Better Care, Closer to Home

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

West London

2012 – 2015
Foreword

I have been working locally as an NHS GP for over 15 years, and am pleased to be Vice Chair of West London Clinical Commissioning Consortium, representing 55 general practices and over 230,000 patients in Kensington and Chelsea, and the North of Westminster.

We have a culturally diverse population and significant local demographic variation, having one of the most deprived wards in London as well as some of the most affluent. People in the northern wards are twice as likely to die before 75 compared to those in the rest of the CCG. We have a high number of people of working age as well as an aging population.

We have a history of working closely together as practices with every practice in the CCG being involved in planning commissioning and monitoring care through locality based Commissioning Learning Sets.

Our vision is to build on our existing out of hospital initiatives and further transform care for the future. We are committed to developing personalised, well coordinated and seamless pathways of care across health and social care; to shift care to community and primary care settings; and reduce hospital admissions and improve early discharge.

Working with our patient panel and colleagues in both the Royal Borough of Kensington and Chelsea and Westminster City Council, we wish to:

- Develop interventions that empower patients to stay healthy for longer, prevent ill-health and reduce health inequalities.
- Develop a greater range of well resourced services in primary and community settings, designed around the needs of individuals
- Ensure quality improvement and innovation across the whole system - this is central to our plans to deliver better value for money in the process.
- Putting the needs of patients first to ensure the coordinated and integrated delivery of health and social care.

This strategy sets out ambitious yet realistic plans to transform out of hospital care and achieve better, more proactive care closer to home for the people of Kensington and Chelsea, and North Westminster.

Fiona Butler - CCG Vice Chair, West London
Executive Summary

This strategy sets out how West London Clinical Commissioning Group (CCG) will deliver better care for people, closer to home. It focuses on care provided out of hospital and follows the launch of North West London’s ‘Shaping a Healthier Future’ – a programme to improve health care for the two million people living in the eight North West London boroughs.

1. The case for improving out of hospital services

There are 3 key factors that require us to change how we deliver health care in West London:

- The needs of our residents are changing. People are living longer and suffering from more chronic and lifestyle diseases, increasing pressure on health and social care services.
- Under our current model of care, we cannot afford to meet future demand. Hospital is too often the answer. We need better planned and more proactive care, delivered out of hospital to provide better outcomes for our patients at lower cost.
- Delivering this change will require us to transform primary, community and social care. Too often our health and social care services are fragmented, and there is variation in both quality and access to care across West London.

2. Our vision: how care will be different for patients

We have a vision for whole system change in West London: “We are committed to the development of personalised, integrated and joined up pathways of care across health and social care; shifting care from acute to community and primary care settings, and reducing hospital admissions and improving early discharge”.

We know from our patients that they want their care to be personal, well-coordinated, and delivered by a clinician who knows them. Putting patients first and empowering them to stay healthier for longer with emphasis on preventing ill health and reducing health inequalities are our key priorities.

There are five specific goals against which we will introduce new initiatives:

- There will be easy to access, high quality and responsive primary care;
- There will be simplified planned care pathways;
There will be a rapid response to urgent needs so that fewer patients need to access hospital emergency care;

Providers (social, health and third sector) will work together with the patient at the centre to deliver well coordinated care for those with long term conditions;

Patients will spend an appropriate time in hospital when admitted and have a well supported discharge.

3. How we will deliver better care, closer to home

To make this change happen we are building on existing initiatives as well as investing in a number of ambitious new out of hospital initiatives.

- Our new ‘Putting Patients First’ initiative cuts across all five of our strategic goals. It will ensure coordinated, quality care for patients with complex needs to prevent emergency admissions to hospital and ensure they are stepped up and down seamlessly from an urgent service to a managed care service.

- As part of our new ‘Putting Patients First’ initiative, primary care will play a more active role in caring for complex patients at risk of hospital admission. We will promote coordinated and multi-disciplinary working at the practice level so that patients receive seamless care across providers.

- We will involve patients in taking an active role in their care and will promote health, self-care and early intervention by providing better information and support and proactively raising issues of lifestyle with them.

- We will invest in a new community-based care of the elderly consultant as part of our Putting Patients First initiative to provide additional capacity and expertise in primary care for complex elderly patients.

- We have enhanced our referral scheme so that we only refer patients to hospital who need secondary care support. The scheme will support our patients to receive the care they need closer to home.

- We will transform and redesign local respiratory pathways to ensure that patients experience seamless treatment and management of their respiratory condition. New paediatric pathways will deliver coordinated and appropriate care in primary and community settings for children.

- Patients will have access to a rapid response team with a broader scope and skill-set when a rapid response is required. The team will be available 24 hours a day, 7 days a week.
• We will improve the joint working arrangements of our community-based health and social care services, including rapid response and intermediate care to create a seamless care pathway between them.

4. How we will work together to deliver the vision

We will organise ourselves more effectively to achieve our vision of pro-active planned care, and care in the right place, at the right time. Through discussion with our patients and their carers we will improve the coordination of care for complex patients and ensure we step patients up and down seamlessly from an urgent to managed care. We will need more nurses and other health professionals, space, and investment in practices, community hubs, support in the patient’s home and in community estates and equipment.

To support delivery we will organise ourselves into two provider networks and five commissioning learning sets (CLSs) across the CCG:

• Establishing two provider networks will allow us to deliver care working together as providers of care in integrated teams, dedicated to serving a population of patients.

• Providers in each area will form a network of care to co-ordinate and integrate care providing enhanced services to our patients. This will involve alignment and some co-location of providers.

• We know to do this will require an integrated approach with adult social care and community providers to ensure efficient and effective working with no duplication e.g. a single assessment process to ensure patients do not fall through the gaps and integrated long term care teams.

5. Enabling our vision

There are a number of key enablers that will need to be put in place to make these organisational changes work:

• Patient engagement at every stage to tell us what is and is not working;

• Governance to hold providers to account and monitor service delivery;

• New contractual arrangements and incentives to promote new and effective ways of working;

• Information and improved IT; and

• Professional and organisational development.
In summary, the changes we have set out in this strategy - Better Care, Closer to Home, are ambitious and far-reaching. Implementation of this strategy will result in real changes in care for both patients and providers.
Table of Contents

1. The case for improving out of hospital services ................................................................. 9

2. Our vision of how care will be different .................................................................................. 11

2.1. Easy access to quality responsive primary care .................................................................. 12

2.2. High quality elective care and well understood planned care pathways .............................. 15

2.3. Rapid response to urgent needs .......................................................................................... 17

2.4. Social and health care providers working together with the patient at the centre .......... 18

3. How we will deliver better care, closer to home ..................................................................... 20

3.1. Improving access to primary care ...................................................................................... 23

3.2. High quality planned care ................................................................................................. 26

3.3. Responsive urgent care ....................................................................................................... 30

3.4. Integrated care for people with long-term conditions .......................................................... 32

3.5. Supported discharge .......................................................................................................... 35

4. How we will work together ..................................................................................................... 37

4.1. Our organising principles .................................................................................................... 38

4.2. Establishing two new provider networks ............................................................................ 39

4.3. Organising into three levels of care .................................................................................... 40

4.4. Coordinating health and social care services ..................................................................... 41

4.5. Estates .................................................................................................................................... 45

5. Supporting the change ............................................................................................................. 46

5.1 Governance and performance management ......................................................................... 48

5.2. Contracts and incentives ..................................................................................................... 52
5.3. Information tools .................................................................................................................. 52

5.4. People and organisational development ............................................................................ 56

6. Investing for the future .......................................................................................................... 58

7. Next steps .............................................................................................................................. 60

7.1. Implementing our key initiatives ....................................................................................... 60

7.2. Implementing our support for change ............................................................................... 61

7.3. Key immediate steps ......................................................................................................... 61
1. The case for improving out of hospital services

There is a clear case for the transformation of our of hospital care.

West London is facing new demographic challenges. The health needs of our residents are changing as the population ages and people live longer with more chronic and lifestyle-related diseases. In 2030, women aged 65 in West London will live for four years with a disability, compared to three years in 2010. The number of stroke survivors will rise by 26% in the next 15 years. Mental health is our biggest burden in terms of reduced quality of life years.

These trends will place unsustainable pressures on our health and social care services, and under our current model of care, we will not have the resources available in the future to meet these growing demands.

Our current model of care is overly dependent on use of hospital services. By focusing on prevention, intervening earlier, joining up care better between and across organisations, and supporting patients who are currently being admitted to hospital in their homes, we can improve outcomes and patient satisfaction and get better value for money. Better care, closer to home, is the only way to maintain quality of care in the face of increasing demand and limited resources.

We need to change the way in which we deliver care. At present, access to and quality of care out of hospital are variable across the CCG, as described by our patients in exhibit 1. There are clear differences in performance between GP practices on a range of indicators including satisfaction with GP opening hours.

Improving the quality of and access to out of hospital services will require new, innovative ways of coordinating and delivering services, more investment and better accountability. Exhibit 2 sets out the reasons for transforming out of hospital care. Further details are available in the NHS North West London’s Shaping a Healthier Future.
Exhibit 1

Healthcare professionals identified issues across the system:

- We need to work better with district nurse teams and the rapid response team so we don’t, at best duplicate care and at worse have the patient falling through the net.
  – Nurse, Westminster

- I would love to work with my neighbouring practices in order to provide a joint phlebotomy service. Will save money for the practices and be more convenient for the patients.
  – GP, Kensington

- Having access to patients hospital records would save us so much time, we would love a system that could work together.
  – GP, Kensington

- It is so frustrating when patients get wrongly admitted to hospital. Especially those on palliative care who want to stay at home, seem to go in at the weekends or evenings because of lack of coordinated care pathways.
  – GP, Kensington

...which have resulted in poor quality care for patients

- I can’t understand how in the days of modern technology our GPs can’t get access to our hospital records and vice versa it would be much easier for us as patients.
  – Patient, Kensington

- I like going to my local clinic for as many things as possible. I hate going to the hospital as it is a hassle to find parking and a real stress waiting for hours and not knowing when I will be seen. I would welcome having more of my care done in my GPs surgery.
  – Patient, Westminster

- So many times my prescriptions have gone wrong because the hospital Consultant doesn’t let me GP know, and the chemist gives me the wrong drugs. It is confusing for me and could lead me to taking too many or too little drugs. I wish they could just communicate with each other better – I would feel less anxious and it would help me manage my illness much better.
  – Patient, Queen’s Park

- I find it really difficult to get an appointment with my GP and I don’t understand why my friend down the road can see his GP on the same day he calls? Why is there such a difference between practices and their appointment systems? Now I just go to the local walk-in centre whenever I need to see anyone and always end up seeing the nurse.
  – Patient, Chelsea

SOURCE: Quotes as reported by patients and GPs at West London GP practices

Exhibit 2

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

Under our current model of care **we can’t afford** to meet future demand. Hospitals are too often the answer. We need to have care that is more proactive and better planned outside of hospital.

