NW London Health & Care Partnership
February 2020 Update

Introduction

This report provides a summary of progress up to December 2019, towards achieving the transformation objectives of the Health and Care Partnership.

Partnership overview

Health and Care Partnership Governance
Since our last report, our system leaders came together for the Partnership Operations Group (14 November/ 12 December and 16 January), the Partnership Board (23 January) and the Clinical Quality Leadership Group (28 November/ 23 January) to shape and drive forward priorities. The focus included, system recovery, the long term plan, primary care network development plans, Integrated Care System (ICS) accelerator programme and our clinical strategy, including two workshops on using transformation diagnostics to focus priorities. Deep dives included standardisation of community pathways, Urgent and Emergency Care and winter planning and the Mental Health Partnership Programme.

We also established a Local Authority Task Force who met on the 28 November, to start working jointly on a road map for taking forward how we collectively work at system level as articulated in the NW London’s draft 5 year strategic plan.

Key areas of focus for the partnership have been:

Development of NW London Strategic Plan, our response to the Long Term Plan, and our clinical strategy that underpins this. Through a number of workshops and through using comparative outcomes data and other diagnostic information we have developed a clinical strategy for North West London articulating how we will improve resident, patient and carer experience, reduce variation in outcomes, improve value and improve staff experience. These priorities have formed the basis for our areas of clinical focus in our 20/21 system recovery plan.

Participation in the ICS accelerator programme - 1 of 5 systems nationally selected to benefit from this support to assist us in becoming an ICS from April 2021. Through this we have accessed support from the Kings Fund, and other specialists, working with us to develop our partnership arrangements and supporting financial approaches to more effectively develop an integrated, systemised approach to care delivery.
Transformation progress

The following section outlines key progress in our 7 interconnected portfolio & enabler areas

1) Healthy Communities & Prevention

Board chaired by Melanie Smith- Dr Public Health Brent Council

Our aim: to empower people to support themselves and others, to live full and active lives in their community.

Using digital approach to support residents to proactively manage their condition

Promoting Self Care

Patient Activation Measurement (PAM) – Patient Activation Measure (PAM) is a validated tool that assesses a person's level of knowledge, skills and confidence in managing their long term condition(s), thus enabling healthcare professionals to tailor their approach to proactive care management. During the first six months of 19/20 there have been over 5,500 PAM assessments conducted for patients across NW London. Evaluation on impact of PAM on clinical indicators has commenced in collaboration with NHSE, ICHP and UCL.

Digital PAM has now commenced a digital roll-out across practices for registered patients with Long Term Conditions of PAM through Health Help Now. This has commenced within a few SystmOne practices to test the uptake. Social Prescribing Link Workers have received PAM training during November focussed on tailoring their approach accordingly.

MyCOPD – This online NHS approved COPD self-management patient tool includes a pulmonary rehabilitation programme, inhaler coaching and smoking cessation videos, localised pollution, pollen and weather forecasting, diary management and over 100 hours of education & lifestyle advice. MyCOPD is being offered free of charge to COPD patients across all eight CCGs in NW London, through acute and community respiratory services and now over 80 General Practices. As well as improving the quality of patient care and patient experience, myCOPD can also add capacity into the system and reduce the likelihood of COPD hospital admissions.

As of the 31st December 2019, across North West London over 1,400 COPD patients have access to a myCOPD patient tool to help them manage their condition and everyday life.
Patient Feedback:

“I tend to use myCOPD mainly when I am unwell and need extra support that my GP cannot provide. I find the breathing videos a huge help”.
Shelia from Brent

Diabetes – The three digital programmes from Oviva, OurPath and Changing Health offer structured education (weight loss and behaviour change) for patients with type 2 diabetes across NW London. Following on from phase one of the roll out, based on positive patient outcome and experience findings, NW London procured 2,200 additional licences (phase two), with all licences now been utilised by patients.

The phase 2 evaluation will be completed by the end of February 2020.

Patient Feedback:

“The app was brilliant at showing me how to change my lifestyle”
A patient from Hammersmith

Asthma – The NHS approved myAsthma tool offers asthma patients 24 hour self-management, education and expert advice. A practice in Harrow has 120 patients utilising the myAsthma to support them to manage their condition. The phase one evaluation has been completed and is being presented to the NW London respiratory group. This will inform next steps.

Heart failure/conditions - The NHS approved myHeart tool offers patients with heart disease an individualised self-management and cardiac rehabilitation platform. The phase one evaluation has been completed with Cardiac Health & Rehabilitation Services at Imperial College Healthcare NHS Trust. The evaluation findings are being presented to the January 2020 NW London Cardiovascular clinical and management leads to define next steps.

Social Prescribing – sometimes referred to as community referral – is about helping people find ways to improve their health and wellbeing by linking them up with what’s going on in their local area. From gardening clubs to toddler groups, from social activities for those who are isolated to benefits advice, social prescribing enables people to access services that meet their wider emotional, physical and social needs.
As of December, 33 Social Prescribing link workers are in post with a further 16 to be expected to commence by the end of 19/20. The first 5 day training programme, which has been developed by NW London, took place in November with 16 Link Workers. Additional training is planned for January and March. Along with the Healthy London Partnership, NW London are planning a Social Prescribing event in February which will enable shared learning and further training opportunities for the Social Prescribing link workers.

Social Prescribing templates have been developed for the two GP clinical systems to support the Link Workers in their role. Clinical sign off is planned for January.

**Promoting Healthy Lifestyles (Prevention)**

**Alcohol misuse** – The programme is a national priority in the NHS Long Term Plan and has been prioritised by the Healthy Communities and Prevention board. The team mapped the current service provision and through engagement with key stakeholders have identified a menu of interventions that can reduce harmful and hazardous drinking. The alcohol misuse prevention priorities were further developed with stakeholder’s engagement.

The team launched the #Knowalcohol social media campaign on the 11th November 2019, in line with Alcohol Awareness Week and the run up to Christmas and the New Year. This approach may enable a behavioural change amongst residents that engage in high risk and hazardous drinking, which may have an impact on their physical and mental health. In addition, the team is making enquiries for the best approach to develop a digital platform within the Health Help Now app. This method is to promote an alcohol screening quiz that will give residents a concise picture of how much they are drinking per week. The results of the quiz will then send push notifications to residents to offer support and encouragement through their local alcohol services in the community.

Also, the team had organised for WDP (Charity) to facilitate training for Link Workers to receive an introduction to alcohol misuse awareness during the Link Worker 5 days training programme. In addition, WDP and Bromley by bow are making arrangements for a more in-depth alcohol misuse awareness training in addition to this programme. The team has undertaken a scoping exercise for alcohol prevention population measures across eight boroughs to establish whether boroughs have implemented health improvement schemes around alcohol licensing policy.

