

Paper 3.1.

NWL Local Services Transformation



DRAFT – under development

Action(s) Required:

The Local Services Programme Executive is asked to:

- Support the recommendations for Local Services priority initiatives to be delivered in common
- Support the establishment of working groups to progress the planning for each focus area
- Support the identified next steps

Summary:

The Local Services programme planning gives us an opportunity to review and consolidate our approach to delivering local services care across NWL, including the delivery approach, progress and priorities.

On 6 May a planning paper was presented to LSPE. The team were asked to progress the following activities:

- Target population cohorts for each initiative
- Local Services outcomes and how they align to the STP
- Benefits analysis (financial, activity and capacity) for each initiative
- Detailed overview of each recommended initiative (including evidence and activities)
- Identify the resources required to deliver each recommended initiative

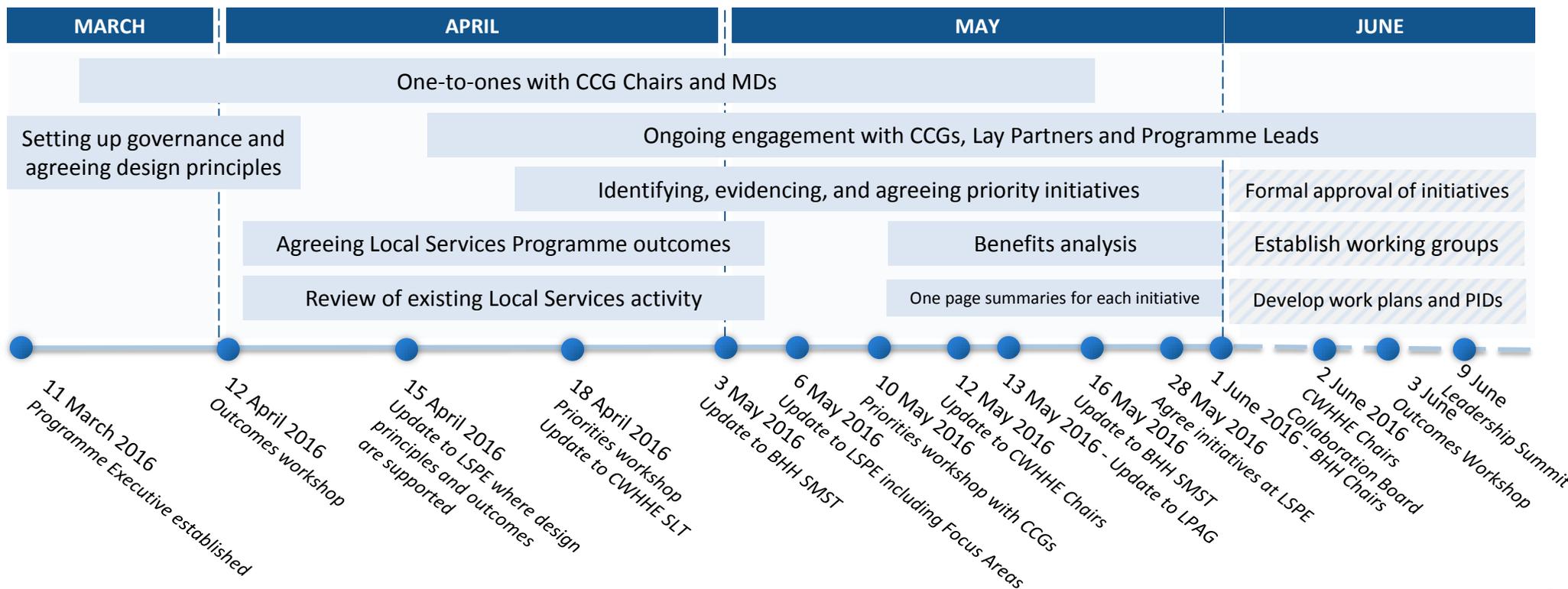
A paper was circulated on the 12 May with this information included. The paper has since been further updated with financial analysis and activity modelling.



Significant progress has been made with the Local Services planning work since March 2016

Through extensive engagement with CCGs, Lay Partners, Local Authorities and Programme Leads, and building from existing work, we have now:

- Agreed a set of design principles for the programme
- Reviewed existing activities and captured the national best practice evidence base for these activities
- Identified and agreed outcomes for the programme which are aligned to the emerging priorities in the STP
- Recommended six high impact initiatives for prioritised delivery in common across NWL in this phase of the Local Services planning work, supported by benefits analysis.



NWL must accelerate delivery of Local Services to improve the quality of health and care, and address financial and system sustainability challenges

NWL must accelerate delivery of Local Services Transformation to improve the quality of health and care for patients like Mary:

Mary is a resident of North West London. She is 77 years old, suffers from frailty and long-term conditions and is at high-risk of deterioration. A lack of coordination and planning means that Mary currently accesses health- and social-care far more often than necessary or beneficial for her.

Under the new **model of local services** care, Mary will have her care co-ordinated through a personalised **care plan**, overseen by a **care navigator** and a **multi-disciplinary team** including specialist nurses, social workers, mental health services and voluntary sector link workers.

As a result of the **health and social care system** working better together in this way, Mary is not only receiving the coordinated support necessary for her health needs, but she is also linking to the wider network of care and social interaction in the community to help her to live more independently for longer.



But we face an immediate financial and system sustainability challenge, so we must prioritise the high impact initiatives which can be delivered at pace:

1. Finance

- The NWL STP base case forecasts a £1billion financial gap in the local Health and Social care system, of which just over half is unmitigated against.

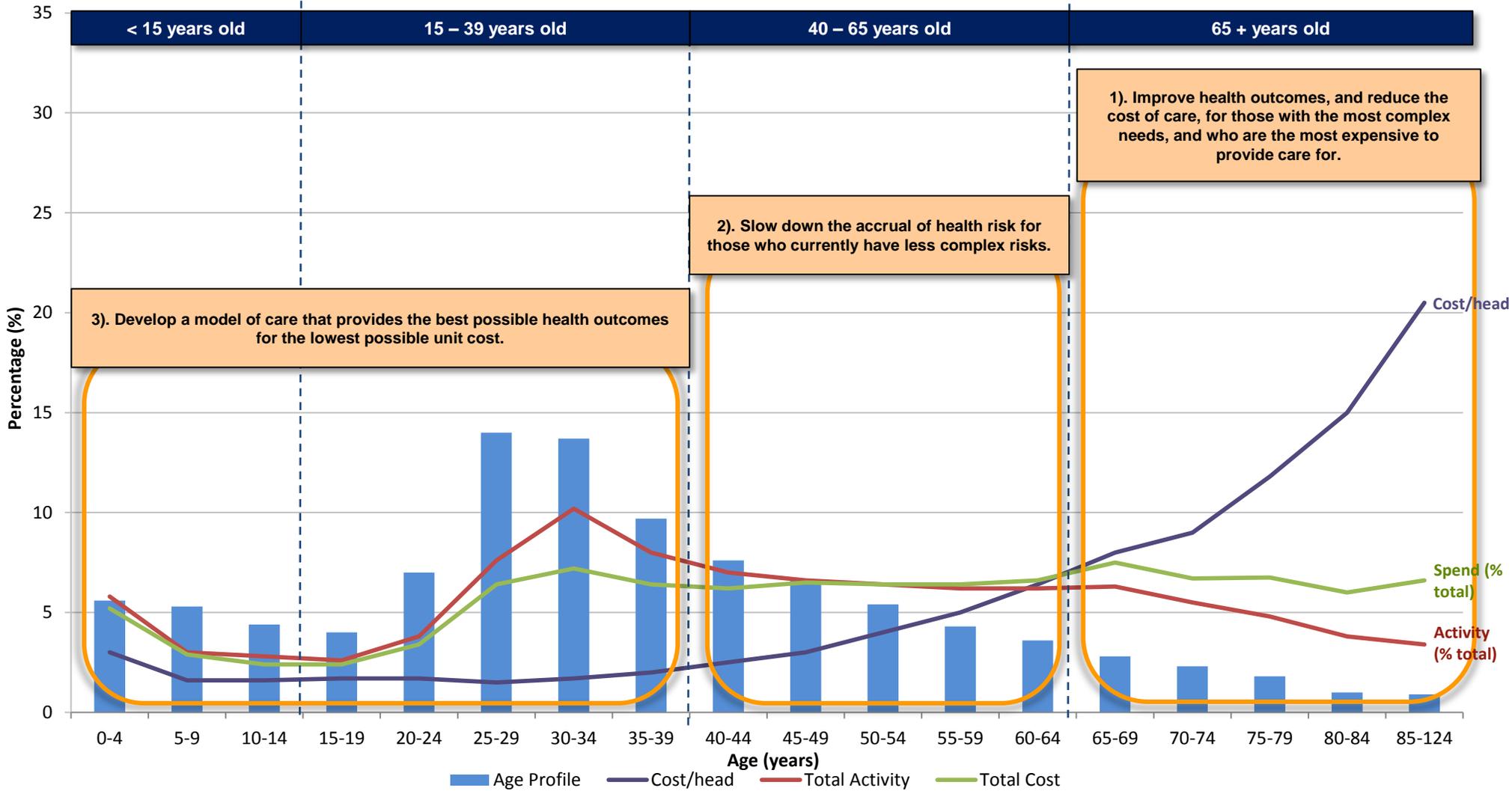
2. System Sustainability

- Analysis of a patient level dataset across NWL has identified an opportunity equivalent to 592 bed reductions due to admission avoidance. The Local Services programme must provide additional capacity in primary and community care settings to support these challenges to be met by:
 - rebalancing and prioritising transformation activity;
 - shifting the focus from strategy to implementation.

