condition, and knows who to contact for advice, support and healthcare.



Miriam works full time and has two young children; she doesn't find it easy to access her GP. With the new local services hubs close to her home, she can visit her GP for her children's health checks at the weekend, when it is convenient for her.



Marvin is 72 and has two complex conditions: diabetes and atrial fibrillation. He is able to see a nurse to support him in self-managing at home, but also utilises social prescribing so he can access activities such as arts classes at his local social centre. By co-ordinating Marvin's social needs, his wellbeing is managed, and he feels more in control of managing his conditions.



Michael, 83, lives in a care home in Brent. When he had a sudden fall, his key worker called the local STARRS team who came out to care for him within two hours; when he next saw his nurse, his records had already been updated and he was able to modify his care plan accordingly. He is now seeing a specialist who is helping him get better, quicker.

Highlight area 1: Access to GPs

All NW London residents can now access primary care services seven days a week (either at their own practice or hub). These additional appointments will soon enable patients to be redirected from urgent care centres to primary care services with a specified appointment, saving them time waiting to be seen at an urgent care centre.

The Five Year Forward View and the General Practice Forward View emphasise the need to extend access to general practice services. We were part of the Wave 1 pilot funding from the Prime Minister's Challenge Fund. By March 2015, 2.1m residents benefited from improved access, including e-prescribing, federation development, IT transformation, in addition to extended access.

Progress

£4.12m was invested in the GP Access Fund in 2017/18 (from NHS England), plus additional £1.7m CCG funding, for staff, IT systems and communications. Across NW London there are **837 hours** of extended access in operation per month (as of June 2017), allowing access to primary care services seven days a week.

We achieved the NHSE target in advance of the deadline set; we now have 7 day extended access, and are aiming to target 90% hub utilisation (100% booked/10% DNA). Once hub utilisation increases we will evaluate potential for further impact on A&E attendances.

Last month we offered an additional 21,000 appointments in NW London. On average there is a 60% usage of these extra appointments across NW London:

- Central: 2338 appointments (63% utilisation)
- West: 2327 appointments (45% utilisation)
- H&F: 1926 appointments (70% utilisation)
- Hounslow: 3523 appointments (57% utilisation)
- Ealing: 3102 appointments (60% utilisation)
- Brent: 6953 appointments (55% utilisation)
- Hillingdon: 542 appts (70% utilisation)¹
- Harrow: 590 appts

¹ figure is due to increase with additional hubs

We have raised awareness of the availability of these appointments with patients through leaflets and posters in surgeries, social media activity, press releases which resulted in coverage in local papers across NW London and via our community engagement programme.

Next steps

In addition to direct booking, implementing improved staff & patient communications and text reminders to increase utilisation, direct appointment booking from 111 and weekend redirection from all Urgent Care Centres (UCCs) into all available primary care access slots will be live by January 2018. We are aiming for all of our residents to have a better experience of service by having accessible, localised primary care services on offer across the sector.

Highlight area 2: Diabetes care

Over 130,000 patients in NW London have diabetes– approximately 90% Type 2 (diet and lifestyle disease) and 10% Type 1 (autoimmune condition) – with a smaller proportion who have other or undefined diabetes too.

At any one time over 30% of hospital beds have people with diabetes in them costing over £340m annually in NW London - ten per cent of our overall NHS spend. Evidence has shown that a stay in hospital for people with diabetes leads to longer stays and a need for more complicated discharge planning than those without diabetes. Over 1000 people annually die early due to diabetes; it accounts for 30% of emergency admissions to hospital; and over 28,000 of our residents are living with poor diabetes control.

By 2020/21, we will have prevented considerable numbers of people from moving onto Type 2 diabetes and established tangible reduction in unwarranted variation in clinical care.

We have been developing diabetes services for several years, including ~£2m investment across CWHHE CCGs in diabetes prevention in 2016/17. The pan-NW London transformation programme builds on this work including use of digital technology, innovative approaches to self-management and we are also redesigning the diabetes foot pathway across the 8CCGs.

Progress

- 23,000 people with diabetes are now achieving all diabetes checks.
- 5,000 more people have a blood sugar level that is controlled (which will prevent complications)
- Over 20,000 people now monitored for hypoglycaemia (diabetes emergency where blood sugars fall to dangerous levels)
- Nearly 50,000 have developed a care plan with their nurse or doctor so they know how to manage their diabetes.
- Diabetes management digital pilot: We are trialling the use of phone apps to understand the impact this has on self-management, initial evidence has shown that this helped 22% of people with type 2 diabetes to go into diabetes “remission” and could reduce their medication. Three diabetes self-care apps have been commissioned and a pilot has taken place with ~500 patients. £50k was invested in this pilot and we are currently evaluating this pilot through Imperial College Health Partners. This is expected to be complete in December 2017.
- Improvements in diabetes care outcomes through the use of an award-winning diabetes dashboard which allows GPs to actively monitor and support our residents with diabetes. This is included in the appendix of this paper.
- KnowDiabetes website launch at World Diabetes Day (Nov 2017); an integrated system for patients and clinicians for education and self-care. (www.knowdiabetes.org.uk)

Next steps

- Development of integrated specification
- Development of standardised integrated guidelines across our eight CCGs
- Diabetes Foot Pathway redesign
- Diabetes Hospital Care Project
- Expansion of the National Diabetes Prevention Programme to BHH CCGs (CWHHE already most successful in England)
- Digital prevention programme pilot - from Nov 2017 (First in England)
- Working towards an integrated care data warehouse including primary, secondary and social care data. (We will be piloting this for London.)

Highlight area 3: Self-care programme

We want to improve the quality of care for individuals, carers and families, empowering and supporting people to maintain independence and to lead full lives as active participants in their community.

Progress

We have been working on improving individuals self-care over the last two years and are embedding an asset-based approach and strategic self-care framework as a commissioning tool.

Self-care digital health apps: Working with the diabetes programme to support diabetes digital self-management is underway. Additionally, MyCOPD is being implemented (at no cost), which is currently the only NHS digital approved health app for people living with COPD, to 20% of our population in NW London by April 2019.

Patient-centred tailoring of Self-Care (PAM): Research shows that people with a higher patient activation measure (PAM) score use hospital services less frequently. By supporting our GPs to monitor people's PAM score, we will be able to identify what level people are at and so tailor services to suit their needs, and work with them to feel more comfortable managing their condition; thereby increasing their PAM score. All patients with a long term condition will have a PAM score and a tailored self-care approach by 2021.

PAM has been running for 12 months across NW London, with over 13,000 PAM licenses in use currently. Harrow CCG has the highest usage, and PAM is a fundamental part of their integrated care programme. The NW London target for 2017/18 is for over 60,000 patients to receive a PAM assessment with plans in place to incrementally increase to 430,000 by 2020/21. Carer PAM, to support people who lack capacity, is being piloted within Harrow Social Care to support carer assessments.

Social prescribing to support self-care: We are developing a consistent approach with HLP to support social activities for people with long term conditions through scoping out current provisions and identifying gaps to support. This includes rolling out the i5Health economic tool and supporting local boroughs with the Department of Health funding applications.

Self-care campaigning at scale: We will undertake an evidence review of local campaigns and roll out best practice to the rest of the sector, this year we supported the Know Your Numbers campaign with five boroughs participating and are supporting the evaluation to gain a NW London wide commitment for 2018.

Next steps

- Further roll out of self-care digital apps including MyCOPD app roll out to 20% of population by 2018/19
- Continued increase of patients with PAM assessments: 60,000 target for 2017/18
- Establish social prescribing pilots where gaps are identified in NW London and support expansion of the current provision
- Key campaigns delivered at a NW London level within 2017/18 based on best practice evidence and need for the population of NW London.

