NHS

North West London
Commissioning Partnership

Better Performance, Better Healthcare

NWL Sector Integrated Strategic Plan 2009 – 2014 January 2010

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1.0 Foreword

This document marks the shift of the Primary Care Trusts (PCTs) in North West London (NWL) from a predominantly Primary Care focus to the leaders of strategic purchasing of health and healthcare. As PCTs separate from their provider arms they become smaller leaner organisations focussing solely on commissioning. This drives issues of scale and partnership which have been addressed through the strengthening commissioning review.

This review has generated five initiatives in the North West London Sector:

1. **The Acute Commissioning Vehicle.** By aggregating our acute commissioning activities we have generated scale and leverage. Current commissioning staff have been brought together and supplemented by further high quality staff to drive this change. Performance Management and Contracting is being enhanced by the focus and dedication of this team.

2. **North West London is supporting Commissioning Support for London.** This organisation is delivering "Once well for London". This includes acute claims management and support for Healthcare for London.

3. **As acute functions are aggregated there is scope for localisation of other functions.** This means each PCT is able to work even more closely with its Local Authority to drive local service change and local integration as appropriate. This delivers better services for citizens locally as well as better value for money.

4. **To really drive change requires clinical engagement.** At a local level this is driven through Practice Based Commissioning. Each PCT, together with the Partnership, is working closely with Practice Based Commissioners. It is their role to specify requirements of hospital services and increasingly design and coordinate out of hospital services through polysystems. The success of polysystems will deliver the change and financial efficiency across the Sector by providing care in the right setting.

5. **All of this work is being brought together in this Integrated Strategic Plan (ISP).** The plan describes the shift of care to lower cost settings in polysystems and the consequent effect upon acute hospitals. It describes how we will drive change through community and primary services and enhance quality in secondary care services.

The plan details the action we will take to implement the 8 Healthcare for London pathways at a local level. This will inevitably result in fewer beds in the acute Sector as resources are transferred to more appropriate settings. Together with the financial situation, this will require substantial acute hospital reconfiguration.

North West London has much to be proud of. It hosts some world class institutions that offer the highest levels of patient care. It has ground-breaking initiatives in the community including exemplar polyclinics. Our challenge is to bring all to the level of the best and drive our already excellent providers to world class standards.

Michael Scott
Chief Executive

Peter Molyneux
Chair

Andrew Steeden
Clinical Director

Mark Spencer
Clinical Director

2.0 Introduction

The NHS in North West London (NWL) offers some of the most advanced healthcare in the country. There are two national specialist hospitals based in the area, Royal Brompton & Harefield NHS Foundation Trust (RBHT) and The Royal Marsden NHS Foundation Trust (RMT), one of the first Academic Health Sciences Centres (AHSC) in Imperial Healthcare (IHCT), and an increasing number of new primary care led services and facilities providing care close to home.

The NHS in NWL as elsewhere faces real challenges over the next five years. We know that demand for healthcare continues to rise each year, and that an ageing population will require more health care. Technology and health science innovation continuously expands the boundaries of health care, and people rightly have increasingly high expectations of their health services. As a group of eight PCTs we have set ourselves challenging targets to improve health and healthcare over the next five years.

We know that after 2010/11, the years of large increases in NHS funding, which have brought healthcare expenditure in line with other OECD countries, will be over. For the following four years, the challenge will be to continue to improve services but within existing resources.

The NHS in London is implementing the health strategy, Healthcare for London (HfL).
This strategy is based on two well evidenced principles - that health care is better when provided closer to people's homes wherever possible, and that greater concentration of certain hospital based services provides better care.

The Primary Care Trusts, Hospital Trusts and Mental Health Trusts in NWL are committed to delivering the Healthcare for London strategy together.

This document describes how we are planning to develop better health services for the future along eight "care pathways". These describe how services should be provided in future, from supporting people to stay healthy to providing the best choices and services for people at the end of their life. In every case, we plan to move appropriate care into local community and primary care settings. Where there is excess capacity in hospitals, we will address this and reallocate the resources released to build local services.

The financial rules of the Operating Framework 2010/11 have brought the financial constraints on hospitals into even sharper focus. This means that there will have to be significant changes to hospital services in order to safeguard quality in the future.

To do this, the eight PCTs are working with their local GPs, community services, local authorities, voluntary Sector and hospital clinicians to develop "polysystems" This word describes integrated local care for up to 100,000 people, managed and delivered by groups of GPs and other healthcare professionals for their patients.

To keep the local NHS moving forward in the next five years, all services must become more productive. We know that there is unacceptable variation in the quality, accessibility and productivity of services across the eight boroughs, and that in many cases improving productivity goes hand in hand with improving services.

This is our vision, and the challenge which we face. The following chapters set out our plan for delivering it.

3.0 Vision

3.1 Vision, values and goals

3.1.1 Vision

Over the next five years the eight Primary Care Trusts in North West London (NWL) will work together to improve the well- being and reduce health inequalities of the population we serve by encouraging healthy behaviours and transforming delivery of health care.

We will improve the quality of health care across NWL, so that everyone has access to high-quality services. This will be achieved by implementing the London strategy, *Healthcare for London - a Framework for Action 2007*. Londoners were consulted on this strategy during 2008. The strategy's proposals to localise care wherever possible and to centralise care where this provides better outcomes, were widely supported by the NWL public.

3.1.2 Values

We agreed these values last year when we started working together as a group of eight PCTs:

Working together for patients. Patients are always put first. The needs of patients and communities come before organisational and administrative boundaries.

Improving lives. Measurable improvements will be made to local people's health, well-being and experience of using NHS services.

Everyone counts. Our resources are used for the benefit of the whole community. Nobody is excluded or left behind.

Commitment to quality of care. Continuous service development is led by clinicians in partnership with patients, founded on the best international research and practice.

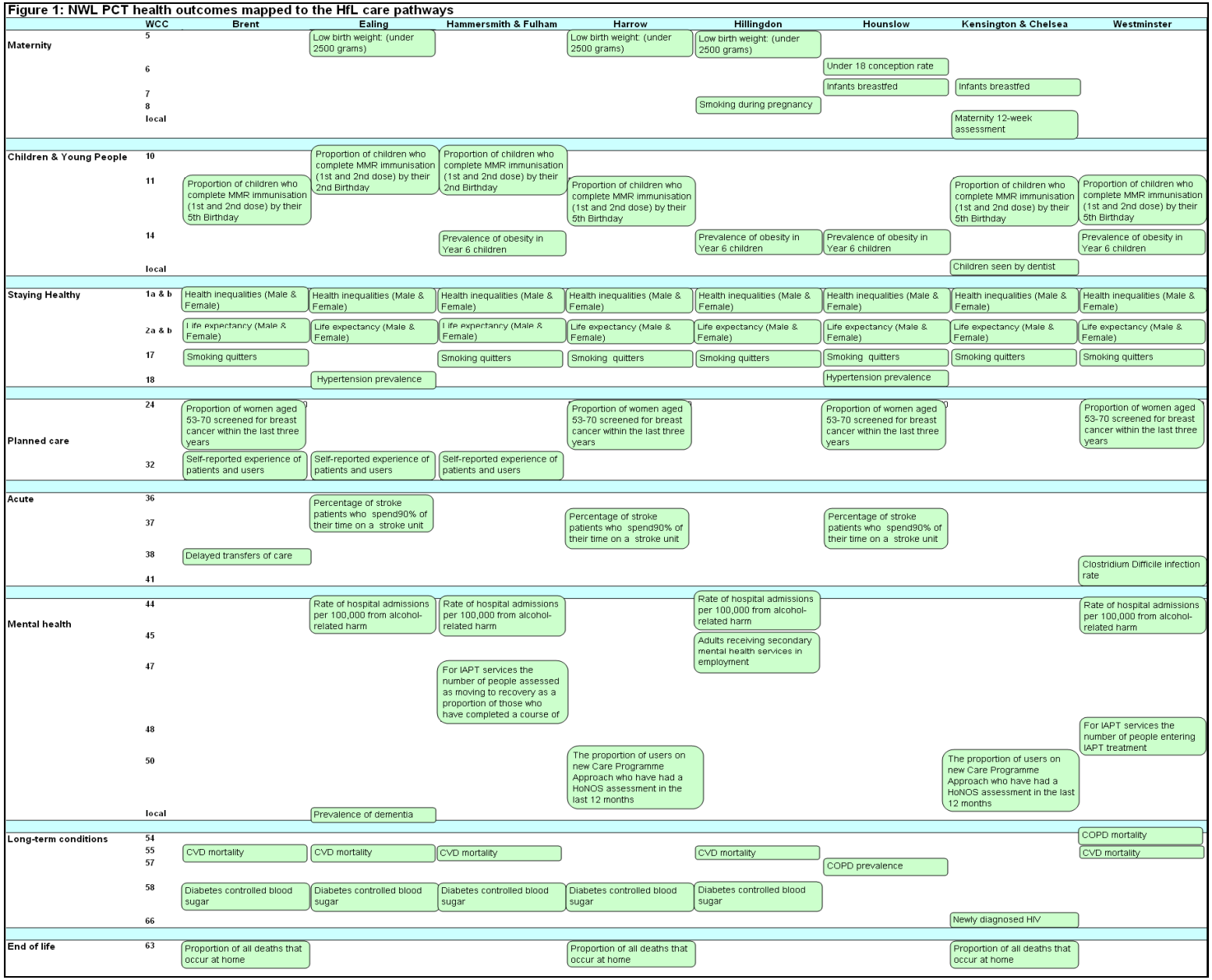
Partnerships in care. Partnerships will be strengthened between the PCTs, patients, carers and the public, healthcare providers, local authorities and not for profit organisations.

Strategic investment of resources. The NHS will always work to improve the productivity and efficiency of its services, making the best use we can of taxpayers' money.

Our vision and values aim to reduce health inequalities in NWL over the next five years which currently see variations in life expectancy of 7-10 years between PCTs, and in some cases within PCTs. Kensington and Chelsea has the highest life expectancy at 85.6 years for females and Hounslow the lowest at 76.6 years for males.

NWL PCTs have identified their main priorities for improving health outcomes over the next five years from their World Class Commissioning (WCC) outcome trajectories. A summary mapped to the HfL care pathways is shown in table overleaf (Figure 1).

Figure 1: NWL PCT health outcomes mapped to the HfL care pathways



3.1.3 Goals

The NWL Sector and constituent PCTs have worked closely and collaboratively during the development of strategic plans to identify and agree priority goals and initiatives.

1. **The implementation of HfL care pathways by 2013 to improve health outcomes and productivity.**

2. **To implement polysystems in each PCT so that everyone has access to high quality local care in line with the timelines agreed in the NWL roll out program, to be completed by 2013.**

3. **To continue to implement service change in hospital settings to improve health outcomes, reduce variability and create providers that are clinically and financially viable.**

The Sector goals support the health outcome indicators which have been selected by the PCTs in response to their Joint Strategic Needs Assessment (JSNA) work. The implementation of the HfL strategy will enable NWL to meet these targets within a challenging financial climate.

The Sector health outcome goals which reflect those chosen most consistently as health needs by the PCTs in NWL are outlined below. The Sector metrics have been identified from an analysis of PCT projected improvements and timescales.

4. **To increase the life expectancy of people in NWL by an average of 18 months by 2014.**

5. **To reduce the assessed health inequalities in NWL by an average of 10% by 2014.**

6. **To ensure that at least 90% of children receive their MMR immunisation by 2014.**

7. **To manage diabetes care better, ensuring that blood sugar levels are well controlled and monitored by increasing to at least 70% of patients with diabetes who have an HbA1c level of 7.5 or less by 2014.**

8. **To reduce premature deaths from cardiovascular disease by an average of 11 per 100,000 population by 2014. Cardiovascular disease (CVD) has been identified as the main cause of health inequalities within NWL.**

9. **To enable at least 25% of deaths to take place at home by 2014.**

4.0 Context

4.1 The Case for Change in NWL

We face significant challenges that need to be addressed to achieve our vision to transform the health care and well being of the population of North West London:

- **People's health and life expectancy varies from place to place.**
- **Healthcare could make more difference to health and length of life.**
- **People are not as healthy as they could be.**
- **Healthcare is not always delivered in the most appropriate setting.**
- **Healthcare could be better at meeting people's expectations.**
- **Healthcare is not always of the highest quality.**
- **We need to get the best possible value for the money we spend on health improvement and healthcare.**

In developing the strategic plan for NWL, five principles of change were adhered to in the consideration and prioritisation of pathway initiatives. These principles found strong public support in 'Consulting the Capital' in 2008 and were therefore considered important in guiding NWL to achieve our vision of improving the health and health care of our population.

Five principles of change:

1. **Services should be focused on individual needs and choices.**
2. **Services should be localised where possible and regionalised where it improves quality.**
3. **Joined-up care and partnership working, maximising the contribution of all the workforce.**
4. **Prevention is better than cure.**
5. **There must be a focus on reducing differences in health and healthcare.**

4.1.1 Evidence of care to support the Case for change

The following tables illustrative key areas of evidence to support the Case for Change:

- Primary care interventions need to be more proactive and consistent.
- Secondary care has preventable levels of variation in quality and outcome.

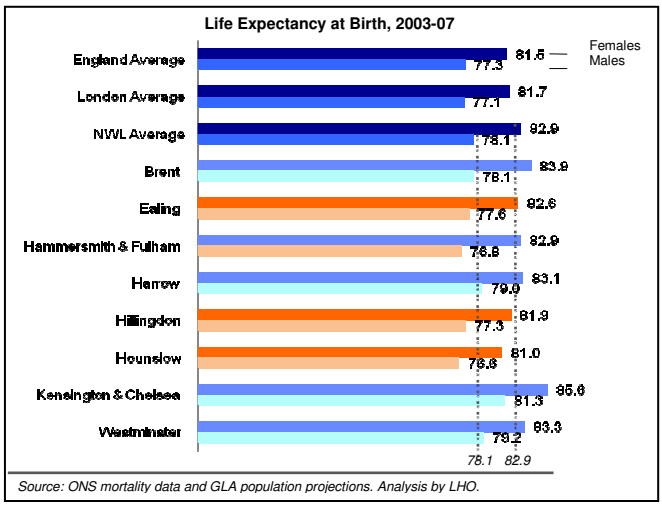
The charts included in this section illustrate PCT health figures against the NWL average using the following colour scheme:

Better than NWL Average

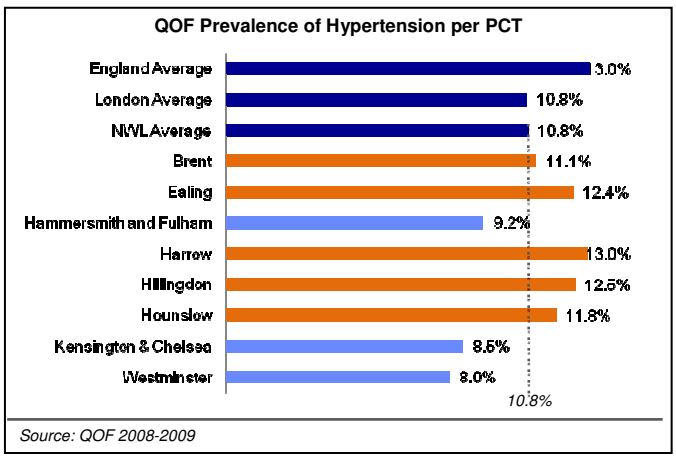
Worse than NWL Average

NWL Average

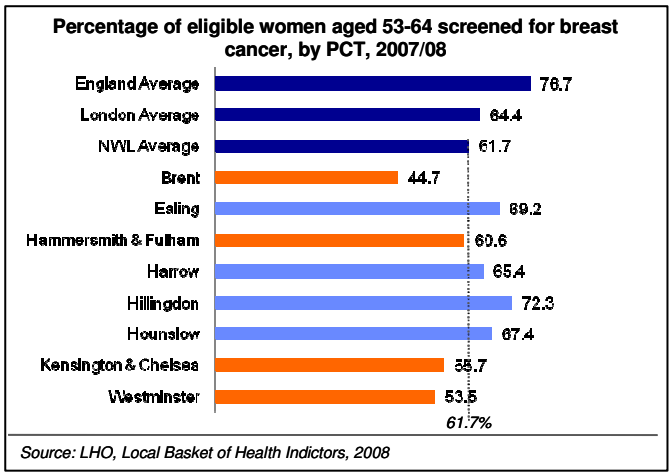
People's health and life expectancy varies from place to place



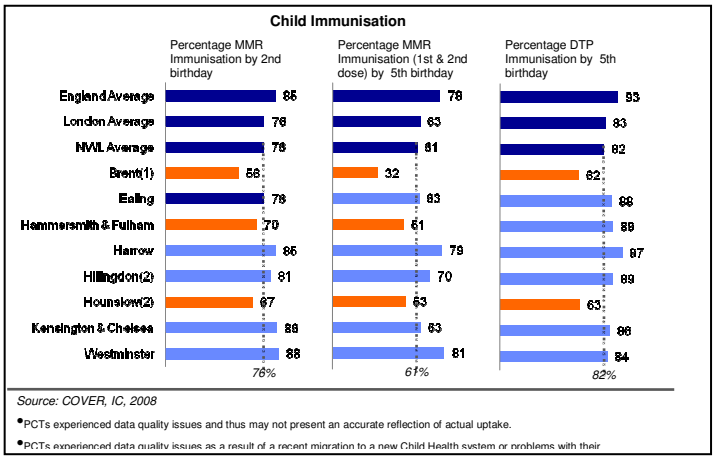
Although life expectancy for NWL is better than for London as a whole, there are big differences across the Sector.



Common long term conditions (LTCs) need excellent management to prevent complications. Their incidence varies across NWL PCTs.

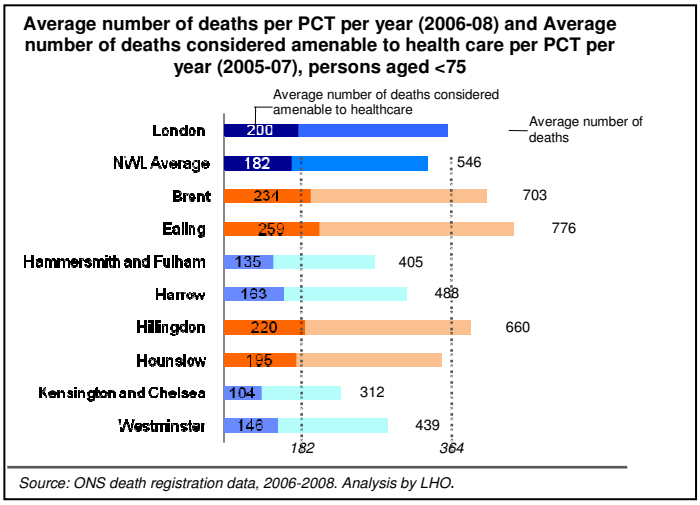


People could be better protected from becoming ill or their conditions could be diagnosed at an earlier stage.

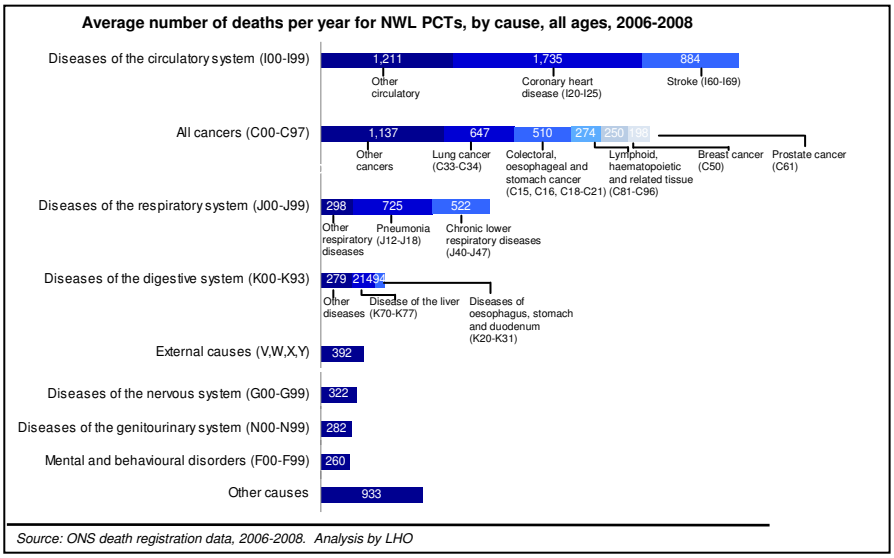


Childhood immunisation rates have improved in recent years but reaching the recommended level of 90% remains a significant challenge in NWL.

Healthcare could make more difference to health and length of life

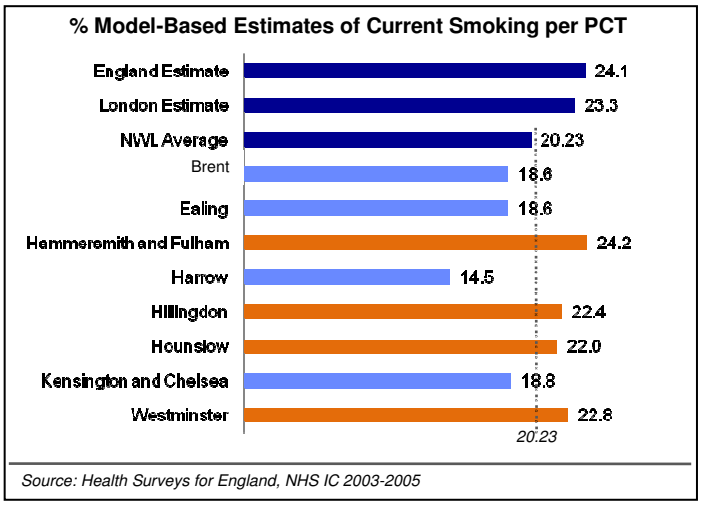


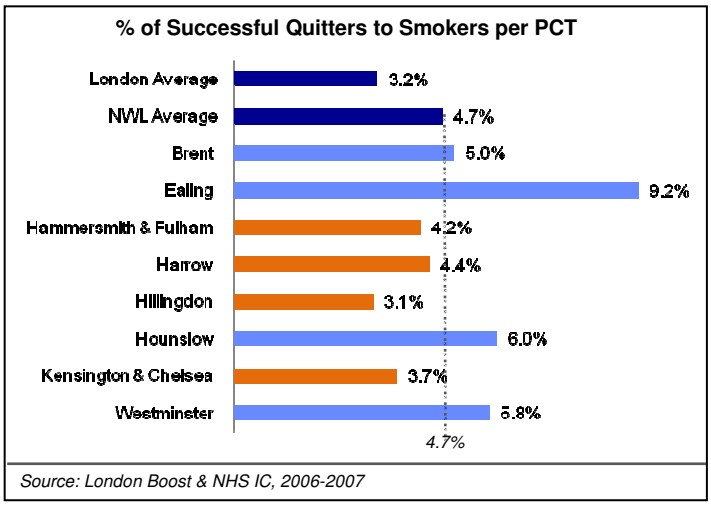
People in NWL die early, or suffer chronic ill health from diseases which could be prevented, or where earlier or more effective interventions could make a difference to their health and life expectancy.



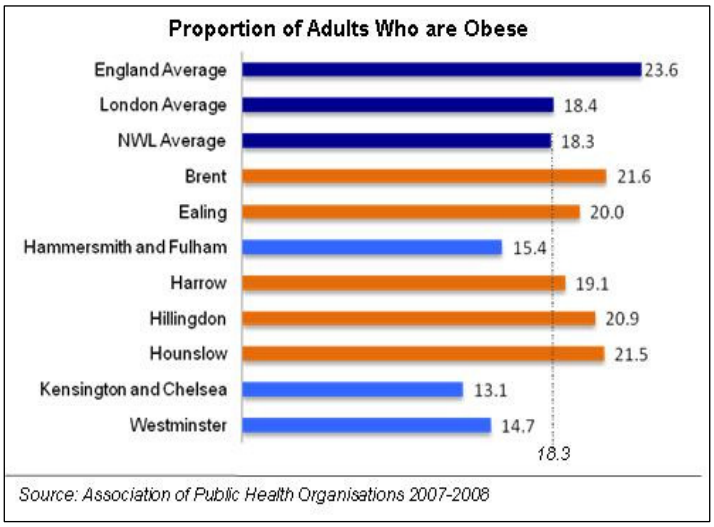
Circulatory diseases and cancers dominate the causes of death. Action to prevent these conditions and to optimise the effectiveness of the healthcare interventions is critical to meeting the health needs of our population.