NWL must tackle the challenges of the triple aim by targeting initiatives to the needs of population cohorts

Activity and Cost Percentage Split

Illustrative, based on Hammersmith and Fulham data



The Programme team have identified initiatives based on the differing needs of population cohorts

< 15 years old	15 – 39 years old	40 – 65 years old	65 + years old
3). Best health outcomes for the lowest unit cost possible		2). Slowing down the accrual of health risk	1). Improving health outcomes, and reducing the cost of care, for those with the most complex needs.



Note: This dataset is illustrative, reflecting the population of Hammersmith and Fulham

These initiatives have been prioritised based on estimated impact, cost and deliverability

The programme team recommends six priority initiatives, which include a range of high impact, high cost initiatives (1, 4 and 6) as well as a range of initiatives that can be implemented at pace (2, 3 and 5).

Priorities A-N have **not** been recommended for prioritisation **at this stage** as there are other initiatives which are expected to have a greater impact in the short-term.

Prioritisation

Recommendations for priority initiatives (recorded in black in figure 1):

Initiative 1: New Models of Local Services Care

Initiative 2: Self-care

Initiative 3: Wider determinants of health

Initiative 4: Rapid Response and Intermediate Care

Initiative 5: Expanding common discharge

Initiative 6: Last Phase of Life

Initiatives not included in recommendations as they are incorporated as part of the prioritised initiatives above, or are already being progressed outside of Local Services (recorded in white in figure 1):

Initiative A: Extend Delivery of 111 Services across NWL

Initiative B: Multi Disciplinary Teams

Initiative C: Care Planning

Initiative D: Prevention initiatives

Initiative E: PAM

Initiative F: Common discharge

Initiative G: Single point of access

Initiative H: Hard to reach populations

Initiative I: Homeless

Initiatives not recommended for prioritisation at this stage (recorded in white in figure 1):

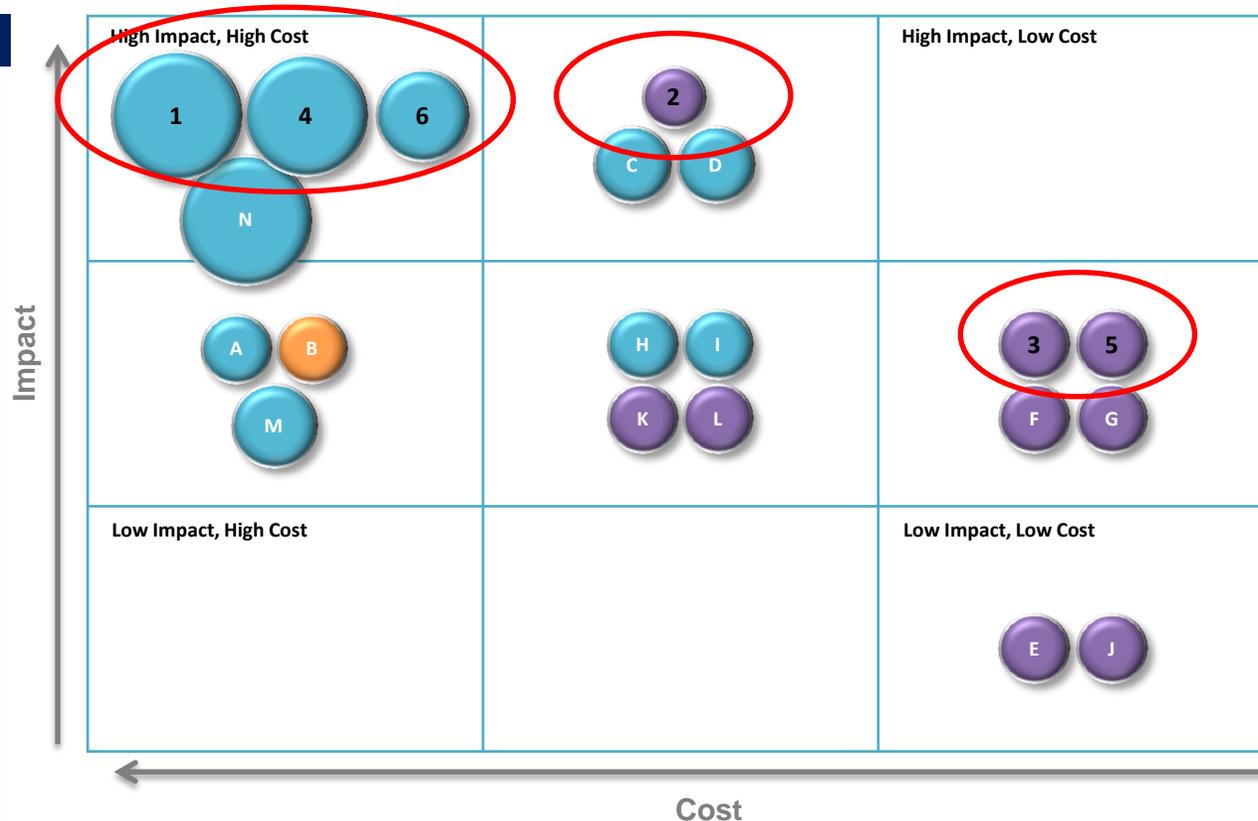
Initiative J: GP Discharge

Initiative K: ICS Common Specification

Initiative L: ICS selection and discharge criteria

Initiative M: Care pathways

Initiative N: Community Health Services

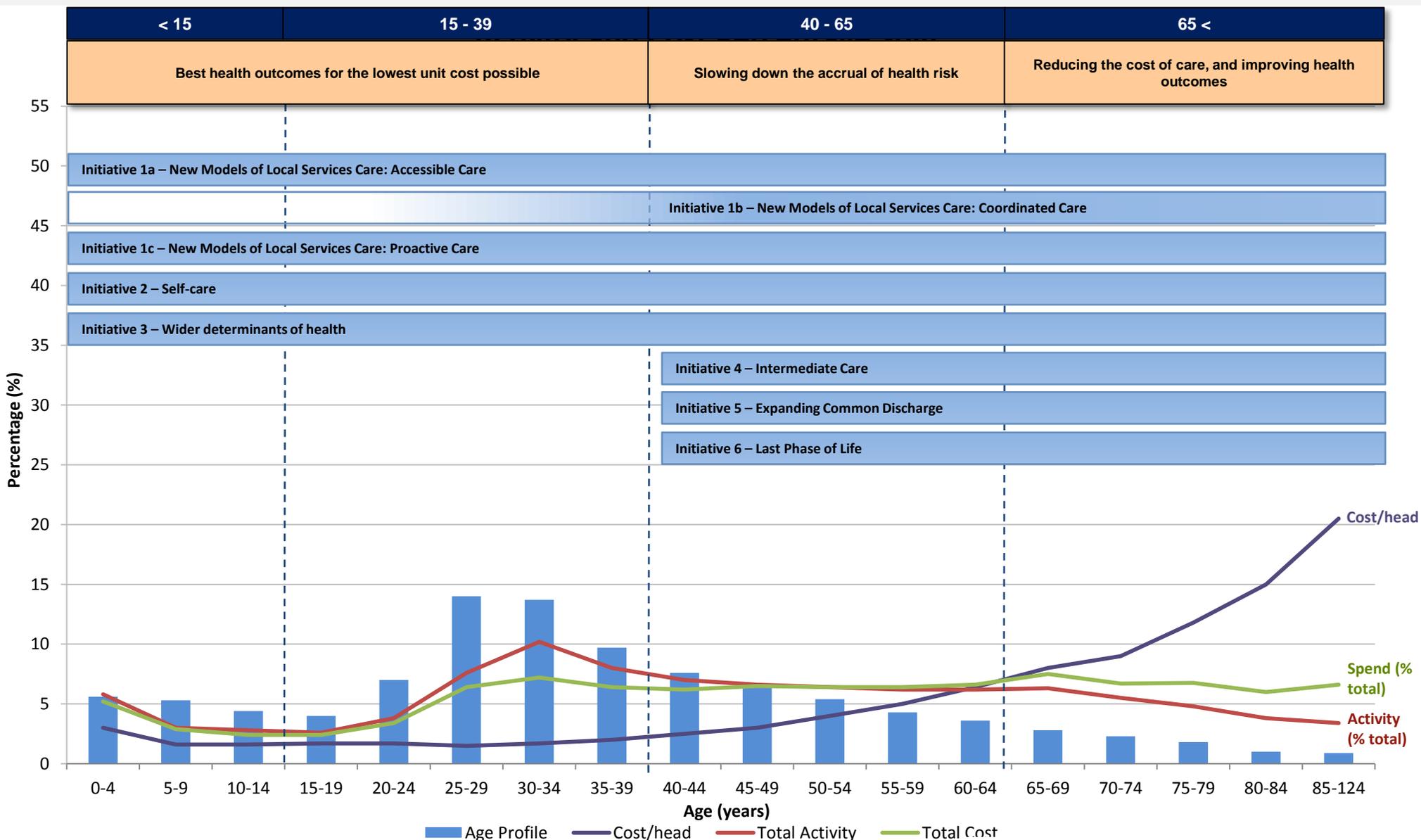


Indicates prioritised initiative

* Size of bubble is indicative of estimated size of project and resource required

	Cost	Impact	Deliverability	
High	£500k <	No direct impact on financial savings or patient experience		By end 16/17
Middle	£100k - £500k	Some impact on patient experience or savings		By end 18/19
Low	< £100k	Significant impact on patient experience or savings		By end 21/22

The prioritised initiatives are targeting different population cohorts



Note: This dataset is illustrative, reflecting the population of Hammersmith and Fulham

Initiatives targeted at more than one population cohort should be tailored to target the specific needs of each population cohort

The table below illustrates how each of the initiatives could be tailored to the unique needs of different population cohorts. It is suggestive, and not expected to represent the final view of how each of the initiatives is delivered.