However, this needs a transformation of primary, community and social care. Currently, there is variation in both quality and access, and standards must improve.
2. Our vision of how care will be different

West London CCG has a clear vision for the future of out of hospital care:

“West London CCG is committed to the development of integrated pathways of care across health and social care, transforming care pathways by shifting care from acute to community and primary care settings where appropriate, and avoiding hospital admissions and improving early discharge”.

We have developed five strategic goals to enable us to achieve this vision:

<table>
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<th>Exhibit 3</th>
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<tr>
<td><strong>Our five strategic goals</strong></td>
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<tr>
<td>▪ Easy access to high quality, responsive primary care to make out of hospital care first point of call for people</td>
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<tr>
<td>▪ Streamlining care pathways to ensure seamless services closer to home</td>
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<tr>
<td>▪ Rapid response to urgent needs so that fewer patients need to access hospital emergency care</td>
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<tr>
<td>▪ Health and social care providers working together, with the patient at the centre to proactively manage LTCs, the elderly and end of life care out-of hospital</td>
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<td>▪ Appropriate time in hospital when admitted, with early supported discharge into well organised community care</td>
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We know from our patients that they want their care to be personal, well coordinated and delivered by a clinician who knows them. **Putting patients first** is our key priority. We develop this theme throughout our strategy and we have integrated it within each of our five strategic goals.

We have provided more detail on each of our five goals below. For each, we describe how our plans will improve care for our patients; and use examples of patient care to illustrate these changes.
2.1. Easy access to quality responsive primary care

We are committed to providing quality care close to home for our population. We will improve primary care so that it is fit for purpose and meets the needs and expectations of our patients. We will address the variation in quality of primary care in West London and ensure that our residents can access quality primary care services when and where they need them.

- Access

Working with other CCGs in North West London, we will establish a common framework to transform access and quality in primary care.

Our GP practices will work together as part of two provider networks to ensure that our GP practices are open at convenient times for our patients. We will extend opening hours for urgent as well as planned care services, and extend the range of services provided, in the most appropriate locations.

Patients will have access to telephone advice and triage 24 hours a day, 7 days a week through General Practice and a new, free non-emergency 111 number. Patients will receive better, streamlined access to urgent care and referral to the right local service, the first time.

Patients with an urgent care need will be given a timed appointment or visit from an appropriate service provider across the system within four hours.

- Quality: our out of hospital standards

Improving quality means ensuring that we deliver care to the right clinical standards in good facilities. Patients and the public need to be confident in the quality of care they will receive as we change where and how we provide care. We have agreed to implement clinical standards for care in the community, which are set out in exhibit 4.

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

Our GP practices will support each other to work together to learn and review best practice as part of five Commissioning Learning Sets (CLS) to drive improvement in primary care and ensure care meets these quality standards.
Putting Patients First

We know that patients and their families carry out 80-90% of the care required for patients with long-term conditions. Seamless care coordinated by a family doctor lowers the risk of admission to hospital for all age groups.

Our new Putting Patients First initiative will develop a network of support around the patient to ensure they receive seamless care across providers. This is important for those who rely on a range of services from a number of different providers. The GP plays a critical role in this model, ensuring that patient care is well coordinated and joined up across providers.

This model of care will also require a changing role for our patients. We will support them in taking greater control over their health. Keeping people healthy, preventing ill-health and reducing health inequalities is a key priority. What happens within an individual’s life – their education, income, skills, work and social connectedness - all impact on their health and length of life. The health sector has unique access to the population. There are tremendous opportunities to support people to keep healthy and influence health inequalities. And we know that people locally want this help and support.

In the future, local NHS providers will be better prepared and able to take action to promote health and address the wider causes of ill-health amongst patients. Patients will be empowered to make informed choices about their care and take responsibility for promoting their own health and wellbeing through supported self-management. Our practice nurses and nurse practitioners will play an important role in prevention of ill health in areas such as smoking and alcohol.

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

High risk patients will develop a personalised care plan with their GP or practice nurse or care co-ordinator to help them manage their health and social needs on a day-to-day basis. It will include an important self-care component. The plans will include goals the patients wants to work towards, the support they need, named individuals responsible for providing their care, emergency numbers, and medicines, diet and exercise plans. They
will be shared across multi-disciplinary teams of professionals to enable seamless care across providers.

Patients, carers and their families will be equipped with the information they need (e.g. on smoking, alcohol, diet, and exercise) to better manage their care and implement their care plans as appropriate. We will invest in trained patient educators so that our patients have the information they need, and we will connect patients to voluntary sector programmes so that they learn how to self-manage their conditions at home. Use of new technologies such as tele-health will support self-management and home care of our patients.
The standards are covered in four key domains

<table>
<thead>
<tr>
<th>Domains</th>
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<tbody>
<tr>
<td>Individual Empowerment &amp; Self Care</td>
<td>• Individuals will be provided with up-to-date, evidence-based and accessible information to support them in taking personal responsibility when making decisions about their own health, care and wellbeing</td>
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<tr>
<td>Access convenience and responsiveness</td>
<td>• Individuals will have access to telephone advice and triage provided 24 hours a day, seven days a week. As a result of this triage:</td>
<td>• Cases assessed as not urgent and that cannot be resolved by phone, individuals will be offered the choice of an appointment within 24 hours or an appointment to see a GP in their own practice within 48 hours</td>
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<tr>
<td>Care planning and multi-disciplinary care delivery</td>
<td>• All individuals who would benefit from a care plan will have one.</td>
<td>• Everyone who has a care plan will have a named ‘care coordinator’ who will work with them to coordinate care across health and social care</td>
<td>• GP will work within multi-disciplinary groups to manage care delivery, incorporating input from primary, community, social care, mental health and specialists</td>
</tr>
<tr>
<td>Information and communications</td>
<td>• With the individual’s consent, relevant information will be visible to health and care professionals involved in providing care</td>
<td>• Any previous or planned contact with a healthcare professional should be visible to all relevant community health and care providers,</td>
<td>• Following admission to hospital, the patient’s GP and relevant providers will be actively involved in coordinating an individual’s discharge plan</td>
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Source: NWL Clinical Board and Programme Board

Exhibit 5 shows how better access to primary care and greater patient control will help to improve the health of our patients.

### Exhibit 5

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

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

<table>
<thead>
<tr>
<th>Event</th>
<th>Outcome</th>
<th>Source</th>
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</thead>
<tbody>
<tr>
<td>Martha comes home from work at 6 pm to find her son has come back from nursery with a fever</td>
<td>Treatment is transactional. Tom misses out on opportunity for broader child welfare e.g., staff do not make sure jabs up to date, check Martha is coping</td>
<td></td>
</tr>
<tr>
<td>Martha rings her GP but they are closed. It is 6 pm.</td>
<td>She is relieved and reassured, feeling confident in the system</td>
<td>GP sees her son and accesses the child’s health record. They assess Tom and send him home with medicine</td>
</tr>
<tr>
<td>A&amp;E is crowded, there is a long wait, Martha is tired and Tom is sick.</td>
<td>If it was more serious the GP could give Tom emergency treatment and send to the local Paediatric Emergency unit</td>
<td>If it was more serious the GP could give Tom emergency treatment and send to the local Paediatric Emergency unit</td>
</tr>
<tr>
<td>They wait 3 hours to be seen</td>
<td>She is given an appointment for 8.30 pm in local GP practice – not their own but one which does 18 hour care – and is only 15 mins walk from her house</td>
<td>GP sees her son and accesses the child’s health record. They assess Tom and send him home with medicine</td>
</tr>
<tr>
<td>Marble uncertain what best course of action is and who to contact</td>
<td>Stressful and time consuming process for Martha to find a solution</td>
<td>A&amp;E staff feel overwhelmed by flow of unscheduled patients</td>
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<tr>
<td></td>
<td></td>
<td>Martha grateful for treatment and idea of A&amp;E as place to get care is reinforced</td>
</tr>
<tr>
<td>In future, patients will have better access to primary care and know how to get it …</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marble comes home from work at 6 pm to find her son has come back from nursery with a fever and calls 111</td>
<td>If it was more serious the GP could give Tom emergency treatment and send to the local Paediatric Emergency unit</td>
<td></td>
</tr>
<tr>
<td>She is given an appointment for 8.30 pm in local GP practice – not their own but one which does 18 hour care – and is only 15 mins walk from her house</td>
<td>GP sees her son and accesses the child’s health record. They assess Tom and send him home with medicine</td>
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<td></td>
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<tr>
<td>Marble understands that 111 can direct her to the most appropriate care</td>
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<td></td>
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<tr>
<td>She is relieved and reassured, feeling confident in the system</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marble is reassured and feels confident to see episode through</td>
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<td></td>
</tr>
<tr>
<td>Record is taken of the event and communicated to the family’s GP</td>
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**2.2. High quality elective care and well understood planned care pathways**
In West London, a proportion of outpatient care and elective procedures occur in the hospital when we could provide higher quality services in the community - at a lower cost, and closer to people's homes.

We will continue to provide MSK, primary care mental health, and dermatology and diabetes services for our patients in the community. Where appropriate, we will transform care pathways and provide additional services in the community. Patients will have access to new services including respiratory and paediatric clinics. This will reduce waiting times and unnecessary hospital appointments for patients. It will also increase their choice of services and enable them to access services at more convenient times closer to home. Patients with respiratory conditions will have access to a new community-based respiratory clinic open at extended hours, six days week. Our new paediatric service in the community will ensure that we diagnose children with common long-term health conditions earlier. It will mean better care closer to home for our patients and fewer unnecessary visits to hospital.

