NHS

North West London

Commissioning Strategy Plan 2012 – 15

Part A: Delivering Service Change in North West London

Document Information

Document Purpose	For review
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Description	This document sets out Part A – delivering service change in North West London - of the Commissioning Strategy Plan for the North West London Cluster for the period 2012-15.
Cross Ref	• NHS NWL's Commissioning Strategy Plan to 2014/15, Part B; Commissioner and provider landscape and enabling strategy • NHS NWL's Quality Standards: Commissioning for Quality in North West London • NWL Commissioning Intentions 2012/13 • Local commissioning and contracting letters issued by individual PCTs • National and regional commissioning plan • London-Wide Commissioning Intentions and Contracting Rules document for 2012-13 • NHS London in September "Three year Commissioning Strategy Plans; What good looks like".
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Purpose of the Commissioning Strategy Plan to 2014/15

NHS Commissioners are required to have clear and credible strategic commissioning plans that best meet the needs of their local population within the resources available to them. These must then be actively managed to ensure the plans deliver safe and high quality care for patients and the public. This Commissioning Strategy Plan (CSP) is a comprehensive plan to describe what healthcare services will be commissioned over the next three years in NWL.

NHS North West London's (NWL) Commissioning Strategy Plan (CSP) for 2012-15:

- Covers three years from 2012/13-2014/15 to match the planning cycle the NHS Commissioning Board will adopt;
- Builds on and refreshes years 2, 3 and 4 from current cluster four-year commissioning strategy and QIPP plan, developing and further substantiates existing cluster plans
- Includes a refreshed case for change, quality standards and strategic service, QIPP and financial plans for the next three years;

The document informs the Cluster's Commissioning Intentions for 2012/13 which sets out the expectations regarding the way that NHS NWL, on behalf of its constituent Clinical Commissioning Groups, will commission from Providers during 2012-13. The strategy is underpinned by the Cluster's Quality Standards: Commissioning for Quality in NWL, which are included as an appendix to this document.

The document has been developed to reflect the guidance issued by NHS London in September "Three year Commissioning Strategy Plans; What good looks like".

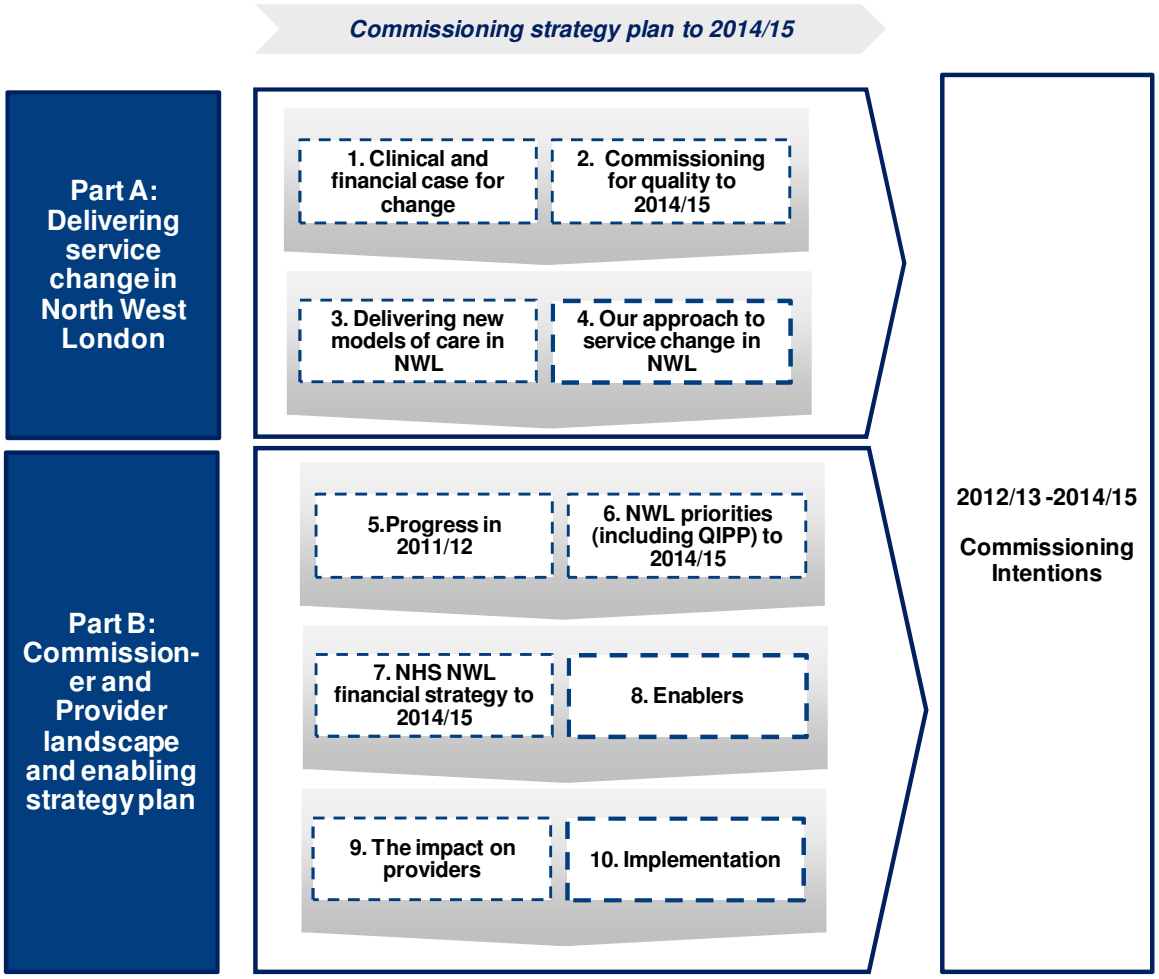
How the CSP is structured

The CSP has been structured in two parts.

- **Part A**; describes how the case for change in NWL and quality standards which commissioners will commission services against requires a step change in the Cluster's development of more sustainable models of care over the next three years. It also describes how the Cluster plans to approach the need for service change in 2012/13.

- **Part B;** describes the Cluster's progress in 2011/12, commissioning priorities (including QIPP) and financial strategy to 2014/15 and the underpinning enabling strategies the Cluster will require to deliver these. It also sets out the local Clinical Commissioning Group (CCG) Plans and how these have been developed into Cluster priorities. It then evaluates how the Cluster's and emerging CCG priorities will impact on providers in NWL.

The diagram below summarises how the three year Commissioning Strategy Plan has been structured;



Purpose of Part A

This document forms part A of NHS NWL's Commissioning Strategy Plan (CSP) to 2014/15 and details the Cluster's strategy plan for delivering service change in NWL. It complements the Cluster's commissioner and provider landscape and enabling strategy plans which are set out in Part B of this document.

Contents

Executive Summary

Despite making good progress in 2011/12 in implementing our existing four year commissioning strategy and QIPP plan, considerable challenges for health care and health services in NWL remain

The clinical case for change for the next three years is articulated under nine headings, building on and refreshing the clinical case for change that was articulated in NWL's 2010/11's Commissioning and QIPP plan to 2014/15.

1	Reducing variation in life expectancy
2	Improving patients' perceptions of our services (especially GP and maternity)
3	Improving care for patients with long term conditions (especially diabetes)
4	Improving primary care (access and outcomes)
5	Improving quality of hospital care (specialisation and decreasing length of stay)
6	Listening and responding to our staff (staff satisfaction)
7	Making better use of our buildings
8	Achieving £1bn of savings
9	Mental Health

The total spend in the NWL health economy is £3.5billion, which represents 24% of health expenditure in London. Based on current services, by 2014/15 we estimate we would need an additional £1bn of funding to keep pace with expected increases in demand.

The updated modelling indicates the savings requirement has increased due to increased financial pressures above plan in 2010/11 and slippage in recurrent QIPP delivery to date. The impact of this has raised the original 5-year commissioner saving requirement from £332m to £553m. The QIPP requirement for the next 3 years will be £121m, £99m and £83m from 2012/13 to 2014/15.

The increased financial pressures, which have particularly affected Harrow and Outer NWL PCTs, has emphasised the need for commissioners to secure transformational and sustainable change in the quality and efficiency of services across the Cluster. Providers are also facing increasing pressures, seen emerging in Imperial College and North West London Hospitals especially, and they need to find ways to deliver services more efficiently and effectively.

During 2011/12 the Cluster developed a set of quality standards against which NHS NWL will commission health care in future to address our case for change

Patients and the public rightly expect high quality care, indeed our staff and healthcare providers want to work in a system that ensures, recognises and

rewards quality of care. NWL has some world-class services and good levels of health but this masks significant inequalities in health status and even greater variation in the quality of healthcare provided. NWL must focus its resources on services which are efficient and effective and are demonstrably high quality. Commissioners in NHS NWL are prioritising a number of quality work programmes based on the following standards;

- Implementation of the National Outcomes Framework
- Quality standards: commissioning for quality in NWL

To address NWL's case for change and achieve the quality standards our patients expect requires a much more sustainable care system in NWL

At the moment, many people go to hospital for some services which could be better delivered out of hospital. Our existing four year plan set out a strategy that proposed that in order to address our case for change and improve the quality of care in NWL required the development of new models of care that delivered health services in a different way and in different settings of care to where they are currently provided.

This three year strategy renews our focus on delivering new models of care in NWL by 2014/15. As described in our current four year plan. The following principles underpin the models of care the Cluster aims to implement;

1. Centralising the most specialist services means better clinical outcomes and safer services for patients.
2. Localising routine medical services means better access closer to home and improved patient experience
3. Where possible, care should be integrated between primary and secondary care, with involvement from social care, to ensure seamless patient care

Whilst we have started to make good progress in developing the models of care identified in our four year plan, more needs to be done if we are to address our the case for change and improve the quality of care over the next three years

We have made good progress in 2011/12 in centralising specialist services in NWL, particularly in relation to cancer, vascular and stroke services. We have also made really strong progress in implementing integrated models of care through our integrated care pilot for diabetic and elderly patients. The learning from this programme is now being rolled out for people with mental health conditions across NWL.

The centralisation of specialist services will impact across the system in NWL and have implications for patient pathways and provider capacity - both in the acute, primary and community sector – so their design and communication must be considered and assured from a cluster-wide perspective. To be successful, this

will need to be complemented by improvements in primary care and community care provision and by health and social care services working together across the system. In particular, any shifts in services to out of hospital settings that arise as a result of the change of the acute landscape in NWL will need to be underpinned by an Out of Hospital strategy which identifies the improvements needed to primary, community and social care.

Over the coming months the Cluster will work closely with local clinicians , providers, patient and public to identify the optimal future design and configuration of services for North West London.

Whilst our existing four year plans described how the financial flows between providers would change to reflect shifts in care from acute to out of hospital settings, the plans did not explicitly say what the service changes would be required and how this would impact on each provider. Instead, NHS NWL asked providers to take this strategic direction and describe for themselves the implications for the provider landscape. Whilst good progress had been made, NWL commissioners now need to lead these service changes to ensure the Cluster delivers the quality improvements that are needed over the next three years.

To enable the Cluster to identify the optimal design for the future services required in NWL, the approach we take will be underpinned by the core principles of the Secretary of State's four tests.

We will seek views from patients, their representatives and other local stakeholders as this work develops. We will also work with colleagues in neighbouring clusters and with London Ambulance Services to consider the broader impact of any proposals.

The Cluster's work will be subject to scrutiny by local Health Overview and Scrutiny Committees (OSCs), which will come together in a Joint Overview and Scrutiny Committee (JOSC). We will consult closely with the JOSC on the design of the public consultation on the service change option(s).

CCGs will be further developing their out-of-hospital care strategies; identifying how they will deliver the improvements to primary and community care that are necessary both to address the case for change and to fully realise the benefits of the proposed models of care.
A robust communications plan is described here that encompasses how we will engage on all elements of the plan as well as delivering the more formal requirements of the formal consultation on service change.

The Clinical Case for Change

Despite making good progress in 2011/12 there remain considerable challenges for health care and health services in NWL. For example, as in London as a whole, life expectancy has risen by 2 years across North West London since the Year 2000. However, significant inequalities in life expectancy remain both between and within boroughs in North West London; at ward level, there is a 16 year gap in male life expectancy. NWL's financial analysis also indicates a requirement to make £1bn of efficiencies by 2014/15, if we were to keep pace with expected increases in demand for services.

The North West London Cluster is made up of eight London boroughs: Brent, Ealing, Hammersmith and Fulham, Harrow, Hillingdon, Hounslow, Kensington and Chelsea, and Westminster. The population of the North West London Cluster is currently approximately 1.9 million.

The population of the North West London Cluster is projected to rise by 7% between 2011 and 2031. A significant proportion of this population growth can be attributed to a predicted rise in the number of older people. The number of people over the age of 75 in the North West London Cluster is projected to rise from 117,000 in 2011 to 176,000 in 2031[1].

Population projections for the North West London Cluster, by borough.

Borough	Estimated 2011 population (000s)	Estimated 2021 population (000s)	Estimated 2031 population (000s)
Brent	283.0	303.5	305.2
Ealing	322.0	346.7	349.7
Hammersmith and Fulham	183.2	197.7	204.6
Harrow	223.8	229.9	233.8
Hillingdon	265.9	279.5	285.0
Hounslow	239.7	246.7	249.8
Kensington and Chelsea	172.2	183.3	184.7
Westminster	221.1	236.5	241.3
NWL Cluster	**1911.1**	**2023.7**	**2054.1**

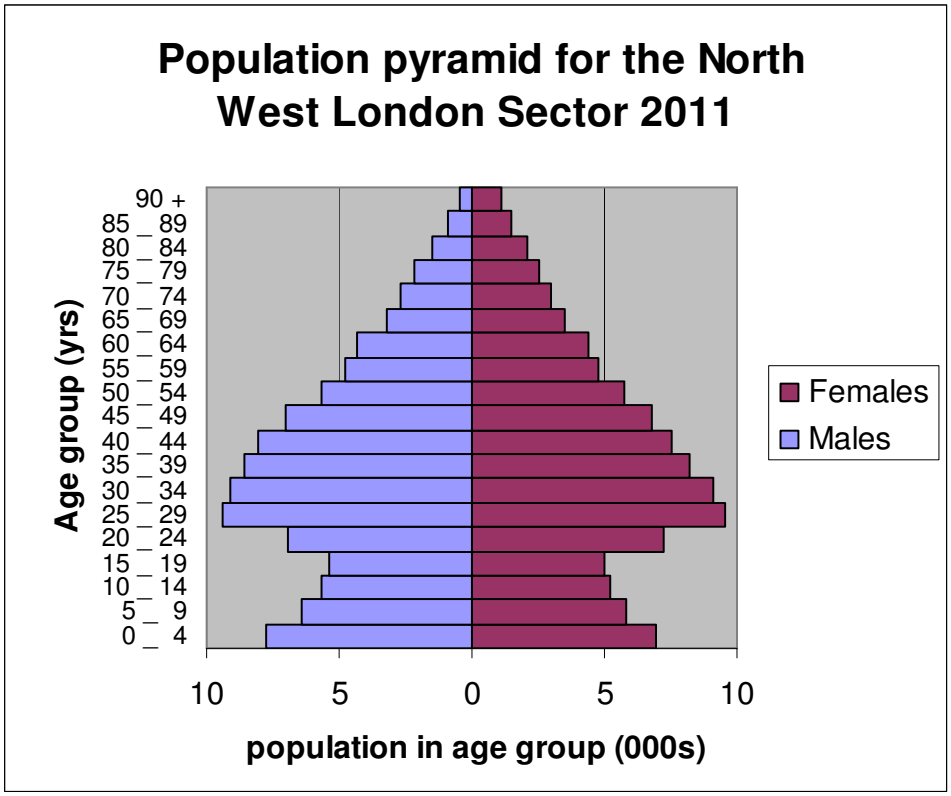
Source: GLA population projections 2010 round

[1] GLA projections

Age and Gender

The make-up of the population by age and gender is shown in the population pyramid below. As in London as a whole, the proportion of the total population that is made up of working age adults is greater than the national average.

Population pyramid for the North West London Cluster, 2011.

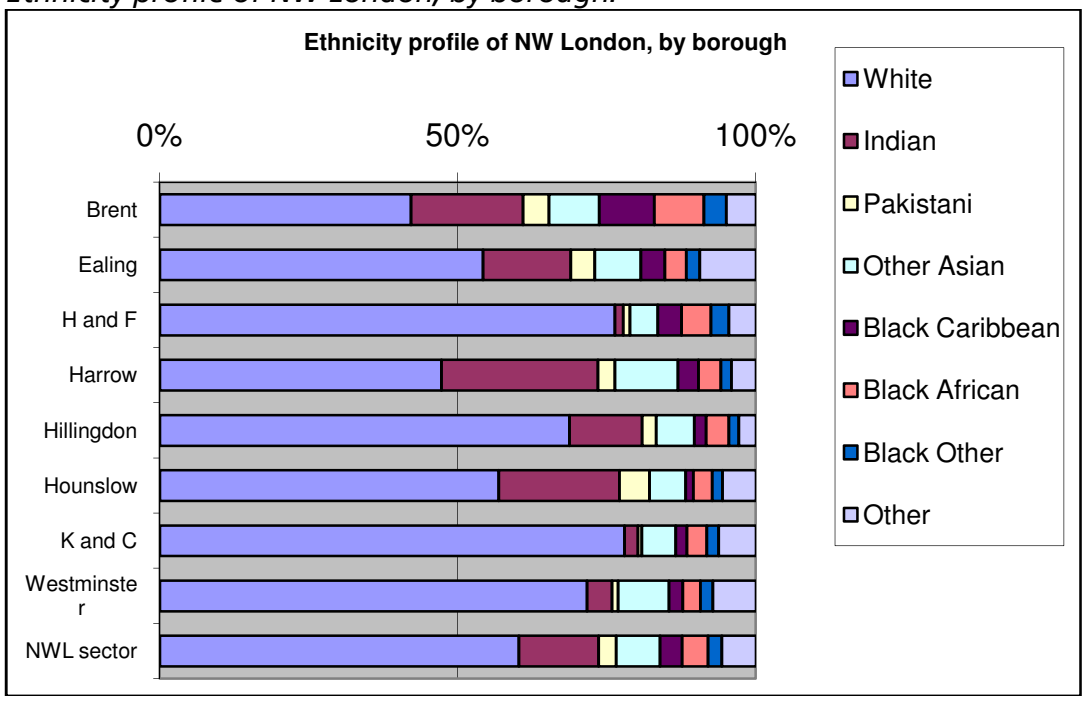


Source: GLA population projections 2010 round

Ethnicity

The ethnicity profile for the population of NWL is highly heterogeneous, with a greater percentage of the population coming from BME groups than the London average. There is also significant variability between the outer boroughs and inner boroughs, with the former being far more ethnically diverse than the latter. This has important implications for the planning and delivery of services in line with the differential disease profiles of the local populations. The ethnicity profile of the NWL Cluster by borough, can be seen below.

Ethnicity profile of NW London, by borough.

