Joint Health Overview & Scrutiny Committee (JHOSC)

Supplementary Agenda

Tuesday 3 December 2013
10.00 am
COMMITTEE ROOM 1 - HAMMERSMITH TOWN HALL, KING STREET, HAMMERSMITH W6 9JU

MEMBERSHIP

Chairman: Councillor Lucy Ivimy (LB Hammersmith & Fulham)

Councillor Mel Collins (LB Hounslow)
Councillor Sheila D'Souza (Westminster City Council)
Councillor Mary Daly (LB Hounslow)
Councillor Pamela Fisher (LB Hounslow)
Councillor Robert Freeman (RB Kensington & Chelsea)
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Councillor Patricia Harrison (LB Brent)
Councillor Anita Kapoor (LB Ealing)
Councillor Vina Mithani (LB Harrow)
Councillor Will Pascall (RB Kensington & Chelsea)
Councillor Victoria Silver (LB Harrow)
Councillor Rory Vaughan (LB Hammersmith & Fulham)

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Date Issued: 27 November 2013

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Supplementary Agenda

3 December 2013

Shaping a healthier future
JHOSC Update

3 December 2013

Contents

IRP & SoS decision

Secretary of State agrees changes to NHS services in North West London

- Wednesday 30 October the Secretary of State for Health accepted advice from the IRP "in full" and agreed that changes to NHS services in North West London should proceed, including the move to five major hospitals.
- Secretary of State said: *(All quotes from Jeremy Hunt's statement to the House of Commons unless otherwise stated)*
  - "These changes represent the most ambitious plans to transform care put forward by any NHS local area to date. They are forward-thinking and address many of the most pressing issues facing the NHS, including seven-day working, improved hospital safety and proactive out-of-hospital and GP services."
  - "The improvements in emergency care alone should save about 130 lives per annum and the transformation in out-of-hospital care many more, giving north-west London probably the best out-of-hospital care anywhere in the country."
  - "The panel says that "Shaping a healthier future" provides "the way forward for the future and that the proposals for change will enable the provision of safe, sustainable and accessible services." Today I have accepted the panel's advice in full and it will be published on the panel's website."
  - "Ealing and Charing Cross hospitals should continue to offer an A&E service, even if it is a different shape or size from that currently offered."
  - "Local services will be designed by clinicians and local residents and will be based on the specific needs of the population."

Secretary of State agrees changes to NHS services in North West London

- “Further work is required before a final decision can be made about the range of services to be provided from the Ealing and Charing Cross hospital sites.”
- “Any changes implemented as part of “Shaping a healthier future” should be implemented by local commissioners following proper public engagement and in line with the emerging principles of the Keogh review of accident and emergency services.”
- “In line with the emerging findings of Bruce Keogh’s review of A&E, Charing Cross and Ealing hospitals must provide:

  -immediate access to specialist consultant opinion

  -a wide range of diagnostic services

  -the ability to admit people for assessment, treatment and rehabilitation”. (DH press release)
- Inline with the IRP report, “changes to A&E at Central Middlesex and Hammersmith hospitals should be implemented as soon as practicable”.
- “I support the Panel’s recommendation that maternity and paediatric inpatient services should be concentrated on the sites identified by Shaping a healthier future”. (Letter from DH)

Keogh Emergency Systems Review

NHS England Urgent and Emergency Care Review

- Phase 1 report from Bruce Keogh published Wednesday 13 November 2013
- Case for change and vision closely aligned with that of north west London
- Sets out national system-wide transformation over the next three to five years
- Proposes a fundamental shift in provision of urgent care nationally, with five proposals:

1. Provide better support for people to self care
2. Help people with urgent care needs to get the right advice – includes enhancing 111 service
3. Provide highly responsive urgent care services outside of hospital – includes extending paramedic training to help deal with more people at the scene and avoid unnecessary journeys to hospital
4. Ensure those with serious or life threatening emergency care receive treatment in centres with right facilities and expertise – Major Emergency Departments and Emergency Departments
5. Connect all urgent and emergency care services and develop broader emergency care networks

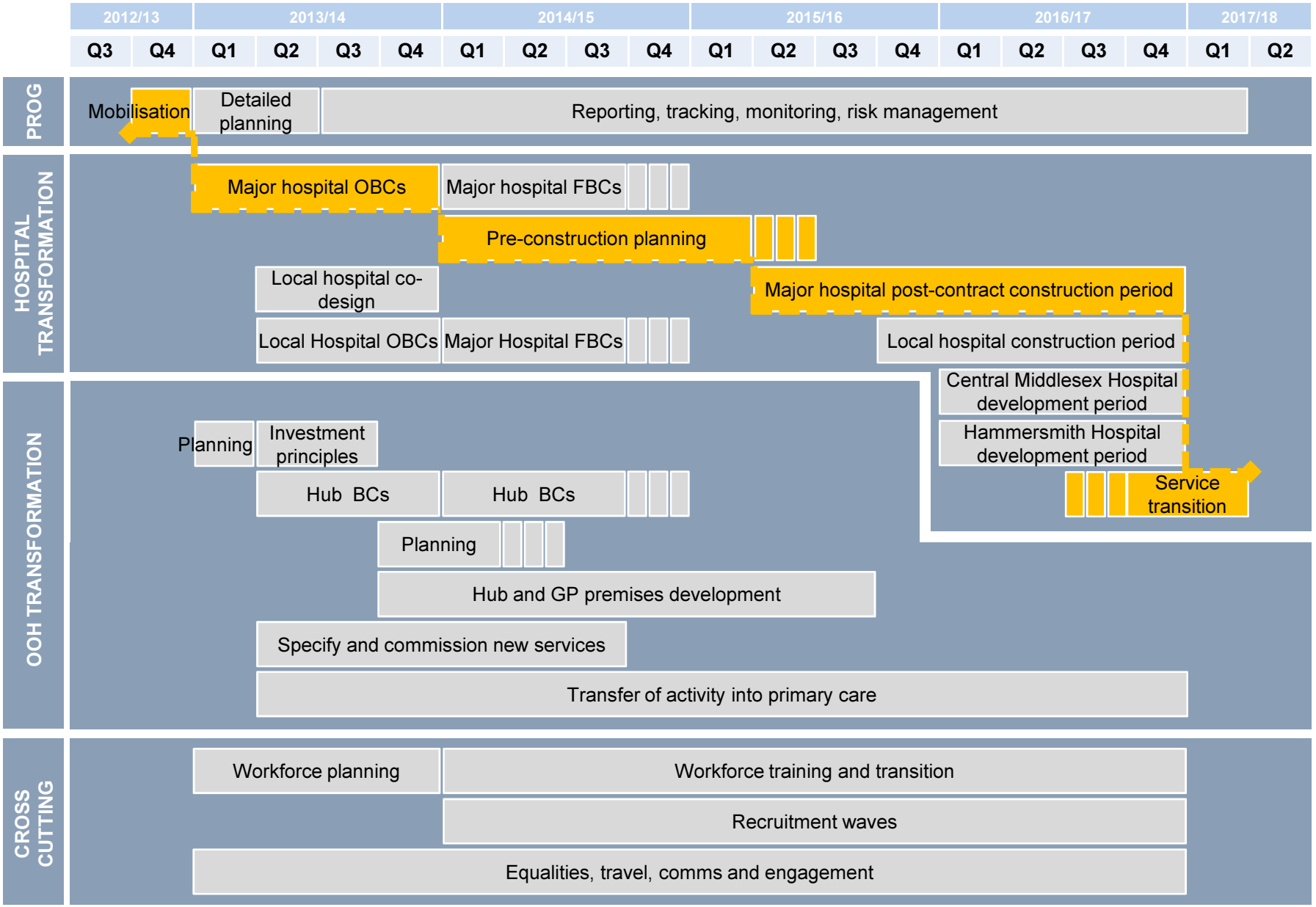
“4. Emergency Centres and Major Emergency Centres”

Final names will be determined in consultation with NHS staff and patients to ensure maximum clarity:

- **Emergency Centres** will be capable of assessing and initiating treatment for all patients. In urban areas, where specialist services are much closer, the assessment and commencement of treatment will often be undertaken by paramedics, followed by direct transfer to the specialist centre best suited to the patient’s needs. This will, in turn, reduce demand at urban Emergency Centres. These will be able to stabilise and initiate treatment for all serious cases, and transfer patients for higher-level care at emergency units.
- **Major Emergency Centres** will be larger units, capable of assessing and initiating treatment for all patients and providing a range of specialist services. Major emergency centres will have consistent levels of senior staffing and access to specialist equipment and expertise. Transfer from a Major Emergency Centre will be rare, with the exception of patients returning to community settings closer to home when they are well on the road to recovery from major illness and injury. They will deal with heart attacks, strokes and other serious illness and injury. It is envisaged that there will be a similar number of emergency centres overall as there are existing A&Es under the current system.
- **Urgent Care Centres** with walk-in facilities including GP out-of-hours care, services for minor injuries and illnesses, sexual health and, potentially, dentistry and pharmacy services too will continue to be needed. The services offered and location of these centres would be organised according to local need, and would include the facilities currently offered by walk-in and minor injury units.

Programme Timeline

As per the programme timeline – our current focus remains on delivering business cases



Changes to A&E at Central Middlesex and Hammersmith hospitals should be implemented as soon as practicable

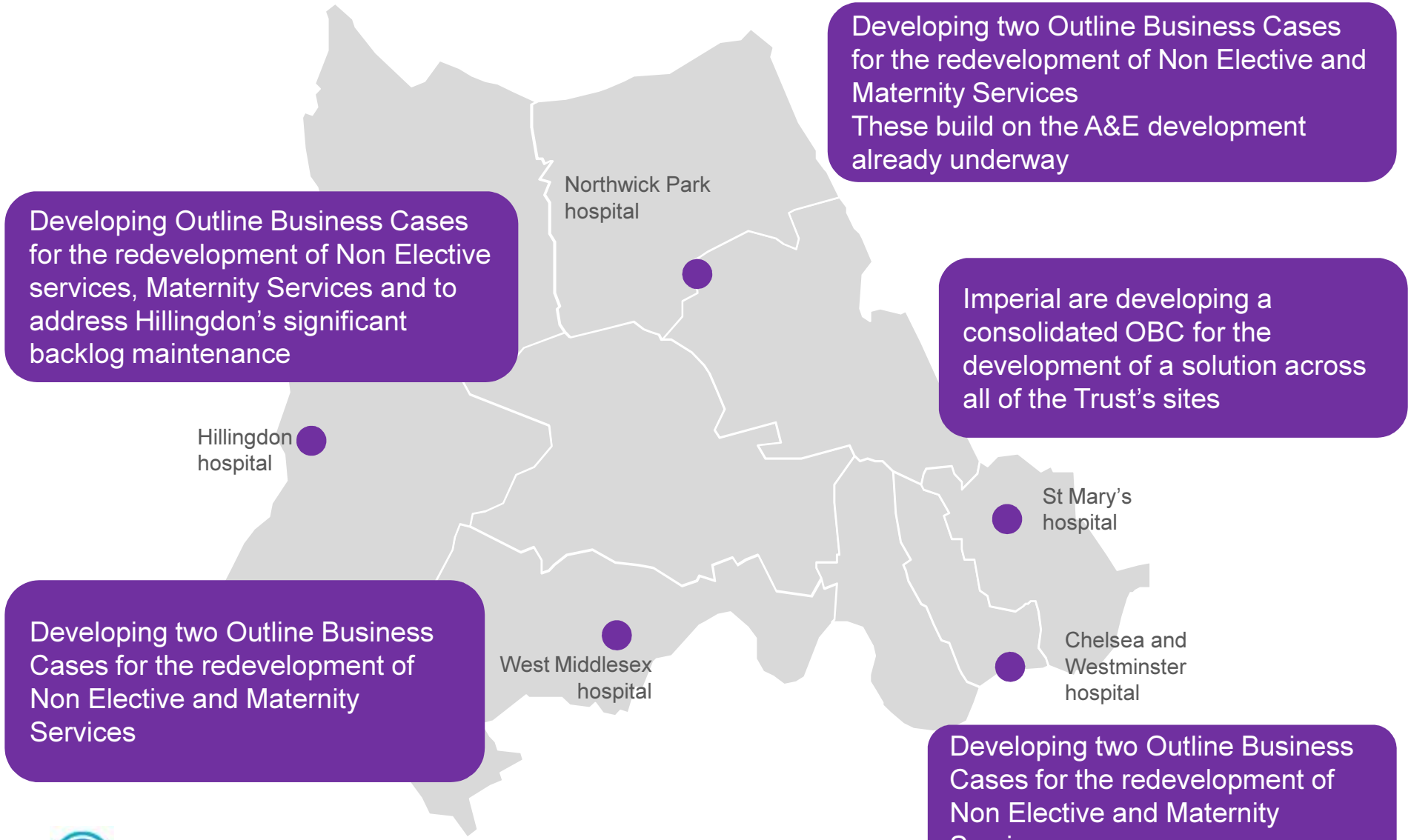
- Work is currently being progressed by the Central Middlesex Zone and the Charing Cross and Hammersmith Zone to review these service transitions in greater detail
- In addition to this the programmes clinical implementation groups are reviewing:
  - Potential impact on neighbouring A&Es
  - Levels of readiness of the UCC required at these sites to be stand alone sites
  - Emerging network arrangements in line with the Keogh review
- It is likely that these changes will occur in Summer 2014.