Highlight area 4: Whole systems integrated care

NW London set up the Whole Systems Integrated Care (WSIC) programme in 2015 to support holistic, patient centred care for our whole population.

Progress

As a national pioneer, we have taken this work programme forward to be locally embedded according to local population needs. Two areas in particular have shown a real difference in patient outcomes and have begun evaluation of their models; West London and Hillingdon.

22% of people over age 65 in West London are enrolled in case management and Hillingdon's Care Connection team has contributed to a 10% decrease in the hospital emergency admission rate for the same population group, meaning that more people are proactively cared for in the right place, their home.

My Care My Way, West London CCG: This coordinated care initiative, based at St Charles hub, has begun to shift health service delivery from reactive disease management to a proactive promotion service, meaning our residents are receiving better care with better health outcomes. To date, 24 GP practices have enrolled, targeting 4,360 patients over age 65. Although the full quantitative evaluation is underway, the initial qualitative evaluation in October 2017 found that patients interviewed had not had a health crisis since enrolling on the programme. GPs also reported working more effectively, and a reduction in GP appointments for complex patients has been found.

Next steps for West London

- Develop the disease management and self-care/health promotion functions
- Develop supporting analytics to ensure we have evaluated the programme and share best practice and outcomes to the rest of the sector

Care Connection, Hillingdon CCG: The Care Connection Team includes a GP, Guided Care Matron and Care coordinator, working with an average case load of 50 to 60 patients, to provide active case management to patients aged 65 years and over. Patients are identified proactively via risk stratification and local practice intelligence. A multi-disciplinary team function is embedded in weekly 'huddles'. To date, 44 GP practices have participated, with each team allocated based on the list size of people aged 65 years and over. The approach has shown a ten per cent reduction in A&E attendances and emergency admissions for this cohort of patients since 2014/15, meaning more patients are now being cared for in the right place at the right time. The results have also increased GP clinical capacity.

Next steps for Hillingdon

- Service implemented but not yet at full case load, so plans are in place to expand the service.
- Operational impact will be measured, including the impact on existing community based services.
- The initial focus has been on older people but the active case management model could be expanded to other age groups or clinical conditions

Highlight area 5: Intermediate Care – London Ambulance Service (LAS) prevention of admission pathway

Too many people get taken by ambulance to hospital when other services could better meet their needs. We have therefore been working with the ambulance service to ensure they are able to refer directly to the most appropriate service.

Progress

We have created a single LAS protocol for non-conveyance that was outlined as a priority for 2016/17 by the NW London Intermediate Care and Rapid Response working group. Providers and commissioners worked collaboratively with LAS to produce the NW London Prevention of Admission pathway. The pathway was signed off by NW London Clinical Board in March 2017. In July, we launched an enhanced communication strategy to increase awareness and utilisation of pathway by LAS. Since then, we have been working with LAS, commencing ride-outs, shadowing and training between rapid response providers and LAS crew. This has enabled services to better understand each other and work together more efficiently.

In this financial year, we have seen a 51% increase in LAS referrals to rapid response services across NW London compared to the same period in 2016/17. In total, there have been 573 referrals by LAS accepted by rapid response services across NW London (this year, up to November 2017).

Next steps

- Review impact of comms campaign
- Rapid response metrics dashboard to support further improvement
- Online information and training resources for LAS crew to embed knowledge and awareness of NW London appropriate care pathways

LAS Case study

An 82 year old female referred with decreased mobility, had a fall, presented with a minor facial graze. Assessment suggested minor pyrexia, otherwise nil else of note in LAS observations. Full mental capacity. LAS called rapid response, spoke to Duty Co-ordinator and GP on duty who agreed to visit within the hour. Agreed with paramedic patient safe to be left at home. Nurse and OT arrived to complete initial assessment. Patient's obs rechecked and urine dipped – there was evidence of a UTI.

A nurse practitioner prescribed antibiotics and the facial wound dressed by Nurse. An OT functional assessment completed, which identified the need for care as well as change in home environment to ensure patient safety during an acute episode and to reduce the risk of further falls. Equipment needs were identified and an order was placed via Medequip for same day delivery.

A handyman called in to create microenvironment downstairs and install key safe. A package of care arranged to start within 24 hours. Rapid Response support was instigated to bridge care gap over next 24 hours and support with hydration, nutrition and blood sugar monitoring.

Highlight area 6: Older People's Care – Home First

One in three patients sat in a hospital bed today are medically fit to leave the ward. In NW London we are working to ensure that our patients return home from hospital as soon as medically fit, with the right support in place. NW London clinicians, social care providers and local voluntary organisations are piloting a new approach to the hospital discharge process called 'Home first'.

For every day an older patient stays in a hospital bed, they can lose 10 per cent of their muscle strength because they are not following their usual routines. 'Home first' aims to reduce length of stay for elderly hospital inpatients and reduce their risk of requiring residential care. Elderly patients have their health and social care needs fully assessed at home rather than while they are still in hospital, with additional support in place at home if required. This leverages integration of health and social care teams in hospital and community.

All Trusts now have a Home First pathway that they have piloted and we are working to ensure that this is scaled up and all patients are able to start benefitting from this approach.

Progress

- All eight boroughs have designed and tested a new Home first pathway – now focused on implementation and sustainability.
- Over 600 patients have been discharged in line with Home first principles in initial six months of project delivery (as of 14 November 2017).

Borough	Total patients discharged via Home first
Brent	146
Harrow	61
Ealing	129
Hillingdon	190
Hounslow	16
Tri-borough – Chelsea & Westminster	31
Tri-borough - Imperial	36
TOTAL	609

- Evaluation of 8 week pilots in four boroughs showed at least a 2 days length of stay reduction per patient.
- NW London Trusts participated in a national Day of Care audit in October which will be used to support demand and capacity modelling, agree realistic KPIs and help identify bottlenecks and inform future focus areas for improvement work.
- Home First at Hillingdon Hospital has supported £100k investment from the acute trust in community and social care partners to provide extra community capacity over winter. A Memorandum of Understanding has been agreed in principle between health and social care partners in to enable full roll out of Home first.

Next steps

- Wider roll-out and spread of Home First into 'Business as Usual'.
- Continued implementation of trusted assessor model.
- Continued increased of assessment of CHC patients outside acute setting.
- Full implementation of shared social care function across NW London, to be integrated into a true MDT team around each ward.

Home First case study

Meet Joy

Joy, 94, a retired charity volunteer, was admitted to Hillingdon Hospital following a bad fall at home.

A referral to 'Home first' meant that she was home two days earlier than she would have been before this new way of working started.

Following Joy's return home the rapid response team visited her within two hours. They assessed Joy's abilities in carrying out daily activities such as: washing and dressing, and getting around the house, and provided her with equipment to aid her at home.

Someone from local charity Age UK accompanied Joy home. Joy tells us: *"It was decided that it would be better if I slept downstairs so they moved the bed downstairs for me; they provided a commode and put a new seat on the downstairs toilet."*

Other services that helped Joy include social services, physiotherapy, and a district nurse. She continues to receive regular visits from physiotherapy to help build back her confidence and independence in her own home.

