Shaping a healthier future
Decision making business case

Volume 6
Appendix L  CCG out of hospital strategies

Edition 1.1
13 February 2013
Appendix L – CCG out of hospital strategies

- Brent
- Central London
- Ealing
- Hammersmith and Fulham
- Harrow
- Hillingdon
- Hounslow
- West London

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1 The out of hospital strategies have been developed based on three year investment figures. It should be noted that the DMBC discusses a five year period.
Appendix L1 – Brent Out of Hospital Strategy

Foreword

Growing up in Brent and being a local GP for 25 years, I am aware that we need to change the way we deliver and receive care. We need to ensure we preserve what we have done well and develop with our residents, partners from secondary care, local council and voluntary sectors, improved care for our patients.

We recognise demand for health care services is increasing as our population is living longer (which is good!), with increased long term conditions and lifestyle diseases, and available interventions are complex, expensive and require high level specialist skills. To respond to these challenges we need to improve our delivery of care in a more co-ordinated integrated approach, without compromising quality, delivering care in settings closer to home. This needs to be done by utilising people’s skills and the buildings around us, in a cost effective manner. We also believe that we need to comply with good standards of care to bring about equity in health, quality and access.

Our ultimate goal is to maintain a healthy population with the ability to self-care, supported by healthy lifestyle choices, and the ability to get appropriate health and social care advice and care with ease and in a joined up manner, avoiding layers of duplication.

Brent residents have experienced the positive changes we have already made towards achieving this goal – such as the ability to be cared for at home (through our Short-Term Assessment, Rehabilitation and Reablement Service) and more proactive care (through Case Management). This is supported by practices working in established Locality networks, sharing extended services between practices, ensuring access of services is fair disregarding which practice one is registered with.

This strategy sets out how we will continue to improve care out of hospital, including:

- Our vision for future- our level of ambition and the out of hospital standards we will adhere to
- What we will do to make this change happen, how we will organise and the key enablers for success
- The financial investment we will make and the time frames for implementation

Brent CCG’s vision “Our Health is in our Hands” signifies health is everyone’s business. Let’s work together to make our plans a reality!

Dr. Etheldreda (Ethie) Kong, CCG Chair, Brent.
Executive summary
This strategy sets out how Brent CCG will commission and deliver better care for people, closer to home. It focuses on care provided out of hospital and follows the launch earlier this year by NHS North West London of Shaping a Healthier Future.

The case for improving out of hospital services
There are three main challenges for Brent that mean how health care in the borough is delivered needs to change.

1. The residents of Brent have changing health needs, as people live longer and live with more chronic and lifestyle diseases – putting pressure on social and community care.
2. Under our current model of care, we cannot afford to meet future demand. We need to have more planned care, provided earlier to our population in settings outside of hospital. This should provide better outcomes for patients, at lower cost.
3. However, this needs a transformation of primary, community and social care. Currently there is variation in both quality and access and standards must improve.

How care will be different for patients in future
We have a clear vision for delivering better care, closer to home in Brent and have started to commission new services that are allowing people to receive the care they need in their homes. At the heart of our vision is providing the right care, in the right place, at the right time to reduce reactive, unscheduled care and do more planned care earlier. There are 5 main areas where we will take action to achieve our vision:

A. There will be easy access to high quality, responsive primary care to make out of hospital care first point of call for people. GPs and primary care teams will be at the heart of ensuring everyone who provides care does so to consistently high standards of care.
B. There will be clearly understood planned care pathways that ensure wherever possible care is delivered outside of a hospital setting. Patients will have access to services closer to home.
C. There will be rapid response to urgent needs so that fewer patients need to access hospital emergency care. If a patient has an urgent need, a clinical response will be provided within 4 hours.
D. Providers (social and health) will work together, with the patient at the centre, to proactively manage people with long term conditions, the elderly and end of life care out of hospital.
E. Patients will spend an appropriate time in hospital when they are admitted, with early supported discharge into well organised community care.

Health and Social Care commissioners are considering how they can work closer together to achieve this vision.

Delivering better care, closer to home
We will implement a number of key initiatives in each of these five areas. These will include:

- The new 111 phone number throughout North West London to provide a single point of access to health and care services
A new referral facilitation and peer review system to support GPs making referrals on from primary care

Providing some outpatient appointments in the community

Establishing rapid response teams to deliver care in patient homes when appropriate

Redesigning our pathways of care, encouraging providers to increase productivity by employing new ways of working

Implementing a new model of care so that different providers work together in multi-disciplinary groups to provide seamless, integrated care for patient

Investing and developing in primary care capacity so our existing gp practices can support more care outside hospital

How we will work together

To achieve our vision and implement these ambitious new initiatives will mean we need to change the way we work to deliver care in Brent.

Ensuring more care is delivered in the right setting and out of hospital means we need to change the way we do things. We have agreed on some organising principles as the basis for this change. Primary, community, social and mental health providers in the localities need to work together in networks to ensure care is coordinated and effective. We have 5 established localities, which will continue to function as existing networks, sensitive to locality needs of Brent’s residents and working collectively to address pan Brent needs. The five Locality networks will consolidate their inter-practice relationships, ensuring there is an enhanced level of care in community settings and effective co-ordination of care across providers.

As we take activity into the community, we need to allocate both clinical and office space to this increased level of activity. We propose four Locality Health Centres, two Standard Hubs and one Hub+, based on our existing sites.

Out of hospital care will be organised and coordinated on three levels:

- **69 individual GP practices** will be responsible for routine primary care and have overall responsibility for patient health in their area.

- **Five locality networks**, based on the current locality structures, will manage services like rapid response, case management, integrated care, specialist primary care, community nursing, community outpatients and end of life care.

- **The Borough/CCG** will be responsible for commissioning the new 111 phone service, rapid response out of hours care, diagnostics, community beds and acute care, including accident and emergency care.

Enabling improved healthcare

We will invest in better information systems, put in place stronger governance structures to hold providers to account and make sure patients have easy ways to tell us what is not working at every stage of care.

We will invest in 5 key enablers to support better care, closer to home:

1. We will step up **patient, user and carer engagement** and improve our patient education and information. We will utilise the existing 5 Locality Patient Participation Groups to enable us to deliver on this commitment.

2. We will put in place clear **locality governance** and a system of support and **performance management** so that the benefits set out in this strategy are delivered.
3. We will put in place the right information systems and tools to support networks.

4. We will ensure that we have the right contracts and incentives to improve care and to underpin the new ways of working we need.

5. We will provide training to localities to support professional and organisational development, in particular in leadership, governance, culture and teamwork, IT skills and patient engagement. We will work closely with the NWL Local Education and Training Board (LETB) and Health Education and Innovation Committee (HEIC) and our practices to train and develop a multi-disciplinary workforce.

Next steps

The strategy set out here will form the basis of further, detailed discussions in the next few weeks with GPs, patients and families, other clinicians, partners in social care and public health, health and well-being board and others, leading to full public consultation in June. A detailed implementation plan for the strategy is outlined in this document.
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1. The case for improving out of hospital services

In this strategy, we are setting out our plans to transform out of hospital care and provide better care, closer to home. Excellent out of hospital services are essential if Brent is to maintain quality of care in the face of increasing demand and limited resources. If we hope to maintain and improve standards in the face of these challenges, we must dramatically change the way we deliver primary, community and social care. In particular, in order to provide better care out of hospital, we will need to improve the quality of and access to primary care. The challenges we face are laid out in Exhibit 1:

EXHIBIT 1

This section has described why out of hospital care in Brent needs to change so that we respond to these challenges urgently. The next section describes our vision for out of hospital care in Brent and what these changes will mean for patients.

2. Our vision for how care will be different for patients

We have a clear vision for how out of hospital care in Brent will look in future:

Brent CCG will provide an integrated preventative model of health and social care services across intermediate care. Building on existing work by the Short-Term Assessment, Rehabilitation and Reablement Service (STARRS) and case management, we will broaden the preventative model by targeting a wider cohort of patients, removing duplication and improving productivity across the health and social care economy. The scope of primary care will be expanded to be central to co-ordination of multidisciplinary services. This may also involve integrating community reablement services provided by Brent social services, with the rehabilitation service provided by Brent Community Services.

At the heart of our vision is providing the right care, in the right place, at the right time to reduce reactive, unscheduled care and provide more planned care earlier in the patient’s journey. We will achieve our vision by improving patient care in 5 areas as shown on Exhibit 2.
2.1. Easy access to high quality, responsive primary care

We are committed to expanding and improving primary care so it meets patients’ expectations and is fit for the future. We will provide recurrent investment in more GPs and nurses so that practices and networks so that we can offer the following:

- Improved access through all practices being open from 0830hrs to 1830hrs Monday to Friday and extended hours access at some locality practices, and at our GP Access Centre, Wembley and Urgent Care Centres (at Central Middlesex Hospital, Northwick Park, and St Mary’s).
- Bookable GP sessions across both mornings and afternoons.
- Access to a health care professional within 24 hours for urgent care and 48 hours for routine care
- 100 bookable clinical appointments per 1,000 weighted population as well as appointments being bookable up to 4 weeks in advance.
- At least one FTE nurse per 3,000 patients (e.g. for wound care)
- Choice of male or female GP
- Better Outcomes for patients as set out in our Commissioning Plans.

This will be supported by providing individuals with up-to-date, evidence-based and accessible information to support them in taking personal responsibility when making decisions about their own health, care and well-being.

This will mean that our patients’ experience of primary care will improve (as outlined in Exhibit 3).
2.2. Clearly understood planned care pathways

We will put in place more specialist services in the community so that out of hospital care is delivered in a more appropriate setting:

- Out of hospital care will be a seven days a week service.
- Community health and care services will be accessible, understandable, effective and tailored to meet local needs. Service access arrangements will include face-to-face, telephone, email, SMS texting and video consultation.
- To ensure that care pathways are effective, with an individual's consent, relevant parts of their health and social care record will be shared between care providers improving the way we work together.
- Monitoring of patients by health professionals will identify any changing needs so that care plans can be reviewed.
- The intention is that by 2015, all patients will have online access to their health records.

As part of our process of pathway re-design, we have re-designed our diabetes pathway, with a Local Enhanced Service in place on provision of diabetic care up to insulin management and support, either at one’s own practices or within the setting of the localities.

This will mean that our patients’ experience of planned care will improve (as outlined in Exhibit 4).
2.3. Rapid response to urgent needs

Hospital admissions should be appropriately prevented wherever possible. We know at present people are admitted to hospital when a rapid community response could keep them in their own homes. To support this, we have set up multi-disciplinary rapid response team, who will go to the patient's home where they have been assessed as being at risk of admission to hospital. We will aim to avoid unnecessary admission by providing expert advice, services, diagnostics or the supply of equipment. Patients will access the service by calling the 111 number and a response will be made within two hours.

The rapid response team and other out of hospital care initiatives are expected to prevent 2,000 emergency admissions a year in Brent.

This will mean that our patients will be able to receive rapid care when their need is urgent (as outlined in Exhibit 5).
2.4. Integrated care for people with long term conditions and the elderly

We will ensure that there is more effective working between social and health teams to support people with long term conditions, the elderly and people nearing the end of their lives to stay out of hospital and have the support they need.

Patients and their carers tell us that they sometimes fall between the gaps in services. In future, we will ensure that patients and their families in Brent who need community health and social care will experience coordinated, seamless and integrated services using evidence-based care pathways, case management and personalised care planning.

This will be facilitated by 5 multidisciplinary groups (MDGs), based on our current locality structures, working across Brent as part of the Outer North West London Integrated Care Pilot. The MDGs will be made up of local GP practices and other providers from community health, mental health, acute hospitals and social care for those patients most at risk of a hospital admission. They will work together to identify and review patients at risk of becoming ill. Initially these groups in Brent will focus on the over 75s. Additionally, case management systems currently piloted at 2 localities will be rolled out to all 5 localities. Such integrated care will be better for patients as they will receive proactive care to keep them well, will not suffer from gaps in provision between services and will not have to constantly repeat their story. It will also be better for professionals as they will have access to full patient information and will be able to learn from colleagues with different expertise developing shared priorities for patients. Integrated care should be better value for taxpayers by reducing costly emergency admissions and visits to hospital, making preventative care across health and social care settings a reality.

Some of the benefits of integrated and proactive care we will have for our patients are outlined in Exhibit 6.
2.5. Appropriate length of time in hospital and supported discharge

We will put in place properly planned discharge and support for patients who can be discharged from hospital so that they avoid longer stays than they need. The patient’s GP and other providers of health and social care will be involved in coordinating an individual’s discharge plan (including intermediate care and reablement) as well as continuing care needs.

There will be more joined-up discharge support, with an appropriate step-down in care (e.g. step-down beds in a community hospital), prompt communication to other providers and clear advice and information for patients.

This will mean that our patients will not stay in hospital when it is not best for their care (as outlined in Exhibit 7).
2.6. Standards to maintain the quality of care

Patients and the public need to be confident that as we change where and how patients are cared for, we will hold ourselves to high clinical standards of care in the community. Therefore, we have agreed standards that set our aspirations for the future. They emphasise the central role of the GP in the coordination and delivery of out of hospital care. The standards encompass both core primary care delivered by GP practices and, more broadly, care delivered outside of hospital. They aim to shift care delivery from more reactive unplanned care to proactive planned care.
EXHIBIT 8
The standards are covered in four key domains

<table>
<thead>
<tr>
<th>Domains</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Empowerment &amp; Self Care</td>
<td>▪ Individuals will be provided with up-to-date, evidence-based and accessible information to support them in taking personal responsibility when making decisions about their own health, care and wellbeing</td>
</tr>
</tbody>
</table>
| Access convenience and responsiveness| ▪ Individuals will have access to telephone advice and triage provided 24 hours a day, seven days a week. As a result of this triage:  
▪ Cases assessed as urgent will be given a timed appointment or visit within 4 hours of the time of calling  
▪ For cases assessed as not urgent and that cannot be resolved by phone, individuals will be offered the choice of an appointment within 24 hours or an appointment to see a GP in their own practice within 48 hours |
| Care planning and multi-disciplinary care delivery | ▪ All individuals who would benefit from a care plan will have one.  
▪ Everyone who has a care plan will have a named ‘care coordinator’ who will work with them to coordinate care across health and social care  
▪ GPs will work within multi-disciplinary groups to manage care delivery, incorporating input from primary, community, social care, mental health and specialists |
| Information and communications       | ▪ With the individual’s consent, relevant information will be visible to health and care professionals involved in providing care  
▪ Any previous or planned contact with a healthcare professional should be visible to a relevant community health and care providers,  
▪ Following admission to hospital, the patient’s GP and relevant providers will be actively involved in coordinating an individual’s discharge plan |
This section sets out the key initiatives we will take to deliver improved care out of hospital in each of the six areas described previously. Some of these initiatives are new and specific to Brent, while others are part of broader work such as the 111 service. Exhibit 9 outlines the out of hospital initiatives we will be implementing.

**EXHIBIT 9**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Initiative description</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Easy access to high quality, responsive care</td>
<td>▪ Primary care development</td>
</tr>
<tr>
<td></td>
<td>▪ Rolling out of 111 across NWL</td>
</tr>
<tr>
<td></td>
<td>▪ Shifting mental health patients to a less intensive model of care supported by a primary care plus system</td>
</tr>
<tr>
<td>□ Simplified planned care pathways</td>
<td>▪ Reducing variation in GP referral rates through Referral management</td>
</tr>
<tr>
<td></td>
<td>▪ Shifting a proportion of elective procedures into enhanced community clinics</td>
</tr>
<tr>
<td></td>
<td>▪ Reducing cost of outpatients through shifting a proportion of acute outpatient services to community settings</td>
</tr>
<tr>
<td></td>
<td>▪ Carrying out a proportion of pre-op assessments in GP clinics</td>
</tr>
<tr>
<td>□ Rapid response to urgent needs</td>
<td>▪ Treating patients that are part of the “STARRS” cohort in alternative care settings in the community</td>
</tr>
<tr>
<td></td>
<td>▪ Expansion of urgent care centres reducing A&amp;E admissions</td>
</tr>
<tr>
<td>□ Integrated care for LTC and elderly</td>
<td>▪ Outer sub-cluster integrated care to reduce NEL admissions (including mental health)</td>
</tr>
<tr>
<td></td>
<td>▪ Proactively managing the care provided to a proportion of our residents who are high users of our acute services</td>
</tr>
<tr>
<td></td>
<td>▪ Integrate consideration of mental health co-morbidities in the Integrated Care Pilot</td>
</tr>
<tr>
<td></td>
<td>▪ Ensuring patients are able to choose their end of life care</td>
</tr>
<tr>
<td>□ Appropriate time in hospital</td>
<td>▪ Discharge support reducing patients stay in hospitals when not required</td>
</tr>
<tr>
<td></td>
<td>▪ Establish a psychiatric liaison service</td>
</tr>
</tbody>
</table>
3.1. Easy access to high quality responsive primary care

Initiative A1: Primary care development

We have established a programme to expand and improve the quality of primary care in Brent in four key areas: clinical outcomes, service, enhanced primary care, patients and the public. The programme will have an incentive scheme with ten indicators taken from the London Outcomes Framework (LOF). Each practice will be supported to develop a practice plan for how they will achieve the indicators and how that will improve services. The programme will strengthen working relationships between practices, encourage the development of Clinical Commissioning Group, and will enable primary care to be better placed to deliver more services in the context of current NHS changes.

Improved quality of primary care will be supported by an expansion in primary care capacity. We will agree capacity and delivery plans with practices to support them in meeting the out of hospital standards through funding additional healthcare professional capacity.

For patients, this will mean improvements in quality, consistency and access so that their choice of GP will be based on location and convenience. This will also mean that patients have a choice of a male or female GP.

Initiative A2: Single point of access through the new 111 phone number

The roll out of the new 111 phone number across NHS North West London will provide a single point of access for patients, carers and clinicians to the appropriate level of care. The free to call 111 number is available 24 hours a day, 7 days a week, 365 days a year. Patients will call 111 when:

- They need medical help fast, but it is not a 999 emergency
- They do not know who to call for medical help or do not have a GP to call
- They think they need to go to A&E or another NHS urgent care service
- They require local health information or reassurance about what to do next

The NHS 111 service will provides management information to commissioners on the demand for and usage of services to enable the commissioning of more effective and productive services that are designed to meet people’s needs.

Call handlers will be highly trained and supported by experienced clinicians. They will follow agreed clinical pathways and will have access to a local directory of services, with escalation to clinical support as appropriate. Agreed service standards will mean that urgent cases will be dealt with within 4 hours, and those whose needs are not urgent will be seen within 24 hours, or 48 hours if they want to go to their own GP practice.

For patients, this will mean quick and easy direction to the right level of care.

Initiative A3: Shifting mental health patients to a less intensive model of care supported by a primary care plus system.

For people who are being treated by a mental health provider, there is an opportunity to provide more care from primary care. As many as 10% of patients currently under the care of mental health trusts have low level needs that could be met in primary care.

Having GPs responsible for more patients with non-complex mental health needs will require a structured approach. It is proposed that an agreed pathway is adopted for the transfer of responsibility for care from community mental health teams to GP practices. This will include setting criteria for the transfer of responsibility, a case review to confirm criteria have been met and joint work between the community mental health team, the GP and the patient to develop a care plan. Primary care will also have access to ongoing support in the form of a "primary care plus system" outlined in Exhibit 10.
3.2. Clearly understood planned care pathways

**Initiative B1: Referral facilitation**

We will launch a new referral facilitation and peer review system to support GPs in the decision making process when they make referrals on from primary care. In this way, we will not only reduce the number and costs of referrals but also improve the quality of decision making by GPs.

The system will involve continuous professional development, peer review, implementation of best practice and increased use of benchmarking and current data.

GPs will take part in skills development sessions, undertake regular and frequent peer review and will attend referral panels with GP clinical champions.

This will mean that patients will only be referred for further investigation or treatment when it is really necessary.

**Initiative B2: Move some elective procedures from secondary to primary care**

Brent CCG has identified procedures that could be performed outside a hospital setting by GPs and specialist providers in enhanced community clinics. This project will be carried out in full discussion with GPs and potential specialist providers. Primary care services will, as a result, be able to identify potential specialist procedures they are able to provide though clinical networks. Those procedures that cannot be provided in primary care can be opened up to other potential providers on the basis of quality and cost.

For patients, this will mean having services delivered closer to home.

**Initiative B3: Move a proportion of acute outpatient services to community settings**

<table>
<thead>
<tr>
<th>Ongoing CPN support for more complex patients</th>
<th>Mental health training for GPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. CPNs provide low level step down care to patients transferred from secondary care into primary care</td>
<td>1. Dedicated course aimed at providing education in basic mental health care for example:</td>
</tr>
<tr>
<td>2. Average 2-3 contacts per patient in first 6 months step down</td>
<td>- 4-6 week course, 1 evening per week</td>
</tr>
<tr>
<td>3. Annual assessment</td>
<td>- Run by experienced mental health experts</td>
</tr>
<tr>
<td>4. 2-3 appointments per patient per year</td>
<td>- Each practice nominates 1 members to participate</td>
</tr>
<tr>
<td>5. Follow up aid from care support worker</td>
<td>- Courses run annually to ensure continual training</td>
</tr>
<tr>
<td>6. CPN work overseen by 1 psychiatrist in each borough</td>
<td></td>
</tr>
<tr>
<td>7. Patient care remains the overall responsibility of the GP at all other times</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expert mental health advice for GPs</th>
<th>Mental health induction for GP surgeries</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Telephone and e-mail support from mental health consultant:</td>
<td>1. Annual session run by CPN in each surgery to provide overview of care management of mental health patients, including:</td>
</tr>
<tr>
<td>- Part of “on call” duties for consultant</td>
<td>- Discussion of unique care requirements of mental health patients</td>
</tr>
<tr>
<td>- 5 hour per week per CCG dedicated to answering GP mental health questions (e.g., advice on medication, care plans etc.)</td>
<td>- Introduction to patient care path</td>
</tr>
<tr>
<td>- Informal coaching of GPs as part of involvement in ICP MDG meetings</td>
<td>- Provision of information on full support for mental health patients (e.g., voluntary sector)</td>
</tr>
</tbody>
</table>

**SOURCE:** Working group
Similarly, we will take a two-tier approach to plan outpatient care. Some services will be provided by GP networks as a Local Enhanced Service. Where services can be provided by a specialist provider, including networks, this will be done through competitive dialogue (developing specifications in collaboration with potential providers). In Brent, this is already the case for ophthalmology and cardiology outpatient services.

Services will be commissioned on the basis of outcomes, with providers expected to deliver on a set of clearly defined clinical and patient reported measures. Bids will be assessed on three criteria: quality of service, cost effectiveness and capacity and resilience. For patients, this will mean high quality outpatient services and better value for money.

3.3. Rapid response to urgent needs

Initiative C1: Treating patients that are part of the “STARRS” cohort in alternative care settings in the community

Brent CCG has already begun to implement the STARRS program which involves short-term, intensive interventions which prevent hospital admissions and enable patients to reach their rehabilitation potential before moving on to their ultimate care destination. This includes both time-bound rehabilitation (health therapy care) and reablement (social care, with therapy management).

The key operational elements of the service are a Rapid Response team and a short-term service. The rapid response team will carry out urgent assessment and intervention to stabilise a patient for a maximum of 72 hours as an alternative to A&E attendance or short term hospital admission, whilst the short-term service will include temporary beds (health step-up and step-down beds and social care beds) and time-bound reablement/rehabilitation services. To ensure the continued success of our rapid response service we will focus on improving awareness of the service among patients and carers.

For certain patients, the STARRS programme will mean they will not have to go to hospital to receive rapid assessment and medical support but will receive this promptly in their own home.

3.4. Integrated care for people with long term conditions and the elderly

Initiative D1: Integrated care pilot

Brent will implement a model of integrated care with other CCGs in outer North West London. Integrated care is an internationally proven system of bringing health and social care services together to work in a model of care that supports and develops multidisciplinary working between local GP practices and other providers from community health, mental health, acute hospitals and social care for those patients most at risk of a hospital admission.

We will establish five multidisciplinary groups across Brent who will work together to identify and review patients at risk of becoming ill. Initially their focus in Brent will be on the over 75s. Exhibit 11 outlines how the integrated care model will work in practice.
Aligned services will:

- Enhance patient, user and career involvement
- Share joint governance through the integrated management board and borough-based management groups with a shared performance framework
- Align incentives through an innovative financial model (e.g., innovation fund to pump-prime investment into services)
- Have access to timely data analysis and information sharing
- Develop a strong organisational culture (through holding each other to account in performance review discussions)
- Deliver substantial financial savings
- Improve professional experience via joint governance, aligned incentives and transparent information sharing

For patients, integrated care by multi-disciplinary groups will mean seamless, preventive care, which will reduce the likelihood of unplanned admission to hospital.

**Initiative D2: Integrate consideration of mental health co-morbidities in the integrated care pilot.**

People who have a physical long term health need, such as diabetes, are also more likely to have mental health problems. And where these mental health “co-morbidities” exist, care can be between 45-75% more expensive than for patients with just the physical ailment. Therefore, it is crucial that the Integrated Care Pilot consider mental health needs. For patients this will include mental health screening as part of annual reviews and specially tailored psychological therapy sessions when necessary. Exhibit 12 below outlines how

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1 “Long-term conditions and mental health: the cost of co-morbidities,” Chris Naylor et al., February 2012, King’s Fund and Centre for Mental Health.
mental health will be considered at each stage from patient registry through to case conference discussions.

EXHIBIT 12

**Initiative D3: Proactive case management for frequent users of hospital services**

All patients who have had three or more emergency admissions in the previous year or who are identified as being at significantly increased risk of emergency admissions will be referred for case management by experienced community nurses. These patients will have care plans and support in primary care to reduce their need for hospital admissions, which will be better for patients and better for the health system. The community nurses will work closely with GPs to ensure these patients have appropriate proactive care in place.

**Initiative D4: Ensuring patients are able to choose their end of life care**

Patients who have expressed a wish to remain in their own homes as they approach the end of their lives frequently end up being admitted to hospital. The Brent end of life strategy seeks to move the place of death for 70% of people on the end of life pathway out of hospital and back into the community, preferably their own homes. For this group of patients, we also aim to reduce by 70% the number of spells in hospital for unplanned care.

We will achieve this by using the London-wide end of life register in Brent which records patients' wishes on their place of death; raising skills of staff and standards of care by greater use of the Gold Standards Framework and the Liverpool Care Pathway; and by providing incentives for practices to ensure staff time for training on these tools. We will increase our capacity to provide care outside hospital and this will include 24/7 support for hospice at home.
3.5. Appropriate length of time in hospital and supported discharge

**Initiative E1: Reducing patients stay in hospitals with our discharge team**

One function of our STARRS team is to facilitate the safe early discharge of patients from acute hospital wards.

The service is designed for patients who would benefit from a short-term crisis intervention in a community setting. The team will be accessed by a single point of contact. Staff will undertake a full assessment of patient needs within 2 hours. The team will draw up a care plan with clear goals for the patient to work towards that is responsive to their needs. Each patient will be allocated a single case manager to coordinate the care for that patient across the health and social care economies as part of the virtual team. Where appropriate, the patient will receive a package of care over a 24 hour period, 7 days a week. The case manager will monitor the patient’s progress throughout the intervention. Referrals will be made by the case manager in consultation with the patient and directed to appropriate health and social care agencies.

This will mean patients who are medically fit for discharge but require continued support will be able to receive this in their own home, avoiding unnecessarily lengthy hospital stays.

**Initiative E2: Establish a psychiatric liaison service**

A psychiatric liaison service will be set up. The liaison team will be multidisciplinary as outlined in Exhibit 13. These teams are a flexible resource within the hospital that can be deployed anywhere to support patients with mental health problems. This may prevent unnecessary admission into hospital or for existing inpatients it should mean quicker discharge (more often to a patient’s own home) and overall improved outcomes.

**EXHIBIT 13**

<table>
<thead>
<tr>
<th>What is it?</th>
<th>What does the service look like?</th>
</tr>
</thead>
<tbody>
<tr>
<td>The ‘Optimal Standard’ is a high quality liaison psychiatry service designed to operate in acute general hospitals in NWL, providing the following services:</td>
<td>Highly visible multi-disciplinary mental health team fully integrated into the hospital</td>
</tr>
<tr>
<td>Care for patients with significant mental health needs (outside specialist MH units)</td>
<td>Single point of contact for all patients (16+) in hospital with diagnosed or suspected mental health conditions of any severity</td>
</tr>
<tr>
<td>Training for other hospital staff to enable them to support patients’ mental health needs</td>
<td>Rapid response for patients requiring mental health support and 24/7 support in A&amp;E and wards</td>
</tr>
<tr>
<td>Integration with other parts of the health system e.g., GPs, specialist mental health teams</td>
<td>Training experts on mental health problems and related issues for non-mental health clinicians</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Who delivers the service?</th>
<th>Coordination with out-of-hospital care providers and housing services</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 Consultant Psychiatrists</td>
<td>Integrated with broader health and social care system</td>
</tr>
<tr>
<td>1 Team Manager</td>
<td>Single management structure</td>
</tr>
<tr>
<td>12 Team Nurses (Bands 6 and 7)</td>
<td></td>
</tr>
<tr>
<td>1 Alcohol Nurse</td>
<td></td>
</tr>
<tr>
<td>2 Specialist Registrars</td>
<td></td>
</tr>
<tr>
<td>1 Generic Therapist</td>
<td></td>
</tr>
<tr>
<td>1 Occupational Therapist</td>
<td></td>
</tr>
<tr>
<td>1 Social Worker</td>
<td></td>
</tr>
<tr>
<td>1 Administrative support</td>
<td></td>
</tr>
<tr>
<td>1 Research/Business Support Officer</td>
<td></td>
</tr>
</tbody>
</table>

Having the psychiatric liaison team in place should help all clinicians by ensuring better mental health care in acute hospitals with improved risk management. One of the roles of the liaison team will be to train staff members in mental health care. For the whole health and social care system, there should be benefits in terms of fewer admissions, reduced length of stay and lower accommodation costs for local authorities (with more patients discharged directly home).
For patients psychiatric liaison will mean their mental health needs are treated earlier.

3.6. Conclusion

The new services that we have described in this section will mean that we need to put in place new ways of working. The next section sets out how we will do this so that patients, carers, users and professionals are well informed and have confidence in the success of the new services and so that the changes are handled well.
4. How we will work together

To achieve our vision and implement these ambitious new initiatives will mean we need to change the way we work to deliver care in Brent. Exhibit 14 outlines the 6 aspects to this:

EXHIBIT 14

1. We need to change the way we do things – and we have agreed some **organising principles** we need to stick to as we change

2. Primary, community, social and mental health providers in the localities need to work together in **networks** to ensure care is coordinated and effective

3. As we take activity into the community, we need to allocate both **clinical and office space** to this increased level of activity – we are proposing making use of our existing sites to support this

4. There are three distinct ‘levels’ of care where it makes sense to co-ordinate services locally vs. Borough level – and have therefore organised how services are managed and delivered outside the GP and acute setting

5. To deliver care effectively in networks requires new ways of working, including care coordinators, and network coordinators

The following sections look at these 6 aspects in more detail.

4.1. Organising principles

The strategy we are proposing for Brent involves big changes in how and where care is delivered: it includes integrated care, case management and rapid response; beds in the community; and some outpatient appointments and some elective procedures taking place in the community. To deliver these significant changes, providers need to work more closely together to ensure care is organised around the patient and to extend the range of services offered in the community.

To guide this closer working, we have developed some organising principles:

- We need to organise in a way that enables **collaboration and co-ordination** of care across Brent
- We must **avoid duplication** of activity
- Activity should be delivered at most efficient point **financially**, equally balanced with where it is **most effective** for the patient
- **Care will be GP-led, with primary care teams** remaining central to patient care
- We should design our care around Locality **network practice population** which broadly reflects geographical boundaries
- **Existing contracting arrangements** should not constrain the design.
- **Workforce, training and planning** should support these organising principles.
4.2. Primary, community, social and mental health providers in the localities need to work together in networks

In Brent we have established GP networks working together to improve outcomes for patients, we have already successfully worked together to deliver effective immunisation, health risk checks, and stop smoking campaigns. We will continue to organise ourselves as 5 Locality networks based on our current localities/multi-disciplinary groups. The five Locality networks will provide an enhanced level of care in community settings and will also collaborate with other providers to provide integrated primary and secondary care services. Exhibit 15 shows the location and sizes of the 5 Locality networks in Brent.

EXHIBIT 15

<table>
<thead>
<tr>
<th>Locality</th>
<th>Population</th>
<th># of Practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wembley</td>
<td>53,896</td>
<td>12</td>
</tr>
<tr>
<td>Kingsbury</td>
<td>73,953</td>
<td>16</td>
</tr>
<tr>
<td>Willesden</td>
<td>50,084</td>
<td>10</td>
</tr>
<tr>
<td>Kilburn</td>
<td>77,372</td>
<td>15</td>
</tr>
<tr>
<td>Harness</td>
<td>80,559</td>
<td>16</td>
</tr>
</tbody>
</table>

4.3. Working with our partners to provide coordinated care

In order to provide seamless and well-co-ordinated care in Brent, the CCG is committed to working very closely with its partners.

One of the important ways in which we will improve the way we work together is by establishing five multidisciplinary groups across Brent who will work together to identify and review patients at risk of becoming ill. The role of multidisciplinary groups is outlined below in Exhibit 16:

3 out of 5 of our localities already have established social enterprise bodies for provision of care as networks.
The role of multidisciplinary groups:

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

High risk patient cases are discussed at monthly case conferences by the members of the multidisciplinary group. There will also be regular performance review meetings to hold different providers to account, evaluate the effectiveness of local care pathways and propose key investments to close gaps in care delivery. An IT tool is being procured which will automate much of the data for the ICP, including risk assessment, work planning and messaging between providers. Providers will be reimbursed for the care coordination activities (work planning, case conferences and performance reviews) done to deliver integrated care. Exhibit 5 shows the working arrangements of the multidisciplinary groups.

In addition to MDGs, Brent CCG and social care are exploring the benefits and risks of integrated commissioning. If this was pursued health and social care budgets could be pooled to support earlier intervention.

To improve coordination amongst providers, we will put in place a genuine single point of access to coordinate patient referrals from multiple providers. This will be supported by a case manager who will put in place care packages (for those patients who it is deemed necessary) aimed at reducing long term need of patients. The structure of our integrated, preventative model of care is outlined below in Exhibit 17.
4.4. Allocating space to support this increased level of activity

As we take activity into the community, we need to allocate both clinical and office space to this increased level of activity. There will be three tiers where services are provided: the Hub+, Standard Hubs and Locality Health Centres.

The Hub+ could provide specialist pathways and services commissioned on behalf of all localities as well as community beds (step up and step down), the urgent care centre and GP Practices.

Standard Hubs will provide one-stop assessment and treatment that requires more specialist input or access to more complex diagnostics.

Locality Health Centres will provide community services. They will be consolidated to provide care to identified groups of GP practices within the locality.

We can make use of existing sites to deliver our out of hospital strategy in Brent. We propose six Locality Health Centres, two Standard Hubs and one Hub+. Exhibit 18 shows the proposed locations based on existing sites.

EXHIBIT 18

4.5. Three levels for the co-ordination of care in Brent

In future, out of hospital care will be organised and co-ordinated on three levels. The 69 individual GP practices will be responsible for routine primary care and navigating patients through the health system. They will have overall responsibility for patient health in their area. GPs, nurse practitioners, practice nurses and district nurses will deliver care at this level.

We will retain our current locality structure as Locality networks. These will manage the following services:

- Rapid response – admission avoidance, discharge support
- Social services reablement and rehabilitation
- Walk-in centres
- District nursing – case management
- Integrated care – multi-disciplinary groups for elderly patients
- Specialist primary care
- Community outpatients
- End of life care
- Referral management

At this level, care will be delivered by community mental health representatives, social care representative, community matrons and district nurses.

The Borough/CCG level will be responsible for:

- 111 phone service
- Rapid response out of hours care
- Community beds
- Acute care including accident and emergency care.

At this level, care will be delivered by acute specialists, mental health specialists and social care specialists.

4.6. New roles to support Locality networks

In each of the 5 Locality networks, we will create new roles to enable them to deliver care effectively. Each Locality network will have:

- 1 clinical lead responsible for overseeing clinical governance (1 session per week)
- 3 clinical champions responsible for being champions of new clinical pathways (2 sessions per month)
- 1 Locality network manager responsible for network coordination including organizing network meetings and providing materials for performance conversations (full-time equivalent)
- IT support for systems implementation.

Exhibit 19 shows the additional support we will put in place for our networks.
4.7. Conclusion

This part of the report has outlined new ways of working together to deliver the strategy. The next section builds on this further by examining the enablers that will facilitate the changes needed in this strategy.
5. Supporting improved out of hospital care for Brent

We have identified 5 key enablers to support better care, closer to home. These are summarised in Exhibit 20 below.

EXHIBIT 20

<table>
<thead>
<tr>
<th>A</th>
<th>Patient, user and carer engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify and target frequent flyers, carrying out patient education specifically focussing on these issues</td>
<td></td>
</tr>
<tr>
<td>Carry out patient education through the use of multiple media</td>
<td></td>
</tr>
<tr>
<td>Provide access to information so we have the same information in all areas of the system (e.g., practice, 111, UCC)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B</th>
<th>Network governance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Networks to have clear management structures and reporting lines in place</td>
<td></td>
</tr>
<tr>
<td>Use a common assessment process across health and social care</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C</th>
<th>Information and tools to support networks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Put in place a macro level information system for commissioning (significant work progress this underway)</td>
<td></td>
</tr>
<tr>
<td>Purchase a real time patient information system, based on a scoping on available systems</td>
<td></td>
</tr>
<tr>
<td>Develop and implement information sharing agreements across health and social care networks</td>
<td></td>
</tr>
<tr>
<td>Develop specific contract support and specifications</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D</th>
<th>Contracts and incentives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Put in place standards to ensure practices meet a minimum level of quality/productivity in order to bid for provision of other services</td>
<td></td>
</tr>
<tr>
<td>Develop mechanisms to provide up-front investment for care</td>
<td></td>
</tr>
<tr>
<td>Set consistent standards for care</td>
<td></td>
</tr>
<tr>
<td>Standardise investment across primary care for the core</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E</th>
<th>Professional and organisational development</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline current workforce and understand current skill-mix carry out gap analysis</td>
<td></td>
</tr>
<tr>
<td>Increase utilisation of GPwSIs</td>
<td></td>
</tr>
<tr>
<td>Invest in upskilling and training of clinical staff. “Repurpose” existing staff to deliver care in the OOH setting</td>
<td></td>
</tr>
</tbody>
</table>

The following sections describe the actions we will take around each of these areas.

5.1. Patient, user and carer engagement

We will build on the plans we already have in place to increase patient, user and carer engagement, which is essential for success as we make the changes outlined in this strategy.

In addition to the engagement already taking place through Patient Participation Groups in localities, we will build on our existing Borough-wide equality, diversity and engagement strategy.

We will carry out patient education using a variety of different media. Focussing on supporting our diverse population with multilingual access guides, engaging with community structures (e.g. religious and community centres) and identifying the key segments of our population who can benefit from increased engagement (e.g., young mothers, those with long term conditions).

We will identify people who have frequent contact with the health system and carry out patient education specifically aimed at their needs.

Exhibit 21 sets out the specific commitments we are making to patients, users and carers in Brent about how they will be involved.
5.2. Locality network governance

In Brent CCG, we recognise the potential conflict of GPs as both commissioners and providers. Our arrangements for managing this will be embedded in our CCG constitution. We will have a separation of practice and locality commissioning and provision roles so that a locality is not commissioning from itself. The CCG as a commissioning body will be responsible for placing contracts with networks and monitoring performance in addition to the networks’ governance arrangements. Our governance arrangements for GP networks are emerging. While there will be a separation of commissioning and provision responsibilities to manage conflict, GP networks will be integral to our Clinical Commissioning Group. The GP network and networks for the ICP will overlap. However, as the ICP is a provider network with social care and other providers, the governance structures for the ICP and the GP networks will be distinct.

As part of our development of GP networks and as a Clinical Commissioning Group, we will strengthen arrangements for supporting improvements in outcomes for our patients. Data on organisational performance will be reviewed at 3 levels:

- By GP practices, daily and in real time
- By localities, fortnightly, reviewing clinical performance and benchmarking against others
- By a performance sub-group, monthly looking at priority areas, such as prescribing.

Robust performance metrics need to be developed. These could include key areas of a practice’s work, such as the number of patients with long term conditions or at end of life who have care plans; Quality and Outcomes Framework scores and MORI access poll results; and response times for community services and social care. Indicators could also include whether practices are reducing outpatient referral rates, emergency admissions rates and accident and emergency rates of admission.
5.3. Information and tools to support locality networks

Better sharing of information will be central to achieving our vision. It will achieve the following:

- Real-time shared records will inform health care providers and link GPs, community, acute and mental health teams where the decision to refer is made. Duplication will be reduced.
- Transparency of information gathered will help us drive up standards and deliver equality of care across Brent.
- Planned care will become more streamlined as referrals follow precisely defined pathways and GPs have access to granular reporting on referrals.
- Urgent care will become better informed as information input by the GP is visible to staff at the UCC and care is visible to GPs and prompts are given for follow-up actions.
- Long term care will become more proactive as a result of risk stratification of patients by GPs, care plans being put in place and regular checkups and early intervention based on these.

Exhibit 22 shows the key information flows and IT systems that enable an integrated approach.

EXHIBIT 22
5.4. Contracts and incentives

We need to create the right contracts and incentives to improve care and to ensure that they underpin the new ways of working that are needed to deliver better care, closer to home. We have already developed, working closely with Brent LMC, specific incentives to bring about change and will invest in these so that GPs can deliver change effectively. These include:

- **Improvement plans for primary care: practices will develop individual improvement plans.** We will reward practices that achieve better outcomes. We will also reward practices that participate in the Locality GP network. We will fund protected time for practices to develop their improvement plan and network plan.

- **Moving towards a common core specification and more equitable funding for primary care:** we will make funding available to practices each year so that they can increase their capacity for care outside of hospital in a sustainable and planned way.

- **Support for GP networks to establish their business model for delivery of out of hospital services:** funding will support the development of business models, including governance arrangements, implementation plans, inter-practice payment mechanisms and new infrastructure.

In future, we will go further. Exhibit 23 summarizes how targets, contracts and incentives could be aligned to support each of the five goals of our better care, closer to home strategy.

**EXHIBIT 23**

<table>
<thead>
<tr>
<th>Target</th>
<th>How we can achieve this</th>
<th>Re-imbursement to support this</th>
</tr>
</thead>
<tbody>
<tr>
<td>Easy access to high quality, responsive care</td>
<td>Improve access, Improve satisfaction</td>
<td>Meeting minimum primary care requirements, Incentives for delivery, Penalties for failing to meet requirements</td>
</tr>
<tr>
<td>Simplified planned care pathways</td>
<td>Reduce Outpatient attendances, Elective admissions</td>
<td>Peer review/referral management system, Inter-practice referrals, Referral incentive scheme, Activity-based reimbursement, Shared incentives across network reach targets</td>
</tr>
<tr>
<td>Rapid response to urgent needs</td>
<td>Reduce A&amp;E attendances, Improve reliability</td>
<td>111, UCC, extended hours, Walk-in centres, Shared budget allocation for urgent care split across UCC, A&amp;E, OC, Shared incentives across network reach targets</td>
</tr>
<tr>
<td>Integrated care for LTC and elderly</td>
<td>Reduce NEL admissions, Increase Integration, Increase proactive care</td>
<td>Coordination ratings, Care plans, Payments for care plans, Payments for clinicians to attend conference, Shared incentives across providers to reach targets</td>
</tr>
<tr>
<td>Appropriate time in hospital</td>
<td>Reduce length of stay</td>
<td>Discharge coordinator, HSCC, Rapid response, Contracting HSCC, Discharge coordinator and rapid response</td>
</tr>
</tbody>
</table>
5.5. Professional and organisational development

The Government’s ambition for the NHS to deliver health outcomes among the best in the world is rooted in the three principles of giving patients more information and choice, focusing on healthcare outcomes and quality standards, and empowering frontline professionals with a strong leadership role. At the heart of these proposals are clinical commissioning groups (CCGs).

CCGs will be different from any predecessor NHS organisation. Whilst statutory NHS bodies, they will be built on the GP practices that together make up the membership of a CCG. CCGs must ensure that they are led and governed in an open and transparent way which allows them to serve their patients and population effectively.

It will be vitally important that CCGs are clinically led, with the full ownership and engagement of their member practices, so that they can bring together advice from the broadest range of health and care professional to influence patterns of care and focus on patients’ needs. At the same time they will need to demonstrate probity and governance commensurate with their considerable responsibilities for their patients healthcare and taxpayers money.

NHS Brent CCG will build on its experience to date, through Professional Executive Committees, Practice Based Commissioning and now as a shadow CCG, to further develop leadership and governance to deliver Brent’s Out of Hospital Strategy.

This will mean:

- Practices will work together in localities to provide services and work in integrated care networks with other providers to provide joined up services for patients.

- Practices will work together in the CCG to hold each other to relevant on improving primary care services and to hold other providers to account for senior delivery through contracts the CCG holds.

- NHS Brent CCG will adopt a constitution that clearly sets out our governance arrangements for undertaking our statutory duties.

Governance

In order to ensure that Locality networks engage in decision making on their structures, that working groups meet regularly and that board structures are formalised, we will focus on outlining roles and responsibilities, decision making, resource sharing, legal issues and performance management.

IT skills

We will provide training for all relevant staff to ensure that they have the necessary IT skills to deliver the changes we are putting in place, such as care packages, which will rely on IT support to be fully effective.

Patient engagement

We will provide training for clinical leaders to ensure that we reach out to communicate more effectively with the diverse communities that make up Brent. This will help to ensure that we engage patients and the wider public in planning.

Professional Training

We will work closely with the NWL Local Education and Training Board (LETB) and Health Education and Innovation Committee (HEIC) and our practices to train and develop a multi-
disciplinary workforce, fit for purpose, with the ability to implement the out of hospital work plans with innovative technology. We will add to the training set out above with development for particular professional groups:

- We will support GPs to specialise where appropriate, increasing the number of GPs with a special interest
- We will up skill our practice nurses so that they are able to carry out tasks that GPs have traditionally carried out (e.g. chronic disease management)
- We will build the capabilities of our healthcare assistants so that they are able to carry out technical procedures (e.g. ECG scans, ear syringing and audiometry)
- We will develop the skills of our managers so that they are effective at coordinating Locality networks, monitoring outcomes and developing strong relationships with CSS.
6. Investing for the future

This strategy has started to lay out our vision for a fundamentally different model of care. To deliver our vision, we will make significant investments in staff and estates across different settings of care. Exhibit 24 broadly outlines the investment we will aim to make in services delivered at home, in GP practices and community health centres over the next three years as investment shifts from hospital to out of hospital sector.

These investments will be subject to approval of full business cases that are likely to be investment led and include disinvestments in other services and will have measureable benefits that will be performance managed.

**EXHIBIT 24**

<table>
<thead>
<tr>
<th>Where you will receive care</th>
<th>Services offered</th>
<th>Additional Investment</th>
<th>Additional space</th>
<th>Additional workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td>At Home</td>
<td>Community care&lt;br&gt;Elderly care&lt;br&gt;Postnatal care&lt;br&gt;Rapid Response</td>
<td>£0.5-1.0m</td>
<td>Access to consulting rooms/team room</td>
<td>20 – 25 WTE</td>
</tr>
<tr>
<td>At a GP Practice</td>
<td>nGMS plus extended hours&lt;br&gt;Core primary care services</td>
<td>£3.5-4.0m</td>
<td>150-200 m²&lt;br&gt;&lt;3 consulting rooms&lt;br&gt;Team room</td>
<td>10 – 15 WTE</td>
</tr>
<tr>
<td>In a Local hub</td>
<td>ECG, possibly ultrasound&lt;br&gt;Rapid access to blood tests&lt;br&gt;Rapid access referral to hub/hospital</td>
<td>£6.0-6.5m</td>
<td>1,300-1,350 m²&lt;br&gt;&lt;18 consulting rooms&lt;br&gt;Team rooms&lt;br&gt;&lt;5 beds</td>
<td>60 – 70 WTE</td>
</tr>
</tbody>
</table>

**TOTAL** £ 10–12m

1 Based on bottom up calculation of saving initiatives. Each initiative build on granular assumptions: e.g. “Outpatient at lower cost” initiative assumes re-provision cost of 0.8 GP appointments of 12 minutes & 0.2 Consultant appointment of 30 minutes per patient per year for 5% of total outpatient cohort.
2 Assumptions based on pilots outcome of Brent Intermediate Care 2009 and BRENT Unplanned Care Initiatives 2011, QIPP 11/12 business cases, Healthcare for London, CCG expert interviews.
3 Initiatives includes: “At Home” - e.g. Rapid Response (Nursing), Case Management, ICP; “At a GP Practice” - e.g. Outpatient at lower cost, Outpatient at lower cost (telephone advice), ICP; “In a community health centre” - e.g. Rapid Response (Bed), Outpatient at lower cost, Outpatient at lower cost (telephone advice), ICP.

The staffing and investment identified in the figure above is indicative based on CCG strategic plans and is dependent on the release of funding from acute providers as activity transfers from acute settings to community settings. Specific investments will be agreed through the normal planning and governance processes of the CCG and as such the production and agreement of robust business cases demonstrating both value for money and affordability to the CCG.

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

The strategy set out here will form the basis of further, detailed discussions in the next few weeks with GPs, patients and families, other clinicians, partners in social care and public health, health and well-being board and others, leading to full public consultation in June. In order to ensure the success of the strategy, we need to take the following critical steps outlined below in Exhibit 25.

**EXHIBIT 25**

### Five immediate steps critical to success of strategy

<table>
<thead>
<tr>
<th>Crucial step</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong> 12/13 budget is set in line with strategy</td>
<td>✔</td>
</tr>
<tr>
<td><strong>2.</strong> Strategy is endorsed by:</td>
<td></td>
</tr>
<tr>
<td>– Health and Wellbeing board</td>
<td>✔</td>
</tr>
<tr>
<td>– CCG board</td>
<td>✔</td>
</tr>
<tr>
<td>– All practices</td>
<td>✔</td>
</tr>
<tr>
<td><strong>3.</strong> Performance framework is agreed by CCG (including metrics, targets, thresholds and escalation process)</td>
<td>✔</td>
</tr>
<tr>
<td><strong>4.</strong> Appropriate governance structures in place for managing performance</td>
<td>✔</td>
</tr>
<tr>
<td><strong>5.</strong> Capabilities are in place to deliver strategy including:</td>
<td></td>
</tr>
<tr>
<td>– Management support in CCG</td>
<td>✔</td>
</tr>
<tr>
<td>– CSS support</td>
<td>✔</td>
</tr>
<tr>
<td>– New workforce required to deliver service</td>
<td>✔</td>
</tr>
</tbody>
</table>

#### 7.1. **Initiative implementation plan**

Implementation of many of our initiatives is already underway. Exhibit 26 outlines our implementation plan and benefits realisation for our key initiatives.
EXHIBIT 26

DELIVERY: Brent needs to start the initiative delivery process now to meet the savings schedule we have set for the next 3 years

<table>
<thead>
<tr>
<th>Initiatives</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q2 Q3 Q4</td>
<td>Q1 Q2 Q3 Q4</td>
<td>Q1 Q2 Q3 Q4</td>
<td>Q1</td>
</tr>
<tr>
<td>Non-elective</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Rapid response teams</td>
<td>Planning and design</td>
<td>Implementation</td>
<td>Delivery ramps up</td>
<td>Fully delivered by March 2015</td>
</tr>
<tr>
<td>▪ Integrated care case management</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Contractual savings</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out-patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Planned care pathway redesign</td>
<td>Planning and design</td>
<td>Implementation</td>
<td>Delivery ramps up</td>
<td>Fully delivered by March 2015</td>
</tr>
<tr>
<td>▪ Access to specialist opinion</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Reprovision in community</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Referral facilitation and peer review</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A&amp;E</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ UCC</td>
<td>Planning and design</td>
<td>Implementation</td>
<td>Delivery ramps up</td>
<td>Fully delivered by March 2015</td>
</tr>
<tr>
<td>▪ Increased Primary Care Capacity &amp; supported self care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elective</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Minor elective procedures in community</td>
<td>Planning and design</td>
<td>Implementation</td>
<td>Delivery ramps up</td>
<td>Fully delivered by March 2015</td>
</tr>
</tbody>
</table>

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

I have felt privileged to work as an NHS GP in Westminster for over 20 years, as well as to be elected as Chair by the Board of NHS Central London Clinical Commissioning Group, representing 36 general practices and over 188,000 patients.