Our referral scheme will improve referrals from primary care by referring patients to the most appropriate provider in the most appropriate setting. This will reduce the number of unnecessary hospital appointments for our patients and improve quality of care. Patients will be referred to community clinics, closer to their homes, wherever appropriate.

With the new technology we will introduce, patients can expect that clinicians - with their consent, can share and access their information with other health and social care professionals involved in providing their care. This will mean patients will not have to repeat their stories to different clinicians and will receive more integrated care. Exhibit 6 shows how transformed care pathways will improve patient care in West London.

Exhibit 6

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

Sometimes the pathway to receive planned care is complex and disorganised:

Jonathan goes to his GP who advises him to have Rest Ice Compression and Elevation. He gives him some pain killers and tells him to come back if he doesn't improve.

One week later, Jonathan is still in a great deal of pain. He has been unable to work, and is hobbling about on an old pair of crutches that his friend gave him. He goes back to his GP who refers him for an MRI scan.

It takes another two weeks to get the MRI scan done, and 48 hours for that report to get back to his GP. He has an anterior cruciate ligament tear and needs to be referred to a surgeon.

Four weeks later, Jonathan sees an orthopaedic surgeon who arranges an operation in a further four week's time.

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

Final Version 17 May 2012
2.3. Rapid response to urgent needs

Hospital admissions should be prevented whenever possible. Currently, many of our patients are being admitted to hospital when an expanded rapid response in the community could keep them in their own homes. In the future, more patients will be supported at home and in the community instead of having to go to hospital.

When our patients require a rapid response they will be appropriately referred with the knowledge and input of the GP to the rapid response service. They will receive a multi-disciplinary response within two hours from a team including nurse consultants, therapists and social care and GP. The team will have access to tele-health and rapid community equipment to keep patients safely in their home. When patients stabilise they will be transitioned seamlessly to the appropriate intermediate care and reablement services. Patients will receive the support they need to regain their independence and confidence.

Elderly patients with complex health needs will receive specialist support in the community from a new care of the elderly consultant as part of our expanded rapid response service. They will work closely with the GP and will do a comprehensive assessment on transition from the rapid response service to inform the future care plan. Exhibit 7 shows how our expanded rapid response service will improve patient care.
2.4. Social and health care providers working together with the patient at the centre

Our new ‘Putting Patients First’ initiative will put the patient at the centre by providing an integrated health and social care response for patients with complex long-term conditions. These patients often have co-morbidities and are frequent users of hospital and health and social care services in the community. In the past, poor coordination between services has caused individuals to ‘fall through the gap’ between services resulting in fragmented and poor quality care.

In the future, patients will receive a coordinated response from health and social care providers and urgent and managed care services. They will have one integrated assessment, and will develop a care plan with their care coordinator and GP, which outlines an appropriate package of care. High risk patients will have a named care coordinator to help them navigate and transition seamlessly between services. In doing so, patients will be empowered to live independently for longer in their own homes, and will avoid unnecessary A&E attendances, hospital admissions and admissions to long term care.
Patients at risk will be supported to better manage their medicines at home so that they stay healthier for longer. A new medicines support team will review their medication and provide the support they need to take their medicines as intended.

Patients at the end of their lives will receive high quality, integrated care and will die in their place of choice.

Exhibit 8 shows how coordinated and integrated care will improve the health and wellbeing of our patients.

Exhibit 8

Providers (social and health) working together, with the patient at the centre

Mabel, 75 years old smoker, suspected diagnosis of COPD, and has severe osteoarthritis

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

Mabel requests a visit from her GP for breathing difficulties. The GP visits and prescribes antibiotics. He asks her to come to the surgery for reversibility testing to confirm diagnosis. Mabel does not make the appointment due to poor mobility.

Mabel deteriorates over the weekend and is admitted to A and E via LAS. There are no records and no diagnosis so Mabel is given antibiotics and an inhaler, referred to the hospital respiratory team and sent home. GP receives discharge fax and decides to refer to community COPD team for assessment, diagnosis and management at home. Request to cancel acute referral is lost.

Mabel knows that she can call her GP when she has a problem. Mabel is worried and upset. She has tried to leave the house to get to the GP, but she feels faint, tired and finds it difficult to move. Mabel is resistant to being sent home as she does not feel any better and is concerned about being home alone without any help. She is very anxious. Mabel is upset. She has forgotten how to use her inhalers and her anxiety is exacerbating her COPD. She is sent two hospital appointments but ignores them because she is not mobile enough to use public transport.

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

Mabel requests a visit from her GP for breathing difficulties. The GP visits and prescribes antibiotics and respiratory medications but is concerned about Mabel’s social isolation, particularly over the weekend. He refers her to the rapid response team for acute management of her respiratory symptoms. The rapid response team also request an urgent social care assessment. The following week, Mabel is assigned to a district nurse case manager who meets with the GP and new social worker to discuss her care plan. Mabel is referred to the community respiratory team for management of her COPD and they make a home visit. She is also referred to community rehab for an assessment of her daily mobility needs. Mabel is involved in her care plan at all stages.

Once Mabel has recovered from her chest infection, the social worker arranges transport for her to attend the local lunch club, which Mabel enjoys very much – easing her anxiety and loneliness. Her care plan is reviewed at the next primary care multi-disciplinary meeting.

Mabel knows that she can call her GP when she has a problem. Mabel is relieved that she doesn’t have to leave her house. She likes the nurses, and feels confident about using her inhaler. Mabel finds the transition to care with other teams easy and hassle free. Mabel is amazed that she has received all this care in her home. She agrees to stop smoking.
2.5. Early supported discharge

Patients are staying in hospital longer than they need to because of a lack of support for discharge and poor co-ordination between health and social care.

In the future, patients will be discharged at the appropriate time and transitioned seamlessly into a new joint health and social care intermediate care service. Patients will be followed into hospital by their care coordinators, who will work with a patient’s GP to coordinate their discharge and coordinate appropriate intermediate support in the community. Patients will have access to a range of services in the community via a single point of access, including community rehabilitation, reablement and tele-care to monitor ongoing progress.

Exhibit 9 shows how patients will benefit from better supported discharge from hospital.

Exhibit 9

3. How we will deliver better care, closer to home
This section outlines some of the schemes we will put in place to meet each of our five strategic goals. Some are improvements on existing schemes, others are new and specific to West London, and others are part of North West London-wide efforts.

Exhibit 10 outlines these schemes by strategic goal.

**Exhibit 10**

This means a number of significant changes that will ensure more care is delivered out of hospital (1/2)

- **Easy access to high quality, responsive primary care to make out of hospital care the first point of call for people with urgent, but not life threatening, needs**
  - The 111 pilot in Central London will provide a single point of access for patients, carers and clinicians to access the appropriate level of care
  - Improved primary care service e.g., extended opening hours in general practice and new ways to communicate with patients
  - Primary care will play a greater role in caring for complex patients using risk stratification and care planning

- **Clearly understood planned care pathways that ensure out of hospital care is delivered in the most appropriate setting of care**
  - A referral scheme will ensure all patient referrals are directed to the most appropriate clinician and everyone has the same access to the care available
  - Some outpatient and elective procedures will be moved out of the acute sector into the community, as a more appropriate setting of care
  - Improved capacity to deal with mental health patients in primary care

- **Rapid response to urgent needs so that fewer patients will need to access hospital emergency care**
  - Our rapid response team will be integrated with social care with a broader scope and skill-set – e.g., reaching into hospitals to prevent avoidable admissions and keeping people at home where possible, or in emergency respite care where necessary. Everyone – patients, carers and clinicians will know about the alternatives to hospital or know to contact 111 for advice. This is particularly important for some groups of patients including nursing home residents, dementia patients, people recently discharged from hospital and those at the end of their lives. Service will provide rapid, coordinated and convenient access to care advice from other providers (GPs, social services, voluntary sector) and single point of contact
  - Care of the elderly consultant will provide additional capacity and expertise in primary care to care for complex elderly patients in their homes
  - For end of life: specialised care management plan using the end of life tool, coordinated by GPs and district nurses will ensure patients receive high quality, integrated care and die in their place of choice

- **Integrated care with providers (social and health) working together – with the patient at the centre – to proactively manage those with LTC and other at risk groups**
  - Joined up, coordinated care for complex patients with LTC & high users of hospital services, including multidisciplinary groups (ICP) across West London CCG who will work together to identify and review patients at risk of becoming ill
  - High risk elderly and diabetic patients receive expert integrated care from multi-disciplinary groups to prevent them being admitted to hospital
  - A new medicines support pathway and review programme to reduce the level of preventable drugs-related hospital admissions

- **Appropriate time in hospital when admitted, with early supported discharge into well organised community care**
  - More joined-up discharge support, with an appropriate step-down in care, reability support, prompt communication to other providers, and clear advice to patients on what to expect after hospital and who they can contact if they feel unwell
  - Psychiatric liaison services will improve coordination with out of hospital providers and housing services to improved supported discharge

Our new ‘Putting Patients First’ initiative cuts across all five of our strategic goals. It will ensure coordinated, quality care for patients with complex needs to prevent emergency admissions to hospital and keep our patients healthier for longer. Exhibit 11 outlines our new seamless care pathway for patients with complex needs.
We want to involve patients in taking an active role in their care and will promote health and self-management and early intervention through providing better information for people and support for self care.

