“I want my care to be co-ordinated and not to feel afraid”

Comprehensive, Compassionate Care for our Patients Aged Over 75

Whole Systems Integrated Care
For the over 75s

Led by London Medical Associates for NHS West London CCG
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Our Vision for Whole Systems Integrated Care

We want to work together with our patients, front line staff and carers\(^1\) to design and deliver a new system of care that ensures the most positive experience possible for our over 75s population in West London. The new system will be more accessible, more effective and more efficient for both patients and providers and will build upon the various initiatives that are already in place or planned to take place.

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\(^1\) In this document, we use the term ‘carer’ to describe a number of people involved in the patient’s care. This could be family members, friends and neighbours who carry out a range of tasks that support and care for the person/patient, or professionals in the health, social and voluntary sectors responsible for the individual’s care.
1A. What is your vision for improving the care people will receive and how will the Whole System change to support this?

“In West London, we're committed to building a new model of care for the over 75s which puts the person - working in partnership with health & social care professionals - front and centre and removes the perverse incentives in the current system which sometimes get in the way.”

*Simon Tucker, Lay Representative*

We envision delivering a system of care which ensures that everyone in West London over the age of 75 receives timely, coordinated care, centred around each person and delivered in the most appropriate setting for them. Professionals will work together as part of a provider network to deliver seamless care for patients. We will ensure that patients receive the necessary support to understand and manage, wherever possible, their condition themselves with a clear treatment plan and information on the range of services available and how to access them. They will be encouraged to give feedback about these services, making clear how this information will be used.

We aim to transform care for older patients along the following three pathways:

1. **Older Patients with Long-term Conditions:**
   - Building on current initiatives to deliver care centred and co-ordinated around each patient
   - Promoting proactive case management and care planning for our complex, vulnerable patients
   - Ensuring that the effective co-ordination of comprehensive, multi-disciplinary care enables patients to remain at home, whenever possible, and to be discharged from hospital earlier

2. **Older Patients at Risk of Developing Long-term Conditions**
   - Identifying this group of patients with a first major diagnosis, such as heart attack, stroke, chronic obstructive pulmonary disease and major fracture
   - Providing appropriate and timely clinical, community and social care support to prevent their readmission to hospital in the first year following their diagnosis

3. **Older Patients Requiring Urgent and/or Emergency Care**
   - Improving co-ordination and communication between all providers of care
   - Reducing unnecessary A&E attendances and admissions
   - Employing relevant technology to keep personalised health records, eliminating gaps in information between care professionals and organisations

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2 In this context, the term older people denotes those over the age of 75
We will focus on the following areas in order to improve patients’ experience across the whole system:

- **A single point of contact into the health system**: Each patient will have a named coordinator to help them navigate their way through the system. This will mean that patients will no longer have to repeat their story to a series of health professionals and there will be a single point of contact for each patient minimising time spent in chasing information.

- **Care plans co-produced with patients and their carers and that will describe their informal networks and community networks**. The process of co-production will have the dual benefit of involving the patient more directly in their own care plan, thereby increasingly their understanding of the health system and available services and improving health professionals’ understanding of the specific way in which their patient’s condition and the quality of services affects their life. The aim of patient involvement when building the care plan will be to support them to achieve their personal and social goals. Promoting a partnership between the person/patient and the professionals so that each person feels empowered and in control of their own health as far as possible.

- **Care closer to home**: Most people would prefer to receive the health and social care they need at or close to their home, rather than in hospital. Those providing this care are also able to develop a better understanding of patients’ living environments. The use of relevant technology means that care can often be provided remotely where it is most convenient for the patient, reducing travel time and expense.

- **Co-ordinated Services**: Currently, too often, provision of services from different providers lacks co-ordination, is frequently duplicated and is at the convenience of the provider rather than the convenience of the patient, leaving patients frustrated and confused. Better co-ordination of services, so that care is delivered in a seamless way, is integral to improving patients’ confidence in the services they receive. This means that these services must be designed and delivered for the patient’s convenience rather than for those providing care. We will ensure that social care is an equal part to the delivery of this vision. Planning between patient and service providers via a care coordinator in a calm atmosphere is key to the seamless provision of services that work for the person/patient.
Given the vision is one of preventative, planned care and early intervention, emergency admissions will usually indicate a failure under the new model of care apart from those medical conditions where an admission is entirely appropriate such as in the case of a stroke, a heart attack, orthopaedic or surgical emergency.

**1B. What will being an early adopter add above existing strategic initiatives that are already happening in your local area (eg, Better Care Fund, 7-day working)?**

The central vision is to redesign the current rather fragmented provision of care from multiple Providers often acting independently into a coordinated cohesive single new Provider, which gets to know the person/patient as a unique individual and ensures they are fully involved in their care and has easy access to it.

Being an early adopter would allow us to build on existing partnerships ensuring we align current strategic initiatives at every level across West London Clinical Commissioning Group, North West London Collaborative and partner organisations to deliver better outcomes for local people over 75.

Section 3b details the local initiatives currently underway and how they will enable Whole Systems Integrated Care. Being an early adopter will ensure that:

- **We make the most efficient use of the total capitated budget for patients over the age of 75.** Currently, there is no single organisation which understands or co-ordinates how care is provided to this group of patients, some of whom have highly complex needs and account for significant NHS resources.

- **Budgets for health and social care are treated as one, with a payment system which addresses the whole spectrum of people’s needs.** A care co-ordinator for each patient with one or more long-term condition will design their care plan with them, looking at every aspect of the care they need.

- **Commissioners and providers develop a much closer, more collaborative relationship based on outcomes which matter to local people.**

- **Those commissioning care link payments to the outcomes which matter to the people using the services.**

- **Those providing care innovate and adapt in response to what local people say they need.**

- **There is greater innovation in primary care, including the development of an extended model of primary care to increase the scope and range of its activity.**

- **We make optimal use of an integrated IT system, with all providers using the same system.**
Involvement of people who use services, carers and frontline staff

We have ensured appropriate and equal representation from all stakeholder groups, engaging them through formal working sessions, steering committee meetings, GP plenaries and individual meetings.

“We are committed to working collaboratively to improve the patient experience of integrated care, admission to and transition from hospital. We intend to co-produce an integrated approach to the care of the population aged over 75 in the participating GP practices. We intend to co-design with patients, carers and service providers a personalised model of self-care which puts the patient/carers at the centre of a coordinated communication and service delivery process in relation to the management of their long term condition(s).”

Prof. Susan Procter,
Clinical Nursing Practice - Buckinghamshire New University
2A. How have you worked with all the people who will be affected, including people who use services, frontline staff, commissioners and providers to co-design your local Whole Systems Plan?

Stakeholder Engagement

We held working sessions with all our stakeholders to discuss the options for redesigning a more efficient and personalised Whole Systems approach to the provision of care for our over 75 year old population. Working sessions were set up to provide the opportunity for representatives at all levels from partnership organisations to have their voice heard, and for their inputs to be incorporated into the development of the Outline Whole Systems Plan. This is in keeping with our commitment to co-production in West London.

The representation at the working sessions was designed to be less executive / managerial in focus and more clinical / practical and participating organisations were asked to delegate attendance appropriately. Each working session had around 35 delegates. The organisations involved included:

<table>
<thead>
<tr>
<th>Representation</th>
<th>Representation Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS West London Clinical Commissioning Group (WLCCG)</td>
<td>Commissioner</td>
</tr>
<tr>
<td>All GP Practices (coordinated by local GP Provider Group, London Medical Associates)</td>
<td>Primary Care</td>
</tr>
<tr>
<td>Patient Groups / Lay Partners Forum</td>
<td>Patients and lay persons</td>
</tr>
<tr>
<td>Age UK (Kensington &amp; Chelsea)</td>
<td>Patients and Carers</td>
</tr>
<tr>
<td>Westminster and Royal Borough of Kensington and Chelsea Social Care</td>
<td>Local Authorities</td>
</tr>
<tr>
<td>Healthwatch Central West London</td>
<td>Patients</td>
</tr>
<tr>
<td>Buckinghamshire New University</td>
<td>Patients</td>
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<tr>
<td>Acute Trusts: Imperial and Chelsea and Westminster</td>
<td>Patients</td>
</tr>
<tr>
<td>Mental Health Trust: Central and North West London (CNWL)</td>
<td>Mental Health Provider</td>
</tr>
<tr>
<td>Central London Community Health Trust (CLCH)</td>
<td>Community Provider</td>
</tr>
<tr>
<td>London Central and West Unscheduled Care Collaborative (LCW UCC)</td>
<td>111 / Out of Hours Provider</td>
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<tr>
<td>London Ambulance Service</td>
<td>Emergency Services Provider</td>
</tr>
<tr>
<td>North West London Commissioning Support Unit (NWL CSU)</td>
<td>Commissioners</td>
</tr>
<tr>
<td>Kensington and Chelsea Social Council</td>
<td>Social and Voluntary Provider</td>
</tr>
<tr>
<td>Pharmacy – CSU Team</td>
<td>Pharmacists</td>
</tr>
<tr>
<td>BME Health Forum</td>
<td>Equality &amp; Diversity</td>
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“In the co-production workshops we attended, it was immediately obvious where our services and community initiatives could add value to the development of integrated care; both services that we already provide and those which would be a natural extension of our work”

Jan Halliday
CEO, Age UK (Kensington & Chelsea)
The two multi-stakeholder working sessions focused on the design of integrated care, as follows:

**Working Session 1**  
- 21st May -
  - Reinforcing co-production
  - Understanding the population group
  - Agreeing the outcomes to meet their needs

**Working Session #1, 21st May**

**Working Session 2**  
- 28th May -
  - Beginning the work to define the new model of care for the three care pathways described on page 3

**Working Session #2, 28th May**

Examples of co-produced ideas and concepts
Additional workshops are planned with local stakeholders, including those who use services, frontline health and social care staff and the voluntary sector, in order to:

1. Refine the details of the models of care
2. Ensure patients are at the centre of all changes/redesign and delivery of services
3. Facilitate the development of GP and provider networks
4. Identify the budgets from all partnership organisations to be included in this whole systems initiative
5. Agree the commissioning arrangements for the management of a pooled budget
6. Decide on the capitation arrangements of the pooled budgets and how the financial benefits and risks will be shared

We will also run a workshop in June in order to capture the views of the wider group of lay partners across West London.

**GP Engagement**

Critical to the success of this model was the buy in from all local GP practices’ in West London CCG. London Medical Associates (LMA), the local GP Provider Company, was selected to take the lead on behalf of the CCG in engendering GP support as well as attracting local Provider buy in. Through a series of local meetings the new Whole Systems model was introduced to all the local practices who formally signed up to being involved. All WLCCG practices are now signed up covering the total population of 201,476 patients, 44 Practices from LMA and 7 from independent Practices.

Two LMA Directors also liaised with all the local providers and patient groups about the LMA proposed new Whole Systems model and arranged a series of meetings. All the local providers agreed to sign up to the expression of interest and to become involved in developing the new model.

GPs are integral to the success of our proposed model, so their effective engagement is a priority. We communicate regularly with members via the CCG’s weekly bulletin and we held two GP-specific workshops to discuss and develop ideas for a new model of care for this patient group.

Key themes included the need to:
- Be able to spend more time with their most vulnerable patients
- Quicker access to specialist opinion
- Services to be co-located wherever possible
- Understand and work more closely to social care
- More capacity in primary care, for example, to support home visiting

The second GP event was held in February 2014 at the end of the Joint Commissioning Learning Set (CLS) meeting and was an additional opportunity for the GPs to discuss and develop new ideas for the model of care for over 75s.
We have also engaged London Central & West Unscheduled Care Collaborative (LCW UCC) as part of our Steering Committee, which functions as a steering group and reports to the Governing Body via the Out of Hospital Steering Group. LCW UCC is a GP-led community benefit society (social enterprise). It is a GP member organisation which includes GPs from all the practices within West London CCG.

Our GPs understand the Pioneer process and the whole systems work underway in North West London. All GPs from the 51 practices locally are formally signed up to Whole Systems Integrated Care. Going forwards, we will need to ensure we meet with all GPs monthly to continue to engage them in the whole systems work and continue to design and refine the model of care.

28. How are people who use services and frontline staff part of your decision-making and governance arrangements?

In conjunction with the WL CCG it was agreed to set up a Whole Systems Steering Committee (WSSC) comprising the major stakeholders. Terms of Reference were drawn up to outline the Governance of this Group (see Appendix B – Terms of Reference). The committee is responsible for the development and completion of a full whole systems plan, which builds on the expression of interest submitted and led by London Medical Associates (LMA), on behalf of primary care, social care, mental health, community, acute and third sector providers in West London.

There is excellent attendance at all the meetings. Following these meetings all organisations were asked to return a statement of commitment, outlining their support in co-design principles and willingness to support with the next stage of the process (see appendix A)

The WSSC is responsible for ensuring decisions relating to the development of the Outline Whole Systems Plan take into account the views of those who use services and frontline staff.

