NHS
North West London
Collaboration of
Clinical Commissioning Groups

Health and Care Partnership Progress update

Introduction

This report provides a summary of progress over the last quarter towards achieving the transformation objectives of the Health and Care Partnership.

Governance review of our Partnership – as reported in the last meeting, proposals to refine the governance of the Health and Care Partnership (formally referred to as the NW London STP) are going through Partnership boards. These include the change of name to Health and Care Partnership, redefinition of all Partnership leadership groups and closer alignment with statutory governance. Our new interconnected programme areas are being worked through to articulate the specific transformation projects where it is of benefit to work across the system to improve the care and experience of our residents. This will be brought to the next meeting of the Joint Committee. The Partnership will start working to the new arrangements from January 2019.

Integrated care – NW London continues to work with the national integrated care team to develop how we work at system level. We await publication of the 10-year plan to provide guidance on how STPs will be able to formally become integrated care systems.

Progress with our specific areas of transformation – whilst working to develop a clearer and more focussed approach for the Partnership into the future, we continue to work together to deliver the existing priorities of our delivery areas. This report details progress over the last quarter. Specific areas to highlight include:

Primary care - on line consultations – our first group of GP practices, in Brent, have introduced an on-line consultation system, enabling patients to make contact and contact receive support digitally.

Supporting our care homes – a booklet to support care home staff to recognise when a resident's health is deteriorating has been developed and distributed to care homes across NW London. This is being supported by training to care homes on "is my resident well". Over 500 staff has now received the training across 86 care homes, with positive feedback indicating they now feel more able to manage the care of their residents over this winter.

Discharge to assess – supporting our patients to leave hospital and continue receiving appropriate care in their own homes has been an area of focus through the discharge to assess programme. From April to October this year, over 3000 older people have gone home from hospital with this enhanced support which has meant over 4000 fewer days have been spent in hospital when the person was fit to be at home. This is now being expanded to people with more complex needs.

Trailblazer sites to implement 'Mental Health Support Teams' - six of the NW London CCGs (Central London, West London, Hammersmith and Fulham, Hounslow, Brent and Harrow) have applied to become Trailblazer sites, to implement 'Mental Health Support Teams'. They will create a new mental health workforce, encouraging schools and colleges to appoint a designated lead for mental health and reduce 4 week waiting times. The announcement of successful pilot sites is expected to be made soon.

Outpatients' transformation - all five initial specialties - cardiology, musculoskeletal services, gynaecology, gastroenterology and dermatology - have completed their redesign and will start to be implemented from 2 January 2019. A contracting model has been agreed across NW London to support this. A further 4 specialties – respiratory, ophthalmology, urology and neurology are now being taken forward with initial workshops planned to take place before March 2019.

Transformation progress

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.

Childhood obesity - working with councils to reduce the prominence of sugar, and to promote Super Zones around primary schools to create healthier environments.

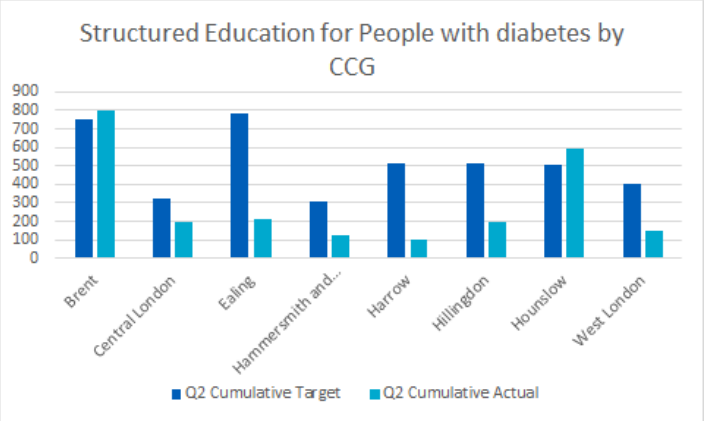
Alcohol misuse - working with partners to collate data from Emergency Departments to support the review of licensed premises and/or to help inform the licensing teams; Focussing on alcohol-related attendances at A&E (and highlighting the prevalence of alcohol-related assaults to NHS staff via a communications campaign); Scrutinize availability of appropriate alcohol services.