Exhibit 11

<table>
<thead>
<tr>
<th>PRACTICE BASED PRIMARY CARE TEAM</th>
<th>SPECIALIST COMMUNITY BASED OUT OF HOSPITAL SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk stratification using combined predictive tool identifies patient’s risk of hospital admission</td>
<td>Specialist Community Teams: Diabetes, Respiratory, MSK, Dermatology, Heart Failure, Continence, Primary Care Mental Health Team, Care of Older Peoples Team:</td>
</tr>
</tbody>
</table>
| Patient has moderate risk of hospital admission  
- Multidisciplinary care planning led by GP  
- Care monitored and reviewed regularly by responsible GP and discussed by MDT quarterly  
- Patients’ risk increases they are stepped up to be care co-ordinated  
- Patients risk decreases they are stepped down to GP/CHN care | - Input to MDT’s assessment and advice to GPs from specialist community teams  
- Community based clinics  
- Usage of referrals  
- Short term management (up to 12 weeks) of patients whose condition has stabilised, with a view to rehabilitating them and stepping down their care back to primary care |
| Patient has high risk of hospital admission  
- Care Co-ordinator appointed following multidisciplinary assessment and review  
- If patients admitted Care Co-ordinator follows patient into hospital and is actively involved in discharge planning  
- GP remains medically responsible, involved in MDT meetings and undertakes medication review, reconciliation and assessment of the patients adherence to prescribed medication  
- Reviews GP appointments and ensures that whole sector input is well co-ordinated  
- Patients’ risk score is monitored and, when the risk of hospital admission reduces they are stepped down to GP and DH team care | Rapid Response Team  
- Patient becomes acutely ill, following skilled assessment and discussion with GP receives intensive phone based nursing package for up to 14 days  
- Patient is stepped back down to Care Management or CINCH care or input from the Re-ablement team  
- GP team consultant provides medical cover for more complex patients |
| Patients’ GP responsible for monitoring the quality and performance of all services involved in the patient care pathway | Re-ablement/Intermediate care team  
- Short term social care and rehabilitation packages for patients who would benefit from early supported discharge or home based care to prevent the need for hospital admission |
| Integrated Care Pilot  
- Multidisciplinary case discussion and co-ordination of a small number of very complex patients  
- Joint learning and sharing of best practice to improve the care of patients managed at practice level | Integrated Care Pilot  
- Multidisciplinary case discussion and co-ordination of a small number of very complex patients  
- Joint learning and sharing of best practice to improve the care of patients managed at practice level |
3.1. Improving access to primary care

a) Single point of access via 111

- The 111 pilot in West London will provide patients with a free-to-call ‘111’ number 24 hours a day, 365 days a year. It will provide a single point of access for patients, carers and health professionals to access appropriate care.

- Call handlers will use NHS pathways to provide assessment of their clinical needs. They will use a comprehensive directory of local health, social care, voluntary and mental health services so that they can direct patients to the appropriate service locally the first time.

- In an emergency, handlers will pass the call immediately to the ambulance service. They will provide clinical advice or refer patients to the local service for minor injuries or illnesses. If the patient needs to see a GP, they will be referred to an out-of-hours service or GP practice for an appointment. Call handlers will have the ability to book an appointment or telephone consultation directly with the patient’s own GP practice.

- Those with an urgent care need will be seen within the system within 4 hours.

- We will see patients with non-urgent needs within 24 hours by a health professional and 48 hours by a GP.

b) Developing primary care

We are working with other CCGs in North West London to set up a common framework to transform access and quality in primary care.

- In West London, we will organise into two primary care networks of 20 – 30 practices to increase access to the right services, close to home, at the right times for our patients.

- We will further extend opening hours for our patients in primary care for planned and urgent appointments. We know this is what our patients want. Within three months of our recent pilot GP Access Initiative, we have seen 2,000 more patients as emergency walk-in patients, across 33 practices. Extending opening hours will increase access to urgent care as a convenient alternative to busy A&E departments. GP-led urgent care centres and walk-in centres, based strategically across the CCG, will continue to provide urgent care for our patients. These services can now book appointments and telephone consultations with a patient’s GP practice directly, to improve continuity of care. We will explore via our provider hubs how a number of local practices can work together to deliver and 8 until 8 service.
We will explore new ways to communicate with our patients by making better use of the latest technologies e.g. by using email, SMS texting and video consultation.

GP practices will work together as part of Commissioning Learning Sets (CLS) to improve quality of primary care. This will include peer review and support as well as sharing knowledge and best practice.

We will implement prevention plans which support our patients in maintaining healthy lifestyles, increasing healthy eating and activity, losing weight and stopping smoking.

c) Increased role in care of complex patients

As part of our ‘Putting Patients First’ initiative, primary care will play a more proactive role in caring for complex patients with ambulatory sensitive conditions (ACS) at high risk of hospital admission. A Putting Patients First locally enhanced scheme (LES) will draw on the lessons learned and successes of two key local initiatives.

- Very High Intensity User (VHIU) LES: Key interventions including risk stratification, case management and action planning have had significant impact on quality of care and unnecessary hospital admission rates for high intensity users of services and patients with complex long-term conditions.

- Inner North West London Care Pilot: This pilot promotes the integration of services across primary and secondary care. High risk patients are identified using a risk stratification tool. Practices are responsible for managing very high risk patients (specifically those who are elderly or have diabetes) through their participation in multi-disciplinary groups with neighbouring practices, hospital consultants, social workers and community nurses. The meetings provide a vital opportunity to learn, share good practice and improve capability in primary care.

Putting Patients First will promote coordinated and multi-disciplinary working at the practice level so that patients receive joined up care across providers. This will promote a more central role for GPs in organising care around their patients so that patients receive a coordinated package of care to support the care they receive in primary care from different community services. Specifically:

- Practices will use a risk stratification tool to identify high risk patients. The needs of these patients will be reviewed, and they will be assigned to an appropriate professional to coordinate their care, and carry out their health and social care assessment.
The care coordinator will work with the patient to develop a multi-disciplinary care plan. Care coordinators will be an integral part of long-term care teams and could be a social worker, district nurse, GP or practice nurse.

GPs will continue to take overall medical responsibility for the patient ensuring continuity of care. This includes responsibility for medication review and input, review of specialist input and routine hospital attendance, crisis planning, and providing medical support to the rapid response and joint intermediate care teams where necessary. A new community consultant for care of the elderly will provide these teams with additional support.
3.2. High quality planned care

In West London, a proportion of outpatient care and elective procedures occur in the hospital when we could provide higher quality services in the community at a lower cost, and closer to people’s homes. We will add to a number of existing services set up through practice based commissioning and operating in the community to deliver this across more clinical specialties.

a) Referral Scheme

- We will build on the success of our existing local referral scheme to manage demand and improve the quality of referrals. The scheme will ensure GPs make appropriate decisions about where to refer their patients and in doing so, will reduce the number of inappropriate outpatient referrals across a range of specialties. It will reduce the number of unnecessary hospital appointments for patients by ensuring they are treated closer to home whenever clinically appropriate and feasible.

- The scheme will involve GP peer review and learning as part of five re-configured Commissioning Learning Sets (CLS). Practices that sign up to the scheme will receive monthly audits of their referral data for a comprehensive list of clinical specialties, including respiratory medicine, gynaecology, general surgery, general medicine, and paediatrics. Practices will review these audits as part of regular CLS meetings and agree on a plan of action for improvement.

b) Transforming pathways of outpatient care

- We will continue to provide consultant-led specialist services in the community for conditions including MSK, mental health, dermatology and diabetes. These services will increase access to assessment and treatment for these conditions, improve waiting times for patients from referral to first appointment, and reduce the number of inappropriate referrals to secondary care and improve the quality of services provided in primary care

  **Dermatology**

- A team including a specialist dermatology nurse, specialist GP in dermatology, and dermatology consultant will deliver a multi-disciplinary dermatology service in the community from St. Charles Hospital and Earl's Court area hub.

  **Musculoskeletal**
We will deliver a new high quality musculoskeletal (MSK) service from two community hubs north and south of borough, as well as from six spoke sites. The multi-disciplinary team will provide a responsive single point of access for triage and advice and referral to the most appropriate member of the team at a convenient time and location. It includes physiotherapy, osteopathy, acupuncture, hydrotherapy, injection therapy and pain management and offers and quick and easy access for face-to-face assessment and treatment.

We will also shift specialist care from the acute sector into the community for a number of new clinical areas.

**Respiratory**

- We will redesign this pathway so that it includes the following components: smoking cessation, pulmonary rehab, spirometry testing, COPD and asthma clinics, care at home and consultant input.
- Our patients will be encouraged to self-manage their condition. New technologies such as tele-health will assist them in home-care and in managing their care on discharge from hospital.
- A consultant-led specialist team will deliver the service in a community clinic, offering appointments 6 days a week, with extended hours. The team will also provide home-visits for house-bound patients. GPs and Practice Nurses will continue to manage stable respiratory patients in GP practices.
- Offering new respiratory services in the community will reduce patient diagnosis and treatment times, reduce unnecessary hospital admissions and improve integration with other specialist community teams such as rapid response and district nursing.

**Paediatrics**

- We will introduce a new paediatric service in the community to improve the management of common, long-term conditions for children and their families, including asthma and other allergic illnesses.
- The service will operate from hub and satellite sites across the borough, and will work with other specialist teams in the community to improve the management of children with complex needs. We will give training opportunities to our GPs and practice nurses to improve the management of allergies and respiratory issues in primary care.
- This service will create a seamless pathway between primary and community paediatric care. It will also reduce unnecessary referrals to hospital paediatric outpatients and the use of urgent care and A&E services.
Community cardiology

- We will pilot a community-based, nurse-led alternative to hospital treatment for cardiac pathways, including atrial fibrillation, hypertension, heart failure and chronic chest pain. The service will improve the quality of referrals to secondary care and reduce unnecessary referrals for patients.

- We will learn from a similar pilot in Westminster, and will consider locating this service in both the north and south of the borough.

c) Mental health

We have developed a unique service to improve management of mental health patients in primary care – the Primary Care Mental Health Service (“PCMHS”). The service is for patients with common mental health problems such as depression and anxiety, as well as for those with more complex needs and those with stable severe mental illness who need more support from time to time. Our enhanced, patient-centred model of primary care provision for mental health supports more people with mental health needs and additional needs in primary care settings. The multi-disciplinary team will provide a single point of access for mental health patients and provide triage and risk assessment, case management, short interventions and delivery of training and education to GPs.

The PCMHS is delivered by a partnership of four organisations: a local community provider, a local mental health trust, and two organisations from the third sector - Depression Alliance and the Reader Organisation. The organisations work together closely to provide a seamless service, using planned care pathways. There is a single point of access to the service. The range of treatments available are coordinated and tailored to the needs of the individual patient.

As part of North West London pilot, we will further develop this “primary care plus” system to deliver a new ‘supported discharge’ pathway which will transfer responsibility of care for appropriate patients from community mental health teams to GP practices using our multi-disciplinary team based in primary care. This pathway will include criteria and shared care protocols for the transfer of responsibility; a case review to confirm criteria have been met; and joint work between the multi-disciplinary mental health team, the GP and the patient to develop a care plan. Shared care electronic communication and data processes will support this pathway. This supported discharge system is outlined in exhibit 12 below.
Creation of a "Primary Care Plus" system will enable GPs to care for patients transferred from CMHT care.

