Better Care, Closer to Home

Our strategy for co-ordinated, high quality out of hospital care

NHS Central London Clinical Commissioning Group

2012 - 2015
Letter from the Chair

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

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

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

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

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

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

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

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

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

1. The case for improving out of hospital services

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

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

2. Our vision of how care will be different

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

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

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

- Encourage providers to increase productivity by employing new ways of working
- Build on our successful inter-practice referral system
- Invest in and develop primary care capacity
- Encourage all of our providers across health to proactively raise lifestyle issues with their patients
- Introduce the new 111 phone number throughout North West London to provide a single point of access to health and care services
- Redesign our pathways of care, providing some outpatient appointments in the community
- Establish rapid response teams to deliver care in patient homes when appropriate
- Implement a Wellwatch telephone-based case management service for patients with long term conditions (LTCs)
- Introduce multidisciplinary teams to proactively manage high risk patients.

4. How we will work together

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

- GP practices will remain at the centre of patient care, providing routine care near to where patients live. Practices will continue to promote health and assist patients in making complex care choices. They will retain overall accountability for a patient’s health and coordinate care for patients with long term conditions.
- We are introducing a new level of care within three localities – north, central and south. When it is appropriate to do so, providers will work together at the locality level to provide care to patients in an appropriate setting for them.
- For example, we will establish integrated intermediate care teams to ensure care is provided seamlessly across health and social care and third sector providers where appropriate. These teams will be coordinated by health and social care coordinators who will sit centrally, but will each also be responsible for coordination in a locality.
- Where it makes sense clinically and financially we will provide CCG-wide services to serve the whole Central London population. These services include preventative services, 111, some shared services e.g. diagnostics, end of life care, Wellwatch and the Patient Referral Service (PRS).
5. Supporting the change

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

This approach provides improved patient care, by not only being more efficient and effective, but is also more sustainable.

6. Investing for the future

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

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

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

7. Next steps

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

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

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

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

Figure 1

There is a strong case for improving out of hospital services

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

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

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

4. However, primary and community care requires significant improvement to be able to deliver this. Currently there is variation in quality and access, meaning people have very different experiences in different locations
1 Patients and professionals share frustrations with the current system

<table>
<thead>
<tr>
<th>Healthcare professionals identified issues across the system</th>
<th>…which have resulted in poor quality care for patients</th>
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</thead>
<tbody>
<tr>
<td>We need to work better with district nurse teams and the rapid response team so we don’t at best duplicate care and at worse have the patient falling through the net</td>
<td>…Our hospitals focus on the medical not the social side of our lives. It is better for me to keep my son at home under my supervision and my carer’s supervision, than let him go to hospital with people who do not understand him or his needs.</td>
</tr>
<tr>
<td>…I would love to work with my neighbouring practices in order to provide a joint phlebotomy service. Will save money for the practices and be more convenient for the patients</td>
<td>…The lunch was delivered by meals-on-wheels at 12 noon. The carer was due to arrive at 1.30 pm to help with lunch. Left to herself she certainly wouldn’t have eaten anything and by the time the carer was due to arrive the food would have been unpalatable. I helped the lady to eat.</td>
</tr>
<tr>
<td>Having access to patients hospital records would save us so much time, we would love a system that could work together</td>
<td>…It is so frustrating when patients get wrongly admitted to hospital. Especially those on palliative care who want to stay at home, seem to go in at the weekends or evenings because of lack of coordinated care pathways</td>
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The next section looks at what the changes we make to care will mean for our patients.
1.1 Sustainability

NHS Central London CCG is committed to reducing its carbon emissions and developing a sustainable health policy in line with the NHS sustainability policy. It intends to influence our partners in the health and social care system to do the same. Good clinical care is sustainable clinical care – economically, socially and environmentally.

The commissioning and implementation of the Out of Hospital Strategy gives us a unique opportunity to do this - introducing sustainable care delivery and reducing our carbon footprint.

Climate change is one of the greatest threats to health and wellbeing. By improving the health and wellbeing of some members of our population through the delivery of health and social care we have an opportunity to address this wider issue at the same time.

By delivering care closer to home we will reduce the use of transport (environmental sustainability), by changing care settings we will make use of more energy efficient premises (economic sustainability), and as we work with patients to manage their own care we will proactively plan and integrate care (social sustainability).

We will take proactive steps as we implement the strategy

- when we procure new services we will ensure the providers deliver their services in a sustainable way
- as we work with existing providers (including our member practices) to change their ways of working to deliver the OOH strategy we will support them to ensure the new ways of working have less impact on the environment

We will work in partnership with providers to do this, but will also introduce strong contractual leavers to ensure our environment outcomes are delivered, including as a first step ensuring all providers have their own sustainable management plan.

These objectives in regard to a sustainable health and social care system in Central London will support the CCG to deliver the other outcomes of the OOH strategy, improve health and wellbeing for patients and deliver efficiency savings for the NHS.
NHS resources, which influence...

...levels of demand for health services which impacts on...