Homelessness - increase the amount of joined-up working with the Healthy London Partnership (HLP) on homelessness - have representation on their new homelessness board; Working with HLP on the 'Listening to London' engagement exercise with people with lived experience of homelessness; Working with HLP to promote the 'Healthy Mouth' campaign to support homeless people to access dental services and adopt good oral hygiene.

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

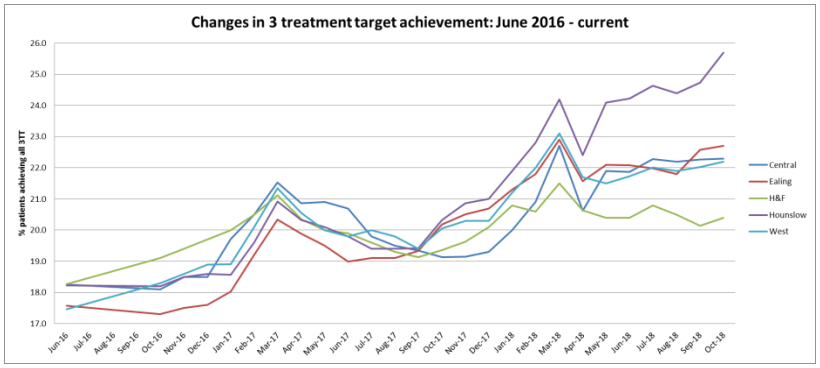
Diabetes

Structured education for people with diabetes - the programme continues to work with local diabetes teams to provide newly-diagnosed people with diabetes access to a range of



education options to help them manage their conditions. Whilst 6 out of our 8 CCGs continue to be behind projected education numbers, detailed plans are now in place to reach more patients. This includes the development of digital education options following a successful pilot, support of patient engagement experts, organisation of large-scale events and importantly the development of a contact centre. The contact centre location has now been agreed for NW London, this will help to increase the accessibility and experience of learning about diabetes for up to 60,000 people with or at risk of diabetes across NW London.

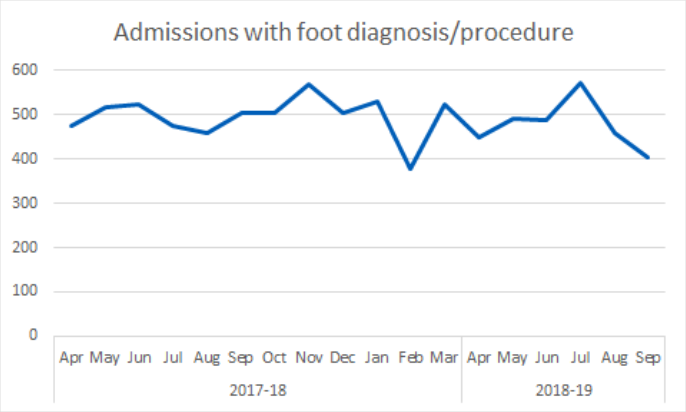
Reducing variation in the 3 treatment targets - the management of HbA1c, cholesterol and blood pressure (the 3 treatment targets) is the cornerstone of excellent long term diabetes health outcomes. Our aim is to reduce variation in these targets across NW London by improving clinical skills in diabetes management through PITstop training (373 CCG staff have attended face to face PITstop programmes), online training licences for Cambridge Diabetes Education Programme (259 used to date), face-to-face 10-point training (for care givers in their place of work – 800 have been trained so far) and by designing and incorporating mental health modules in all these training programmes).