	< 15	15 - 39	40 - 65	65 <
	Setting off on the best health trajectory	Best health outcomes for the lowest unit cost possible	Slowing down the accrual of health risk	Reducing the cost of care, and improving health outcomes
Initiative 1a – New models of Local Services Care: Accessible care	Need – Same day GP access or ability and confidence to self-care Solution may involve reviewing core hours of GP access	Need - On the go and require transactional urgent care Solutions may include app-based access and technology	Need – Convenience of access and ability to complete care episode Solutions may involve creating the ability to refer	Need – Continuity of care Solution may involve reviewing core hours of GP access; ambulatory care
Initiative 1b – New models of Local Services Care: Coordinated care		*There will be some need for people with long-term conditions within this cohort	Need – conditions becoming increasingly complex Solutions – care planning established effectively so that conditions do not escalate	Need - conditions now often very complex Solutions – managing condition through a care plan and named care navigator to avoid acute episodes.
Initiative 1c – New models of Local Services Care: Proactive care	Need – herd immunity for common diseases (public health); making correct lifestyle choices at the beginning of life. Solutions may include schools programmes to educate around healthy lifestyle choices (exercise, and not smoking).	Need – population may have excessive use of alcohol and cigarettes, often vulnerable to mental health illnesses. Solutions may include substance awareness and prevention programmes. Early intervention in psychosis, and prevention of conduct disorder through social and emotional learning programmes.	Need – population increasingly likely to be developing conditions relating to diabetes, MSK, hyper tension, smoking and obesity. Solutions may include prevention programmes relating to blood pressure, diabetes, MSK, smoking and obesity.	Need – Population increasingly likely to have developed long-term conditions, and need to avoid developing related illnesses; dementia Solutions may include prevention programmes relating to diabetes, hypertension, obesity, Alzheimer’s and Diabetes.
Initiative 2: Self-care	Need – Embed healthy practices within lifestyle from an early age Solutions – Education for care navigation; daily choices and lifestyle	Need – time poor and able to self-manage minor ailments Solutions – online support communities to find information when needed	Need – starting to develop health conditions and at risk of acute episodes Solutions – organise questions for health professionals, map options and choices.	Need – At risk of acute episodes, living with long-term conditions for some time Solutions – Self-care as a necessary part of daily life; integrated with care plan; mentoring; able to make decisions on their own care.
Initiative 3: Wider determinants of health		Needs – may include employability, homelessness, poor quality and damp housing Solutions may involve working with local authorities to combat poor housing conditions , for example.	Needs – may include employability, social isolation Solutions may involve social prescribing, for example.	Needs – social isolation, cold houses, houses with poor access for people with limited mobility Solutions may include social prescribing, or working with other providers (such as the fire service) to improve accessibility and safety within homes.
Initiative 4: Intermediate Care Services			Need – Those with complex conditions may have their first escalation and require support to reable themselves. Solutions – Reablement ICS	Need – May have been treated through intermediate care before and be less able to self-care. Solutions may be home-based and bed-based intermediate care
Initiative 5: Expanding common discharge process			Need – may be discharged for the first time for a condition that they have only recently developed Solution - common discharge process so that service users get the support they need post-discharge	Need – may be routinely discharged from hospital Solution - common discharge process so that service users get the support they need post-discharge in the most appropriate setting
Initiative 6: Last Phase of Life			Need – patients may be in their last phase of life unexpectedly Solutions – palliative care close to home	Need – patients may have carers and may have choices about where they want to spend their last days Solutions – including place of death on care plans; palliative care; support for carers and families.

Source: Extrapolated from existing population segmentation work in Hammersmith & Fulham

The prioritised initiatives can be delivered at pace to improve the quality of care, and will help to address the immediate financial and sustainability challenges

This slide summarises the **six initiatives that we are recommending** and the rationale behind them – further evidence for our assertions can be found in the appendix.

Initiative 1. New Models of Local Services Care

Implementing a compelling and ambitious Local Services model of care for NW London, incorporating both Whole Systems and Primary Care work to date:

Element 1 – Meeting the SCF criteria by end of March 2019 for:
1a – accessible care – strategies, including innovative use of technology, that offer patients additional options to access a GP/care team for routine/urgent care during and after core hours.
1b – co-ordinated care - commission and provide integrated and more coordinated care for people who receive care across multiple settings. This includes improving the care planning process and embedding PAM within it.
1c – proactive and preventative care - Bring together the evidence gathered by the HLP Commissioning for Prevention analysis and the proactive care elements of the Strategic Commissioning Framework to deliver a high impact prevention and proactive care framework for implementation by 2018

Element 2 – Define and deliver an ambitious model for any additional individual CCG commissioned services.

Element 3 – Define and deliver an ambitious model for additional NWL-wide commissioned services, for example: urgent care.

Rationale:

Primary care provides the co-ordinating function for local services care and is at the heart of system transformation. Primary care needs to meet the SCF criteria by the end of March 2019.
To support delivery of the whole systems vision: ‘To improve the quality of care for individuals, carers and families and to empower and support people to maintain independence and to lead full lives as active participants in their communities.

Dependent on:

Provider development – All federations formed, delivering, and agreeing to a common set of standards.

Workforce – New roles and skills; increased primary care workforce to deliver the new models of primary care. MDT teams in place to support care co-ordination.

Technology – online/app-based support communities; interoperable IT systems; Skype/telephone consultations; Telehealth.

Estates – Hubs fully functional increasing the accessibility of primary care by 2021.

Finance – Primary Care Business Cases/Financial Cases approved.

Initiative 2. Self-care

Complete the prioritisation against the self-care framework across all eight local areas in 16/17. Provide intensive support to address priority areas, and enable common solutions, through to April 2017.

Rationale:

People with long term conditions are effectively self-managing 99.97% of their lives. If we can support them to do this better, we should reduce the need for care, and improve their quality of life.

Dependent on:

Workforce – training to local health and social care providers to give them the capability to deliver the range of self-care interventions. Work with third sector organisations to support collaborative working.

Technology – Developing online/app-based self-management solutions. PAM to be included in the patient dashboards.

Outcomes – Pre and post PAM scoring to provide evaluation of individual self-care programmes.

Initiative 5. Expanding Common Discharge

Expanding the single needs-based discharge form and process to include neighbouring London boroughs, bedded community services and/ or referring into joint health and social care reablement packages.

Rationale: The average length of stay for a cross-border admission within NWL is 2.9 days longer than one within a CCG boundary. We can reduce length of stay by expanding the common discharge process.

Dependent on:

Workforce – training required to ensure primary, secondary and intermediate workforce understand how to use intermediate care services;

Technology – to support information sharing.

Local Government – existing work on discharge expanded to all discharge teams.

Initiative 3. Wider determinants of health

Developing integrated and shared delivery models with Local Authorities, third sector and wider public sector to tackle the most significant wider determinants of health.

Phase 1 – Work with Local Government and HLP data to identify early phase one priorities, which may include: isolation, housing and employment.

Rationale:

The Kings Fund suggest that social factors determine approximately half of our health outcomes. Improving the social determinants of health will reduce the need to access care and improve quality of life.

Dependent on:

Workforce – training to local health and social care providers to deliver the models for improving the social determinants of health. Agreed strategies for working with third sector organisations to support collaborative working.

Initiative 6. Last Phase of Life

Complete scoping in 2016 to confirm the high-impact areas, which may include: care homes, advanced care planning, technical skills to implement care plans, clear telephone advice, role of the social and voluntary sector, and encouraging difficult conversations to take place. Delivery of recommendations identified through the review by end of 2016.

Rationale:

Those in the last phase of life have the most complex needs and occupy a disproportionate amount of activity in the system.

Dependent on:

Workforce – ensuring workforce have the required skills to support the change;

Technology – informatics support required to enable advance care planning initiative.

Initiative 4. Rapid Response and Intermediate Care

Agree the definition, scope and offer of Intermediate Care Services (both step-up/rapid response, and step-down/discharge) in NW London through a discrete piece of scoping and planning work, identifying the cost-effectiveness of existing ICS in NW London and national best practice. This would include a review of home-based care/ domiciliary nursing. Implementation of the recommendations of the review to:

- Standardise the service to the level of the current best;
- Invest and scale the agreed offer across NWL;
- Integrate the intermediate care offer with social care.

Rationale:

ImBC modeling identified an opportunity of reducing NEL admissions by over 30,000 by investing in intermediate care.