**Childhood obesity** – There is a collective need to tackle the rising prevalence of obesity and diseases associated with it. London has the worst obesity prevalence of children in school year 6 (10-11 years old, 23.1%), higher than any other region in England. The Government have committed to halving childhood obesity by 2030 and tackling the growing health inequality.

Through on-going wide stakeholder engagement, three NW London identified priority areas have been identified and prioritised and action plans developed:

- **Priority area 1**: Pregnant women and new parents.
- **Priority area 2**: BME parents of young children and schools
- **Priority area 3**: Weight management pathways/services

At the 26th November 2019 NW London Childhood obesity delivery group meeting the following priorities were set for the next 3 to 6 months:

**Priority 1)** Development of the North West London Mum and Baby app to increase and improve information on health promotion, healthy living and lifestyle advice, thus increasing easy accessible education & training for pregnant women and new parents.
Priority 2) Increase the number of Water Only Schools. This means making sure that water (and plain reduced fat milk) is the only drink in your school. Focus on areas of high deprivation and areas of low sign-up. “Water is the best and healthiest drink.” Chief Medical Officer report – Time to Solve Childhood Obesity (October 2019).

Priority 3) Increase the school uptake of the daily active mile (incentivise by local authorities where possible), with focus on schools with the highest deprivation and areas of low sign-up. https://thedailymile.co.uk/

Priority 4) (Developmental priority) To develop an understanding of how to engage new parents and parents of young children and their needs - independent local focus groups with initial focus on Arabic, Bangladesh, eastern European and Somalia populations to be conducted to confirm actions for 2020/21. Local intelligence to be collected.

2) Maternity, Children and Young People (MCYP)

CYP Programme Executive chaired by Mohini Parmar (CYP Programme SRO/Health and Care Partnership Clinical Lead) & Mando Watson (CYP Programme Clinical Lead/Consultant Paediatrician)

Our aims: to develop our Health and Care System offer for Maternity, Children and Young People that looks beyond illness and to improve safety, continuity and personalisation of care.

2.1) Children & Young people (CYP)

The Early Years Prevention and Education – Oral Health

This project presents the case for establishing a six month ‘prototype’ in a PCN in which early dental visits are promoted and a supervised tooth brushing (2-4 years) programme is introduced in targeted early years settings. Whilst a strong return on investment can be demonstrated, discussions continue at a regional level to help resolve the funding and commissioning complexities.

The Early Years Prevention and Education (joint project maternity and CYP projects)

Subject to the outcome of the current prioritisation process, two joint quality improvement projects are currently being scoped. These projects will focus on improving immunisation rates and increasing the proportion of women in NW London living in smoke free households. Key stakeholders will be invited to attended workshops that are being planned for March.

Children with Long Term Conditions (Asthma)

A proposal for the development of a joint adult and children asthma dashboard was presented to the Population Health Board in January 2020. The proposal was approved and is a prerequisite for evaluating the impact of the proposed interventions associated with this programme.

In order to help inform the NWL CYP Asthma Transformation Programme, members of the NW London CYP asthma network were invited to attend a workshop in January to discuss how the objectives of the programme to decrease morbidity and mortality and to reduce unwarranted outcome variation could be best achieved. Stakeholders included Asthma Nurse Specialists, GPs, Pharmacists, Paediatricians, Local Authority and representatives of Public Health.
2.2) **Maternity Transformation Programme**

**NW London Local maternity system – Chaired by Anita Hutchins (Director of Midwifery, The Hillingdon Hospital)**

The Local Maternity System (LMS) meets monthly to discuss, plan and approve Maternity Transformation Programme activity undertaken in the four acute maternity services in NW London in line with the NHS Long Term Plan (NHSE 2019) and Better Births (NHSE 2016). Six workstreams are now actively working towards deliverables set by NHS England, including:

**Choice and Personalisation:**

Through collaborative working across the six maternity services standardised criteria for midwifery led care have been agreed.

**Continuity of Care:**

By the end of October 2019, 26% of women were booked onto a continuity of care model of care for their pregnancy and birth. This means that these women see a consistent team of midwives during their pregnancy journey. Women who are cared for throughout their maternity journey by the same small team of midwives are known to have improved clinical outcomes. North West London is on target to reach 35% of women booked onto a continuity pathway of care by the end of March 2020.

**Safer Care:**

Progress on the sector-wide Smoke Free Pregnancy Project In partnership with the NWL MatNeo Collaborative (a three-year national programme to support improvement in the quality and safety of maternity and neonatal units across England) is well underway. The project has wide buy-in and aims to reduce smoking during pregnancy in NW London from 4% to 3% by September 2020 and to reduce variation across the sector from 6% to 5% by September 2020. Trusts meet quarterly to report back on their initiatives and learn from each other.

The LMS successfully bid for funding from Health Education England and plans to develop a bespoke training package to improve staff awareness, prediction, preparation and management of preterm birth for completion by May 2020.

**Post natal and perinatal:**

2020 will see a focus on improving postnatal wards, acknowledging the hard work undertaken by midwives, maternity support workers and others to make hospital ward environments welcoming and safe. The photograph below was taken at a recent ward celebration at Imperial.
Workforce:

NW London is one of the first LMS to launch a Maternity Support Worker (MSW) Apprenticeship programme. The project was a collaboration between HEENWL and NW London LMS with the support of the Royal College of Midwives and NW London Clinical Commissioning Groups and senior leaders in the sector. A launch event was held on 9 December 2019. Sixteen MSWs have commenced on the programme.

“We need to set the bar high for MSW apprenticeships and that’s what we’re trying to do in North West London....” (quotation from British Journal of Healthcare Assistants, November 2019, vol.13, no. 11, page 550).

Digital:

With support from Public Health England, the NW London Mum & Baby app leads team is developing a strategy to evaluate the effectiveness of the app which was launched in November 2018 and upgraded to version 4 in October 2019.

The digital team is reviewing the digital maturity of the maternity IT systems in NW London to ensure compliance with the recently published Information Standards Notice (ISN) for the Maternity Record Standard. This work will progress throughout 2020.
3) **Primary, Social & Community** NB: there are many interdependencies between this portfolio area and other transformation programmes. For this report Urgent and Emergency Care, is a particular interdependency. Please ensure the 2 areas are taken as a ‘whole’.

Board chaired by Andrew Ridley, Central London Community Health Care & Neville Purssell, Central London CCG

**Our aim:** to improve community based care so as to support people closer to home and prevent deterioration in their health and wellbeing.

