Local Services Transformation within Northwest London

Our strategy for transforming Primary Care and out of hospital services

DRAFT

Précis v0.4
Strategy v0.9.7

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Executive summary

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The challenges facing the NHS, and the need to radically transform the way we deliver care were set out in the Five Year Forward View (5YFV). In NW London, our Sustainability and Transformation Plan (STP) sets out our ambitious plans to close the three gaps identified: health and wellbeing, care and quality and finance and efficiency. The development of a complete and comprehensive model of out of hospital care is critical to the delivery of these plans and social care is an essential part of this model.

Our plans span from prevention through to short-term support and long-term care. This integrated out of hospital care – Local Services – will deliver personalised, localised, specialised and integrated care to the whole population. Patients will be able to take more control, supported by an integrated system which proactively manages care, provides this care close to people's homes wherever possible, and avoids unnecessary hospital or care home admissions. This will improve health and wellbeing, and care and quality, for patients and residents.

Social care is fundamental to the sustainability of the future health and care system. Financial, demographic and demand pressures on the system mean that both health and care need to work together to transform how we look after people. If we are to keep people close to their home and achieve our ambition of treating people in the least intensive care setting possible, we will need to do more to support people in their own homes, providing high quality flexible care that can support those with even very substantial needs.

Our aim is to accelerate investment in infrastructure for a network of care hubs: develop the skills of our front-line staff, and boost the capacity and capability of GP leaders to strengthen the delivery of Primary Care services in NW London. The hubs will be a key centre for the delivery of preventative and short-term social care, and the co-ordination of longer-term care options. General Practice and Intermediate Care will be transformed with consistent services to the whole population ensuring proactive, co-ordinated and accessible care is available to all.

Together, these parallel ambitions form our Local Services Transformation Programme, which brings together a range of high-impact initiatives (See boxes to right).

Enhanced Primary Care and related out of hospital service improvements are critical in achieving the ambitions set out in our STP and Implementation Business Case (ImBC). Our immediate and longer-term plans will deliver accessible and integrated care which offer 'right time, right care, right place'.

This document sets out our strategy for achieving these ambitions.

'There is arguably no more important job in modern Britain than that of the family doctor'

GPs are by far the largest branch of British medicine. A growing and ageing population with complex multiple health conditions means that personal and population orientated Primary Care is central to any country's health system. As a recent British Medical Journal headline put it – 'if General Practice fails, the whole NHS fails'. *General Practice Forward View – 2016.*

We are determined that NW London succeeds.

Enhanced Primary Care: locally owned plans are in place for delivery of the SCF priorities – delivering extended access, patient-centred and pro-active care. Primary and Social Care will integrate with Social Care will co-ordination across key parts of the system against a single shared care-plan. Those people in bedded social care will have access to excellent Primary Care to prevent hospital admissions.

Self-Care: embedding an asset-based approach and self-care framework as a commissioning tool and implementing Patient Activation Measures (PAM) to support co-ordinated LTC management

Upgrading Rapid Response and Intermediate Care Services: delivering consistent outcomes and contributing to an integrated older peoples' pathway of care, in conjunction with **Last Phase of Life** and related initiatives

Transfer of Care: implementing a single, needs-based assessment process, with a single point of access in community services. This will ensure quick and safe, co-ordinated discharge from acute services back in to the community, in partnership with Local Authorities

Social Care: delivering a social care system that supports people in their own home as much as possible by being enhanced to a level where the additional needs of those people who would have otherwise been in hospital are supported safely

1 Case for change

The key challenges facing Local Services

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Health and wellbeing

- The number of people aged over 85 is expected to increase by 20.7% by 2020/21 and 43.8% by 2025/26. These people are likely to have more and more complex, long term conditions
- Nearly half of our 65+ population are living alone, increasing the potential for social isolation
- 1 in 5 children aged 4-5 are overweight, 10-28% of children live in households with no adults in employment

Demand

- Growing demand and increased activity in out of hospital and acute services
- Demand is outstripping our ability to deliver care
- General practice is struggling to meet the needs of urgent Primary Care and same day appointments
- This had had a negative impact on A&E Primary Care attendances and Non-Elective Admissions (NELs)
- There is variation in access to Intermediate Care Services across NW London