Dependent on:

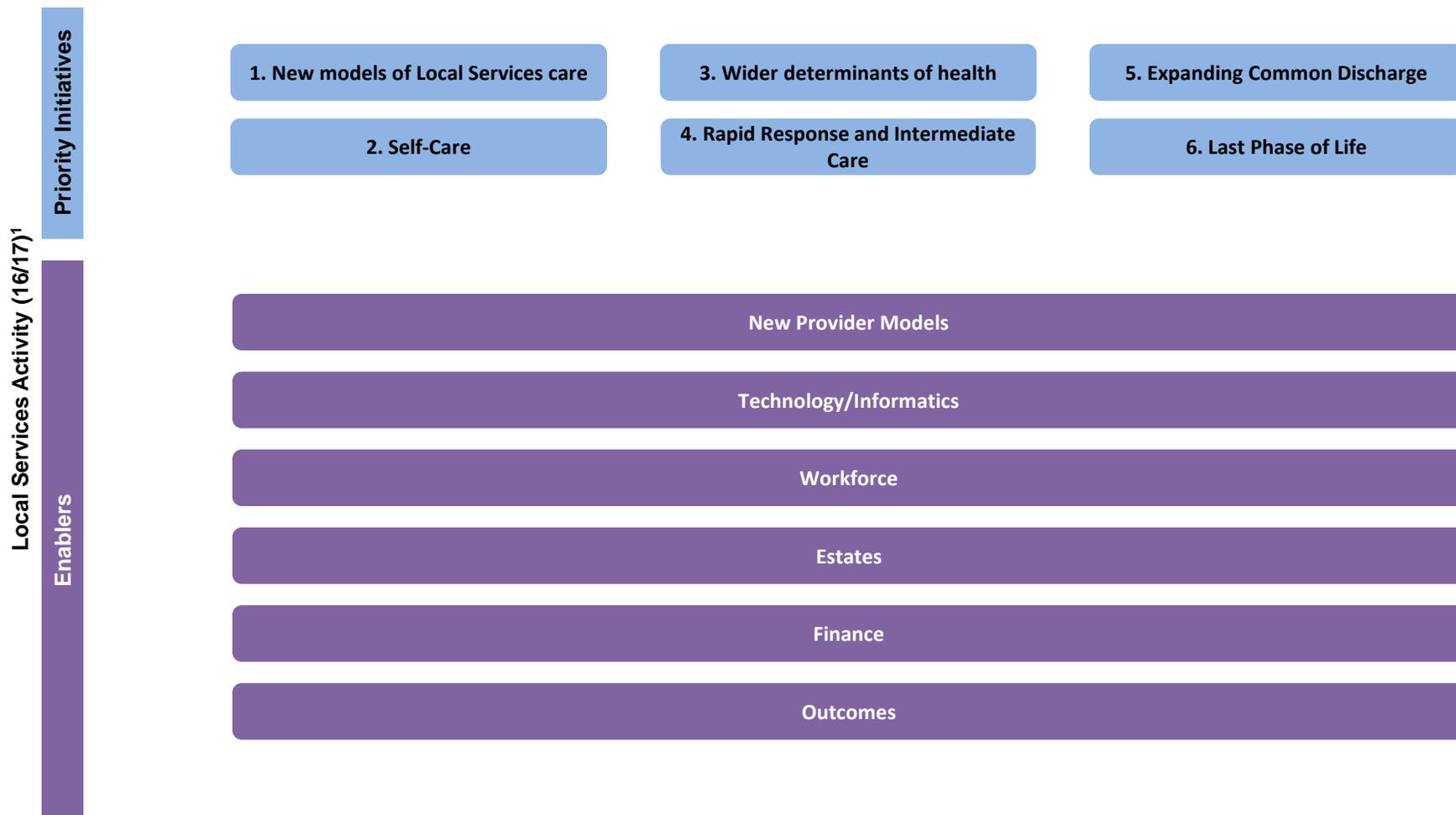
Workforce – training required to ensure primary, secondary and intermediate workforce understand how to use intermediate care services;

Technology – to support information sharing.

Local Government – existing work on discharge expanded to all discharge teams.

Details of initiatives that have not been prioritised at this time, can be found in Appendix C.

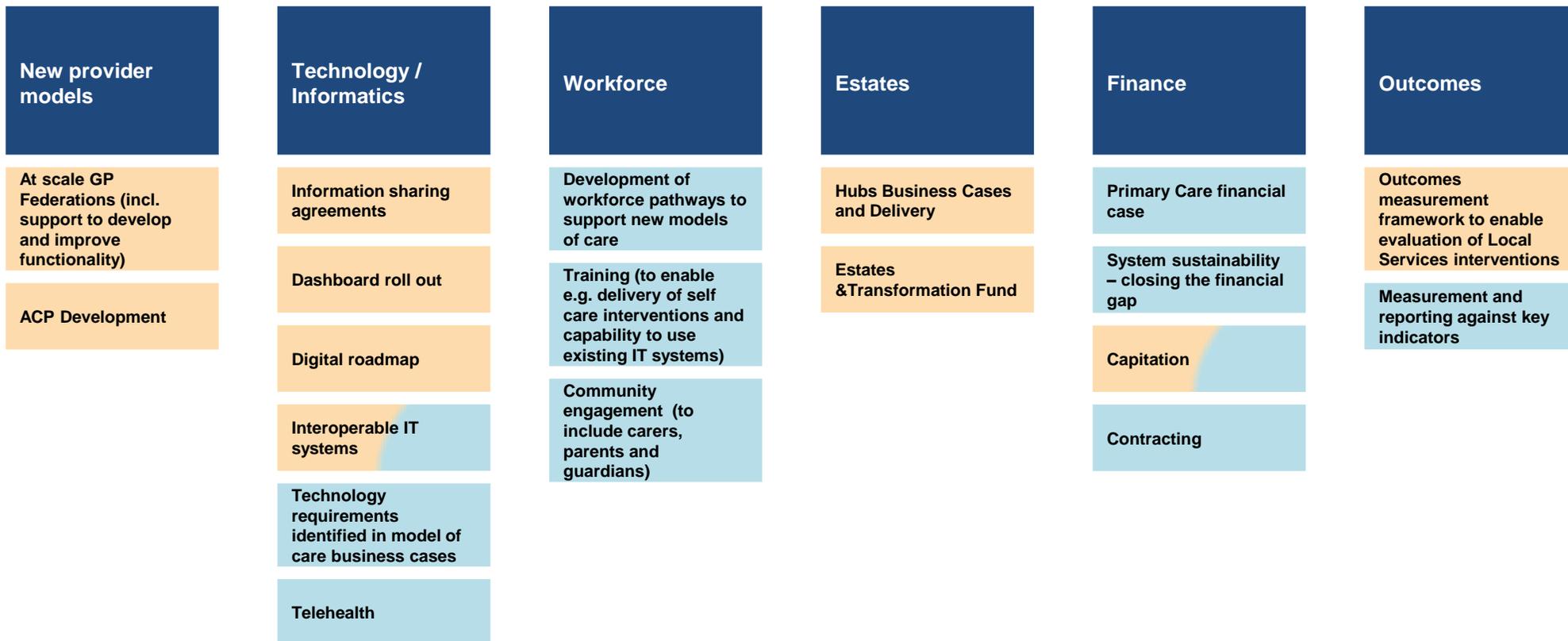
The six priority initiatives will be underpinned by enabling workstreams



Local Services Activity (16/17)¹

¹ Mental Health transformation is an integral part of all Local Services transformation work packages.

The enabling workstreams contain a combination of proposed schemes and those that are existing or have funding secured



KEY	Existing/proposed schemes
	Scheme in progress and/or funding secured
	Proposed scheme

The programme team have identified the benefits that the Local Services programme must achieve, using the 'Triple Aim' – these are aligned with STP priorities

The benefits have been developed and tested through engagement with CCG Chairs, MDs and COOs, a workshop on the 18 April, and by aligning the outcomes of existing programmes (Whole Systems and Primary Care Transformation) with the outcomes agreed through the STP process.

Triple Aim	Focus	Benefits
<p>Improving health & wellbeing</p>	<p>Prevention People supported to take responsibility for their own wellbeing and health and making healthy choices</p>	<ul style="list-style-type: none"> People are supported to live healthier lives and navigate care in a way that works for them Patients are less anxious and overwhelmed managing their conditions, resulting in improved health outcomes Improving the wider determinants of health (including, for example, housing and employment) to improve wellbeing and reduce the need for care. Improving the quality and quantity of social relationships to reduce health inequalities arising from social isolation
<p>Improving care & quality</p>	<p>New model of accessible and integrated person-centered care Local integration of services across all providers at the place where the person needs it (primary, community, MH, some acute) delivered via multi-disciplinary teams</p>	<ul style="list-style-type: none"> Improve the overall quality of care for people in their last phase of life and enabling them to die in their place of choice Reduction in unwarranted variation in the clinical management of the North West London population People are able to access the right care in the right place at the right time People are treated holistically for their health, care and support needs by moving away from episodic care and integrating health and care services
<p>Improving productivity & closing the financial gap</p>	<p>System Sustainability Local services are driving sustainability as c.592 acute beds are taken out of the system</p>	<ul style="list-style-type: none"> Reduction in non-elective admissions, as patients are able to better manage their conditions, and receive care in a more appropriate setting when it is needed. Decreases in length of stay, so that patients stay in an acute bed for no longer than is needed

Implementation of the priority initiatives will improve the health and quality of care for the NWL population

The table on this slide matches each initiative to the non-financial programme outcomes that we would expect each initiative to drive.

The benefits have been developed and tested through engagement with CCG Chairs, MDs and COOs, a workshop on the 18 April, and by aligning the outcomes of existing programmes with the outcomes agreed through the STP process.

		Priority Initiatives							
		1a – Accessible Care	1b – Coordinated Care	1c – Proactive Care	2 – Self Care	3 – Wider determinants of health	4 – Rapid Response and Intermediate Care	5 – Expanding Common Discharge	6 – Last Phase of Life
Benefits	People are supported to live healthier lives and navigate care in a way that works for them	X	X	X	X	X			
	Patients are less anxious and overwhelmed, resulting in improved health outcomes	X	X	X	X	X			
	Improving the wider determinants of health (including, for example, housing and employment) to improve wellbeing and reduce the need for care					X			
	Improving the quality and quantity of social relationships to reduce health inequalities arising from social isolation	X	X		X	X			X
	Improve the overall quality of care for people in their last phase of life and enabling them to die in their place of choice	X	X		X	X	X		X
	Reduction in unwarranted variation in the clinical management of the North West London population	X	X	X	X	X	X	X	X
	People are able to access the right care in the right place at the right time	X	X	X	X		X	X	X
	People are treated holistically for their health, care and support needs by moving away from episodic care and integrating health and care services	X	X	X		X	X	X	X
	Reduction in non-elective admissions, as patients are able to better manage their conditions, and receive care in a more appropriate setting when it is needed	X	X	X	X	X	X		X
	Decreases in length of stay, so that patients stay in an acute bed for no longer than is needed	X	X	X		X	X	X	X

Implementation of the priority initiatives will help NWL to address the financial and system sustainability challenges

The Strategy and Transformation finance team have carried out financial analysis on the six recommended priority initiatives to estimate the size of the financial, activity and bed opportunities that they are likely to provide.