Dr Daniel Sommer, specialist in older people's care and 'Home first' project lead said: *"As a doctor specialising in the care of older people, it is incredibly frustrating seeing my patients unable to return home as soon they are ready to do so. With 'Home first' I am really excited to know that patients will be able to leave the ward when they are ready and that we can provide real support to aid their recovery at home."*

Joy adds: *"I am very happy, this experience has been unexpected and overwhelming but I am eternally grateful for the help that I received."*

CCG	Network	Values											
		Diabetes register	% 9 key care processes in 15m	% Controlled NICE targets (HbA1c, BP, lipids)	% HbA1c ≤ 53 in newly diagnosed	% HbA1c ≤ 58	% BP ≤ 140/80	% Chol ≤ 4	% Care planning in 15m	% Hypoglycaemia monitoring	% Structured education in newly diagnosed	Non-diabetic hyperglycaemia register	NDH: diabetes ratio
Central	Central	2338	53.3	18.4	67.0	59.1	62.9	38.4	64.2	76.3	65.4	1766	0.76
	North	3380	47.1	19.0	66.9	57.2	60.0	40.8	56.8	66.2	60.0	2546	0.75
	South	2280	55.3	20.0	66.5	60.5	65.7	38.3	63.5	79.9	68.8	1370	0.60
Central Total		7998	51.2	19.1	66.8	58.7	62.5	39.4	60.9	73.0	64.4	5682	0.71
Ealing	South Southall	4845	47.3	18.1	63.3	53.5	63.5	40.3	71.3	87.4	66.3	3796	0.78
	Acton And Chiswick	3223	61.0	21.3	71.7	62.8	66.1	41.7	78.5	89.2	71.3	2740	0.85
	Central Ealing	2425	55.8	25.1	73.6	65.2	69.0	43.5	78.8	89.9	73.2	1980	0.82
	North Southall	7743	51.1	17.8	62.8	56.8	64.3	40.7	70.4	79.0	74.0	4744	0.61
	South Central	2092	41.4	22.0	64.0	60.9	64.6	41.4	63.7	75.9	67.7	1481	0.71
	South North	3768	55.9	20.5	66.4	60.1	67.9	45.0	69.1	74.4	68.1	3222	0.86
	North North	4626	59.9	21.9	64.8	58.6	66.7	43.5	74.2	87.3	81.6	3918	0.85
Ealing Total		28722	53.3	20.2	65.6	58.7	65.6	42.1	72.1	82.9	72.2	21881	0.76
H&F	Central	3805	52.0	21.2	71.2	59.6	60.2	44.9	70.6	84.9	54.9	2809	0.74
	North	2452	47.8	17.6	67.5	54.2	65.0	37.8	69.1	83.4	59.1	1415	0.58
	South	2381	38.3	18.3	68.0	59.8	58.5	40.3	58.2	78.8	54.0	1868	0.78
H&F Total		8638	47.0	19.4	69.2	58.1	61.1	41.6	66.7	82.7	55.7	6092	0.71
Hounslow	HoH	5602	65.7	21.3	68.6	60.2	66.8	43.9	77.7	94.5	79.5	5919	1.06
	Brentford	3258	55.8	19.7	70.9	63.0	59.5	40.6	71.9	82.1	73.0	3283	1.01
	Feltham	4373	64.1	21.2	65.3	58.4	69.3	40.6	79.9	90.2	79.1	3086	0.71
	Chiswick	1624	63.4	23.4	71.7	63.5	70.7	41.4	77.6	90.7	77.1	1833	1.13
	Great West	4838	57.7	17.8	63.2	57.4	63.1	39.2	69.4	85.8	69.9	4376	0.90
Hounslow Total		19695	61.6	20.3	66.8	59.8	65.6	41.3	75.2	89.1	75.8	18497	0.94
West London2	North	4085	59.4	20.3	68.3	57.8	65.4	42.4	70.6	83.9	74.4	3261	0.80
	North Central	2429	49.5	18.9	63.9	58.6	66.6	38.9	70.2	84.3	67.2	1056	0.43
	South East	1402	50.1	20.8	73.4	64.7	62.5	41.2	62.8	84.4	65.2	762	0.54
	South West	2448	52.3	20.4	64.3	57.3	65.6	38.9	71.5	87.1	63.1	1648	0.67

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NW London JHOSC

5 December 2017

5.3b Benchmarking and indicators for making changes at Ealing Hospital

8b Data needed to assess how changes are impacting on patient care

Introduction

At the last JHOSC meeting, we discussed how we will know that it is safe to make changes at Ealing Hospital when the appropriate time comes.

Our approach to the transformation of Ealing Hospital will follow the same process to the transformation of maternity and paediatrics which have been completed. We have summarised this approach below as this demonstrates, with real examples, that we ensure that the system is fully ready for a change before any change is made and that appropriate indicators are identified so we can measure impact on patients and the system.

We remain committed to a full engagement process with regard to all aspects of our transformation plans, and that will include on the indicators that we will use so these have not yet been finally defined.

SaHF approach to Maternity and Paediatric transitions

The approaches to these transitions were in line the fundamental principles that have always underpinned Shaping a Healthier Future:

- Changes are led and owned by local clinicians;
- Patients and the public are given regular opportunities to inform the development of our work, including the way in which we communicate with them;
- Expert programme management is undertaken with robust planning and risk and issue management to ensure change is delivered effectively and sequentially;
- Implementation does not conclude at transition date. It is important to recognise that post decision and service transition, on-going work is required to ensure new or updated ways of working are fully embedded and are operating effectively, that performance is tracked and issues jointly resolved, and that regular communications are maintained, with a particular focus on improving knowledge of NW London health services and the benefits achieved through service changes.

Sequential planning of changes is key to ensuring an optimal approach to transition. The critical path for the transition of maternity and paediatric services from Ealing Hospital was based on:

1. Ensuring physical and workforce capacity at all receiving Trusts;
2. Implementing a revised clinical model to reflect the changes to pathways while ensuring women and children received the same or enhanced access to care;
3. Delivering clear and targeted communications with stakeholders and the public and;
4. Ensuring staff at Ealing transitioned effectively to receiving Trusts.

Governing principles and ways of working were established up front, with governance and operational groups set up across the main service planning elements:

- Activity modelling
- Clinical planning
- Operational planning

- Operational readiness
- Transition of services
- Review and on-going monitoring.

The SaHF programme ensured activity modelling analysis and scenario planning was undertaken to forecast the impact of the service changes. The maternity modelling focused on forecasting changes in birth activity across NWL Trusts, the need to increase the midwife to birth ratios, bookings at Ealing Hospital and number of hours of consultant presence on labour wards. To predict how many additional patients would go to the five hospitals after Ealing children's ward and children's A&E closed, the team looked at where patients were likely to go based on geographical location and used the results of a survey which asked people where they were most likely to go. Additional capacity requirements were predicted for the five hospitals based on the higher of these numbers to ensure all hospitals would have enough space to care for additional patients. The proposed approach for paediatrics was to plan for 127% of activity as a result of the changes at Ealing hospital – in other words, all of the existing activity from Ealing as well as 27% more.

The programme also ensured that a standard model of care for services was implemented across NW London. There was a phased operational approach to ensure that the transition was safe and sustainable. The approach ensured that children receive a consistent approach to care across the hospital sites but allowed for local nuances to be incorporated into the paediatric pathway.

Full engagement of clinicians in implementation planning and delivery helped to enable smooth, effective and safe transition of services. The paediatric pathway development process and scenario testing meant that those involved felt confident that the new pathways were robust.

The resulting changes improved care for women, children and their families in NW London, The 2017 review of the transition of children's inpatient and A&E services from Ealing Hospital found that:

- Changes occurred safely - despite all sites in London reporting unseasonably busy demand all units managed the transition effectively with no serious incidents reported.
- Almost all activity seen has been within the limits modelled.
- Robust operational management arrangements were in place throughout the transition across the sector and continue to provide oversight and support as the new model of care embeds.
- Changes resulted in improvements to children's care throughout NW London - over 90 additional children's nurses were recruited in NW London by September 2016 and four of the major hospitals now provide senior consultant cover up to 10pm. Four new Paediatric Assessment Units ("PAUs") were opened for children who arrive needing assessing and treating but not an overnight stay in hospital. Our major hospitals are now meeting the majority of relevant Acute Care Standards for Children and Young People.
- Significant extra capacity - 27 extra children's beds - was put into the relevant hospitals in NW London resulting in a significant decrease in the number of children who needed to be transferred outside of NW London to receive care post transition.