The programme is strengthening its engagement strategies across all NWL boroughs

- The programme communications team is developing a revised communication strategy to support the next phase of activity
- Tailored communications strategies are being developed for each of the programme zones/workstreams
- Plans will involve a number of different engagement tools and techniques to support programme implementation
- Inline with the SoS direction, there is an enhanced focus on Ealing and Hammersmith and Fulham in support of the development of proposals for the Local Hospital sites
- The programme communications strategy compliments, and works in conjunction with CCGs and provider communication activities
- A timeline of planned programme communication activity will be provided to the JHOSC

Developing Major Hospitals

We are working across all of our sites and developing capital business cases that will be delivered in early 2014



Shaping a healthier future

We continue to work with providers to support them in developing their OBCs

- Providers continue to liaise with the central programme team to ensure consistency – progress is being monitored through the programme governance and early OBC drafts will be shared with the programme in mid December
- The Finance and Activity Modelling group have brought together all Finance Directors to agree common activity assumptions this has included:
  - Refresh of all the activity data
  - Update on the QIPP data being used by the CCGs
  - This data will be approved by all FDs in early December
- A two month iteration period has been included in the programme schedule to allow for business cases to incorporate feedback
- The programme team are liaising with the National Trust Development Authority and the Department for Health to confirm the business case sign off process.

SaHF OBCs are the first significant business cases that CCGs have needed to review

- SaHF Major Hospital OBCs require sign off in early 2014 – this is a complex process which requires wide stakeholder engagement
- CCG governing bodies will be asked to provide letters of support to all major-hospital business cases where significant patients use the sites
- The review process will be lead through our existing governance structure and will build on established assurance processes
- Prior to CCG review, programme lead working groups will complete a detailed scrutiny of the OBCs focussing on four areas (Clinical Quality and Safety, Finance, Workforce and Statutory responsibilities)
- The SaHF Implementation Programme Board will review all OBCs to ensure that they remain consistent with the Feb 2013 decision of the NWL JCPCT.

Developing Major Hospitals

- **Chelsea and Westminster**

Chelsea and Westminster development

Chelsea and Westminster hospital

Developing two Outline Business Cases for the redevelopment of Non Elective and Maternity Services

- Chelsea and Westminster are creating two business cases to respond to the requirements of SaHF.
- The non-elective business case builds on the work already underway at the site to redesign the emergency department.
- They are currently assessing their shortlisted options reflecting the revised finance and activity data from the Finance & Activity Group.

Artists impressions of Chelsea & Westminster emergency department re-design

- Given some recent changes and developments at Chelsea & Westminster that have freed up some additional maternity capacity the SaHF capital requirements for the maternity may be reduced. Options for these are currently being considered.

Developing Major Hospitals

- **Hillingdon Hospital**

Hillingdon Hospital development

Developing Outline Business Cases for the redevelopment of Non Elective services, Maternity Services and to address Hillingdon's significant backlog maintenance

- Hillingdon hospital are developing non-elective and maternity business cases to address the requirements of SaHF as well as using the opportunity to address some of the site's significant backlog maintenance in the tower.
- These business cases build on the work already underway re-engineering their Emergency Care Department that is due to complete in 2014.
- Whilst a new build is being considered to address the maternity requirements of SaHF, the non-elective business case is favouring the refurbishment and remodelling of the existing estate instead.

Shaping a healthier future

Developing Major Hospitals

- **Northwick Park**

Northwick Park development

Developing two Outline Business Cases for the redevelopment of Non Elective and Maternity Services
The build on the A&E development already underway

- NWL Hospitals Trust received a £21 million grant from the Department of Health in 2012 to build the new ED, children's ED and urgent care centre at the hospital
- Building work commenced in February to enable the new building to be complete by Spring 2014
- The redevelopment of this site is a key enabler to the transition of activity from CMH A&E which is being planned for post winter 2013/14

Timeline for NWP existing development

- The SaHF capital business cases build on this extensive infrastructure investment by improving the critical care and maternity capability within Northwick Park to meet the needs of SaHF as well as addressing some of the backlog maintenance at the site.

Progress that has been made to date

February 2013 Space is cleared at the back of the hospital to make way for the new emergency department

March 2013 The site is cleared and the first metal piles are driven into the ground

April 2013 Drainage and floor slab completion is undertaken

June 2013 Construction of the Urgent Care Centre is underway

September 2013 The steel work is erected across the site

Developing Major Hospitals

- **St Mary's**

St. Mary's development

Developing two Outline Business Cases for the redevelopment of Non Elective and Maternity Services

- In developing their SaHF Outline Business Case (consolidated for all sites) Imperial College Healthcare NHS Trust have shortlisted 3 options that they are now assessing in greater detail.
- Each of these options deliver a space that meets the clinical requirements for St Mary's to become a Major Hospital and also includes provision for the co-location for specialist services such as Western Eye Hospital.
- The emerging solution for St. Mary's consolidates the hospital into a reduced footprint by refurbishing the Queen Elizabeth Queen Mother building and redeveloping additional space in the Acrow building and far triangle of the site **(shown in light blue).**

- To make this affordable, the solutions assume benefits from the sale of the land that is no longer required **(shown in yellow)**

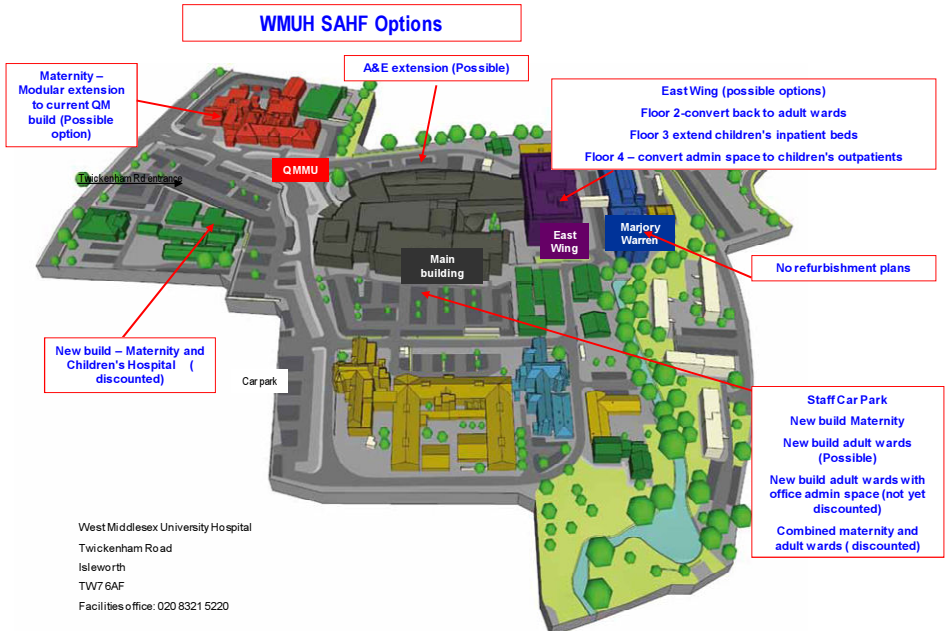
Developing Major Hospitals

- **West Middlesex**

West Middlesex developments

Developing two Outline Business Cases for the redevelopment of Non Elective and Maternity Services

- West Middlesex University hospital are developing two capital business cases to respond to the requirements of SaHF.
- Their maternity business case is currently considering a range of options from extending the current maternity facility at Queen Mary maternity building to developing a new Womens' and Childrens' building on a separate part of the site. The business cases will identify the preferred option including, importantly, an assessment of affordability.
- The unscheduled care business case is currently considering two short-listed options for the configuration of emergency care services. Again, a preferred option will be identified as the business case is completed.



Shaping a healthier future

Developing CMH

IRP and SoS confirmed as in SaHF proposals that CMH will be a Local Hospital and Elective Centre

- A Joint Partnership Board consisting of affected CCGs, providers and the NTDA is being led by the programme on behalf of commissioners to build long term sustainable model for CMH site
- This group reports to the Implementation Programme Board
- The group consists of four working groups:
  - **Clinical Options Evaluation** - quality of care, deliverability, research and education
  - **Estates and Finance Analysis** - affordability and value for money
  - **Access to Care Analysis** - access to care and impact of changed patient journeys
  - **Equalities Impact Assessment** – analysis on protected patient groups
- Full patient involvement is required in the development of options for CMH
- An engagement plan is being developed – including full consideration of any potential needs for further consultation if not already covered by SaHF consultation

Options currently being considered for the CMH site

1. **Hub Plus for Brent** – using CMH as a major hub for primary and community services including 24/7 Urgent Care Centre.
2. **Elective Orthopaedic Centre** – a joint venture for local providers.
3. **Specialist Rehabilitation Services** moving from NPH.
4. **Rehousing Mental Health Services** from Park Royal Centre for Mental Health.
5. **Relocating some or all of St Marks Hospital**.
6. The closure of the CMH site as a comparator

An independent clinical group has now undertaken a review of all six options and produced draft scores for each option

- The group, lead by Dr Mark Spencer, were nominated by the London Clinical Senate
- The group focussed on scoring across **Clinical Quality, Deliverability** and **Research and Education**
- During the evaluation the negative clinical evaluation for options 3 and 5 meant that financial, estates and access were not further examined as it had been agreed that no option would be pursued that would lower the clinical quality.
- Whilst considering the varied other clinical services that are used by the St Marks the Regional Genetics Unit was highlighted as a potential service for relocating to CMH and this was reviewed as option 5b.
- Option 6 was ruled as non desirable
- Further estates and finance, access to care and equalities scoring will continue to be undertaken – this will involve wider public and patient input
- The next slides highlight summarise the clinical evaluation of all options.

1 Hub Plus for Brent

- CMH becomes a hub for primary and community care services, including General Practice, Urgent Care Centre, outpatients, diagnostics and intermediate care.
- This option has a sub-option of Hub Plus Plus which includes Willesden rehabilitation beds
- The Hub ++ option has a greater impact as it uses more of the CMH estate and potentially increases quality more than Hub + as it co-locates inpatient beds alongside other clinical support, and allows the development of larger teams to support, orthopaedics, rehab and community services
- This option has an impact on the viability of Willesden Hospital and this will need greater assessment.

Evaluation Domain		Sub - domain	Estimate	Key reasoning
1	**Clinical Quality**	Clinical Quality	+	Rehab beds co-located with a wider range of services and support
		Patient Experience		
4	**Deliverability**	Workforce	+	Building larger team of AHPs on one site.
		Expected Time to Deliver	-	Reconfiguration at CMH cf. continued use of Willesden
		Wider Co-Dependencies	-	Creates vacancy at Willesden Site
5	**Research and Education**	Education and Research		

2 Elective centre for NW London

- After discussion it has been recommended that an orthopaedic centre similar to the South West London Elective Orthopaedic Centre (SWLEOC) be developed as a joint venture for NWLHT and Imperial (and potentially the RNOH).
- Alongside the orthopaedic work SaHF includes current CMH elective activity and a proportion of the elective work that has moved from Ealing Hospital. To reduce risk of infection this general surgical work should be separated from the orthopaedic work.
- The Orthopaedic centre should learn from and adopt the service delivery model from SWLEOC, requiring 24/7 consultant led HDU to enable rapid recovery, reduced complications and reduced LOS.

Evaluation Domain		Sub - domain	Estimate	Key reasoning
1	**Clinical Quality**	Clinical Quality	++	Dedicated elective care, with improved LoS, low infection and complication rate
		Patient Experience	++	Very high satisfaction of SWLEOC model
4	**Deliverability**	Workforce		Challenges of joint venture model
		Expected Time to Deliver	o*	Reconfiguration at CMH for EOC requires some rebuild
		Wider Co-Dependencies	+	Helps support NWL/EHT merger
5	**Research and Education**	Education and Research	+	SWLEOC undertakes considerable research and training

* The expected time to deliver was scored as o as it had already been considered in the DMBC and all scoring has been against those original proposals

3 Specialist Rehabilitation Services

- The Regional Rehab Unit (RRU) at Northwick Park is constrained by space and there are patients in more distant units and waits for admission. The unit is commissioned by Specialised Commissioning at NHS England. It is the only level 1 hyper-acute rehabilitation unit in London.
- The patients have complex needs. The National Guidelines for these services recommend they be located an acute hospital site. An audit of activity at the RRU showed a very wide range of inputs from diagnostics and specialists from the acute services at NPH.