...the health of the local population which can help reduce...

...the NHS's capacity to provide quality services which affects...

...levels of demand for health services which impacts on...

...local economic, social and environmental conditions which impact on...

...the health of the local population, which can help reduce...
2. Our vision of how care will be different

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

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

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

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

This promise translates into six goals as outlined in figure 3, which determine how we will change care in Central London.

We have provided more detail on each of our six goals below. For each, we describe how our plans will improve care for our patients and use an example of patient care now and in the future to illustrate this change.
2.1. Easy access to quality responsive primary care

- **Access**

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

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

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

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

We describe a range of these new services in section 3.

- **Quality: our out of hospital standards**

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

These standards emphasise that your GP will have a central role in the coordination and delivery of out of hospital care. They apply to both core primary care delivered by GP practices and, more broadly, care delivered outside of hospital. They aim to shift care delivery from more reactive unplanned care to proactive planned care. These standards have been agreed across North West London and will be implemented locally.
Figure 4

The standards are covered in four key domains:

- **Individual Empowerment & Self Care**
  - Individuals will be routinely asked about and will be provided with up-to-date, evidence-based and accessible information and advice regarding their lifestyle and conditions to support them in taking personal responsibility when making decisions about their own health, care and wellbeing.

- **Access convenience and responsiveness**
  - Individuals will have access to telephone advice and triage provided 24 hours a day, seven days a week. As a result of this triage:
    - Cases assessed as urgent will be given a timed appointment or visit within 4 hours of the time of calling.
    - For cases assessed as not urgent and that cannot be resolved by phone, individuals will be offered the choice of an appointment within 24 hours or an appointment to see a GP in their own practice within 48 hours.

- **Care planning and multi-disciplinary care delivery**
  - All individuals who would benefit from a care plan will have one.
  - Everyone who has a care plan will have a named “care coordinator” who will work with them to coordinate care across health and social care.
  - GPs will work within multidisciplinary groups to manage care delivery, incorporating input from primary, community, social care, mental health and specialists.

- **Information and communications**
  - With the individual’s consent, relevant information will be visible to health and care professionals involved in providing care.
  - Any previous or planned contact with a healthcare professional should be visible to all relevant community health and care providers.
  - Following admission to hospital, the patient’s GP and relevant providers will be actively involved in coordinating an individual’s discharge plan.

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

**Figure 5**

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

Claire is 36. She is a working mother who struggles to manage her work and home life. She has a young son, Jason who is 4 years old and has a fever.

**Primary care has been difficult for some patients to access, putting pressure on other parts of the health system:**

- Claire comes home from work at 6pm to find her son has come back from nursery with a fever and calls 111
- Claire rings her GP but it is too late to be seen that evening. She decides to take Jason to her local A&E
- A&E is crowded and there is long wait. The conditions are stressful and Jason’s condition worsens.
- Treatment is transactional. Jason misses out on opportunity for broader child welfare e.g., staff do not make sure jabs up to date, check Claire is coping
- Claire is given an appointment for 8.30pm in local GP practice - not their own but the one which leads on urgent care and is only 15 mins walk away
- If it was something more serious (e.g. rash with query meningitis, then the GP could have given an injection of penicillin before sending on to paeds unit)
- Claire comes home from work at 6pm to find her son has come back from nursery with a fever and calls 111
- She is given an appointment for 6.30pm in local GP practice - not their own but the one which leads on urgent care and is only 15 mins walk away
- GP sees her son and have access to child’s (and family's) health record, they check child over, look for rash and send home
- She is relieved and reassured, feeling confident in the system
- Claire understands that 111 can direct her to the most appropriate care
- Record is taken of the event and communicated to the family’s GP
2.2. Keeping people healthy, preventing ill-health and reducing health inequalities

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

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

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

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

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

Figure 6 provides an example of how a diabetic patient will be better supported to manage his condition.
Mohammed is 42. He was diagnosed with Type 2 Diabetes 2 years ago. He lives alone and suffers from occasional feelings of anxiety.

Managing and understanding diabetes can be difficult for some patients

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<thead>
<tr>
<th>Event</th>
<th>Description</th>
<th>Action</th>
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<tbody>
<tr>
<td>Mohammed is diabetic and has been feeling unwell. He is sweating and feeling weak.</td>
<td>Mohammed’s GP enquires about his condition, checks he is taking his medications and runs some tests.</td>
<td>Before Mohammed is able to return to his GP, for the results, he has a hypoglycemic attack and attends A&amp;E.</td>
</tr>
<tr>
<td>Mohammed is unsure what to do and contacts his GP</td>
<td>The hospital makes a diagnosis and changes his medication based on his current state of health.</td>
<td>Mohammed has learnt new medication he is feeling better but is unsure as to why he became unwell.</td>
</tr>
<tr>
<td>Mohammed experiences anxiety waiting for the test results and continues to feel unwell.</td>
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In future, patients will have better access to services that assist them in managing their condition