*nb data for Brent, Harrow and Hillingdon will be available going forward

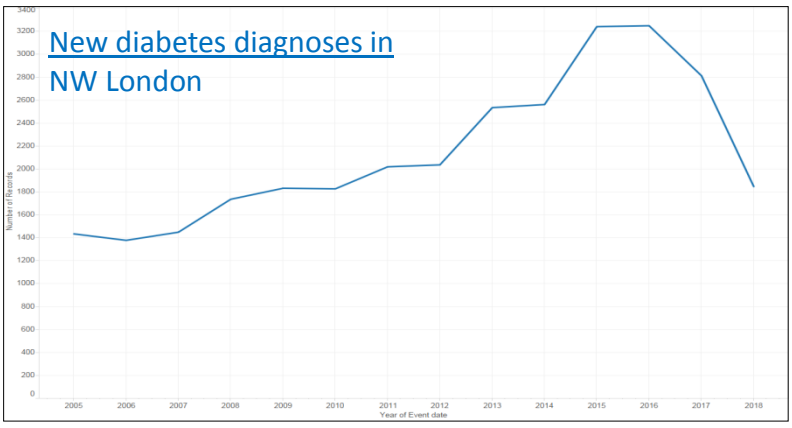
A GP lead, nurse consultant and support officer in each CCG are working with GP practices offering support including virtual clinics, specialist review, patient-level dashboard training and clinical training to help improve the management of diabetes within primary care.

Diabetes foot - a system-wide multi-disciplinary footcare team (clinical lead & podiatrist) are actively engaging with the acute & community providers to harmonise the footcare pathway across NW London. Additionally, a footcare network group was held on 18 October, attended by over 70 stakeholders.



Diabetes type 2 prevention - across North West London, over 75,000 patients have been coded as "at risk of diabetes" (Non-Diabetes Hyperglycaemia- NDH) since 2016, of which 50% have had their annual review completed and an offer of referral into a lifestyle intervention programme including NHS Diabetes Prevention Programme (NDPP). To date over 8500 patients have started the programme. The outcomes for people on the programme are impressive. For those with higher BMI (>25), their average weight loss after 9 months is 4.34kg with 38% of patients losing 5% of their body weight. Moreover, of those who completed the programme, around 60% have come out of NDH range.

Across the inner CCGs we are now seeing a decrease in the number of newly-diagnosed people with diabetes each year. The programme has been offered for the first time in Brent, Harrow and Hillingdon from September 2018.



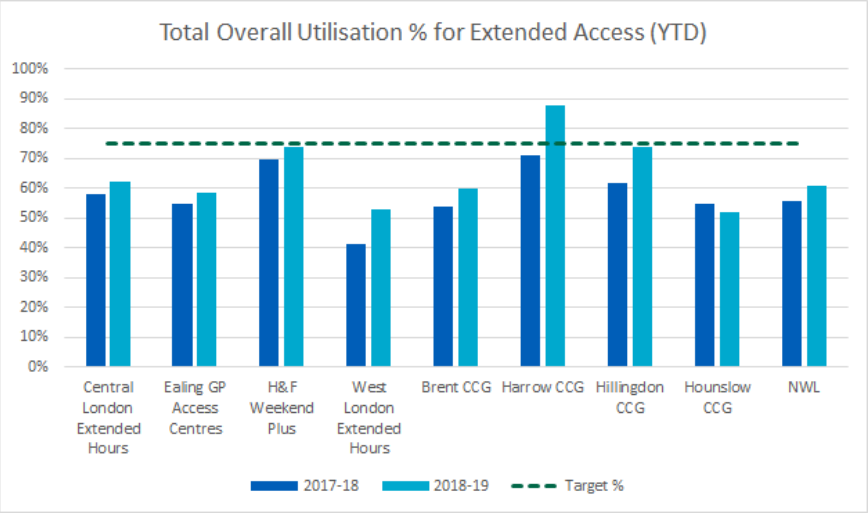
Primary care

Developing General Practice at scale - 35 networks and 8 federations are in place and work is on track to deliver against the agreed development plans in each CCG area. The maturity evaluation framework has been carried out with 6/8 Federations with a date set for 11th December for the next one. The provider maturity evaluation framework has also been carried out with 7/35 networks. Spend against the "at scale" funding is not at the same pace in Harrow and in Hillingdon as in other areas.