Evaluation Domain		Sub - domain	Estimate	Key reasoning
1	**Clinical Quality**	Clinical Quality	--	The service needs substantial support from the acute hospital services
		Patient Experience	+	Greater space at NPH could reduce waits to enter the service
4	**Deliverability**	Workforce	-	Changes to this specialist unit would be likely to disruption to the workforce
		Expected Time to Deliver	-	Reconfiguration at CMH cf. continued use of NPH
		Wider Co-Dependencies	--	This would be in contradiction to the National Service Specification
5	**Research and Education**	Education and Research	-	The current unit is active in E&R

Because of the negative clinical evaluation the clinical review recommended that further evaluation of this option should not be pursued.

4 Rehousing Mental Health Service from Park Royal Hospital

- The Park Royal Hospital is almost adjacent to the CMH site, provided by CNWL FT. It contains a range of services and office facilities including a mother and baby unit, an acute assessment service and treatment wards. It has a small number of beds for low-security patients. Current accommodation does not comply with modern facility specifications.
- Re-locating services into CMH on the ground floor may be a cost effective option.
- CNWL are also considering developing a single pharmacy service for their range of services. If this were to be based at CMH then this service could also support the other services at the site.

Evaluation Domain		Sub - domain	Estimate	Key reasoning
1	**Clinical Quality**	Clinical Quality	+	Providing services in facilities that reach best standards will reduce risk and optimise care
		Patient Experience	+	Rebuilt mother+baby unit and modern pharmacy services
4	**Deliverability**	Workforce		
		Expected Time to Deliver	+	Reconfiguration at CMH would be quicker than a decant and rebuild at the current PkRyl site.
		Wider Co-Dependencies		
5	**Research and Education**	Education and Research		

5 Moving all or part of St Marks

- St Marks is a specialist gastroenterology hospital co-located with Northwick Park. It provides regional specialist diagnostics and services for inflammatory bowel disease, familial polyposis coli, and the full range of GI conditions. It also provides colorectal screening services.
- The service is currently constrained at the NPH site which limits the necessary expansion of the colorectal screening services for example.
- The surgical and medical teams provide clinical support to the general hospital (for example emergency endoscopy).

Evaluation Domain		Sub - domain	Estimate	Key reasoning
1	**Clinical Quality**	Clinical Quality	--	Co-dependencies with NPH acute service. Effective single MDT team with screening service. Acute GI admissions denied St Marks skills.
		Patient Experience		Specialist site hospitals typically score highly. Disruption of combined MDT will lower experience
4	**Deliverability**	Workforce	-	Duplication of key staff at both CMH and NPH
		Expected Time to Deliver	-	Reconfiguration at CMH cf. continued use of NPH
		Wider Co-Dependencies	+	Moving Screening services would allow expansion
5	**Research and Education**	Education and Research	-	St Marks research and teaching would be disrupted

Because of the negative clinical evaluation the clinical review recommended that further evaluation of this option should not be pursued.

5b Relocation of Regional Genetics service from NPH to CMH

- This is a specialised service that provides outreach services across North West London and surrounding counties. It is supported by two laboratories which analyse samples from wide range of units. The labs are not interdependent with the general labs for NPH, which are provided by a private provider.
- The service needs a new IT infrastructure. This is not interdependent with other IT services at NPH.
- No co-dependencies with the acute service at NPH were identified.
- Moving the service from NPH would allow profitable service lines to be developed at NPH.

Evaluation Domain		Sub - domain	Estimate	Key reasoning
1	**Clinical Quality**	Clinical Quality	+	Moving from NPH could allow other services to develop at that site
		Patient Experience		This is an outpatient service, mostly at distant sites.
4	**Deliverability**	Workforce		
		Expected Time to Deliver	-	Reconfiguration at CMH cf. continued use of NPH
		Wider Co-Dependencies		
5	**Research and Education**	Education and Research	+	New IT and labs would facilitate research.

6 Disposal of CMH and dispersal of services

- CMH is a modern facility, but is sited in an industrial estate and has substantial PFI costs. The PFI could be bought and the site then redeveloped for non-health uses.
- This would be contrary to the SaHF proposals, supported by the IRP and confirmed by the SoS, recommending CMH as a local hospital with UCC and an elective centre.
- Sale of an underused NHS site is unlikely to support simultaneous Treasury applications to fund other sites expansion.
- The CCG and SaHF consultation have supported the future of CMH, which helped allay local opposition to change. Closure of the site would have CCG, public and political opposition.

Evaluation Domain		Sub - domain	Estimate	Key reasoning
1	**Clinical Quality**	Clinical Quality	-	Moving services from NPH would prevent the development of an elective centre
		Patient Experience		
4	**Deliverability**	Workforce	-	Moving all staff from the site would require redundancies and skills loss
		Expected Time to Deliver	-	Other sites would need to increase capacity to allow movement of surgical activity
		Wider Co-Dependencies	--	This is contrary to SaHF, IRP and SoS. It would weaken funding applications and face significant opposition
5	**Research and Education**	Education and Research		

This option has been ruled out as it is non deliverable

Timelines and next steps

November	21st	CMH Partnership Board update
	Wk 4	Further detailing of options across the workstreams
December	Wk 1-4	
	Wk 2/3	Patient focused sessions on CMH option
	Wk 3/4	1:1 meetings with providers delivering service
January	Wk 1/2	Option evaluations workshop (NWL wide representatives)
	Wk 1/4	CMH Strategic Outline Case
	Wk 4	CMH Partnership Board recommends SOC
February	6th	SaHF Implementation Programme Board receives SOC

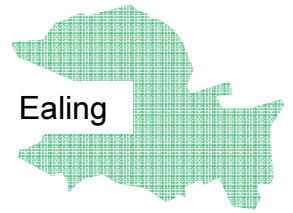
- In addition to support progress there is a weekly steering meeting with CCG, SaHF, NHSE, NTDA, NWLHT representation.

Developing Local Hospitals

The Local Hospital project will produce three key outputs for Ealing and Hammersmith & Fulham CCGs

The SaHF Decision Making Business Case set out core models for the two new Local Hospitals in Ealing and Charing Cross. Alongside the DMBC, alternative specifications for the Local Hospital's were put forward by Ealing and Hammersmith & Fulham CCGs. These specifications were not fully developed and the financial viability and affordability was not clear.

The purpose of this project is to co-develop the visions for the Local Hospitals within the context of wider developments to Out of Hospital care. These visions will then be refined and reflected in agreed Outline Business Cases.



Specifically, there are three key deliverables for both Ealing and Hammersmith & Fulham:

1 Out of Hospital Delivery Strategies co-created with Ealing CCG and Hammersmith & Fulham CCG

2 Co-created service models and specifications for the Local Hospitals*

** This will include: the vision, clinical service model and potential services that can be delivered across health and social care outside of hospital*

3 Outline and Full Business Cases for both Ealing Local Hospital and Charing Cross Local Hospital

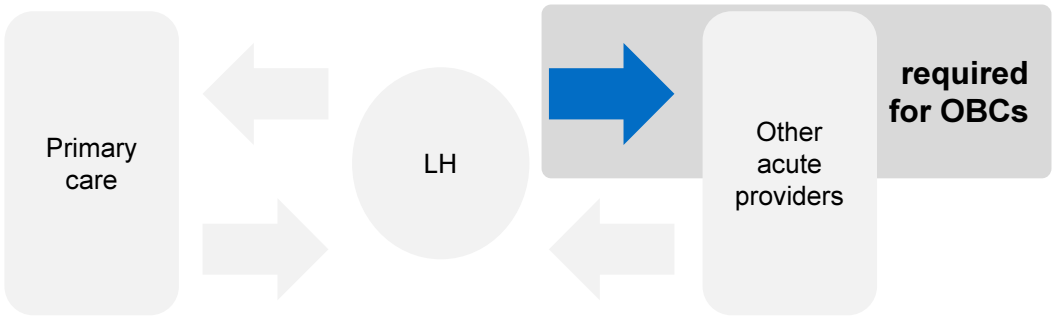
Shaping a healthier future

21st Century Local hospitals at Ealing and Charing Cross

Summary

- Formalised into an OBC in January
- Other acute providers are seeking clarity on aspects of this model to develop Major Hospital OBCs
- Further work to support an OBC is being undertaken including further detailed financial modelling.

Touch points between local hospitals with other parts of the system



Commissioner context

- Local Hospitals allow development of innovative clinical pathways to improve care and cost effectiveness
- They will provide care and change the model of care.
- Both CCGs are developing these models
- Development of local hospitals does not impact on other acute providers and this part of the service redesign as set out in the DMBC.

Provider context

- Major Acute Hospital Providers are producing OBCS that are consistent with the DMBC.
- Answers to key questions that impact on these OBCs have been the priority focus for the Local Hospital work

The work done to date has identified a number of common themes that have helped to develop defining features for a 21st century Local Hospital

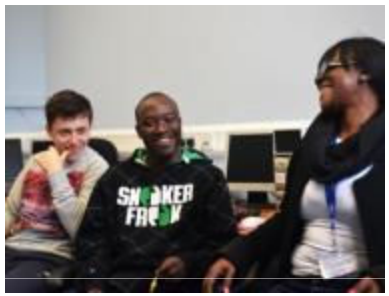
These themes have been identified through a series of engagement events in H&F and work with the Steering Group

Interactive Design Workshop – 22/10/13

Headlines

- *Empower patients and carers to take control*
- *Care centred around the patient*
- *Multidisciplinary and multi skilled workforce*

H&F Action on Disability – 28/10/13



Headlines

- *Difficult transition from young people to adult services*
- *Hard to communicate with clinicians*
- *Need to empower young people to take control*

'Drop in' Dawes Road Hub – 30/10/13

Headlines

- *Enable community champions*
- *Need to be better, more comfortable spaces*
- *We need NHS system navigators*

Broadway Homeless Centre – 28/10/13

Headlines

- *prejudice is a barrier to many homeless people*
- *Lifestyle makes it harder to stick to regular appointments and medication*

We will be doing further engagement over the next few months to support the development of the business case

Similar themes are emerging in Ealing through engagement events in Ealing and work with the Steering Group

Interactive Design Workshop 23/10/13

Headlines

- *Care centred around patient – enabled by IT and shared records*
- *Multiskilled and multidisciplinary workforce*
- *Empower patients to take control*

'Drop in' Session Lido Centre 24/10/13

Headlines

- *Enable community champions*
- *Empower patients and carers to take control through education and accessibility*
- *Build cultural awareness of professionals*

Southall Market 01/11/13

Headlines

- *People value access to healthcare professionals who speak their language*
- *Health conversation and education outside of healthcare settings Flexibility of services*

Interactive Design Workshop 06/11/13

Headlines

- *Harmonise with existing community skills and assets*
- *Deliver services from, not in, hospital where possible*
- *On-going evaluation and monitoring*
- *Ensure cultural sensitivity and translation*

We will be doing further engagement over the next few months to support the development of the business case