Finance, infrastructure and workforce

- Financial pressure across health and social care economy has left the long-term affordability and access of health care at risk
- Social Care providers struggle to provide care in the face of continued financial pressures and to recruit the necessary workforce
- Recruitment and retention in General Practice, in particular an ageing workforce, is also problematic
- The condition of much of the NHS estate in NW London is poor, and requires financial investment
- Our current IT infrastructure does not readily support the sharing of information across systems

Care and quality

- Continued financial pressure on Social Care providers risks destabilising the market and compromising quality and safety
- Inadequate access to Primary Care significantly below the national average
- Only 60% of people with a long-term condition feel supported to manage their condition
- 23% of practices inspected by the CQC are performing below the national average
- There is unwarranted variation in the management of long-term conditions (LTCs), such as diabetes, atrial fibrillation, hypertension and chronic obstructive pulmonary disorder (COPD)

London-wide drivers

- There are **inconsistent levels of care** across London
- Care should be **integrated** with other services, including services such as housing
- More routine care should be delivered **out-of-hospital** and in a cohesive way
- Services provided must be **staffed appropriately** to provide safe and effective services
- Long-term sustainability of the provider landscape (including social care providers) should be secured though **targeted intervention** and **investment**
- More services should move towards being available **seven days a week**
- Integrated and increasingly streamlined **commissioning**

Primary and Community Care under significant pressure → Transformation required → Local Services Transformation embodies delivery of SCF and 5YFV

Our vision for integrated primary and out of hospital care

Our vision for health and care in NW London is that everyone living, working and visiting here has the opportunity to be well and to live well. We know that the quality of care varies across NW London and that where people live can influence the outcomes they experience. We want to eliminate unwarranted variation to give everyone access to the same, high quality services.

We will deliver integrated out-of hospital care across a range of Local Services that will have four key components:

Personalised

Care is to be personalised, enabling people to manage their own care themselves and to offer the best treatment to them. This ensures care is **UNIQUE**.

Localised

Care is to be localised where possible, allowing for a wider variety of services closer to home. This ensures care is **CONVENIENT.**

Integrated

Delivering care that considers all the aspects of a person's health and wellbeing and is coordinated across all the services involved. This ensures care is **EFFICIENT**.

Specialised

Centralising services where necessary for specific conditions ensuring greater access to specialist support. This ensures care is **BETTER.**

Personalised

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

Localised

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

Integrated

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

Specialised

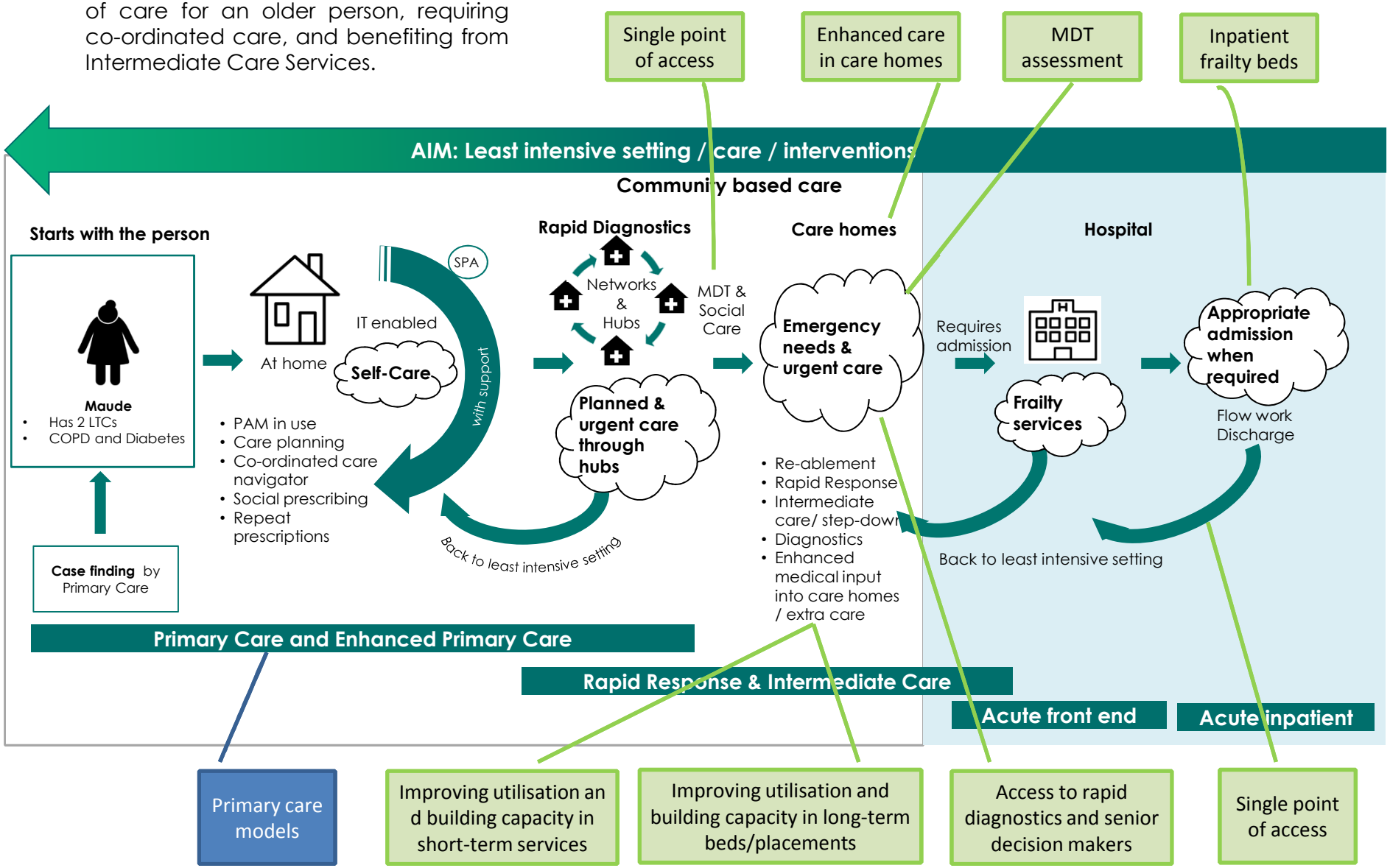
Michael, 83, lives in a care home in Brent. When he had a sudden fall, his key worker called the local STARRS team who came out to care for him within two hours; when he next saw his nurse, his records had already been updated and he was able to modify his care plan accordingly. He is now seeing a specialist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