A specific area of focus is the development of comprehensive population health management reporting. This uses the Whole Systems Integrated Care system to identify rising risk cohorts of patients. It has been clinically tested and is now being fully developed for roll out across NW London.

GP extended access - appointments are available from 08:00 to 20:00, 7 days a week across NW London. Utilisation of these additional appointments is now at 66%, a continued improvement from previous months. In order to increase utilisation and to provide extra capacity in primary care over winter, NW London will be offering in-hours direct booking, which will enable patients to be directly booked into their own practice from a 111 triage, where appropriate. This is now live in Hounslow & West London. In addition testing has been successful in Brent & Harrow for 111 to directly book into Extended Access hubs. This is expected to go live in November.

The 'did not attend' rate at the extended hubs is comparatively high against the rest of London. This is being investigated with a range of solutions being put in place, including maximising GP receptionist training.



Online consultations - in addition to ensuring our residents are able to see a GP or nurse face to face we are working to improve digital access by email, phone and potentially video consultations. The training for the e-hub clinicians in Brent took place on the 22 October and the on line consultation hub is now live. Thirty-five patients were seen in the virtual hub on the first day and this number has been maintained.

The information governance due diligence process has now been signed off for the Central London supplier allowing the team to commence technical roll-out for practices in the South Westminster Primary Care Home. Additionally, scoping work for Online Consultation has begun for the other NW London CCGs.

Self-Care

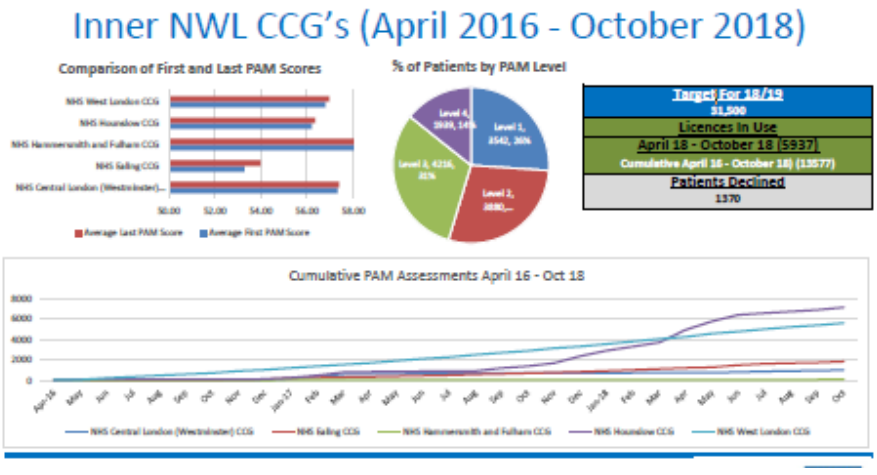
Significant achievement has been delivered by each CCG in the majority of self-care areas (digital solutions to long term condition management; patient activation measures; and expansion of social prescribing across NW London).

Digital solutions to long term condition management - following the successful pilot of diabetes health apps during 2017-18, 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. To date 150 patients have enrolled onto this programme and a plan is in place to rapidly expand this.

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 all of the eight CCGs and the main COPD service providers. Over 200 myCOPD app licenses are now being used by patients in NW London. Additionally, Hillingdon & Harefield Hospitals are now offering the health app to patients.