Shaping a healthier future

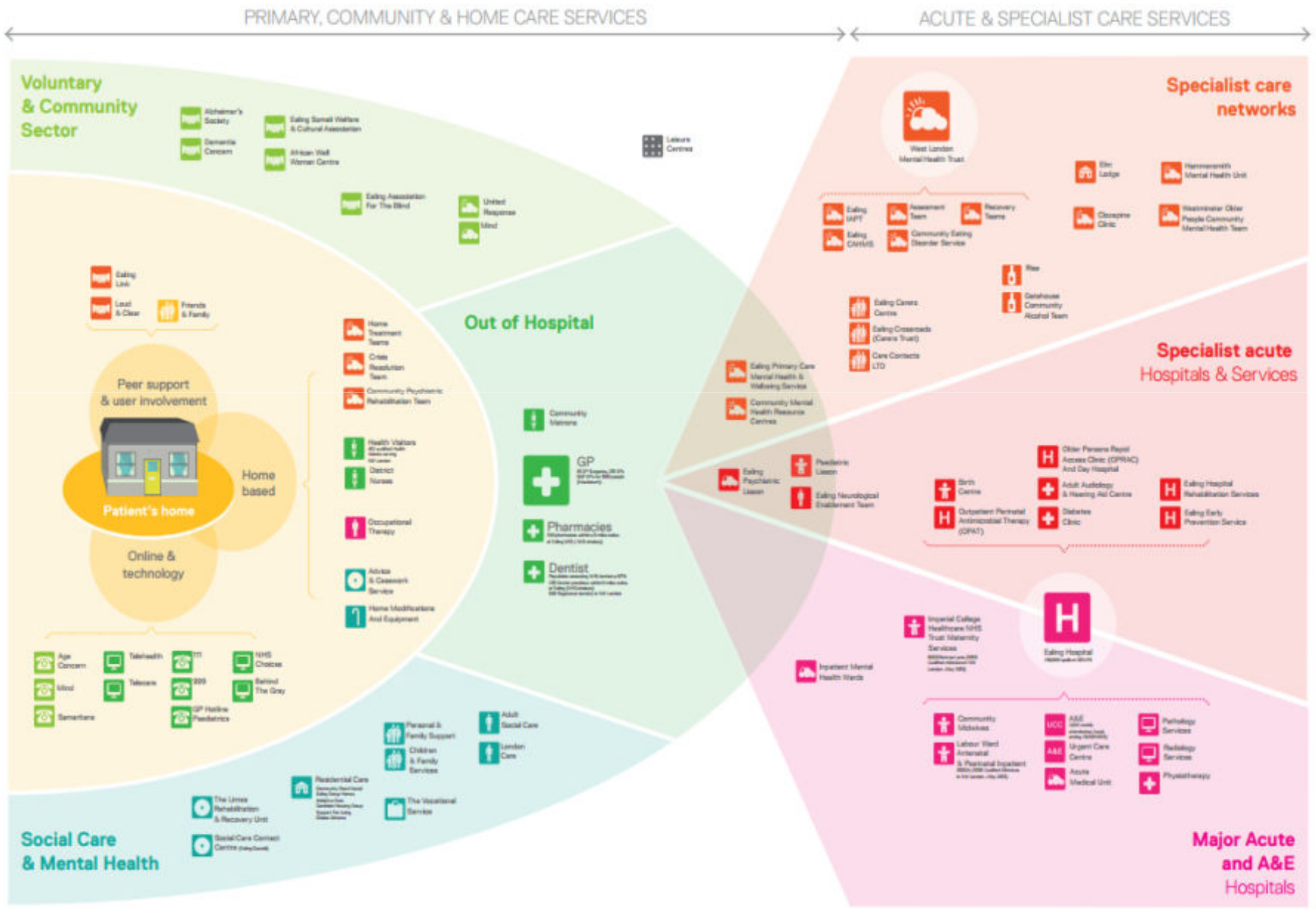
The work with stakeholders and the steering group has highlighted that similar views on how the local hospital should operate and integrate with the rest of the healthcare system

	Factor
Do want	✓ major community infrastructure to support the wellbeing of the population ✓ An environment that is conducive for new ways of working, which transcend boundaries between hospital, community, and primary care ✓ A dedicated care co-ordination and planning function ✓ A model and facility that supports user-owned care, and access to care ✓ A model that supports the mobilisation of community assets, such as volunteers, peer support networks, etc. ✓ Co-location of services, such as GPs and community providers, to support the creation of networks of carers and clinicians that blur the boundaries between different settings of care ✓ A model and facility that is financially viable and supports the delivery of the DMBC vision, including the QIPP and Out of Hospital challenges ✓ Supports the optimal use of bedded capacity with each borough ✓ A local hospital that is plugged into acute care (eg quick access for emergency care)
Do not want	× Hospital only for sick people × A facility that cannot cope with future system pressures / ways of working × A model that cannot flex to meet evolving patient needs × A model that is not future proof × To miss the opportunity of a lifetime to develop care in NW London

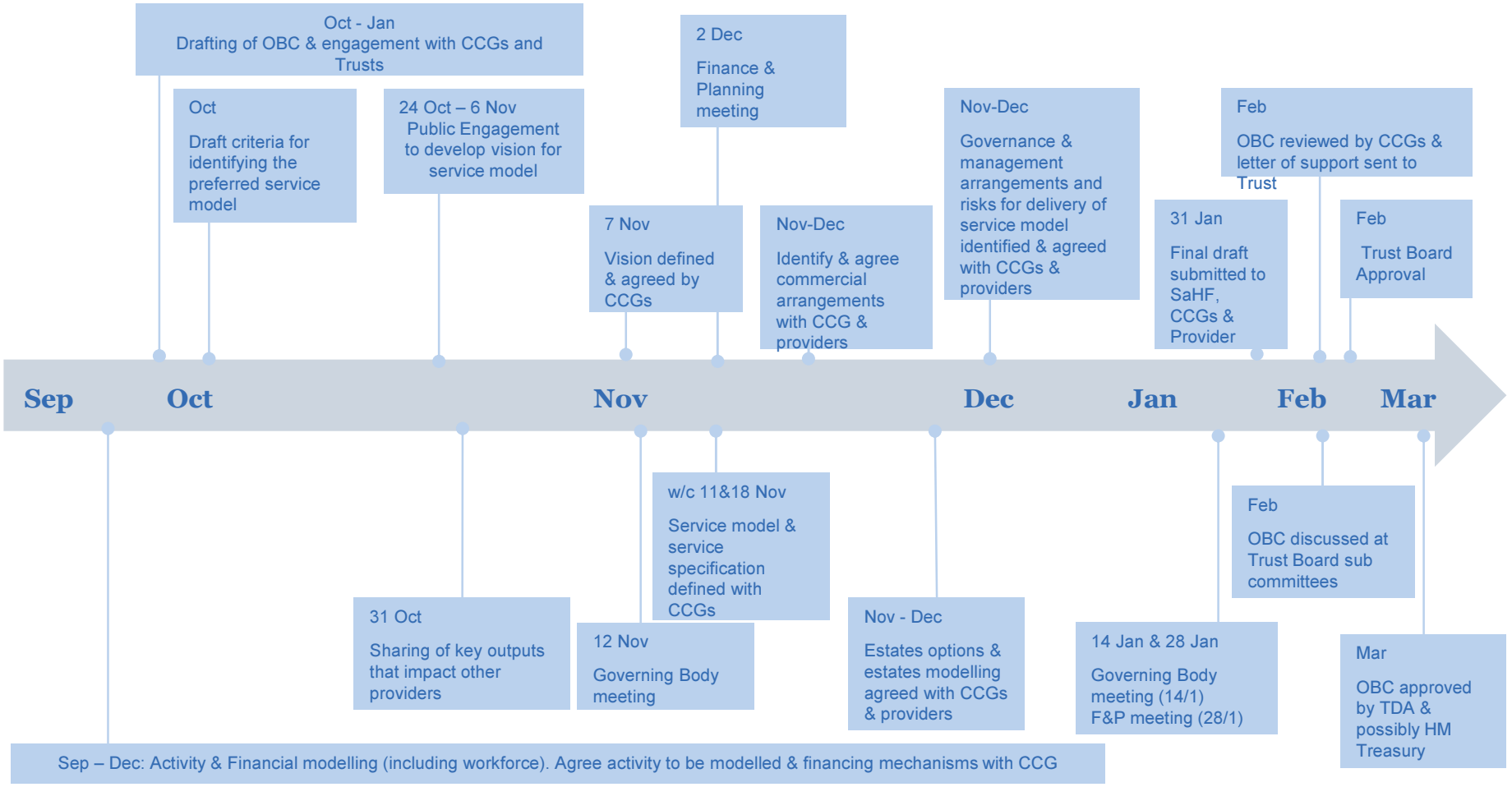
To facilitate the development of other acute business cases, we have been asked a number of questions

Question	Charing Cross	Ealing
Will there be an A&E department?	Within the Local Hospital setting	Within the Local Hospital setting
Will there be beds?	Step-up/down	Step-up/down
Will there be maternity services?	Ante natal & post natal	Maternity services & day assessment centre (maternity)
Will there be MRI and CT scanning?	MRI / CT	MRI / CT
Will there be endoscopy?	Endoscopy	Endoscopy
Will there be renal dialysis and chemotherapy?	Renal and ambulatory cancer care centre (LinAccs and chemo)	Renal and chemotherapy
Will there be significant therapy services (and specifically a gym requirement)?	Therapies	Therapies
What diabetes service will be on site?	Yes	Diabetic centre of excellence
Will there be outpatient services and associated diagnostics?	Yes	Yes

Initial development of a new model of care



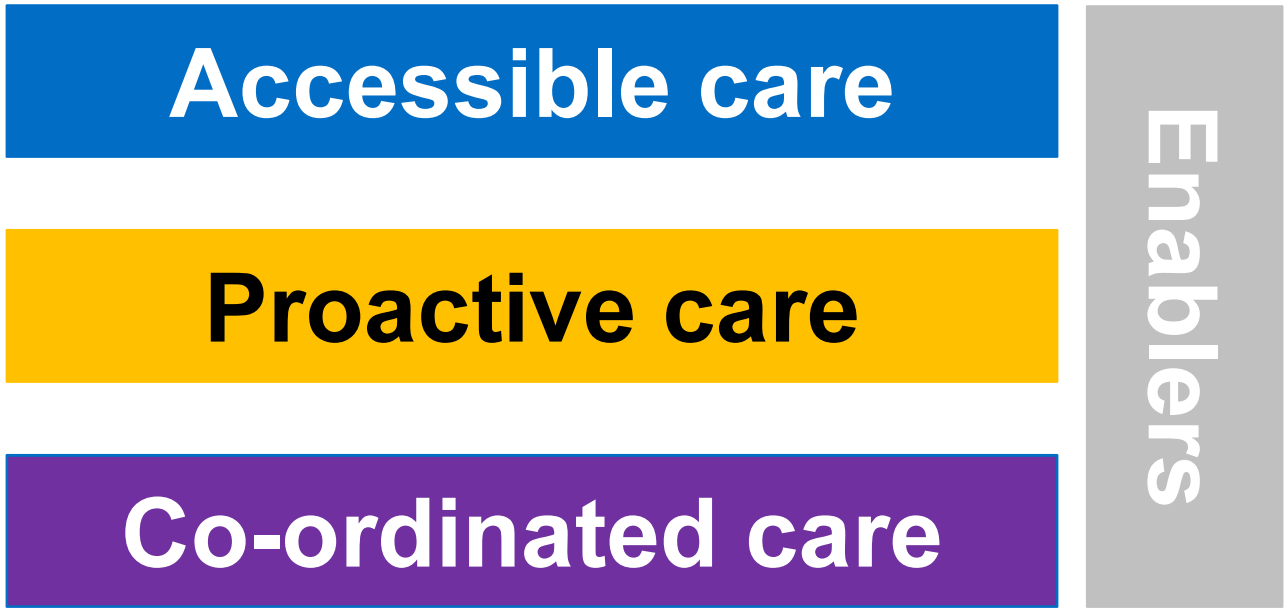
We continue to focus on the service model for the local hospital and understanding the estates needs to support the out of hospital work



Shaping a healthier future

Developing OOH Services

Each CCG has specific OOH delivery strategies to articulate their deliver model but each shares common features



Accessible care

- **Self-management**: Supported by information and training, self-care is supported wherever possible.
- **Extended access**: GPs work together in networks/localities to offer extended access (0800 – 2000, 7 days a week).
- **Urgent access**: Patients with urgent needs can make use of 111 or urgent care centres.
- **Centralised triage / appointment booking**: CCGs are moving towards alignment of appointment booking, with GP triage to manage as many patients as possible without the need for a face-to-face appointment.
- **Virtual consultations**: Telephone and electronic communication (e-mail, Skype) between patients, GPs and consultants reduces the need for appointments and referrals.

Proactive care

- **Preventative care**: Immunisation, screening, health checks and risk assessments are conducted at the GP practice.
- **Referral management**: Referrals to other services are triaged to ensure quality and appropriateness.
- **Specialist primary care**: GPs work together across networks to share specialist skills and resources, improving the range of services available in primary care.
- **Specialist clinics**: Hubs provide centres for planned care, including outpatient clinics, elective procedures and simple diagnostics.

Co-ordinated care

- **Differentiated models of care:** Patients with LTCs always see their named GP, who is responsible for their care (enabled by longer appointments) while patients with more episodic needs can be treated by other available GPs via localities (enabled by shared systems).
- **Care planning**: GPs or dedicated care planners create and co-ordinate care plans for patients with LTCs, ensuring the system meets their needs.
- **Multi-disciplinary groups**: MDGs, based around common GP networks, offer fora for case management. Community services (including nursing) and social care are aligning with GP networks to ensure effective working across teams.
- **Rapid response**: Patients with urgent needs receive rapid care in their home within four hours of referral.

Enablers

- **Ways of working**: including co-design, co-production and new contracting models
- **Workforce**: including a combination of new roles, repurposed and enhanced healthcare roles
- **ICT and telephony:** including information sharing, triage and single telephone booking appointments
- **Estates**: reuse of existing estates and investment in new premises to deliver out of hospital vision

CCG update

Central London CCG 2013 successes

Extending access to primary care

- From April 2013 three GP practices have opened at weekends for eight hours every Saturday and Sunday for walk in and booked appointments. This is to be extended to additional practices this winter.