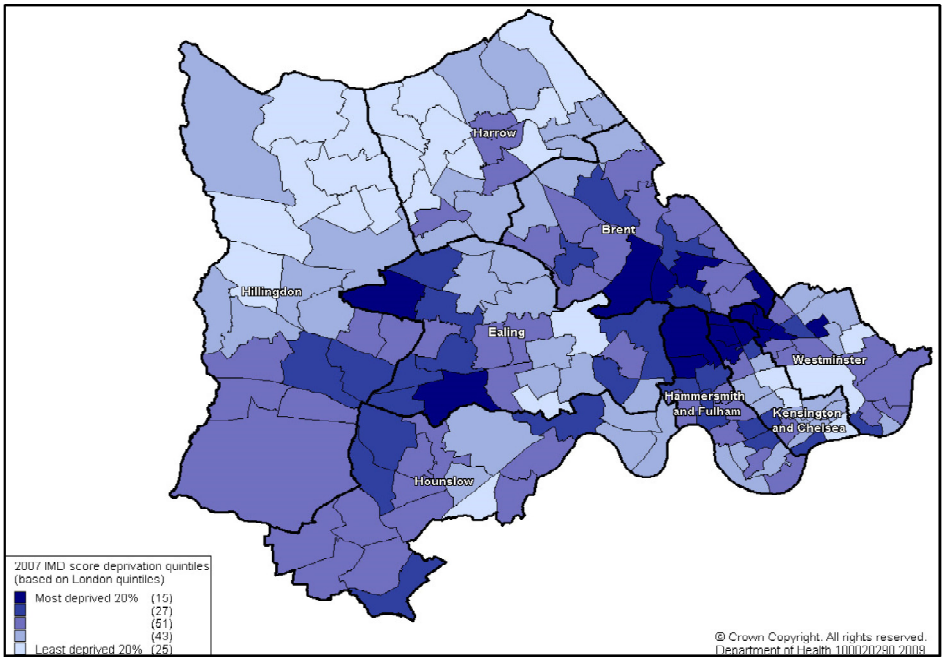


Source: GLA ethnicity projection 2011, (2010 round).

Deprivation

As in the whole of London, the NWL Cluster contains some very affluent areas alongside areas with high levels of deprivation. 15 electoral wards in the NWL Cluster are among most deprived 20% of electoral wards in London.

Map of NWL showing deprivation at ward level.



NHS NWL's nine areas of focus

During 2010/11 clinical and managerial leaders, clinicians and patient and public representatives from across NWL worked together on identifying and assessing the key challenges which exist across the Cluster and which, taken together, form a compelling and fact-based case for change for NW London for the Cluster's existing four year commissioning strategy and QIPP plan to 2014/15. This identified nine areas of focus

Summary of the Case for Change in NW London

1	**Reducing variation in life expectancy**
2	**Improving patients' perceptions of our services (especially GP and maternity)**
3	**Improving care for patients with long term conditions (especially diabetes)**
4	**Improving primary care (access and outcomes)**
5	**Improving quality of hospital care (specialisation and decreasing length of stay)**
6	**Listening and responding to our staff (staff satisfaction)**
7	**Making better use of our buildings**
8	**Achieving £1bn of savings**
9	**Mental Health**

Whilst the case for change has been refreshed to reflect the current context with the most recently available data, in many instances this data still relates to performance before the production of the existing four year commission strategy. It would therefore be inappropriate to attribute any improvements in performance to service changes since that time. Where more immediate performance data is available whilst observations can be made about the direction of change, meaningful analysis requires consideration of trends over longer periods.

The Cluster clinical case for change for this refreshed three year commissioning strategy plan to 2014/15 therefore remains focused on these nine areas, each of which is described in more detail below.

Reducing variation in life expectancy

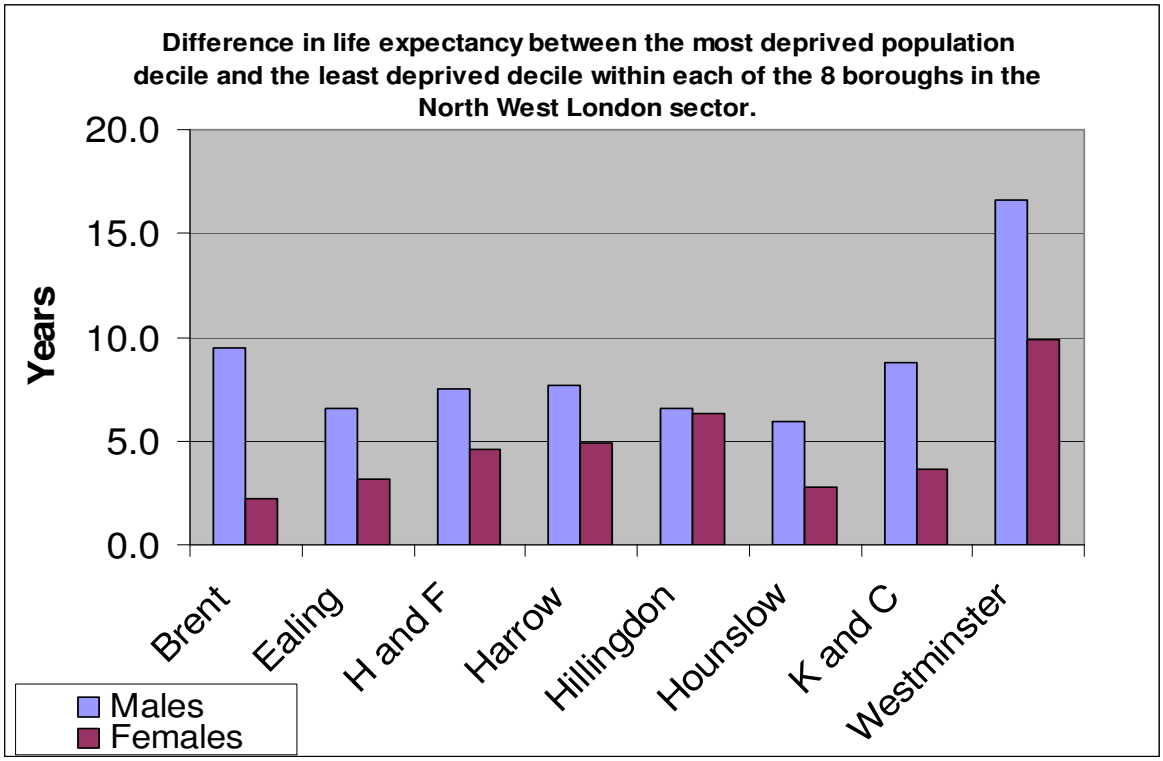
As in London as a whole, life expectancy has risen by 2 years across NWL since the Year 2000. However, significant inequalities in life expectancy remain both between and within boroughs in NWL.

At borough level, Kensington & Chelsea has the highest life expectancy in England for both males and females, whereas life expectancy in Hounslow is slightly below the national average.

At ward level, there is a 16 year gap in male life expectancy between Queen's Gate in Kensington and Chelsea, where life expectancy is 88.3 and Harlesden in Brent, where life expectancy is 71.5 years[2].

In each borough in the Cluster there is a significant gap in life expectancy between the most and least deprived deciles in the borough (see figure below).

In all 8 boroughs the gap in life expectancy is greater for males than for females. The gap in male life expectancy according to deprivation is greatest in Westminster, where males living in the most affluent parts of the borough can expect to live for 16.6 years longer than males living in the most deprived parts of the borough.



Source: ONS. Slope index of inequality 2005-2009.

As in the rest of England, cardiovascular disease and cancer are the major causes of death across the NWL Cluster. Together these conditions account for around 60% of all deaths in each of the 8 boroughs in NWL.

Over the past 10 years, we have been successful in reducing rates of premature mortality from cardiovascular disease and cancer across the NWL Cluster However inequalities in premature death rates from cardiovascular disease and cancer have persisted during this period and are major contributors to the inequalities in life expectancy described above.

Although non-infectious diseases such as cardiovascular disease and cancer are responsible for the majority of deaths across the North West London Cluster,

[2] ONS data (2007-2009)

infectious diseases are re-emerging as an important cause of ill health across the Cluster. Brent, for example, has the second highest rate of new cases of tuberculosis in England, and rates of tuberculosis across NWL are significantly higher than the national average.

HIV prevalence is also higher than the national average across the NWL Cluster. Kensington and Chelsea has the highest HIV prevalence rate in the Cluster of 8.5 per 1,000 population aged 15-59 years. Kensington and Chelsea is ranked 4th of the 151 PCTs in England for HIV prevalence. In addition, all 8 boroughs in NWL have seen a significant increase in the prevalence of HIV over the last 5 years.

The role of health services in reducing health inequalities

Many of the underlying causes of inequalities in life expectancy, such as employment, income, education and housing, are beyond the control of health services.

However, the NHS can help to reduce health inequalities by ensuring that all residents in NWL have access to high quality health services.

In addition the NHS can reduce health inequalities by enabling people to make healthy lifestyle choices and reduce the prevalence of upstream risk factors for disease such as smoking, obesity and harmful alcohol consumption.

Smoking rates across the NWL Cluster have fallen over the last 10 years. 1 in 5 adults in NWL now smoke compared to 1 in 4 adults 10 years ago.

However, inequalities in smoking rates persist across NWL both within and between boroughs, and smoking remains responsible for over 2,000 preventable deaths each year in the Cluster.

Obesity is an important risk factor for both physical and mental health problems, including diabetes, musculoskeletal disease and depression. Across NWL over 1 in 6 adults and over 1 in 5 eleven year old children are classified as obese. Rates of obesity for both children and adults have been relatively stable over the last 3 years in spite of efforts to tackle the problem.

Harmful alcohol consumption not only causes significant health problems across NWL, but also places a significant burden on health services in the Cluster. Alcohol related admission rates are higher than the national average in 5 of the 8 boroughs in NWL. Alcohol related hospital admissions ranged from 1,213 per 100,000 residents in Kensington and Chelsea to 2,218 admissions per 100,000 residents in Ealing in 2009/10[3].

Of particular importance to reducing health inequalities are health services which can prevent ill health including cancer screening, childhood immunization and NHS vascular health checks.

[3] Source: Hospital Episode Statistics.

Cancer screening

Early diagnosis and prevention of cancers through established national cancer screening programmes are of critical importance for improving cancer survival rates.

Currently, uptake of screening programmes across the Cluster is not meeting national standards. For breast cancer screening, coverage rates for 2010/11 were lower than the national standard of 70% in all PCTs in the Cluster apart from Harrow and Hillingdon. For bowel and cervical cancer screening coverage, rates are below the national standard (60% for bowel cancer and 80% for cervical cancer) in all 8 PCTs.

Cervical screening coverage (2010/11) performance against national standard of 80%.

PCT	Q1	Q2	Q3	Q4
Brent	69.7%	69.7%	69.8%	70.2%
Ealing	71.1%	70.8%	70.6%	70.5%
Hammersmith and Fulham	67.8%	67.6%	67.3%	67.2%
Harrow	71.8%	71.5%	71.1%	71.2%
Hillingdon	74.7%	74.6%	74.3%	74.3%
Hounslow	72.9%	72.5%	71.9%	71.6%
Kensington and Chelsea	66.3%	66.9%	67.1%	71.2%
Westminster	68.4%	69.1%	69.3%	72.5%
London	73.7%	73.7%	73.5%	74.0%

Breast cancer screening coverage performance against national standard of 70%

PCT	Q1	Q2	Q3	Q4
Brent	62%	64%	65%	
Ealing	67%	66%	66%	
Hammersmith and Fulham	60%	60%	60%	
Harrow	67%	71%	72%	
Hillingdon	69%	69%	71%	
Hounslow	67%	68%	69%	
Kensington and Chelsea	57%	57%	57%	
Westminster	62%	63%	63%	

Bowel cancer screening coverage performance (2010/11) against national standard of 60% uptake

PCT	Q1	Q2	Q3	Q4
Brent	44.8%	39.0%	40.0%	34.0%
Ealing	42.0%	41.2%	43.9%	42.4%
Hammersmith and Fulham	39.2%	37.6%	36.9%	34.7%
Harrow	50.4%	48.8%	49.0%	44.6%
Hillingdon	47.8%	49.1%	49.6%	45.1%
Hounslow	44.9%	47.1%	44.1%	43.5%
Kensington and Chelsea	35.1%	33.6%	36.2%	31.7%
Westminster	35.4%	36.1%	34.2%	33.0%

Childhood immunisation

There is considerable variation between boroughs in vaccination rates for routine childhood immunisation programmes. For example, the proportion of 5 year old children who are fully vaccinated against measles mumps and rubella (MMR) varies from 68% in Hounslow to 88% in Westminster (see table below). However, uptake rates for MMR have improved year on year in 7 of the 8 boroughs in the Cluster and we must aim to continue improving vaccine coverage.

Uptake of full course of MMR vaccine by 5th birthday in NWL

	Percentage of 5 year olds fully vaccinated with 2 doses of MMR (2009/10)	Percentage of 5 year olds fully vaccinated with 2 doses of MMR (2010/11)
Brent	71.6	82.2
Ealing	73.6	80.1
Hammersmith and Fulham	58.5	69.0
Harrow	68.5	78.4
Hillingdon	85.4	86.8
Hounslow	68.0	68.0
Kensington and Chelsea	65.3	66.4
Westminster	88.2	87.6
NW London	**72.7**	**n/a**
London	**72.2**	**76.6**
England	**82.7**	**84.2**

Source: NHS information centre

Repeat abortions

The rate of repeat abortions can be used as an indicator of inadequacy in relation to contraception, whether insufficient service access, sub-optimal service provision or ineffective individual use of contraceptive method. In NWL the percentage of abortions that are repeat abortions range from 12% in Ealing and Hillingdon to 21% in Hammersmith and Fulham.

Improving patients' perceptions of our services

Lord Darzi's 2008 review. *High Quality Care For All* set out a vision for high quality care in the NHS. Patient experience of health services was one of the three core components of quality health care highlighted by the review, along with effectiveness of care and safety of care.

Although some hospitals in NWL deliver care which provides excellent levels of patient satisfaction, this is not the case for all hospitals. For primary and maternity care in the NWL Cluster, levels of patient satisfaction are, in general, lower than those seen across England as a whole.

Patient experience of primary care

In 2010/11, 84% of NWL residents expressed satisfaction with the overall level of care provided by their GP. This compares with a satisfaction rate of 89% for England as a whole. In all 8 boroughs in the Cluster, overall satisfaction with GP care was lower than that seen for England as a whole (see table below).

Patient satisfaction with care from their GP.

Local authority	% of residents satisfied with care from GP
Brent	81.9
Ealing	82.3
Hammersmith and Fulham	86.2
Harrow	84.0
Hillingdon	85.3
Hounslow	82.3
Kensington and Chelsea	87.6
Westminster	85.9
North West London	**83.9**
London	**85.2**
England	**89.7**

Source: GP Patient survey 2010/11

Patient experience of maternity care

In 2010 the Care Quality Commission carried out a national patient survey for maternity services (see table). None of the 6 NHS trusts providing maternity care in NWL achieved higher than average scores in any of the 5 domains of patient care that were considered in the survey. In addition, in 2 of the 6 NHS trusts providing maternity services, patient satisfaction with antenatal care was significantly worse than the national average.

Patient experience of maternity services – Care Quality commission patient survey 2010.

	Patient satisfaction score out of 10 (squares with red background indicate poor performance compared to the England average, green background indicates good performance compared to the England average)				
Hospital Trust	Antenatal care	Care during labour and birth	Rating of staff during labour and birth	Postnatal care	Support for breastfeeding initiation)
Ealing Hospital	7.7	6.8	7.8	7.2	6.0
North West London Hospitals	7.6	7.1	8.0	7.6	6.9
Chelsea and Westminster	8.0	7.6	8.6	6.9	6.0
Imperial Healthcare	7.1	7.4	8.6	7.6	6.1
Hillingdon Hospital	8.1	7.3	8.2	7.3	6.0
West Middlesex Hopsital	8.2	7.5	8.2	7.3	6.1

Source: Care quality commission - National survey of maternity services 2010

Patient experience of in-patient services.

In late 2009 the Care Quality Commission carried out a national patient survey for in-patient services (see table below). Patient experience of in-patient services in North West London Hospitals was variable. While the Royal Brompton, the Royal Marsden and the Royal National Orthopaedic Centre performed very well compared to average standards across England, several hospital trusts in the Cluster performed poorly compared to the average standards across England.

It is particularly concerning that care from nursing staff was perceived as poor in 4 of the 9 trusts in the Cluster.

Patient experience of in-patient services – Care Quality commission patient survey 2009.

	Patient satisfaction score out of 10 (squares with red background indicate poor performance compared to the England average, green background indicates good performance compared to the England average)					
Hospital Trust	**A and E services**	**The ward and hospital**	**Care from doctors**	**Care from nurses**	**Care and treatment**	**Overall experience**
Chelsea and Westminster	7.4	7.5	8.4	7.5	7.2	6.4
Ealing Hospital	7.0	7.6	7.9	7.6	7.0	6.1
Hillingdon Hospital	6.9	7.8	8.1	7.8	6.9	6.3
Imperial Healthcare	7.6	8.0	8.4	8.1	7.3	6.8
North West London Hospitals	7.0	7.7	8.1	7.8	6.8	6.0
Royal Brompton	n/a	8.5	8.9	8.9	8.2	7.5
Royal Marsden	n/a	8.6	9.4	9.1	8.4	7.1
Royal National Orthopaedic Hospital	n/a	8.3	9.1	8.7	7.8	7.1
West Middlesex	7.3	7.9	8.3	7.8	7.0	6.1

Source: Care quality commission - National survey of in-patient services 2009

Improving care for people with long-term conditions

NWL has a significant number of residents living with long-term conditions such as diabetes, hypertension, COPD, coronary heart disease and asthma. Harrow, for example, has the highest prevalence of diabetes of any London borough, and Harrow, Ealing, Hillingdon and Hounslow have some of the highest recorded rates of coronary heart disease in London[4].

Across NWL there are over 234,000 people diagnosed with hypertension, over 93,000 people diagnosed with diabetes, over 49,000 people diagnosed with coronary heart disease, over 18,000 people diagnosed with COPD and over 98,000 people with asthma[5]. (see table below)

Table: Numbers and prevalence of people in NWL on disease registers for selected long-term conditions

[4] QOF data 2009/10
[5] QOF data 2009/10

	Coronary heart disease		Hypertension		Diabetes		COPD	
Year	Number on disease register	Prevalence (%)	Number on disease register	Prevalence (%)	Number on disease register	Prevalence (%)	Number on disease register	Prevalence (%)
2006/07	48,759	2.34	216,753	10.41	78,936	3.79	16,532	0.80
2007/08	48,577	2.34	220,229	10.60	83,330	4.01	17,156	0.83
2008/09	48,783	2.37	226,938	11.02	88,604	5.34	18,076	0.88
2009/10	49,417	2.33	234,634	11.05	93,939	5.58	18,907	0.89

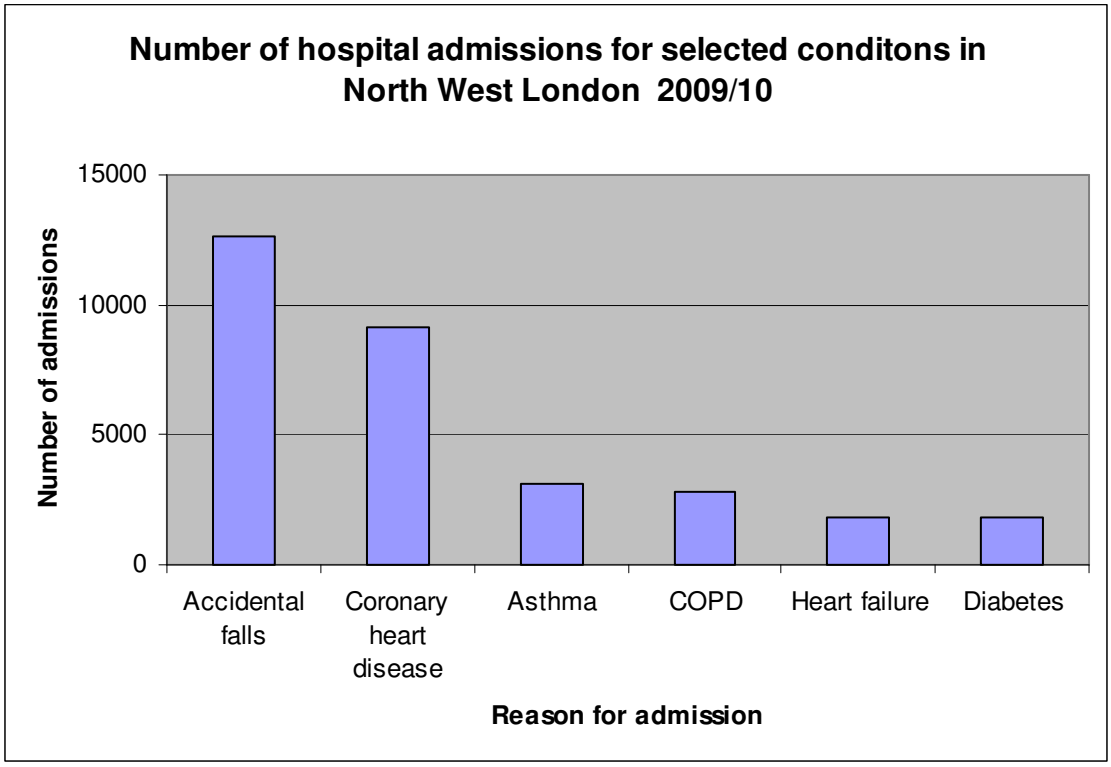
Source: Quality Outcomes Framework

The number of people diagnosed with long-term conditions such as diabetes, hypertension and COPD in NWL has risen over the last 4 years. Although a significant part of this rise is due to improved identification and diagnosis of people with long-term conditions, there is also likely to be an underlying rise in the true prevalence of certain long-term conditions such as diabetes.