For several years in Westminster, we have had a vision of care. This strategy sets out this vision for a coordinated system of health and social care focused on the individual patient, with well resourced General Practice playing a key coordinating role.

Such a model will allow higher quality care to be delivered out of hospital and closer to home, and will avoid unnecessary hospital admissions and visits to hospital-based clinics. It will also allow us to cope with the challenges ahead, as we live longer, more expensive high tech therapies become available and there is increasing demand on finite NHS resources.

Implementing this strategy will improve quality of care from a patient's perspective as services are better coordinated, and health and social care are joined up in a way that simply didn't happen in the past. The changes we propose are sustainable, and address the NHS sustainability agenda.

Working with our patients in our active User Panel, clinical colleagues from Public Health and hospitals as well as colleagues in Westminster City Council, we have developed ambitious but realistic plans to:

- Develop a greater range of more integrated services in community settings, designed around the needs of individuals.
- Develop interventions that keep people healthy for longer, prevent ill-health and reduce health inequalities.
- Drive continuous quality improvement and innovation across the whole system, securing better value for money in the process.
- Ensure the coordinated and integrated delivery of health and social care.

This strategy sets out the detail of what these plans are and how we intend to achieve them so that the people of Westminster get better care, closer to home.

Dr Ruth O’Hare, Chair, NHS Central London Clinical Commissioning Group
Executive Summary

NHS Central London Clinical Commissioning Group (NHSCL) has come into existence at a time of unprecedented change in the National Health Service (NHS). We are fully committed to the principles of the NHS and see our core function as commissioning quality health services, delivered in the most cost effective way for our patients. This three-year strategy outlines how we will transform out of hospital care for the people of Central London.

The case for improving out of hospital services

There are clear challenges to delivering high quality care for our patients:

- Population changes are increasing demands on health care services and the resources available are not increasing at the same rate. As the population ages and the number of people with chronic diseases rises, the way we currently use our hospitals is becoming unsustainable.
- Improving our out of hospital services will improve patient care and cost less. Better care, closer to home is the only way to maintain quality of care in the face of increasing demand and limited resources.
- However, access to care and quality are variable across the CCG. Improving primary and community services in Central London will require new and innovative ways of coordinating services, more investment and greater accountability.

Our vision of how care will be different

Too often today our patients can’t get the care they need when they need it, and too often they have a fragmented experience. Our vision is to deliver care at the right time across integrated care pathways, which coordinate the health, social, community and voluntary sectors. The six major goals of our vision for the future are as follows:

- There will be easy access to high quality, responsive primary care;
- There will be greater emphasis on keeping people healthy, preventing ill-health and reducing health inequalities;
- There will be simplified planned care pathways;
- There will be rapid response to urgent needs so that fewer patients need to access hospital emergency care;
- Providers (social, health and third sector) will work together, with the patient at the centre; and
- Patients will spend an appropriate time in hospital when they are admitted.

How we will deliver better care, closer to home

Primary and community care has always been a priority in Central London. We have already invested in the building blocks to make this vision a reality and we have specific plans for the future against each of the above themes:

- Encourage providers to increase productivity by employing new ways of working
- Build on our successful inter-practice referral system
- Invest in and develop primary care capacity
- Encourage all of our providers across health to proactively raise lifestyle issues with their patients
- Introduce the new 111 phone number throughout North West London to provide a single point of access to health and care services
- Redesign our pathways of care, providing some outpatient appointments in the community
Establish rapid response teams to deliver care in patient homes when appropriate

Implement a Wellwatch telephone-based case management service for patients with long term conditions (LTCs)

Introduce multidisciplinary teams to proactively manage high risk patients.

**How we will work together**

We will organise out of hospital care at three levels: in GP practices (smallest catchment area), within 3 "localities" and across the CCG (largest catchment area).

GP practices will remain at the centre of patient care, providing routine care near to where patients live. Practices will continue to promote health and assist patients in making complex care choices. They will retain overall accountability for a patient’s health and coordinate care for patients with long term conditions.

We are introducing a new level of care within three localities – north, central and south. When it is appropriate to do so, providers will work together at the locality level to provide care to patients in an appropriate setting for them.

For example, we will establish integrated intermediate care teams to ensure care is provided seamlessly across health and social care and third sector providers where appropriate. These teams will be coordinated by health and social care coordinators who will sit centrally, but will each also be responsible for coordination in a locality.

Where it makes sense clinically and financially we will provide CCG-wide services to serve the whole Central London population. These services include preventative services, 111, some shared services e.g. diagnostics, end of life care, Wellwatch and the Patient Referral Service (PRS).

**Supporting the change**

We need more than just new services and new ways of working to be effective. We will invest in better information systems, put in place stronger governance structures to hold providers to account and make sure patients have easy ways to tell us what is not working at every stage of care.

**Investing for the future**

To deliver our vision we will make significant investments in staff and estates across primary and community care as investment shifts from the hospital to the out of hospital sector. This will be of the order of approximately £5 - 6m extra investment over the next 3 years.

Nonetheless, the scale of the workforce and estates requirements is a challenge to the system. This additional capacity is unlikely to be met by investing in additional people alone - simply providing more of the same is not the answer for the future.

Providers will need to commit to better, smarter ways of working to improve productivity. This will also mean creating new roles, with different skills to improve connectivity within the system. Similarly, we will review existing space available in the community and wherever possible look to use space better to deliver future care.

**Next steps**

This strategy lays out our vision of where we want to get to and a plan to get us there. The real challenge begins now - to start delivering this vision. The plans laid out here will steer us on that journey. However, these will adapt and change as we work together with our partners and providers on the details. Much work remains to put detailed business plans behind these 3 year aspirations. Nonetheless, the value of the scoping done in this strategy is to signal the scale of the changes needed and the need to act now to make them happen. The strategy set out here will form the basis of further, detailed discussions in the next weeks and months with GPs, patients, public, carers, our partners in social care and public health, the Health and Wellbeing Board (HWBB), and others, leading to full public consultation in June 2012.
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1. The case for improving out of hospital services

There is a clear case for the transformation of our out of hospital care. The health needs of our residents are changing as the population ages and people live longer with more chronic and lifestyle-related diseases. These trends are placing unsustainable pressures on our health and social care services and, under our current model of care, we will not have the resources available in the future to meet these demands.

Currently, our health system is overly dependent on hospital services and patients end up in hospital when they don’t need to be there. By intervening earlier, coordinating care and improving services in the community we can improve patient outcomes and value for money. Better prevention and care, closer to home, are the best ways to maintain people’s health and quality of care in the face of increasing demand and limited resources. Figure 1 sets out the rationale for transforming out of hospital care.

At present, access to and quality of care are variable. There are differences in performance between GP practices and we know that our patients and health professionals are frustrated with the current system (see figure 2). Improving the access, quality and scope of out of hospital services will require new and innovative ways of coordinating services, more investment and greater accountability.

Figure 1

There is a strong case for improving out of hospital services

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

2. Under our current model of care we can’t afford to meet future demand. It is not sustainable either financially or environmentally

3. Across the UK we know that care can be delivered out of hospital at low cost and with better outcomes for the patient

4. However, primary and community care requires significant improvement to be able to deliver this. Currently there is variation in quality and access, meaning people have very different experiences in different locations
The next section looks at what the changes we make to care will mean for our patients.

2. Our vision of how care will be different

This section sets out our vision for how care will be different for patients in the future.

We want to make this promise to our patients registered with a GP within NHS Central London CCG:

“We are committed to delivering care at the right time across integrated care pathways, which are coordinated across the health, social, community and voluntary sectors. We will put our patients at the centre, and develop a system that delivers recovery-focused patient outcomes”.

What this means is that people will receive timely care that is organised to meet their needs. The services they require will be coordinated across sectors as a coherent package, with a focus on helping them to keep healthy, get better, prevent relapse and get on with their normal lives.

This promise translates into six goals as outlined in figure 3, which determine how we will change care in Central London.
We have provided more detail on each of our six goals below. For each, we describe how our plans will improve care for our patients and use an example of patient care now and in the future to illustrate this change.

2.1. Easy access to quality responsive primary care

2.1.1. Access

Improving access to quality primary care is at the heart of this strategy. Improving access means providing care at convenient times and offering a wider range of services delivered in a flexible way that meets the specific needs of our patients.

We will provide access at more convenient times for our patients by opening additional practices within the CCG on Saturdays and Sundays and others late on weekday evenings for walk-in patients, unregistered patients and visitors to the area. Local urgent care centres at St. Mary’s and Chelsea and Westminster Hospitals, and the walk-in centre at the Soho Centre for Health, will continue to provide our patients with alternatives to busy A&E departments.

Patients will have access to telephone advice and triage 24 hours a day, 7 days a week through General Practice and a new free 111 number. Patients calling with an urgent need will be given a timed appointment or visit from an appropriate service provider within four hours of calling. Patients using our urgent care centres and 111 services will have appointments and telephone consultations with their GP booked directly for them and unregistered patients offered an appointment with an appropriate practice.

We will also improve access by offering a wider range of services out of hospital. For example, we are developing an enhanced model of primary care provision to support patients with mental health needs. By working together better, many of our practices will now make their locally enhanced services available to patients from nearby practices.

We describe a range of these new services in section 3.
2.1.2. Quality: our out of hospital standards

Improving quality means ensuring that we deliver care to the right clinical standards in good facilities. As part of our Productive Practice initiative we will ensure our patients receive a better service in primary care. Patients and the public need to be confident in the quality of care they will receive as we change where and how we provide care, so we have agreed to implement clinical standards for care in the community, which are set out in figure 4.

These standards emphasise that your GP will have a central role in the coordination and delivery of out of hospital care. They apply to both core primary care delivered by GP practices and, more broadly, care delivered outside of hospital. They aim to shift care delivery from more reactive unplanned care to proactive planned care. These standards have been agreed across North West London and will be implemented locally.

Figure 4

The standards are covered in four key domains

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

Figure 5 provides an example of how better access to primary care will improve care for our patients.

Figure 5
### 2.2. Keeping people healthy, preventing ill-health and reducing health inequalities

What happens within an individual’s life – their education, income, skills, work and social connectedness - all impact on their health and length of life. There are tremendous opportunities to support people to keep healthy and influence health inequalities and we know that people locally want this help and support.

In the future, local NHS providers will be better prepared and able to take action to promote health and address the wider causes of ill-health amongst patients. By finding opportunities sensitively to raise the issues of lifestyle such as diet, physical activity, smoking and alcohol consumption, or wider issues known to adversely impact on people’s health such as poor housing or social isolation, our providers will be able to:

- promote healthy behaviour of individuals and families and
- facilitate the integration between statutory and community services and
- act as effective advocates for our residents in influencing local policies around housing, sustainability, urban planning and childhood poverty
- advocate for and support investments in preventative services

The key focus of our activities will be on planned, sustainable and meaningful interaction with patients through primary, secondary and tertiary prevention.

Interventions need to happen across the spectrum of need. We will provide and commission services to cover the spectrum of local needs and routinely assess their impact on our most vulnerable population groups, testing our ability to meet the needs of all our residents including those who don’t routinely engage with mainstream services.

Figure 6 provides an example of how a diabetic patient will be better supported to manage his condition.

---

<table>
<thead>
<tr>
<th>Claire comes home from work at 6pm to find her son has come back from nursery with a fever and calls 111</th>
<th>She is relieved and reassured, feeling confidence in the system</th>
<th>Claire is measured and feels confident to see episode through</th>
<th>Record is taken of the event and communicated to the family’s GP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claire is 36. She is a working mother who struggles to manage her work and home life. She has a young son, Jason who is 4 years old and has a fever.</td>
<td>She is given an appointment for 8.30pm in local GP practice - not their own but the one which leads on urgent care and is only 15 mins walk away.</td>
<td>GP sees her son and has access to child’s and family’s health record, they check child over, look for rash and send home.</td>
<td>If it was something more serious (e.g. rash with query meningitis, then the GP could have given an injection of penicillin before sending on to paeds unit)</td>
</tr>
<tr>
<td>Claire comes home from work at 6pm to find her son has come back from nursery with a fever and calls 111</td>
<td>Claire understands that 111 can direct her to the most appropriate care</td>
<td>She is relieved and reassured, feeling confidence in the system</td>
<td>Claire is measured and feels confident to see episode through</td>
</tr>
</tbody>
</table>

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

---

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

Claire is 36. She is a working mother who struggles to manage her work and home life. She has a young son, Jason who is 4 years old and has a fever.
2.3. High quality elective care and well understood planned care pathways

We will prioritise high quality care in primary and community settings so that we can treat an increasing number of our patients in community facilities. This will mean fewer unnecessary hospital appointments for our patients, shorter waiting times, and appointments closer to home at locations and times that they find more convenient. For example, our patients will be able to access specialist GP opinion from nearby GP practices for specialties such as ophthalmology, anti-coagulation and complementary therapies. Our patients will be able to see consultants working in specialist clinics in the community for conditions such as dermatology, diabetes and cardiology.

Care pathways are becoming more consistent and efficient as a result of our Patient Referral Service (PRS). This service will ensure that our patients receive specialist care from the most appropriate clinician the first time, as quickly as possible. If possible this will be in another GP practice or community clinic rather than the hospital. When referrals to hospital are required, the service will ensure that all relevant diagnostic tests have been completed and the results and information are available so that our patients have the most effective consultation possible.

With the new technology we are rolling out, patients can expect that clinicians, with their consent, can share and access their information with other health and care professionals involved in providing their care. Patients will not have to repeat their stories to different clinicians and will receive better integrated care.
Figure 7 provides an example of how patients can expect their care to improve.

### Clearly understood planned care pathways that ensure out of hospital care is not delivered in a hospital setting

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

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

- Paul needs immediate progress being made and information is efficiently passed between GP and consultant.
- His GP is able to check in on Paul’s progress with rehab.
- Paul feels immediate progress is being made and information is efficiently passed between GP and consultant.
- Paul is reassured by the structured approach.
- His GP is able to check in on Paul’s progress with rehab.
- Paul meets with GP who examines him and explains pathway to clarify diagnosis and treatment.
- Paul is measured by the structured approach.
- Paul feels immediate progress is being made and information is efficiently passed between GP and consultant.
- Paul is reassured by the structured approach.
- His GP is able to check in on Paul’s progress with rehab.
- Paul meets with GP who examines him and explains pathway to clarify diagnosis and treatment.
- Paul is measured by the structured approach.
- Paul feels immediate progress is being made and information is efficiently passed between GP and consultant.
- Paul is reassured by the structured approach.
- His GP is able to check in on Paul’s progress with rehab.

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

- Paul meets with his GP who examines him but lacks equipment to diagnose specifically.
- Paul still does not understand what his treatment options are.
- Paul has to take time off work to attend.
- Paul does not have the results with him and his GP is unable to give further advice.
- Paul has been referred to an OP clinic for a scan which may take 4-6 weeks.
- Paul still does not understand what his treatment options are.
- Paul has to take time off work to attend.
- Paul does not have the results with him and his GP is unable to give further advice.
- Paul goes to hospital 2 weeks later and meets same consultant for operation. He has a brief stay on the ward and is discharged with a rehab plan.
- Paul feels immediate progress is being made and information is efficiently passed between GP and consultant.
- Paul is reassured by the structured approach.
- His GP is able to check in on Paul’s progress with rehab.
- Paul meets with GP who examines him and explains pathway to clarify diagnosis and treatment.
- Paul is measured by the structured approach.
- Paul feels immediate progress is being made and information is efficiently passed between GP and consultant.
- Paul is reassured by the structured approach.
- His GP is able to check in on Paul’s progress with rehab.
- Paul meets with GP who examines him and explains pathway to clarify diagnosis and treatment.
- Paul is measured by the structured approach.
- Paul feels immediate progress is being made and information is efficiently passed between GP and consultant.
- Paul is reassured by the structured approach.
- His GP is able to check in on Paul’s progress with rehab.

### 2.4. Rapid response to urgent needs

Currently, many of our patients are being admitted to hospital when well coordinated community services could care for them effectively in their own homes. In the future, more patients will be supported at home and in the community instead of having to go to hospital.

We will work proactively with our patients to reduce their need of reactive urgent care. Our new Wellwatch team and GPs working with Health and Social Care Coordinators will ensure our patients have the correct packages of care in place to keep them healthy. If our patients require out-of-hours care, our new IT portal will enable providers to access the information they need about their patients so that they can provide the best possible care. They will also have access to the care preferences of patients at the end of their lives through our ‘Coordinate My Care’ system so that our patients are cared for and die in their place of choice.

When our patients require a rapid response, they will have access to GP and nursing care 24 hours a day, 7 days a week from our multi-disciplinary rapid response team. The rapid response team will visit any individual clinically assessed to be at risk of a preventable emergency admission to hospital within four hours. Patients will receive packages of care in their own homes for up to 72 hours, typically delivered by experienced community nurses. If necessary, we will provide community respite care to our patients in a local rehabilitation unit. When it is appropriate, our rapid response service will support patients in returning home from A&E as an alternative to their admission to hospital. Figure 8 shows how our improved rapid response service will improve patient care.
2.5. Social and health care providers working together to deliver the best care for patients

Patients and their carers tell us that they fall between the gaps in health and social care services. Family, community and voluntary services often fill in the gap.

In the future, our residents will experience well coordinated and integrated health and social care based on evidence-based pathways, case management and personalised care planning of which carers, community and voluntary services will be a part (see figure 9 below).

Identified patients with the most complex needs will receive specialist proactive care from integrated groups of multi-disciplinary providers. These groups will share patient information and use their combined expertise to deliver the best care package possible. Other patients with long term conditions whose health and wellbeing is at risk of rapid deterioration will have access to a new Wellwatch team to help them stay healthy and reduce their risk of hospital admission. Patients admitted to the programme will agree a care plan and ongoing package of care based on a joint health and social care assessment. These plans will be available to all health and social care professionals involved in their care so patients do not have to repeat their details to different providers. When patients are discharged from the programme they will have a lower risk of admission to hospital and will have the tools they need to manage their health so that they can stay well for longer.

Patients at the end of their lives will receive an integrated health and social care service that meets their needs. We will ensure that their preferences for end of life care and place of death are respected by using new planning tools (‘Coordinate My Care’) and implementing the Gold Standards Framework.
Laura, 75 years old smoker has recently been diagnosed with COPD and lives at home with her husband Jim.

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

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

Laura is identified as a patient in need of an integrated care plan by her GP. Her care plan is made available to all health care professionals involved in her care. Laura’s records, and has no indication about the progression of Laura’s condition.

Laura is discussed by her GP at a case conference with a specialist respiratory physician. They identify that Laura needs education on how to use her inhaler properly, rather than a stronger dose prescription. Laura is referred to the community-based COPD team to improve her inhaler technique.

Laura gains confidence that she can deal with her breathlessness.

Laura can see that her care is coordinated and that she is being supported to manage her COPD.

Laura feels her care is uncoordinated as no one knows her history, see worries that she may not receive the best care as clinicians are dependent on what she can tell them.

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

Laura is reassured that all those caring for her have the information they need.

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

Laura is given a stronger dose prescription. However, she is put on an inhaler. After a period of no improvement, Laura’s GP prescribes her a stronger dose. Laura’s records, and has no indication about the progression of Laura’s condition.

Laura is discharged to home, but her records and history are not available to either social care workers or district nurses during their follow up visits.

Laura is discussed by her GP at a case conference with a specialist respiratory physician. They identify that Laura needs education on how to use her inhaler properly, rather than a stronger dose prescription. Laura is referred to the community-based COPD team to improve her inhaler technique.

Laura is reassured that all those caring for her have the information they need.

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

Laura gains confidence that she can deal with her breathlessness.

Laura can see that her care is coordinated and that she is being supported to manage her COPD.

Laura feels her care is uncoordinated as no one knows her history, see worries that she may not receive the best care as clinicians are dependent on what she can tell them.

2.6. Early supported discharge

Our patients are staying in hospital longer than they need to, often because of a lack of support for discharge. In the future, the patient’s GP and relevant providers will be actively involved in coordinating an individual’s discharge plan and continuing care needs including across mental health, intermediate care and reablement services. This means that fewer patients will stay in hospital longer than they need to.

We will establish a seamless discharge process for patients so that on discharge from hospital they receive the support they need on the path to recovery. Patients will not ‘disappear from view’ when they are admitted to hospital because their GPs and new Health and Social Care Coordinators (HSCC) based in Central London hospitals, will continue to monitor them with reference to their agreed care plan. A patient’s GP and HSCC will begin planning their discharge as soon as they are admitted to hospital (or before for planned admissions). Patients will receive a joined-up and appropriate package of care on their discharge from hospital, coordinated by their HSCC. Their HSCC will give them advice on what to expect after hospital and who they can contact if they feel unwell.

Figure 10 shows how patients will benefit from better supported discharge from hospital.

Figure 9

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

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

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

Laura is reassured that all those caring for her have the information they need.

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

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3. How we will deliver better care, closer to home

This section outlines the key initiatives that we will put in place to enable us to deliver our five strategic goals. Some of these initiatives are new and specific to Central London; others are part of North West London efforts, including the North West London Integrated Care Pilot.

Figure 11 outlines these initiatives by strategic goal.

<table>
<thead>
<tr>
<th>Figure 11</th>
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<tbody>
<tr>
<td>Easy access to high quality, responsive primary care to make out of hospital care the first point of call for people with urgent, but not life-threatening, needs</td>
</tr>
<tr>
<td>a) The 111 pilot in Central London will provide a single point of access for patients, carers and clinicians to access the appropriate level of care</td>
</tr>
<tr>
<td>b) Extended GP opening hours will improve access to primary care</td>
</tr>
<tr>
<td>c) More productive practices will improve patient experience in primary care</td>
</tr>
</tbody>
</table>

Clearly understood planned care pathways that ensure out of hospital care is not delivered in a hospital setting |
| a) Some outpatient and elective procedures will be moved out of the acute sector into the community, as a more appropriate setting of care |
| b) A referral facilitation service will ensure all patient referrals are directed to the most appropriate clinician and everyone has the same access to the care available |
| c) We will develop an enhanced, patient-centred model of primary care provision for mental health to support people with complex needs in primary care settings |

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

Integrated care with providers (social and health) working together – with the patient at the centre – to proactively manage LTC and other at risk groups |
| a) There will be multidisciplinary groups across Central London CCG who will work together to identify and review patients at risk of becoming ill. These will focus on diabetic patients and the over-75s. |
| b) Wellwatch and care management programmes will improve care for patients suffering from one or more LTC and reduce the chance of their being admitted to hospital |
| c) Specialised care management plan using the end of life tool - coordinated by GPs and district nurses will improve end of life care |
| d) A new medicines supports pathway and reviews programme will reduce the level of preventable drug-related hospital admissions |
| e) We will integrate mental health co-morbidities in the Integrated Care Pilot to better address the psychological component of long-term conditions |

Appropriate time in hospital when admitted, with early supported discharge into well organised community care |
| a) We will provide more joined-up discharge support, with an appropriate step-down in care, prompt communication to other providers, and clear advice to patients on what to expect after hospital and who they can contact if they feel unwell |
| b) Psychiatric Liaison services will support patients in Acute General Hospitals with mental health needs |
3.1. Improving access to primary care

3.1.1. Single point of access via 111

We offer a range of options for accessing non-emergency healthcare, including walk-in centres, out-of-hours GP services, urgent care services and minor injury units. However, patients are not often sure where to go for treatment when they need medical help but their situation is not life-threatening.

- The 111 pilot in Central London will provide a free-to-call 111 number available 24 hours a day, 365 days a year. Call handlers will provide a single point of access for patients, carers and clinicians to access the appropriate level of care.
- Call handlers will have access to a comprehensive local directory of health, social care, voluntary and mental health services so that they can direct patients to the most appropriate local service the first time. They will have the ability to book an appointment or telephone consultation directly with the patient’s own GP practice.
- We will deal with urgent cases within 4 hours. We will see patients with non-urgent needs within 24 hours, or 48 hours if they want to go to their own GP practice.

3.1.2. Extending GP opening hours

- Following a successful pilot, we will open practices within the CCG on Saturdays, Sundays, Bank Holidays, and make late weekday appointments available for walk-in patients from other practices, unregistered patients, visitors to the area, and patients redirected from the Urgent Care Centre. Call-handlers will direct patients calling 111 to an open practice.
- We will take part in the “Choice of GP” pilot in Westminster.
- Extended opening hours in a high proportion of our practices Monday to Friday will increase access to urgent care for our patients closer to home as an alternative to busy A&E departments, and increase financial efficiency through reduced attendances at A&E. We will base these services in strategic locations across Central London, based on patient flow analysis.
- Patients can continue to access our local Urgent Care Centres or A&E, including those at St. Mary’s and Chelsea and Westminster Hospitals, and the walk-in centre at the Soho Centre for Health.
- In the future, Urgent Care Centres and walk-in facilities will be able to book appointments and telephone consultations with a patient’s GP practice directly to provide seamless patient care.

3.1.3. Increasing productivity in primary care

- We have a new programme of work to improve the productivity of General Practice in NHSCL, which follows the NHS Institute of Innovation and Improvement’s Productive Practice guidance. We are currently auditing interactions with our patients in General Practice to assess the whole patient experience. This includes ease in accessing an appointment, experience in the practice (for example, how patients are dealt with by reception) and the consultation itself. Our practices will develop action plans based on our findings.
- Action plans will introduce change across a range of areas including front-of-house, planning and scheduling appointments, referrals to secondary care and the consultation itself to maximise the productivity of our practices. This will allow our practices to release staff time to invest in caring better for our patients.
• We will implement plans with local pharmacists to allow patients entitled to free prescriptions to access non-prescription medicines free-of-charge from their local pharmacists without requiring an additional GP appointment.

• We will implement prevention plans which support our patients in maintaining healthy lifestyles, increasing healthy eating and activity, losing weight and stopping smoking.

3.2. High quality planned care

3.2.1. Outpatient appointments in the community

Too many outpatient appointments occur in our hospitals when they can happen closer to a patient’s home and with better links to primary and social care.

• New patient pathways will shift activity out of Central London hospitals into primary care. We will increase the number of inter-practice GP referrals for specialties such as ophthalmology, urology, anti-coagulation, minor surgery and psychological therapies. This will be facilitated by the Patient Referral Service (PRS).

• We will maintain existing and develop new consultant-led specialist services in the community for conditions including musculo-skeletal, dermatology, diabetes, cardiology and pulmonary conditions.

3.2.2. Referral standardisation

We will ensure that GP referrals follow locally-agreed guidelines and thresholds so that GPs make the most appropriate decisions about “how, when and where” to refer patients from primary care. This will reduce the number of clinically inappropriate outpatient referrals across a range of specialties and will be accomplished by:

• GP practices working together within localities to develop and implement action plans to better manage referrals for a range of specialties.

• Peer review which will ensure that referrals are supported by best clinical practice, that correct investigations have been carried out, and recommended care pathways followed.

• Educational sessions linked to clinical specialties, and special interest groups will advise CCG members.

• Our centrally-based Patient Referral Service (PRS) will play a central role in managing referrals from primary care to ensure referrals are directed to the most appropriate clinician, and patients are offered choice and equity of access. The service works by peer review of referrals, challenging and reducing non-GP referrals, providing feedback to the referring clinician and the provision of patient information and choice.

3.2.3. Caring for mental health patients more effectively in primary care

We will develop an enhanced, patient-centred model of primary care provision for mental health to support more people with complex mental health needs and additional needs (such as substance misuse and co-morbid physical conditions) in primary care settings.

• A new ‘supported discharge’ pathway will transfer responsibility of care from community mental health teams to GP practices through multi-disciplinary teams based in primary care. This pathway will include criteria and shared care protocols; a case review; and joint work between the shared care mental health team, the GP and the patient to develop a care plan. Shared care electronic communication and data processes will support this pathway. The shared care team (or ‘primary care plus system’) will provide support as outlined in figure 12.

• The shared care team will provide a single point of access for mental health patients and provide triage and risk assessment, care coordination, short interventions and
delivery of training and education to GP practices. This will be provided by the extension of our existing Patient Referral Service (PRS).

- We will build the shared care team by reorganising existing teams. A consultant-grade psychiatrist will lead and coordinate the team and a specialist GP will build capability and commitment among GPs. The team will also include a Community Psychiatric Nurse (CPN), Health and Social Care Worker, navigator, senior manager (clinician) and administrative, database management and reporting staff. The team will have a shared governance structure.

Figure 12: ‘Primary Care Plus System’ model delivered through the shared care team

3.3. Responsive emergency care

3.3.1. Rapid response service

When a rapid resource is required, access to both GP and nursing care will be available 24 hours a day, 7 days a week from an expanded rapid response team with a broader scope and skill-set. Early intervention will prevent avoidable hospital admissions and provide care at home to patients as an alternative

- Our rapid response team will be multi-disciplinary, incorporating social workers, nurses and therapists.

- The team will visit any individual clinically assessed to be at risk of hospital admission within four hours. The team will use a single assessment process across health and social care and make decisions about the packages of care required to support people in their own homes.

- If necessary, we will provide community respite care in a local rehabilitation unit as an alternative.
• The rapid response team will also work closely with staff in A&E departments redirecting patients attending A&E to an integrated service based around General Practice.

3.4. Integrated care for people with long term conditions

3.4.1. Integrated Care Pilot

NHSCL is one of the first sites involved in the North West London Integrated Care Pilot.

• We have established multidisciplinary groups, composed of primary care, social care and mental health staff, which work together to identify and review patients at risk of becoming ill. Their initial focus is on diabetic patients and the over 75s.

• The groups share a common database of patients, used to identify those at greatest risk of hospital admission.

• Through a regular process of working planning, the multi-disciplinary groups will develop integrated care plans with high-risk patients. The groups use clinically-agreed pathways to keep these patients out of hospital.

• The groups discuss possible care for high-risk patients at monthly case conferences.

• A new IT tool will automate the data and coordinate risk assessment, work planning and communication within groups. A summary of the working arrangements of these groups is provided in figure 13.

Figure 13

We will promote a proactive, integrated approach to care for our most complex patients

3.4.2. Wellwatch

Whilst the Integrated Care Pilot focuses on patients whose needs are the most complex, our new Wellwatch programme will work with patients with one or more long term conditions, whose health and wellbeing is at risk of rapid deterioration.

• The Wellwatch team will consist of health and social care professionals, including a GP, Senior Nurse, Health Care Assistant, and a Health and Social Care Coordinator (HSCC).
• Wellwatch is a telephone-based case management service, which will use a computerised risk stratification tool to improve care for patients.

• The service will identify patients at risk of being hospitalised and invite them to participate in the programme. On the programme, the team will case manage patients to help them stay healthy and reduce their risk of admission to hospital.

• The GP-led team will assess whether patients identified by the programme are receiving the right care. Where there are gaps in service provision, the team will develop personalised care plans with the patients and people involved in their care (e.g. carers), and agree on an ongoing package of care based on a joint health and social care assessment. The team will proactively coordinate this package of care across providers.

• Care plans will be accessible to all health and social care professionals to coordinate care and ensure patients do not have to repeat their details to different providers.

• When patients are 'discharged' from the programme they will have a lower risk of hospital admission and be equipped to better manage their health so that they stay well for longer.

• Recognising the importance of employment and its links to prosperity and mental health, the Fit for Work Service will be further explored with the aim of helping patients avoid long-term sickness absence, potential loss of employment and subsequent further impact on their health.

• Patients will be supported in increasing their knowledge and skills to self manage through referrals to structured self management education, and to peer support programmes

• Patients will be encouraged to take part in screening programmes to promote awareness, early detection and diagnosis of conditions

3.4.3. End of life care
We are committed to ensuring those approaching the end of their lives are cared for and die in their place of choice.

• End of life patients will receive integrated health and social care and specialised care plans coordinated by district nurses with specialist training. Care plans will record patient preferences for treatment and place of death, on a new electronic register – Coordinate My Care. GPs, community Macmillan nurses and district nurses will work together to follow patient preferences in care delivery. Providers will implement the Gold Standards Framework and Liverpool Care Pathway for the Dying.

• One NHSCPL GP recorded her experience of using this tool:

“A relatively young patient of ours was diagnosed with lung cancer. He deteriorated quite quickly and the palliative care team became involved over the last few months of his life when active treatment was no longer appropriate. He had a few admissions to the hospice for symptom control, but he was clear that if possible, he wanted to die at home with his family around him.

By having these discussions, and by placing him on Coordinate My Care, we were able to make sure that the Hospice at Home team were in place at the end, and he died peacefully at home with all the support that was needed. It was one of the better deaths we can remember”.

3.4.4. Integration of mental health co-morbidities in the Integrated Care Pilot
We will develop an enhanced primary care model to better address the psychological component of long term conditions and tackle health anxiety and phobic disorders.

• The model will include a GP single assessment tool for common mental health disorders; a streamlined single point of access for psychological therapies; and a
stepped care psychological therapy pathway for people with long term conditions. We will provide additional specialist psychological therapy to deliver this pathway if required.

- Mental health will be a focus of Wellwatch and the multi-disciplinary groups. Using the risk stratification and GP single assessment tools for common mental health disorders will improve the detection of patients with long term conditions combined with anxiety and depression.

### 3.4.5. Medicines review programme

Four main drug groups account for more than 50% of drug-related hospital admissions, including diuretics (water tablets) and anti-coagulants (blood thinners).

- We will consider introducing a team of two pharmacists and an administrator to work with GPs to review patient medication.
- This would include monitoring of patients taking potent diuretics to reduce the number of patients admitted with dehydration and/or renal failure as well as patients on oral anticoagulants.

### 3.5. Supported discharge

#### 3.5.1. Early supported discharge into well organised community care

People are staying in hospital longer than necessary because of a lack of support for timely discharge.

- In the future, GPs and new HSCCs will monitor patients against agreed care plans regardless of place of care. From admission, a patient’s GP and other providers will be actively involved in coordinating their discharge plan and continuing care needs (or before admission for planned care).
- New HSCCs will support this process. Based in hospitals, they will facilitate discharge, coordinate appropriate step-down care and provide advice to patients on what to expect after hospital and who they should contact if unwell. We will consider GP ‘ward rounds’ within hospitals to facilitate timely discharge.

#### 3.5.2. Psychiatric Liaison Services

Psychiatric Liaison supports patients in acute hospitals with mental health needs.

- We will develop “optimal standard” Psychiatric Liaison services beginning at St. Mary’s and Chelsea and Westminster hospitals (see figure 14). These multi-disciplinary liaison teams will provide 24x7 emergency cover to A&E and wards, and significant direct care, support and staff training during normal working hours.
- The Psychiatric Liaison teams will support clinicians by improving mental health care and risk management in acute hospitals and training staff in mental health care. This will result in fewer admissions, reduced length of stay and lower accommodation costs for local authorities (more patients discharged home directly).
4. How we will work together

To achieve our vision will require new ways of working in Central London. There are a number of aspects to consider, as set out in figure 15.

Figure 15

How we will work together

1. Making these changes means that we need to change the way we do things – we have agreed some organising principles we will stick to as we change

2. There are 3 distinct ‘levels’ of care where it makes sense to organise and deliver services outside the acute setting

3. Primary, community, social and mental health providers need to work together across all levels to ensure care is coordinated and effective

4. As we take further activity into the community, we need to allocate clinical and office space to this increased level of activity – we are exploring a range of options including South Westminster Centre and Church Street
4.1. Our organising principles

Achieving the service changes we want will mean health and social care providers working together more closely to extend the range of services offered in the community and ensure more integrated and better coordinated care for our patients.

We have developed a number of key principles as outlined in figure 16 to shape how we organise in the future.

Figure 16

<table>
<thead>
<tr>
<th>Our strategy has some big changes for how and where care is delivered e.g.,</th>
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<tbody>
<tr>
<td>▪ Integrated care, case management, rapid response</td>
</tr>
<tr>
<td>▪ Beds in the community</td>
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<tr>
<td>▪ Outpatients and some elective procedures in the community</td>
</tr>
<tr>
<td>Providers need to work more closely together to ensure care is organised around the patient</td>
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</table>

<table>
<thead>
<tr>
<th>Core principles of how we organise</th>
</tr>
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<tbody>
<tr>
<td>✔ We need to organise in a way that enables <strong>collaboration and co-ordination</strong> of care across Central London</td>
</tr>
<tr>
<td>✔ We must <strong>avoid duplication</strong> of activity</td>
</tr>
<tr>
<td>✔ Activity should be delivered at the most efficient point <strong>financially</strong>, where it is most practical to do so, and where it is <strong>most effective</strong> for the patient</td>
</tr>
<tr>
<td>✔ <strong>Care will be GP-led, with Primary care teams</strong> remaining central to patient care</td>
</tr>
<tr>
<td>✔ A <strong>flexible</strong> system of organisation that promotes organisation only when it is appropriate to do so</td>
</tr>
</tbody>
</table>
4.2. Organising into three levels of care

As described in figure 17 below, we will deliver out of hospital care at three levels: in GP practices (smallest catchment area), within localities and across the borough (largest catchment area).

Figure 17

- GP practices will remain at the centre of patient care, providing routine care near where patients live. Practices will continue to assist patients in making complex care choices. They will retain overall accountability for a patient’s health and coordinate care for patients with long term conditions.
- We are introducing a new level of care within three localities – north, central and south. Services provided within localities will include rapid response services, enhanced primary care services including walk-in and extended hours, district nursing and social services reablement.
- Where it makes sense clinically and financially we will provide CCG-wide services to serve the whole Central London population. These services include 111, some shared services e.g. diagnostics, end of life care, Wellwatch and the Patient Referral Service (PRS).

Figure 18 outlines the levels at which we plan to deliver health and social care services in Central London.
4.3. Working with our partners to deliver better care

4.3.1. Locality-based working

We will organise our health and social care providers within our three localities to improve the coordination and integration of care for our patients.

We expect improved interaction between GP practices, Central London Community Health (CLCH), Westminster Social Services, Central and North West London Foundation Trust, and acute hospital trusts.

As part of the Integrated Care Pilot, Acute, mental health and social care specialists will provide additional support to their primary care teams (see figure 19 below).
In the future, we will integrate our intermediate care teams in the community so that our patients receive seamless care across health and social care services. We will do this by re-organising our rapid response, short-term reablement, community health and social care and rehabilitation teams within localities, and provide a single point of access to and coordination of these services (see figure 20).

**Figure 20**

**4.3.2. Health and Social Care Coordinators**

We will employ a team of four Health and Social Care Coordinators (HSCC) to coordinate our intermediate care teams. These HSCC will sit centrally as part of our Wellwatch team, but three of the four will be responsible for coordinating care within an assigned locality. This will include liaison with local voluntary sector services which provide support to patients in the community.

Figure 21 describes the roles of these HSCC.

**Figure 21**

- We will have a coordinator responsible for each locality
- Coordinators will draw on local teams with flexibility to draw on teams from neighbouring localities

**Coordinators could:**
- Coordinate rapid response
- Coordinate case management teams (e.g., DN, social care)

**Role of HSCC:**
- To act as a single point of contact for GPs and community staff post patient admission and discharge
- To liaise with GP’s and local pharmacists in relation to prescriptions
- To participate in the discharge planning process from the point of admission
- Ensure accurate discharge planning records are kept & shared with CLCH community based services & adult social care
- Telephone follow up of patients post discharge to provide reassurance, utilise colleagues to resolve any queries and initiate referrals if required
- To be responsible for liaising, communicating and if required escalating any identified operational issues in facilitating effective discharge planning into community services

We will match capacity to demand through a flexible workforce
4.3.3. Working with our partners in health, City Council and the voluntary sector

We know that we will not deliver the improved care and improved outcomes for patients if we work in isolation. We already work closely with our colleagues in other parts of the health service and with the City Council. We have a number of initiatives where hospital consultants deliver their services in the community, including in GP practices. We also commission a large number of services with social care, including learning disabilities, and many services for older people.

Designing, commissioning and providing services jointly with social care will become the default way of working, as will ensuring patients have access to the right clinical skills in the right place, at the right time, regardless of organisational boundaries.

Westminster is an early implementer of Health and Wellbeing Boards (H&WBB). In partnership with the City Council, we have developed a structure to ensure that together we deliver a healthier Westminster.

The H&WBB has not only developed close links between health and social care, but it has also ensured a whole range of City Council services contribute to a healthier Westminster. The Church Street master plan is a good example of this. The Church Street plan is a regeneration project designed to improve housing and environment and make a significant contribution to health and wellbeing in the area. As part of the regeneration, a new Health and Wellbeing Hub will provide easier access to health services for those who traditionally choose not to access the NHS. We will continue to work closely with the City Council and Public Health to address the wider determinants of health such as housing, education and employment.

We will further develop our relationship with third sector organisations that will help us understand the diverse needs of our population and commission flexible services to meet these needs. As providers, third sector organisations often deliver innovative services in a way that statutory services find difficult to do. We will continue to commission specialist services focused on particular patient groups when necessary. We see an important role for the 3rd sector in assisting the CCG to support marginalised groups to better access mainstream services.

Our approach to working with the voluntary and community sector is set out in figure 22.

Figure 22

- Voluntary and community sector leaders are valued partners in the design and delivery of this strategy, we will continue to work with them closely and listen to their community intelligence
- We will work alongside these groups to mediate with and explain effectively what this strategy will mean to our community
- We will work with local health and social sector organisations that can help our patients stay well, develop the capacity of a broad range of community ponders to provide quality services, and invest in creating supportive networks of care to sustain people with LTC in the community
- We will develop appropriate systems and structures to enable local organisations to advise and be involved in the development of our services
- We will develop an information database in partnership with local groups so that our providers and patients know who they can refer to for support from the community
4.4. Estates

In order to transform out of hospital care we will consider the implications for our estates:

- We will shift some care out of Central London hospitals and deliver it in the community setting. This will require clinic space, procedure rooms, and diagnostic equipment and community beds.
- Closer working between providers may require office space and meeting rooms.

This additional space requirement will be absorbed either in a single building or in a network of buildings, with excellent transport links. We will use existing facilities across the CCG where possible, and are exploring the development of two new health and social care centres that could act as community hubs. This will enable us to:

- Provide an integrated non-acute setting for care delivered by specialists, GPs, and Allied Health Professionals.
- Co-locate health and social care teams to facilitate integration of care, for example by providing easy access to other providers to decide the most appropriate care packages and support for patients.
- Serve as a base for consultants when they work in the community, and for mobile Allied Health Professionals/Community Health providers.
- Host regular contact among consultants, multi-disciplinary teams, community health services and GPs.
- Allow local access to advanced diagnostic equipment and specialist care in a selection of clinical areas.

*We will work closely with Westminster City Council to ensure that any urban development proposals consider the implications on out of hospital services and that monies available from developers to support public service infrastructure (s106 and community infrastructure levy) are used to improve health facilities to their maximum effect.*

Figure 23

5. Supporting the change

We have identified five key enablers to support the change for better care, closer to home in Central London, as set out in figure 24:
The following sections outline how we address each of these key enablers.

5.1. Engagement with patients and carers

Patient involvement is central to everything that we do. We understand what matters to our patients and will put them at the heart of our decision-making. We have developed four key values that guide our approach to patient involvement, as out in figure 25.

We have a CCG User Panel and the Chair sits on the CCG’s Commissioning and Management Boards, as set out in figure 26 below.
5.2. Governance and performance management

We will improve care at each level in NHSCL (see figure 27). Individual GP practices will be responsible for establishing action plans to improve their productivity and performance. Localities will develop plans to improve performance within their area, and will conduct peer review and learning across practices. The CCG will host educational sessions for all practices and support underperforming GP practices.

We will develop a clear governance framework to drive performance improvement across NHSCL (see figure 28).
Our localities will develop clear plans against which we will measure performance in primary care and reward good performance. Figure 29 describes our approach to local performance management.

Figure 29

<table>
<thead>
<tr>
<th>Steps in local performance management</th>
<th>Central London’s approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish clear metrics, targets, and accountability</td>
<td>• Each locality and practice plan establishes clear targets (e.g., OPE referrals, NEL admissions) and indicators to track performance. • Expectation that practices are in the achieving or high achieving categories of general practice outcomes standards (with the possible exception of specialist practices).</td>
</tr>
<tr>
<td>Create clear locality plans</td>
<td>• Each locality has an annual locality plan. • Each practice has an individual practice action plan.</td>
</tr>
<tr>
<td>Track performance effectively</td>
<td>• PRS enables clear system of monitoring to track performance. • Monthly reports to track progress in practices and localities against plans. • Key questions: responsible for tracking performance. • Monthly reports on expenditure vs. budget in practices.</td>
</tr>
<tr>
<td>Hold regular performance meetings</td>
<td>• Performance reviews with practices based on performance data, particularly for underperforming practices. • Additional performance reviews (at six monthly intervals) to assess progress.</td>
</tr>
<tr>
<td>Ensure rewards, consequences, and actions</td>
<td>• Support from locality and CCG to individual practices. • Payment incentives to recognize work undertaken to establish plan, develop and participate in localities and implement plans. Payments linked to shift in delivery of cost-effective, high quality care outside of hospital. • Staged review process as outlined below. Practices to develop remedial action plans if performance is off trajectory with six monthly assessment process.</td>
</tr>
</tbody>
</table>

Practices will receive a monthly performance report based on their referral numbers, broken down into specialty, referring clinician, secondary care, community care and PRS referrals rejected. The report will rate their performance to other practices within the locality and the CCG average. At six monthly intervals, practices will be sent a report outlining the cost of their referrals to secondary care versus the available budget.

We will improve the quality of referrals from primary care using a stepped review process, supporting practices to deliver Excellence in General Practice. We will assist practices with plans for improvement and support them to deliver these plans.

We will develop a coherent process to monitor progress within this system (figure 30).
We have established clear targets and indicators to measure progress individual practice and locality plans, as set out in figure 31 below.

**Figure 31**

| Example areas of our strategy against which we could measure progress |
|---|---|
| Shift from unscheduled to planned care | IT |
| • Non-elective admissions for LTCs | • Use of risk stratification system 'Stratify', Urgent Care Dash Board and iCaps (or replacement systems) |
| • Unscheduled attendances | • Review of monthly performance and activity reports at Practice and Locality level |
| • LTC/EoL patients with active care plans | Coordinated health and social care |
| • Reduce use of A&E and UCC for care that could better be provided by own GP. | • Delayed transfers of care |
| • 30-day readmissions | • Response times for community services and social care |
| | • Single assessment process |
| | • Shared Clinical Information (IT) |
| Shift from acute to community for planned care | | |
| • 18-week wait & 2 week 'cancer' wait | | |
| • % Patients receiving inter-practice referral | | |
| • % patients seen in the community (referred by GP, Consultant or others) | | |
| Empower patients | | |
| • % Referrals Routed via the PRS | | |
| • % Patients offered choice of provider including general practice or community. | | |
| | • NICE Commissioning outcomes |
| | • End of Life Gold standards / LCP |
| Finance & compliance | 5. Clinical governance |
| • Revenue resource limit | • Use of risk stratification system 'Stratify', Urgent Care Dash Board and iCaps (or replacement systems) |
| • Cash limit | • Review of monthly performance and activity reports at Practice and Locality level |
| • Revenue surplus target | Coordinated health and social care |
| | • Delayed transfers of care |
| • QIPP plan | • Response times for community services and social care |
| | • Single assessment process |
| | • Shared Clinical Information (IT) |
| | | |

### 5.3. Contracts and incentives

We need to have the right contracts and incentives in place to transform out of hospital care. We will continue to develop these ideas as we move forwards:

- Facilitate financial flows within groups of practices, for example, by incentivising inter-practice referrals.
- Align provider and patient interests by incentivising providers to meet the out of hospital standards.
- Manage performance at the locality level and request providers to share data on their performance at this level.
• Commissioning on outcomes: we often commission based on activity – for example, how many nurses or number of beds there are, without considering whether that activity actually delivers improvements for the patient. In the future, we will commission based on outcomes. For example, whether a patient of working age with long term conditions is able to return to work, or whether patients have a lower risk score after rehabilitation.

• Period of care tariffs: Paying for care based on level of activity is an issue when multiple providers are involved in patient care. Each provider could deliver the activity they are contracted to do but because of poor integration between providers, patient outcomes are not achieved. In future, we will commission based on ‘years of care’ for patients with long term conditions and shorter periods of care for others. Providers will be paid to deliver outcomes for a patient. This will encourage integration and simplify contracting and monitoring arrangements for the CCG. It will allow providers to deliver care as they like, providing the care is delivered to a high quality and the target outcomes are achieved.

• The CCG takes on the responsibility for setting up new services and developing premises in primary care, to reduce risk for primary care providers.

5.4. Information tools

5.4.1. IT portal project

We are piloting a new exciting IT portal project, which will transform how we manage data Central London.

What is the Clinical Portal?

• A clinically-led solution designed to allow the sharing of data and information between disparate IT systems, via a single clinical portal

• Clinicians will be able to view an enriched up-to-date patient record which links multiple health care data sources including data from GPs, Out of Hours, acute and community settings

• Web-based portal, secure access via NHS N3 network

• Role-based access control

• System integration with iCaps and UCC QIPP

• Notifications – when data arrives in the portal you can set up notification emails

The portal will link the acute hospital, Rio (community) and GP IT systems. It will mean data is available in real time for all providers and will allow the exchange of information between them. Patients will avoid duplicate investigations in different settings of care and having to repeat their stories to different providers. Figure 32 outlines the structure of this portal.
5.4.2. Urgent care dashboard

A new urgent care dashboard will monitor the urgent care demands of regular health service users. GPs will be able to use the urgent care dashboard to identify why their patients went to A&E and whether or not this was appropriate. See figure 33.
5.5. People and organisational development

We will develop an organisational development plan to ensure that the CCG Board, emerging leaders and all personnel have the skills required in governance, commissioning, performance management, procurement and leadership. Figure 34 outlines the key areas that to be addressed in our plan.