**Supporting Primary Care at scale**

NW London have now approved all 49 Primary Care Networks (PCNs) across the eight NW London CCGs.

Following the approval of the Primary Care Network Development plans, funding has been distributed to the networks. This is to support the networks to deliver the range of identified development areas within their plans. In addition to support this, the team are planning to hold Master Classes for the most frequently identified areas within the development plans (Workforce, Population Health Management and Online Consultations). A menu of support has been developed for the Primary Care networks that identify organisations that can help Primary Care Networks with their Organisational Development needs.

In addition, further decisions are taking place with the Community Trusts across NW London on how Primary Care Networks can be supported by the Community providers.

A Primary Care Network event was held with attendance from 60+ stakeholders across the CCGs, Primary Care Networks, Federations, and other key stakeholders to encourage discussions. This event had presentations from the three top identified areas through the Development plans that Primary care networks – Workforce (Additional Roles Recruitment), Population Health Management and Online Consultations (Brent eHub model). The next event will take place in February 2020.
A workshop was held in December between CCG Primary Care and integrated Care leads and S&T Quality Improvement and Clinical leads to discuss how the Primary Care Networks can be supported to deliver the NW London Health and Care priorities. Further progress is being made to commence delivery of the priorities at the Primary Care network level.

Work has commenced across the Primary, Social and Community Care portfolio to deliver the core community pathways in the context of the Primary Care networks and PCN DES specifications. The draft specifications have been published with feedback due from CCGs, Primary Care Networks and Community providers. (See within the Community and Social care part)

The **Population Health Management** dashboard takes a proactive approach to managing health and well-being, focusing on the total care needs of the whole patient population within the PCN, and enables targeted interventions for individual patients within the agreed target groups. The team have continued to meet with the Primary Care Network Clinical directors in progress to discuss the roll-out and the use of the ‘Rising Risk’ dashboards and the Primary Care Network Population health data packs. In addition, the team are working with ICHP and other WSIC users to develop case studies.

**GP extended access** – work continues to ensure that there are appointments available & utilised from 08:00 to 20:00, seven days, across NW London. In December there were over 26,000 Extended Access appointments available for patients through the Extended Access hubs. Within the extended access hubs utilisation rates were at 72% across NW London. This includes 8,558 between 22 December and 31 December 2019 which had a utilisation rate of 64% (3% increase from 2018/19).

![Baseline Appointment Utilisation by CCG in December](image)

In order to increase utilisation and awareness for patients, leaflets have been designed which will include messages on how to access the services and the other services available to patients (Mental Health, Pharmacists and A&E). This will be distributed to patients across NW London.

Additionally, to reduce DNAs across the hubs, MJOG (Text messaging System) has now been rolled out across all CCGs in NW London. In addition, this will also support the communications for GPs for messaging their patients across the winter period.
Online consultations

NW London CCGs are committed to meet the national target of 100% online consultations coverage by March 2020 whilst continuously learning from the innovation and progress made in the Digital First Programme.

Following a phased roll-out across all three of the localities in Brent, Online Consultations is now available to all patients. Below is some of the feedback received from patients in Brent.

Patient feedback:

Below is some of the feedback from Brent:

- "Quick response time and was able to give a prescription without having to wait for a GP appointment."
- "Very satisfied. It’s the best service available as its quick, efficient, and easy. I have 3 young children and I am too tired or busy to go to the doctors. I’m really happy with econsult service as my problems are resolved by receiving referrals, blood/urine tests or prescribed medicine."
- “Treated from the comfort of my home. Great if you have anxiety or depression or any of the ailments that need treatment. Unless frightened I will continue to use this online care plus saves on cabs fairs.”

4) Social & Community

Core community services

The core community services programme focuses on a delivering a consistent model of service delivery across North West London for rapid care, community nursing, and intermediate care. Since August 2019 the Community Pathways programme has focused on rapid care services.

The objectives of this programme are to ensure that care is delivered in the community keeping people well in their own home and locality where possible. One of the goals for the programme is to increase the number of people who are referred to rapid care so that they receive timely and effective care.

There has been a proven increase in monthly referrals from LAS to rapid care services between November 2017 and November 2019; which means that more of our residents have been successfully treated in their own homes and locality rather than going into hospital.
Our residents are now receiving care from the most appropriate teams, based on their location. Following the trial of a single telephone number system, LAS crews can now access the right rapid care services quickly. This does not replace existing telephone lines. The system was trialed between October and November. Initial issues are being resolved and the new line will be fully implemented by early February 2020.

Community teams will be dispatched to those who need them more quickly, following the agreement of NW London system partners (community providers, CCGs, and LAS) referral pathway from LAS clinical assessment hub to rapid care teams. The pathway went live at the beginning of this year.

In order to respond more effectively to the needs of our patients, a system wide dashboard has been developed so that our system can provide rapid care services that meet the demand and capacity required by our residents.
Community beds

The objectives of the community beds workstream are to:

- Reduce inequalities of access to care services and develop a consistent core offer across NW London
- Increase the number of residents being discharged home from hospital to receive post-acute rehabilitation or assessment services
- If a resident requires a community bed, ensure they are able to access it as quickly as possible
- Develop a community bed base that is flexible and responsive and better supports the needs of NW London residents

In Hounslow and Hillingdon an economic evaluation of different models of care has been conducted which aligns with wider community programmes of work. We have agreed a set of consistent definitions of ‘types of need’ that require community beds, which will support a day of care audit being conducted in early January. Our residents will benefit from agreeing this consistent approach, as variation in the use/access and types of community beds will be reduced.

NW London Last Phase of life

There has been strong engagement across the system through a number workshops aimed at shaping the NW London last phase of life programme. Our Patients and clinicians voices were heard on a number of topics, including identifying people at the last phase of life, advance care planning, support to families and carers and developing a consistent specialist palliative care offer across NW London.

As part of developing a new standardised model of care for specialist palliative care services in the community for NW London, a programme of work to review programme palliative care services in the community is currently taking place across four of the eight CCGs (Hammersmith & Fulham, West London CCG, Central London CCG and Brent CCG).

A new public and patient reference group has been established and three patient and public engagement workshops were undertaken during September and October 2019. The workshops were broken up into 3 themes: 1) Access, 2) Care and 3) Moving between care settings and Bereavement/ Aftercare. The objectives of the workshops were to discuss the end to end pathway of care for palliative care services. Our patients and clinicians insight and input will be invaluable in progressing the new models of care which will deliver better outcomes for people in their last phase of life.