As per its terms of reference, the committee comprises commissioner, patient and multi provider representatives at executive/board level, as follows:

<table>
<thead>
<tr>
<th>Representation</th>
<th>Representation Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthwatch</td>
<td>Patient Representation</td>
</tr>
<tr>
<td>London Medical Associates – 2 x Directors</td>
<td>Primary Care</td>
</tr>
<tr>
<td>2 x additional GPs</td>
<td>Primary Care</td>
</tr>
<tr>
<td>Central &amp; North West London NHS Foundation Trust</td>
<td>Community &amp; MH Provider</td>
</tr>
<tr>
<td>Tri-borough Adult Social Care</td>
<td>Social Care Commissioner &amp; Provider</td>
</tr>
</tbody>
</table>
The committee is chaired by a lay representative, with a further four lay members who are all actively involved in making decisions about the plan for our new model of care. The Committee met for the first time on 9th May 2014, with subsequent meetings on 21st and 28th May.

LMA are represented by two of its own directors. LMA called for applications from GPs who are not part of their organisation to sit on the Steering Committee. In order to demonstrate that GPs on the Steering Committee represent the views of practices in their area, each member has to demonstrate that they had the support of five practices for their application for the Steering Committee. Two additional GPs are now members on the Steering Committee, representing the North and South of the area. Organisations represented on the Steering Committee provide assurance through their statements of commitment that they will work with their internal communications teams to engage actively with frontline members of staff about the new model of care.

2C. How will you support and train partners to support their participation in co-design?

With co-production central to the success of our proposals, we are further developing how we engage with those who use services, lay partners and carers in the next phase of our work. The North West London WSIC Embedding Partnership Team will provide them with training and support so as to make the most of their contribution. We will also develop working groups to define the model of care for each of these stakeholder groups, building on work already underway.
The GP Provider Group recognises that education and training is critical to ensure that we have an appropriately trained Primary Care GP workforce. We will be liaising closely with the North West London Local Education and Training Board (NWL LETB) to establish regular Primary Care Educational sessions for the whole Primary Care Workforce. We will ensure that there is appropriate training in the management of long term conditions. Half-day training events will be organised to ensure that multidisciplinary teams convene comprising of ‘expert patients’, acute trust consultants, community nursing teams, social care teams, GP teams, out of hours providers and London Ambulance Service representatives to define the new care pathways. The goal in the first year will be to develop a new organisational structure charged with overseeing all at risk patients. This new team will be responsible for ensuring proactive, timely early intervention to improve patient care, improve patient health and reduce the risk of admission and avoid admission where possible.
Our ambition is to provide a truly integrated system of care for all people over 75 years of age in West London. Specifically we will be grouping these elderly people as those with long term conditions, those who have developed a long term condition and those who are in need or urgent or emergency care.
3A. Which population group(s) described in the toolkit will you prioritise and what are the local needs?

Our expression of interest focuses on all over 75s in West London. As such, our prioritised population groups will be:

**Group 4 - elderly people with one or more LTC**

Mr J is a typical patient with one or more long term condition, over 75 years of age living in West London. In a year he will have:

- 3 out-patient visits
- 1 A&E visit
- 1 non-elective admission
- 20 GP visits

Annual costs of care will be modelled as we develop the full whole system plan.

Source: Integrated Data set from Hammersmith and Fulham, ICP data warehouse, FIMS 2012/13, CLCH budget, WLMHT budget, LA Budget, McKinsey analysis

**Group 2 – mostly healthy elderly people**

Mrs Y is a typical, mostly healthy patient over 75 years of age living in West London. In a year she will have:

- 2 out-patient visits
- 1 A&E visit
- 9 GP visits
- No Social Care

Annual costs of care will be modelled as we develop the full whole system plan.

Source: Integrated Data set from Hammersmith and Fulham, ICP data warehouse, FIMS 2012/13, CLCH budget, WLMHT budget, LA Budget, McKinsey analysis

We are also including over 75s from other groups such as people with cancer, organic brain disorders and physical disability as we are focusing on all over 75s. Together these groups account for approximately 11,000 of our 230,000 population in West London. Within these groups that make up all elderly people, and as laid out above in our vision, we have chosen to focus on three distinct sub-groups of elderly people:

- Known elderly patients with long term conditions
- Previously well elderly patients at risk of developing long term conditions
- Elderly people requiring urgent and/or emergency care
These three sub-groups represent the greatest opportunity to positively impact care delivery in West London; these patients are the ones who will benefit most from whole systems integrated models of care that bring together health and social care, as well as the voluntary sector, in a way that is centred around the patient and meets the needs of the person. They are also the sub-groups for whom the healthcare system has not provided the highest level of care.

<table>
<thead>
<tr>
<th>Sub-groups</th>
<th>Rationale for focusing on these patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fit and well older people</td>
<td>Ensuring they are supported to maintain a healthy lifestyle and help them to keep fit and well for as long as possible.</td>
</tr>
<tr>
<td>Known elderly people with long term conditions</td>
<td>Traditionally insufficient self-management support for those with long term conditions.</td>
</tr>
<tr>
<td>Previously well older people who develop a long term condition</td>
<td>Currently there is poor provision of aftercare when patients in this group are discharged from hospital following their first acute event such as a Heart attack (MI) or stroke (CVA). Patients are often frightened and vulnerable following their first Acute event such as a Stroke (CVA). They are worried that it might happen again. Post hospital discharge they are often only functioning at 60 – 70% of their pre-admission level but often fail to ask for help, try to do too much on their own at home and this can lead to accidents and readmissions within 12 months of initial discharge. They frequently fail to eat properly can become malnourished and end up with malnutrition making them more susceptible to infections and pneumonia. Prior to the first admission they may have been completely capable of shopping and cooking.</td>
</tr>
<tr>
<td>Elderly people requiring urgent and/or emergency care</td>
<td>Urgent and emergency care pathway is an area of huge cost which has been fragmented with poor inter-agency communication. Patients are often taken to the Emergency Department unnecessarily because of a lack of knowledge of that patient’s past medical and social history and then subsequently admitted. If the GP had been involved the patient might not have needed to go to hospital. Audits of Emergency Admissions have shown that in as many as 80% of cases the GP had no knowledge that the patient had been admitted to hospital. It might only be when the discharge summary is sent to the GP Practice that they know their patient was admitted as an Emergency.</td>
</tr>
</tbody>
</table>
Information regarding the typical profile and the needs of our older population in West London can be found in the Kensington and Chelsea localities Joint Strategic Needs Assessment extract as shown below.

Kensington and Chelsea’s older people report a low rate of limiting long-term illness when compared to London or national figures. However disparity exists between the north and the south of the borough, with over 50 per cent of older residents in the four most northerly wards stating they have a limiting long-term illness, compared to approximately one third in most other parts of the borough.

As the age profile of the borough changes over time, with an increasing proportion of the population over the age of 65, there will be significant increases in the number of older people with a limiting long-term illness. By 2015, the number is expected to have risen by five per cent or an additional 450 people. By 2030, it is expected that there will be an additional 2,200 older people with a limiting long-term illness (a 23 per cent rise on the current number) – this includes a 30 per cent rise in patients with dementia compared to today’s figures.

In Kensington and Chelsea, 61 per cent of people over the age of 65 live alone, and more than one in seven households is a lone pensioner household. This is particularly high compared to other boroughs and means there is increased risk of social isolation amongst the older population. Living alone can lead to malnutrition, anxiety, depression, and a general neglect of health and well-being. Lone pensioner households are most common in the Chelsea area, where they represent nearly one in five of all households.

Extract from “Joint Strategic Needs Assessment”, Royal Borough of Kensington & Chelsea, 2010

The availability of the above information and data is currently limited to the Kensington & Chelsea localities but provides a flavour of this group’s local needs.

A&E usage by over 75s in West London is predominantly due to long term conditions including hypertension and cardiac problems. This applies for both number of patients and the amount of activity, as shown in the chart below.
Within the elderly people group, we have approximately 2,600 patients (estimate) with a medium to high risk score, as can be seen below.

Although our top priority is elderly people with a risk score of 65 or over, our elderly population with a risk score of 20 or over is our focus group for the new model of care. These are the patients who traditionally fall into sub-groups 1 and 2 (i.e., those whose health is deteriorating and those with long term conditions).
### 3B. What initiatives are planned over the coming year to improve care for this group (e.g, BCF) and how will your plans align with them?

<table>
<thead>
<tr>
<th>WS Building Block</th>
<th>Current Initiatives</th>
<th>Description</th>
<th>Outcomes</th>
<th>How it will being an early adopter enhance these initiatives and what is the link with WS?</th>
</tr>
</thead>
</table>
| Developing our model of care | • Putting Patients First  
  • Out of Hospital Strategy | PPF is an integrated approach to managing frail and vulnerable patients. It aims to develop the principles of care planning, case management and multi-disciplinary team working – these same principles form the basis of our WSIC model of care. | • Practice having monthly meeting  
  • Care planning for patients as risk of unplanned admissions  
  • Case management for the most complex and vulnerable patients | • Partner organizations will have their incentives aligned and be held to accountability for outcomes  
  • Make optimal use of an integrated IT system  
  • Attract high quality staff to work as part of a provider network and a co-located, embedded team  
  • Benefit from opportunities of additional out of hospital services being provided by GP networks |
| Commissioning an integrated health and social care system | • Better Care Fund initiative - patient experience and self-management | Aimed at transforming health and social care, generating local integrated working partnerships. Local schemes include developing pathways around Intermediate Care, 7 day access and self-management | • Local integrated partnership working  
  • Integrated health and social care commissioning | • Services commissioned that will align with Whole Systems provider sites and respond to local delivery models and need |
| Developing our model of care Approaches to care planning, case management and multi professional working | • Locally Commissioned Schemes  
  • OOH Specification for Care Planning and case management  
  • Enhanced Service for Avoiding unplanned admissions  
  • PM Challenge Fund | Specifications for the delivery of services focusing of WS type interventions with a focus on delivery at a network level. | • GP Networks set up to deliver services | • Will form the basis of WS interventions which need to take place across multiple providers |
| How we organise ourselves | • PM Challenge Fund  
  • OD Support for networks  
  • Development of Community Hubs | Two outline business cases to develop community hubs, one within each network (North and South). | • Establish functioning networks that are able to hold contracts.  
  • Community hubs will place primary care delivery and its coordination by the primary care workforce at the heart of delivery.  
  • Put in place the IT infrastructure needed to streamline appointment booking, broaden access and enable networked working.  
  • Provide the workforce with the training and education needed to deliver the new model of care. | • GP networks will be established to deliver a wider range of primary care services these will likely form the central hub for wide WS provider Networks.  
  • The new community hubs will be planned in line with the emerging model of care for WS |
<table>
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<th>Outcomes</th>
<th>How it will being an early adopter enhance these initiatives and what is the link with WS?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developing our workforce</td>
<td>- Network Learning Forums</td>
<td>Multi Provider Forums (originally ICP MDGs) with a focus on good quality education and case reviews</td>
<td>- Multi provider learning and development</td>
<td>- Will support the development of OD Plan and be a key forum for training and development</td>
</tr>
</tbody>
</table>
| Improving access | - PM Challenge Fund – 7 day access  
- Better Care Fund Initiative on 7 day social care access  
- GP NHS 111 Pilot | Plans to ensure access to high quality health and social care services 7 days a week  
Improved management through NHS 111 with addition of GP support in management of complex cases including elderly with LTCs or special patient notes | - 7 day access  
- Improved access for complex patients and reduction in 9999 referrals | - Will enable use of the National GP NHS 111 pilot outcomes to further develop over 75s care pathways for single point of access via NHS 111 |
| Community Assets | - Better Care Fund  
- Community Assets | The Community Assets programme comprises three projects in order to evaluate and recommend a model ultimately for tri-borough wide implementation:  
- to map community assets,  
- to design a trial for strengthening current networks,  
- to make the business case for authorisation and mobilisation of the trial.  
Community Independence Services: Rehabilitation | - Networks of Community Assets in place | - This programme will identify, strengthen and develop community assets which will complement and align with the formal integrated of clinical and social care provision |
| Capturing User Experience | - Better Care fund initiative - patient experience and self-management | 1. Mapping exercise to capture patients’ experiences of using health and social care services and using this to inform co-production.  
2. Developing an innovation and new way of capturing patient experience | - Up to date ‘live’ information about user experience that is captured in a regular basis | - WS Steering Committee will make use of results of mapping exercise and incorporate the new methodology as a way of capturing information about the quality of its provision. |
| Supporting physical and mental health | - WS SEMI  
- Dementia Project  
- The Primary Care Mental Health Service (PCMHS) and particularly the IAPT (psychological therapies) | WS SEMI Programme to change the outcomes for people who experience long term mental health needs  
Dementia Project - to increase diagnosis rates and provide support in living with dementia.  
PCMHS and IAPT - being further developed to target older people to support health and well-being. | - Improved role of peer support, proactive case management and coordinating care responses across organisations | - WS Model of care will incorporate MH initiatives |
Outcomes

Through individual meetings, working sessions and steering committee meetings, our stakeholders identified the priority overarching outcome from this early adopter project as being a reliable, efficient and trustworthy system of care which they own and direct and can easily access. Preliminary performance measures have been considered and these will be developed as we complete the full Whole Systems plan.
4A. What are the priority outcomes to be achieved by the targeted population group for each of the areas given in the outcomes framework in the Toolkit?