Additional digital solutions to supporting patients' self-management of their long-term condition(s) have been identified for pilots within 2018-19 to provide an evidence base for larger scale roll out for 2019-20. It has been agreed that Hammersmith & Fulham CCG will pilot the MyHeart health app, whereas Harrow & Hillingdon CCG will pilot the MyAsthma health app. Additionally, plans are being developed for the roll-out of Sleepio and Migraine Buddy.

Patient Activation Measure (PAM) Assessment – PAM is an evidence-based self-assessment tool that enables health professionals to understand a patient's knowledge and skills and to support tailored approaches to proactive care planning. PAM has now been embedded within all eight CCGs across NW London. The NW London activity up to the end of quarter two is 27,487 patients with an assessment and 3,718 patients with at least one reassessment. The target for 2018-19 is 52,000. Additionally, there is agreement that for Health Help Now app with PAM embedded will be piloted in West London in November.



Social prescribing – NW London have been collaborating with the London Mayor's Office to develop the social prescribing vision and work plan for 2019/20. The best practice evidence approaches were shared at the Self-Care working group in September. The digital directory of service is being developed in collaboration with Health Help Now and West London CCG. Additionally, Healthy London Partnerships are supporting the NW London team to complete a gap analysis exercise to identify the priorities across NW London.

Delivery Area 3 - Improving Care for Older People

Enhanced care in care homes

At the end of October, over 500 staff across 86 nursing and residential homes had received 'Is my resident well?' training based on ten everyday questions to ask to help recognise when care home residents are becoming unwell. Feedback from care homes has been extremely positive with participants stating this training is 'exactly what I need' to deliver better care.

47 registered care home managers continue leadership development training and have reached the half-way point in the training. 92% of managers' report that the quality of their leadership and communication skills has increased; 82% report improved quality of experience for people using the service; 84% report feeling increased confidence as a professional; 74% report improved interaction between staff.

A system-wide hospital transfer protocol based on the use of a red bag to transport care home residents' medical notes and belongings is being used by all CCGs. There are currently 270 red bags across 101 care homes in NW London. We will be evaluating the impact of this system and we expect it to have resulted in care home residents receiving quicker, more appropriate care and spending less time in hospital.

NW London has secured national funding for three pharmacists and a pharmacy technician to support care home residents by reviewing their medications.

Last phase of life (telemedicine)

By the end of October, a specialist telephone advice line was available to care homes Monday to Friday, 08:00 – 02:00, staffed by nurses with specialist skills in supporting people at the end of their life. There were 421 calls from 177 care homes in October. We are working with care homes and colleagues in CCGs and Local Authorities to increase the take-up of this service.

Frailty

Frailty teams involving clinicians from hospital and community care are up-and-running in four out of seven of the A&Es in NW London.

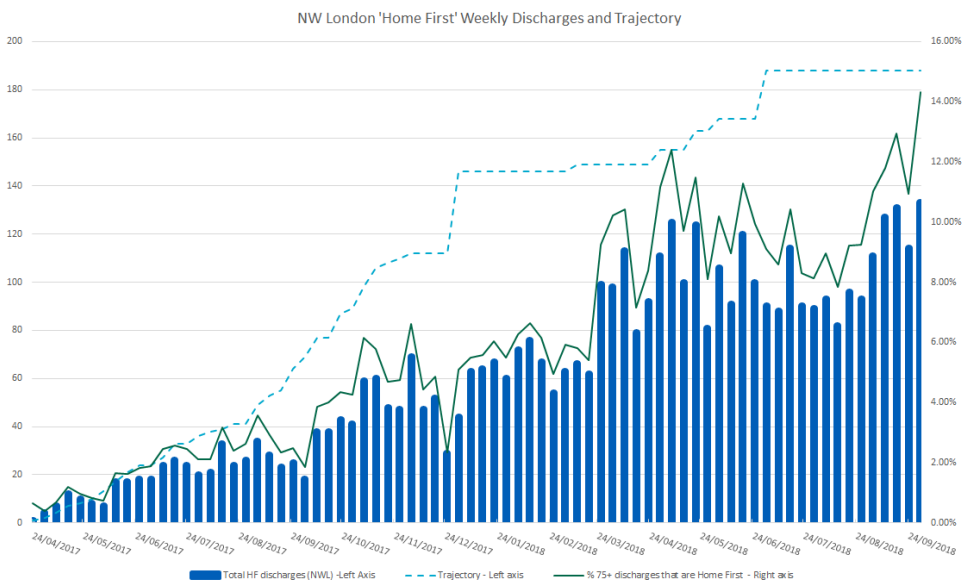
These teams help to identify and manage older frail patients who require specialised support. This will ensure frail patients are not admitted unnecessarily and be supported at home with full wrap around services.

