NHS
North West London
Collaboration of
Clinical Commissioning Groups

Sustainability and Transformation Plan (STP) progress update

September 2018

Introduction

This report provides Joint Committee members with a summary of progress in key STP programmes of work.

As reported at the last Joint Committee, work is underway to refresh our STP, ensuring we continue to have the appropriate focus so that we are best able to help our residents keep well, support them in time of crisis and when people need to be treated in hospital that they are there only as long as their condition requires. The new NHS 10 year plan is anticipated to be published in November 2018 and our plans will also be reviewed to ensure we are best able to deliver to national priorities.

Over the last two months, plans have been developed through working with our STP health programme board and clinical board as well as our lay partners. We will continue to work with CCG Governing Bodies and our other statutory bodies and will bring the outputs of these discussions to the next Joint Committee.

Following the NW London integrated care workshops, reported at last Joint Committee, a stocktake of all borough plans has been undertaken and a further STP workshop is scheduled for 13 September to consider the outputs of this and agree the next steps in developing a strong NW London integrated care system to which boroughs can align.

Delivery Area 1 – Improving health and wellbeing

Over the last month our health (including public health) and social care leaders for improving health and wellbeing have been engaging with stakeholders to identify priority areas of focus for the three key programme areas: childhood obesity, alcohol misuse and homelessness. These are as described below:

Childhood obesity

- Reducing the prominence of sugary drinks and actively promoting free drinking water. Water fountains are being installed in schools.

- Super Zones around primary schools to create healthier environments. No unhealthy foods to be sold or advertised within the zone, school drop off lay-bys moved to outside of the zone to encourage children to walk further each day. We plan to introduce these measures across all boroughs in line with the mayor's office work.

Alcohol misuse

- Review of licensed premises and use of illicit alcohol.
- Supporting alcohol-related attendances at A&E (especially in period Thursday evenings to Monday mornings) and addressing the impact of alcohol-related assault.
- Provide appropriate alcohol services e.g. ambulatory detox to admitted patients based on clinical need, not patient postcode.

Homelessness

- 'Listening to London' engagement exercise with people with lived experience of homelessness
- 'Healthy mouth' campaign to support homeless people to access dental services and adopt good oral hygiene.
- Hospital discharge protocols to support the particular need of homeless people leaving hospital.

Delivery Area 2 – Better care for people with long term conditions

This delivery area brings together a range of programmes aimed at keeping people well and helping people to manage their care proactively - outside of hospital, where possible.

Key achievements over the last two months are as follows:

Primary care

- **Developing General Practice at scale** – Working in networks GP practices will be able to more effectively offer residents a wider range of services. NHS England have now awarded NW London £2.4million for 2018/19 to facilitate this and help develop General Practice at scale. CCGs have been working with GP Federations and networks to identify geographical populations for networked care. A workshop was held in July for all Federation and network clinical leads, to compare progress and identify next steps. Ares of focus

include workforce and skills audit as well as data analysis for population health management, using the Whole Systems Integrated Care dashboard.

- **GP extended access** - In addition to normal opening times, all NW London residents are now able to access appointments with a GP or nurse when their own practice is closed, by calling their GP practice or NHS 111.

  Utilisation of these additional appointments is now at 61%, a continued improvement from previous months. Learning from surveys undertaken by Hillingdon HealthWatch and the NW London CCG engagement team, actions are underway to further improve utilisation and ensure all residents are aware of this service, these include working with Healthwatch to help publicise the service, staff training so that receptionists can sign post services and continuing to deliver the direct booking roll-out from 111.

- **Online Consultations** – in addition to ensuring our residents are able to attend to see a GP or nurse we are working to improve digital access. Suppliers have been selected for pilot sites in Brent and Central London CCGs to develop online consultations at either practice or network level. It is expected that pilots will be in place for November/December 2018.

Self-Care

- Significant achievement has been delivered by each CCG in the majority of self-care areas (Patient Activation Measures; Digital solutions to Long Term Condition Management; and expansion of social prescribing across NW London). This work is coordinated through the NW London Self-Care Project Delivery Board that meets monthly.

- **Digital Health Apps -** Following the successful pilot of diabetes health apps during 2017-18, with positive results highlighted in the evaluation (patients had lost an average weight of 4kg and also had a mean Hb1Ac reduction of 6-8 mmol/mol), we have procured an additional 2,500 licenses to be delivered across the eight CCGs. These are targeted to general practices where the need is most with 55 practices identified. Information sharing agreements have now been signed for half of the 55 practices and referrals are to commence in September, supported by an independent evaluation delivered by Imperial College Health Partners.