What will be different for patients?

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

We have developed an example care pathway for older people

This pathway is an example of a model of care for an older person, requiring co-ordinated care, and benefiting from Intermediate Care Services.



We have developed our Local Services model of care for the whole population

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Principles

- Care and support should be safely provided in the **least intensive** setting necessary
- Care should be quick, safe and **accessible** to all
- Care is focused **around the individual**; their needs and their care plans
- Individuals will have needs that simultaneously **exist across the system**
- Care is co-ordinated, personalised, specialised and integrated, with the **person at the centre**

Increasing intensity of need

Enhanced Primary Care model

Urgent & Intermediate care pathway

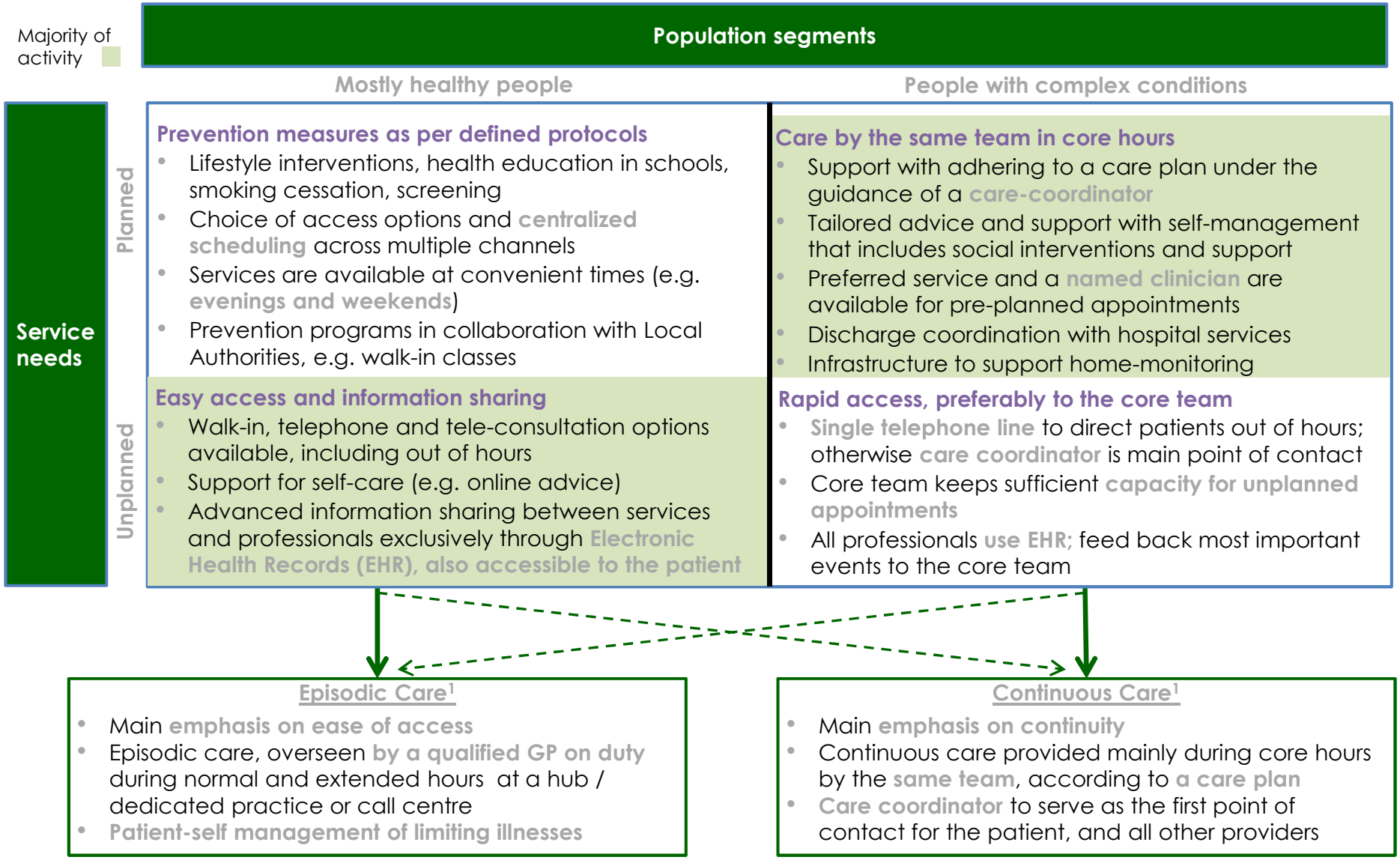
1	2	3	4	5
Proactive and Accessible Care	**Co-ordinated and Proactive Care**	**Co-ordinated Care for LTCs or periods of ill-health**	**Urgent/ Intermediate care to support recovery or maintenance**	**Acute inpatient admissions**
Prevention: • Self-care • pro-active care • Health goals/ annual check-ups **Convenient access:** • Same day appointments • online booking • telephone consultations • Skype consultations **Social Prescribing** • Access to support services (e.g. debt, social isolation)	**Proactive Care:** • Care plans • Case finding • Tailored risk stratification (PAM) **Co-ordinated Care:** • Continuity of care • Long-Term Conditions (LTC) management • Self-care • Multi-Disciplinary Team (MDT) approach to and care planning	**Co-ordinated Care:** • Care for individuals that require on-going support (LTCs) • Intermittent illnesses requiring co-ordinated care • Care planning • Risk stratification • Same-day access to care • Planned access • Enhanced medical input into long term care (residential, nursing, extra care, home care)	**Rapid Response and Intermediate Care Services** • Support to patients with urgent needs within the community, including those in care homes • MDT approach • In partnership with Primary Care • Encompasses bedded (with a focus on recovery & re-ablement) and non-bedded care	• Inpatient admission for shortest time necessary • Supported by SPA and discharge processes to get home sooner • Social Care & intermediate care capable of supporting enhanced discharge • Planned admissions when possible • Supporting those in last phase of life

Better transitions and transfers across different parts of the system, enabled by standardised assessments and Single Point Access

Enablers to support integrated working including dashboards, technology and workforce

Living healthy

The whole population approach will deliver integrated out of hospital care in NW London



1. Mostly healthy people can follow the "continuous" model of care situationally (e.g., when recovering from a complex surgery); people with complex condition can follow "episodic" model when treated for completely unrelated conditions (e.g. ankle sprain for a diabetic)

A Social Care model has been developed that integrates with Primary and Secondary care, while supporting people in their communities