The NHS in NWL has an important role to play in helping people with long term conditions stay economically and socially active. Key to this is supporting patients to take responsibility for managing their conditions, maximising their ability to live independent lives in the community and avoiding the need for unnecessary hospital admissions.

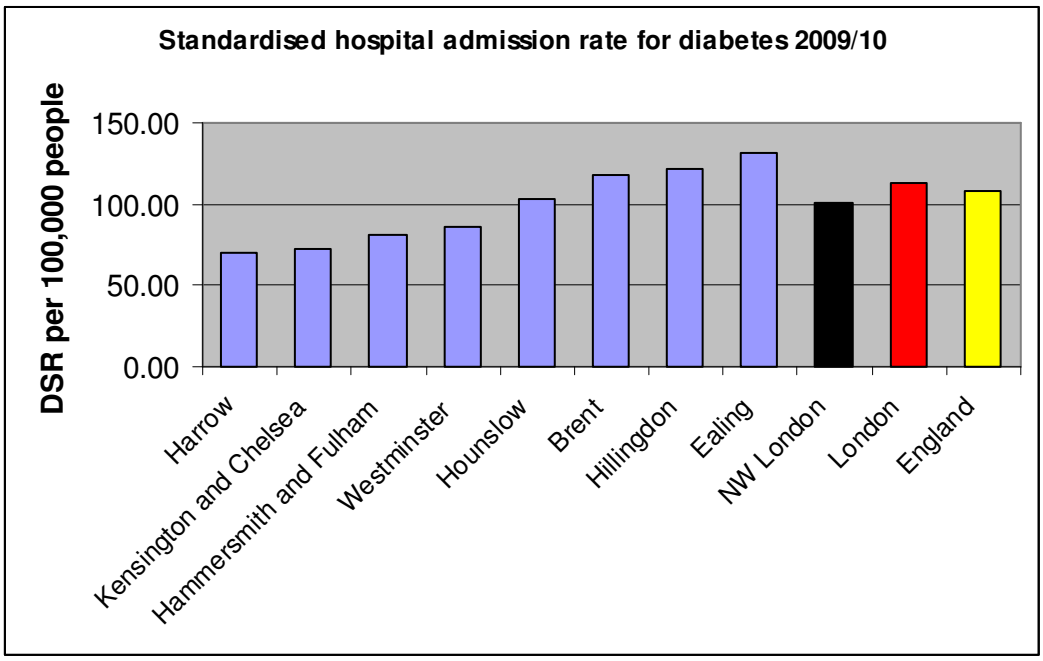
Long-term conditions account for a significant number of hospital admissions across the NWL Cluster, many of which are avoidable. In NWL in 2009/10, there were over 9,000 hospital admissions for coronary heart disease, over 3,000 admissions for asthma, over 2,800 admissions for COPD and over 1,800 admissions for both heart failure and diabetes. (see figure below)

Accidental falls account for an even greater number of hospital admissions than those for individual long-term conditions. However, many admissions from accidental falls are a result of suboptimal management of people with long-term conditions such as dementia.



Throughout the Cluster there is variation in the hospital admission rate for long-term conditions. Taking the example of diabetes there was considerable variability in the acute hospital admission rate for the condition across the NWL Cluster in 2009/10 (see figure below).

Harrow has the highest prevalence of diabetes in the NWL, and yet it has the lowest rate of hospital admissions for the condition in the Cluster. This suggests that patients with diabetes are being effectively managed in the community in Harrow.



Source: Hospital Episode Statistics 2009/10

By learning from and sharing best practice across the NWL Cluster, we can optimize care pathways for long-term conditions such as diabetes and help to reduce variability in hospital admission rates across the Cluster.

The NHS in NWL is already striving to improve care pathways for long-term conditions as exemplified by the Integrated Care Pilot for diabetes currently being delivered by Imperial Healthcare NHS Trust.

At present, around 75% of people with long-term conditions in NWL feel they have the necessary support to remain independent and in control of the condition[6]. This, however, compares unfavourably with the average for England as a whole, where over 80% of people with long-term conditions feel they have sufficient support to remain independent.

In order to support people with long-term conditions to remain independent it is important that we have responsive and effective community health services to meet their healthcare needs.

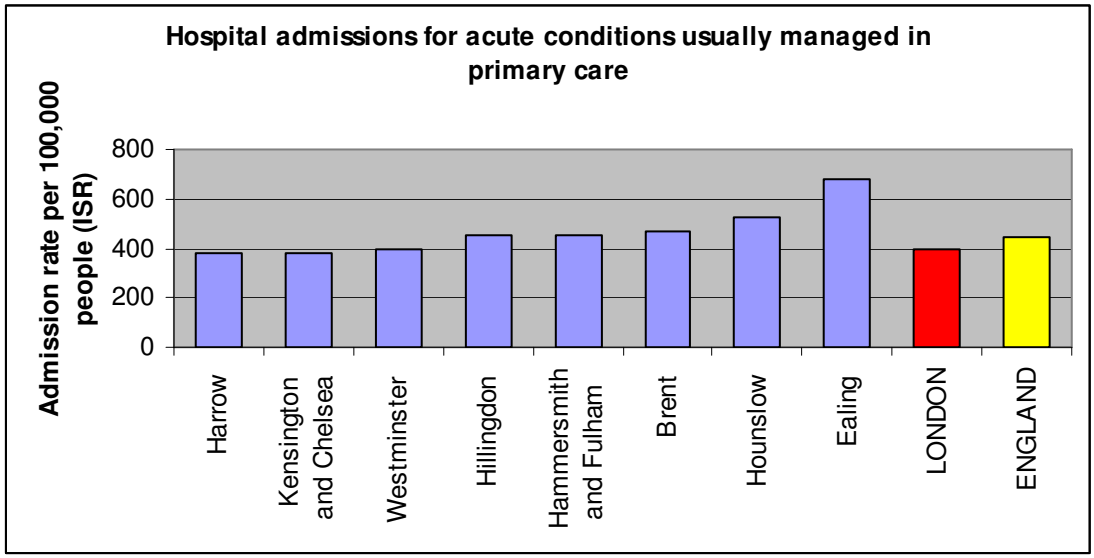
[6] Department of Communities and Local Government:

Improving primary care

We need to improve the overall quality of primary care in NWL and reduce the variability in quality of care between GP practices.

At present, one in four people in NWL report that they struggle to see their GP within 48 hours. This can potentially result in unnecessary emergency hospital admissions for acute conditions that could be managed in primary care, such as urinary tract infections and hypertension. In Ealing and Hounslow in 2008/09 there were significantly more hospital admissions for acute conditions that could have been managed in primary care than across London or England as a whole (see figure below).

In order to help prevent unnecessary hospital admissions it is important that NWL residents have rapid access to GP led care, both within normal GP opening times and out of normal hours.



Source; Hospital Episode Statistics 2008/09. Emergency hospital admissions: acute conditions usually managed in primary care (ICD10 codes: H660, H664, H669, I500, I501, J020, J028, J029, J030, J038, J039, J040, J060, J068, J069, I509, N159, N300, N390, I11, J310-J312)

Patients and professionals want to see high quality healthcare services being provided in the community rather than in hospitals, where it is safe and appropriate to do so. This puts primary and community care at the heart of NWL's future health system.

Moving services such as diagnostic services, outpatient clinics and minor procedures into the community setting can be more convenient for patients, and it can also be more cost effective. Westminster PCT has been able to save 30% of costs by relocating services such as gynaecology into the community, closer to patients' homes.

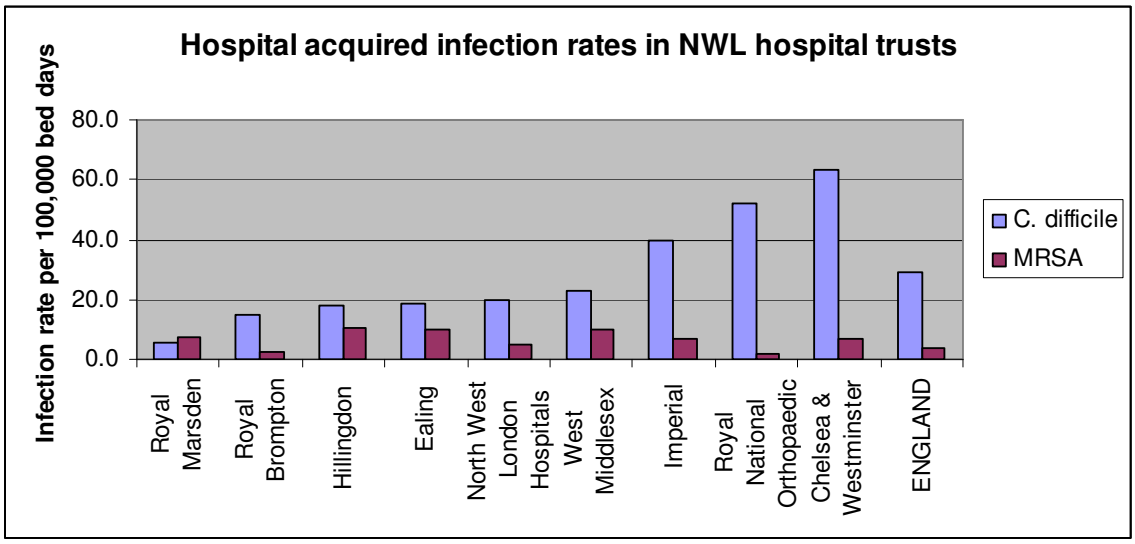
Improving hospital care

There is a great deal of variation in quality of care between NWL's hospitals.

Hospitals such as the Royal Marsden, Royal Brompton and the Royal National Orthopaedic Hospital provide care which yields excellent levels of patient satisfaction, whereas other hospitals in the Cluster provide care that gives poor levels of patient satisfaction compared to the national average (see figure in section 2 above).

There is also considerable variation in the rates of hospital acquired infections between hospital trusts in NWL (see figure below). Rates of clostridium difficile infection were significantly higher than the national average at Imperial Healthcare NHS Trust, Chelsea and Westminster NHS Foundation Trust and the Royal National Orthopaedic Hospital NHS Trust. Rates of MRSA bacteraemia were significantly higher than the national average at Ealing, West Middlesex and Hillingdon NHS Trusts.

As we make a transition towards a new structure for commissioning acute services across North West London it is important that we strive to maintain and improve patient safety in areas such as hospital acquired infection.



Source: HPA surveillance 2010/11

Structure of acute services

We know that if we structure acute services in the right way, with access to the right expertise at the right time, we can save lives. As a result of major efforts to improve care for people in North West London who suffer a heart attack, we increased the proportion of people receiving best in class treatment (primary angioplasty) to 83% – saving an estimated 300 lives each year[7].

In other areas, however, care remains fragmented. NWL provides many specialist services at multiple sites in a relatively uncoordinated manner. Recent work across London on stroke, heart attacks and cancer has highlighted the benefits of co-locating key specialties and there is also evidence that for some conditions patient outcomes are better when they are treated at sites that deal with a high volume of cases, such as Abdominal Aortic Aneurysm (AAA) and Coronary Artery Bypass Graft (CABG).

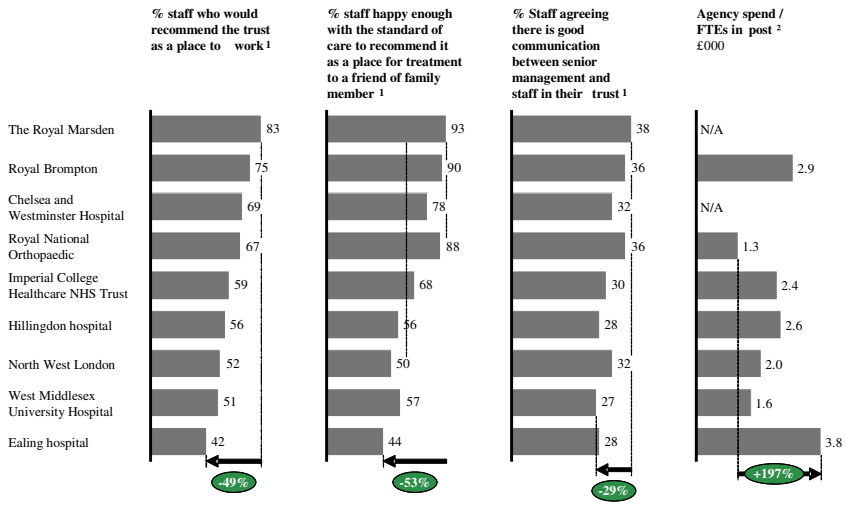
[7] Myocardial Ischaemia National Audit Project (MINAP) 8th Public Report, June 2009

Listening and responding to staff

More than half of staff in some of our hospitals do not recommend them as a place to work or to be treated. Most of our staff (60% or more) feels that there is not good communication between senior management and staff in their hospital. (see figure below).

We need to listen to our local NHS staff more, so they can lead improvements to services.

Variation in staff satisfaction and agency spend also exist in NWL hospitals



1 StaffCare Quality Commission – Staff survey 2009
2 NHS London Workforce Transformation Performance Report 1

Making better use of buildings

We need to make the best use of our buildings and facilities in NW London. Currently three quarters of hospitals in NWL require significant investment and refurbishment to meet modern standards.

The work of providing healthcare in NWL takes place in hundreds of different buildings. Many are not fit for purpose or are not being used appropriately.

There is a pressing need to rebuild or renew all but three of our hospital sites. We have not spent the money needed to maintain the fabric of our buildings, and as a result the risk adjusted backlog maintenance costs (the measure used to determine how much investment is needed to bring hospital buildings up to an acceptable standard), is nearly £250m for estates in NWL. In a time of tight financial constraints it is unlikely that all these sites can be rebuilt.

All acute organisations in NWL face a significant challenge simply to sustain services, given decreased growth rates in funding. It will therefore be a struggle for trusts to invest to improve existing buildings. Some organisations also have considerable PFI burdens which mean they have little flexibility to reduce costs. We therefore need to find creative ways to make the best possible use of our estate.

Although we have a very high number of buildings in our estate we are not using them efficiently. Many of our sites are not fully occupied all of the time, so we are spending money on half-empty buildings that could, and should, be spent on patient care.

Mental Health

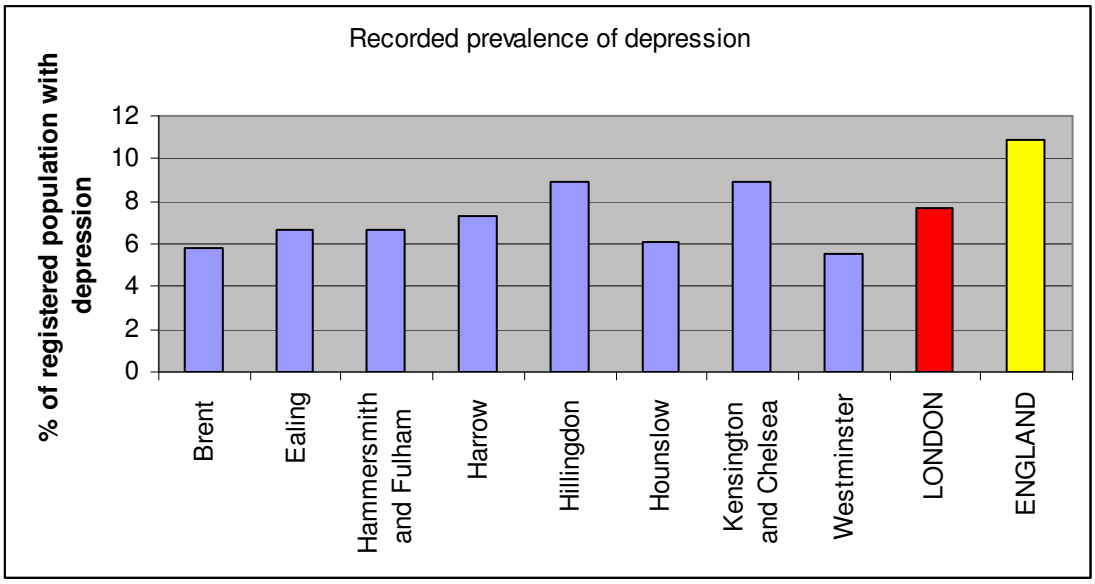
Across London, in any given week, 1 in 6 adults experience symptoms of mental illness.

In North West London, mental illness is not only a major contributor to the overall burden of disease, but also accounts for a significant proportion of health spending across the Cluster.

In addition to spending on health and social care, mental illness has wider economic implications, because poor mental health is often a barrier for people obtaining employment.

Poor mental health is also linked to poor physical health and people with long-term conditions such as COPD are at increased risk of mental health problems.

In North West London, the recorded prevalence of depressive illness varies from 5% to 9% in the 8 boroughs in the Cluster[8], which, although is lower than the national average (11%), still places a considerable demand on health services (see figure below).

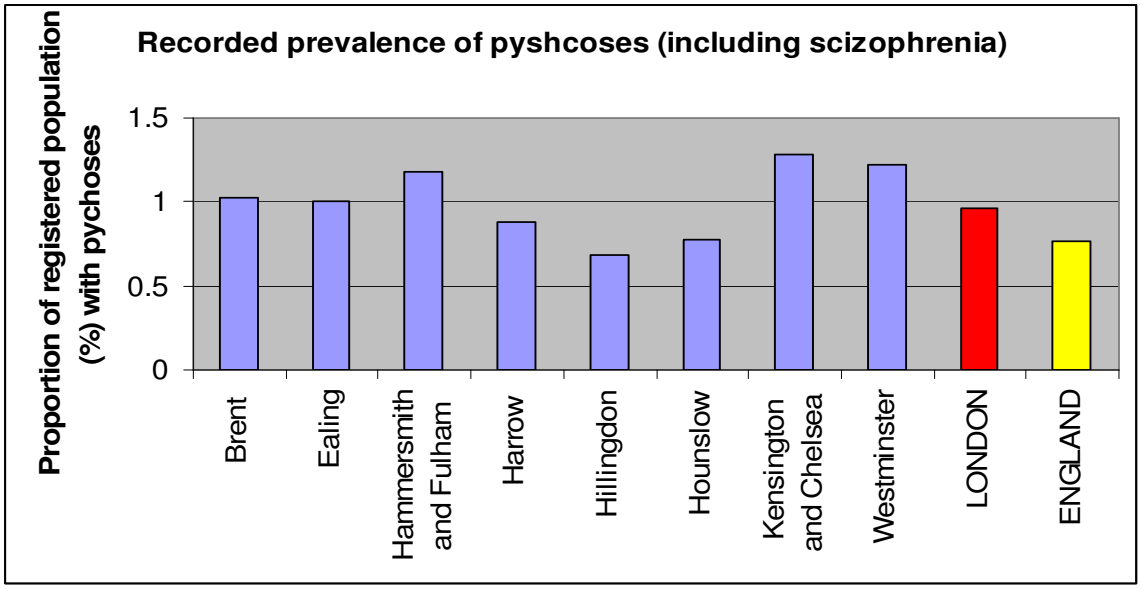


Source: QOF 2009/10

The prevalence of psychotic illnesses, including schizophrenia, varies across the 8 boroughs in the North West London Cluster (see figure below). Kensington and Chelsea, Westminster, Brent, and Hammersmith and Fulham have a higher prevalence of psychotic illnesses than the London average.