Figure 34

<table>
<thead>
<tr>
<th>Governance</th>
<th>Outputs:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workshops for all CCG Board Members &amp; Emerging Leaders in:</td>
<td>Practices and Localities are heavily engaged in commissioning &amp; general decision making on a local basis and have input to the overall strategy</td>
</tr>
<tr>
<td>- Roles and responsibilities, decision making, and organization structure</td>
<td>- Working groups are formalised and meeting regularly</td>
</tr>
<tr>
<td>- Resource sharing</td>
<td>- Board structures; responsibilities; accountabilities and decision rights are known; understood &amp; operating across all activities and locals</td>
</tr>
<tr>
<td>- Performance management</td>
<td>- Legal issues</td>
</tr>
<tr>
<td>- Legal issues</td>
<td>- 1:1 coaching for Board &amp; Emerging Leaders</td>
</tr>
<tr>
<td>Culture and teamwork</td>
<td>Able to identify &amp; bring the strengths from previous CCG to build on</td>
</tr>
<tr>
<td>Leadership style workshops planned</td>
<td>- Networks are excited to be working together and beginning to understand their cultural makeup</td>
</tr>
<tr>
<td>Action Learning on teamwork and trust</td>
<td>- A range of formal and informal leaders and champions emerging and involved in networks through our distributed CCG leadership arrangements</td>
</tr>
<tr>
<td>Practice interviews and survey</td>
<td>- Increasing awareness of the need to continue to develop leaders and Emerging Leaders champions</td>
</tr>
<tr>
<td>Leadership and management</td>
<td>- Key learning from the training sessions became part of day-to-day work (e.g., best practice meeting agendas and developmental feedback)</td>
</tr>
<tr>
<td>Training sessions on the following</td>
<td>- Leadership style workshops planned</td>
</tr>
<tr>
<td>- Roles and responsibilities, decision making, and organization structure</td>
<td>- Managing and communicating change</td>
</tr>
<tr>
<td>- Resource sharing</td>
<td>- Managing and communicating change</td>
</tr>
<tr>
<td>- Performance management</td>
<td>- Effective problem solving</td>
</tr>
<tr>
<td>- Legal issues</td>
<td>- Whole system commissioning</td>
</tr>
<tr>
<td>IT skills</td>
<td>- Leadership style workshops planned</td>
</tr>
<tr>
<td>Advanced Excel training</td>
<td>Support for the training and development and MDT functions</td>
</tr>
<tr>
<td>Patient engagement</td>
<td>Ensure patient and public engagement in planning e.g. in development of PPE strategy and model</td>
</tr>
<tr>
<td>Run specific skills-building session for all interested clinical leaders on practical tips for how they as individuals can engage most effectively</td>
<td>Engage media management skills to effectively communicate with external parties</td>
</tr>
<tr>
<td>Stakeholder engagement</td>
<td>Relationship building with external stakeholders engaged in OOH delivery</td>
</tr>
</tbody>
</table>

We have agreed on the following leadership behaviours to guide our work within our practice groupings. See figure 35 below.

Figure 35

<table>
<thead>
<tr>
<th>From...</th>
<th>To...</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>X</strong> We don’t often refer between GPs due to strong patient links and potential contractual issues</td>
<td><strong>✓</strong> We collaborate across the locality, referring patients to each other, or other members of the Primary Care Team if appropriate</td>
</tr>
<tr>
<td><strong>X</strong> We don’t want to talk about performance or have challenging conversations</td>
<td><strong>✓</strong> We hold each other to account around differences in outcomes, including celebrating success</td>
</tr>
<tr>
<td><strong>X</strong> We have seen all this change before – it will not stick and we will be bailed out</td>
<td><strong>✓</strong> We need to do something different, now, to deliver better care for our patients in the right setting</td>
</tr>
<tr>
<td><strong>X</strong> It’s a system-wide problem, not mine</td>
<td><strong>✓</strong> It’s up to me and my contribution to the system working together to deliver good patient outcomes</td>
</tr>
</tbody>
</table>

We will focus our training on the areas outlined in figure 36.
Making progress on these five enablers will be crucial to making changes to out of hospital care popular with patients, sustainable and effective in keeping people healthy and supporting those who have a condition to manage it well. They will be a crucial part of the ‘next steps’ the CCG will need to take.

6. Investing for the future

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

Patients will receive care in a variety of settings. Where possible, care will be delivered at home, or close to home. As care becomes more specialised, patients will need to travel further. GPs will offer a broader range of services in local practices and clinics, and we are planning two health and social care hubs to provide integrated care for our patients. The services offered within these hubs will include community outpatient appointments (e.g. respiratory and paediatric clinics).

Figure 37 outlines the investment we aim to make in services delivered at home, in GP practices and in hubs over the next three years as investment shifts from the hospital to the out of hospital sector. The investment shown represents investment in service provision only. In addition to this, we will make capital investment in our estates, and seed investment in our IT provision and organisational development.
**Figure 37 – Initial estimates of scale of investment**

We have made planning assumptions on how much we will invest and broadly what space and workforce we will need.

<table>
<thead>
<tr>
<th>Investment by 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where you will receive care</td>
</tr>
</tbody>
</table>
| At Home | • Community care  
• Elderly care  
• Postnatal care  
• Admission Avoidance | £1.0-1.5m | 25-30 WTE | • Access to consulting rooms/team room |
| At a GP Practice | • Extended Primary Care | £2.5-3.0m | 15 - 20 WTE | • 150-200m²  
• <3 consulting rooms  
• Team room |
| In Community Health Centres | • ECG, possibly ultrasound  
• Rapid access to blood tests  
• Rapid access referral to hub/hospital | £1.0-1.5m | 18 – 22 WTE | • 550-600m²  
• <3 consulting rooms  
• Team rooms  
• <12 beds |

1 Based on bottom up calculation of saving initiatives. Each initiative build on granular assumptions. e.g., “Outpatient at lower cost” initiative assumes re-provision cost of 0.8 GP appointment of 12 minutes & 0.2 Consultant appointment of 30 minutes per patient per year for 5% of total outpatient cohort.

2 Assumptions based on pilots outcomes of Brent Intermediate Care 2009 and Harrow Unplanned Care Initiatives 2011, QIPP 11/12 business cases, Healthcare for London, CCG input and expert interviews.

3 Initiatives include: “At Home” - e.g. Rapid Response (Nursing), Case Management, ICP; “At a GP Practice” - e.g. Outpatient at lower cost, ICP; “In a community health centre” - e.g. Rapid Response (Bed), Outpatient at lower cost, Outpatient at lower cost (telephone advice), ICP.

| TOTAL $ | £5 - 6m |

The staffing and investment identified in the figure above is indicative based on CCG strategic plans, as activity transfers funding will be transferred from acute settings to primary and community settings. It is accepted that upfront investment in primary and community care will be needed to allow the transfer to take place, however future savings will cover this investment. Specific investments will be agreed through the normal planning and governance processes of the CCG and as such the production and agreement of robust business cases demonstrating both value for money and affordability to the CCG.

7. **Next steps**

This strategy sets out an ambitious plan for improving out of hospital care in Central London. We need to move quickly to implementation in order to make early improvements in care for our patients and to realise the scale of savings required by 2014/15. In this section, we outline timelines for delivering elements of the strategy.

7.1. **Implementing our key initiatives and enablers for change**

As described in figure 38 and 39, we have started implementing some of our initiatives and key enablers. Others are ramping up to their full scope; some we will implement over the next 12 months.
7.2. Key immediate steps

By the end of June 2012
• Our Wellwatch service will be operational, supporting patients with long term conditions.
• We will have started the first phase of our redesign of Community Mental Health Services.
• Our practices will have developed plans to develop primary care for their practice, their locality and across the CCG (we will have in post locality coordinators to support this work).
• The 111 service will be live, including routing back to primary care.

By the end of September 2012
• We will have in place our Health and Social Care Coordinators (HSCC) to begin the process of community and social care teams being focused on GP Practices and localities.
• We will have HSCC focusing on coordinated discharge embedded in at least one hospital.
• We will have at least 3 more ‘inter-practice’ referral services live.
• Our shared clinical information system will be live in all GP practices combining GP / Community and Hospital information from Imperial healthcare.
• We will have developed our plans to ensure we maximise the benefit of 3rd sector providers.
• We will have determined the model and contractual arrangements for Urgent Care, including centres in hospitals and walk-in to GP practices.
• We will have developed an outline specification for the Health and Wellbeing Centre in Church Street and agreed the detailed development of the new building for the Fitzrovia Practice.
• We will have developed a strategy to route non GP referrals via the PRS, including specialist triage where necessary.

By the end of Dec 2012 -
• New model of Community Mental Health Services implemented and preparation for phase 2 of the programme underway.
• Our Practices will meet the primary care standards. By working together in localities and across the CCG, practices will offer a full range of enhanced primary care services to all Central London patients.
• Community and social care services will be delivered by integrated teams built around GP practice population (clustered into localities where appropriate) coordinated by our HSCC.
• All hospitals will have embedded HSCC focusing on coordinated discharge linking to the locality HSCC.
• Our shared clinical information system will bring together all information from our key providers.
• We will have plans to use different contractual and payment mechanisms to promote integration and encourage innovation from a range of providers including the 3rd sector. These will include AQP and ‘Year of Care’.
• We will have a responsive service provision for urgent care, including GP walk-in, 24/7 Rapid Response nursing and appropriate GP led services at hospitals.
• We will have a comprehensive estates strategy.
• All elective referrals will route via the PRS or will be subject to similar triage and routing.
Ealing Clinical Commissioning Group (ECCG) came into existence in April 2011.

Our objective is to provide the right care at the right time and at the right place for the residents of Ealing.

Our vision is to ensure that our health care system keeps patients well and at home and, when patients do become unwell, provides cost-effective, evidence based and timely care at the right place appropriate to their needs.

As demand rises with increasing health needs and the development of new treatments, we need to respond to the challenges while delivering the highest quality of care. We need to build and preserve what we do well and continue to look for new developments to deliver the best standards of care.

There are times when we use hospitals to provide care for patients when that care could be provided closer to their home and in the community. Developing the right care outside hospital is a key part of how we will continue to maintain the provision of quality and cost effective care for the residents of Ealing.

This is our three-year strategy to design and deliver out of hospital care.

To achieve this, our out-of-hospital initiatives will be:

- **Inclusive**: We want our services to be inclusive and for this to happen we will involve patient and public groups in our proposals. As we develop our initiatives it should be clear to all users how we are developing our plans.

- **Integrated**: We will work with all our stakeholders who provide out of hospital care e.g. primary care, community services, social care, nursing homes, voluntary groups to provide joined up care.

- **Sustainable**: Our approach will be sustainable and we will invest when we need to deliver the care.

Our strategy aims to improve quality and efficiency across the system, the experience of all patients, and make the best use of our resources.

We recognise this is a different and substantial shift from how we deliver health today. In the coming months we will be meeting with patient and public groups to explain our plans and to fully involve you as we develop our initiatives.

We need to continue to respond to the challenges we face and to evolve to deliver the best sustainable health care for the residents of Ealing.

**Dr. Mohini Parmar, CCG Chair, Ealing**
Executive Summary

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

The case for improving out of hospital services

- Demand for care is growing as people live longer, chronic and lifestyle diseases become more common and new developments in treatments become available
- In order to meet this demand within the resources available, we need to improve prevention, early intervention and care at home and reduce demand on hospitals
- To make these improvements we need to change and work in partnership with primary, community and social care to improve access, quality and capacity

Our vision of how care will be different

Our vision is that patients will feel confident and secure in the care they receive out of Hospital.
- This will mean joint working between GPs, community and social care, hospital and consultants, with early intervention and care in the right place and at right time
- Patients will have easier access to consistently high quality primary care
- More consultant led planned care will take place closer to home
- Patients with long term conditions who need care from different services will receive better coordinated care with one package of care
- Patients will be supported when they are discharged from hospital
- We are developing standards to hold ourselves and other providers to account for delivering high quality care out of hospital

How we will deliver better care, closer to home

The examples of the initiatives we have and we are developing are:

- Urgent Care Centre: this is already providing 24 hour urgent care to patients at Ealing hospital
- 111 and single point of access: this will be piloted in Ealing from April 2013
- Improving access to GPs: we will work with our GPs to improve access to GPs
- Integrated Rapid Response Service: this will start in July 2012 to provide a response to patients to provide care in their home and to support them on discharge from hospital.
- Children’s nursing service: we have developed a children’s nursing service to provide care for children closer to and in a more convenient location for them and their families.
- Palliative care service: we are working with the Marie Curie service to provide a rapid response team to assist and support those people who wish to die at home.

- Psychiatric liaison: we are piloting a psychiatric liaison service at Ealing hospital to provide a rapid response to patients who need this care.

**How we will work together**

We have identified better coordination of services as a priority in order to improve care. For example:

- Ealing GPs will work in six Health Networks ensuring care is clinically led and consistent across GP practices

- Within our six geographical multi-disciplinary groups, we will roll out the Integrated Care pilot to provide integrated care across health and social care

- We will work closely with partners in community and social services to support patients to use health and social care services effectively

- We are developing a service to provide coordinated and joined up care to Ealing residents who are in nursing homes

**Supporting the change**

In order to make these changes we have identified some key things we need to do:

- We will step up patient, user and carer engagement and improve our patient education and information

- We will ensure that we have the right contracts and incentives to improve care, to underpin the new ways of working

- We will put in place network governance and define the standards to which care will be delivered

- We will put in place the right information systems and tools to support networks.

- We will provide training to networks to support professional and organisational development in leadership, governance, teamwork, IT skills and patient engagement

**Investing for the future**

To deliver this vision of out of hospital care we will invest in our staff, estates and IT.

- We will need more clinical staff and we will invest in our workforce to deliver the changes we need.

- We will invest in better IT systems, to allow us to share clinical information (with the patient’s consent) to provide seamless care

- We will invest in our estates to allow us to deliver more care closer to home

**Next steps**

We recognise this is a different and substantial shift from how we deliver health care today. This will require commitment from all service providers - secondary care, mental health, community services and social care - to work together to ensure its success.
We need to continue to respond to the challenge we face and to evolve to deliver the best sustainable health care for the residents of Ealing.
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1. The case for improving out of hospital services

In this three-year strategy we set out our plans to transform out of hospital care in Ealing. We need to do this because population changes are increasing the demand on healthcare services and the resources available are not increasing at the same rate. As the population ages and the number of people with a long term conditions (LTCs) increases; the way we currently use hospital is becoming unsustainable.

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

We need to change the way we deliver care. At present access to care and the quality of care are variable across the borough. Improving the access, quality and scope of out of hospital services will require new ways of coordinating services, investment and greater accountability. Exhibit 1 sets out reasons for transforming out of hospital care. Further details are found in NHS North West London’s Shaping a Healthier Future programme and in the appendix to this document.

EXHIBIT 1

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>There is a strong case for improving out of hospital services</strong></td>
<td>The residents of North West London have <strong>changing health needs</strong>, as people live longer and with more chronic and lifestyle diseases - putting pressure on social and community care.</td>
</tr>
<tr>
<td></td>
<td>Under our current model of care, <strong>we can’t afford</strong> to meet future demand. Hospital is too often seen as the answer and we need to have <strong>more planned care, earlier</strong>, outside of hospital.</td>
</tr>
<tr>
<td></td>
<td>However, this needs a <strong>transformation of primary, community and social care</strong>. Currently there is variation in both <strong>quality and access</strong> and standards must improve.</td>
</tr>
</tbody>
</table>

2. Our vision of how care will be different

This section sets out our vision for how care will be different for patients in the future.

Our vision for out of hospital care is to work in partnership with patients, public, community and hospital clinicians and managers, out-of-hours services, social care and the voluntary sector to provide integrated care pathways for people with a LTC. This will include changing the way we fund healthcare services to ensure different providers work together better.

We have broken this vision down into five themes to describe how care will be different as shown in exhibit 2:
EXHIBIT 2

We will achieve our vision through five strategic goals

Ealing’s five strategic goals | Specifically, this means
--- | ---
1. Easy access to high quality, responsive primary care to make out of hospital care first point of call | GPs and primary care teams will be at the heart of ensuring everyone who provides care does so to consistently high standards of care
2. Clearly understood planned care pathways that ensure out of hospital care is not delivered in a hospital setting | Whenever possible, patients will have access to services closer to home
3. Rapid response to urgent needs so that fewer patients need to access hospital emergency care | If a patient has an urgent need, a clinical response will be provided within 2 hours
4. Providers (social and health) working together, with the patient at the centre to proactively manage long term conditions, the elderly and end of life care out-of hospital | Patients will have a named coordinator who will make sure they have all the services they need. If a patient’s condition becomes more complex, GPs will be able to direct to a clinician with specialist skills close to home
5. Appropriate time in hospital when admitted, with early supported discharge into well organised community care | Care providers will know when an individual patient is in hospital and will manage discharge into planned, supportive out of hospital care

This vision builds on our aims set out in our commissioning intentions, as shown in Exhibit 3:

EXHIBIT 3 – COMMISSIONING INTENTIONS AIMS

- Patients feel that they are at the heart of the system, and are confident that they’re getting the best quality care.
- We enable all health professionals to do the best for their patients, thereby reducing health inequalities and improving health for all.
- We provide joined-up care for everyone who needs it – working together effectively with our patients and across different healthcare providers.
- We practise smart spending, with sound financial management that enables us to control our own destiny and ensure that the Ealing NHS survives and thrives.

“We envision is to commission and deliver the best healthcare in London”

We are seeking to deliver joined up care across health and social care in Ealing, with all services working together to provide the best possible care for patients as represented in Exhibit 4:
EXHIBIT 4 – Joined up health and social care for Ealing

Objective: Joined up care across health and social care in Ealing

This section describes our vision for how care will be different for patients in the future in each of these five areas. In addition, section 2.1 sets out the out of hospital standards which apply to all out of hospital care and which will help us measure if the new approach is working. In section three we describe our initiatives to make these goals a reality, across the same five themes.

2.1. Easy Access to High Quality Responsive Primary Care

There is variation in the quality and access to primary care within Ealing and improving this is a local priority.

A. Access

We are committed to improving access to primary care so it meets patients’ expectations. Improving access will mean opening at convenient times, offering a wider-range of services and being located in the right places.

To provide access at convenient times means being open when people want to use services and managing demand at peak times. Out of hospital care will operate as a seven day a week service, with telephone advice and triage, like the Urgent Care Centre, available 24 hours a day, seven days a week. To improve access at peak times, we will work to develop a range of access routes into services as appropriate (for example, face-to-face, by telephone, by email, by SMS texting and by video consultation). Some of our practices already offer email consultations, or contact people by text and we will expand this for those patients who want this rather than more traditional consultations.

We will also improve access by offering a wider range of services out of hospital. For example, GPs, working with the Ealing Improving Access to Psychology Therapies (IAPT) service and working in the Integrated Care Pilot will be able to support more people with common mental illnesses such as depression and anxiety, as well as people with stable enduring mental illnesses, providing better access to care.

Access will also improve by locating care in the right place. More services, such as anticoagulation and spirometry will be delivered in practice networks meaning the service will be available to every patient locally.

B. Quality: Our out of hospital standards

Improving quality will mean ensuring that care is being delivered to the right clinical standards, in good facilities. Improvements in facilities are described in section 5.1d: our
standards to drive improved quality are set out below. Patients and the public need to be confident in the quality of care as we change where and how patients are cared for, so we have agreed to implement clinical standards for out of hospital care, which are set out in exhibit 5. Our intention is to deliver these over the next three years.

These standards emphasise that GPs will have a central role in the coordination and delivery of out of hospital care. The standards apply to both core primary care delivered by GP practices and more broadly to care delivered outside of hospital. They aim to shift care delivery from more reactive unplanned care to proactive planned care. Ealing Clinical Commissioning Group will ensure transparency of information in order to help raise standards of care: we will publish our progress on a regular basis so our patients can see how we are doing in achieving these standards.

The standards in Exhibit 5 below have been agreed across North West London and we will be seeking to implement them locally:

EXHIBIT 5 – OUT OF HOSPITAL STANDARDS

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

2.2. High quality planned care

An increasing number of patients will be seen in community facilities so they do not have to travel to hospital for outpatients, underpinned by robust and clear care pathways. For example, ophthalmology (eye) patients can now use a consultant led service at Grand Union Village Health Centre and Hanwell Health Centre. In addition, we are currently discussing with local GPs how the increasing number of patients who need warfarin can be seen in local practices. Our survey of patients told us that patients needing this service preferred going to local services, rather than having to go to hospital. New care pathways offering an increasing range of outpatient provision in the community will include ECG (heart tests), blood tests and spirometry (lung function test) services.

Care pathways are becoming more consistent and efficient as a result of our Referral Facilitation Service (RFS). Through this service significantly more patients are referred directly to the most appropriate clinician first time. We expect this to improve further over time. With the new technology we are rolling out patients can expect that clinicians, with the patient’s consent will be able to share and access patient information with other health care professionals who are involved in providing care to the patient. This will mean that previous or planned contact with a healthcare professional should be visible to all relevant community
health care providers, resulting in better informed care, reduced duplication and improved patient satisfaction with the care offered.

2.3. Responsive Urgent Care

In future, more patients will be supported at home by our rapid community response service (intermediate care) which most patients prefer instead of having to go to hospital. Any individual who is clinically assessed to be at risk of an emergency admission to hospital, which could be prevented, will be visited by the rapid response team, within four hours, depending on their clinical urgency. Packages of care to support people in their own home will typically be delivered by experienced community nurses, therapy staff and supported by Ealing’s Reablement Team. If necessary, patients will be able to access an inpatient rapid response facility, such as Magnolia ward. Some patients will also be supported to return home from A&E by our rapid response service as an alternative to being admitted to hospital. Mental health patients will be provided with additional support by our Mental Health Crisis Resolution Team, which aims to support people with severe and enduring mental health problems to stay out of hospital.

Exhibit 6 sets out an example of how improved rapid response will change patients’ experiences:

EXHIBIT 6

<table>
<thead>
<tr>
<th>John is 84 and lives with his wife. He has usually stable Parkinson’s disease and walks with a stick. Recently he has developed an urinary tract infection which has led to him becoming confused.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urgent care has been stressful when patients need support...</strong></td>
</tr>
<tr>
<td>John’s wife is worried and is not sure what to do</td>
</tr>
<tr>
<td>She takes him to A&amp;E. The strange surroundings make John even more confused and he becomes disruptive and aggressive</td>
</tr>
<tr>
<td>While struggling, John rolls out of bed and severely hurts his leg</td>
</tr>
<tr>
<td>Three weeks later, John is still in hospital and his mental state has deteriorated, he is discharged into a care home</td>
</tr>
<tr>
<td>Hospital nurses are not sure how to deal with him, causing them stress</td>
</tr>
<tr>
<td>John becomes more dependent on care and regaining independence is unlikely</td>
</tr>
<tr>
<td><strong>In future, we will meet patients’ needs at home...</strong></td>
</tr>
<tr>
<td>The area John lives in has a single point of access for health and social care coordination</td>
</tr>
<tr>
<td>Stress is minimised and the people with the most appropriate skills are available</td>
</tr>
<tr>
<td>Early intensive support accelerates recovery</td>
</tr>
<tr>
<td>A smooth transition is made to a locally based multi-disciplinary care team</td>
</tr>
<tr>
<td>ICE team arrive within 4 hours and assess his current health and social care needs. They authorise a three day planned package of care for John at home</td>
</tr>
<tr>
<td>The team start medication/fluids, move the furniture in his lounge and arrange mobilising and pressure-relieving equipment</td>
</tr>
<tr>
<td>Over the next three days a nurse regularly visits to review/assist with fluids. A domiciliary care agency brings meals, changes clothes and gives baths</td>
</tr>
<tr>
<td>John is referred to intermediate care service for Ealing (ICE) by his GP. He has been unable to get out of his chair for the past few days. His wife is caring for him</td>
</tr>
<tr>
<td>John’s confusion abates and he recovers from UTI at home. ICE discharges him back to the care of his GP</td>
</tr>
</tbody>
</table>

2.4. Health and social care providers working together to deliver the best care for patients

We want Ealing residents using community health and care to experience coordinated, seamless and integrated services using evidence-based care pathways, case management and personalised care planning. All patients will benefit from the greater coordination between services we are developing in local healthcare networks. Some examples of more joined up care patients will receive in future are set out below:

Patients with diabetes and older people will have a care plan, which will be developed jointly with a clinician and their carer to ensure that all parts of their care, including social care are coordinated. Care plans will help people stay well, avoiding a worsening of their condition and in knowing what to do if they see existing problems re-starting it. Additional information on this can be found in Section 3.

The most vulnerable sick children and elderly patients in nursing homes will also benefit from our two new specialist teams. For children there will be a community nursing service with
close links Social Services and schools. This will seek to provide proactive care helping children with illnesses such as cancer stay at home and children with long term conditions, such as diabetes, to stay well. Nursing home residents in all of the borough’s 22 nursing homes will benefit from a new service involving GPs, pharmacists and nurses that will support them and work with nursing home staff to deliver the best care. Additional information on both these schemes can be found in Section 3.

Exhibit 7 sets out an example of how improved working together will change patients’ experiences:

**EXHIBIT 7**

<table>
<thead>
<tr>
<th>After visiting her GP, Laura has a spirometry test and is diagnosed with COPD</th>
<th>After a series of complications, Laura is referred to a respiratory specialist. Her visit is extended as the specialist does not have access to Laura’s records, and has no indication about the progression of Laura’s condition</th>
<th>Unexpectedly, Laura is admitted to A&amp;E and inpatient care for one week later with breathlessness</th>
<th>Laura is discharged to home, but her records and history are not available to either social care workers or district nurses during their follow up visits.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laura is identified as a patient in need of an integrated care plan by her GP. Her care plan is made available to all health care professionals involved in her care</td>
<td>Laura is discussed by her GP at a case conference with a lung specialist. They identify that Laura needs education on how to use her inhaler properly, rather than a stronger dose prescription.</td>
<td>Nonetheless, Laura experiences complications. On referral, her lung specialist has access to Laura’s care records through full information to assess her progression</td>
<td>Admissions to A&amp;E and interaction with social care are supported by having her care plan. Upon discharge, the care plan recommends multi-disciplinary pulmonary rehabilitation and self management and would be followed up with a visit at home or an appointment with the community respiratory service</td>
</tr>
<tr>
<td><strong>2.5. Supported discharge</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In future, following admission to hospital the patient’s GP and relevant providers will be actively involved in coordinating an individual’s discharge plan to meet on-going or continuing care needs. As a result we expect there will be fewer people staying in hospital longer than they need or wish to, due to lack of adequate support for discharge.

Exhibit 8 sets out an example of how better supported discharge will change patients’ experiences:
EXHIBIT 8

Brenda is 79. She is a complex elderly patient with both diabetes and COPD. She has recently fallen, fractured her hip and been admitted to hospital, where she has had an operation and is soon ready to go home.

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

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

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

| When Brenda was admitted to hospital she was flagged as on the high risk patient register and her history was available to staff | Her care coordinator is notified and discharge planning begins immediately | The care coordinator talks to her family, calls her social worker and speaks to a community home to pass on information | Next steps are captured in clear care plan and all pieces are in place for discharge when the time comes |

| Hospital staff feel less anxious as they have a support structure around the patient | Early intensive support accelerates recovery | First week after discharge, she receives daily visits by her physio to check on her walking and see she is making good progress |

### 3. How we will deliver better care, closer to home

This section describes what we are doing to make our vision a reality in each of the five areas described in section 2.

Some of these initiatives are already successfully in place in Ealing, and others are new for our borough, including several organised at a wider level, for example, NHS 111 and the North West London Integrated Care Pilot. Our initiatives for improving out of hospital care are set out in exhibit 9:
3.1. Easy Access to High Quality Responsive Primary Care

A: Developing Primary Care

We will work with primary care to organise into health networks of 50,000 - 70,000 patients to improve access and quality and deliver care closer to home.

We will work with practices to embed a system of peer review built around strengthening joint working and sharing of data on prescribing and activity, in order to reduce variance and to share skills and resources.

We will review the appropriateness of practice opening times, the quality of our facilities and explore new ways of triage and communicating by making better use of the latest technology, for example, Tele-health.

We will support collaboration to increase the capacity and quality in primary care and will build the right incentives to ensure general practice is actively involved and is driving forward service improvement and development.
**B: 111 Pilot**

The 111 pilot in Ealing will provide a single point of access for patients, clinicians and the wider public to access the appropriate level of care.

By January 2013 the CCG working closely with colleagues in Harrow, Brent and Hounslow will establish a Borough-wide 111 service with 1 provider across all 4 boroughs.

The service will use a local directory of services, which we are currently developing, to direct people to a range of clinically appropriate services.

Call handlers will be able to book appointments at the Urgent Care Centre and at your GP practice.

**C: Ealing Urgent Care Centre**

The existing urgent care centre at Ealing Hospital provides a 24 hour primary care alternative to A&E for observation, diagnostics and treatment of minor illness and minor injuries.

£3 million is being invested in the Urgent Care Centre. It provides an alternative to A&E for those people with more minor illness or injury.

The centre is also aiming to reduce total urgent attendances by 5% a year through better access to primary care and patient education.

Since it opened in July 2011 the service has already seen over 42,000 people and in its first year we estimate it will see up to 50,000 people. We have plans to expand this to see up to about 70,000 people a year.

3.2. High quality planned care

**A: Referral Facilitation Service (RFS)**

Our redesigned Referral Facilitation Service will ensure all outpatient referrals are directed to the most appropriate clinician first time thereby reducing duplication and unnecessary costly appointments.

**B: Outpatients appointments in the community**

New treatment pathways will increase the number of outpatient appointments that take place outside a hospital setting. Care will be delivered by consultants or, in the case of certain musculoskeletal services, physiotherapists. The services we will focus on initially will include an anticoagulation service, a pulmonary rehabilitation service for patients with chronic obstructive pulmonary disease and community diabetes, musculoskeletal and ophthalmology services. These will be delivered in community facilities.

We are currently advertising for organisations to express an interest in providing a pulmonary rehabilitation service. We expect the new service to be in place from November 2012.

We are working with practices to agree how they will provide anti-coagulation services in each network. The new capacity should be in place by July 2012 and will be for those on warfarin and for those needing to start it.

In conjunction with Macmillan Cancer Relief and Ealing Integrated Care Organisation (ICO) we are launching a pilot scheme which will better coordinate and manage the care of patients who have had cancer. More people are now surviving cancer and we need to provide more help and support outside of hospital to make sure they keep well and that we spot any reoccurrences early.

As part of our planning for 2013/14 we are developing plans to increase the number of services available in the community so we will see more patients with heart and lung diseases seen in the community. We are starting to plan in our initiatives for the next two years and we will be able to share more details by the end of July 2012.

3.3. Responsive Urgent Care
A: Rapid response admission avoidance (to be known as ICE – Integrated Care Ealing)

We are developing a rapid response team with a broader scope and skill set, including in reach into A&E departments to prevent avoidable admissions and keep people at home where possible and clinically safe. ICE will start to operate in the new model from June 2012 and will be fully operational by November 2012.

Our rapid response team will be multi-disciplinary, including hospital consultants, GPs, social care, occupational therapists, physiotherapists, nurses and mental health professionals.

They will provide timely assessments and will be able to organise care packages to keep people out of hospital. Assessment will occur within 4 hours and where necessary will be followed by intensive intervention for up to 72 hours and/or on-going rehabilitation and reablement for up to 6 weeks.

Care packages will include nurses and therapy staff visiting people in their own homes, or community beds (Magnolia ward) with 24/7 nursing care. The rapid response team should prevent around 4,000 emergency hospital admissions each year.

A similar but smaller service focusing on providing rapid support for patients at the end of their life has recently been set up. This service is accessible to patients who have a palliative or end of life care plan and is designed to help patients and their families or carers to avoid an unnecessary hospital admission, wherever patients choose to end their life in their own home or usual place of residence.

3.4. Health and social care providers working together to deliver the best care for patients

A: Roll out the Integrated Care Pilot across Ealing

We are establishing six healthcare networks across Ealing, including one which has already started to function in Acton. Clinicians in each network will work together to identify and review patients at risk of becoming ill. Initially their focus will be on diabetic patients, patients with chronic obstructive airways disease and older people. This is a roll out of the pilot already taking place in Acton and develops the model used successfully in Inner North West London.

GPs will use specialist I.T tools to identify the patients who are at highest risk of unplanned admission to hospital and who could benefit from more proactive care.

Care plans will be developed with the patient and carer (where appropriate), ensuring all the services that the patient is assessed as needing are working together.

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

Since many people with long term conditions also have mental health problems such as depression, mental health specialists will play a central role in the programme so that patients receive better coordinated care.

B: Active case management for sick children and elderly patients in nursing homes

In addition, two multi-disciplinary teams are being established to provide case management for these two vulnerable groups. The children’s nursing team will support children at home as described in section two and will work closely with schools, social care and acute hospitals to ensure all aspects of their care is well coordinated.

Secondly, the nursing home team will comprise GPs, pharmacists and nurses and will provide specialist medical services for patients living in any of the 23 nursing homes within the borough of Ealing. This service will be tailored to meet particular needs of elderly patients who live in nursing homes through good care coordination, including good end-of-life care planning. This service will be in place by the end of 2012.
3.5. Supported Discharge

A: Supported discharge

We will ensure that the work of the community services which we commission and the efforts of Ealing Social Services and of voluntary sector organisations are aligned to the efforts of acute hospitals to reduce unnecessary delays in hospital discharge once patients are ready to return home. We will achieve this by requiring our community services to develop integrated teams and joint working protocols with the main acute hospitals and with Ealing Social Services.

B: Establish a psychiatric liaison service at Ealing Hospital

The psychiatric liaison service was set up in March 2012 to provide care for patients with significant mental health needs in acute settings (outside specialist mental health units), train other hospital staff to enable them to support patients’ mental health needs and provide integration with other parts of the health system including GPs.

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

The service is being piloted for three months but we anticipate that funding will continue for this service which is provided by West London Mental Health Trust (WLMHT) at Ealing Hospital.

4. How we will work together

To achieve our vision will require new ways of working in Ealing. There are a number of aspects to consider as set out in Exhibit 10.

A further key part of how we work together will be empowering patients and carers as described in section 5.1.

EXHIBIT 10

How we will work together

We will work in new local healthcare networks based on patient populations in order to:

1. Better co-ordinate the provision of care
2. Deliver services
3. Develop our workforce
4. Develop our estates

To support this collaborative working, the CCG is setting out how it will cooperate with its partners in social care and the voluntary sector to deliver care to the people of Ealing.

4.1. Working in new healthcare networks

In order to deliver our out of hospital strategy we are forming healthcare networks, which are based on patient populations of 50,000 – 70,000. These will involve GPs in a geographical area working together to coordinate care, deliver services and develop our workforce. Our proposed local healthcare networks are set out in exhibit 11:
Patients receive better care when the different clinicians providing care are working closely together. However, we cannot afford to have specialist nurses, community matrons and other healthcare professionals working in every practice. By forming healthcare networks we can enable clinicians to work together more closely. In order to do this, we are geographically aligning health and social care services round patient populations of 50,000 – 70,000.

As part of the Integrated Care Pilot, GPs from every participating practice, acute consultants, social workers and district nurses, practice nurse and mental health nurse representatives will discuss agreed patient case management in multi-disciplinary case conferences. Initially, these will focus on patients with diabetes, mental health and care for the elderly, to be extended to COPD (chronic obstructive pulmonary disease) and CHD (coronary heart disease) and other long term conditions, as described is section three.

Health networks will also improve the coordination of care through the alignment of services. Community and social services will align their services to work within health networks as set out in exhibit 12. For example, in each health network, there will be a member of the district nursing team leading community nurses within the health network, who will work with the GP chair of the multi-disciplinary group to ensure effective working between district nursing and general practice within the network.

### Local Healthcare Networks

<table>
<thead>
<tr>
<th>Region</th>
<th># Practices</th>
<th>Patient pop</th>
</tr>
</thead>
<tbody>
<tr>
<td>North 1</td>
<td>13</td>
<td>55,000</td>
</tr>
<tr>
<td>North 2</td>
<td>11</td>
<td>60,000</td>
</tr>
<tr>
<td>Central Ealing</td>
<td>15</td>
<td>96,000</td>
</tr>
<tr>
<td>Southall South</td>
<td>9</td>
<td>49,000</td>
</tr>
<tr>
<td>Southall North</td>
<td>15</td>
<td>64,000</td>
</tr>
<tr>
<td>Acton</td>
<td>16</td>
<td>66,000</td>
</tr>
</tbody>
</table>
As well as developing the way we coordinate services locally, we are improving the ways we share learning between different areas, so that each healthcare network can benefit from best practice elsewhere. The integrated care pilot puts in place a structure which sets out how each multi-disciplinary group interacts with the supporting teams at a borough and North West London wide level. This means that clinicians have local organisational support allowing them to focus on patient care. In addition, GP leaders of local groups will share what is working well in their healthcare network so the most effective local innovations spread.

### B: Delivering Services

Healthcare networks will offer services that can be delivered in GP surgeries or network hubs, but which are not necessarily provided by all GP surgeries. Examples of services offered within the networks will be anticoagulation, heart tests such as ECGs, ambulatory blood pressure monitoring and spirometry.

Working as healthcare networks will increase the capacity of clinicians to invest and innovate to meet local health needs. As part of the integrated care pilot, an innovation fund is available, which healthcare networks will be able to use to meet local health needs. For example, in the Acton area the healthcare network has employed a specialist diabetic nurse to meet a need identified through multi-disciplinary group discussions. Practices could also work together to improve access, for example, by coordinating extended opening hours or emergency appointment availability across the network.

### C: Developing our workforce

Healthcare networks provide an opportunity for our workforce to develop, through participating in multi-disciplinary groups, through peer review and through localised support. Offering the opportunity to discuss the care of a patient with a consultant psychiatrist and diabetic specialist consultant gives clinicians the opportunity to develop their own knowledge and their ability to treat conditions.

Peer reviews within practices in healthcare networks will review information such as attendances of their patients in A&E, inpatient admissions, referrals for different conditions.
and mental health activity, providing clinicians with opportunities to learn from each other and develop plans to improve quality.

Healthcare networks will be supported by the CCG through access to financial planning, analysis of activity data, informatics, data management and medicine management and the support of a network manager.

**D: Developing our estates**

Our plans to move care out of hospital and into community settings will mean continual improvement and development of our facilities. We will make the best use of existing infrastructure including the use of Ealing Hospital, which will continue to provide an essential element of our out of hospital strategy given its central location and excellent transport links. This will take the strategic use of capital. As we develop local infrastructure of clinical expertise, different healthcare networks will choose to deliver services in different ways. For example, in some networks every practice may deliver anticoagulation, while in another this may be concentrated in a few hubs.

Our initial strategy is to ensure there is a hub offering extended opening hours and a range of services within each local healthcare network. Exhibit 13 provides extended services that will be delivered in each of these hubs, examples of further services that will be located in some hubs but not others and the criteria we will use to decide where different services will be located.

**EXHIBIT 13**

**We will use a range of criteria to decide which services to locate at hubs within local healthcare networks**

<table>
<thead>
<tr>
<th>Each of our hubs will deliver extended services</th>
<th>Examples of services that could be located in hubs</th>
<th>The services offered will be based on a range of criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services at all local network hubs</td>
<td>Further services that could potentially be delivered at hubs</td>
<td></td>
</tr>
<tr>
<td>▪ GP practice</td>
<td>▪ Community outpatients – cardiology, respiratory, MSK, dermatology, diabetes, paediatrics</td>
<td></td>
</tr>
<tr>
<td>▪ Extended hours</td>
<td>▪ Community health services: district nursing, community matrons</td>
<td></td>
</tr>
<tr>
<td>▪ Diagnostics</td>
<td>▪ Additional capacity for care planning</td>
<td></td>
</tr>
<tr>
<td>▪ Base for local healthcare network</td>
<td>▪ Staff coordinating health and social care (not a current Ealing initiative but an option for future)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ Non-clinical space and meeting rooms</td>
<td></td>
</tr>
</tbody>
</table>

Hubs already exist at Grand Union, Jubilee Gardens, Featherstone Road Clinics and Hillview Surgery. We are planning to invest in enhancing services at Acton Health Centre, Mattock Lane Health Centre and Featherstone Road, as well as linking with Harrow CCG for the joint use of Alexandra Avenue Clinic which is very accessible for residents of Northolt.

By August 2012 we aim to have confirmed the location of a hub within each local healthcare network and detailed the services to be located (locations and service offerings at different locations are still under discussion). Exhibit 14 outlines potential hubs in each network and summaries the services offered at that location at present.
4.2. Working with our partners to deliver better care

To meet our goal of coordinated care for the residents of Ealing, the Ealing Clinical Commissioning Group commits to working closely with our partners. For example:

A: Hospital Providers

We are working with several acute providers and our neighbouring Commissioning Groups to ensure the needs of Ealing residents are a core component of local hospital provision and continue to be so, whatever the outcome of the potential merger of Ealing & North West London Hospitals NHS Trusts and the reconfiguration programme currently being developed.

We are working with all Commissioning Groups in Northwest London, to commission specialist services from our acute hospitals (e.g. specialist cancer care and renal services).

We also work with acute hospitals to manage a shift in service provision from acute setting into the community, which allow hospital consultants to run clinics in community facilities (for example the provision of consultant-led diabetic outpatient appointments in the community).

B: Ealing Health and Wellbeing Board (HWBB)

Under the leadership of the HWBB a joint prevention strategy is being developed and will be ready by August 2012.

The HWBB will provide guidance for our commissioning by describing how we will be more pro-active in preventing illness and reducing the impact and burden of diseases. For example it will describe plans to increase the number of people helped to stop smoking, increase the number of NHS health checks, tackle obesity locally and increase the uptake of screening e.g. to identify bowel, breast and cervical cancers early so treatment can be provided.

The HWBB will also give strategic direction to how the CCG and Ealing Council work together to prevent ill health. They will build on our Public Health Strategy, which is set out in Exhibit 15:
At the heart of this strategy is the coordinated multi-agency support for local residents to understand the factors that impact on their health and to help them to take actions that help them stay healthy or manage their condition with confidence in a way that allows them to live independent and fulfilling lives.

**C: London Borough of Ealing**

NHS Ealing and Ealing Social Services have a well-established joint commissioning function. This covers the commissioning of services where a common strategy and approach is required across a range of local services (e.g. young people, mental health, care of the elderly, physical disabilities and learning disabilities). The work of each of these areas is overseen and coordinated by specialist boards which in turn feeds into and supports the overall strategy of the Health and Wellbeing Board.

A key area of joint work with Ealing Social Services is the development of common response to technology enabled care (Tele-care and Tele-health). This relates to technology that supports the delivery of health and social care and promotes independence. Following a successful evaluation of the impact of Tele-health technology for patients with COPD and heart failure in 2011, we will develop a strategy for Tele-health and Tele-care, which will set out our aspirations and approach to rolling out technology as a means of supporting better health and social care in 2012. Our strategy will build on the work the Council are already doing, e.g. in supporting people with dementia to live at home.

Another import area of collaboration is our Falls Strategy, which we are currently updating to have a specific focus on helping those at risk of falls and fragility fractures. Our strategy will support those at risk of falls to improve their physical health, prevent or minimise the harm suffered if they fall and help them to continue to live independently.

We are increasing the amount of money we spend on equipment to use at home, for example for specialist beds and hoists. We are doing this both through specific schemes such as ICE and through the general equipment service, which is largely managed by social care and community nurses and therapists.
We are currently developing a joint strategy on dementia services involving London Borough of Ealing as well as partners in the voluntary sector, carers etc. This will be ready by June 2012 and will support the out of hospital care strategy by enhancing services provided in the community such as memory clinics as well as support for people with dementia to stay in their own homes. A major focus of the work is on better supporting carers as we recognise this is currently a gap.

D: Ealing’s Voluntary Sector

In 2012/13, jointly with Ealing Social Service, we spent nearly £3 million on funding voluntary sector organizations to support over 60 projects covering advice, information and advocacy services, respite, day opportunities, counselling and health promotion services.

Funding priorities are informed by the Joint Strategic Needs Assessment and Ealing’s shared commissioning outline for Independent Health and Well Being.

Provision is designed to complement statutory services in particular focussing on prevention, early intervention, re-ablement, access to services and building connections in the community that help vulnerable people stay well. The voluntary sector has an important role in supporting community based provision and therefore is key to the Out of Hospital Strategy.

5. Supporting the change

We have identified five key enablers for better care, closer to home as set out in Exhibit 16:

EXHIBIT 16

<table>
<thead>
<tr>
<th>To be successful we need to…</th>
<th>Requirements</th>
</tr>
</thead>
</table>
| **1. Engage patients and carers** | ▪ Inform patients, listen to them and act on their input  
▪ Engage GPs, community and hospital providers and other stakeholders to ensure buy-in and commitment to shared solutions |
| **2. Develop our people and our organisation** | ▪ Develop behaviours to work effectively together  
▪ Communicate using face to face, email, SMS and other methods |
| **3. Agree on how we will be governed** | ▪ Commit to common set of clinical standards and process of monitoring and variance management  
▪ Assign roles and responsibilities  
▪ Create development plan to ensure consistency and clarity on our accountabilities |
| **4. Put in place the right information tools** | ▪ Unified IT systems providing shared records, leading to better patient care and transparency on performance |
| **5. Develop the right contracts and incentives** | ▪ Align contracts and incentives for all providers, to ensure delivery of care to appropriate clinical standards |

5.1. Engagement with patients and carers

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

Exhibit 17 shows our new commitments to patients on how their views will inform decision-making and how they will be kept informed about changes we are making:
5.2. Developing our people and organisation

This strategy requires primary care teams to take on new and exciting roles. To allow this happen, we need to develop our member practices through closer team-working within networks and sessions focussed on learning, development, team working etc. within the new networks. Leadership and management training will be provided to facilitate the development of a range of formal and informal leaders within networks. Support with information technology skills will also be made available.

Development will also be tailored to professionals’ needs; some examples are set out in exhibit 18:

<table>
<thead>
<tr>
<th>Our commitment</th>
<th>How we’ll deliver</th>
</tr>
</thead>
<tbody>
<tr>
<td>You’ll be involved</td>
<td>▪ Patients will be represented on key committees and project teams involved with service redesign&lt;br&gt;▪ Every network will have a patient group supported by LINk / Health Watch and other partners&lt;br&gt;▪ Care plans will be co-developed with you</td>
</tr>
<tr>
<td>You’ll be informed</td>
<td>▪ We’ll set out the standards we are aiming for and report to you how the CCG, localities and individual practices / care providers are performing against them&lt;br&gt;▪ We’ll explain what is changing, why it is changing, and how your input shaped decisions using clear concise language&lt;br&gt;▪ We will make sure that communication across health and social care are clearly understood by you and your carers</td>
</tr>
<tr>
<td>Your input will shape services</td>
<td>▪ We will hold events to consult on key issues, such as commissioning intentions and our Out of Hospital strategy&lt;br&gt;▪ We will work with the widest possible range of health service users, by working with LINk, Health Watch and the voluntary sector to get input from difficult to reach groups&lt;br&gt;▪ We will use nationally and locally collected patient experience data to inform decision making&lt;br&gt;▪ We will commission services which provide evidence of listening to service users’ views</td>
</tr>
</tbody>
</table>
5.3. Governance and Variance Management

There will be a clear governance structure which will have the CCG board underpinned by the six networks (see Exhibit 19):

**EXHIBIT 18**

<table>
<thead>
<tr>
<th>Role</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPs</td>
<td>We will support GPs with education and training</td>
</tr>
<tr>
<td>Practice Nurses</td>
<td>We will train our practice nurses to offer a wider range of specialist care (e.g. triage and case management)</td>
</tr>
<tr>
<td>HCA</td>
<td>We will build the capabilities of our healthcare assistants so that they are able to carry out technical procedures and develop the integrated health and social care support function within their roles</td>
</tr>
<tr>
<td>Managers</td>
<td>We will develop the skills of our managers so that they are effective at coordinating networks, monitoring outcomes and developing strong relationships with the Commissioning Support Service</td>
</tr>
</tbody>
</table>

**EXHIBIT 19**

**Proposed network management structure**

- Monthly board meeting, including representatives from all group chairs
- Coordinators will ensure practices have data to conduct performance conversation
- Commissioning Group support will be delivered at network level, for example, medicines management, informatics, finance
- Each locality will have 2 representatives on the Ealing CCG Board

Ealing CCG will also put in place ways of working together to ensure patients see the benefits of changes in how care is delivered. To achieve this, we will develop a performance framework based on the steps set out in exhibit 20:
This will build on current work practices are doing to work together to peer review against benchmarked information e.g. prescribing and emergency admissions. We will define the process, but typically it could be on a monthly basis for key metrics such as data on prescribing. Indicators will look both at a practice’s performance on its key primary care activity, but also how it is doing in reducing emergency admissions, outpatient referrals and A&E attendances.

5.4. Information tools

We aspire to have real-time shared records across GPs, community, acute and mental health teams. We have already started to develop an information management strategy to support and enable the delivery of more care out of hospital. We expect to have this completed by summer 2012.

The benefits we hope to realise by more effective information sharing are set out in Exhibit 21 below:
EXHIBIT 21

What better information sharing will achieve

1. Better clinical decisions can be made with the better information a real-time electronic record can provide shared between GPs/Community and Secondary care clinicians.

2. Transparency of information gathered will help us drive up standards across Ealing

3. Planned care becomes more consistent as
   - Sharing of data allows better evaluation of GPs use of planned care, supporting a better referral facilitation service
   - GPs have access to granular reporting on referrals

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

5. Long term care becomes more pro-active through
   - Risk stratification of patients by GPs
   - Care plans being put in place
   - Enabling regular check ups and early intervention
   - Decrease repetitive investigation and prescribing

EXHIBIT 22

What better information sharing will achieve

1. Better clinical decisions can be made with the better information a real-time electronic record can provide shared between GPs/Community and Secondary care clinicians.

2. Transparency of information gathered will help us drive up standards across Ealing

3. Planned care becomes more consistent as
   - Sharing of data allows better evaluation of GPs use of planned care, supporting a better referral facilitation service
   - GPs have access to granular reporting on referrals

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

5. Long term care becomes more pro-active through
   - Risk stratification of patients by GPs
   - Care plans being put in place
   - Enabling regular check ups and early intervention
   - Decrease repetitive investigation and prescribing

5.5. Contracts, Incentives and payments

As we introduce new services and new ways of working, we need to ensure that the contracts and incentives that we have in place will support this and reinforce the behaviours we want to see. Exhibit 22 shows our five key goals the targets that we will set for each and the new types of contracts, incentives and behaviours that will align with these.

EXHIBIT 22

<table>
<thead>
<tr>
<th>Target</th>
<th>Behaviors this will require</th>
<th>Re-imbursement to support this</th>
</tr>
</thead>
</table>
| Easy access to high quality, responsive care | • Improve access  
• Improve satisfaction | • Meeting minimum primary care requirements | • Incentives for delivery |
| Simplified planned care pathways | • Reduce Outpatient attendances  
• Elective admissions | • Peer review/referral management system  
• Inter-practice referrals | • Referral management scheme  
• Shared incentives across network to reach targets |
| Rapid response to urgent needs | • Reduce A&E attendances  
• Improve reliability | • 111, UCC, extended hours  
• Walk-in centres | • Robust contracts with UCC, rapid response and extended hours |
| Integrated care for LTC and elderly | • Reduce NEL admissions  
• Increase integration  
• Increase proactive care | • Coordination ratings  
• Care plans | • Payments for care plans  
• Payments for clinicians to attend case conference  
• Shared incentives across providers to reach targets |
| Appropriate time in hospital | • Reduce length of stay | • Discharge coordinator  
• Co-ordination with social care  
• Rapid response | • Contracting with social care, discharge coordinator and rapid response teams |
6. **Investing for the future**

This section summarises investment we anticipate making to achieve realise our strategy. We break this down by investment needed to reduce activity in hospital, investment in different settings of care and the workforce implications of our strategy.

6.1. **Investing in out of hospital care**

This strategy has started to set out our vision for a fundamentally different model of care. As we reconfigure the hospital landscape we will invest in out of hospital care. Exhibit 23 outlines our projected savings and investment for our main initiatives. These investments are recurrent costs of running the services. In addition to this, we will have to develop separate plans for capital expenditure where development of our estates is required and for funding the transition to out of hospital care, including development of our IT and organisational development. We also know that we will have to fund the additional costs of more people in the community e.g. needing equipment, drugs etc.

