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Clinical Commissioning Groups

Delivering the North West London STP urgent and emergency care priorities

Reducing the need for non-elective hospital care

This paper outlines how we will work across our STP to manage non-elective demand, mitigating growth in the system

These priorities form part of our Sustainability and Transformation Plan (STP), building on our system-wide agreed local services strategy for primary and out-of-hospital care. It focusses on high-impact changes to manage patients' needs more proactively and where possible, and clinically appropriate, to do this without being admitted to hospital.

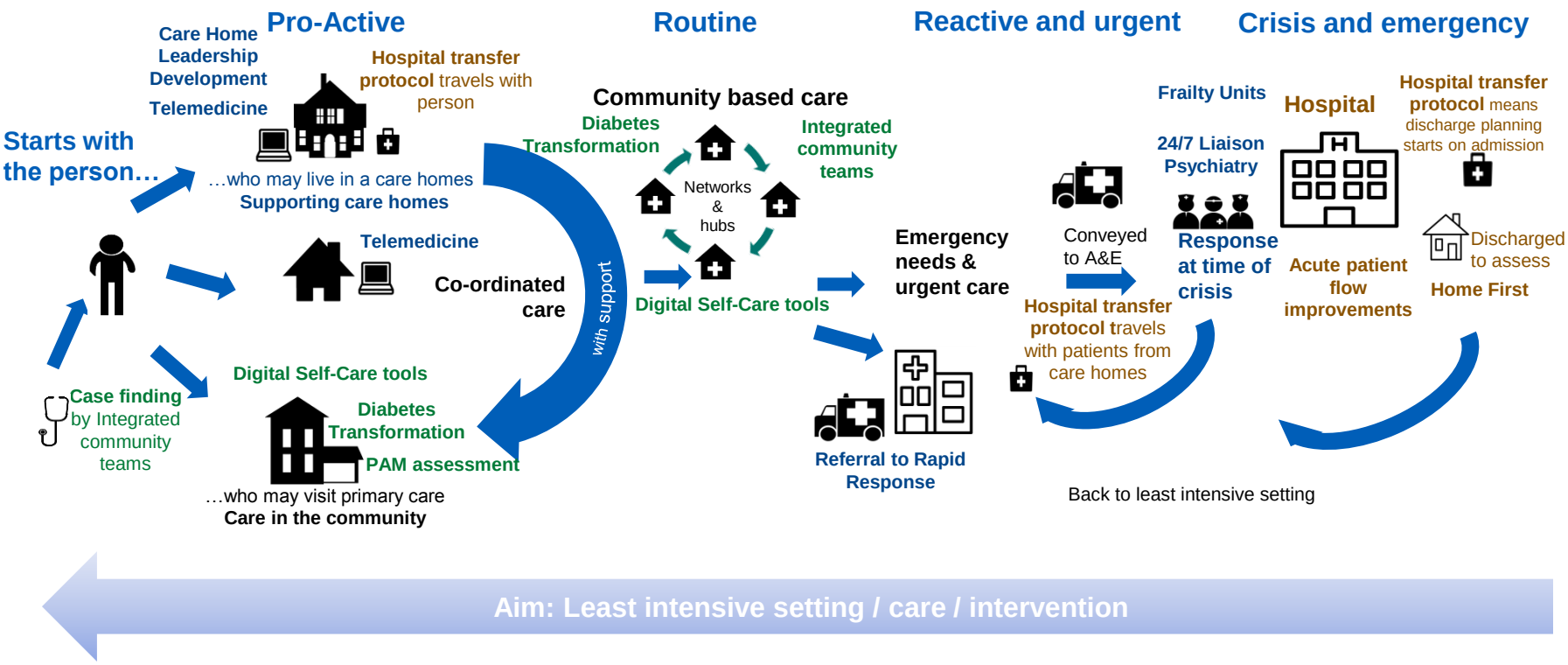
The overall aim is to reduce the need for non-elective hospital care. Improving health and care for our population, as well as the sustainability of our health and care system.

We are doing this through three key (interdependent) programmes. Work streams across these programmes are working together to improve care across the whole spectrum of non-elective activity :

- Our **keeping people well** programme proactively supports people with long-term conditions to prevent exacerbation and crisis which could lead to hospitalisation.
- When people are in crisis, our **support in times of crisis** programme ensures people receive a swift and effective package of care and out of hospital support so that they can be cared for in the home or a community setting.
- If people do need acute hospital care, our **appropriate time in hospital** programme makes sure that they see the right experts at the right time in the right place, so that they can be admitted, treated and discharged as quickly as possible.