[8] QOF data 2009/10

In addition, Brent, Kensington and Chelsea and Westminster all have a significantly higher rate of emergency admissions to hospital for schizophrenia than the London average.[9]



Source: QOF 2009/10

Across the Cluster a significant proportion of the healthcare budget is spent on mental health services (see figure below). There is also considerable variation in spending on mental health services between the eight primary care trusts in the sector. This variation in spending partly reflects varying levels of population mental health need across the sector. However, it is also important that we ensure that any variations in mental health spending costs are not a result of inefficient delivery of mental health services.

Proportion of PCT budgets allocated to mental health services

Primary Care Trust	Percentage of total budget spent on mental health services (2009/10)
Brent	12.4
Ealing	15.1
Hammersmith and Fulham	15.4
Harrow	14.7
Hillingdon	8.9
Hounslow	12.6
Kensington and Chelsea	18.8
Westminster	15.8
London average	**14.1**
England average	**12.1**

Source: Department of Health – programme budgeting toolkit.

Primary care clinicians have identified the need to both improve the quality of mental health services and reduce spending on mental health. In order to do this, we must aim to promote the management of common mental health problems in primary care settings and strive to reduce hospital admissions for mental health problems.

[9] Hospital episode statistics 2009/10

Effective, integrated and responsive mental health services will enable people with mental health conditions to successfully manage their illnesses in the community allowing them to continue to play an active role in society.

The Financial Case for Change

NHS NWL is one of the largest PCT Clusters in England. The total spend in the NWL health economy is £3.5billion, which represents 24% of health expenditure in London. Based on current services, by 2014/15 we estimate we would need an additional £1bn of funding above that which is likely to be available, in order to keep pace with expected increases in demand. This pressure would broadly fall one third for commissioners and two thirds across all the providers (acute and non-acute).

We updated our forecast of NHS NWL's financial position to cover the next 3 years, using the latest planning assumptions given by NHS London and locally agreed adjustments. In addition, growth in demand for services has been projected using the planning assumptions of each PCT, based on their own populations. The headline assumptions used are:

- Growth in PCT allocations of an average 2.6% p.a. from 2012/13 to 2014/15
- NHS prices generally falling by 1.5% p.a. due to low pay and non-pay inflation (2.5% average) and an annual 4% efficiency requirement on all providers
- Demand for services rising, due to population, technological changes and patient expectations, by between 2% and 5% per annum
- NHS NWL will deliver the minimum1% annual surplus with individual PCTs contributing greater or lesser sums dependent on their financial and capitation positions.
- A Cluster Transition Fund contribution of 1-2% per annum from PCTs

There is commitment from the current Government for NHS funding growth to keep pace with inflation. While the forecasts are based on certain levels of growth and inflation that may vary, the 4% efficiency requirement for NHS providers is not intended to change, therefore the forecast savings requirement from the modelling will remain valid.

The updated modelling indicates the savings requirement has increased due to increased financial pressures above plan in 2010/11 and slippage in recurrent QIPP delivery to date. The impact of this has raised the original 5-year commissioner saving requirement from £332m to £553m. The QIPP requirement for the next 3 years will be £121m, £99m and £83m from 2012/13 to 2014/15.

The increased financial pressures have emphasised the need for commissioners to find ways to reduce demand and/or find cheaper ways of delivering healthcare and so all commissioners are developing out of hospital strategies. Providers are also facing increasing pressures, seen emerging in Imperial College and North West London Hospitals especially, and they need to find ways to deliver services more efficiently.

The planning assumptions assume that significant provider efficiencies are made in NWL, in both the acute and no-acute sectors. These are required as a minimum to manage the annual reductions in the tariff. As the commissioners implement their own QIPP schemes, the savings requirement will increase. Analysis carried out for NHS London indicates the NWL non-Foundation Trust providers will need to make £360m of savings over the next three years in order to become financially qualified for FT status. This is a required objective for all NHS Trusts.

This level of required saving will not be possible for Trusts from purely operational productivities and as such service change may be needed to meet these ambitions. Potential changes, driven by increasing Quality Standards, are being actively considered by a number of Trusts, supported by NWL Commissioners.

Resources will be required to temporarily support providers while they re-align services and reduce their cost base. The Cluster Transition Fund is being created in order to provide this support. Any funding provided will only be in support of changes that have been subject to full Business Case development and that demonstrate the clinical case for change. The Cluster will not provide financial support for unaffordable models of care.

The breakdown of individual PCTs' projected QIPP targets and detailed planning assumptions are set out in the Financial Strategy section.

Commissioning for Quality

During 2011/12 the Cluster developed a set of standards against which NHS NWL will commission health care in future to address our case for change

Patients and the public rightly expect high quality care, indeed our staff and healthcare providers want to work in a system that ensures, recognises and rewards quality of care. NWL has some world-class services and good levels of health but this masks significant inequalities in health status and even greater variation in the quality of healthcare provided. NWL must focus its resources on services which are efficient and effective and are demonstrably high quality. Commissioners in NHS NWL are prioritising a number of quality work programmes based on the following standards;

- Implementation of the National Outcomes Framework
- Quality standards: commissioning for quality in NWL

NHS NWL's approach to commissioning for quality standards will help commissioners and providers deliver a step-change in new models of care that patients expect and staff want to deliver in line with NHS NWL's model of care to localise care close to patients' homes, centralise specialist care and to develop integrated care services for people with long term conditions and the elderly. Although we have made progress in 2011/12 in delivering improved quality services and delivering our services around patients rather than organisations, we are only part-way through this planning cycle and there is more to do to deliver our aims. As commissioners and system managers we now need to take the thoughts from the providers based on the quality standards to inform the future service landscape in NWL.

Implementation of the National Outcomes Framework

Liberating the NHS (DH, 2010) set out a vision of an NHS that achieves health outcomes that are among the best in the world and to achieve this, an *NHS Outcomes Framework* that provides national level accountability for the outcomes that the NHS delivers. Its purpose is threefold:

- To provide a national level overview of how well the NHS is performing, wherever possible in an international context;
- To provide an accountability mechanism between the Secretary of State for Health and the NHS Commissioning Board; and
- To act as a catalyst for driving quality improvement and outcome measurement throughout the NHS by encouraging a change in culture and behaviour, including a renewed focus on tackling inequalities in outcomes.

The first *NHS Outcomes Framework* sets out the outcomes and corresponding indicators that will be used to hold the NHS Commissioning Board to account for the outcomes it secures through its oversight of the commissioning of health services from 2012/13. We expect the second *NHS Outcomes Framework* to be published for 2012/13 towards the end of 2011.

NHS NWL's Commissioning Intentions for 2012/13 and approach to commissioning quality standards in NHS NWL to 2014/15 will supplement the *NHS Outcomes Framework* and include the local delivery of national outcome goals.

NHS NWL Quality Standards

NHS NWL is underpinning its work on quality through a discussion document which aims to support both current and future commissioners to deliver a step-change in commissioning high quality care and not simply volumes and costs of care. To bring to life the standard of care we should expect our patients to receive when they use the NHS in NWL the document, appended to this plan at **Appendix A**, illustrates what high quality services should look like for a number of our most common patient journeys. Underpinning each patient story are published standards, metrics and guidelines from Royal Colleges, NICE, London Health Programmes and others that have extensively reviewed clinical research and worked with patients and clinicians to describe what good quality of care looks like.

NWL providers meet many aspects of the standards now and can improve further with revision of existing pathways. The advent of clinical commissioning groups provides the Cluster with the opportunity to collectively pursue a commissioning strategy with emerging CCGs that will address the variations in quality identified in our case for change through the rigorous application of a set of agreed quality standards. These will be used by the Cluster to inform the accelerated development of the appropriate models of care with our providers that will deliver the standard of care we should expect our patients to receive.

Patient stories

Although the names and scenarios are fictitious, the patient stories below describe the high quality care we want to commission:

- In acute services (focusing on emergency surgery, A&E, inpatient paediatrics, and maternity services)
- For planned care and the management of Long Term Conditions (standards for high-level clinical pathways with two illustrative in-depth pathways)
- In primary care, when it is part of an integrated care pathway (illustrated for diabetes) or as part of an end-to-end pathway including care in an acute setting (illustrated with emergency care and paediatrics)
- In a mental health care pathway
- For a complex patient at the health and social care interface

A long list of the priorities that NHS NWL commissioners are reviewing with the intention of implementing in contractual arrangements with providers are included in NHS NWL's Commissioning Intentions for 2012/13. All standards are sourced in the full document 'Quality Standards: Commissioning for Quality in North West London', but are taken from:

- NCEPOD (2007) Emergency admissions: A journey in the right direction?
- RCP (2007) The right person in the right setting – first time
- RCS (2011) Emergency Surgery Standards for unscheduled care
- NICE (2008) Metastatic spinal cord compression
- NCEPOD (2005) An acute problem
- AoMRC (2008) Managing urgent mental health needs in the acute trust
- NCEPOD (1997) Who operates when?
- NCEPOD (2004) The NCEPOD classification of Intervention
- Standards for maternity care: report of a working party. (2008) RCOG, RCM, RCA, RCPCH

- Safer Childbirth – Minimum Standards for the Organisation and Delivery of Care in Labour (2007), RCOG.
- Facing the Future: Standards for Paediatric Services, Royal College of Paediatrics and Child Health, April 2011
- Children's NSF Standard for Hospital Services (DH, 2003)
- Services for Children in Emergency Departments (RCPCH, 2002)
- Children and Young People's Mental Health: A Framework for Promotion, Prevention and Care (Scottish Executive, 2005)
- Primary total hip replacement: A guide to good practice (British Orthopaedic Association, 2006)
- London Health Programmes

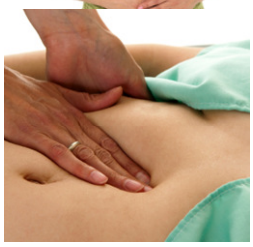
Patient journey in emergency care

Illustrative patient journey

Referral

- Ruth is 23 years old and generally considers herself healthy. She has had 36 hours of stomach aches and a temperature and on Saturday morning she wakes up with worsening symptoms. At 8am she phones her GP and gets a morning appointment.
- The GP examines her, is concerned about her high temperature and abdominal pain and refers her to A&E for further investigations.

A&E



- Within 1 hour of arrival, an A&E doctor sees and examines Ruth and is concerned she may have appendicitis.
- She is transferred to ASU.
- She is reviewed by a consultant, who also suspects appendicitis.
- She is given pain relief, rehydrated with IV fluid and is kept nil-by mouth. All information is recorded on a document which travels with her. Her GP is informed that she has been admitted.

Imaging

- Differential diagnostic tests are performed to confirm Ruth's suspected appendicitis. Ultrasound does not give a clear result so a CT scan is performed and reported within 2 hours.
- Based on the severity of symptoms and diagnostic findings, the consultant recommends Ruth for emergency surgery.

Emergency surgery

- Ruth consents to a laparoscopic appendicectomy (LA). Following a discussion with consultant anaesthetist she is classified as ASA1 and "low risk". A fully staffed emergency theatre and consultant on site within 30 minutes is available, and her surgery is performed 6 hours after admission

Ward

- Postoperatively Ruth is transferred back to the surgical ward, where she is assigned with a estimated discharge date and discharge plan.
- She is seen by a consultant on twice daily ward rounds. After 2 days, she feels much better and the consultant gives her permission to go home.

GP/ follow-up

- Before she leaves the hospital an appointment with her GP is booked for three days time.
- She is given an emergency helpline number to contact in case of complications.
- Her GP is send her full patient record and discharge information on the day she leaves the hospital.

SOURCE: NCEPOD 2007, RCP 2007, RCS 2011, NICE 2008, ASGBI 2010, Map of Medicine

Patient journey in emergency surgery

Illustrative patient journey

Ambulance services

- Mr Sarang Patel arrives at A&E in an ambulance at 2am. He is unconscious, in shock and he has been resuscitated during the journey. A&E has been alerted in advance of his arrival.
- He is 67 years old, smokes and has high blood pressure.

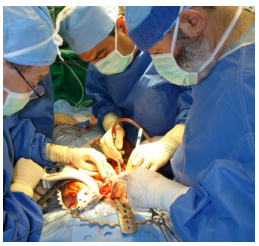
A&E

- He is seen by the A&E team on arrival who examine him, instigate treatment with an IV line and conduct tests.
- Sarang gains consciousness briefly and talks about his abdominal pain.
- The A&E consultant suspects a possible abdominal aortic aneurysm (AAA) and he is immediately transferred to a vascular unit for emergency surgery.

Imaging

- While the operating theatre is being prepared, ultrasound is used to confirm the diagnosis.

Emergency surgery



- During transfer, the operating theatre was prepared. Within 30 minutes of arriving at A&E, Sarang is in theatre. An open repair operation is performed. Sarang loses a large amount of blood, but the operation is successful.

Critical care

- Sarang is admitted to ICU (level 3)
- The surgeon briefs the ICU consultant. The ICU has full ventilatory support and monitoring and is staffed by a medical team with specialist training.
- Sarang stays on ICU for 5 days.

Ward

- Sarang is transferred to the surgical ward, where he is given an estimated discharge date and discharge plan. He is seen by a consultant on twice daily ward rounds. After 14 days, he feels much better and the consultant gives him a permission to go home. He is provided with information about follow-up and next steps.

SOURCE: NCEPOD 2007, RCP 2007, RCS 2011, NICE 2008, ASGBI 2010, RCA 2009, Map of Medicine

Patient journey maternity care – Sarah's difficult labour

Illustrative patient journey

Booking and antenatal care

- Sarah is 31 years old and pregnant with her second child. She uses her GP's website to book an appointment with the midwife directly.
- The midwife estimates Sarah is 8 weeks pregnant and takes her medical history. She explains that she and the local midwifery team will provide care throughout Sarah's pregnancy. Sarah agrees for her GP to give her midwife access to her medical records. Sarah had obstetric cholestasis during her last pregnancy, so the midwife also refers her to an obstetrician.
- At 12 weeks, Sarah has her first ultrasound scan and at 20 weeks she has her second scan. The midwife encourages Sarah's partner to come along to Sarah's appointments.

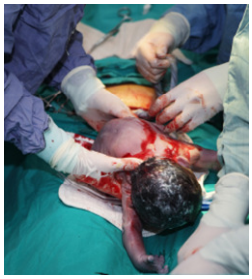
Antenatal care (26-39 weeks)

- Sarah has an appointment with the obstetrician and they discuss what to do if the obstetric cholestasis recurs.
- In her antenatal appointments routine checks* are performed and written in her pregnancy notes. Her midwife talks to her about a birth plan, options for pain relief and birth settings (risks and benefits), and gives her a leaflet to take home. Sarah prefers a midwife led unit and is offered a visit to the unit.
- At 28 weeks, Sarah gets stomach pains and vomits over the weekend. She rings her midwife who advises her to go to A&E. She is seen by A&E staff as well as the obstetrician on-call, who contacts her midwife. She is given fluids and sent home later that day for follow up in community. She recovers quickly.

Presentation and admission to maternity ward

- At 39 weeks, Sarah goes into labour. She rings the midwife-led unit and the midwife suggests she comes into the unit
- Sarah is greeted and assessed by a midwife, who introduces her to the team and explains she will be responsible for her care throughout her labour.
- Her contractions are regular but her midwife is concerned about the baby's heartbeat. She informs Sarah and speaks to the consultant midwife, who advises her to contact the neighbouring consultant-led obstetric unit.
- The senior obstetrician in the unit advises transfer to the unit. The midwife ensures Sarah and her partner understand what's going on. Sarah is transferred immediately.

Delivery



- On arrival she is cared for by a senior midwife and an obstetrician. She and her baby are constantly monitored.
- Sarah requests an epidural. The anaesthetist arrives in 20 minutes and after discussion the epidural is performed.
- The baby's heartbeat shows persistent changes, and the consultant obstetrician asks for a fetal blood sample to be taken. The obstetrician discusses the results with Sarah and her partner, and advises an emergency C-section; they agree. Indications for the C-section are clearly documented in Sarah's notes.
- While Sarah is prepared for theatre a senior paediatric colleague trained in neonatal resuscitation is informed; she attends the procedure.
- Sarah delivers a healthy baby boy weighing 3.5kg.

Postnatal care and admission to postnatal ward

- Postoperatively Sarah and her baby boy are transferred to the postnatal ward for monitoring
- Whilst recovering from anaesthesia, Sarah is observed on a 1-to-1 basis. All seems well so she is then monitored every half an hour for the next couple of hours and then hourly by her midwife.

Footnote: *Patient story adapted from Maternity services, DoH (2005), * Routine checks in accordance with NICE guidelines include: check size of abdomen, measure blood pressure, and urinanalysis.

Source: *Standards for maternity care : report of a working party*. London : RCOG, 2008; *Safer childbirth : minimum standards for the organisation and delivery of care in labour*. London : RCOG, 2007; *Towards better births : a review of maternity services in England.* (2007). Healthcare Commission Maternity Review, National Institute for Health and Clinical Excellence (NICE). *Intrapartum care: care of healthy women and their babies during childbirth*. London: NICE; 2007, *Future Role of Consultant: A working party report* (2005). RCOG

Patient journey maternity care – Sarah's difficult labour

Illustrative patient journey

Hospital postnatal care

- Two days after the birth, Sarah feels a bit down and quite tearful. She wants to go home, but she is finding breastfeeding difficult; her midwife encourages her to continue and spends some time discussing the benefits and that initial difficulty is a common problem. They also talk through the labour and the need for an emergency C-section with Sarah and her partner. They agree that so long as she feels happier and confident with her breast feeding, she can soon be discharged.
- On the 2nd day, the baby has a documented baby check.

Discharge and follow up in community

- Before she is discharged, Sarah and her partner are given their baby's personal child health record, and the Birth to Five information book. They are also given contraceptive advice (which will be reiterated by her midwife and GP)
- Sarah's usual midwife visits her at home several times to check she and the baby are well. The midwife encourages Sarah to continue to breastfeed.
- On day 7, the midwife (with Sarah's permission) performs a bloodspot screening test.
- As care shifts from the midwife to the health visitor Sarah is offered a joint home visit involving them both. From this point onwards the health visitor will support Sarah and her partner

Footnote: *Patient story adapted from Maternity services, DoH (2005)

Source: Standards for maternity care : report of a working party. London : RCOG, 2008; Safer childbirth : minimum standards for the organisation and delivery of care in labour. London : RCOG, 2007; Towards better births : a review of maternity services in England. (2007). Healthcare Commission Maternity Review, National Institute for Health and Clinical Excellence (NICE). Intrapartum care: care of healthy women and their babies during childbirth. London: NICE; 2007, Future Role of Consultant: A working party report (2005). RCOG

Patient journey maternity care – Claire's emergency complication

Illustrative patient journey

Booking and antenatal care

- Claire is 28 years old and this is her first pregnancy. Claire books an appointment with her GP who estimates that she is 7 weeks pregnant and advises her to book an appointment with the midwifery team.
- The midwife advises that she (and the midwifery team) will provide care and advice throughout Claire's pregnancy. After taking Claire's medical history, she explains what to expect in the next few months and recommends that Claire and her partner attend antenatal classes. The midwife explains screening tests offered and gives Claire a leaflet with more information.
- Claire agrees to screening tests and has scans at 12 and 20 weeks.