Improving care for people with long term conditions

- In 2012 we launched a new service called Well Watch to provide care planning and coordination services for patients with long term conditions.
- Well Watch is growing from strength to strength and targets patients who are at risk of an unplanned admission with the objective of keeping patients well for longer.

Improving the health and wellbeing of the homeless

- We are investing in 30 hours per week additional nursing support for our two GP practices for the homeless to prevent A&E attendance.
- One nurse is carrying outreach work in the hostel that provides the highest A&E usage and the other carrying out street outreach.

Central London CCG: 2014 commissioning intentions

Integrated care and use of the Integration Fund

- Currently designing integrated care across health and social care, commissioners and providers. Early implementation sites planned to launch April 2014.

Community Independence Service

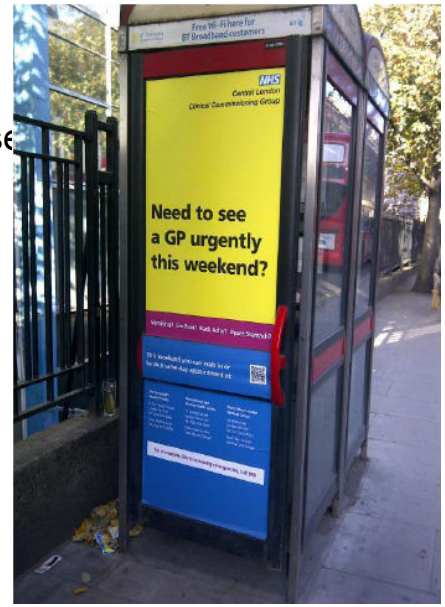
- Developing across tri-borough health and social care multidisciplinary teams will provide seamless tailored packages of care to support people to keep people well and remain at home.

Urgent and emergency care

- Wide range of activity including retendering of urgent care centres at local hospitals; GP weekend opening; commissioning of 7 day a week rapid response team.

Other

- Redesign of the Community Respiratory and Gynaecology community se
- Dermatology community service re-tender;
- introduction of direct access of diagnostics;
- procure and implement a new wheelchair service.



NHS Brent CCG: 2013 successes

Implementation of locality GP extended hours service

- A practice in each of the five localities in Brent (Harness, Kilburn, Kingsbury, Wembley and Willesden) now offers GP and nurse appointments in evenings and on Saturdays to all patients who are unable to get an appointment at their own practice within 48 hours. These appointments are within 24 hours and for Saturdays can be booked up to two weeks in advance.

Procurement of outpatient services

- A number of new outpatient services currently provided in secondary settings are being re-commissioned so that patients are treated closer to home. Cardiology and ophthalmology are the first services to be re-commissioned.
- Contract negotiations are being finalised with the new ophthalmology provider. The provider will offer a service six days a week and offer at least one evening session in both the north and south of the borough. A public consultation is about to start on developing integrated pathways for musculoskeletal and gynaecology outpatient services.

STARRS

- Integrated support for patients ready to be discharged from A&E at Northwick Park Hospital who may require extra support at home. Short term assessment rehabilitation and reablement service (STARRS) therapists and nurses work with GPs, social workers and A&E to help patients return safely to their homes as soon as possible. The hours of the service have been recently extended from 8 pm to 10 pm. The service will also soon be extended to Imperial Trust.

Psychiatric liaison service has been established

Single point of access and supported discharge service for mental health launched

NHS Brent CCG: 2014 commissioning intentions

Currently engaging with local people on the draft commissioning intentions

Intentions set out key areas of activity and change in 2014/15 including:

- Extend the GP locality hubs service
- Extend STARRS to Royal Free Hospital
- Continue the redesign of outpatient pathways
- Referral facilitation service – undertake a review of referrals and seek to reduce variation across Brent. This will inform the discharge planning process and work with clinicians to improve the discharge process to reduce readmissions.
- Ambulatory Care Pathways – expand from the existing 10 pathways to develop, as a minimum, an additional 10 pathways
- Develop a Primary Care Plus services with CNWL to enable a stable cohort of patients to be discharged from secondary care services and managed within primary care
- Provide more care in the community and support for self care for diabetes patients
- Developing a respiratory OOH pathway in each locality to help prevent emergency admissions and support patients with long term conditions

Hillingdon CCG: 2013 successes

Non-elective care:

- Expanded successful community rapid response team and invested in Rapid Assessment and Triage in A&E. Leading to more people being supported and managed in their own home and avoiding admission
- Successfully launched 24/7 UCC at the front of Hillingdon A&E in October. The UCC performing very well (above trajectory). The UCC provider and the A&E team have established positive working relationships
- Coordinate My Care (CMC) being utilised to support people to die in the place of their choice
- Book for patients and carers on how to access unscheduled care appropriately developed and launched

Planned care:

- A range of new planned care pathways have been developed including MSK, gynaecology, gastroenterology, ENT and Urology. Three have been implemented with the final two to be implemented in last quarter of the year

Supporting more integrated service delivery

- Support implementation of Early Supported Discharge requiring integrated approach between acute, community and social care

Hillingdon CCG: 2014 commissioning intentions

Process to engage public and voluntary sector to inform commissioning intentions

Intentions reflect OOH strategy, JSNA and Health and Wellbeing Strategy priorities

Intentions set out key areas of activity and change in 2014/15 including amongst others:

- Introduction of “care navigator” roles to support patients and the effective delivery of care plans
- Review of certain community services with a view to bundling into care packages
- Development of primary care networks to support delivery of primary care
- Full year effect of planned care pathway redesign
- Focus on strengthening LTC management and self-care
- Implementation of Shifting Settings of Mental Health Care
- Review and possible re-commissioning of CAMHS

Hounslow CCG 2013 successes

Roll out of the Integrated Care Pilot across Hounslow

- Groups of GP practices are now working 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 was on diabetic patients and the over 75s and plans are in place to extend it to wider integrated working.

Urgent Care

- The Urgent Care Centre at West Middlesex University Hospital site was re-commissioned to provide a 24 hour GP led service for dealing with immediate urgent illness and injury.

End of life care

- Hounslow CCG have implemented the Co-ordinate My Care (CMC) initiative across the locality to improve end of life care for patients.

Integrated Community Response Service (ICRS)

- Health and social care professionals including a handy man provide care at home for patients who would otherwise need to go to A&E or be admitted to hospital. It also supports patients to go home from hospital earlier than they could otherwise.

Hounslow CCG: 2014 commissioning intentions

Developing a new urgent care service for Hounslow residents

- We want patients to be able to “Phone First” – integrating urgent care with the 111, the Urgent Care Centre and GP Out of Hours services to ensure that patients requiring emergency care are treated in the timeframe and setting appropriate for their needs.

Developing integrated care services

- Work with Hounslow Council to commission an increasingly wide range of integrated health and social care services alongside the Integrated Community Response service.

Care Navigator Service

- A 15 month pilot started in September 2013 will ensure that patients can access all the services they need, self-manage their conditions and support carers. Will be commissioned following evaluation in 14/15 if successful.

Rehabilitation and Reablement Service and Community Recovery

- Develop and deliver a more integrated reablement and rehabilitation service to enable more people to live independently in their own homes with less on-going need for statutory services.

H&F CCG 2013 successes

Extending access to primary care

- Winter pressures pilot currently being introduced for GP weekend opening for walk in and booked appointments.

Community independence Service

- Developing across tri-borough, health and social care multidisciplinary teams will provide seamless tailored packages of care to support people to keep well and remain at home.
- GPs now have improved access to specialist opinions, including telephone support, for example in paediatrics, elderly medicine, mental health, and rapid access clinics for the elderly that GPs can refer into.

Parkview Centre for Health and Wellbeing

- Based in White City, due to open Spring 2014 the recently named centre will hold a range of health and social care services delivering integrated care.

End of life care

- H&F CCG have implemented the Co-ordinate My Care initiative across the locality to improve end of life care for patients.

H&F CCG: 2014 commissioning intentions

Continue to develop local hospital business case for Charing Cross

- Vision includes: primary, secondary and social care hub for the local population; integrating primary with community; mental health and social care for elderly patients and those with long-term conditions; local Hospital with an A&E; diagnostics comprising X-ray, Ultrasound, CT and MRI scanning, endoscopy and ECG; ambulatory cancer care centre, including delivery of radiotherapy and chemotherapy; therapies including a gym, renal service centre, including delivery of dialysis& potential addition of community beds / step up / down beds.

Community Nursing

- The CCG and our Community Services provider are implementing the recommendations from a Community Nursing Review with key focus on alignment of District Nursing to our GP Networks and improved joint monitoring of performance and activity

Other

- Fully establish virtual ward model; improve patient transport; develop care planning, transformation of community services across tri-borough, proposal to introduce home tissue viability service.

West London CCG 2013 successes

Extending access to primary care

- Winter pressures pilot currently being introduced for GP weekend opening for walk in appointments.

Integrated health and social care

- Health and Social Care professionals from our Putting Patients First programme are now helping patients with complex needs to remain healthy and in their own home preventing hospital admission.

Community Independence Service (CISa)

- A joint health and social care service consisting of a Rapid Response team, Intermediate Care rehabilitation team and Re-ablement team providing an intermediate care in people's own homes.

Community hubs

- Work continued on the development of community hubs at St Charles and Earl's Court.

West London CCG: 2014 commissioning intentions

Developing Putting Patients First

- Ensure all patients eligible have a care plan in place with case management by multidisciplinary teams where appropriate.

Community Independence Service

- The development of Whole Systems working to deliver more integrated care across health and social services, e.g. the development of a common Community Independence Service and a single team for the commissioning of nursing homes

SystmOne IT Service

- Move towards a single patient record through the implementation of new systems that are compatible with the GP IT system or through ensuring interoperability of existing systems with the GP IT system

Other

- Implementation of a new service model for community nursing and development of a new service model for musculoskeletal services.

Ealing CCG: 2013 successes

- NWL WSIC – Locally have established Health & Social Care Integration Steering Group and a Co-design Working Group engaging with all key stakeholders
- MSK Pathway Redesign – triaging GP referrals to community clinics
- Diabetes Pathway Redesign – increased investment and establishment of community clinics.
- Enhanced Primary care Service for Nursing Home residents – preventing inappropriate admissions to hospital
- Paediatric Phlebotomy - pathway redesign to develop a range of providers in community
- Intermediate Care Ealing (ICE) established in order to avoid A & E attendances and admissions.
- Mental Health - Shifting the Settings of Care Programme implemented
- Integrated Care Pathway (ICP) – there are a number of successful schemes:

-Monitoring Officer for Dementia and Dementia Advisor **-Volunteer Link Scheme Befriending Service** **-ESTAR Events - To Promote Integration** **-Befriending Service**	**-Falls Assessment and Response Service** **-Emergency Awareness Scheme (EAS)** **-Communities Against Diabetes (CAD)** **-Support Ealing Health Network** **-Community Quality Assured Spirometry** **-Cardiac Rehabilitation**

Ealing CCG: 2014 Commissioning Intentions

PRINCIPLE	WHAT WILL IT INVOLVE?	WHAT WILL BE THE IMPACT?
Keeping patients well and out of hospital	• Self-managed care • Stabilising and further investments in CCG 'Out of Hospital' strategy • Increasing primary care support and patient access • Developing primary care and community workforce • Improving access to services , including a community transport to support OOH.	1. Improved independence for patients 2. Improved access to services 3. Better outcomes, safer services 4. Improved access for patients out of hours 5. Reduced duplication as patients cross organisational boundaries 6. Better outcomes through greater adherence to treatment regimes by patients 7. Reduced reliance on emergency care 8. Improved patient satisfaction with the care they receive 9. Better value for money
Strategically transforming how we deliver care	• Implementing genuine transformational programmes, for example • Whole systems integration – NWL Pioneer Programme • Focus on 7 day working • Better quality care in appropriate settings • Improved relationship with third sector.	

Ealing CCG: 2014 Commissioning Intentions

Out-of-hospital work-streams

Primary Care

- Primary Care Strategy, Estates Strategy
- Re-tender GP out of hours service
- Seven primary care networks.
- Education, training and skills.

Community Services

- Community falls service.
- Coordinate my Care.
- Pain management service.
- Extending intermediate care.
- Community transport.