A graphic interpreter captured discussions and views regarding the current and future state of community palliative care services. These graphics are very powerful and have been published on Central CCG’s website. For example:
We have also reached a consensus view across all CCGs on how to spend the NW London share of the £25m fund for hospices and palliative care services announced by the government in August 2019. Of the c£950k, we have agreed to support children’s and young people’s services with £100k of funding, and adult services with the remainder. While the majority of this fund will support hospices with current financial challenges, a portion of this funding will support a NW London End of Life Care development initiative to support more and better quality care planning for people approaching the end of their lives.

**Cardiovascular disease**

The overall aim of the cardiovascular disease (CVD) programme is to reduce non elective admissions for heart attacks, strokes and heart failure in NW London across cardiovascular disease prevention, non-ST-elevation myocardial infarction (NSTEMI, a type of heart attack), stroke and heart failure.

A significant part of the programme is on prevention of CVD conditions, including working with stakeholders in primary care with an aim for early detection of atrial fibulation (AF, a heart condition that causes an irregular and often abnormally fast heart rate), high blood pressure and genetic high cholesterol to prevent the occurrence of a stroke.

Patients requiring treatment and support following a stroke will now all receive a consist approach to their care, following the agreement of a single model for stroke pathway, a standardised approach to support early discharge from hospital and increasing capacity of neuro rehab beds in the community. In October, a hospital site visit at Hammersmith hospital took place to see how the NSTEMI pathway has been implemented this gave a real insight into how the pathway works in delivering high quality and efficient patient care. An evidence based review is currently being developed with an aim to implement the pathway at LNWT.

In December, data packs for AF and high blood pressure were sent to each of the CCGs. The programme will support PCNs to deliver the London ambition targets, an expression of interest has also been sent for targeted funding for CVD Prevent audit and integrated stroke delivery networks (ISDNs). A NW London CVD commissioner’s forum has commenced and these monthly
discussions give an opportunity for commissioners to provide input on the programme and discuss lessons learnt from local projects. Next month meetings will be held with external Academic Health Science Networks (AHSNs) and the voluntary sector to identify resources available to meet the London ambition.

**Respiratory update**

As outlined in the Long Term Plan, we will improve care for people with respiratory conditions by working as a system to implement new/improved models for detection, diagnosis, medication management and pulmonary rehabilitation (PR). We will create electronic tools enabling PCNs to identify people at risk of respiratory conditions. PCNs will implement diagnostic hubs to improve the quality of diagnosis of asthma and chronic obstructive pulmonary disease (COPD). MDT teams will run virtual reviews to improve use of inhalers and reduce overuse of high dose steroids. We will increase availability of, referral to, uptake and completion of PR.

Commissioners, providers and community/primary care have recently formed working groups to focus on the aims of the programme. A WSIC COPD aggregate population dashboard will be developed in the coming months enabling targeted diagnostic hubs and virtual review clinic models to be tested and rolled out within PCNs. More work is needed by the system beyond the scope of this programme to realise the potential savings associated with vaccination and prevention (including smoking cessation). Some savings made by the programme interventions may need to be reinvested into pulmonary rehab services capacity in order to make the impacts required on the system and further improve patient outcomes.

**Supporting People with Diabetes**

The NW London Diabetes Transformation team are actively engaged in improving outcomes for people living with diabetes through transformation initiatives across primary, community and secondary care.

The key priorities for this year 2019-20 are:

- **REducing Weight with Intensive Dietary (REWIND) Support Service**: Scale up type 2 diabetes remission through face-to-face and digital approaches.
- **Know Diabetes Digital Service and Website**: Rapid roll out of at-scale digital patient support for people with diabetes and non-diabetic hyperglycaemia.
- **NW London Diabetes Integrated Service Specification implementation**: Working with CCGs to implement the outcomes-based integrated service specification via the primary care networks and driving in-patient transformation.
- **Streamlining Diabetes Footcare Pathway**: Improving the footcare pathway with weekend foot clinics to drive down diabetes foot ulcer costs and amputations.

The NW London Diabetes Transformation Programme was shortlisted for two awards at the 2019 HSJ Awards.

Dr Tony Willis – Clinical Director, was nominated for ‘Clinical Leader of the Year’; and the first book providing visual carb awareness guide for BAME communities’ the programme published earlier in the year ‘World Foods: was nominated for the ‘Primary Care Innovation of the Year’ award.
Patient Feedback:

The World Foods book has become an invaluable tool for Health Care Professionals and Diabetes patients across NW London. One of the programme’s patient representatives recently fed back the following:

‘World Foods has become my most useful resource by far at health fares and talks!’

World Diabetes Day takes place on the 14th November each year. In 2019, a series of events were held across North West London to raise awareness for Diabetes and the services provided by the NW London Diabetes Transformation Programme. The NW London Diabetes team participated in a series of events across Harrow, Brent and Ealing on the day by supporting awareness sessions for diabetes patients and supporting clinics with spot checks on patients potentially at risk of diabetes.

The team have been promoting the drive towards a “digital first” approach to encourage self-care through information and education, and to support new ways of communicating with people living with Diabetes and at risk of Diabetes using the KnowDiabetes website which was also promoted.
REWIND Programme:

The REWIND (REducing Weight with INtensive Dietary support) programme has successfully been rolled out in H&F, Hounslow and Ealing who are the early adopters of the programme. Training sessions have been delivered in Primary Care and central training is organised at Marylebone road every month for all NW London HCPs. All CCG’s are given primary care training packs and resources to support them in identifying individuals who are eligible for the programme. Patient and HCP resources, as well as a series of videos on REWIND can be viewed on the KnowDiabetes website.

Fig: Webpage for REWIND on the Know Diabetes website.

KnowDiabetes Service:

Around 226 GP practices in NW London have signed the Data Processing Agreement for the Know Diabetes Service. This means that over the coming months, more than 164,000 patients with either diagnosed diabetes or NDH will be able to receive email campaigns from the Know Diabetes Service or access their patient record via the Know Diabetes Website (https://www.knowdiabetes.org.uk). Currently the service has gone live in three pilot practices across North West London where patients have already created accounts and have tried the NICE accredited e-learning patient education courses accessible via the website.