Each of our work streams fits within the overall model of care as set out in our Local Services Strategy. It aims to meet people's needs in the most appropriate setting

Keeping People Well | **Support in Times of Crisis** | **Appropriate Time in Hospital**



Aim: Least intensive setting / care / intervention

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In order to achieve our model of care, each of the strategy's three programmes contains a number of work streams. These form the basis for implementing the strategy and realising its benefits.

Keeping people well

- Long Term Condition management: Diabetes Transformation
- Integrated Community Teams

Support in Times of Crisis

- Frailty services
- Mental health support
- Referral to Rapid Response
- Supporting care homes & people in last phase of life

Appropriate Time in Hospital

- Acute patient flow improvements – including:
  - SAFER Patent Flow Bundle
  - Red and Green days
- Home First
- Hospital Transfer (Red Bag) protocols

Programme 1: Keeping people well

What does the programme include?

Our Diabetes Transformation Programme is the first of our comprehensive programmes aimed at keeping people with long-term conditions (LTCs) well and at home

Integrated community teams (ICT) are avoiding hospital admissions by supporting patients to self-care and to be cared for in the community

Why has this programme been included in the strategy?

Keeping people well – especially those with long-term conditions (LTCs) - will reduce demand on acute hospital services by:

- **Avoiding admissions** as patients actively managing their health and care will prevent ill health and therefore acute care needs.
- **Avoiding admissions** as integrated, holistic community-based service manage long-term conditions effectively, preventing exacerbation.
- **Reducing length of stay** as community-based support facilitates faster discharge and reduces risk of re-admission.
- **Reducing length of stay** through effective diabetes management in acute settings, reducing complications.

Keeping people well

Over 38%of people admitted to our hospitals for emergency treatment have diabetes; our **Diabetes Transformation Programme** is the first of our comprehensive programmes aimed at keeping people with long-term conditions well and at home

What are we doing?

- Our programmes of long term condition management, centred around the patient, provide comprehensive services aimed at keeping people with a wide range of LTCs well and at home.
- This strategy focuses on our work with diabetes as it is our most comprehensive programme to date, and so we are keen to maximise benefit and learning for other areas.
- 38.2% of people admitted to hospital for non-elective care in NW London have diabetes.
- Our diabetes transformation programme will allow us to achieve optimum diabetes outcomes, save patients from complications and reduce costs.
- We are focused on four main areas of work:
  - Self-care and structured education: supporting those with diabetes better self-manage through tools and information
  - Integrated diabetes care: reducing complications associated with diabetes by managing three clinical treatment targets and delivering an NW London single diabetes service specification
  - A re-designed diabetes foot pathway to prevent amputation and foot disease
  - Diabetes prevention: increasing referrals to the national diabetes prevention programme

What have we achieved so far?

- Our *Know Diabetes w*ebsite has been launched
- A shared record viewable to all clinicians involved in diabetes care.
- Clear improvements in a range of clinical indicators evidenced to reduce the risk of morbidity and mortality, e.g., 3,088 patients with the NICE 3 Treatment Target controlled since June 2016
- 55k patients with a collaborative care plan allowing more coordinated care for these patients

Who will benefit?

- Adults of all ages with diabetes across NW London, **who accounted for 35, 897 admissions and the equivalent of 852 beds in 2017/18.**
- For diabetes prevention, adults of all ages across NW London at risk of developing diabetes.

Evidence underpinning our approach

- 235 **NW London GP** practices have already transformed their diabetes care –with clear improvements in a range of clinical indicators.
- **RAMP-DM, Hong Kong:** In over 121k patients, 66% reduction in mortality, 41% reduction in emergency attendance and 59% reduction in admissions at 5 years.
- **Camden:** integrated unit covering the whole CCG area has led to decreases in numbers of emergency admissions due to diabetes and numbers of people developing complications.

Delivery area 2 - Better care for people with long term conditions.
Providing the right care every time to prevent serious illness

Keeping people well

Integrated community teams are avoiding hospital admissions by supporting patients to self-care and to be cared for in the community

What are we doing?