The working session discussions around outcomes focused on patient ‘Quality of Life’ and ‘Quality of Care’. Below are the key considerations relating to outcomes decided upon during the working session:

The things about care that make quality of life better. For example, safety, effectiveness, and experience of care, e.g.,

- Patients have trust in the system
- A single, named person coordinating care, developing patient confidence and enabling the development of a relationship with that person
- Better coordinated provision of care between providers
- Active involvement in coproducing and owning care plans. Strive for patient-owned care plans

The overall health and quality of life of individuals and their carers, e.g.,

- People should be able to achieve their personal and social goals
- Eliminating ‘Fear’ for patients
- Holistic needs assessment based on the ‘whole person’
- Minimizing the amount of time spent in a healthcare ‘environment’ i.e. away from home

Translating these considerations into outcomes that can be measured, the following formal outcomes are defined as the prioritised target outcomes for our chosen population groups:

- Patient (and carers) trust in the system
- Consistency of healthcare system contact for the patient
- Fewer hospital visits
- Seamless patient experience when transferring between services
- Patients have ‘ownership’ of their own care
- More services provided at / close to home
- Opportunities for peer support are identified and made available
- Holistic care planning which addresses both wider issues of well-being and living as independently as possible and issues which that individual considers important to them and provides knowledge to professionals/services in working effectively with that person
**48. What performance management measures will you adopt?**

**Quality of Care**

<table>
<thead>
<tr>
<th>Outcome(s)</th>
<th>Performance Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Patient / carer trust in the system</td>
<td>Patient satisfaction surveys will be used to measure patient confidence and satisfaction. We are in discussions with <a href="http://www.iwantgreatcare.com">www.iwantgreatcare.com</a> to act as a provider of statistical analysis on measures such as:</td>
</tr>
<tr>
<td></td>
<td>- Do the patient and carer feel listened to and believe their views and wishes have been taken into consideration at all times?</td>
</tr>
<tr>
<td></td>
<td>- Do they feel that where there are constraints or limitations on how their views and wishes have been incorporated that the reasons have been fully explained?</td>
</tr>
<tr>
<td></td>
<td>- Does the patient / carer feel they can ‘whistle blow’ without negative consequences for them?</td>
</tr>
<tr>
<td></td>
<td>- Does the patient feel comfortable complaining?</td>
</tr>
<tr>
<td></td>
<td>- Does the patient have a named first point of contact at all times?</td>
</tr>
<tr>
<td></td>
<td>- Can the user / carer access the system reliably via the named point of contact?</td>
</tr>
<tr>
<td></td>
<td>- How many different professionals does the patient engage with?</td>
</tr>
<tr>
<td></td>
<td>- How long does the user / carer need to wait for a response in times of need?</td>
</tr>
<tr>
<td>- Consistency of healthcare system contact for the patient</td>
<td>As well as patient satisfaction surveys this outcome will also be measured for:</td>
</tr>
<tr>
<td></td>
<td>- Time taken to transfer between services</td>
</tr>
<tr>
<td></td>
<td>- # transfers in a given period / episode</td>
</tr>
<tr>
<td></td>
<td>- Waiting time to be transferred</td>
</tr>
<tr>
<td></td>
<td>- Does the patient / carer understand the care they will receive and the transfer process?</td>
</tr>
<tr>
<td></td>
<td>- Is there a clear and effective discharge plan for the patient?</td>
</tr>
<tr>
<td>- Seamless patient experience when transferring between services</td>
<td>Patient satisfaction surveys will measure how involved the patient feels in directing their own care. This outcomes will also be measured by the number of ‘sign offs’ the patient makes on their care plan – through each stage of the patient’s journey through the health system, checkpoints will ensure the patient has understood the services they have received and will provide the patient opportunity to feedback on how their care has been provided. Measures to include:</td>
</tr>
<tr>
<td></td>
<td>- Does the patient understand how to manage their condition(s)?</td>
</tr>
<tr>
<td></td>
<td>- Does the patient feel confident in managing their own condition?</td>
</tr>
<tr>
<td></td>
<td>- Has the patient been provided with relevant and accurate information regarding their care plan?</td>
</tr>
<tr>
<td></td>
<td>- Can the patient express their goals / objectives as part of their care planning?</td>
</tr>
<tr>
<td></td>
<td>- Are the patient’s goals and preferences understood and respected?</td>
</tr>
<tr>
<td>- Patients have ‘ownership’ of their own care</td>
<td></td>
</tr>
</tbody>
</table>

22
### Quality of Life

<table>
<thead>
<tr>
<th>Outcome(s)</th>
<th>Performance Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Less Hospital Visits</td>
<td>- # Patient spells</td>
</tr>
<tr>
<td></td>
<td>- # Non-Elective admissions</td>
</tr>
<tr>
<td></td>
<td>- # Bed days</td>
</tr>
<tr>
<td></td>
<td>- # A&amp;E visits</td>
</tr>
<tr>
<td>- More services provided at / close to home</td>
<td>- # patient days at home</td>
</tr>
<tr>
<td></td>
<td>- # patient contacts at 'local' services (should increase)</td>
</tr>
<tr>
<td></td>
<td>- # days within traditional service setting (should decrease)</td>
</tr>
</tbody>
</table>

Further working sessions will be held with patient groups, lay representatives, carer groups, clinicians and providers individually and collectively to identify more relevant outcomes and define how these will be measured.
At this early stage, we have received indication of support for pooled commissioning arrangements from the CCG and Local Authorities. We have been delighted with the enthusiasm and willingness to tackle this issue from our partners within acute, primary, social and community care and the voluntary sector. Going forward, we will be facilitating in depth discussions around this topic through individual meetings as well as working sessions and steering committee meetings.
5A. Which organisations want to form integrated commissioning arrangements?

The CCG and Local Authority have indicated their support to pool commissioning budgets. We plan to consult and obtain formal endorsement of this joint working arrangement from the CCG Governing Body and the Health & Wellbeing Boards. Given the importance of agreeing commissioning arrangements going forward, both the CCG and Local Authority partners are consulted as active members of our Whole Systems Steering Committee.

5B. Which budgets do you intend, at this point, to pool to support integrated care?

The further development of the new models of care (see chapter 7) will inform the requirements for integrated commissioning. The models of care are at a very early stage of their development and so our commissioning partners are not yet in a position to commit to funding a joint, capitated budget.

However, as indicated above we have held high level discussions to highlight the need for consideration of this topic. From these discussions, willingness and intent have been signaled by acute, primary care, social care, community care, the voluntary sector and mental health to form a working group dedicated to the consideration of finances, pooling of budgets and capitation. This group will be responsible for:

- the development of a joint commissioning model that overcomes the fragmentation currently experienced between commissioning bodies
- the development of a governance framework for the new commissioning model

We expect that the chair for this working group will act as the lead for the Finance and Activities Work Stream within our Implementation Plan (Chapter 11).

5C. Which contracts will be affected by the pooling of these budgets?

Preliminary discussions during our Steering Committee meetings have identified the contracts likely to be affected as being from:

- acute
- primary care
- social care
- community care
- voluntary sector
- mental health
Capitation

How you pay for health and social care encourages different behaviours. This is because people respond to incentives and risks. The payment model determines what incentives people have and how risks are shared. In order to succeed, Whole Systems Integrated Care needs to provide incentives and share risks so that providers work together to keep people well.
6A. What is the estimated capitated budget envelope, taking into account the population cared for and the budgets being pooled?

**Average Annual Cost per population group**

<table>
<thead>
<tr>
<th>Age</th>
<th>Mostly healthy</th>
<th>One or more long term conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>75+</td>
<td>3,333</td>
<td>4,132</td>
</tr>
<tr>
<td></td>
<td>£13.8</td>
<td>£21.9</td>
</tr>
</tbody>
</table>

Note: The dataset includes a subset of the population of Hammersmith and Fulham; it represents “90% of the population of that borough.
Source: Integrated Data set from Hammersmith and Fulham, ICP data warehouse, FIMS 2012/13, CLCH budget, WLMHT budget, LA Budget, McKinsey analysis

These capitation figures are the best available information on patterns of health and social care activity and spend and provide a sensible estimate for the likely budget for this group. The analyses are based on a linked person-level data set in Hammersmith and Fulham (H&F) of health and social care spend and activity and covers approximately 90% of the population for H&F. The Primary Care, Mental Health, Social Care and Community Care Budgets need to be quantified.

In the next phase of the programme, and as we develop more detailed local plans for West London, our local data will be used to refine these estimates and determine the actual historic spend of the people in our selected groups across primary, social, community and acute care. This next phase of work regarding the budget will also take local RRLs into account, including anticipated changes in demand and savings requirements for example. A robust budget will also enable us to determine and stress test the affordability of our proposed model of care for over 75s in West London to ensure sustainability.
New Models of Care

Our emerging model of care responds to the co-production process which has so far highlighted a need for better care closer to home and for more coordination of services. The model outlined below describes ambitious plans to have a single provider entity and a small number of General Practices specialising in Older People's Care. At the core of our emerging model is also a single point of contact provided by a Central Coordination Team. The specifics in the model demonstrate one option, further models may be identified as we move through the next stage of the process all of which would be subject to a robust consultation plan.

Together, we will co-design a model of care that will:-

- Focus on the person not the condition
- Be available in hours as well as out of hours
- Develop care plans with patients and carers and make them more ‘humane’
- Feel ‘calm’ for people who are using the services
- Support patients to maximise their own health
- Focus on the entire population of people aged over 75 in West London and develop a model that is right for them.
What is the current model of care for your population group, including the frequency, setting and length of interventions?

The current model of care is reactive in nature rather than preventative and planned as per our vision for this population group. It is often fragmented with no central coordination of care for those patients living with the greatest degrees of risk. As such, the majority of care for older patients in West London is provided in the hospital setting. For example, approximately three-quarters of all admissions at Chelsea and Westminster are for people over the age of 75. This equates to approximately 50% of spend for older people with and without long term conditions.

Care today is also generic in nature and often organised around the professionals who deliver it, rather than being based on the users’ needs. This results in people spending more time than necessary in acute settings that does not align with their preferences. For example, a Day of Care Audit in December 2013 at Chelsea & Westminster Hospital NHS Foundation Trust showed that 37% of patients should not have been in hospital and could have been cared for elsewhere.

Access into the system today is typically via 999. In West London, GPs are often unaware of 80% of emergency admissions until the discharge summary is sent to them from the hospital.

Currently there is no formal risk rating of patients at the point of discharge. If this was undertaken then appropriate levels of Community and Social Care could be input rapidly to meet the needs of the patient and thereby reduce their risk of being readmitted.

Today older patients are distributed across most GP practices in West London rather than being concentrated in specific practices with the expertise to meet their needs. GP appointments are traditionally 10 minutes long, which is insufficient for patients with the most complex needs.

The current key vehicle for delivering integrated services is a CCG-led Putting Patients First (PPF) initiative. PPF is an integrated approach to managing frail and vulnerable patients. It aims to develop the principles of care planning, case management and multi-disciplinary team working – these same principles form the basis of our Whole Systems Integrated Care model of care.

PPF supports an approach where the most relevant member of the multi-disciplinary team (MDT) is identified to case manage a patient based on their need. A Case Manager could be a GP, Community Case Manager, Social Worker or Mental Health professional. All West London practices have ‘signed up’ to PPF with around 80% of practices having monthly MDT meetings and in 2013/14 the CCG reported around 6,000 care plans completed.

PPF has the following key objectives:-

“Patients should have humane, truly personalised care plans”
Sonia Richardson
Patient Representative
(West London CCG Governing Body)
- improving access to high quality and responsive primary care
- implementing efficient and effective clinical pathways
- reducing the need for patients to visit hospital through the provision of a new urgent / emergency care pathway
- ensuring comprehensive coordination between social, health and third sector services to provide a ‘seamless’ patient journey
- minimizing the amount of time a patient needs to spend in hospital (where appropriate) and ensuring they are fully supported after discharge
- involving patients to play an active role in their care
- promoting self-care (where appropriate)

In addition the CCG has commissioned a team of Primary Care Navigators (PCNs) to support case management. The PCNs are provided by Age UK Kensington and Chelsea and initial findings are very positive in terms of their impact on reducing unscheduled admissions.