The size of the opportunity and investment was derived from the following:

1. Evidence for the opportunity and investment of each initiative from a variety of sources, as detailed in Appendix B.
2. National data that has been pro-rated to NWL, or CCG level data extrapolated to NWL, as appropriate.
3. 15/16 SUS data used, where available, to evaluate activity
4. Average tariff costs for POD to calculate the size of the opportunity

The Local Services Programme team recommends that initiative N is not prioritised as there is insufficient resource to deliver this as well as initiative one, which requires a similar level of resource and demonstrates larger health and quality benefits to the system as a whole.

		Benefits by 2020/21					
		Gross Opportunity £('000)	Gross Investment £('000)	Net Benefit £('000)	Activity (attendances or admissions relating to POD)	Beds	POD
Recommended priority initiatives	Initiative 1: New Models of Local Services Care	£2,406	£1,699	£708	17,187	0	A&E
		£18,842	£13,301	£5,540	2,979	117	NEL
	Initiative 2: Self-Care	£2,460	£195	£2,264	17,568	0	A&E
	Initiative 3: Wider Determinants of Health	£4,348	£1,290	£3,058	1,012	3	NEL
	Initiative 4: Rapid Response and Intermediate Care	£64,908	£20,148	£44,760	38,165	409	NEL
	Initiative 5: Expanding Common Discharge	£8,465	£7,930	£535	3,848	31 ²	NEL
	Initiative 6: Last Phase of Life	£7,000	£4,942	£2,058	2,300	32	NEL
Sub-Total for recommended priority initiatives		£108,429	£49,505	£58,923	83,059¹	592	
Social Care (impact to be quantified from WLA Plan)		<i>tbc</i>	<i>tbc</i>	<i>tbc</i>	<i>tbc</i>	<i>tbc</i>	<i>tbc</i>
Initiative N: Community Health Services		£54,704	£43,763	£10,941	420,305	0	OP
Total		£163,133	£93,269	£69,864	503,364¹	592	

¹ represents the number of people now treated in a more appropriate care setting

² relates to a reduction in beds related to Length of Stay

Next steps

- Gain support for Local Services priorities and programme structure at Collaboration Board on 2 June, and a mandate to progress with the planning phase to implementation.
- Develop Project Initiation Documents for each initiative by the 3rd June.
- CCGs to identify Clinical and CCG lead for each initiative by the 10th June.
- Set up 8x working groups for each initiative, including clinical, commissioner, Local Authority, and provider representation to develop plans.
- Working groups to develop project plans based on existing material where possible in June.
- Local Services priorities recommendations to be discussed at governing bodies in July and August.



APPENDICES

Appendix A - The Local Services outcomes, initiatives and enablers are aligned to the STP



Appendix B – Assumptions underpinning Local Services Benefits analysis¹

Finance

NEL Admission	Cost = £2200
A&E Attendance	Cost = £140
Outpatient First	Cost = £151
Outpatient Follow-up	Cost = £86

Activity

Used activity from 15/16 (or where not available from Jan - Dec 15).

Opportunity

New Models of Care	Kings Fund, HLP and RCGP evidence applied to NWL activity.
Community Health Services	Specialty-specific OP reduction of cost
Self- Care	Proportion of A&E attendances attributable to LTCs saved
Social Determinants of Health	Extrapolation of Mansfield & Rotherham pilots across 8 NWL CCGs.
Step-up ICS	Underpinned by the GE/Finnamore analysis
Expanding Discharge	Underpinned by the GE/Finnamore analysis
Last Phase of Life	Underpinned by Nuffield Trust evidence

Investment

New Models of Care	Underpinned by the GE/Finnamore analysis
Community Health Services	Specialty-specific OP cost
Self- Care	Cost of 430k PAMS licenses
Social Determinants of Health	Extrapolation of Mansfield & Rotherham pilots across 8 NWL CCGs.
Step-up ICS	Underpinned by the GE/Finnamore analysis
Expanding Discharge	Underpinned by the GE/Finnamore analysis
Last Phase of Life	Underpinned by Nuffield Trust evidence

¹ Produced by Strategy and Transformation finance team

Appendix C – rationale for initiatives not recommended for prioritisation

Initiatives not prioritised		Initiatives not prioritised (cont.)		Initiatives not prioritised (cont.)			
<p>Initiative a: Extend Delivery of 111 Services across NWL Develop 111 services to form part of a wider integrated system, with out of hours, urgent care and primary care, and with a view to greater fulfilment of user needs closer to the point of initial contact with the NHS.</p> <p>Reason not prioritised: This is one of the areas of work being reviewed by the NHS 111 re-procurement board.</p>	Imp.	<p>Initiative g: Single point of access A single point of access to community healthcare support for patients discharged from acute inpatient wards or assessment centres.</p> <p>Reason not prioritised: Work close to completion. Phase 2 of this common discharge and single point of access work included as 'Initiative 6 – Expanding Common Discharge'.</p>	Imp.	<p>Initiative l: ICS selection and discharge criteria Agreed common selection and discharge criteria for intermediate care services by 2017.</p> <p>Reason not prioritised: Lack of evidence suggesting this is the right initiative to harness the opportunity identified within intermediate care services. Scoping exercise planned within Initiative 5 – Intermediate Care Services, which may cost/ benefit analysis on common specifications.</p>	Imp.		
	Cost		Cost		Cost		
	Pace		Pace		Pace		
<p>Initiative b: Multi Disciplinary Teams Local Services hubs are used as a pilot for multi-disciplinary team working by 2021 (according to the opening date for each hub),</p> <p>Reason not prioritised: Not sufficiently stretching/ challenging. Multi disciplinary teams to be developed as part of 1b 'Co-ordinated care'.</p>	Imp.	<p>Initiative h: Hard to reach populations All GP networks have targeted efforts to work with hard to reach populations (including the homeless, those who speak limited English, tourists) by 2019.</p> <p>Reason not prioritised: Clear, tangible benefits to initiative in some NWL CCGs e.g. Central London, but this is not replicated across all CCG populations, therefore benefit to delivery at scale limited.</p>	Imp.	<p>Initiative m: Care pathways A common agreed care pathway for target disease groups (cancer, diabetes, CVD) across all CCGs by 2017.</p> <p>Reason not prioritised: Focus on unplanned care (NEL admissions and A&E attendances) as this accounts for 80% of acute bed capacity. Note: separate work is being progressed on planned care within CWHHE.</p>	Imp.		
	Cost		Cost		Cost		
	Pace		Pace		Pace		
<p>Initiative c: Care Planning All patients with identified LTCs receive a personalised care plan and named care professional by 2019. To ensure this we will review local care planning processes against agreed NWL principles. Develop action plan where gaps have been identified by end 2016, and provide support to bridge them by April 2017.</p> <p>Reason not prioritised: Incorporated within 1b 'Co-ordinated care'. Evidence shows that care planning must be part of an integrated care model. Risk of benefit double counting if included separately.</p>	Imp.	<p>Initiative i: Homeless All boroughs to agree the method through which they work with housing organisations to ensure that 'hospital discharge to homelessness' is a never event by 2017.</p> <p>Reason not prioritised: Clear, tangible benefits to initiative in some NWL CCGs e.g. Central London, but this is not replicated across all CCG populations, therefore benefit to delivery at scale limited. Wider initiative on homeless included in initiative 4 'Wider determinants of health'.</p>	Imp.	<p>Initiative n: Community health services Pathway redesign to deliver existing levels of activity for urology, orthopaedics, ophthalmology, gastroenterology, cardiology, dermatology, respiratory medicine, rheumatology and gynaecology services at reduced cost.</p> <p>Reason not prioritised: There is insufficient resource to deliver this initiative as well as initiative one, which requires a similar level of resource and demonstrates larger health and quality benefits to the system as a whole.</p>	Imp.		
	Cost		Cost		Cost		
	Pace		Pace		Pace		
<p>Initiative d: Prevention initiatives Based on Commissioning for Prevention health economy analysis, develop and share high impact prevention framework to drive CCG prevention activities implementation by 2018.</p> <p>Reason not prioritised: Incorporated within 1c 'Proactive care' as prevention is a core part of the new model of Local Services care. Risk of benefit double counting if included separately.</p>	Imp.	<p>Initiative j: GP Discharge Acute inpatient wards and assessment units to copy GPs on all hospital discharge information across NWL by 2017.</p> <p>Reason not prioritised: Specific process initiative/ enabler with limited direct benefit, rather than clinical transformation.</p>	Imp.				
	Cost		Cost			Cost	
	Pace		Pace			Pace	
<p>Initiative e: PAM PAM embedded within care planning process by end 2016. *NHSE funded.</p> <p>Reason not prioritised: PAM is an enabling activity with no direct benefits.</p>	Imp.	<p>Initiative k: ICS Common Specification Rapid response and intermediate care services operating to a common service specification across NWL by 2017.</p> <p>Reason not prioritised: Lack of evidence suggesting this is the right initiative to harness the opportunity identified within intermediate care services. Scoping exercise planned within Initiative 5 – Intermediate Care Services, which may cost/ benefit analysis on common specifications.</p>	Imp.				
	Cost*		Cost*			Cost*	
	Pace		Pace			Pace	
<p>Initiative f: Common discharge A common discharge process from acute inpatient wards or assessment units for patients with a requirement for community healthcare support by end 2016.</p> <p>Reason not prioritised: Work close to completion. Phase 2 of this common discharge and single point of access work included as 'Initiative 6 – Expanding Common Discharge.'</p>	Imp.						
	Cost						
	Pace						