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<thead>
<tr>
<th>Event</th>
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<tr>
<td>Mohammed is diabetic and has been feeling unwell. He is sweating and feeling weak.</td>
<td>Mohammed’s GP enquires about his condition and is able to ensure that Mohammed takes his medicines correctly and eats and exercises appropriately. While running some tests, the GP is able to contact the local diabetologist to ask for advice and alters Mohammed’s medication.</td>
<td>Mohammed is feeling better on the new medication. His anxiety is greatly decreased. His GP has ensured that he is attending regular eye checks and offers to refer him to the X-ray programme.</td>
</tr>
<tr>
<td>Mohammed recognises the symptoms and contacts his GP</td>
<td>Mohammed is clear about the management of the acute problem and knows to follow up with his GP.</td>
<td>Mohammed is feeling more confident in how to manage his condition and in the support he receives, and is more motivated to do what he can to stay well.</td>
</tr>
<tr>
<td>Mohammed experiences anxiety waiting for the test results and continues to feel unwell.</td>
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2.3. High quality elective care and well understood planned care pathways

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

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

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

Figure 7 provides an example of how patients can expect their care to improve.

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

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

**Sometimes the pathway to receive planned care is complex and disjointed…**

- Paul meets with his GP who examines him but lacks equipment to diagnose specifically
- Paul is referred to an OP clinic for a scan which may take 4-6 weeks
- After 2 weeks Paul is called in for a follow up appointment and receives 2nd scan and is advised he needs a hospital appointment
- Paul still does not understand what his treatment options are
- Paul has to take time off work to attend
- Paul does not have his results with him and his GP is unable to give further advice
- 2 weeks later Paul has not received a follow up and returns to GP for further advice

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

- Paul meets with GP who examines him and explains pathway to clarify diagnosis and treatment
- Within 2 weeks Paul has had a scan at a nearby diagnostic clinic. The specialist physiotherapist or the GP checks in on the results and arranges appointment with a consultant for specialist opinion. They agree on procedure and books a hospital admission and discharge date
- Paul goes to hospital 2 weeks later and meets same consultant for operation. He has a brief stay on the ward and is discharged with a rehab plan
- On arriving home he receives an email from the hospital to both himself and his GP explaining plans for rehab
- Paul feels immediate progress is being made and information is efficiently passed between GP and consultant
- Paul is reassured by the structured approach
- His GP is able to check in on Paul’s progress with rehab
2.4. Rapid response to urgent needs

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

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

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

Figure 8
2.5. Social and health care providers working together to deliver the best care for patients

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

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

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

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

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

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Description</th>
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<tbody>
<tr>
<td>After visiting her GP, Laura is diagnosed with COPD and is put on an inhaler. After a period of no improvement, Laura’s GP prescribes her a stronger dose</td>
<td>Laura feels her care is uncoordinated as no one knows her history, she worries that she may not receive the best care as clinicians are dependent on what she can tell them.</td>
</tr>
<tr>
<td>After a series of complications, Laura is referred to a respiratory physician. Laura’s visit is extended as a specialist does not have access to Laura’s records, and has no indication about the progression of Laura’s condition.</td>
<td>Laura gains confidence that she can deal with her breathlessness. Laura can see that her care is coordinated and that she is being supported to manage her COPD.</td>
</tr>
<tr>
<td>Unexpectedly, Laura is admitted to A&amp;E and inpatient care for one week later with breathlessness</td>
<td>Laura is discharged to home, but her records and history are not available to either social care workers or district nurses during their follow-up visits.</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Description</th>
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<tbody>
<tr>
<td>Laura is identified as a patient in need of an integrated care plan by her GP. Her care plan is made available to all health care professionals involved in her care.</td>
<td>Laura is discussed by her GP at a case conference with a specialist respiratory physician. They identify that Laura needs education on how to use her inhaler properly, rather than a stronger dose prescription. She is referred to the community-based COPD team to improve her inhaler technique.</td>
</tr>
<tr>
<td>Nonetheless, Laura experiences complications, however on referral, her respiratory physician has access to Laura’s care records and full information to assess her progression.</td>
<td>Laura is reassured that all those caring for her have the information they need. Laura gains confidence that she can deal with her breathlessness. Laura can see that her care is coordinated and that she is being supported to manage her COPD.</td>
</tr>
<tr>
<td>Admissions to A&amp;E or interaction with social care are also supported by having her care plan accessible to all. Upon discharge the care plan recommends multi-disciplinary pulmonary rehab and self-management, and would be followed up with a visit at home by the specialist COPD team.</td>
<td></td>
</tr>
</tbody>
</table>
2.6. Early supported discharge

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

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

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

Figure 10

**Appropriate time in hospital when admitted, with early supported discharge into well organised community care**

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

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

- The duty doctor reviews her case and deems her fit to leave following physiotherapist review
- However, the review happens on a Friday and physiotherapists are not available until Monday, leaving Sue in hospital over the weekend
- Additionally, nurses assume that discharge to a nursing home is needed, however a place cannot be found
- Finally, after several further days in a nursing home a package of care is arrange to allow her to go home

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

- When Sue was admitted to hospital she was flagged as on the high risk patient register and her history was available to staff
- Her health and social care coordinator is notified and discharge planning begins immediately
- The duty doctor reviews her case and deems her fit to leave following physiotherapist review
- The HSCC talks to her family, calls her social worker and speaks to a community home to pass on information
- Next steps are captured in clear care plan and all pieces are in place for discharge when the time comes
- Early intensive support accelerates recovery
- Early intensive support accelerates recovery
- First week after discharge, she receives daily visit by physiotherapist to facilitate her

Sue is desperate to go home and cannot understand this delay or why she is occupying a bed that someone else could use.