7B. What is the hypothesis for your model of care, including the frequency, setting and length of interventions?

A priority for the next phase of work is broader engagement on the development of the model of care to test and refine the initial hypotheses with a broader range of stakeholders than has been possible in the time so far

**HYPOTHESIS: At every interaction with a patient the following question should be asked**

“What Medical, Community, Social or Voluntary Care Provision needs to be provided to keep this patient safely at home?”

Our lay members have told us the current system is fragmented and there is a need for a centralised, coordinated, new system.

In response to this, an initial model is emerging which would establish a single provider model in West London. This could be a ‘West London Healthcare Organisation’, managed by a Senior Management Team which would oversee health and social care provision for all older people in West London.

The **Senior Management Team** would include the following members:

- Chief Executive
- Chief Operating Officer (who is responsible for the operations of the central co-ordination team and the hubs)
- Chief Medical Officer (who is responsible for the quality of health and social care)
- Chief Financial Officer (who is responsible for budgets, spend and performance and monitoring)
The Senior Management Team would be responsible for the safe and effective delivery of health and social care to all older people within the capitated budget for this group. This management team would be supported by an assistant and analysts. This team would monitor performance against the desired outcomes for this population group. These outcomes will be determined in close consultation/co-production with patients, carers and community organisation representatives.

Directly accountable to this Senior Management Team would be the Central Coordination Team which is the group responsible for overseeing the whole organisation on a day to day basis. This Central Coordination Team will be accessed through use of a single number (e.g., 111) as the single point of access. This will provide patients and carers with a simple, consistent, safe and responsive method of access which covers all of West London.

It would have daily activity data, a central register of all at risk patients, and would ensure that all these patients were monitored consistently. The team would co-ordinate all clinical and social care and all Providers would be accountable to them.

The need for a single point of access through a Central Coordination Team arose during a Whole Systems stakeholder workshop (see right).

Their principal role would be to ensure high quality provision of health and social care in the community, avoidance of unnecessary admissions and early safe discharge of patients from hospital. It oversees and performance manages the Clinical, Community and Social Care Teams. It will be recognised as a robust and trusted single point of access, as “999” is today. As such, requirements for this team include the following:

- Staffed 24/7 with GP input 24 / 7
- Representatives from all sectors including social care, mental health, pharmacy, community nursing, voluntary sector, etc.
- Responsive and have accountability and authority to delegate
- Highly skilled and experienced team that can assess and triage
- Are able to work closely with acute providers including to plan discharge
- IT / information system with up-to-date care plan and medical and social care records
- Ability to book appointments and mobile transport
- Trained together and with input from patients and carers

This team will advise the LAS as needed and contact the caller’s / user’s named GP. The acute providers should contact this team when patients arrive in A&E.
Callers will include carers, users and professionals. Emerging thinking is that care for older people in West London will be delivered through two **North and South Integrated Hubs**. These hub response teams would deliver the care based on what the Central Coordination Team delegates to them. They work with the individual’s GP and home carers, who sit in the GP practices, and the wider multi-disciplinary team to deliver the right interventions at the right time and in the right setting.

They will primarily focus on patients when they become less stable or as a place where older people can have their care plan reviewed on a regular basis by the integrated team. Hub Teams will be co-located and fully integrated, including dementia specialists, voluntary sector and intermediate care services with access to housing and benefits advice. In addition when a patient is having a crisis there will be rapid access clinics for older people. Here teams will have access to basic diagnostics such as X-ray and blood tests and will be able to mobilise rapid response services in the home as needed.

In addition to the two Integrated Hubs each patient will have a named GP and a named care coordinator. In this new model it is anticipated that not all GP practices will care for people of all ages as is the case today; potentially 10 practices across West London will care for this cohort of elderly patients over 75 years old and the GPs in these practices will each act as the named GP for a specific patient list. These GP Hubs could focus on fit and well older people as well as those with LTCs but who are stable. **Older People GP Hubs** could act as part of a GP Network. The following diagram describes the structure of the emerging model.

---

**Organisational structure for West London Healthcare Organisation**

- **Senior management team**
  - Single point of accountability
  - Covers entire population group (>75s)
  - Financial management
  - Clinical advisory and operational oversight
  - Monitoring and performance

- **Central Co-ordination Team**
  - 24/7 Responsive, highly experienced care team for all health and social care queries
  - Booking appointments, dispatching transport
  - Determines appropriate response and delegates to delivery teams
  - Representation from acute, primary, community, mental health and social care

- **GP Practice Hub**
  - Named GP
  - Care coordinator
  - Manages patients when they are stable
  - Manages patients who are over 75 and well

- **North Integrated Health and Social Care Hub**
  - Integrated health and social care delivery teams (two hubs) with access to diagnostics
  - Manages patients when they need care stepping up or for regular review of care plan with named GP
  - Medically led
  - Frontline provider staff including primary care, social care, mental health, voluntary sector, community health services
  - Linked to specific GP practices (approx. 10) where GPs have named elderly patients

- **South Integrated Health and Social Care Hub**
  - Integrated health and social care delivery teams (two hubs) with access to diagnostics
  - Manages patients when they need care stepping up or for regular review of care plan with named GP
  - Medically led
  - Frontline provider staff including primary care, social care, mental health, voluntary sector, community health services
  - Linked to specific GP practices (approx. 10) where GPs have named elderly patients
An additional consideration for the system is step-down and step-up beds, potentially at St Charles Hospital. This will be key for enabling the vision for timely and supported discharge to keep people in their preferred environment and out of hospital where this is not needed, and timely enhanced care when needed to ensure only appropriate admissions occur.

We continue to amass knowledge about whole systems models in existence within the UK and internationally. This will provide us with underpinning evidence for our emerging model. The Staffordshire ‘Primecare-led model’, the Waltham Forest ‘Single Point of Discharge, Single Point of Access model’ and the US ‘Chenmed model’ are among those we are investigating.

The following two diagrams illustrate the emerging Whole Systems Model for the over 75s, along with the Long Term Conditions Health Continuum, to illustrate potential care responses and care delivery mechanisms:
Emerging model of care for each of the elderly people sub-groups

Design and development of the model of care is still underway and this will be a key focus of the next phase. The emerging hypothesis for the model of care is described below and is set out for each of the three sub-groups we are focusing on.

People over 75 who are well

These patients are managed by a named GP at GP Hub level. An annual care plan which seeks to maintain their physical and social health with personal goals will be maintained.

Our model will seek to encourage self-management of care through direct and peer to peer education. Typical services (e.g. falls and continence) will continue and we will be looking to expand the range of services available to facilitate the provision of care closer to home. Voluntary sector organisations will play a significant part in ensuring that people are connected with their contemporaries and roadshows and events organised to raise people's awareness and promote the use of social amenities and facilities (e.g. exercise programmes for over 75s, cultural outings, gym classes). Older peoples' groups will be run in order to minimise their isolation within the community.

People over 75 with LTCs

This cohort of people is supported by the multi-disciplinary team of workers in the Hubs to manage their conditions and prevent deterioration and exacerbation. There is a strong emphasis on planned care and prevention, trying to avoid ‘cliff-edges’ wherever possible. As such, carers, the voluntary sector and ‘community capital’ are at the heart of this model.

Known older people with LTCs have care plans which they develop in partnership with their GP or community nurse and their carers. This includes suggested interventions to keep the user well and healthy. It also contains information about triggers and warning signs, and how to respond in the case these appear. The carer, as the person who sees the individual most regularly, is most likely to notice changes first.
This group contacts the system through the Central Coordination Team when issues arise. Each older person has a named GP.

**Example model of care for a patient with COPD**

<table>
<thead>
<tr>
<th>Social care and voluntary sector</th>
<th>Patient</th>
<th>Health sector</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review and reduce social care input, re-engage voluntary sector</td>
<td>Expert home visit reassess health and social care need</td>
<td>Stabilise home care interventions medications, education etc.</td>
</tr>
<tr>
<td>Increase in peer and social care support for duration of acute episode</td>
<td>Daily or more frequently review</td>
<td>Adjust medications, O2 refer to specialist/acute assessment centre etc.</td>
</tr>
<tr>
<td>Home care, support for carers, social activities, adaptation to trajectory of LTC</td>
<td>Home visit by expert clinician</td>
<td>Contact named clinician/team known to patient</td>
</tr>
<tr>
<td></td>
<td>Exacerbation/acute episode</td>
<td>Equipment, telehealth, education about medications, acute episodes, titrating medications, health promotion, adaptation to trajectory of LTC</td>
</tr>
<tr>
<td></td>
<td>Preventative intervention strategies</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Expert home visit: integrated health and social care assessment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospital discharge</td>
<td></td>
</tr>
</tbody>
</table>

**Source**: Prof. Susan Procter, Buckinghamshire New University

**Previously healthy people over 75 at risk of developing LTCs**

This cohort is typically at risk post their initial acute episode, when they are likely to be vulnerable and frightened. After such an episode, the model of care covers two phases: (1) post-discharge support and (2) ongoing support and prevention.

1. **6-week post discharge support**

   - Named contact person: responsible for assessing patient at home on day of discharge and determining whether they are at low, medium or high risk. High risk patients will have a minimum of a weekly visit. This person will be the key link for provision of all health and social care for this patient. They will liaise daily with the local Hub.
   - Multi-disciplinary team on a single contact number that oversees co-ordination of discharge, assesses ongoing medical and social needs and accesses and delivers the required support 8am – 10pm, 7 days a week.
   - Co-ordination needs to be through one team that follows the patient from admission to acute into community setting (rotational posts from acute and community would support communications and required breadth of knowledge).
   - Co-ordinator to determine whether immediate voluntary sector support is required to ensure home environment is suitable at time of discharge (i.e. food, heating, company), environmental risk factors (LA services).
• Specialist (relevant consultant) to provide verbal ‘handover’ to GP within 48 hours.
• GP to proactively contact patient within 48 hours post discharge to arrange a home visit within first three days.
• Pharmacist provides medicines reconciliation prior to GP visit so that errors are picked up.
• Scheduled session with pharmacist (over phone or in person) within 5 days of discharge.
• Patient held ‘blue book’ record (as per health visitor ‘red book’ – could be electronic for those patients who are familiar with IT) which addresses issues wider than medical care and social care services, but focuses on how patient/person likes to be treated/how their needs as unique individuals should be addressed.

2. Ongoing support and proactive care
• Hub team determines most suitable team member to be ongoing contact.
• Contact frequency will be determined by risk of patient. High risk patients will have weekly contact. Minimum of 3 monthly proactive contact for low risk patients from designated team member.
• Pharmacy register of over 75s set up to enable medicines reviews and audits.
• Use of telehealth/telecare to enable ongoing self-management.
• Voluntary sector support assessed and implemented to include:
  - Befriending
  - Transport
  - Wellbeing services
  - Interaction with faith and community groups/opportunities for participation and involvement
• Care team should have access to specialist input either by phone or via an older people’s rapid assessment ‘hot clinic’.
• Potentially GP led beds for step up/step down (although these would need to be very closely driven by protocols to prevent shifting bottle necks)
People over 75 who need access to urgent / emergency care

There are three main touch points for the model of care for this sub-group including first response, arrival at A&E and then at the time of admission.

1. First response

First response when something happens should include input from the named GP but could be through highly skilled home carers who access the Rapid Response Service. The London Ambulance Service (LAS) will contact the Hub Team who will contact the relevant GP. Ideally the carer would be the first on the scene, and are located in GP surgeries. Carers should report back to the GP and have access to a “GP hotline for carers” to ensure their call can be responded to.

In the case of a 999 call, the LAS needs to be able to recognise when West London older patients access the emergency care system and consult the GP directly as soon as the call comes in. GPs need to agree to take urgent calls when they come through. The LAS should also be able to refer directly to the Rapid Response Service to avoid unnecessary A&E attendances.

The diagram below was developed during the model of care session and shows how the care plan should be used to ensure the appropriate response in the case where the urgent and emergency care pathway is accessed via 999.
2. A&E attendance

When the patient arrives at A&E, the hospital needs to be able to access the patient’s full history including recent assessment or episodes in other hospitals. They need to speak to the patient’s named GP (or another GP in the network if between 8am – 5pm or a dedicated out of hours service outside that window) to obtain the relevant context and information. GPs are usually best placed to make a medical assessment of their patients and so need to be well integrated into this process. The Patient Passport which contains holistic information, preferences, how to ensure effective communication, etc. will also be reviewed.

Senior health professionals should also be involved as soon as possible in the process as junior doctors are less able to make the right call in a timely manner.

These elements are critical for reducing duplicate and unnecessary assessment, and ensuring providers do not start at the beginning every time. This will help ensure only appropriate admission and those who do not need admission can be easily dealt with within the 4 hour time limit.