KEY	Cost	Impact	Pace
R	£500k <	No direct impact on financial savings or patient experience	By end 21/22
A	£100k - £500k	Some impact on patient experience or savings	By end 18/19
G	< £100k	Significant impact on patient experience or savings	By end 16/17

Initiative 1: New Models of Local Services Care

Initiative 1A: Providing increased access to care

Delivery Date: Phase 1 06/2017; Phase 2 03/2018*

Financial Impact (£'000)	Activity Impact	Beds Impact
£21,248	Reduction of 17,187 A&E attendances and 2,979 NEL admissions	117

Product / Deliverable	Initiative Description
<p>Each CCG will have an agreed vision for the end state of primary care, and an investment case for 16/17 allocations by Q3 2016.</p> <p>By the end of March 2019, each CCG will have implemented a new model of primary care that meets the envisioned end state, and meets the SCF criteria.</p>	<p><i>Implementing a compelling and ambitious Local Services model of care for NW London, incorporating both Whole Systems and Primary Care work to date:</i></p> <p><i>Element 1 – Meeting the SCF criteria by end of March 2019 for:</i></p> <p><i>1a – accessible care</i></p> <p><i>1b – co-ordinated care</i></p> <p><i>1c – proactive and preventative care -</i></p> <p><i>Element 2 – Define and deliver an ambitious model for additional individual CCG commissioned services.</i></p> <p><i>Element 3 – Define and deliver an ambitious model for additional NWL-wide commissioned services, for example: urgent care.</i></p>
<p>Resource to deliver (across 1A, 1B, 1C):</p> <p>Programme: 1 FTE Project Manager, 2 FTE Project Support, 1 FTE PMO</p> <p>System (per Borough): 1 clinician (0.05 FTE); 1 commissioning lead (0.2 FTE); Provider lead (0.05 FTE); Local Authority lead (0.05 FTE).</p>	<p>Key steps:</p> <ol style="list-style-type: none"> 1) Review existing WSIC plans and business cases and determine areas for improvement and implementation priorities 2) Work with primary care leads in the CCGs to develop plans to provide more accessible care in alignment with the SCF requirements, building on existing access programmes where appropriate. 3) Develop a business plan for a 'new model of primary care' to drive local commissioning intentions and result in the letting of new contracts that span traditional organisational barriers. 4) Determine how implementation lessons learnt will be shared across CCGs, for example through developing a clinical community of interest to share progress and learnings 5) Co-produce a provider development plan with providers to ensure that they are able to deliver the services described through the business plans for both WSIC and the new model of primary care. 6) Implement the new model of primary care as per the plans developed through the business case. 7) Develop and agree an approach to focus on continuous quality measurement and improvement 8) Implement monitoring improvements, working with the CCGs to support them in evaluating their initiatives. 9) Provider development teams could work with CCGs and providers to evaluate and prioritise best options to increase primary care access, e.g. same day appointments.
<p>Benefits</p> <ul style="list-style-type: none"> • People are supported to live healthier lives and navigate care in a way that works for them • Patients are less anxious and overwhelmed, resulting in improved health outcomes • Improving the wider determinants of health (including, for example, housing and employment) to improve wellbeing and reduce the need for care. • Improving the quality and quantity of social relationships to reduce health inequalities arising from social isolation • Improve the overall quality of care for people in their last phase of life • Reduction in unwarranted variation in the clinical management of the North West London population • People are able to access the right care in the right place at the right time • People are treated holistically for their health, care and support needs by moving away from episodic care and integrating health and care services • Reduction in non-elective admissions • Decreases in length of stay 	<p>Evidence for these assertions</p> <p>In 2014 the Royal College of General Practitioners reported that in the short term, improved access to general practice has the potential to reduce significantly the demand for secondary care, specifically A&E attendances. This could potentially lead to further savings from reduced social admissions and ambulance call outs. It is estimated that these short term savings could amount to £315 - £447 million per year in the UK. On a pro-rata population basis this would mean savings of £11 - £15 million per year for NWL. In the medium term, improved access to general practice could support patients to take a more pro-active approach to managing their conditions. This is estimated to have the potential to lead to an 8 - 11% reduction in avoidable admissions. This translates to a potential annual saving of £148 - £333 million per year in the UK. On a pro-rata population basis this would mean savings of £5 - £11 million per year for NWL .</p> <p>Improved access to care is a main feature of the US Patient Centred Medical Home recognition programme. An evidenced based study in JAMA in 2015 found that in 9 of 11 studies, increased access to primary care resulted in: a reduction in Medicare spend by 5%; a reduction in A&E visits by 5%; improvements in population health indicators and an increase in preventive health services.</p>

Initiative 1: New Models of Local Services Care

Initiative 1B: Effectively using integrated care teams and providing more coordinated care

Delivery Date: Phase 1 06/2017; Phase 2 03/2018*

Financial Impact (£'000)	Activity Impact	Beds Impact
£21,248	Reduction of 17,187 A&E attendances and 2,979 NEL admissions	117

<p>Product / Deliverable</p> <p>Each CCG will have an agreed vision for the end state of primary care, and an investment case for 16/17 allocations by Q3 2016.</p> <p>By the end of March 2019, each CCG will have implemented a new model of primary care that meets the envisioned end state, and meets the SCF criteria</p>	<p>Initiative Description</p> <p><i>Implementing a compelling and ambitious Local Services model of care for NW London, incorporating both Whole Systems and Primary Care work to date:</i></p> <p><i>Element 1 – Meeting the SCF criteria by end of March 2019 for:</i></p> <p><i>1a – accessible care</i></p> <p><i>1b – co-ordinated care</i></p> <p><i>1c – proactive and preventative care -</i></p> <p><i>Element 2 – Define and deliver an ambitious model for additional individual CCG commissioned services.</i></p> <p><i>Element 3 – Define and deliver an ambitious model for additional NWL-wide commissioned services, for example: urgent care.</i></p> <p>Key steps:</p> <ol style="list-style-type: none"> 1) Review existing WSIC plans and business cases and determine areas for improvement and implementation priorities. This will involve a review of local care planning processes against agreed NWL principles. 2) Work with primary care leads in the CCGs to develop plans to provide more coordinated care in alignment with the SCF requirements in general, and to meet the gaps identified through the care planning process review. 3) Develop a business plan for a 'new model of primary care' to drive local commissioning intentions and result in the letting of new contracts that span traditional organisational barriers. 4) Determine how implementation lessons learnt will be shared across CCGs, for example through developing a clinical community of interest to share progress and learnings 5) Co-produce a provider development plan with providers to ensure that they are able to deliver the services described through the business plans for both WSIC and the new model of primary care. 6) Implement the new model of primary care as per the plans developed through the business case 7) Develop and agree an approach to focus on continuous quality measurement and improvement 8) Implement monitoring improvements, working with the CCGs to support them in evaluating their initiatives.
<p>Resource to deliver (across 1A, 1B, 1C):</p> <p>Programme: 1 FTE Project Manager, 2 FTE Project Support, 1 FTE PMO</p> <p>System (per Borough): 1 clinician (0.05 FTE); 1 commissioning lead (0.2 FTE); Provider lead (0.05 FTE); Local Authority lead (0.05 FTE).</p>	
<p>Benefits</p> <ul style="list-style-type: none"> • People are supported to live healthier lives and navigate care in a way that works for them • Improving the wider determinants of health (including, for example, housing and employment) to improve wellbeing and reduce the need for care. • Improve the overall quality of care for people in their last phase of life and enabling them to die in their place of choice • People are able to access the right care in the right place at the right time • People are treated holistically for their health, care and support needs by moving away from episodic care and integrating health and care services 	<p>Evidence for these assertions</p> <p>Evidence on the impact of case management is promising but mixed. It is usually difficult to attribute any system changes explicitly to case management as there are often multiple factors at play, and as case management isn't a standard intervention - it can be implemented in a variety of different ways. Case management works best when it is part of a wider programme where the cumulative impact of multiple strategies can be successful in improving patient experiences and outcomes.</p> <p>In the US, when compared with a control group, older people enrolled in the PACE programme (case management) showed a 50% reduction in hospital use and were 20% less likely to be admitted to a nursing home. They did, however, use more ambulatory care services. Evaluations of Guided Care have found similar results. Evercare was trialled in the UK after success in the US, but unfortunately only showed negligible results. In Wales, an evaluation of case management showed a reduction in non-elective admissions of 9.1% compared to a control group (and pre-intervention years) and a reduction in length of stay of 10.41%. Despite mixed evidence on the impact of case management on capacity in the system, there is strong evidence that case management results in an increase in patient satisfaction.</p>

Initiative 1: New Models of Local Services Care

Initiative 1C: Providing more proactive and preventative care

Delivery Date: Phase 1 06/2017; Phase 2 03/2018*

Financial Impact (£'000)	Activity Impact	Beds Impact
£21,248	Reduction of 17,187 A&E attendances and 2,979 NEL admissions	117