NW London Diabetes Integrated Service Specification implementation:

The NW London Integrated Service Specification implementation saw an important meeting between acute and community providers and all 8 CCG commissioners to discuss the 2020-21 contracting round and planning diabetes care for the NW London population living with diabetes. This was a very useful and important meeting to ensure care is more integrated, safe, quality and outcomes driven and aimed at ensuring the best experience for patients. The Integrated Specification provides box-standard guidance on providing diabetes care at various levels e.g in primary care, in community care, secondary care and also focuses on ensuring that mental health and wellbeing are an integral part while managing people with diabetes. Cost and activity modelling has been done in addition to understanding the risk stratification of diabetes patients, to ensure the right level of service is provided in the right place to improve patient experience and outcomes. This will also support the GIRFT (Getting it Right First time) process where hospitals are scrutinised with regard to quality of diabetes care.
A key set of outcome indicators to monitor the diabetes related care are being devised at an NW London system level (which includes PROMs – Patient Reported Outcomes Measures) and there is a significant amount of work underway to ensure that the right level of investment goes in the right level of care depending on need to reduce unwarranted variation and address health inequalities by providing equitable services across the NW London area. The next step in the process is for the CCG Commissioners to ensure the specification and the KPIs are used in the 2020-21 planning, contracting, monitoring and reporting process in partnership with primary care, community care and acute care provider Trusts to ensure care is delivered in an integrated way to improve outcomes.

**The Multi-disciplinary Diabetes Footcare Team (MDFT):**

The MDFT team is showing impact on early identification and treatment leading to a reduction in amputation rates in NW London. 974 HCP’s have been trained in identifying foot emergencies to date, and an estimated 3,946 outpatients and 1,518 inpatients have been seen by STP Podiatrists in Inner and Outer London. The NW London Diabetic Foot Hub and the STP Podiatrists have been supporting discharges from the vascular hubs and the renal hub to signpost inpatients to the correct local foot teams.

The 7th NW London Diabetes Foot Network meeting was a big success in November. The meetings have maintained high levels of engagement for foot teams, service users and commissioners across NW London. Work from the November meeting will be used to draft vascular pathways at the inner and outer NW London vascular hubs and to feedback to the London Diabetes strategic clinical network for its review of the London root cause analysis tool.

**The Diabetes Footcare Dashboard was launched in November 2019** and will be an important tool for clinicians and commissioners to manage and monitor footcare for people with diabetes providing, for the first time, essential data including ulcer prevalence, foot risk stratification and trends in hospital admissions and amputations. Beta testing involving foot teams from all 8 CCGs for the newly created SystemOne NW London Podiatry consultation templates is expected to be completed by mid-January 2020. The feedback will be collated and the template will be finalised and adopted by NW London Foot teams. This will ensure the capture of reliable information for the Footcare Dashboard and the National Diabetic Foot Audit.
Consultant Feedback:

Feedback from Dr Daniel Morganstein and Dr Aikaterini Theodoraki, Consultants in Endocrinology and Diabetes at Chel West, on the impact of the MDFT programme:

‘The STP podiatrist post has given us the ability to expand capacity and comply with the NICE guidance on the Prevention and Management of Diabetic Foot Problems (NG19) and has allowed systematic teaching of Healthcare Professionals on the assessment and simple management of Diabetic Foot conditions. With the STP support and with extra 0.3 WTE Podiatry time, the activity in the clinic has increased by 41% for new patients and by 35% for follow ups compared to the mean number of patients seen in the previous 2 years (2016/2017 and 2017/2018).’

5) Urgent & Emergency Care

Board chaired by Julian Redhead, Medical Director Imperial and Rob Hodgkiss, COO Chelsea and Westminster

Our aim: to ensure Urgent and Emergency care is delivering the right care in the right place (i.e. home, community or hospital) first time.

Same day emergency care (SDEC)
All Trusts are working to achieve against the minimum standards and identify further opportunities to optimise SDEC. All Trusts have agreed that 9 medical conditions should be a priority for NW London in 19/20 and local communication to primary care colleagues is underway. In December, Ealing hospital relocated their SDEC unit to be co-located with Older Person’s Rapid Access Clinic (OPRAC). At Northwick Park, a London Ambulance Service direct access pathway to SDEC unit was launched as a test phase to ensure patients are not being brought to A&E inappropriately.

West Middlesex established front door frailty MDT input from November with both Ealing and Northwick Park delivering from December. The NW London Acute Frailty standards have been reviewed in line with the SDEC medical unit minimum standards to ensure consistency.
Appropriate Care Pathway
Same Day Emergency Care (SDEC)
Northwick Park Hospital

Service Description:
The Ambulatory Emergency Care Unit at Northwick Park is able to accept direct referrals from LAS patients who are of low acuity, with symptoms that are typically managed by physicians and who have the potential to be investigated, treated and discharged the same day.

Referral criteria:
- Over 16 years of age
- NEWS2 less than or equal to 4
- Patient must be mobile or mobile in a wheelchair (not bedbound)

Categories of patients accepted:
- Unilateral leg swelling/redness
- Dysuria/urinary frequency/ loin pain/fever
- UTI/pyelonephritis
- Syncope (i.e. TLOC) where the patient has now recovered consciousness. Check JRCALC Plus and TLOC Guidance
- Cough, sputum, breathlessness
- Hot swollen joint (not prosthetic)

Other patients may be suitable – please phone to discuss

LAS RRT/DN ACP must have been considered before SDEC and documented on PRF

Categories of patients NOT accepted
- Abdominal pain
- Back pain
- Mental health problems as primary presentation
- Alcohol or substance abuse or intoxication
- Suspected stroke
- Acute confusional state/patient must not be confused
- No mechanical falls (Frailty)
- No infectious patients

Non-registrants and NOPs must use this pathway in conjunction with the Patient Referral Tool (at Steps 7/8) and JRCALC Guidelines.

Please ensure you have used MiDoS / CMIC for any other ACP before referral and document on PRF.

Monday to Friday
09:00-18:00 for advice and admissions.

Handover:
Clinician to clinician
- Situation
- Background
- Assessment
- Recommendation

A NEWS 2 score must be included as part of the handover.

A full assessment of the patient must be documented.

Record keeping
Document the time and name of the accepting clinician.

LAS must telephone
for ‘clinician to clinician’ conversation before agreement for direct access

Date of issue: October 2019
Date of review: October 2021
Authorised by: LAS medical directorate
To be reviewed by: Appropriate care pathway development team
Version 1.6
The impact of this is clear to see – despite an increase in A&E attendances in 2019/20 of 17,000, admissions for an overnight stay to hospital have decreased by 1.2%. This means that 3,400 more people have been able to receive the emergency treatment they need without having to stay overnight in hospital.

**SPC chart shows the step change in rate of admission (to an overnight stay) in September 2019. This has been maintained September to January.**

---

### Reducing Extended Length of Stay

All NW London systems continue to focus on and prioritise Long Length of Stay and work towards achieving the national 40% reduction target. Across all systems, there has been strong engagement with stakeholders and system partners to address external causes of delay. Weekly senior long stay escalation meetings took place across all systems to unblock and facilitate complex discharges of stranded patients with CCG, Community and Local Authority input. Emergency Care Intensive Support team (ECIST) support has been in place to support internal causes of delay across trusts. Multiple approaches have been taken such as the implementation of Clinical Criteria Led Discharge, Red2Green days, discharge coordinator roles and robust weekly long stay review via the Discharge Patient Tracking List to keep traction and ensure all patients have robust plans for discharge. There is strong senior engagement across all NW London systems with LLoS performance reviewed at A&E Delivery Boards with progress updates on the associated streams of work. The system has shown steady performance in meeting trajectory with the NW London overall position at 12%, making it the second highest performing STP in London. Priority going forward is to realise the opportunities around reducing long length of stay due to internal delays with a particular focus on clinical leadership through various national led workshops and local initiatives.