  4862 myCOPD (an evidence based online self-management platform for patients with COPD) licenses are being rolled out across NW London for 2018-19. All eight CCGs are engaged with the project with providers identified

and pathways developed through project start-up meetings. Training has been held for seven of the eight CCGs and over 120 myCOPD app licenses are now being used by patients in Central London, West London, Hammersmith & Fulham, Ealing and Brent. Activity is expected to increase dramatically within quarter two with all eight CCGs live and additional providers embedding the approach within their pathways.

Additional digital solutions to supporting patients' self-management of their long terms condition(s) are being identified for pilots within 2018-19 to provide an evidence base for larger scale roll out for 2019-20. Apps focussed on asthma, heart failure, anxiety and migraine management are to be reviewed through the Self-Care Project Delivery Group in September to agree on priority areas.

- **Patient Activation Measure (PAM) Assessment -** PAM is an evidence based self-assessment tool that enables health professionals to understand a patient's knowledge, skills and to support tailored approaches to proactive care planning. PAM is embedded within seven of the eight CCGs (H&F to commence use within South Hub for Quarter Two). NW London activity up to the end of quarter one is 25,686 patients with an assessment and 3,262 patients with at least one reassessment. The target for 2018-19 is 52,000.

  By October PAM will be embedded within the Health Help Now app to enable patients to self-complete and receive tailored advice, with information uploaded to their health records. PAM to also be embedded within the NW London Diabetes Hub, once live.

  Ealing's Carers Trust are piloting the use of Carer PAM with results, released within quarter two, to be shared with CCGs leads to potentially expand across NW London.

- **Social Prescribing -** NW London achieved one of the highest STP rates of completion of the NHS England social prescribing scoping process. West London CCG has been successful in applying for grant funding from Sport England to support social prescribing. The London Mayor priorities have been developed through the NW London group to ensure local engagement. Health Help Now and West London are collaborating to embed social prescribing directories within the digital solution as part of wave one sites.

  CCGs will be supported by Health London Partnership along with third sector and local authorities to identify gaps for potential support this year.

Diabetes

- Diabetes clinical transformation teams are now established in each CCG and are proactively working with individual GP practices to ensure all patients are able to receive assessment in the 3 key areas – blood pressure, blood sugar and cholesterol. Other areas of focus for the diabetes programme include improving access to structured education, prevention of type 2 diabetes and work to improve access to footcare for diabetic patients. Diabetes foot pathway co-ordinators and podiatrists are now in post, with work underway to review patient flow and ensure all patients are able to access the same quality of care. Access has been improved through extending the footcare service to weekends.

- An Education, Information and Engagement team are now in place and actively developing further patient education offerings (particularly co-produced with and for the BME population). Examples include a Carbs and Cals booklet and improving the digital information that is available for people with diabetes.

Improving Access to Psychological Therapies (IAPT)

- Our programme of work to improve Access to Psychological Therapies has been extended to include people with long term conditions in all 8 boroughs. We are increasing the number of IAPT practitioners to increase access to services year in year.

Delivery Area 3 - Improving Care for Older People

A number of workstreams are underway to improve care for older people. The majority focus on ensuring support to older people when they have a health crisis, with the aim of supporting them to remain out of hospital.

Enhanced care in care homes

- Care homes across NW London are being supported by the Strategy and Transformation team to procure a variety of training packages, funded by Health Education England North West London (HEENWL). The training aims to provide care home managers and staff with the right tools to support their residents and thus make informed decisions that avoid potential unnecessary and stressful conveyances to Hospital A&E Departments.

- A 'recognising and acting of early signs of deterioration' best practice pocket guide for care homes staff entitled '***Is my resident well?'*** has been developed and distributed to care homes and the associated training has commenced with 20 sites. There has been an overwhelmingly positive reaction to this initiative by users and next anticipated steps include development of the tool for home carers and creation of a digital version of the pocket guide.

- With funding provided by NHS England, a pharmacist has been recruited for Brent CCG to enhance medicines optimisation in care homes through deployment into care home pharmacy roles. By the end of March 2019 NW London intends to have deployed 4 W.T.E pharmacists and 0.6 W.T.E. pharmacy technicians for Brent, Harrow, Hillingdon and Hounslow CCGs.

Last phase of life (Telemedicine)

- The aim of this project is to improve care for older people in their final twelve to eighteen months of life, enabling them to die in their place of choice and reduce unplanned visits to hospital.

- The roll out of the NW London NHS 111 *6 service for care homes to support all residents, crucially those in their last phase of life was successfully launched on 6 August. From 08.00 to 20.00 hours trained nurse specialists give clinical advice to care home staff and make onward referrals to services in support of care home staff and London Ambulance Service. Out of hours, the existing NHS 111 integrated urgent care service will support this initiative whilst the full service is rolled out on a phased basis ahead of winter.