- Avoidable admissions for patients across NW London are being reduced through embedding an integrated model of care that enables patients with long term conditions (LTC) to plan and manage their own care by themselves, with carers and/or with community support.
- NW London is a pioneer for integrated care and each borough has its own care model for bringing together a multidisciplinary team to proactively meet the needs of patients with LTC. Whilst all CCGs have implemented this for three years, West London and Hillingdon CCGs demonstrate the most significant admission reductions. They are amongst 15 nationally that have reduced both total emergency admissions, and admissions per capita, over the last two years.
- Future work focuses on learning from key success factors and adapting care models across NW London to reflect best practice, including in areas such as: risk stratification and case finding, multi-disciplinary case management and use of the patient activation measure (PAM) assessment to support patients to set and achieve self-care goals, with appropriate monitoring.
- Implementing this model across NW London reduces hospital admissions, supports earlier discharges, and supports patients to self-care and be cared for in their own home for longer.

What have we achieved so far?

- All NW London CCGs and boroughs have integrated care models in place. We now need to learn from those which have had greatest success in improving outcomes – West London and Hillingdon.
- Hillingdon had seen the fourth biggest reduction nationally (13%) in total emergency admissions, and admissions per capita, over the last two years. West London had achieved nearly 10%.

Who will benefit?

- Patients of all ages across NW London who are eligible for integrated care in their boroughs.
- The initial focus will be on frail patients.
- **In 2017/18, patients who could be managed through primary care accounted for 36,033 admissions and the equivalent of 748 beds in 2017/18.**

Evidence underpinning our approach

- In **West London**, GPs report working more effectively and no patients enrolled had not had a health crisis since being case managed.
- Since 2014, **Hillingdon's** Care Connection Teams have delivered a 15% reduction in older people (65+) NEL admissions.
- **Islington** CCG PAM data suggest non-activated patients are 38% more likely to attend A&E than activated patients.

Delivery area 2 - Better care for people with long term conditions.
Supporting people to take control of their own health

Programme 2: Support in times of crisis

What does the programme include?

Proactive Frailty Services will avoid admissions by providing a holistic response for frail older people.

Mental health support is about building capacity in local mental health units and providing 24/7 access to specialists for people in crisis

Referral to rapid response will reduce admissions by providing immediate care assessment and brief care interventions in the community

Supporting care homes and people in last phase of life will help care home staff and carers to manage patient care in the community

Why has this programme been included in the strategy?

Supporting people in times crisis by providing them with care and advice in the community, without an admission to hospital, will reduce demand on acute hospital services by:

- **Avoiding admissions** as patients receive suitable interventions to manage crisis either in community settings, or more swiftly in acute settings (preventing acute attendances converting to admissions)
- **Reducing length of stay** as co-morbidities between mental and physical health are managed effectively in acute settings (liaison psychiatry).
- **Reducing length of stay** as patients with more effective community-based support can be discharged sooner.

Support in Times of Crisis

Proactive Frailty Services will avoid admissions by providing a holistic response for frail older people.

What are we doing?

Our new proactive frailty service model that is being implemented across NW London will reduce avoidable admissions of frail older people (65+) who present in A&E in crisis. The service is being developed in phases. Initial implementation has focused on acute-based frailty units but there are five elements in total to be developed:

1. **Acute-based frailty units:** frailty teams will operate in all A&E sites, reflecting peak hours of presentation.
2. **Acute ambulatory care:** to support the emerging acute frailty pathways in A&Es, this will create streamlined access to ambulatory care services.
3. **Community frailty teams:** this will shift the focus of the service away from an acute hospital setting, using MDTs to proactively manage care in the community.
4. **Community ambulatory care:** ambulatory care pathways will also shift focus into a community setting.
5. **GPs, practices and primary care:** the GP Forward View focuses proactive management of frailty through regular reviews and falls risk assessments. This works in parallel with other elements of the programme.

Taken together, these interventions will better enable frail patients to stay well and independent for longer by providing treatment and care that allows them to stay in their own home and avoid the clinical risks associated with hospitalisation.

What have we achieved so far?

- A small scale pilot initiative ran at Ealing hospital in 2017. This showed an opportunity to run a proof of concept pilot in Northwick Park.
- Frailty standards agreed with NW London geriatricians group, including standard frailty assessment tool.
- A pilot of the community frailty unit is in operation in West London.

Who will benefit?