Short term support

Community resilience

Long term support

Component	What is proposed
Effective decision making prior to admission / at discharge	• Access point which works with the locality teams and specialist services to triage / assess and get access to the right interventions within the appropriate response times • Supporting a consistent, high quality approach to discharge/ avoiding admissions by proactive planning, involving the right people • No wrong door – same process wherever accessed
Holistic Step up / step down support	• Increased intensity of home care for sub acute patients including e.g. Waking nights/ integrated with community nursing support • Intensive re-ablement/ rehabilitation • Social Care assessment in-reach into sub acute beds • People will be kept in their own home or home-like setting (eg. Extra Care) where possible. Where step up/ down beds are required these will be minimal and recovery based
Building resilience in individuals and communities	• Information Advice & Guidance to manage demand towards self-care • Using technology and other equipment to be more independent • Investing in community groups and the 3rd sector to provide low level support • Access to low level services through social prescribing – could include social isolation schemes, debt advice, carer's services, dementia support etc • Takes a whole person approach – i.e. includes mental wellbeing
Integrated Teams aligned to agreed local footprints	• Hubs to be key centre for delivering short term social care including community resilience (section 1), decision making / triage (section 3), step up / down (section 4) and links / coordination into long term care (sections 5 and 6) • Teams of multi skilled professionals, aligned to hubs • Integrated Case Management to work out the best way of improving outcomes • Access to appropriate specialist resources and services • Focused on better condition management, preventing admissions and facilitating discharge
Long term care in the home or home-like setting	• Flexible, locality focused, linked to re-ablement • Engaged in assessment and planning • Enhanced medical input in order to avoid unnecessary hospital admissions • Linked to assistive technology • Includes housing options such as Extra Care and Sheltered Housing • Dignity and choice in end of life care as a result of right skills to support choices
Long term bedded care	• Limited use of Residential or Nursing Care – more use of alternative options • Enhanced medical input into long term bedded care in order to avoid unnecessary hospital admissions, • Dignity and choice for those at the end of life

3 Delivering the vision

The transformation of Local Services is central to the delivery of the ambitions set out in the NW London STP

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How Local Services areas of focus fit within STP delivery areas

DA2

Eliminating unwarranted variation and improving LTC Management:

a. Delivering the Strategic Commissioning Framework and Five Year Forward View for primary care
b. Improve cancer screening to increase early diagnosis and faster treatment
c. Better outcomes and support for people with common mental health needs, with a focus on people with long term physical health conditions
d. Reducing variation by focusing on Right Care priority areas
e. Improve self-management and 'patient activation

DA3

Achieving better outcomes and experiences with a focus on older people:

a. Improve market management and take a whole systems approach to commissioning
b. Implement accountable care partnerships
c. Upgraded rapid response and intermediate care services
d. Create an integrated and consistent transfer of care approach across NW London
e. Improve care in the last phase of life

Our areas of focus

- Promoting **self-care** and **prevention**
- Improved **access** and **co-ordination** of care
- Reducing pressure on A&E and secondary care
- Implementing **co-produced standards** for integrated out of hospital care
- Building on local work, knowledge of local work, curating **best practice**
- Improving access and linking the management of physical and mental health conditions to **reduce clinical variation** in LTC management

- Delivering **consistent outcomes** for patients within Primary Care, irrelevant of in which borough they reside
- Standardising the Older People's **clinical pathway**
- Standardising care across pathways, including **Intermediate Care Services and Rapid Response**
- Introducing contracting and whole population budgets
- Creating co-operative structures across the relevant of the system, e.g. older people cohort

The impact of our plans

A healthier NW London

- Early identification and intervention, leading to better health outcomes for the population
- Reduction in A&E attendance, non-elective admissions, length of stay, and re-admissions
- Delivery of care in more appropriate settings
- Cross-organisation productivity savings from joint working
- Consolidation and improved efficiency, in commissioning and delivery of care
- Improved patient satisfaction from better access, quality of care and integrated care

More productive care

- Increased collaboration
- Reduced duplication
- Management of flow
- Sustainable Primary Care providers and provision of care

More effective system

- Aligned decision-making resulting in faster implementation
- Increased transparency and accountability

In order to achieve our vision we have initiated our workstreams to deliver at-scale and at pace

Our enhanced Primary Care and Self-Care workstreams, encompassing delivery of the SCF, will deliver:

- **Accessible care** through a variety of channels (digital, phone, face-to-face) and at convenient time **will achieve our vision for localised and personalised care.** As part of the GP Forward View, neighbourhood groups of GP practices within NW London are prioritising the delivery of extended access to Primary Care services. By April 2017 the Extended Primary Care Service will be available 8am-8pm, 7 days per week, with Sunday access dependent on demand, providing significantly higher levels of access to NW London residents than ever before. We will achieve extended access across our population by the end of March 2017; the remaining aspects of Accessible Care will be embedded by Q1 of 2018.
- **Proactive care** through the work with communities, patients, their families, charities and voluntary sector organisations to co-design approaches to improve the health and wellbeing of the local population **will achieve our vision for integrated and personalised care.**
- **Co-ordinated care** through patients identified for co-ordinated care to receive regular multidisciplinary reviews by a team involving health and care professionals with the necessary skills to address their needs **will achieve our vision for specialised care**.
- Each locality in NW London is phasing delivery of accessible, proactive and coordinated care in order to ensure that changes are fully embedded. CCGs are working to gain consistency across their practices and focusing on long term behavioural change as well as the technical aspects of transformation.
- At-scale Primary Care is at the heart of our vision for more localised, integrated and specialised care. In order to deliver accountable care for patients across NW London, strong Primary Care services are crucial, we are therefore continuing to work with CCGs to develop their federations. This support will focus on three key areas: Developing leaders across Primary Care and strengthening care teams to support GPs, encouraging clinical effectiveness across NW London by sharing resources and implementing consistent organisational standards across General Practice. All of these changes will help deliver better care that is more convenient and efficient for patients.

As well as reducing unwarranted clinical variation, we are also focusing on achieving better outcomes for older people:

- **Upgrading Rapid response and Intermediate Care Services**, in conjunction with our **Last Phase of Life** and **Transfer of Care** initiatives, will work in partnership with social care to deliver new older peoples' pathways to provide specialised, integrated, personalised care. In the future, older people's care will be commissioned as part of an accountable care partnership. Each person will have a care plan and team coordinated through Primary Care. Services will be designed to fulfil a patients needs, with the aim of keeping people out of hospital or other institutional care settings when appropriate. Single points of access will enable the safe and effective flow of people from settings and services. The third sector will also play a role in coordination supporting older people's care.

4 Enabling The change

We will be supported in our transformation by the following programmes and initiatives