Lessons learned documents as well as reviews have been produced for both programmes of work to further refine our approach and ensure success. These are both available online.

In conclusion, we believe that the approach taken to maternity and paediatric transitions has been proven to work, and will be replicated for future service transformations.

Making changes at Ealing Hospital

We have been very clear that no changes will be made until we know that we have sufficient alternative capacity in place in the community and at our receiving trusts, and that our local services plans are working for patients – are the community service improvements impacting on hospital activity as expected? Are more people being kept well for longer? Are people treated closer to home when they need it? Are fewer people admitted to hospital unnecessarily?

To monitor that, we expect to look at some key metrics such as:

- Reduction in occupied bed days
- Non-elective admissions
- Length of stay
- Capacity of A&E to manage attendances
- Capacity to manage admissions, including critical care capacity.

In SOC1 we have predicted a reduction in emergency admissions following the development of new models of care and hub premises within the community. Additionally, capacity is also linked to how long patients stay in bed, and there are initiatives planned to reduce this and to make sure there is support to enable patients to return home as soon as they are medically fit. More detail on progress on hubs, local services and initiatives such as Home First can be found elsewhere in papers for this JHOSC meeting.

When changes happen, we expect to have already made positive reductions in hospital activity – both admissions and occupied beds. This will mean fewer people are requiring hospital treatment which enables a reduction in bed numbers.

We will also need to be assured of the wider NW London system readiness to absorb any remaining Ealing activity, looking at:

- Capacity of out of hospital to absorb any further activity as a result of changes at Ealing Hospital
- Capacity in our receiving hospitals to manage the level of activity still being seen in Ealing at the point of transition, including likely future demand
- Flexibility of the system to cope with peaks in demand – both at busy times of the day and during busy winter periods.

These elements will initially be evidenced within the Outline Business Cases and Full Business Cases, which are the final opportunities prior to committing to the building changes. The final decision regarding the changes to the services will follow that and will be based on the actual activity and capacity at that point in time.

As we have said previously, as part of our engagement around changes to Ealing Hospital, we will be speaking to people about what metrics we look at. We welcome your input now and as that engagement continues.

In addition to these metrics, which are specific to making safe changes at Ealing, our joint working on local services has been exploring metrics for outcomes relating to older people. Appendix 1 sets out the thinking to date.

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Proposed Outcome overview Care of the elderly Delivery Board

Executive summary

Proposed overarching outcome measures for delivery area

Ask of DA3 programme board:

Agree or refine proposed measures

November 2017

West
London
Alliance



IMPROVING OUTCOMES FOR WEST LONDON

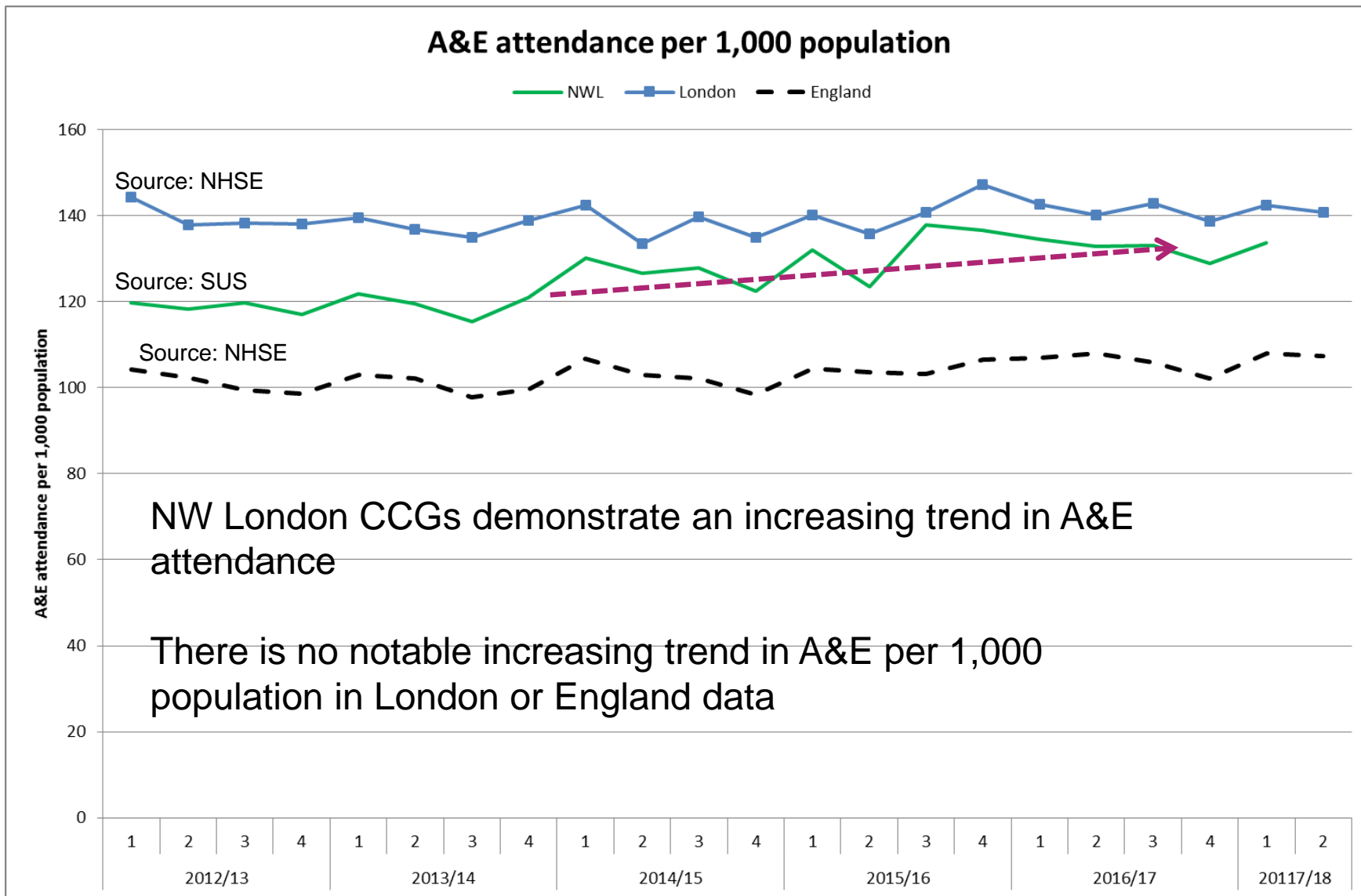
NHS

North West London
Collaboration of
Clinical Commissioning Groups

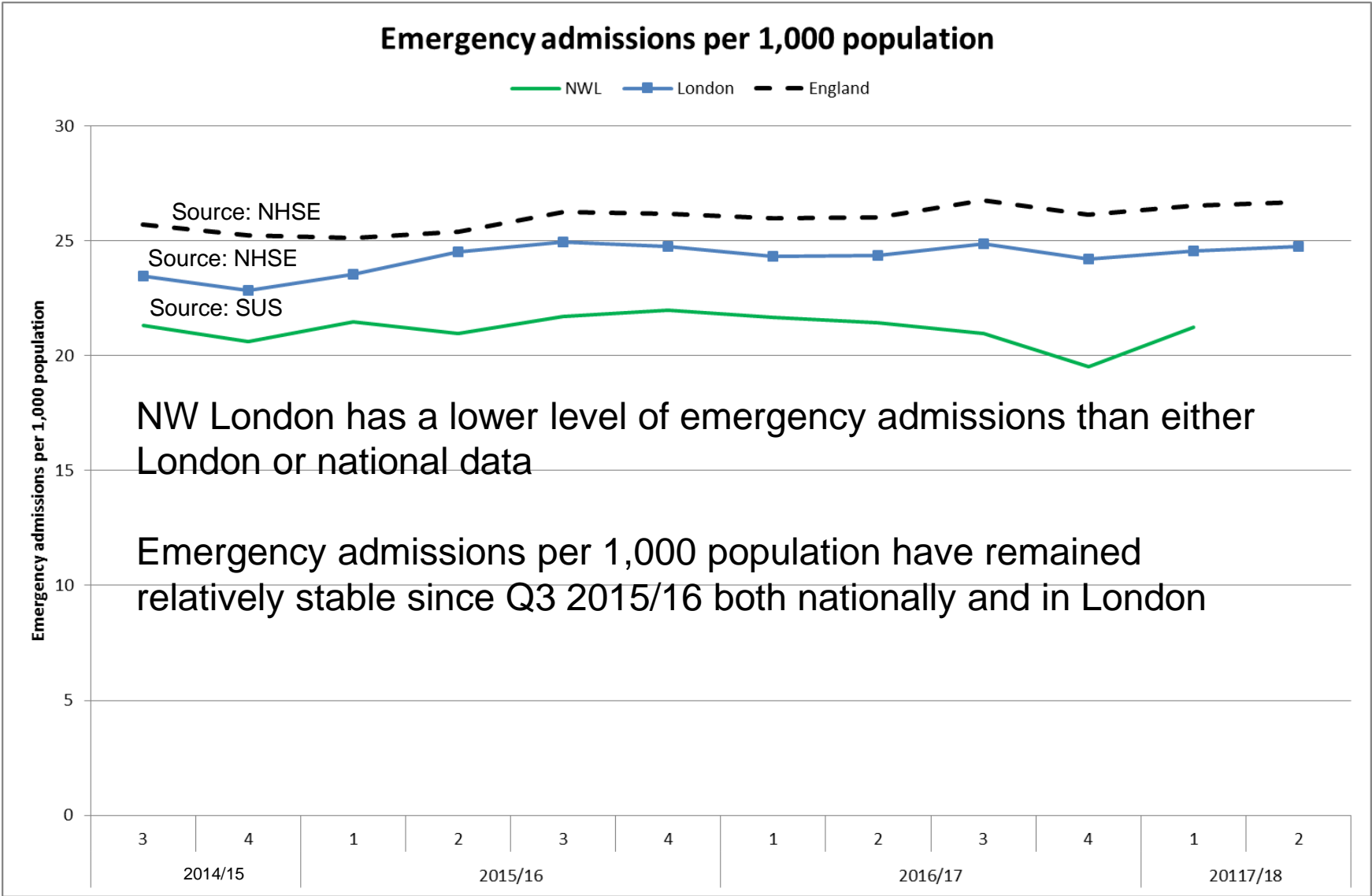
Background and context for delivery area

DRAFT

A&E attendance per 1,000 population



Emergency admissions per 1,000 population



NW London has a lower level of emergency admissions than either London or national data

Emergency admissions per 1,000 population have remained relatively stable since Q3 2015/16 both nationally and in London

Standardised Hospital Mortality index (SHMI)

DRAFT

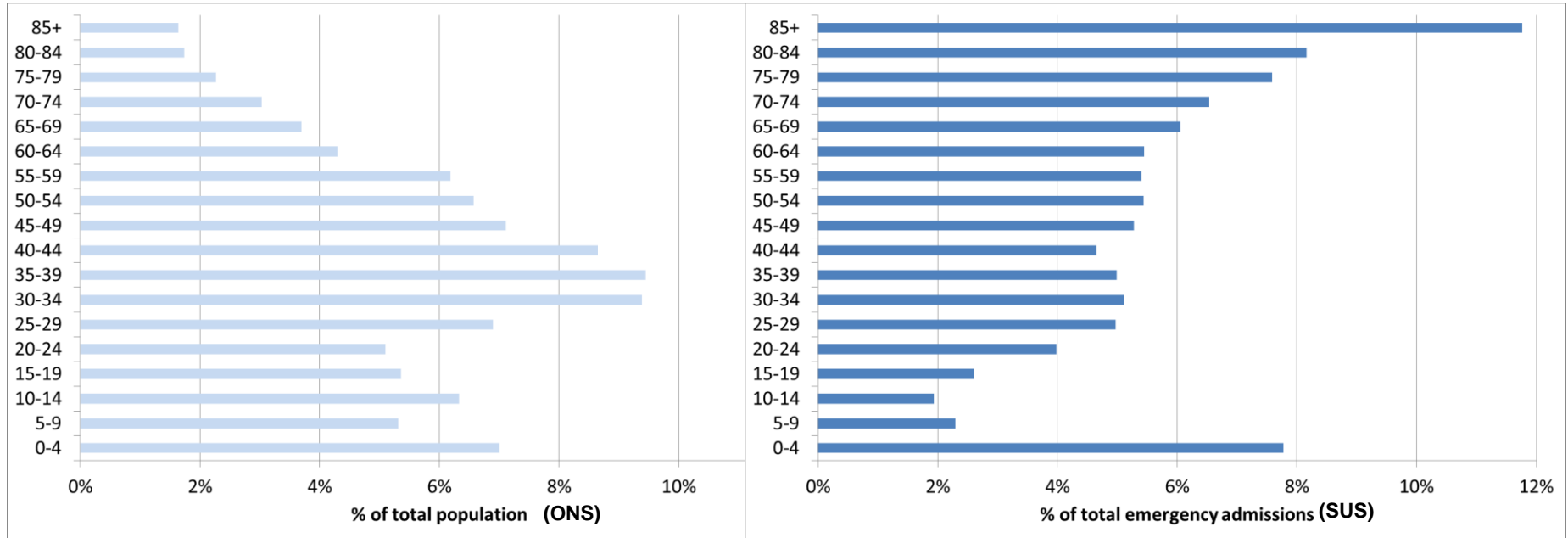
This data is available at trust level only

← Observed mortality lower than expected Observed mortality greater than expected →