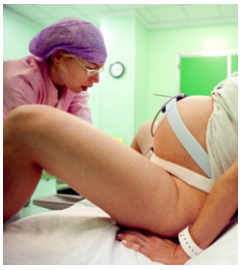
Antenatal care (26-39 weeks)

- Claire attends her antenatal appointments. Routine checks** are performed and written in her pregnancy notes. The midwife continues to provide advice to promote about a healthy lifestyle and encourages involvement of Claire's partner.
- Claire's midwife talks to her about a birth plan and options for pain relief in labour. Claire has no significant past medical, obstetric or social history, so her pregnancy is assessed as 'low-risk'. Her midwife also discusses (and gives her a leaflet) about birth settings including the option of a home birth. Claire wants to give birth in a midwife-led unit and is offered to visit the unit prior to delivery.
- Claire and her partner attend antenatal and parenting classes.

Presentation and admission to maternity ward

- Two days after her due date, Claire goes into labour. She rings the midwife-led unit. The midwife advises her to come in, and that they will be ready for Claire when she arrives.
- The midwife on-duty also reminds her to bring her pregnancy notes and an overnight bag.
- Claire is greeted and assessed by a midwife who introduces her to the rest of the team who will be involved in her care.
- Claire's midwife explains she will be responsible for her care throughout her labour.

Delivery



- Claire delivers a healthy baby but afterwards she continues to bleed. The midwife calls for help and tries to stem the bleeding, but Claire loses over a litre of blood.
- The consultant midwife arranges immediate transfer to the consultant-led unit next door. She informs the obstetric ward so they are prepared for resuscitation, monitoring and investigation into underlying causes.
- The bleeding continues and Claire is going into shock. Protocols are followed involving the senior midwife, consultant obstetrician, consultant anaesthetist and consultant haematologist. Porters deliver blood from the transfusion lab. As her vital signs deteriorate, Claire is given a general anaesthetic and taken to theatre
- The obstetric unit has access to an interventional radiology service. This enables the bleed to be controlled through selective closure of blood vessels.

Postnatal care and admission to postnatal ward

- Claire is transferred to ICU on the labour ward where she is monitored continuously. Monitoring takes the form of an early warning system.
- Support and information is provided for Claire's partner to help him understand what happens and to help hi

Footnote: *Patient story adapted from Maternity services, DoH (2005), ** Routine checks in accordance with NICE guidelines including check size of abdomen, measure blood pressure, and urinanalysis.

Source: Standards for maternity care : report of a working party. London : RCOG, 2008; Safer childbirth : minimum standards for the organisation and delivery of care in labour. London : RCOG, 2007; Towards better births : a review of maternity services in England. (2007). Healthcare Commission Maternity Review, National Institute for Health and Clinical Excellence (NICE). Intrapartum care: care of healthy women and their babies during childbirth. London: NICE; 2007, Future Role of Consultant: A working party report (2005). RCOG

Patient journey maternity care – Claire's emergency complication

Illustrative patient journey

Hospital postnatal care

- Claire makes good progress over the next week and continues to be monitored by midwife for signs of complications. The obstetrician talks through what happened with Claire and her partner and they have a chance to ask questions.
- Claire's partner is very supportive and has been solely responsible for care of their new baby boy.
- On the 2nd day, a baby check is carried out and documented

Discharge and follow up in community

- A discharge plan is made. The midwife talks to Claire and her partner about screening tests and support services. Claire is given contraceptive advice.
- Claire and her baby are discharged home with ongoing support from the midwife and a contact telephone number. Claire's usual midwife continues to pay home visits which continue according to her needs.
- On day 7, the community midwife asks Claire for permission to perform a bloodspot screening test and tells Claire that she will get the results before her 6-8 week postnatal check.
- To ensure continuity of care, the midwife and the health visitor offer Claire a joint home visit. From this point onwards the health visitor will provide support and advice for Claire and her partner.

Footnote: *Patient story adapted from Maternity services, DoH (2005)

Source: *Standards for maternity care : report of a working party*. London : RCOG, 2008; *Safer childbirth : minimum standards for the organisation and delivery of care in labour*. London : RCOG, 2007; *Towards better births : a review of maternity services in England*. (2007). Healthcare Commission Maternity Review, National Institute for Health and Clinical Excellence (NICE). *Intrapartum care: care of healthy women and their babies during childbirth*. London: NICE; 2007, *Future Role of Consultant: A working party report* (2005). RCOG

Patient journey in paediatrics – Laura's asthma attack

Illustrative patient journey

Out-of-hours GP visit

- Laura is 6 years old and has asthma. On Sunday, Laura starts wheezing badly and has some difficulty breathing. She has a temperature.
- Laura's mother calls 111. She speaks to a nurse who asks questions to understand Laura's condition, and advises her to go to the Urgent Care Centre to see a GP.
- Within 10 minutes of arriving at the UCC she sees a GP who starts her treatment immediately. Within an hour Laura has stopped wheezing.

A&E

- Within 4 hours her symptoms suddenly deteriorate. Her mother calls 111 again; as her breathing problems are severe now the nurse advises her parents to take her to the nearest A&E.
- On arrival, the triage fast-tracks her to be seen immediately in paediatric A&E
- Treatment is effective and Laura soon gets better. In an hour she is transferred to the children's ward by a paediatric nurse.

Paediatric ward

- During the night, Laura's condition worsens and the duty paediatrician calls the respiratory consultant-on-call at the tertiary centre for advice.
- Laura gets further treatment but transfer to the specialist unit is unnecessary. Laura steadily improves, she stays in hospital for the next 2 days and is treated according to the agreed plan.
- Laura's parents are offered a bed beside Laura in her room in the children's ward.

Discharge and follow-up

- Before discharge, a revised asthma action plan is agreed between Laura, her parents and the consultant. Inhaler technique and information of what to do if it Laura becomes breathless again are taught to both Laura and her parents.
- A follow-up appointment is booked at the outpatient clinic, a discharge letter is written to the GP and the GP receives an update to Laura's patient record about her admission to hospital.
- Laura's parents are given a phone number to call, if Laura's condition deteriorates again.

Self-management and support

- In her follow-up appointment with her GP, the GP discusses with Laura's mother how best she and Laura can manage her asthma. She also has an appointment with the asthma specialist nurse.

SOURCE: RCPCH 2007/2011, DH 2006, RCoA 2005, CSF 2007, NICE 2007, PICS 2001

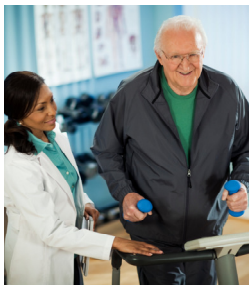
Patient journey planned care – elective hip replacement

Illustrative patient journey

GP appointment

- Reginald is 69 and lives alone. He's been enjoying an active retirement, but over the last couple of years he has found walking increasingly painful. It's got so bad that he finds leaving the house difficult – and with so little exercise, he's also struggling with his weight.
- He goes to see his GP and describes his pain and difficulty walking. His GP organises investigations including an x-ray and asks Reginald to come back in two weeks time.

GP-led treatment and referral

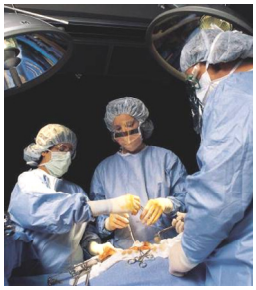


- At the next appointment, the GP explains to Reginald that he has degenerative changes in his left hip. The GP talks about the treatment options and together they work out a management plan, including changes to Reginald's diet. The GP refers Reginald to a physiotherapist, tells him about the other healthcare professionals who will be involved in his care and gives him information to read at home.
- Reginald's pain worsens over the next few months. He visits his GP again, who suggests the option of a hip replacement.

Decision to operate and transfer to waiting list

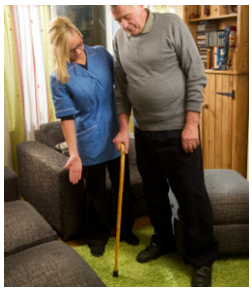
- Reginald agrees to consider a hip replacement
- The GP goes through an assessment of reginald's severity, drawing on the physiotherapist input. There is a standard form which the GP, Reginald and physio complete and this gives a "score" which indicates whether or not Reginald can expect to benefit from surgery. .
- The GP also gives Reginald a booklet about having a hip replacement for him to read
- Reginald meets the criteria for hip replacement surgery and is keen to have it done. so the GP places him on the waiting list.
- Reginald attends an outpatient pre-op assessment appointment to assess his fitness for surgery 2 weeks before his scheduled procedure and also has an opportunity to ask the nurse questions about the procedures.

Admission, surgery and recovery



- The date of his operation arrives. Reginald goes to the hospital in the morning. An anaesthetist and the surgeon who will be carrying out the operation come to see him. They explain what will happen and the surgeon marks the limb which is to be operated on. Reginald is assessed for risks of complications.
- There are no complications in the operation, and Reginald is transferred to the wards for recovery.
- In the ward he is continuously monitored, and his care includes pain relief and antibiotics. His physiotherapy and mobilisation start straight away.
- An X-ray of Reginald's hips is taken 2 days after his operation to assess its success.

Rehabilitation and follow up in community



- Reginald rehabilitation is going well; by the time he is discharged 3 days after the operation he can manage stairs and has a home exercise programme.
- A multidisciplinary care plan is arranged, and a discharge summary is sent to his GP for follow up in the community. He's also given contact details of someone to call if he's worried.

SOURCE: Osteoarthritis: National clinical guideline for care and management of adults (National Collaborating Centre for Chronic Conditions, 2008), Delivering quality and value: Focus on primary hip and knee replacement (NHS Institute for Innovation and Improvement, 2006), Primary total hip replacement: A guide to good practice (British Orthopaedic Association, 2006)cac

Patient journey – long-term condition (diabetes)

Illustrative patient journey

GP-led care

- Joan Smith is 70 and lives alone. Over the past few months she has been feeling increasingly tired; she books an appointment with her GP.
- Her GP does a blood test which shows her blood glucose levels is raised. A urinalysis and formal glucose tolerance test are performed (OGTT) which confirm the diagnosis. He arranges a follow-up appointment.
- At the next appointment, Joan's GP explains the diagnosis and the importance of self-monitoring, diet and exercise. He does further tests including BMI, blood pressure, cholesterol and a foot check. He tells Joan about all the health care professionals who will be involved in her care and gives her a booklet about managing her diabetes. She starts regular medication.

Integrated care pathway

- At her next appointment, Joan and her GP agree on an integrated care plan over the next 12 months. Her GP explains the importance of documenting her blood sugar levels to reduce chances of complications, attending regular follow ups and how her treatment will be monitored.
- A target HbA1c is recorded and agreed with Joan.
- She has retinal screens and feet checks annually and her care is reviewed every 3 months
- The GP and patient agree for Joan to be a patient in the ICP service but snce Joan is a low risk, she remains on a standard low-risk ICP. The care plan has a series of interventions agreed by the local MDT and this is shared securely with all providers, including Joan and the A&E.
- On her 6 month appointment, Joan fails to attend. Her absence is followed up by her care-coordinator.
- 12 months later Joan's care plan and glycaemic control are reviewed

Admission to A&E

- One evening Joan feels dizzy and has a fall. She is found by her daughter the following morning still lying on the floor. She remembers little about the fall and has not had any food or drink since last night. Her daughter calls 999 and an ambulance takes Joan to the nearest hospital. The UT system flags that Joan is a member of the ICP and the receptionist provides her care plan to the clinical staff.
- The diabetes care Joan receives is seamless from the care she receives from her GP.
- Within an hour of arrival, Joan is reviewed and a hip fracture is suspected. She is given pain relief and referred for early radiological assessment. She is given IV fluid to fluid and electrolyte abnormalities. Her care is overseen by the specialist diabetes team. She is reviewed by the medical team and followed up by the diabetic specialist nurse, who checks her current and past glycaemic control.

Assessment, surgery and post-operative recovery

- Imaging is performed within an hour and radiological assessment confirms a hip fracture. Within 4 hours, Joan is transferred onto an acute orthopaedic ward.
- Within 12 hours, a multi-disciplinary assessment is completed. The consultant surgeon recommends a surgical fixation (hemi-arthroplasty). Joan consents to the procedure.
- A discharge plan and an estimated discharge date are formalised.
- Within 36 hours of admission, Joan is in theatre for surgical fixation.
- Afterwards, her blood glucose levels are regularly monitored.
- Shortly after Joan's multidisciplinary rehabilitation plan is started and with the help of the physiotherapist, she starts to mobilise.

Rehabilitation and follow up in community

- Joan continues to make good progress in hospital and is reviewed on a daily basis by both the orthopaedic and diabetic team. Before her discharge, Joan is mobilising well, managing stairs and has a home exercise programme.
- A multidisciplinary care plan is agreed by the multi-disciplinary team set up to look after patients in the community. Joan's GP and community nursing team attend this and it means that the care package agreed is only slightly more intensive than she was receiving before.
- Follow up includes monitoring her diabetes in accordance with her ICP as well as a routine elderly check-up. Since Joan had her fall at home a community nurse and social worker visit Joan to check on her social circumstances, and perform a needs assessment.

Source: London data-pack evidence; NCEPOD 2007, RCP 2007, RCS 2011, NICE 2008, ASGBI 2010, Map of Medicine ; Osteoarthritis: National clinical guideline for care and management of adults (National Collaborating Centre for Chronic Conditions, 2008), Delivering quality and value: Focus on primary hip and knee replacement (NHS Institute for Innovation and Improvement, 2006), Primary total hip replacement: A guide to good practice (British Orthopaedic Association, 2006)

Patient journey in mental health

Illustrative patient journey

GP lead care

Lemar is a 32 year old events organiser from Ealing. He has been increasingly stressed with a large project at work and he took some cocaine to try to deal with the pressure.
He has had schizophrenia since the age of 23. It is Friday evening and he ran out of his antipsychotic medication two days ago because he forgot to get his prescription. He is starting to hear an aggressive voice telling him to harm himself. He goes to his mum's house, which is in Harrow.
He is very upset, but his mum has been given counselling on how to manage acute problems. She calls the local out of hours GP

Integrated care pathway

The out of hours GP has had training on how to assess the gravity of such situations and decides that it is safe currently for Lemar to stay with his mum at her home. Meanwhile he is able to phone the psychiatric liaison on-call.
The psych liaison nurse is able to access the Lemar's notes and advanced care plan which he and his mum had previously agreed to being accessible across the North West London mental health services.
It is noted that he has had a few similar episodes in the past, one resulted many years ago in him being admitted for a month for observation which led to Lemar feeling slightly wary of mental health services afterwards as he feared being 'sectioned' again. Trust however was re established by regular meetings with his community CPN and consultant who allowed him initially to have his medication in a supervised hostel. Since then the notes state that he has had a couple of glitches with taking his medication since returning to his private home but these were quickly resolved.
The psych liaison and the GP met Lemar at home to help make Lemar feel more comfortable rather than him having to go to A+E along. The GP was able to give him an emergency supply of medication according to the dose documented in the notes.
His mum felt reassured by the liaison nurses assessment and all agreed she would look after him that night

Multidiscipline care

The following morning Lemars GP, CPN and community psychiatrist were alerted to the incident.
His CPN met Lemar discussed the event and checked nothing new had changed, such as recent alcohol or illicit drug use (NICE) and reported back to the MDT. It was felt that he should be offered depot injections to prevent this happening anymore. The pharmacist was happy to arrange for this with Lemars consent. His GP checked for any obvious medical problems (His CPN suggested this to Lemar who was happy with it especially as it could be given at his GP practice, where he would also be monitored medically

Patient journey in mental health
Illustrative patient journey

Specialist follow up

In his follow up with his community psych consultant Lemar was fully recovered. He reflected that part of the reason he had lapses was that his current flat was far from public transport and made it hard to go to visit his parents. The psych consultant felt that it was important for his wellbeing that he had support from his mum and asked the assigned social worker to see if he could be re-housed

His mum was contacted by the CPN later to see if she had any concerns or emotional issues as a result of the incident

Lemar was also offered CBT to help him to understand his illness to help prevent any relapse

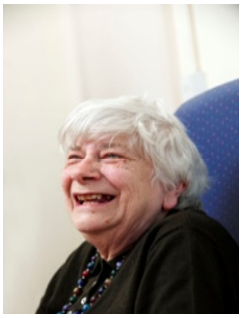
GP Continuity Of care

Lemar continued to have medical monitoring and support from his local GP surgery

Patient journey in the complex health and social problems

Illustrative patient journey

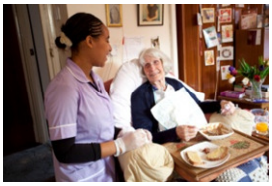
GP lead care



Mavis is a 78 year old widow. She pays for a private cleaner/carer to come in on weekdays. The carer is worried that she isn't as bright as usual and found her slumped in a chair. She had clearly not been self caring or drinking over the weekend. She has lived alone since the death of her husband and sometimes appears confused and wanders out of the house. She has no other social service intervention and no nearby next of kin. She calls Mavis' GP to speak t the doctor on-call.

The carer very kindly waits for the GP to arrive for a home visit feels that she has developed pneumonia exacerbating this reported gradual deterioration hence she is not suitable for emergency social service intervention to be initiated. He notes from the practices last care check of Mavis that her husband had died a little over a year ago, but that she had no significant health, cognitive or social problems previously and was fully independent. Given the gravity of the situation, he cancels the request for the rapid response team and calls the on-call Care of the Elderly Consultant, who arranges for her direct admission to the Elderly Medical Unit. Meanwhile the GP has her notes and next of kin details faxed to the EMU.

Acute Medical Care



She is considered to be dehydrated and perhaps depressed.

Investigation results also confirm that she has a chest infection. This has clearly made her more confused.

Integrated care Pathway

A Mini Mental Score Examination performed as part of the Elderly Care Teams full medical, social and psychological assessment suggested mild dementia.

The ward sister meanwhile decided after consulting the multidisciplinary team to refer to social services for consideration of a residential home as her current state of wellbeing would suggest that she would not manage at home.

A Psychogeriatrician assesses her and agrees that she is mildly demented and has probably been depressed since the recent passing of her husband. He advises commencing an antidepressant and makes a full report concerning her cognition, emotional wellbeing and memory for follow up in the community by the dedicated dementia team.

Patient journey in the complex health and social problems

Illustrative patient journey

Integrated care pathway

Meanwhile her son arrives from the other side of London and is very upset at the welfare of his mother and wants her to go home for with full time carers. He doesn't want her to go to the nursing home as he feels she will deteriorate in this environment as it will mean being further from her friends and familiar surroundings. Also her family home will be sold to fund this. The physiotherapists are not sure at this stage as to whether she is strong enough to manage at home with carers

Multidiscipline care

Social services are able to use the patient profile from an earlier assessment of Mavis and they can be more confident that her current level of confusion is largely due to the acute illness. They also note that it was borderline as to whether she needed care at home before. They feel informed enough from this information to tentatively plan for her to return home with an additional care package, which the family feel much happier about too.