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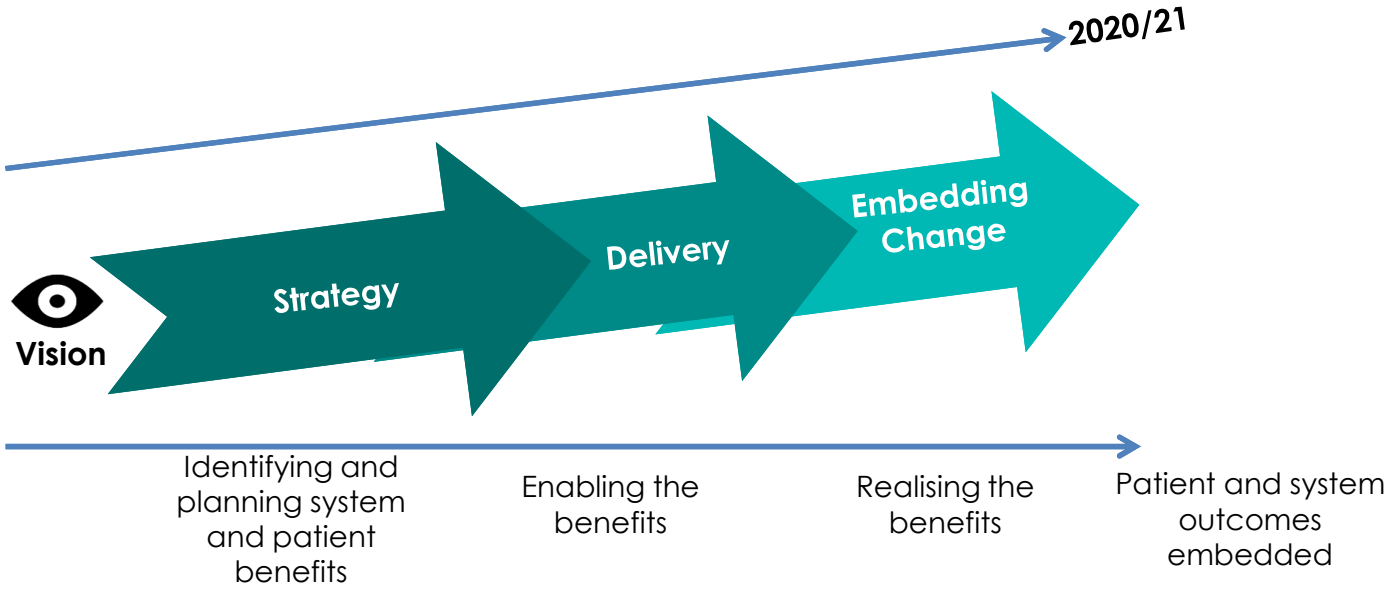
Workforce	To support the delivery of the SCF we need to increase the capacity of the workforce by increasing productivity in Primary Care, making sure that activity is carried out by the most appropriate member of the team and building on the 10 High Impact Actions, as part of the General Practice Development Programme. We will strengthen the care team by broadening the number and type of professionals in Primary Care. We are also focused on the resilience of the Primary Care workforce, making sure we maintain high levels of recruitment to GP training, continuing to attract committed and skilled professionals into NW London and retaining staff within, particularly addressing challenges we have associated with the number of staff within 5 years of retirement age.
Co-commissioning	We will explore delegated co-commissioning with our CCG membership and engage with all of our stakeholders throughout 2016/17. Any consideration of a move from Level Two to Level Three will be driven by: 1) the flexibilities afforded to commissioners of Primary Care (at all 'Levels') within the STP process and related policy change; 2) assurance upon access to resources, capacity and capability to successfully act under full delegation; 3) significant engagement with and democratic support and mandate from CCG membership before delegation; and 4) open book approach to funding and budget setting (including all Primary Care allocations / budgets) and an appropriate due diligence assessment on existing committed expenditure and budget provision.
Federation development and contracting	We will have fully engaged federations, driving GP accountability to reduce unwarranted variation in LTC management. The fully established federations are: 1) legal entities with substantial operational capabilities which hold out of hospital and other contracts; and 2) actively participating in Accountable Care Partnerships which hold capitated budget for selected segments of patients on their lists. The Accountable Care is delivered to the whole population.
Finance and activity	We will assess the cumulative finance and activity impacts for delivering the SCF, primary medical care position in 2016/17 and primary medical care allocations up to 2020/21. In order to achieve SCF delivery, we will need to invest an additional £21 million in new models of Primary Care services across NW London. It is expected that this investment will reduce secondary care activity and result in a net financial benefit of circa £11 million over the next five years.