  One of the key work streams of this project is the delivery of telehealth support in care homes, giving clinicians and practitioners access to the patient's clinical record and care plan to enhance their clinical decision making for patients. The allied video consultation technical solution, (using Skype for Business) has been successfully tested in 8 early adopter homes across NW London. Roll out of the technology to additional care homes is scheduled over the coming months.

Intermediate care & rapid response

- This project aims to develop intermediate care and rapid response services to provide equitable, safe and effective care closer to, and in, home settings. To maximise the existing Rapid Response pathways and ensure consistent London Ambulance Service (LAS) usage, a shadowing scheme has been rolled out in Hounslow which has led to an increase in referrals for the local Rapid Response team. Communications and engagement across the whole of NW London have continued with newsletter items and a video featuring LAS crews and Rapid Response team members.

- To increase referrals for common problems such as catheter issues, a District Nursing pathway was launched w/c 16 July following approval from the N W London Clinical Board. The project group continue to explore an increasing number of pathway options to reduce the need for patients to be conveyed to hospital. Overall the use of existing rapid response and district nursing protocols is benefitting over 120 patients each month.

Response in time of crisis

- The primary aim of this initiative is to maximise independence of older & frail patients in NW London. To achieve this, multi-disciplinary frailty models are being established at the front-door of acute hospitals to identify and manage older frail patients who require specialised support. This will ensure frail patients are not admitted unnecessarily and are supported at home with full wrap around services. If the patient does require an admission, this model ensures they are managed by teams with frailty expertise and only stay in hospital as clinically required.

- As of August 2018, front-door frailty services are available in 4 of the 7 hospitals with emergency departments. 240 older people have been identified and managed at home, rather than being admitted into the hospital.

Discharge to Assess (Home First)

- The risks associated with extended hospital stay is well evidenced, “10 days in a hospital bed leads to 10 years’ worth of lost muscle mass in people over age 80”.

- The Home First model is being implemented in all acute trusts and boroughs in NW London to ensure patients are discharged with appropriate support at home, as soon as they no longer require hospital care. As of August 2018, over 1,900 patients were supported using Home First principles (since April 20180, already exceeding the 2017/18 full year total of 1,873 patients.

  Evaluation of Home First showed a significant reduction in the length of time patients stayed in hospital (1.7 days reduction in average lengths of stay (LOS) for patients who have been in hospital for more than 7 days and a 3.9 days reduction in average LOS for 14+ day LOS cohort). Evaluation also showed 92% patient satisfaction with the support received at home and a 33% reduction in 30 day readmission rate.

  The initiative also has significant cost saving ambitions relating to reducing excess bed days. The project planned to reduce by 1,539 excess bed days by October 2018, and as of June 2018, this initiative has already exceeded the target and decreased excess bed days in NW London by 1,937.

Delivery Area 4 - Improving Mental Health Services

The following summarises some of the key achievements within the STP mental health programme.

Serious and Long Term Mental Health Needs

- A new model of care has been introduced to simplify and standardise pathways across NW London and improve community support by rebalancing the emphasis between community and inpatient mental health care.

- We are delivering higher numbers of physical health checks for people on severe mental illness registers through their GP Practice.

- NW London led an evaluation of different models of primary mental health services across London, identifying particular areas of good practice.

- Our two specialist mental health trusts have made significant progress in reducing local bed occupancy enabling more people to be cared for in NW London rather than be sent out-of-area.

- We are rolling out increased Individual Placement Support for people with severe mental illness, i.e. helping people to access employment

Perinatal Mental Health

- Increased investment in community perinatal mental health services will allow all new mothers who need support to access specialist services for 12 months

Transforming Care Partnership

- This programme supports people with learning disabilities and / or autism, with challenging or offending behaviour, to live in their local communities. There are 79 people currently in inpatient beds (15 above planned trajectory) which is directly linked with the complexity of the need and their legal status. Regular surgeries are in place to discuss discharge plans and provide assurance that every effort is being made to discharge patients when it is clinically safe to do so.

Crisis Care

- We are reviewing the services that support mental health crisis care (e.g. Single Point of Access, Crisis Resolution & Home Treatment Teams) against national best practice and analysing the experience of people using crisis services, especially those with multiple short admissions.

- We are engaging with stakeholders about the future of Health Based Places of Safety i.e. services supporting people detained by the police for their own / others safety during a mental health crisis, in line with a London-wide programme of improvement.

Children and Young People

- Evaluation of Community Eating Disorder Services has shown a 30% reduction in the number of children placed in inpatient units over 20 miles away, as well as a 59% reduction in bed days and 52% reduction in eating disorder admissions

- The STP team is supporting the systematic collection of information by all providers delivering NHS child and adolescent mental health services (CAMHS), to make sure access to services is properly monitored.