Sue is in hospital over the weekend and whilst the care Sue received has been good she hasn’t been able to rest and recuperate at home.

When Sue was admitted to hospital she was flagged as on the high risk patient register and her history was available to staff.
3. How we will deliver better care, closer to home

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

Figure 11 outlines these initiatives by strategic goal.

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

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

<table>
<thead>
<tr>
<th>C</th>
<th>Rapid response to urgent needs so that fewer patients need to access hospital emergency care</th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>Our rapid response team will be better coordinated, with a broader scope and skill-set, providing the ability to intervene quickly and early to prevent avoidable admissions and keep people at home where possible, or in emergency respite care where necessary. The team support rapid discharge from hospital, when necessary working in the hospital to facilitate discharge. Everyone – patients, carers and clinicians will know about the alternatives to hospital or know to contact 111 for advice. This is particularly important for some groups of patients including nursing home residents, dementia patients, people recently discharged from hospital and those at the end of their lives. We will ensure rapid, coordinated, convenient access to care advice from other providers (GPs, social services, voluntary sector).</td>
</tr>
</tbody>
</table>

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

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

a) Single point of access via 111

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

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

b) Extending GP opening hours

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

- We have a new programme of work to improve the productivity of General Practice in NHSCL, which follows the NHS Institute of Innovation and Improvement’s Productive Practice guidance. We are currently auditing interactions with our patients in General Practice to assess the whole patient experience. This includes ease in accessing an appointment, experience in the practice (for example, how patients are dealt with by reception) and the consultation itself. Our practices will develop action plans based on our findings.

- Action plans will introduce change across a range of areas including front-of-house, planning and scheduling appointments, referrals to secondary care and the consultation itself to maximise the productivity of our practices. This will allow our practices to release staff time to invest in caring better for our patients.

- We will implement plans with local pharmacists to allow patients entitled to free prescriptions to access non-prescription medicines free-of-charge from their local pharmacists without requiring an additional GP appointment.

- We will implement prevention plans which support our patients in maintaining healthy lifestyles, increasing healthy eating and activity, losing weight and stopping smoking.
3.2. High quality planned care

a) Outpatient appointments in the community

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

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

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

b) Referral standardisation

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

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

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

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

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

c) Caring for mental health patients more effectively in primary care

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

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

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

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

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

a) Rapid response service

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

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

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

- If necessary, we will provide community respite care in a local rehabilitation unit as an alternative.

- The rapid response team will also work closely with staff in A&E departments redirecting patients attending A&E to an integrated service based around General Practice.
3.4. Integrated care for people with long term conditions

a) Integrated Care Pilot

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

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

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

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

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

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

---

Figure 13

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

1 Icons are illustrative only: any number of other professionals may be involved in a patient’s care, a case conference or performance review.
b) Wellwatch

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

- The Wellwatch team will consist of health and social care professionals, including a GP, Senior Nurse, Health Care Assistant, and a Health and Social Care Coordinator (HSCC).

- Wellwatch is a telephone-based case management service, which will use a computerised risk stratification tool to improve care for patients.

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

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

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

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

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

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

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

c) End of life care

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

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

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

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

d) Integration of mental health co-morbidities in the Integrated Care Pilot

We will develop an enhanced primary care model to better address the psychological component of long term conditions and tackle health anxiety and phobic disorders.

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

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

e) Medicines review programme

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

• We will consider introducing a team of two pharmacists and an administrator to work with GPs to review patient medication.

• This would include monitoring of patients taking potent diuretics to reduce the number of patients admitted with dehydration and/or renal failure as well as patients on oral anticoagulants.
3.5. Supported discharge

a) Early supported discharge into well organised community care

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

- In the future, GPs and new HSCCs will monitor patients against agreed care plans regardless of place of care. From admission, a patient’s GP and other providers will be actively involved in coordinating their discharge plan and continuing care needs (or before admission for planned care).

- New HSCCs will support this process. Based in hospitals, they will facilitate discharge, coordinate appropriate step-down care and provide advice to patients on what to expect after hospital and who they should contact if unwell. We will consider GP ‘ward rounds’ within hospitals to facilitate timely discharge.

b) Psychiatric Liaison Services

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

- We will develop “optimal standard” Psychiatric Liaison services beginning at St. Mary’s and Chelsea and Westminster hospitals (see figure 14). These multi-disciplinary liaison teams will provide 24x7 emergency cover to A&E and wards, and significant direct care, support and staff training during normal working hours.