People are not as healthy as they could be – some health behaviours and lifestyle choices can damage health

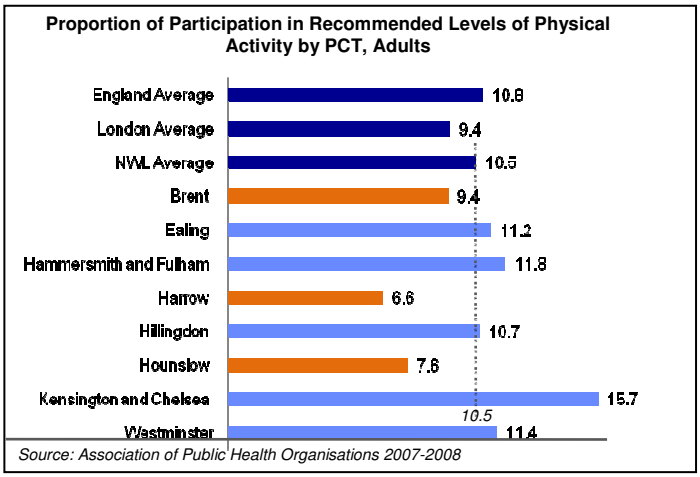




Smoking is the biggest single cause of preventable illness and death and is a major contributing factor to cardiovascular disease. 20% of people in NW London smoke, some stop smoking services get better results than others.



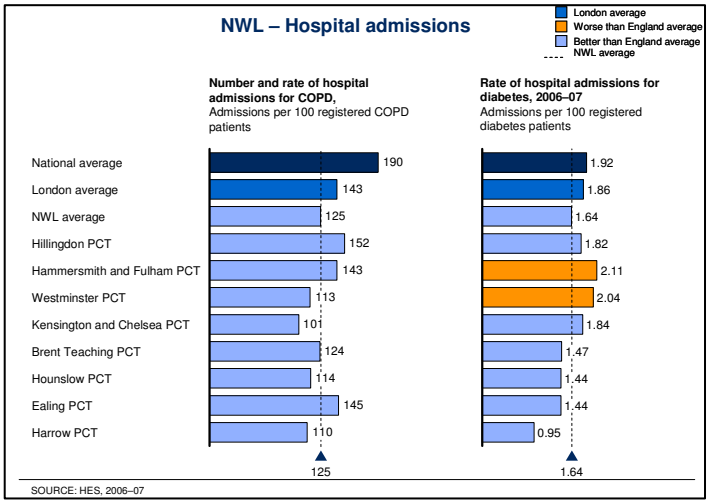
Managing weight, eating healthily, and exercising sufficiently are not easy but NWL PCTs are planning interventions which will support people to manage their health.



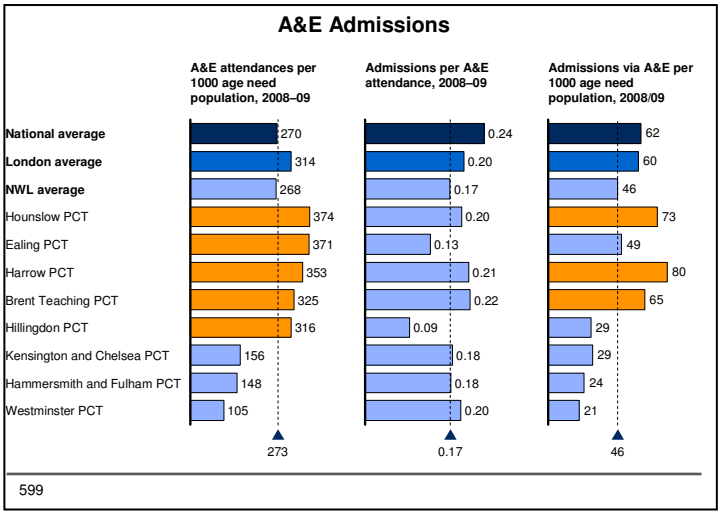
And NWL PCTs are responding to this in order to reduce the risk of developing cardiovascular disease and diabetes.

Healthcare is not always delivered in the most appropriate setting

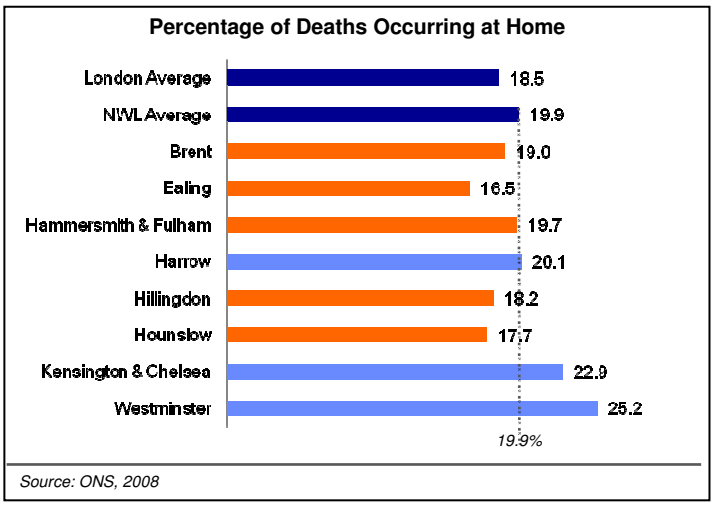
The healthcare available to people is not always in the best place – either locally convenient or at the most appropriate level of complexity.



Admission rates for common long term conditions vary across the Sector, suggesting more can be done to optimise care and reduce the need to be admitted to hospital.



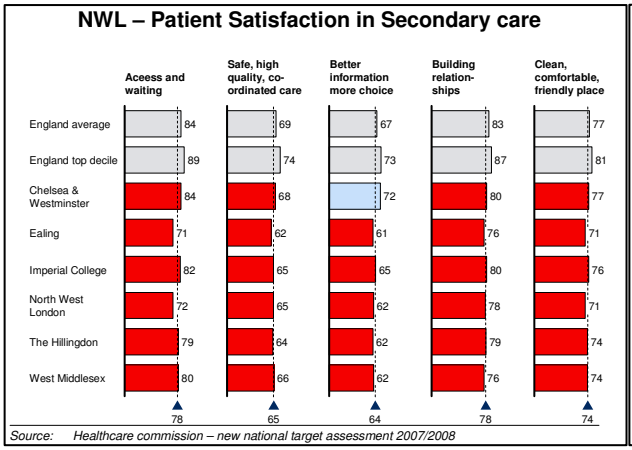
Accident and Emergency Services are much more heavily used in some parts of the Sector than others; in general, evidence suggests that heavier usage is associated with alternative services being less accessible or acceptable than hospital A&E.

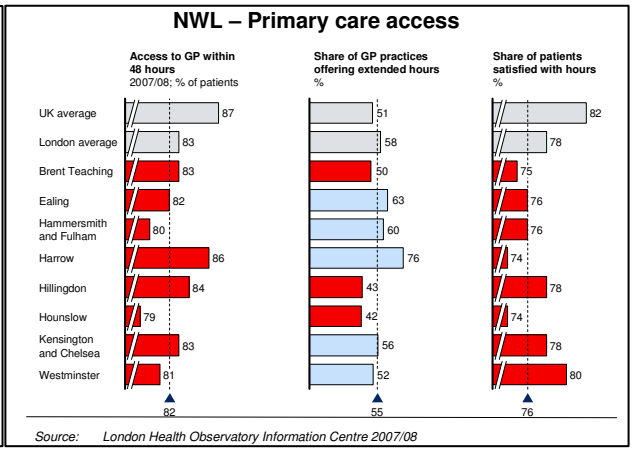


Care at the end of life has been shown to be an important example of care which is too often given in hospital rather than at home, and where people's experience is less good than it should be.

Healthcare could be better at meeting people's expectations

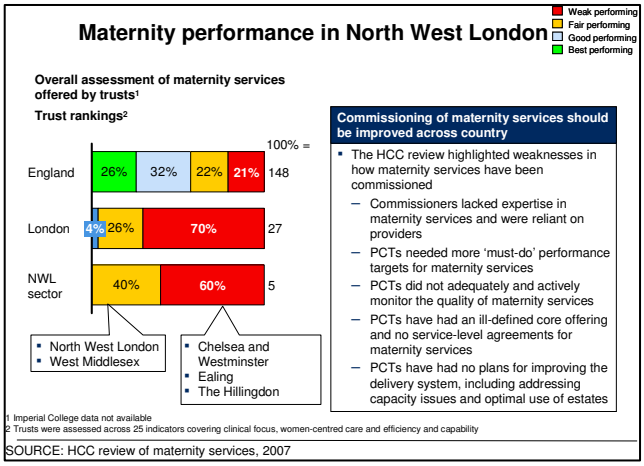
The healthcare available is not always what people want (for example, improved GP access around the working day), or delivered in a way that is acceptable to them (secondary care satisfaction).





Healthcare needs to be the best possible

Healthcare should be the best and most effective care – care pathways should be those known to result in the best outcomes, use the most modern technology, and staff who have the right skills. For example, the HCC review of maternity services shows that the quality of services in NWL lags behind England.



We also know that for specialist services, there is a strong clinical case for making sure that teams of clinicians see larger volumes of each type of case as this leads to better patient outcomes.

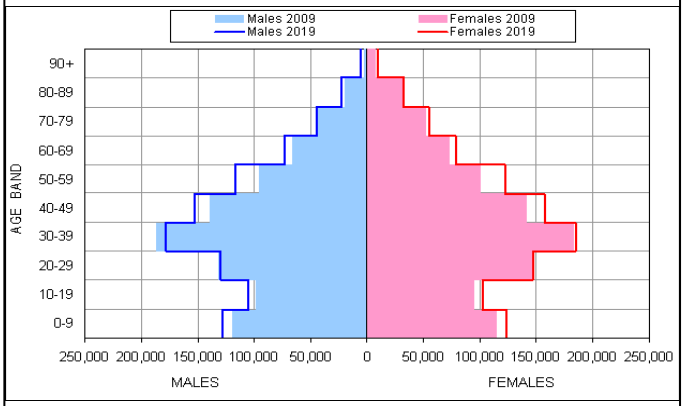
Healthcare needs to be the best value for money
We know that the NHS will receive very little growth in its overall funding and that current services are not as productive as they could be. We must transform the way services are delivered with a greater emphasis on prevention and more effective management of long-term conditions.

4.2 Population demographics and health need

4.2.1 Population demographics

The population of NWL is estimated to be 1.85 million people. The population rise projected for the Sector in the next 10 years is about 7%, in line with the London average and a much smaller rise than that expected to the east of London.

NWL Population Pyramid 2009 and 2019

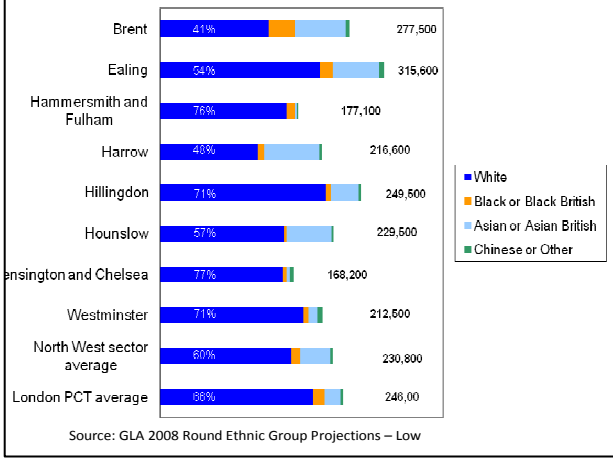


Source: GLA 2008 Round Ethnic Group Projections – Low

The age structure of the population shows that the greatest increase in the population in the next ten years will be those in the 40-60 age groups. This age group will increase by 15%, compared with increases of 7% in those under 19 and 8% in those aged over 70. Although this age group makes lower demands on health services than the elderly, they are the age group with the greatest potential for lifestyle changes to reduce the likelihood of avoidable illness and premature death.

The sizes of the boroughs in NWL vary significantly, contributing between 9% and 17% of the Sector population. The biggest increases in population over the next ten years are projected to be in Hammersmith and Fulham, Hillingdon and Brent, each expected to increase by around 7%. The expected increase of just over 3% overall in the proportion of the population from black and minority ethnic backgrounds is focused mainly in Harrow, Hillingdon and Hounslow, with a smaller increase in Ealing. By 2021, Ealing and Hounslow will join Brent and Harrow as boroughs where less than 50% of the population are from white ethnic backgrounds.

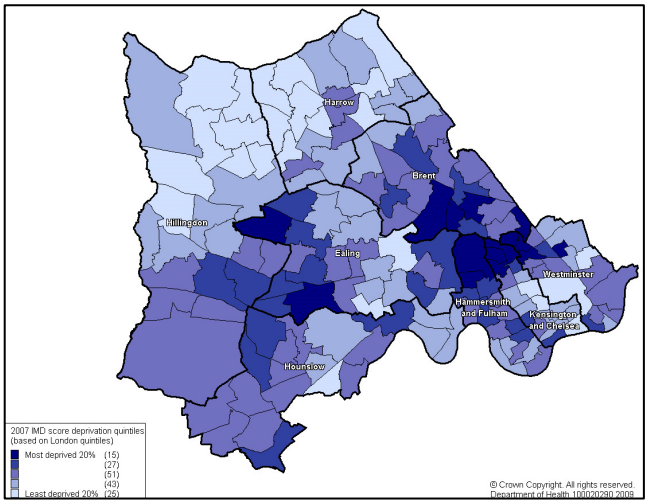
Figure: Borough population and ethnic composition 2009



Source: GLA 2008 Round Ethnic Group Projections – Low

The ethnic composition influences both the disease risk and kinds of interventions that are appropriate. The prevalence of coronary heart disease, high blood pressure, stroke and diabetes is higher in black and minority ethnic populations. Differences in willingness to seek advice on health matters and beliefs about illness need to be taken into account by prevention and care services.

4.2.2 Deprivation



Deprivation is a key component of social and health inequalities. It increases the risk of dying early and is associated with higher rates of a wide range of illnesses. The Index of Multiple Deprivation can be used to rank areas by degree of deprivation. Over NWL as a whole the population is not particularly deprived, but at ward level there are pockets of deprivation that are amongst the 20% most deprived in London.

4.3 Insights from patients, public, clinicians and local partners

To prepare the healthcare strategy for NWL we are drawing on the expertise and experience of a wide range of people and groups.

We have analysed the public and group responses to the 'Consulting the Capital' exercise which introduced the concepts of localising care where possible and centralising specialist care where necessary. There is strong support for the 'HfL' principles across the Sector.

The public response to the recent stroke and major trauma consultation also showed that the public understands and accepts well evidenced clinical cases for change.

We will take care to make sure that traditionally under represented groups of people have the opportunity to work with us on the future shape of healthcare in NWL, using techniques which were found effective in the London consultations.

The Chairs of the eight boroughs' Overview and Scrutiny Committees meet regularly with the Sector team, and have been briefed on the emerging strategy.

Four Clinical Working Groups (CWGs), one each for Maternity and Newborn, Children and Young People, for Medicine and for Surgery, are working on the clinical case for change. Each CWG is chaired by a lead clinician from the Sector. The CWG Chairs presented their emerging recommendations to a Sector-wide clinical engagement event in late November 2009 to which all clinicians in the Sector were invited.

Clinical leadership is provided by two Clinical Directors from Trusts in the Sector and a Clinical Director role within the Sector taken by two local PEC Chairs. Support to develop and increase our level of clinical engagement and provide expert external challenge has been provided by an external consultancy. This approach has resulted in a strongly clinically-led view on the need for service change.

Meetings have been held with each Borough Local Involvement Network (LINk) and with the eight LINks as a group. The Partnership is developing a Public and Patient reference group to support service planning.

The two emerging themes from these initial meetings are that LINk members from the outer London boroughs are the most concerned at what they perceive could become the over-centralisation of acute services. The view of LINks is that localisation and improved accessibility to primary care in

polysystems is welcomed but community and primary care will need to demonstrate how they will provide a high volume of service which is currently provided in hospital.

A Communications and Engagement Strategy has been developed to ensure full public and patient involvement and engagement in both the pre-consultation and formal consultation stages of service transformation.

4.4 Existing targets and local and national health priorities

The Sector performs well against the majority of existing national targets including access to cancer treatment and access to secondary care (18 week target). The following areas present greater challenges particularly in relation to the uptake of preventative services:

- Breast cancer screening
- Childhood immunizations
- Smoking quitters
- Stroke care
- Maternity services 12 week access
- London Ambulance Service category A and B calls

NWL PCTs have included specific initiatives to address these areas within their CSPs. The Sector goals and initiatives also address areas of greatest risk / underperformance.

4.5 Current Provider Landscape

Across the NWL Sector, a range of providers, from GP practices to Alternative Provider Organisations (APOs), large Acute Hospitals and mental health community and inpatient services, serve a local population of approximately 1.85 million, and a much wider population regionally and nationally.

The variation in provider performance as assessed by the CQC Annual Health Check, published in October 2009 is shown below:

Trust	Overall Quality Score	Financial Management Score
Acute Trusts		
Chelsea and Westminster	Excellent	Excellent
Ealing	Good	Good
Hillingdon	Good	Good
Imperial College Healthcare	Good	Good
NWL Hospitals	Excellent	Weak
Royal Brompton & Harefield	Excellent	Excellent
West Middlesex	Fair	Weak
Mental Health Trusts		
Central and NWL	Good	Excellent
West London	Weak	Good

Whilst the Sector has a wide range of provider types, it has a high density of acute care provision, including an AHSC, specialist hospitals, large acute hospitals and local hospitals. This high level of provision, along with perceived inefficiency in service configuration across the Sector, has prevented some acute care organisations from achieving Foundation Trust (FT) status, although two Trusts are FTs and a further two are in the pipeline (Imperial College Healthcare Trust, The Hillingdon Hospital Trust).

Community and non-acute care is provided by five Autonomous Provider Organisations whose annual budgets are in the region of £300 million, and primary care through an extensive network of GP clinics. The current status of some of the organisations within the NWL health economy is of concern:

- Two of the Provider Trusts are currently under review (Hillingdon and Ealing)

- Two Provider Trusts are underperforming and are working with the Challenged Trust Board to resolve their prior year deficits (West Middlesex University Hospital and North West London Hospitals)
- The CQC recently reported on the poor quality of services at the West London Mental Health Trust.

Strengths and weaknesses of current provision

Strengths	Weaknesses
● The Sector is fully engaged in the redevelopment and redesign of primary and community care, particularly with a view to reducing acute setting admissions and improving access to care locally ● 2 existing acute FTs (C&W and RB&HT) and a further two are in the pipeline (THH, ICHT) and one Mental Health FT ● Staff and patients in the Sector are accustomed to acute providers with different roles: the Sector already has an AHSC, specialist hospitals, major acute hospitals and local general hospitals ● Standards of care in the Sector are high ● Hospital standardised mortality rates are low – all NWL Trusts are below 100 (national average) ● 2 of the first polyclinics established in NWL ● Best practice Urgent Care Centres as part of the polyclinics in NHS Hammersmith and Fulham have delivered a 65% shift in activity	● High density of hospitals and corresponding overprovision of acute care ● Previous attempts at reconfiguration have been unsatisfactory and as such, have not resulted in meaningful change ● The current overprovision of certain specialties within the Sector (e.g. A&E and maternity) causes financial and quality issues ● Low productivity in community services. Variable population coverage of community services ● Variable quality and access in primary care ● Six NWL PCTs fall below the national average for QOF points ● Sub-scale clinical specialties e.g. vascular and cancer surgery with low outcomes ● Viability of clinical rotas ● Coverage of emergency surgery is sub-optimal for a population of 500,000 ● Variable performance in mental health services

Acute providers in the North West London Sector performed 425,000 inpatient spells in 2008/09; there were 688,000 A&E attendances at seven sites; and the Sector saw in excess of 30,000 live births across seven maternity units. Critical care and emergency surgery is currently offered at each of the Trusts with A&E departments. The Sector has a high dependence on A&E for access to urgent care compared to the rest of the country. There is good evidence to suggest that a large proportion of A&E attendances could be more appropriately treated by primary care rather than by an acute specialist.

We will be addressing excess capacity in the system through the outputs of the provider landscape work and clinically informed configurations based on the HfL recommendations for models of care, see section 5.5 – page 51.

4.6 Activity commissioned

Acute Commissioning Vehicle (ACV)

The eight PCTs have pooled their acute commissioning resources to create an Acute Commissioning Vehicle (ACV) as part of the NWL Commissioning Partnership.

On behalf of the PCTs in NWL the NWL Commissioning Partnership has taken responsibility during 2009/10 for:

- Acute Sector commissioning and contracting
- Acute Sector performance management
- The commissioning consequences of acute Sector strategic change as services are reshaped with the implementation of HfL

The vision for the Commissioning Partnership is that *"The Partnership will tangibly improve hospital healthcare performance through World Class Commissioning. NWL will have access to higher quality, innovative healthcare and a higher quality of patient experience"*

Summary of current year's commissioning activity

The ACV is implementing the new model of care for stroke and major trauma across NWL, and these new services will be fully operational in 2010.

For 2009/10 the Sector Clinical Reference Group (CRG) agreed a list of procedures of limited clinical benefit, and the PCTs have decommissioned these services. The clinicians are using the map of medicine to set clinical criteria for when a further range of services will be commissioned.

The partnership will concentrate on decommissioning less effective interventions , setting thresholds for treatment and consistently commissioning the most effective procedures and treatments.

A Sector wide market testing exercise is currently underway to provide pathology services more cost effectively and efficiently.

The ACV is also making changes to the way that sexual health is commissioned along with the rest of London, and will bring in sexual health tariffs from next year.

Commissioning for Quality and Innovation (CQUIN) was introduced into acute contract in 2009/10, and while there has been variability in the incentives applied it has been successful in all trusts in improving quality. Standardising the CQUINs in contracts across the Sector to improve clinical quality and patient experience will be a key focus of the next contracting round.

Driving down costs

The Commissioning Partnership will use benchmarking and best value techniques to deliver value for money in non-tariff price negotiations. Approximately one third of acute expenditure is on non-tariff activity, and there is substantial variation in the prices charged, both in the Sector and across London.

The Partnership will support and incentivise Trusts to deliver improved quality and productivity across all specialities, in line with national and international best practice.

Specialised Commissioning

London Specialised Commissioning Group (SCG) works on behalf of London's PCTs to ensure the people of London have access to the most specialised healthcare when they need it, and to improve the quality and value for money of specialised care. The SCG is working to align locally with each of the main sector strategies on service configuration and is fully aligned to the core approach of local services where possible, and centralisation where necessary. For specialised services there will need to be some centralisation, and also a greater role for networks. The SCG's strategic goals reflect specific local drivers for specialised services in London such as Healthcare for London themes including more patients receiving care in local polysystems and demand management, as well as Major Trauma, Tertiary Paediatric, Cancer and Cardiovascular services.

5.0 Strategy

Our strategy is to ensure that care is delivered by the right person in the most appropriate setting. We will achieve this by analysing each of the eight HfL care pathways and with strong clinical leadership we will redesign care pathways to provide more care in primary and community settings through polysystems. We will address the consequent impact on acute hospitals which together with the concentration of specialist services will mean taking out excess capacity and reinvesting resources to build local services.

5.1 Implementing Healthcare for NWL

The goals outlined in section 3.1.3 (page 6) aim to deliver our vision to improve the quality of health care in NWL and support the PCTs to improve health outcomes. The goals will be achieved through the delivery of a focused set of initiatives within each HfL care pathway.

The initiatives focus on service redesign and productivity improvements to ensure that care is delivered in the most appropriate setting. Four CWGs were established as outlined in section 4.3 (page 14) to develop recommendations for acute service transformation. Their recommendations are outlined in the relevant care pathway.