Discharge to assess (Home First)

We want to maximise the independence of older and frail people in NW London by ensuring they are discharged from hospital with appropriate support at home. Discharge to assess means people are assessed for their ongoing care needs at home in their own environment rather than in and disorientating hospital ward.

From April to October this year, over 3000 older people have gone home from hospital with this enhanced support, which has meant over 4000 fewer days have been spent in hospital when the person was fit to be at home.

We are currently working on extending this approach to people who cannot go home immediately or have complex and long-term assessment needs. We plan for our first group of people in this cohort to go home with 24 hour wrap-around support in November. We expect that, as we extend this offer, there will be a significant impact on people who stay in hospital for an extended period.



Delivery Area 4 - Improving Mental Health Services

Serious and long term mental health needs –

Out of hospital services - national policy expects 60% of people with a severe mental illness to receive comprehensive annual physical health checks. GP Practices in 5 of 8 CCGs now

have access and are using the Physical Health Template to record their physical health checks in clinical record systems.

Once signed off this will be rolled out (alongside training videos) to Brent and Hillingdon GP practices. Harrow CCG has yet to adopt the system. The number of recorded health checks completed for patients in Q2 2018/19 has reached 38.7%.

Primary care mental health services London-wide evaluation - Healthy London Partnership commissioned a London-wide evaluation of Primary Care Mental Health Services which reported in July 2018. Five areas (one in each STP area) were evaluated, which for NW London included Hounslow. The NW London Mental Health Programme Executive has agreed to carry out a similar study with each NW London Borough's primary care mental health team. An initial launch event is being organised mid-November to discuss the approach to and timescales for completion of this audit which will enable our system to identify best practice areas and support development of improvement opportunities.

Individual placement and support – this helps people with severe mental illness secure employment. Additional funding was secured in 2018/19 to expand the service offered by Central and North West London Trust. Four Band 5 Employment Specialists, commenced in post at the end of October and a Band 7 Project Manager post has been filled to support cross-trust learning and to help ensure West London NHS Trust are ready to bid for Phase 2 NHS England funding to increase access to Individual Placement and Support services in their catchment area.

Perinatal mental health

Both Trusts have implemented enhanced community perinatal mental health services as a result of additional funding from NHS England, offering mothers up to 12 months of specialist support.

Transforming Care Partnership

This programme is concerned with supporting people with learning disabilities and autism to live in their own communities as an alternative to inpatient/long-term residential care. As of 01 November 2018, NW London had a total of 37 inpatients, which is 10 above the original trajectory for Q2. Due to the complex needs and circumstances of the individual patients and readiness for discharge, there is a significant risk that the programme will not meet its original trajectory. The Transforming Care Partnership has been allocated £1.62m funding from NHSE specialised commissioning, as well as a one-off payment of £360k, which will be equally shared amongst the 8 CCGs to support speedier discharge and prevent re-admission. The programme has also successfully secured a bid funding of £172k to be used in-year to develop intensive support functions in each borough to support faster discharges and prevent re-admissions.

Crisis care

There has been slow progress this month to mobilise the optimisation work due to capacity issues both at Trusts and within the Mental Health transformation team. A system level workshop will be held to map 'as-is' pathway using case studies from London Ambulance Service, general practice and Single Point Access (SPA) to define the 'to-be' pathways.