- The Psychiatric Liaison teams will support clinicians by improving mental health care and risk management in acute hospitals and training staff in mental health care. This will result in fewer admissions, reduced length of stay and lower accommodation costs for local authorities (more patients discharged home directly).

Figure 14
4. How we will work together

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

**Figure 15**

### How we will work together

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

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

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

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

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

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

Our strategy has some big changes for how and where care is delivered e.g.,

- Integrated care, case management, rapid response
- Beds in the community
- Outpatients and some elective procedures in the community

Providers need to work more closely together to ensure care is organised around the patient

Core principles of how we organise

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

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

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

- We are introducing a new level of care within three localities – north, central and south. Services provided within localities will include rapid response services, enhanced primary care services including walk-in and extended hours, district nursing and social services reablement.

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

Figure 18 outlines the levels at which we plan to deliver health and social care services in Central London.
Figure 18

Services offered at each level

52 Individual practices
- Routine primary care
- Coordinated care planning of long-term patients
- Overall accountability for patient health

3 Localities
- North
  - Pop of c. ~ 75,000
- Central
  - Pop of c. 75,000
- South
  - Pop of c. 77,000
- Shared geographically-based services delivered locally – enhanced primary care, walk-in, extended hours
- Rapid response – admission avoidance, discharge support and readmissions, coordinated by HSCC
- District nursing – case management
- Social services reablement
- Integrated services – GP/nursing out of hospital
- Community outpatients and elective procedures
- Medicines support pathway

Central-London wide
- 111
- Shared CCG-based services – diagnostics, community clinics, inter-practice services
- Community outpatients
- Community beds
- End of life care
- Integration and coordination of services – Wellwatch, PRS
4.3 Working with our partners to deliver better care

a) Locality-based working

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

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

As part of the Integrated Care Pilot, Acute, mental health and social care specialists will provide additional support to their primary care teams (see figure 19 below).

Figure 19

In the future, we will integrate our intermediate care teams in the community so that our patients receive seamless care across health and social care services. We will do this by re-organising our rapid response, short-term reablement, community health and social care and rehabilitation teams within localities, and provide a single point of access to and coordination of these services (see figure 20).
b) Health and Social Care Coordinators

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

Figure 21 describes the roles of these HSCC.

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

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

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

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

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

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

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

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

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

Our approach to working with the voluntary and community sector is set out in figure 22.
▪ Voluntary and community sector leaders are valued partners in the design and delivery of this strategy, we will continue to work with them closely and listen to their community intelligence.

▪ We will work alongside these groups to mediate with and explain effectively what this strategy will mean to our community.

▪ We will work with local health and social sector organisations that can help our patients stay well, develop the capacity of a broad range of community ponders to provide quality services, and invest in creating supportive networks of care to sustain people with LTC in the community.

▪ We will develop appropriate systems and structures to enable local organisations to advise and be involved in the development of our services.

▪ We will develop an information database in partnership with local groups so that our providers and patients know who they can refer to for support from the community.
4.4. Estates

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

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

- Closer working between providers may require office space and meeting rooms.

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

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

We will work closely with Westminster City Council to ensure that any urban development proposals consider the implications on out of hospital services and that monies available from developers to support public service infrastructure (s106 and community infrastructure levy) are used to improve health facilities to their maximum effect.
Additional activity could be absorbed by existing GP practices delivered by the GP as well as specialists and others making use of the facilities within practices.

Maximise existing community clinics
- We will maximise existing state where it exists in the community.
- Our existing clinics are well distributed across the CCG, which will ensure easy access for all our patients.
- These clinics will include the following: Lisson Grove, Brampton House, Marylebone, South Westminster Centre, Maida Vale, Chelsea and Westminster – Dean Street, Soho Centre.

We have new plans for estates in the pipeline
- We have some new and existing plans for new health and social care sites in Central London.
- The two major planned projects are: a) East Fitzrovia on the old Middlesex site, and b) Church Street.
5. Supporting the change

We have identified five key enablers to support the change for better care, closer to home in Central London, as set out in figure 24:

Figure 24

<table>
<thead>
<tr>
<th>We must consider…</th>
<th>Recommended solutions</th>
</tr>
</thead>
</table>
| 1 Engage patients, carers and users | - CLH User Panel – advice and influence on all aspects of strategy  
- Chair of CLH User Panel is a member of Management Board  
- Patient Participation Groups to give patients a local voice  
- Co-production of CCG strategies and plans with our patients and community  
- Working with our patient representatives to clearly communicate with our local communities on this shift in model of care |
| 2 Governance and performance management | - Locality plan - Primary care system to manage variance in primary care and improve patient experience  
- Coherent process to monitor and assure progress with in the system  
- Each locality will have a clear plan against which performance will be measured |
| 3 Contracts and incentives | - Aligning financial incentives with patient flows  
- Commissioning on outcomes (providers responsible for integration)  
- Periodic tariff (e.g., work on fail)  
- CCG acts as the umbrella for setting up new services and developing premises in primary care – removes the risk from providers  
- We will explore how practices can be incentivised to work together e.g., through IF referrals |
| 4 Have the information tools required | - Expand our work on interoperability linking of IT systems across health economy to enable providers to exchange clinical information  
- SP urgent care dashboard on their patient urgent care contacts  
- Risk stratification of our patients, and results available to all our providers |
| 5 Organisational and workforce development | - Develop organisational development plan to ensure CCG Board, emerging leaders and all personnel have skills required to successfully implement the strategy  
- Establish day to day leadership behaviours to guide our work in practice groups  
- Training for GPs, Practice Nurses, Health Care Assistants and Managers |

The following sections outline how we address each of these key enablers.
5.1. Engagement with patients and carers

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

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

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

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

![Figure 29](image)

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

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

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

**Figure 31**

- **Performance system** will build on existing data sources e.g., iCaps, VCD, CCG analysis

<table>
<thead>
<tr>
<th>Level of organization</th>
<th>Frequency</th>
<th>Performance system will build on existing data sources e.g., iCaps, VCD, CCG analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central London CCG</td>
<td>Real time</td>
<td>Quarterly performance updates</td>
</tr>
<tr>
<td></td>
<td>Weekly</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Monthly</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Quarterly</td>
<td></td>
</tr>
</tbody>
</table>

**Locality**
- Review clinical performance and support improvement
- Quarterly reports on progress against plan

**GP practice**
- Performance reports practice on priority areas e.g., planned and emergency admissions data
- Quarterly reports on progress against plan

**Finance & compliance**
- Revenue resource limit
- Cash limit
- Revenue surplus target
- QIPP plan

**Empower patients**
- % Referrals Routed via the PRS
- % Patients offered choice of provider including general practice or community
- % Patients receiving inter-practice referral
- % patients seen in the community (referred by GP, Consultant or others)
- 18-week wait & 2 week ‘cancer’ wait
- Unscheduled attendances
- Non-elective admissions for LTCs
- LTC/EoL patients with active care plans

**5. Clinical governance**
- % Patients offered choice of provider including general practice or community
- % Patients receiving inter-practice referral
- % patients seen in the community (referred by GP, Consultant or others)
- 18-week wait & 2 week ‘cancer’ wait
- Unscheduled attendances
- Non-elective admissions for LTCs
- LTC/EoL patients with active care plans

**Example areas of our strategy against which we could measure progress**

- **Shift from unscheduled to planned care**
  - Use of risk stratification system ‘Stratify’, Urgent Care Dash Board and iCaps (or replacement systems)
  - Delayed transfers of care
  - % Patients offered choice of provider including general practice or community
  - % Patients receiving inter-practice referral
  - % patients seen in the community (referred by GP, Consultant or others)
  - % Referrals Routed via the PRS
  - % Patients offered choice of provider including general practice or community
  - % Patients receiving inter-practice referral
  - % patients seen in the community (referred by GP, Consultant or others)

- **Shift from acute to community for planned care**
  - Use of risk stratification system ‘Stratify’, Urgent Care Dash Board and iCaps (or replacement systems)
  - Delayed transfers of care
  - % Patients offered choice of provider including general practice or community
  - % Patients receiving inter-practice referral
  - % patients seen in the community (referred by GP, Consultant or others)
  - % Referrals Routed via the PRS
  - % Patients offered choice of provider including general practice or community
  - % Patients receiving inter-practice referral
  - % patients seen in the community (referred by GP, Consultant or others)

- **Empower patients**
  - Use of risk stratification system ‘Stratify’, Urgent Care Dash Board and iCaps (or replacement systems)
  - Delayed transfers of care
  - % Patients offered choice of provider including general practice or community
  - % Patients receiving inter-practice referral
  - % patients seen in the community (referred by GP, Consultant or others)
  - % Referrals Routed via the PRS
  - % Patients offered choice of provider including general practice or community
  - % Patients receiving inter-practice referral
  - % patients seen in the community (referred by GP, Consultant or others)

**IT**
- Use of risk stratification system ‘Stratify’, Urgent Care Dash Board and iCaps (or replacement systems)
- Delayed transfers of care
- % Patients offered choice of provider including general practice or community
- % Patients receiving inter-practice referral
- % patients seen in the community (referred by GP, Consultant or others)
- % Referrals Routed via the PRS
- % Patients offered choice of provider including general practice or community
- % Patients receiving inter-practice referral
- % patients seen in the community (referred by GP, Consultant or others)

**Coordinated health and social care**
- Use of risk stratification system ‘Stratify’, Urgent Care Dash Board and iCaps (or replacement systems)
- Delayed transfers of care
- % Patients offered choice of provider including general practice or community
- % Patients receiving inter-practice referral
- % patients seen in the community (referred by GP, Consultant or others)
- % Referrals Routed via the PRS
- % Patients offered choice of provider including general practice or community
- % Patients receiving inter-practice referral
- % patients seen in the community (referred by GP, Consultant or others)