**Mental health training for GPs**
- Dedicated course aimed at providing education in basic mental health care, for example:
  - 4-6 week course, 1 evening per week
  - Run by experienced mental health experts
  - Each practice nominates 1 member to participate
- Courses run annually to ensure continual training

**Ongoing CPN support for more complex patients**
- CPNs provide low level step down care to patients transferred from secondary care into primary care
- Average 2-3 contacts per patient in first 6 months step down
- Annual assessment
- 2-3 appointments per patient per year
- Follow up aid from care support workers
- CPN work overseen by 1 psychiatrist in each borough
- Patient care remains the overall responsibility of the GP at all other times

**Expert mental health advice for GPs**
- Telephone and e-mail support from mental health consultant:
  - Part of "on call" duties for consultant
  - 5 hour per week per CCG dedicated to answering GP mental health questions (e.g., advice on medication, care plans etc.)
  - Informal coaching of GPs as part working interaction with Shared Care Team and peer group and MDG meetings

**Mental health induction for GP surgeries**
- Annual session run by CPN in each GP surgery to provide overview of care for mental health patients, including:
  - Discussion of unique care requirements of mental health patients
  - Introduction to patient care pathway
  - Provision of information on further support for mental health patients (e.g., voluntary sector)

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<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPN</td>
<td>Provide low level step down care to patients transferred from secondary care.</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>Support through telephone and e-mail, including advice on medication.</td>
</tr>
<tr>
<td>Care support workers</td>
<td>Assist with step down care for complex patients.</td>
</tr>
<tr>
<td>GP</td>
<td>Attend dedicated courses aimed at providing education in basic mental health care.</td>
</tr>
</tbody>
</table>
3.3. Responsive urgent care

a) Enhancing our rapid response service

- As part of our ‘Putting Patients First’ initiative, patients will have access to a rapid response team with a broader scope and skill-set when a rapid response is required. A rapid response nursing team will be available 24 hours a day, 7 days a week (a rapid response nursing team from 8 am – 10 pm and an out-of-hours nursing team at night).

- The rapid response team will intervene quickly and early to prevent avoidable admissions and keep people at home. The team will incorporate nurses and therapists, as well as additional social care support to provide timely assessment and establish the packages of care required to support people in their own homes. The team will stabilize the patient before they are transferred to services for ongoing care or further short-term community treatment e.g. intensive rehabilitation and reablement services.

- In the future, we will set explicit standards for referral to this service and clarify the level of GP input required in order to maximise the effectiveness of the service.

b) Care of the elderly consultant

- We will invest in a community-based care of the elderly consultant as part of our ‘Putting Patients First’ initiative. This will provide additional capacity and expertise in primary care to care for complex elderly patients in their homes and so avoid their exposure to hospital-acquired infection.

- The consultant will support and supervise the rapid response team, enabling them to manage more complex patients at home. They will take on short-term clinical responsibility for up to 10 days for particularly complex and unwell patients cared for by the rapid response team. This consultant will assess patients discharged from the rapid response team, and develop a care plan with the patient and their GP. They will provide advice to GPs on the management of elderly patients.

c) End of life care

- We will implement a joint strategy on end of life care based on an integrated health and social care system. At its centre is use of the ‘Coordinate My Care’ planning tool and implementation of the Gold Standards Framework, which will ensure patients at the end of their lives are enabled to have a “good death”, receive high quality integrated care including input from palliative care nurses, and are cared for and die in their place of choice.
This strategy builds on work already started by nursing homes, out of hours doctors, and emergency services. It promotes early identification, co-ordination and planning of care for all patients with a death limiting disease. The views and medical care wishes of every patient will be treated with respect and dignity.
3.4. Integrated care for people with long-term conditions

a) ‘Putting patients first’ – an integrated health and social care response

We will provide an integrated health and social care response to support patients with complex long-term conditions, their families and carers, with support from the voluntary sector where appropriate. These patients often have co-morbidities and are frequent users of hospital and community-based health and social care services. In the past, poor coordination and integration between these services and ambiguity as to how a patient is ‘stepped up’ or ‘stepped down’ from urgent to managed care service has caused individuals to ‘fall through the gap’. In the future, patients will move seamlessly between these services.

- We will place patients at the centre of their care and empower them to take greater control and responsibility for their health and wellbeing.
- We will form two provider networks in West London (see 4) to improve joint working and coordination between community providers.
- We will review the joint working arrangements of our community-based health and social care services, including rapid response nursing, intermediate care (reablement and rehabilitation), district nurse case management and care management teams, and create a seamless care pathway between them. Clear protocols will support the seamless transfer of patients from the rapid response team (including rapid social care) and intermediate care teams. Liaison arrangements between the intermediate care team and the GP will be clarified.
- Complex patients will receive a single, integrated health and social care assessment and develop a multi-disciplinary care plan (see 3.1) with the appropriate professionals. Assessments will include a physical and mental health assessment, medication review, formal and informal care arrangements, and a social care needs and carers review.
- Complex patients will be designated an appropriate care coordinator e.g. social worker, district nurse, GP, practice nurse, who will work with a team of professionals to organise and deliver personalised integrated patient care. The coordinator will use the care plan as a structure to make referrals to the required services. They will also liaise with the different professionals involved in the patient’s care, monitor their progress, ensure a crisis plan is in place, and follow patients into hospital to support their early discharge. The GP will retain medical responsibility for their patients.

b) Integrated care pilot
Our Putting Patients First initiative builds on the success of the integrated care pilot and incorporates a complementary model of integrated care that we have successfully tested in inner North West London.

- High level multi-disciplinary groups of acute, primary care, social care and mental health professionals share a common database of patients, which is used to identify patients at greatest risk of hospital admission (‘risk stratification’). They work together to identify and review patients at risk of becoming ill. The focus of the ICP is currently on diabetic patients and the over 75s, but will be expanded to include additional respiratory and cardiovascular pathways.

- As part of NW London pilot the model will include a GP single assessment tool for common mental health disorders, a single point of access for psychological therapies, and a stepped care psychological therapy pathway for people with long-term conditions.

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

- A new IT tool will automate the data and coordinate risk assessment, work planning and communication within the groups. Exhibit 13 outlines the working arrangements.

- We have also multi-disciplinary teams at the practice level, which mirror higher level groups to improve the coordination of care for all patients whose health and social care needs put them at risk of unnecessary hospital admission.
c) Medicines management

Our ‘Putting Patients First’ initiative will incorporate an improved medicines management scheme.

- Nationally, between 33% and 50% of medicines prescribed for long-term conditions are not taken as recommended. Evidence indicates that up to 6% of all hospital admissions are medicines-related.

- We will introduce a new medicines support service to work with patients at risk of not taking their medicines correctly. The service will support patients to manage their own care better at home.

- The service will have two key components: (1) medicines adherence and support, such as tailored dispensing, to ensure patients take their medicines as intended. (2) Targeted review of patients' medicines regimes to prevent medicines-related harm.
3.5. Supported discharge

a) Early supported discharge into well organised community care

People are staying in hospital longer than they need to, often because of a lack of support for timely discharge and poor coordination between health and social care.

- In the future, our Putting Patients First initiative will ensure joined-up, integrated health and social care discharge support.
- Care coordinators will follow their patients into hospital and coordinate plans to ensure a seamless discharge from acute settings into integrated community-based intermediate health and social care services.
- Care coordinators will use a new single point of access for the intermediate care services, through which they can access a range of services including community rehabilitation, reablement, tele-care and community equipment.
- Care coordinators will provide patients with advice on what to expect after hospital and who they should contact if they feel unwell.

b) Psychiatric Liaison Services

- Psychiatric Liaison support patients in acute hospitals with mental health needs.
- We will develop ‘optimal standard’ psychiatric liaison services in our hospitals. These multi-disciplinary liaison teams will provide 24x7 emergency cover to A&E and wards, and direct care, support and training to staff during normal working hours.
- The Psychiatric Liaison teams will support clinicians by improving mental care and risk management in acute hospitals, and training staff in mental health care. This will result in fewer admissions, reduced length of staff, and lower accommodation costs for local authorities (more patients discharged home directly).
### Summary of Optimal Standard Liaison Model for a NWL hospital of ~500 beds

#### What is it?
- The 'Optimal Standard' is a high quality liaison psychiatry service designed to operate in acute general hospitals in NWL, providing the following services:
  - Care for patients with significant mental health needs (outside specialist MH units)
  - Training for other hospital staff to enable them to support patients' mental health needs
  - Integration with other parts of the health system e.g., GPs, specialist mental health teams

#### Who delivers the service?
- 2 Consultant Psychiatrists
- 1 Team Manager
- 12 Team Nurses (Bands 6 and 7)
- 1 Alcohol Nurse
- 2 Specialist Registrars

#### What does the service look like?
- Highly visible multi-disciplinary mental health team fully integrated into the hospital
- Single point of contact for all patients (10+) in hospital with diagnosed or suspected mental health conditions of any severity
- Rapid response for patients requiring mental health support and 24/7 support in A&E and wards
- Training experts on mental health problems and related issues for non-mental health clinicians
- Coordination with out-of-hospital care providers and housing services
- Integrated with broader health and social care system
- Single management structure
4. How we will work together

Our strategy will have significant implications for how and where we deliver care in West London. In order to achieve our vision and implement the transformational initiatives we have described, we need to change how we work.

There will be five main changes to the way we work, as set out in exhibit 15.

Exhibit 15

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

2. We have created two new **provider** networks around which we will deliver care.

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

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

5. As we take further activity into the community, we need to allocate clinical and office space to this increase increased level of activity – we are exploring options including St. Charles Health and Wellbeing Centre, and Earl’s Court Medical Centre.

The following sections examine each of these in detail.
4.1. Our organising principles

Implementing the changes described in section 3 of our strategy will require providers in West London to work together closely. Providers must work to ensure care is organised around our patients, and to extend the range and quality of out of hospital services provided in the community.

To help providers work together effectively, we have developed some key organising principles, as set out in exhibit 16.