- Acute based frailty units will benefit frail older people (65+) who present to in A&E in crisis.
- In future years, proactive management by community teams will benefit people with frailty of all ages.
- **These patients accounted for 45,519 admissions and the equivalent of 1,059 beds in 2017/18.**

Evidence underpinning our approach

- A small scale pilot initiative ran at **Ealing hospital** in 2017. Of the 29 patients who were seen during the pilot, 67% were able to go home on the same day and were not admitted. The baseline admission rate is around 70%, suggesting that this model presents a significant opportunity to deliver care in a different way.
- **Leicester:** NEL admissions reduced by 20-30% and LoS by 0.5 days.
- **Poole:** 42% reduction in the number of care of older people bed days.
- **Royal Free Hospital:** same day discharge increased from 12% to 16% and LoS reduced by an average of three days per patient.

Delivery area 3 - Better care for older people.
Getting the whole health and care system working together for older people

Support in Times of Crisis

Mental health support is about building capacity in local mental health units and providing 24/7 access to mental health specialists for people in crisis through acute trusts and through direct referral

What are we doing?

Mental health support reduces avoidable admissions and length of stay for patients with mental health conditions by:

1. **Offering a 24/7 liaison psychiatry service (LPS):**

- In acute trusts a psychiatric liaison team is available 24/7 to provide a timely and responsive assessment and care to patients in mental health crisis**.** These teams assess patients in A&E within 1 hour of referral and patients on wards within 24 hours of referral.
- Wider work to reduce unnecessary A&E attendances of people in mental health crisis focuses on providing access to alternative support by Community Crisis Teams.

2. **Implementing Single Point of Access (SPA):**

- Single point of access (SPA) helplines provide 24/7 access to trained mental health advisors and clinicians who can offer help or advise to patients and carers in a crisis. GPs and police colleagues can also call the SPA for advice or to make referrals.

3. **Increasing capacity in mental health units:**

- Mental Health (MH) trusts are implementing Red to Green days to improve patient flow and increase bed capacity so patients in MH crisis are quickly transferred to the appropriate place of care. They are also working to reduce long stays (>50 days) to improve flow.

What have we achieved so far?

- Flow improvements at West London Mental Health Trust (WLMHT) has increased the average number of available mental health in-patient beds from 5 to 14.4 and there is a downward trend in patients staying over 50 days.
- Liaison Psychiatry Teams operate during normal hours in all acute trusts
- The 24/7 SPA helpline launched in 2016 has received over 5,000 calls for people managing a mental health crisis.

Who will benefit?

- Patients presenting at A&E or on acute wards who have an identified mental health need.
- **This group of pepole accounted for 23,863 admissions and the equivalent of 545 beds in 2017/18.**
- Our longer term changes will also benefit patients with mental health needs in the community.

Evidence underpinning our approach

- Analysis of **RAID in Birmingham** found reduced length of stay with 9,290 bed days saved over the 8-month study period, from a total of 2,497 referrals (equivalent to 13,935 bed-days in a full year).
- Implementing the RAID model across **four East London Hospitals** showed a decrease in length of stay for patients with mental health and drug and alcohol problems of approximately 2833 bed days in 2014/15, driven by a reduction in non-elective patient bed usage.

Delivery area 3 – Improving mental health services.
Crisis care

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Support in Times of Crisis

Referral to rapid response will reduce admissions by providing immediate care assessment and brief care interventions in the community

What are we doing?

- Rapid response is a highly responsive multidisciplinary community team providing assessment and short-term treatment for adult patients with urgent needs, available in all NW London boroughs. Patients access the services via a number of referral routes, with most referrals being from GPs.
- NW London started the redesign of its Rapid Response services in 2009 and this work has now taken place across all 8 CCGs. We now have Rapid Response services working 7 days per week for the whole population of NW London.
- Currently, NW London operates a rapid (within two hours) Multi Disciplinary Team assessment and care planning. Teams include nurses and therapists with access to medical and social care resource.
- We are now working to deliver consistent outcomes across the region through standardising our approach and sharing best practice across our Boroughs.
- The service will expand to serve more people via more access routes, providing a more comprehensive service. We will also extend rapid response teams to include mental health and social care expertise, in line with practice elsewhere, and ensure that services are integrated with pre-crisis patient care management in primary care, in particular for frailty syndromes.

What have we achieved so far?

- Rapid response services are in place in all eight NW London CCGs.
- A prevention of admission pathway has been in place with LAS since April 2017.

Who will benefit?

- Patients fulfilling the criteria for referral to the service (varies by Borough).
- **People who could use these services instead accounted for 666 admissions and the equivalent of 6 beds in 2017/18.**
- Wider rapid response impact is realised from delivery within integrated community teams (for which rapid response is a fundamental part).
- LAS referrals release ambulance resources to attend to other patients.