**5. Clinical governance**
- Use of risk stratification system ‘Stratify’, Urgent Care Dash Board and iCaps (or replacement systems)
- Delayed transfers of care
- % Patients offered choice of provider including general practice or community
- % Patients receiving inter-practice referral
- % patients seen in the community (referred by GP, Consultant or others)
- % Referrals Routed via the PRS
- % Patients offered choice of provider including general practice or community
- % Patients receiving inter-practice referral
- % patients seen in the community (referred by GP, Consultant or others)
5.3. Contracts and incentives

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

- Facilitate financial flows within groups of practices, for example, by incentivising inter-practice referrals.
- Align provider and patient interests by incentivising providers to meet the out of hospital standards.
- Manage performance at the locality level and request providers to share data on their performance at this level.
- Commissioning on outcomes: we often commission based on activity – for example, how many nurses or number of beds there are, without considering whether that activity actually delivers improvements for the patient. In the future, we will commission based on outcomes. For example, whether a patient of working age with long term conditions is able to return to work, or whether patients have a lower risk score after rehabilitation.
- Period of care tariffs: Paying for care based on level of activity is an issue when multiple providers are involved in patient care. Each provider could deliver the activity they are contracted to do but because of poor integration between providers, patient outcomes are not achieved. In future, we will commission based on ‘years of care’ for patients with long term conditions and shorter periods of care for others. Providers will be paid to deliver outcomes for a patient. This will encourage integration and simplify contracting and monitoring arrangements for the CCG. It will allow providers to deliver care as they like, providing the care is delivered to a high quality and the target outcomes are achieved.
- The CCG takes on the responsibility for setting up new services and developing premises in primary care, to reduce risk for primary care providers.
5.4. Information tools

a) IT portal project

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

What is the Clinical Portal?

- A clinically-led solution designed to allow the sharing of data and information between disparate IT systems, via a single clinical portal
- Clinicians will be able to view an enriched up-to-date patient record which links multiple health care data sources including data from GPs, Out of Hours, acute and community settings
- Web-based portal, secure access via NHS N3 network
- Role-based access control
- System integration with iCaps and UCC QIPP
- Notifications – when data arrives in the portal you can set up notification emails

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

Figure 32
b) Urgent care dashboard

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

Figure 33
5.5. People and organisational development

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

Figure 34

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

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

Figure 35

<table>
<thead>
<tr>
<th>From...</th>
<th>To...</th>
</tr>
</thead>
<tbody>
<tr>
<td>We don’t often refer between GPs due to strong patient links and potential contractual issues</td>
<td>We collaborate across the locality referring patients to each other, or other members if the Primary Care Team if appropriate</td>
</tr>
<tr>
<td>We don’t want to talk about performance, or have challenging conversations</td>
<td>We hold each other to account around differences in outcomes, including celebrating success</td>
</tr>
<tr>
<td>We have seen all this change before – it will not stick and we will be bailed out</td>
<td>We need to do something different, now, to deliver better care for our patients in the right setting</td>
</tr>
<tr>
<td>It’s a system-wide problem, not mine</td>
<td>It’s up to me and my contribution to the system working together to deliver good patient outcomes</td>
</tr>
</tbody>
</table>
We will focus our training on the areas outlined in figure 36.

Figure 36

1. GP - We will support GPs to specialize where appropriate, increasing the number of GPs with a special interest.
2. Practice Nurses - We will upskill our practice nurses so they are able to carry out tasks that GPs have traditionally carried out (e.g., chronic disease management) and work together to identify further areas of nurse-led support.
3. HCA - We will build the capabilities of our Healthcare Assistants so that they are able to carry out technical procedures (e.g., ECG scans, Bar eryting and Audiometry).
4. Managers - We will work closely with, and develop the skills of our managers so that they are effective at coordinating networks, monitoring outcomes and developing strong relationships with CCG.
5. Patient - We will support our patients with training in self-management, and effective patient representation.

Making progress on these five enablers will be crucial to making changes to out of hospital care popular with patients, sustainable and effective in keeping people healthy and supporting those who have a condition to manage it well. They will be a crucial part of the ‘next steps’ the CCG will need to take.
6. Investing for the future

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

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

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

Figure 37 – Initial estimates of scale of investment

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

<table>
<thead>
<tr>
<th>Where you will receive care</th>
<th>Services offered</th>
<th>Additional Investment</th>
<th>Additional workforce</th>
<th>Additional space</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>At Home</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community care</td>
<td>£1.0-1.5m</td>
<td>25-30 WTE</td>
<td>Access to consulting rooms/team room</td>
<td></td>
</tr>
<tr>
<td>Elderly care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Postnatal care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admission</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoidance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>At a GP Practice</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extended Primary Care</td>
<td>£2.5-3.9m</td>
<td>15 – 20 WTE</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>In Community Health Centres</strong></td>
<td></td>
<td>£1.8-1.5m</td>
<td>18 – 22 WTE</td>
<td></td>
</tr>
<tr>
<td>ECG, possibly ultrasound</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rapid access to blood tests</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rapid access referral to hub/hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