The initiatives build on the work initiated in the Collaborative Commissioning Intentions plan 2009-14, which provided a strong platform for service transformation. The NWL Joint Committee of the Primary Care Trusts (NWL JCPCT) has shaped the strategy through formal meetings and a seminar held in September 2009. The initiatives were prioritised through a Sector workshop (in November 2009) involving the NWL Commissioning Partnership and PCTs and these are reflected in both the Sector and PCT strategies. The initiatives were prioritised based on the following criteria:

- Supports the implementation of HfL.
- Ability to deliver improved health outcomes.
- Supports the transformation of health services to create a clinically sustainable and affordable provider landscape.
- Can be implemented within five years.

The strategy has been developed in partnership with the PCTs to ensure that our plans are aligned and that the initiatives are complementary.

Further work is planned to develop a prioritisation framework to enable the Sector to determine how the initiatives would need to change under different financial scenarios. The Sector Chief Executives have agreed to review examples of best practice from PCTs across the Sector so that they can be adapted and a common approach used to prioritise areas within the scope of the NWL JCPCT delegated authority.

This section details the vision, scope of the pathway, best practice, key challenges, initiatives to improve health outcomes and the impact on care settings for each of the HfL care pathways. The impact on activity volumes and investment / disinvestment is outlined in the Sector financial plan (section 5.6 - page 56)

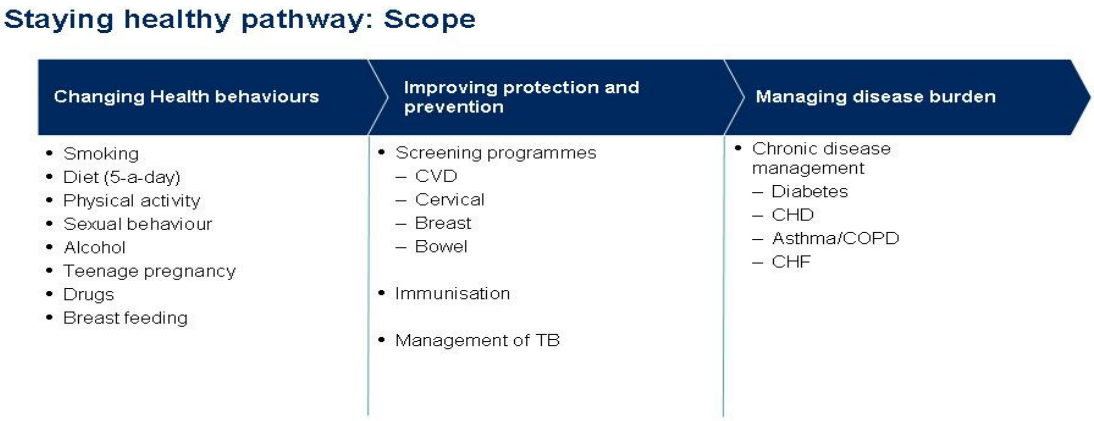
5.2 Pathways/Initiatives

5.2.1 Staying Healthy

Vision

The staying healthy pathway is fundamental to implementing the HfL strategy. Initiatives will be focused on population groups and based on best evidence. Benefits of individual PCT programmes to other boroughs will be identified through a Sector wide performance framework.

Scope of the pathway



Source: Pathway Based Commissioning: NWL, NHS London, November 2009

The priority areas for NWL Sector are outlined below. They are categorised by pathway component.

Changing health behaviours

The priority areas agreed by NWL Sector for changing health behaviours are:

- Stopping smoking (seven of the eight Sector PCTs have World Class Commissioning (WCC) outcomes, all eight PCTs describe initiatives in their Community Strategic Plans (CSPs)).
- Initiatives to support individuals to maintain a healthy weight including diet and physical activity (seven out of eight PCTs describe initiatives in their CSPs). These initiatives are closely linked to Cardiovascular Disease (CVD) (five out of eight PCTs describe as a WCC outcome). Child obesity is a WCC outcome for four PCTs and initiatives are described in all eight PCT CSPs.
- Young people's sexual health (four of eight PCTs describe initiatives in the CSPs).
- Reduce the incidence of low birth weights (three of eight PCTs have WCC outcomes, all PCTs describe initiatives to improve health of pre-conception and pregnant women to reduce low birth weights and ensure healthy pregnancies).
- Breastfeeding support (two of eight PCTs have WCC outcomes, all PCTs describe initiatives in CSPs).
- Alcohol use (rate of hospital admissions from alcohol related harm is a WCC outcome for four PCTs).
- All PCTs have life expectancy and health inequalities as a mandatory WCC outcome initiative although life expectancy is already high in some NWL PCTs.

Improving protection and prevention

The priority areas identified by the Sector for improving protection and prevention are:

- Immunisations (refer to Children & Young People and Maternity & Newborn pathways)
- Screening programmes, especially Coronary Heart Disease (CHD), CVD, bowel cancer, breast cancer and HIV
- Management of TB (particularly Hounslow and Hillingdon)
- Chlamydia

Managing disease burden

The scope includes those long term conditions that affect large numbers of the population and includes diabetes, CHD, Asthma/ Chronic Obstructive Pulmonary Disease (COPD), Heart Failure, dementia and mental health problems. This section is closely related to the long term conditions pathway but it focuses on working with the population to minimise complications of the condition by case finding, early identification and diagnosis, comprehensive Multi Disciplinary Team (MDT) care packages and patient/carer education to ensure the person remains as well as possible with the long term condition (for diabetes, controlled blood sugar is a WCC outcome for five of eight PCTs). It also

ensures that health inequalities (a WCC outcome for all PCTs) are improved as proactive case finding leads to improved equity of access to services.

Best Practice
The best practice around changing healthy behaviours are interventions such as targeting programmes at specific population groups, ensuring programmes are evidence based and targeting population segments. For example, in Hillingdon there is a biking group for people with severe mental illness which increases stamina and fitness levels, reduces caffeine intake, encourages healthy eating, leads to weight loss and increases social contact so improving healthy behaviour for physical and mental well-being.

The best practice around improving protection and prevention is targeting programmes at specific populations. There is evidence to suggest there is good practice across the Sector in screening, for example, Brent has Chlamydia screening available from over 60 sites including 80% of GP practices and Hillingdon, Harrow and Ealing PCTs are all over the National average for the percentage of people screened for diabetic retinopathy. The London PCTs currently spend £750,000 on social marketing (smoking cessation and immunisations) and social inclusion with CSL – to which the eight Sector PCTs contribute.

The best practice around managing disease burden is described in the long term conditions pathway.

Current Challenges
The case for change section identifies the Sector challenges around staying healthy including obesity, and smoking cessation. Further challenges include:

- High HIV prevalence in NWL (4.7 compared to 1.8 nationally and three NWL PCTs have an HIV prevalence of 6.8 or higher).
- Cervical screening (all PCTs in NWL are worse than the national average - 63% of women are screened compared to 68.7% nationally)
- Low uptake rates for breast cancer screening.
- Variation in success rates per £ spent on health promotion activities.
- A highly mobile population means that PCTs are challenged by investing in healthy behaviours when the benefits are realised in other parts of London or the country.

The challenges for improving protection and prevention are:

- There is a lower percentage of MMR and DPT immunisation in NWL compared to the national percentage.
- All PCTs in NWL are worse than the national average for population aged 15-24 screened and tested for Chlamydia (2.3% are screened and tested in NWL compared to 5.0% nationally and all PCTs have a lower screening and testing percentage than the national average).

The challenges for managing disease burden are:

- Low diagnosis against expected prevalence (e.g. HfL needs assessment for Dementia shows that only Hounslow at 41% is above the London average of 37% of people registered on QOF as a proportion of estimated prevalence of dementia. Ealing is 37%, the rest are 30% and below.)
- Variable performance of GPs in case management.
- Poor systems for identifying and screening those at risk of priority long term conditions.
- Excessive use of unscheduled and planned hospital care for people with long term conditions.

Key Initiatives
Initiatives for this pathway will be addressed by NWL PCTs as outlined in each CSP.

- **Seven PCTs are focusing on supporting individuals to maintain a healthy weight**. Initiatives include a physical activity summit and major health campaign obesity strategy, school population targeted healthy eating, and initiatives to support individuals maintain a

healthy weight. For example, the aim of these is to reduce prevalence of obesity in year 6 children to 19.10% (Hillingdon) and 20% (Hounslow and Westminster) by 2014.

- **All PCTs are focusing on smoking cessation**. Initiatives include diversifying, incentivising and performance managing providers, targeting specific populations and targeting work of health trainers. The aims of these initiatives are to increase smoking quitters from between 1505 to 1545/ 100,000 (Hillingdon); from 1053 to 1800 (Hounslow) and 1100 to 1240 (Kensington and Chelsea) as examples by 2011 – 2014.

- **Seven PCTs are rolling out NHS health checks (to identify CVD risk) targeting the adult population**, for example, Brent plans to ensure that all the identified adults are invited for a health check via a local enhanced service by 2014. Kensington and Chelsea and Westminster PCTs are planning to provide health checks for 60% and 50% of the eligible population respectively by 2014.

- **Seven PCTs will be improving cancer screening uptake**. For example, Harrow, Hounslow, Kensington and Chelsea and Westminster PCTs are aiming for 75% - 80% of women aged 53-70 to be screened by 2014.

- **All PCTs plan to improve childhood immunisations uptake**. For example, Brent, Harrow, Kensington and Chelsea and Westminster PCTs are aiming to increase to at least 90% the proportion of children who complete MMR immunisation (1st and 2nd dose) by their 5th birthday by 2014.

- **Four PCTs have aiming to impact the rate of hospital admissions from alcohol related harm and have selected this outcome for WCC**. For example, Ealing PCT is planning to improve specialist treatment for alcohol-related harm and implement community communication campaigns to decrease their expected rise in alcohol-related harm by 2014.

- **PCTs will be using a risk stratification tool to identify population at high risk of LTCs including diabetes**.

Next steps to implement the Sector Initiatives across the pathway

Initiative	Actions	Owner	Timescale
Work collaboratively across the sector	• Share best practice through Director of Public Health network	Sector	June 2010
Work collaboratively across the sector	• Create work plan for staying healthy through the network	Sector	December 2010
Risk Stratification Tool	• Develop and roll-out risk stratification tool for early identification of LTCs including diabetes	CSL	December 2010

5.2.2 Mental Health pathway

Vision

People with mental illness will receive quality care in all settings and move safely and seamlessly between settings of care. Care for people with mental illness will focus on recovery in line with their personal goals.

People with dementia will be identified early so that they and their families can plan for life with dementia, and receive supportive services, whilst living as long as possible in the community.

Description of the pathway

The Sector agreed that the scope of the pathway is grouped: common mental illness (CMI), severe mental illness (SMI), and children and young people (C&YP). Although it was agreed that dementia should sit in long term conditions it is considered as part of the clustered mental health pathway. The Sector also identified that Mental Health was a priority for PCTs.

Best Practice
Whilst it is not possible to outline all the quality and productivity best practice in this document some of the core principles are as follows:

- Education of employers, public and health care professionals, including GPs.
- Early identification and intervention.
- Equitable access to quality services at the appropriate level with appropriate training
- Focus on return to usual activities.
- Partnership working with voluntary Sector, local authority, police, teachers and probation services.
- User focused treatment including physical needs and medication reviews.
- Working with and supporting carers.
- Improving assessment and care of people with dementia in acute hospitals
- Early planning for end of life care for people with dementia.
- For adults of working age this best practice will be delivered through a tiered framework, from tier one, self care and support from community groups, to tier four, inpatient care.

People should have access to the most appropriate level of care, with inpatient stays kept to a safe minimum.

Current Challenges
The particular challenges for the Sector are:

- Common Mental Illness
    - There are low rates of identification of mental health problems in primary care and access to talking therapies is highly variable (ranging from 0 to 15.4 per 100,000 population across NWL).
- Severe Mental Illness
    - Spend per capita on severe mental illness is higher than national (adult services account for 8.4% of total PCT spending in NWL compared to 6.4% nationally) especially in the inner London Boroughs. Local services appear to be expensive.
    - There are high re-admission rates to acute wards (5.4% in NWL compared to a national average of 3.8% and all PCTs are higher than the national level) and variable quality inpatient services.
    - There are poor physical health outcomes for people with Severe mental illness
- Children &Young People
    - There is inequitable access to services across NWL (caseload per 100,000 population varies from 1,849 to 5,792).
- Dementia
    - There are poor rates of identification and diagnosis compared to average (0.24% reported prevalence of dementia compared to 0.39% nationally)
    - There is poor patient satisfaction with care in acute hospital and longer than average lengths of stay in NWL.

However, there is some best practice across the Sector. For example, since January 2009, Ealing PCT has provided a multi-lingual Improving Access to Psychological Therapies (IAPT) service. They have achieved a 40% increase in BME referrals and now provide language specific literature. The staffs sit within multidisciplinary teams alongside counsellors, vocational advisors, gateway workers, community development workers, advocates, primary care mental health workers and a physical health co-ordinator.

Gaps Analysis
The Sector needs to address a wide range of issues, including:

- Lack of GP awareness of how to identify and address common mental illness and dementia and the value of early diagnosis and planning.

- Poor public awareness of mental health problems and how to maintain mental well-being. This includes some ethnic groups not aware of mental illness, unwilling to go to GP (who may be known to family) and not aware of treatment available.
- A lack of robust data around quality and productivity of secondary care services, due to the block contract arrangements.
- Lack of knowledge around quality of rehabilitation services across the Sector.
- Variable access to older peoples' psychiatric liaison teams in acute hospital.
- Not all boroughs have integrated memory assessment services.

Key Initiatives:
The priority initiatives to improve quality and productivity for the Sector are to:

- Review role of polysystem in improving mental health outcomes.
- Education for GPs in early identification and intervention.
- Roll out IAPT in five PCTs and ensure full implementation by 2014.
- Ensure clear cost effective role of CMHTs, rehabilitation and other specialist mental health teams and alignment with primary care interventions. Implement clear framework for service delivery by 2014.
- Ensure VFM for Sector commissioning of out of Sector and specialist placements.
- Implement HfL dementia pathway by 2013.

Impact on Care Settings
Community mental health services will be integrated with polysystems.
Ward occupancy will reduce over the planning period and free up resources for community services.

Next steps to implement the Sector Initiatives across the pathway

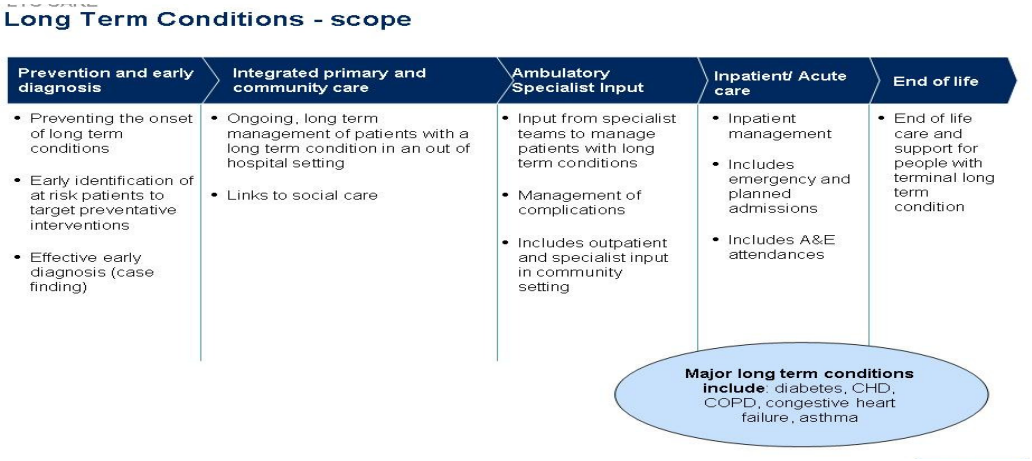
Initiative	Action	Owner	Timescale
Commissioning dementia services	• Seven PCTs to commission dementia services per the HfL pathway, as both a long term condition and an end of life condition	PCTs and sector	2010 - 2011
Deliver service through polysystems	• Develop implementation plans for community services across all PCTs, with services delivered increasingly through polysystems rather then secondary care services, and integration with other public sector services. On-going roll-out of service implementation plans.	PCTs	2010 - 2014
Improve productivity and quality of inpatient services	• Sector review of ACV secondary, tertiary and out of sector placements mental health commissioning to improve productivity and quality of inpatient services	PCTs/ Sector	Sector review: 2011/12
Improve quality, value and consistency of mental health services	• Collaborate with sector partners and appropriate Mental Health Trust to devise and implement an efficiency programme to improve quality, value and consistency of mental health services.	Sector and PCTs	Plan by 2010 Implementation by 2015
Programme implementation	• Programme of work to be agreed by CEOs to address sector challenges	Sector	By mid 2010

5.2.3. Long Term Conditions Pathway

Vision

People with LTCs will be identified earlier so that case management in the community can be implemented with the patient's input. This will take place through the polysystem framework. Use of secondary care will be for clinical complexity and unscheduled care presentations will be minimised.

Scope of the pathway



Source: Pathway Based Commissioning: NWL, NHS London, November 2009

The LTC scope includes diabetes, CHD, COPD, congestive heart failure and asthma. The Sector also identified dementia as a possible LTC (and this is reflected in some PCTs CSPs) and suggested mental health could sit in LTC as well. This strategy considers mental health as a separate pathway.

Description of the pathway

With all long term conditions there are number of serious (and expensive) complications that arise from not managing the condition well. For example, diabetic kidney disease is the most common single cause of the need for dialysis/transplantation, diabetic eye disease is the most common preventable cause of blindness and diabetic foot disease increases the risk of ulcer and amputation, as well as other problems. Therefore, early detection of diabetes and complications is important both to maintain the health of the patient but also to prevent unnecessary admissions.

This is similar for other conditions e.g. early detection and care management of dementia allows patients to plan their care including end of life care, prevent crisis presentations to A&E and improves the health of people with dementia. The story is similar for COPD.

Best Practice

Diabetes has been identified as a priority pathway to implement in the polysystem to improve health outcomes and shift activity from the acute Sector. It will be one of the first end to end pathways to be adopted and implemented across the Sector.

The best practice for diabetes is described in the HfL Diabetes guide. The key principles of care include ensuring the individual with diabetes is at the centre of their care, making care planning a collaborative exercise, integrating the services that provide care and quality assurance, evaluation and monitoring interventions. The model describes four tiers of care as follows:

- Tier 1 specialist practices/ GPs/ MDTs will provide enhanced care in the polysystem by GPs and practice nurses. The size of the polysystem population makes this cost effective (productivity) and ensures competency in the system to deliver this care (quality).
- Tier 2 should include treatment escalation and structured education programmes.
- Tier 3, specialist care, is delivered by a consultant. This can be delivered in the community via a polysystem hub or local health centre. The diagnostics, IT support systems (access to shared

records and case finding), improved communication and opportunities for governance arrangements across the polysystem will improve care.
- Tier 4 includes interventions for people with complex needs that require an inpatient stay. Again this is replicable for many LTC with local interpretation based on local requirements.

A review of the incentives to deliver this best practice in the polysystem is required, including for example, commissioning the whole pathway from one provider who then contracts out the components they are unable to deliver, or reviewing how primary care contracting/ practice based commissioning can deliver this pathway through a transformed community and primary care. This work is further discussed in the developing polysystems (see section 5.4 – page 45).

Westminster PCT has successfully implemented the diabetes pathway in the community. This was shared at the Sector pathway event during November 2009.

A further example of LTC best practice management is the respiratory project over three years in Brent that managed patients with severe COPD (76%), chronic asthma, chronic respiratory failure, and bronchiectasis in the community. The project showed the following outcomes: mortality was better than expected; there was a significant reduction in all aspects of secondary care use over years two and three; reductions in admissions generated significant cost savings and patients rated the service as very satisfactory compared with previous care.

Current Challenges
NWL faces considerable challenges as follows:
- The reported prevalence of diabetes is higher in NWL (4.9 persons per 100,000 populations in NWL compared to 3.7 nationally and five out of eight PCTs are above the nationally reported prevalence).
- LTCs that are not well case managed can contribute to unscheduled care attendances in both primary and secondary care. Poor case management therefore contributes to some PCT's higher than average A&E attendances (see information on A&E attendances in Case for Change, Section 4.1.1 – page 7).

Key Initiatives
The priority actions are:
- Apply consistent pathways across the PCTs and hospitals, initially for diabetes and COPD and then expanding the range of LTCs covered over the planning period. All PCT CSPs have identified initiatives around care planning and on-going screening for complications to be implemented between 2010 and 2014.
- Implement expert patient programmes for 5 LTCs including HIV, Diabetes, COPD, CHD and Dementia in seven PCTs by 2011 for example, Hillingdon, Hounslow and Kensington and Chelsea PCTs have already implemented expert patient programmes and plan to continue roll out and extend to target groups.

Impact on Care Settings
The implications on the settings of care are considerable. Polysystems are required to have protocols, standards, expertise, facilities and performance frameworks in place to deliver quality care to improve outcomes. GPs and other primary and community health care professionals are required to think and work in a different way. Care settings must link together to provide different levels of expertise across the polysystem and ensure that the polysystem responds to the local population and delivers the pathways in a patient centred way. The impact on the acute providers will be considerable. As the pathway will be delivered in a different way through the polysystem, capacity will not be required in the acute hospitals.

Next steps to take action across the Sector

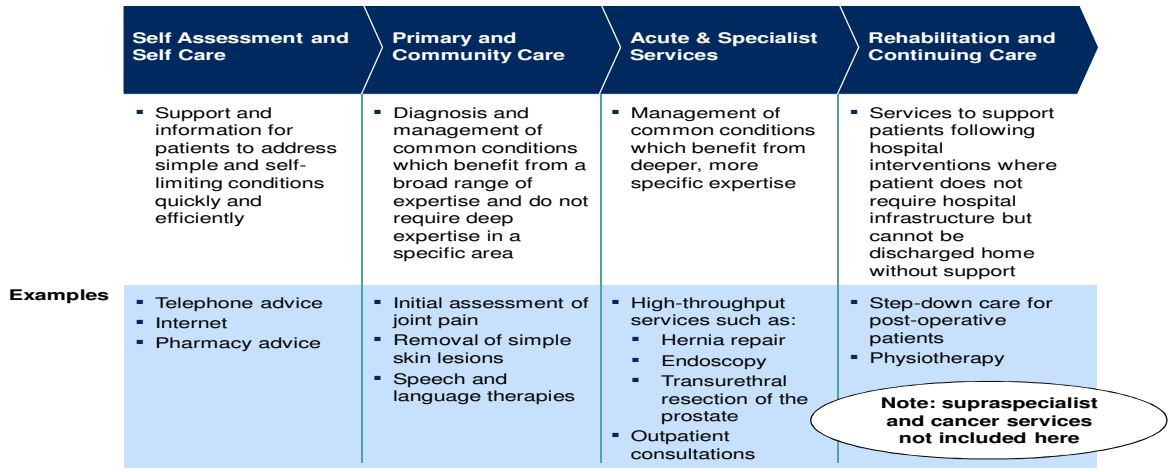
Initiative	Action	Owner	Timescale
Develop risk predictive tool	• Develop and implement a risk predictive tool across the sector for early identification of 10% increase in the identified people with LTC towards the expected prevalence across the sector by 2014	CSL	Implementation to begin in 2010/2011
Deliver services through polysystems	• Implement polysystem network of support for primary care delivering essential care and reducing unscheduled admissions as well as planned admissions for complex care by early targeting of at risk groups	Sector	2009 - 2010
Apply consistent care pathways	• Apply consistent care pathways across the PCTs and Trusts, initially for diabetes and COPD, then expanding the range of LTCs by implementing care planning and on-going screening.	Sector/ PCT	2010 - 2014
Implement expert patient programmes	• Implement expert patient programmes for 5 LTCs, including HIV, Diabetes, COPD, CHD and Dementia	PCTs	Sept 2011
Model impact of improved LTC management	• Model impact on improved management of LTCs and EOL in the polysystem on acute capacity in conjunction with Acute Planning pathway actions	Sector	Jan-Mar 2010

5.2.4 Planned Care

Vision

Users of Planned Care services will have access to high quality and clinically safe care as close to home as possible. Routine care will be provided as locally as feasible with specialist care being concentrated where the required level of expert knowledge and skills can be developed and maintained, thus offering the safest level of patient care. Through providing care in the appropriate setting and reducing duplication across primary and secondary care, healthcare providers will become more efficient and effective, addressing issues of quality and productivity. Patients will benefit from accessing care closer to home and be treated in hospital only where necessary.