**EXHIBIT 23**

<table>
<thead>
<tr>
<th>Initiatives</th>
<th>Gross savings £m</th>
<th>Net savings projected £m</th>
<th>Investment in services £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Rapid Response</td>
<td>10.2</td>
<td>6.8</td>
<td>3.4</td>
</tr>
<tr>
<td>1.1 Nursing</td>
<td>7.6</td>
<td>5.4</td>
<td>2.3</td>
</tr>
<tr>
<td>1.2 Bed²</td>
<td>2.5</td>
<td>1.4</td>
<td>1.1</td>
</tr>
<tr>
<td>2 Case Management</td>
<td>4.1</td>
<td>2.7</td>
<td>1.4</td>
</tr>
<tr>
<td>3 Outpatients In the community</td>
<td>2.6</td>
<td>1.4</td>
<td>1.4</td>
</tr>
<tr>
<td>4 ICP¹</td>
<td>5.3</td>
<td>2.3</td>
<td>3.0</td>
</tr>
<tr>
<td>5 UCC</td>
<td>1.9</td>
<td>1.2</td>
<td>0.7</td>
</tr>
</tbody>
</table>

1 Based on Outer NWL ICP strategy drafted March 2012. Includes investment spend on initiatives with no out-of-hospital activity implication

2 Could be virtual beds

3 In addition to this, there is additional investment of ~£0.7m which do not expand resources (e.g. referral standardisation)
The major investment that will be made is in employing additional clinicians out of hospital to deliver these initiatives. These may come from the existing out of hospital workforce, if efficiency savings are made elsewhere, from the acute sector or may be additional roles. The types of staff delivering each initiative are set out below:

EXHIBIT 24

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Who’ll do it</th>
<th>What they’ll do</th>
<th>Source: Ealing – DSU Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Rapid Response</td>
<td>- Nurses, healthcare assistants and allied healthcare professionals under consultant leadership</td>
<td>- Support patients stay at home instead of needing to be admitted to hospital</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- A nursing team</td>
<td>- Provide step-up care in a community facility such as Claypools</td>
<td></td>
</tr>
<tr>
<td>2 Case Management</td>
<td>- Nurses and allied health professionals</td>
<td>- Support patients who frequently need hospital to manage their health</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- None (delivered at patients’ homes)</td>
<td></td>
</tr>
<tr>
<td>3 Outpatients in the community</td>
<td>- GPs and consultants</td>
<td>- Provide outpatient appointments in community facilities</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- 180</td>
<td></td>
</tr>
<tr>
<td>4 ICP1</td>
<td>- GPs, consultants, nurses and allied health professionals</td>
<td>- Care planning, case conferences and performance reviews</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- 300</td>
<td></td>
</tr>
<tr>
<td>5 UCC</td>
<td>- Consultants, GPs and nurses</td>
<td>- Provide urgent care for minor illnesses and injuries</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- No additional space</td>
<td></td>
</tr>
</tbody>
</table>

1 Investment in estates is not included in calculation of investment above

These initiatives will take place at people’s home and in primary care facilities. Some initiatives, such as the ICP will take across GP practices. Others, such as outpatients at in the community are will be concentrated in to a smaller number of community facilities. The numbers on the additional workforce are current estimates based will be refined and may change significantly as we produce detailed business plans.
EXHIBIT 25:

We have made an initial forecast of the staff it would require to deliver this

<table>
<thead>
<tr>
<th>Where you will receive care</th>
<th>Services offered</th>
<th>Additional Investment</th>
<th>Additional space</th>
<th>Additional workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td>At Home</td>
<td>Community care</td>
<td>£4.5-5.0m</td>
<td>Access to consulting rooms/team room</td>
<td>75 – 80 WTE</td>
</tr>
<tr>
<td></td>
<td>Elderly care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Admission</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Avoidance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In primary care</td>
<td>nGMS plus extended hours</td>
<td>£4.5-5.5m</td>
<td>&lt;10 consulting rooms</td>
<td>50 – 55 WTE</td>
</tr>
<tr>
<td></td>
<td>Core primary care services</td>
<td></td>
<td>Team rooms</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ECG, possibly ultrasound</td>
<td></td>
<td>&lt;20 beds</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rapid access to various diagnostic tests</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rapid access referral to hub/hospital</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>£9-11m</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 Based on bottom-up calculation of saving initiatives. Each initiative build on granular assumptions: e.g. “Outpatient at lower cost” initiative assumes re-provision cost of 0.8 GP appointment of 12 minutes & 0.2 Consultant appointment of 30 minutes per patient per year for 5% of total outpatient cohort.

2 Assumptions based on pilots outcome of Brent Intermediate Care 2009 and Harrow Unplanned Care Initiatives - 2011, QIPP 11/12 business cases, Healthcare for London, CCG input and expert interviews.

3 Initiatives includes: “At Home” - e.g. Rapid Response (Nursing), Case Management, ICP; “AT a GP Practice” - e.g. Outpatient at lower cost, ICP; “In a community health centre” - e.g. Rapid Response (Bed), Outpatient at lower cost, Outpatient at lower cost (telephone advice), ICP.

SOURCE: NHS NWL Team; Commissioning Service Plan, 1st December 2011, QIPP plans 15th December 2011, QIPP revision, Healthcare for London, HES; CCG input and expert interviews.

The staffing and investment identified in the figure above is indicative based on CCG strategic plans and is dependent on the release of funding from acute providers as activity transfers from acute settings to community settings. Specific investments will be agreed through the normal planning and governance processes of the CCG and as such the production and agreement of robust business cases demonstrating both value for money and affordability to the CCG.

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

These initiatives will deliver the acute savings we need to make to meet rising demand with limited resources. As shown by exhibit 26, if we do nothing, our spending on acute services will go up.
EXHIBIT 26:

**Growth in demand if we do nothing**

<table>
<thead>
<tr>
<th>£ million</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute spend today</td>
<td>283</td>
</tr>
<tr>
<td>Expected growth</td>
<td>21</td>
</tr>
<tr>
<td>Acute spend in 2014/15 if we do nothing</td>
<td>304</td>
</tr>
</tbody>
</table>

- If we do nothing our spend on hospital will go up
- Our future spend on hospital will be bigger than it is today

1 From 2011/12 – 2014/15

**SOURCE:** Ealing CSP

The savings identified in exhibit 23 will come from both preventing demand on hospital going up and reducing the current level of spending, as shown by exhibit 27.

EXHIBIT 27:

**Our plan for making savings by 14/15**

<table>
<thead>
<tr>
<th>£ million</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Do nothing 14/15 acute spend</td>
<td>304</td>
</tr>
<tr>
<td>Investment in out of hospital services</td>
<td>34</td>
</tr>
<tr>
<td>Target gross acute savings</td>
<td>281</td>
</tr>
</tbody>
</table>

- We need to invest in services out of hospital
- £21 million of this saving is from avoiding growth in demand
- £13 million is from reducing current acute spend

**SOURCE:** Ealing CSP

7. **Next steps**

In this strategy we have set out an ambitious vision for transforming out of hospital care in Ealing. We need to move quickly to implementation in order to make early improvements for patients and to make the scale of the savings that are needed by 2014/15. In this section we outline timelines for delivering elements of the strategy.
7.1. Immediate steps

Our immediate steps focus on sharing the strategy with our partners and getting their endorsement, then developing our internal structures to deliver the strategy. Exhibit 28 summarises the immediate next steps we will take:

EXHIBIT 28

<table>
<thead>
<tr>
<th>Crucial step</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 12/13 budget is set in line with strategy</td>
</tr>
<tr>
<td>2 Strategy is endorsed by:</td>
</tr>
<tr>
<td>▪ Health and Wellbeing board</td>
</tr>
<tr>
<td>▪ CCG board</td>
</tr>
<tr>
<td>▪ All practices</td>
</tr>
<tr>
<td>3 Performance framework is agreed by CCG (including metrics, targets, thresholds and escalation process)</td>
</tr>
<tr>
<td>4 Appropriate governance structures in place for managing performance</td>
</tr>
<tr>
<td>5 Capabilities are in place to deliver strategy including</td>
</tr>
<tr>
<td>▪ Management support in CCG</td>
</tr>
<tr>
<td>▪ CSS support</td>
</tr>
<tr>
<td>▪ New workforce required to deliver service</td>
</tr>
</tbody>
</table>

7.2. Implementing our key initiatives

As we have described work has already started on developing business cases for some the initiatives in this strategy. These will include detailing the investment required, how costs will be covered, the impact that will be achieved - qualitative and quantitative - and will include mapping other activities that may overlap.

Each scheme is at a different stage, for example, the extended Intermediate Care Service will be in place from July, community ophthalmology service is already in place and seeing people.

Exhibit 29 sets out the timelines for the schemes we have agreed so far that will be in place during this year. Services start operating during the implementation stage and during the ramp-up stage are having an increasing impact on reducing demand on hospital services. During the steady stage they will continue to have an impact on demands placed on hospital but this impact is no longer increasing.
EXHIBIT 29

<table>
<thead>
<tr>
<th>Initiatives</th>
<th>Non-elective</th>
<th>Out-patient</th>
<th>A&amp;E</th>
<th>Elective</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Planning and design</td>
<td>Implementation</td>
<td>Delivery 47%</td>
<td>Delivery 76%</td>
</tr>
<tr>
<td></td>
<td>Planning and design</td>
<td>Implementation</td>
<td>Delivery 81%</td>
<td>Delivery 92%</td>
</tr>
<tr>
<td></td>
<td>Planning and design</td>
<td>Implementation</td>
<td>Delivery 44%</td>
<td>Delivery 75%</td>
</tr>
<tr>
<td></td>
<td>Planning and design</td>
<td>Implementation</td>
<td>Delivery 34%</td>
<td>Delivery 70%</td>
</tr>
</tbody>
</table>

### Project phasing

<table>
<thead>
<tr>
<th>Initiatives</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
</tr>
<tr>
<td></td>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
</tr>
<tr>
<td></td>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
</tr>
<tr>
<td>Non-elective</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out-patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A&amp;E</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elective</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Cumulative gross savings plan £m

<table>
<thead>
<tr>
<th>Year</th>
<th>12/13</th>
<th>13/14</th>
<th>14/15</th>
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<tbody>
<tr>
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<tr>
<td>Q3</td>
<td>12</td>
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</tr>
<tr>
<td>Q2</td>
<td>12</td>
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</tr>
<tr>
<td>Q1</td>
<td>8</td>
<td>12</td>
<td>16</td>
</tr>
</tbody>
</table>

### Implementation planning and design

- **Elective procedures in community**
  - Delivery 47%
  - Delivery 70%
  - 100% delivery by March 2015

- **UCC**
  - Delivery 44%
  - Delivery 75%
  - 100% delivery by March 2015

- **Redirection to primary care**
  - Delivery 34%
  - Delivery 70%
  - 100% delivery by March 2015

- **Planned care pathway redesign**
  - Delivery 47%
  - Delivery 76%
  - 100% delivery by March 2015

- **Access to specialist opinion**
  - Delivery 47%
  - Delivery 76%
  - 100% delivery by March 2015

- **Reprovision in community**
  - Delivery 47%
  - Delivery 76%
  - 100% delivery by March 2015

- **Referral facilitation and peer review**
  - Delivery 47%
  - Delivery 76%
  - 100% delivery by March 2015

- **Rapid response teams**
  - Delivery 47%
  - Delivery 76%
  - 100% delivery by March 2015

- **Integrated care case management**
  - Delivery 47%
  - Delivery 76%
  - 100% delivery by March 2015

- **Contractual savings**
  - Delivery 47%
  - Delivery 76%
  - 100% delivery by March 2015

- **Minor elective procedures in community**
  - Delivery 47%
  - Delivery 76%
  - 100% delivery by March 2015

**SOURCE:** Commissioning Service Plan, 1st December 2011; QIPP plans 19th December 2011; QIPP revision; NHS DSU CCG finance teams.
DMBC Appendix L4 – Hammersmith and Fulham Out of Hospital Strategy

Foreword from Dr. Tim Spicer, Chairman

This April 2012 marks an important step in the development of clinically-led commissioning in Hammersmith and Fulham. From 1st April we will operate in shadow form leading to full authorisation from April 2013.

We are excited to present our new out of hospital strategy. This strategy is patient-focused and reflects the innovative planning of our Clinical Commissioning Group (CCG). Our priorities align with the NHS Operating Framework and Shaping a Healthier Future programme in North West London.

Top priorities

As a CCG, our priority is the successful implementation of this out of hospital strategy. Implementation will improve our health and social care services, which the residents of Hammersmith and Fulham tell us they want to see. It will also increase value for money.

We are committed to working with our partners to deliver an integrated health and social care system, which enables people to live healthier and more productive lives. This system will shift the emphasis towards providing more care in GP surgeries, people’s homes, local communities, and in children’s centres and schools. It will require us to drive change in our primary and community services, and equip our GP and community providers with the skills, facilities and equipment they require to take on new roles. Creating these changes in the community will enable us use our hospital services more appropriately in future.

Our local residents and clinicians have shaped the development of this strategy. A new system of public engagement will continue to improve the quality and breadth of this exchange in the future.

Solid foundations

Primary care has responded positively to these changes. Through the innovative Practice Plan, GP practices have established themselves into networks so they can work together collaboratively to improve patient care. Networks also meet on a multi-disciplinary basis as multi-disciplinary groups (MDGs) so that GPs and other health professionals can challenge and support each other to improve patient care and treatment.

This is just the beginning and the challenges should not be under-estimated. Transforming frontline services requires us to develop our commissioning skills, redesign services, and work in new partnerships with NHS bodies, the Council, and our neighbouring CCGs.

We have made significant progress already. Local innovations, such as the Practice Plan, which focuses on referring patients to the right place, at the right time, have improved quality in primary care and the productivity of the local NHS economy. Together we can make the NHS deliver even more.

Tim Spicer - Chairman of Hammersmith and Fulham Clinical Commissioning Group
Executive Summary
This strategy sets out how we will deliver better care for our residents, closer to their homes. It focuses on care provided out of hospital and follows the launch of NHS North West London’s (NWL) Shaping a Healthier Future - a programme to improve healthcare for the two million people living in the eight North West London boroughs. This document describes our clearly established vision and strategy for the future. We recognise that delivering these changes will be an ongoing process and our plans will necessarily develop as we begin implementation. Nonetheless, our ambition is clear and we are committed to meeting future challenges with bold plans so that we can continue delivering quality care for Hammersmith & Fulham. We will work closely with our service providers and local partners as we do this.

The case for improving out of hospital services

There are 3 key factors that require us to change how we deliver health care:

1. The needs of our residents are changing. People are living longer and suffering from more chronic and lifestyle diseases, increasing pressure on health and social care services.

2. Under our current model of care, we cannot afford to meet future demand. Hospital is too often the answer. We need better planned and more proactive care delivered out of hospital to provide better outcomes for our patients at lower cost.

3. Delivering this change will require us to transform primary, community and social care. Too often our health and social care services are fragmented and there is variation in both quality and access to care across the borough.

How care will be different for people in future

We have a vision for whole system change in Hammersmith and Fulham. We will shift away from relying on unscheduled care to delivering care in a planned way, which is better for our patients – whether they are adults, children or elderly. This will require us to better involve our patients in their own health care, improve coordination of health and social care, and equip our teams with the information they need to provide joined-up services.

Delivering better care closer to home

We will implement a number of changes to reduce unscheduled care and improve planned care.

Reducing unscheduled care

Our GP practices and providers have been organised into new multi-disciplinary groups (MDGs). We will use a new IT tool to identify patients at highest risk of admission and will proactively care for these patients using 30,000 patient-owned care plans, shared across relevant professionals. We will support our patients in taking greater control over their health and wellbeing.

Each MDG will have a new virtual ward: a multi-disciplinary team of integrated, co-located health, community and social care professionals. New health and social care coordinators (HSCC) will coordinate care across providers so our patients receive integrated and seamless support.

Establishing these wards will require significant change:

- Reorganising our district nursing and community matron service so that we have the right number of people, with the right skills, in the right place, targeting patients with the highest risk of hospital admission.
• Integrating the hospital-at-home service to provide skilled, multi-disciplinary care to prevent unnecessary hospital and long-term care admissions and facilitate safe, early discharge of patients from acute hospital wards.

• Strengthening and up-skilling our reablement team to provide a rapid health and social care response for our patients in their homes. In the future, they will be able to provide additional minor, non-invasive medical care.

• Commissioning a new service from hybrid workers, who have both health and social care qualifications, so that our community teams can access additional support at short notice when they need it.

• Integrating our Practice Networks with the virtual ward to ensure our virtual community teams support GPs in their medical care of the patient.

**Improving planned care**

• Improve remote access to specialist advice and opinion for GPs via phone, email, and video. This will mean GPs do not have to refer patients to hospital for outpatient appointments, which creates delays.

• Enhance three of our community services - musculoskeletal (MSK - for pain management, physiotherapy, rheumatology), dermatology and gynaecology. These will be run by GPs with a special interest and Consultant specialists.

• Improve the quality and reduce the number of referrals made by GPs through peer review and support.

• Review the opportunity to provide more mental health care in primary care. Up to 10% of patients under the care of mental health trusts have low-level needs, which could be met in primary care and coordinated by a GP. This will normalise care and free-up mental health staff to focus on more serious cases.

**Supporting improved health care**

We will focus on six crucial areas to support better care, closer to home and make the changes discussed above a reality:

• **Engagement with patients, carers and users:** We will continue to involve our patients in helping us plan system changes. Our patient engagement network will ensure the representation of patient views in decision-making at all levels. At an individual level, patient-owned care plans will equip people with the information and support they need to promote their own health and wellbeing.

• **People and organisational development:** This whole system change requires us to change the way we work with social care, community and acute professionals. We will launch a multi-disciplinary organisational development programme so we can see the benefits of working together differently.

• **Information tools:** We will invest in IT tools to enable our teams to work together effectively and provide seamless and coordinated patient care. To make this most effective we will have information governance systems in place to allow staff to share information relevant to joint patient care.

• **Estates:** We need more space in the community to deliver services and integrate our multi-disciplinary teams. We are looking at ways to maximize use of the space that
we have in GP practices, community clinics (e.g. White City Collaborative Care Centre) and office buildings.

- Governance and performance management: We have established a new performance management system: the network plan. This plan sets new targets, performance indicators and methods of tracking performance, as well as rewarding good and penalizing poor performance.

Next steps

Delivery of our Out of Hospital Strategy will build upon existing work programmes already underway in Hammersmith and Fulham.

- Continuity of Care Programme: we have been working closely with social care providers, acute hospitals, and community services to begin to further integrate provision of health and social care services within the borough. Some of the initiatives are described later in this strategy. The programme structure will be refreshed to ensure delivery of the Out of Hospital initiatives.

- Network Planning: we have used the second year (2012-13) of the network planning process to support practices in acting collectively to deliver specific elements of the Out of Hospital Strategy. These include, peer referral review, non elective admission avoidance, and care planning.

- Integrated Care Pilot: the cross sector working underpinning the multi-disciplinary groups (MDGs) provides a positive experience on which to build the virtual ward concept described in the strategy.

Each of these programmes will report regularly to the Clinical Commissioning Group Governing Body which will monitor delivery.
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1. The case for improving out of hospital services

There is a clear case for the transformation of our out of hospital care. The health needs of our residents are changing as the population ages and people live longer with more chronic and lifestyle-related disease. These trends are placing unsustainable pressures on our health and social care services and under our current model of care, we will not have the resources available in the future to meet these demands.

Currently, our health system is overly dependent on hospital services and patients end up in hospital when they don’t need to be there. Earlier intervention, better coordinated care, and improved services in the community will improve patient outcomes and value for money. Better care, closer to home is the best way to maintain quality of care in the face of increased demand and limited resources. Exhibit 1 sets out the rationale for transforming out of hospital care.

Exhibit 1:

At present access and quality of care out of hospital are variable. There are clear differences in performance between GP practices across a range of indicators\(^1\). And we know that our patients and health professionals share a number of frustrations with the current system, as documented in exhibit 2 below.

\(^1\) www.apho.org.uk
The next section looks at what the changes in care that we need to make will mean for patients.

2. How care will be different in the future

We have a new vision for whole systems change. We will reform our system from one that predominantly responds to crises (unscheduled care) to one that delivers care in a planned and coordinated way, which is better for our patients. This will require us to support proactive patient involvement in their own health care, improve coordination of health and social care, and build information rich teams to enable informed and integrated care for our patients. It will also require exemplary governance at all levels. Exhibit 3 sets out this new vision:

Exhibit 3

Our ambitious approach is inclusive of all patients. This includes the young, adults or elderly; those with specific long-term conditions, mental health or physical conditions; and infrequent and regular users of the health service. Our approach as outlined in exhibit 3 above is applicable to most services.
The examples given in this document are not exhaustive. They are illustrative of the ways in which we will change services and coordinate health and social care.

2.1. Empowered patients

Taking action to deliver this vision will create positive change for individuals, carers and communities in Hammersmith and Fulham.

We will involve individuals in decisions about their care and support greater self-management so that they can actively participate in promoting their well-being. Patients with long-term conditions and the elderly will agree a care plan with their GP setting out their wishes and how they can play a more active role in their care. Exhibit 4 shows a patient’s experience now and in the future, as a result of these changes. Where appropriate, children will be involved in the discussion about their care plan, which will be agreed between the GP and the child’s parents or guardian.

Exhibit 4

Mr Jenkins a retired art historian with no living relatives, is admitted to hospital following a fall…

<table>
<thead>
<tr>
<th>Services each respond appropriately to the situation they assess......</th>
</tr>
</thead>
<tbody>
<tr>
<td>In hospital, staff notice that he is somewhat confused and disorientated and often forgets conversations</td>
</tr>
<tr>
<td>Mr Jenkins is discharged to his council flat and the deterioration in his cognition goes unnoticed due to his isolation. He struggles with his finances and leaves appliances on</td>
</tr>
<tr>
<td>Mr Jenkins floods his flat as he forgets he has left the taps running. He is placed into respite care whilst the flat is repaired</td>
</tr>
<tr>
<td>Whilst in an unfamiliar environment Mr Jenkins’ cognition deteriorates even further and he is too impaired to move home when his flat is repaired. He is placed in a care home</td>
</tr>
<tr>
<td>Mr Jenkins feels lonely</td>
</tr>
<tr>
<td>Mr Jenkins wants to go back home and isn’t sure where he is</td>
</tr>
<tr>
<td>Mr Jenkins doesn’t understand why they won’t let him go home</td>
</tr>
</tbody>
</table>

In future, Mr Jenkins would have a different experience of integrated care.....

<table>
<thead>
<tr>
<th>In hospital, staff notice that he is somewhat confused and disorientated and often forgets conversations. They refer Mr Jenkins to the Westminster Memory Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr Jenkins is discharged to his council flat. Within a week he is visited by the memory service staff and diagnosed with Alzheimers disease and started on medication to slow his decline. He visits a ‘Mind Gym’ to manage his memory difficulties</td>
</tr>
<tr>
<td>An OT visits him to place environmental memory aids around his home including a timer for when he is running a bath. He is assisted by the dementia Advisor to identify a friend and make a Lasting Power of Attorney</td>
</tr>
<tr>
<td>Mr Jenkins is able to live independently monitored by the memory service. He manages his finances and continues to meet at the memory cafe which has reduced his isolation</td>
</tr>
<tr>
<td>Mr Jenkins understands he needs help and enjoys the visits to the Mind Gym</td>
</tr>
<tr>
<td>Mr Jenkins feels he is a little more in control of his memory problems</td>
</tr>
<tr>
<td>Mr Jenkins has begun to volunteer at the Royal Academy of Art and feels there is a real role for him there</td>
</tr>
</tbody>
</table>

2.2. Better coordination of health and social care

We will improve the coordination of health and social care for patients by working effectively alongside our partners, including the local authority and health and wellbeing boards. New health and social care coordinators (HSCC) will be introduced as a first point of contact for patients discharged from hospital to organise the necessary social and health care support. Social care staff will be trained to carry out some non-invasive health procedures. This will reduce the large and confusing number of different health professionals who visit individuals in their homes.

Exhibit 5 illustrates a patient experience of such integrated care.
2.3. Building intelligence-rich teams

We will reform our systems and processes so that commissioners and providers have quality information on which to base their decisions and ensure individuals receive the best possible care.

We will remove the need for particular tests to be repeated in hospital by making the most recent results accessible to clinicians involved in the patient’s care. Care plans will be accessible to all relevant professionals. Because plans will have been discussed with patients and their carers in advance, patients' wishes will be known and respected. This is especially important for people reaching the end of their lives, their carers and families.

Exhibit 6 provides an example of the care that might be received now, and the care received in the future.
2.4. Unscheduled to planned care

The plans and initiatives we are putting in place aim to make a fundamental shift from unscheduled to planned care. Teams will work together and with patients and their families to manage care in a planned, proactive way. This will involve agreeing and regularly updating care plans with patients who would benefit from their use.

GPs will use the care plan to work with patients at high risk of hospital admission to arrange health and social care support to prevent crises. In this way, patients will receive timely care to keep them well. Better coordination and planning of patient care—tailored to meet individual needs, will remove gaps between services. Patients will no longer need to repeat their stories with different providers. Exhibit 7 shows a patient experience now and how it will improve in the future.

Exhibit 7

<table>
<thead>
<tr>
<th>Services each respond appropriately to the situation they assess...</th>
<th>A social worker, a community nurse &amp; an occupational therapist (OT) &amp; physio visit Mr Dobson at home to do assessments, following his last hospital admission.</th>
<th>Now a homecare worker comes everyday to help with household tasks, the district nurse visits to monitor his condition &amp; medication adherence, a physio assistant takes him through the exercise regime.</th>
<th>Mr Dobson is out when the district nurse visits. This means he misses his medication.</th>
<th>Lack of medication means Mr. Dobson suffers from nausea and is readmitted to hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr Dobson cannot remember what all these people wanted him to do.</td>
<td>Mr Dobson likes all the visits but is confused who is visiting for what reason.</td>
<td>It is a sunny day so Mr Dobson feels able to go out.</td>
<td>Later that day Mr. Dobson feels poorly, he overdid it going out</td>
<td></td>
</tr>
</tbody>
</table>

In future, Mr. Dobson is identified by a risk stratification process as having a high likelihood of being admitted to hospital in the coming year. His GP therefore invites him to the surgery to discuss his health and goals...

| Mr. Dobson says that continuing to visit his grandchildren in a nearby town and getting to church on Sundays as two things which are very important to him. The information about his needs and goals are captured in a care plan which Mr. Dobson and his daughter are given a copy of. | With input from other members of the multi-disciplinary group, the GP is able to complete a comprehensive assessment of Mr. Dobson’s health and social care needs, including simplifying his medication regime to reduce the interactions which make him nauseous. | A ‘hybrid’ health and social care worker, Jane, visits Mr. Dobson for a few months to provide practical assistance with household tasks, takes Mr. Dobson through the physio’s exercise programme, and helps Mr. Dobson to monitor his vitals signs and adjust his medication accordingly. | My Dobson’s daughter visits him regularly to check his medication and Mr. Dobson works hard at his medication compliance and physiotherapy so he is well enough to maintain his visits to his grandchildren. |
| Mr. Dobson was a bit surprised to be asked to visit his GP | Mr. Dobson is pleased not to have to take so many tablets | Mr. Dobson has got to know Jane who visits regularly | Mr. Dobson understands that taking his tablets means he is well enough to visit his grandchildren |

Mr Dobson, age 74, has both heart and breathing problems. He’s been prescribed eight different medications by his GP and hospital specialists, although he sometimes misses doses because taking all the meds as prescribed gives him nausea. He has had several admissions to hospital recently.
2.5. Ensuring exemplary governance to maintain high clinical standards

In Hammersmith and Fulham CCG, we have sound clinical, information, financial and research governance processes in place to ensure quality and safety, and to manage risk. In the future, the doctors and nurses in the CCG will ensure a constant process of evaluation and review of outcomes. Patients can be reassured that each stage of their care is clinically appropriate and that the quality and safety of systems and services routinely evaluated. Patients and the public need to be confident that as we change where and how patients are cared for, and through these governance structures we will hold ourselves to high clinical standards of care in the community.

We have agreed standards that set our aspirations for the future. They emphasise the central role of the GP in the coordination and delivery of out of hospital care. The standards encompass both core primary care delivered by GP practices and, more broadly, care delivered outside of hospital. They aim to shift care delivery from more reactive unplanned care to proactive planned care.

Exhibit 8 below outlines how we will hold ourselves to high clinical standards of care in the community as we maintain more of our patients outside of the hospital.

Exhibit 8

<table>
<thead>
<tr>
<th>Domains</th>
<th>The standards are covered in four key domains</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Empowerment &amp; Self Care</td>
<td>• Individuals will be provided with up-to-date, evidence-based and accessible information to support them in taking personal responsibility when making decisions about their own health, care and wellbeing</td>
</tr>
<tr>
<td>Access convenience and responsiveness</td>
<td>• Out of hospital care operates as a seven day a week service. Community health and care services will be accessible, understandable, effective and tailored to meet local needs. Service access arrangements will include face to face, telephone, email, SMS texting and video consultation.</td>
</tr>
<tr>
<td>Care planning and multi-disciplinary care delivery</td>
<td>• Individuals using community health and care will experience coordinated, seamless and integrated services using evidence based care pathways, case management and personalised care planning. Effective care planning and preventative care will anticipate and avoid deterioration of conditions.</td>
</tr>
<tr>
<td>Information and communications</td>
<td>• With an individual’s consent, relevant parts of their health and social care record will be shared between care providers. Monitoring will identify any changing needs so that care plans can be reviewed and updated by agreement. By 2015, all patients will have online access to their health records.</td>
</tr>
</tbody>
</table>

Source: NWL Clinical Board and Programme Board
3. Delivering better care, closer to home
This section describes the new services that we will introduce in the community. We will introduce new models of care to make a fundamental shift from care that is unscheduled to planned care. The new services will mean that we need to make changes to the way we are organised and changes to how we work.
This section is organised into three parts:
3.1. Shifting from unscheduled care
3.2. Improving planned care
3.3. Improving mental health services

3.1. Shifting from unscheduled care
The following sections set out the new ways of working and service changes that we will introduce to shift more care from being unscheduled to planned. This involves identifying and targeting those people at highest risk of admission to hospital and ensuring we put in place multi-disciplinary teams to care for them.

3.1.1. Identifying individuals at greatest risk of admission
Our multi-disciplinary teams will focus on providing care to individuals who are at greatest risk of unscheduled admission to hospital. Using a new IT tool, we have categorised our patients by their risk of admission to hospital. We now know which of our patients are in the greatest need of our help, and can target our resources – doctors, nurses, social workers, appropriately towards those in greatest need.

In addition, these risk scores have been collated by multi-disciplinary group so that we can plan and tailor services to the needs of patients at a local level.
Exhibit 9 outlines the risk stratification process.

Exhibit 9

Our new IT tool categorizes each of our patients by risk of admission

We then collate these scores by each of our MDGs

Key insight: The reason this is important is because we know which of our patients are in the greatest need of our help, and can therefore target our resources – doctors, nurses, social workers, towards those who need us most...

Key insight: Understanding the collective level of risk of our patients by MDG is important because it enables us to better plan and tailor services provided to our patients at the local level.

Exhibit 10 shows the distribution of our highest risk patients across the borough. It demonstrates why we need to organise our services locally to cater for the needs of our patients. This is why we have organised into four networks of multi-disciplinary groups.
Knowing who is at highest risk and where they live has enabled us to organise and coordinate care around them. 

**Insight:** this map shows the density of high risk patients across H and F. Our high risk patients are spread across the borough. We need to organise our services locally to cater for the needs of our patients. This is why we organised into four MDGs of providers.

### 3.1.2. Care planning

We will put in place care plans for up to 30,000 people across at risk of admission to hospital, as identified across the five networks.

We will ensure our patients at highest risk have one comprehensive assessment, contributed to and shared across a multi-disciplinary team of providers including health, social care and mental health professionals. On the basis of this assessment, each patient will create a personalised and integrated care plan in partnership with their GP or Practice Nurse. A care plan is an agreement between the patient and an appropriate health professional (e.g. GP or nurse) to help patients manage their health and social needs on a day-to-day basis.

The plan will cover a set of defined areas, including goals the patient wants to work towards (e.g. return to work); the support services the patient needs; named individuals responsible for providing these services; emergency numbers – whom a patient should contact if they are unwell and their doctors surgery is closed; and medicines, diet and exercise plans. Each patient will have a single, comprehensive care plan that they own. It will be shared across a multi-disciplinary team of professionals to ensure that patients receive coordinated, quality care from a range of different providers across settings. The plan will be reviewed at fixed points in time (at least once a year) so that it is kept up to date.

We will also develop a form of care plan called a ‘transition plan’ when our patients are discharged from hospital. Transition plans will help manage a patient’s recovery back to health and their normal daily lives. They will ensure a smooth transition between places and phases of care so that our patients receive seamless service across health and social care providers.

We will also develop end of life care plans with our patients who are approaching the end of their lives. This will be supported by a new IT tool - “Coordinate My Care”, which records patient preferences for end of life care so that in their final days they are cared for and supported as they had wanted.
3.1.3. A new role for patients

Embedding these changes will require a change in role for our patients. We will provide individuals with more information and support to enable them to take greater responsibility for promoting their own health and wellbeing. We will:

- Equip patients, carers and their families with the information they need to self-manage their care and implement their care plans;
- In the case of children, this will mean working very carefully with their parents or carers to ensure they are able to manage care on their behalf.
- For some patients nearing the end of their life, the care plan needs to take account of their and their family’s wishes. Particular attention needs to be paid to support carers so that an unwanted hospital admission does not happen by default if there is not sufficient timely, appropriate support.
- Connect patients to expert patient programmes and relevant voluntary sector organisations so that they learn how to self-manage their conditions, receive the support they need, and take better control over their health e.g. Dementia UK, Macmillan Support Package.

We will also work with patients, carers and their families to effectively implement their care plans. Patients will own their own plans and we will ensure that they understand them and know what they have to do to implement them day-to-day. Involving carers and family members in these plans will enable those close to the patient can better support their implementation.

3.1.4. Creating virtual wards

Having identified patients at highest risk of admission to hospital or those in need of additional assistance after hospital admission, we need to ensure we have a system in place to care for them in the community.

We will create 'virtual wards' in the community, comprised of integrated and co-located health, community and social care teams. The virtual ward will connect GP practices, occupational therapists, hybrid workers, intermediate care and community nursing teams. They will build upon the multi-disciplinary teams that already meet and work together in Hammersmith and Fulham.

Clinical Leadership to virtual wards

GPs will provide clinical leadership to the virtual ward. GPs are in a unique position to agree on the care package a patient requires via the patient’s care plan.

The success of the virtual ward is dependent on prompt access to medical input and advice to prevent hospital admission or facilitate early supported discharge of patients from hospital. On discharge, the critical step is the transfer of medical responsibility from the hospital doctor to a GP supported by the virtual ward team.

At the moment, each practice operates an on-call doctor during practice hours. Practices have discussed cross-practice provision and seeking an IT solution to enable access to patient notes between practices.

One of our MDGs is piloting telephone access from the A&E doctor to the practice GP. We will learn from these experiences to ensure timely medical cover and advice. An interface with the patient’s own GP is crucial. It will ensure patients have access to the required
diagnostic services and prescribed medication; and if necessary, a home visit to avoid admission.

Exhibit 11 below illustrates the component services of the virtual wards. The virtual ward will operate in the community but each will have a ‘management centre’ where details about each patient under care are available and decisions can be made collectively to deploy appropriate care effectively.

Each virtual ward will include a number of Health and Social Care Coordinators (HSCC) who will have a pivotal function. Exhibit 11 outlines the roles of the HSCCs. They include: acting as a single point of contact for patients discharged from hospital and supporting GPs and community staff to prevent the readmission of their patients to hospital.

Exhibit 11

Multidisciplinary working in the virtual wards will be facilitated by access to the patient’s care plan and the case conferencing method of working established by the multi-disciplinary groups (MDGs) to provide specialist advice, including social care, mental health and acute medicine.

Together, virtual wards and the new HSCCs will ensure that when the need for unscheduled care does arise, patients receive timely, well coordinated and seamless care from the relevant health and social care services, working together. This way patients can be cared for effectively in the community and there is reduced risk of admission to hospital.

3.1.5. Organising as multi-disciplinary groups (MDGs)

Building our virtual wards will be made easier by the fact that our GP practices already have a history of working together. GP practices work together in networks of practices to deliver improvements in patient care. These networks also meet on a multi-disciplinary basis so that GPs and other health and social care professionals can challenge and support each other about patient care and treatment. The virtual wards will build on this multi-disciplinary approach.

The 31 individual GP practices in H&F will remain responsible for discharging clinical accountability through their coordination of all aspects of patient care (including inpatients). We will configure the virtual wards as shown in exhibit 12.
They will be responsible for the following: (1) proactively managing patients with long-term conditions at risk of unscheduled admission through coordinated health, social and community teams in the virtual wards; (2) delivering care beyond the practice level, for example diagnostics, GP extended hours, community services and minor surgery; and (3) resolving issues that arise in relation to local delivery.

### Exhibit 12

<table>
<thead>
<tr>
<th>Level</th>
<th>Key roles</th>
</tr>
</thead>
<tbody>
<tr>
<td>H and F CCG-wide</td>
<td>No specific role</td>
</tr>
<tr>
<td>4 MDGs</td>
<td>Proactively manage patients with LTC at risk of unscheduled admission through coordinated health, social, and community teams. Deliver care beyond practice level, e.g., diagnostics, extended hours, community services, and minor surgery. Resolve local delivery issues.</td>
</tr>
<tr>
<td>31 individual practices</td>
<td>Understand relationship between resource allocation and individual benefit. Discharge clinical accountability by coordinating all aspects of patient care (including inpatients).</td>
</tr>
</tbody>
</table>

### 3.1.6. Remodelling our services

In order to establish virtual wards, Hammersmith and Fulham will fundamentally remodel our services and how we work together.

**Remodelling district nursing and community matron services**

Community nurses offer an integrated managed care service, providing early pro-active monitoring and support for patients in their homes. We have 90 community nurses and 15 different community nursing teams, scattered across the borough.

We are realigning the nursing teams so that they better match the needs of our patients within each MDG. As shown in exhibit 11, we identified the patients within each MDG at greatest risk of admission to hospital. We then mapped these patients by risk score onto our current nursing case-loads and contacts. We found that many of our patients at highest risk were not on the case-loads of our nursing team. This means that we are not seeing the right patients.

Using this information we worked out the number of patients in each MDG requiring community nursing care, and corresponding nursing capacity required by MDG to meet this demand. On this basis, we are reorganising our nursing teams - realigning them and adjusting their capacity and skills mix to meet the needs of each MDG. As patients' needs change, we will fine tune capacity to meet changes in demand. In the future, our teams will have the capacity and skills to care for our highest risk patients across the borough. It will mean that patients receive timely, proactive care in their own homes, with the support they require to keep themselves healthy.
Remodelling a hospital-at-home service

We have established a community hospital-at-home service to provide skilled, multidisciplinary care and prevent unnecessary hospital admissions and admissions into long-term care. The service also facilitates safe early discharge of patients from acute hospital wards. The team is composed of 6 specialist nurses and 4 therapists, responsible for maintaining and caring for more complex patients in their own homes. The service is for patients who would benefit from a short-term crisis intervention in a community setting.

This service is accessible via a single point of contact. Staff will undertake a full assessment of patient needs within two hours, and working with the patient will draw up a care plan responsive to their needs. Each patient will have a single case manager to coordinate their health and social care as part of the virtual ward team. In the future, the patient can receive a package of care 24 hours a day, 7 days a week. The case manager will monitor the patient’s progress throughout the intervention, and make referrals to appropriate health and social care agencies.

Strengthening the reablement team

We currently have a team of 30 reablement officers, coordinators, occupational therapists and admin staff. This team works with our hospital-at-home team to provide an integrated rapid health and social care response for our patients. Among other tasks, the team promotes social and personal self-help skills, treats movement and mobility disorders, supports self-management and end of life care, provides pain relief; and provides practical support and personal care.

We plan to upgrade the skills of our 17 reablement officers to carry out non-invasive medical procedures (for example, applying pressure bandages). The Hospital at Home nurses and therapists will be able to undertake social care assessments. These skill changes will increase the efficiency of the reablement and hospital at home teams. They will be able to support one another’s activities and can free-up time for the hospital at home nurses to focus on more complex tasks. This will mean faster support for our patients and a reduction in the vast number of visits patients receive from different care professionals.
Establishing a new hybrid worker scheme

Hybrid workers are a new role introduced by Hammersmith and Fulham. Hybrid workers have both health and social care qualifications. They can provide social inclusion support; practical support and personal care; help manage people with long-term conditions and end-of-life care; and conduct non-invasive medical procedures.

This commissioned service will provide additional support to our virtual wards. In the first year, teams will be able to draw on the equivalent of five hybrid workers when required. In the future, this service will include night care for patients. Hybrid workers will improve patient care by providing flexible, integrated health and social care support in people’s homes at short notice to prevent unnecessary admissions.

3.2. Improving planned care

3.2.1. Improving access to specialist advice

We will ensure that GPs across our five networks have access to specialist consultant advice in new ways. This will be better for patients. They will have fewer outpatient appointments, and receive better quality care closer to home from their local GP in their local GP surgery, and faster diagnosis and treatment.

At present, when specialist advice is required from a consultant, GPs refer their patients to hospital for an outpatient appointment. This can take up to six weeks with further delay when patients return to their GP for results.

In many cases, specialist advice is accessible by other means, avoiding the need for the patient to attend hospital. We have piloted email and telephone-based systems, and have considered video of a patient's condition (e.g. for dermatology). We will identify those specialties and conditions for which these models are appropriate, and make arrangements with our local hospitals to commission consultants' time for remote consultations. We will ensure consultant work plans are amended to set aside time for consultations.

3.2.2. New services in the community

Some conditions require an outpatient appointment which might best be provided by a consultant led community service, a GP with special interest or by a specialist nurse or other community professional.

We will review the opportunity in planned care for services which might be best provided by increasing the skills of clinicians in primary care e.g. gynaecology. If it is appropriate, we will expand the dermatology community service to make it more accessible and convenient services for patients in the North of the borough. We will review and ensure most effective use of current community based services (e.g. musculoskeletal - for physiotherapy and pain management). Increasing referrals to these services, where clinically appropriate, will reduce outpatient referrals and care for patients closer to home.

3.2.3. Improve the quality of referrals by GPs

At present there is considerable variation in GP referral patterns across our practices and networks. By benchmarking referrals by weighted population, we have identified practices that are over-referring compared to their peers. We will seek to understand the reason for these variations. Peer review of referrals before they are made reduces unnecessary hospital appointments and improves the quality of care provided to patients. We will introduce a new referral peer-review system to support GP decision-making. The scheme will not only reduce referrals to secondary care but also improve their quality.

The peer-review system for referrals will include ongoing training and support; peer review and demonstration of best practice; and a performance dashboard. The dashboard will provide GP practices and their networks with up-to-date information to track performance.
against targets. Peer review and support will be provided by network Clinical Leads and Network Chairs. Incentive payments will reward networks for meeting targets and will help fund training and regular peer review.

For patients, the scheme will improve the quality of referrals from primary care, increase access to services closer to home, and reduce unnecessary hospital appointments.

3.3. Improved mental health services

Our vision of a shift from unscheduled to planned care is applicable to mental as well as physical health services. We will conduct an options appraisal three ways in which we could improve our mental health services and pilot them accordingly.

3.3.1. Establish a psychiatric liaison service

We will establish a multi-disciplinary psychiatric liaison service as outlined in exhibit 14. The team will support improved mental health care in acute hospitals, and improved risk management. A key role of the team will be to train acute staff members in mental health care. Benefits include: fewer admissions, reduced length of stay, and lower accommodation costs for local authorities (with more patients discharged directly home).

Exhibit 14

<table>
<thead>
<tr>
<th>What is it?</th>
</tr>
</thead>
<tbody>
<tr>
<td>The ‘Optimal Standard’ is a high quality liaison psychiatry service designed to operate in acute general hospitals in NWL, providing the following services:</td>
</tr>
<tr>
<td>Care for patients with significant mental health needs (outside specialist MH units)</td>
</tr>
<tr>
<td>Training for other hospital staff to enable them to support patients' mental health needs</td>
</tr>
<tr>
<td>Integration with other parts of the health system e.g., GPs, specialist mental health teams</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Who delivers the service?</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 Consultant Psychiatrists</td>
</tr>
<tr>
<td>1 Team Manager</td>
</tr>
<tr>
<td>12 Team Nurses (Bands 6 and 7)</td>
</tr>
<tr>
<td>1 Alcohol Nurse</td>
</tr>
<tr>
<td>2 Specialist Registrars</td>
</tr>
<tr>
<td>1 Generic Therapist</td>
</tr>
<tr>
<td>1 Occupational Therapist</td>
</tr>
<tr>
<td>1 Social Worker</td>
</tr>
<tr>
<td>1 Administrative support</td>
</tr>
<tr>
<td>1 Research/Business Support Officer</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What does the service look like?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highly visible multi-disciplinary mental health team fully integrated into the hospital</td>
</tr>
<tr>
<td>Single point of contact for all patients (16+) in hospital with diagnosed or suspected mental health conditions of any severity</td>
</tr>
<tr>
<td>Rapid response for patients requiring mental health support and 24/7 support in A&amp;E and wards</td>
</tr>
<tr>
<td>Training experts on mental health problems and related issues for non-mental health clinicians</td>
</tr>
<tr>
<td>Coordination with out-of-hospital care providers and housing services</td>
</tr>
<tr>
<td>Integrated with broader health and social care system</td>
</tr>
<tr>
<td>Single management structure</td>
</tr>
</tbody>
</table>

3.3.2. Shifting mental health patients to less intensive model of care

We will consider increasing the responsibility of GPs for patients with non-complex mental health needs by adopting an agreed pathway for the transfer of responsibility for care from community mental health teams to GP practices.

This would include: setting criteria for the transfer of responsibility; holding a case review to confirm criteria have been met; and joint work between the community mental health team, the GP and the patient to develop a care plan. Primary care would also have ongoing support from a “primary care plus system” as outlined in Exhibit 15.

Exhibit 15

3.3.3. Integrate consideration of mental health co-morbidities in ICP

People with physical long-term health needs (e.g. diabetes) are also more likely to have mental health problems. Care for such patients can be between 45 – 75% more expensive than for patients with just physical ailments. It is therefore important that the integrated care pilot (ICP) is extended to include a patient’s mental health needs. For patients, this will include mental health screening as part of annual reviews, and specifically tailored psychological therapy sessions where necessary. Exhibit 16 outlines how mental health could be integrated at each stage of the care process.

In this section, we have set out the new services and initiatives we will implement to ensure high quality care is delivered out of hospital. We have also described the new ways of working requires to support these changes. The next section examines the enablers we have identified to support the new services and ways of working.

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2 Long-term conditions and mental health: the cost of co-morbidities,” Chris Naylor et al., February 2012, King’s Fund and Centre for Mental Health.
4. Supporting improved out of hospital care

As set out in exhibit 17, we have identified five crucial areas that will support the change for better care, closer to home. The following sections our plans around each of these enablers.

Exhibit 17

<table>
<thead>
<tr>
<th>We must consider ...</th>
<th>Recommended solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Engage patients, carers and users</strong></td>
<td>• Commitment to principle of shared decision-making with patients and public</td>
</tr>
<tr>
<td></td>
<td>• Clear structure in place to promote systematic and meaningful engagement</td>
</tr>
<tr>
<td><strong>People and organisational development</strong></td>
<td>• We have undertaken an organisational development process with CCG Board members to ensure we have a CCG fit for purpose.</td>
</tr>
<tr>
<td></td>
<td>• The next phase is to undertake a series of organisational development sessions with our networks to develop their collective provider capacity.</td>
</tr>
<tr>
<td><strong>Have the information tools required</strong></td>
<td>• We are committed to develop a number of IT solutions that will provide our networks with the information they require to monitor their performance, and to enable our providers to share patient data online, in real-time with all appropriate health and social care professionals</td>
</tr>
<tr>
<td><strong>Estates</strong></td>
<td>• Our out of hospital strategy will result in more activity in the community, as well as the need for more office space for the co-location of our virtual teams</td>
</tr>
<tr>
<td></td>
<td>• We will explore space opportunities in GP practices, in new community clinics (e.g., White City) and office space in four central network locations (e.g. Parsons Green, White City)</td>
</tr>
<tr>
<td><strong>Governance and Performance Management</strong></td>
<td>• Our MDG networks will develop network plans to drive performance in primary care.</td>
</tr>
<tr>
<td></td>
<td>• We are developing clear systems and tools, including review meetings and performance dashboards, to monitor and improve performance across our networks.</td>
</tr>
</tbody>
</table>
|                                               | • Each network will have three leadership positions – a Chair, Coordinator and Clinical Lead, who will report to the CCG Board.
4.1. Engage with patients, clients and their carers

We are committed to the principle of shared decision-making with patients and the public. This means having a clear structure in place to promote systematic and meaningful engagement. Our aim is to be a patient advocate and trusted partner in individual health and healthcare decision-making. This involves engaging a population that is interested in their health, empowered to make healthier choices, has voice in the design of local health services, and uses services appropriately.

Some of this is business as usual for our CCG shadow Board. We have patient representatives who help us to share our plans and work with the public and those groups most affected. We have taken advantage of publicity conducted to promote healthy lifestyles and support ‘prevention of ill health’ initiatives.

We are producing a CCG communications and engagement strategy, which will incorporate the key elements of our Out of Hospital work. We plan to update our community regularly in three ways:

- **News bulletins**: we will produce a quarterly electronic bulletin aimed at patients, public and other stakeholders. This will be the primary mechanism by which the CCG will cascade information and messages.

- **Urgent news bulletin**: When we need to communicate urgently with patients, public and other stakeholders we will issue special updates urgently.

- **Website**: We will develop a website to market our business to public and stakeholders.

Additionally, Exhibit 18 shows we will represent patient views in decision making at the network level.

Exhibit 18:
4.2. People and organisational development

Our strategy is comprehensive and ambitious. It will not be deliverable unless we change how we work across each part of the health and social care system. This level of change requires individual organisations to encourage and achieve change within each of their teams as well as to support change in areas of collective working. To succeed in providing integrated care all parts of the system must achieve the level of change needed.

We start from a strong base. There is a collective recognition of the need to change how we work across social care, community and acute providers in Hammersmith and Fulham. Exhibit 19 outlines the areas where change is required across the system.

Exhibit 19

<table>
<thead>
<tr>
<th>Key interventions</th>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Leadership and management</strong></td>
<td>▪ A range of formal and informal leaders and champions emerge across organisations</td>
</tr>
<tr>
<td>▪ Training sessions on the following:</td>
<td>▪ Key learning from the training sessions became part of day-to-day work (e.g. developmental feedback)</td>
</tr>
<tr>
<td>▪ Managing and communicating change</td>
<td>▪ Increasing awareness of the need to continue to develop leaders</td>
</tr>
<tr>
<td>▪ Effective problem solving</td>
<td></td>
</tr>
<tr>
<td>▪ Coaching, feedback &amp; time management</td>
<td></td>
</tr>
<tr>
<td>▪ Functional knowledge areas</td>
<td></td>
</tr>
<tr>
<td>▪ Running effective meetings</td>
<td></td>
</tr>
<tr>
<td><strong>Culture and teamwork</strong></td>
<td>▪ Clinicians value the support offered by working across organisational boundaries</td>
</tr>
<tr>
<td>▪ Myres-Briggs inventory workshops</td>
<td>▪ Networks are excited to be working together and beginning to understand their cultural makeup</td>
</tr>
<tr>
<td>▪ Workshops on teamwork, trust and interdependence</td>
<td></td>
</tr>
<tr>
<td>▪ Practice interviews and survey</td>
<td></td>
</tr>
<tr>
<td>▪ Run skills-building session for clinical leaders on how they can engage most effectively</td>
<td></td>
</tr>
<tr>
<td>▪ Run ‘hard to have’ conversation training for End of Life Care patients</td>
<td></td>
</tr>
<tr>
<td><strong>Patient engagement</strong></td>
<td>▪ Engage media management skills to effectively communicate with external parties</td>
</tr>
<tr>
<td>▪ Workshops and organisation specific problem-solving sessions on:</td>
<td>▪ Equip all clinicians to build on feedback from patients</td>
</tr>
<tr>
<td>▪ Roles and responsibilities, decision making, and organisation structure</td>
<td>▪ Engage social marketing skills to engage diverse communities in planning</td>
</tr>
<tr>
<td>▪ Resource sharing</td>
<td></td>
</tr>
<tr>
<td>▪ Performance management</td>
<td></td>
</tr>
<tr>
<td>▪ Clinical accountability</td>
<td></td>
</tr>
<tr>
<td><strong>Clinical Governance</strong></td>
<td>▪ Clinicians are clear about clinical accountability so this is not a barrier to integrated working.</td>
</tr>
<tr>
<td>▪ Workshops and organisation specific problem-solving sessions on:</td>
<td>▪ Board structures and decision rights are beginning to formalise</td>
</tr>
<tr>
<td>▪ Roles and responsibilities, decision making, and organisation structure</td>
<td></td>
</tr>
<tr>
<td>▪ Resource sharing</td>
<td></td>
</tr>
<tr>
<td>▪ Performance management</td>
<td></td>
</tr>
<tr>
<td>▪ Clinical accountability</td>
<td></td>
</tr>
<tr>
<td><strong>Clinical Quality</strong></td>
<td>▪ Ensure all elements of the system are providing service to the optimal quality to ensure continuity of quality of care</td>
</tr>
<tr>
<td>▪ Run internal workshops to optimise service clinical quality</td>
<td></td>
</tr>
</tbody>
</table>
We have undertaken a series of organisational development workshops with leaders of social care, acute, community, and primary care to establish our strategy.