Estates	We will have a number of hubs delivering integrated care: co-location of 'out of hospital' services provided by teams of multi-disciplinary healthcare professionals across Primary Care, community care and social care. GP estates are modernised or rebuilt in order to meet the required clinical standards.
Technology and digital enablers	We will have integrated data sharing to enable interoperability and whole systems performance monitoring; shared care plans across all providers that are accessible to patients; and systems in place that support practices in managing patients.

Local Services Transformation delivery is underway

We will deliver components in phases, supporting the CCGs and providers to deliver at the pace of the fastest by sharing best practice, consolidating knowledge and learning, deploying key resources where required, and developing and implementing outputs and models across the sector.

We are monitoring our delivery through our STP structures. The key deliverables and outcomes for each Local Services initiative will be updated with a greater granularity added as the Business Cases get developed. This will be an iterative process.



Our NW London benefits are defined as quantified outcomes; how we measure our impact on the system, and to our population. We have now defined our outcomes, and are consolidating our dataset with our stakeholders.

Once our metrics are agreed, and our measurable benefits defined, we will baseline our data and begin implementing our benefits realisation plan. These metrics will be monitored on a monthly basis, with gateway reviews at every stage of the programme lifecycle, to ensure that we are on track with delivery.

Benefits will begin to be realised throughout our transformation journey.

5 Implementing the outcomes

Our key deliverables that will achieve our vision, by embedding our outcomes leading to the benefits realisation

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SCF Implementation

- Accessible Care
- Proactive Care
- Co-ordinated Care
- At-scale Primary Care development
- Delegated commissioning
- GP Access Fund

2016/17

- Deliver affordable extended access solutions for 8-8, 7 day requirements
- Create minimum standards for appointment requirements
- Align extended access provision with urgent care and 111
- Develop two condition-specific clinical pathways and test against provider-models and outcome-measures
- Establish formal GP federation leadership network to share best practice ideas
- Design a contract to monitor and incentivise care teams
- Develop incentive model for practices to better participate as a member of the network