Scope of the pathway



Source: Pathway Based Commissioning: NWL, NHS London, November 2009

Description of the pathway
The Planned Care pathway encompasses all non-acute medicine and surgery, it ranges from self-care through to primary care, ambulatory care and specialist services such as cancer care.

Best practice
Best practice in Planned Care exists in abundance including in the following settings;

- **Primary & Community Care**
  - New models of service provision, polyclinics, will offer a greater range of services as close to home as possible. By clustering PBC around the polyclinic, a system of care can be created that responds to local need, links with community pharmacy, is part of the system of unscheduled care and offers an opportunity to improve primary care.
  - Specific care pathways will be redesigned to deliver care closer to home.
  - Protocols will be put in place to prevent inappropriate referral to secondary care and primary care will use referral decision aids to assess the need for referrals as appropriate.

- **Acute & Specialist Services**
  - Separation of elective and emergency surgery, with more elective work being undertaken in elective centres (see Section 5.2.5 – page 30, Unscheduled Care on the concentration of all emergency surgery on fewer sites).
  - Direct-listing to planned surgical procedures.
  - Streamlined pre-operative assessment services (linking to primary care and not duplicated in the acute setting).
  - Increased rates for procedures carried out as day-cases, leading to reduced lengths of stay
  - Patient Reported Outcome Measures should inform commissioning.
  - Specialist care will be provided at centres of excellence. It is now widely recognised that hospitals providing high volumes of complex specialist care deliver better clinical outcomes. A recent meta-analysis of studies into specialist surgery found that there is a positive relationship between volumes of specialist surgery and three key outcome measures; that is, mortality rates, reduced lengths of stay and complication rates (*Healthcare for London: A Framework for Action 2007*). The increasing sub-specialisation of medical careers and the need to comply with European Working Time Directive (EWTD) is also a key driver for increased centralisation of services. The centralisation of some services for rarer cancers provide examples of good practice, for instance the current configuration across London for rarer urological cancers and sarcoma services are considered to be effective (*Emerging Model of Cancer Care*, NHS London, November 2009).
- **The interface between Primary and Secondary Care**
  - Protocols will be put in place to prevent inappropriate referrals to secondary care, the Sector has already completed work on interventions not normally funded on the basis of insufficient evidence of clinical and cost effectiveness and procedures for which there should be no routine follow up.

- **Rehabilitation and Continuing Care**
  - Planned discharges and community services to facilitate discharge as soon as possible.
  - Local intermediate care and step down beds should be aligned to patient needs and community services to ensure support for patients following procedures.

Current Challenges
There are clear benefits to patients of providing planned care in the community closer to home. Patient satisfaction with Planned Care services across the Sector is variable and on average worse than the national average (Healthcare Commission 2007-08). Productivity benefits can be achieved through increasing day case rates, reducing length of stay and reducing readmission rates, as well as better performance against 18 weeks.

- **Outpatient Services**
  There is good evidence to suggest that a large proportion of outpatient care could be delivered in the community, either by GPs and/or nurses (National Primary Care Research and Development Centre, March 2007). For specialist outpatient care, this could similarly be provided within the community via secondary outreach. This shift of activity from the acute Sector could help to ensure care is delivered closer to home and more cost effectively.

  Work completed by the CRG last year identified a significant percentage of outpatient attendances that will be decommissioned by eliminating the number of follow up appointments that have no clinical benefit. Across the Sector there is variability in the number of follow up appointments per first appointment, on average, the Sector performs worse than the England average (HES 2008-09).

- **Elective Surgery**
  From a productivity perspective, day case rates across the Sector could be increased. Currently there is insufficient separation of elective and urgent care with opportunities for elective centres to be more productive, thus utilising the high quality estate. With the reconfiguration of emergency surgical work there is a clear need to also look at the concentration of a larger proportion of (routine high through put) elective work at dedicated elective centres.

- **Specialist services**
  Across London, specialist services such as for both common and rarer cancers require centralisation where necessary in order to ensure sufficient levels of volumes of activity to develop centres of excellence, thus delivering safer, more efficient and effective standards of care. In respect to common cancers, this includes concentration of breast and colorectal surgery and rarer cancers. The pan-London review of cancer services will address these issues and locally, implementation of the pan-London models of care will be led by the NWL Cancer Network.

- **Clinical productivity**
  There is variability across Trusts in performance against clinical productivity measures:

  - Whilst the average performance for reducing length of stay (LOS) across the Sector falls within the top quartile (11.66% against 13.12%, as at Q1 09/10), this represents three Trusts' poorer than average performance whilst three further Trusts achieving top quartile performance and one Trust performing at the national average.
  - Five Trusts reported poorer than average performance against readmission rates within 14 days (national average of 4.80% as at Q4 08/09) and only one Trust achieving upper quartile performance (3.13% against top quartile of 3.90% as at Q4 08/09).
  - Only one Trust in NWL achieved upper quartile performance in increasing day case rates (81.31% against the Q1 09/10 upper quartile of 80.17%). The remaining Trusts performed poorer than the national average (74.68%), which is below the Audit Commission's recommended figure of 75% carried out as day cases out of a basket of 25 procedures (Q1, 09/10).
  - Variability exists between Trusts in reducing elective pre-operative bed days with the majority of Trusts performing below the national average (0.14 as at Q1 09/10).

Gap Analysis

Current gaps in care identified across the Sector include:

- A single point of access (SPA) and directory of planned care services (similarly for Unscheduled Care services see Section 5.2.5 – page 30, Unscheduled Care).
- A consistent referral management service across the Sector.
- A systematic and consistent pre-operative assessment process across the Sector.
- Sector-wide standards and initiatives involving PBCs.
- Detailed progress/performance of elective centres which are currently not cost-effective.
- Primary care benchmarking, e.g. a balanced scorecard for the Sector.

Key Initiatives
The PCTs in NWL have identified a number of key priority areas to be addressed under this pathway, the level at which these are to be addressed are shown in parentheses:

- **Identify the appropriate number of elective centres in 2010 and maximise their use to improve productivity to top quartile, see also point below (SPD and ACV)**
    - The CWG for Surgery has agreed in principle that more (non-complex) elective work would occur at established elective centres. In addition, the CWG agreed in principle that the concentration of all emergency surgery may mean that a 'shift' of non-complex elective work to sites with no emergency surgery will be necessary to balance capacity across the Sector. Further modelling of patient flows as well as the impact on workforce and training is required.
    - Concentration of elective work to elective sites would also help to redress the financial viability of elective centres and will enable estate utilisation.

- **By 2014, improve productivity to achieve top-quartile metrics within Trusts, e.g. reducing length of stay (LOS); increasing day case rates; reducing pre-operative bed days; readmission rates (Sector/Acute Commissioning Vehicle (ACV))**
    - By 2014, variability between Trusts' performances will be reduced in line with targets to achieve top quartile across these clinical productivity measures.
    - The Sector will set clinical productivity targets which will underpin the clinical reconfiguration options.

- **Consistent application and monitoring of compliance to agreed Sector-wide policies on standardising clinical practice (Acute Commissioning Vehicle (ACV)/PCTs)**
    - 30% of outpatient attendances will be decommissioned by reducing follow-ups and 55% provided in the polysystems by 2014. PCT CSPs outline specific activity shifts in line with the HfL assumptions.
    - Model future acute capacity requirements in light of planned activity shifts.
    - Monitor compliance with existing policies regarding new-to-follow-up ratios; consultant-to-consultant referrals and interventions not normally funded.

- **Implementation of pre-referral and pre-operative diagnostic services within the polysystem, avoiding duplication in the acute setting (PCTs).**

- **Develop thresholds for referrals to orthopaedic, gynaecology, ophthalmology and urology services by 2011 (Sector/ACV).**

- **Standardisation of referral and discharge letters (Sector/Acute Commissioning Vehicle (ACV).**

- **Review of specialised services to be concentrated on fewer centres of excellence by 2014, in line with HfL reviews, for example, cardiovascular and cancer services.**

Impact on Care Settings
- Increased diagnostic and outpatient services provided in primary and community settings, reducing acute care capacity.
- Specialist services centralised in fewer centres of excellence.
- Improved productivity e.g. increasing day case rates, reduced length of stay, reduced pre-operative bed days, reduced overall outpatient attendances and reduced new: follow up attendances.

Next steps to take action across the Sector

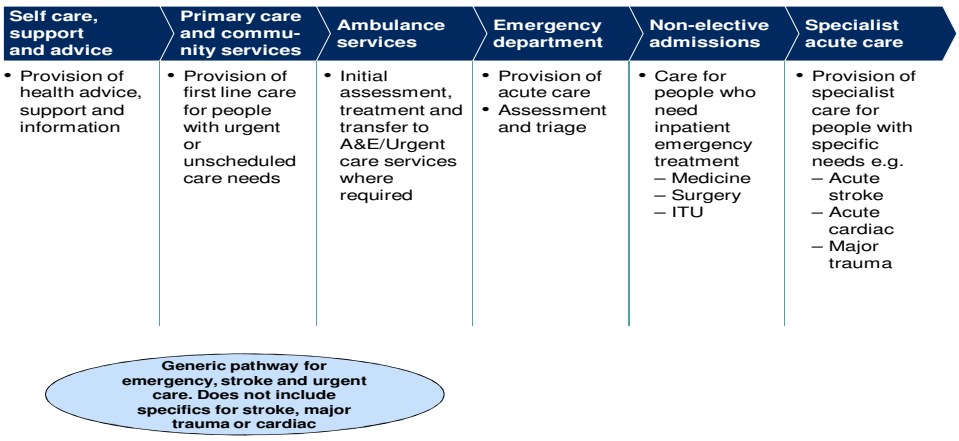
Initiative	Actions	Owner	Timescale
Reconfiguration	• Develop site specific options to include future designation of elective centres. • Produce pre-consultation business case	Sector Sector	Jan-Mar 2010 Sept 2010
Commissioning for Quality	• Agree clinical productivity targets to underpin SLAs and reconfiguration options • Audit of compliance to standardising clinical practice policies, e.g. INNF, new-to-follow up ratios, consultant-to-consultant referrals	Sector/ACV Sector/ACV	Jan-Mar 2010 Jan-Mar 2010
Pathway redesign	• Model for delivering O/P services in the polysystems, e.g. GPwSIs (General Practitioner with Specialist Interests), secondary outreach • Audit of diagnostic shifts to the polysystem	Sector/PCTs Sector/PCTs	Jan-Jun 2010 Jan-Jun 2010

5.2.5 Unscheduled Care

Vision

Users of acute care services in NWL will have access to appropriate high quality care provided by the right person, in the right place, first time. Through providing care in the appropriate setting, healthcare providers will become more efficient and effective as well as address issues of quality and productivity. Patients will benefit from accessing care closer to home and be treated in hospital only where necessary.

Scope of the pathway



Source: Pathway Based Commissioning: NWL, NHS London, November 2009

Best practice

A wealth of best practice guidance in emergency and urgent care exists spanning all Sectors, most notably this includes:

- **Self-care, advice and support**
  - Advice and information to be available by a number of means, e.g. telemedicine and online
  - Signposting services and alternatives to A&E, e.g. through a single point of access (SPA).

- **Primary & Community Care**
  - Provision of a single urgent care service for each local community, provided on a 12/7 basis as a minimum and aligned to primary care/urgent care service.
  - Access to diagnostic services, not to be duplicated in the acute setting.
  - Integration with wider range of services including LTC management, avoiding hospital admissions.
  - Extended hours for GP services and GPs to be able to see patients within 2 hours.
  - Capability to manage hospital discharges, avoiding unnecessary bed days.
  - Primary care front end service at A&E.

- **Ambulance services**
  - Robust pathways and protocols to allow ambulance staff to direct patients to the most appropriate place for care.
  - Signposting services, including referral to alternatives to A&E.
  - Appropriate treatment at scene.

- **Secondary Care**
  - Emergency surgery should be available 24/7 and should be supported by an appropriate critical mass to maintain large volumes of activity and therefore build and maintain the required level of expertise and experience to manage patients safely, delivering better surgical outcomes. In NWL, NWLH has recently ceased its emergency surgery service on the Central Middlesex Hospital site with all emergency surgery to be provided from Northwick Park Hospital.
  - 24/7 availability of senior clinical decision-makers enabling early diagnosis and timely provision of definitive treatment.
  - Rapid access to community care, LTC coordinator and specialist advice.

Current Challenges

- **Unscheduled Care**
  - Delivery of and access to the appropriate unscheduled care in NWL remains a key challenge for the Sector in regards to quality and productivity. Historically, the Sector has experienced a high dependence on A&E for access to unscheduled care. On average, there are 268 A&E attendances per 1000 population compared to the national average of 270 (2008/09, see Section 4.1.1 – page 7) with the majority of the outer NWL PCTs experiencing higher volumes than this (see Case for Change Section 4.1 – page 7). There is good evidence from Hammersmith and Fulham PCT UCC's outcomes that suggest that a large proportion of A&E attendances could be more appropriately treated by Primary care rather than by an acute specialist (see polysystems Section 5.4 – page 45).
  - There is a strong indication that this high dependence on A&E is associated with a lack of alternatives in primary care. In five PCTs across London, patient satisfaction with access to GP services is worse than both London and the national average, and all NWL PCTs are worse than the national average (see Case for Change Section 4.1 – page 7).

- **Specialist Acute (Unscheduled care) Services**
  The Healthcare for London strategy identifies specialist acute care for the most seriously ill and injured should be centralised in order to deliver higher quality and safer care. In some areas across NWL, such services are being provided on a sub-optimal scale and concentration would allow for better building of expert care. The Sector already holds some effective clinical models for centralised specialist emergency care including primary angioplasty and some major vascular procedures. In addition, the HfL consultation on Stroke and Major Trauma has identified designations across London for the provision of these services.

- **Cardiovascular services**
  HfL has launched a project to review cardiovascular services. The project is divided into work streams, looking at Vascular Services, Cardiology and Cardiac Surgery, it is anticipated that the proposed models of care and recommendations will be submitted for public consultation in early 2010.

- **Emergency Surgery**
  Currently all hospital Trusts in NWL provide 24/7 emergency surgery, this indicates over-provision of this service and would suggest that sites are operating at sub-optimal scale. In addition, there is the need to maintain EWTD compliance across the surgical specialties.

- **Complex inpatient paediatric surgery**
  During 2008, the Sector agreed on the centralisation of complex inpatient paediatric surgery to one site. This is due to be implemented by April 2010.

Key challenges in both Acute and Primary and Community Care services persist and it is across the interface of the providers that vast improvements to the quality, access and productivity of acute care are both challenging and necessary.

Gap analysis
Key gaps in the current Acute Care pathway across the Sector most notably include the following:

- Optimal LTC management in primary and community care to prevent unscheduled care presentations for people with LTCs.
- Optimal support to ethnic populations for accessing information and advice on health services, including credible alternatives to A&E.
- Inappropriate hospital admissions following unscheduled care presentations at A&E.
- Optimal social care provision and planned discharges.
- Insufficient critical mass for emergency surgery.
- Low registration of some populations with GPs and poor access to unscheduled care in primary and community settings.
- Inconsistent implementation of LAS alternative pathways following 999 calls.

Key Initiatives
The PCTs in NWL have identified a number of key priority actions to be addressed under this pathway, the level at which these will be addressed are shown in parentheses (see Delivery Section 6 – page 60)

- **Rationalisation of urgent care, including emergency surgery provision in line with HfL and the CWG recommendations (Sector)**

The Acute Medicine and Surgery Clinical Working Groups (CWGs) have agreed a number of high-level principles which will guide the rationalisation of urgent care, including emergency surgery, by 2014. Clearly, development and implementation of plans will be phased and robust transitional planning will be critical.

Emerging recommendations from the Acute Medicine and Surgery CWGs are as follows:

  - All emergency surgical services (including some elements of Orthopaedic Trauma) should be rationalised onto a smaller number of sites. The concentration of specialist services to achieve critical mass and improve outcomes as well as the availability of appropriate expertise means that no more than four 24/7 emergency surgical rotas may be viable. This is in line with Royal College of Surgeons (RCoS) guidance (1997) on the number of emergency surgical rotas needed on population size. Provision of emergency surgery for periods of less than 24 hours

is not clinically or financially sustainable. It will be necessary to maintain an emergency surgery rota to support specialist centres and this will constitute one of the four emergency surgical rotas. Further modelling of future activity, patient flows and capacity will be carried out in developing site specific options.

- A model for continuing to accept an unselected medical take with no emergency surgery on site will be explored. Sites without emergency surgery that continue to provide emergency care will require access to a senior surgical opinion when required (this could be provided in a number of ways); adequate level 3 critical care and anaesthetics support; clear bypass and transfer protocols and networked arrangements with neighbouring major acute providers. If this is not possible, alternative models of acute medical receiving need to be considered, including accepting a 'selected' medical take. Existing models within the Sector (e.g. CMH and the Hammersmith Hospital) and out with the Sector are to be considered in modelling.

- Improved management of LTCs and improved End of Life (EoL) Care in the polysystem is essential in reducing inappropriate admissions to hospital. The reduction in hospital admissions and subsequent release of acute capacity will be quantified. These initiatives are further described in the LTC and EoL pathway sections.

- **Development of a Primary Care led Urgent Care Centre at each A&E by 2013 which will shift 60% of emergency activity into polysystems (PCTs)**
  - The Sector has agreed to recommend the adoption of NHS Hammersmith and Fulham's best practice model for Urgent Care Centres, at other sites across the Sector (see Section 5.4 – page 45). The founding principle of the model is that patients are assessed by a GP first and always. All self presenting unscheduled attendances and Category C ambulance attendees are seen by, and streamed by an experienced GP streamer. Accesses to diagnostic services are directly from the UCC. A GP surgery onsite at the UCC operates on a 12/7 basis.

- **Development of a single point of access (SPA) for urgent care (PCTs/Sector)**
  - The single point of access (SPA) model developed by the inner North West London PCTs will be shared across the Sector. The SPA's aim is to improve access to appropriate services for people presenting with unscheduled care needs via a single telephone number. The service in inner NWL is currently out of hours but is developing plans for 24/7 operation. (see Section 5.4 – page 45)
  - The Sector PCTs will explore with Sector partners by 2011 the establishment of a Sector wide SPA.
  - There will be work with the LAS to ensure optimal benefit of the SPA by ensuring patients are either conveyed or treated at the most appropriate location.

- **Implementation of HfL Stroke and Trauma service reconfiguration by April 2012 (HASUs and SUs will be fully operational by April 2010) (PCTs/Sector)**
  - From 2010/11 the new standardized pathways for Stroke patients will be in operation. This new model will be supported across the Sector by two new Hyper Acute Stroke Units (HASUs), which provide immediate treatment following a stroke (including thrombolysis agents where appropriate). HASUs will be supported by six Stroke Units (SUs), which provide multi-therapy rehabilitation and ongoing medical supervision, and six Transient Ischemic Attack (TIA) clinics, which provide rapid diagnostic treatment and assessment by a specialist. PCTs will reflect prevention and community rehabilitation pathway in CSPs. This work is being led by the NWL Stroke and Cardiac Network.
  - Implementation of the NWL Trauma Network, including designation of Trauma Centres supporting the Major Trauma Centre (MTC) at St Mary's Hospital, by 2012.

- **Implementation of the complex inpatient paediatric surgery service reconfiguration by April 2010 (Sector)**
  - Chelsea and Westminster Hospital NHS Foundation Trust (C&W) have been identified as the preferred provider for this service with the service commencing from 1 April 2010. A provider

network for all paediatric surgery has been established and is being led locally by NHS Kensington and Chelsea (K&C) and C&W.

- **Transformation of London Ambulance Service (LAS) to ensure that all patients are taken to the most appropriate setting by 2013 and increase the number of times patients are given treatment at the scene or successfully referred to alternative pathways other than hospital A&E departments to 65% by 2013. The aim is to manage and reduce the current 999 demand (Sector Acute Commissioning Vehicle)**
  - The LAS performance across NWL Sector continues to be variable. In November 2009 the Sector performance against Category A incidents was 73.5% in 8 mins (London year to date 74.2%) and 99.1% in 19 mins. And for category B incidents was 89.6% in 19 mins. (London year to date 85.9%).
  - The best performing NWL PCT areas are Hillingdon and Westminster for Cat A (77.6 % and 77.5% respectively) and K&C and Westminster for Cat B (92.4% and 92.3% respectively).
  - The poorest performing NWL PCT's currently are Ealing and Brent for Category A (potentially life threatening) responses (ytd of 68.2% and 69.4% respectively) and category B for Hillingdon and Hounslow (ytd 81.9% and 82.6% respectively).
  - There have been considerable actions implemented in NWL Sector. For example, flagging those NWL Sector hospitals with hand over delays, A&E redirections have taken place and protocols agreed for both Hounslow PCT walk-in centre and Hillingdon A&E based front end.

The LAS Transformation Team has identified a number of key priority areas to be addressed across London, which are also be implemented in Northwest London:

- Updating the Ambulance Commissioning Strategy, in particular regarding the model of care and workforce requirements ("hear and treat" and "see and treat") to result in fewer conveyances by 2010.
- Establishing a multi-agency NWL Unscheduled, Urgent and Emergency Care Innovation Network with direct links to the London-wide Urgent & Emergency Care Board by April 2010
- Manage and reduce 999 demand (currently c. 3.5% growth p.a.) by identifying key causes of demands by 2010;
- Identify current care pathways, develop new ones where appropriate, and communicate these consistently to support unnecessary A&E admissions by 2010/11 (see Section 5.2 – page 18, LTCs and other pathway initiatives).
- Reduce hospital ambulance turnaround times, clinical hand over of patient and transfer from LAS trolley to bed to consistently reflect the lowest in London by 2011;
- Ensure that LAS have effective clinical protocols in place across the sector so that access to non-A&E facilities and pathways such as Walk in Centres (WiC's) and Urgent Care Centres (UCC's) are seamless and reflect the default preference for conveyed patients by 2011
- Strengthen contract management with the LAS including undertaking a formal review of the Emergency Bed Service, Urgent Care Service and Clinical Telephone Advice, which in turn may lead to formal tendering to deliver improvement and better value by 2011.

Impact on Care Settings

Changes within the Acute Care pathway carry some major changes to care settings:

For the Acute setting:

- Clinical and financial feasibility of some current A&E departments following shift of activity to the polysystem.

For Primary and Community Care:

- Investment required to develop credible alternatives to A&E.

For the home:

- More care delivered in the home as a result of better management of LTCs, avoiding presentation at A&E and hospital admissions.

Next steps to take action across the Sector

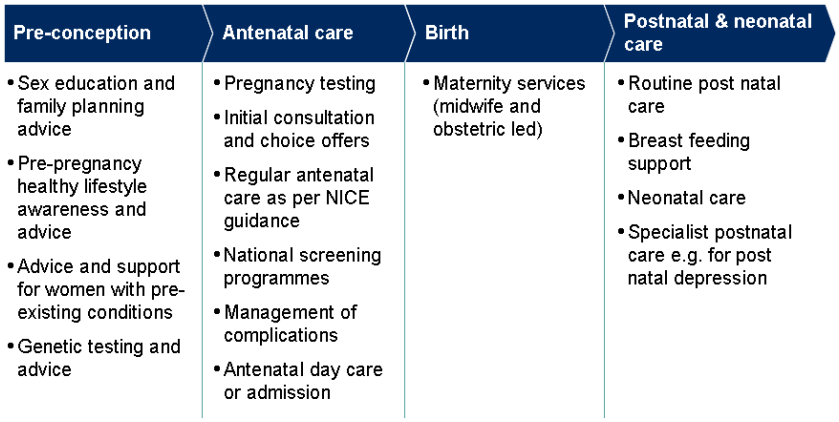
Initiative	Actions	Owner	Timescale
Reconfiguration	• Develop site specific options to include future designation of emergency surgery and acute medical take. • Produce pre-consultation business case	Sector Sector	Jan-Mar 2010 Sept 2010
Commissioning for Quality	• Agree clinical productivity targets to underpin SLAs and reconfiguration options	Sector/ACV	Jan-Mar 2010
Pathway redesign	• Model the impact of improved management of LTCs and End of Life Care in the polysystem on acute capacity (see LTCs and EoL pathway section 5.2 for pathway initiatives)	Sector/PCTs	Jan-Mar 2010
Share Best Practice	• Refresh Unscheduled, Urgent and Emergency Innovation Network	LAS team	Mar 2010
LAS Response	• Recommend and agree across the Sector alternative LAS response in the community to 999 calls	LAS team	Mar 2011
Workforce	• Review workforce requirements to support the shift of activity to community based unscheduled care access points	Sector	2010/11

5.2.6 Maternity and Newborn

Vision

To design high quality, sustainable and flexible maternity services, based on national and international best practice, providing choice and high quality outcomes and experience for women and their families.