3. Admission to hospital and planned coordinated discharge

When patients are admitted, robust discharge processes need to be in place as early as possible to ensure unnecessary length of stay can be avoided. Early notification is needed and patients need the right social care and other support, clear information and interventions identified and delivered in a timely manner to ensure they can be safely discharged.

The GP needs to be advised of any important changes e.g. medication changes, before the patient is discharged. This is critical for avoiding readmission.

7C. How do you intend to make full use of social care, self-care, and community capital in your model of care?
Older people, their carers and community capital will play an important central role for older people especially with regards to management of long term conditions, staying fit and healthy, and preventing isolation.

The individual and their carers should be supported and trained on self-management of conditions by the patient’s named care professional (usually a nurse). They should clearly understand warning signs / triggers and know how to respond. They are empowered to call for help when it is needed, and can do this via the Central Coordination Team, for which there is a single number, or their named care coordinator. Users and carers are provided with accurate and unambiguous information on their conditions and other services available to them to help them stay fit, alert and well. Better support and education for patients and carers will minimise hospital attendances and reduce avoidable escalations.

We envisage social care management as part of, or linked into, the Central Coordination Team, and social care services, such as Home Care and Meals on Wheels, will be part of the care team around the patient. In some cases, social care staff may be the most appropriate person to undertake care coordination.

The voluntary sectors plays a key role in providing a range of services, including those based on peer support models, as well as support to combat isolation to older people. Individuals and carers are encouraged to use suitable services locally that fit with their goals and preferences and volunteers, including older volunteers are used extensively within the sector. Building trusting and consistent relationships will be key.

7D. How will your model of care incorporate individual care plans, multi-disciplinary teams and care coordination?

Personalised Care plans
Each older person would have one, single, care plan that is tailored to the individual and which they, the professionals who care for them, and their carer and family can access. It will be drawn up by the patient and their carer/family. It should be co-produced between patient and care-coordinator and focussed on the patient as a whole person. The plan is essentially a health and social wellbeing plan and contains information about what patients will do for themselves, how professionals will support them, and what to do in a crisis. It should highlight trigger/warning signs with a clear plan for how users and carers should respond in the case of a trigger. It must be far broader than doctor-generated information alone and should include all medical and social care information, as well as the older person’s goals and preferences. It also includes pharmacy input such as medication reviews and repeat prescription information.

There will likely be an emphasis on social care and voluntary sector i.e. home care, escorting service, transport, befriending etc., social and community involvement, especially for people who have been discharged after an acute episode. For these people it should focus on the plan for transition from intense support to living independently.
The care plan should be written in non-clinical language for the parts that the carer and older person will use and access. It should be legible and accessible to the older person and their carers/family i.e. large font, native language, easy-read where appropriate. The care planning process should be transparent, with consent for accessing relevant parts of the care plan sought from the person/patient.

The care plan will be reviewed annually as a minimum for older people, but more frequently as appropriate, and always after any touch point with the acute setting. Those older people who have deteriorating conditions, those who are at risk of developing LTCs and those who require urgent and emergency care will likely need more frequent reviews.

The care plan could build on the Co-ordinate My Care model for end of life care, and would need to link to SystmOne.

**Multi-disciplinary Teams**
The North and South Integrated Health and Social Care Hubs will be multi-disciplinary teams that work closely together to deliver seamless care to the named patients they care for. These teams would ideally be co-located at Hubs, such as St Charles Hospital. At the Hub, they would have access to basic diagnostics such as X-ray and blood tests and be able to access Rapid Response Services.

For older people, the team would include the individual themselves, their named GP who offers longer appointments, the carer, community nurses, social workers, pharmacists, mental health workers, dementia nurses, the voluntary sector, the out of hours service and rapid response nurses. The wider multi-disciplinary team for each patient could include neighbours, friends, community or peer support (e.g. diabetes group). The voluntary sector plays an important role in providing a “non-medical” carer role.

A care coordination function will be embedded into each of these teams.

**Care coordination**
Every aspect of the care of patients with one or more long term conditions needs to be evaluated to ensure that each user receives the right care at the right time, and the total pool of resources can be used most effectively and efficiently. To achieve this, care coordination is essential.

A central clinical coordinator needs to be allocated to each patient who will co-design a care plan with that patient and their carer/family. The coordinator will review the plan regularly, as much as weekly for the most complex patients with the most complex needs, such as those requiring urgent or emergency care, or those whose condition is deteriorating, such as those nearing end of life. Providers will be expected to respond and follow the recommendations of the coordinator.
Enablers

Key enablers for this model of care include IT and systems to enable information sharing across settings of health and social care and between healthcare, social care and the voluntary sector. The workforce using the system must have the ability to efficiently and effectively access an older person’s contact details and named people involved in their care. It must also take into consideration individuals’ permission to share their information as needed.

Other enablers include the use of improved technology e.g. telecare and telehealth, which when used appropriately can support self-care and self-management for many older people in their own homes.

A&E attendance

When the patient arrives at A&E, the hospital needs to be able to access the patient’s full history including recent assessment or episodes in other hospitals. They need to speak to the patient’s named GP (or another GP in the network if between 8am – 5pm or a dedicated out of hours service outside that window) to obtain the relevant context and information. GPs are usually best placed to make a medical assessment of their patients and so need to be well integrated into this process.

Senior health professionals should also be involved as soon as possible in the process as junior doctors are less able to make the right call in a timely manner.

These elements are critical for reducing duplicate and unnecessary assessment, and ensuring providers do not start at the beginning every time. This will help prevent unnecessary admission to hospital as the patients’ needs can be easily met within the 4 hour time limit.

Admission to hospital and planned coordinated discharge

When patients are admitted, robust discharge processes need to be in place to ensure unnecessary length of stay can be avoided. Early notification is needed and patients need the right social care and other support and interventions identified and delivered in a timely manner to ensure they can be safely discharged.

The GP needs to be advised of any important changes e.g., medication changes, before the patient is discharged. This is critical for avoiding readmission.

Next Steps

The model of care is has emerged with input from users and frontline staff. The next phase of the process will be to focus on building this up in more detail through co-production. Some key questions that need addressing include:
Challenges / Risks

1. Building patient confidence to use the care co-ordination centre instead of 999.
2. Getting acute expertise out to patients without disrupting hospitals.
3. How to assure providers’ statutory responsibilities whilst delegating delivery to a new organisation e.g. social care.
4. Changing attitudes, behaviours and mindsets - changing organisational structures, pooling budgets and co-locating are not enough on their own.

- How do we best leverage care planning, patient and public engagement, developing a responsive and reliable service to provide a credible and preferred alternative to “999”?
- How will we build older people’s and their carers’ confidence in the emerging model, particularly in instances where carers and older people view “999” as the only immediate crisis response?
- What is the Central Coordination Team’s role in managing and planning beds capacity, e.g., step down?
- What diagnostics are provided in the hub versus the hospital?
- Could hubs be at the hospital?
- Do we want specific practices focused on elderly people? What is the ideal number and location?
- Do patients move GP practice or just access the named GP when needing step up care. If the patient is required to move practice, will their carers (if at the same current practice) also need to move with them?
- What do we need to provide in terms of transport and information to make this work?
- Are residential care homes within scope and if so how do these fit into the model of care?
- How do we fully leverage environmental health especially to support post discharge?
- Can NHS 111 be developed to become the Central Co-ordination Team, or will these be two different things which redirect to each other, for example? If they are separate, how do we manage the complexity of an additional number for the Central Co-ordination Team?
- How will we ensure there is patient choice?
- How does palliative, end of life care and Coordinate My Care fit into the model?
- What does success look like and how do we measure it?
- How do we ensure a team is known to the individual in order to provide continuity of care and a steady and calm service?
- Do we need a Directory of Services? If so how do we implement this?
7E. How does your model of care compare in terms of affordability against the capitated budget envelope?

The model described previously is subject to further scrutiny, consultation and requires costing. Financial modelling will need to demonstrate a version of a model of care which is affordable and sustainable. However because the new model looks at the whole system, we know that better integrated care will benefit the whole system in the following ways:

- Reduction in non-elective admissions
- Reduction in number of hospital spells
- Increased provision by third sector
- Better coordination
- More efficient use of resources
- Cost of single management team
- Support older people to keep well for longer
GP networks

NHS West London CCG recognises the need for Primary Care to be at the centre of the new care system and has therefore asked London Medical Associates (LMA) – a network of GPs in West London – to lead on this early adopter project. LMA recognises that if the new systems of care are to be led by primary care, GP networks need to be developed so that they are capable of holding contracts of various forms and so that they are of a scale and configuration that is suited to its locality.
8A. Which GP Practices will participate in the early adopter partnership?

LMA is a GP provider organisation and will act as the umbrella organisation for its member practices who are involved in whole systems. It is currently providing leadership to support development of the Whole Systems Plan. 44 LMA practices and seven independent ‘non-LMA’ practices are interested in participating the being an early adopter.

Part of the emerging model of care includes Primary Care practices operating as Primary Care Hubs with a number (perhaps 10) of practices specialising in Older People. These Older People GP Hubs would operate as part of a network and could potentially look after all the people aged over 75 in that network. This model has yet to be agreed and needs further work and consultation. However, there is a clear drive for Primary Care to form as networks as can be seen by the ‘Prime Minister’s Challenge Fund’ (PM Challenge Fund) and the recent Locally Commissioned Service Specifications that require practices to work as Networks.

In order to develop operational GP Networks the CCG is supporting all its practices with a programme of organisational development which is in addition to the PM Challenge Fund programme. The organisational development support will take practices through a process so they are set up as Primary Care Networks and are able to hold contracts.

As Networks are developed the following needs to be considered: -

- Developed Networks must be entities that are capable of holding NHS contracts, as well as other forms of contract, including local authority contracts.
- In terms of size and configuration, the status quo will not deliver the required benefits and specifically:
  - Networks must be ‘geographically confluent’ in order to support the delivery of integrated services to local, registered populations, and
  - The number and size of networks in WLCCG should be locally determined and may be influenced by a range of factors depending on the specific network function being considered, e.g. seven-day working, diabetes care etc.

This support will need to encompass the CCG’s expectation of consistent messages and information sharing (i.e. the case for change), development for primary care staff (both clinical and non-clinical), and support to the Primary Care team in preparing practices for these discussions.

The support will take the form of externally-facilitated workshops; providing access to specialist advice e.g. legal frameworks; and investment in leadership capacity and capability.

**Challenges / Risks**

There are some notable challenges and risks with regards to GP networks, which we will need to manage and develop over the next phase. These are as follows:
• Underperforming practices may struggle with additional workload
• Ensuring GP Buy in
• Financial and practical challenges of “switching” patients between GP practices (i.e., negotiating moving over 75s from surgeries to specific practices who will serve this population and moving patients from other population groups, e.g., healthy adults, into these surgeries for reciprocity)
• Fact that 40% of our practices are single-handed emphasises some the above challenges
• Need to fully understand actual spend on the elderly population group locally to make the model work in practice
• Delivery will require pump priming
Provider Networks

The requirements of the provider network are evolving as we develop the model(s) of care for our chosen population groups. At this stage, a preliminary group of providers have been identified. Going forward, we will be running a work stream dedicated to the development of this network and the governance that will apply.
9A. Which providers will participate in the early adopter partnership?

Preliminary discussions around the membership of the provider networks have been held at previous working sessions and Steering Committee meetings. The provisional members are as follows:

<table>
<thead>
<tr>
<th>Provider</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health &amp; Wellbeing Boards</td>
<td>Integration Facilitator and Clinical Services Provider</td>
</tr>
<tr>
<td>Central North West London NHS Foundation Trust</td>
<td>Community &amp; Mental Health Provider</td>
</tr>
<tr>
<td>Adult Social Care (Tri-Borough)</td>
<td>Social Care Provider</td>
</tr>
<tr>
<td>Chelsea and Westminster NHS Foundation Trust</td>
<td>Acute Provider</td>
</tr>
<tr>
<td>Imperial Healthcare Trust</td>
<td>Acute Provider</td>
</tr>
<tr>
<td>Central London Community Health Care Trust</td>
<td>Community Provider</td>
</tr>
<tr>
<td>Kensington &amp; Chelsea Social Council</td>
<td>Voluntary Sector</td>
</tr>
<tr>
<td>London Ambulance Service</td>
<td>Emergency Services Provider</td>
</tr>
<tr>
<td>London Central &amp; West Unscheduled Care Collaborative</td>
<td>111 and GP Out of Hours / Urgent Care Provider</td>
</tr>
<tr>
<td>Westminster Voluntary Action</td>
<td>Voluntary Sector</td>
</tr>
<tr>
<td>Age UK (Kensington &amp; Chelsea)</td>
<td>Voluntary Sector</td>
</tr>
</tbody>
</table>

Membership of the provider networks will evolve as the development of the Full Whole Systems Plan defines how many different provider organisations will be involved.