Our next step is to undertake an organisational development process with CCG Board members to ensure we have a CCG fit for purpose. The next phase will involve a series of organisational development sessions with our networks to develop their collective provider capacity.

The behaviours we are seeking to change are outlined in exhibit 20.

### Exhibit 20

<table>
<thead>
<tr>
<th>From...</th>
<th>To...</th>
</tr>
</thead>
<tbody>
<tr>
<td>✗ We don’t often refer between GPs due to strong patient links and potential contractual issues</td>
<td>✓ We collaborate across the network, referring patients to each other if appropriate</td>
</tr>
<tr>
<td>✗ We don’t want to talk about performance, or have challenging conversations</td>
<td>✓ We hold each other to account around differences in outcomes, including celebrating success</td>
</tr>
<tr>
<td>✗ We have seen all this change before – it will not stick and we will be bailed out</td>
<td>✓ We need to do something different, now, to deliver better care for our patients in the right setting</td>
</tr>
<tr>
<td>✗ It’s a system-wide problem, not mine</td>
<td>✓ It’s up to me and my contribution to the system working together to deliver good patient outcomes</td>
</tr>
</tbody>
</table>

Once we have established a core of clinical champions within our networks we will begin the organisational development process summarised in exhibit 21 above.

The Health and Wellbeing Board has expressed a keen interest in monitoring the cross organisational working required to deliver these changes and we will work closely with them as we implement our strategy.

### 4.3. Information tools

Information technology is critical to the integration and coordination of patient care - one of the fundamental building blocks of this strategy. We are committed to developing IT solutions that enable our providers to share patient data online, in real-time, with all appropriate health and social care professionals.

Fragmented IT systems affect the quality of patient care and create difficulties for providers. At present, information about patient needs is often collected manually, rather than electronically, which restricts sharing of information between providers. As a result, patient care is fragmented, transfers between settings and sectors of care - for example discharge from hospital - are often poorly managed, and patients are frustrated as they are repeatedly asked for the same information from different parts of the health and social care systems. We will tackle this problem in four main areas:

#### 4.3.1. Common patient information systems

It is our strategic intent that all partners in the health and social care community would ideally use the same patient information systems which would truly enable us to provide a continuity of coordinated care.
Early discussions have centered on the experience in adjacent boroughs, of all GPs adopting the same patient information system which is compatible with acute hospital and social care systems. We are also supporting the development of a technical ‘interoperability’ solution as a stepping stone to full integration. Other software packages are being investigated which would provide common management of individual care packages. The strategic aim is to improve communication and co-ordination of care and support to people at home – which is a vital component of any system where we are reliant on a more rapid and flexible response in the community, rather than the default position of admitting people to hospital.

4.3.2. Shared care planning

We will support the development of the next phase of the ICP care planning tool, intended to be a universal shared care plan. This solution enables GPs and other social care and health professionals to input to a care plan on their own system. Agreed sections of that data are then extracted and presented in a composite care plan made available to any health or social care professional involved in that patient's care. The underlying data warehouse enables monitoring of care planning activity to support the lead clinician in ensuring care is provided and recorded for the patient.

4.3.3. GP information pack

A GP information pack is currently provided as a monthly pack of data for practices. This system will be enhanced by the Commissioning Support Service to provide practices with the data they need to identify trends in care and monitor performance.

4.3.4. Virtual Ward monitoring systems

Staff in the virtual ward will require information systems, which quickly display the patients they are responsible for in the virtual community ward. We will develop IT systems based on ward monitoring systems in hospitals to manage packages of care for patients in the community and in real time provide data about patients admitted to hospital and their progress towards discharge.

4.3.5. Integrated telecommunications

Hammersmith and Fulham is a pilot for the national 111 telephone service. Locally this means calls from 111 will be routed without redialling to local GP practices or community services. This will require direct access to the virtual ward (HSCC) and for both the ward and the 111 call handler to have immediate access to a patient’s care plan. We will establish systems to enable this level of communication and real time access to databases. Exhibit 21 shows the specific information and tools that the new IT systems will provide, including tools for risk stratification, care planning and discharge.

Exhibit 21
4.4. Estates

Our plans to establish integrated teams (including hospital at home, reablement, community nursing, hybrid workers), create 'virtual wards' and move some outpatient advice and consultations to the community means we will need more space in the community. We need space to deliver care, as well as additional office space and meeting rooms to enable our integrated teams and providers to work together effectively. Wherever possible to will maximize use of existing space and facilities to do this.

Basing these activities in the community has the following advantages:

- Care will be closer to patients;
- It provides an integrated setting for care delivered by specialists, GPs and other health professionals;
- Co-locating health and social care teams facilitates integration of care e.g. by providing easy access to other providers to agree on the most appropriate care packages and support for patients;
- It provides a base for consultants when they work in the community and for mobile community providers
- It allows local access to advanced diagnostic equipment
- It provides specialist care in a selection of clinical areas

We are doing more work to determine where this activity could be located in the community. We are exploring three options – GP practices, community clinics and office spaces for our virtual wards, as set out in exhibit 22 below.

Exhibit 22

As we develop more community based services for both unscheduled and planned care there will be opportunity to reconsider the services provided from our hospitals. Where the full range of services to be found at a major hospital is not required then a ‘hub plus’ configuration, developed for example around the Charing Cross site, might provide:

- Urgent Care Pathways such as a 24/7 urgent care centre, out of hours services, rapid response and reablement services and community beds
- Specialist pathways / services commissioned on behalf of all MDGs
- Planned care pathways to include specialist diagnostics, low volume high specialism consultant care and outpatient services
4.5. Performance management and governance

4.5.1. Performance management

We will put in place a new system of performance management and governance based on five practice networks. Each network will develop a network plan to drive performance in primary care and we will develop clear systems and tools to monitor and improve performance across them.

Our performance management scheme will have five stages as set out in exhibit 23:

Exhibit 23
Our network scheme follows these steps:

1. Establish network plans
   - Each network will develop an annual network plan – either routine or enhanced plans
   - Plans should outline how networks plan to deliver change against 3 core objectives

2. Establish clear targets and indicators to measure progress
   - Key performance indicators selected, including referrals to OP, NEL admissions for LTC
   - Holistic, balanced scorecard across all aspects of performance e.g., quality, access
   - Set targets and thresholds by network and practice to define different levels of performance

3. Track performance effectively
   - Transparent monitoring process to track performance against stated goals
   - Performance dashboards cascaded down from the CCG, indicating current performance vs. targets
   - Publish regular scorecard of performance by practice

4. Peer review of performance
   - Where performance is strong identify how it can be shared and celebrated
   - Constructive dialogue with under performing practices to pinpoint problem areas
   - Establish clear plan of action with deadlines and metrics to track performance improvement

5. Rewards, incentives and consequences
   - Payment to MDG networks on achievement of targets
   - Requirement for networks to evidence achievements against plans to secure payment
   - Innovation fund for funding of innovative projects
   - Agreed consequences for continued under performance, including escalation to CCG Board, NCB

Each network will produce a collaborative ‘network plan’ outlining how they will deliver change against core objectives:

1. To improve quality of and reduce variation in referrals to improve quality of primary care, and improve patient experience and outcomes;

2. To proactively manage patients at risk of unscheduled admission;

3. To deliver efficiency savings on drug budgets and improve quality of prescribing.

Networks will have two options for the kind of plan that they produce: (1) network plans – where practices work together to deliver plans, targets are set at individual practice level, and achievement is assessment and payment made based on achievement of practice-level targets. (2) Enhanced network plans, where networks use network-based targets, practices share the risk of achievement and networks are entitled to a share of the savings from meeting targets. Exhibit 24 outlines the details that should be included in network plans:

Exhibit 24
We will establish clear targets and indicators to measure progress against our strategy. Exhibit 25 outlines the type of indicators the CCG, networks and practices could monitor for each strategic area. We will monitor targets and indicators in relation to finance and compliance as part of our commitment to best practice in governance.

 Exhibit 25

<table>
<thead>
<tr>
<th>Network plan objectives</th>
<th>What plan should contain</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Improved quality of, and reduced variation in referrals to improve quality of primary care and ensure patients have a better experience and outcome by being referred to the most appropriate place first time</td>
<td>• Costing: How consistency of coding of referrals will be improved and how referrals will be counted at practice level? • Referral letters: What will be done to improve the quality of referral letters? • Peer review and audit: How peer review and audits of referrals will be conducted? • Improved use of community pathways: How referrals to community services will be maximised; how will you reduce variation in the number of referrals being made; how overall reduction will be made across the network; how patient choice will be encouraged and how they will comply with PPwI?</td>
</tr>
<tr>
<td>2. To proactively manage patients at risk of unscheduled admission</td>
<td>• Care planning: Active care plans will be developed for all patients with a risk score of 24+ as identified using the combined predictive model. Should include all patients that are part of the IOP and/or on the EoI, register • Participating in and attending case conferences • Following up patients discharged from hospital after an unscheduled admission. All patients who have been discharged from hospital following an unscheduled admission to receive contact within 48 hours of discharge (by telephone, home visit, or appointment) • End of life care: All patients identified as being at the end of their life to have a care plan “coordinate my care” tool should be used to manage EoI, care plan</td>
</tr>
<tr>
<td>3. To deliver efficiency savings on drug budgets and improve quality of prescribing</td>
<td>• Drug budgets: How efficiency savings will be delivered on drug budgets • Prescribing: How quality of prescribing will be achieved and how management of prescribing expenditure will be achieved?</td>
</tr>
</tbody>
</table>

We are developing a performance dashboard with clear metrics so that progress against network plans can be monitored easily and transparently. Exhibit 26 shows the core performance metrics for each of the performance priorities.
Each network will conduct a series of review meetings to measure progress and encourage robust performance conversations, on the basis of the data collected in the process described above. Performance-focused network meetings will take place each month, involving a GP from each practice in the network and the network coordinator. Network coordinators will ensure the appropriate data is available, including network performance dashboards (strategic and financial), which will indicate current performance in relation to targets. Coordinators will analyse areas of under-performance, highlight root causes and suggest corrective action. The aim of the discussion will be to reach common understanding of the problems, their root causes, agree actions, deadlines and responsible persons to follow them up. Consequences of good and poor performance will be agreed. Ongoing meetings will follow-up areas of concern.

Networks will send monthly reports to the CCG, who will be responsible for providing quarterly reports on priority areas to the National Commissioning Board. Exhibit 27 shows how performance information will flow through the system, enabling networks and others to identify best practice and target support where needed.
Exhibit 27

We are exploring a variety of non-financial incentives to reward good performance, as well as penalties, as set out in exhibit 28.

Exhibit 28

<table>
<thead>
<tr>
<th>Type of Incentive</th>
<th>Examples from elsewhere</th>
<th>Examples from H&amp;F</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Perfomance transparency</strong></td>
<td>Providing quality of care information and variation to patients and patient advocates</td>
<td>Practice-level benchmarking</td>
</tr>
<tr>
<td><strong>Peer pressure</strong></td>
<td>Creating peer benchmarking and conducting peer reviews</td>
<td>Enhanced network plans offer chance to pass share</td>
</tr>
<tr>
<td><strong>Other rewards</strong></td>
<td>Offering opportunity for involvement and control in the CCG’s affairs (ability to influence strategic direction), and increased levels of freedom</td>
<td>Additional non-financial resources (e.g. diabetic nurse, MMT)</td>
</tr>
<tr>
<td></td>
<td>Recognition and rewards e.g. access awards</td>
<td>Training and development opportunities</td>
</tr>
<tr>
<td></td>
<td>Innovation Fund for networks, focused on initiatives to deliver GSSP, reduce variation, reduce inequalities</td>
<td></td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Frequency</th>
<th>CCG reviews broader set of indicators monthly</th>
<th>Quarterly performance updates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekly</td>
<td>Monthly reports on priority areas</td>
<td>Monthly dashboard of performance by practice</td>
</tr>
<tr>
<td>Monthly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quarterly</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Our system to monitor and review progress

- Weekly monitoring of patient outcomes, weekly practice meetings
- Daily monitoring of patient outcomes, weekly practice meetings
- Real-time reports, weekly spend data
- Monthly spend data

4.5.2. Governance

Below CCG level, we will establish a clear governance structure and leadership positions to help us to implement these changes. Each network will have 3 leadership positions: a Chair, a Coordinator and Clinical Lead, who will report to the CCG Board. Each network will have a ‘linking’ member of the board, who will liaise with practices, an assigned network and the CCG. Exhibit 29 shows this structure.
5. Investment required

This strategy has clarified our vision for a fundamentally different model of care. To deliver this vision, we will make significant investments in staff and estates across different settings of care. This section describes an initial estimate of the investment required in order to realise our plans – providing our patients with better care out of hospital, and making the savings on acute care that are necessary to budget within our resources.

In Hammersmith and Fulham we have made significant investments in previous years to begin the process of providing more care outside of hospital. Some of these investments are described in section 3. To deliver our vision we will make significant additional investment in staff and estates across different settings of care. Exhibit 30 outlines the investment we will aim to make in services delivered at home, in GP practices, and community health centres over the next three years as investment shifts from the hospital to the out of hospital sector. The strategy is only deliverable in the context of this level of resourcing. Because the hospital sector provides services to several CCGs it is important that we act collectively to enable the hospitals to make the necessary changes to release resources for increased amount of care in primary and community settings.
The staffing and investment identified in the exhibit above is indicative based on CCG strategic plans and is dependent on the release of funding from acute providers as activity transfers from acute settings to community settings. Specific investments will be agreed through the normal planning and governance processes of the CCG and as such the production and agreement of robust business cases demonstrating both value for money and affordability to the CCG.

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

This level of service change will only be successful if significant non recurrent investment, in the order of £3m, is made to support all providers to understand and adopt new ways of working. This will support the organisational development initiatives and additional time required from clinicians and service managers.

Taken together, these changes and standards will enable us to deliver our aim of providing more care in the right setting for our patients.

6. **Next steps**

We will need to start the initiative delivery process quickly to ensure benefits are realised according to schedule. See exhibit 31 below.
Exhibit 31

**DELIVERY: H&F needs to start the initiative delivery process now to meet the savings schedule we have set for the next 3 years**

<table>
<thead>
<tr>
<th>Initiatives</th>
<th>Project phasing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2012 Q2  Q3  Q4  2013 Q1  Q2  Q3  Q4  2014 Q1  Q2  Q3  Q4  2015 Q1</td>
</tr>
<tr>
<td>Non-elective</td>
<td>Planning and design  Implementation  Fully delivered by March 2015</td>
</tr>
<tr>
<td>1</td>
<td>Delivery begins  Delivery ramps up</td>
</tr>
<tr>
<td></td>
<td>• Rapid response teams</td>
</tr>
<tr>
<td></td>
<td>• Integrated care case management</td>
</tr>
<tr>
<td></td>
<td>• Contractual savings</td>
</tr>
<tr>
<td>Out-patient</td>
<td>Planning and design  Implementation  Fully delivered by March 2015</td>
</tr>
<tr>
<td>2</td>
<td>Delivery begins  Delivery ramps up</td>
</tr>
<tr>
<td></td>
<td>• Planned care pathway redesign</td>
</tr>
<tr>
<td></td>
<td>• Access to specialist opinion</td>
</tr>
<tr>
<td></td>
<td>• Reprovision in community</td>
</tr>
<tr>
<td></td>
<td>• Referral facilitation and peer review</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>Planning and design  Implementation  Fully delivered by March 2015</td>
</tr>
<tr>
<td>3</td>
<td>Delivery begins  Delivery ramps up</td>
</tr>
<tr>
<td></td>
<td>• UCC</td>
</tr>
<tr>
<td></td>
<td>• Increased Primary Care Capacity &amp; supported self care</td>
</tr>
<tr>
<td>Elective</td>
<td>Planning and design  Implementation  Fully delivered by March 2015</td>
</tr>
<tr>
<td>4</td>
<td>Delivery begins  Delivery ramps up</td>
</tr>
<tr>
<td></td>
<td>• Minor elective procedures in community</td>
</tr>
</tbody>
</table>

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

Successful implementation will rely on all our enablers being addressed in good time.

Exhibit 32
<table>
<thead>
<tr>
<th>Crucial step</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  <strong>12/13 budget is set in line with strategy</strong></td>
<td>✔️</td>
</tr>
<tr>
<td><strong>Year 2 Network Plans set in line with strategy</strong></td>
<td></td>
</tr>
<tr>
<td>2  <strong>Strategy is endorsed by:</strong></td>
<td></td>
</tr>
<tr>
<td>– Health and Wellbeing board</td>
<td>✔️</td>
</tr>
<tr>
<td>– CCG board</td>
<td>✔️</td>
</tr>
<tr>
<td>– All practices</td>
<td></td>
</tr>
<tr>
<td>3  <strong>Performance framework is agreed by CCG (including metrics, targets, thresholds and escalation process)</strong></td>
<td>✔️</td>
</tr>
<tr>
<td>4  <strong>Governance structures in place for managing delivery of individual projects and monitoring performance</strong></td>
<td>✔️</td>
</tr>
<tr>
<td>– Interface agreed with projects outside of CCG Control</td>
<td>✔️</td>
</tr>
<tr>
<td>5  <strong>Capabilities are in place to deliver strategy including:</strong></td>
<td>✔️</td>
</tr>
<tr>
<td>– Clinical Leadership (from CCG and other?)</td>
<td>✔️</td>
</tr>
<tr>
<td>– Project Management</td>
<td>✔️</td>
</tr>
<tr>
<td>– BIU analytics via CSS support</td>
<td>✔️</td>
</tr>
<tr>
<td>– Plans for new workforce required to deliver service</td>
<td>✔️</td>
</tr>
</tbody>
</table>
DMBC Appendix L5 – Harrow Out of Hospital Strategy

Foreword

I have felt privileged to work as an NHS GP in Harrow for over 22 years as well being recently elected as Chair by the board of Harrow CCB representing 35 general practices and over 230,000 patients.

Having lived in Harrow for forty years I have seen first-hand examples of the excellent health and social care most of us enjoy. However, in spite of Harrow having some of the best skilled doctors, nurses and social care teams, I have been struck by the lack of consistency of access to timely, high quality care some of us experience.

In spite of most of us wishing to avoid going to hospital (unless we absolutely have to) and having 21st century technology to allow patients to be treated out of hospital, our over dependence and over commitment of resources to hospitals has compromised our ability to deliver consistently high quality primary care for our patients. Exacerbated by a relative lack of coordination with social and community care this leads to greater need for last minute care being provided in overstretched emergency medical and surgical services sited in hospital. We need to change this (through increased resources in the community) so that patients receive more timely proactive, preventative and better coordinated care that will prevent them from falling seriously ill and having to go into hospital as an emergency.

In Harrow CCG we are committed to adequately resourcing commissioning and delivering an out of hospital service that gives patients and our clinical colleagues confidence that care at home and in primary care will be consistently high quality and readily accessible. However, we can only do this by working in close partnership across primary, community, secondary, social care and the voluntary sector - providing an integrated and preventative model of health and social care services. We have already begun to build the relationships necessary to facilitate improved work with our partners – as Bill Stephenson Chair of Harrow’s Health and Well Being Board has highlighted:

"We are fortunate in Harrow to have built a strong partnership between the Council and the Clinical Commissioning Group. As the Chair of Harrow’s Health and Well Being Board and on behalf of all its members I look forward to building on this strong foundation and working together to deliver an aligned Out of Hospital and Health and Wellbeing strategy that will achieve better outcomes for our local residents"

Too often changes to our health care have been narrowly focussed on buildings or workforce and less so patients. This strategy and the broader reconfiguration of our services (including hospital services) seeks to address that, setting out a comprehensive plan for how we can improve care for patients both when needing to go into hospital and out of hospital. In Harrow we have already made significant progress towards achieving our goal of improved care out of hospital, moving several traditionally hospital based services out of hospital (including Diabetes, Cardiology, Headaches and a unified musculoskeletal service). These services in the community consistently receive over 90% good or excellent patient satisfaction rating.

This strategy sets out in detail how we will continue to improve care for patients out of hospital avoiding unnecessary hospital admissions and visits to hospital based clinics.

Dr Amol Kelshiker, MBChB, FRCGP, PG Dip Card., CCG Chair

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

The case for improving out of hospital services
There are three main challenges for Harrow that mean how health care in the borough is delivered needs to change.

- The residents of Harrow have changing health needs, as people live longer and live with more chronic and lifestyle diseases placing greater demand on primary and community care to adapt or risk further unnecessary dependence on hospital care.
- Under our current model of care hospital admissions or attendances happen too readily and are not always in the best interest of the patient. We need to have more preventative interventions happening out of hospital. Care should be shifted out of hospital in order to provide better outcomes for patients, at lower cost.
- However, this needs a greater transformation of primary, community and social care. Currently there is variation in both quality and access and Harrow CCG must place greater emphasis on improving these.

Our vision for how care will be different for patients
We have a clear vision for delivering better care, closer to home in Harrow. At the heart of our vision is providing the right care, in the right place, at the right time by the right healthcare professional to reduce reactive, unscheduled care and provide planned care earlier. There are 5 main areas where we will take action to achieve our vision:

A. There will be easy access to high quality, responsive primary care to make out of hospital care first point of call for people. GPs and primary care teams will be at the heart of ensuring everyone who provides care does so to consistently high standards of care.

B. There will be clearly understood planned care pathways that ensure out of hospital care is not delivered in a hospital setting. Whenever possible, patients will have access to services closer to home.

C. There will be rapid response to urgent needs so that fewer patients need to access hospital emergency care. If a patient has an urgent need, a rapid clinical response will be provided.

D. Providers (social and health) will work together, with the patient at the centre, to manage proactively people with long term conditions, the elderly and end of life care out of hospital.

E. Patients will spend an appropriate time in hospital when they are admitted, with early supported discharge into well organised community care.

Delivering Better Care, Closer to Home
We will implement a number of key initiatives in each of these five areas. These will include:

- The new 111 phone number throughout North West London to provide a single point of access to health and care services
- A new referral facilitation and peer review system to support GPs making referrals from primary care
• Providing most outpatient appointments in the community
• Establishing rapid response teams to deliver care in patients homes when appropriate
• Redesigning our pathways of care, encouraging providers to increase productivity by employing new ways of working
• Implementing a new model of care so that different providers work together in multi-disciplinary groups to provide seamless, integrated care for patient

How we will deliver better care closer to home

To achieve our vision and implement these ambitious new initiatives will mean we need to change the way we work to deliver care in Harrow.

Ensuring more care is delivered in the right setting and out of the hospital means we need to change the way we do things. We have agreed some organising principles as the basis for this change. Primary, secondary, community, social and mental health providers in MDGs need to work together in networks to ensure care is coordinated and effective. We will organise into six networks based on our current multi-disciplinary groups. The six networks will provide an enhanced level of care in community settings and will ensure effective co-ordination of care across providers.

As we redesign and redirect activity into the community, we need to allocate both clinical and office space to this increased level of activity. We propose two hubs based on existing sites in the south and west of the borough (Alexandra Avenue and The Pinn Medical Centre) with alternative hubs being explored in central and east Harrow.

Out of hospital care will be organised and coordinated on three levels:

• Thirty five individual GP practices will be responsible for routine primary care and have overall responsibility for patient health in their area.
• Six new networks, based on the multi-disciplinary group structures, will manage services such as rapid response, integrated care, specialist primary care, community outpatients and end of life care.
• The Borough/CCG will be responsible for the new 111 phone service, rapid response out of hours care, community beds and acute care, including accident and emergency care.

Supporting improved healthcare

We will invest in better information systems, put in place stronger governance structures to hold providers to account and make sure patients have easy ways to tell us what is not working at every stage of care.

We will invest in 5 key enablers to support better care, closer to home:

• We will step up patient, user and carer engagement and improve our patient education and information.
• We will put in place clear network governance and a system of performance management so that the benefits set out in this strategy are delivered.
• We will put in place the right information systems and tools to support networks.
• We will ensure that we have the right contracts and incentives to improve care, and to underpin the new ways of working we need.
We will provide training to networks to support professional and organisational development, in particular in leadership, governance, culture and teamwork, IT skills and patient engagement.

Next Steps

The strategy set out here will form the basis of further, detailed discussions in the next few weeks with GPs, patients and families, other clinicians, partners in social care and public health, the health and well-being board and others, leading to full public consultation in June. A detailed implementation plan is set out in this document.
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1. The case for improving out of hospital services

In this strategy we are setting out our plans to transform out of hospital care and provide better care, closer to home. Excellent out of hospital services are essential if Harrow is to maintain quality of care in the face of increasing demand and limited resources. If we hope to maintain and improve standards in the face of these challenges we must dramatically change the way we deliver primary, community and social care work. In particular we will need to improve the quality of, and access to, primary care. The challenges we face are laid out in Exhibit 1:

EXHIBIT 1

There is a strong case for improving out of hospital services

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

2. Under our current model of care we can’t afford to meet future demand

3. National and international experience shows that care can be delivered out of hospital at **lower cost** and with **better outcomes for the patient**, particularly when accompanied by new ways of working, patient education and supported self-management

4. However, primary and community care requires significant improvement to be able to deliver this. Currently there is variation in **quality and access** meaning people have **very different experiences** in different locations

This section has described why out of hospital care in Harrow needs to change so that we respond to these challenges urgently. The next section describes our vision for out of hospital care in Harrow and what these changes will mean for patients.

2. Our vision for how care will be different for patients

We want to make this promise to those patients registered with a GP within Harrow CCG.

**Harrow CCG is committed to improving primary, secondary and community care in its locality by providing the right care in the right place, at the right time by the most appropriate health or social care professional.**

*By offering a much wider range of high-quality services over extended hours to the community, we will improve care for patients in the community and reduce the need for patients to attend hospitals and help reduce demand on acute hospital services.*

This promise translates into five goals for how care will change in Harrow (see Exhibit 2).
2.1. Easy Access to High Quality Responsive Primary Care

We are committed to improving primary care so it meets patients’ expectations and is fit for the future.

Working with GP practices and the other CCGs in North West London we will set up a common framework to transform access and quality in primary care. Out-of-hospital care will operate as a seven day a week service supported by a network of GP Practices, GP Walk-in Centres in the community and community based urgent home visiting services where required. These and the Urgent Care Centre at Northwick Park Hospital will provide an alternative to the busy A&E departments. We are committed to improve care for residents with a learning disability by ensuring that they have an improved access to generic health services provided by staff with an understanding of their needs and supported by specialist advice from the Harrow Learning Disability Team.

Improving access will mean investing resources into primary care and community services. Community health and care services will be accessible, understandable, effective and tailored to meet local and individual patient’s needs. Services will be accessible face-to-face, by telephone, by email, by SMS texting and by video consultation.

Practices will be encouraged to work in networks to:

- Provide extended opening hours
- Offer pre and post operative care
- Provide follow up for long term conditions
- Develop and implement care plans for vulnerable patients
- Provide a wider range of diagnostics
- Share care arrangements with secondary care (e.g. long term drug monitoring for patients with long term conditions).

In particular, telephone advice and triage will be available 24 hours a day, seven days a week. This will be either through people’s General Practice or known care provider’s telephone number or through the new free 111 number. Cases assessed as urgent by
telephone triage will be given a timed appointment or visit with the appropriate service provider (including a doctor where required) within 4 hours of the time of calling.

This will mean that our patients’ experience of primary care will improve (as outlined in Exhibit 3).

**EXHIBIT 3**

**Patient Story**

Maria is 48. Maria has made an urgent appointment to see her GP after noticing that she had been bleeding vaginally for the last two days. She had not had her period for the last 10 months which she thought was due to the menopause, but realised she is unsure about the symptoms of the menopause.

*The situation now:* Maria meets with her GP who is unsure of best treatment options. Maria is referred to the Outpatients clinic to see a gynaecologist. Maria is called in for a hospital appointment and receives an ultrasound, hysteroscopy and endometrial sampling. Each time she has had to take time off work to be seen. Maria after a long wait is finally referred to hospital for treatment and is then discharged home. Maria is left to plan her own rehabilitation, with her GP not aware the procedure has taken place.

*The situation in the future:* Maria meets with her GP who discusses options and shares information about treatment and impact. The GP refers to evidence based guidance and Maria is booked for a one stop pre-assessment within the practice. On the same day Maria has had a scan at the onsite diagnostic clinic. The GP checks in on the results and she is referred to the community based consultant led gynaecology team. She is booked in for a procedure and Maria goes to hospital 2 weeks later and meets the same consultant for her operation. She has a brief stay on the ward and is discharged with a copy of her rehabilitation plan back to her GP. The GP sees her for post operative follow up and has access to the consultant via telephone and email for advice if required.

2.2. **Clearly understood planned care pathways that ensure out of hospital care is not delivered in a hospital setting**

Too many outpatient appointments and elective procedures are occurring in hospital, when they can be done nearer to a patient’s home, at lower cost and at high quality in the community.

We will achieve a shift of activity out of hospital by having more specialist services in the community facilitated by primary and community health and care services that are accessible, understandable, effective and tailored to meet local and individual needs. Services will be developed to provide a range of access routes: face-to-face, by telephone, by email, by SMS texting and by video consultation. This will be supported by a referral facilitation service to ensure all patient referrals are directed to the most appropriate clinician and everyone has the same access to the care available.

Clinical protocols with access to routine investigations will be made available and followed by service providers. To support effective pathways, with the individual’s consent, relevant information will be visible to health and care professionals involved in providing care. Any previous or planned contact with a healthcare professional should be visible to all relevant community health and care providers. This should ensure that care providers are aware of any planned or outstanding activities required for the individual and avoid the need for patients to keep repeating their history every time they see a health professional. This will mean that our patients’ experience of planned care will improve (as outlined in Exhibit 4).
Patient Story
Melanie is 36. She is a working mother who struggles to manage her work and home life. She has a young daughter, Maya who is 3 years old. Melanie has taken Maya to the Urgent Care Centre at Northwick Park Hospital on two occasions over the last 6 weeks with a recurrent fever.

The situation now: Melanie collects Maya from the nursery at 6pm and is told she has a fever. Melanie rings her GP but cannot get through. After several attempts decides to take Maya to her local A&E. A&E is crowded and there is a long wait. The conditions are stressful and Maya’s condition worsens. Maya is eventually seen, but her treatment focuses just on the fever. An opportunity for a focus on broader child welfare is missed as staff do not make sure Maya’s immunisations are up to date nor do they check if Melanie is getting the support she needs. Nonetheless, Melanie is grateful for the treatment Maya receives and will now use A&E as her first port of call next time she is ill.

The situation in the future: Melanie collects Maya from the nursery at 6pm and is told she has a fever. She calls 111, the new number for local NHS unscheduled care. She is given advice on reducing Maya’s temperature and told to ring back if she develops any other symptoms or her temperature does not go down. Later that evening Maya is a little better but Melanie is still concerned, rings 111 again and is given an appointment with her own GP for the next morning. If she was unable to wait Maya could be offered an appointment with a local GP practice in her area who offers out of hours care. When she sees her GP the next morning he reminds Melanie that Maya’s immunisations are not complete and makes her an appointment to complete the course. He also notes that Melanie, who is known to be depressed, is finding it difficult to cope and contacts the health visitor for extra support. Melanie feels positive and confident about the care and how straightforward and timely it was to access.

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

Hospital admissions should be prevented wherever appropriate. We know at present people are being admitted to hospital when a rapid community response could keep them in their own homes.

To provide the capacity and capability to do this Harrow will have a multi-disciplinary rapid response team provided as part of the Short Term Assessment, Rehabilitation & Reablement Service (STARRS). Accessible via the 111 number and a local single point of access phone line, the rapid response team will visit any individual who is clinically assessed to be at risk of an admission to hospital which could be prevented by expert advice, services, diagnostics, or the supply of equipment, within two hours. They will be able to arrange packages of care to support people in their own home, typically delivered by a team of experienced nurses and therapists. If necessary, community respite care (e.g. through beds in a small local community hospital) will be provided as an alternative. The rapid response team will also work closely with A&E Departments, the patient’s GP and social care reablement teams to prevent avoidable admissions.

This will mean that our patients will be able to receive rapid care when their need is urgent (as outlined in Exhibit 5).
2.4. Providers (social and health) working together, with the patient at the centre

In future, we will ensure that there is more effective working between social and health teams to support people with long term conditions, the elderly and people nearing the end of their lives to stay out of hospital and have the support they need.

Patients and their carers tell us that they sometimes fall between the gaps in services. In future, we will ensure that patients and their families in Harrow who need community health and social care will experience coordinated, seamless and integrated services using evidence-based care pathways, case management and personalised care planning. This will be facilitated by six multidisciplinary groups working across Harrow as part of the North West London Integrated Care Pilot. They will work together to identify and review patients at risk of becoming ill. Initially they will focus on diabetic patients and the over 75s. Such integrated care will be better for patients as they will receive proactive care to keep them well, will not suffer from gaps in provision between services and will not have to constantly repeat their story. It will also be better for professionals as they will have access to full patient information and will be able to learn from colleagues with different expertise. This will mean that our patients will not fall through the gaps of multiple providers (as outlined in Exhibit 6).
Patient Story
Fred is a 79 year old gentleman with a number of long term conditions: diabetes, heart disease and more recently he has developed Parkinson’s disease. He lives alone but is supported by his family who live locally. In the last three months he has had two falls and on both occasions he has been sent to A&E by his GP. The falls have led to a loss of confidence and he is not managing his diabetes very well and as a result has been admitted to hospital with a hypoglycaemic episode.

The situation now: Fred’s GP visits him and reinforces the need for him to keep to his diabetes regime and eat regularly. He suspects that Fred may be depressed and starts him on a low dose of anti depressant but these make Fred very sleepy. He has been referred for his Parkinson’s disease and has been put on a new drug but is confused about when to take them. He and his family contact the practice and the out of hours service frequently for advice. There is no co-ordination between services- each service treats Fred within their area of expertise but treatment plans are not shared.

The situation in the future: Fred’s case is discussed at the multi disciplinary group (MDG). The MDG includes representatives from health and social services and with their help his GP puts together a care plan: A local pharmacist will provide his medication in a dosette box and monitor his compliance; social services will assess his social needs and provide aids to daily living, adaptations to his home and carer support when necessary; the diabetes specialist nurse will support him to manage his diabetes; His GP will discuss his Parkinson’s with his community based Neurologist and adjust his medication if necessary and Age Concern will be asked to invite him to a friendship club. As all agencies will receive copies of the care plan, Fred’s care can be co-ordinated, key contacts known to all and any duplication avoided.

2.5. Appropriate time in hospital

People are staying in hospital longer than they need to, often because of a lack of support for discharge. This will change so that following admission to hospital, the patient’s GP and relevant providers will be actively involved in coordinating an individual’s discharge plan (including any mental health provision, intermediate care and reablement) as well as continuing care needs.

There will be more joined-up discharge support, with an appropriate step-down in care, prompt communication to other providers and clear advice to patients on what to expect after hospital and who they can contact if they feel unwell.

This will mean that our patients will not stay in hospital when it is not best for their care (as outlined in Exhibit 7).
Patient Story
David is an 80 year old widower. He has been generally healthy throughout his life, but over the past year his daughter has become worried that he has become unsteady on his feet. In the past year he has had several falls at home and has recently fallen, fractured his hip and been admitted to hospital.

The situation now: The duty doctor reviews David’s case and deems him fit to leave following physiotherapist review. However, the review happens on a Friday and physiotherapists are not available until Monday, leaving David in hospital over the weekend. Additionally, nurses assume that discharge to a community hospital is needed, however the local hospital is full. David is transferred to a community hospital after several further days and then has to wait another 3 weeks for social care to organise a package of care for discharge.

The situation in the future: When David was admitted to hospital he was flagged as on the high risk patient register and his history was available to staff. His Health and Social Care Coordinator is notified and discharge planning begins immediately. The HSCC talks to his family, calls his social worker and speaks to a community home to pass on information. Next steps are captured in clear care plan and all pieces are in place for discharge when the time comes. In the first week after discharge, he receives daily visit by physiotherapist to stabilise him.

2.6. Standards to maintain the quality of care

Patients and the public need to be confident that as we change where and how patients are cared for, we will hold ourselves to high clinical standards of care in the community (see Exhibit 8). Therefore, we have agreed standards that set our aspirations for the future. They emphasise the central role of the GP in the coordination and delivery of out of hospital care. The standards encompass both core primary care delivered by GP practices and, more broadly, care delivered outside of hospital. They aim to shift care delivery from more reactive unplanned care to proactive planned care.
2.7. Conclusion

In this section we have set out the differences that patients will see. In the next, we describe the key initiatives that we will put in place in each of the six areas in order to improve care in Harrow by 2014/15.
3. How we will deliver better care, closer to home

For each of the five strategic goals this section sets out the key initiatives, necessary investments and expected impact. Some of these are new and specific to Harrow, whilst others are parts of much broader work such as the Outer North West London Integrated Care Pilot. Exhibit 9 outlines the out of hospital initiatives we will be implementing.

EXHIBIT 9

<table>
<thead>
<tr>
<th>Theme</th>
<th>Initiative description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Easy access to high quality, responsive care</td>
<td>▪ Rolling out of 111 across NWL</td>
</tr>
<tr>
<td>Simplified planned care pathways</td>
<td>▪ Expansion of urgent care centres reducing A&amp;E admissions</td>
</tr>
<tr>
<td>Primary care development</td>
<td>▪ Shifting mental health patients to a less intensive model of care</td>
</tr>
<tr>
<td>Reducing variation in GP referral rates through Referral management</td>
<td>▪ Shifting a proportion of elective procedures into enhanced community clinics</td>
</tr>
<tr>
<td>Reducing cost of outpatients through shifting a proportion of acute</td>
<td>▪ Carrying out a proportion of pre-op assessments in GP clinics</td>
</tr>
<tr>
<td>Outputpatient services to community settings</td>
<td>▪ Ensuring more patients are able to receive high quality care in their homes rather than hospital</td>
</tr>
<tr>
<td>Rapid response to urgent needs</td>
<td>▪ Treating patients with ACS conditions/&quot;STARRS&quot; cohort in alternative care settings</td>
</tr>
<tr>
<td>Integrated care for LTC and elderly</td>
<td>▪ Proactively managing the care provided to a proportion of our residents who are high users of our acute services</td>
</tr>
<tr>
<td>▪ Outer sub-cluster integrated care to reduce NEL admissions</td>
<td>▪ Establish a psychiatric liaison service</td>
</tr>
<tr>
<td>▪ Integrate consideration of mental health co-morbidities in the Integrated Care Pilot</td>
<td>▪ Ensuring more patients are able to receive high quality care in their homes rather than hospital</td>
</tr>
</tbody>
</table>
3.1. Easy Access to High Quality Responsive Primary Care

**Initiative A.1:** The roll out of the new 111 phone number across NHS North West London will provide a single point of access for patients, carers and clinicians to the appropriate level of care. The free to call 111 number is available 24 hours a day, 7 days a week, 365 days a year when:

- You need medical help fast, but it’s not a 999 emergency
- You don’t know who to call for medical help or you don’t have a GP to call
- You think you need to go to A&E or another NHS urgent care service
- You require local health information or reassurance about what to do next

The NHS 111 service also provides management information to commissioners on the demand for and usage of services to enable the commissioning of more effective and productive services that are designed to meet people’s needs.

Call handlers will be highly trained and supported by experienced clinicians. They will follow agreed clinical pathways and will have access to a local directory of services. Agreed service standards will mean that urgent cases will be dealt with within 4 hours, and those whose needs are not urgent will be seen within 24 hours, or 48 hours if they want to go to their own GP practice.

**Initiative A.2:** The existing Urgent Care Centre at Northwick Park Hospital will provide a primary care alternative to A&E for observation, diagnostics and treatment.

Patients attending A&E for minor injuries and illnesses will be streamed by the Urgent Care Centre with a best practice target of a clinical assessment within 30 minutes of presentation. This service will sit directly in front of A&E and will positively redirect any appropriate patients attending the UCC with no urgent primary care needs to their own GP or stream to the most appropriate service.

Alongside this Harrow will develop a network of GP Centres which will provide extended access to GP services and diagnostics support for patients away from A&E and UCCs. Staffed by experienced GPs and Practice Nurses patients will receive more appropriate care in settings closer to their homes.

The UCC and GP Centres will provide an alternative to A&E, allowing A&E specialists to focus on the most serious and life threatening conditions and reducing patient’s waiting times.

**Initiative A.3:** Improving the quality of primary care in Harrow

Working with GP Practices, and the other CCGs in North West London we will set up a common framework to transform access and quality in primary care. Improving access will mean investing resources into Primary Care to facilitate opening at convenient times, offering a wider-range of services and being located in the right places. Improving quality will mean ensuring that care is being delivered to the right clinical standards, in excellent facilities and with good patient service. Practices will be encouraged to work in networks to support each other, provide extended opening hours and a wider range of services.

**Initiative A.4:** Shifting mental health patients to a less intensive model of care.

For people who are being treated by a mental health provider (normally Central and North West London Foundation Trust in Harrow) there is an opportunity to provide more care from their GP surgery. As many as 10% of patients currently under the care of mental health trusts have low level needs that could be met in primary care.
People with common mental illnesses such as depression and anxiety, as well as people with stable enduring mental illnesses should have GPs coordinating and providing care. This enables people to return to their normal lives, as well as freeing mental health staff to focus on providing support to more serious cases.

Having GPs responsible for more patients with non-complex mental health needs will require a structured approach. It is proposed that an agreed pathway is adopted for the transfer of responsibility for care from community mental health teams to GP practices. This will include setting criteria for the transfer of responsibility, a case review to confirm criteria have been met and joint work between the community mental health team, the GP and the patient to develop a care plan. Primary care will also have access to ongoing support in the form of a “primary care plus system” outlined in Exhibit 10.

EXHIBIT 10

<table>
<thead>
<tr>
<th>Ongoing CPN support for more complex patients</th>
<th>Mental health training for GPs</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image1.png" alt="CPN" /> CPNs provide low level step down care to patients transferred from secondary care into primary care</td>
<td><img src="image2.png" alt="GP" /> Dedicated course aimed at providing education in basic mental health care, for example:</td>
</tr>
<tr>
<td><img src="image3.png" alt="Psychiatrist" /> Average 2-3 contacts per patient in first 6 months step down</td>
<td>– 4-6 week course, 1 evening per week</td>
</tr>
<tr>
<td><img src="image3.png" alt="Psychiatrist" /> Annual assessment</td>
<td>– Run by experienced mental health experts</td>
</tr>
<tr>
<td><img src="image1.png" alt="CPN" /> 2-3 appointments per patient per year</td>
<td>– Each practice nominates 1 members to participate</td>
</tr>
<tr>
<td><img src="image1.png" alt="CPN" /> Follow up aid from care support worker</td>
<td><img src="image4.png" alt="Courses run annually to ensure continual training" /></td>
</tr>
<tr>
<td><img src="image1.png" alt="CPN" /> CPN work overseen by 1 psychiatrist in each borough</td>
<td></td>
</tr>
<tr>
<td><img src="image1.png" alt="CPN" /> Patient care remains the overall responsibility of the GP at all other times</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expert mental health advice for GPs</th>
<th>Mental health induction for GP surgeries</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image3.png" alt="Psychiatrist" /> Telephone and e-mail support from mental health consultant:</td>
<td><img src="image5.png" alt="Community psychiatrist" /> Annual session run by CPN in each GP surgery to provide overview of care for mental health patients, including:</td>
</tr>
<tr>
<td>– Part of “on call” duties for consultant</td>
<td>– Discussion of unique care requirements of mental health patients</td>
</tr>
<tr>
<td>– 5 hour per week per CCG dedicated to answering GP mental health questions (e.g., advice on medication, care plans etc.)</td>
<td>– Introduction to patient care pathway</td>
</tr>
<tr>
<td><img src="image3.png" alt="Psychiatrist" /> Informal coaching of GPs as part of involvement in ICP MDG meetings</td>
<td>– Provision of information on further support for mental health patients (e.g., voluntary sector)</td>
</tr>
</tbody>
</table>

SOURCE: Working group

Harrow
3.2. Clearly understood planned care pathways that ensure out of hospital care is not delivered in a hospital setting

**Initiative B.1:** A referral standardisation service will ensure all patient referrals are directed to the most appropriate clinician and everyone has the same access to the care available.

Referral rates vary between GP practices in Harrow and also between GPs working within the same practice. High referral levels can be the result of poorly communicated care pathways, lack of GP access to specialist advice or demand from patients who think hospital is best. GPs in Harrow are working together within their practices to review the referrals they make and to identify any that could have been appropriately avoided. Support with data will be provided by analytical specialists. GPs will be encouraged to deliver more care “in-house” and will have access to specialist advice to do this (e.g. being able to email or phone a consultant or access advice from senior or specialist colleagues in their own practice). Inter practice referrals are being used and supported by practices starting to work in Peer groups and networks. The goal of this initiative is that patients should be referred for the most appropriate care.

**Initiative B.2:** Some elective procedures will be moved into a community setting.

Some elective procedures currently carried out in hospital settings will transfer into community clinics. Harrow currently has purpose built treatment rooms at Pinn Medical Centre and Alexandria Avenue Health and Social Care Centre (our healthcare “hubs”) which are underused. Outreach consultant led services will operate from these and more community clinics to carry out some less complex procedures without need for a hospital visit or referral. This will free up more hospital based capacity to carry out day case surgery and reduce inpatient surgery levels.

Examples of procedures that maybe carried out away from hospital would be those under local anaesthetic such as removal of lumps, management of piles, endoscopy, chemotherapy and exercise testing for heart disease. Where surgery is required to be provided in the hospital we will develop Pre-operative assessment services in the community either by the patient’s own GP or a Clinic.

**Initiative B.3:** Some outpatient consultations will be moved out of Northwick Park Hospital into a community setting.

We will aim to shift outpatient consultations into more convenient community location. We will initially focus on expansion of existing services we currently provide within the community e.g. in cardiology, ophthalmology, paediatrics and dermatology but also others such as gastroenterology, gynaecology, as they are not currently covered by community based outpatient clinics despite there being potential to shift some care. Care will be delivered by consultants or GPs with a special interest in community facilities including the two healthcare hubs and GP practices.
3.3. Rapid response to urgent needs so that fewer patients need to access hospital emergency care

Initiative C.1: A rapid response team is available with a broader scope and skill set, e.g. in reach into hospitals to prevent avoidable admissions and keep people at home where possible or emergency respite care where necessary. This is completed by a short term intensive community care service (STARRS)

£2.5 million will be invested in this initiative. Multidisciplinary rapid response teams will incorporate GPs, social workers, nurses and mental health professionals. They will provide timely assessments and be able intervene to stabilise a patient for a maximum of 72 hours, as an alternative to A&E attendance.

This will be complemented by the STARRS service, which involves short-term, intensive interventions which enable patients to reach their rehab potential before moving on to their ultimate care destination. This includes both time-bound rehabilitation (health therapy care) and reablement (social care, with therapy management). Patients will be referred on to them by the rapid response team, and they will also support those who are medically fit for discharge from acute care (and have a reablement / rehabilitation need). They will deliver some care in patient’s own homes, but will also have access to temporary beds (health step-up and step-down beds and social care beds).
3.4. Providers (social and health) working together, with the patient at the centre

**Initiative D.1:** Proactive case management for frequent users of hospital services.

All patients who have had three or more emergency admissions in the previous year will be the subject of case management from a dedicated team of community nurses as well as being the subject of case management whilst in hospital. These patients will have care plans and support in primary care to reduce their need for hospital admissions, which will be better for patients and better for the health system. The community nurses will work closely with GPs to ensure these patients have appropriate proactive care in place. Nearly £1 million will be invested in this case management approach.

**Initiative D.2:** Roll out the Integrated Care Pilot across Harrow.

Harrow is following a model of integrated care which has already been successfully applied in Inner North West London. To achieve this we will invest in establishing six multidisciplinary groups (MDGs) care manage patients at risk of becoming ill without an appropriate package of interventions in the community. Initially their focus will be on vulnerable patients over the age of 75 and diabetic patients. By the end of 2012/13 additional respiratory and cardiovascular pathways should also have begun to be implemented to improve care for these groups. Exhibit 11 provides an overview of how the integrated care pilot will work.

**EXHIBIT 11**

The pilot in Harrow will be overseen by an Integrated Management Group (IMG) as well as a North West London wide Integrated Management Board (IMB). The IMB and IMGs will regularly manage the performance, evaluate the success of the Pilot and hold each other to account. The Harrow IMG will govern the usage of the local Innovation Fund, which is available to all six multidisciplinary groups for local investment in additional services to improve integration, raise the quality of patient care and close gaps between local services.

**Initiative D.3:** Consideration integration of mental health co-morbidities in the Integrated Care Pilot

People who have a physical long term condition, such as diabetes, are also more likely to have mental health problems. These mental health “co-morbidities” can further complicate the patient’s ability to manage their physical health increasing the risk of further
complications and need for hospital care. Where mental health “co-morbidities” exist care can be between 45-75% more expensive than for patients with just the physical ailment.¹

Therefore it is crucial that the Integrated Care Pilot considers mental health needs of patients with long term conditions. For patients this will include mental health screening as part of annual reviews and specially tailored psychological therapy sessions when necessary.

Exhibit 12 below outlines how mental health will be considered at each stage from patient registry through to case conference discussions.

### EXHIBIT 12

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

**Initiative E1: Hospital at home reducing patients’ stay in hospitals when not required**

Our hospital at home team provides a proactive, dynamic, skilled, multidisciplinary community-based service to prevent unnecessary hospital admissions and admissions into long-term care. It also facilitates the safe early discharge of patients from acute hospital wards.

The service is designed for patients who would benefit from a short-term crisis intervention in a community setting. The team will be accessed by a single point of contact. Staff will undertake a full assessment of patient needs within 2 hours. The team will draw up a care plan with clear goals for the patient to work towards that is responsive to their needs. Each patient will be allocated a single case manager to coordinate the care for that patient across the health and social care economies as part of the virtual team. The patient will receive a package of care 24 hours a day, 7 days a week. The case manager will monitor the patient’s progress throughout the intervention. Referrals will be made by the case manager in consultation with the patient and directed to appropriate health and social care agencies.

**Initiative E.2: Establish a psychiatric liaison service at Northwick Park**

¹ Long-term conditions and mental health: the cost of co-morbidities,” Chris Naylor et al., February 2012, King’s Fund and Centre for Mental Health.
A psychiatric liaison service is currently being piloted in Northwick Park. The Acute Psychiatric Liaison pilot will be continued until the end of the financial year 12/13. Work is underway with local acute providers to ensure that this service continues as part of the generic future service provide to Harrow residents. These teams are a flexible resource within the hospital that can be deployed anywhere to support patients with mental health problems. This is much better for patients as it means their mental health needs are addressed earlier and treated. This may prevent unnecessary admission into hospital, or for existing inpatients it should mean quicker discharge (more often to a patient’s own home) and overall improved outcomes. The liaison team will be multidisciplinary as outlined in Exhibit 13.