Scope of the Pathway



Source: Pathway Based Commissioning: NWL, NHS London, November 2009

Best practice

The Royal College of Obstetrics and Gynaecology (RCOG), Royal College of Midwives (RCM) and National Midwifery Council (NMC) best practice recommendations indicate that 1:1 midwife care during established labour should be offered and there is a need for 98 hour Consultant cover to ensure safe Obstetric services.

All women should receive continuity of care in the antenatal and postnatal period. All women should receive 1:1 care in labour with most women getting care in labour from one of their team. For vulnerable women it is recommended that they should receive one to one care from a named midwife antenatally, during labour and postnatally. Maternity networks – involving maternity commissioners

and all providers – should be formally established across London and be linked with neonatal networks. Women's social and medical needs should be assessed at an early stage, and then reassessed throughout their pregnancy, with their care based on these assessments.

Current Challenges
In 2006 the Healthcare Commission undertook a review of maternity services across London, of the seven maternity providers in NWL four of them received a 'weak' rating while the remainder received a 'less well performing rating' (Healthcare Commission 2007).

- **Pre-conception**
  - A woman should be able to present to her GP who would be able to advise her on how she can best ensure a safe pregnancy and when to present to a health professional on discovering she is pregnant.
  - In NWL a lower than national average number of women see a health professional within 12 weeks of pregnancy.

- **Antenatal care**
  - Currently provided in different ways across the Sector, many midwives spend time on antenatal routine tasks which could be undertaken by maternity support workers, if they were developed.
  - There are substantial vacancy gaps in the midwifery workforce (currently a 17% FTE vacancy gap – Local Supervising Authority (LSA) for Midwives, February 2009), with resources spread so thinly there is a challenge to ensure that women get the best antenatal care that they can, as close to home as possible.
  - A lot of high risk women are not identified until the point of labour which presents a challenge of how the Sector can educate women on the importance of seeing a health professional within 12 weeks to ensure the safety of the mother and the baby.

- **Intrapartum care**
  - Caesarean sections that are performed in the Sector should be reduced; currently NWL has a 2% home birth rate (LSA for Midwives 2007-08) and a 29% caesarean section rate with an emergency caesarean section rate of 18% (Dr Foster 2007-08).
  - There is a challenge to change the way that intrapartum care is delivered to ensure home birth rates are improved and caesarean sections reduced without restricting patient choice.

- **Postnatal care**
  - Post-neonatal mortality is currently at a rate of 1.6 per 1000 births compared with the 1.5 national average (the Perinatal Network, 2007-08). Neonatal care should run along side maternity units, this support is mainly provided by paediatricians in the Sector which impacts on the paediatric workforce, further discussed in the Children and Young People section.

- **Workforce**
  - The maternity units in NWL are not meeting the Royal College of Obstetricians and Gynaecologists (RCOG) guidelines regarding level of consultant cover required on a labour ward to ensure that mothers and babies are not put at unnecessary risk.
  - The midwifery workforce currently cannot meet the national guidelines for 1:1 care for women in established labour or the Maternity Matters requirement for a named midwife supporting the woman at every stage of the pathway.
  - Midwives in NWL are also over capacity for the number of births that they support at any one time, NMC guidelines indicate that no midwife should have a caseload of more than 30 women at any one time; this is exceeded in every Trust in the Sector.

Key Initiatives

- **Pre-conception**
  - Deliver a programme of education and promotion of pre-conception advice to all women in NWL planning a pregnancy. This service could be provided in a polysystem setting (the planning of this is described in more detail in the polysystem section of this document and in PCT plans). This will be taken forward between PCTs and Public Health Departments under the staying healthy pathway to ensure that women understand the impact of factors such as diet, exercise, weight and lifestyle (e.g. smoking) on potential pregnancy and will need to be achieved by 2014.
  - The Sector will facilitate an acute care in the community task and finish group to develop a model for which services could be better provided in the community, this group will work closely with PCT commissioners, workforce and maternity and neonatal clinicians. The outcomes of this group will be linked into the polysystems workstream and close working will be needed during the modelling.

- **Antenatal care**
  - All pregnant women need to have been assessed by a health professional within the first 12 weeks of pregnancy. The Sector has developed a standard antenatal referral form which is being piloted in GP Surgeries. The form is due for review in February 2010, once any changes/recommendations have been agreed the form will be shared and fully implemented by the PCTs by April 2010. The Sector will achieve the 12 week assessment target for 100% of pregnant women by 2014.

- **Intrapartum care**
  - Work with clinicians to identify the best configuration of maternity units in NWL in order to meet recommendations for safe, high quality services with the necessary staffing levels subject to business case approval and public consultation:
    - The NWL clinical working group (CWG) for maternity recommended that stand alone midwifery units were not cost effective and would need to be co-located with an obstetric-led unit.
    - Over a five year time frame, it is anticipated that there will be fewer maternity units in NWL in order to meet the recommendations for safe, high quality services and to meet the recommendations for staffing these units;
    - The Sector will facilitate a task and finish group which will draw on national and international experience to validate the recommendations that in order to recruit staff and provide a reasonable quality of care and experience for mothers and babies, the maternity units in NWL should not support more than 6,000 births a year. This is, however, an area where there is a thin evidence base and in the short-term the number of units and their capacity is unlikely to change significantly.
    - The task and finish group will also produce workforce models for:
      - Establishing the necessary midwifery workforce to support choice of home birth for 10% of women by 2014.
      - Achieving the RCOG recommendations for consultant cover on a labour ward by 2016.

- **Postnatal Care**
  - The Perinatal Network to continue to engage with clinical working groups short term and long term goals for neonatal support for maternity.
  - Workforce development plans to be produced by September 2010 to ensure higher quality and more specialised skills in neonatology which will reduce the pressure on the paediatric workforce, which currently supports neonatal services in many of the hospitals in NWL.
  - The polysystem and mental health pathways highlight the need for support for the mother during the postnatal period. Assistance with breastfeeding, links with midwives,

health visitors and mental health specialists could be provided within a polysystem network.

- **Whole pathway initiative**
  - Design and implement a clinically-led network for maternity services by 2011 to ensure continuity of care and standard clinical approach by 2014, which will work closely with the proposed network for children and young people and the existing NWL Perinatal Network. The network will support sharing of learning, skills and development between all staff engaged in providing services across the pathway by allowing staff to rotate between sites and get exposure to different levels of maternity risks and conditions.

- **Commissioning for quality in the maternity pathway**
  - By 2011, the Acute Commissioning Vehicle to commission for quality in the maternity pathway for a reduction in caesarean section rates, increased patient satisfaction and implementation of NICE standards for maternity.

Impact on Care Settings
The implication on care settings for implementing the HfL pathway for maternity and newborn indicates a desire to shift care from the acute setting to the primary and community care setting; this is also reflected in *Healthcare for London: A Framework for Action 2007*. Resources that could be invested into midwifery-led units may be better placed to support community midwifery case loading teams as part of a polyclinic provision to not only promote home births and 1:1 midwife care in labour but to provide more services at all stages of the pathway in or close to the home.

Next steps to take action across the Sector

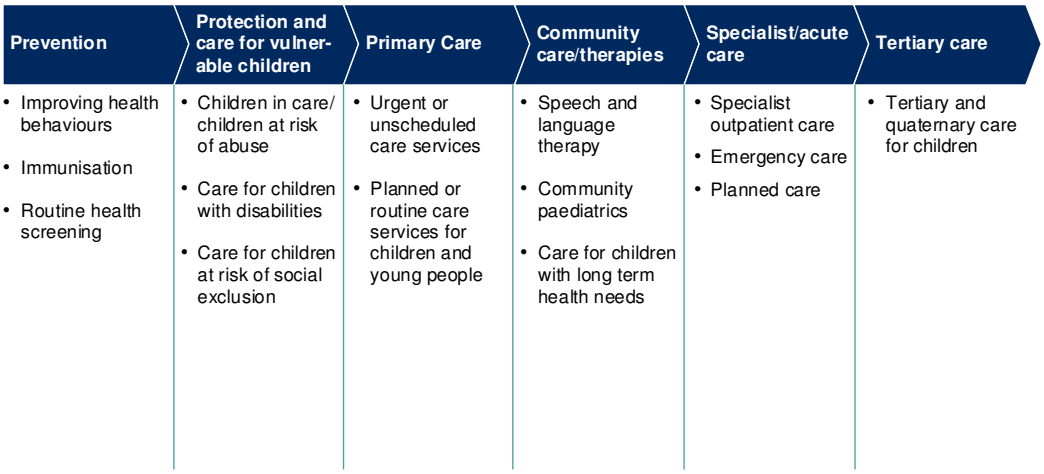
Initiative	Action	Owner	Timescale
Deliver a programme of education and promotion	• Task and finish group meetings. • PCTs to develop and deliver local plans.	Sector PCTs	Between Jan-Jun 2010 Deliver by 2014
12 Week Assessments	• Sector developed antenatal referral form to be reviewed and recommended amendments made. An audit template will be developed for use in the PCTs • PCTs to implement forms within GP practices and undertake audits to monitor uptake to feedback to the sector	Sector PCTs	In Feb 2010 By Apr 2010
Acute Reconfiguration	• Task and finish group meetings • The sector will develop a pre-consultation business case setting out the options for service configuration	Sector Sector	Jan-Jun 2010 Sept 2010
Workforce	• Task and finish group meetings	Sector	Jan-Jun 2010
Development of managed clinical networks	• The current CWG membership will form the basis of this as they have been working collaboratively for the last two years	Sector	By March 2011

5.2.7 Children and Young People

Vision
To provide safe, high quality integrated care, underpinned by robust health promotion, delivered by a workforce trained to appropriate standards for children in a clinically appropriate location as close to home as possible. Services should be innovative, continually evolving and provide value for money whilst delivering ever improving outcomes for children and young people. The options for delivery of services include polyclinics or other community based settings, local and major hospitals however all

services must be child and family focussed and take account of the views of children, young people and their families.

Scope of the Pathway



Source: Pathway Based Commissioning: NWL, NHS London, November 2009

Best Practice

The HfL model of care specifies the following as key guidelines to achieve high quality paediatric services:

- Health services will be delivered locally, where this is clinically appropriate and delivers value for money.
- Healthcare will be delivered in the home or as close to home as possible, including in school.
- Delivering services which meet national, regional and local care and quality standards.
- Close working between tertiary, secondary and primary care services alongside partners such as local authorities and children and adolescent mental health services (CAMHS).
- All staff involved in the assessment, stabilisation and transfer of children and young people must have the required competencies, training and skills, particularly in basic life support.

It also aims to provide a seamless journey for children and young people through:

- Creating more appropriate access points for unplanned care.
- Creating more appropriate facilities in all hospitals for observation and treatment of children and young people without necessarily admitting them.
- Creating multi-disciplinary teams of health professionals who work across traditional care settings.
- Moving care closer to home by providing more planned care locally and investing in community to provide care for children who are ill, have long-term conditions or complex health needs.

Current Challenges

- **Prevention and Protection**
  - NWL is currently below the London average for uptake of immunisations.
  - There is a high prevalence of obesity among children and young people.

- **Primary/Community and Acute Care**
  - Inpatient attendances are high in NWL and the average length of stay for 0-14 year olds is 2.8 days and 15-18 year olds is 1.9 days (Dr Foster 2008-09).
  - 56% of 0-17 year olds attending A&E in London are discharged with no further treatment (HES 2007-08).
  - There is fragmentation between primary, community, social and acute care across the whole pathway.

Key Initiatives

- **Prevention and Protection**
  - Ensure safeguarding children is considered across all stages of the pathway; this is already being implemented across NWL commissioners and providers and will be reinforced by the proposed managed clinical network.
  - PCTs need to integrate NHS children's services with local authority children's services, the world class commissioning priority health outcomes for the PCTs focus on immunisation, breast feeding and obesity in children and these are reflected in the PCT plans. The staying healthy initiative includes children in the recommendation to support individuals in maintaining a healthy weight and lifestyle and this is being implemented at a PCT level. In 2010 the Sector will share best practice through the CWGs and task and finish groups to ensure that this integrated working is promoted across NWL.

- **Primary Care**
  - Polysystem plans are in development to ensure that services are co-located in a primary care hub in each geographical area with access to 12/7 urgent care children's service integrated with primary care services. Children's services including children's centres need to be integrated into these systems.
  - PCT plans outline specific plans to improve primary care enablers and capability in paediatrics and facilitate the shift of services from the acute Sector.
  - The Sector will facilitate an acute care in the community task and finish group to develop a model for which services could be better provided in the community. The group will work closely with PCT commissioners, workforce leads and maternity and neonatal clinicians. The outcomes of this group will be linked into the polysystems workstream and close working will be needed during the modelling.

- **Community Care/Therapies**
  - PCTs need to ensure that there is a strong community service including the provision of acute nursing in the community to support the changes in settings of care.
  - PCT plans outline specific plans to develop community services in paediatrics and facilitate the shift of services from the acute Sector and manage complex needs.
  - The Sector will facilitate a task and finish group to develop a workforce, education and training model to support acute care in the community and improve GP paediatric skill sets. The group will work closely with PCT commissioners, workforce leads and maternity and neonatal clinicians. The outcomes of this group will be linked into the polysystems workstream and close working will be needed during the modelling.

- **Specialist/Acute Care**
  - Consolidate inpatient paediatric services in three units in line with HFL/CWG/CRG recommendations subject to business case approval (September 2010) and public consultation (September 2010 to December 2010) for implementation by 2014:
    - In 2010 continue to engage clinical staff in redesigning outpatient services in order to understand what could be more appropriately delivered in the community.
    - Admission to an acute hospital should be only where absolutely necessary, with care being provided in an ambulatory setting – through a paediatric assessment unit (PAU), attached to every A&E or UCC; with clear, robust transfer protocols in place by 2014. A model for a PAU including opening hours and workforce requirements will be produced by a Sector facilitated, clinically-led task and finish group. The outputs of this will be used to assess the financial viability of the service and inform the business case.
    - The allocation of paediatric inpatient units (PIU) is currently planned inline with the allocation of the Major Acute Hospitals (three); further work is needed to model the future activity and patient flows to determine the future capacity requirements. The Sector needs to consider the designation of Chelsea and

Westminster Hospital as a preferred provider of complex paediatric surgery and acting as the hub for the Paediatric Surgery Clinical Network and how this fits into the configuration across the Sector.

- **Tertiary Care**
  - There is a pan-London Tertiary review underway for paediatrics; this programme is linked into the work.
  - The Sector will facilitate a clinically-led task and finish group which will assess the tertiary services currently provided in NWL and how these link into other services.

- **Whole pathway initiative**
  - Design and implement a clinically-led network by 2011 for paediatric services to ensure continuity of care and standard clinical approach by 2014, this network should work closely with a developed clinically-led network for maternity and the NWL Perinatal Network. This will also serve to support sharing of learning, skills and development between all staff engaged in providing services across the pathway by allowing staff to rotate between sites and get exposure to different levels of maternity risks and conditions. The Paediatric Surgery Network has launched (January 2010) and will form part of the managed clinical network for the whole of paediatrics in NWL.

Impact on Care Settings
The implication on settings of care for implementing the HfL pathway for children and young people is a reduction in the admissions to inpatient units at hospital which will require more care delivered closer to home. This will require more training for GPs and community teams. The placement of paediatric assessment units should reduce admissions to A&E departments. The provision of children's services, children's centres and PAUs will need to be developed in close alignment with the polysystem configuration.

Next steps to take action across the Sector

Initiative	Action	Owner	Timescale
Acute Care in the Community	• Facilitate clinically-led task and finish groups	Sector	Jan-Jun 2010
Acute Nursing in the Community and Development of GP Paediatric Skills	• Task and finish group meetings. This will serve as recommendations to the PCTs who can use them for financial modelling to identify the level of investment needed.	Sector/ PCTs	Jan-Jun 2010
Acute Reconfiguration/PAUs and PIUs	• Task and finish group meetings: detailed work is needed to understand the patient flows and financial implications • The sector will develop a pre-consultation business case setting out the options for service configuration	Sector Sector	Between Jan-Jun 2010 Sept 2010
Implementation of managed clinical networks	• The current CWG membership will form the basis of this	Sector	By March 2011

5.2.8 End of Life Care

Vision
That people will die in their choice of setting through early planning joined up community services and family/ carer involvement. This vision will lead to the best practice in Hillingdon being replicated across the Sector that will enable more people to choose to die outside hospital.

Scope of the Pathway

Source: Pathway Based Commissioning: NWL, NHS London, November 2009

Description of the pathway for the Sector

The Sector pathway is based on the End of Life Strategy (EoL) published by the Department of Health in July 2008. The primary objective of the London EoL Care strategy is to provide for 60% of deaths outside hospital (although evidence from the Sector suggests this may be conservative) and to improve the experience of all patients who are nearing the end of their life, whilst being cared for by health and social care services. It also emphasises the importance of thinking widely to include not just cancer, but dementia, long term conditions (HfL identified that 10% of people die from diabetes complications), kidney failure, COPD and learning disabilities.

End of life care has been identified as a Sector priority pathway.

Best Practice

The best practice is described in the EoL strategy – but key principles to maximise quality and productivity are:

- Improved public and health professional's awareness.
- Early discussions and planning which involves the carers.
- Patient centred care plans that are regularly reviewed and include carers needs.
- Good co-ordination of all care based on shared records (including ambulance service), clear clinical responsibility, case management, effective communication systems. Close working with Nursing and Residential Homes.
- High quality care in the right settings at the right time with the right level of expertise.
- Support for patient and carer in last days (58% of complaints to hospital trusts are linked to people dying – so supporting people to remain at home could prevent some of these).
- Patient centred response to wishes regarding place of death and resuscitation, etc.
- Support for the carer and family following death.

We plan to roll out the HfL best practice pathway, sharing best practice implementation models used by NHS Hillingdon. NHS Hillingdon has aligned their palliative care nursing workforce to nursing homes and has reduced the number of transfers of patients who subsequently die in hospital from 35% to 6%. This has been a nurse led initiative which has worked closely with nursing home and community nurses to ensure sustainability of these successes. HfL recommend that models such as this should be adopted across the Sector. This good practice was shared at the November 2009 Sector Clinical Engagement Pathways Event.

Current Challenges

The challenges for the Sector are:

- There is a shortage of care home placements (NWL has a 7% deficit).
- There are a lower percentage of deaths in care homes than the national average (9.6% in NWL compared to 16.2% national average).

- There is a slightly worse than average number of people dying at home (NWL average 18.8% against a national average of 18.9%) however, there is wide variation across the Sector with Westminster PCT and Hillingdon PCT at over 20% and Brent and Ealing PCTs at below 17%).
- The number of GPs in NWL signed up to the gold standard framework is lower than the national average (83.7% in NWL compared with 92.3% nationally).

Gap Analysis

It is acknowledged that in line with the rest of London there are some gaps in care identified across the Sector. These include:

- Lack of systems to identify EoL patients and poor identification of the dying phase.
- Lack of good understanding of the religious and cultural complexity.
- Poor workforce competency: Nursing home, GPs, Community nursing.
- Inadequate carer support and poor understanding of current carer and family experience.
- Lack of care plans, poor roll out of common care records and regular reviews.
- Limited case management.
- No forum for spreading good practice and support.
- Lack of home equipment, support and education for patients and carers to stay at home.
- Variable and inequitable access to hospices.
- No consistent recognition of wishes e.g. resuscitation.

Key Initiatives

Initiatives for this pathway will be addressed by NWL PCTs and include:

- Each polysystem to include an end of life partnership, working with nursing homes to manage end of life care by 2010/11.
- Ensure that GPs universally apply the “gold standard” framework for end of life care by 2010/11.
- Commission for high quality end of life care – in acute trusts, hospices, nursing homes, community and GP contracts (acute commissioning vehicle or PCT where appropriate). This will be in partnership with Local Authorities where appropriate by 2013.
- Implement a Sector wide trajectory of at least 25% of people dying at home by 2014.

Impact on Care Settings

The implications on settings of care for implementing the HfL pathway for end of life care is a reduction in the use of hospital beds by at least 20% by 2013 as people die in their usual place of residence. This will require training and support for nursing home staff, community nurses and GPs. There should also be a contribution in the planned reduction in the number of unscheduled care presentations at A&E of 60% by 2013 (see also section 5.2.5 – page 31, on Unscheduled Care).

Next steps to take action across the Sector

Initiative	Action	Owner	Timescale
Commissioning for high quality care	• Share Hillingdon PCT good practice implementation model across the sector	Sector	2010
Commissioning for high quality care	• Commissioning plan to be developed for high quality end of life care in acute Trusts, hospices, nursing homes, community and GP contracts	Sector/ PCT and LAS	Developed: 2010 Implemented: 2013
Commissioning for high quality care	• Identify workforce competencies in both the polysystem and hospitals to implement the EOL pathway and work with NHS London to develop these competencies	Sector/ PCT	2010/11
Commissioning for high quality care	• Develop co-ordination plan to enable commissioning of hospices to deliver training across the sector	Sector	2013

5.3 Delivering new models of healthcare provision

HfL set out six new future settings of healthcare provision in the capital:

- Home
- Polyclinic (system)
- Local hospital
- Elective centre
- Major acute hospital
- Specialist hospital

These models of provision were based upon the five principles of care including models supporting services focussed on individuals and localised where possible but centralised where necessary.

The HfL delivery model encompassed the following seven key proposals to help commissioners plan for new models of healthcare provision:

- More healthcare should be provided at home.
- New service provision – polyclinics – should be developed that can offer a far greater range of services than can be offered by GP practices.
- Local hospitals should provide the majority of inpatient care.
- Most high-throughput surgery should be provided in elective centres.
- Some hospitals should be designated as major acute sites, handling the most complex treatments.
- Existing specialised hospitals should be valued and other hospitals should be encouraged to specialise.
- Academic Health Science Centres should be developed in London to be centres of clinical and research excellence.

We have been working with Sector clinicians in the CWGs and CRG to develop plans to implement the new models of care across London as outlined in section 4.3, page – 14. Their recommendations were outlined in the pathway initiatives in section 5.2, page – 18.

HfL set out Healthcare Resource Groups (HRG) level assumptions which were used to estimate the proportion of activity that would be provided across each of the above care settings as the model of care is implemented. NWL clinicians have adapted these assumptions, particularly in relation to paediatrics and obstetrics. The proportion of home births is assumed to double from 2 – 4% rather than 10% outlined in HfL, which will be challenging to achieve and is subject to a significant increase in community midwives. In terms of paediatrics, it was felt that, with appropriate training and skill mix of staff, a higher proportion of activity could be delivered in a polyclinic setting. Both sets of assumptions result in the most significant shifts in activity away from acute providers in A&E and outpatients.

Future activity volumes to 2014/15 have been modelled from a 2008/09 baseline, HfL affordability assumptions have been applied and then mapped across the care settings by applying the assumptions described above. The outputs are outlined in the Sector financial plan section 5.6.

5.4 Developing the polysystem

Scope of the Polysystem

The polysystem is a framework for effective delivery of community and primary care in response to local need. Each polysystem needs a hub or polyclinic, a local centre for providing care supported by a network of community spokes. The polyclinic is required to have a minimum specification of services so that the population know what services are available to them when they attend, services will be flexible depending on the needs of the local population.