Winter initiatives to reduce pressures on emergency care services are underway across the STP. Initiatives include:

- **Improving 111 clinical revalidation rates**
When 111 call handlers return a 120 or 180min low acuity ambulance outcome for the patient, the call will be transferred to a clinician to review and determine whether there are suitable alternatives to an ambulance. Where clinically appropriate the clinician will signpost or directly book in to an alternative care pathway, reducing inappropriate ambulance dispatches.

- **Increased GP Extended Access appointments and introducing direct booking functionality from the LAS Clinical Hub**
  Offering additional primary care extended access slots over the winter and making these appointments directly bookable by the LAS Clinical Hub to ensure capacity is utilised effectively and inappropriate UTC attendances, ambulance dispatches and conveyances are avoided.

- **LAS Clinical Hub direct booking to Rapid Response Services**
  Introducing direct booking functionality from the LAS Clinical Hub to Rapid Response Services providing a 2 hour response, avoiding the need for an ambulance dispatch and conveyance to ED.

- **LAS – 111 Winter Integration Pilot**
  NW London is piloting LAS transferring their lowest acuity calls to the 111 Clinical Assessment Service to be clinically assessed. This will enable the LAS Clinical Hub to focus on clinically assessing higher acuity calls and downgrade where clinically appropriate to reduce unnecessary ambulance dispatches and conveyances to ED.

- **Mental Health cars**
  To improve our responsiveness to MH patients over winter NW London will be working in partnership with LAS to provide specialist cars to respond to those in crisis and ensure unnecessary ED conveyances are avoided.

**Flu vaccination**

- Trusts are encouraged to sign the NHSE/I Service Level Agreement (SLA) for flu vaccination delivery, currently Imperial and Chelsea and Westminster have signed up in NW London. Other Trusts are encouraged to sign up and have received copies of the SLA.
- Uptakes across all London cohorts are still lower than the baseline year of 2017/18. West London CCG has the lowest uptake in London for both children aged 2-3 and over 65s.

**High intensity users**

High intensity users (HIUs) are a relatively small number of patients who account for a large proportion of service utilisation. Each borough has a scheme in place for managing their HIU population but information gathered shows that there is considerable variety in every aspect of the schemes offered - from how they are defining an HIU, to how many patients are being reviewed and managed, to the intervention being provided and the assessment of impact of the intervention. There are also issues regarding management of cross-boundary patterns of attendance and data sharing.

In 2020/21 we have agreed to work across NW London, collectively to better support this group of residents. The aim is to improve the ease by which appropriate people for support are identified, support services in how they work with patients and introduce a common set of minimum standards for local areas to work towards in managing this patient group.

North West London HIUs programme have partnered with Imperial College Health Partners (ICHP) to deliver this.
**Mental Health, Learning Disabilities and Autism**

North West London Mental Health & Wellbeing Transformation Board chaired by Carolyn Regan, CE WLNHS Trust & Genevieve Small, Harrow CCG Chair

**Our aim:** to improve outcomes for children and adults with mental health, learning disability and autism needs, and enable them to live well through timely access to community based and high quality of care no matter where they live.

Following submission of the mental health, learning disabilities and autism response to the NHS Long Term Plan in November, work has focussed on refining the delivery plans to achieve implementation of NW London’s commitments.

**Community Mental Health Care**

**Transformation funding**

In order to meet expectations set out in the NHS Long Term Plan, work is underway to transform community mental health services in partnership with PCNs and CCGs, as well as local authorities and the Voluntary, Community and Social Enterprise sector (VCSE), service users, families and carers. These are Community Mental Health Hubs in Harrow, Hillingdon and Central London, provided by Central & North West London NHS FT, and Mental Health Integrated Network Teams in West London Trust facing boroughs. Recruitment to new posts underway with Link Worker and Project Manager posts in place and with wider job descriptions for staff teams in development.

To support mobilisation, two successful site visits were made by the national mental health policy team at NHS England & NHS Improvement. Overall support was given for the models being developed and NHS England & NHS Improvement was responsive to requests for support around recruitment challenges, GP practice charges and funding arrangements. Colleagues were able to discuss issues around language, job roles, local authority provision to support the model and how best to link in older adult services and improve transitions from children and young people’s services.

There are plans for a joint evaluation across both new models supported by an Academic Health Science Network and our stakeholders are providing feedback on the national evaluation approach.

**NW London IAPT Delivery Plan**

A NW London-wide IAPT delivery plan has been developed and agreed with providers and CCGs and submitted with trajectories as part of NW London STP’s Long Term Plan response. We plan to deliver a minimum of 22% access for all CCGs by the end of March 2021 in order to reduce variation in outcomes across the STP area and address inequalities in service delivery. The priorities in the plan set out what is to be delivered in the short, medium and longer term to 2023/24.

In the short term work will be undertaken to further understand workforce challenges, to improve co-location with primary care, and increase referrals to the service. Other areas for development include further roll out of the IAPT Long Term Conditions programme to other condition areas, enhancing the digital offer, increasing access to black and minority ethnic (BAME) communities and considering expansion to include 16 and 17 year olds and other groups e.g. people with learning disabilities.
Mental Health Crisis Care

Transformation funding

As part of the implementation of the mental health commitments in the NHS Long Term Plan, crisis care transformation funding in boroughs served by Central & North West London NHS FT has been utilised to recruit to a new ‘First Response’ service. A new Head and Deputy Head of Urgent Care have been recruited alongside five Clinical Team Leads. The aim of the service is to provide a more timely response to mental health crises than is currently on offer. The service is accessible via the Single Point of Access which can also receive warm transfers from NHS 111.