Age structure and emergency admissions 2017/18

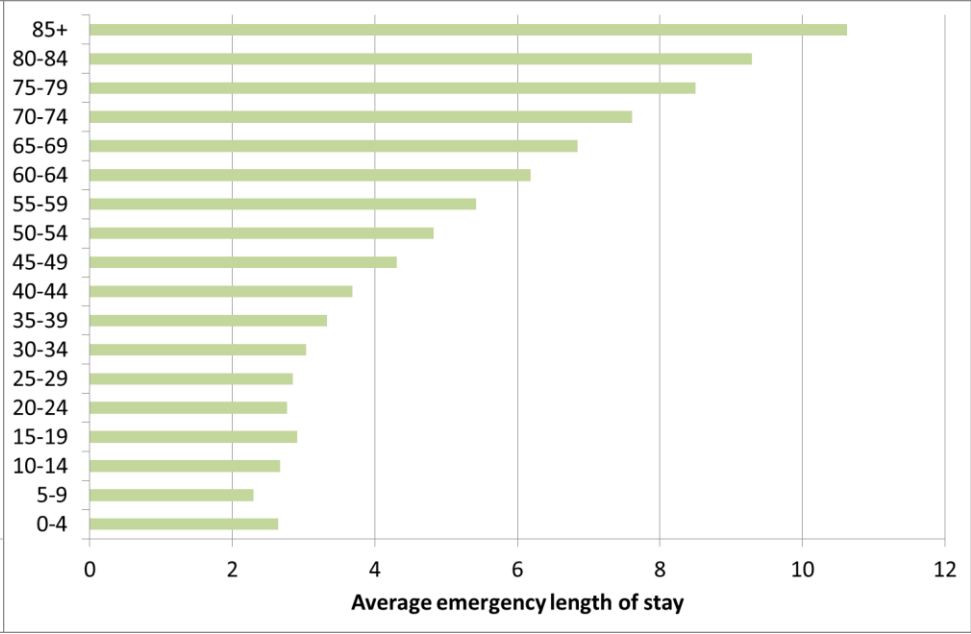
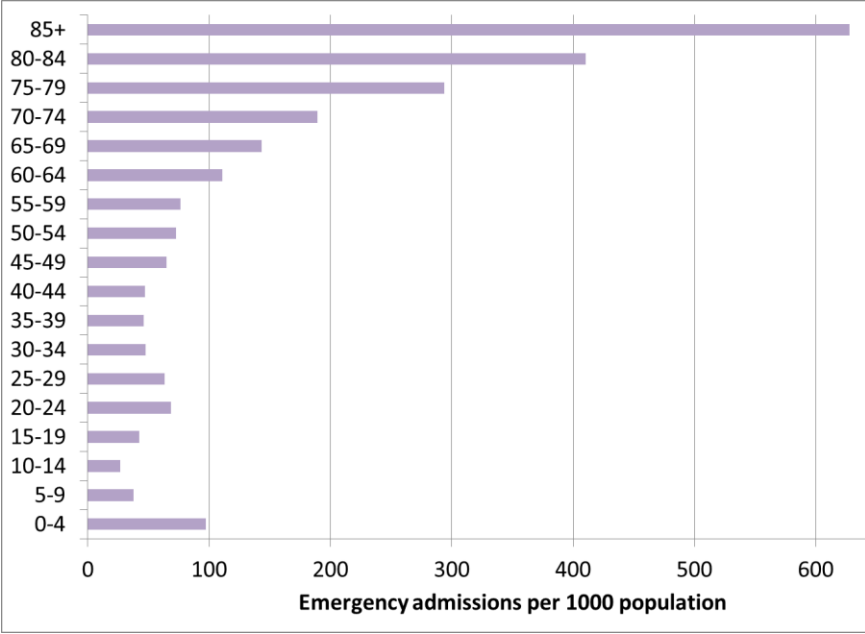
DRAFT



12.4% of NW London's population are 65+
40.1% of NW London's emergency admissions are from the 65+

1.6% of NW London's population are 85+
11.8% of NW London's emergency admissions are 85+

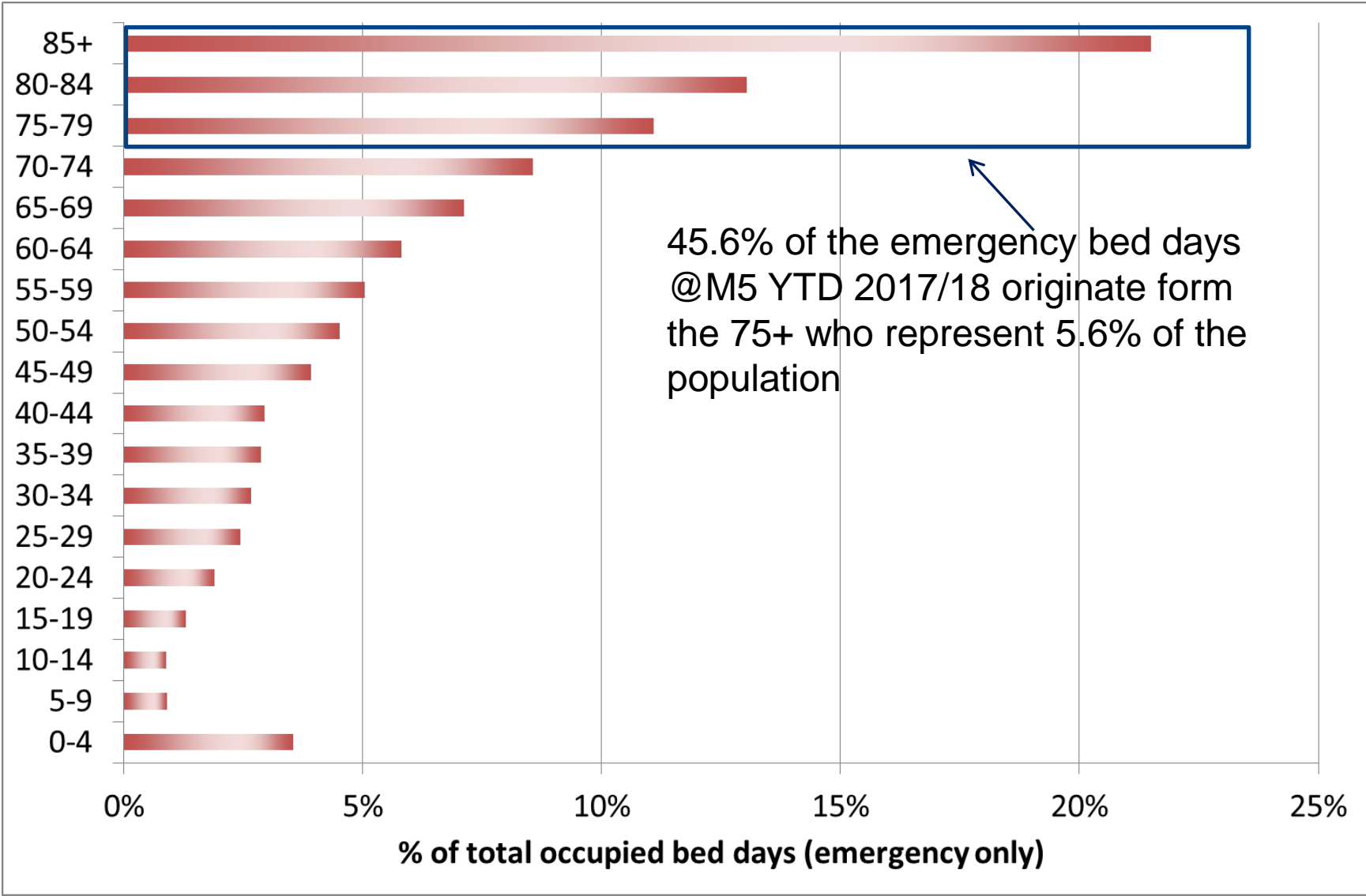
Emergency admission rate and average length of stay 2017/18



Logic following on from age structure and NW London’s emergency admissions demonstrates that the rate of emergency admissions per 1,000 population increase with age, significantly so for the older age groups.

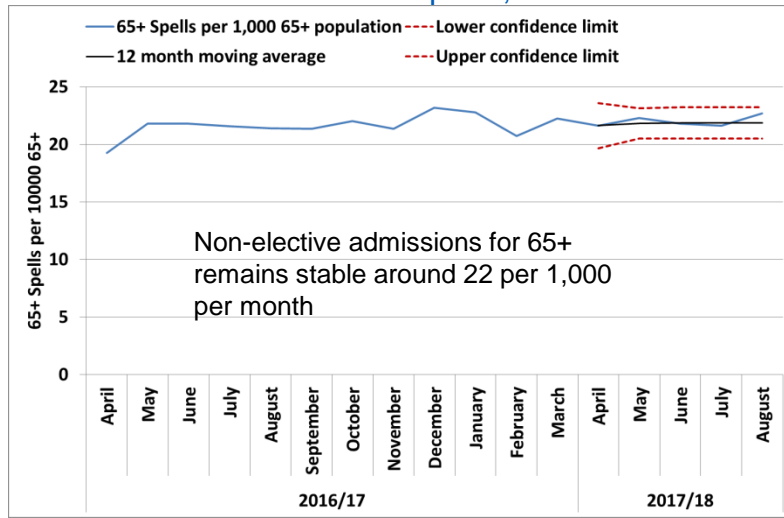
It’s also true that average length of stay increases with age as well, meaning the number of bed days generated by older people is disproportionate to population size