<p>Product / Deliverable</p> <p>Each CCG will have an agreed vision for the end state of primary care, and an investment case for 16/17 allocations by Q3 2016. By the end of March 2019, each CCG will have implemented a new model of primary care that meets the envisioned end state, and meets the SCF criteria</p>	<p>Initiative Description</p> <p><i>Bringing together the evidence gathered by the Commissioning for Prevention health economy analysis, and the proactive care elements of the Strategic Commissioning Framework, to develop and share a high impact prevention and proactive care framework that drives the implementation of CCG preventative care activities by 2018.</i></p> <p>Key steps:</p> <ol style="list-style-type: none"> 1) Reviewing evidence gathered by the Commissioning for Prevention health economy analysis, and existing WSIC plans and business cases to determine areas for improvement and implementation priorities 2) Work with primary care leads in the CCGs to develop plans to provide more proactive care in alignment with the SCF requirements, building on existing work where appropriate. 3) Develop a business plan for a 'new model of primary care' to drive local commissioning intentions and result in the letting of new contracts that span traditional organisational barriers. 4) Determine how implementation lessons learnt will be shared across CCGs, for example through developing a clinical community of interest to share progress and learnings 5) Co-produce a provider development plan with providers to ensure that they are able to deliver the services described through the business plans for both WSIC and the new model of primary care. 6) Implement the new model of primary care as per the plans developed through the business case. 7) Develop and agree an approach to focus on continuous quality measurement and improvement 8) Implement monitoring improvements, working with the CCGs to support them in evaluating their initiatives.
<p>Resource to deliver (across 1A, 1B, 1C):</p> <p>Programme: 1 FTE Project Manager, 2 FTE Project Support, 1 FTE PMO</p> <p>System (per Borough): 1 clinician (0.05 FTE); 1 commissioning lead (0.2 FTE); Provider lead (0.05 FTE); Local Authority lead (0.05 FTE).</p>	<p>Evidence for these assertions</p> <p>Work commissioned by the Healthy London Partnerships (HLP) in 2016 reported the opportunity of financial savings through investment in illness prevention across London. The analysis proceeded on the basis that illness prevention activities work by compressing morbidity, i.e. people fall ill later in their lives, less severely and less often, and does not consider the argument that illness prevention simply delays expenditure on other, ageing related illnesses. To achieve these savings, HLP reported that the health and care system would need to drastically change to focus on patient engagement, prevention and integration. This requires greater collaborative working and aligning of incentives between local government and health and between primary and secondary care, with a rate of improvement not currently achieved by the system.</p> <p>The potential cost saving opportunity of investing in the preventative priority areas across NWL is significant – for example if just 20% of the eligible population were affected by prevention programmes targeting smoking and diabetes, we could expect cost savings of £38,059,291 and £41,465,076 respectively.</p>
<p>Benefits</p> <ul style="list-style-type: none"> • People are supported to live healthier lives and navigate care in a way that works for them • Improving the wider determinants of health (including, for example, housing and employment) to improve wellbeing and reduce the need for care. • People are able to access the right care in the right place at the right time • People are treated holistically for their health, care and support needs by moving away from episodic care and integrating health and care services 	

Delivery Date: March 2018

Financial Impact (£'000)	Activity Impact	Beds Impact
£2,460	Reduction of 17,568 A&E attendances	0

<p>Product / Deliverable</p> <p>A plan and support to embed self-care framework as identified by the CCG across each Borough.</p>	<p>Initiative Description</p> <p><i>Complete the prioritisation against the self-care framework across all eight local areas in 16/17. Develop and provide Intensive support to address the priority areas of the framework, and enable common solutions, through to April 2017.</i></p> <p>As of December 2015 the NWL Self Care Commissioning Framework has been endorsed by Self Care Leads across the eight CCGs. This framework focusses on a solid foundation based on:</p> <ul style="list-style-type: none"> • Best practice completed by the Kings Fund, the Health Foundation, and NESTA. • Series of engagement events including WSIC service users and voluntary services <p>The NWL Self Care Task and Finish Group recommended the following framework with the requirement for all five to occur in parallel:</p> <ul style="list-style-type: none"> • Commissioning organisations to deliver a menu of self-care programmes e.g. social prescribing, online peer support, care planning. • Activating the workforce e.g. inclusive training in multi-disciplinary settings, motivational interviewing techniques. • Improving provision and quality of information e.g. accessible information, online self-management solutions, directory of services. • Commissioning an activation tool e.g. PAM to support tailoring and evaluation of self-care • Borough wide 3rd sector infrastructure e.g. developing infrastructure to connect, single point of access, 3rd sector representation within MDTs. <p>Key steps now include:</p> <ol style="list-style-type: none"> 1) Complete gap analysis and prioritisation against the Self Care Commissioning Framework for each CCG 2) Review the returns of the gap analysis and identify common needs across each CCG 3) Develop a bespoke support offer to meet the gaps identified by each CCG 4) Deliver support so that the Self Care Commissioning Framework is embedded across each CCG
<p>Resource to deliver :</p> <p>Programme: 0.5 FTE Project Manager, 1 FTE Project Support, 0.5 FTE PMO</p> <p>System (per Borough): 1 clinician (0.05 FTE); 1 commissioning lead (0.1 FTE); Provider lead (0.05 FTE); Local Authority lead (0.05 FTE).</p>	<p>Evidence for these assertions</p> <p>Evidence suggests that proactively supporting self-management and focusing on self-efficacy and behaviour change can have an impact on clinical outcomes, crisis and unplanned admissions. (Health Foundation, 2011):</p> <ul style="list-style-type: none"> • Self-care is thought to save an hour per day of GP time which is currently spent on minor ailment consultations. For every £1 invested in self-care for long-term conditions, £3 is saved in reducing avoidable hospital admissions and improving participants' quality of life. (If you add in social value, this goes up to £6.50 for every £1). (Kings Fund, 2010) • Self-management training is associated with reduced hospital visits (0.9 versus 2.9 per patient per year) and fewer GP visits (0.3 versus 0.9 per patient per year) (Robinson et al, 2001). • A randomised trial in 19 hospitals in North West England found self-management plans resulted in fewer hospital visits and a cost effectiveness analysis favoured self-management over usual care (Kennedy et al, 2003). • A randomised trial in Canada on self-management education for COPD was associated with 40% fewer hospital visits for COPD and 57% for other problems (Bourbeau et al, 2003). • A report on over 5,000 GP consultations found that 6% of those could have been dealt with through the patient self-caring and didn't need to see GP. Supporting self-care can thus reduce demand on primary care (Primary care Foundation 2015).
<p>Benefits</p> <ul style="list-style-type: none"> • People are supported to live healthier lives and navigate care in a way that works for them • Patients are less anxious and overwhelmed, resulting in improved health outcomes • Improving the wider determinants of health (including, for example, housing and employment) to improve wellbeing and reduce the need for care. • Improving the quality and quantity of social relationships to reduce health inequalities arising from social isolation • Improve the overall quality of care for people in their last phase of life • Reduction in unwarranted variation in the clinical management of the North West London population • Reduction in non-elective admissions 	

Delivery Date: October 2016

Financial Impact (£'000)	Activity Impact	Beds Impact
£4,348	Reduction of 1,012 NEL admissions	3

Product / Deliverable

Joint delivery models set up with each CCG and Local Authority to address the wider determinants of health, including social isolation, housing and employment.

Resource to deliver :

Programme: 0.5 FTE Project Manager, 1 FTE Project Support, 0.5 FTE PMO

System (per Borough): 1 clinician (0.05 FTE); 1 commissioning lead (0.1 FTE); Provider lead (0.05 FTE); Local Authority lead (0.05 FTE).

Benefits

- People are supported to live healthier lives and navigate care in a way that works for them
- Improving the wider determinants of health (including, for example, housing and employment) to improve wellbeing and reduce the need for care.
- Improving the quality and quantity of social relationships to reduce health inequalities arising from social isolation
- People are treated holistically for their health, care and support needs by moving away from episodic care and integrating health and care services
- Reduction in non-elective admissions
- Decreases in length of stay

Initiative Description

Develop integrated shared delivery models with Local Authorities, the 3rd sector, and the wider public sector, to tackle the social determinants of health. Early priorities include social isolation, housing, and employment.

Key Steps:

- 1) Map current activities
- 2) Build network of partners with London Councils, WLA, LAs, and 3rd sector
- 3) Compare current models and expected benefits with best practice, through desk based review drawing on ongoing national work
- 4) Series of workshops to explore priority issues: social isolation, housing, and employment
- 5) Form and support working groups to develop workable proposals
- 6) Develop initiatives to a) pilot new ideas, and b) mainstream existing pilots

Evidence for these assertions

The Kings Fund suggest that social factors determine approximately half of our health outcomes.

Housing: The Kings Fund suggest that poor housing costs the NHS £2.5 billion per year in treating people with illnesses directly linked to living in cold, damp and dangerous homes. Proportionately, this would mean that the NHS in NWL spends £86 million p.a. on treating these people. The Assisted Hospital Discharge Scheme in Mansfield aims to find appropriate, alternative accommodation prior to discharge for patients who would otherwise be homeless. 60 interventions per month through that scheme equate to £1.3 million net savings per year. The NHS Alliance website 'Housing for Health' give benefits of housing schemes including: Discharge support (£3.37 ROI for every £1 invested); End of life support (reduction in GP visits by 55%); Warm homes (33% fewer OP visits, 28% fewer GP visits). If every borough spent the same as Mansfield on discharge support, this would give us a gross saving across NWL of £6.3m and a net saving of £4.4m through reductions in length of stay.

Employment: Workers who have experienced involuntary job loss have a more than twofold increase in the risk of subsequent AMI and stroke relative to working persons (US Health & Retirement Survey). Previously healthy unemployed people are more than twice as likely to develop a limiting illness in a given year than those in employment.(UCL, 2014). DWP (2010) estimate that when an unemployed person moves into work they incur £508 less in NHS costs per annum, and if they have a disability the saving is £1,016 (2008 prices).