A procurement exercise to establish voluntary sector led crisis ‘Havens’ (alternatives to hospital admission) is underway and on track for services provided by Hestia to launch in February 2020. The Haven will support people by providing a time limited safe space to enable those in crisis to relax with the offer of group/individual therapeutic activities if wanted. All attendees will be greeted by a Recovery/Peer Support Worker. It will be open every day of the year and is anticipated it will support 1,000 people. Learning from a ‘Sanctuary’ pilot has fed into the design of the Havens. Feedback from the pilot included:

Patient Feedback:

“[I was welcomed at the Sanctuary where I felt safe from myself and my bad thoughts. It was a nice, quiet, peaceful environment. The Sanctuary and staff really saved me from myself, the self-destructive thoughts disappeared and I left for home feeling strong enough to have another bash at life]”

In boroughs served by West London NHS Trust, nurses have been recruited to crisis teams and a ‘Safe Haven’ crisis alternative will be launched in Hounslow by the end of January 2020.

Proposals for funding ‘Core 24’ compliant liaison psychiatry teams at Chelsea and Westminster Hospital (£484,253) and West Middlesex Hospital (£392,806) were approved for 2019/20 and 2020/21 which will result in both sites being compliant by Q2 2020/21. This will improve response, assessment and treatment for patients with mental health needs attending A&E.

Mental health winter funding

A NW London wide approach was taken to develop mental health winter funding schemes. Just over £500k was secured to support three schemes; enhancement to liaison psychiatry teams (Ealing and Charing Cross Hospitals) where these are not ‘Core 24’ compliant, a NW London wide winter resource team (an additional B6 mental health nurse in every NW London ED) and additional discharge coordinators in our two mental health trusts. It is anticipated that these initiatives will minimise the impact of increased winter months demand, provide effective triage and support to access alternative services and help to ensure patients are better supported to return home with social care and other welfare needs addressed.

London Mental Health Joint Response Car initiative

Both of NW London’s Mental Health Trusts are engaged in expansion of the London Mental Health Joint Response Car project from a South East London initiative during Q4 2019/20. The purpose is to provide mental health nurse support to paramedics including a dedicated response vehicle. It is anticipated that the new service will reduce ambulance conveyances to EDs and provide mental health care on attendance. Results from the six month pilot in South East London highlighted lower rates of conveyance to ED; 18% of incidents required conveyance compared with 52% for a business as usual response. The service also showed a positive risk-taking culture and future success will rely on integrating skilled and experienced clinicians into the existing team.
**Suicide postvention bereavement service**

NW London received £112,500 transformation funding to establish a suicide postvention bereavement service. A specification for this service was recently co-designed at a well-attended workshop with stakeholders from public health, Metropolitan Police, mental health trusts, CCGs and those leading suicide bereavement support groups. A service specification has been drafted and further engagement on this is currently taking place. The intended outcomes of the service include: reduction in complex grief responses, reduction in suicide risk for service users and increased confidence among other agencies in the need for support after suicide.

A preferred provider has been identified and it is intended to launch the service in February 2020. It will provide brief support and signposting to close family and friends of those bereaved by suicide in NW London, who identified by the police and logged onto a pan London information hub which the new service will have access to.

**Children and Young People’s Mental Health**

**Transformation Funding**

To support sustainable expansion and improvements in waiting times for access to children and young people’s (CYP) mental health services, NW London was successful in obtaining an additional £260k of transformation funding for this year. Work over the past month has focused on mobilisation of the initiatives approved by NHS England: (1) demand and capacity review; and (2) trialling integrated digital solutions to support access to assessment and treatment.

- **NW London-wide demand and capacity review to better understand current and future issues and patient flows across the eight boroughs.**

  Work has been undertaken with commissioner and provider colleagues to set out a detailed scope for the demand and capacity work, and programme plans have been put in place. The work will look at tier 1-3 services (with some exceptions) including digital pathways, commissioned or jointly commissioned by NW London CCGs and provided by NHS Trusts or the voluntary/independent sector. It is expected that a provider will be in place in February 2020, with delivery of the final report by end of March 2020.

- **Integrating digital solutions into the current NW London CAMHS pathways to support assessment and treatment.**

  Pilot sites in NW London have now been selected – working jointly with commissioners, clinicians and providers – to test digital options for improving access to services for CYP. The work aims to demonstrate benefits, proof of concept and financial implications for integration of digital services at scale from 2020/21 onwards. Two pilots will be established, linked to each of the two mental health trusts: (1) WLT will work with two primary care networks (PCNs) in Hammersmith and Fulham; and (2) CNWL will work with three PCNs in Hillingdon. Sites were selected based on: level of need (review of referral data from PCNs); capacity for delivering transformation work (a number of CCGs are already delivering other transformation programmes e.g. mental health support teams in schools); current performance against national access standards; and understanding of local health inequalities and vulnerable groups. A preferred provider has now been identified and engagement with trusts and PCNs is underway to mobilise the offer. Work is planned with clinicians in January to identify outcomes and metrics to inform evaluation.
CYP Mental Health and Wellbeing Local Transformation Plan 2015-2020

A finalised version of the NW London CYP Local Transformation Plan was submitted to NHS England in December. The plan constitutes the annual refresh of the original 2015 document, which sets out ambitious plans for system-wide transformation of CYP mental health services. Feedback from NHS England is due this month, after which the documents will be refined (as necessary) and published on CCG websites.

Consistent CYP mental health specification

Work has now begun with all commissioning teams to jointly review the current CAMHS specification, with a view to updating it to ensure consistency of offer for CYP across NW London and that all NHS Long Term Plan commitments are appropriately reflected. This work will be completed in January/February 2020, and will be represented in contracts for the upcoming year.

Learning disabilities (LD) and autism

LD and autism funding

In addition to the £2.52m already secured from specialised commissioning to support the development of community services and the continued reduction of inpatient bed usage, NW London has now also secured funding to deliver a pilot in Harrow to offer family centred support for young autistic people in transition to adult services. The funding will be used to create a Family Outreach Worker post. NW London has secured funding for a dedicated post to help make sustainable improvements in care (education) and treatment reviews (C(E)TRs). The programme has been invited to submit capital bids for 2020/21, and work is now underway with commissioners to identify priorities.

Programme update

Work was completed with key stakeholders to finalise the NHS Long Term Plan response and the trajectories for inpatient numbers and annual health checks, including identifying interdependences with wider workstreams. The Learning Disabilities (LD) and Autism Steering Group has agreed four priority areas aligned to the wider commitments in the NHS Long Term Plan which are aimed at addressing health inequalities: autism diagnostic pathways and support; annual health checks; reasonable adjustments; and workforce. Working groups are being established to drive these programmes of work, and base lining work is underway.

The programme is working closely with the colleagues leading the development of the CAMHS and Forensic Adults Provider Collaboratives which are due to go live in April 2020. Governance structures are being agreed and work is underway to ensure the collaboratives are linked in to work around C(E)TRs, patient surgeries and the development of the community infrastructure including the community LD forensic service.