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

a) Implementing our key initiatives and enablers for change

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

Figure 38

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

<table>
<thead>
<tr>
<th>Project phasing</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
<td>Q1</td>
</tr>
<tr>
<td>Initiatives</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-elective</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Rapid response teams</td>
<td>Planning and design</td>
<td>Implementation</td>
<td>100% delivery by March 2015</td>
<td></td>
</tr>
<tr>
<td>▪ Integrated Health &amp; Social Care teams around locations</td>
<td>Wellwatch</td>
<td>Contractual savings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out-patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Planned care pathway redesign</td>
<td>Planning and design</td>
<td>Implementation</td>
<td>100% delivery by March 2015</td>
<td></td>
</tr>
<tr>
<td>▪ Access to specialist opinion</td>
<td>Delivery 56%</td>
<td>Delivery 80%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Inter Practice Referrals</td>
<td>Enhanced Primary Care</td>
<td>Referral facilitation and peer review</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A&amp;E</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ 111</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ UCC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Primary care ‘walk-in’</td>
<td>Planning and design</td>
<td>Implementation</td>
<td>100% delivery by March 2015</td>
<td></td>
</tr>
<tr>
<td>▪ Redirection to primary care</td>
<td>Delivery 41%</td>
<td>Delivery 73%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Shared clinical portal</td>
<td>Community diagnostics</td>
<td>Minor elective procedures in community</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elective</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Community diagnostics</td>
<td>Planning and design</td>
<td>Implementation</td>
<td>100% delivery by March 2015</td>
<td></td>
</tr>
<tr>
<td>▪ Minor elective procedures in community</td>
<td>Delivery 47%</td>
<td>Delivery 75%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Figure 39

<table>
<thead>
<tr>
<th>Activity</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Apr</td>
<td>May</td>
</tr>
<tr>
<td>Initiatives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient engagement on out of hospital strategy</td>
<td>Build business cases</td>
<td>Procure</td>
</tr>
<tr>
<td>Governance and Performance Management as part of Practice Plan</td>
<td>Gain buy in for Practice plan and locality working. Ongoing discussions with GP practices.</td>
<td>Monitor and refine</td>
</tr>
<tr>
<td>Information systems</td>
<td>Pilot and refine IT Portal and Urgent Care Dashboard</td>
<td>Implementation and ongoing improvements</td>
</tr>
<tr>
<td>Contracts / incentives</td>
<td>Agree on incentives</td>
<td>Agree procurement processes</td>
</tr>
<tr>
<td>Organisational development</td>
<td>Establish leadership team</td>
<td>Build skills</td>
</tr>
</tbody>
</table>

47
b) Key immediate steps

By the end of June 2012

• Our Wellwatch service will be operational, supporting patients with long term conditions.

• We will have started the first phase of our redesign of Community Mental Health Services.

• Our practices will have developed plans to develop primary care for their practice, their locality and across the CCG (we will have in post locality coordinators to support this work).

• The 111 service will be live, including routing back to primary care.

By the end of September 2012

• We will have in place our Health and Social Care Coordinators (HSCC) to begin the process of community and social care teams being focused on GP Practices and localities.

• We will have HSCC focusing on coordinated discharge embedded in at least one hospital.

• We will have at least 3 more ‘inter-practice’ referral services live.

• Our shared clinical information system will be live in all GP practices combining GP / Community and Hospital information from Imperial healthcare.

• We will have developed our plans to ensure we maximise the benefit of 3rd sector providers.

• We will have determined the model and contractual arrangements for Urgent Care, including centres in hospitals and walk-in to GP practices.

• We will have developed an outline specification for the Health and Wellbeing Centre in Church Street and agreed the detailed development of the new building for the Fitzrovia Practice.

• We will have developed a strategy to route non GP referrals via the PRS, including specialist triage where necessary.

By the end of Dec 2012 -

• New model of Community Mental Health Services implemented and preparation for phase 2 of the programme underway.
• Our Practices will meet the primary care standards. By working together in localities and across the CCG, practices will offer a full range of enhanced primary care services to all Central London patients.

• Community and social care services will be delivered by integrated teams built around GP practice population (clustered into localities where appropriate) coordinated by our HSCC.

• All hospitals will have embedded HSCC focusing on coordinated discharge linking to the locality HSCC.

• Our shared clinical information system will bring together all information from our key providers.

• We will have plans to use different contractual and payment mechanisms to promote integration and encourage innovation from a range of providers including the 3rd sector. These will include AQP and ‘Year of Care’.

• We will have a responsive service provision for urgent care, including GP walk-in, 24/7 Rapid Response nursing and appropriate GP led services at hospitals.

• We will have a comprehensive estates strategy.

• All elective referrals will route via the PRS or will be subject to similar triage and routing.