Mavis recovers from the chest infection and with the help of the physiotherapy team regains her ability to care independently and self mobilise. With the help of her antidepressant her mood has improved and with it her memory appears to have improved when re-tested prior to her planned discharge

Patient journey in the complex health and social problems

Illustrative patient journey

GP/Social work Continuity of care

Mavis returns home with her increased care package. She will be followed up initially by the discharge team to ensure that she is managing. Her GP was given a full report of the input from all of the multi disciplinary needs and has arranged to visit her at home to review and problems since her medications had been altered. She has a 'smart' button to press should she encounter any problems and will see the memory team in the next 3 months to reassess her wellbeing and see if any further medication or investigation of her dementia is required. The son is also relieved to know that should the attempt to keep her at home fail, she can be placed in a residential home nearer to him and his sister on the other side of London

The GP also referred her to a falls clinic as the discharge summary noted that her son was worried that she was bumping into things more often. It was discovered at this clinic that her eyesight had deteriorated significantly and she was referred on to an ophthalmologist for cataract surgery. A local charity was able to arrange lifts to these clinics. She also began to attend a local charity's coffee mornings. Social services also kept in regular contact with the son and Mavis' neighbour who kindly offered to look in on her to ensure that they felt adequately supported

Principles for Delivering New Models of Care

To address NWL's case for change and achieve the quality standards our patients expect requires a much more sustainable care system in NWL. At the moment, many people go to hospital for some services which could be better provided out of hospital. For example, some people with long standing back or hip or knee pain are still referred to hospital when we know that they will get better results from seeing a physiotherapist who can advise on exercises rather than an operation. Other people visit hospital because they struggle to get an appointment with their GP at a time to suit them – this is not good healthcare – far better would be to ensure that they can see their GP, or another GP who can provide high quality primary care at a time and place more convenient for the patient. At the same time too many older people end up being admitted to hospital and then running the risk of contracting a hospital acquired infection, or getting confused in an unfamiliar environment, and often this results in them being unable to return home. Not only does this make health care more expensive it also leads to poorer standards of care.

A better model of healthcare would be one in which people are cared for in a high quality, consistent, integrated way in the most appropriate location. Specifically, one in which people can get access to regular and urgent medical advice from their GP practice or a community based urgent care centre, where specialist advice and diagnostic tests can be obtained outside of hospital, and where the care for people with long term conditions, and older people is organised around their day to day needs outside of hospital. Hospitals will still be a key component of the healthcare landscape – providing modern state of the art facilities where highly experienced and specialist staff can provide excellent care, working as part of highly trained teams, with access to leading edge technology. That is what hospitals are for – other centres are better able to provide for the day to day needs of the over whelming majority of the population.

Our existing four year plan set out a strategy that proposed that in order to address our case for change and improve the quality of care in NWL required the development of new models of care that delivered health services in a different way and in different settings of care to where they are currently provided.

This three year strategy renews our focus on delivering new models of care in NWL by 2014/15. As described in our current four year plan, the following principles underpin the models of care the Cluster aims to implement;

1. Centralising the most specialist services means better clinical outcomes and safer services for patients.
2. Localising routine medical services means better access closer to home and improved patient experience
3. Where possible, care should be integrated between primary and secondary care, with involvement from social care, to ensure seamless patient care

Each of these is described in further detail below.

Centralising the most specialist services means better clinical outcomes and safer services for patients

Delivering high-quality, safe and effective services requires significant investment in staff and facilities. Furthermore there is increasing evidence that clinical outcomes improve when teams treat larger numbers of patients with the same condition and also that specialised conditions require the collaboration and support of a number of different clinical teams that should be based in the same organisation. These needs will increase over the next few years with improvements in medicine, the implementation of quality standards from the Royal Colleges and increasing demand on services. Increasing the volume of care delivered by teams and through specific sites is an important factor for some services in delivering improved quality of care to local residents.

The Cluster is focused on improving care by consolidating particular specialties where the evidence is clear that there is a substantial benefit to patients in being treated by a team who see large numbers of people with their particular condition. Coordinating services across several acute hospitals will enable the Trusts to improve the quality of care:

- Patients will be better able to see consultants when appropriate, no matter what time of day or day of the week they are in hospital. Emerging quality guidelines will increase the amount of time that consultants need to be present
  in hospitals providing direct patient care rather than being available on call from home. This is harder to achieve in smaller teams because there are fewer consultants available to provide care around the clock, seven days a week and would thus need a substantial investment to increase consultant numbers to achieve this if the Trusts remained as separate organisations

- The growth of medical subspecialisation has resulted in significant benefits in terms of improved care for patients as doctors and their teams have become more and more expert in specific areas of healthcare – but it also makes it harder to have every sub-specialist available around the clock in every hospital, particularly smaller hospitals. Larger teams can support more consultants with expertise in sub specialities (for example, cardiologists as opposed to general physicians), so that the Trusts can treat patients better and more safely

- There is a proven relationship between the amount of work conducted and the
  quality of care for teams and hospitals across a range of specialities. There is clear evidence that staff with more experience in managing specific conditions or procedures achieve better results for those patients. Larger units can ensure that all clinical teams see at least the minimum number of patients necessary to keep skills up to date and demonstrate high-quality outcomes.

Increasingly, Commissioners will be expected to commission services only from departments which can meet quality standards relating to the critical mass of patients seen, numbers of consultants available and availability of key related specialities that are needed to ensure a high quality outcome. A larger organisation is better placed to meet these standards thus minimising the risk of services, or parts of

services, being decommissioned. Increasing the volume of care allows the Trusts to provide care more efficiently and in a more targeted way.

- Duplication across sites and teams can be reduced so that clinicians are kept busy seeing patients rather than being on stand-by, and resources are focused on patient care instead of on underused buildings and equipment

- Larger teams will allow the Trusts to re-design services across sites so that teams are truly integrated and can offer "hub and spoke" services, combining the maximum local access for patients with expert resources available

- Integration between the Hospital and Community services on this scale will also lead to greater opportunities to manage patients in their own homes, avoid unnecessary admissions reduce the length of time that people need to stay in hospital and prevent readmission.

- Integration can facilitate more responsive patient pathways, particularly around long-term conditions, with better links to primary care

- Ealing Hospital has already integrated with the community services of Ealing, Harrow and Brent and Integration is already delivering some of these benefits in areas of all three Boroughs. The pace and scope of integration would be increased further through the proposed merger

- Integration provides a clear incentive for the newly merged organisation to shift activity into the community and patient's homes to create capacity to reorganise acute.

Larger organisations are better able to capture and use technology for the benefit of patients and to deploy it more quickly.

- The high pace of change in medical science and technology allows hospitals to deliver better care every year. For example, interventional radiology – a discipline which has appeared only in the last few years – enables life threatening bleeding to be stopped and blocked arteries to be reopened.

- The latest clinical equipment is highly specialised and requires extensive training to use effectively. In general it is only a good use of resources to acquire this equipment if there is a large patient catchment area so that the equipment is used most of the time.

- Diagnostic advances are rapid and offer massive advantages to patients. MRI scanners allow hospital teams to diagnose patient conditions with much greater accuracy and reliability than older technologies such as ultrasound and x-ray. New blood testing machines used in pathology can treat a much greater range of blood samples more quickly than older machines. New technologies are affordable on the NHS provided they can be used intensively, which requires a large patient catchment. This makes it difficult to justify providing them at every site if they are rarely or intermittently used.

Localising routine medical services means better access closer to home and improved patient experience

The majority of patients are best cared for in the community, providing better access to care closer to home and avoiding unnecessary visits to hospitals for routine care. Although more care may be provided in the community this may still be provided by hospital staff with the appropriate skills and competencies.

The interface between the GP surgery and the acute hospital will be the area for greatest transformation, with community services moving from a poorly organised, under resourced function, to become the pivotal force in the organisation of health and social care. Bringing together those already working in the community into a coherent system of locality leadership will positively impact on the delivery of scheduled and unscheduled care, as well as improving the patient experience.

Primary care must continue to provide the crucial core key services currently delivered at practice level. They will also play an active role in the identification of patients in high-risk groups which would benefit from the enhanced services available from the Community Service Teams. This proactive approach will lead to the maintenance of independence and wellbeing and the avoidance of unnecessary hospital admissions.

Community Service Teams will be developed and include all those health and social care professionals currently working in localities (outside primary care practices), and will be boosted, over time, by additional members, depending on local needs and service re-design. They may include GPs and other primary care professionals including pharmacists, nurses, therapists and social workers with advanced skills in assessment and management of complex needs with consultants working seamlessly across the old divide between acute and community-based care. These teams will create a strong, multidisciplinary approach focused on the maintenance of more complex cases in the community. Existing co-ordinated care management systems will be developed further and new ones will evolve to include:

- Specific admission avoidance schemes
- Support of primary care rapid response teams
- Supportive discharge schemes
- Support of long-term condition pathways of care
- Enhanced preparation for scheduled care
- Enhanced medicines management
- Enhanced access to a range of diagnostic tests at community settings as these services become commissioned
- Active rehabilitation to avoid admission to hospital and speed discharge.

These services will actively support assessment and discharge planning at the "front-door" of the acute hospital and will also support the clinical supervision of cases within community hospitals, nursing homes and other health and social care settings.

Whilst responsive to local circumstances and need, the Community Service Teams will operate to common standards of delivery and performance across NWL. They will also have a key role in the education, training, recruitment and retention of highly skilled practitioners across primary care and community services and, where necessary, provide supportive interventions and networks for practices and teams where they struggle to meet standards. The relationship between GP practices, community staff

and locality structures is critical to success. In implementing future changes we will need to work with all parties in building teams that ensure continuity, trust and effective joint decision making according to the needs of the community. This must include detailed consideration of clinical responsibility at all levels.

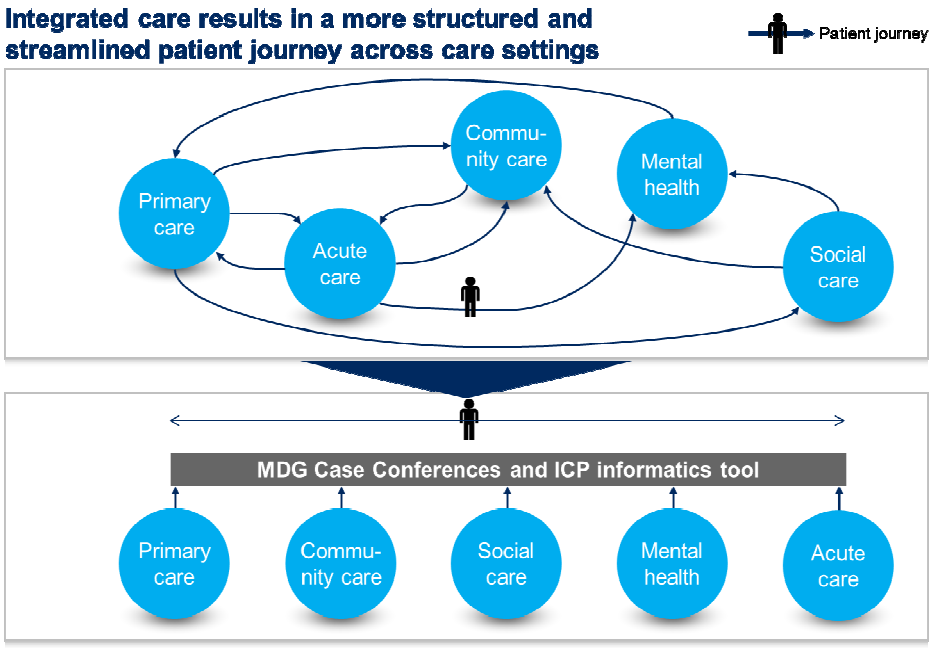
<table>
<tr><th colspan="2">CASE STUDY: HOME THERAPY</th></tr>
<tr><td colspan="2">Joanna is a 36 year old single mother of two children aged 10 and 14. She was diagnosed with multiple sclerosis three years earlier and has had two previous severe exacerbations. She presents with worsening unsteadiness and several falls. She is well known to her GP who asks for an urgent admission to hospital for intravenous steroids which have been recommended by the neurosciences centre.</td></tr>
<tr><td>As things stand

Joanna is referred by her GP and seen in the medical admissions unit. She has a detailed history and examination and is reviewed the next morning by the admitting medical consultant. Joanna is very unsteady and at high risk of falling. She is on her own with two children and the team decide to keep her in hospital. The children are
being looked after by a friend and a referral is made to social services. A neurology referral and an MRI brain scan are requested. MRI confirms the diagnosis of MS but adds nothing else to her care. The neurologist recommends high dose intravenous
steroids for five days. Joanna is tearful and upset that she cannot be with her children. She tries to take her own discharge but is too unwell to get home. She responds to steroid therapy and also receives daily physiotherapy. After seven days she is improved enough to be discharged home with a short period of additional social services support and follow up with neurology.</td><td>In the integrated organisation

Joanna's GP speaks to the consultant in the medical admissions unit and explains the home situation and that Joanna is desperate to avoid admission. Joanna comes to the Medical Assesment Unit (MAU) for assessment to exclude any other cause of deterioration. She is seen by the medical consultant and also has a multi-professional assessment. Joanna is very unsteady and at high risk of falling. The MAU refer her to the community response team who assess her as suitable to be at home with short term support. MAU also refer her to the home intravenous therapy service. Joanna goes home nine hours after referral having received her first dose of steroids in the MAU. She is visited daily by a nurse to complete the five days course of steroids. Joanna is visited by occupational therapy to assess her home environment and receives physiotherapy daily. Hand rails are put up in her bathroom and hallway. She is given a temporary wheelchair to allow her to get out of the house. She is also given help with personal care and put in touch with a voluntary agency funded support group. Follow up is arranged with neurology by the MAU.</td></tr>
</table>

Where possible, care should be integrated between primary and secondary care, with involvement from social care, to ensure seamless patient care

Developing greater integration between primary and secondary care services, with the involvement of social care, would improve clinical outcomes, care planning and patient satisfaction through seamless patient pathways. There will be changes to pathways and settings of care in areas where 'District General Hospitals' have traditionally delivered services, such as A&E 'minors' and outpatients. More integrated care will also mean that different organisations and staff need to be incentivised to work together in multi-disciplinary settings, so patients can access the required expertise and high quality care without the need to access acute hospitals.



SOURCE: NWL ICP Operations Team

At the heart of integrated care is a transformation in the way that professionals work together. It implies several important shifts in ways of working:

- **From patient to population**. Integrated care shifts the care model from reactively diagnosing and treating patients when they are sick to proactively reaching out to predict and prevent ill-health

- **Clinical reasoning.** The integrated care case conferences lead to a different form of clinical reasoning. There is an important shift from a didactic approach – where a single professional presents their view – to a dialectical approach where discussion and debate amongst professionals from different disciplines leads to a richer consideration of the best approach. In the contest of ideas and approaches that this implies, a better overall result can be achieved for the individual patient.

- **Relationships**. Integrated care implies a shift from transactional interactions to enduring relationships across settings. Rather than solely sending formal

referral letters or discharge communications, professionals from across settings develop relationships by working in the same multi-disciplinary group, participating in monthly face-to-face meetings, and exchanging direct contact information (e.g., mobile phone numbers). This is a fundamental shift in the nature of interactions across settings of care that implies an improvement in care continuity and an enhancement in professional skills (professionals are able to seek the council and advice from one another).

- **New knowledge, skills and perspectives.** We have heard clearly from the professionals engaged in the integrated care pilot that the new way of working has enriched their professional experience and expertise. For primary and community care, it is an opportunity to learn from the deep specialism of the acute specialists. For the specialists and acute trusts,, they are able to have a richer understanding of the reality of the patient outside of acute settings and establish integrated and parallel discharge processes to eliminate unnecessary discharge delays. Social care is able to benefit from increased awareness of individuals physical health and information impacting their social well-being. All professionals commented that they had learned from the input of mental health, which has historically been under-leveraged in the management of long-term conditions.

- **New conceptions of accountability.** The integrated care pilot takes a pathway approach to care. This implies a shift in notions of accountability. Multi-disciplinary groups of professionals from across settings are accountable for outcomes for a whole population, rather than just for the individual patient in front of them. Furthermore, through the shared integrated care plans, the flow of information across settings, and the performance review mechanisms, a new form of mutual accountability to the performance across the patient pathway is created. This implies a fundamental shift in the culture, mindset, and behaviours of professionals across health and social care.

Current services are often not as well integrated as they could be. This means that some patients may be discharged from hospital and find that district nursing services, or their GP practice, may not know about their hospital admission or about what treatment they should be continuing to have; it may mean that some patients end up being admitted to hospital just to get advice from a hospital based specialist; and it may mean that social care services are not sufficiently aligned with the healthcare service to ensure that an older person's home is equipped and adjusted in time to enable them to be discharged home at an appropriate time.

Health and social care services across NWL are currently exploring how they can best address these challenges and are increasingly looking to work more collaboratively across organisations to ensure improved quality of care. For example, community and social care staff are now holding regular monthly meetings with GPs and hospital specialists across NW London to proactively identify older people with increasing health needs and plan services to ensure that services are aligned to the needs of patients, rather than the traditional approaches of different organisations.

There is also scope to improve the efficient use of buildings and associated staff – for example community services could be provided out of hospital buildings to enable more integration between hospital and community care; primary care services can be more closely aligned with community care through the use of common space. In some

instances, this will enable more efficient use of new, high quality buildings such as Willesden Green Community centre

Our goal, therefore, is to become a beacon for integrated care in the NHS through better care for a patient that makes more productive and targeted use of resources.

Progress in delivering new models of care in 2011-12

Whilst we have started to make good progress in developing the models of care identified in our four year plan, more needs to be done if we are to address our the case for change and improve the quality of care over the next three years

We have made good progress in 2011/12 in centralising specialist services in NWL, particularly in relation to cancer, vascular and stroke services. We have also made really strong progress in implementing integrated models of care through our integrated care pilot for diabetic and elderly patients. The learning from this programme is now being rolled out for mental health patients in NWL.

Centralising specialist services

Cancer

Across the cluster we have many complex provider pathways with a significant proportion of our patients diagnosed within cancer units in NW London but treated outside the cluster's providers, at the Mount Vernon Cancer Centre and at the Royal Marsden. There are also complex patient flows into the area. This complex provider landscape can result in the duplication of specialist services. Across London a review of cancer services produced a new model of care that described radical changes to the provision and commissioning of cancer care across the capital. Of the changes to provision it is intended that some cancer services would be consolidated over the next three years. Consolidation planned for 2012/13 includes surgery for breast and cancers of the brain and central nervous system. Service changes recommended for 2013/14 are lung surgery, bladder and prostate surgery, haematology, gynaecology, head and neck cancers, oesophago-gastric, and haematopoietic progenitor cell transplantation. The following year pancreatic surgery would be reconfigured. Acute trusts from NW London will join with those of South West and South East London to form the London Cancer Alliance Integrated Cancer System (ICS) which will, in time, be commissioned to deliver entire patient pathways.

Vascular surgery

Over the last year, a range of projects have been implemented by the network to improve the quality of care across acute cardiac, stroke and vascular services. The rationale and mandate for these changes were set out in pan-London reviews of these services, with input from a range of clinicians and services users.

The models of care implemented following the reviews of cardiac and vascular services recommended that complex vascular surgery and specialist cardiac care are delivered by centralised units. For vascular surgery, it was outlined that outcomes for arterial vascular surgery patients could be improved by ensuring that all complex arterial vascular surgery is undertaken in a specialist vascular unit. Northwick Park and St Mary's were identified as the specialist vascular surgery hubs for NWL, with additional infrastructure set up during 11/12 at Northwick Park. For cardiac services, new pathways have been introduced to ensure that all high-risk non-ST elevation acute coronary syndrome (NSTEAC) patients presenting at A&E can access immediate angiography and angioplasty at a specialist centre, rather than being admitted at their local unit and transferred at a later date. Similar processes are being introduced during 11/12 for patients undergoing acute aortic dissection and mitral valve surgery and for patients undergoing electrophysiological procedures to ensure that patients are treated by experienced cardiac specialists with the appropriate level of expertise.

Local unit	Vascular Centre
Hillingdon	Northwick Park
Ealing	
West Middlesex	St Mary's
Chelsea and Westminster	

Progress has been made in setting quality standards for how these specialist services should be delivered, and the networks are assessing these units during 11/12 to ensure that they can deliver services in line with the expected quality standards. The overall aim of introducing these standards for complex cardiac and vascular surgery is

to ensure that outcomes for these patients in London are comparable to the best in Europe.