The configurations of the provider networks will also evolve as the Full Whole Systems Plan develops and will likely evolve after the implementation of the plan has started. We plan to discuss the configuration, roles and responsibilities of the provider networks in future working sessions, Steering Committee meetings and individual meetings with providers.

Policies and processes for governance and performance measurement will start to be defined after the membership and configuration of the provider networks have initially been agreed. As with the configurations of the networks, the methods of governance of performance evaluation will be reviewed, updated and communicated regularly and as required over the development of the Full Whole Systems Plan.

A dedicated work stream focusing on the development of provider networks has been established as a key element of the project implementation plan (see Chapter 11).
Challenges / Risks

Some of the risks associated with the development of provider networks have been identified at this stage as follows:

- Several acute providers currently redesigning pathways independently but these will need to reflect and enable the new models of care
- Need for providers in all settings to take more responsibility for the services delivered
Information and Informatics

Arrangements for sharing information between our partnership organisations are starting to take shape: a governance framework for information sharing has now been validated by the HSCIC and we are starting to hold discussions with our partners around how and what information needs to be shared and used. This is a key enabler to developing a full whole systems plan as gathering and analysing information will be key to optimising the model(s) of care.
10A. How will you use the data collected in the data warehouse to support more detailed analytics and planning after May 2014?

Good intelligence is critical to enabling and delivering Whole Systems Integrated Care. This will require robust provider and reference data to compile good quality analytics. The planned delivery timeline is June to October / November 2014 for this capability. During this phase the data will modelled and validated, tools developed and shared, and finally amendments made. The programme team’s aim is to start to on-board early adopters in October / November 2014 once local stakeholders have signed the agreement.

We acknowledge that the delivery of the type of analytics support described above is contingent on the support of our partner organisations to provide data and that this needs to be done appropriately and securely. For example, we recognise that social care data will not be automatically gathered by the NHS data warehouse and that alternative arrangements - both technical and information governance - will need to be put in place around data sharing between health and social care and independent providers. The programme team, with legal support, has developed a robust information governance framework that has been validated by the Health & Social Care Information Centre (HSCIC) for information sharing. Through the early adopters process the programme team will provide us with further information on the data required and establishing the process for our partners to share information. Our partners will prepare our relevant stakeholders, information governance leads and business intelligence teams as needed to support this process.

Once we have access to the full dataset, we will develop population demographics dashboards, analytics tools and performance measurement tools using the data from the data warehouse, enabling providers to realise better outcomes for patients. The data warehouse will aggregate data from the various existing information systems from primary, acute, community and social care as well as mental health and the voluntary and third sector.

This data will be specifically be used to:

- Determine population needs and trends and service-users that would most benefit from integrated care
- Develop capitated framework to plan, mobilise, monitor and manage health and social care integrated delivery
- Support continual improvement in delivery and outcomes integrated care through regular reviews and evaluation
- Share information between professionals to improve delivery of care to service-users
- Engage patients and carers in providing feedback and evaluation

10B. How do you plan to share data between providers in your network to support cooperation at a day-to-day and strategic level?

See 10A. Governance on how we will share data will be developed as more information regarding the aggregation and use of data is determined.
Planning, communication and sharing learning

We recognise that all organisations involved in the new ‘whole system’ will need to develop new skills in order to manage their evolution and operation. As such we plan to run a dedicated work stream to support our partner organisations with their development. The statements of commitment from our partners give us confidence that moving forward we will learn from each other and evolve collaboratively and strategically.
11A. How have commissioning/provider leadership expressed support for Whole Systems development?

Statements of Commitment have been provided by senior representation from each of our key partnership organisations (see Appendix A). These Statements of Commitment confirm:

- that these organisations have actively involved themselves in the co-production process in West London to develop an emerging model of care for patients who are over the age of 75.
- that these organisations are committed to actively engaging and involving our frontline staff
- that these organisations will move forward collaboratively to further develop this model into a Full Whole Systems Plan.

11B. How will you make decisions together, as commissioners and as providers in the next phase as underpinned by your statement of commitment? What are your governance processes? How are people who use services and front-line staff involved?

The Whole Systems Steering Committee will be the key decision-making vehicle and it has provided oversight to the process thus far. The Steering Committee described above is chaired by a Lay Member and is a provider, commissioners and user represented group with 4 lay people included as members and representation from the third sector.

11C. What is your Organisational Development plan including:

- Cultural change
- Shared leadership
- Workforce development
- Estate and resource planning
- Supporting investments

Organisational Development (OD) is a key work stream of our programme going forward and a detailed OD Plan will be a key priority for completion in June 2014. We plan to utilise our well established Network Learning Forums (NLFs) to support the development of an OD Plan for Whole Systems. NLFs are well attended by health and social care colleagues including acute specialists, voluntary sector and primary care. Over 80% of GPs attend on a regular basis. The CCG supports in the agenda planning process and integrated care is a key learning need which has been highlighted. Going forward the agendas for NLFs will be developed collaboratively the WS OD lead and the two CCG Governing Body Leads who currently set the agenda and plan the events.
11D. What is your programme plan to develop a full Whole Systems Plan after the May checkpoint?

The WS Steering Committee will steer the development of the full WS Plan and act as a programme board providing oversight and ensuring delivery of an implementation plan. 10 key work streams have been identified and multi professional leads have agreed to multi provider leadership across the work streams.

A PMO style approach will be adopted and a priority for June 2014 will be ensuing that each work stream has key milestones agreed to ensure West London is ready to go live in April 2015.

<table>
<thead>
<tr>
<th>Work streams</th>
<th>Engagement and Communication Work stream</th>
<th>Finance and Activity</th>
<th>Organisational and MDT Development</th>
<th>Operational Policy</th>
<th>Transitions of Care</th>
<th>Informatics</th>
<th>Provider Network, Governance and Legal</th>
<th>Model of Care (inc. dementia)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jun-14</td>
<td>1. Lay Workshop 2. ‘All GP’ Working Lunch Agree patient consultation process</td>
<td>Agreement on Capitation Budget</td>
<td>Desk top review of collaborative OD initiatives Draft OD Plan</td>
<td>Mapping exercise to show bottle necks current issues</td>
<td>Map out current as is position</td>
<td>WSIC Working Session</td>
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<tr>
<td>Aug-14</td>
<td>WSIC Working Sessions</td>
<td>Integrated Activity &amp; Finance data obtained</td>
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<th>Work streams</th>
<th>Engagement and Communication Work stream</th>
<th>Finance and Activity</th>
<th>Organisational and MDT Development</th>
<th>Operational Policy</th>
<th>Transitions of Care</th>
<th>Informatics</th>
<th>Provider Network, Governance and Legal</th>
<th>Model of Care</th>
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<tr>
<td><strong>Oct-14</strong></td>
<td>1. Bimonthly Lay Session 2. Bimonthly GP Session 3. WSIC Working Sessions</td>
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<td>Data Warehouse - Full Data Set Available</td>
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<tr>
<td><strong>Nov-14</strong></td>
<td>WSIC Working Sessions</td>
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<td></td>
<td>GP Networks In Operational</td>
<td>ONGOING</td>
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<tr>
<td><strong>Jan-15</strong></td>
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<tr>
<td>Work streams</td>
<td>Engagement and Communication Work stream</td>
<td>Finance and Activity</td>
<td>Organisational and MDT Development</td>
<td>Operational Policy</td>
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<td>Informatics</td>
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<td>Feb-15</td>
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<td>ONGOING</td>
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<td>Mar-15</td>
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<td>Model of Care Finalised</td>
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<td>Apr-15</td>
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<td></td>
<td>WSIC GOES 'LIVE'</td>
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Appendices

A. Statements of Commitment
B. Terms of Reference
Appendix A – Statements of Commitment

1. Central London Community Healthcare NHS Trust - Statement of Commitment

<table>
<thead>
<tr>
<th>Confirmation of involvement to date with co-production and intention to continue in the development of the Whole Systems Integrated Care Plan for West London</th>
<th>Central London Community Healthcare NHS Trust have been actively involved with the Whole Systems co-production process in West London to develop an emerging model of care for people who are over 75. This has facilitated the production of an Outline Whole Systems Plan. We are committed to actively engaging and involving our frontline staff and to moving forward collaboratively to further develop this model into a Full Whole Systems Plan. We are keen to be active participants in the next stages of this process.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any personal statement you wish to provide to support the Outline Plan and presentation to panel on 11 June</td>
<td>Our trust has been a keen contributor to initiatives in our sector to promote more integrated care to improve patient safety and outcomes and to realise productivity and efficiency gains making it easier for professionals to do the right thing for their patients. Therefore we welcome this opportunity to build multi-disciplinary and multiagency working around this cohort of patients.</td>
</tr>
<tr>
<td>Confirmation of strategic initiatives which align with Whole Systems in West London</td>
<td>This endeavour will make a substantial contribution to the out of hospital component of the Shaping a Healthier Future Programme and to delivering the Better Care Fund with our local authority partners.</td>
</tr>
</tbody>
</table>
Appendix A – Statements of Commitment

### 2. Holland Park Surgery – Statement of Commitment

<table>
<thead>
<tr>
<th>Confirmation of involvement to date with co-production and intention to continue in the development of the Whole Systems Integrated Care Plan for West London</th>
<th>Dr Richard Hooker (GP Holland Park Surgery London W11 and Governing Body Member West London CCG) has been actively involved with the Whole Systems co-production process in West London to develop an emerging model of care for people who are over 75. This has facilitated the production of an Outline Whole Systems Plan. We are committed to actively engaging and involving our frontline staff and to moving forward collaboratively to further develop this model into a Full Whole Systems Plan. We are keen to be active participants in the next stages of this process.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any personal statement you wish to provide to support the Outline Plan and presentation to panel on 11 June</td>
<td>I am absolutely committed to supporting the WSIC. I can also state this on behalf of the team at Holland Park Surgery. Clearly the WLCCG Governing Body is firmly behind the initiative. One sign of the CCG’s commitment is the active support that the CCG has given me to contribute to the development of the project.</td>
</tr>
<tr>
<td>Confirmation of strategic initiatives which align with Whole Systems in West London</td>
<td>At a personal level I am collaborating with a multidisciplinary team to refine a Care Plan Strategy for the CCG.</td>
</tr>
<tr>
<td></td>
<td>I am working with IT leads from all NW London CCGs to develop a co-ordinated IT strategy.</td>
</tr>
<tr>
<td></td>
<td>I am supporting a network level project to look at solutions for addressing care planning, WSIC, the Prime Minister’s Challenge Fund and the role of networked IT.</td>
</tr>
<tr>
<td></td>
<td>I am involved in a project to develop the role of carers within the WSIC framework.</td>
</tr>
</tbody>
</table>
## Appendix A – Statements of Commitment

3. London Central and West Unscheduled Care Collaborative – Statement of Commitment

<table>
<thead>
<tr>
<th>Confirmation of involvement to date with co-production and intention to continue in the development of the Whole Systems Integrated Care Plan for West London</th>
<th><strong>London Central and West Unscheduled Care Collaborative</strong> have been actively involved with the Whole Systems co-production process in West London to develop an emerging model of care for people who are over 75. This has facilitated the production of an Outline Whole Systems Plan. We are committed to actively engaging and involving our frontline staff and to moving forward collaboratively to further develop this model into a Full Whole Systems Plan. We are keen to be active participants in the next stages of this process.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any personal statement you wish to provide to support the Outline Plan and presentation to panel on 11 June</td>
<td>London Central and West Unscheduled Care Collaborative welcome this approach to developing a whole systems integrated model of care. As the Out of Hours and 111 provider we see a range of opportunities to improve care for our patients and this approach provides a framework to develop new and innovative ways of working. Our Clinicians have welcomed the opportunity to be involved in this programme which places patients at the centre of care.</td>
</tr>
</tbody>
</table>
| Confirmation of strategic initiatives which align with Whole Systems in West London | **INWL 111 Pilot and Early GP intervention pilot** (commencing May 2014)  
**GP support to Rapid Response Nursing Team** (current, in hours) using a GP in hours model  
**Co-ordinate my Care**  
**Local health care professional single point of access 24/7**  
**Provision of data on frequent users of out of hours and the 11 data service and their care plan requirements such as update required or requirement to initiate a care plan.**  
**Specialist local pathways for out of hours, LAS, Community and Rapid Response Nursing, mental health teams, extended hours GP access.** |
## Appendix A – Statements of Commitment