Emergency occupied bed days

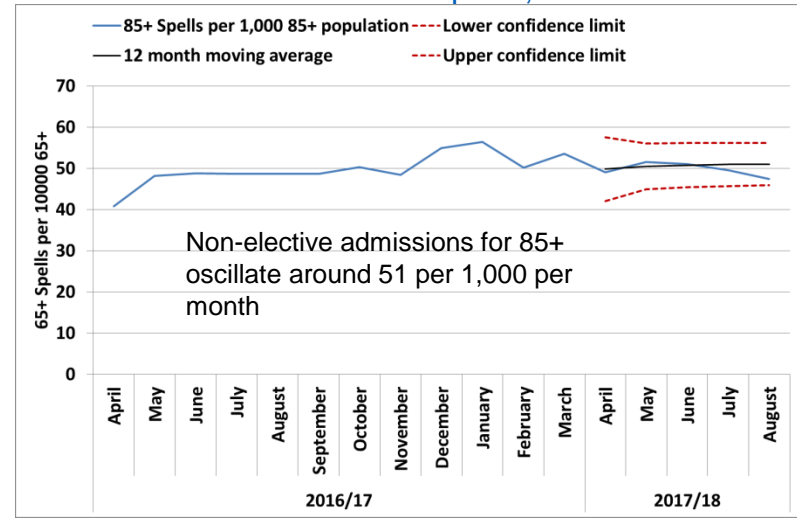


Proposed outcome overview

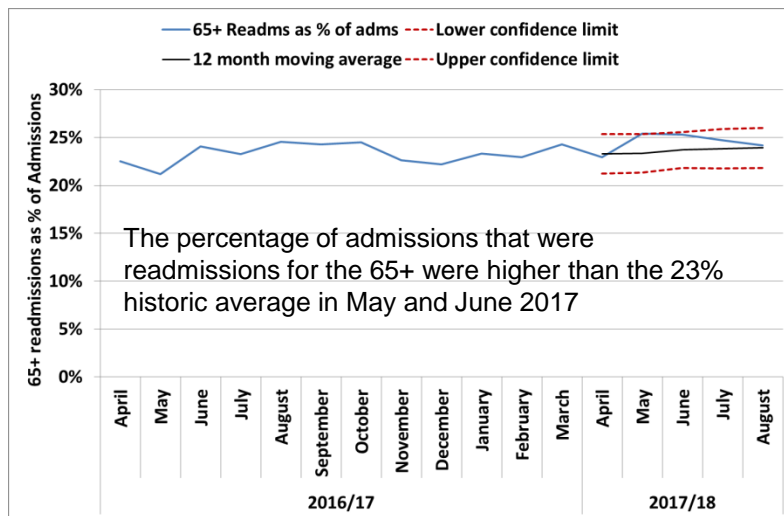
65+ Non-elective admissions per 1,000 65+



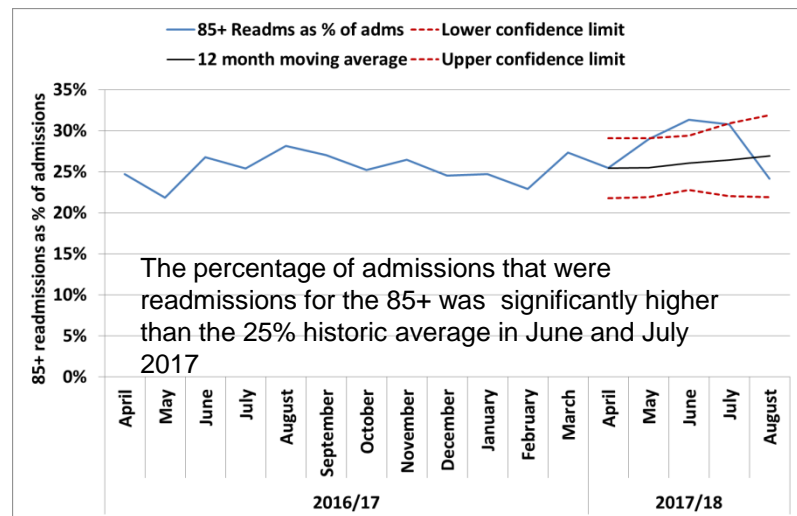
85+ Non-elective admissions per 1,000 65+



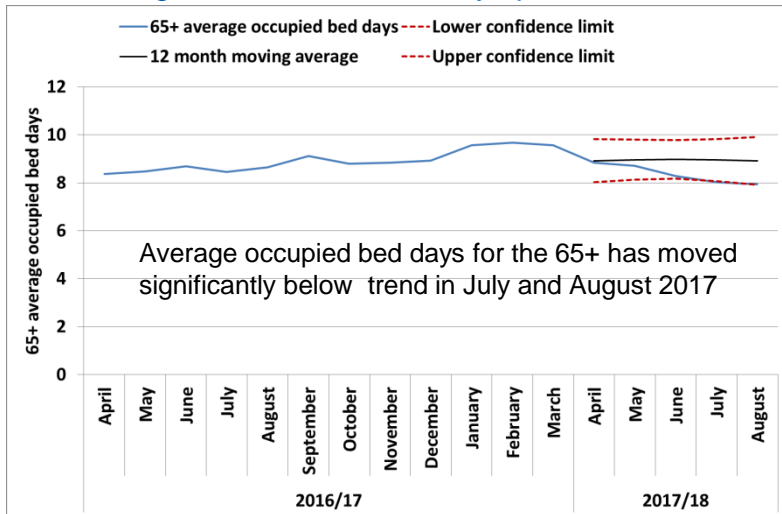
65+ readmissions as % of all non-elective admissions



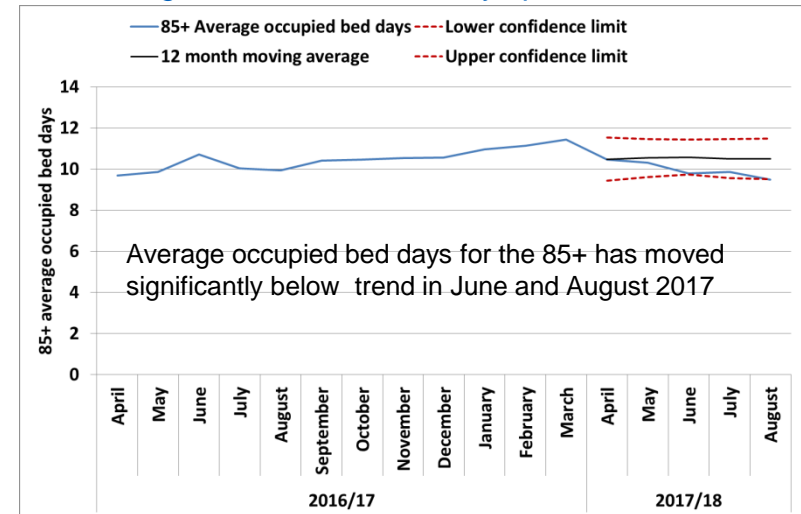
85+ readmissions as % of all non-elective admissions