The case for change for cardiovascular services outlined in the review stated that outcomes for arterial vascular surgery patients could be improved by ensuring that all complex arterial vascular surgery is undertaken in a specialist vascular unit with a dedicated 24 hour vascular surgery team and access to 24/7 interventional radiology. Northwick Park and St Mary's have been identified as the central hubs for the NWL area, which can achieve the required level of activity for complex arterial surgery to meet the appropriate quality standards, set out in the cardiovascular review.

Stroke

For stroke care, 11/12 saw the continued implementation of a new model of acute stroke care. This new centralized model of care saw patients transferred immediately to hyper-acute units at Northwick Park and Charing Cross hospitals, where they received life-saving thrombolysis treatment and intensive treatment to aid their recovery. After this initial stay at the hyper-acute units, patients were discharged to a network of stroke units across NWL. 2011/2012 saw the full accreditation of these units against a range of quality standards that provided assurance that all stroke patients in NWL received a consistently high quality of care across their whole pathway of care. The new system has seen a significant reduction in length of stay (from 15 to 11.5 days) and has led to more patients than expected being discharged home from the hyper-acute units, with 35% being discharged home compared to the expected 20%. In addition more patients (14 per cent) are being given clot-busting thrombolytic drugs than anywhere else in the UK or other large cities around the world. A more detailed analysis of the new system, published in November 2011, will inform about whether the health gains introduced through the new system can be translated into economic benefits for the whole health economy. Work will also be undertaken to potentially adapt the existing acute tariff to best incentivise the rehabilitation phase of the pathway during 12/13 and beyond, with the aim of incentivizing best-practice rehabilitation services and embedding quality across the whole patient pathway.

Ealing and North West London Hospitals NHS Trusts

Smaller hospitals will find it increasingly difficult to fulfil the Promise to Patients and other quality requirements. Ealing Hospital Trust ICO in particular, lacks critical mass when compared to other Trusts in key acute specialties. The North West London Hospital Trust faces similar future challenges in some areas. Currently both Trusts are working on their Outline Business Case that will include scenarios for clinical configuration between sites. The developing outline business case recognises that service change is for commissioners to lead, but makes reference to the need for possible service change to deliver the full benefits of the merger.

Imperial College Healthcare and West Middlesex University Hospital NHS Trusts

In 2011/12 the Trusts began a piece of work, jointly with the Cluster, to develop a case for change and corresponding joint clinical vision, which is expected to describe the need for service change.

During 2011/12 discussions have taken place at a Cluster level, with Ealing and North West London Hospitals NHS Trusts, Imperial College Healthcare and West Middlesex University Hospital NHS Trusts and with NHS London, to understand the

interdependencies between the two programmes and the potential requirement for a NWL-wide consultation programme - ensuring work is joined up and transparent and that the implications of the proposals on local patients are clearly understood. The overlap in the geography served by both sets of providers provides further impetus to undertake this activity jointly.

Localising routine medical services

The centralisation of specialist services will impact across the system in NWL and have implications for patient pathways and provider capacity - both in the acute, primary and community sector – so their design and communication must be considered and assured from a cluster-wide perspective. To be successful, this will need to be complemented by improvements in primary care and community care provision and by health and social care services working together across the system. In particular, any shifts in services to out of hospital settings that arise as a result of the change of the acute landscape in NWL will need to be underpinned by an Out of Hospital strategy which identifies the improvements needed to primary, community and social care.

Community care services represent about 10% of total NHS spend and is an essential element of delivering care to people in their own homes or community facilities. We know that there is considerable scope to improve the current level of community care in NWL in order to improve services to patients and reduce levels of hospital admission. This will result in more people being cared for in their own homes and communities but does require an increase in the level of activity in community services, better planning of those services, and greater integration with other services to avoid duplication and/or gaps in services. There is considerable scope to improve the efficiency of service delivery.

Recent work has identified the scope to increase the number of appointments carried out by a community based team by around 20% or a fifth. Over the next few years, commissioners will be looking to commission more and better quality care from community care providers, but at increased rates of efficiency. In some instances this will require increases in productivity. This could be delivered through additional services provided from within the existing resource level, the development of new ways of working and skills and competencies, the commissioning of new pathways of care and health outcomes, including integrated care models spanning organisational boundaries. In other instances this will require new investment

Clinical commissioning groups (CCGs) across NWL are in the process of developing borough specific out of hospital strategies in response to both the case for change in NWL and the associated shift in activity from acute to non-acute providers.

Whilst CCGs in each of the five outer boroughs (Brent, Ealing, Harrow,Hillingdon and Hounslow) are developing locally tailored approaches they all start with the premise that good out of hospital care starts with high quality primary care and that better networked commissioning and provision will be key.

Pathways

Four pathways have consistently emerged across the boroughs as priorities for change:

- Planned care
- Unscheduled care
- Long term conditions
- Mental Health

Whilst the details of what changes are needed vary by pathway and by CCG the elements that seem to resonate across all include:

- Improved access
- Single point of access and ensuring 111 works
- Same day access to GP/primary care
- 24 hr home based response

- Better early diagnosis and intervention, rapid integrated response, including social community services

- Implementation of effective and efficient intermediate care service out of hours

- Better integration of all pathways with mental health services.

Short Term Assessment, Rehabilitation and Re-ablement Services

A successful example of a new service delivery arrangement is STARRS (Short Term Assessment, Rehabilitation and Re-ablement Services). The STARRS intermediate care service was implemented in Brent in October 2010. The clinical model treats acute exacerbations of Ambulatory Care Sensitive (ACS) conditions for an admission avoidance pathway, in addition to supporting hospital discharges and facilitating community rehabilitation. The service is aligned with Brent Council Social Care to support the assessment and set-up of re-ablement packages of care.

The STARRS project is delivering patient benefits as a result of a Single Point of Access (SPA) to care that integrates care services across Brent. This creates a seamless patient pathway, delivering consistent and reliable services that offer greater choice and personalised care closer to home, or in an appropriate community setting. Thus unnecessary or prolonged acute hospital admissions are avoided. Such support for patients in living independently reduces long-term reliance on care services and substantially improves recovery times and long-term wellbeing. Services like STARRS reduce the need for prolonged care services (>6 weeks) in up to 50% of patients.1

Priorities to 2014/15

To take forward the future plans for further centralisation of services, underpinned by a robust primary and community care strategy, a programme of work is being developed to engage on these models of care and future options for delivery with the public in 2012/13. This is described in more detail in the next section.

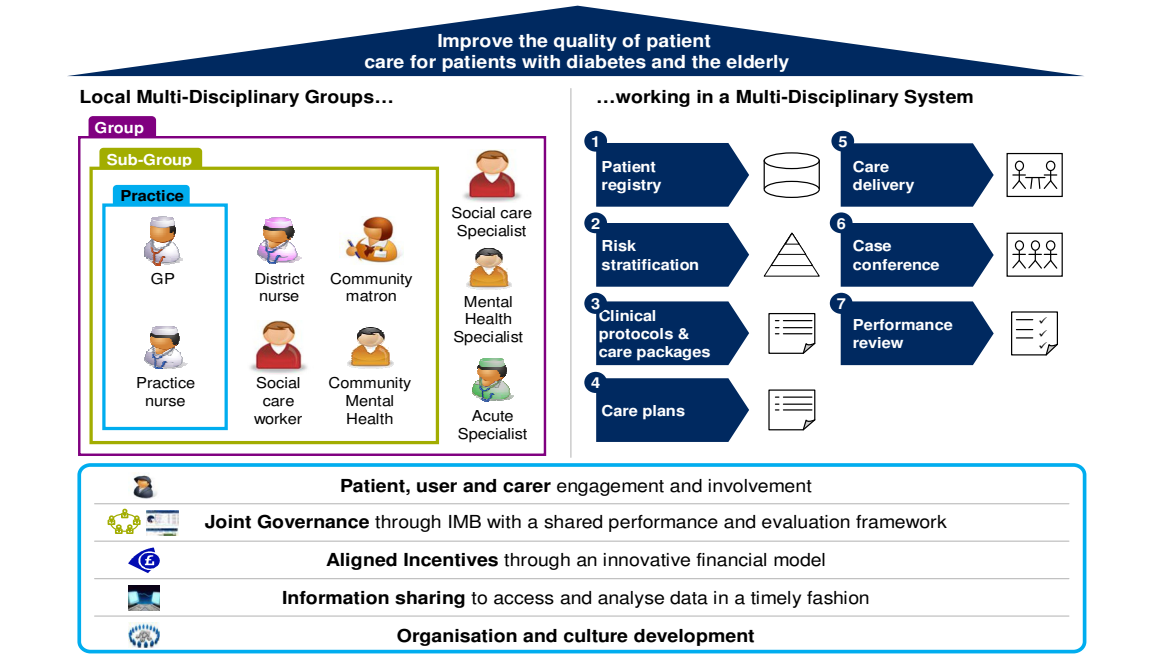
Integrating care between primary and secondary care, with involvement from social care

The Integrated Care Pilot

In June this year, inner NWL launched a highly ambitious pilot to provide better, more integrated care for ~500,000 registered patients, with a specialty focus on diabetic and elderly patients. The goal is to raise the quality of care for people with diabetes and the elderly. Integrated care requires a new way of working between different settings, thereby raising the quality of care for patients, reducing the need for emergency care in the acute sector.

With a population list size in excess of 500,000 engaged in the pilot, it is the largest pilot in the NHS – and the largest attempt to create integrated care between participants in a health system rather than within a single hierarchical organisation globally. The pilot includes nearly 100 GP practices, three community services providers, two mental health trusts, two acute trusts, five local authorities and patient groups. The ICP has been designed by local clinicians who came together in seven working groups to determine every aspect of the Pilot, and by an integrated management board which has set the direction and approved the development of the proposition. The ICP is supported by a small operational team and led by Pilot Co-Directors who are both local GPs.

What's the big idea?

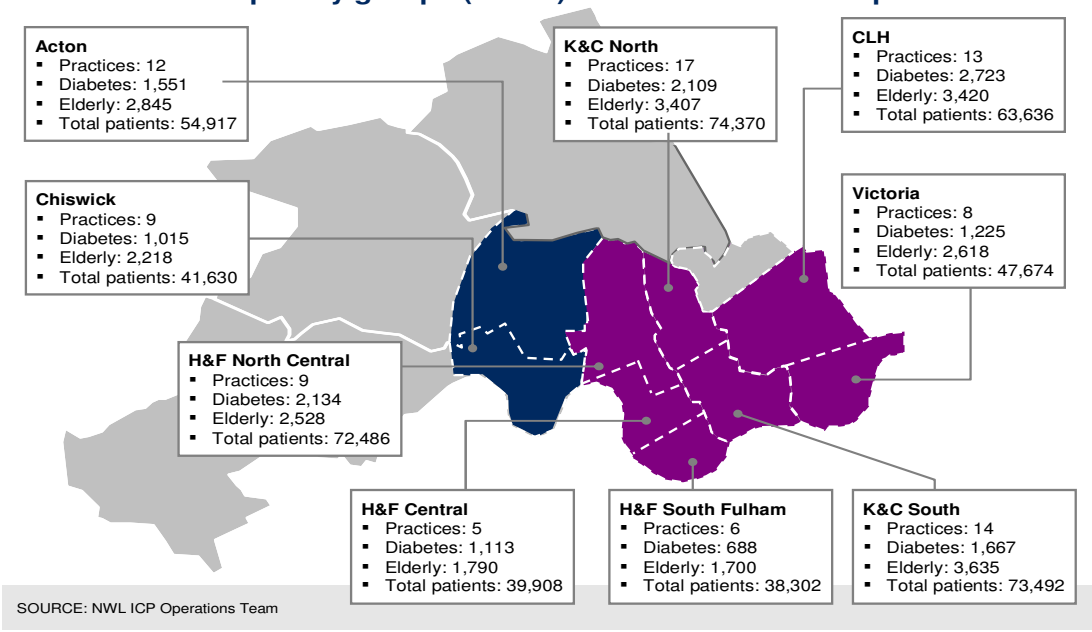


All patients within the targeted subpopulations have their information aggregated to a single patient registry. This information is then risk stratified to identify those patients most at risk of hospital admission. GP practices are then responsible for ensuring patients have integrated care plans that span across settings of care. For the most complex or challenging patients, all members of the Multi-Disciplinary Group – GPs, acute specialists, mental health professionals, social care colleagues, community care professionals – come together for a monthly 'case conference' to figure out the

best way to care for the individual patient. Performance is regularly reviewed by the different participants who hold one another jointly to account for management of the patient and delivery of the care according to the care plan.

In its scale, the pilot has already exceeded expectations. The initial target catchment population of the pilot was around 375,000 people. However, over the past three months, the Integrated Care Pathway partners have organised themselves into nine multi-disciplinary groups (MDGs), covering a combined list size of ~510,000 – or 30% bigger than anticipated.

Over the last three months, the ICP partners have organised themselves into 9 multi-disciplinary groups (MDGs) that reach over 500K patients



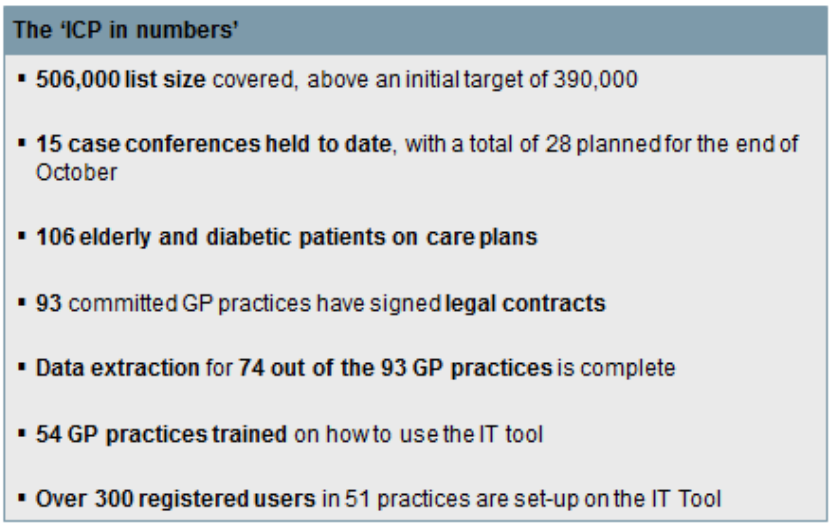
SOURCE: NWL ICP Operations Team

Locally, we have a constant stream of practices interested in joining the Pilot and are currently in the process of setting up our 10th MDG. Nationally, we have been identified as an example of good practice in the NHS1, referenced on Question Time and visited by the NHS Future Forum work stream on integrated care. The innovation and benefit of the Integrated Care Pilot has led to its shortlisting for 2 HSJ Awards, 2 HSJ articles, London Councils recommendation to extend the pilot for diabetes across London5 and a segment on BBC radio 4.

Each MDG needs to go through an intensive mobilisation phase, including formation and governance (signing of legal contracts, approval of resource plans, clarification of governance, and establishment of the baseline); data extraction (authorisation and completion); care planning design & set-up (approve templates, map services and customise the IT tool); and finally care planning implementation (plan activity rate, organise support, load and train users within the MDGs and GP practices, risk stratify the patients and start care planning).

Despite this intensive process, mobilisation is progressing at a steady rate – case conferences are gaining momentum, with 106 elderly and diabetic patients on care plans so far, the majority of committed practices have signed legal contracts and been trained on the tool, and data extraction has been completed for ~70% of practices.

Mobilisation is progressing at a steady rate



The 'ICP in numbers'
▪ **506,000 list size** covered, above an initial target of 390,000
▪ **15 case conferences held to date**, with a total of 28 planned for the end of October
▪ **106 elderly and diabetic patients on care plans**
▪ **93** committed GP practices have signed **legal contracts**
▪ **Data extraction** for **74 out of the 93 GP practices** is complete
▪ **54 GP practices trained** on how to use the IT tool
▪ **Over 300 registered users** in 51 practices are set-up on the IT Tool

SOURCE: NWL ICP informatics group

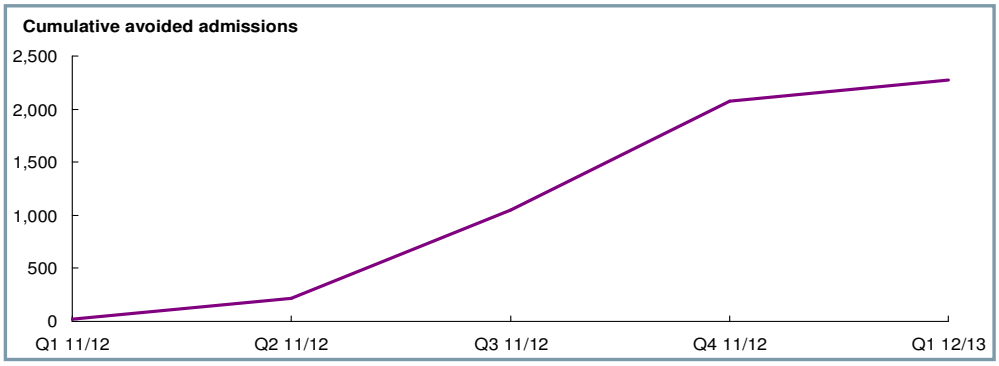
The current practices involved in the ICP are comprised of approximately 356 GPs across inner North West London. Working with this many GP's requires a lot of time , skill and coordination and is a unique process that is being led by the operations team. In 15 case conferences to date, 75 patients have been discussed and over 100 care plans created.