Health and social care integration

- Seamless care for the patient across primary, community and social, with continuous coordination based upon individual care plan.
- Focus on care for the elderly and long term conditions
- Prioritisation and care planning based upon risk stratification
- Joint application for the Integration Transformation Fund by CCG and LBE

Shaping a healthier future

Harrow CCG: 2013 successes

Primary Care

- A public event was held in July 2013, where the CCG's Out of hospital strategy was promoted with substantial buy-in from those in attendance as an admirable way of bringing care closer to home
- A patient consultation event on the Community Ophthalmology Service was held in October 2013 with broad consensus for a service as close to patients' homes as possible in sites that are conveniently accessible with good public transport links and parking facilities, and that minimises the travelling for service users
- Recruiting to CCG Transformation Team to support the development of GP networks. The development of GP networks will support improvements in primary care and enhanced services
- GP engagement in estate development to support SaHF. Well attended consultation events with GPs and other stakeholders about potential sites and services to be provided in community locations

Mental Health

- Appointing additional capacity through Mental Health Transformation Team to support the delivery of the Harrow Mental Health Strategy
- Commencement of pilot work in 3 practices to define mental health patient cohort, whose needs can be met in primary care; aligned with requisite training, additional specialist support and care pathways

Harrow CCG: 2013 successes

Unscheduled Care

- Successfully revised the criteria of admission avoidance STARRS scheme to increase the impact
- Supported providers to align pathways to reduce A&E attendances where possible through direct referral from LAS & UCC to STARRS
- Jointly implemented with NHS Brent CCG the Ambulatory Emergency Care Unit, starting initially with 10 clinical pathways and moving to sign off a further 3 pathways in November for implementation
- Piloting a nursing home support schemes and a home settling schemes to reduce A&E attendances and re-admissions
- Jointly developed and implementing across a range of providers through Urgent Care Board a number of winter schemes to support A&E performance between November 13 and March 14
- Jointly signed off a dispute resolution process to support the fast discharge of continuing care patients.
- Developed revised escalation process for the management of health and social care DTOC.

Harrow CCG: 2014 commissioning intentions

- The 2014/15 Commissioning Intentions have been developed as part of Harrow's of the 3 year planning process. Harrow has identified a number of overarching Commissioning Intentions for all providers, including:
  - Integrated Care
  - Informatics - real-time patient record sharing
  - Quality and safety
  - Safeguarding
  - Equality, including access to skilled clinicians for patients/users with Learning Disabilities and/or Challenging Behaviours
- Harrow's key commissioning priorities by service area for 2014/15 cover:

  Children's Services and Maternity, Integrated Care, Unscheduled Care, Planned Care, Primary Care, Community Services, Medicines Management, Adult Mental Health, Adult Learning Disabilities & Challenging Behaviours and Continuing Care.

North West London Collaboration of Clinical Commissioning Groups

Winter 2013/14 – NW London planning update

3 December 2013

The North West London urgent and emergency care systems have been actively preparing for winter with all stakeholders

Background

- Accident and Emergency departments across the country are experiencing pressure to see and treat patients within the recommended four-hour target time.
- While NW London A&E waiting time performance is generally strong, the following measures are in place in preparation for winter, when demand for A&E services tends to increase:
  - ***A&E Recovery and Improvement Plans***: A&E improvement plans have been developed around each NW London A&E department, to ensure that high standards can be sustained all year round. The plans identify how best to ensure that services are responsive to patients' needs this coming winter, and encompass A&Es, Urgent Care Centres and GP practices.
  - ***Urgent Care Boards***: these Boards are in place across NW London – they are collaborative groups of hospital, community and primary care clinicians responsible for ensuring A&E services meet four-hour standards and provide high quality care. They have led on development of the Recovery & Improvement Plans.
  - ***Winter pressure fund***: £250m was allocated in September across the NHS for winter planning, targeted at local systems that would benefit the most from the extra funding (in NW London: NWL Hospitals, Ealing Hospital and West Middlesex Hospital). In November an additional £150m of funding from NHS England was announced to enhance existing plans to maintain services and reduce the pressure on A&Es caused by cold weather.

    Details of winter funding allocations in NW London are provided on the following slides. Note that while Hillingdon was not awarded any monies from the £250m Winter Funding, it is expected to receive funding from the additional £150m.
- Urgent Care Boards and CCGs will carefully monitor implementation of the A&E Recovery and Improvement plans, including use of additional winter funds.

CWHH - A&E Recovery & Improvement Plan

CWHH Collaboration (Central London, West London, Hammersmith & Fulham, & Hounslow)

- The priority actions have been determined through discussion and are those which system urgent care leaders strongly believe will have the biggest impact on the urgent care pathway:
  - ***Primary Care***: to ensure the quality and consistency of primary care provision.
  - ***Community Nursing***: to improve the responsiveness of community nursing in order to prevent avoidable unscheduled admissions.
  - ***Psychiatric Liaison***: to develop a sustainable model for Psychiatric Liaison services.
  - ***Ambulatory Care Pathways***: to review pathways for ambulatory care sensitive conditions to ensure people who could be looked after in the community are not admitted to acute care.
  - ***Acute medical models at Imperial College Hospital NHS Trust***: to improve the acute medical model at Imperial to meet acute commissioning standards.
  - ***Delayed Transfers of Care***: to reduce delayed transfers of care, particularly for people with dementia and neurological rehabilitation needs.
  - ***Whole year planning***: to develop a 'whole year' plan for managing predicted and unexpected fluctuations in demand for urgent care services.

Central London, West London and Hammersmith & Fulham – Winter Funding

Tri-borough (Central London, West London, and Hammersmith & Fulham)

- While these CCGs were not allocated any central funding, they have jointly allocated £3.76m for a number of schemes, including:

Responsible organisation	Scheme
Primary care	• Seven day access – provision of a weekend walk in service through general practices • Enhanced GP access, including evenings and weekends
Local Authorities	• Reablement - to support 7 day social working, improve rapid access and expand existing community services
Central London Community Healthcare NHS Trust	• Step up/step down beds • Additional nursing care and therapy support with rapid response teams
Imperial College Healthcare NHS Trust	• Expanded clinical input and opening hours at UCCs (St Mary's and Hammersmith) • Emergency discharge support • Increased senior decision making in A&E
Chelsea & Westminster NHS Foundation Trust	• Therapy services Winter Pressure • Ambulatory care support doctor & nurse • Additional Emergency Department Consultant cover
West London Mental Health NHS Trust (WLMHT)	• 24/7 psychiatric liaison at Hammersmith Hospital

Hounslow – Winter Funding

Hounslow (West Middlesex Hospital)

- £2.3m of central funding has been allocated to a number of schemes, including:

Responsible organisation	Scheme
West Middlesex University Hospital (WMUH)	• Surge capacity • Emergency Department IT usage
Community / primary	• Community neurological rehabilitation capacity • Increase the multi-disciplinary capacity within the Integrated Community Response Service (ICRS) • Community IV Therapy • Redirection from A&E and Urgent Care Centre (UCC) into primary care services • Reduction in A&E attendance
Local Authority	• Early identification of residents requiring social services input and early and timely supported discharge from hospital
London Ambulance Service	• Improve ambulance handover times at WMUH

Brent & Harrow - A&E Recovery & Improvement Plan

Brent and Harrow (North West London Hospitals, including Northwick Park)

- This plan has developed a local description of the patient journey based on the outputs of a local Risk Summit, which has informed the 5 top priorities to improve performance:
  - ***Admission avoidance pathway development***: including primary care access, case management, and ambulatory care.
  - ***Improving acute flow and bed capacity***: including workforce and operational processes.
  - ***Improved discharge performance***: including community capacity and processes.
  - ***Patient experience and safeguarding***: including an update of complaints processes.
  - ***Improving care for key groups***: Mental Health patients, Carers, patients who have fallen, and Care Home residents.

Brent & Harrow – Winter Funding

Brent and Harrow (North West London Hospitals, including Northwick Park)

- £6.45m of central funding has been allocated to a number of schemes, including:

Responsible organisation	Scheme
North West London Hospitals NHS Trust (NWLHT)	• 24/7 working to improve flow • Enhanced STARRS • Weekend therapy • Extra CEPOD lists • 24 hour surgical assessment unit • Medical 7 day ward rounds • 24 hour stroke service • Extended hours of Gynae assessment unit • 24 hour critical care outreach • Extra diagnostic and anaesthetic support
Brent & Harrow CCGs	• 24 hour critical care outreach • Extra diagnostic and anaesthetic support
Brent & Harrow Adult Social Care	• Residental Reablement beds
Brent & Harrow Community	• Additional bed capacity (including 20 at Willesden)
Central & North West London NHS Foundation Trust	• Acute Psychiatric Unit – co-located

Ealing - A&E Recovery & Improvement Plan

Ealing (Ealing Hospital NHS Trust)

- The health and social care economy have worked together to implement considerable improvements and identified the necessary initiatives to improve the flow of patients through the urgent care system.
- Using the three key stages of the patient journey, the top three priorities to reap the most significant benefits are:
  - ***Tackling avoidable hospitalisation***: this priority brings together the effort to reduce A&E attendance from GP referrals, out of hospital, 111, and nursing home referrals (as well as London Ambulance Service conveyances). The review of GP referrals is the highest priority in this group.
  - ***Home based solutions and not bed based solution***: the Non-Elective Audit has provided quantified evidence of the opportunity; reducing admissions by up to 19% will transform the service. The QIPP is addressing this area.
  - ***Improving patient flow in hospitals***: this priority combines both capacity planning and the process of patient flow through from admission to discharge. The highest priority is implementation of the demand–capacity-modelling work, which must deliver both a bed capacity model and a clinical staffing requirement model.

Ealing – Winter Funding

Ealing (Ealing Hospital NHS Trust)

- £2.9m of central funding has been allocated to a number of schemes. These are targeted particularly at meeting the A&E 4 hour target, 7 day working, and supported discharge, and include:

Responsible organisation(s)	Scheme
Community/ primary	• Primary Care duty doctor • Primary Care telephone support line • Primary Care Walk In service • Demand/capacity balancing community beds
Ealing Hospital NHS Trust	• Frail Elderly clinician in Emergency Department • Therapy service extended to 7 day working • Ambulatory Care Unit – weekends • Rapid Assessment and Treatment (7 day) • Weekend trauma • Discharge team – additional capacity • Substance Misuse Pathway – extended hours • Early Pregnancy Unit – weekends • Paediatrics Clinical Decision Unit • Weekend Cardiac Catheter Lab
Ealing Social Services & London Ambulance Services	• Various initiatives

NW London's A&E performance against the 95% target is the highest in London, achieving 96.92% to date over Quarter 3

Weekly A&E Performance Dashboard (*week ending 17th November*)

NW London acute performance against the 95% performance target in November 2013

(The operational standard for A&E is that 95% of patients admitted transferred or discharged within 4 hours)

Last 4 weeks sitrep

	27/10/13	03/11/13	10/11/13	17/11/13	**4 weeks average**	**Quarter 3**	Estimated average required to meet standard in Quarter
Chelsea & Westminster	98.09%	98.60%	97.62%	98.21%	98.13%	98.25%	91.37%
Ealing	97.52%	98.10%	93.08%	96.96%	96.41%	96.46%	93.37%
Hillingdon	95.64%	97.22%	93.88%	93.80%	95.12%	95.84%	94.06%
Imperial	95.08%	96.06%	96.02%	96.00%	95.77%	96.24%	93.62%
North West London Hospitals	93.48%	97.87%	95.89%	94.15%	95.31%	94.44%	95.63%
West Middlesex	95.78%	98.15%	98.81%	98.86%	97.88%	97.51%	92.20%
North West London Trusts	**96.30%**	**97.89%**	**96.67%**	**96.80%**	**96.90%**	**96.92%**	**92.86%**
Barnet & Chase Farm	87.94%	88.62%	87.84%	94.71%	89.82%	88.32%	102.46%
Moorfields	99.64%	99.88%	99.40%	100.00%	99.73%	99.77%	89.67%
North Middlesex	95.00%	98.38%	95.03%	96.51%	96.21%	95.79%	94.11%
Royal Free	95.49%	98.30%	97.63%	96.61%	96.98%	96.72%	93.08%
UCLH	91.04%	95.45%	93.22%	92.84%	93.09%	92.55%	97.73%
Whittington	97.19%	97.35%	96.75%	95.96%	96.82%	95.57%	94.36%
Barking, Havering & Redbridge	88.51%	88.85%	95.70%	95.14%	92.09%	88.29%	102.49%
Bart's Health	95.75%	95.98%	96.14%	96.03%	95.97%	96.00%	93.89%
Homerton	94.02%	95.36%	94.91%	97.40%	95.43%	95.66%	94.27%
North and East London Trusts	**94.42%**	**95.53%**	**95.78%**	**96.49%**	**95.55%**	**94.77%**	**95.25%**
Guys & St Thomas'	96.63%	97.53%	96.08%	97.20%	96.84%	96.83%	92.96%
King's College	91.16%	90.11%	90.74%	91.86%	90.98%	90.16%	100.41%
Lewisham & Greenwich	91.22%	92.53%	92.01%	93.14%	92.20%	91.68%	98.70%
Epsom & St. Helier	96.67%	97.52%	96.80%	95.04%	96.49%	96.25%	93.61%
Kingston	95.64%	96.72%	96.54%	95.06%	95.98%	95.49%	94.45%
Croydon Healthcare	91.39%	97.08%	94.51%	95.33%	94.51%	92.29%	98.03%
St. George's	89.57%	95.90%	92.83%	93.59%	92.92%	93.64%	96.52%
South London Trusts	**93.83%**	**95.33%**	**94.54%**	**94.97%**	**94.65%**	**94.23%**	**95.86%**
Total London Performance	**94.81%**	**96.16%**	**95.67%**	**96.13%**	**95.68%**	**95.24%**	**94.73%**

All types

Emergency admissions in NW London are falling

- April - September (6 months) 2013 compared to 2012
- Total emergency admissions (Non elective finished consultant episodes)

Ealing Hospital	-1%
Imperial	-4%
Hillingdon	-1%
North West London	+2%
West Middlesex	-4%
Chelsea and Westminster	-5%

North West London has begun to implement 7 Day GP Access to improve access to services and reduce demand for A&E

- The opening of GP practices at weekends closely aligns with Shaping a healthier future and the CCGs' Out of Hospital Strategies.
- Many patients would prefer to receive care (when clinically appropriate) at their local GP practice; this also reduces UCC and A&E attendances.