Evidence underpinning our approach

- Reporting of **Brent STARRS** indicates 2,325 admissions avoided in 2014/15, and 2,539 in 2015/16. Conversion rates from referral to avoided admission are consistently 80-90% per month.
- Other NW London boroughs are also avoiding significant numbers of admissions, including 1.546 in **Ealing** and 1,981 in **Hounslow** in 2016/17.
- The **South Manchester Rapid Response Service** resulted in 293 non elective admissions being avoided, from 319 referrals.
- In **Kent,** of 342 referrals recorded as being made to avoid admission, 94.4% of patients were discharged to their usual place of residence, avoiding admission.

Delivery area 3 - Better care for older people.
Getting the whole health and care system working together for older people

Support in Times of Crisis

Supporting care homes and people in last phase of life will avoid admissions by helping care home staff and carers to feel manage patient care in the community

What are we doing?

Avoidable admissions from care home and last phase of life patients will be supported in two ways:

1. **Through a leadership development programme and acuity and dependency tool:**

- Funding for the Care Home Manager Leadership Programme has been secured for up to 100 out of 140 care homes.
- The acuity and dependency tool informs care home staff about dependency needs of residents so that they identify those at risk of admission and manage their care pro-actively before they reach crisis.

2. **Through supporting care homes, and patients in the community, through telemedicine:**

- By April 2018, all care homes in NW London will have a telemedicine service staffed by a specially trained nursing team who have access to patients' primary care records. This involves 111 calls being re-routed or through the use of video technology.
- Admission avoidance targets from telemedicine in care homes have been agreed and a dashboard is in place to monitor these targets.
- Following successful implementation and evaluation of telemedicine for care homes, phase two will be implemented to provide telemedicine support to people in the last phase of life in the community.

What have we achieved so far?

- A pilot providing care homes with 24/7 access to clinical advice pan-London showed a 6.5% monthly decrease in care home 999 calls. Some providers also had access to video-conferencing facilities.
- Service design and planning for telemedicine implementation in care homes has been completed.
- Video conferencing procurement has commenced.

Who will benefit?

- All care home residents across NW London will benefit from improved care home leadership.
- All patients in their last phase of life will also benefit from telemedicine, both those in care homes and those in their own homes. **This group of people accounted for 27,197 admissions and the equivalent 674 beds in 2017/18.**

Evidence underpinning our approach

- Across **NW London**, care homes patients account for 4% of A&E attendances and 8% of NEL admissions.
- The **Airedale** Vanguard tele-health hub has shown a 37% reduction in NEL admissions from care homes.
- **Ealing CCG** has an enhanced primary care service for care homes. Since 2013, NEL admissions from care homes have decreased by 7% year on year despite rising acuity. Length of stay is decreasing.

Delivery area 3 - Better care for older people.
Last phase of life

Programme 3: Appropriate time in hospital

What does the programme include?

Acute patient flow improvements are reducing length of stay at NW London acute hospitals.

Home First will support timely discharge from hospital by assessing patients in their home environment to make informed choices about long term care.

Hospital transfer (Red Bag) protocols will support patients to have a swift journey through our hospitals by providing documentation that can speed up care decisions.

Why has this programme been included in the strategy?

Ensuring that patients receive care in an efficient and effective manner in hospital - and that they are discharged as soon as they no longer need acute care - will reduce demand on acute services:

- **Reducing length of stay** by progressing patients from admission to discharge as efficiently as possible.
- **Reducing length of stay** by discharging patients into the community as soon as they no longer need acute treatment.

Appropriate Time in Hospital

Acute patient flow improvements are reducing length of stay at NW London acute hospitals.

What are we doing?

- We are reducing length of stay for patients in hospital through a wide range of patient flow programmes across our acute trusts.
- To develop a seven-day model of care that prevents unnecessary waits for patients, pilot projects to improve patient flow have been implemented and evaluated.
- Those showing clear benefits will then be rolled out more widely. Two flow programmes are being implemented by all Trusts across the region:
  - SAFER Patient Flow Bundle
  - Red and Green Days
- Each Trust also has a wide range of initiatives in place designed to improve flow throughout the non-elective pathway.
- These programmes will ensure that patients stay in hospital for no longer than clinically required.
- Patients will receive value adding care only and can progress towards discharge in the timeliest manner, improving patient experience and avoiding risks of increased length of stay including muscle deterioration, infection and pressure ulcers.