Early signs on impact on acute activity

The initial modelling of the expected impact showed a steady ramp-up of avoided emergency admissions over 2011/ 12:

- In the first six months, the majority of the target population is expected to be placed on care plans
- While minimal impact on acute activity was expected in the first quarter, avoidance of emergency admissions was expected to accelerate in the second quarter, to reach ~2000 by the end of the first year

As a result, we expect to see a steady ramp-up of avoided emergency admissions over the next year



	First quarter	Second quarter	Third quarter	Fourth quarter	Total
Avoided admissions per 2,000 patients	0.2	1.35	2.45	3	**7**
Avoided admissions per 100 pilot patients	0.12	0.83	1.51	1.84	**4.30**
Avoided in Wave 1[1]	23	195	825	1029	**2071**

1 Wave 1 includes interested practices in CLH, Ealing, and North Kensington
2 Wave 2 includes Chiswick, H&F and the remaining practices in K&C

SOURCE: HES 2007/08 - 2008/09, ICO benefits and costs modelling

Qualitative impact

Avoiding unnecessary emergency admissions to hospital is an important benefit of the ICP. However, the benefits to clinicians and patients extend well beyond this narrow metrics. These benefits include:

- **Improved awareness of available local services** e.g. clinicians have told us that they have a much better understanding about how to access the falls service for elderly patients.
- **Increased awareness of the scope of other professionals' roles and abilities,** e.g. role of community matrons
- **Shared learning** about a variety of conditions, drugs and services e.g. the impact of needle length on insulin effect
- **Highlighted areas that may need further attention**, in individual patients and the overall population, e.g. the need for formal cognitive assessments in many of the elderly
- **Valuable discussions involving all disciplines**, taking a holistic view e.g. complicated diabetics with psychiatric co-morbidity & heavy drug burden
- **Professional support**, e.g. reassurance that there is no more that can be done, or alternatively, suggestions for investigations and management in complicated case
- **Tangible changes in the way clinicians are working together.**

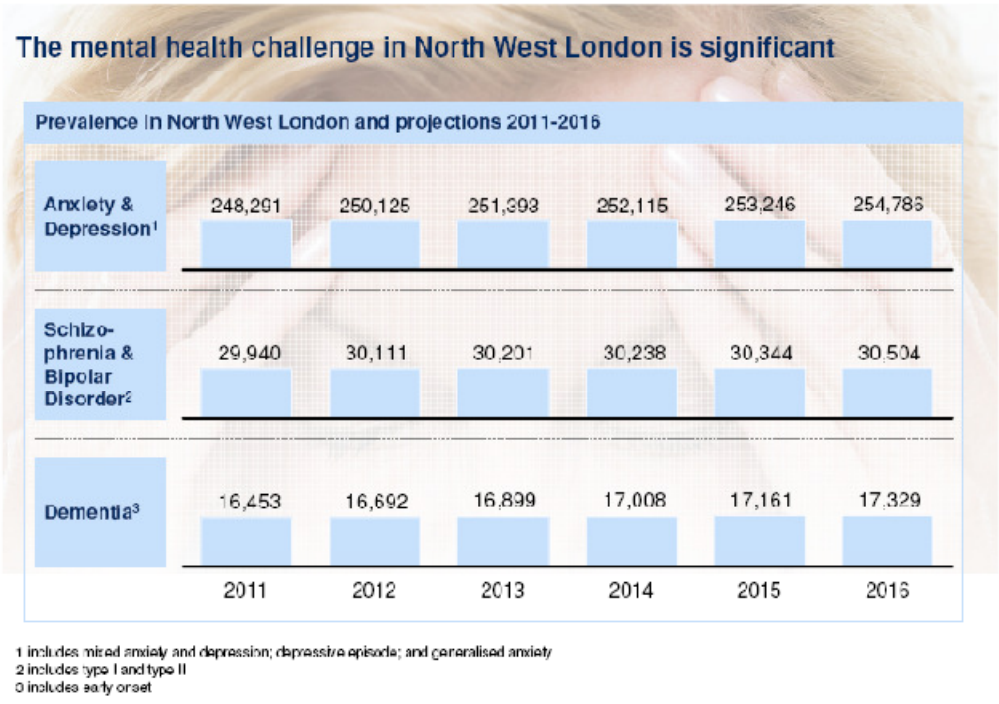
Priorities to 2014/15

- Fully mobilise all partners in full range of ICP activity
- Incorporate key learning across the patch into the delivery of care
- Understand performance levers and drive toward high-performance
- Enhance integration with local authorities and other providers
- Continue to develop and enhance the IT tool
- Conduct a robust evaluation at the end of the pilot year to better understand the impact of the pilot on acute and planned activity, patient outcomes and experience and professional experience and ways of working
- Scale up within NWL:

- An additional ten practices in Inner North West London have already been added, including Chelsea Pensioners, but the plan is to roll out across more practices
- We will also potentially roll out across more pathways, drawing on learning and leveraging synergies, if the pilot is proven to be a success
- Plan to build on this model in Outer North West London in the next few months
- Hounslow has expressed interest in joining the Integrated Care Pilot, which needs to be further explored

Integrated Mental Health

Mental Health prevalence in NWL is significant. There is a wide variation in spend across the boroughs, with different models of care and quality of provision



1 includes mixed anxiety and depression; depressive episode; and generalised anxiety
2 includes type I and type II
3 includes early onset

Current spend on mental health is £333 million and the 2012/13 across the cluster with a QIPP challenge of £20million in 2012/13. In order to achieve this we will support the development of new models of service provision in 2012/13 to improve care and make savings. NHS NWL has embarked on an innovative model of integrated care for mental health that will be part of the overall approach to integration across the cluster.

Priorities to 2014/15

In 2011/12, we developed a three phase approach in developing a new model of integrated care for mental health. Phase 1: scope, has been completed with phases 2 and 3 planned by year end. The programme of work was agreed, steered and delivered by 3 groups: clinical, steering and working. Membership spanned clinical disciplines, providers and commissioning bodies, as well as key partners. The various groups identified the following themes for the integrated mental health care pilot:

- Shifting settings of care (inpatient–community-primary)
- Psychological services for long term conditions
- Acute Trust pathways for mental health (both A&E and in-patient)

Indicative benefits and reinvestment priorities have identified significant quality and financial opportunities can be realised

Summary of valuation across all themes

	Benefits	Costs	Valuation
Improved integration of mental health in general hospitals	£33,155,000	£8,485,000	£24,670,000
Shifting settings of care	£20,570,000 – 32,200,000	£7,360,000	£13,210,000 – 24,840,000
Adherence to care plans for patients with LTCs	£13,580,000	£8,535,000	£5,045,000
Total	£67,305,000 – 78,935,000	£24,380,000	£42,925,000 – 54,455,000

Shifting Settings of Care

Shifting settings of care requires a whole system approach to service redesign. In short, reductions in occupied bed days deliver savings and efficiencies which can support other parts of the mental health pathway. It is essential that community provision is re-specified and commissioned to support patients to achieve recovery and rehabilitation in the community. Liaison, referral and support to primary care will also enable patients with common mental health illness and stable severe and enduring mental health to be cared for without secondary care admissions and

outpatient attendances. This area also integrates the models of care developed by the London Healthcare Programme for mental health.

Mental health care in acute hospital settings including A&E

By ensuring that each of Hospital Trust in NWL has access to a gold standard 24/7 psychiatric liaison service, A&E attendances can be reduced; admissions avoided, and for those patients admitted with co-morbidities, improved inpatient care, reduced length of stays and appropriate post admission care can be achieved.

People living with long term conditions and adherence to their care plans

People living with long term conditions have high rates of anxiety and depression and are more likely to be admitted to hospital. By delivering an integrated approach to physical and mental health, a reduction in outpatient attendances, A&E attendances and emergency admissions can be achieved

Out of Area placements

Again, there is wide variation across the cluster on out of area and high cost placements. A co-ordinated approach across the clinical commissioning groups working closely with our local providers to identify patients who can be repatriated to local services

In phase 1, the following key objectives have been met:

- Identification of patient cohorts
- Prioritised list of mental health pathways
- Model Pathways developed
- Key interventions identified
- Fully engaged health economy, including GP's and mental health trusts

Building on the success of phase 1, we have begun to develop a strategy for mental health services across the Cluster. We have also established a Clinical Commissioning Programme Board, which will drive forward changes in mental health collectively across the Cluster whilst maintaining the local focus for our constituent CCG's

As well as implementing a model of integrated care, other areas of mental health have been prioritised by providers, clinical commissioning group and key partners

Dementia

Dementia services vary widely across NWL in relation to models of care, current spend and quality. The prevalence of dementia far exceeds those patients currently diagnosed and we need to focus on identification and early intervention, particularly in our hard to reach communities. Investment and redesign will be necessary in memory services as well as ensuring our networks of providers have improved access to a range of preventative and treatment services. The prescribing of anti dementia drugs (ACI medication) at earlier stages of the condition will improve patients ability to self care and live more independently for longer, reducing the need for both health and social care placements

Forensic

There is considerable variation in spend and models across NWL for forensic care. We will work with our local providers, partners and specialist commissioning colleagues to address quality and value for money issues across the forensic pathway

CAMHS and eating disorders

Our clinical commissioning group has identified the need to review our current commissioned CAMHS services. The quality of inpatient services needs to be improved and we need to redesign the current Tiers 1-3 services to be more flexible and responsive to the mental health needs of young people.

Personality Disorder

Clinicians have recognised that to address the needs of people with personality disorders, the quality of care and intervention must be improved and this will also generate efficiencies by reducing inpatient spells and reliance on secondary care services

Substance Misuse

Substance misuse has an enormous impact on the lives of many of our residents. In redesigning our services and moving to an integrated model of care, we must ensure that substance misuse prevention, interventions and support are integral parts of our network of providers and care. This requires and integrated approach in both the models of care and the commissioning approach.

Our Approach to Service Change

Over the coming months the Cluster will work closely with local clinicians , providers, patient and public to identify the optimal future design and configuration of services for NWL.

Whilst our existing four year plans described how the financial flows between providers would change to reflect shifts in care from acute to out of hospital settings, the plans did not explicitly say what the service changes would be required and how this would impact on each provider. Instead, NHS NWL asked providers to take this strategic direction and describe for themselves the implications for the provider landscape. Whilst good progress had been made, NWL commissioners now need to take a role lead these service changes to ensure the Cluster delivers the quality improvements that are needed over the next three years.

Both commissioners and providers in NWL believe that services in NWL will need to change to achieve the Cluster's objectives. There are four major reasons underpinning the need to change services; each of which draw upon our case for change, the three overarching principles which underpin our models of care and our quality standards:

- **The need to ensure care is delivered in the most appropriate setting** – a high volume of patients use acute services who could be treated in closer to home by primary care or community care. We need to improve the quality of care in all care settings (as we have set out in our quality standards) and reduce acute care provision.

- **The need to make better use of the medical workforce** - a key element of the quality standards is better workforce provision. Research demonstrates that consultant-delivered services achieve better clinical outcomes. Consolidating some services onto fewer sites would enable the consolidation of the associated workforce; improving the service available to patients and, in particular, supporting a move towards 24/7 consultant presence in key specialties (e.g. in A&E, obstetrics ward)

- **The need to centralise some services –** there is increasing evidence that busier units achieve better clinical outcomes; greater clinical specialisation leads to better outcomes; Separation of planned and urgent surgery leads to better outcomes and that some new treatments/diagnostics that improve clinical outcomes are only affordable if heavily utilised.

- **Need to make effective use of resources and achieve financial sustainability for commissioners and providers in NWL** - budget forecasts suggest that the current configuration of services is unsustainable. Services are fragmented across community and acute sectors and need to be better integrated. Consolidation of some acute services onto fewer sites would enable more efficient use of resources.

- To be successful, this will be complemented by a strong narrative on the improvements in primary care and community care provision.

Proposed approach

To enable the Cluster to identify the optimal design for the future services required in NWL, the approach we take will be underpinned by the core principles of the Secretary of State's four tests:

- **Clinically led and supported by GP commissioners -** We will actively engage local clinicians at each stage of development to understand the clinical impact of any proposals, ensuring that our guiding principle is improving the quality and safety of care and patient experience. The work will be led by two Medical Directors, one representing primary care and one representing acute care. Together they will ensure that the development and shortlisting of options is clinically-led and that solutions we identify are clinically appropriate and viable. Clinical Commissioning Groups (CCGs) will be directly involved in development of proposals and will be part of programme decision-making

- **Informed by engagement with the public, patients and local authorities engagement** – We will actively engage with local stakeholders at each stage of development to understand the potential impact of any proposals; including direct involvement of NWL's Patient and Public Advisory Group (PPAG) and engaging the Shadow Health and Wellbeing Boards. We will undertake formal public consultation, for at least 12 weeks, during which we will explain our proposals to the wider public and listen to their views on the implications of those proposals. This will include specific work to understand the implication of proposals on different equalities groups, in particular traditionally under-represented groups.

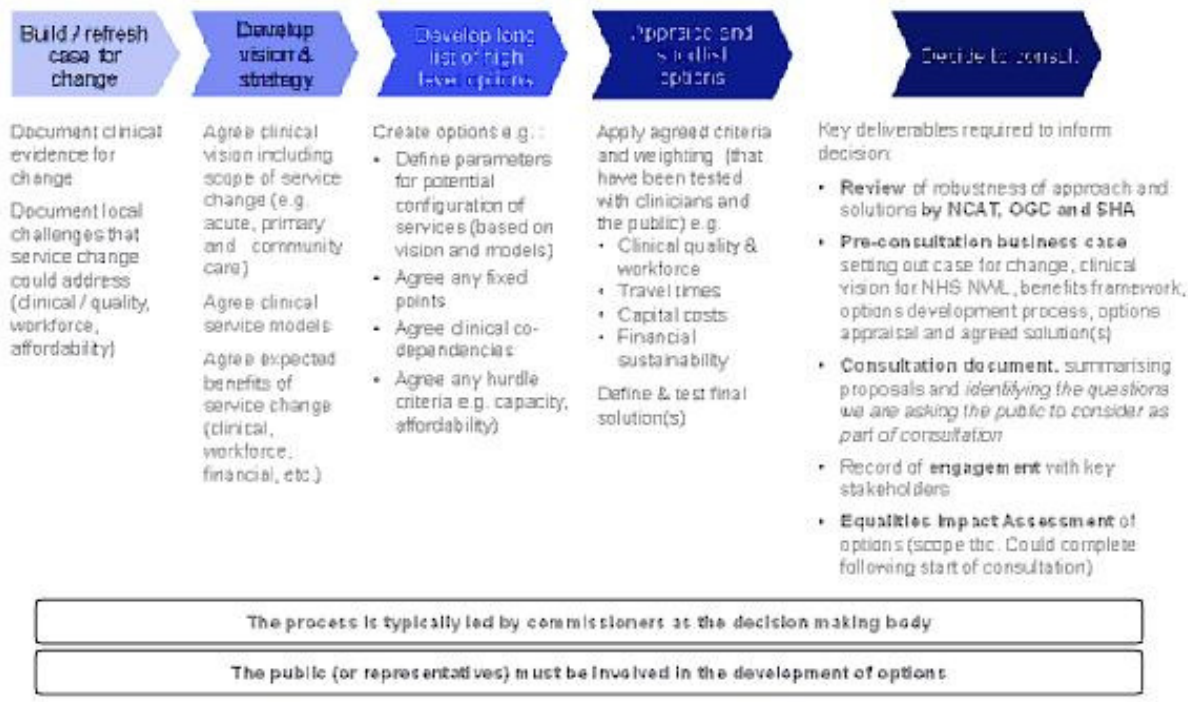
- **Robust and transparent process underpinned by a sound clinical evidence base –** our case for change and quality standards are already based on sound local and national clinical evidence. We will develop a robust, evidence-based process for developing and appraising options for change that we will share with stakeholders at each stage of its development; working in particular with an expert clinical panel to ensure any options are clinically sound. This will also include testing the impact of proposals on patients and the public – for residents of each borough, for inequalities, for patients with specific healthcare needs, patient travel times – and considering impacts on activity, capacity at different sites, financial and capital implications for providers and commissioners.

- **Consistency with current and prospective patient choice –** the core principles of centralising, localising and integrating will impact on the way services are provided, and therefore on the choices available to the public. We believe this will have a positive impact, providing a greater choice of higher quality services for North West London. We will work with local clinicians, our PPAG and a Overview and Scrutiny Committees to consider how any proposals for service change may affect other aspects of patient choice (i.e. choice of provider, setting and intervention) as described in the NHS constitution.

We will seek views from patients, their representatives and other local stakeholders as this work develops. We will also work with colleagues in neighbouring clusters and with London Ambulance Services to consider the broader impact of any proposals.

The Cluster's work will be subject to scrutiny by local Health Overview and Scrutiny Committees (OSCs), which will come together in a Joint Overview and Scrutiny Committee (JOSC). We will consult closely with the JOSC on the design of the public consultation on the service change option(s).

The overall approach is summarised in the diagram below.



Design of a Service Change Programme

It is proposed that we will establish a Cluster-led Service Change Programme to manage the design and agreement of the proposals. The programme will require a formal governance structure and plan to manage this work programme.

The overall governance structure will be designed to ensure that all key stakeholder groups (or their representatives) have been actively engaged or consulted at regular stages in the development of programme deliverables and that their views have been taken into consideration.
It is proposed that formal decision-making will take place through:

- The Cluster Board;
- The Programme Board – i.e. Cluster Directors, Sub-cluster CEOs, CCG Chairs and Provider CEOs; and
- The Clinical Senate (or Clinical Reference Group) [10]- i.e. CCGs and acute sector Medical Directors.

[10] This needs to be a body that include the acute provider Medical Directors. The Clinical Senate is still being scoped and may be able to fulfil this function but if not, the Clinical Reference Group (CRG) is constituted for this.

- A joint Overview and Scrutiny Committee from across the 8 boroughs will need to be constituted to provide formal oversight and scrutiny. NHS London will have a separate assurance role throughout the process.
- The Cluster Chief Executive will act as the Senior Responsible Owner (SRO) for the Programme.
- There will be a clear link to boroughs and CCGs to develop and deliver out of hospital care strategies delivering improvements in primary care and community care.

Expected benefits of service change

The benefits which the change of services can be expected to deliver include:

- More effective integration of care, enabling more patients to be treated closer to their homes where this leads to improved outcomes
- In acute care, increase in consultant presence, enabling patients to be seen and treated commenced at the earliest possible stage and more effectively;
- Greater opportunities for clinicians to specialise or sub-specialise; enhancing their skills;
- Improving equity of access, continuity and quality of care; and
- These benefits should collectively deliver improved outcomes for the NWL health economy, including:
    - Reductions in mortality and morbidity rates;
    - Reductions in readmission of patients;
    - Increased patient satisfaction;
    - Increased staff satisfaction; and
    - Improved financial sustainability of local health economy.

The development and agreement of a benefits framework for service change will be an important part of our pre-consultation activity.

Out-of-hospital care strategies

In the same period, the CCGs will be further developing and delivering their out-of-hospital care strategies; identifying how they will deliver the improvements to primary and community care that are necessary both to address the case for change and to fully realise the benefits the proposed models of care on which the service change is dependant.

CCGs and local teams will be closely involved in the development of service change proposals, with borough-specific proposals used to inform the appraisal of different options for change

Communications and engagement strategy

The communications and engagement strategy plan has been subject to extensive engagement but we recognise, given the challenges to be addressed, this will need to widen both in scope and scale.

A robust communications plan is described here that encompasses how we will engage on all elements of the plan as well as delivering the more formal requirements of the formal consultation on service change.

Communications objectives

1. To deliver sufficient levels of awareness of, understanding about and support for service change across NWL among key target audiences
2. To provide regular opportunities to engage with key target audiences, both before, during and following formal consultation
3. To facilitate audience engagement and consultation through high-quality, credible communications channels and messages
4. To benchmark and track support among target audiences over time, both before and during consultation

NWL's communications strategy can be summarised as a 'consultation-plus' campaign – i.e. as well as supporting our legal obligations to consult the local population on service change, seeking opportunities to undertake wider levels of strategic communications in order to support the system change needed to bring about a fully reformed health economy in NWL. This means achieving sufficient 'ownership' throughout the population of NWL to enable sustainable system change in healthcare.

In practice this means focusing communications sufficiently on both the supply-side:

- Principally senior clinicians across primary, secondary and specialist providers, plus other delivery partners including local government, voluntary sector and possibly neighbouring London clusters

And on the demand-side:

- Principally patients, their elected and non-elected representatives, and also front-line healthcare staff – e.g. around the change they need to make in order to interface effectively and efficiently with a reformed healthcare system in NWL

This campaign approach is intended to manage risks associated with undertaking large-scale and high-profile NHS service change programmes.

Communications principles

A number of core communications principles will be adopted from an IRP review of lessons learnt from service change elsewhere to help underpin the approach taken in NWL:

- Ensure adequate community and stakeholder engagement early on in the planned change programme
- Ensure the clinical case for change is convincingly described and then promoted
- Ensure strong clinical integration across different sites and a strong broader vision of integration throughout the entire health economy
- Ensure proposals do not emphasise what cannot be done and underplay the benefits of change and plans for additional services
- Ensure important content is not missing from the service change plans
- Ensure there is a sufficiently overarching, comprehensive and integrated communications plan to support effective consultation
- In particular ensure sufficient work is undertaken in advance of consultation on key issues impacting on patients around money, transport and emergency care
- Ensure adequate attention is given to responses during and after consultation

Assumptions

- Communications will need to follow the overall timeline of the service change programme
- There will be different and distinct phases of communications activity associated with each element of the programme, during pre-consultation, consultation and post-consultation
- Our approach to formal consultation will seek to meet fully our legal obligations under the 2006 NHS Act, while also bearing in mind structural changes under way in the NHS associated with new commissioning arrangements
- Governance structures to support the Communications work stream will be consistent with overall programme management structures, including the interface between Communications in the Cluster and in Trusts and other partner organisations (e.g. Local Authorities)

Initial ramping up of resources in anticipation of pre-consultation communications activity has focused on PR support (i.e. expert media relations, editorial and public affairs support) to complement existing in-house NHS resources.