Polysystems will support the following shifts of activity out of acute care through implementing the HfL strategy in community and primary care:

- 55% outpatient appointments and 60% A&E attendances will be delivered through polysystems.
- More effective management of long term conditions in polysystems will deliver a reduction of 10% complex and 30% non-complex non-elective medicine.
- 40% future long term conditions cases prevented.
- 10% of non-elective medicine actively prevented through early detection and counselling in polysystems.
- 7% electives, 30% outpatient, 10% A&E activity and 10-15% diagnostics decommissioned.

To deliver these improved outcomes, the transformation of community and primary care through polysystems needs to focus on:

- More health care being provided at home.
- New service provision – polyclinics – offering a far greater range of services as locally as possible.
- Clustering PBC around the polyclinic to enable a system of care that responds to local need, links with community pharmacy, is part of the system of unscheduled care response and offers an opportunity to improve primary care.

Polysystems must be in place and capable of delivering safe and effective services before activity is shifted into community and primary care.

Sector Case for Polysystems

- There is variable quality of primary care (six out of eight PCTs fall below the national average for QOF points) in the Sector.
- Old buildings often not fit for purpose are still used across the Sector, an additional challenges is the high cost of property in some boroughs.
- There is a high proportion of people attending A&E who could be seen in primary care.
- Polysystems will support the implementation of the HfL strategy.

Best Practice across the Sector

There were two polyclinics opened in NWL in 2009 as part of the first wave in London including: Alexandra Avenue (Harrow PCT) and Heart of Hounslow (Hounslow PCT). There are now a further two: Hammersmith Hospital and Charing Cross Hospital (Hammersmith and Fulham PCT).

However, each of these polyclinics presents challenges:

- Ensuring the polyclinic becomes a polysystem hub which supports the health needs of the local population.
- Ensuring that PBC is aligned to create an incentive framework that delivers improved quality of primary care for the local population.
- Ensuring that the polysystem is responsive to local need.
- Ensuring that the needs of children and young people are integrated into polysystem services.

Implementation of Polysystems

The Sector, in partnership with the clinicians, has agreed the following priority pathways to implement in the polysystems: Diabetes and End of Life care. Children and maternity primary care services will also be integrated. Acute physicians and GPs, along with other health care professionals, have worked in partnership to agree the implementation method for these pathways. Further pathway development work will follow for COPD and cardiology.

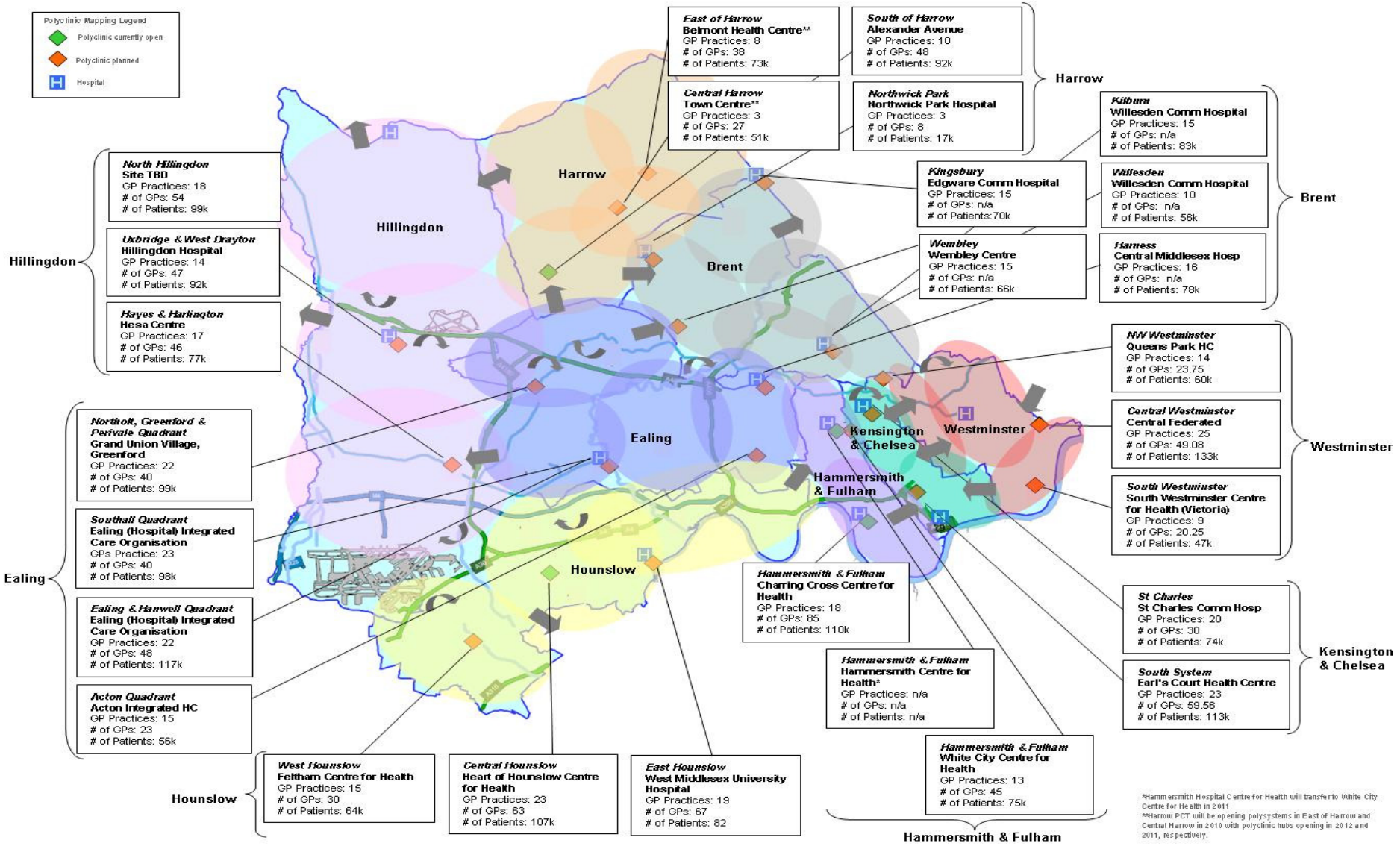
There has been considerable work developing the leadership of the PCT polysystem across the Sector. This has included integrating plans for unscheduled care (including agreeing where patient flows indicate cross boundary planning) to maximise the opportunity for using polysystems to improve

primary care and sharing learning from those PCTs who have already opened a polyclinic or urgent care centre.

Twenty-seven polyclinics are planned. There are four polyclinics currently open, seven are planned to open by 2010, eight planned in 2011, six in 2012, and the remaining to be opened by 2013/14.

The following map and chart show the Sector wide plans for polysystems and bordering PCTs in other Sectors.

Polyclinic Mapping & Patient Flows



Polyclinic Implementation Plans

PCT	Polysystem Name	Location of Hub	# of GP Practices	# of GPs	# of Registered Patients (thousands)	Currently Open	Open by end of year			
							2010	2011	2012	2013/2014
Brent	Wembley	Wembley Centre for Health and Care	15	n/a	66					
	Willesden	Willesden Community Hospital	10	n/a	56					
	Kilburn	Willesden Community Hospital	15	n/a	83					
	Kingsbury	Edgeware Community Hospital	15	n/a	70					
	Harness	Central Middlesex Hospital	16	n/a	78					
Ealing	Northholt, Greenford and Perivale Quadrant	Grand Union Village HC LIFT scheme, Greenford	22	50	96					
	Ealing & Hanwell Quadrant	Ealing (Hospital) Integrated Care Organisation	22	53	110					
	Acton Quadrant	Acton Integrated Health and Social Care Centre	16	31	61					
	Southall Quadrant	Ealing (Hospital) Integrated Care Organisation	23	42	96					
Hammersmith & Fulham	Hammersmith & Fulham	Hammersmith Hospital Centre for Health*	n/a	n/a	n/a					
		White City Centre for Health	13	45	75					
		Fulham Centre for Health	18	85	110					
Harrow	South of Harrow	Alexandra Avenue	10	48	92					
	East of Harrow	Belmont Health Centre**	8	38	73					
	Central Harrow	Town Centre**	3	27	51					
	Northwick Park	Northwick Park Hospital	3	8	17					
Hillingdon	North Hillingdon	Site TBD	18	54	99					
	Hayes & Harlington	Hesa Centre	17	46	77					
	Uxbridge & West Drayton	Hillingdon Hospital	14	47.65	92					
Hounslow	Central Hounslow	Heart of Hounslow Centre for Health	23	63	107					
	West Hounslow	Feltham Centre for Health	15	30	64					
	East Hounslow	West Middlesex University Hospital	19	67	82					
Kensington & Chelsea	St Charles	St Charles Community Hospital	20	30	74					
	South System	Earl's Court	23	59.56	113					
Westminster	South Westminster	South Westminster Centre for Health (Victoria)	9	20.25	47					
	North West Westminster	Queens Park Health Centre	14	23.75	60					
	Central Westminster	Central Federated	25	49.08	133					

*Hammersmith Hospital Centre for Health will transfer to White City Centre for Health in 2011
**Harrow PCT will be opening polysystems in East of Harrow and Central Harrow in 2010 with polyclinic hubs opening in 2012 and 2011, respectively.

Unscheduled care in polysystems
The Sector unscheduled pathway suggests that 75% of people of presenting at A&E would be better cared for in primary care. Polysystems need to respond to this challenge.

The HfL strategy describes a reduction in A&E attendances through a framework of community and primary care services with co-ordinated access to unscheduled care and the LAS using different pathways. A number of unscheduled care access points in polysystems exist across the Sector including:

- Telephone / Home
- GP unscheduled appointments
- Walk in centres
- Urgent Care Centres
- Out of Hours
- Community pharmacies
- A&E

These will be mapped and consolidated across the Sector in line with the acute hospital reconfiguration work.

There are two best practice examples of primary care provision of unscheduled care, which the Sector Unscheduled and Urgent Care Innovation network have agreed to share:

- Kensington and Chelsea, Westminster and Hammersmith and Fulham PCTs Single Point of Access (see description in section on Unscheduled Care).
- Hammersmith and Fulham Urgent Care Centre (with GP practice behind) (see description in Section 5.2.5 - page 33, Unscheduled Care).

The Hammersmith Hospital UCC has delivered a 65% shift to the UCC primary care front end and reduced the admissions to hospital from 741 in October 2001 to 614 in September 2009 over a 12 month period. This shift has made financial savings.

The Sector has agreed to roll out the A&E front end UCC model piloted by Hammersmith and Fulham PCT: a GP first clinical contact for all self presenting unscheduled attendances and Category C ambulance attendees with protocols to underpin all these streams including alcohol and drugs, mental health and suicidal risk assessment. The front end is supported by a GP practice where planned care takes place and unregistered patients are offered a registered GP service.

UCCs at the front end of A&E with direct access to diagnostic services are currently open at Hammersmith Hospital, Charing Cross Hospital and Northwick Park.

Primary care front end services in A&E without direct access to diagnostic services (i.e. patients have to be referred into the Emergency Department for diagnostic services) are currently open at the Hillingdon Hospital and West Middlesex Hospital.

UCCs at Ealing Hospital, Chelsea and Westminster Hospital, Central Middlesex, and St Mary's Hospital will open in 2010.

Improving the Quality of Primary Care

- **Using the polysystem framework**
  The polysystem commissioning framework allows groups of GPs to commission services on behalf of their local populations through practice based commissioning. With the right incentive, framework services can be delivered locally, GP practices can be consolidated and primary care networks set up so that at-risk patients across the whole polysystem are identified and diagnosed. The polysystem framework also allows for competitive contracting for community and primary care services with a focus on contracting incentives that support cross-agency working, for example,

community providers, social care and acute trusts to manage falls or support people with dementia to stay in their homes.

Work is underway to develop incentives across the Sector PCTs and the Sector is linked into the NHSL project that includes incentives for commissioning across pathways. We recognise that incentives will be critical to support the implementation of the pathways in primary and community care and this will be progressed in the 2010 focusing on long term conditions.

- **Schemes for performance managing primary care**
  There are two examples of good practice across the Sector for developing incentives to improve the quality of primary care. In Hammersmith and Fulham, the Quality and Outcomes Framework Plus aims to improve the quality of care across all practices by raising the bar for achievement of existing QOF major chronic disease targets, introducing new clinical targets focussed around health promotion and disease prevention and opening new avenues for support and engagement with practices. There have been several health improvement successes of this incentive scheme.

  In Kensington and Chelsea PCT a step up approach model is being used which is directly integrated with the polysystem approach to transforming community and primary care.

  The PCTs across the Sector will share best practice to support the transforming community and primary care outcomes possible through polysystem implementation based on the good practice examples described above.

- **Role of the Sector**
  The role of the Sector in the short term was agreed by the Sector Chief Executives as:

Sector actions	Impact on PCT outcomes
Map and co-ordinate plans for polysystems across the Sector, ensuring that they are robust and will deliver HfL strategy and the resulting shifts in activity.	Maximise use of resources especially estates.
To ensure assumptions for cost modelling are shared across the Sector.	Supports PCT negotiations with Acute Hospital providers.
To build a common understanding of system management levers in primary and community care across the Sector Link with NHS London incentives project and develop Sector wide incentive schemes to support PCTs re-vitalise PBC.	Best practice can shared and implementing which will improve the quality of poorer performing health economies across the Sector.
To agree priority pathways across the PCTs so that providers can business plan and ensure that as activity shifts remaining clinics are still viable, clinically and financially. Develop those pathways on a Sector wide basis.	Supports PCT negotiations with Acute Hospital providers.
To share best practice and knowledge.	Best practice can shared and implementing which will improve the quality of poorer performing health economies across the Sector.
Where appropriate engage clinicians on a Sector wide basis e.g. the workshop described above.	Support the PCTs clinical engagement strategies.

A review will take place in the 2010 of the Strategic Directorate's role across the Sector. The emphasis will be on continuing to drive the development of polysystems through a single programme roll-out.

5.5 Provider requirements and plurality of provision

5.5.1 Current issues and the Sector response

North West London PCTs and Trusts are working together to address the three main drivers for change in the way that services will be provided in future- the increasing specialisation of clinical services, the implementation of Healthcare for London and the national economic position. The current configuration of providers is not sustainable in the context of these three drivers.

The NWL Sector is currently addressing several provider Trust organisational issues, in order to support the Trust with potential to become Foundation Trusts and to manage those which have entrenched financial or performance difficulties.

Key actions include:

- The Sector is actively promoting and supporting the concept of the Integrated Care Organisation, bringing the PCT provider services of NHS Ealing and NHS Harrow together with Ealing Hospital Trust. All three Boards support this proposal. The provider services of NHS Brent are likely to join this organisation. This will promote an innovative locally based model of community provision. All involved acknowledge that this will, over time, reduce the level of acute services on the Ealing site and they will be transferred or tendered to other acute provider management to ensure their clinical and financial viability. This acute activity change will enhance the viability of the surrounding acute hospitals.

- The Board of West Middlesex Hospital Trust have recently clarified that they do not believe that their organisation has an independent future. This position is supported across the Sector and we believe there is clinical logic for them to be partnered with another Trust. We are currently working on proposals for next steps, which will involve a competitive process.

- Service configuration at NWL Hospitals Trust is moving ahead. Emergency surgery has stopped at the Central Middlesex Hospital (CMH) with the support of the local Overview and Scrutiny Committees. This change was made on safety grounds and is consistent with the Sector strategy. The Trust plans to centralise paediatric inpatient services at Northwick Park Hospital. These changes are providing “proof of concept” for the local hospital model which it is proposed to adopt across the Sector. CMH is one of the few hospitals in London to successfully operate an undifferentiated medical take without onsite surgical cover.

- The financial problems of NWL Hospitals Trust need to be resolved and further work has been commissioned to do so, with the support of the Challenged Trust Board and local PCTs. This work will be integrated with the overall Sector work.

- We support Hillingdon Hospital’s application to be a Foundation Trust. NHS Hillingdon and the Hillingdon Hospital have decided to progress a vertical integration model for community and acute services.

- Chelsea and Westminster Hospital NHS Foundation Trust has been designated to provide specialist inpatient neonatal and paediatric surgery and as lead centre for the NWL Children’s surgical provider network.

- The provider services of NHS Kensington and Chelsea, NHS Westminster and NHS Hammersmith and Fulham have merged to form Central London Community Healthcare (CLCH). It is likely that this will progress to Community Foundation Trust status. NHS Hounslow is considering bringing its provider services into this organisation.

5.5.2 How is the current landscape likely to change in line with Healthcare for London's Framework for Action?

The clinical case for reviewing the current acute provider landscape

Changes in the organisation and delivery of healthcare, including the increasing specialisation of medical practice, technological advances and the European Working Time Directive require a strategic response. There is strong evidence from a number of disciplines that specialisation – by teams and not simply individual clinicians – where larger volumes of work are undertaken in fewer places, leads to improved clinical outcomes. For example in vascular surgery there is evidence that centres performing larger volumes of surgery have better clinical outcomes (pan-London Cardiovascular Review). Our growing ability to deliver more complex, more costly care to save and improve lives means there is a need to find more efficient ways of providing existing services – engaging the patient more actively in their care, or simplifying the delivery of care to make it more cost effective in order to meet the anticipated financial challenge.

Clinical evidence gathered during the development of Healthcare for London shows that nearly a third of current inpatients would be better cared for outside an acute setting.

In 2007, 97 percent of outpatient appointments were provided in a hospital setting in London. Changing the model of service and delivering this care closer to home will reduce the need for patients to travel to many of these appointments.

Care Settings Model

In consultation with our clinicians, we have modelled, by HRG, the activity to be delivered in future in the Framework for Action settings of care.

NW London Provider Landscape	*Volume of activity provided by setting (spells, attendances) Forecast 2014/15*							
Care Setting Template	Forecast spells / attendances 2014/15	Specialist/ major acute	Elective centre	Local hospital	Polyclinic	GP	Home	Decommissioning
Adjusted HFL	*North West London Acute Trusts*							
Elective medicine	97,246	37,822	4,838	36,238	18,348	-	-	-
Non-elective medicine	133,000	44,335	-	69,317	15,376	-	-	3,973
Elective surgery	71,385	27,986	30,362	-	7,881	-	-	5,156
Non-elective surgery	55,749	35,881	96	18,609	1,122	41	-	-
Paediatrics	24,392	6,630	-	665	17,097	-	-	-
Obstretics	64,179	36,725	-	21,758	3,304	-	2,392	-
Total number of inpatient spells	445,951	189,378	35,296	146,588	63,128	41	2,392	9,129
Regular attendances	21,692	6,057	-	7,948	7,686	-	-	-
Outpatients	1,554,099	207,406	207,406	207,406	621,198	-	-	310,684
A&E	957,111	239,278	-	191,422	478,555	-	-	47,856

The financial case for reviewing the current acute provider landscape

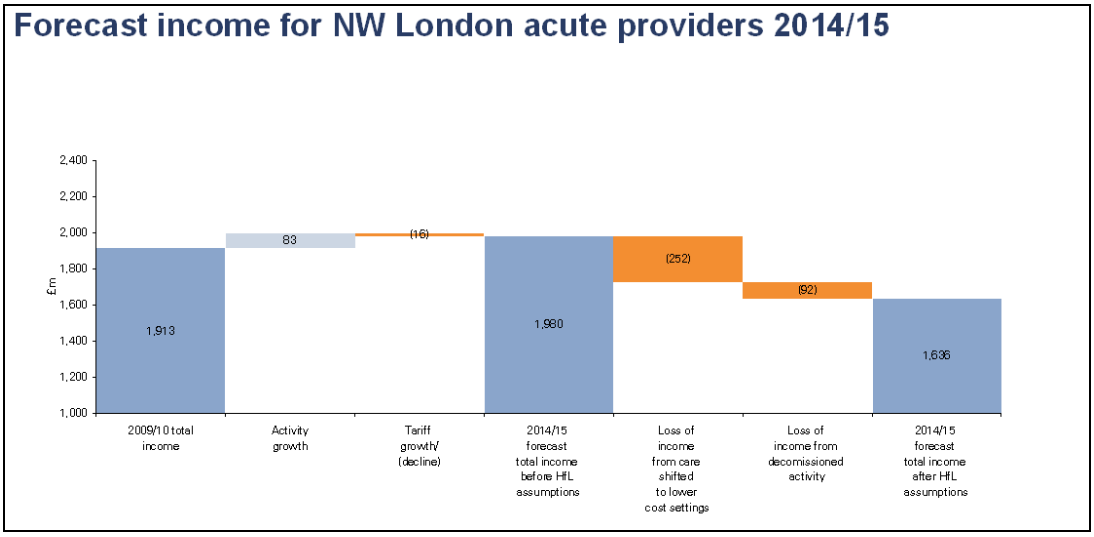
NHS funding is expected to increase by 5.1% in 2010/11, but after that to remain stable. Demand for healthcare continues to grow, and will have to be managed within existing resources by improving productivity, including delivering healthcare in the most appropriate settings.

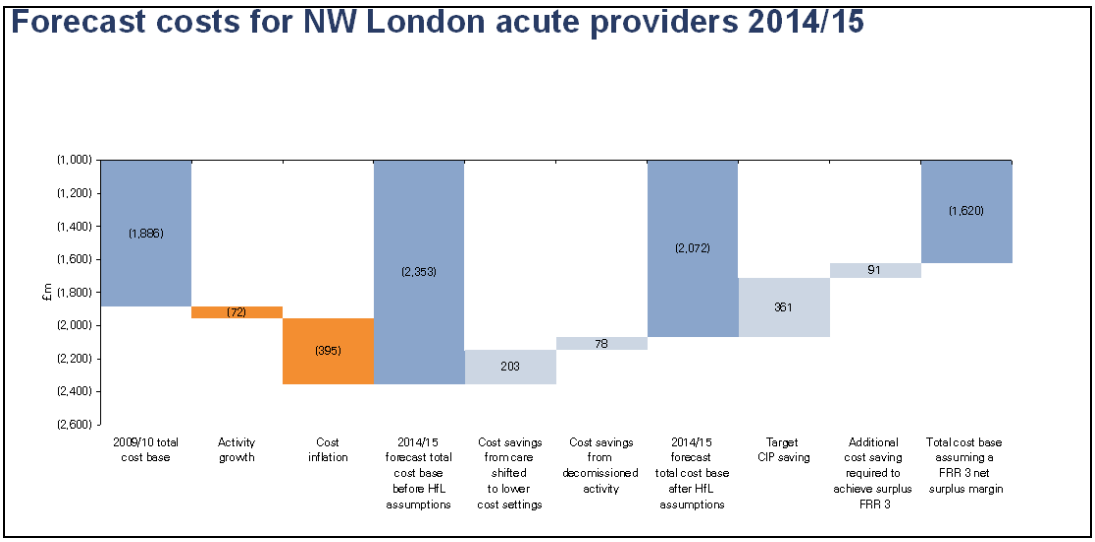
The national tariff paid to hospitals for each unit of activity will not be increased over the next four years. At the same time, commissioners will commission services closer to home in the polysystems.

This means that acute hospitals will face a challenging financial future. For both clinical and financial reasons, the current disposition of services between NWL hospitals must change.

Our analysis indicates that the national target efficiency savings alone – although challenging in themselves – are not sufficient to bridge the gap created by commissioners moving care to alternative settings or decommissioning services. As the activity delivered by acute providers reduces, their income decreases proportionally but fixed costs remain the same.

Consolidation of major acute activity onto a smaller number of sites, and avoiding unnecessary duplication of services will reduce fixed and variable costs.





This initial analysis suggests that a gap of £91million will be left for acute providers to meet, in addition to the £361million target efficiency saving, in order to reach the surplus margin required to achieve a financial risk rating acceptable for a Foundation Trust in 2014/15.

Determining the appropriate configuration of acute services for North-West London
All the provider organisations in the Sector were represented through the CWGs and the CRG and this enabled the process to be clinically led, which is vital if it is to result in change that will benefit patient care.

The working groups' recommendations about the combination and configuration of provider types appropriate for the Sector were then sense checked against care settings assumptions based on Healthcare for London's *A Framework for Action 2007*.
A detailed financial model was used to test how different configurations of numbers of major acute hospitals, numbers of local hospitals and polysystems would affect the financial viability of the acute providers in the Sector.