2017/18

- Deliver SCF Co-ordinated Care targets (by October 2017)
- Move identified commissioning incentives from practice to population-based coverage
- Roll-out of digital solutions to support Patient Activation Measure scores
- Review of locally commissioned services to develop extended access at scale
- Develop relevant clinical pathways (LTC and acute)
- Monitor efficiency of care planning processes by multidisciplinary teams

2020/21

- Deliver SCF Accessible Care targets (by March 2019)
- Deliver SCF Proactive Care targets (by October 2018)
- Enable digital access for key patient-groups and practices
- Ambulatory and emergency care schemes in place
- Expand opportunities for single point of access with shared summary care record
- Monitor outcomes-based commissioning against delivery of pathways by specified care-models
- Link with outcomes-based commissioning initiatives (and ACP development/delivery) to achieve specified clinical benefits and release of QIPP benefits

Self-Care

- Self-Care Commissioning Framework

2016/17

- Establishment of CCG Self-Care Steering Groups in each CCG aligned to NW London PDG and Self-Care Framework
- Develop recommended MH Digital tools for Self-Care
- Define best practice approaches to online-management solutions utilising Vitrucare as local example
- Develop workforce strategy aligned to Self-Care Framework
- Development of 3rd Sector support programme framework
- All eight CCGs supported in implementation of PAM programme (43,920)

2017/18

- Health apps forming part of self-care offer for targeted patient populations
- PAM utilised as outcome based metric
- Evidence of third sector organisations accessing patient information to support integrated ways of working
- Embedding of online self-management solutions building on evidence of local approaches to expand across NW London
- Expansion of activating the workforce offer with focus on Health Coaching and Making Every Contact Counts

2020/21

- Evidence of full delivery of Self-Care framework with consistent best practice approaches across the five elements of the framework
- Online management solutions in place to support self-management and health education
- Full roll out of PAM to all patients with LTC's (428,700) and **evidence of impact of PAM score improvements aligned to cost savings in health spend per capita**
- 3rd sector organisations fully integrated within ACPs with a Single Point of Access and forming geographically based consortiums
- NW London workforce supported by embedded Self-Care training programmes

5 Implementing the outcomes

Our key deliverables that will achieve our vision, by embedding our outcomes leading to the benefits realisation cont'd

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Intermediate Care/Rapid Response

- New Model of Intermediate Care Services (ICS)

2016/17

- Analysis document of current provision of intermediate care across NW London completed
- National and international best practice review document completed
- Scoping document for NW London ICS provision completed incorporating Improvement areas, evidence, action plans (including prototyping, PDSA cycles) AND quality outcomes for the service

2017/18

- Intermediate and rapid response model of care improvements, specification and outcomes
- New contractual arrangements/tender process agreed by Project delivery Group (if required)
- Implementation of ICS model based on outputs of phase 2

2020/21

- ICS transformations are fully implemented
- Benefits realisation

Transfer of Care

- Needs Based Assessment
- Single Point of Access

2016/17

- Single Points of Access in place for non-bedded services in each CCG area
- NW London-Wide Needs Based Assessment Form (NBA) Implemented for non-bedded services (health & social care
- LA hosted model running on key sites
- Joint working agreements between LA
- Direct access for staff across LA to systems
- Key discharge worker model introduced
- Staff training and development

2017/18

- Streamlined pathways in to the community
- Expansion of trusted assessor model with health & ASC
- Introduction of a shared IT portal to allow LAs to share information
- Test and evaluate elements of emerging model of care
- Single points of access & needs-based form in use for all non-bedded services

2020/21

- Social workers, therapists, nurses, discharge workers working as a single discharge function
- Single set of processes and protocols across NW London
- Electronic NBA form
- New commissioning model across health and social care
- Single management structure for discharge

Last Phase of Life

- Improved and co-ordinated service provision
- Skilled workforce within care homes

2016/17

- Identification of patients in the last phase of life
- Develop a plan to commission Single Home / Single GP
- Pilot implement of a 24/7 telemedicine coordination, advice and support line for patients and care home staff (restricted CCGs)
- Publish Directory of Services for Last Phase of Life across all 8 CCGs
- Analysed gaps in service provision including Out of Hours

2017/18/19

- Single Home / Single GP coverage across the 8 boroughs
- 24/7 advice line(s) across the 8 boroughs, accessible to anyone
- Training and education package for GPs, Care Home staff and LAS crews
- Training and support for unpaid carers and patients in the community

2020/21

- A sustained 5% reduction in NEL activity for patients from NW London care homes and in the community