EXHIBIT 13

<table>
<thead>
<tr>
<th>What is</th>
<th>The ‘Optimal Standard’ is a high quality liaison psychiatry service designed to operate in acute general hospitals in NWL, providing the following services:</th>
</tr>
</thead>
<tbody>
<tr>
<td>it?</td>
<td>- Care for patients with significant mental health needs (outside specialist MH units)</td>
</tr>
<tr>
<td></td>
<td>- Training for other hospital staff to enable them to support patients’ mental health needs</td>
</tr>
<tr>
<td></td>
<td>- Integration with other parts of the health system e.g., GPs, specialist mental health teams</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Who delivers the service?</th>
<th>What does the service look like?</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 Consultant Psychiatrists</td>
<td>- Highly visible multi-disciplinary mental health team fully integrated into the hospital</td>
</tr>
<tr>
<td>1 Team Manager</td>
<td>- Single point of contact for all patients (16+) in hospital with diagnosed or suspected mental health conditions of any severity</td>
</tr>
<tr>
<td>12 Team Nurses (Bands 6 and 7)</td>
<td>- Rapid response for patients requiring mental health support and 24/7 support in A&amp;E and wards</td>
</tr>
<tr>
<td>1 Alcohol Nurse</td>
<td>- Training experts on mental health problems and related issues for non-mental health clinicians</td>
</tr>
<tr>
<td>2 Specialist Registrars</td>
<td>- Coordination with out-of-hospital care providers and housing services</td>
</tr>
<tr>
<td></td>
<td>- Integrated with broader health and social care system</td>
</tr>
<tr>
<td></td>
<td>- Single management structure</td>
</tr>
<tr>
<td></td>
<td>- 1 Generic Therapist</td>
</tr>
<tr>
<td></td>
<td>- 1 Occupational Therapist</td>
</tr>
<tr>
<td></td>
<td>- 1 Social Worker</td>
</tr>
<tr>
<td></td>
<td>- 1 Administrative support</td>
</tr>
<tr>
<td></td>
<td>- 1 Research/Business Support Officer</td>
</tr>
</tbody>
</table>

Having the psychiatric liaison team in place should help all clinicians by ensuring better mental health care in acute hospitals with improved risk management. One of the roles of the liaison team will be to train staff members in mental health care. For the whole health and social care system there should be benefits in terms of fewer admissions, reduced length of stay and lower accommodation costs for local authorities (with more patients discharged directly home).

3.6. Conclusion

This section has considered in detail the different initiatives that are needed to deliver better care, closer to home. This describes how the CCG will work both internally and with its partners.
4. **How we will work together**

Achieving our vision will require new ways of working within the CCG. There are six aspects to consider as outlined in Exhibit 14 below.

**EXHIBIT 14**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>We need to change the way we do things – and we have agreed some <strong>organising principles</strong> we need to stick to as we change.</td>
</tr>
<tr>
<td>2.</td>
<td>Primary, community, social and mental health providers in the MDGs need to work together in <strong>networks</strong> to ensure care is coordinated and effective</td>
</tr>
<tr>
<td>3.</td>
<td>We will change the way we work with partners in Harrow, working in a more coordinated and integrated way</td>
</tr>
<tr>
<td>4.</td>
<td>As we take activity into the community, we need to allocate both <strong>clinical and office space</strong> to this increased level of activity – we are proposing making use of our existing sites to support this</td>
</tr>
<tr>
<td>5.</td>
<td>There are three distinct ‘levels’ of care where it makes sense to co-ordinate services locally vs. Borough level – and have therefore organised how services are managed and delivered outside the GP and acute setting</td>
</tr>
<tr>
<td>6.</td>
<td>To deliver care effectively in networks requires new roles, including network coordinators and clinical champions</td>
</tr>
</tbody>
</table>
4.1. Organising Principles

The strategy we are proposing for Harrow involves big changes in how and where care is delivered: it includes integrated care, case management and rapid response; beds in the community; and some outpatient appointments and some elective procedures taking place in the community. To deliver these significant changes, providers need to work more closely together to ensure care is organised around the patient and to extend the range of services offered in the community.

To guide this joint working we have developed some organising principles (see Exhibit 15).

EXHIBIT 15

<table>
<thead>
<tr>
<th>Our strategy has some big changes for how and where care is delivered</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Integrated care, case management and rapid response</td>
</tr>
<tr>
<td>▪ Beds in the community</td>
</tr>
<tr>
<td>▪ Outpatients and some elective procedures in the community</td>
</tr>
</tbody>
</table>

Providers need to work more closely together to ensure care is organised around the patient and to extend the range of services offered in the community.

<table>
<thead>
<tr>
<th>Core principles of how we organise</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ We need to collaborate, co-ordinate and communicate to improve and integrate care across Harrow</td>
</tr>
<tr>
<td>✓ We must avoid duplication of activity</td>
</tr>
<tr>
<td>✓ Activity should be delivered at most efficient point financially, equally balanced with where it is most effective for the patient</td>
</tr>
<tr>
<td>✓ Care will be patient focussed with Primary care teams remaining central to patient care</td>
</tr>
<tr>
<td>✓ We should design our care around network practice population which broadly reflects geographical boundaries</td>
</tr>
<tr>
<td>✓ Existing contracting arrangements should not constrain the design</td>
</tr>
</tbody>
</table>

SOURCE: Current thinking developed at Out of Hospital workshop, 1st February 2012 with representatives from all providers

4.2. Networks of Provision

We will establish six networks in Harrow linked to the existing multidisciplinary groups created as part of the Integrated Care Pilot. Their boundaries are outlined in Exhibit 16. At this level we would expect interaction between GP practices, community health services, Harrow Social Services, Central and North West London Mental Health Trust and North West London Hospitals NHS Trust. Acute, mental health and social care specialists will all be participating and supporting the primary and community care team.
4.3. Working with our partners to provide coordinated care

In order to provide seamless and well-co-ordinated care in Harrow, the CCG is committed to working very closely with its partners. In particular continuing to develop our relationship, through regular meetings and ongoing dialogue, with the Harrow Health and Wellbeing Board is central to this.

One of the important ways in which we will improve the way we work together is by establishing six multidisciplinary groups across Harrow who will work together to identify and review patients at risk of becoming ill. The role of multidisciplinary groups, as part of the Integrated Care Pilot (ICP) is outlined below in Exhibit 17 below:

EXHIBIT 17

The role of multidisciplinary groups:

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

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

To ensure we safeguard the most vulnerable individuals we have committed to being part of a Multi Agency Safeguarding Hub (MASH), working with the police and social care to ensure we identify any concerns and make timely and effective response. This will be complemented by a single point of access to children’ services, to be implemented by social care, that we will align our services to.
To support improved working between primary and community care we have already begun the process of aligning our district nursing services to the new network structure. Exhibit 18 outlines how we have re-organised our community nurses. We will also implement regular (at least monthly) meetings between district nurses and primary care teams to ensure integrated working and monitoring of most vulnerable patients.

EXHIBIT 18

Currently our district nursing teams operate as part of borough wide team, matching nursing teams to MDGs will enable more provide proactive care to those most at risk of falling ill

<table>
<thead>
<tr>
<th>MDG</th>
<th>District Nurse Structure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1 district nursing sister</td>
</tr>
<tr>
<td>2</td>
<td>2 district nursing sisters</td>
</tr>
<tr>
<td>3</td>
<td>1 district nursing sister</td>
</tr>
<tr>
<td>4</td>
<td>1 district nursing sister</td>
</tr>
<tr>
<td>5</td>
<td>1 district nursing sister</td>
</tr>
<tr>
<td>6</td>
<td>1 district nursing sister</td>
</tr>
</tbody>
</table>

Differences from today

- Named ‘account manager’ to work with GP network lead, providing greater accountability
- Each peer group has 2 named nursing sisters/charge nurses supported by staff nurses and healthcare assistants
- Same service is available in both mornings and afternoons to meet patient need
- Regular meetings with district nursing staff and practice staff
- Team of district nurses allocated to peer-groups on a population basis, providing greater efficiency

4.4. Healthcare Hubs

This strategy has two main implications for estates:

1. Some care will be moved out of hospital and will be delivered in a community setting. This will require clinic space, procedure rooms, diagnostics and community beds.
2. Closer working between providers may require office space and meeting rooms

The best way to do provide this extra space will be to co-locate it in a community “hub” which will:

- Provide an integrated non-acute setting for care delivered by specialists, GPs and Allied Health Professionals
- Facilitate integration of care by co-locating health and social care teams. This would provide easy access to other types of provider to decide the most appropriate care packages and support for patients
- Serve as a base for consultants when they work in the community, and for mobile AHP/CHS providers
- Provide space for regular meetings of multi-disciplinary groups, GPs and provider networks.
- Allow local access to advanced diagnostic equipment

We are proposing two initial hubs for Harrow, with alternative hubs to serve the central and eastern part of the Borough currently being explored (see Exhibit 19).
4.5. Three Levels of Care

Out of Hospital care will be delivered at three levels. These are described in turn from smallest catchment area to largest.

35 Individual GP Practices: This will remain the foundation of care, providing routine care for minor conditions near where patients live. Practices should help people trying to navigate through more complex healthcare needs, a role which the Royal College of Physicians have summarised as “GPs must be engaged fully in deploying their key skills of interpreting complex choices for patients.” Overall accountability for a patient’s health will remain at this level.

6 Networks: This is the new level of care that we are introducing to achieve greater collaboration between GP Practices, community and social services. Services operating at a network level will include rapid response teams, specialist primary care, community outpatients, district nursing, social services reablement, end of life care and the multidisciplinary groups that are part of the Integrated Care Pilot. Networks of practices would also support improving access to primary care as an important alternative to hospital A&E departments.

1 Borough/CCG: At the level of the whole borough there will be the 111 urgent care phone number, GP out of hours services, out of hours rapid response, community beds and acute hospitals services including A&E. The Referral Management Service will also operate borough-wide.

---

4.6. New Network Roles

To allow the networks to function effectively new roles will be created (see Exhibit 20). These will include clinical leads (with responsibility for overseeing network clinical governance), clinical champions (encouraging use of new clinical pathways) and network managers (responsible for network coordination).

EXHIBIT 2018

4.7. Conclusion

This section has focussed on the new working arrangements necessary to deliver better care, closer to home. The next section looks at the “enablers” such as governance, IT and patient involvement that will support the changes needed in this strategy.
5. Supporting improved out of hospital care for Harrow

We have identified 5 key enablers to support better care, closer to home. These are summarised in Exhibit 21 below.

EXHIBIT 21

To be successful we need to:

<table>
<thead>
<tr>
<th>Area</th>
<th>Proposed solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Engage patients, users and carers</td>
</tr>
<tr>
<td></td>
<td>▪ Outline and communicate our commitments to patients</td>
</tr>
<tr>
<td></td>
<td>▪ Develop Harrow wide patient engagement plan, working collaboratively with local LNKs</td>
</tr>
<tr>
<td></td>
<td>▪ Maximise the potential for self management by investing in patient and carer education and self management support</td>
</tr>
<tr>
<td>B</td>
<td>Agree on how we will be governed…</td>
</tr>
<tr>
<td></td>
<td>▪ Put in place clear management structures for networks and reporting lines in place</td>
</tr>
<tr>
<td></td>
<td>▪ Develop and use a common governance and assessment process across health and social care</td>
</tr>
<tr>
<td>C</td>
<td>Have the information tools required</td>
</tr>
<tr>
<td></td>
<td>▪ Implement a Harrow-wide roll-out of EMIS web</td>
</tr>
<tr>
<td></td>
<td>▪ Implement a single electronic patient record</td>
</tr>
<tr>
<td></td>
<td>▪ Develop more virtual ways of working facilitated by a common shared IT system</td>
</tr>
<tr>
<td>D</td>
<td>Agree on issues such as contracts and incentives</td>
</tr>
<tr>
<td></td>
<td>▪ Put in place standards to ensure practices meet a minimum level of quality/productivity in order to bid for provision of other services</td>
</tr>
<tr>
<td></td>
<td>▪ Utilise mechanisms of CQC inspections and revalidation to facilitate performance management</td>
</tr>
<tr>
<td>E</td>
<td>Professional and organisational development</td>
</tr>
<tr>
<td></td>
<td>▪ Baseline current workforce and understand current skill-mix carry out gap analysis in Harrow</td>
</tr>
<tr>
<td></td>
<td>▪ Maximise the potential of all resources in primary, community care and voluntary sector in Harrow</td>
</tr>
<tr>
<td></td>
<td>▪ Maximise the potential of carer and patient user involvement</td>
</tr>
<tr>
<td></td>
<td>▪ Invest in education and training of clinicians staff. “Realign” existing staff to deliver care in the OOH setting.</td>
</tr>
<tr>
<td></td>
<td>▪ Develop an overarching strategy for CPD</td>
</tr>
</tbody>
</table>

The following sections describe the actions we will take around each of these areas.
5.1. Patient Involvement

This strategy puts patients at the centre, so in its implementation it will be vital that patients are fully involved. This table summarises the key ways this will happen.

<table>
<thead>
<tr>
<th>Our commitment</th>
<th>How we will deliver</th>
</tr>
</thead>
</table>
| You will be involved                  | ▪ Ensure patient representation on key committees and decision making bodies, including Harrow CCG Board  
▪ Work with LINk and other partners to ensure as broad a range of service users as possible are consulted |
| You will be informed                  | ▪ Be pro-active in explaining services changes and the reasons for decisions to the public through regular communication  
▪ Use clear concise language in all communication to ensure it is meaningful  
▪ Work with partners, such as the Council to ensure consistent use of language |
| You feedback will shape services      | ▪ Use nationally and locally collected patient experience data to inform decision making  
▪ Commission services which provide evidence of listening to service users’ views  
▪ Run patient events to get more detailed input on existing services and future plans |
| We’ll respond to your concerns        | ▪ Explain how patient input has influenced decisions  
▪ Commission services to demonstrate that they have reacted to service users’ views |

To ensure we achieve these commitments we will develop a borough wide equality, diversity and engagement strategy.
5.2. Governance and Performance Management

Harrow CCG will put in place a strong management structure, as outlined in Exhibit 22.

**EXHIBIT 192**

We will also create a robust means of managing performance to ensure patients are seeing the benefits of changes in how care is delivered. This will have the following steps:

- **Establish clear commitment and plan for performance management**
  - Outline clear plan and expectations for performance management
  - Make clear commitment to patients and each other to implement what is expected

- **Establish clear targets and indicators to measure progress**
  - Select key performance indicators, which should include should include referrals to OP and NEL admissions for LTC
  - Develop a holistic, balanced scorecard across all aspects of performance e.g., quality, access, referrals etc.
  - Set targets and thresholds by network and practice to define different levels of performance

- **Track performance effectively**
  - Transparent monitoring process to track performance against stated goals
  - Performance dashboards cascaded down from the CCG, indicating current performance vs. targets
  - Publish regular scorecard of performance by practice

- **Peer Review of Performance**
  - Where performance is strong identify how it can be shared for wider benefit and celebrated
- Constructive dialogue with underperforming practices to pinpoint problem areas
- Develop practical and proactive solution to address challenges, with named responsible persons
- Establish clear plan of action with deadlines and metrics to track performance improvement
- Regular reporting on progress and consequences for poor performance agreed

- **Rewards, Incentives and Consequences**
  - Explore payment to local practice groupings or practices on achievement of targets
  - Requirement for local practice groupings to evidence what they have achieved against agreed plans to secure payment
  - Agreed consequences for continued under performance, including escalation to CCG board in the first instance, and ultimately to National Commissioning Board.

Details of reporting need to be worked out, but typically it could be on a monthly basis for key metrics such as data on prescribing. Indicators will look both at a practice's performance on its key primary care activity (such as Quality and Outcomes Framework scores and MORI Access poll data) but also how it is doing in reducing emergency admissions, outpatient referrals and A&E attendances.

### 5.3. Contracts/Incentives

Leading on from performance management, we need to create the right contracts and incentives to improve care. This means we will:

- Facilitate financial flows within practice groupings e.g. incentivise inter-practice referrals
- Align provider and patient interests by incentivising providers to meet the out of hospitals standards
- Manage performance at level of practice groupings, asking providers to share data on their performance on a locality level
- Commission services from practice groupings
- Promote financial stability by incentivising providers to reduce total cost of a patient’s care, for example, GPs and practice groupings reducing emergency admissions amongst their patient population

Exhibit 23 outlines how we will use financial levers such as the payment for care plans, to support achievement of our goals.

---

3 Provided CCG are given power to contract non-core primary care
Exhibit 24 then considers some of the non-financial mechanisms we have to support good performance, such as greater say for practices in CCGs affairs and increased staff resources.

### EXHIBIT 24

<table>
<thead>
<tr>
<th>Type of Incentive</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance transparency</td>
<td>• Providing quality of care information and variation to patients and patient advocates</td>
</tr>
<tr>
<td></td>
<td>• Creating peer benchmarking and conducting peer reviews</td>
</tr>
<tr>
<td></td>
<td>• Offering opportunity for involvement and control in the CCG’s affairs (ability to influence strategic direction) and increased levels of freedom</td>
</tr>
<tr>
<td></td>
<td>• Additional non-financial resources (e.g. diabetic nurse, MMT)</td>
</tr>
<tr>
<td></td>
<td>• Training and development opportunities</td>
</tr>
<tr>
<td></td>
<td>• Recognition and awards (e.g. access awards)</td>
</tr>
<tr>
<td>Peer pressure</td>
<td>• CCG leadership monitor performance and suggest improvements</td>
</tr>
<tr>
<td></td>
<td>• Increased data requirements</td>
</tr>
<tr>
<td></td>
<td>• Developmental help (non-threatening) to address problem</td>
</tr>
<tr>
<td>Other rewards</td>
<td>• Deeper investigation of performance and understanding of the root causes</td>
</tr>
<tr>
<td></td>
<td>• More frequent visits, and expert help provided to practices</td>
</tr>
<tr>
<td></td>
<td>• Complete transparency of data and performance to CCG</td>
</tr>
</tbody>
</table>

#### Under-performing practices could face disincentives and simultaneously begin to climb the ‘support and intervention’ ladder of escalation

1. **CCG monitoring and support**
   - CCG leadership monitor performance and suggest improvements
   - Increased data requirements
   - Developmental help (non-threatening) to address problem

2. **CCG investigation**
   - Deeper investigation of performance and understanding of the root causes
   - More frequent visits, and expert help provided to practices
   - Complete transparency of data and performance to CCG

3. **Formal warning to practice**
   - Formal warning issued to practice outlining the issues identified, the resolutions required and implications of not changing
   - Practice compelled to invest in necessary capacity to resolve the issues, by using external support

4. **Formal complaint to CB**
   - Formal complaint made to the NHS Commissioning Board, with outline of suggested next steps
   - Issue identified may be with:
     - Primary care as a provider (e.g. quality issues significantly detrimental to patient safety), or
     - Practice has no reasonable prospect of being able to improve

5. **Loss of CCG membership**
   - Removal of practice from the CCG
   - Assumptions being:
     - Patients safety, health outcome and experience is compromised and/or prolonged unaddressed overspend

- **Retention of existing financial mechanisms**
  - Payment for care plans
  - Payments for clinicians to attend case conference
  - Shared incentives across providers to reach targets

- **Other rewards**
  - Recognition and awards (e.g. access awards)
  - Training and development opportunities
  - Additional non-financial resources (e.g. diabetic nurse, MMT)
  - Providing quality of care information and variation to patients and patient advocates

- **Performance transparency**
  - Creating peer benchmarking and conducting peer reviews

- **Other incentives**
  - Under discussion
5.4. IT/Information

Better sharing of information will be central to achieving our vision. It will achieve the following:

- Real-time shared records inform providers and link GPs, community, acute and mental health teams
- Transparency of information gathered will help us drive up standards across Harrow
- Planned care becomes more consistent as
  - Referrals follow precisely defined pathways
  - GPs have access to granular reporting on referrals
- Urgent care becomes better informed as
  - All information input by GP is visible to staff at UCC
  - Care is visible to GP and prompts are given for follow-up actions
- Long term care becomes more pro-active through
  - Risk stratification of patients by GPs
  - Care plans are put in place
  - Enabling regular check ups and early intervention

Exhibit 25 sets out our proposal for how we will migrate practices to EMIS Web.

EXHIBIT 25

We propose offering an upgrade to EMIS Web for all practices in Harrow:

- We will offer an upgrade from the current IT software systems to EMIS Web for all Harrow GP practices
- We are proposing that practices move to EMIS Web rather than any alternative clinical system because:
  - The majority of practices in Harrow already use EMIS LV and transferring to EMIS Web would involve the least disruption to current services
  - EMIS Web offers the highest level of functionality (e.g., enabling prescriptions to be sent electronically to the patients’ chosen pharmacy)
  - EMIS Web is the most cost effective solution. It would cost £4,000 per practice to upgrade from EMIS LV to EMIS Web, but £7,000 to upgrade to Vision and £12,000 to System 1

For the upgrade scheme to proceed, individual GP practices will need to sign up for the upgrade on an individual basis

- A project plan will then be put in place to manage the upgrade (with technical support from the Brent & Harrow IT Department and EMIS)
- Each practice will need to allocate a staff member to manage the process and liaise with the PCT ICT Project Analyst.
- The upgrade of all practices is planned to take place over the course of 8 months between April and November 2012

EMIS Web will allow community, hospital and GP practices to all access one shared patient record. Just this simple information transparency could lead to more appropriate care as a Harrow hospital nurse has observed “In many case without access to patients history we have no choice but to admit. In hindsight this often turns out to have been unnecessary.”
5.5. Developing our People and Organisation

We want to ensure that across the CCG we display new behaviours, rather than old approaches, as outlined in Exhibit 26 below:

EXHIBIT 26

<table>
<thead>
<tr>
<th>From…</th>
<th>To…</th>
</tr>
</thead>
<tbody>
<tr>
<td>![X] We don’t often refer between GPs due to strong patient links and potential contractual issues</td>
<td>![✓] We collaborate across the network, referring patients to each other if appropriate</td>
</tr>
<tr>
<td>![X] We don’t want to talk about performance, or have challenging conversations</td>
<td>![✓] We hold each other to account around differences in outcomes, including celebrating success</td>
</tr>
<tr>
<td>![X] We have seen all this change before – it will not stick and we will be bailed out</td>
<td>![✓] We need to do something different, now, to deliver better care for our patients in the right setting</td>
</tr>
<tr>
<td>![X] It’s a system-wide problem, not mine</td>
<td>![✓] It’s up to me and my contribution to the system working together to deliver good patient outcomes</td>
</tr>
</tbody>
</table>

SOURCE: Harrow OOH workshop 01/02/12

This strategy requires primary care teams to take on new and exciting roles. The CCG needs to develop its members to allow this to happen. Development will include workshops to facilitate team-working within networks and sessions focused on the governance issues for the new networks. Leadership and management training will be provided to facilitate the development of a range of formal and informal leaders within networks. IT skills will be developed so that everybody who needs to can effectively operate key IT programmes used for multi-disciplinary working. Finally, there will be training on how best to involve patients from the role of the media and social marketing to getting patients included in service planning.

Development will also be tailored to professionals’ needs (as outlined in Exhibit 27).
5.6. Conclusion

Making progress on these five enablers will be crucial to making changes to out of hospital care popular with patients, sustainable and effective. They will be an important part of the Next Steps the CCG needs to take.
6. Investing for the future

This strategy has started to lay out our vision for a fundamentally different model of care. To deliver our vision, we will make significant investments in staff and estates across different settings of care. Exhibit 28 broadly outlines the investment we will aim to make in services delivered at home, in GP practices and community health centres over the next three years as investment shifts from hospital to out of hospital sector. An overview of this investment is laid out in Exhibit 28.

EXHIBIT 218

<table>
<thead>
<tr>
<th>Where you will receive care</th>
<th>Services offered</th>
<th>Additional Investment</th>
<th>Additional space</th>
<th>Additional workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td>At Home</td>
<td>Community care</td>
<td>£2.0-2.5m</td>
<td>Access to consulting rooms/team room</td>
<td>38 – 40 WTE</td>
</tr>
<tr>
<td></td>
<td>Elderly care</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Postnatal care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Admission Avoidance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>nGMS plus extended hours</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Core primary care services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>At a GP Practice</td>
<td>ECG, possibly ultrasound</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rapid access to blood tests</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rapid access referral to hub/hospital</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In Community Health Centres</td>
<td></td>
<td>£5.0-5.5m</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>£17-19m</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 Based on bottom up calculation of saving initiatives. Each initiative build on granular assumptions: e.g. “Outpatient at lower cost” initiative assumes re-provision cost of 0.8 GP of 12 minutes & 0.2 Consultant appointment of 30 minutes per patient per year for 5% of total outpatient cohort
2 Assumptions based on pilots outcome of Brent Intermediate Care 2009 and Harrow Unplanned Care Initiatives 2011, QIPP 11/12 business cases, Healthcare for London, CCG input and expert interviews
3 Initiatives includes: “At Home” - e.g. Rapid Response (Nursing), Case Management, ICP; “At a GP Practice” - e.g. Outpatient at lower cost, ICP; “In a community health centre” - e.g. Rapid Response (Bed), Outpatient at lower cost, Outpatient at lower cost (telephone advice), ICP

The staffing and investment identified in the exhibit above is indicative based on CCG strategic plans and is dependent on the release of funding from acute providers as activity transfers from acute settings to community settings. Specific investments will be agreed through the normal planning and governance processes of the CCG and as such the production and agreement of robust business cases demonstrating both value for money and affordability to the CCG.

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

The strategy set out here will form the basis of further, detailed discussions in the next few weeks with GPs, patients and families, other clinicians, partners in social care and public health, the health and well-being board and others, leading to full public consultation in June. In order to ensure the success of the strategy we need to take the following critical steps outlined below in Exhibit 29.

**EXHIBIT 29**

**Five immediate steps critical to success of strategy**

<table>
<thead>
<tr>
<th>Crucial step</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 12/13 budget is set in line with strategy</td>
<td>✔</td>
</tr>
<tr>
<td>2. Strategy is endorsed by:</td>
<td></td>
</tr>
<tr>
<td>- Health and Wellbeing board</td>
<td></td>
</tr>
<tr>
<td>- CCG board</td>
<td></td>
</tr>
<tr>
<td>- All practices</td>
<td></td>
</tr>
<tr>
<td>3. Performance framework is agreed by CCG (including metrics, targets, thresholds and escalation process)</td>
<td></td>
</tr>
<tr>
<td>4. Appropriate governance structures in place for managing performance</td>
<td></td>
</tr>
<tr>
<td>5. Capabilities are in place to deliver strategy including:</td>
<td></td>
</tr>
<tr>
<td>- Management support in CCG</td>
<td></td>
</tr>
<tr>
<td>- CSS support</td>
<td></td>
</tr>
<tr>
<td>- New workforce required to deliver service</td>
<td></td>
</tr>
</tbody>
</table>

This strategy sets out an ambitious plan for improving out of hospital care in Harrow. Implementation is crucial – the quicker this is done the faster the benefits for patients can be realised. The following sections outline the implementation plans we will put in place.
7.1. Initiative implementation plan

Implementation of many of our initiatives is already underway. Exhibit 30 outlines our implementation plan and benefits realisation for our key initiatives.

EXHIBIT 30

DELIVERY: Harrow needs to start the initiative delivery process now to meet the savings schedule we have set for the next 3 years

<table>
<thead>
<tr>
<th>Initiatives</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
<td>Q1</td>
</tr>
<tr>
<td></td>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
</tr>
<tr>
<td></td>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
</tr>
<tr>
<td></td>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
</tr>
<tr>
<td>Non-elective</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Rapid response teams</td>
<td>Delivery begins</td>
<td>Implementation</td>
<td>Delivery ramps up</td>
<td>Fully delivered by March 2015</td>
</tr>
<tr>
<td>▪ Integrated care case management</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>▪ Contractual savings</td>
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<tr>
<td>Outpatient</td>
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<td></td>
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</tr>
<tr>
<td>▪ Planned care pathway redesign</td>
<td>Delivery begins</td>
<td>Implementation</td>
<td>Delivery ramps up</td>
<td>Fully delivered by March 2015</td>
</tr>
<tr>
<td>▪ Access to specialist opinion</td>
<td></td>
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<tr>
<td>▪ Reprovision in community</td>
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<tr>
<td>▪ Referral facilitation and peer review</td>
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<tr>
<td>A&amp;E</td>
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<tr>
<td>▪ UCC</td>
<td>Delivery begins</td>
<td>Implementation</td>
<td>Delivery ramps up</td>
<td>Fully delivered by March 2015</td>
</tr>
<tr>
<td>▪ Increased Primary Care Capacity &amp; supported self care</td>
<td></td>
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<tr>
<td>Elective</td>
<td></td>
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</tr>
<tr>
<td>▪ Minor elective procedures in community</td>
<td>Delivery begins</td>
<td>Implementation</td>
<td>Delivery ramps up</td>
<td>Fully delivered by March 2015</td>
</tr>
</tbody>
</table>

SOURCE: Commissioning Service Plan, 1st December 2011, QIPP plans 15th December 2011, QIPP revision; NHS DSU; CCG finance teams
**DMBC Appendix L6 – Hillingdon Out of Hospital Strategy**

**Foreword**

As a GP, I see first-hand the way in which our community and hospital services are delivering care and the experiences of our patients and clinicians. Too often our care is fragmented and we have an over-reliance on hospital care. It is now well recognised that many hospital admissions could be prevented or treated in a community setting which is better for patients.

The NHS also faces a time of unprecedented challenge. Demand is rising as our population gets older and lifestyle factors contribute to a greater prevalence of long-term conditions. The costs of new drugs and treatments are also increasing. The resources available to us are rising but at a slower rate. Indeed, if we continue with ‘business as usual’ we will face a funding gap of £35 million over the next three years.

We need to transform the way care is delivered to meet these challenges. Our vision is to ensure that the residents of Hillingdon can access high quality, evidence-based care in a setting appropriate to their needs. Moving care out of hospital is a key part of realising this vision. This strategy sets out the plan for how our system will come together and collaborate to prevent people becoming unwell and to offer effective alternatives to hospital when patients need it.

We have already made some real improvements such as launching a new free ‘phone number for patients to find out about local services and receive advice 24 hours a day. We are just about to launch an integrated care pilot, joining up care for those most at risk of falling ill. This will help individuals to proactively manage their own conditions and provide access to help and clinical expertise when they need it so they are less likely to become acutely unwell.

However, there is still much more to do. We need to seize the moment and work together to transform our out of hospital care for the benefit of our local population.

**Dr Ian Goodman, CCG Chair, Hillingdon**
Executive Summary

This strategy sets out our plans to transform out of hospital care. Section one looks at the case for change. We need to transform how care is delivered because demographic changes are increasing demand on healthcare services and the resources available are not increasing at the same rate. Improving our out of hospital services will make care better and less expensive. By intervening earlier, joining up care and supporting patients at home, we will be able to improve outcomes and patient satisfaction, whilst delivering greater value for money.

In section two we outline what the changes will mean for patients, and in section three we describe how we will achieve this. We are using five themes to summarise the changes we intend to make:

1. **Easier access to high quality, responsive primary care**
   We will ensure our residents have easy access to primary care. GPs will work together to extend the range of services offered in primary care. The 111 telephone number will provide a single point of access for patients, carers and clinicians and our Urgent Care Centre will offer 24/7 primary care at Hillingdon Hospital.

2. **Simplified pathways for patients requiring planned care**
   GPs will strengthen the process we use to refer patients. This will ensure patients are placed in the most appropriate healthcare setting and, where possible, patients will be able to access more services, such as outpatients and X-ray, closer to their home.

3. **A rapid response to urgent healthcare needs**
   Where possible, we will avoid admitting patients into hospital. We will do this by creating ‘virtual teams’ who will be trained to respond and provide the required services without admitting the patient. We will also target patients with conditions where effective management and treatment should reduce emergency admission to hospital (often known as Ambulatory Care Sensitive (ACS) conditions).

4. **More integrated care for patients most at risk of becoming ill**
   Our strategy will identify and provide better care for patients most at risk of becoming ill. This includes people with long-term conditions (e.g. diabetes), the frail elderly and those at the end of their life. Working collaboratively with GPs, clinicians, specialists and the patient, we will monitor and provide the best care for that individual at each stage of their condition.

5. **Appropriate time in hospital and support after discharge**
   We will ensure patients admitted into hospital stay for the right amount of time and continue to receive care in the community when discharged. By working collaboratively, we will ensure patients have joined up care plans when they are discharged from hospital and that they continue to receive care and support throughout and beyond their recovery. This will improve the patient experience and clinical outcomes.

**Working together to put patients in the centre of better health care**

This will mean changing how we work together in Hillingdon. In section four we describe how we are organising ourselves and working with others to deliver better care. We have introduced six new clinical sub-groups (Northwood, Ruislip, Uxbridge, West Drayton, Hayes, and Harlington) across the Borough, which will coordinate key services around the patient (for example, integrated care for people with diabetes).

**Implementing the Strategy**
Section five describes the key enablers that will support us in making these changes. These include patient and public engagement, leadership and workforce development, governance and information requirements. We will adapt and make best use of existing premises in Hillingdon to deliver more care out of hospital.

We will need to invest in our future; section six gives an overview of the investment we will make. In the coming months we will begin work to achieve our vision as outlined in this strategy, and will engage both clinicians and managers in how this will be delivered and funded. Section seven provides some more detail of our implementation plans and when we will make these important changes to how care is delivered.
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1. The case for improving out of hospital services

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

Improving our out of hospital services will make care better and less expensive. By intervening earlier, joining up care and supporting patients at home, we will be able to improve outcomes and patient satisfaction, whilst delivering greater value for money. Better care, closer to home is an essential way to maintain the quality of care in the face of increasing demand and limited resources.

Exhibit 1 sets out reasons for transforming out of hospital care. Further details are provided in the North West London’s *Shaping a Healthier Future* programme and the appendix to this document.

EXHIBIT 1

**There is a strong case for improving out of hospital services**

1. The residents of Hillingdon have **changing health needs**, as people live longer and live with more chronic and lifestyle diseases - putting pressure on social and community care. For example, the number of older people with dementia is expected to increase by 7% over five years to 2015.

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

3. However, this needs a **transformation of primary, community and social care**. Currently there is variation in both **quality and access** and standards must improve.

---

1 Source: Hillingdon’s 2012 Joint Strategic Needs Assessment sets out the health and well being needs of the local population over the next 5 years and beyond
2. Delivering quality care, differently

Our vision is to:

‘ensure that the residents of Hillingdon can access high-quality, evidence-based care in a setting appropriate to their needs’

We will achieve this by working in constructive collaboration with patients, their carers, and providers of health and social care. In conjunction with our partners, we have identified five strategic goals that will make our vision a reality.

EXHIBIT 2

<table>
<thead>
<tr>
<th>Hillingdon’s five strategic goals</th>
<th>Specifically, this means</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Easy access to high quality, responsive primary care</strong> to make out of hospital care the first point of call</td>
<td>GPs and primary care teams will be at the heart of ensuring everyone who provides care does so to consistently high standards of care</td>
</tr>
<tr>
<td><strong>2. Clearly understood planned care pathways</strong> that ensure out of hospital care is not delivered in a hospital setting</td>
<td>Whenever possible, patients will have access to services closer to home</td>
</tr>
<tr>
<td><strong>3. Rapid response to urgent needs</strong> so that fewer patients need to access hospital emergency care</td>
<td>If a patient has an urgent need, a rapid clinical response will be provided.</td>
</tr>
<tr>
<td><strong>4. Providers (social and health) working together, with the patient at the centre to proactively manage LTCs, the elderly and end of life care</strong></td>
<td>Patients will have a named coordinator who will make sure they have all the services they need. If a patient’s condition becomes more complex, GPs will be able to direct to a clinician with specialist skills close to home</td>
</tr>
<tr>
<td><strong>5. Appropriate time in hospital</strong> when admitted, with early supported discharge into well organised community care</td>
<td>Care providers will know when an individual patient is in hospital and will manage discharge into planned, supportive out of hospital care</td>
</tr>
</tbody>
</table>

This section describes how care will be different for our patients.
This will mean real changes to how patients receive care

<table>
<thead>
<tr>
<th>Theme</th>
<th>Example patient</th>
<th>From...</th>
<th>To...</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Easy access to high quality, responsive care.</td>
<td>Melanie is 36. A working mother with a young daughter (Maya) who has a fever</td>
<td>Melanie rings her GP but cannot get through, and takes Maya to A&amp;E</td>
<td>Melanie rings 111 and is given an appointment for that evening at a practice with extended hours or at the local hospital urgent care centre</td>
</tr>
<tr>
<td>B. Simplified planned care pathways</td>
<td>Maria is 48. She has made an urgent appointment with her GP after bleeding vaginally for the last two days</td>
<td>Maria meets with her GP who is unsure of the best treatment options and refers her to an outpatient clinic</td>
<td>A GP who books her for one stop assessment and diagnostic on site</td>
</tr>
<tr>
<td>C. Rapid response to urgent needs</td>
<td>Archie is 80. He has developed an urinary tract infection which has led to him becoming confused</td>
<td>Archie is still in hospital and his mental state has deteriorated</td>
<td>Two hours later the GP checks in on the results and phones a consultant for specialist opinion and together agree on appropriate procedure</td>
</tr>
<tr>
<td>D. Integrated care for LTC and elderly</td>
<td>Sameera is 45. She sees her GP complaining of shortness of breath and chest tightness</td>
<td>Sameera is identified as a patient in need of an integrated care plan by her GP and he raises it at a case conference with a specialist chest doctor</td>
<td>A GP, social worker and physiotherapist from the rapid response team arrive and make a health and social care assessment authorising a 7 day package of care to stabilise him at home</td>
</tr>
<tr>
<td>E. Appropriate time in hospital</td>
<td>David is 80. He has recently fallen, fractured his hip and been admitted to hospital</td>
<td>Duty doctor reviews his case and deems him fit to leave following physiotherapist review</td>
<td>When David was admitted to hospital his history is available to staff</td>
</tr>
</tbody>
</table>

2.1. Easier access to high quality, responsive care

We are committed to improving access to primary care so it meets patients’ expectations and needs. For patients this will mean:

- 24/7 telephone access (via the 111 number) for advice on local services, triage and booking urgent appointments.
- 24/7 access to primary care at the Urgent Care Centre (UCC) at the Hillingdon hospital.
- 9am-8pm access to the Minor Injuries Unit at Mount Vernon Hospital
- Greater use of email, text, video and ’phone for information and consultations.
- The opportunity to go to another GP to access a wider range of services.
2.2. Simplified pathways for planned care

An increasing number of patients will be seen in community facilities so they do not have to travel to hospital for outpatient appointments. For example, we are developing community based pathways for musculoskeletal (MSK) patients.

All patients will have access to the same planned care as a result of our Referral Facilitation Service (RFS). This will mean significantly more patients are referred directly to the most appropriate clinician first time.

2.3. Improved response to urgent healthcare needs

Where a patient has an urgent need, we will make sure that they are able to access timely alternatives to hospital. Our multi-disciplinary Rapid Response team will care for more patients at home, meaning they will not need to be admitted to hospital. Patients will be able to navigate the system easily via clear signposting, such as 111 and GP websites, as well as information from knowledgeable staff.

Any individual who is clinically assessed to be at risk of an admission to hospital that could be prevented by short term intervention and support will be seen within four hours. This includes access to expert advice, services, equipment and diagnostics. The Rapid Response Team will organise enhanced support for up to 10 days for those patients who need it to help them remain in their own home.

2.4. Social and health providers working together with the patient at the centre

We will help patients to stay well. For patients most at risk of becoming ill, we will work with other providers to help individuals manage their conditions. This will mean developing integrated, evidence-based care pathways and coordinating care between providers. As a result, patients will experience more seamless care and know who to contact for help and advice. For example, patients with diabetes, or in the last 12 months of life, will have a care plan which they (and where appropriate their carer) will develop jointly with a clinician.
2.5. Appropriate time in hospital and support after discharge

In future, following an admission to hospital, the patient’s GP and other relevant providers will be actively involved in coordinating their discharge to support the transition from hospital to the community. As a result, we expect there will be fewer people staying in hospital longer than they need or wish to, due to lack of adequate supported discharge. Patients with care plans will maintain the continuity of their care throughout their admission to hospital. For example; discharge can be delayed due to mental rather than physical health problems. Hillingdon Hospital is piloting a psychiatric liaison service on all wards which enables care plans to reflect mental health needs and support a smooth transition from hospital.

2.6. Standards to maintain the quality of care

Patients and the public need to be confident that as we change where and how patients are cared for, we will hold ourselves to high clinical standards. Therefore, we have agreed standards that set our aspirations for the future. They emphasise the central role of the GP in the coordination and delivery of out of hospital care. The standards encompass both core primary care delivered by GP practices and the wider care delivered outside of hospital. They aim to shift care delivery from more reactive unplanned care to proactive planned care.

The out of hospital standards for care in NWL are shown below.

EXHIBIT 4

STANDARDS: Local clinical leads have set providers high clinical standards of care to which they will be held

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

Source: NWL Clinical Board and Programme Board, March 2012
3. How we will deliver better care, closer to home

This section describes the key initiatives that will enable us to deliver our five strategic goals. Some of these initiatives are already being implemented in Hillingdon, whilst others are new and are part of work taking place at a wider level, for example the North West London Integrated Care Pilot.

EXHIBIT 5

Our initiatives to deliver our strategic vision

<table>
<thead>
<tr>
<th>Hillingdon’s population will have:</th>
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<tbody>
<tr>
<td>Easy access to high quality, responsive primary care:</td>
<td></td>
</tr>
<tr>
<td>▪ GPs will work together to extend the range of services offered in primary care</td>
<td></td>
</tr>
<tr>
<td>▪ The 111 telephone number will provide a single point of access for patients, carers and clinicians</td>
<td></td>
</tr>
<tr>
<td>▪ The UCC will be developed to offer 24/7 primary care at The Hillingdon Hospital</td>
<td></td>
</tr>
<tr>
<td>Simplified pathways for planned care:</td>
<td></td>
</tr>
<tr>
<td>▪ A referral facilitation service will ensure all patient referrals are directed to the most appropriate clinician and everyone has the same access to the care available</td>
<td></td>
</tr>
<tr>
<td>▪ We will develop community based pathways for some services such as MSK</td>
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</tr>
<tr>
<td>A rapid response to urgent needs:</td>
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</tr>
<tr>
<td>▪ We will broaden the scope of the Rapid Response team to prevent avoidable admissions and keep people at home where possible or provide emergency respite care where necessary</td>
<td></td>
</tr>
<tr>
<td>Integrated care with providers working together:</td>
<td></td>
</tr>
<tr>
<td>▪ There will be six multidisciplinary groups across Hillingdon who will work together to identify and review patients at risk of becoming ill. Initially this will focus on diabetic patients and the over 75s</td>
<td></td>
</tr>
<tr>
<td>▪ We will extend the use of telecare into telehealth care to monitor patients in their home</td>
<td></td>
</tr>
<tr>
<td>Appropriate time in hospital and support after discharge:</td>
<td></td>
</tr>
<tr>
<td>▪ More joined-up discharge support, with an appropriate step-down in care, prompt communication to other providers and clear advice to patients on what to do if they feel unwell</td>
<td></td>
</tr>
<tr>
<td>▪ We have established a psychiatric liaison service to better integrate care in an acute setting with other parts of the health system and increase the number of patients that can be treated in the community</td>
<td></td>
</tr>
</tbody>
</table>
3.1. Improving access to primary care

3.1.1. Improving access to GPs

- We will establish and offer the best mix of appointment (e.g. telephone appointments and emergency appointments booked for the next 48 hours). Online booking will also be available 24 hours a day.
- We will explore better ways to triage patients, getting the right people to focus on the right things. We will publish performance and ensure that practices are held to account to meet quality standards and patient expectations.
- GPs will work together to extend the range of services and hours of availability offered in primary care.

3.1.2. 111 telephone number – a single point of access

- A new phone number, 111, now directs patients to the most appropriate service for all calls except emergencies and routine appointments with their GP
- The 111 team have detailed knowledge of Hillingdon’s services. For example, they may provide clinical advice or direct patients to their GP or a local pharmacy.
- The 111 team is also trailing the direct booking of patients into GP appointments.

3.1.3. Convenient access to the Urgent Care Centre

- We are developing the Urgent Care Centre at the Hillingdon Hospital. This provides a 24-hour GP led service for dealing with minor illnesses and injuries. Mount Vernon Hospital also has a minor injuries unit open 9am to 8pm every day for patients in the north of Hillingdon.
- Our UCC will see approximately 80,000 patients each year. This will reduce usage of A&E by around 50,000 attendances allowing A&E specialists to focus on the most serious and life threatening conditions and reducing patient waiting times.
- The UCC will use the same system as the GP out of hours and 111 services. It will have links with each GP practice (e.g. sending discharge summaries by 8am the following day) as well as links into A&E’s patient administration system (via scanning) for patients who require admission to acute care.
- The aspiration is that the UCC will use NHS Pathways, aligning its practice with the 111 service to ensure a consistent service at all points of access.
3.2. High quality planned care

3.2.1. Referral Facilitation Service

- The Referral Facilitation Service (RFS) will ensure referrals are directed to the most appropriate clinician and everyone has the same access to care.
- This will help ensure that patients are seen by the right clinician at the right time, reducing duplication and unnecessary appointments.

3.2.2. Outpatients in a community setting

- We will aim to shift 10% of outpatient consultations into a community setting. We are developing community-based pathways of care for services such as musculoskeletal (MSK).
- Care will be delivered by consultants or other allied health professionals where appropriate (such as physiotherapists for MSK). We will also look at new ways of working such as tele-access to a specialist opinion.
- Consultants will play a key role in ensuring that out of hospital care is delivered to high standards. They will help ensure consistency and standards across the system: for example, by providing leadership to clinical networks (groups of local experts in a particular disease area), developing care pathways, and providing guidance and leadership on new developments in a disease area.

3.2.3. Responsive Emergency Care

3.2.3.1. The Rapid Response team

- We are widening the scope and range of skills within the Rapid Response team. This will prevent avoidable admissions and provide enhanced support for people to remain independent at home following a crisis.
- This major investment in the Rapid Response will incorporate enhanced medical care access to step-up beds and health and social care professionals including mental health.
- The Rapid Response team will assess people within 4 hours.
- Patients with conditions known as Ambulatory Case Sensitive conditions (ACS), i.e. health problems which should not require hospitalization will also benefit from access to enhanced care if they experience a health crisis event.
- The Rapid Response team will work with other community services such as case managers and community nurses where community care is required.
- The team will provide a holistic assessment of needs and intensive multi-disciplinary support at home for up to ten days. In some cases, people may require a short admission to a community step-up bed (the Northwood and Pinner unit at Mount Vernon) for up to 3 days, to enable an enhanced level of medical support.
- After this initial phase of care, patients who need further support will be able to access other core community services, including a further period of rehabilitation or reablement, or community nursing support.
- This will be facilitated in part by reducing the number of people being admitted to hospital with a length of stay that is very short (under 1 day), and where only low-level care is required. This will help align incentives to the aim of treating more people in primary care and the community where possible.
3.2.4. Risk stratification, care planning and case conferences

- We will roll out the Integrated Care Pilot across Hillingdon. We are establishing six multi-disciplinary groups, which will work together to identify and review patients at risk of becoming ill. Initially their focus will be on diabetic patients and the over 75s.

- GPs and other members of the multi-disciplinary group will identify the most complex patients who require integrated care from a number of professionals.

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

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

Exhibit 6 outlines how the integrated care model will work in practice

**EXHIBIT 6**

How the integrated care model will work in practice

- An IT tool is being procured across North West London which will automate much of the data for the ICP, including risk assessment, work planning and messaging between providers.

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

- This type of integrated approach will primarily support older people and people who have a range of long-term health conditions.

- We are exploring how this integrated approach can help people with mental health needs to be cared for in primary care without the need for more intensive settings.
The role of multi-disciplinary groups:

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

High risk patient cases are discussed at monthly case conferences. There will also be regular performance review meetings to hold different providers to account, evaluate the effectiveness of local care pathways and propose key investments to close gaps in care delivery.

3.2.4.1. Proactive case management for frequent users of hospital services

All patients who have had three or more emergency admissions in the previous year will be offered case management by a dedicated team of community nurses. These patients will have care plans and support in primary care to reduce the number of avoidable health crises and hospital care or admission. This will be better for patients and for the health system. The community nurses will have a key role in the extended primary care health team and will work closely with GPs to ensure these patients have appropriate proactive care in place.

3.2.4.2. End of life care

- We are committed to increasing the proportion of people dying in their place of choice. To achieve this we are:
  - increasing support to care homes;
  - providing a programme of education and workforce development;
  - Improving access to palliative care professionals.
- End of life patients will have a specialised care management plan, coordinated by the district nurses with specialist training.
- We are creating a borough-wide end of life Care register, which will include people's wishes on their preferred place of death. We will explore the use of IT tools to support end of life care so providers can understand and act upon the patients preferred place of care.

3.2.4.3. Using technology to keep people healthy

We are working with social care to identify and develop how telehealth and telecare services can help keep people, such as those with respiratory conditions, healthy and in their own homes.
3.3. Supported Discharge
Supported discharge enables people to leave hospital as soon as they are medically fit. At this stage of a person’s care, some people require hospital, community and social services to work together and take a joint approach across health and social care. This is particularly important for older people to help them retain their independence as far as possible.

3.3.1. Joined up discharge support and step-down care
We are working with partners to develop a new model of supported discharge that enables a seamless patient journey and a multi-disciplinary approach to care. This includes proactive in-reach and out-reach services, managing the transition from the acute to the community, and enhanced care at home. Services could include joined up intermediate care for up to 6 weeks at home or in a step-down bed, and access to supportive services such as equipment, tele-care, rehabilitation and reablement. This will also help patients to return to their home rather than institutional care after discharge from hospital.

3.3.2. Establish a psychiatric liaison service
Hillingdon Hospital is currently piloting a psychiatric liaison service. This service will help diagnose mental health problems while the patient is in hospital. This will enable care for patients with significant mental health needs to be addressed in acute settings (outside specialist mental health units), train other hospital staff to enable them to support mental health needs and provide integration with other parts of the health system including GPs. The service will improve coordination with out-of-hospital care providers and housing services, meaning a higher proportion of patients can be discharged directly to their own homes or appropriate accommodation.
4. How we will work together

Earlier this year, we agreed some organising principles to guide the development of our strategy:

- We need to organise in a way that enables collaboration and co-ordination of care across Hillingdon
- We must avoid duplication of activity
- Activity should be delivered where it is most effective for the patient and most efficient financially
- Care will be GP-led, with primary care teams central to patient care
- We should design care around networks of practice populations which broadly reflect geographical boundaries
- Existing contracting arrangements should not constrain design

The changes proposed in our strategy will mean that providers need to work more closely together. In response to this we will:

- Introduce networks of provision
- Work with our partners to provide coordinated care
- Develop three community ‘hubs’

Another integral part of this is how we work with patients and carers; this is described in section 5.

4.1. Networks of provision

Out of hospital care will be delivered at different four levels. This is because different types of services work better with different user population sizes. To coordinate and integrate care around the patient, the major healthcare providers will work together in networks. These networks will need to form between providers at the existing locality and the new sub-group levels. The four levels of care are described in turn from smallest catchment area to largest (Exhibit 10).
GP practices will remain the foundation of care, providing routine care for minor conditions near where patients live. Overall accountability for a patient’s health will remain with GPs. Practices will also continue to help patients with complex needs to navigate the healthcare system.