The clinical models proposed by the clinical working groups
The four CWGs made a series of recommendations to optimise the settings of healthcare across NWL, which are detailed in the eight Care Pathways sections.

Conclusion – what is the appropriate combination of major acute providers and local hospitals for the patients of North-West London?
Using the outputs of the Care Settings Template to sense-check the recommendations of the clinical working groups produces an emerging model of the future configuration of acute providers in North-West London.

Specialist Hospitals - Two national specialist hospitals, the Royal Brompton & Harefield NHSFT and the Royal Marsden NHSFT are located on the Fulham Rd. It is not proposed to change the services provided by these hospitals as part of the NWL strategy, although they will be subject to the London wide reviews of cancer and cardiovascular services.

Several other hospital sites in the Sector also provide specialised services to a wider population than NW London, and this will continue.

Major Acute Hospitals - The Clinical recommendations that the Sector should be served by three main emergency surgery rotas and three medical paediatric inpatient units supports a model of a maximum of three major acute hospitals.

The NHS in London has designated St Mary's Hospital as a major trauma centre and this thereby fixes the site as the inner North West London major acute hospital. The choice of other sites as major acute hospitals will be based on a formal option appraisal which will assess clinical and financial viability in detail. We will work with the Trust to consider the disposition of services within Imperial Healthcare.

It is essential to ensure that each major hospital will care for a sufficient volume of patients in each speciality, and that each major acute hospital provides the full range of supporting services required to perform complex acute work safely. Our initial work on the volumes of activity to be provided in each care setting will be expanded to consider each major speciality.

The Sector has modelled transport times to Sector sites by ambulance and public transport. Access to services, which is of great importance in delivering high quality care, will be factored in to all option appraisals.

Local Hospitals - Local hospitals will concentrate on providing high quality, accessible services to their local population, linked closely to the polysystems and referring more complex work to the major acute hospitals.

The Sector vision for local hospitals, emerging from the recommendations of the Clinical Working Groups, is that they will include:

- GP led Urgent Care service.
- Acute medical admissions.
- Consultant led paediatric assessment unit.
- Elective surgery, including simple day case surgery for children over two, and scheduled surgery for the frailty fractures of older people.
- Outpatient and diagnostic services.
- Services for regular attendances, such as chemotherapy and renal dialysis.
- Inpatient rehabilitation beds.
- Obstetric unit in some local hospitals.

We are modelling several options for our local hospitals. The Sector sees great potential to deliver productive integrated services through vertical integration of local hospitals with community services and/ or with the major acute hospitals. The CRG supports the designation of some local hospitals additionally as elective surgery centres.

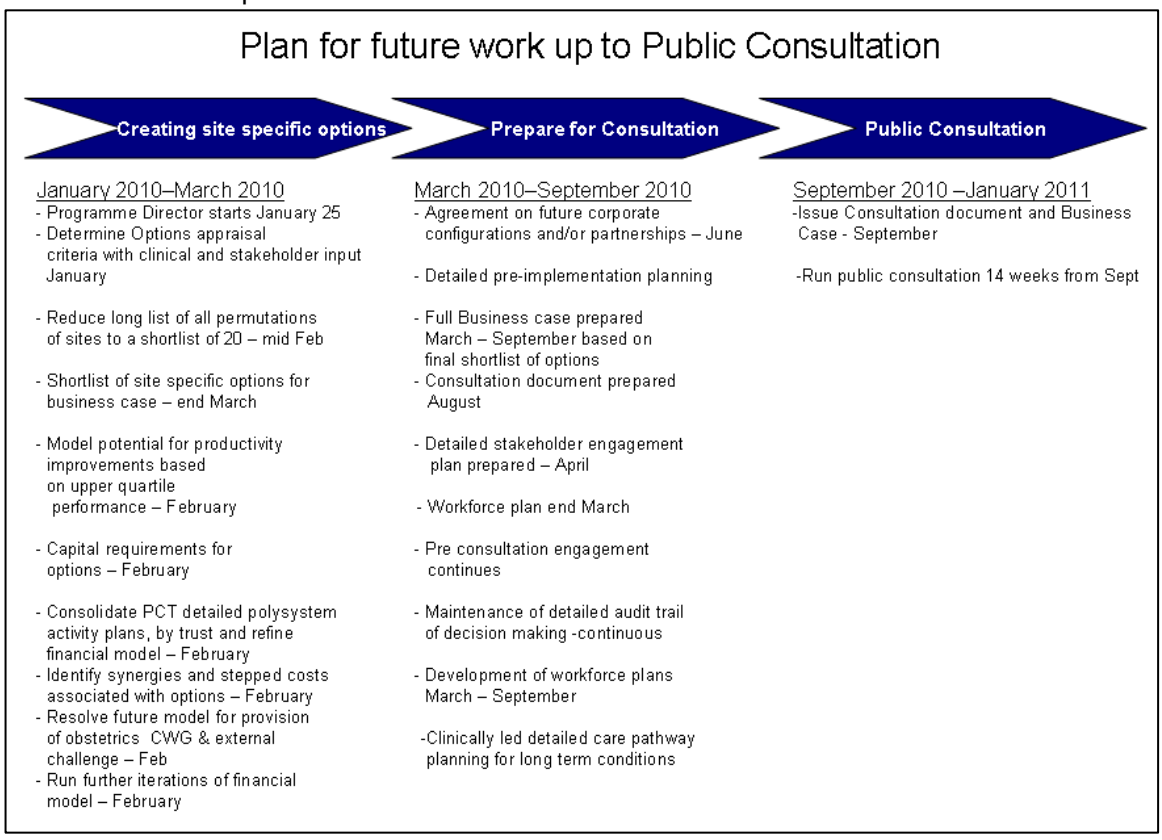
The Chelsea and Westminster NHSFT, which works closely with the Royal Brompton NHSFT and the Royal Marsden NHSFT, which are all located on Fulham Road, is likely to provide a model of a Local Hospital with specialised services.

Options will also be modelled in which not all current hospital sites are designated as either major acute or local hospitals. It is likely that one or more sites will become the base for polysystems, providing GP services, diagnostics and inpatient rehabilitation as well as a range of the less acute services provided by local hospitals.

Initial modelling of the financial impact of the clinical recommendations indicate potential cost savings of £6million to £40million as a result of service reconfiguration. The higher range of savings is dependant on at least one existing hospital site being designated as a polysystem hub.

Next steps
This is the beginning of transforming healthcare for the population of NWL– and the next phase of the work will concentrate on understanding the patient pathways and the subsequent flow of activity. Further work will also be undertaken to test – both clinically and financially – various combinations of the existing acute providers in the Sector fulfilling the different roles for acute providers set out above. This testing will take into account clinical synergies, travel times, the financial implications of various combinations and existing provider strengths and weaknesses. It will allow the Sector to produce options for consultation on site specific plans for the acute provider landscape.

Plan for future work up to Public Consultation:



5.5.3 Market Management

The Sector has made some progress in understanding and stimulating the market in the last year. We commissioned a review of the acute provider landscape which determined that not all acute Trusts would meet the requirements for FT status and have completed some initial modelling the determine the impact of implementing HfL and PCT strategies on the future viability of acute providers. Further work will be undertaken to test the future financial viability of acute providers as we examine options for providers to fulfil the roles set out in HfL.

The Sector completed a successful tender exercise to select the preferred provider for specialist complex inpatient neonatal and paediatric surgery to resolve the current fragmentation of services.

In addition, we have been working with NWL PCTs to understand the actions they have taken to stimulate the market over the last year and to identify best practice examples that can be rolled out across the Sector. NHS Hammersmith and Fulham opened two polyclinics to improve unscheduled care following a successful tender process and were the first to adopt the model of a primary care front-end to A&E. NHS Harrow led a pathology services market testing exercise market testing exercise on behalf of seven NWL PCTs, which provided a market and negotiating platform with current providers and will lead to collaborative procurement arrangements and better quality / cost outcomes. NHS Westminster has developed a market management strategy that identifies nine steps to improved market management, from prioritising market segments that need intervention, to developing strategies in priority segments, to turning that strategy into action. This strategy will be shared as an example of best practice across the Sector.

The Sector will develop a market management strategy setting out how acute services have been segmented for commissioning and how they will fit into planned service re-configuration. This will be undertaken in the 2010 based on the NHS Westminster best practice example described above.

5.6 Sector Financial Plan

5.6.1 Introduction

The NHS is facing significant economic pressures after 2010 following a period of record growth in funding. Planning assumptions are based on real terms flat funding from 2011 – 2012. NHS London has modelled the effect of this together with activity and expenditure increases on the delivery of the HfL programme and has determined that the current model of healthcare in London is not affordable.

5.6.2 Current financial position of NWL PCTs

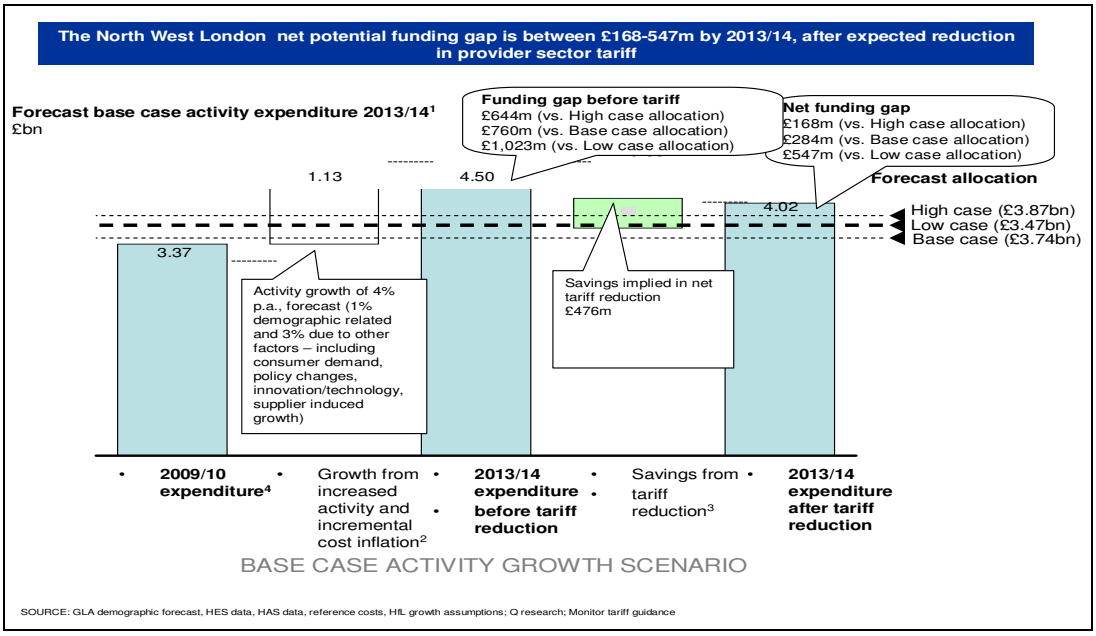
Despite very substantial over performance on acute services all PCTs are expecting to breakeven and meet their control totals. However, the inner NWL PCTs have higher surpluses – in year and carried forward.

5.6.3 Possible funding scenarios (2010/11 – 2013/14)

The funding scenarios have been calculated according to NHSL guidance as follows:

- The “base case” a 2.5% increases from 2010 onwards to cover general inflation.
- The “downside case” (scenario 1) a flat cash or 0% increase from 2010 onwards.
- The “upside case” (scenario 2) a 3.25% increase from 2010 onwards.

NWL commissioners face a funding gap of between £168 - £547m by 2013/14, after the expected reduction in provider Sector tariff, if decisive action is not taken.



A number of actions are available to commissioners to help to close the gap including:

- Pathway redesign to move services that can be provided safely and more cost effectively in polysystems.
- Increased focus on preventative services.
- Proactive management of long-term conditions.
- Decommissioning services that are of limited clinical value.
- Improving productivity and reducing the cost of community and primary care through polysystems.
- Increasing value for money through greater efficiency of non clinical expenditure.

The strategy section outlines how the Sector initiatives will implement the above to improve quality and realise the financial benefits. The impact on NWL acute provider organisations is shown in section 5.5.2 – page 52.

5.6.4 Addressing the funding gap over multiple financial scenarios

Base case scenario

The potential gross gap before after allowing for tariff efficiencies is £760m and after tariff is taken into account the gap closes to £284m**.** To close the gap the following actions have been costed across the Sector based on the implementation of HfL and the associated NHSL affordability analysis.

- **Move acute activity to a lower cost setting – net savings of £52m**
- **Long term condition management and the decommissioning of activity across the range of services - saving £64m**
- **Improved efficiencies in primary and community settings and other and value for money initiatives - saving £168m**

I&E position for the Sector showing surplus over the period of the plan

Financial year	2009/10	2010/11	2011/12	2012/13	2013/14
Total Income in millions	3,416.0	3,488.7	3,584.7	3,684.1	3,779.7
Total Expenditure in millions	3,376.8	3,450.4	3,533.9	3,613.0	3,677.9
Sector Surplus in millions	39.2	38.3	50.8	71.1	101.8

The base case scenario is considered to be the most realistic scenario following the recent publication of the Operating Framework.

Downside scenario (scenario 1)
The potential gross gap before after allowing for tariff efficiencies is £1023m and after tariff is taken into account the gap closes to £547m.This is £263m higher than the base case and the additional savings required have also been calculated and the impact on the I&E position is listed below.

I&E position for the Sector showing surplus over the period of the plan

Financial year	2009/10	2010/11	2011/12	2012/13	2013/14
Total Income in millions	3,416.0	3,496.3	3,529.5	3,558.4	3,573.1
Total Expenditure in millions	3,376.8	3,455.7	3,487.6	3,509.5	3,526.9
Sector Surplus in millions	39.2	40.6	41.9	48.9	46.2

Upside scenario (Scenario 2)
The potential gross gap before after allowing for tariff efficiencies is £644m and after tariff is taken into account the gap closes to £168m This is £116m lower than the base case however as this scenario is somewhat unrealistic in the long term no further analysis is included in this report. The I&E position is shown below:

I&E position for the Sector showing surplus over the period of the plan

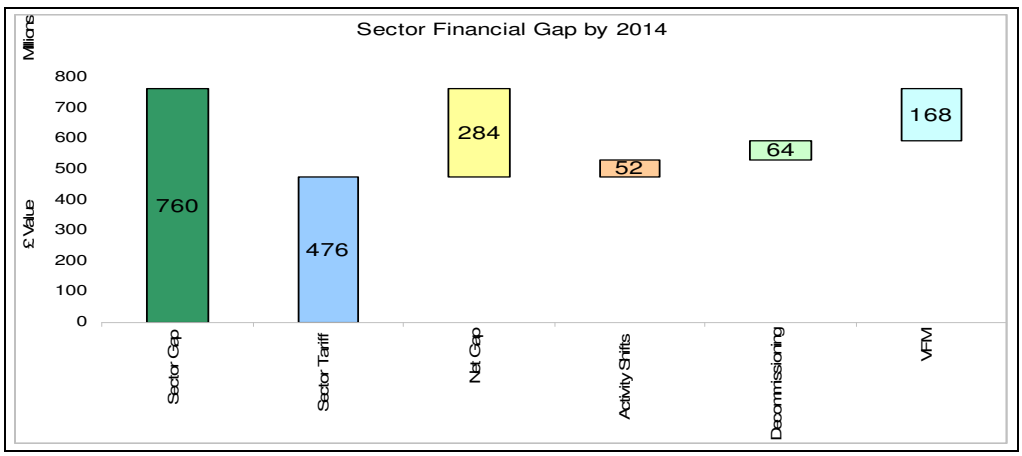
Financial year	2009/10	2010/11	2011/12	2012/13	2013/14
Total Income in millions	3,416.0	3,496.3	3,620.2	3,741.2	3,862.1
Total Expenditure in millions	3,376.8	3,455.7	3,547.5	3,635.8	3,712.4
Sector Surplus in millions	39.2	51.7	72.7	105.4	149.7

The above shows that the NWL PCTs produce a minimum 1% surplus in each of the three scenarios.

Commissioners managing the future financial pressure
The base case plans indicate that the NWL PCTs have a combined financial pressure of £760Million by 2013/14.

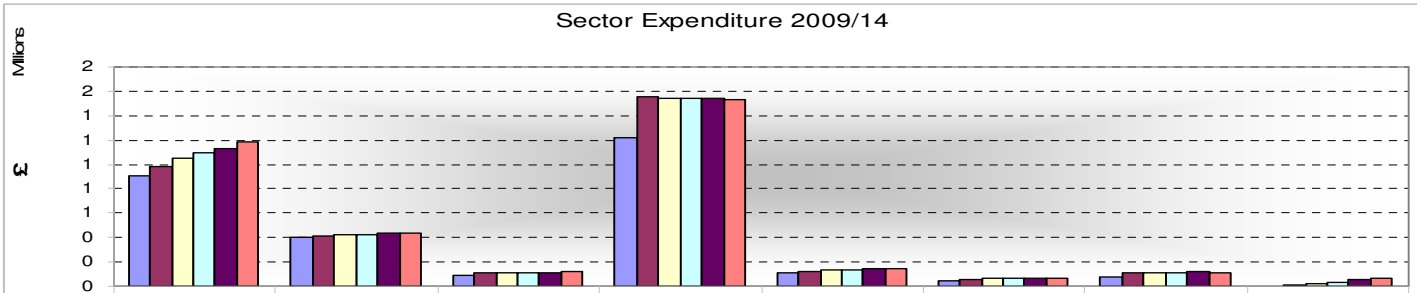
The PCTs have all made plans, consistent with the London affordability model, to decommission services, transfer services to lower cost settings, and to make savings in other areas such as management costs, prescribing, and community services productivity.

A waterfall chart showing the funding gaps and the actions taken to address these is shown below for information.



Movements in settings of care

The Sector expenditure position expressed across the various care settings for the plan period is shown below for information for the base case:



	Primary and community	MH and LD commissioning	Continuing care	Secondary or tertiary acute care	Specialised Commissioning	Other PCT Commissioning Spends	Other PCT Spend	Contingencies
2008/09	903,950	403,634	92,999	1,223,374	116,081	41,103	82,749	319
2009/10	987,356	415,166	107,158	1,557,647	127,137	56,963	113,842	5,866
2010/11	1,045,726	421,001	109,334	1,544,959	133,040	63,105	109,383	18,576
2011/12	1,091,791	429,384	111,163	1,541,240	136,038	64,419	116,690	36,486
2012/13	1,132,694	434,142	114,877	1,542,280	140,073	66,285	117,568	55,316
2013/14	1,179,760	440,008	118,993	1,536,178	144,044	67,647	112,315	62,862

The key financial risks and their mitigation are described in Section 6.3 – Page 62, Risk Management.

6.0 Delivery

6.1 Review of delivery of 2008/09 CCI milestones

Over the last 12 months the Sector has strengthened the collaborative commissioning arrangements and made significant progress in areas of major strategic change.

The strategic initiatives outlined in the 2009-14 Collaborative Commissioning Intentions (CCI) i.e. stroke, major trauma, complex paediatric surgery and elements of unscheduled care, have reached the implementation stage. Progress against each of the initiatives is summarised below.

Cancer
Progress has been made in each of the three sub-initiatives; Improving Outcomes Guidance (IOG) compliance, cancer waiting times and supportive and palliative care as highlighted below:

- The Head and Neck IOG was successfully agreed with the National Cancer Action (NCAT) in July 2009 following a peer review visit of the UAT (Upper Airways Tract) and thyroid Multi Disciplinary Team (MDTs) at Northwick Park.
- Skin and sarcoma implementation plans have been agreed by NCAT and are currently being implemented.
- The Children's Cancer service model was agreed after a robust tendering process with the final decision ratified by the Primary Treatment centre (PTC) at Great Ormond Street Children's hospital and the specialist commissioners.
- The CQC only used Q1-Q3 to assess Trusts performance against the Cancer Waits indicators in the Annual Report and as such all Trusts in the Network met the indicators.
- Key recommendations progressed in the Supportive and Palliative Care IOG which covers several aspects of the cancer patient pathway from diagnosis onwards including end of life care.

Maternity

- A Sector-wide quality services specification for the provision of effective, efficient and reliable maternity services in NWL was developed and implemented within 2009-10 SLAs. The specification covers the entire pathway focusing on pre-conception, antenatal care, in-labour and post natal care. Compliance will be robustly monitored as part of the ACV performance framework.
- A standardised referral form for access to antenatal services for GPs and direct referral by women has been implemented. An audit tool will be used to monitor compliance and uptake after a 6 month monitoring period.
- A capacity planning sub-group was established to develop a baseline of current activity and project future demand and capacity requirements.
- The Strategic Planning Directorate (SPD) and clinicians actively participated in shaping future maternity services on a pan-London basis as part of the HfL maternity workstream and NHSL maternity services improvement board.

Improving surgical services for children and young people

- The NWL JCPCT commissioned a tender process to identify a lead centre for specialist inpatient neonatal and paediatric surgery and resolve the current fragmentation of services.
- The NWL JCPCT approved Chelsea and Westminster Hospital NHS Foundation Trust be selected as the Preferred Provider and designated Lead centre for the NWL Children's surgical provider network. The Pre-consultation Business Case was approved by NHSL in May 2009 and the eight NWL OSC Chairs indicated that no formal public consultation was required given the extensive pre-consultation engagement undertaken. The new service will commence in April 2010.
- In the longer term the women's and children's CWGs will form a network to implement maternity and paediatrics improvements in line with HfL models of care.

Stroke

- The primary care work stream focused on risk assessment, prevention, raising awareness and education including the roll out of the national FAST campaign and vascular checks.
- Two hyper-acute centres and seven stroke units in NWL were designated following public consultation. New capacity will opened in November 2009 and will be fully operational by April 2010. It is anticipated that the new model will lead to significant improvements in the quality of stroke services and patient outcomes by 2011.
- Go live designation assessments are being undertaken by the ACV and stroke network, C&W FT was the first to be completed in London.
- Referral protocols for TIA and rehabilitation have been developed to standardise practice in line with HfL quality standards.
- The rehabilitation work stream has mapped current services, identified gaps and provided a report outlining recommendations for each NWL PCT. A best practice 6-week programme was evaluated and will inform future commissioning of rehabilitation services.

Trauma

- St Mary's was designated as one of four major trauma centres in London in line with the HfL trauma strategy. This will lead to significant improvements in the quality of trauma services and patient outcomes by 2012.

Unscheduled care

- NHS Hammersmith and Fulham was one of six London PCTs examined in detail to inform the HfL USC delivery model.
- The SPD and local PCT representatives actively participated in the development of the HfL USC delivery model through the commissioning group.
- The development of primary care led UCCs at the front end of A&E has been progressed by constituent PCTs and best practice and experience gained has been shared Sector-wide. UCCs at the front end of A&E with direct access to diagnostic services are currently open at Hammersmith Hospital, Charing Cross Hospital and Northwick Park sites. Primary care front-end A&E without direct access to diagnostic services without streaming to the Emergency Department is currently open at the Hillingdon Hospital and West Middlesex Hospital. A resulting shift of 65% of A&E attendances has been realised in NHS Hammersmith and Fulham.
- Access to primary care has been increased through GP led health centres with extended opening hours.

Improving clinical practice

Progress was made in identifying and reducing inappropriate variation in clinical practice in primary and secondary care across a number of work streams. The outputs were pulled together in a set of recommendations to be consistently applied by NWL PCTs in the 09/10 SLAs:

- A list of eight procedures were identified that should not have a routine follow-up in either acute or primary care. Attendances above a 10% tolerance level would not be reimbursed.
- A Sector-wide policy on interventions not normally funded detailing the evidence base for decisions.
- Gold standard DNA first and follow up attendance rates were agreed.
- First to follow up ratios were agreed for ten selected specialties.
- PCTs where GP Severe Acute Respiratory Syndrome (SARS) rates for the top ten specialties are either 20% below or above the GP SAR of 100 to put in place a primary / secondary / PH multidisciplinary peer review panel to determine the drivers and agree an appropriate response. However, variation in GP referral rates is a complex and multi-faceted issue. NHS Hammersmith and Fulham have since agreed to commission Imperial College to complete a detailed analysis of GP referrals and make recommendations on behalf of the Sector.