Exhibit 16

<table>
<thead>
<tr>
<th>Core principles of how we organise</th>
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</thead>
<tbody>
<tr>
<td>✔️ We need to organise in a way that enables collaboration and co-ordination of care across West London</td>
</tr>
<tr>
<td>✔️ We must avoid duplication of activity</td>
</tr>
<tr>
<td>✔️ Activity should be delivered at most efficient point financially, equally balanced with where it is most effective for the patient</td>
</tr>
<tr>
<td>✔️ Care will be GP-led, with primary care teams remaining central to patient care</td>
</tr>
<tr>
<td>✔️ We should design our care around network practice population which broadly reflects geographical boundaries</td>
</tr>
<tr>
<td>✔️ Existing contracting arrangements should not constrain the design</td>
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</tbody>
</table>

Our strategy has some big changes for how and where care is delivered

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

Providers need to work more closely together to ensure care is organised around the patient and to extend the range of services offered in the community.
4.2. Establishing two new provider networks

We will establish two new provider networks in West London – one in the north, and one in the south, around which we will deliver out of hospital care in the community. These networks will facilitate improved coordination and integration between our primary and community providers.

Each provider network will have its own integrated health and social care hub, in which we can base new integrated services. As set out in exhibit 17, our networks will have three key roles: coordinating out of hospital providers, providing additional out of hospital services, and facilitating the sharing of skills and services in primary care.

Exhibit 17
4.3 Organising into three levels of care

We will organise and deliver care across three levels in West London: in our 55 GP practices, two new provider networks, and at the CCG-wide level. Organising care this way will help us to clarify responsibilities between providers, improve accountability and facilitate coordination of care between providers. Exhibit 18 outlines the roles of these three levels for West London.

Exhibit 18

We will provide a range of services at each level. GP practices will remain at the foundation of care, providing routine care near to where patients live, retaining clinical accountability, and assisting people in the navigation of complex care choices. Exhibit 19 shows the services we will provide at each level in the future.

Exhibit 19
4.4. Coordinating health and social care services

We will organise and co-locate our community health and social care providers around our two provider networks, with GP practices at their centre.

a) Realigning local teams

As described in exhibit 20 below, we will realign local teams – including rapid response, district nursing and intermediate care (reablement and rehabilitation) teams with our new provider networks and co-locate teams where appropriate to facilitate their integration. Multidisciplinary groups (MDGs) - as part of the integrated care pilot (ICP), will be aligned to and coordinated by these networks.

b) Named care coordinators

We will establish an integrated health and social care service through named care coordinators. Care coordinators (e.g. district nurse, GP) will have a list of names of patients from the local area for whom he or she will be responsible. The care coordinators will be aligned to the networks to improve accountability.

We recognize that there is a good range of services available for patients with long-term needs that are hard to find and sometimes difficult to access. This is made worse by poor communication between health and social care. We are working closely with the voluntary sector to pilot a GP practice-based navigator role in five practices. The care navigators will: support patients to navigate between services; improve planned uptake of services, increase attendance, and reduce unplanned demand. The navigators will provide live ‘feedback’ on the service to GPs.
c) Working better with our partners

We are committed to working closely with our health and social care partners to improve the coordination of care for our patients.

- **Health and Wellbeing Boards:**
  
  We have Board-level representation on both Westminster and Kensington & Chelsea Health & Wellbeing Boards. Our Chair, Deputy Chair and Managing Director attend the developmental workshops for Kensington and Chelsea; our Westminster Lead and Managing Director attend the developmental workshops for Westminster.

  West London CCG has presented its out of hospital strategy to the Kensington and Chelsea Health and Wellbeing Board, outlining current issues in the health care system and its vision for out of hospital care. It has informed the Board about the planned development of new service provision hubs, in the North and South. We aim to do a similar presentation at the next Westminster Health and Wellbeing board. Joint Commissioning staff and senior Local Authority staff have been instrumental in the development of this strategy.

  In the future, our Health and Wellbeing boards will play an important role in informing how we commission services. For example, they will help us make plans to increase the number of people that stop smoking, increase number of NHS health checks, tackle obesity, and increase uptake of screening so early treatment can be provided. They will also provide strategic direction to actions that the local health service can take with the Council to prevent ill-health.
At the heart of this strategy is coordinated multi-agency support for local health promotion and disease prevention efforts so that our residents take action to help them better manage their health and live independent and fulfilling lives.

**Exhibit 21**

**d) Engaging our patients, users and carers**

We are committed to:

- Engaging patients and the wider public in planning, developing, and implementing our commissioning arrangements;

- Ensuring responsive two-way communication and information sharing process with our constituents;

- Establishing clear structures, roles and responsibilities to ensure continuous and meaningful engagement;

- Ensuring that we monitor and evaluate how effective we are in implementing this commitment, and learn from and improve based on this experience;

- Public education.

Exhibit 22 outlines the mechanisms we are putting in place to ensure effective communication and engagement with patients and the public.
WLCCG is committed to the principle of shared decision making with our patients and public. We are committed to:

▪ Engaging patients and the wider public in planning, developing, and implementing our commissioning arrangements

▪ Ensure responsive two-way communication and information sharing process with our constituents

▪ Establish clear structures, roles and responsibilities to ensure continuous and meaningful engagement

▪ Ensure that we monitor and evaluate how effective we are in implementing this commitment, and learn from and improve based on this experience

▪ Public education

Our engagement structure to ensure systematic engagement

<table>
<thead>
<tr>
<th>Health and wellbeing board</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCG board</td>
</tr>
<tr>
<td>Clinical lead for public and patient engagement</td>
</tr>
<tr>
<td>Patient representative (Member of CCG Board and patient panel)</td>
</tr>
<tr>
<td>Patient panel of local patient and voluntary sector representatives</td>
</tr>
<tr>
<td>Existing patient reference groups</td>
</tr>
</tbody>
</table>

Key roles

▪ Representative on the health and wellbeing board
▪ Acts on behalf of the board – attends meetings, public meetings etc.
▪ Leads regular meetings with Healthwatch 4 times a year

▪ Sits on the board, attends all board meetings
▪ Provides direct link between patients and the decision making process
▪ Chair elected from core panel membership through annual election
▪ Caretaker of flow of information between patient panel and WLCCG board
▪ Acts as voice of patient and voluntary sector groups

▪ Advise and question board on public and patient engagement issues
▪ Overseas development & implementation of the WLCCG OOH strategy
▪ Formed by selection process, representatives from wide range of patient groups including residents, mental health, older residents, disability etc.
▪ Help ensure effective communication between patients, public, and CCG

▪ E.g., INWL lay procurement panel
▪ Database of key patient reference groups available by area for commissioners

The CCG’s existing Patient Panel - formed of local patient representatives, LINKs and voluntary organisations, will oversee the implementation of this strategy. The Patient Representative on the CCG Board is also a member of the Patient Panel and will provide a direct link between patients and the CCG Board. They will be a powerful voice at Board level for patient and voluntary sector organisations.

The CCG is also establishing a new Patient and Public Engagement Board sub-committee. The sub-committee will be led by a GP clinical lead, accountable to the Board, with delegated responsibility for patient engagement.
4.5. Estates

Our plans to move care out of hospital and into community settings mean that more space will be needed in the community. We will require space to deliver care such as more beds in the community, and to carry out more outpatient appointments in community settings. In addition, closer working between professionals will mean that they need office space to co-locate and more meeting rooms.

We propose to establish two new provider hubs, with roles as set out in exhibit 24 below.

Exhibit 24

<table>
<thead>
<tr>
<th>What a hub would do</th>
<th>What a hub would not do</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Provide an integrated non-acute setting for care delivered by specialists, GPs, and Allied Health Professionals</td>
<td>▪ Function only as an outpatient specialist centre</td>
</tr>
<tr>
<td>▪ Organising base for co-located community and social care teams</td>
<td>▪ Displace GP practices, although some may co-locate</td>
</tr>
<tr>
<td>▪ Serve as a base for consultants to provide community led services, and for mobile Allied Health Professionals or community health services</td>
<td>▪ Operate in isolation</td>
</tr>
<tr>
<td>▪ Host regular contact among consultants, MDTs, CHS and GPs</td>
<td>▪ Duplicate what is already provided in other settings</td>
</tr>
<tr>
<td>▪ Allow local access to advanced diagnostic equipment</td>
<td>▪ Provide care in all clinical areas</td>
</tr>
<tr>
<td>▪ Provide specialist care in a selection of clinical areas</td>
<td>▪ Be identical to other hubs</td>
</tr>
</tbody>
</table>

Each hub will be different, depending on local circumstance and need. Hubs will not only function as outpatient specialist centres, nor will they replace local GP surgeries, although some GP practices may decide to co-locate within the hubs. Hubs will not duplicate what is already provided in other settings; and they will operate in cooperation with other services, not in isolation.

We have considered a number of different options for the new hubs in West London. We have agreed that our hubs will be based in St. Charles Health and Wellbeing Centre and Earl's Court area, including Earl's Court Medical Centre, Earls Court Health and Wellbeing Centre and Chelsea and Westminster – see exhibit 25, because of the reasons set out in exhibit 26.
This section described the new organisational arrangements needed to support high quality, accessible and responsive services in the community. The next section develops this further examining key enablers required to support this change.

5. Supporting the change

We have identified four key enablers required to support the transformation in out of hospital services in West London.
The four enablers and proposed solutions for each are outlined in exhibit 26 below.

Exhibit 26

<table>
<thead>
<tr>
<th>We must consider…</th>
<th>Recommended solutions</th>
</tr>
</thead>
</table>
| **1. Governance and Performance Management** | ▪ WLCCG has organised into two different structures – as provider networks and complimentary Commissioning Learning Sets  
  ▪ Each set of structures will have its own governance system, which coordinate at CCG level  
  ▪ The CLS’s will be responsible for performance managing primary care, and we have started developing a clear system to do this |
| **2. Contracts and incentives** | ▪ Over the next few months we will explore solutions to key questions, including:  
  ▪ Develop incentives to maximise use of new community services and to reduce unplanned admissions  
  ▪ Agreeing suitable tariff arrangements for the sharing of staff and premises  
  ▪ Ensure clarity on services provided within core contracts and those over and above them |
| **3. Information tools** | ▪ We are committed to develop an IT solution that will enable our providers to share patient data online, in real time with all appropriate health and social care professionals  
  ▪ We are exploring a number of different options, including solutions from commissioning services support, Westminster’s interoperability project, online data sharing in Scotland, and the ICP |
| **4. People and organisational development** | ▪ We have developed new leadership behaviours to drive changes in services and support new ways of working  
  ▪ Organisational and workforce development to enhance skills and increase productivity |

The following sections outline how we address each of these key enablers.
5.1 Governance and performance management

West London CCG has organised into two different structures: two provider networks and five complementary Commissioning Learning Sets (CLSs). Each set of structures will have its own governance system, coordinated at CCG level.