What have we achieved in this area so far?

- A number of initiatives have been piloted and analysed. Those showing a clear positive impact are now being rolled out.
- All of our acute Trust have programmes in place to improve non-elective flow. These will be developed in future as new initiatives come on-stream.
- The pilots implemented across NW London, along with trust-level flow initiatives, have had a combined impact of a 10% LoS reduction for patients (65+) across NW London providers.

Who will benefit from this change?

- All patients accessing acute care.

Evidence underpinning our approach

Pilots have shown a LoS reduction of:

- 1.0 days from weekend therapies
- 1.4 days from weekend pharmacy TTAs
- 0.6 days from increased weekend downstream medical cover.

Delivery area 5 – Safe, high quality and sustainable hospital services.
Getting hospital patients better, quicker

Appropriate Time in Hospital

Home First will support timely discharge from NW London's hospitals by assessing patients in their home environment to make informed choices about long term care.

What are we doing?

- Home First is a model of care where the assessment of a patient's ability to successfully function and carry out their normal daily activities is performed in their own home and not in a hospital bed.
- All acute Trusts in NW London have been piloting a Home First service. A core deliverable of the workstream has been the consolidation and simplification of existing discharge pathways**.**
- By 2020/21 all acute trusts in NW London will be moving away from piloting Home First to operating a Home First service as 'business as usual'.
- The Home First pathway provides significant opportunity to reduce length of stay and reduce the need for longer-term care packages.
- However, following successful implementation and service evaluation of Home First, increased length of stay reductions will be gained through piloting and implementing the approach with patients with more complex needs that need step-down or long term care packages.

What have we achieved in this area so far?

- All 8 boroughs across NW London have designed and tested a new Home First pathway, and are now focused on implementation and sustainability.
- Over **1500 patients** have been discharged successfully in the initial six months of project delivery (as of Feb 2018).
- Work on discharge pathway and capacity mapping has been completed.

Who will benefit?

- Patients who are medically fit to be discharged form acute hospitals, but who require further support at home or in the community (other than those in care homes).
- **This group of patients accounted for the equivalent of 656 beds in 2017/18.**

Evidence underpinning our approach

- **NW London:** Hillingdon Hospital's 8 week Home First pilot in mid 2017 found a 2.2 day reduction in average length of stay. This represents 158 bed days saved over pilot period.
- **Medway**: 25% reduction in 'Delayed Transfer of Care' rates after initial 3 months.
- **South Warwickshire:** reduced average LoS for over 75s by 19.4% (7.7 to 6.2 days) in 4 years, and by 24% for whole population (12.6 to 9.5 days).

Delivery area 3 - Better care for older people.
Home from hospital

Appropriate Time in Hospital

Hospital transfer (Red Bag) protocols will support patients to have a swift journey through our hospitals by providing documentation that can speed up care decisions.

What are we doing?

- **Hospital transfer (Red Bag) protocol –** a 'Red Bag' contains standardised documentation about a care home patient to facilitate quick clinical decisions in a hospital environment.
- It impacts on length of stay by:
  - Providing A&E assessors with the information they need to make decisions about the best pathway for the patient – limiting time spent in A&E
  - Providing ward staff with information they need to speed up care decisions
  - Facilitating direct liaison between ward and care home staff about discharge planning, so that discharge planning can start as soon as possible.
- The hospital transfer protocol is supported by in-reach training for care home staff about how to maintain high-quality information in the red bags.
- Local plans for roll out are being scoped and developed. Implementation will be complete by April 2018.
- Following implementation, further process changes in acute settings will be identified, as well as linking red bag contents with care planning.

What have we achieved in this area so far?

- Plans are being finalised for the roll out hospital transfer protocols across care homes for older people (65+).
- The current scope is older people in care homes, however, Hillingdon and Hounslow have plans to extend the use of Red Bags to mental health, physical disability, learning disability and sheltered housing services.

Who will benefit?

- All care home residents in NW London who access acute care. Patients who could benefit from this **accounted for the equivalent of 235 beds in 2017/18.**
- Later phases will further benefit care home residents by linking with care planning and other public services.

Evidence underpinning our approach

- Early monitoring of the impact and outcomes of the **Sutton CCG Red Bag Vanguard** has show that length of stay is 3 to 4 days shorter for care home residents who have had a Red Bag than those without a Red bag.

Delivery area 3 - Better care for older people.
Getting the whole health and care system working together for older people