Health Based Places of Safety suites demand and capacity analysis and patient experience surveys have been completed and shared at the NW London Crisis Care Concordat meeting on 20 September 2018. Engagement with stakeholders across Mental Health Trusts, local authorities, service users, LAS, Metropolitan Police, and CCGs has been on-going. A full options appraisal will be formulated by the end of 18/19, with two options being developed into full business cases by March 2018.

Children and young people

The first manual data collection of 2018-19 access and waiting times exercise has been completed to improve the capture of all relevant activity data. The data shows that in the first six months a total of 5017 children and young people across NW London have accessed mental health services, against a full year target of 8258. Based on the first two quarters data, it seems that four of the boroughs are likely to exceed their targets, whilst the other four may have difficulties achieving their trajectories. Discussions are taking place with commissioners to identify issues earlier to ensure they meet their targets.

Six of the NW London CCGs (Central London, West London, Hammersmith and Fulham, Hounslow, Brent and Harrow) have applied to become Trailblazer sites to implement 'Mental Health Support Team'. They will create a new mental health workforce, encouraging schools and colleges to appoint a designated lead for mental health and reduce 4 week waiting times. The announcement of successful pilot sites is expected to be made in early November.

Refresh of the Local Transformation Plan is underway and will be submitted by mid-November. The 2018 priorities continue to be; improve access and waiting times, community eating disorder service, implement Thrive model, redesign crisis pathway and improve outcomes for vulnerable groups. The supporting enablers have been refreshed and focus on workforce, performance monitoring and management and co-production.

Delivery Area 5 - Safe, High Quality Sustainable Acute Services

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

Improvements to women's services

The Local Maternity System (maternity providers and commissioners in NW London) is tasked with implementing all seven recommendations within *Better Births*, the National Maternity Five-Year-Forward-View by 2020/21 and to deliver on the Health Secretary's ambition to "halve it" and reduce the rate of still births, maternal mortality by 2025. NHS

England has provided funding to support delivery of the Local Maternity System plan for 2018/19.

The Maternity team are working to:

- Increase the numbers of women booked onto a continuity of carer pathway, to reach 20% by March 2019.
- Introduce and offer personal care plans to women, from October 2018, and reach at least 50% by March 2019
- Increase midwifery led births (home births and birth centre) by 1% by March 2019
- Reduce the numbers of still births, neonatal deaths and intrapartum brain injuries by 20% by March 2021
- Launch 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 October 18.
- Work with commissioners to support four Maternity Voices Partnerships (user groups) aligned to each Trust, for women across 8 boroughs
- Evaluate and share the learning of the full 'early adopters programme' (by December 2018)

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. All five initial specialties (cardiology, musculoskeletal services, gynaecology, gastroenterology and dermatology) have completed their redesign. Specific examples of change include:

- New referral guidelines to ensure that patients are seen in the right place at the right time by the right clinicians
- The use of tele-dermatology to expedite the review of skin conditions which would reduce the need for patients to attend in person at outpatients
- Introduction of patient education activities allowing patients to receive information and guidance locally and in a supportive group environment

These pathways will go live with a soft launch from January 2019, where the specialist will continue to accept all referrals but provide feedback to the referring GP if an alternative approach would have been more appropriate. The pathways will be fully implemented from April 2019. A contract model to support this way of working has been agreed across NW London.

Four additional specialities have been selected for phase 2 of the programme. These are Urology, Respiratory, Neurology, and Ophthalmology with the first workshops scheduled for December 2018.

Conclusion

This paper has provided a summary of progress within each of our delivery areas. This work will continue to be progressed and will be reported through the new interconnected programme areas identified within the Health and Care Partnership governance. In addition, comprehensive programmes are in place for each of our enablers – workforce, digital and estates and will be brought to the Joint Committee in future reports.