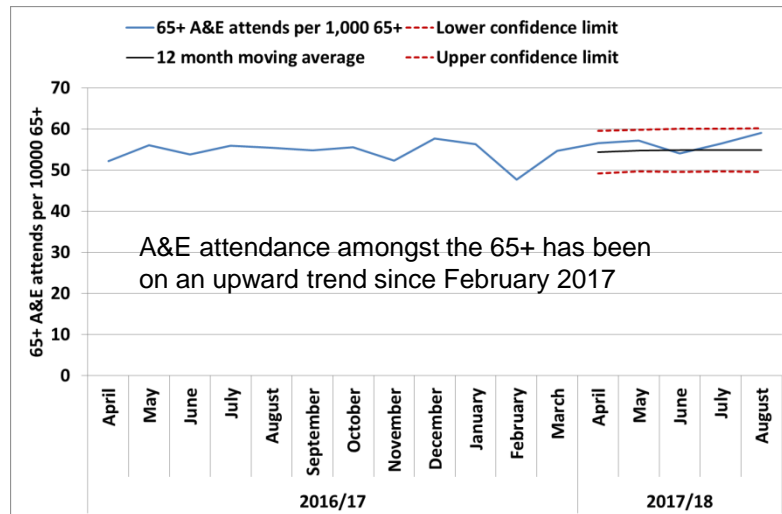
65+ average non-elective bed days per admission



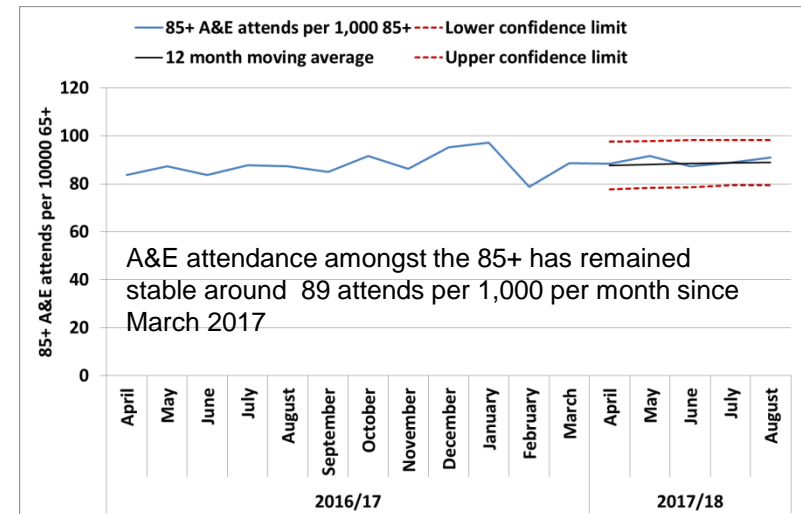
85+ average non-elective bed days per admission



65+ A&E attendance per 1,000



85+ A&E attendance per 1,000



Social Care (1)

Proposed measures:

Patient activation measures - some NHS primary care data available

Adult Social Care Outcomes Framework – updated annually but some measures may be available more frequently – to be determined

Number of deaths in hospital from those admitted from care homes - Data currently being investigated

Social Care (2)

Proposed Measures:

Community Care — *No direct sources identified yet without requiring individual submissions from each LA. ADASS draft data collection does not include activity counts.*

- **Number of care packages** (Split between Home Care and Direct Payments?)

ASCOF annual return provides numerator and denominator details for the following indicators:

- Total hours of care
- Total Cost

New Placements — *No direct sources identified yet without requiring individual submissions from each LA. ADASS draft data collection does not include activity counts.*

- Nursing care
- Residential care
- Dementia care (likely not recorded consistently between LAs)
- Extra care (likely not recorded consistently between LAs)

Care homes

Proposed measures

- Number of admissions from care homes
 - Average Hospital spell length of stay of admission from care homes
 - Number of deaths in hospital from those admitted from care homes
 - Delayed transfers of care that are attributable to Social Care (sourced from UNIFY2)
 - Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services — Annually available from ASCOF return
- Can be met with health datasets



The voice of nursing in the UK

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Councillor Mel Collins
Chair, North West London Joint
Health Overview and Scrutiny Committee
c/o Members Services London Borough of Hounslow
Civic Centre
Lampton Road
Hounslow TW3 4DN

3 August 2017

Dear Councillor Collins

I am writing on behalf of the RCN London Region to express a number of concerns about the North West London Sustainability and Transformation Plan. Whilst the RCN supports the aim of the STP we can only maintain that support if the reality of the STP matches their ambitions.

To date the plans have been light on detail, light on engagement with front line clinical staff and this concerns us greatly. We can see that STPs could help improve the health of residents NW London if they prevent ill health, join up services, and deliver care in more appropriate settings. However, we fear that they may be used as a smokescreen for savings instead, and that services may be cut without good alternative arrangements being made for people needing care. The size of the deficit is enormous (c£1.4bn) and it is difficult to see how the aspirations of North West London's STP will be met in the way they have currently been described.

STPs mean potential changes for staff who may have to work across sectors or across different organisations. These could offer opportunities, such as new roles and more autonomous working. But if financial considerations come first, the RCN fears the plans could result in unsafe nurse staffing levels and skill mix. The RCN will oppose any reduction in the number of registered nurses because of the impact this would have on patient care. In London we know that 1 in 6 Nursing posts are vacant, patient care is compromised currently because of this and nurses are leaving the profession in droves due to work pressures, the impact of Brexit and pay restraint.

We fear STPs are being rushed through without proper engagement and consultation with staff and the communities that use health and care services. This needs to change. I ask that the JHOSC seeks assurances that full and meaningful engagement with frontline nursing staff will take place where changes to services that impact patients are made.

On that basis of our concerns we ask that as you review STP proposals at the JHOSC, you consider the following:

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Chief Executive & General Secretary
Janet Davies BSc (Hons), MBA, RGN, RMN, FRCN

*The RCN represents nurses
and nursing, promotes
excellence in practice and
shapes health policies*

- 1) **Evidence.** There must be clear evidence to support any proposed changes, including evidence about how STPs will improve patient safety, quality of care, workforce and financial balance. Plans must also be accompanied by a robust Equality Impact Assessment.
- 2) **No planning behind closed doors.** Any proposed changes must be made public and shared with staff, their Trade Unions, their representatives and local communities. Change will only succeed if organisations ‘take people with them’, with early and meaningful engagement.
- 3) **Involve nursing staff.** Nursing staff know what works best for the services they deliver and the people they care for. They and the RCN should be involved in plans as they develop, not as an afterthought.
- 4) **Funding.** The plans must be funded properly to succeed. We support efficient care delivery but improving care must always be the priority. We need to see evidence that this is happening. Service re-design must show how resources will be re-used in other parts of health and care services.
- 5) **Workforce strategy.** Each plan must have a workforce strategy that deals with staffing levels, skill mix, training requirements, transfer and protection arrangements. It must be discussed and agreed in partnership with staff and their representatives.
- 6) **Job security.** Each STP proposal must give staff security in relation to their employment status, continuity of employment, terms and conditions, pension entitlement and training/development needs. This must be developed in partnership with staff and their representatives.

In particular in North West London we are concerned about the pressure that the Capped Expenditure Process is adding to an already difficult financial landscape. We are also concerned about the reliance on admission avoidance as a means to save money when significant pressures continue on many of the A and E’s in the footprint. Equally concerning are the high numbers of vacant posts in Community Nursing teams which will only compound the challenge of achieving greater admission avoidance.

We do recognise and welcome the work of the Capital Nurse Programme in seeking to secure adequate nursing staff within North West London. We also acknowledge and welcome the initial opportunities for engagement created by the STP Communications Lead.

We will also be writing to the Accountable Officers for the STPs as well as MPs expressing our concerns. We are keen and willing to engage fully in ensuring that the people of North West London get the best possible future health and care system. We also want to support a future that has the right nurses in the right place with the right skills. We will be attending JHOSCs wherever possible and look forward to full and meaningful debate around the issues raised above.

I look forward to receiving your response to the above issues. If you wish to discuss this letter further please do not hesitate to contact me,

Yours sincerely,



Sharon Bissessar
Senior RCN Officer
London region