There has been increased scrutiny on the quality of inpatient provision following press articles about some patients being subject to seclusion and segregation. In line with new national policy, NW London has now established an online care register to monitor discharge planning, reviews, visits and quality issues.
Performance

Inpatient trajectories

The programme has over-performed against the Q3 2019/20 targets for reducing mental health/specialist learning disability hospital inpatients for CYP and adults, and is on track to meet March 2020 inpatient targets. The table below illustrates performance against the trajectory.

<table>
<thead>
<tr>
<th>Category</th>
<th>As at 31 Dec</th>
<th>Q3 Target ($)</th>
<th>Q4 Target ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCG</td>
<td>32</td>
<td>33</td>
<td>29</td>
</tr>
<tr>
<td>Spec Comm (adults)</td>
<td>27</td>
<td>33</td>
<td>29</td>
</tr>
<tr>
<td>Spec Comm (CYP)</td>
<td>9</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>68</strong></td>
<td><strong>78</strong></td>
<td><strong>70</strong></td>
</tr>
</tbody>
</table>

Care and Treatment Reviews (CTRs)

NW London met two of the CTR policy targets: under 18s current inpatients with CTR in the last 3 months (100%) and secure adults current inpatients with CTR in the last 12 months (79%) at the end of November 2019.

NW London needs to improve performance related to repeat six monthly CTRs for adults in non-secure settings as only 21% of patients had a review. NW London has secured funding from NHS England to recruit a CTR Coordinator to lead on our recovery plan and ensure targets are met in future.
6) Improving Cancer Care

Our Aim to improve cancer care by early identification, rapid treatment and living well with or beyond cancer. (Earlier diagnosis through strengthened interventions and informed choice, supported by timely and effective multi-disciplinary care which enables people to live as independently as possible with, and beyond a cancer diagnosis).

Key updates

- We have conducted a review of cancer inequalities in NW London, showing a clear link between increased deprivation and poorer screening coverage, and the profound impact this has on disease prognosis and patient outcomes.
- We are aiming to improve early diagnosis rates in NW London through initiatives to increase screening uptake to be consistent with London and national averages.
- We are setting up rapid cancer pathways for faster diagnosis and treatment of patients.
- We continue to work with Macmillan Cancer UK to develop holistic care programmes to support patients throughout their cancer journey.
- Cervical screening, commissioned by NHSE/NHSI, is changing to so that Human papillomavirus (HPV) will be offered as the primary screening test from 31st December 2019.
- Transforming Care Services Team (TCST) are undertaking a National Cancer Diagnosis Audit (NCDA) that has received good uptake from GP practices thus far.
- Progress continues to reduce inter-trust delays through weekly joint working.

Cancer ‘early identification’ programme

CtheSigns
The ‘C the signs’ is a software application that can be used to assist GPs in decision making when diagnosing all types of cancer, as well as management of non-diagnosed patients who are deemed to be “at risk”.
- RM Partners Cancer Alliance has completed a procurement process whereby 4 out of the 8 NW London CCGs can take part in a pilot study.
- Following an Expressions of Interest process it was determined by an independent panel that the 4 NW London CCG’s that would partake in the pilot would be: Brent, H&F, Hillingdon and Hounslow.
- The first steering group for CtheSigns was held on 17th December with plans to meet on a monthly basis hereafter. Discussions were held on the processes for attaining IT and IG sign-off, and developing a communications strategy to go-live.
- It is expected that the software will be rolled out at GP practices in the 4 pilot sites by March/April 2020.

Screening

RM Partners are leading on increasing screening participation across NW London:
- Breast - 15000 patients who have missed appointment to be rung and offered another suitable appointment; to begin in December 2019
- Cervical – Additional screening clinics being offered in all CCG areas except Brent and Harrow – however these areas are to be prioritised if there are any slippage funds
- Bowel – call reminder service will roll out in NW London in December with approx. 3000 patients per CCG contacted, prioritising lowest performing practices
- Already seen a 21/22% increase in participation from usage of community links
Screening colleagues and commissioners are jointly working in preparation for Faster Diagnostics Programme, with Trusts participating in diagnostics optimisation workshops. An MRI optimisation event found inconsistent referrals across NW London and that further training needed to be offered to registrars and consultants on optimal referral methods to adhere to 2ww rules.

**Rapid Cancer Treatment**

- RAPID prostate pathway is now live in Chelsea and Westminster Hospital NHS Foundation Trust, and estates found for the planned roll out at Hillingdon Hospital
- RM Partners are conducting three pilots this year for Rapid Diagnostic Centres (RDC):
  o Sarcomas (diagnostic pathway at Chelsea & Westminster is due to go live in Q3 2019/20)
  o Head & neck
  o Lumps & bumps
- This was in anticipation of national guidance which states that commissioners need to launch a site specific and non-site specific model. The long term ambition is for all cancers to be diagnosed through RDCs in future.

**Cancer ‘living with and beyond’ programme**

- Macmillan developing an integrated psych-oncology service at LNWHT; the first steering group was held on 5th December, and clinicians have been put in post for the service, scheduled to begin in January 2020.

7) **Hospital Care**

*Provider Board chaired by Lesley Watts, CEO Chelsea and Westminster, & Carolyn Regan, CEO West London*

**Our aims:** to implement good quality, sustainable acute care in the most appropriate places as close to people’s home as possible and for NHS Providers to work together to improve value and patient experience whilst increasing quality and reducing costs

**Outpatients Transformation**

The NW London Outpatients Transformation programme continues to build the relationship between primary care and secondary care services. Triage is now in place for the first wave of specialties. Guidelines for the second and third wave are in the process of publication and triage against these services will start in early 2020.

Some focussed work looking at follow up rates prior to orthopaedic surgery has been launched, this will look at implementing simple interventions to reduce the number of times a patient needs to come into a clinic prior to being listed for surgery. This is a key priority for 2020 onwards, where the programme will look at how follow up appointments can be delivered more effectively, and in some cases reducing the need for patients to attend a traditional hospital appointment.

Advice and Guidance remains a priority for the programme, supporting GPs in accessing timely specialist advice. Excellent data has been received from Hillingdon Hospital which demonstrates that the trust have implemented a service which responds rapidly to questions, and that the conversion rate from an advice request to a referral is low. It is planned that themes from advice and guidance requests will be identified and used to support a more tailored education offering from the specialist services.
Clinical pathways for the third wave of specialities are now in the process of publication, with guidelines launched for general surgery, and guidelines undergoing clinical review for clinical haematology, endocrinology and ENT. These guidelines will be published in early 2020.

**Conclusion**

This paper has provided a summary of progress for the latest reporting period. The next report will outline our system priorities for 2020/21 – plans, outcomes and governance to facilitate delivery.