We are introducing six sub-groups, each of which will have a population of 50-70,000. These will play a key role in coordinating care and providing a greater range of services locally. Within each sub-group there will be services offering extended opening hours. District nursing and specialist primary care, such as our joint injections service, will be organised within these six sub-groups. Multi-disciplinary groups, which we are introducing as part of the Integrated Care Pilot, will increase the coordination of professionals within sub-groups through monthly case conferences.

The six sub-groups fit into three localities, which will provide more specialized care, such as community outpatient and elective procedures. Patients will travel to local centres for these services, which will be available during extended hours, seven days a week. Rapid Response teams that travel to the patient to provide discharge support and admissions avoidance will work within localities.

Other services which need to operate on a larger scale will function across the borough. Many will be provided around the clock, for example, the 111 urgent care phone number, GP out of hours services, community beds and acute hospitals services including A&E. Services such as Rapid Response, social care and tele-care will be part of a borough level service which can be aligned to the networks.
In order to increase the coordination between different services, we are aligning them to our new boundaries. For example, we propose to reform district nursing (DN) teams into six teams that align to the clinical sub-groups as shown in Exhibit 8:

EXHIBIT 8

There are currently 10 DN teams, moving to 6 will enable closer alignment with each of the multidisciplinary groups to provide proactive care to those most at risk of falling ill.

- 6 teams align to the new sub-groups to provide greater flexibility and collaborative working
- Each team has a senior district nurse and is aligned to a community matron
- A named locality lead oversees the sub-cluster teams and works closely with the GP networks
- The same service is available in both mornings and afternoons to meet patient need
- Twilight service remains at a borough level (due to volumes)
- Each DN team has access to a specialist in palliative care

4.2. Working with our partners to provide coordinated care

Given our aim to provide coordinated care for the residents of Hillingdon, the CCG commits to working closely with our partners. Some examples of how we will do this are included below.

Acute trusts

- Co-design service developments with clinical teams including shared medical models and job-plans

Hillingdon Health and Wellbeing Board (HWBB)

- Under the leadership of the HWBB, a joint health and wellbeing strategy is being developed.
- The HWBB will provide a framework for planning and commissioning care. It will describe how we will be more pro-active in preventing illness and reducing the impact of diseases. For example, it will describe plans to increase the number of people helped to stop smoking, increase the number of NHS health checks, tackle obesity locally and increase the uptake of screening e.g. to identify bowel, breast and cervical cancers.
- The HWBB will also give strategic direction to the actions local health services can take with the council to prevent ill health.

Hillingdon Social Services

- We will develop an integrated service approach across the localities, ensure alignment with personal budgets, and enable people to remain independent at home.
Examples of integrated working with health and social care include intermediate care, telehealth and integrated mental health services.

- Hillingdon social services can also provide information and signposting to individuals to support them to manage their own care.

**Hillingdon’s voluntary sector**

- The voluntary sector plays a valuable role in Hillingdon in both improving health and providing front-line services. The voluntary sector has a key role in co-developing services with patients to enable greater choice and control as well as promoting and supporting self-directed care.

- Voluntary sector services can also work collaboratively with each other and with statutory services, to innovate care to better meet service user needs.

- Their role in communities can also support the new networks with co-developing services and involving patients and the public.

**4.3. Three Healthcare Hubs**

This strategy aims to meet more healthcare needs in the community. To do this will require clinic space, procedure rooms, diagnostics and community beds. We will also need office space and meeting rooms to enable closer working between service providers.

With our partners, we have used a set of criteria to identify three healthcare hubs - Mount Vernon Hospital, Hillingdon Hospital and the HESA Health Centre – as shown in the exhibit below.

**Exhibit 9**

**We propose developing three healthcare hubs**

These leverage our existing estates and provide ease of access to our resident population.

**Criteria**

- **Scale of activities**
  - How many hubs can be supported economically?

- **Clinical effectiveness**
  - What makes sense for the number of appointments?

- **Patient convenience**
  - What sites are easy to get to?

- **Estates availability**
  - Which locations can we use (practically)?

**Mt Vernon Hospital site**

- Already has a diagnostic and treatment centre and minor injuries unit

**Hillingdon Hospital site**

- Already has accident and emergency, the urgent care centre and GP Out of Hours located in one place.

- Is well positioned providing easy access for Uxbridge and West Drayton, as well as Hayes and Harlington residents

**HESA health centre**

- Best community site, with redevelopment work already planned.

- Good transport links
This approach will:

- Provide an integrated non-acute setting for care delivered by specialists, GPs, and AHPs;
- Serve as a base for consultants when they work in the community, and for mobile community providers;
- Provide space for regular meetings of multi-disciplinary groups, GPs and provider networks;
- Allow local access to advanced diagnostic equipment;
- Utilise existing facilities.

5. **Enabling improved healthcare for Hillingdon**

We have identified six key enablers for better care, closer to home:

- Patient and public engagement
- Leadership
- Workforce development
- Governance and variance management
- Information management and technology
- Contracts and incentives

5.1. **Patient and public engagement**

We are committed to engaging and involving patients and the public as set out in the NHS constitution:

‘You have the right to be involved, directly or through a representative, in the planning of healthcare services, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services’

Our approach to patient and public engagement (PPE) is to create and sustain an on-going dialogue. This will ensure our population is aware of the changes proposed and have had the opportunity to shape the design.

We are adopting the PPE engagement model developed by our Local Involvement Network:
In practice, there will be three aspects to this engagement:

1. **Strategic planning**: patient representatives have already contributed to the development of this strategy and we will continue to seek views as we develop our plans
2. **Development of services**: we will involve patient representatives in service developments such as the community-based MSK pathways
3. **Wider communication**: we will use a range of channels to communicate with Hillingdon residents and specific groups on key priorities such as using 111 to access information on local services
5.2. Leadership

This ambitious strategy can only succeed with the right clinical leadership.

We see developing GP leadership as an essential part of driving up standards of care. We will use our networks to provide peer-to-peer learning and challenge. Each clinical subgroup will establish its own structure with clear clinical leadership coming from the clinicians working within that geographic location. The potential for development of clinical leaders is significant and the CCG will provide the necessary resources to maximise this process. In future, we will focus on the following key areas in order to increase the skills of our different professional groups to deliver enhanced out of hospital care:

Exhibit 11

Our GP-led networks require some new leadership roles

As a principle, decisions should be taken at most local level possible

- Overall accountability for patient health
- Provide health navigation
- Provide links to patient groups

48 GP Practice leads

- Lead local network in each of the six areas
- Responsible for clinical governance and variance within the network
- Monitor performance and variance
- Reporting by community and social services
- Administer local budgets

6 Clinical network leads (by subgroup), tbc

- ‘Public face’ and main advocate
- Ensure robust clinical governance and monitor outcomes
- Provide clinical leadership
- Facilitate peer challenge of subgroups

CCG Chair
Dr Ian Goodman

SOURCE: Hillingdon OOH workshops
5.3. Workforce development

Our workforce is critical to the delivery of the out of hospital strategy. Our plans to develop the workforce are as follows:

- We will support GPs to specialise where appropriate, increasing the number of GPs with a special interest.
- We will up skill our practice nurses so that they are able to carry out tasks that GPs have traditionally carried out (e.g. chronic disease management).
- We will build the capabilities of our healthcare assistants so that they are able to carry out technical procedures (e.g. ECG scans, ear syringing and audiometry).
- We will develop the skills of our managers so that they are effective at coordinating networks, monitoring outcomes and developing strong relationships with community services.
- We will work with the acute to adapt the job-plans of consultants and other medical staff to support working in the community.
- We will facilitate integration between health and social care through the introduction of care coordinator roles.

5.4. Governance and variance management

Hillingdon CCG will put in place a robust means of managing performance to ensure patients experience improved care. We will:

1. Establish clear targets and indicators to measure progress
   - Select key performance indicators (e.g. outpatient referrals and non-elective admissions for patients with a long term conditions).
   - Bring our indicators together in a balanced scorecard with the following domains: clinical outcomes, patient experience, operations, and finance.

2. Track performance effectively
   - Establish a transparent monitoring process to monitor performance against stated goals.

3. Peer review of performance
   - Identify ways to spread strong performance.
   - Establish a clear plan of action to address challenges.
   - Report regularly on progress and consequences for poor performance agreed.

4. Rewards, incentives and consequences
   - Explore payment to practices on achievement of targets.
   - Agree consequences for continued under performance.

This is illustrated in exhibit 12
5.5. Information management and technology (IM&T)

Better sharing of information will be central to achieving our vision. We aspire to have real-time shared records across GPs, community, acute and mental health teams as shown in the exhibit below. We will develop an IM&T strategy to support and enable the work to deliver more care out of hospital by autumn 2012. We plan to move to a common GP platform (EMIS Web). We will also develop an information governance approach and standards for the networks.
5.6. Contracts and incentives

As we introduce new services and ways of working, we need to ensure that the contracts and incentives that we have in place underpin these and reinforce the behaviours we want to see. Exhibit 14 shows some example targets that we will set for each of our five key goals and the new types of contracts, incentives and behaviours that will align with these.

EXHIBIT 14

Incentivising out of hospital care

<table>
<thead>
<tr>
<th>Hillingdon’s five strategic goals</th>
<th>Example measures and incentives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Easy access to high quality, responsive primary care</td>
<td>Access times</td>
</tr>
<tr>
<td>Clearly understood planned care pathways</td>
<td>Patient satisfaction</td>
</tr>
<tr>
<td>Rapid response to urgent needs</td>
<td>Shared incentives across networks</td>
</tr>
<tr>
<td>Providers working together to proactively manage care</td>
<td>Outpatient referral rates</td>
</tr>
<tr>
<td>Appropriate time in hospital and supported discharge</td>
<td>Adherence to evidence-based pathways</td>
</tr>
<tr>
<td>A&amp;E attendance rates and conversions</td>
<td>NEL admissions</td>
</tr>
<tr>
<td>NEL admission rates</td>
<td>Case conference attendances &amp; outcomes</td>
</tr>
<tr>
<td>Length of stay</td>
<td>Readmission rates</td>
</tr>
</tbody>
</table>
6. Investing for the future

This section summarises the investment we anticipate making to realise our strategy. To deliver our vision we will make significant investments in staff and estates across the different settings of care. Exhibit 15 outlines the broad investment we will make in services delivered at home, in GP practices, community health centres and community hospitals over the next three years as investment shifts from the hospital to the out of hospital sector.

EXHIBIT 15

The staffing and investment identified in the figure above is indicative based on CCG strategic plans and is dependent on the release of funding from acute providers as activity transfers from acute settings to community settings. Specific investments will be agreed through the normal planning and governance processes of the CCG and as such the production and agreement of robust business cases demonstrating both value for money and affordability to the CCG.

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

In this strategy, we have set out an ambitious vision for transforming out of hospital care in Hillingdon. We need to move quickly to make early improvements for patients and to make the scale of the savings that are needed by 2014/15. Work has already begun on developing business cases for the initiatives in this strategy. This includes detailing the investment required, how costs will be covered, the impact that will be achieved - both qualitative and quantitative - and mapping against other activities that may overlap. Exhibit 16 summarises the key next steps we will take:

EXHIBIT 16

<table>
<thead>
<tr>
<th>Next steps critical to success of strategy</th>
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<tbody>
<tr>
<td>Checkmark</td>
</tr>
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</table>

| Checkmark | Out of hospital strategy incorporated into the commissioning intentions for 2013-14 as well as the health and wellbeing strategy |

| Checkmark | Patient and public engagement strategy finalised and implemented to involve Hillingdon’s residents in co-design and communicating the changes |

| Checkmark | Leadership and governance structures set up to lead the transformation and manage performance |

| Checkmark | Out of hospital strategy integrated with the 2012-13 Quality, Innovation and Productivity (QIPP) plans |

| Checkmark | Detailed IM&T strategy developed which sets out how technology can support and enable delivery of care outside of hospital |

7.1. Implementing our key initiatives

We have already begun to implement a number of initiatives whilst others will be implemented over the next 12 months as shown below. The phasing of some of the key initiatives, along with the anticipated timing of when some of the more tangible benefits will be realized.
**DELIVERY:** Hillingdon needs to start the initiative delivery process now to meet the savings schedule we have set for the next 3 years

Project phasing

<table>
<thead>
<tr>
<th>Initiatives</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q2  Q3  Q4</td>
<td>Q1  Q2  Q3</td>
<td>Q1  Q2  Q3</td>
<td>Q1</td>
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<tr>
<td>Non-elective</td>
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<tr>
<td>• Rapid response teams</td>
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<tr>
<td>• Integrated care case management</td>
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<tr>
<td>• Contractual savings</td>
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<tr>
<td></td>
<td>Planning and design</td>
<td>Implementation</td>
<td>Delivery ramps up</td>
<td>Fully delivered by March 2015</td>
</tr>
<tr>
<td>Out-patient</td>
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<tr>
<td>• Planned care pathway redesign</td>
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<tr>
<td>• Access to specialist opinion</td>
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<tr>
<td>• Reprovision in community</td>
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<tr>
<td>• Referral facilitation and peer review</td>
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<tr>
<td></td>
<td>Planning and design</td>
<td>Implementation</td>
<td>Delivery ramps up</td>
<td>Fully delivered by March 2015</td>
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<tr>
<td>A&amp;E</td>
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<tr>
<td>• UCC</td>
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<td></td>
</tr>
<tr>
<td>• Increased Primary Care Capacity &amp; supported self care</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Planning and design</td>
<td>Implementation</td>
<td>Delivery ramps up</td>
<td>Fully delivered by March 2015</td>
</tr>
<tr>
<td>Elective</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>• Minor elective procedures in community</td>
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</tr>
<tr>
<td></td>
<td>Planning and design</td>
<td>Implementation</td>
<td>Delivery ramps up</td>
<td>Fully delivered by March 2015</td>
</tr>
</tbody>
</table>

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

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

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

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

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

Nicola Burbidge, Hounslow Clinical Commissioning Group Chair
Executive Summary

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

**The case for improving out of hospital services**

- Demand for care is growing as people live longer, chronic and lifestyle diseases becomes more common and the technology and interventions we use become more expensive.

- In order to meet this demand within the resources available we need to improve prevention, early intervention and care at home and reduce demand on hospitals.

- To make these improvements we need to transform primary, community and social care and the way they work together to improve access, quality and capacity. The CCG will work closely with colleagues in the Local Authority and local provider organisations to achieve this.

**Our vision of how care will be different**

- Our vision is that all patients will feel secure in all care they receive out of hospital through effective and safe partnership between GPs, community and social care, hospital and consultants, with early intervention and care in the right setting.

- Patients will have easier access to consistently high quality primary care.

- More consultant led planned care will take place closer to home, including if their home is a care home.

- Patients will phone first for urgent care and more will be treated at home.

- Patients with long term conditions who need care from different services will receive one coordinated package of care.

- Care will be better coordinated when patients are being discharged from hospital.

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

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

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

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

How we will work together

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

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

Supporting the change

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

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

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

Next steps

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

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

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

We need to change the way we deliver care. At present access to care and the quality of care are variable across the borough. Improving the access, quality and scope of out of hospital services will require new ways of coordinating services, investment and greater accountability. Diagram 1 sets out reasons for transforming out of hospital care. Further details are found in NHS North West London’s Shaping a Healthier Future, programme and the appendix to this document.

DIAGRAM 1

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

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

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

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

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

**DIAGRAM 2**

**This will mean delivering across 5 key areas**

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

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

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

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

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

**SOURCE:** GWCCG Commissioning Strategy 2012/13 – 2014/15

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

We have identified that lack of coordination between services sometimes limits the effectiveness of local services. We are aiming to achieve the five aims set out above through coordinating services better. Our ambition of a joined up system with strong links between each part is represented by Diagram 3. Section four sets out our plans achieving a more joined up system.
2.1. Easy Access to High Quality Responsive Primary Care

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

Development opportunities for GP practices will drive up quality in primary care: through the increasing interactions between consultants and GPs, our HEAT (Hounslow Education and Training) events, through embedding peer mentoring in mentoring cells. We are adding to this by further developing the role of consultants in the community and launching multidisciplinary case conferences, which are discussed in section three.

Diagram 4 sets out an example of how better access to primary care will change patients’ experiences:
2.2. High quality elective care and well understood planned care pathways

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

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

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

Diagram 5 sets out an example of how improved elective care will change patients’ experiences:
2.3. Rapid Response to Urgent Needs

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

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

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

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

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

**Diagram 7**

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

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

2.5. Supported discharge

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

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

Diagram 8 sets out an example of how better supported discharge will change patients’ experiences:
2.6. Standards to maintain the quality of care

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

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

<table>
<thead>
<tr>
<th>Urgent care has been stressful when patients need support . . .</th>
</tr>
</thead>
<tbody>
<tr>
<td>The duty doctor reviews her case and deems her fit to leave following physiotherapist review.</td>
</tr>
<tr>
<td>However, the review happens on a Friday and physiotherapists are not available until Monday, leaving Brenda in hospital over the weekend.</td>
</tr>
<tr>
<td>Additionally, nurses assume that discharge to a community hospital is needed, however the local hospital is full.</td>
</tr>
<tr>
<td>Finally, after several further days in community hospital social care takes three weeks to organise a package of care for discharge.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>In future, we will meet patients’ needs at home . . .</th>
</tr>
</thead>
<tbody>
<tr>
<td>When Brenda was admitted to hospital she was flagged as on the high risk patient register and her history was available to staff.</td>
</tr>
<tr>
<td>Her care navigator is notified and discharge planning begins immediately.</td>
</tr>
<tr>
<td>The care navigator talks to her family, calls her social worker and speaks to a community home to pass on information.</td>
</tr>
<tr>
<td>Next steps are captured in a clear care plan and all pieces are in place for discharge when the time comes.</td>
</tr>
<tr>
<td>First week after discharge, she receives daily visit by physiotherapist to stabilise her.</td>
</tr>
</tbody>
</table>

Hospital staff feel less anxious as they have a support structure around the patient. The care navigator takes paper work off nurses, freeing their time to care for patients. Early intensive support accelerates recovery. The duty doctor reviews her case and deems her fit to leave following physiotherapist review. However, the review happens on a Friday and physiotherapists are not available until Monday, leaving Brenda in hospital over the weekend. Additionally, nurses assume that discharge to a community hospital is needed, however the local hospital is full. Finally, after several further days in community hospital social care takes three weeks to organise a package of care for discharge.
2.7. NWL out of hospital standards

DIAGRAM 9

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

3. How we will deliver better care, closer to home

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

We have identified the key challenges we face in each of the five areas and the initiatives that will allow us to address these, which are set out in diagram 10.
<table>
<thead>
<tr>
<th>Issue we faced</th>
<th>Initiatives to deliver our vision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Primary Care</td>
<td>We are developing primary care by supporting GPs to improve access, improving education opportunities for clinicians, increasing GP access to consultants and increasing accountability for access and quality</td>
</tr>
<tr>
<td>High quality planned care</td>
<td>The Urgent Care Centre offers patients an alternative to A&amp;E for non-emergency urgent care</td>
</tr>
<tr>
<td>Responsive emergency care</td>
<td>A joined up system of 111, out of hours provision and linked to the urgent care centre will direct patients to the right place in the system first time and stop inappropriate A&amp;E attendances</td>
</tr>
<tr>
<td>Support at discharge</td>
<td>We are developing better access to mental health services through shifting settings of care in mental health</td>
</tr>
<tr>
<td>Providers working together</td>
<td>Our Referral Facilitation System is creating consistent planned care: 29 Hounslow GPs triage patients and ensure patients get straight to the right place for them</td>
</tr>
<tr>
<td>Integreated care – to proactively manage long term conditions and other at risk groups</td>
<td>Consultants in the community are providing clinical leadership, inputting into care of individual patients and seeing patients in the community themselves</td>
</tr>
<tr>
<td>Support at discharge</td>
<td>A joined up system of 111, out of hours provision and linked to the urgent care centre will direct patients to the right place in the system first time and stop inappropriate A&amp;E attendances</td>
</tr>
<tr>
<td>Support at discharge</td>
<td>We are developing better access to mental health services through shifting settings of care in mental health</td>
</tr>
</tbody>
</table>

3.1. Easy access to high quality responsive primary care

3.1.1. Improving access to GPs

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

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

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

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

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

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

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

111 will direct patients to out of hours services

**DIAGRAM 11**

3.1.3. Convenient access to the Urgent Care Centre (UCC)

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

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

- This will reduce usage of A&E by 70%.
The UCC is integrated with GP Practices through IT: staff at the UCC have shared access to the primary care IT system, SystmOne, which means that they can view and update patient records. It also means that GPs are fully informed about concerns, decisions and treatments and can ensure follow-up where necessary.

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

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

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

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

The ICRS will work with the GP Out of Hours provider and with the ambulatory care service, supporting people with urgent care or complex needs to stay at home.

3.1.4. Shifting settings of care in mental health

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

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

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

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

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

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

To support better primary care for mental health patients we will offer training for non-specialist primary care clinicians. Diagram 12 sets out the key parts of this initiative:
3.2. High quality elective care and well understood planned care pathways

3.2.1. Referral Facilitation Service

- The Referral Facilitation Service (RFS) uses local GPs to ensure all referrals are following locally agreed referral guidelines and thresholds for referrals.
- The RFS provides a system to monitor, process and control referrals from all sources and to all providers in order to improve quality and consistency.
- The RFS results in planned care that is standardised, ensuring that patients are on the right pathway, and that all providers are complying with agreed local guidelines.

3.2.2. Role of consultants in community settings in raising standards

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

- By ensuring consistency and standards across the system: for example, by providing leadership to clinical networks (groups of local experts in a particular disease area, including specialist nurses and therapists), developing care pathways, and providing guidance and leadership on new developments in a disease area.
- By providing input into the care of individual patients: by advising other clinicians (by phone or email) and participating in case conferences at MDG level. For example, mental health consultants are available to take calls from GPs at set times of the day.
- By providing direct care for patients in community clinics, for example, the new ophthalmology service.
3.2.3. Integrated Rehabilitation and Reablement Service

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

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

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

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

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

- There will be a particular focus on stroke and falls rehabilitation for this service to further develop the work of the stroke and falls co-ordinator.

3.3. Rapid Response to Urgent Needs

3.3.1. The Integrated Community Response Service (ICRS)

- Provides care at home for patients who would otherwise need to go to A&E or be admitted to hospital within the next 24 hours.

- Supports patients to go home from A&E or AAU when they would otherwise need to be admitted to hospital.

- Supports patients to go from hospital to their chosen setting when they need support beyond core services.

- Provides an assessment of needs and intensive multi-disciplinary support at home for up to seven days for complex patients, for example, those with two or more diseases, followed by referral onto core community services.

- Made up of a multi-disciplinary team of nurses, occupational therapists, physiotherapists, mental health nurses with expertise in cognitive impairments, social workers, a handy man and a GP.

- Supports people to recover at home and to be independent, rather than relying on hospital.
Examples of patients who have benefited from the ICRS

### 3.3.2. Ambulatory Care Service

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

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

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

### 3.4. Social and health providers working together with the patient at the centre

#### 3.4.1. Develop existing IT to enable more integrated care

- The primary care IT system, SystmOne, which clinicians in Hounslow use, will be developed further to give all providers in health and social care appropriate access to patients’ records and to use and up to date records in real time.
- The SystmOne is currently used by all GPs in the borough, in the UCC, in the community diabetes service and in the community ophthalmology service.
Community health services, child health, and drugs and alcohol services will all start using it in the near future.

- Later this year, it will be possible to link up with the hospital system, Real Time. Social care and community health care Co-ordinate My Care system could be linked in to the system by 2013. West London Mental Health will also use SystmOne.
- By 2013, patients will be able to see their complete record.
- Developing our IT systems in this way means better informed clinical decision-making, and ultimately supports the development of a single care plan for patient, rather than multiple plans from each provider of care.
- It will also allow CCG-wide reporting of information and inform commissioning decisions.

3.4.2. Risk stratification, care planning and case conferences:

Roll out of the Integrated Care Pilot across Hounslow
- We are establishing five multidisciplinary groups of GP practices across Hounslow, which will work together with their local community health and social care teams, supported by a lead consultant to identify and review patients at risk of becoming ill. Initially their focus will be on diabetic patients and the over 75s and plans are in place to extend it to patients with COPD and patients with CHD. This is a roll out of the pilot already taking place in Chiswick.
- GPs will identify the patients who are at highest risk of unscheduled admission to hospital and who could therefore benefit from more proactive care. IT could be used to support this process.
- The practice nurses will co-develop a care plan with the patient and carer (where appropriate), ensuring all the services that the patient needs are working together.
- A new Care Navigator (see below) will support the highest risk 150 patients and will ensure that that they can access all the services they need, self manage their conditions and proactively ask for help, and that their carer is supported.
- Case conferences will bring together hospital specialists, GPs, community health providers, social workers, mental health specialists and others to discuss how best to provide for complex patients. Case conferences will also develop clinicians' knowledge of conditions and the roles other services can play.
- SystmOne underpins co-ordination by ensuring that all clinicians have up to date patient information and that GPs are notified when follow up action is needed.
- The key benefit for patients will be improved outcomes since they will receive earlier and more coordinated intervention

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

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

### 3.4.3. Care navigators

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

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

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

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

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

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

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

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

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

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

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

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

- To support families with bereavement services.

3.4.5. Care for patients with long term mental health needs

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

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

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

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

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

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

3.5.1. Integrated Rehabilitation and Reablement service

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

3.5.2. Supporting social care discharge teams

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

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

3.5.3. Psychiatric liaison service

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

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

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

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

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

**DIAGRAM 14**

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

4.1. Care will be clinically led and consistent

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

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

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

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

- In future, patients, carers and all relevant providers will have access to their records. Patients will be able to see their complete record, appointments and prescriptions and their care plan. A district nurse, for example, could view a patient's record and see which other services are providing care. The patient's GP will be able to see all the care that is happening, ensuring greater accountability and transparency for other providers of care.
4.3. Care will become more coordinated, through clinicians and social workers working together in multi-disciplinary groups

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

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

MDGs will increase coordination of care through care planning. Our aim is that all diabetic patients and half of our elderly patients will receive care plans. Once a year the patient will meet a single primary care representative who will work with them to produce a proactive plan of care for the coming year. It will be based on clinical pathways, and IT will enable all relevant providers to have access to it. This shifts the focus of care from being reactive to planned and allows a single view of an individual's care for all providers.

The locations of the five multi-disciplinary groups are set out in Diagram 18. These groups are the same as the London Borough of Hounslow's area committees, which are responsible for monitoring council services and making local decisions. These common boundaries raise the possibility of closer working together in the future, including management of combined budgets.
Case conferences will help different professionals in the five MDGs to provide more coordinated care. Care providers and practitioners in each pathway will meet monthly for three hours to review and solve complex patient needs. This improves the quality of care that patients receive and is a key professional development opportunity.

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

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

DIAGRAM 19

4.4. We will work with our partners to ensure care is patient focused

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

Working with acute and mental health providers

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

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

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

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

Working with Hounslow and Richmond Community Healthcare

- Hounslow and Richmond Community Healthcare (HRCH) will provide a single point of access seven days a week from 7am to 7pm for all community referrals which will be triaged to ICRS and core community services.
• HRCH will play a key role in the Integrated Care Pilot, which will support better integrated health and social care and closer coordination through MDGs

• Combing HRCH’s rehabilitation team with LBH’s reablement team, is a set towards creating more coordinating out of hospital care

**Working with the London Borough of Hounslow**

• The Local Authority play a crucial role in providing domiciliary care services with and on behalf of the CCG, including commissioning and procuring a medication administrative service

• A Social Care single point of access is being developed as part of the adult social care review and will be in place by 2013

• The 111 service will link with the health and social care single point of access and deal with calls outside these times

• Use of NHS monies for social care to support carers and to employ more social workers, including in the hospital discharge team and a consultant social worker, and improve the care for patients with long term conditions or who have had a stroke

• We are working with Hounslow Council on a shared agenda of reducing dependence on bed based services and supporting people to live in their own homes as well giving local residents choice, and control over their care

**Working with Hounslow Health and Wellbeing Board**

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

**Working with the voluntary sector and faith groups**

• As outlined in the previous section, Care Navigators will work between GPs and social care to ensure patient care is coordinated across the pathway, ensuring that patients are aware of who is able to support them and supporting decisions on commissioning services from the voluntary sector

• We will commission services and work together with the voluntary sector and faith groups as part of wider programme to promote health and well being
4.5. Workforce development will enable us to meet new demands out of hospital

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

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

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

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

- In future, we will develop expertise through rotating staff between specialist and locality based teams. Specialist staff will be transferred out of acute settings and rotate among teams. Members of specialist teams, such as the Integrated Community Response Service, Ambulatory Care Service and Heart Failure teams will rotate with staff in locality teams. In this way teams will develop their skills and working relationships in order to deliver better care in different settings as shown in Diagram 20.

**DIAGRAM 20**

- In future, we will focus on providing training and development the following key areas in order to increase the skills of our different professional groups to deliver enhanced out of hospital care:
• Providing an education and development programme for practice nurses, training them to offer a wider range of services (e.g. chronic disease management and flu vaccination).

• Developing the capabilities of our Healthcare Assistants so that they are able to carry out technical procedures (e.g. ECG scans, ear syringing and audiometry).

• Developing the skills of our CCG and practice managers so that they are effective at coordinating and facilitating patient practice groups, our MDGs, mentoring cells, monitoring outcomes from practices and developing strong relationships with local stakeholders.

• Supporting the integration of community health and social care staff to provide better coordinate rehabilitation and reablement service.

• Increasing the number of social workers in the system.

• Developing core community nursing in accordance with the needs to find in our workforce analysis.

4.6. In order to deliver more care out of hospital we will develop our estates

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

It is embedded in the CCG goal of shifting any primary and intermediate care from secondary care to out of hospital. Whilst the development of networked MDGs will require continued improvement in estate it is not only about a physical infrastructure developed by strategic use of capital over five, but also about a clinical expertise infrastructure. Current clinical leadership in Hounslow will be supplemented through this work.

Over the five year period 2009 – 2013 we have been working to an estates strategy that has seen the development of Heart of Hounslow, Feltham and Brentford.

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

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

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

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

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

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

DIAGRAM 22

<table>
<thead>
<tr>
<th>To be successful we need to...</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engage patients and carers</td>
<td>* Involve, consult and inform patients and carers</td>
</tr>
<tr>
<td>Develop our leadership</td>
<td>* Develop GP leadership within Hounslow</td>
</tr>
</tbody>
</table>
| Agree on how we will be governed | * Monthly dashboard showing performance and targets  
|                                | * Process for holding ourselves to account for these targets |
| Put in place the right information tools | * Unified IT systems providing shared records leading to better patient care and transparency on performance |
| Develop the right contracts and incentives | * Align contracts and incentives of all providers, to ensure system-wide coherence of behaviour and spend |

This section sets out how we will address with each of these issues.
5.1. Engagement with patients and carers

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

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

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

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

**DIAGRAM 23**

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

5.2. Develop our Leadership

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

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

Improvements in performance will be led through benchmarking GP activity, practice by practice, education and peer review, developing leaders of the MDGs, developing our GP triagers for the referral facilitation service and making best use of our integrated IT system, SystmOne. We will establish a clear clinician-led system of peer review through our mentoring cells and our buddy system to ensure that performance is transparent and all practices meet high standards. The five steps of our peer review system are set out in Diagram 25:
A series of review meetings will take place to measure performance and encourage robust performance dialogue. GP practices will carry out day-to-day monitoring of performance. Mentoring cells will review clinical performance and benchmark against others in the CCG and the peer group on a monthly basis. On a quarterly basis they will review reports on priority areas, including prescribing, which will then go to the CCG board. The CCG board will receive overall quarterly performance updates. Diagram 26 illustrates this process. In order for this process to be effective we will develop performance metrics to measure progress in the four main dimensions of quality, access and responsiveness, coordinated health and social care and financial sustainability. A similar process will pertain to the 5 MDGs.
5.4. Information tools

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

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

**DIAGRAM 27**

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

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

### DIAGRAM 29

<table>
<thead>
<tr>
<th>Target</th>
<th>Behaviors this will require</th>
<th>Re-imbursement to support this</th>
</tr>
</thead>
<tbody>
<tr>
<td>Easy access to high quality, responsive care</td>
<td>• Improve access • Improve satisfaction</td>
<td>• Incentives for delivery • Penalties for failing to meet requirements</td>
</tr>
<tr>
<td>Simplified planned care pathways</td>
<td>• Reduce Outpatient attendances • Elective admissions</td>
<td>• Referral incentive scheme • Shared incentives across network to reach targets</td>
</tr>
<tr>
<td>Rapid response to urgent needs</td>
<td>• Reduce A&amp;E attendances • Improve reliability</td>
<td>• Shared budget allocation for urgent care split across UCC, A&amp;E, OOH • Shared incentives across network to reach targets</td>
</tr>
<tr>
<td>Integrated care for LTC and elderly</td>
<td>• Reduce NEL admissions • Increase integration • Increase proactive care</td>
<td>• Payments for care plans • Payments for clinicians to attend case conference • Shared incentives across providers to reach targets</td>
</tr>
<tr>
<td>Appropriate time in hospital</td>
<td>• Reduce length of stay</td>
<td>• Contracting with social care, discharge coordinator and rapid response teams</td>
</tr>
</tbody>
</table>
6. Investing for the future

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

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

We have broadly outlined the investment we will aim to make in services delivered at home, in GP practices and hubs over the next three years as investment shifts from the hospital to the out of hospital sector. The investment represents investment in service provision. In addition to this we will make capital investment in our estates and seeding investment in our IT provision and organisational development. Initial estimate on the scale of investment is £8 – 9m by 2015. Investment will be across community services, and in general practice and in health centres – hubs.

**DIAGRAM 30**

**Initial estimates of scale of Investment**

<table>
<thead>
<tr>
<th>Where you will receive care</th>
<th>Services offered</th>
<th>Additional Investment</th>
<th>Additional space</th>
<th>Additional workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td>At Home²</td>
<td>Community care</td>
<td>£1.5-2.0m</td>
<td>Access to consulting rooms/team room</td>
<td>32 - 34 WTE</td>
</tr>
<tr>
<td></td>
<td>Elderly care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Postnatal care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Admission</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Avoidance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>At a GP Practice³</td>
<td>nGMS plus extended hours</td>
<td>£3.5-4.0m</td>
<td>450-500m²</td>
<td>28 – 32 WTE</td>
</tr>
<tr>
<td></td>
<td>Core primary care services</td>
<td></td>
<td>Team room</td>
<td></td>
</tr>
<tr>
<td>At a Local Hub</td>
<td>ECG, possibly ultrasound</td>
<td>£2.5-3.0m</td>
<td>550-600m²</td>
<td>32 – 36 WTE</td>
</tr>
<tr>
<td></td>
<td>Rapid access to blood tests</td>
<td></td>
<td>&lt;5 consulting rooms</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rapid access referral to hub/hospital</td>
<td></td>
<td>Team rooms</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>TOTAL £8-9m</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The staffing and investment identified in the figure above is indicative based on CCG strategic plans and is dependent on the release of funding from acute providers as activity transfers from acute settings to community settings. Specific investments will be agreed through the normal planning and governance processes of the CCG and as such the production and agreement of robust business cases demonstrating both value for money and affordability to the CCG.
The reductions in acute activity planned by the CCG are consistent with and reflected in the acute PCBC base case modelling.

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

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

Similarly, we will review existing space available in the community and wherever possible look to use space better to deliver future care. We know that we do not currently use our existing space as well as we could.

Together these changes mark major challenges we face over the coming years. We are committed to tackling them, to make the vision described in this strategy a reality.

7. Next steps

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

7.1. Five immediate steps

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

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

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

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

One of the greatest challenges in delivering the strategy will be training and recruiting the right work force. In order to plan for this, by September 2012 we will have completed an audit of workforce skills across providers and identified where our out of hospital workforce will be drawn from and what steps we will need to take to develop staff moving to new roles and recruit and train staff where we have skill gaps.
As these initial steps are underway, we will develop a financial recovery plan for 13/14 and 14/15 underpinned by Out of Hospital strategy and public health analysis, to determine financial stability across the health and social care system in Hounslow. This will feed into our commissioning intentions for 13/14.

Work on the enablers - patient involvement and communication, governance, contracts and incentives, IT and professional development - will take place in parallel with the creation of business cases for the new initiatives.

Diagram 31 summarizes the five immediate next steps we will take:

**DIAGRAM 31**

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

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

DIAGRAM 32

DELIVERY: Hounslow needs to start the initiative delivery process now to meet the savings schedule we have set for the next 3 years

<table>
<thead>
<tr>
<th>Initiatives</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
<td>Q1</td>
</tr>
<tr>
<td></td>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
</tr>
<tr>
<td>1. Non-elective</td>
<td>Planning and design</td>
<td>Implementation</td>
<td>Delivery begins</td>
<td>Delivery ramps up</td>
</tr>
<tr>
<td>• Rapid response teams</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Integrated care case management</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Contractual savings</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Outpatient</td>
<td>Planning and design</td>
<td>Implementation</td>
<td>Delivery begins</td>
<td>Delivery ramps up</td>
</tr>
<tr>
<td>• Planned care pathway redesign</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Access to specialist opinion</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Reprovision in community</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Referral facilitation and peer review</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. A&amp;E</td>
<td>Planning and design</td>
<td>Implementation</td>
<td>Delivery begins</td>
<td>Delivery ramps up</td>
</tr>
<tr>
<td>• UCC Increased Primary Care Capacity &amp; supported self care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Elective</td>
<td>Planning and design</td>
<td>Implementation</td>
<td>Delivery begins</td>
<td>Delivery ramps up</td>
</tr>
<tr>
<td>• Minor elective procedures in community</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

I have been working locally as an NHS GP for over 15 years, and am pleased to be Vice Chair of West London Clinical Commissioning Consortium, representing 55 general practices and over 230,000 patients in Kensington and Chelsea, and the North of Westminster.

We have a culturally diverse population and significant local demographic variation, having one of the most deprived wards in London as well as some of the most affluent. People in the northern wards are twice as likely to die before 75 compared to those in the rest of the CCG. We have a high number of people of working age as well as an aging population.

We have a history of working closely together as practices with every practice in the CCG being involved in planning commissioning and monitoring care through locality based Commissioning Learning Sets.

Our vision is to build on our existing out of hospital initiatives and further transform care for the future. We are committed to developing personalised, well coordinated and seamless pathways of care across health and social care; to shift care to community and primary care settings; and reduce hospital admissions and improve early discharge.

Working with our patient panel and colleagues in both the Royal Borough of Kensington and Chelsea and Westminster City Council, we wish to:

- Develop interventions that empower patients to stay healthy for longer, prevent ill-health and reduce health inequalities.
- Develop a greater range of well resourced services in primary and community settings, designed around the needs of individuals
- Ensure quality improvement and innovation across the whole system - this is central to our plans to deliver better value for money in the process.
- Putting the needs of patients first to ensure the coordinated and integrated delivery of health and social care.

This strategy sets out ambitious yet realistic plans to transform out of hospital care and achieve better, more proactive care closer to home for the people of Kensington and Chelsea, and North Westminster.

Fiona Butler - CCG Vice Chair, West London
Executive Summary

This strategy sets out how West London Clinical Commissioning Group (CCG) will deliver better care for people, closer to home. It focuses on care provided out of hospital and follows the launch of North West London’s ‘Shaping a Healthier Future’ – a programme to improve health care for the two million people living in the eight North West London boroughs.

1. The case for improving out of hospital services

There are 3 key factors that require us to change how we deliver health care in West London:

- The needs of our residents are changing. People are living longer and suffering from more chronic and lifestyle diseases, increasing pressure on health and social care services.

- Under our current model of care, we cannot afford to meet future demand. Hospital is too often the answer. We need better planned and more proactive care, delivered out of hospital to provide better outcomes for our patients at lower cost.

- Delivering this change will require us to transform primary, community and social care. Too often our health and social care services are fragmented, and there is variation in both quality and access to care across West London.

2. Our vision: how care will be different for patients

We have a vision for whole system change in West London: “We are committed to the development of personalised, integrated and joined up pathways of care across health and social care; shifting care from acute to community and primary care settings, and reducing hospital admissions and improving early discharge”.

We know from our patients that they want their care to be personal, well-coordinated, and delivered by a clinician who knows them. Putting patients first and empowering them to stay healthier for longer with emphasis on preventing ill health and reducing health inequalities are our key priorities.

There are five specific goals against which we will introduce new initiatives:

- There will be easy to access, high quality and responsive primary care;

- There will be simplified planned care pathways;

- There will be a rapid response to urgent needs so that fewer patients need to access hospital emergency care;

- Providers (social, health and third sector) will work together with the patient at the centre to deliver well coordinated care for those with long term conditions;

- Patients will spend an appropriate time in hospital when admitted and have a well supported discharge.

3. How we will deliver better care, closer to home

To make this change happen we are building on existing initiatives as well as investing in a number of ambitious new out of hospital initiatives.

- Our new ‘Putting Patients First’ initiative cuts across all five of our strategic goals. It will ensure coordinated, quality care for patients with complex needs to prevent emergency admissions to hospital and ensure they are stepped up and down seamlessly from an urgent service to a managed care service.

- As part of our new ‘Putting Patients First’ initiative, primary care will play a more active role in caring for complex patients at risk of hospital admission. We will promote coordinated and multi-disciplinary working at the practice level so that patients receive seamless care across providers.
• We will involve patients in taking an active role in their care and will promote health, self-care and early intervention by providing better information and support and proactively raising issues of lifestyle with them.

• We will invest in a new community-based care of the elderly consultant as part of our Putting Patients First initiative to provide additional capacity and expertise in primary care for complex elderly patients.

• We have enhanced our referral scheme so that we only refer patients to hospital who need secondary care support. The scheme will support our patients to receive the care they need closer to home.

• We will transform and redesign local respiratory pathways to ensure that patients experience seamless treatment and management of their respiratory condition. New paediatric pathways will deliver coordinated and appropriate care in primary and community settings for children.

• Patients will have access to a rapid response team with a broader scope and skill-set when a rapid response is required. The team will be available 24 hours a day, 7 days a week.

• We will improve the joint working arrangements of our community-based health and social care services, including rapid response and intermediate care to create a seamless care pathway between them.

4. How we will work together to deliver the vision

We will organise ourselves more effectively to achieve our vision of pro-active planned care, and care in the right place, at the right time. Through discussion with our patients and their carers we will improve the coordination of care for complex patients and ensure we step patients up and down seamlessly from an urgent to managed care. We will need more nurses and other health professionals, space, and investment in practices, community hubs, support in the patient’s home and in community estates and equipment.

To support delivery we will organise ourselves into two provider networks and five commissioning learning sets (CLSs) across the CCG:

• Establishing two provider networks will allow us to deliver care working together as providers of care in integrated teams, dedicated to serving a population of patients.

• Providers in each area will form a network of care to co-ordinate and integrate care providing enhanced services to our patients. This will involve alignment and some co-location of providers.

• We know to do this will require an integrated approach with adult social care and community providers to ensure efficient and effective working with no duplication e.g. a single assessment process to ensure patients do not fall through the gaps and integrated long term care teams.

5. Enabling our vision

There are a number of key enablers that will need to be put in place to make these organisational changes work:

• Patient engagement at every stage to tell us what is and is not working;

• Governance to hold providers to account and monitor service delivery;

• New contractual arrangements and incentives to promote new and effective ways of working;

• Information and improved IT; and

• Professional and organisational development.
In summary, the changes we have set out in this strategy - Better Care, Closer to Home, are ambitious and far-reaching. Implementation of this strategy will result in real changes in care for both patients and providers.
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The case for improving out of hospital services
There is a clear case for the transformation of our hospital care.

West London is facing new demographic challenges. The health needs of our residents are changing as the population ages and people live longer with more chronic and lifestyle-related diseases. In 2030, women aged 65 in West London will live for four years with a disability, compared to three years in 2010. The number of stroke survivors will rise by 26% in the next 15 years. Mental health is our biggest burden in terms of reduced quality of life years.

These trends will place unsustainable pressures on our health and social care services, and under our current model of care, we will not have the resources available in the future to meet these growing demands.

Our current model of care is overly dependent on use of hospital services. By focusing on prevention, intervening earlier, joining up care better between and across organisations, and supporting patients who are currently being admitted to hospital in their homes, we can improve outcomes and patient satisfaction and get better value for money. Better care, closer to home, is the only way to maintain quality of care in the face of increasing demand and limited resources.

We need to change the way in which we deliver care. At present, access to and quality of care out of hospital are variable across the CCG, as described by our patients in exhibit 1. There are clear differences in performance between GP practices on a range of indicators including satisfaction with GP opening hours.

Improving the quality of and access to out of hospital services will require new, innovative ways of coordinating and delivering services, more investment and better accountability. Exhibit 2 sets out the reasons for transforming out of hospital care. Further details are available in the NHS North West London’s Shaping a Healthier Future.

Exhibit 1

<table>
<thead>
<tr>
<th>Healthcare professionals identified issues across the system...</th>
<th>...which have resulted in poor quality care for patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>We need to work better with district nurse teams and the rapid response team so we don’t, at best duplicate care and at worse have the patient falling through the net</td>
<td>...I cant understand how in the days of modern technology our GPs cant get access to our hospital records and vice versa it would be much easier for us as patients</td>
</tr>
<tr>
<td>Nurse, Westminster</td>
<td>Patient, Kensington</td>
</tr>
<tr>
<td>I would love to work with my neighbouring practices in order to provide a joint phlebotomy service. Will save money for the practices and be more convenient for the patients</td>
<td>...I like going to my local clinic for as many things as possible. I hate going to the hospital as it is a hassle to find parking and a real stress waiting for hours and not knowing when I will be seen. I would welcome having more of my care done in my GPs surgery...</td>
</tr>
<tr>
<td>GP, Kensington</td>
<td>Patient, Queen’s Park</td>
</tr>
<tr>
<td>Having access to patients hospital records would save us so much time, we would love a system that could work together</td>
<td>...So many times my prescriptions have gone wrong because the hospital Consultant doesn’t let me GP know, and the chemist gives me the wrong drugs. It is confusing for me and could lead me to taking too many or too little drugs. I wish they could just communicate with each other better – I would feel less anxious and it would help me manage my illness much better...</td>
</tr>
<tr>
<td>GP, Kensington</td>
<td>Patient, Queen’s Park</td>
</tr>
<tr>
<td>It is so frustrating when patients get wrongly admitted to hospital. Especially those on palliative care who want to stay at home, seem to go in at the weekends or evenings because of lack of coordinated care pathways</td>
<td>...I find it really difficult to get an appointment with my GP and I don’t understand why my friend down the road can see his GP on the same day he calls? Why is there such a difference between practices and their appointment systems? Now I just go to the local walk-in centre whenever I need to see anyone and always end up seeing the nurse...</td>
</tr>
<tr>
<td>GP, Kensington</td>
<td>Patient, Chelsea</td>
</tr>
</tbody>
</table>

SOURCE: Quotes as reported by patients and GPs at West London GP practices
1. Our vision of how care will be different

West London CCG has a clear vision for the future of out of hospital care:

“West London CCG is committed to the development of integrated pathways of care across health and social care, transforming care pathways by shifting care from acute to community and primary care settings where appropriate, and avoiding hospital admissions and improving early discharge”.

We have developed five strategic goals to enable us to achieve this vision:

Exhibit 3

<table>
<thead>
<tr>
<th>Our five strategic goals</th>
<th>Specifically, this means</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Easy access to high quality, responsive primary care to make out of hospital care first point of call for people</td>
<td>▪ GPs and primary care teams will be at the heart of ensuring everyone who provides care does so to consistently high standards of care</td>
</tr>
<tr>
<td>▪ Streamlining care pathways to ensure seamless services closer to home</td>
<td>▪ Whenever possible, patients will have access to services closer to home</td>
</tr>
<tr>
<td>▪ Rapid response to urgent needs so that fewer patients need to access hospital emergency care</td>
<td>▪ If a patient has an urgent need, a rapid clinical response will be provided.</td>
</tr>
<tr>
<td>▪ Health and social care providers working together, with the patient at the centre to proactively manage LTCs, the elderly and end of life care out-of hospital</td>
<td>▪ Patients will have a named care coordinator who will ensure patients have seamless step-up and step-down care across services</td>
</tr>
<tr>
<td>▪ Appropriate time in hospital when admitted, with early supported discharge into well organised community care</td>
<td>▪ Care providers will know when a high risk patient is in hospital and will manage discharge into planned, supportive out of hospital care</td>
</tr>
</tbody>
</table>

We know from our patients that they want their care to be personal, well coordinated and delivered by a clinician who knows them. **Putting patients first** is our key priority. We develop this theme throughout our strategy and we have integrated it within each of our five strategic goals.

We have provided more detail on each of our five goals below. For each, we describe how our plans will improve care for our patients; and use examples of patient care to illustrate these changes.
1.1. Easy access to quality responsive primary care

We are committed to providing quality care close to home for our population. We will improve primary care so that it is fit for purpose and meets the needs and expectations of our patients. We will address the variation in quality of primary care in West London and ensure that our residents can access quality primary care services when and where they need them.

1.1.1. Access

Working with other CCGs in North West London, we will establish a common framework to transform access and quality in primary care.

Our GP practices will work together as part of two provider networks to ensure that our GP practices are open at convenient times for our patients. We will extend opening hours for urgent as well as planned care services, and extend the range of services provided, in the most appropriate locations.

Patients will have access to telephone advice and triage 24 hours a day, 7 days a week through General Practice and a new, free non-emergency 111 number. Patients will receive better, streamlined access to urgent care and referral to the right local service, the first time.

Patients with an urgent care need will be given a timed appointment or visit from an appropriate service provider across the system within four hours.

1.1.2. Quality: our out of hospital standards

Improving quality means ensuring that we deliver care to the right clinical standards in good facilities. Patients and the public need to be confident in the quality of care they will receive as we change where and how we provide care. We have agreed to implement clinical standards for care in the community, which are set out in exhibit 4.

These standards emphasise that your GP will play a central role in the coordination and delivery of out-of-hospital care. They apply to both core primary care delivered by GP practices and, more broadly, to care delivered outside of hospital. They aim to shift care delivery from more reactive unplanned care to proactive planned care. They will be locally implemented and apply across North West London.

Our GP practices will support each other to work together to learn and review best practice as part of five Commissioning Learning Sets (CLS) to drive improvement in primary care and ensure care meets these quality standards.

1.1.3. Putting Patients First

We know that patients and their families carry out 80-90% of the care required for patients with long-term conditions. Seamless care coordinated by a family doctor lowers the risk of admission to hospital for all age groups.

Our new Putting Patients First initiative will develop a network of support around the patient to ensure they receive seamless care across providers. This is important for those who rely on a range of services from a number of different providers. The GP plays a critical role in this model, ensuring that patient care is well coordinated and joined up across providers.

This model of care will also require a changing role for our patients. We will support them in taking greater control over their health. Keeping people healthy, preventing ill-health and reducing health inequalities is a key priority. What happens within an individual's life – their education, income, skills, work and social connectedness - all impact on their health and length of life. The health sector has unique access to the population. There are tremendous opportunities to support people to keep healthy and influence health inequalities. And we know that people locally want this help and support.
In the future, local NHS providers will be better prepared and able to take action to promote health and address the wider causes of ill-health amongst patients. Patients will be empowered to make informed choices about their care and take responsibility for promoting their own health and wellbeing through supported self-management. Our practice nurses and nurse practitioners will play an important role in prevention of ill health in areas such as smoking and alcohol.

Interventions need to happen across the spectrum of need. We will provide and commission services to cover the spectrum of local needs and routinely assess their impact on our most vulnerable population groups testing our ability to meet the needs of all our residents including those who don’t routinely engage with mainstream services.

High risk patients will develop a personalised care plan with their GP or practice nurse or care co-ordinator to help them manage their health and social needs on a day-to-day basis. It will include an important self-care component. The plans will include goals the patients want to work towards, the support they need, named individuals responsible for providing their care, emergency numbers, and medicines, diet and exercise plans. They will be shared across multi-disciplinary teams of professionals to enable seamless care across providers.