- Commissioning learning sets

We have established five new commissioning learning sets (CLSs). These CLSs will be responsible for performance managing primary care; providing peer-to-peer review, challenge and mentoring support; and sharing knowledge and learning within primary care. They meet monthly and at least one GP from every one of our 55 practices has to be present. Exhibit 28 outlines the roles of the networks and CLSs respectively.

Exhibit 27

- Governance arrangements

We will establish clear governance arrangements both in the networks and the CLSs to ensure roles, responsibilities and accountabilities are clear and well-understood. See exhibits 28 and 29 below.
Exhibit 28: Governance structure of provider networks

Both structures will have a clear system of governance e.g. provider networks:
- **CCG Board**
- **Provider Network 1**
  - Clinical Lead
  - Lead – Community Services
  - Lead – MH
- **Provider Network 2**
  - Clinical Lead
  - Lead – Community Services
  - Lead – MH

- **Operational Leads** – e.g., community services, MH, social care, specialist OOH care
- **Key contact for OOH providers for particular area, e.g., social care**
- **Monitors issues and performance of providers in the relevant area**
- **Clinical Leads**
- **Oversee clinical governance in provider networks**
- **IMG: Co-chaired by GP and local authority representatives**
- **Provide clinical leadership**

Exhibit 29: Governance structure of CLSs

**CLS roles and responsibilities**
- **GP Practice leads**
  - Overall accountability for patient health
  - Provide links to patient groups
- **CLS GP facilitators**
  - Monitor CLS performance and variance
  - Stakeholder engagement
  - Organize a lead constructive dialogue with underperforming practices
  - Co-develop solutions with practices to address problem areas
  - Monitor and oversee local rewards and penalties, including incentive scheme and escalation of issues to the board
- **Practice leads**
  - Quarterly plenaries will be held by the Board to discuss issues common across CLS’s, and to ensure exchange of lessons between CLS groups.
- **CCG Chair**
  - Ensure robust clinical governance and monitor outcomes
  - Provide support to CLS GP facilitators, e.g., in peer challenge, underperforming practices
  - Inform board of issues escalated to CCG board, and decide on best course of action for repeatedly poorly performing practices
  - Escalate major issues to NCB where appropriate

We will do more work over the coming months to define the relationship between the two networks and commissioning learning sets, including how they are aligned.

- **Performance management scheme**

  Through our Commissioning Learning Sets (CLSs), we will establish a clear clinician-led system for performance within primary care. The system will have the following steps, as outlined in exhibit 30 below.
Exhibit 30

Steps in local performance management

1. Establish clear commitment and plan for performance management
   - Outline clear plan and expectations for performance management
   - Make clear commitment to patients and each other to implement what is expected

2. Establish clear targets and indicators to measure progress
   - Select key performance indicators, which should include referrals to OP and NEL admissions for LTC
   - Develop a holistic, balanced scorecard across all aspects of performance e.g., quality, access, referrals etc.
   - Set targets and thresholds by network and practice to define different levels of performance

3. Track performance effectively
   - Transparent monitoring process to track performance against stated goals
   - Performance dashboards cascaded down from the CCG, indicating current performance vs. targets
   - Publish regular scorecard of performance by practice

4. Peer review of performance
   - Where performance is strong identify how it can be shared for wider benefit and celebrated
   - Constructive dialogue with under performing practices to pinpoint problem areas
   - Establish clear plan of action with deadlines and metrics to track performance improvement
   - Develop practical and proactive solution to address challenges, with named responsible persons
   - Establish clear plan of action with deadlines and metrics to track performance improvement
   - Regular reporting on progress and consequences for poor performance agreed

5. Rewards, incentives and consequences
   - Explore payment to local practice groupings or practices on achievement of targets
   - Requirement for local practice groupings to evidence what they have achieved against agreed plans to secure payment
   - Agreed consequences for continued under performance, including escalation to CCG board on the first instance, and ultimately to NCB

A series of review meetings will take place to measure performance and encourage robust performance dialogue. GP practices will carry out day-to-day monitoring of performance. CLSs will review clinical performance and benchmark against others on a monthly basis. On a quarterly basis they will review reports on priority areas, including prescribing, which will go to the CCG board. The CCG board will receive overall quarterly performance updates.

Exhibit 31 shows how performance information will flow between the three levels.

Exhibit 31

Our system to monitor and review progress

We will develop a set of performance metrics to measure progress in quality, access and responsiveness, coordinated health and social care, and financial sustainability.
Exhibit 32 provides example indicators, illustrative of what could be measured at the practice level.

Exhibit 32

<table>
<thead>
<tr>
<th>Priority</th>
<th>Potential practice level indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>▪ Consistent high quality primary care</td>
</tr>
<tr>
<td></td>
<td>▪ # LTC/E of L patients with care plans</td>
</tr>
<tr>
<td></td>
<td>▪ QOF sources</td>
</tr>
<tr>
<td></td>
<td>▪ New indicators reflecting out of hospital standards</td>
</tr>
<tr>
<td>Access &amp; responsiveness</td>
<td>▪ Good patient access</td>
</tr>
<tr>
<td></td>
<td>▪ Responsive health service</td>
</tr>
<tr>
<td></td>
<td>▪ MORI access poll</td>
</tr>
<tr>
<td></td>
<td>▪ Unscheduled NEL admissions</td>
</tr>
<tr>
<td></td>
<td>▪ New indicators reflecting standards</td>
</tr>
<tr>
<td>Coordinated health and social care</td>
<td>▪ Integrated and coordinated health and social care response</td>
</tr>
<tr>
<td></td>
<td>▪ Response times for community services and social care</td>
</tr>
<tr>
<td></td>
<td>▪ MDG composition and activity</td>
</tr>
<tr>
<td></td>
<td>▪ Multichannel access to care plans</td>
</tr>
<tr>
<td>Financial sustainability</td>
<td>▪ Deliver planned care initiatives</td>
</tr>
<tr>
<td></td>
<td>▪ OP referral rates</td>
</tr>
<tr>
<td></td>
<td>▪ IP admission rates</td>
</tr>
<tr>
<td></td>
<td>▪ A&amp;E rate</td>
</tr>
<tr>
<td></td>
<td>▪ Emergency admissions rate</td>
</tr>
<tr>
<td></td>
<td>▪ Deliver unscheduled care initiatives</td>
</tr>
</tbody>
</table>
5.2. Contracts and incentives

Changes to services and ways of working will require us to revise our contracts and incentives, as outlined in exhibit 33.

Exhibit 33

<table>
<thead>
<tr>
<th></th>
<th>Facilitate financial flows within practice groupings, for example incentivise inter-practice referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Align provider and patient interests by incentivising providers to meet the out of hospitals standards</td>
</tr>
<tr>
<td>3</td>
<td>Manage performance at the level of practice groupings, asking providers to share data on their performance on a locality level</td>
</tr>
<tr>
<td>4</td>
<td>Commission services from provider networks</td>
</tr>
<tr>
<td>5</td>
<td>Promote financial stability by incentivising providers to reduce the total cost of a patient’s care. For example, GPs and practice groupings could be incentivised to reduce non-elective admissions for their patients.</td>
</tr>
<tr>
<td>6</td>
<td>Agree suitable tariff arrangements for sharing staff, premises and services</td>
</tr>
<tr>
<td>7</td>
<td>Develop incentives to maximise use of new services/tools and thus reduce unplanned admissions</td>
</tr>
<tr>
<td>8</td>
<td>Create clarity on the services provided within core contracts, and those over and above core contracts (local enhanced services)</td>
</tr>
<tr>
<td>9</td>
<td>Resolve potential conflicts of interest (e.g., LMA, Urgent Care Centres)</td>
</tr>
<tr>
<td>10</td>
<td>Consider contractual implications for GPs, Trusts, staff (rotas etc.), and who holds contracts for enhanced services — the hub or practice</td>
</tr>
</tbody>
</table>

We have a number of contractual levers that we can use:

- The type of contract for the provision of services
- The potential to select alternative providers (Any Qualified Provider initiative)
- The use of the Local Enhanced Service: agreed incentives for local GP practices, or DES (as directed by the DoH).
- Flexing or withholding a significant proportion of contract payment if providers fail to meet goals on a service by service basis
- Patient satisfaction
- Audits and independent review
- CQUIN’s for quality standards
- Increased productivity including higher percentage of face to face time (clinician to patient)
- Teams to be mapped to GP practices with named link practitioners
- Payments linked to patient outcomes
- QOF points

5.3. Information tools
Central to achieving our vision of transforming care is ensuring that all appropriate health and social care professionals can share patient data on-line in real time.

As set out in exhibit 34, we will invest to ensure that GPs, community, acute and mental health teams have linked IT systems and access to real-time shared records. Information will be transparent and will help us drive up standards across West London. It will mean:

- Planned care will become more consistent as referrals follow precisely defined pathways. GPs will have access to detailed reporting on referrals including test results such as blood, x-ray and scan results.
- Urgent care will become better informed because all information input by GPs will be visible to staff at Urgent Care Centres (UCCs). Care received by a patient at an UCC will be visible to GP and prompts will be given for follow-up actions.
- Long term care will become more pro-active as IT tools enable GPs to risk stratify their patients, develop care plans with their patients, and facilitate regular check ups and early intervention.

Further issues under active consideration are data quality, on which to base patient decisions and information governance, ensuring that the correct data is available for the appropriate health care professional, at the correct time and that patient confidentiality is maintained in all circumstances.

In addition, patients will benefit from new forms of communication such as text messaging and tele and video conferencing which can be targeted appropriately and can offer a further opportunity to support at risk patients.