### 4. Dr Rachael Garner - Statement of Commitment

<table>
<thead>
<tr>
<th>Confirmation of involvement to date with co-production and intention to continue in the development of the Whole Systems Integrated Care Plan for West London</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I, Dr Rachael Garner,</strong> have been actively involved with the Whole Systems co-production process in West London to develop an emerging model of care for people who are over 75. This has facilitated the production of an Outline Whole Systems Plan. I am committed to actively engaging and to moving forward collaboratively to further develop this model into a Full Whole Systems Plan. I am keen to be an active participant in the next stages of this process.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Any personal statement you wish to provide to support the Outline Plan and presentation to panel on 11 June</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whole Systems is the vehicle by which primary care will be transformed into a modern and efficient service with resources focused on those with the greatest need. As a GP Principal in the North of West London Clinical Commissioning Group (WLCCG), I am really motivated to represent my colleagues in primary care on the Whole Systems Steering Committee to build a great local model of integrated care which wraps care around the patient.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Confirmation of strategic initiatives which align with Whole Systems in West London</th>
</tr>
</thead>
<tbody>
<tr>
<td>DES Unplanned admissions</td>
</tr>
<tr>
<td>CLS Plan</td>
</tr>
<tr>
<td>PPF</td>
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<tr>
<td>OPRAC (Imperial)</td>
</tr>
</tbody>
</table>
## Appendix A – Statements of Commitment

### 5. Central and North West London NHS Foundation Trust – Statement of Commitment

<table>
<thead>
<tr>
<th>Confirmation of involvement to date with co-production and intention to continue in the development of the Whole Systems Integrated Care Plan for West London</th>
<th>Central and Northwest London Mental Health Foundation Trust have been actively involved with the Whole Systems co-production process in West London to develop an emerging model of care for people who are over 75. This has facilitated the production of an Outline Whole Systems Plan. We are committed to actively engaging and involving our frontline staff and to moving forward collaboratively to further develop this model into a Full Whole Systems Plan. We are keen to be active participants in the next stages of this process.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any personal statement you wish to provide to support the Outline Plan and presentation to panel on 11 June</td>
<td>CNWL supports and commits to the co-production process of Whole Systems in West London. The process faces the challenges of improving care for patients over 75 (in this case) and addresses the considerable financial challenge of the health economy faces. Co-production is very important too; it is a partnership of experts; front line staff bring expertise and knowledge to the exercise as do patient and carer views with those responsible for commissioning. This interaction, this partnership, is a good arena to work through the challenges to reach the ambition, realistically and on time. We are committed to the process and the project</td>
</tr>
<tr>
<td>Confirmation of strategic initiatives which align with Whole Systems in West London</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix A – Statements of Commitment

6. Age UK (Kensington & Chelsea) – Statement of Commitment

<table>
<thead>
<tr>
<th>Confirmation of involvement to date with co-production and intention to continue in the development of the Whole Systems Integrated Care Plan for West London</th>
<th><strong>Age UK (Kensington &amp; Chelsea) Kensington &amp; Chelsea</strong> have been actively involved with the Whole Systems co-production process in West London to develop an emerging model of care for people who are over 75. This has facilitated the production of an Outline Whole Systems Plan. We are committed to actively engaging and involving our frontline staff and to moving forward collaboratively to further develop this model into a Full Whole Systems Plan. We are keen to be active participants in the next stages of this process.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any personal statement you wish to provide to support the Outline Plan and presentation to panel on 11 June</td>
<td>Our experience on the ground as a long-established voluntary sector provider of services to older people enables us to see straightaway that this project will benefit the largest proportion of our service users. To work at its best, it will need the input of voluntary organisations such as Age UK (Kensington &amp; Chelsea) K&amp;C and we are ready and able to contribute to improve the health and well-being outcomes for over 75s. In the co-production workshops we attended, it was immediately obvious where our services and community initiatives could add value to the development of integrated care; both services that we already provide and those which would be a natural extension of our work. Our extensive experience of volunteer involvement (350+ volunteers in RBKC) will enhance the programme and engage local citizens in the objectives of integrated care.</td>
</tr>
<tr>
<td>Confirmation of strategic initiatives which align with Whole Systems in West London</td>
<td>Existing Age UK (Kensington &amp; Chelsea) Kensington &amp; Chelsea projects supporting the integrated work include: Primary Care Navigators, Food and Friends (addressing malnutrition in older people) Friends and Neighbours (addressing social isolation) Good Companions (engaging older people who have experienced depression) Safe at Home – home safety assessments to assess falls and linked to De cluttering Service; community based dementia services including support for cares. Dementia Strategy; Malnutrition strategy</td>
</tr>
</tbody>
</table>
## Appendix A – Statements of Commitment

### 7. Chelsea & Westminster Hospital NHS Foundation Trust – Statement of Commitment

<table>
<thead>
<tr>
<th>Confirmation of involvement to date with co-production and intention to continue in the development of the Whole Systems Integrated Care Plan for West London</th>
<th><strong>Chelsea &amp; Westminster Hospital NHS Foundation Trust</strong> have been actively involved with the Whole Systems co-production process in West London to develop an emerging model of care for people who are over 75. This has facilitated the production of an Outline Whole Systems Plan. We are committed to actively engaging and involving our frontline staff and to moving forward collaboratively to further develop this model into a Full Whole Systems Plan. We are keen to be active participants in the next stages of this process.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any personal statement you wish to provide to support the Outline Plan and presentation to panel on 11 June</td>
<td></td>
</tr>
<tr>
<td>Confirmation of strategic initiatives which align with Whole Systems in West London</td>
<td>‘Shaping a Healthier Future’</td>
</tr>
<tr>
<td></td>
<td>‘Boundary-less Patient Flow’ (year 2 of Emergency Care Programme)</td>
</tr>
<tr>
<td></td>
<td>Development of Ambulatory Care</td>
</tr>
<tr>
<td></td>
<td>Development of Accountable Care Group</td>
</tr>
</tbody>
</table>

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65
## Appendix A – Statements of Commitment

8. Healthwatch (Central West London) – Statement of Commitment

<table>
<thead>
<tr>
<th>Confirmation of involvement to date with co-production and intention to continue in the development of the Whole Systems Integrated Care Plan for West London</th>
<th><strong>Healthwatch Central West London</strong> has been actively involved with the Whole Systems co-production process in West London to develop an emerging model of care for people who are over 75. This has facilitated the production of an Outline Whole Systems Plan. We are committed to actively engaging and involving our frontline staff and to moving forward collaboratively to further develop this model into a Full Whole Systems Plan. We are keen to be active participants in the next stages of this process.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any personal statement you wish to provide to support the Outline Plan and presentation to panel on 11 June</td>
<td>Healthwatch Central West London is committed to working collaboratively to improve the patient experience of integrated care, admission to and transition from hospital. We intend to co-produce an integrated approach to the care of the population aged over 75 in the participating GP practices. Healthwatch Central West London will engage with patients through the current membership and project groups and through targeted outreach.</td>
</tr>
<tr>
<td>Confirmation of strategic initiatives which align with Whole Systems in West London</td>
<td></td>
</tr>
</tbody>
</table>
### Appendix A – Statements of Commitment


<table>
<thead>
<tr>
<th>Confirmation of involvement to date with co-production and intention to continue in the development of the Whole Systems Integrated Care Plan for West London</th>
<th><strong>Kensington and Chelsea Social Council</strong> have been actively involved with the Whole Systems co-production process in West London to develop an emerging model of care for people who are over 75. This has facilitated the production of an Outline Whole Systems Plan. We are committed to actively engaging and involving voluntary and community organisations to moving forward collaboratively to further develop this model into a Full Whole Systems Plan. We are keen to be active participants in the next stages of this process.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any personal statement you wish to provide to support the Outline Plan and presentation to panel on 11 June</td>
<td>We see our role as the local infrastructure organisation for the voluntary and community sector in Kensington and Chelsea to work with local partners to ensure that the voluntary and community sector agencies in all its diversity is integrated within whole systems model of care for over 75s. We will also work with our counterpart in Westminster (QPP) with the aim to reach as wide and diverse range of voluntary organisations as possible.</td>
</tr>
<tr>
<td>Confirmation of strategic initiatives which align with Whole Systems in West London</td>
<td>We deliver a yearly grants programme funded by WLCCG which could align some of its strategic outcomes to whole systems.</td>
</tr>
<tr>
<td></td>
<td><strong>KCSC aims to further develop its online voluntary sector directory</strong></td>
</tr>
<tr>
<td></td>
<td><strong>KCSC is funded through WLCCG to support the development of the integration of voluntary and community sector services within St Charles alongside clinical services. This work will continue throughout 2014/15</strong></td>
</tr>
</tbody>
</table>
# Appendix A – Statements of Commitment

## 10. Sonia Richardson (Patient Representative, West London CCG Governing Body) – Statement of Commitment

<table>
<thead>
<tr>
<th>Confirmation of involvement to date with co-production and intention to continue in the development of the Whole Systems Integrated Care Plan for West London</th>
<th>Sonia Richardson, Patient Representative on the West London CCG Board, has been actively involved with the Whole Systems co-production process in West London to develop an emerging model of care for people who are over 75. This has facilitated the production of an Outline Whole Systems Plan. We are committed to actively engaging and involving our frontline staff and to moving forward collaboratively to further develop this model into a Full Whole Systems Plan. We are keen to be active participants in the next stages of this process.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any personal statement you wish to provide to support the Outline Plan and presentation to panel on 11 June</td>
<td>My professional background involved managing social work services in local Acute Trusts and as a Local Authority Dementia specialist in Kensington and Chelsea. I am very committed to helping improve cohesive and person-centred ways of working with older people and ensuring services are aligned to their individual needs and aspirations. I am therefore enthusiastic about being part of this work.</td>
</tr>
<tr>
<td>Confirmation of strategic initiatives which align with Whole Systems in West London</td>
<td>Co-production between patients, carers and commissioning and provider organisations</td>
</tr>
<tr>
<td></td>
<td>Joint budgets which aim to ensure seamless and personalised ways of working and personalised service delivery</td>
</tr>
<tr>
<td></td>
<td>The patient/person (and carer) at the heart and centre of care</td>
</tr>
</tbody>
</table>
### Appendix A – Statements of Commitment

11. **Professor Susan Procter (Clinical Nursing Practice, Buckinghamshire New University) – Statement of Commitment**

<table>
<thead>
<tr>
<th>Confirmation of involvement to date with co-production and intention to continue in the development of the Whole Systems Integrated Care Plan for West London</th>
<th><strong>Professor Susan Procter</strong> has been actively involved with the Whole Systems co-production process in West London to develop an emerging model of care for people who are over 75. This has facilitated the production of an Outline Whole Systems Plan. She is committed to actively engaging and involving our frontline staff and to moving forward collaboratively to further develop this model into a Full Whole Systems Plan. She is keen to be an active participant in the next stages of this process.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any personal statement you wish to provide to support the Outline Plan and presentation to panel on 11 June</td>
<td>I have personal experience of researching and publishing on the patient experience of primary/secondary care transitions. As a result of this work I have developed and led a number of projects designed to provide a more integrated experience for patients working with a wide range of service providers across health and social care. I have evaluated the patient response to integrated care and identified and worked to address system challenges to integration. I am very pleased to have the opportunity to work on this whole system integrated care initiative as the scope and scale is large enough to make a significant impact on improving patient experience and outcomes. This is particularly enhanced the support of the LMA.</td>
</tr>
<tr>
<td>Confirmation of strategic initiatives which align with Whole Systems in West London</td>
<td>Scoping educational needs for practice nurses in NW London sponsored by the NHS North West London Collaboration of CCGs</td>
</tr>
</tbody>
</table>
APPENDIX B – Terms of Reference

Terms of Reference

Draft V0.11 (16 May 2014) Subject to approval by the Out of Hospital Committee

V11 (16 May 2014)

Background

The West London Whole System Steering Committee is a commissioner, patient and multi provider group. It is responsible for the development and completion of a Whole Systems Plan, which builds on the Expression of Interest submitted and led by London Medical Associates, on behalf of primary care, social care, mental health, community, acute and third sector providers in West London.

The proposals were discussed individually with the following stakeholders who agreed to sign up and develop these proposals.

- Central North West London Foundation Trust
- Adult Social Care (Tri Borough)
- Non LMA practices
- Chelsea and Westminster Foundation Trust
- Imperial Healthcare Trust representative
- Central London Community Health Care Trust
- Kensington & Chelsea Social Council
- London Ambulance Service
- Out of Hours (London Central & West Unscheduled Care Collaborative)

The Expression of Interest proposed taking full responsibility for the capitated budget for patients over 75 years of age and developing a multi-agency and multi-professional approach to providing the most effective care to this group of patients. This will need to be agreed and approved by providers and commissioners as part of the development of a Whole System Plan for West London.

Key interventions/programmes will build on the following:

- Putting Patients First (PPF) initiative – proactive multidisciplinary case management of complex frail elderly people over 75. All Stakeholders to develop this initiative to ensure that each participating Provider Organisation including GP Providers have financial incentives aligned to improvements in quality of patient care and performance.