Patients, carers and their families will be equipped with the information they need (e.g. on smoking, alcohol, diet, and exercise) to better manage their care and implement their care plans as appropriate. We will invest in trained patient educators so that our patients have the information they need, and we will connect patients to voluntary sector programmes so that they learn how to self-manage their conditions at home. Use of new technologies such as tele-health will support self-management and home care of our patients.

Exhibit 4

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

Source: NWL Clinical Board and Programme Board

Exhibit 5 shows how better access to primary care and greater patient control will help to improve the health of our patients.
1.2. High quality elective care and well understood planned care pathways

In West London, a proportion of outpatient care and elective procedures occur in the hospital when we could provide higher quality services in the community - at a lower cost, and closer to people’s homes.

We will continue to provide MSK, primary care mental health, and dermatology and diabetes services for our patients in the community. Where appropriate, we will transform care pathways and provide additional services in the community. Patients will have access to new services including respiratory and paediatric clinics. This will reduce waiting times and unnecessary hospital appointments for patients. It will also increase their choice of services and enable them to access services at more convenient times closer to home. Patients with respiratory conditions will have access to a new community-based respiratory clinic open at extended hours, six days week. Our new paediatric service in the community will ensure that we diagnose children with common long-term health conditions earlier. It will mean better care closer to home for our patients and fewer unnecessary visits to hospital.

Our referral scheme will improve referrals from primary care by referring patients to the most appropriate provider in the most appropriate setting. This will reduce the number of unnecessary hospital appointments for our patients and improve quality of care. Patients will be referred to community clinics, closer to their homes, wherever appropriate.

With the new technology we will introduce, patients can expect that clinicians - with their consent, can share and access their information with other health and social care professionals involved in providing their care. This will mean patients will not have to repeat their stories to different clinicians and will receive more integrated care. Exhibit 6 shows how transformed care pathways will improve patient care in West London.

Exhibit 6
Jonathan is 43. He is in good health but has been experiencing severe discomfort in his knee following a recent bout of exercises.

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

Jonathan is 43. He is fit and well. Yesterday, after playing a football match, he has significant pain in his right knee, which became acutely worse overnight.

Jonathan goes to his GP. He is referred for an MRI scan and told to come back if he doesn't improve.

One week later, Jonathan is still in great deal of pain. He has been unable to work, and is hobbling about on an old pair of crutches that his friend gave him. He goes back to his GP who refers him for an MRI scan.

It takes a further two weeks to get the MRI scan done, and 48 hours for that report to get back to his GP. He has an anterior cruciate ligament tear and needs to be referred to a surgeon.

Four weeks later, Jonathan sees an orthopaedic surgeon who arranges an operation in a further four week's time.

Four hours later he sees the GP again who informs him he has an ACL tear.

Jonathan is off work for weeks, he can’t drive a car, and he can’t go back to work. He hobbling about on an old pair of crutches that his friend gave him.

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

Jonathan is off work for weeks, he can’t drive a car, and he can’t go back to work. He hobbling about on an old pair of crutches that his friend gave him.

Jonathan feels that the GP is taking him seriously and is being given the best possible care.

Jonathan doesn’t know what is wrong with him and wonders if RICE isn’t working.

Jonathan is in great pain. He can’t go back to work. He Hobbling about on an old pair of crutches that his friend gave him.

Jonathan is off work for weeks, he can’t drive a car, and he can’t go back to work. He hobbling about on an old pair of crutches that his friend gave him.

Jonathan is extremely frustrated – the whole process is taking such a long time. He is dreading telling his work that he needs to take another month off.

Jonathan is off work for weeks, he can’t drive a car, and he can’t go back to work. He hobbling about on an old pair of crutches that his friend gave him.

Jonathan is extremely frustrated – the whole process is taking such a long time. He is dreading telling his work that he needs to take another month off.

On arrival home, patient, physio and consultant are working together to ensure he is fighting fit and ready to play football again!

On arrival home, patient, physio and consultant are working together to ensure he is fighting fit and ready to play football again!

1.3. Rapid response to urgent needs

Hospital admissions should be prevented whenever possible. Currently, many of our patients are being admitted to hospital when an expanded rapid response in the community could keep them in their own homes. In the future, more patients will be supported at home and in the community instead of having to go to hospital.

When our patients require a rapid response they will be appropriately referred with the knowledge and input of the GP to the rapid response service. They will receive a multi-disciplinary response within two hours from a team including nurse consultants, therapists and social care and GP. The team will have access to tele-health and rapid community equipment to keep patients safely in their home. When patients stabilise they will be transitioned seamlessly to the appropriate intermediate care and reablement services. Patients will receive the support they need to regain their independence and confidence.

Elderly patients with complex health needs will receive specialist support in the community from a new care of the elderly consultant as part of our expanded rapid response service. They will work closely with the GP and will do a comprehensive assessment on transition from the rapid response service to inform the future care plan. Exhibit 7 shows how our expanded rapid response service will improve patient care.

Exhibit 7
1.4. Social and health care providers working together with the patient at the centre

Our new ‘Putting Patients First’ initiative will put the patient at the centre by providing an integrated health and social care response for patients with complex long-term conditions. These patients often have co-morbidities and are frequent users of hospital and health and social care services in the community. In the past, poor coordination between services has caused individuals to ‘fall through the gap’ between services resulting in fragmented and poor quality care.

In the future, patients will receive a coordinated response from health and social care providers and urgent and managed care services. They will have one integrated assessment, and will develop a care plan with their care coordinator and GP, which outlines an appropriate package of care. High risk patients will have a named care coordinator to help them navigate and transition seamlessly between services. In doing so, patients will be empowered to live independently for longer in their own homes, and will avoid unnecessary A&E attendances, hospital admissions and admissions to long term care.

Patients at risk will be supported to better manage their medicines at home so that they stay healthier for longer. A new medicines support team will review their medication and provide the support they need to take their medicines as intended.

Patients at the end of their lives will receive high quality, integrated care and will die in their place of choice.

Exhibit 8 shows how coordinated and integrated care will improve the health and wellbeing of our patients.
1.5. Early supported discharge

Patients are staying in hospital longer than they need to because of a lack of support for discharge and poor co-ordination between health and social care.

In the future, patients will be discharged at the appropriate time and transitioned seamlessly into a new joint health and social care intermediate care service. Patients will be followed into hospital by their care coordinators, who will work with a patient’s GP to coordinate their discharge and coordinate appropriate intermediate support in the community. Patients will have access to a range of services in the community via a single point of access, including community rehabilitation, reablement and tele-care to monitor ongoing progress.

Exhibit 9 shows how patients will benefit from better supported discharge from hospital.

Exhibit 9
2. How we will deliver better care, closer to home

This section outlines some of the schemes we will put in place to meet each of our five strategic goals. Some are improvements on existing schemes, others are new and specific to West London, and others are part of North West London-wide efforts.

Exhibit 10 outlines these schemes by strategic goal.

Exhibit 10

**This means a number of significant changes that will ensure more care is delivered out of hospital (1/2)**

<table>
<thead>
<tr>
<th>A</th>
<th>Easy access to high quality, responsive primary care to make out of hospital care the first point of call for people with urgent, but not life threatening, needs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• The 111 pilot in Central London will provide a single point of access for patients, carers and clinicians to access the appropriate level of care</td>
</tr>
<tr>
<td></td>
<td>• Improved primary care service e.g., extended opening hours in general practice and new ways to communicate with patients</td>
</tr>
<tr>
<td></td>
<td>• Primary care will play a greater role in caring for complex patients using risk stratification and care planning</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B</th>
<th>Clearly understood planned care pathways that ensure out of hospital care is delivered in the most appropriate setting of care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• A referral scheme will ensure all patient referrals are directed to the most appropriate clinician and everyone has the same access to the care available</td>
</tr>
<tr>
<td></td>
<td>• Some outpatient and elective procedures will be moved out of the acute sector into the community, as a more appropriate setting of care</td>
</tr>
<tr>
<td></td>
<td>• Improved capacity to deal with mental health patients in primary care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C</th>
<th>Rapid response to urgent needs so that fewer patients will need to access hospital emergency care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Our rapid response team will be integrated with social care with a broader scope and skill-set – e.g., reaching into hospitals to prevent avoidable admissions and keeping people at home where possible, or in emergency respite care where necessary. Everyone – patients, carers and clinicians will know about the alternatives to hospital or know to contact 111 for advice. This is particularly important for some groups of patients including nursing home residents, dementia patients, people recently discharged from hospital and those at the end of their lives. Service will provide rapid, coordinated and convenient access to care advice from other providers (GPs, social services, voluntary sector) and single point of contact</td>
</tr>
<tr>
<td></td>
<td>• Care of the elderly consultant with provide additional capacity and expertise in primary care to care for complex elderly patients in their homes</td>
</tr>
<tr>
<td></td>
<td>• For end of life - specialised care management plan using the end of life tool, coordinated by GPs and district nurses will ensure patients receive high quality, integrated care and die in their place of choice</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D</th>
<th>Integrated care with providers (social and health) working together – with the patient at the centre – to proactively manage those with LTC and other at risk groups</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Joined up, coordinated care for complex patients with LTC &amp; high users of hospital services, including multidisciplinary groups (ICP) across West London CCG who will work together to identify and review patients at risk of becoming ill</td>
</tr>
<tr>
<td></td>
<td>• High risk elderly and diabetic patients receive expert integrated care from multi-disciplinary groups to prevent them being admitted to hospital</td>
</tr>
<tr>
<td></td>
<td>• A new medicines support pathway and review programme to reduce the level of preventable drugs-related hospital admissions</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E</th>
<th>Appropriate time in hospital when admitted, with early supported discharge into well organised community care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• More joined-up discharge support, with an appropriate step-down in care, reablement support, prompt communication to other providers, and clear advice to patients on what to expect after hospital and who they can contact if they feel unwell</td>
</tr>
<tr>
<td></td>
<td>• Psychiatric liaison services will improve coordination with out of hospital providers and housing services to improved supported discharge</td>
</tr>
</tbody>
</table>

Our new ‘Putting Patients First’ initiative cuts across all five of our strategic goals. It will ensure coordinated, quality care for patients with complex needs to prevent emergency admissions to hospital and keep our patients healthier for longer. Exhibit 11 outlines our new seamless care pathway for patients with complex needs.

We want to involve patients in taking an active role in their care and will promote health and self-management and early intervention through providing better information for people and support for self care.
2.1. Improving access to primary care

2.1.1. Single point of access via 111

- The 111 pilot in West London will provide patients with a free-to-call '111' number 24 hours a day, 365 days a year. It will provide a single point of access for patients, carers and health professionals to access appropriate care.

- Call handlers will use NHS pathways to provide assessment of their clinical needs. They will use a comprehensive directory of local health, social care, voluntary and mental health services so that they can direct patients to the appropriate service locally the first time.

- In an emergency, handlers will pass the call immediately to the ambulance service. They will provide clinical advice or refer patients to the local service for minor injuries or illnesses. If the patient needs to see a GP, they will be referred to an out-of-hours service or GP practice for an appointment. Call handlers will have the ability to book an appointment or telephone consultation directly with the patient’s own GP practice.

- Those with an urgent care need will be seen within the system within 4 hours.

- We will see patients with non-urgent needs within 24 hours by a health professional and 48 hours by a GP.

2.1.2. Developing primary care

We are working with other CCGs in North West London to set up a common framework to transform access and quality in primary care.

- In West London, we will organise into two primary care networks of 20 – 30 practices to increase access to the right services, close to home, at the right times for our patients.

- We will further extend opening hours for our patients in primary care for planned and urgent appointments. We know this is what our patients want. Within three months of our recent pilot GP Access Initiative, we have seen 2,000 more patients as emergency walk-
in patients, across 33 practices. Extending opening hours will increase access to urgent care as a convenient alternative to busy A&E departments. GP-led urgent care centres and walk-in centres, based strategically across the CCG, will continue to provide urgent care for our patients. These services can now book appointments and telephone consultations with a patient’s GP practice directly, to improve continuity of care. We will explore via our provider hubs how a number of local practices can work together to deliver and 8 until 8 service.

- We will explore new ways to communicate with our patients by making better use of the latest technologies e.g. by using email, SMS texting and video consultation.
- GP practices will work together as part of Commissioning Learning Sets (CLS) to improve quality of primary care. This will include peer review and support as well as sharing knowledge and best practice.
- We will implement prevention plans which support our patients in maintaining healthy lifestyles, increasing healthy eating and activity, losing weight and stopping smoking.

2.1.3. Increased role in care of complex patients

As part of our ‘Putting Patients First’ initiative, primary care will play a more proactive role in caring for complex patients with ambulatory sensitive conditions (ACS) at high risk of hospital admission. A Putting Patients First locally enhanced scheme (LES) will draw on the lessons learned and successes of two key local initiatives.

- Very High Intensity User (VHIU) LES: Key interventions including risk stratification, case management and action planning have had significant impact on quality of care and unnecessary hospital admission rates for high intensity users of services and patients with complex long-term conditions.
- Inner North West London Care Pilot: This pilot promotes the integration of services across primary and secondary care. High risk patients are identified using a risk stratification tool. Practices are responsible for managing very high risk patients (specifically those who are elderly or have diabetes) through their participation in multi-disciplinary groups with neighbouring practices, hospital consultants, social workers and community nurses. The meetings provide a vital opportunity to learn, share good practice and improve capability in primary care.

Putting Patients First will promote coordinated and multi-disciplinary working at the practice level so that patients receive joined up care across providers. This will promote a more central role for GPs in organising care around their patients so that patients receive a coordinated package of care to support the care they receive in primary care from different community services. Specifically:

- Practices will use a risk stratification tool to identify high risk patients. The needs of these patients will be reviewed, and they will be assigned to an appropriate professional to coordinate their care, and carry out their health and social care assessment.
- The care coordinator will work with the patient to develop a multi-disciplinary care plan. Care coordinators will be an integral part of long-term care teams and could be a social worker, district nurse, GP or practice nurse.
- GPs will continue to take overall medical responsibility for the patient ensuring continuity of care. This includes responsibility for medication review and input, review of specialist input and routine hospital attendance, crisis planning, and providing medical support to the rapid response and joint intermediate care teams where necessary. A new community consultant for care of the elderly will provide these teams with additional support.
2.2. High quality planned care

In West London, a proportion of outpatient care and elective procedures occur in the hospital when we could provide higher quality services in the community at a lower cost, and closer to people’s homes. We will add to a number of existing services set up through practice based commissioning and operating in the community to deliver this across more clinical specialties.

2.2.1. Referral Scheme

- We will build on the success of our existing local referral scheme to manage demand and improve the quality of referrals. The scheme will ensure GPs make appropriate decisions about where to refer their patients and in doing so, will reduce the number of inappropriate outpatient referrals across a range of specialties. It will reduce the number of unnecessary hospital appointments for patients by ensuring they are treated closer to home whenever clinically appropriate and feasible.

- The scheme will involve GP peer review and learning as part of five re-configured Commissioning Learning Sets (CLS). Practices that sign up to the scheme will receive monthly audits of their referral data for a comprehensive list of clinical specialties, including respiratory medicine, gynaecology, general surgery, general medicine, and paediatrics. Practices will review these audits as part of regular CLS meetings and agree on a plan of action for improvement.

2.2.2. Transforming pathways of outpatient care

- We will continue to provide consultant-led specialist services in the community for conditions including MSK, mental health, dermatology and diabetes. These services will increase access to assessment and treatment for these conditions, improve waiting times for patients from referral to first appointment, and reduce the number of inappropriate referrals to secondary care and improve the quality of services provided in primary care

  **Dermatology**

- A team including a specialist dermatology nurse, specialist GP in dermatology, and dermatology consultant will deliver a multi-disciplinary dermatology service in the community from St. Charles Hospital and Earl's Court area hub.

  **Musculoskeletal**

- We will deliver a new high quality musculoskeletal (MSK) service from two community hubs north and south of borough, as well as from six spoke sites. The multi-disciplinary team will provide a responsive single point of access for triage and advice and referral to the most appropriate member of the team at a convenient time and location. It includes physiotherapy, osteopathy, acupuncture, hydrotherapy, injection therapy and pain management and offers and quick and easy access for face-to-face assessment and treatment.

We will also shift specialist care from the acute sector into the community for a number of new clinical areas.

  **Respiratory**

- We will redesign this pathway so that it includes the following components: smoking cessation, pulmonary rehab, spirometry testing, COPD and asthma clinics, care at home and consultant input.

- Our patients will be encouraged to self-manage their condition. New technologies such as tele-health will assist them in home-care and in managing their care on discharge from hospital.

- A consultant-led specialist team will deliver the service in a community clinic, offering appointments 6 days a week, with extended hours. The team will also provide home-visits for house-bound patients. GPs and Practice Nurses will continue to manage stable respiratory patients in GP practices.
• Offering new respiratory services in the community will reduce patient diagnosis and treatment times, reduce unnecessary hospital admissions and improve integration with other specialist community teams such as rapid response and district nursing.

**Paediatrics**

• We will introduce a new paediatric service in the community to improve the management of common, long-term conditions for children and their families, including asthma and other allergic illnesses.

• The service will operate from hub and satellite sites across the borough, and will work with other specialist teams in the community to improve the management of children with complex needs. We will give training opportunities to our GPs and practice nurses to improve the management of allergies and respiratory issues in primary care.

• This service will create a seamless pathway between primary and community paediatric care. It will also reduce unnecessary referrals to hospital paediatric outpatients and the use of urgent care and A&E services.

**Community cardiology**

• We will pilot a community-based, nurse-led alternative to hospital treatment for cardiac pathways, including atrial fibrillation, hypertension, heart failure and chronic chest pain. The service will improve the quality of referrals to secondary care and reduce unnecessary referrals for patients.

• We will learn from a similar pilot in Westminster, and will consider locating this service in both the north and south of the borough.

c) Mental health

We have developed a unique service to improve management of mental health patients in primary care – the Primary Care Mental Health Service (“PCMHS”). The service is for patients with common mental health problems such as depression and anxiety, as well as for those with more complex needs and those with stable severe mental illness who need more support from time to time. Our enhanced, patient-centred model of primary care provision for mental health supports more people with mental health needs and additional needs in primary care settings. The multi-disciplinary team will provide a single point of access for mental health patients and provide triage and risk assessment, case management, short interventions and delivery of training and education to GPs.

The PCMHS is delivered by a partnership of four organisations: a local community provider, a local mental health trust, and two organisations from the third sector - Depression Alliance and the Reader Organisation. The organisations work together closely to provide a seamless service, using planned care pathways. There is a single point of access to the service. The range of treatments available are coordinated and tailored to the needs of the individual patient.

As part of North West London pilot, we will further develop this “primary care plus” system to deliver a new ‘supported discharge’ pathway which will transfer responsibility of care for appropriate patients from community mental health teams to GP practices using our multi-disciplinary team based in primary care. This pathway will include criteria and shared care protocols for the transfer of responsibility; a case review to confirm criteria have been met; and joint work between the multi-disciplinary mental health team, the GP and the patient to develop a care plan. Shared care electronic communication and data processes will support this pathway. This supported discharge system is outlined in exhibit 12 below.
2.3. Responsive urgent care

2.3.1. Enhancing our rapid response service

- As part of our ‘Putting Patients First’ initiative, patients will have access to a rapid response team with a broader scope and skill-set when a rapid response is required. A rapid response nursing team will be available 24 hours a day, 7 days a week (a rapid response nursing team from 8 am – 10 pm and an out-of-hours nursing team at night).

- The rapid response team will intervene quickly and early to prevent avoidable admissions and keep people at home. The team will incorporate nurses and therapists, as well as additional social care support to provide timely assessment and establish the packages of care required to support people in their own homes. The team will stabilize the patient before they are transferred to services for ongoing care or further short-term community treatment e.g. intensive rehabilitation and reablement services.

- In the future, we will set explicit standards for referral to this service and clarify the level of GP input required in order to maximise the effectiveness of the service.

2.3.2. Care of the elderly consultant

- We will invest in a community-based care of the elderly consultant as part of our ‘Putting Patients First’ initiative. This will provide additional capacity and expertise in primary care to care for complex elderly patients in their homes and so avoid their exposure to hospital-acquired infection.

- The consultant will support and supervise the rapid response team, enabling them to manage more complex patients at home. They will take on short-term clinical responsibility for up to 10 days for particularly complex and unwell patients cared for by the rapid response team. This consultant will assess patients discharged from the rapid response team, and develop a care plan with the patient and their GP. They will provide advice to GPs on the management of elderly patients.
2.3.3. End of life care

- We will implement a joint strategy on end of life care based on an integrated health and social care system. At its centre is use of the ‘Coordinate My Care’ planning tool and implementation of the Gold Standards Framework, which will ensure patients at the end of their lives are enabled to have a “good death”, receive high quality integrated care including input from palliative care nurses, and are cared for and die in their place of choice.

- This strategy builds on work already started by nursing homes, out of hours doctors, and emergency services. It promotes early identification, co-ordination and planning of care for all patients with a death limiting disease. The views and medical care wishes of every patient will be treated with respect and dignity.

2.4. Integrated care for people with long-term conditions

2.4.1. ‘Putting patients first’ – an integrated health and social care response

We will provide an integrated health and social care response to support patients with complex long-term conditions, their families and carers, with support from the voluntary sector where appropriate. These patients often have co-morbidities and are frequent users of hospital and community-based health and social care services. In the past, poor coordination and integration between these services and ambiguity as to how a patient is ‘stepped up’ or ‘stepped down’ from urgent to managed care service has caused individuals to ‘fall through the gap’. In the future, patients will move seamlessly between these services.

- We will place patients at the centre of their care and empower them to take greater control and responsibility for their health and wellbeing.

- We will form two provider networks in West London (see 4) to improve joint working and coordination between community providers.

- We will review the joint working arrangements of our community-based health and social care services, including rapid response nursing, intermediate care (reablement and rehabilitation), district nurse case management and care management teams, and create a seamless care pathway between them. Clear protocols will support the seamless transfer of patients from the rapid response team (including rapid social care) and intermediate care teams. Liaison arrangements between the intermediate care team and the GP will be clarified.

- Complex patients will receive a single, integrated health and social care assessment and develop a multi-disciplinary care plan (see 3.1) with the appropriate professionals. Assessments will include a physical and mental health assessment, medication review, formal and informal care arrangements, and a social care needs and carers review.

- Complex patients will be designated an appropriate care coordinator e.g. social worker, district nurse, GP, practice nurse, who will work with a team of professionals to organise and deliver personalised integrated patient care. The coordinator will use the care plan as a structure to make referrals to the required services. They will also liaise with the different professionals involved in the patient’s care, monitor their progress, ensure a crisis plan is in place, and follow patients into hospital to support their early discharge. The GP will retain medical responsibility for their patients.

2.4.2. Integrated care pilot

Our Putting Patients First initiative builds on the success of the integrated care pilot and incorporates a complementary model of integrated care that we have successfully tested in inner North West London.

- High level multi-disciplinary groups of acute, primary care, social care and mental health professionals share a common database of patients, which is used to identify patients at
The greatest risk of hospital admission ('risk stratification'). They work together to identify and review patients at risk of becoming ill. The focus of the ICP is currently on diabetic patients and the over 75s, but will be expanded to include additional respiratory and cardiovascular pathways.

- As part of NW London pilot the model will include a GP single assessment tool for common mental health disorders, a single point of access for psychological therapies, and a stepped care psychological therapy pathway for people with long-term conditions.

- Through a regular process of work planning, the multi-disciplinary groups develop integrated care plans with high-risk patients. The groups use clinically-agreed pathways to keep these patients out of hospital.

- A new IT tool will automate the data and coordinate risk assessment, work planning and communication within the groups. Exhibit 13 outlines the working arrangements.

- We have also multi-disciplinary teams at the practice level, which mirror higher level groups to improve the coordination of care for all patients whose health and social care needs put them at risk of unnecessary hospital admission.

Exhibit 13

2.4.3. Medicines management

Our ‘Putting Patients First’ initiative will incorporate an improved medicines management scheme.

- Nationally, between 33% and 50% of medicines prescribed for long-term conditions are not taken as recommended. Evidence indicates that up to 6% of all hospital admissions are medicines-related.

- We will introduce a new medicines support service to work with patients at risk of not taking their medicines correctly. The service will support patients to manage their own care better at home.

- The service will have two key components: (1) medicines adherence and support, such as tailored dispensing, to ensure patients take their medicines as intended. (2) Targeted review of patients’ medicines regimes to prevent medicines-related harm.
2.5. Supported discharge

2.5.1. Early supported discharge into well organised community care

People are staying in hospital longer than they need to, often because of a lack of support for timely discharge and poor coordination between health and social care.

- In the future, our Putting Patients First initiative will ensure joined-up, integrated health and social care discharge support.

- Care coordinators will follow their patients into hospital and coordinate plans to ensure a seamless discharge from acute settings into integrated community-based intermediate health and social care services.

- Care coordinators will use a new single point of access for the intermediate care services, through which they can access a range of services including community rehabilitation, reablement, tele-care and community equipment.

- Care coordinators will provide patients with advice on what to expect after hospital and who they should contact if they feel unwell.

2.5.2. Psychiatric Liaison Services

- Psychiatric Liaison support patients in acute hospitals with mental health needs.

- We will develop ‘optimal standard’ psychiatric liaison services in our hospitals. These multi-disciplinary liaison teams will provide 24x7 emergency cover to A&E and wards, and direct care, support and training to staff during normal working hours.

- The Psychiatric Liaison teams will support clinicians by improving mental care and risk management in acute hospitals, and training staff in mental health care. This will result in fewer admissions, reduced length of staff, and lower accommodation costs for local authorities (more patients discharged home directly).

Exhibit 14

Summary of Optimal Standard Liaison Model for a NWL hospital of ~500 beds

<table>
<thead>
<tr>
<th>What is it?</th>
</tr>
</thead>
<tbody>
<tr>
<td>The 'Optimal Standard' is a high quality liaison psychiatry service designed to operate in acute general hospitals in NWL, providing the following services:</td>
</tr>
<tr>
<td>- Case for patients with significant mental health needs (including specialist MH units)</td>
</tr>
<tr>
<td>- Training for other hospital staff to enable them to support patients' mental health needs</td>
</tr>
<tr>
<td>- Integration with other parts of the health system e.g., GPs, specialist mental health teams</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Who delivers the service?</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 Consultant Psychiatrists</td>
</tr>
<tr>
<td>1 Team Manager</td>
</tr>
<tr>
<td>12 Team Nurses (Bands 3 and 7)</td>
</tr>
<tr>
<td>1 Alcohol Nurse</td>
</tr>
<tr>
<td>2 Specialist Registrars</td>
</tr>
<tr>
<td>1 Generic Therapist</td>
</tr>
<tr>
<td>1 Occupational Therapist</td>
</tr>
<tr>
<td>1 Social Worker</td>
</tr>
<tr>
<td>1 Administrative support</td>
</tr>
<tr>
<td>1 Research/Business Support Officer</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What does the service look like?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highly visible multi-disciplinary mental health team fully integrated into the hospital</td>
</tr>
<tr>
<td>Single point of contact for all patients (16+) in hospital with diagnosed or suspected mental health conditions of any severity</td>
</tr>
<tr>
<td>Rapid response for patients requiring mental health support and 24/7 support in A&amp;E and wards</td>
</tr>
<tr>
<td>Training experts on mental health problems and related issues for non-mental health clinicians</td>
</tr>
<tr>
<td>Coordination with out-of-hospital care providers and housing services</td>
</tr>
<tr>
<td>Integrated with broader health and social care system</td>
</tr>
<tr>
<td>Single management structure</td>
</tr>
</tbody>
</table>
3. How we will work together

Our strategy will have significant implications for how and where we deliver care in West London. In order to achieve our vision and implement the transformational initiatives we have described, we need to change how we work.

There will be five main changes to the way we work, as set out in exhibit 15.

Exhibit 15

1. Making these changes means that we need to change the way we do things – we have agreed some organising principles we will stick to as we change

2. We have created two new provider networks around which we will deliver care.

3. There are three distinct levels of care where it makes sense to organise and deliver services outside the acute setting.

4. Primary, community, social and mental health providers need to work together across all levels to ensure care is coordinated and effective

5. As we take further activity into the community, we need to allocate clinical and office space to this increase increased level of activity – we are exploring options including St. Charles Health and Wellbeing Centre, and Earl’s Court Medical Centre.

The following sections examine each of these in detail.

3.1. Our organising principles

Implementing the changes described in section 3 of our strategy will require providers in West London to work together closely. Providers must work to ensure care is organised around our patients, and to extend the range and quality of out of hospital services provided in the community.

To help providers work together effectively, we have developed some key organising principles, as set out in exhibit 16.
3.2. Establishing two new provider networks

We will establish two new provider networks in West London – one in the north, and one in the south, around which we will deliver out of hospital care in the community. These networks will facilitate improved coordination and integration between our primary and community providers.

Each provider network will have its own integrated health and social care hub, in which we can base new integrated services. As set out in exhibit 17, our networks will have three key roles: coordinating out of hospital providers, providing additional out of hospital services, and facilitating the sharing of skills and services in primary care.

Exhibit 17
3.3. Organising into three levels of care

We will organise and deliver care across three levels in West London: in our 55 GP practices, two new provider networks, and at the CCG-wide level. Organising care this way will help us to clarify responsibilities between providers, improve accountability and facilitate coordination of care between providers. Exhibit 18 outlines the roles of these three levels for West London.

Exhibit 18

We will provide a range of services at each level. GP practices will remain at the foundation of care, providing routine care near to where patients live, retaining clinical accountability, and assisting people in the navigation of complex care choices. Exhibit 19 shows the services we will provide at each level in the future.

Exhibit 19

3.4. Coordinating health and social care services

We will organise and co-locate our community health and social care providers around our two provider networks, with GP practices at their centre.

3.4.1. Realigning local teams

As described in exhibit 20 below, we will realign local teams – including rapid response, district nursing and intermediate care (reablement and rehabilitation) teams with our new provider networks and co-locate teams where appropriate to facilitate their integration. Multidisciplinary groups (MDGs) - as part of the integrated care pilot (ICP), will be aligned to and coordinated by these networks.
3.4.2. Named care coordinators
We will establish an integrated health and social care service through named care coordinators. Care coordinators (e.g. district nurse, GP) will have a list of names of patients from the local area for whom he or she will be responsible. The care coordinators will be aligned to the networks to improve accountability.

We recognize that there is a good range of services available for patients with long-term needs that are hard to find and sometimes difficult to access. This is made worse by poor communication between health and social care. We are working closely with the voluntary sector to pilot a GP practice-based navigator role in five practices. The care navigators will: support patients to navigate between services; improve planned uptake of services, increase attendance, and reduce unplanned demand. The navigators will provide live ‘feedback’ on the service to GPs.

Exhibit 20

3.4.3. Working better with our partners
We are committed to working closely with our health and social care partners to improve the coordination of care for our patients.

3.4.4. Health and Wellbeing Boards:
We have Board-level representation on both Westminster and Kensington & Chelsea Health & Wellbeing Boards. Our Chair, Deputy Chair and Managing Director attend the developmental workshops for Kensington and Chelsea; our Westminster Lead and Managing Director attend the developmental workshops for Westminster.

West London CCG has presented its out of hospital strategy to the Kensington and Chelsea Health and Wellbeing Board, outlining current issues in the health care system and its vision for out of hospital care. It has informed the Board about the planned development of new service provision hubs, in the North and South. We aim to do a similar presentation at the next Westminster Health and Wellbeing board. Joint Commissioning staff and senior Local Authority staff have been instrumental in the development of this strategy.

In the future, our Health and Wellbeing boards will play an important role in informing how we commission services. For example, they will help us make plans to increase the number of people that stop smoking, increase number of NHS health checks, tackle obesity, and increase uptake of screening so early treatment can be provided. They will also provide strategic direction to actions that the local health service can take with the Council to prevent ill-health.

At the heart of this strategy is coordinated multi-agency support for local health promotion and disease prevention efforts so that our residents take action to help them better manage their health and live independent and fulfilling lives.
3.4.5. Engaging our patients, users and carers

We are committed to:

- Engaging patients and the wider public in planning, developing, and implementing our commissioning arrangements;
- Ensuring responsive two-way communication and information sharing process with our constituents;
- Establishing clear structures, roles and responsibilities to ensure continuous and meaningful engagement;
- Ensuring that we monitor and evaluate how effective we are in implementing this commitment, and learn from and improve based on this experience;
- Public education.

Exhibit 22 outlines the mechanisms we are putting in place to ensure effective communication and engagement with patients and the public.

The CCG’s existing Patient Panel - formed of local patient representatives, LINKs and voluntary organisations, will oversee the implementation of this strategy. The Patient Representative on the CCG Board is also a member of the Patient Panel and will provide a direct link between patients and the CCG Board. They will be a powerful voice at Board level for patient and voluntary sector organisations.

The CCG is also establishing a new Patient and Public Engagement Board sub-committee. The sub-committee will be led by a GP clinical lead, accountable to the Board, with delegated responsibility for patient engagement.
3.5. Estates

Our plans to move care out of hospital and into community settings mean that more space will be needed in the community. We will require space to deliver care such as more beds in the community, and to carry out more outpatient appointments in community settings. In addition, closer working between professionals will mean that they need office space to co-locate and more meeting rooms.

We propose to establish two new provider hubs, with roles as set out in exhibit 24 below.

Exhibit 24

<table>
<thead>
<tr>
<th>What a hub would do</th>
<th>What a hub would not do</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Provide an integrated non-acute setting for care delivered by specialists, GPs, and Allied Health Professionals</td>
<td>• Function only as an outpatient specialist centre</td>
</tr>
<tr>
<td>• Organising base for co-located community and social care teams</td>
<td>• Displace GP practices, although some may co-locate</td>
</tr>
<tr>
<td>• Serve as a base for consultants to provide community led services, and for mobile Allied Health Professionals or community health services</td>
<td>• Operate in isolation</td>
</tr>
<tr>
<td>• Host regular contact among consultants, MDTs, CHS and GPs</td>
<td>• Duplicate what is already provided in other settings</td>
</tr>
<tr>
<td>• Allow local access to advanced diagnostic equipment</td>
<td>• Provide care in all clinical areas</td>
</tr>
<tr>
<td>• Provide specialist care in a selection of clinical areas</td>
<td>• Be identical to other hubs</td>
</tr>
</tbody>
</table>

Each hub will be different, depending on local circumstance and need. Hubs will not only function as outpatient specialist centres, nor will they replace local GP surgeries, although some GP practices may decide to co-locate within the hubs. Hubs will not duplicate what is already provided in other settings; and they will operate in cooperation with other services, not in isolation.

We have considered a number of different options for the new hubs in West London. We have agreed that our hubs will be based in St. Charles Health and Wellbeing Centre and Earl's Court area, including Earl's Court Medical Centre, Earls Court Health and Wellbeing Centre and Chelsea and Westminster – see exhibit 25, because of the reasons set out in exhibit 26.
This section described the new organisational arrangements needed to support high quality, accessible and responsive services in the community. The next section develops this further examining key enablers required to support this change.
4. Supporting the change

We have identified four key enablers required to support the transformation in out of hospital services in West London.

The four enablers and proposed solutions for each are outlined in exhibit 27 below.

Exhibit 27

<table>
<thead>
<tr>
<th>We must consider...</th>
<th>Recommended solutions</th>
</tr>
</thead>
</table>
| Governance and Performance Management | – WLCCG has organised into two different structures – as provider networks and complimentary Commissioning Learning Sets  
– Each set of structures will have its own governance system, which coordinate at CCG level  
– The CLS’s will be responsible for performance managing primary care, and we have started developing a clear system to do this |
| Contracts and incentives | – Over the next few months we will explore solutions to key questions, including:  
  □ Develop incentives to maximise use of new community services and to reduce unplanned admissions  
  □ Agreeing suitable tariff arrangements for the sharing of staff and premises  
  □ Ensure clarity on services provided within core contracts and those over and above them |
| Information tools | – We are committed to develop an IT solution that will enable our providers to share patient data online, in real-time with all appropriate health and social care professionals  
– We are exploring a number of different options, including solutions from commissioning services support, Westminster’s interoperability project, online data sharing in Scotland, and the ICP |
| People and organisational development | – We have developed new leadership behaviours to drive changes in services and support new ways of working  
– Organisational and workforce development to enhance skills and increase productivity |

The following sections outline how we address each of these key enablers.

4.1. Governance and performance management

West London CCG has organised into two different structures: two provider networks and five complementary Commissioning Learning Sets (CLSs). Each set of structures will have its own governance system, coordinated at CCG level.

4.1.1. Commissioning learning sets

We have established five new commissioning learning sets (CLSs). These CLSs will be responsible for performance managing primary care; providing peer-to-peer review, challenge and mentoring support; and sharing knowledge and learning within primary care. They meet monthly and at least one GP from every one of our 55 practices has to be present. Exhibit 28 outlines the roles of the networks and CLSs respectively.
4.1.2. Governance arrangements

We will establish clear governance arrangements both in the networks and the CLSs to ensure roles, responsibilities and accountabilities are clear and well-understood. See exhibits 29 and 30 below.

Exhibit 29: Governance structure of provider networks

- CCG Board
- Provider Network 1 Clinical Lead
- Provider Network 2 Clinical Lead
- Lead - Community Services
- Lead - MH
- Lead - Social Care
- Lead - Specialist OOH Care
- Lead - Community Services
- Lead - MH
- Lead - Social Care
- Lead - Specialist OOH Care
- IMG: Co-chaired by GP and local authority representatives

Provider network roles and responsibilities:
- Operational Leads – e.g., community services, MH, social care, specialist OOH care
- Clinical Leads
- Key contact for OOH providers for particular area, e.g., social care
- Monitors issues and performance of providers in the relevant area
- Oversee clinical governance in provider networks
- Provide clinical leadership

- Performace management
- Peer-to-peer review & challenge
- Sharing knowledge and learning
We will do more work over the coming months to define the relationship between the two networks and commissioning learning sets, including how they are aligned.

4.1.3. Performance management scheme

Through our Commissioning Learning Sets (CLSs), we will establish a clear clinician-led system for performance within primary care. The system will have the following steps, as outlined in exhibit 31 below.

A series of review meetings will take place to measure performance and encourage robust performance dialogue. GP practices will carry out day-to-day monitoring of performance. CLSs will review clinical performance and benchmark against others on a monthly basis. On a quarterly basis they will review reports on priority areas, including prescribing, which will go to the CCG board. The CCG board will receive overall quarterly performance updates.

Exhibit 32 shows how performance information will flow between the three levels.

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We will develop a set of performance metrics to measure progress in quality, access and responsiveness, coordinated health and social care, and financial sustainability.

Exhibit 33 provides example indicators, illustrative of what could be measured at the practice level.

### Exhibit 33

<table>
<thead>
<tr>
<th>Priority</th>
<th>Potential practice level indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality</strong></td>
<td>▪ Consistent high quality primary care</td>
</tr>
<tr>
<td></td>
<td>▪ # LTC/E of L patients with care plans</td>
</tr>
<tr>
<td></td>
<td>▪ QOF sources</td>
</tr>
<tr>
<td></td>
<td>▪ New indicators reflecting out of hospital standards</td>
</tr>
<tr>
<td><strong>Access &amp; responsiveness</strong></td>
<td>▪ Good patient access</td>
</tr>
<tr>
<td></td>
<td>▪ Responsive health service</td>
</tr>
<tr>
<td></td>
<td>▪ MORI access poll</td>
</tr>
<tr>
<td></td>
<td>▪ Unscheduled NEL admissions</td>
</tr>
<tr>
<td></td>
<td>▪ New indicators reflecting standards</td>
</tr>
<tr>
<td><strong>Coordinated health and social care</strong></td>
<td>▪ Integrated and coordinated health and social care response</td>
</tr>
<tr>
<td></td>
<td>▪ Response times for community services and social care</td>
</tr>
<tr>
<td></td>
<td>▪ MDG composition and activity</td>
</tr>
<tr>
<td></td>
<td>▪ Multichannel access to care plans</td>
</tr>
<tr>
<td><strong>Financial sustainability</strong></td>
<td>▪ Deliver planned care initiatives</td>
</tr>
<tr>
<td></td>
<td>▪ OP referral rates</td>
</tr>
<tr>
<td></td>
<td>▪ IP admission rates</td>
</tr>
<tr>
<td></td>
<td>▪ A&amp;E rate</td>
</tr>
<tr>
<td></td>
<td>▪ Emergency admissions rate</td>
</tr>
</tbody>
</table>
4.2. Contracts and incentives

Changes to services and ways of working will require us to revise our contracts and incentives, as outlined in exhibit 34.

Exhibit 34

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Facilitate financial flows within practice groupings, for example incentivise inter-practice referrals</td>
</tr>
<tr>
<td>2</td>
<td>Align provider and patient interests by incentivising providers to meet the out of hospitals standards</td>
</tr>
<tr>
<td>3</td>
<td>Manage performance at the level of practice groupings, asking providers to share data on their performance on a locality level</td>
</tr>
<tr>
<td>4</td>
<td>Commission services from provider networks</td>
</tr>
<tr>
<td>5</td>
<td>Promote financial stability by incentivising providers to reduce the total cost of a patient’s care. For example, GPs and practice groupings could be incentivised to reduce non-elective admissions for their patients.</td>
</tr>
<tr>
<td>6</td>
<td>Agree suitable tariff arrangements for sharing staff, premises and services</td>
</tr>
<tr>
<td>7</td>
<td>Develop incentives to maximise use of new services/tools and thus reduce unplanned admissions</td>
</tr>
<tr>
<td>8</td>
<td>Create clarity on the services provided within core contracts, and those over and above core contracts (local enhanced services)</td>
</tr>
<tr>
<td>9</td>
<td>Resolve potential conflicts of interest (e.g., LMA, Urgent Care Centres)</td>
</tr>
<tr>
<td>10</td>
<td>Consider contractual implications for GPs, Trusts, staff (rotas etc.), and who holds contracts for enhanced services – the hub or practice</td>
</tr>
</tbody>
</table>

We have a number of contractual levers that we can use:

- The type of contract for the provision of services
- The potential to select alternative providers (Any Qualified Provider initiative)
- The use of the Local Enhanced Service: agreed incentives for local GP practices, or DES (as directed by the DoH).
- Flexing or withholding a significant proportion of contract payment if providers fail to meet goals on a service by service basis
- Patient satisfaction
- Audits and independent review
- CQUIN’s for quality standards
- Increased productivity including higher percentage of face to face time (clinician to patient)
- Teams to be mapped to GP practices with named link practitioners
- Payments linked to patient outcomes
- QOF points

4.3. Information tools

Central to achieving our vision of transforming care is ensuring that all appropriate health and social care professionals can share patient data on-line in real time.

As set out in exhibit 35, we will invest to ensure that GPs, community, acute and mental health teams have linked IT systems and access to real-time shared records. Information will be transparent and will help us drive up standards across West London. It will mean:

- Planned care will become more consistent as referrals follow precisely defined pathways. GPs will have access to detailed reporting on referrals including test results such as blood, x-ray and scan results.
- Urgent care will become better informed because all information input by GPs will be visible to staff at Urgent Care Centres (UCCs). Care received by a patient at an UCC will be visible to GP and prompts will be given for follow-up actions.

- Long term care will become more pro-active as IT tools enable GPs to risk stratify their patients, develop care plans with their patients, and facilitate regular check ups and early intervention.

Further issues under active consideration are data quality, on which to base patient decisions and information governance, ensuring that the correct data is available for the appropriate health care professional, at the correct time and that patient confidentiality is maintained in all circumstances.

In addition, patients will benefit from new forms of communication such as text messaging and tele and video conferencing which can be targeted appropriately and can offer a further opportunity to support at risk patients.

These IT developments will have significant impact on our patients. Our patients will benefit from improved continuity of care between providers. All providers will be fully informed about a patient's condition, so the quality of decision-making and therefore patient care will improve. Patients will not have to repeat their stories to different care professionals, and will not have to undergo repeated investigations in different places.

Exhibit 35

We will develop our IT systems by learning from the implementation of a range of different IT initiatives. These include:

- Real-time, online data sharing in Scotland, led by Professor Andrew Morris, Chief Scientist of Scotland and Professor of informatics and diabetes in Dundee.

- The Integrated Care Pilot (ICP) has a separate portal for data entry, specifically for used for elderly and diabetic patients.

- The Westminster interoperability project, which is connecting local systems across the acute, community, primary care and social services sector.

- IT support from Commissioning Support Organisations in London, which will provide an opportunity for North West London to unify IT systems across the cluster.

4.4. People and organisational development

Strong and effective leadership will be required to drive significant change in services and ways of working. Exhibit 36 outlines the leadership behaviours which we are committed to as
we begin implementing this strategy and building our new provider networks and reconfigured CLSs.

Exhibit 36

We are also committed to investing in developing the capacity and capability of our workforce in order to deliver our out of hospital strategy. Exhibit 36 outlines the support we should provide to staff in 3 areas: mobilisation, developing new skills to provide new models of care and prevention; changing the roles and responsibilities of staff to deliver productive prevention and care.

Exhibit 37

We recognize there is variation across out of hospital services. We will use primary care and other quality standards as a framework for organisational and workforce development in these areas:

- Mobilization
  - Change management
  - Cultural change – increased prevention through patient education and information by all clinical staff
  - Clinical risk management in the community and practitioner autonomy
  - Changing roles and responsibilities to deliver integrated health and social care services and support

- Skills development
  - Shift and embed skills from acute to out of hospital settings
  - Safe working environments, including lone, remote and outreach working
  - Appropriate skill-mix across care pathways, including the different approaches to risk management and practitioner autonomy
  - Develop CLS program through sharing best practice and enablers such as peer review and audit
  - Career progression for Practice Nurses and Nurse Practitioners
  - Shift of staff – training and education required for acute nurses to extend their clinical knowledge and skills management of long-term conditions
  - Consider improved career progression for practice nurses and nurse practitioners

- Productivity
  - Prevention and self-care
  - Practice Team Development, including increasing deployment of Practice Nurses, Practice Managers and Health Care Assistants
  - Increase patient contact time
  - Seamless interface between CLSs and provider hubs and social care
  - Ability to deliver more within the community environment

Making progress on these five enablers will be critical to the successful implementation of this strategy. In the next section, we outline the ‘next steps’ the CCG will need to take to develop these enablers and begin implementing the initiatives outlined in section 3.
5. Investing for the future

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

Patients will receive care in a variety of settings. Where possible, care will be delivered at home, or close to home. As care becomes more specialised, patients will need to travel further. GPs will offer a broader range of services in local practices by working in two provider networks across West London. Two of our existing sites – St. Charles Health and Wellbeing Centre and Earl’s Court Area Hub including Earl’s Court Medical Centre will provide additional services locally, serving as a support ‘hub’ to local integrated teams. The services offered within these hubs will include community outpatient appointments (e.g. respiratory and paediatric clinics).

Exhibit 38 outlines the investment we aim to make in services delivered at home, in GP practices and in hubs over the next three years as investment shifts from the hospital to the out of hospital sector. The investment shown represents investment in service provision only. In addition to this, we will make capital investment in our estates, and seed investment in our IT provision and organisational development.

Exhibit 38 – Initial estimates of scale of investment

---

### Exhibition 38

**Where you will receive care**

<table>
<thead>
<tr>
<th>Where you will receive care</th>
<th>Services offered</th>
<th>Additional Investment</th>
<th>Additional workforce in the community</th>
<th>Additional space</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>At Home</strong></td>
<td>Specialist community nursing e.g. District Nursing and Respiratory, Rapid Response, Elderly care, Nursing/ Patients First, Medicines adherence</td>
<td>£1.5-2.0m</td>
<td>36 – 40 WTE</td>
<td>Access to consulting rooms/team room</td>
</tr>
<tr>
<td><strong>At a GP Practice</strong></td>
<td>Core primary care services, Local/Enhanced Services e.g. Phlebotomy, Specialist community clinics e.g. diabetes, Extended access in Primary care</td>
<td>£1.5-2.0m</td>
<td>14 – 20 WTE</td>
<td>200-300m, 0-2 consulting rooms, Team room</td>
</tr>
<tr>
<td><strong>In Community Health Centres</strong></td>
<td>A range of diagnostics e.g. Ultrasound and X Ray, Rapid access to blood tests, Specialist community clinics e.g. MSK, Mental Health, Dermatology, Respiratory and Paediatrics</td>
<td>£2.0-2.5m</td>
<td>34 – 40 WTE</td>
<td>1,100-1,200m, &lt;24 beds</td>
</tr>
</tbody>
</table>

**Investment does not include estate cost**

---

The staffing and investment identified in the figure above is indicative based on CCG strategic plans and is dependent on the release of funding from acute providers as activity transfers from acute settings to community settings. Specific investments will be agreed through the normal planning and governance processes of the CCG and as such the production and agreement of robust business cases demonstrating both value for money and affordability to the CCG.

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

This strategy sets out an ambitious plan for improving out of hospital care in West London. Implementation is crucial – the quicker implementation is started the faster the benefits for patients can be realised.

6.1. Implementing our key initiatives

As described in exhibit 39, we have started implementing some initiatives; others are ramping up to their full scope; and others will be implemented over the next 12 months.

Exhibit 39

**DElivery: West London needs to start the initiative delivery process now to meet the savings schedule we have set for the next 3 years**

<table>
<thead>
<tr>
<th>Project phasing</th>
<th>Initiatives</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
<td>Q1</td>
</tr>
<tr>
<td>1 Non-elective</td>
<td>Rapid response teams</td>
<td>Planning and design</td>
<td>Implementation</td>
<td>Delivery ramps up</td>
<td>Fully delivered by March 2015</td>
</tr>
<tr>
<td></td>
<td>Integrated care case management</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Contractual savings</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Out-patient</td>
<td>Planned care pathway redesign</td>
<td>Planning and design</td>
<td>Implementation</td>
<td>Delivery ramps up</td>
<td>Fully delivered by March 2015</td>
</tr>
<tr>
<td></td>
<td>Access to specialist opinion</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reprovision in community</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Referral facilitation and peer review</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 A&amp;E</td>
<td>UCC</td>
<td>Planning and design</td>
<td>Implementation</td>
<td>Delivery ramps up</td>
<td>Fully delivered by March 2015</td>
</tr>
<tr>
<td></td>
<td>Increased Primary Care Capacity &amp; supported self care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Elective</td>
<td>Minor elective procedures in community</td>
<td>Planning and design</td>
<td>Implementation</td>
<td>Delivery ramps up</td>
<td>Fully delivered by March 2015</td>
</tr>
</tbody>
</table>

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

6.2. Key immediate steps

The key next steps are:
- By the end of May 2012
  - Roll-out of Referral Scheme complete across all West London practices.
  - Agreed final specification for Putting Patients scheme and roll out across all West London practices.
- First phase of the redesign of the Primary Care Mental Health Services will be finalised and integrated service fully operational.

- By the end of June 2012
  - Plans for the modelling and redesign of the Respiratory and Paediatric pathways will be complete, including project milestones.
  - Reviewed care pathways for responsive/urgent care along with Putting Patients First Initiative to integrate and join up pathways where appropriate.
  - Finalised business case for the Care of the Elderly Consultant.
  - Developed our plans to ensure we maximise the benefit of 3rd sector providers.
  - The 111 service will be live, including routing back to Primary Care

- By the end of Dec 2012
  - Put out advert for the tender of a new community Respiratory service for West London CCG. Care of the Elderly Consultant recruited and project plan for service mobilization in place.
  - The new Musculoskeletal Service will be up and running, and all patients new and follow up will be transferred to the service by September 2012.
  - Our Practices will meet primary care standards. By working together in provider networks and across the CCG, practices will offer a full range of enhanced primary care services to all West London patients.
  - Plans in place to use different contractual and payment mechanisms to promote integration and encourage innovation from a range of providers including the 3rd sector.
  - Developed responsive and integrated service provision for urgent care, including GP walk-in, 24/7 Rapid Response service and appropriate GP led services at hospitals.
  - We will have a comprehensive estates strategy.