These IT developments will have significant impact on our patients. Our patients will benefit from improved continuity of care between providers. All providers will be fully informed about a patient’s condition, so the quality of decision-making and therefore patient care will improve. Patients will not have to repeat their stories to different care professionals, and will not have to undergo repeated investigations in different places.
### What better information sharing will achieve

<table>
<thead>
<tr>
<th></th>
<th>Real-time shared records inform providers and link GPs, community, acute and mental health teams</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Transparency of information gathered will help us drive up standards across West London</td>
</tr>
<tr>
<td>3</td>
<td>Planned care becomes more consistent as</td>
</tr>
<tr>
<td></td>
<td>- Referrals follow precisely defined pathways</td>
</tr>
<tr>
<td></td>
<td>- GPs have access to granular reporting on referrals</td>
</tr>
<tr>
<td>4</td>
<td>Urgent care becomes better informed as</td>
</tr>
<tr>
<td></td>
<td>- All information input by GP is visible to staff at UCC</td>
</tr>
<tr>
<td></td>
<td>- Care is visible to GP and prompts are given for follow-up actions</td>
</tr>
<tr>
<td>5</td>
<td>Long term care becomes more pro-active through</td>
</tr>
<tr>
<td></td>
<td>- Risk stratification of patients by GPs</td>
</tr>
<tr>
<td></td>
<td>- Care plans are put in place</td>
</tr>
<tr>
<td></td>
<td>- Enabling regular check-ups and early intervention</td>
</tr>
</tbody>
</table>
We will develop our IT systems by learning from the implementation of a range of different IT initiatives. These include:

- Real-time, online data sharing in Scotland, led by Professor Andrew Morris, Chief Scientist of Scotland and Professor of informatics and diabetes in Dundee.
- The Integrated Care Pilot (ICP) has a separate portal for data entry, specifically for used for elderly and diabetic patients.
- The Westminster interoperability project, which is connecting local systems across the acute, community, primary care and social services sector.
- IT support from Commissioning Support Organisations in London, which will provide an opportunity for North West London to unify IT systems across the cluster.
5.4. People and organisational development

Strong and effective leadership will be required to drive significant change in services and ways of working. Exhibit 35 outlines the leadership behaviours which we are committed to as we begin implementing this strategy and building our new provider networks and reconfigured CLSs.

Exhibit 35

We are also committed to investing in developing the capacity and capability of our workforce in order to deliver our out of hospital strategy. Exhibit 36 outlines the support we should provide to staff in 3 areas: mobilisation, developing new skills to provide new models of care and prevention; changing the roles and responsibilities of staff to deliver productive prevention and care.
We recognize there is variation across out of hospital services. We will use primary care and other quality standards as a framework for organisational and workforce development in these areas:

<table>
<thead>
<tr>
<th>Mobilization</th>
<th>Change management&lt;br&gt;Cultural change – increased prevention through patient education and information by all clinical staff&lt;br&gt;Clinical risk management in the community and practitioner autonomy&lt;br&gt;Changing roles and responsibilities to deliver integrated health and social care services and support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skills development</td>
<td>Shift and embed skills from acute to out of hospital settings&lt;br&gt;Safe working environments, including lone, remote and outreach working&lt;br&gt;Appropriate skill mix across care pathways, including the different approaches to risk management and practitioner autonomy&lt;br&gt;Develop CLS program through sharing best practice and enablers such as peer-review and audit&lt;br&gt;Career progression for Practice Nurses and Nurse Practitioners&lt;br&gt;Shift of staff – training and education required for acute nurses to extend their clinical knowledge and skills management of long-term conditions&lt;br&gt;Consider improved career progression for practice nurses and nurse practitioners</td>
</tr>
<tr>
<td>Productivity</td>
<td>Prevention and self-care&lt;br&gt;Practice Team Development, including increasing deployment of Practice Nurses, Practice Managers and Health Care Assistants&lt;br&gt;Increase patient contact time&lt;br&gt;Seamless interface between CLSs and provider hubs and social care&lt;br&gt;Ability to deliver more within the community environment</td>
</tr>
</tbody>
</table>

Making progress on these five enablers will be critical to the successful implementation of this strategy. In the next section, we outline the ‘next steps’ the CCG will need to take to develop these enablers and begin implementing the initiatives outlined in section 3.
6. Investing for the future

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

Patients will receive care in a variety of settings. Where possible, care will be delivered at home, or close to home. As care becomes more specialised, patients will need to travel further. GPs will offer a broader range of services in local practices by working in two provider networks across West London. Two of our existing sites – St. Charles Health and Wellbeing Centre and Earl's Court Area Hub including Earl's Court Medical Centre will provide additional services locally, serving as a support ‘hub’ to local integrated teams. The services offered within these hubs will include community outpatient appointments (e.g. respiratory and paediatric clinics).

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

<table>
<thead>
<tr>
<th>Where you will receive care¹</th>
<th>Services offered</th>
<th>Additional Investment</th>
<th>Additional workforce in the community</th>
<th>Additional space</th>
</tr>
</thead>
<tbody>
<tr>
<td>At Home²</td>
<td></td>
<td>£3.5-2.0m</td>
<td>36-40 VTE</td>
<td>Access to consulting rooms/team room</td>
</tr>
<tr>
<td></td>
<td>Specialist community nursing e.g. District Nursing and Respiratory</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Elderly care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Putting Patients First</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medicines adherence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>At a GP Practice³</td>
<td></td>
<td>£3.5-2.0m</td>
<td>14–20 VTE</td>
<td>200-300m</td>
</tr>
<tr>
<td></td>
<td>Core primary care services</td>
<td></td>
<td></td>
<td>-3 consulting rooms</td>
</tr>
<tr>
<td></td>
<td>Local Enhanced Services e.g. Phlebotomy</td>
<td></td>
<td></td>
<td>Team room</td>
</tr>
<tr>
<td></td>
<td>Specialist community clinics e.g. diabetes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Extended access to Primary care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In Community Health Centres</td>
<td></td>
<td>£2.0-2.5m</td>
<td>34–40 VTE</td>
<td>1,100-1,200m</td>
</tr>
<tr>
<td></td>
<td>A range of diagnostics e.g. ultrasound and X-ray</td>
<td></td>
<td></td>
<td>-3 consulting rooms</td>
</tr>
<tr>
<td></td>
<td>Rapid access to blood tests</td>
<td></td>
<td></td>
<td>Team rooms</td>
</tr>
<tr>
<td></td>
<td>Specialist community clinics e.g. MSK, Mental Health, Dermatology, Respiratory and Paediatrics</td>
<td></td>
<td></td>
<td>-24 beds</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>£5.7m</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The staffing and investment identified in the figure above is indicative based on CCG strategic plans and is dependent on the release of funding from acute providers as activity transfers from acute settings to community settings. Specific investments will be agreed through the normal planning and governance processes of the CCG and as such the production and agreement of robust business cases demonstrating both value for money and affordability to the CCG.

The reductions in acute activity planned by the CCG are consistent with and reflected in the acute PCBC base case modelling.
7. Next steps

This strategy sets out an ambitious plan for improving out of hospital care in West London. Implementation is crucial – the quicker implementation is started the faster the benefits for patients can be realised.

7.1. Implementing our key initiatives

As described in exhibit 38, we have started implementing some initiatives; others are ramping up to their full scope; and others will be implemented over the next 12 months.

Exhibit 38

<table>
<thead>
<tr>
<th>Activity</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q2</td>
<td>Q3</td>
</tr>
<tr>
<td>RIS</td>
<td>Roll-out</td>
<td>Ramp-up</td>
</tr>
<tr>
<td>Community mental health</td>
<td>Re-design</td>
<td>Implement and ramp-up</td>
</tr>
<tr>
<td>Putting People First</td>
<td>Review care pathways</td>
<td>Implement changes and ramp-up</td>
</tr>
<tr>
<td>Rolling out 111</td>
<td>“Live”</td>
<td>Ramp-up</td>
</tr>
<tr>
<td>A) Urgent case services</td>
<td>Develop integrated services</td>
<td>Implementation and ramp-up</td>
</tr>
<tr>
<td>B) Care of Elderly Consult.</td>
<td>Business case</td>
<td>Recruitment</td>
</tr>
<tr>
<td>C) Integrated Care Pilot</td>
<td>Ramp-up</td>
<td></td>
</tr>
<tr>
<td>Existing OP services in community setting</td>
<td>Ramp up</td>
<td></td>
</tr>
<tr>
<td>Respiratory and paediatric pathways</td>
<td>Complete plans</td>
<td>Outcome specifications</td>
</tr>
</tbody>
</table>

NOTE: Major projects shown only
SOURCE: Initiative business cases
7.2. Implementing our support for change

We have also identified when we will implement key changes to support our strategy.

Exhibit 39

<table>
<thead>
<tr>
<th>Activity</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Apr</td>
<td>May</td>
</tr>
<tr>
<td>Estates</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Build business cases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comprehensive estates strategy in place</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Governance and Performance Management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree on performance management role and system for new CLS structures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monitor and refine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information systems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree on IT system strategy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implementation and ongoing improvements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contracts / incentives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plans in place to use different contractual and payment mechanisms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organisational development</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Establish leadership behaviours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Build skills and improve productivity</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7.3. Key immediate steps
The key next steps are:

- **By the end of May 2012**
  
  o Roll-out of Referral Scheme complete across all West London practices.
  
  o Agreed final specification for Putting Patients scheme and roll out across all West London practices.
  
  o First phase of the redesign of the Primary Care Mental Health Services will be finalised and integrated service fully operational.

- **By the end of June 2012**
  
  o Plans for the modelling and redesign of the Respiratory and Paediatric pathways will be complete, including project milestones.
  
  o Reviewed care pathways for responsive/urgent care along with Putting Patients First Initiative to integrate and join up pathways where appropriate.
  
  o Finalised business case for the Care of the Elderly Consultant.
  
  o Developed our plans to ensure we maximise the benefit of 3rd sector providers.
  
  o The 111 service will be live, including routing back to Primary Care

- **By the end of Dec 2012**
  
  o Put out advert for the tender of a new community Respiratory service for West London CCG. Care of the Elderly Consultant recruited and project plan for service mobilization in place.
  
  o The new Musculoskeletal Service will be up and running, and all patients new and follow up will be transferred to the service by September 2012.
  
  o Our Practices will meet primary care standards. By working together in provider networks and across the CCG, practices will offer a full range of enhanced primary care services to all West London patients.
  
  o Plans in place to use different contractual and payment mechanisms to promote integration and encourage innovation from a range of providers including the 3rd sector.
  
  o Developed responsive and integrated service provision for urgent care, including GP walk-in, 24/7 Rapid Response service and appropriate GP led services at hospitals.
We will have a comprehensive estates strategy.