- A refresh of CAMHS Local Transformation Plans by each CCG will be complete by the end of September 2018.

Delivery Area 5 - Safe, High Quality Sustainable Acute Services

There are three main areas of focus for our STP within acute services – a programme to transform outpatient services, continued improvement of maternity services, securing capital investment to improve our estate and facilitate acute reconfiguration.

Outpatients
The North West London Outpatients Transformation programme is progressing with a clinically led redesign of outpatient pathways to support patients receiving the right care, in the right place and at the right time. This is a rolling programme, which started with the redesign of five specialties (plus renal which had already started) and involved patient representatives: cardiology, musculoskeletal services (MSK), gynaecology, gastroenterology and dermatology. It was agreed from the outset that all eight CCGs and all Trusts will implement the new pathways, once agreed.

Four of the five specialties have completed the redesign and the remaining specialty is due within the next month. All the redesigned pathways include:

- consistent evidence-based guidelines for appropriate referrals. Recent discussions with the LMC highlighted that the increased use of local referral guidelines should be helpful and should increase skills and confidence in the management of more complex patients.
- effective and consistent triage, including for consultant referrals with all appropriate information available to ensure that all 1st outpatient appointments are of value,
- appropriate clinicians managing first outpatient appointments to ensure effective treatment plans are agreed as appropriate
- patients only physically attending follow up clinics when clinically appropriate.

Specific examples of change include:

- The use of the eRS based Referral Assessment System (RAS) triage functionality to support senior electronic clinical review of referrals. (being tested)
- Gastroenterology will introduce urgent flare up clinics for patients with IBS to ensure they are reviewed at times of clinical need (evidence from elsewhere

shows great patient satisfaction and 40% reduction in patients attending follow up clinics)

- Gynaecology will introduce needs based follow up clinics for appropriate patients, reducing the numbers of patients who are automatically given follow up appointments.
- All specialties will use evidence-based guidance to discharge patients earlier as appropriate.
- Redevelopment of Renal pathways to support early clinician triage of Chronic Kidney Disease referrals with a view to supporting continued management in primary care (with extended specialist advice and care planning).
- Currently, on average, only four of ten patients referred to orthopaedic outpatients for hip or knee surgery results in surgery with a significant (and variable) number of appointments prior to surgery. This is contributing to excessive waits for first outpatient consultation and leading to patients not receiving the interventions they require in a timely manner. By adopting the principles of Shared Decision Making, consistent competent physiotherapy led triage and by ensuring that senior clinicians review patients at their first outpatient appointment, we aim to ensure that a higher proportion of patients with hip and knee pain, who need surgical intervention, are referred to outpatients and that they have fewer unnecessary pre-surgical appointments.

Next Steps:

- GPs to start using new referral guidelines; CCGs and GPs to receive data on adherence to guidelines in order to focus support.
- Resolve technical issues from RAS pilot and roll out use of RAS
- Trusts and CCGs to agree implementation plans and timescales for each pathway
- NW London CCGs and Trust CFOs endorse a financial and contracting model for each specialty to be agreed by CCG joint shadow committee

Capital business cases to support clinical improvements

- As reported in July 2018, NW London STP has prioritised capital schemes in a bid against the latest wave of STP capital funding. The outcome of these submissions is likely to be known in the Autumn.

Improvements to women's services

Key areas of focus for maternity service development across NW London include:

- Four new models of continuity of care, with continuity pathways now being expanded to reach more women across all sites. So far we have achieved an increase of women receiving continuity of carer, including intrapartum care, from a 1% (baseline) to 8%. With plans to reach 20% by March 2019.

- Tailored Making Every Contact Count training to over 100 multidisciplinary maternity staff within the STP.
- Two maternity booklets, “your pregnancy” antenatal booklet and “After your baby’s birth” postnatal booklet, providing standardised, evidence based maternity information to women across all 8 boroughs.
- Set up of four Maternity Voices Partnerships (user groups) aligned to each Trust, for women across 8 boroughs
- Piloted personal postnatal care plans, with >250 women, with plans to roll out personal care plans to all women in digital format via mum and baby maternity app and paper versions also available
- Implementation of ‘meet the team’ photobooks in each midwifery group practice team, to increase women’s experience, and familiarity with their maternity teams
- A sector-wide maternity app – an “information, choice and personalisation” toolkit for women, including digital personal care plans, standardised maternity care information and choice / personalisation functions. Due to launch 2 October.
- NW London is considered a leader in developing maternity services and the team has organized several learning events for others involved in maternity care across the country.