Central London CCG

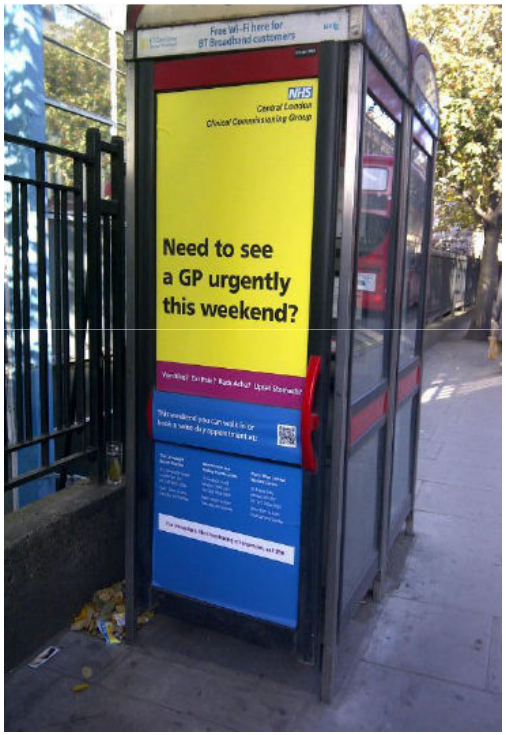
- Three GP practices in Westminster are now open all day every Saturday and Sunday, enabling more patients to be seen close to their homes.
- Early results have been encouraging - patient satisfaction is high and there is evidence of a reduction in emergency presentations.

Brent CCG

- If a patient calls their practice and is unable to see a GP or nurse within 48 hours, they will be offered an appointment within 24 hours at another practice in the area (that is offering the extended hours service).
- Additional appointments are available Mon - Fri, 3pm to 9pm and Saturday 9am to 9pm.

Ealing CCG

- Ealing CCG will run two schemes:
  - Monday to Saturday will run a GP walk-in service that will see practices opening for morning sessions which patients can access without an appointment six days a week; and
  - GP surgeries will offer a 'duty doctor' service two days a week (those days when practices experience the highest demand for appointments).



Whole Systems Integrated Care

CCG Collaboration Board

14th November 2013

Living *longer* and living *well*

Whole System Integrated Care

We are a pioneer

Living ***longer***
and living ***well***

Our vision

Our shared vision of the WSIC programme …

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

… supported by 3 key principles

1. People will be empowered to direct their care and support and to receive the care they need in their homes or local community.
2. GPs will be at the centre of organising and coordinating people's care.
3. Our systems will enable and not hinder the provision of integrated care.

Integrated care is what people who use services want, what professionals aspire to deliver, and what commissioners want to pay for

*"I know who is the **main person in charge** of my care. I have one first point of contact. They understand both me and my condition."*

*"The professionals involved with me **talk** to each other. I can see that they work as a **team**."*

*"There are **no big gaps** between seeing the doctor, going for tests and getting the results."*

*"I am as **involved** in decision making as I wish to be."*

Integrated care means care that is coordinated around the individual, provided in the most appropriate place, and funding flows to where it is needed

- People with needs such as long-term conditions have a care plan
- There is one set of records shared across organisations
- Professionals provide continuity of care as funding supports it
- Joined up health and social care

Care is coordinated around the individual

Care is provided in the most appropriate setting

- Multidisciplinary home care teams
- More specialist support for management of people in the community
- Fewer people are treated in hospital, and those that are leave sooner

Funding flows to where it is needed

- More investment in primary and community care
- Social care and mental health needs considered holistically with physical health and care needs
- Less spending on acute hospital based care

One practical example of integrated care is ChenMed which has reduced admissions by 18%, bed days by 38%, and doubled patient satisfaction

ChenMed®

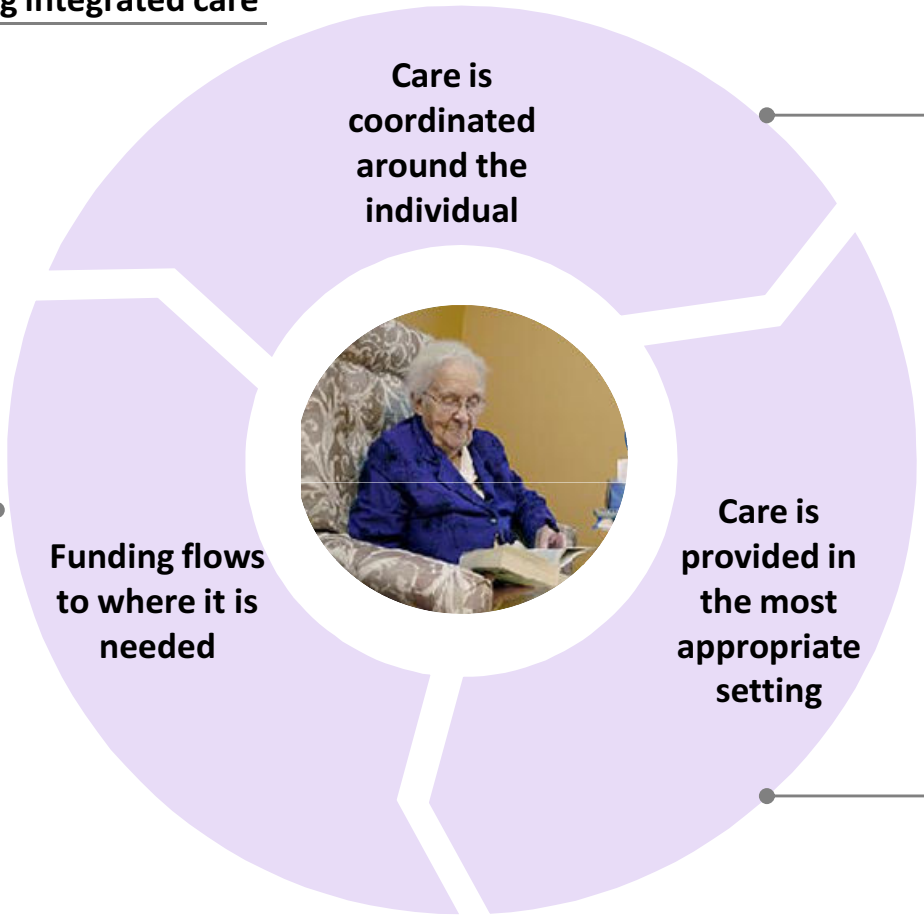
Care model	Payment model	People model
• Each GP has ~450 registered patients **all** are over 65 and have multiple LTCs • 95% of people seen by same GP and within 20 mins so continuity is strong • On site specialists, pharmacy and diagnostics • Medical model, no social care or home care • Patients transported to the centres by shuttle bus, open 7.30am to 4.30pm	• Only open to people over 65 with multiple LTCs and eligible for Medicare (the US' public health system) • Receive fully capitated budget for whole healthcare spending - £6,500-£15,000 • If patients go to hospital ChenMed pays out of capitated budget (over £30,000 costs are covered by third party insurer to ChenMed)	• GP-led team with 4-5 GPs in each centre • Recruit GPs that are passionate about providing care for people with complex needs • GPs are supported by a team of specialists and nurses • Peer review for every admission to hospital

Given the absence of a social care system in the US, ChenMed is a medically focused model that targets one specific population. What are the lessons for the whole system?

Social care has an essential role in supporting integrated care through its focus on personalisation, holistic outcomes and supporting independent living

Role of social care in enabling integrated care

- Investing in keeping people well at home means fewer people need to enter high cost residential or care homes
- Early intervention and prevention support to reduce escalation of care needs and higher cost interventions



- Social care has a strong personalisation agenda that:
  - Continues to focus on personal budgets as a way of service user managing their own care in the best way
  - Focuses around outcomes not just for specific care needs but also wellbeing and quality of life

- An integrated approach to care that supports people to live independently in the community through:
  - Services provided in the home to keep people living independently
  - Opportunities to participate in local community

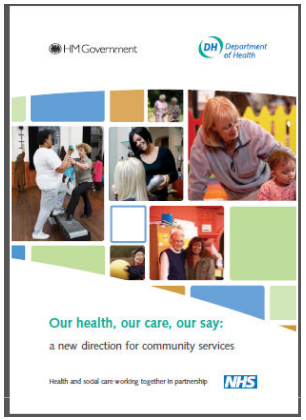
Living *longer* and living *well*

Locally and nationally there has been strong commitment to moving to integrated care closer to home, with examples of success

There have been many successful local initiatives that have improved care for parts of the population

Integrated Care Programme	WellWatch	Health Navigators	Inter-mediate and Rapid Care
Telehealth and telecare	Hospital at Home	Rehabil-itation	Virtual wards
STARRS	Community health locality working	Early supported discharge	Mental health for Primary care
Microcom-missioning	Direct payments	Outpatients in a community setting	Continuity of Care

"Care closer to home" has been a national strategy for most of the past decade, under both Labour and Coalition