- Emergency Admissions - older fit patients who after a hospital admission receive a new acute diagnosis such as an MI, CVA or cancer will be pro-actively case managed by an appropriate member of the MDT

- Urgent and Emergency Care Pathway – ensuring appropriate response for patients when they are in a crisis
1 Purpose and scope

1.1 The NHS West London CCG Whole System Steering Committee is a commissioner, patient and multi provider group.

1.2 The Steering Committee is responsible for the development and completion of a Whole Systems plan and will further develop the overall approach to Whole Systems in West London and which will build on the Expression of Interest submitted by London Medical Associates.

1.3 The aim of the Steering Committee is to agree a philosophy and a model of care - through co-production with key stakeholders across the West London health and care system, including patients, commissioners and providers, and to support the development of a key set of outcomes.

1.4 As part of the Business Case, a funding model will also need to be developed as will the operational detail of how providers will work together as part of a network.

1.5 In the first instance the Steering Committee will exist until the submission of the Whole Systems plan for approval in May. Following the approval the group may transition to a different form that supports the ongoing development and implementation of Whole Systems in West London.

1.6 Steering Committee Objective: to agree an Outline Business Plan (OBP) with all Providers by May 19th and a Full Business Plan (FBP) by Oct 2014.

2 Responsibilities

2.1 The Steering Committee will act with a view to developing and completing the Whole Systems plan to support delivery of West London CCG’s Out of Hospital Strategy. In support of this, its responsibilities are:

- To oversee the development of the Whole Systems plan and ensure alignment with the Whole Systems programme through use of the Whole Systems toolkit, including support in planning workshops at each key decision point.
- To maintain and embed co-production as a core principle of the Whole Systems approach.
- To develop a shared understanding of an innovative model of care to support delivery of key outcomes.
- To develop an organisational development plan which supports collaboration and strengthens partnerships.
- To galvanise providers so they are able to agree a model of care which supports delivery of a key set of outcomes.
- To develop a workforce plan.
- To develop transition process for a formal Provider Network.
- To ensure alignment with other relevant West London strategies and initiatives.
- To ensure regular communication and engagement with all stakeholders.
3 Chair

3.1 CCG Governing Body Lay Member

4 Membership and attendance

4.1 The membership of the Steering Committee will reflect the Whole Systems principle of co-production, including lay members, commissioners and providers. Members may be clinicians or members of management teams.

- West London CCG Lay member (Chair)
- Patient Representatives x 2 (including 1 from Healthwatch)
- London Medical Associates Director x 2
- Primary care provider representatives (1 x North and 1 x South)
- CCG senior responsible officer for Whole Systems
- Whole Systems Project Manager
- CCG Managing Director (or deputy)
- CCG Governing Body member (clinical lead for Whole Systems)
- Central North West London Foundation Trust representative
- Adult Social Care (Tri Borough) representative
- Chelsea and Westminster Foundation Trust representative
- Imperial Healthcare Trust representative
- Age UK (Kensington & Chelsea) representative
- Central London Community Health Care Trust representative
- Kensington & Chelsea Social Council representative
- London Ambulance Service representative
- London Central & West Unscheduled Care Collaborative CEO
- CCG Governing Body Practice Manager representative
- Strategy and Transformation Programme Support Team representative

4.2 While only members of the Steering Committee have the right to attend meetings, other individuals, including external advisers, may be invited to attend for all or part of any meeting as and when appropriate.

5 Quoracy

5.1 Six members, including the Chair (or deputy) including a minimum of four clinicians. Deputies may attend in exceptional circumstances, but attendance will not count towards the quorum.
6 **Secretary**

6.1 Member of the Whole Systems management team.

7 **Frequency of meetings**

7.1 The group will meet monthly, until the business case is completed.

8 **Accountability, reporting and constitution**

8.1 The Steering Committee will formally report to the West London CCG Out of Hospital Committee.

8.2 The OOH Committee will make a final recommendation regarding the approval of the Business Case prior to it being submitted to the Governing Body, Royal Borough of Kensington & Chelsea Health & Wellbeing Board and Westminster Health & Wellbeing Board.

9 **Conduct and operation of committee**

9.1 The Steering Committee Chair will ensure that any disagreements or issues of conflict are discussed and a majority consensus agreed. The Chair will hold the casting vote if opinions are evenly divided.

9.2 The secretary will prepare an agenda for meetings and will collate papers and circulate them to members and attendees no less than five days before the meeting. Late papers will not be permitted except in exceptional circumstances and at the discretion of the Chair.

9.3 The terms of reference will be reviewed and ratified by the NHS West London CCG Out of Hospital Committee.
### APPENDIX C – GP Practices in West London signed up to this Whole Systems Integrated Care Expression of Interest

<table>
<thead>
<tr>
<th>PRACTICE NAME</th>
<th>GPs</th>
<th>Practice Manager</th>
<th>Practice List Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreland Medical Centre</td>
<td>Dr Bradley A. Pearl and Dr Lisa Crem</td>
<td>Mr Arjuna Somasekaram</td>
<td>3945</td>
</tr>
<tr>
<td>The Good Practice</td>
<td>Dr E. Sinclair and Dr Hammond</td>
<td>Mrs Gill Mooney</td>
<td>3340</td>
</tr>
<tr>
<td>The Garway Medical Centre</td>
<td>Dr J. Phonnanit</td>
<td>Mr Hugh Smith</td>
<td>4577</td>
</tr>
<tr>
<td>Brompton Medical Centre</td>
<td>Dr A. Ali</td>
<td></td>
<td>2341</td>
</tr>
<tr>
<td>The Golborne Medical Centre</td>
<td>Dr Ramasamy and Dr Nannithamby</td>
<td>Mrs Karen Randle</td>
<td>4973</td>
</tr>
<tr>
<td>Scarsdale Medical Centre</td>
<td>Dr Evans and Dr Lebents</td>
<td>Marzena Grymala</td>
<td>5622</td>
</tr>
<tr>
<td>Golborne Medical Centre</td>
<td>Dr H. Dathi</td>
<td>Ms Tasneem Dathi</td>
<td>2580</td>
</tr>
<tr>
<td>Knightsbridge Medical Centre</td>
<td>Dr Sweeney and Dr Brunton</td>
<td>Martin Levantine</td>
<td>8071</td>
</tr>
<tr>
<td>Stanhope Mews West</td>
<td>Drs Gillies, Steeden &amp; Hussein</td>
<td>Ms Anita Ladd</td>
<td>8970</td>
</tr>
<tr>
<td>Emperor’s Gate Surgery</td>
<td>Drs King, Stott and Parkhurst</td>
<td>Mrs Maryla Karge</td>
<td>5950</td>
</tr>
<tr>
<td>Pembridge Villas Surgery</td>
<td>Dr Ramsden and Dr Reid</td>
<td>Alesandra Iglesias</td>
<td>9953</td>
</tr>
<tr>
<td>Notting Hill Medical Centre</td>
<td>Dr R. Garner</td>
<td>Ms Merriere Smiley</td>
<td>3120</td>
</tr>
<tr>
<td>St Quintin Health Centre</td>
<td>Dr E. Denham</td>
<td>Mrs Michelle Aitchay</td>
<td>2131</td>
</tr>
<tr>
<td>The Meanwhile Garden Medical Centre</td>
<td>Dr N. Jasani and Dr J. Kraemer</td>
<td>Mr Kevin McDonald</td>
<td>3021</td>
</tr>
<tr>
<td>Scarsdale Villas</td>
<td>Dr M. Malhas and S. Malhas</td>
<td></td>
<td>2233</td>
</tr>
<tr>
<td>Abingdon Medical Practice</td>
<td>Drs Corbett, Kilduff, Chua and Raby</td>
<td>Ann Murray</td>
<td>7923</td>
</tr>
<tr>
<td>Queens Park Health Centre</td>
<td>Dr Pauline Lai Chung Fong</td>
<td>Mrs Joyce Kiyani</td>
<td>1408</td>
</tr>
<tr>
<td>Colville Health Centre</td>
<td>Drs Blake, Mok and The</td>
<td></td>
<td>6256</td>
</tr>
<tr>
<td>Dr Acib Surgery</td>
<td>Dr Adib</td>
<td>Mrs Fatima Kassab</td>
<td>2229</td>
</tr>
<tr>
<td>Bayswater Medical Centre</td>
<td>Dr Konstantinos Vranakis</td>
<td>Ms Amanda Walsh</td>
<td>7828</td>
</tr>
<tr>
<td>Medical Centre</td>
<td>Doctors/Names</td>
<td>Contact Name</td>
<td>Phone</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-----------------------------------------------------------</td>
<td>-------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Westbourne Grove Medical Centre</td>
<td>Dr Chin</td>
<td>Mrs Veronica Pilgrim</td>
<td>7264</td>
</tr>
<tr>
<td>Lancaster Gate Medical Centre</td>
<td>Dr Sunil Maini</td>
<td>Ms Mera Akhtar</td>
<td>2549</td>
</tr>
<tr>
<td>Shirland Road Medical Centre</td>
<td>Drs Garfield and Samicki</td>
<td>Ms Anne Marie Joseph</td>
<td>3676</td>
</tr>
<tr>
<td>West Two Health Centre</td>
<td>Dr N. Langdon</td>
<td>Mrs Vindhya Chandrapala</td>
<td>3117</td>
</tr>
<tr>
<td>Colville Health Centre</td>
<td>Dr Chung</td>
<td>Terence Tsakok</td>
<td>3113</td>
</tr>
<tr>
<td>Holland Park Surgery</td>
<td>Dr Bloom, Hooker and Dharmawardene</td>
<td>Ms Anne Barnes</td>
<td>8664</td>
</tr>
<tr>
<td>Earls Court Medical Centre</td>
<td>Drs Kathirgam anathan, Periyasamy, Nayak, Rajakulendran,</td>
<td>Mrs Soledad Malabanan</td>
<td>5959</td>
</tr>
<tr>
<td></td>
<td>Kogulanathan and Kathirgam anathan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Rose Surgery</td>
<td>Dr Rose</td>
<td>Mrs P Rose</td>
<td>3166</td>
</tr>
<tr>
<td>Harrow Road Health Centre</td>
<td>Dr Fluvman</td>
<td>Mr Dan Redmay</td>
<td>4374</td>
</tr>
<tr>
<td>Kymarne Practice</td>
<td>Dr McKeanun</td>
<td>Josephine Doyle</td>
<td>1472</td>
</tr>
<tr>
<td>The Chelsea Practice</td>
<td>Dr Scudder</td>
<td>Ms Kas Shackleford</td>
<td>3136</td>
</tr>
<tr>
<td>The Redcliffe Surgery</td>
<td>Drs Rees, Farrar and Butler</td>
<td>Ashley Ramsay</td>
<td>10049</td>
</tr>
<tr>
<td>The Portland Road Practice</td>
<td>Dr Watson Topham</td>
<td>Ms Yvonne Fraser</td>
<td>7506</td>
</tr>
<tr>
<td>Chelsea Medical Services</td>
<td>Dr Joshi</td>
<td>Ms Kim Rose Grosso</td>
<td>2693</td>
</tr>
<tr>
<td>Kensington Park Medical Centre</td>
<td>Dr Dua</td>
<td>Ms L French</td>
<td>6216</td>
</tr>
<tr>
<td>Elgin Clinic</td>
<td>Dr Philip Henry Mackney</td>
<td>Deborah McCarthy</td>
<td>4946</td>
</tr>
<tr>
<td>New Elgin Practice</td>
<td>Dr Judith Tate and Dr Naomi Katz</td>
<td>Mr Shah Hussain</td>
<td>4980</td>
</tr>
<tr>
<td>Sydney Street Surgery</td>
<td>Dr Ashok Maini</td>
<td>Ms Anu Radha</td>
<td>3196</td>
</tr>
<tr>
<td>Exmoor Surgery</td>
<td>Drs Rahim and Rahim</td>
<td>Ms Kamya Paliamsamy</td>
<td>3166</td>
</tr>
<tr>
<td>Sirdar Road Surgery</td>
<td>Dr Wijayasingehe</td>
<td>Ms Michelle Gallagher</td>
<td>1710</td>
</tr>
<tr>
<td>St Quintin Health Centre</td>
<td>Dr Kelso and Dr Hames</td>
<td></td>
<td>4509</td>
</tr>
<tr>
<td>Thurloe Road Surgery</td>
<td>Drs Boreham and Rowley</td>
<td>Mrs Deborah Boreham</td>
<td>2337</td>
</tr>
<tr>
<td>Srikrishnamurthy Health Centre</td>
<td>Dr Kun and Srikrishnamurthy</td>
<td>Ms Rajalakshmi Parayil Tongi</td>
<td>2291</td>
</tr>
<tr>
<td>Portobello Medical Centre</td>
<td>Drs Neilan and Pryce</td>
<td>Mr Ray Read</td>
<td>1850</td>
</tr>
<tr>
<td>Queens Park Health Centre</td>
<td>Dr N. Ahmed</td>
<td>Mrs Simi Ahmed</td>
<td>2326</td>
</tr>
</tbody>
</table>