The cataract care pathway was reviewed in light of best practice evidence and standardised referral guidelines for access to hospital services were developed by the ophthalmology network and implemented.

Strengthening the provider landscape
A review of the acute provider landscape was commissioned and completed in two phases. Phase 1 comprised an options assessment of the FT pipeline and determined that not all Trusts would meet the requirements for FT status. Phase 2 modelled the impact of HfL, PCT CSPs and NWL CCI on the future financial viability and clinical sustainability of acute providers. This demonstrated that some hospitals would be left in a clinically unsustainable and / or financially non-viable position, however further work was necessary to determine the optimum configuration of services. The ISP builds on this and encompasses two themes to deliver HfL i.e. transforming acute care and transforming primary and community care.

The SPD will work closely with the ACV to ensure that commissioning consequences resulting from service reconfiguration through implementing HfL are reflected in future acute contracts.

6.2 Resources allocated to deliver the Strategic Plan

As part of the Commissioning Partnership, the SPD is resourced to enable the successful delivery of these initiatives through appropriate programme and project management arrangements. Senior Responsible Officers from amongst the PCT Chief Executives have also been identified for each key workstream.

6.3 Risk management

A risk register is maintained by the Acute Commissioning Partnership. Directors of the Partnership are responsible for ensuring that the risk register is regularly reviewed. The risk register details the nature of the risk, which is then assesses on a five point scale for both the likelihood of the risk occurring and the severity of the risk.

Directors of the Partnership are required to complete the section of the risk register which demonstrates how the identified risk will be managed and mitigated. The risk register is considered monthly at the Partnership Executive Team meeting and actions to mange the risks identified are agreed and monitored.

The top risks for the partnership, those with a risk score of 12 or greater, are reported to the NWL JCPCT. The NWL JCPCT requires sufficiently detailed risk mitigation plans to be in place to provide assurance that adequate and reasonable steps are being taken to manage the risk.

The main risks for the Sector Acute Commissioning Vehicle centre on the availability of sufficient skilled and experienced staff, especially the recruitment of skilled information analysts. The over performance on acute contracts evident in 2009/10 will lead to a very significant risk for future financial planning if it is not controlled for future years.

The risks to the delivery of the Strategic Plan come from the short timescale for the work and the complexity of the Sector. Some PCTs are already experiencing financial difficulties whilst others are able to plan to manage double running and transitional costs.

The delivery of the Integrated Strategic Plan (ISP) is dependant on the ability of the eight PCTs to plan robustly for service change consistent with the aggressive HfL implementation scenario. The significant risk is that this requires a pace of change in primary and community care which has not been demonstrated in previous years, and that the implementation of new primary care community services may slip behind plan. This would impact on the delivery of transformational change in all the settings of care.

The delivery of the plan is equally dependant on the quality of clinical engagement across the Sector, and the clinical leadership of the eventual public consultation on service change. External clinical support has been commissioned from KPMG, and local clinical leaders appointed from two of the acute Trusts and two of the PCTs.

Key Risks and Mitigation

Key Risk	Mitigation	Likelihood	Impact	Combined score
The implementation of polysystems is inconsistent and does not deliver rapid and effective service transformation across the sector	Managed sector wide workstream to support the development of polysystems and sharing best practice.	3	5	15
The financial model is based on three scenarios, which do not include the possibility of PCT allocations moving to weighted capitation over the planning period.	Further financial modelling and mitigation of downside scenarios has been undertaken by individual PCTs which are above capitation	2	5	10
Risk that the public and stakeholders do not accept the case for substantial change to deliver high quality, clinically appropriate services for the future	Communication strategy in place to deliver high quality pre consultation and public consultation work. Task and finish group led by Chair of Harrow PCT to provide assurance to NWL JCPCT on engagement work.	4	5	20
Demand for healthcare increases at a higher rate than estimated	Higher growth scenarios modelled. To mitigate growth in demand at the level seen in 2009/10 would require additional initiatives to be implemented, and the strategic programme to be accelerated.	4	4	16
Providers of healthcare are unable to deliver productivity improvement at the rate mandated by the annual tariff and move into deficit	Providers of healthcare will be supported to identify high impact productivity improvements. Options for integrated services will be explored.	4	4	16
Misalignment of workforce changes across care settings.	Sector-wide planning structures engaging employers across care settings	4	5	20
Lack of engagement and support for new ways of working from staff and/or external bodies.	Stakeholder management strategy to involve staff and external bodies (e.g. regulatory bodies, unions)	3	5	15
Lack of education and training to support new ways of working and new roles.	Sector engagement in education commissioning and engagement of education providers in service design discussions.	3	5	15

6.4 Delivery schedule and in-year monitoring of initiatives

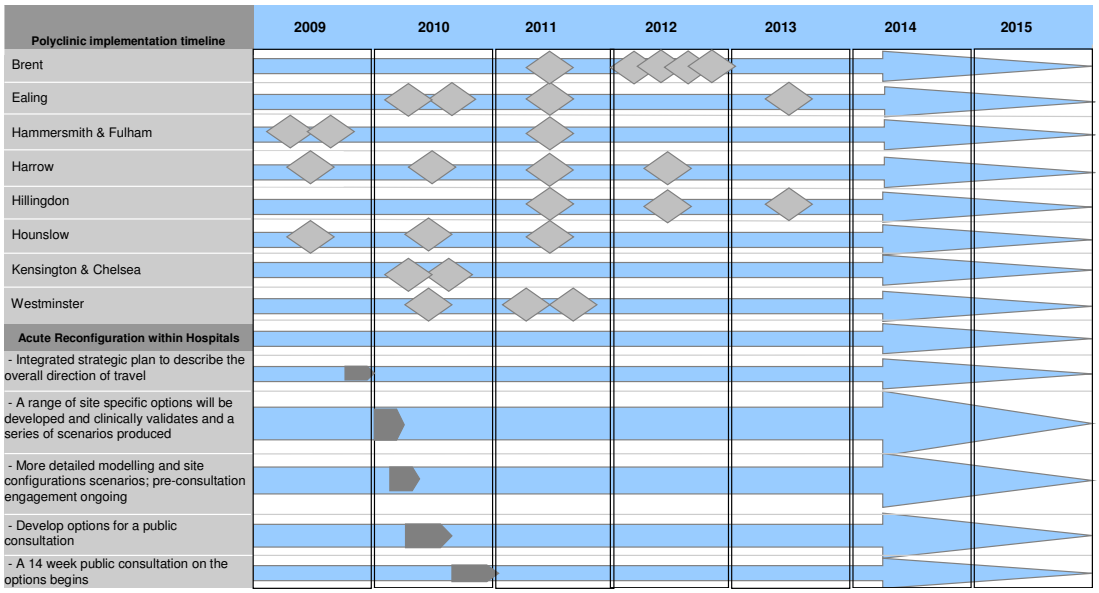
Delivery Schedule and monitoring of initiatives
Priority initiatives have been identified as the first priorities for the implementation of the HfL care pathways in the NWL Sector. The timescales are shown in the table overleaf.

The priority actions include some which are long term, and which will require full public consultation across the Sector. Examples of these are the concentration of acute surgery and of inpatient paediatrics. Others are changes which each PCT will need to implement individually, but which taken together will greatly improve the healthcare experience of people in NWL, such as expert patient programmes and end of life care.

All will improve the quality, effectiveness and productivity of health care in NWL.

Aligning the development of community and primary care with acute hospital re-configuration
The Sector acknowledges the importance of aligning polysystem development and implementation of the HfL pathways with the reconfiguration of the acute hospitals. The table below shows how the implementation timeline to deliver the planned 27 polyclinics align with the acute Sector hospital reconfiguration.

Timescale for Polysystem implementation and parallel Acute Reconfiguration
The following table shows the implementation timeline to deliver the 27 polyclinics planned in NWL and implementation timeline for acute reconfiguration. The Sector will develop a business case and consultation document for September 2010. Public consultation on proposed service change will then take until December 2010, and implementation of the service changes will follow.



Pathway Initiatives:

Page	Goal No (see p.6)	Pathway Initiatives	Responsible	Target date
		Planned Care		
29	2	Pre referral and pre operative diagnostic workups should take place in the polysystem, and not be duplicated in the hospital.	PCTs and sector	With polysystems rollout
29	1,2,3	30% of outpatient attendances should be decommissioned, (e.g. by reduction of new to follow up, determining services which do not require follow up), and 55% reprovided in polysystems. To be standardised as far as possible through sector workshops.	PCTs and sector	2010- 2014
29	3	Maximise use of designated local hospitals as elective centres	Sector	2011- 2014
29	1, 2	Drive productivity metrics to the top quartile within Trusts and primary/ community care, ensuring that poly systems are operating at an effective scale.	ACV/ SPD/ PCTs	2010- 2014
		Long Term Conditions (LTCs)		
25	1,7,8	Apply consistent care pathways across the PCTs and Trusts, initially for diabetes and COPD then expanding the range of LTCs covered over the planning period.	Sector/ PCTs	Five year programme From 2010
25	7,8	Expert patient programmes for 5 LTCs in each PCT	PCTs	5 by September 2011
		End of Life Care		
43	9	Each polysystem to include an end of life partnership, working with nursing homes to manage end of life care	PCTs	2010/11
43	9	Ensure that GPs universally apply the gold standard framework for end of life care.	PCTs	2010/11
43	9	Commission for high quality end of life care- in acute Trusts, hospices, nursing homes community and GP contracts.	PCTs/ LAS	From April 2010
		Staying Healthy		
21	6	Sector to share Best Practice examples	Sector	2010/11
21	6	PCT plans to achieve Immunisation and screening targets. Sector to share best practice examples	PCT	PCT trajectories
21	8	PCT plans to combat obesity and alcohol abuse	PCTs	Programme from 2010 to 2014

21	**7, 8**	PCT plans to manage diabetes and CVD risk **<u>Unscheduled Care</u>**	PCTs	Programme from 2010-2014
33	**3,8**	Implementation of HfL stroke and trauma service reconfiguration	Sector	April 2011
33	**2**	Develop a single point of access system for urgent care – inner NWL best practice model.	Sector and PCTs	2010- 2013
33	**2**	Primary care front end at each A&E and Urgent care centre	PCTs	2010-2015
32	**1,3**	Rationalise urgent care, including emergency surgery provision, in line with HfL and CWG/ CRG recommendations, subject to business case and consultation	Sector	2011- 2014
33	**2**	Levelling up of the quality and accessibility of primary care to a pan sector standard, using appropriate incentives **<u>Maternity</u>**	Sector/ PCT	2010- 2014
37	**3**	Configuration of maternity units in line with HfL/ CWG/CRG recommendation subject to business case and consultation	Sector	2011- 2014
38	**1**	Commissioning for quality in the maternity pathway- C section rate, patient satisfaction, NICE standards	ACV	2010-2011
38	**2**	Implement team midwifery to support choice of home birth **<u>Children's and Young peoples' services</u>**	PCTs/Sector	2011-2013
40	**2**	A strong community service, including acute nursing in the community, must be in place to support the changes in settings of care.	PCTs	2011- 2014
40	**3**	Rationalise inpatient paediatric services and implement Paediatric Assessment units at all urgent care centres	Sector	2011- 2014
40	**2,6**	Children's centres to be a spoke of polysystems	PCTs	Polysystem trajectory
40	**6**	PCTs to ensure that immunisation and breastfeeding targets are met, and to put plans in place to reduce child obesity. **<u>Mental Health services</u>**	PCTs	PCT trajectories
23	**1**	PCTs to commission dementia services per the HfL pathway, as both a long term and an end of life condition.	PCTs/ sector	2010- 2011

6.5 Enabling transformation

6.5.1 Communications and Stakeholder Engagement

As we plan and deliver the NWL strategic plan, we will engage closely with a wide range of stakeholders to ensure that the strategy is informed by and understood by them.

- We will engage stakeholders as we develop site-specific options for service change, and then we will deliver a public consultation exercise in line with London and statutory guidelines.
- We recognise that we need to improve the sign-posting of services, so patients and the public are well informed about how and where services are delivered.
- The Sector will work with the PCTs to support the local launch of polysystems and Urgent Care Centres, to generate support for and understanding of their role and capacity.
- We will commission a website that promotes information sharing between commissioners and providers and promotes patient choice.

6.5.2 Workforce

Care Settings and Patient Pathways

Delivery of the ISP will see a transformation of the workforce within and across pathways and care settings. A workforce transformation programme will deliver new ways of working, new roles and improved workforce productivity.

Workforce Productivity

Many of above re-design interventions will have an impact on both quality and efficiency. However, with the major financial pressures all organisations within the Sector will need to significantly improve workforce productivity. The transformation plan will incorporate actions to improve workforce productivity over and above those identified within the care setting and pathway plans.

Careers, Education and Innovation

The workforce transformation plan will deliver changes to careers structures under the national modernising careers agenda (i.e. Modernising Medical Careers, Modernising Nursing Careers, Modernising Scientific Careers) and the delivery of a talent management strategy. In addition, the Sector will look at alternative career opportunities for those staff in high-risk functions (e.g. administration roles). The Sector has one of only five AHSCs in the country. It also has been successful in developing a Health Innovation and Education Cluster (HIEC). The workforce transformation plan will seek to maximise the opportunities created by the AHSC and HIEC for the benefit of the Sector. We will maximise the opportunities afforded by changes to medical education commissioning and actively engage with London's education commissioning hub to ensure education meets service need.

Workforce Impact Assessment

A systematic workforce impact assessment will be conducted across care settings and patient pathways to distinguish changes relating to:

- Staffing numbers / levels
- Skills and skill-mix
- Ways of working
- Patterns & location of work
- Roles
- Knowledge and skills
- Accreditation / authorisation to act
- Terms and conditions

Workforce Interventions

The workforce impact assessment will guide the design of workforce interventions across care settings and patient pathways. These interventions include:

- Staff engagement activities
- Recruitment and workforce supply initiatives
- Retention initiatives
- Re-deployments
- New ways of working
- Role re-design
- Skill-mix changes
- Education and skills development
- Regulatory changes
- Employment contract changes
- Talent management

Change Management and Partnership Working
Stakeholder and staff engagement activities will be part of the workforce transformation plan. Changes will be managed in accordance with the Change Management principles agreed at the London Partnership Forum. The Director of Workforce Transformation will work with the Sector staff side leads as well as local HR Directors/Leads to ensure effective staff engagement and consultation.

Wider Organisational Development
The Sector will develop an organisational development plan by April 2010. A number of supporting activities have already been identified, including:

- The PCTs will consider the business case for pooling Human Resources functions across the Sector early in 2010.
- The Commissioning Partnership has assessed the skills of its team against the London commissioning competencies and identified the areas for development.
- The Commissioning Partnership will identify a programme of training and rotations to develop commissioning staff working at the Sector level and in individual PCTs. Full use will be made of the World Class Commissioning programmes offered by CSL.

Developing and Delivering the Plan
Key milestones in developing and delivering the workforce transformation plan includes:

Workforce impact assessments	Feb-Mar 2010
Stakeholder validation & prioritisation (Staffscope)	Mar-Apr 2010
Developing delivery structures & programme management	Mar-Apr 2010
Developing Sector and stakeholder programme plans	Apr-May 2010

6.5.3 Estates

The implementation of HfL will lead to significant changes in the delivery of care and the settings for the delivery of care. Delivering the service changes will depend upon making the most productive use of the available NHS Estate across the Sector. There will be very limited new capital money available; the task for the Sector will be to release cost and value from inefficiently used estate to invest in new settings of care.

PCT plans reflect the expectation that they will manage the implementation of polysystems within the resources available to each PCT. They recognise that the early polyclinics were capital intensive, and that capital will not be available for major refurbishments or new buildings in future. Future polysystems will be based upon existing high quality estate, on a hub and spoke model. Most PCTs are planning to dispose of surplus estate in order to generate capital receipts to refurbish buildings. A Sector wide view of the viability of these proposals will be completed in January 2010.

The Sector plans for transforming acute care are not yet site specific. There will be capital requirements where planned service change requires the concentration of services.

By March 2010 the plans for the Sector will be more site specific, and the Sector will then work with NHS London to develop a Sector wide estates strategy. There is potential to rationalise sites to provide the capital funding required. This will be scoped early in 2010.

The current national capital funding regime makes it difficult to work as a Sector to deliver service change. NHS London will work with the Sectors to develop a workable set of incentives for the disposal of surplus estate and the use of capital receipts at Sector level. There will also be a consistent approach across London to prioritise the use of the limited available capital funding.

6.5.4. Acute Commissioning/ Strengthening Commissioning

The Commissioning Partnership ACV will greatly strengthen commissioning through the standardisation of contracts and consistent commissioning for quality and performance improvement. The ACV will draw on the claims management function of Commissioning Support for London (CSL) to help.

The Sector SPD and ACV will support the Sector and PCTs to achieve level 3 in the majority of World Class Commissioning competencies by April 2011.

The ACV will use the national contract incentives for quality improvement (CQUINS) to drive up the quality of acute hospital services. As a Sector we are committed to reducing the variability of care across the Sector. We will work with our Clinical Directors and Clinical reference group to specify commission and monitor contracts for care pathways which will deliver consistently high quality care.

The ACV will continue to develop its extensive range of performance and quality reports, which will in future include Trust Quality accounts and a stronger emphasis on measuring the quality of patients' experience of healthcare.

6.5.5 Incentives

Acute

In 2008/09 the Sector agreed a range of procedures which were judged by the clinical reference group to offer low clinical value. The Sector also has a track record of using contractual levers to decommission outpatient follow up attendances above agreed numbers by speciality.

The Acute Commissioning team have identified contractual clauses which have not in the past been fully used, and have been successful in enforcing them.

NHS London is working with other SHAs and the Department of Health to consider how the Payment by Results (PbR) tariff and system needs to be adapted. It needs to provide the right incentives to acute Trusts to support service change.

Commissioning for Quality and Innovation (CQUIN) criteria will be applied to all acute, mental health and community provider contracts. A proportion of provider Trust's income will therefore be conditional on delivering measurable quality improvements for NWL residents.

The Sector will use these incentives to support providers, for example, to eliminate avoidable pressure ulcers, to continue to reduce hospital based infections and ensure robust communication between primary, secondary / tertiary and community providers as a priority.

From 2010, part of hospitals' income will be dependant on patient satisfaction with the service. This will be a strong incentive for the NHS to become more patient centred.

Community and primary care incentives

The Sector understands that incentives need to be right to successfully implement the HfL strategy.

Work is taking place within the Sector PCTs, and will be taking place in the Sector to engage local GPs in developing a system of incentives There are good practice examples, such as NHS Hammersmith and Fulham's QOF plus framework, and NHS Kensington and Chelsea's GMS/ PMS additional services framework. Both of these fund primary care to provide additional services which support people to access healthcare closer to home.

In the short term we will roll out these examples of incentives to other PCTs with the aim of levelling up the services offered in primary care.

The Sector will focus on the management of long term conditions as the aspect of care which has the most potential to deliver better and more cost effective care closer to home.

Over a two to five year period we will work with NHS London on this enabling strategy. This will include incentives for vertically integrated providers such as Ealing and Harrow to manage a disease group budget. We will also consider contract mechanisms for integrated care organisations based on Practice based commissioning consortia.

6.5.6 Innovation

Innovation is integral to implementing HfL with flair. Care can be brought closer to home using new technology, some services in hospital will be transformed over the next five years by new techniques, therapies and drug treatments.

The NWL Sector benefits from having the Imperial Healthcare AHSC in the Sector. The AHSC is structured specifically to promote the application and dissemination of research into practice across NWL and beyond.

NWL also has specialised resources, such as the Royal Brompton and Harefield NHSFT and the Royal Marsden NHSFT within the Sector. Together with the Chelsea and Westminster Hospital, these three specialised Trusts, located together on the Fulham Road in Chelsea, provide London wide and national specialist services. These specialist Trusts have developed innovative approaches to caring for patients in their own homes, which will be applied within polysystems.

The PCTs and Trusts have established a Healthcare Innovation and Education Cluster (HIEC) The HIEC will work to develop and spread innovative practice along care pathways, and to develop the workforce we need to bring in new models of service.

The HIEC will focus initially on pathways in two thematic areas: cancer and cardiovascular issues. These themes are aligned with the Sector health outcome priorities and the strengths of HIEC members, including the Royal Marsden, Royal Brompton & Harefield and Imperial College Healthcare.

Imperial College Healthcare NHS Trust and Chelsea and Westminster NHSFT are partners in Collaboration for Leadership in Applied Health Research and Care (CLARCH) this researches service innovations in the community to improve care for people with acute or chronic diseases.

We believe the pathways based approach will promote a patient focus. HIEC members, industry partners, and importantly patients, will contribute their expertise. Lessons learnt in one care pathway will be applied across others, to spread the benefit of innovation widely.

6.5.7 Information Management and Technology (IM&T)

The implementation of HfL is dependant on greater integration of care, and the need for this enabling strategy has been raised in all the clinical working groups.

The development of polysystems which bring together acute, primary and social care requires the integration of systems which were not designed for the purpose.

NHS London has scoped an enabling strategy for IM&T which will support integrated care across London. In some of these areas some NWL PCTs have already made good progress which can be rolled out across the Sector. The main actions planned are:

- London wide roll-out of the Summary Care Record – piloting now, to be complete in March 2011.
- NWL has developed and implemented in several areas an information sharing protocol which enables secure sharing of information between primary, acute and social care organisations. This will be rolled out in 2010.
- Inner NWL care community has successfully implemented the “Prowellness” system, which integrates care records for patients with long term conditions, initially diabetes and COPD, between primary, community and acute care.
- The roll out of image exchange systems, such as PACS, between hospitals and potentially polysystems. This will enable consistent patient care, for example between hyper acute stroke units and their networks. This will be implemented in 2010.

The Sector must now begin to integrate the development of IM&T with our pathways and care setting works. This will require a dedicated resource at Sector level, and clarity of role between the Sector, local organisations and the London wide programme, and a clear programme of delivery including the London BT contract.

7.0 Declaration of Board approval

The NWL JCPCT approved the ISP at the meeting held on 21st January 2010.

The NWL JCPCT has been involved in shaping, challenging and managing the development of the strategy through an informal seminar held in September 2009, which was externally facilitated and focused entirely on strategy and at formal Board meetings.

The NWL JCPCT considered the following strategic issues at formal Board meetings:

Meeting	Topic
12 May 2009	• Collaborative Commissioning Intentions • Improving surgical services for children and young people – approval of the project group's recommendation
5 June 2009	• NWLCP Full Business Case • Provider Landscape update • Improving surgical services for children and young people – NHSL approval of the PCBC
3 July 2009	• Improving surgical services for children and young people – confirmation from 5 OSCs that consultation is not required • NWLCP – Manifesto, Case for Change and Implementation plan, Provider Landscape phase 2 findings • Stroke and trauma consultation findings
30 September 2009	• Draft Communications and Engagement Strategy • Case for Change • ACV SLA endorsed
4 November 2009	• Feedback on ISP Case for Change • NWLCP governance arrangements • Draft commissioning intentions • NWL acute performance report • Top level risks
2 December 2009	• Draft ISP • WCC draft self assessments • NWL acute performance report • Top level risks
21st January 2010	• Final ISP • WCC self assessments • Top level risks

The eight PCT Audit Chairs have met to agree a shared assurance process for acute commissioning and the delivery of Sector plans.

The Sector Chief Executive is accountable for the ISP and the Director of Strategic Planning is responsible for its development. The ISP has been overseen by the Sector Executive Team (SET) and is advised by the Sector Clinical Reference Group (CRG), Provider Reference Group and Clinical Networks. The CRG is also responsible for reconciling the outputs from the Clinical Working Groups (CWGs); of which there are currently four. PCT CEOs undertake the role of Senior Responsible Officer (SRO) for each CWG and Sector-wide polysystem programme to lead the delivery of HfL. A Sector Strategic Planning Group works to ensure alignment between the development of the Sector ISP and the individual PCT CSPs

The NWL JCPCT has led quality and productivity improvements through the delivery of major strategic initiatives as outlined in section 5 (page 18). The NWL JCPCT is responsible for monitoring delivery of the ISP and received monthly updates on progress from the SRO. The NWL JCPCT monitors and challenges performance against each initiative through monthly progress reports outlining actions completed, next steps, risks and mitigation strategies.