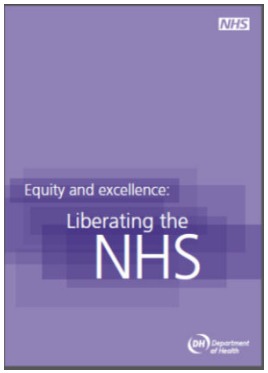


2006

2007

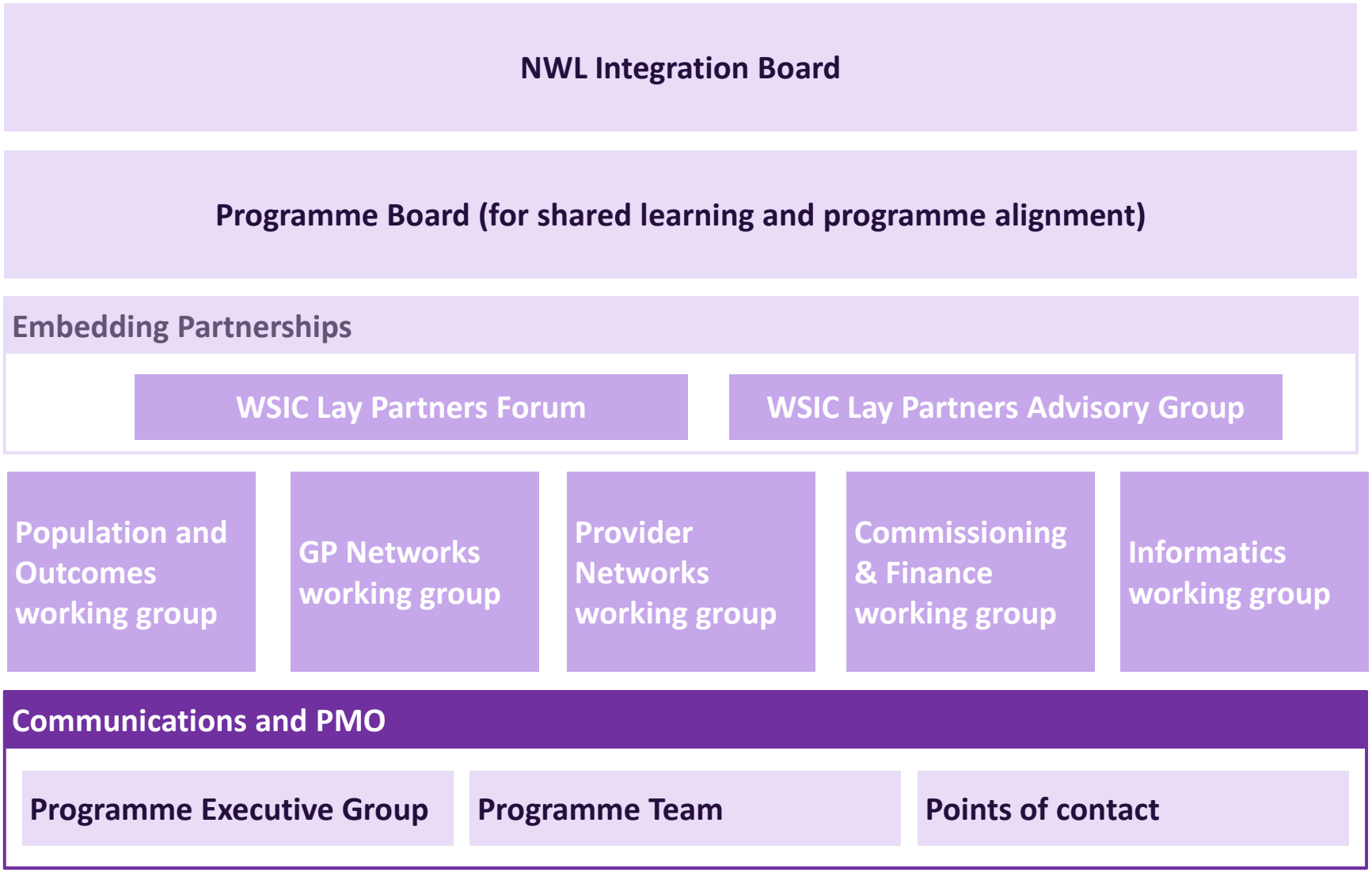
2008

2009



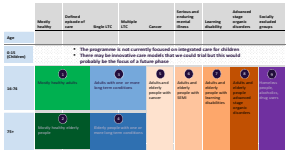
2010

We have a major programme under way



And five working groups tackling the tough questions

Population and outcomes

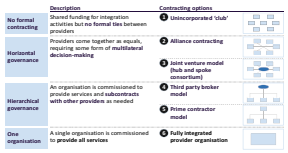


- What is a sensible segmentation of the population?
- What are the opportunities to improve outcomes and care for the different segmented groups?
- What are the outcomes we are trying to achieve for the population?

GP networks

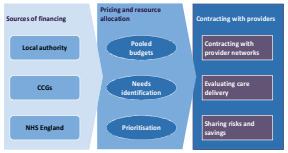
- How can practices work together and what services can they provide across networks?
- How will GP networks organise to support a wider provider network?

Provider networks



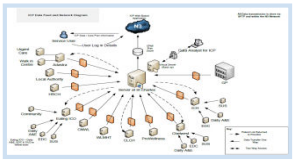
- What do we want provider networks to do?
- How could provider networks make decisions that have an overall benefit for the system but risk negative impacts for individual members?
- How do resources get allocated between providers within a network?

Commissioning and finance



- What do we want joint commissioning governance models to do?
- How can we manage joint commissioning arrangements between health and social care commissioners?
- How are decisions made between commissioners?

Informatics



- What do we need informatics systems to do to support providers?
- What do we need informatics systems to do to support commissioners?
- What are the critical gaps that must be addressed before a whole systems approach can go live?

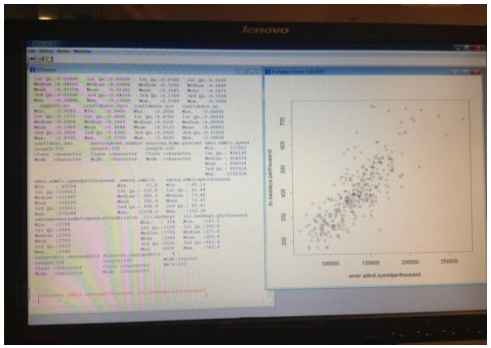
The first step is to understand the population and their needs in a way that is centred around individuals and practical for both health and social care

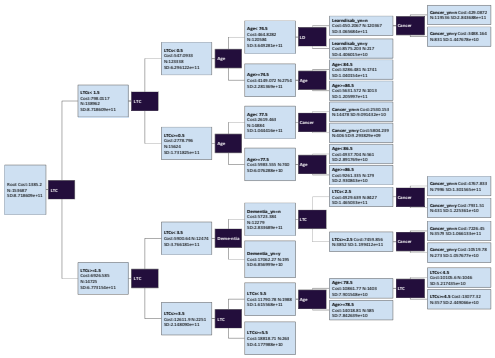
	Description
Current segmentations are not fit for integrated care	• Today, the health and care system segments people by professional groupings such as: – Health vs. social care – Generalist skills (primary care) vs. specialist skills (secondary care) – Physical vs. mental health – Diagnosis (e.g., respiratory) – Anatomy (e.g., cardiothoracic services) • However, most professionals intuitively recognise patterns in the people that they serve that cut across professional groupings, e.g., the elderly; people with long-term conditions
Interventions should be targeted at people with similar needs	• We need to identify groups with similar needs – although theoretically we could have 2 million groups it is not practical to have 2 million care models • International examples show models of care differentiated according to need have the greatest impact • Descriptions of aspiration of impact on outcomes are more meaningful when attached to specific groups rather than for the whole population, otherwise they are too general, difficult to measure and act upon • NHS was founded on the principle that resources should be allocated on the basis of need and not ability to pay; but today, all resources are allocated uniformly in primary care with a strong bias of funding flows towards hospitals
Practically, we need to implement in a step-wise approach	• Grouping allows implementation to follow a staged approach as opposed to tackling the entire population at once • We can prioritise areas of greatest need first

The proposed grouping was developed through three routes: professional judgement, statistical data analysis and a review of other models globally

1 Judgement of multiple professionals and lay partners

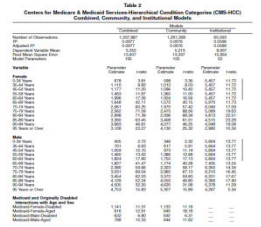
2 Sophisticated data analysis of integrated data set

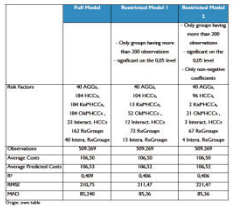


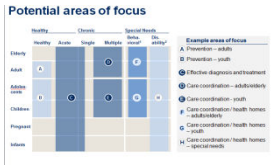


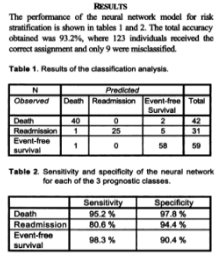
3 Review of internationally applied segmentation models

Segment	Prevalence	Priorities
Healthy	~32%	Maintenance of health (e.g., prevention, screening)
Healthy with acute illness	Variable	Diagnosis, treatment, early detection of complications
At risk	~18%	Prevention of disease and complications
Chronically ill	~45%	Prevention, detection, and treatment of secondary complications
Complex	~5%	Prevention of complications, coordinaton of care









RESULTS

The performance of the neural network model for risk stratification is shown in tables 1 and 2. The total accuracy obtained was 93.2%, where 123 individuals received the correct assignment and only 9 were misclassified.

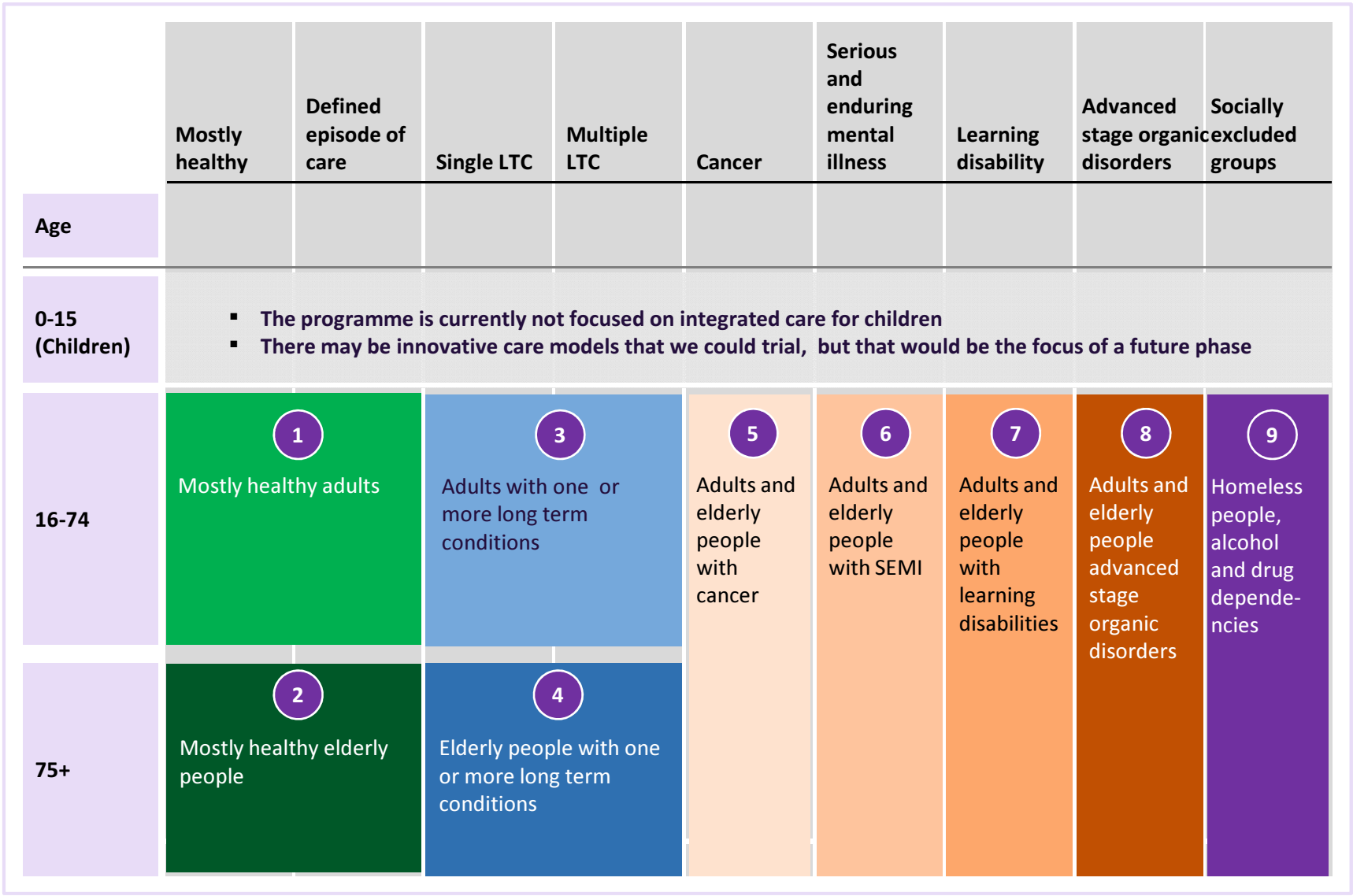
Table 1. Results of the classification analysis.

N	Predicted			
Observed	Death	Readmission	Event-free Survival	Total
Death	40	0	2	42
Readmission	1	25	5	31
Event-free survival	1	0	58	59

Table 2. Sensitivity and specificity of the neural network for each of the 3 prognostic classes.

	Sensitivity	Specificity
Death	95.2 %	97.8 %
Readmission	80.6 %	94.4 %
Event-free survival	98.3 %	90.4 %

Proposed groupings



Clear path forward with real budgets changing in 2015/16

1	2	3	4
Co-design framework centrally once	**Locally agree priorities and plans**	**Preparation for implementation and support Wave One sites**	**Roll out Whole Systems approach**
Oct 2013 – Jan 2014	***Dec 2013 – Mar 2014*** *Feb 15th ITF submission*	***Apr 2014 – Mar 2015***	***Apr 2015 –***
Co-design framework and supporting toolkit for whole systems that • Identifies target population segments, their desired outcomes and finances available • Designs how GP and Provider Networks could work together to support models of care • Sets out joint commissioning governance approach and financial model	Use whole systems framework to develop local Pioneer Plans that will inform and provide content for • 5 year strategic plans for whole systems • 2 year implementation plan • Specification for local Wave One accelerated implementation sites • ITF templates	All areas continue planning and implementation of Whole Systems Integrated Care Wave One implementation sites test key features and share lessons across NWL with shadow budgets Programme supports both of these goals	Facilitate learning from Wave One Implementation sites to scale new models of care with actual budgets attached

"Co-design common solutions once"

"Decide what is on table"

"Shadow budgets in place"

"Actual budgets in place"

integrated care business as usual

Living ***longer*** and living ***well***