Social isolation: Social isolation affects all ages, but particularly older people. 17% of older people are in contact with family, friends and neighbours less than once a week and 11% are in contact less than once a month (Victor et al, 2003). individuals lacking social contact can 'carry a health risk equivalent to smoking up to 15 cigarettes a day and being an alcoholic' (Buffel *et al*). The Campaign to End Loneliness recommend social prescribing and similar interventions to tackle social isolation. The Rotherham Social Prescribing Pilot found "significant benefits to the NHS, with inpatient admissions reduced by 21 per cent; Accident and Emergency attendances reduced by as much as 20 per cent; and outpatient appointments reduced by as much as 21 per cent." "The pilot phase cost £1.1 million [for 1,607 patients]. An independent assessment of the return on investment estimated that the longer-term return on investment could reach £3.38 per pound". The Cornwall 'Living Well' pilot found similar savings, with an ROI in their Newquay pilot of 4:1 and a minimum 29 per cent reduction in the cost of hospital admissions.

Initiative 4: Rapid Response and Intermediate Care

Delivery Date: March 2018

Financial Impact (£'000)	Activity Impact	Beds Impact
£64,908	Reduction of 38,165 NEL admissions	408

Product / Deliverable

A best practice model for intermediate care and rapid response is developed, and support is provided to implement it across NW London.

Initiative Description

Agree the definition, scope and offer of Intermediate Care Services (both step-up/rapid response, and step-down/discharge) in NW London through a discrete piece of scoping and planning work, identifying the cost-effectiveness of existing ICS in NW London and national best practice. This would include a review of home-based care. Implementing the recommendations of the review, intermediate care will be standardised, invested in and scaled up across North West London to provide care that is cheaper, but crucially, better for patients.

Key steps:

- 1) Baseline current models and expected benefits, expanding existing review to incorporate all relevant services (not just those badged 'intermediate care) ie: crisis response, home based, bed based, and re-ablement)
- 2) Compare current model and expected benefits with best practice, through desk based review and liaison with local clinical leaders and national experts (royal colleges, NHSE, ADASS, etc) drawing on ongoing national work such as the national audit
- 3) Workshop with CCG and clinical leads to review opportunities exposed and agree improvements to NWL models, either locally or NWL-wide
- 4) Develop implementation proposals and navigate CCG governance, through: Working group to propose implementation plan; approval from LSPE; test at GB seminars; clear with GBs as needed

Resource to deliver :

Programme: 1 FTE Project Manager, 1 FTE Project Support, 1 FTE PMO
System (per Borough): 1 clinician (0.05 FTE); 1 commissioning lead (0.2 FTE); Provider lead (0.05 FTE); Local Authority lead (0.05 FTE).

Benefits

- Improve the overall quality of care for people in their last phase of life and enabling them to die in their place of choice
- Reduction in unwarranted variation in the clinical management of the North West London population
- People are able to access the right care in the right place at the right time
- People are treated holistically for their health, care and support needs by moving away from episodic care and integrating health and care services
- Reduction in non-elective admissions
- Decreases in length of stay

Evidence for these assertions

ImBC review identified potential to remove 586 beds through improvement in intermediate care services by 2021. Projections from current plans suggest we are currently on target to deliver 177, so there is a significant opportunity gap.

The National Audit of Intermediate Care 2015 considers four main components of intermediate care (crisis response; home based care; bed based care; and re-ablement). It found more than 70% of service users go home after intermediate care, avoiding the need for hospitalisation, and 72% of people maintain their dependency level in intermediate care.

In the 2014 report, average costs for intermediate care were calculated at £1,045, £1,722 and £5,549 per episode of care for home-based, re-ablement and bed-based services respectively. The costs for home and re-ablement look particularly attractive, and the bed based cost is similar to continued care in hospital but, of course, the person is now in a more appropriate rehabilitation environment, and a bed has been released in the hospital for a new acute care episode.

Delivery Date: February 2017

Financial Impact (£'000)	Activity Impact	Beds Impact
£8,465	Reduction of 3,848 NEL admissions	31

<p>Product / Deliverable</p> <p>A common discharge process across neighbouring London boroughs and bedded community services is designed and support is provided to implement across all Boroughs.</p>	<p>Initiative Description</p> <p><i>Expanding the single needs-based discharge form and process to include neighbouring London boroughs, bedded community services and referrals into joint health and social care re-ablement packages.</i></p> <p>As of May 2016 a single needs-based assessment form has been designed for use to refer into community healthcare services provided in patients' homes. This has been approved by each of the NWL acute trusts and community providers. To expand this to include referrals to bedded community services, neighbouring boroughs and adult social care will require the following next steps:</p> <p>Key steps:</p> <ol style="list-style-type: none"> 1) Mapping current bedded community services in North West London, including referral routes and referral forms currently used; 2) Comparison of existing needs-based assessment form against adult social care referral forms, including seeking confirmation that it is Care Act compliant; 3) Establishing a baseline to understand lost bed days due to inappropriate or rejected referrals and scoping potential benefits; 4) Engaging with bedded community service managers, neighbouring London boroughs and adult social care teams and staff to agree amendments or additions to the existing needs-based assessment form; 5) Piloting the needs-based assessment form for use to refer into additional services and boroughs; 6) Measuring the impact of the pilot, amending and achieving sign off of the needs-based assessment form; 7) Communicating the changes to all staff across NWL acute trusts and in bedded community services, adult social care and neighbouring boroughs; 8) Monitoring and evaluating the impact of these changes.
<p>Resource to deliver :</p> <p>Programme: 1 FTE Project Manager System (per Borough): 1 clinician (0.05 FTE); 1 commissioning lead (0.1 FTE); Provider lead (0.05 FTE); Local Authority lead (0.05 FTE).</p>	<p>Evidence for these assertions</p> <p>Total bed day savings are based on 2015/16 activity data which shows the following:</p> <ol style="list-style-type: none"> 1. 35% of all North West London (NWL) non-elective admissions were to a cross-border hospital within NWL in 2015/16. 2. The average length of stay for a cross-border admission within NWL is 2.9 days longer than one within a CCG boundary. 3. If the length of stay of all cross-border admissions within NWL could be reduced to equal that of within borough admissions, the system could release a total of 62 beds. <p>For tri-borough area all cross border activity is defined as all activity excluding Imperial and Chel West. Ealing CCG cross border activity is all activity excluding Ealing Hospital. Brent CCG cross border activity is all activity excluding Northwick Park & Central Mid. Harrow CCG cross border activity is all activity excluding Northwick Park. Hounslow cross border activity is all activity excluding West Mid. Hillingdon cross border activity is all activity excluding Hillingdon and Mount Vernon.</p>
<p>Benefits</p> <ul style="list-style-type: none"> • Reduction in unwarranted variation in the clinical management of the North West London population • People are able to access the right care in the right place at the right time • People are treated holistically for their health, care and support needs by moving away from episodic care and integrating health and care services • Decreases in length of stay 	

Initiative 6: Last Phase of Life

Delivery Date: TBC

Financial Impact (£'000)	Activity Impact	Beds Impact
£7,000	Reduction of 2,300 NEL admissions	32

Product / Deliverable	Initiative Description
<ul style="list-style-type: none"> A self-assessment of last phase of life services across each CCG using the Strategic Clinical Networks commissioning checklist for end of life care Local GAP identification and analysis Communications plans Standard requirements for advice lines and support Standard pathway for advice lines and support Standard requirement for patient advice lines and support 	<p>Whilst there has been significant improvement in the provision of end of life care across North West London in recent years there still remains significant variation across the 8 CCGs, both in terms of access and quality. There are significant opportunities to reduce this variation and enhance clinical quality, with subsequent impact upon unscheduled bed demand within the acute provider network.</p> <p>The vision for this programme is to address issues across an extended End of Life period, which we are defining as the final 12-18 months of life and will subsequently refer to as the Last Phase of Life. By focusing on this extended period we can focus on improvements to planning for this period, building the partnership between patients, families and healthcare providers. A focus on planning, centred on Advanced Care Plans, we envisage that the process will become more patient centric / patient driven and that decisions will help reduce unscheduled acute care.</p> <p>During the first phase of this programme significant focus will be placed upon Care Homes, both residential and nursing, with a view to developing some rapid interventions which will enable homes to support patients locally during the last phase of life, thereby reducing demand upon London Ambulance Service and the NWL acute hospitals.</p> <p>Key Steps:</p> <ol style="list-style-type: none"> 1) Establish contacts across the key stakeholder groups 2) Establish a baseline of last phase of life services across the 8 boroughs 3) Identify the key priorities for phase 1 4). Implement the priorities for phase 1 which may include improving the interoperability of CMC with other systems, improving identification and planning for the last phase of life, improving access to last phase of life advice and services, and defining training standards for clinical staff in care homes.
Resource to deliver :	Evidence for these assertions
<p>Programme: 1 FTE Project Manager; 1 FTE Project Support (SaHF-funded Project Manager and Project Support currently scoping this work and reporting to Provider Board).</p> <p>System (per Borough): 1 clinician (0.05 FTE); 1 commissioning lead (0.1 FTE); Provider lead (0.05 FTE); Local Authority lead (0.05 FTE).</p>	<p>National end of life strategy, Gold Standard framework, and NICE guidelines have outlined the characteristics of high quality end of life care to meet the needs of people in their last phase of life. However, there is a recognition that much more can be done for these patients, and there is evidence that this can provide significant financial benefits as well.</p> <p>Nuffield Trust findings show that the cost of care increases during the last 3 months of life as patients near death and that the system spends on average ~£6,600 caring for each patient during the last 3 months of life with over 50% of spend driven by emergency admissions. (SOURCE: Nuffield Trust report, Sept 2014: Exploring the cost of care at the end of life).</p> <p>More work needs to be done to determine the full potential across further patient cohorts and in terms of financial impact, it is expected to be considerably larger.</p>
Benefits	
<ul style="list-style-type: none"> Improve the overall quality of care for people in their last phase of life and enabling them to die in their place of choice Reduction in unwarranted variation in the clinical management of the North West London population Reduction in non-elective admissions Decreases in length of stay 	